Management Summary

Annual Performance Report

October 1, 2013 – September 30, 2014

Community Mental Health

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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 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, Management Information Systems staff, 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, and staff working within those 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.

- The RRO also serves as the Integrated Healthcare Coordinator (IHC); the IHC is the liaison for 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 IH and health and wellness activities and assists Serenity Center with IH 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 ensure compliance with licensing, rights, etc. The CM also functions as the Board of Financial Responsibility liaison for inter-county agreements.

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.

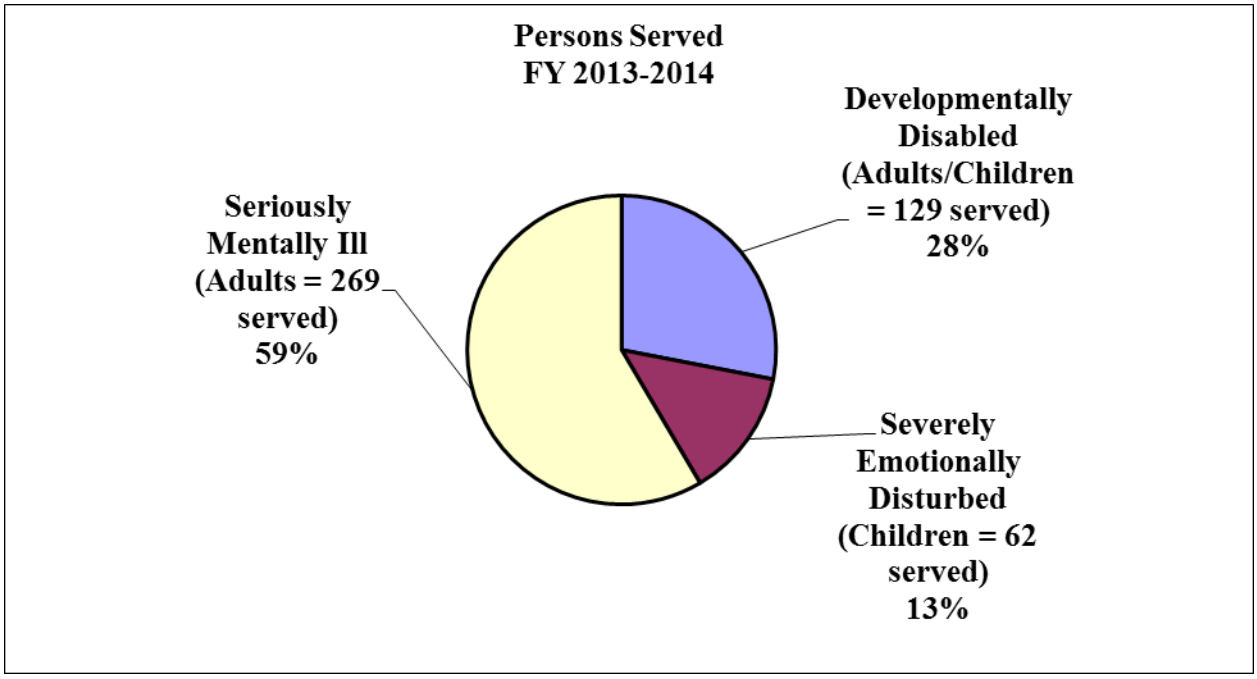
Maintenance Coordinator: The Maintenance Coordinator is responsible to perform light repairs, snow shoveling/blowing/plowing, maintain buildings and grounds, coordinate agency vehicle maintenance, assist with building security and safety, and coordinate maintenance and repairs with the lessee when a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

