Management Summary

(Annual Performance Report)

October 1, 2012 – September 30, 2013

103 West U. S. 2

Wakefield, MI 49968

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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 Recipient Rights Advisory Committee and the Consumer Advisory Council.

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, 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 Human Resources, 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 developmental disabilities, and/or co-occurring disorders. The Clinical Services Director is also responsible for the following services: psychiatric, crisis/emergency services, preadmission inpatient psychiatric screening, jail diversion and OBRA. The Clinical Director directly supervises the Crisis Intervention/Utilization Management Coordinator, Children's Community Services Supervisor, ACT Supervisor, Adult Community Services Supervisor, psychiatrists, and agency physician.

Community Services Director: The Community Services Director is responsible for services for individuals with developmental disabilities. The Community Services Director supervises the Health Services, Rehabilitation, and Residential Services programs.

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. Reports derived from investigations are given to

appropriate supervisory personnel for disposition. The RRO chairs the quarterly Recipient Rights Advisory Committee meetings.

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 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 & Risk Management Committee Chairperson, the Medical Records Coordinator, and representatives from the 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.

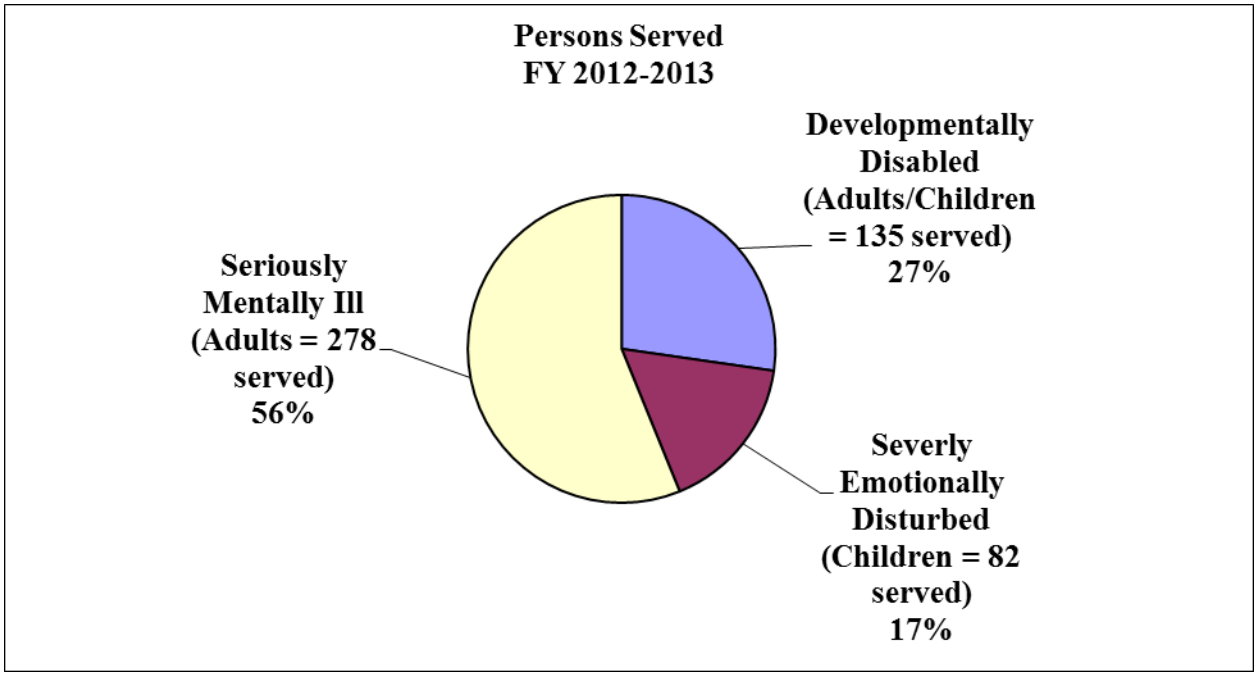
Maintenance Coordinator: The Maintenance Coordinator is responsible to perform light repairs, snow shoveling/blowing/plowing, maintain buildings and grounds, coordinate agency vehicle maintenance, assist with building security and safety, and coordinate maintenance and repairs with the lessee when a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

Available Services

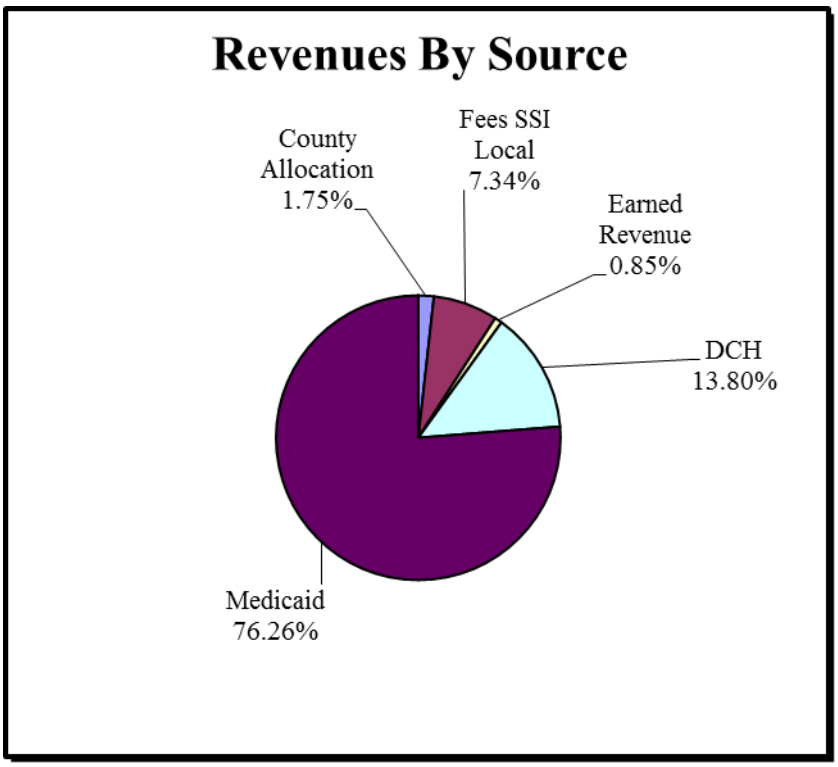
CMHA provides a variety of services for consumers with a serious mental illness, serious emotional disturbance, and/or co-occurring disorder, and a developmental disability. Some of the services include Community In-patient, Case Management/Supports Coordination, Therapy, Jail Diversion, Medication Administration, 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/Supports Coordination, Community Housing (Residential), Employment Services (Supported Employment), Crisis Intervention (Emergency Services), and Assertive Community Treatment.

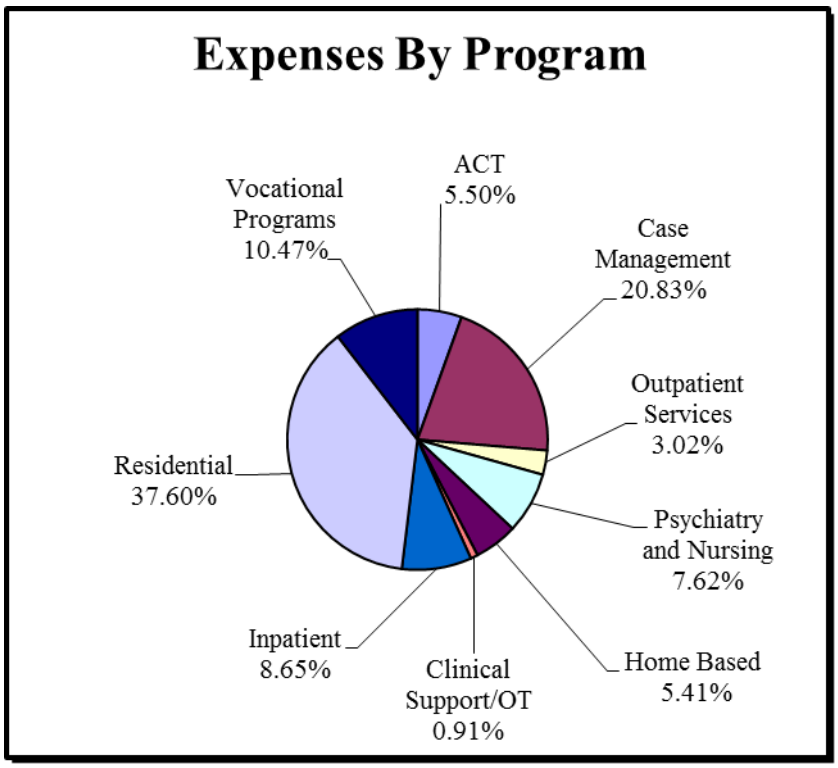
Persons Served

An unduplicated count of 495 individuals received reportable services during FY 2012-2013; a break down per population is shown in the graph.



Financial Profile
FY 2012 – 2013





OFFICE OF RECIPIENT RIGHTS

Site Visits By Rights Office Staff
Ten (10) visits to various sites, includes 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 = 21, Refresher Rights = 93, Incident Reporting = 9, Grievance & Appeals = 35

Training Received By Rights Office Staff (Training that fulfills RRO requirements)
Recipient Rights Officer received 6 hours of training (Diversity: Embracing Diversity in the Workplace; NorthCare Customer Training; Health IT for Primary and Behavioral Healthcare; Code of Ethics; Trauma Informed Primary Care).

Complaints Received
Three (3) complaints were received (two received last fiscal year); one was investigated and found to be substantiated and the other two were outside the agency's jurisdiction.

Incidents
One-hundred eighty (180) incidents occurred, a significant decrease of 141 from last fiscal year (total incidents last fiscal year were 321); the decrease was due, in part, to internal procedure changes pertaining to group home medication administration records. The number of medication refusals decreased, as well, from prior years, which could be attributed to 'transient' residential consumers who may experience clinical instability which may result in refusing to take their prescribed medication. Medication refusals are not "unusual incidents"; however, they are monitored for consumer health and safety. Agency RN's also worked with and provided medication training to residential and Community Living Support staff. Fifty-two (52) different consumers were involved in the various incidents, a decrease of four consumers from last fiscal year. The QI/UM Committee, the Safety Committee, and the Pharmacy & Therapeutics/Medical Services Committee 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.

Origination of Incident	# of Incidents	Category of Incident	# of Incidents
Lakeshore Home	47	Minor Injuries (no ER visit/admit to hospital)	27
Lakeview Home	68	Injuries requiring ER visit/admit to hospital	1
Greenbush Home	29	Serious Challenging Behavior	78
CMH	2	Medication Related	29
Community	34	Physical Illness Requiring Admit to Hosp	1
		Falls	22
		Arrest	5
		ER treatment due to injury or med incident (no hospital admit)	3
		Physical illness/ER visit only	4
		Admit to inpatient psychiatric unit	1
		Hospital admission (planned surgery/chronic illness)	1
		Death	2
		Other/Unknown	6

Quality Assessment and Performance Improvement Program (QAPIP)
Outcomes Summary for FY 2012 - 2013
(with Quality Improvement Plans for FY 2013-2014)

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 develop, implement and monitor all aspects of the QI program.