Available Services

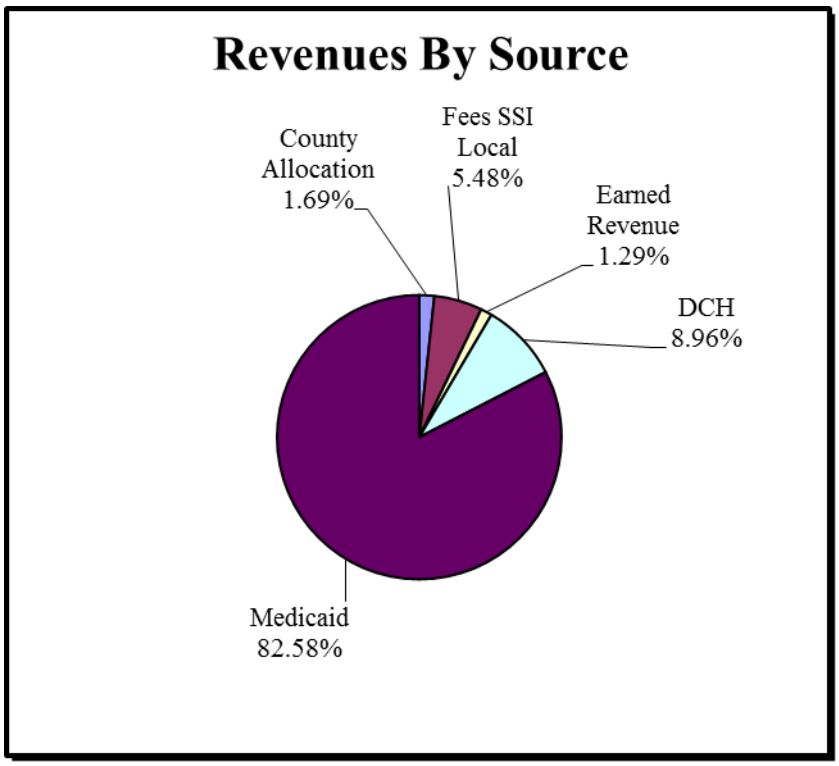
CMHA provides a variety of services for consumers with a serious mental illness, serious emotional disturbance, and/or co-occurring disorder, and/or an intellectual/developmental disability. Some of the services include Community Inpatient, Case Management/Supports Coordination, Therapy, Jail Diversion, 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.

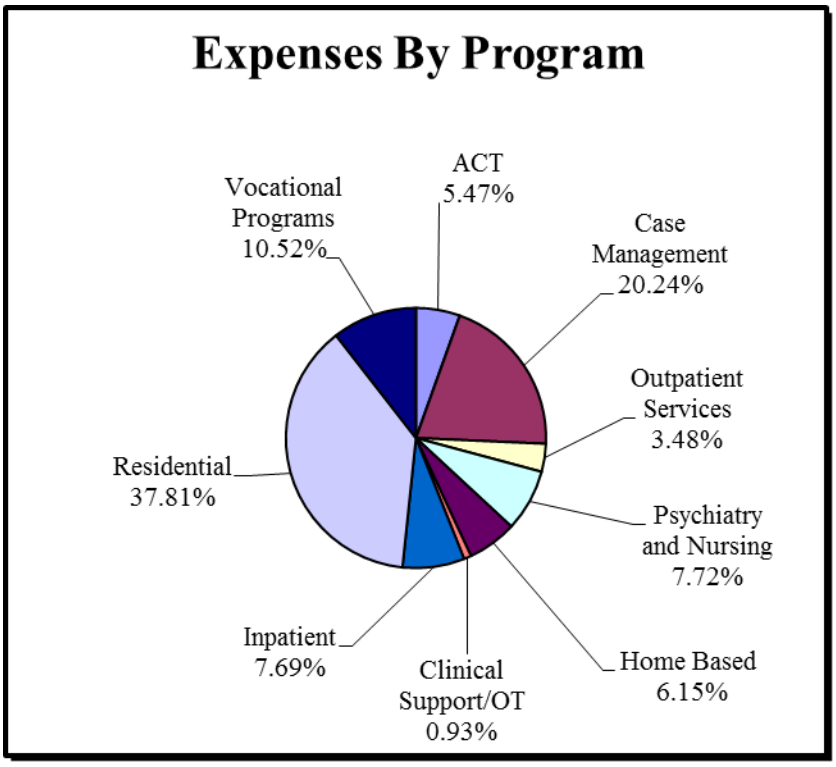
Persons Served

An unduplicated count of 460 individuals received reportable services during FY 2014; a break down per population is shown in the graph.



Financial Profile
FY 2014





OFFICE OF RECIPIENT RIGHTS

Site Visits By Rights Office Staff
Thirteen (13) visits 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 = 25; Refresher Rights = 55; Right to Vote = 36; HIPAA Privacy = 35; HIPAA Notice of Privacy Practices = 33; Consumer Rights = 25; Recipient Rights Advisory Council (RRAC)= 6; RRAC Appeals Committee = 6

Training Received By Rights Office Staff (Training that fulfills Recipient Rights Officer requirements)
Recipient Rights Officer (RRO) received 36.75 hours of training (Self-Compassion and the RRO; Successful Strategies for Thriving in an Atmosphere of Trauma & Stress; The State of Guardianship in the State; Variances in the Actual Implementations of EPIC and the Mental Health Code; Building Block or Report Writing; Code of Ethics; RRAC Committee Training; RRAC Appeals Training; Conducting a Procedurally Fair Investigation; Preparing a Procedurally Fair Investigation; Elder Care; Forensics of Interviewing; Impact of ADA-Employment and Housing Issues; Identifying Least Restrictive Types of Intervention; Guardianship Issues; Let's Talk About Mental Health and Recovery; Disability Rights in the United States).

Complaints Received
Ten (10) complaints were received that included various allegations regarding Recipient's Right To Safe Environment; Safeguarding Money; Confidentiality; Dignity and Respect; Choice of Mental Health Professional; and two outside of RRO jurisdiction to include issues with the public school system and wishes to change guardianship. Those 'outside of jurisdiction' were given information to proper resources to assist them and the other allegations were investigated with follow-up action taken as appropriate.

Incidents
Three hundred fifty-five (355) incidents occurred, a significant increase from last fiscal year (180); the increase is due to the new incident report module implemented in ELMER in the 2nd quarter of the fiscal year. Incidents can now 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-seven (47) different consumers were involved in the various incidents, a decrease of five 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.

Location* of Incident	# of Incidents	Category^ of Incident	# of Incidents
Lakeshore Home	55	accidental non-serious injury from fall	12
Lakeview Home	108	Serious hostility	114
Greenbush Home	69	Other behavior of recipient	8
CMH	1	Subject of aggression by other without apparent injury	29
Community	78	Physical management performed	14
		Non-serious self-inflicted injury	6
		Non-serious injury inflicted by another resident	7
		Non-serious aggression toward others	12
		Property destruction	9
		Non-serious injury of unknown origin	4
		Non-serious injury inflicted by non-recipient	1
		Medication refusals	76
		Missed medication by staff	6
		Incorrect medication dose given by staff	2
		Incorrect medication given by staff	1
		Falls with no injury	8
		Hospitalization due to staff injurious behavior	1
		Emergency medical treatment due to injury	3
		Emergency medical treatment due to illness/medical condition	6
		Hospitalization due to illness/medical treatment	3
		Accidental non-serious injury	5
		Accidental serious injury	1
		Other medical or health/safety issue	7
		Minor injury with no ER/hospital admission	2
		Unauthorized Leave of Absence	2
		Inappropriate sexual behavior	3
		Suicide attempt	1
		Arrest/conviction	2
		Death	2
		Other/not categorized	8
		TOTAL	355

unduplicated count/^duplicated count

Quality Assessment and Performance Improvement Program (QAPIP)

Outcomes Summary for FY 2014

(with Quality Improvement Plans for FY 2015)