Utilization Management (UM)

- The UM Coordinator and/or 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 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 conducted 35 disaster drills in the CMH main building (32 last fiscal year) and Drop-In Center staff conducted 15 disaster drills at the Drop-In Center (10 last fiscal year); residential safety data can be found in each group home. In addition to the drills conducted, there were three "actual" medical emergencies, one "actual" power outage, and one "actual" gas leak during the fiscal year, with appropriate follow-up by CMH staff for all actual events. There were 47 vehicle inspections (seven more than last fiscal year) performed on agency fleet vehicles and 46 inspections were performed on vehicles utilized in the residential settings (two less than last year). Building inspections at the CMH main building continue to be conducted on a quarterly basis; any follow-up action needed was documented on the Internal Inspection Checklist and completed by the Maintenance Coordinator. Thirteen internal inspections were conducted among the three residential group homes (same as last year). The annual "external" building inspection, that required no follow-up action, was completed on October 15, 2012 by a Michigan Certified Building Inspector. On May 30, 2013, the Senior Loss Control Consultant from Citizen's Management Inc (Workman's Comp Carrier) conducted a workplace hazard assessment at the Lakeshore Group Home with no issues identified.
- Thirty-eight (38) different safety trainings were conducted (i.e., CPR and First Aid for both child and adult, OSHA/Blood Borne Pathogens, medication prompting, medication payment authorization, psychiatric medication, seizures, Type 2 Diabetes, visual impairment, Rett Syndrome, OSHA Globally Harmonized System-Revised Hazard Communication Standard, power outages, gas leak emergency, violence in the work place, consumer lifting/transferring, driver safety, initial and refresher non-violent crisis intervention, CMHA disaster drill plan/paging procedures, etc.). For optimal consumer safety using the least restrictive approaches and through the person-centered planning process, CMHA's Occupational Therapist also addressed consumer-based fall prevention, lifting and transferring guidelines, mobility guidelines, adaptive equipment needs, durable medical equipment needs, and safe swallowing/feeding guidelines. The Safety Committee was committed to providing on-going safety awareness for all employees and consumers by conducting various safety activities/projects and by providing safety information to

new employees during orientation and to all employees throughout the year via paycheck stuffers, memos, and posters.

- There were a total of 13 staff injuries (an increase of two from last fiscal year) resulting in a total of one lost work day, compared to 110 lost time days last fiscal year (24 lost days in FY 11-12 and 86 lost time days carried over from FY 10-11). The Safety Committee reviewed all staff injuries on a monthly basis with analysis and follow-up recommendations, as appropriate.
- Through the QI process, consumer incident reports continue to be monitored. The Person-Centered-Planning Team continues to address individual consumer risk for falls with follow-up intervention as directed by the PCP team, including medication reviews, fall-prevention guidelines, and assessment for adaptive equipment needs such as mechanical lifting devices, walker, cane, gait belt, wheelchair, etc.
- 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.
- In May 2013, the Loss Prevention Consultant from the agency's workman's compensation carrier met with the Safety Committee for the purpose of reviewing CMH's reported worker's compensation claims and providing risk management recommendations to reduce future workplace accidents and injuries. There were seven workman's comp claims in 2012 with an incurred cost of $5,376.75 compared to four claims in 2011 with an incurred cost of $33,464.
- 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 (P & T) Committee is now combined with the Medical Services group, meeting every six weeks. The Committee consists of all agency RN's, the agency's Clinical Director, Drs. Joe & Jan Cools, and Dr. Rocco. The group reviews and monitors medication incidents, discusses all pertinent medical issues and reviews data from the Physician Peer Reviews. Agency RN's continued to review agency policies/procedures/forms to assure on-going compliance. Infection Control meetings were also held periodically throughout the fiscal year.

➢ *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 Committee responsibilities.

Strategic Plan

- Goals and objectives continued to be reviewed and monitored quarterly.

➢ *QI Plan*

- Develop new goals and objectives for FY 2013-2014. Maintain quarterly monitoring of the Plan.

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 (Member) Services continued to be monitored, as well. OMS data for the fiscal year shows 56% overall compliance, the same as 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; various reasons for non-compliance were discussed at

staff meetings, as well. The OMS work groups reviewed the goals and objectives and the Program Descriptions and Plans and modified them as needed for FY 2013-2014.

- *Michigan Mission-Based Performance Indicators* ~ Of the five indicators monitored, four have an established compliance rate of 95%; compliance *exceeded* the established 95% standard, scoring 100% every quarter for each indicator except for three quarters scoring below 95% and one quarter one indicator was not applicable. There is one indicator having 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% for both populations for the 2nd and 3rd quarters; the 1st quarter was not applicable as there were no discharges and the 4th quarter had two readmissions out of four discharges, for non-compliance at 50%.
- *Pre-paid Inpatient Health Plan (PIHP) Performance Indicators* ~ The indicators monitored mirror those above, 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 95% standard at 100% for each standard, every quarter except for two quarters of non-compliance and one quarter one indicator was not applicable. For the indicator having a '15% or less' standard, this CMH was compliant, scoring 0% for both the child and adult populations for the 2nd and 3rd quarters; the 1st quarter was not applicable as there were no discharges and the 4th quarter had one readmission out of three discharges, for non-compliance at 33%.