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 39 disaster drills in the CMH main building (35 last fiscal year) and the Serenity Center Director also 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 three "actual" events (power outage, gas leak, and medical emergency) 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 30, 2013 by a Michigan Certified Building Inspector; the inspection resulted in one area needing to be addressed regarding securing electrical and computer cords, which was taken care of immediately.
- On May 28, 2014, 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, no issues were identified. The Consultant provided suggestions for the agency regarding hiring practices, nicotine free policy, and driving exposure (defensive driving, avoidance of driver distractions, etc.). The Consultant also reviewed CMH's reported worker's compensation claims and provided risk management recommendations to reduce future workplace accidents and injuries. There was one workman's comp claim in 2014 with an incurred cost of $312, compared to two claims ($548) in 2013 and seven claims ($5,376) in 2012.
- 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; Controlling Diabetes; Written Hazard Communication Program; Chemical Exposure Control Plan; 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 continued to be 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; examples include: developed a committee dedicated to implementing tobacco-free campus procedures; assured group home residents received flu shots; developed a committee dedicated to assure OSHA Hazard Communication regulations were implemented; held on-site training provided by the Gogebic County Sheriff's Department providing hands on training regarding proper use of infant car seats.

- There were a total of 16 staff injuries (an increase of three from last fiscal year) resulting in zero lost work days, compared to one lost time day 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 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.
- 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, now combined with the Medical Services group, continued to meet every six weeks. The Committee consists of both agency RNs, 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 RNs 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 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 Member Services continued to be monitored, as well. OMS data for the fiscal year shows 71% overall compliance, an increase from 56% 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 2015.
- *Michigan Mission-Based Performance Indicators* ~ Of the five indicators monitored, four have an established compliance rate of 95%; compliance met or *exceeded* (scoring 100%) the established standard every quarter for each indicator except for one indicator that scored 86% in one quarter (6/7=86%) . 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.

- *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 at 100% for each quarter except for one indicator that scored 92% (11/12 = 92%) in one 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.

➢ *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 organizations' 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 14**: Follow-through in addressing identified health and safety concerns for children ~ Indicator #1: 95% of all children with *health* concerns identified in the Bio-psychosocial assessment (BPS) will have those concerns appropriately addressed in the IPOS. Indicator #2: 95% of all children with *safety* concerns identified in the BPS will have those concerns appropriately 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. The initial report for this PIP was completed on 12/30/13. Baseline data for individual children was gathered through clinical documentation reviews (consisting of 11 different standards) of a random sample of 5% of the children in the region who met the specific criteria of the PIP. Thirty-two (32) charts for the region were reviewed and *regional* baseline data showed 96.9% of the reviews met the goal for health concerns to be addressed (Standard 1.1). Gogebic had one record (of the 32) reviewed and scored 100% on all applicable standards.
- NorthCare will collect data on this project again in January/February 2015.

➢ **PIP #2 FY 14**: Engagement in Service ~ a clinical project focusing 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 are undertaken to prevent unnecessary discharge and assure continuity of care. NorthCare's goal is to realize a 20% or more reduction in percent of persons discharged from services due to no-shows for scheduled appointments within 90 days of admission. NorthCare will provide baseline data for this PIP during the second quarter of FY 2015.

- **PIP #3 FY 14**: It was anticipated that this 3rd project topic was going to focus on integrated health, ensuring consumers have had a health and physical with their primary care physician within the past 12 months and/or have had primary care visits. However, NorthCare had discussion with the Health Services Advisory Group (HSAG, the external quality review organization contracted with the State of Michigan to review PIPs) and it was agreed that the focus of the project would be "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 primary health service(s) to address obesity/nutrition". Goal will be determined and baseline data collected during FY 14.
  - NorthCare received the validation report from HSAG, approving the '*Improving Primary Health Services for Consumers with Self-Reported Obesity*' PIP as submitted. NorthCare scored 100% for both the *Evaluation Elements* and the *Critical Elements* (comprised of six different "activities"/37 elements) that were both required to be 'met' to validate the PIP. Validation of the project means that the project will achieve, through ongoing measurements and interventions, significant improvement will be sustained over time.