➢ <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) ~ The Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program contract between the Michigan Department of Community Health (DCH) and NorthCare Network, the Prepaid Inpatient Health Plan (PIHP), contains standards for implementing the QAPIP. The standards published by the Centers for Medicare and Medicaid Services (CMS) require that the PIHP "conducts performance improvement projects (PIP) 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 enrollee satisfaction." Two PIPs were required, the first project topic was mandated by the State and the second project topic was the choice of the PIHP.

➢ <u>Project #1~Increasing the proportion of Medicaid eligible adults with a mental illness who receive at least one peer delivered service or support</u>. (FY's 2010-2011 and 2011-2012) This PIP was to be completed at FY 12 year-end, however, NorthCare continued this PIP for FY 13.

- At the beginning of this PIP, NorthCare's goal was "*12% of Medicaid eligible adults with mental illness, who have a reported encounter to the state's data warehouse, would receive at least one peer delivered service or support*". Baseline performance measurement was calculated for FY 09-10 and out of 2,596 Medicaid eligible adults with mental illness, 254 (9.78%) received a peer delivered service or support - less than NorthCare's goal. Post intervention performance was calculated at the end of FY 10-11; out of 2,629 Medicaid eligible adults with mental illness, 265 (10.08%) received a peer delivered service or support. Although the region did not realize a statically significant increase from the prior fiscal year, regional interventions implemented to date were successful and resulted in a 0.3% increase.
- FY 12 data showed out of 2,661 Medicaid eligible adults with a mental illness, 282 (10.6%) received at least one peer delivered service or support. Although this is an increase from 265 in FY 11, NorthCare's goal of 12% still was not met. Per NorthCare's report for this

project, they noted "*NorthCare is disappointed with the data results for the past six months. We do not believe the data accurately reflects the commitment the region has to provide peer support to the individuals with mental illness who either request a PSS service or staff encourage consumers to explore such an opportunity. Quarterly data comparisons show decreases in the number of adults with a mental illness who are receiving a peer-delivered service or support. We have identified four issues that may have contributed to this reduction.*"

- FY 13 data, as of 09/13/13, shows the need for regionally, 42 additional adults with mental illness to received Peer Support Services.

➢ Project #2~Reducing the Rate of (Medicaid) Adults who are Readmitted to an Inpatient Psychiatric Unit Within 30 Days of Discharge ~ This study is intended to identify and implement interventions that will increase the quality of care while inpatient and upon discharge, reducing the likelihood of adults being readmitted to a psychiatric inpatient unit within 30 days of their discharge. This project continued since FY 10 and in FY 11, the Medicaid *children's* population was included in the project as well as adults. This is also a Performance Indicator monitored quarterly (as noted above in the *Performance Indicator* section). FY 13 data is shown below:

Medicaid Beneficiaries Only	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**
Table 6 Indicator 12 % of Medicaid beneficiaries readmitted to an inpatient psychiatric unit w/in 30 days of discharge. (exceptions removed from #'s)	Child: 0/0=NA Adult: 0/0=NA **Total: 0/0=NA**	Child: 0/1=0% Adult: 0/3=0% **Total: 0/4=0%**	Child: 0/1=0% Adult: 0/0=NA **Total: 0/1=0%**	Child: 0/1=0% Adult: 1/2=50% **Total: 1/3=33%**
Standard=15% or less Standard Met?	**NA**	**Yes**	**Yes**	**No**

➢ *QI Plan*

- Participate in the region's new performance improvement projects for FY 14: (1) Engagement in Service, which is a clinical project that will focus on increasing the number of persons served by reducing the number of consumers discharged from services due to no-shows; and (2) Follow-Through in Addressing Identified Health and Safety Concerns, which is a clinical/ patient safety project that will focus on activities to ensure adequate follow-up is provided for children when health and/or safety concerns are identified in the bio-psychosocial assessment.

Record Review and Service Verification

- Record reviews continued to be conducted quarterly with data analysis reports developed. One hundred eighty-four (184) consumer records were reviewed for FY 13. Of the 29 indicators monitored, 6 indicators scored as "met" (95% or higher) for 21% compliance (39% last fiscal year). Despite development of various checklists to assist staff with required documentation, on-going education, training, and in-services for providers regarding the record review process, a number of indicators continued to be non-compliant for anywhere from five to 14 consecutive quarters.
- 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 97% compliance for Indicator 2.04 (*IPOS clearly indicates services and supports including: amount, scope, and duration*); 88% compliance for Indicator 2.09 (*Frequency of FTF contacts identified in the IPOS match services received or documented why not*); and 94% for Indicator 2.10 (*IPOS is reviewed/updated per agency policy [frequency of periodic reviews occurs as noted in IPOS]*).

- Highline Service Verification: Twelve consumer charts were reviewed for the fiscal year. All scoring sections (as many as 108) were found to be 100% compliant for the entire fiscal year.
- NorthCare conducts *Medicaid* Service Verification and the two Indicators monitored ("*Was the Medicaid service identified in the Individual Plan of Service?*" and "*Was there documented evidence in the record that the Medicaid service was provided?*") both scored 91.2%.

➢ *QI Plan*
- Continue CMH quarterly record reviews and data analysis reports.
- Discuss ways to increase compliance for those record review indicators consistently non-compliant.
- Continue record review education and training for staff.
- Submit and monitor the plan of correction regarding NorthCare's Service Verification review.

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 (Member) Services, representation on the CMH Board and various committees. There were seven suggestions received via the suggestion box for the entire fiscal year; suggestions are reviewed at Program Director meetings and appropriate responses are developed. Suggestions are reviewed by the Consumer Advisory Council and the QI/UM Committee for additional input, as needed; suggestions and the responses are posted periodically throughout the CMH building and provided to the group homes.

➢ *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 (Learning Resource Store – LRS) 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 staff responsibilities; question and answer sessions followed each presentation.
- For Calendar Year 2013, CMH staff provided and/or sponsored 18 trainings in/for the community, various topics included (not all-inclusive list): Signs & Symptoms of Depression/Suicide Prevention/Bullying (community presentation and numerous presentations to area schools by Eric Hipple, U of M Depression Center and Former Detroit Lions Quarterback); Supported Employment; Mental Health in Higher Education; Caring for Children Who Have Experienced Trauma; Mental Health First Aid Training; Overview of CMH Services; and "Disability Awareness" provided by CMH Supported Employment staff to approximately 38 elementary students in the Watersmeet School.

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

Site Surveys

- **NorthCare**
  - NorthCare conducted the site survey on July 24, 2013. The Site Review Report was received early August; however, there were three sections that were not completely scored. Plans of Correction (POC) were developed for indicators scoring anything less than "fully met" and it was submitted to NorthCare on August 30th. A *complete* Site Review Report was received from NorthCare on September 3rd which showed some indicators previously scored as "partially met" and/or "not met" now scored as "met". Out of the 123 indicators reviewed, Gogebic "fully met" 107 indicators for an overall compliance score of 87% (an increase from 81% in FY 12). There were three indicators that were scored as "repeat citations" from the prior year site review. Some of the POC are already complete, with other POC due for completion at the end of the 2013 calendar year.

➢ *QI Plan*

- On-going monitoring of the Plan of Correction and prepare for FY 14 site review.

- **CARF**
  - CARF was on-site to conduct the accreditation re-survey on July 8 & 9, 2013. The audit went extremely well with Gogebic CMH receiving zero recommendations and receiving another 3-year accreditation award.

➢ *QI Plan*

- No plan of correction was needed for the 2013 CARF re-survey.
- Continue on-going monitoring of applicable CARF standards and assure on-going compliance.

- **Department of Community Health (DCH)**
  - DCH conducted a Hab Supports Waiver and a Children's Waiver review on August 20, 2013. Although a site review report has not yet been received, it was noted during the Exit Conference that Gogebic was cited for one indicator, however, it was a "regional" write-up where all CMH's were written up on the same issue, which pertained to the electronic medical record. PCE, the company that developed the electronic medical record, will need to modify computer programming to fix the issue. During the Exit Conference, Gogebic was commended on various agency procedures (i.e., incident reporting and documentation in the children's records) and DCH requested Gogebic share various data tracking documents with them to then share with other CMH's within the State.

➢ *QI Plan*

- On-going monitoring of DCH standards.

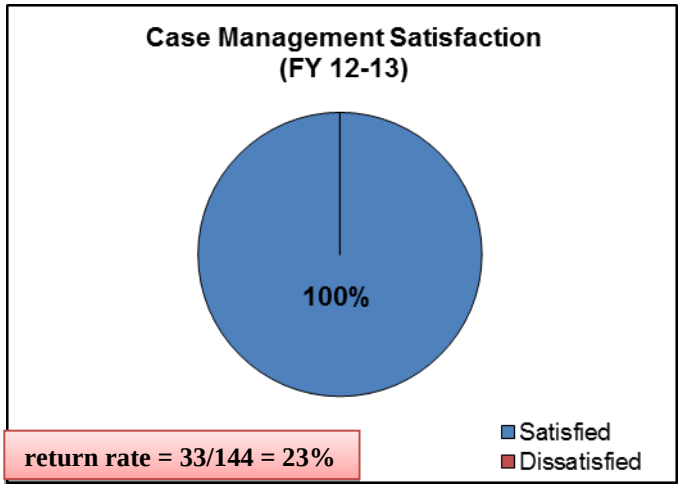
- ***Other Surveys***
  - Lakeview Group Home experienced a fire inspection in January 2013. The report showed four areas that needed plans of correction; the plans of correction were submitted to the Fire Marshall in February. The Fire Marshall accepted the plans of correction, noting "temporary approval was granted until the next inspection". During the 3rd quarter, the Fire Marshall returned to Lakeview to check on their plans of correction from the January inspection. Nothing new was noted; however, additional smoke detectors were installed. The Fire Marshall did another "walk through" at Lakeview during the 4th quarter, with no issues noted.
  - Lakeshore Group Home experienced a fire inspection and a sprinkler system inspection in April 2013. Both inspections were fine, with new smoke detectors installed in each bedroom to assure compliance with a new regulation.