- *QI Plan*
  - Continue to participate in the regional PIPs during FY 2015.

Record Review and Service Verification

- Quarterly record reviews continued to be conducted with data analysis reports developed. Two hundred and six (206) consumer records were reviewed for FY 14. Of the 29 indicators monitored, 15 indicators scored as "met" (95% or higher) for 52% compliance (21% 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 nine to 18 consecutive quarters (2 – 4 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 99% compliance for Indicator 2.04 (*IPOS clearly indicates services and supports including: amount, scope, and duration*); 93% compliance for Indicator 2.09 (*Frequency of FTF contacts identified in the IPOS match services received or documented why not*); and 95% for Indicator 2.10 (*IPOS is reviewed/updated per agency policy [frequency of periodic reviews occurs as noted in IPOS]*). All three indicators increased in their percentage from last fiscal year.
- NorthCare conducts *Medicaid* Service Verification, focusing solely on *Medicaid* services; FY 14 data has not yet been received.
- Highline Service Verification: All scoring sections (as many as 108) in consumer charts where Highline services were provided were found to be 100% compliant for the entire fiscal year.

- *QI Plan*
  - Review the current Record Review Checklist and modify as necessary for FY 15.
  - 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.
  - 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 Member Services, representation on the CMH Board and various committees. There were six suggestions received via the suggestion box that were reviewed at Program Director meetings; appropriate responses are developed and the suggestions and responses are posted periodically throughout the CMH building and provided to the group homes. Suggestions and their responses were also reviewed by the Consumer Advisory Council and the QI/UM Committee for additional input.

➢ *QI Plan*

- Program Directors to 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 staff responsibilities; question and answer sessions followed each presentation.
- For Calendar Year 2014, CMH staff provided and/or sponsored 16 trainings in/for the community, various topics included (not all-inclusive list): Personality Disorders; School Success; Trauma/ Resiliency; Overview of CMH Services; and Mental Health First Aid Training.

➢ *QI Plan*

- Continue to utilize the regional Required Training List and assure required training is assigned.
- Continue to monitor training via myLearningPointe and enter 'other/external' trainings that staff participate in.
- Assign additional trainings as needed and/or requested.
- Training Coordinators to continue to participate in the myLearningPointe User's Group meetings.
- Schedule 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 July 21, 2014. Out of the 138 applicable indicators reviewed, 121 indicators scored as "fully met", 14 indicators scored as "partially met", and three indicators scored as "not met", for an overall compliance score of 92.75% (an increase from 87% last fiscal year). One indicator scored as a "repeat citation" from the prior year site review. Plans of Correction (POC) were developed for indicators scoring "partially met" and "not met" and were submitted to NorthCare. Some of the POC were already complete, with other POC due for completion at the end of the 2014 calendar year.

➢ *QI Plan*

- On-going monitoring of the Plan of Correction and prepare for FY 2015 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 2014 annual report was submitted to CARF in July 2014 and acknowledged by CARF that they '*recognize Gogebic's commitment to ongoing conformance to the CARF standards throughout the term of accreditation as a means of maintaining quality services*'.

- 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 September 2014, specific to topics of "*Change in Leadership*" (CEO) and "*Reorganization*" (Clinical Director).

➢ *QI Plan*

- Continue on-going monitoring of applicable CARF standards and assure on-going compliance.