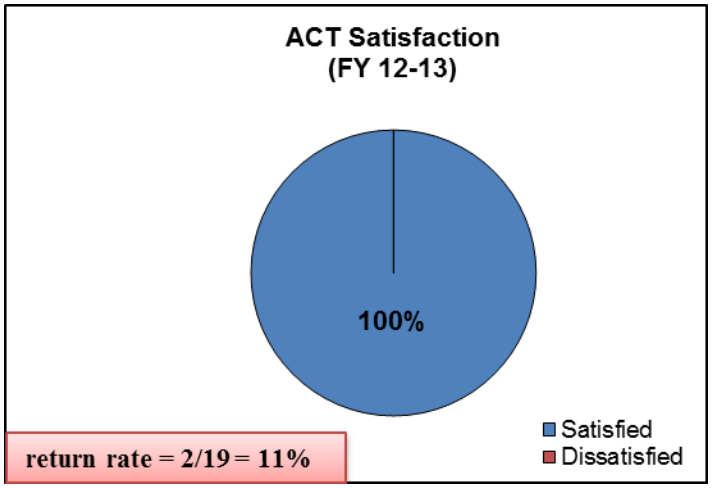
Satisfaction Survey Summary

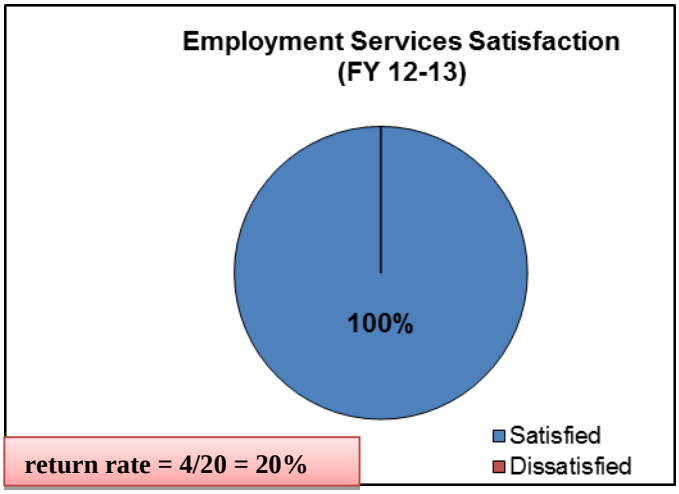
- Satisfaction surveys continued to be distributed monthly to consumers. Satisfaction data is reviewed by the CMH Board, the QI/UM Committee, the Consumer Advisory Council, and staff. An annual report is also shared with consumers/families/guardians; copies of the report are placed in the CMH lobby, in the Outpatient waiting area, and provided to the group homes.
- The following graphs show satisfaction results for each CARF accredited program (Case Management, Assertive Community Treatment [ACT], Employment Services, Community Housing, and Crisis Intervention) and programs not CARF accredited (Outpatient, Home Based, Peer Support Specialists, Serenity [Drop-In] Center). It is noteworthy to point out all programs scored 100% overall satisfaction.
- The agency 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.

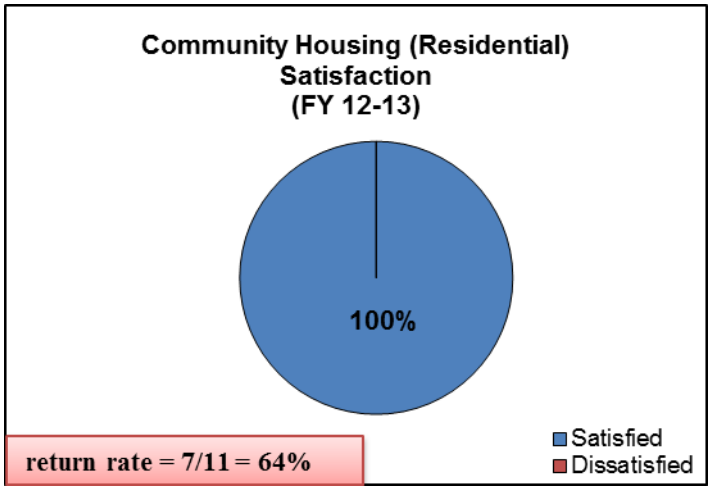
➢ *QI Plan*

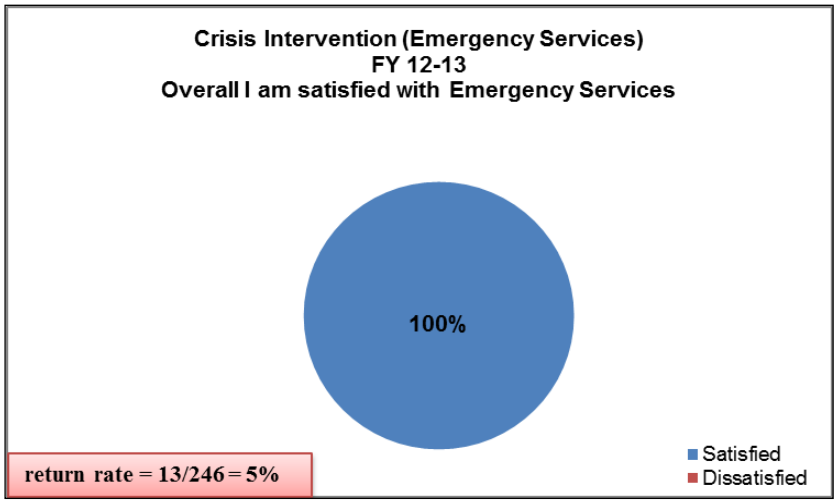
- Continue to assess satisfaction with CMH services and programs.
- Assist the region with developing a regional Recovery Satisfaction Survey for FY 14, as required by the State (Application for Participation process) for NorthCare Network.

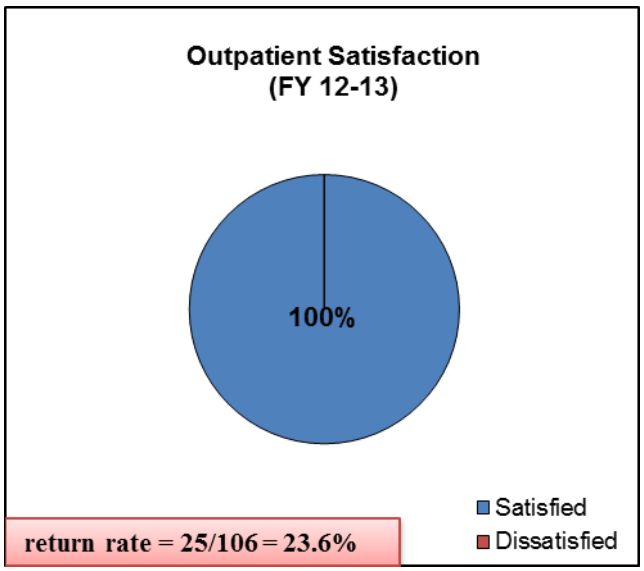


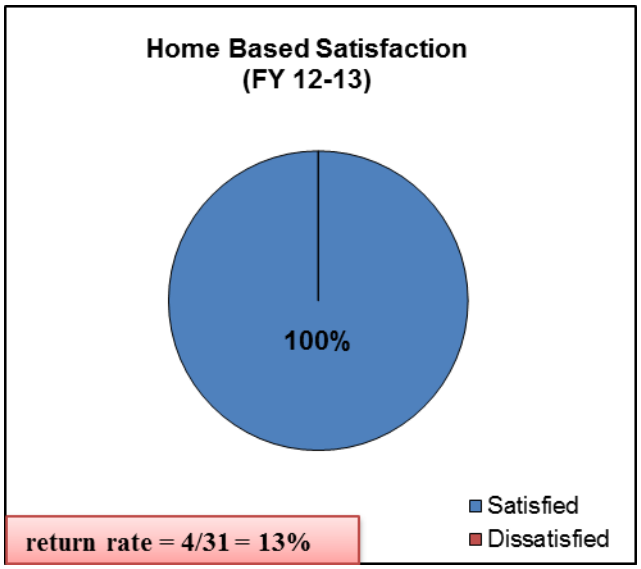


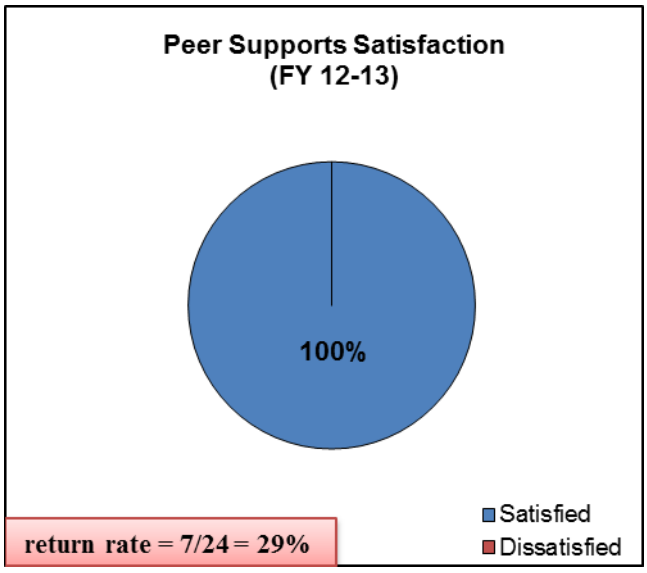


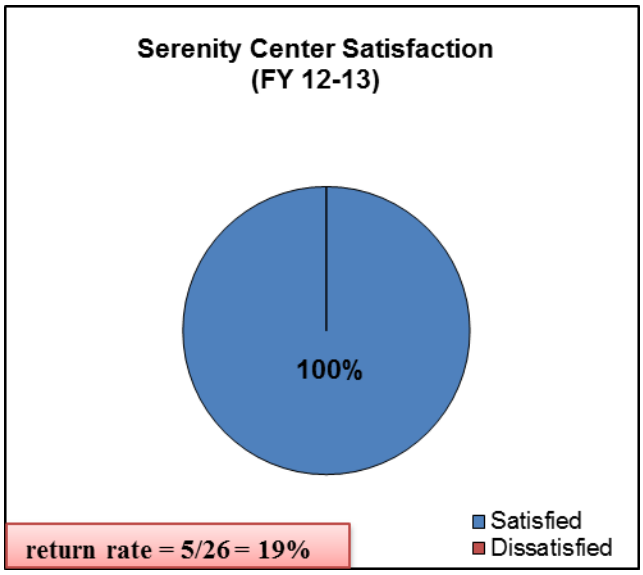



Crisis Intervention (Emergency Services)
FY 12-13
Overall I am satisfied with Emergency Services
100%
return rate = 13/246 = 5%
Satisfied
Dissatisfied


Outpatient Satisfaction
(FY 12-13)
100%
return rate = 25/106 = 23.6%
Satisfied
Dissatisfied


Home Based Satisfaction
(FY 12-13)
100%
return rate = 4/31 = 13%
Satisfied
Dissatisfied


Peer Supports Satisfaction
(FY 12-13)
100%
return rate = 7/24 = 29%
Satisfied
Dissatisfied


Serenity Center Satisfaction
(FY 12-13)
100%
return rate = 5/26 = 19%
Satisfied
Dissatisfied

Consumer Comments on Satisfaction Surveys

- I have asked for counseling and only saw someone once at CMH and asked for info on anger management and all I got was a photocopy. Should have referred me to someone.
- I am very satisfied as a guardian with the work that CMHA does.
- Staff provide excellent care! So happy she is there. I feel confident "name" reviews all she needs – compassion of staff – outstanding.
- I'm sad to lose Colleen as a case manager, she understood me the most, but I'm excited to work with Laurie.
- I felt the ACT team worked the best when Jeff took over. Switching to Colleen will be ok, but I don't think it will be best for clients.
- This was written by the guardian since resident is unable to answer. Heard some complaints about "name" from group home staff. She wanted to talk to staff not the client.
- Everybody at CMH is really nice and helpful. I couldn't ask for better services and treatment especially from Dr. Cools.
- Lonesome issues. I look forward to having more social contacts and interaction of some type.
- I have always been more than happy with the care "name" has had at CMH. The staff and case workers are a credit to their profession!
- Yes, I am very pleased with the services we are receiving.
- I am satisfied with the care our son receives at "Wakefield home". He appears to be happy and is well cared for. His visits "home" with mom and dad and family are great.
- I may have to move to Ewen and would like to stay with Wakefield Mental Health. It is going to be hard for me to start with another mental health. I am established with my case worker and Dr. Cools and would hate to have to change now. I can still do my DHS through Ontonagon County, why not Mental Health as long as I continue my appointments. Not to mention working with getting my medications right as I am on a trial and error basis right now.
- Everyone at Mental Health has been a great help to me. Without Laurie getting me to my first AA meeting; my chances of staying sober would not have probably lasted. Also Marion going to meeting with me has been a great encouragement. All of the groups and classes are helping me. Between AA classes and group therapy and my time with Laurie; I am forced to get out of bed. Sometimes it takes Joe's support and lectures to get me out of my room but when I do; it is worth it. My life has changed greatly thanks to everyone at Mental Health. I learned what I have is not my fault and that I am not alone. Laurie has gone out of her way to help me get my prescriptions. Without her help my life would be turned upside down. Without those prescriptions I am a time bomb and unpredictable and I usually lose control and it is very scary for me and everyone with me. Laurie has been very patient dealing with all my paperwork that I can't do and don't want to. It been a problem all my life. I thank everyone for helping me.
- Both my daughters and I have been treated great with everybody at CMH.
- I think every kid should have the right for respite care, if the caretaker asks for it.
- Thank you for the good work.
- Julie H (OTR) does an excellent job.
- Lakeshore staff takes awesome care of this person.
- "Name", his mom and dad, are very happy with services he receives at CMH.
- Ashley B. is simply amazing. The time and effort she puts into helping us is awesome. She is so wonderful.
- I would appreciate a 24 hour notice before having my therapist come to my home. We are a very active family and spend a lot of time outdoors.
- I would like to see more groups. Last one for BPD only met a few times. Didn't learn very much.
- I feel very fortunate to have services in this area. I know people who could use this service but don't because of stigma - Mental Health - how sad.

- All involved has done a wonderful job. We love the staff.
- Wendy is a blessing. She listens to our questions and concerns and does everything in her power to help us. I feel extremely comfortable calling her with any concerns I have. She visits the school and helps out the teacher and aide with suggestions for our son. I know she is doing a wonderful job and "Name" just loves her and so do we. I don't know what we would do without her.
- Have many physical ailments as well, so I also have that to deal with, which makes it all that much more difficult.
- I can only speak for myself. One thing I am concerned about the changing of case managers in my recovery. It seems like I just get comfortable with someone, I am changed to someone else. I realize that people get job promotions etc. and good for them. Thank God I've liked everyone I've had but when I am into my illness (depression) I feel like I am just being "plunked" somewhere, whoever is available. I'm not saying I'm right about this situation, but this is how I feel. I sometimes wonder if I should just make a recording of me and my life and just hand it over and say this is my life, watch it. My service that I have received has been great, so I'm not complaining about that. I just feel when my depression is bad I need stability. Thank you very much for reading and also for all the great things you do for me and other consumers. It is appreciated. Thanks Missy, once again, great job.

Supported Employment Review FY 2012-2013

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 (15 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

- ❖ It is wonderful that this resource is available to our community, not only for the employers, but for the employees. We are very fortunate to be able to utilize this service.
- ❖ "Name" acts as an independent contractor for us. I have not had any complaints about his performance or conduct while working. He is a valued member of our team and we are definitely glad to have him.
- ❖ I am so happy to have "name" as an employee. Thank you!
- ❖ Your program has been a valuable service for several years. A fantastic opportunity for the workers to learn skills and increase self-esteem. Hope this program will continue many years into the future. CMH staff are great to work with.
- ❖ "Name" always arrives with a job coach and is never alone while working. "Name" is a fun loving young man.
- ❖ "Job Coach" does an awesome job. He talks to "name" with respect and is always pleasant with her and myself.
- ❖ Decreased hours has been difficult for "name" to accept, but time has helped her deal with changes.
- ❖ Many of our residents look forward to seeing "name". I would like to see her grow and take initiative. We enjoy having her with us.
- ❖ "Job Coach" is in constant contact with me. I look forward to continuing our partnership.
- ❖ We are happy to offer "name" the opportunity to help us. Thank you.
- ❖ "Name" is initiating conversation more frequently, especially regarding interests at home.
- ❖ *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.