- **Department of Community Health (DCH)**
  - The report from the Children's Waiver site review from August 2013 was received; CMH met 24 out of the 25 indicators scored for an overall compliance rate of 96%. A plan of correction for the one indicator not met was submitted to DCH by their due date of March 10, 2014. DCH did provide a "positive observation" regarding the indicator "*The IPOS addresses all service needs reflected in the assessments*.", noting '*Documentation includes extensive evidence of evolving goals that address changing needs of consumer……*' and '*Goal-related data sheets reflect frequency of work by CLS staff related to each specific goal*.'
  - The report from the Habilitation Waiver site review from August 2013 was also received. There were five group homes throughout the NorthCare Network that were reviewed and only one was found to be in full compliance, which was Gogebic's Lakeshore Home! Positive observations listed from DCH staff include:
    - ❖ All of the individuals in the home were engaged in activities with staff.
    - ❖ A large covered patio had been constructed and a wheelchair swing had been ordered.
    - ❖ The CMH has a Safety Committee that meets regularly. During the month of August 2012 there were seven incidents of falls. The committee reviewed each and made recommendations to prevent further incidents of the same type. The recommendations were all implemented. For example, one consumer fell head first out of the wheelchair. A new anatomical support was recommended and installed.
    - ❖ A total of 12 incident reports were reviewed. These reports appeared to be consistently completed when appropriate and documentation was regularly present to address needed changes to prevent future incidents of the same type.
  - DCH conducted a follow-up review in September 2014, via desk audit at NorthCare, for the Children's Waiver Program. The review team "*found the actions taken by CMH were effective in correcting the findings noted during the initial site review*".

➢ *QI Plan*

- On-going monitoring of DCH standards and prepare for their full site review in FY 15.

- ***Other Surveys***
  - The Home Manager at the Greenbush and the Lakeshore group homes conducted quarterly in-house inspections. In addition, Lakeshore group home had fire sprinklers replaced during the 1st quarter. Lakeview group home had a new fire panel and smoke detectors installed in December 2013.
  - The Fire Marshall conducted an inspection at the Lakeview Home on January 30, 2014 and was found to be in compliance with applicable rules.
  - The Fire Marshall conducted an inspection at the Lakeshore Home on January 30, 2014 and found one deficiency regarding a door not latching upon closure; although the latch was fixed prior to DCH's departure, a plan of correction was submitted by their deadline of February 28th.

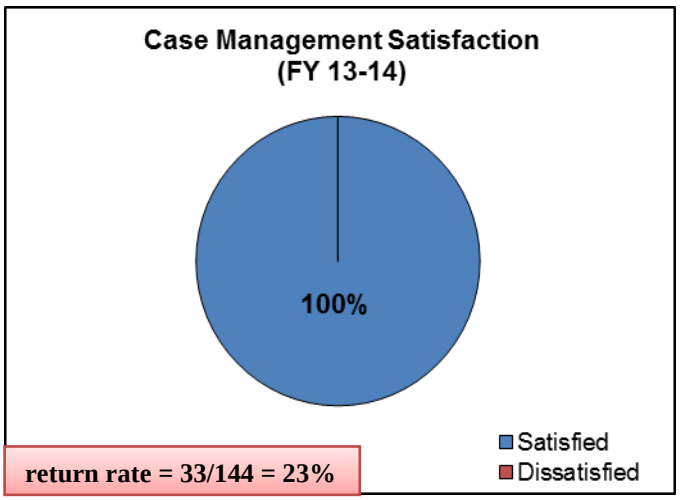
- The Health Department conducted an inspection at the Lakeshore Home on March 5, 2014; the inspection went very well, with no deficiencies or recommendations.
- Theresa Norton, Licensing Consultant with the Bureau of Children and Adult Licensing, conducted a renewal licensing study at the Lakeview and the Greenbush group homes in March 2014; the license and special certification was renewed for both homes.
- The Bureau of Children and Adult Licensing conducted an inspection at the Lakeshore Home on June 4, 2014 and the study determined "*substantial compliance with applicable licensing statues and rules*"; the license was renewed.
- NorthCare's UM Coordinator conducted a site review at the Lakeshore Home during the NorthCare site review in July 2014. Although there were some recommendations made in the report, no plan of correction was required; some positive comments were received as well.

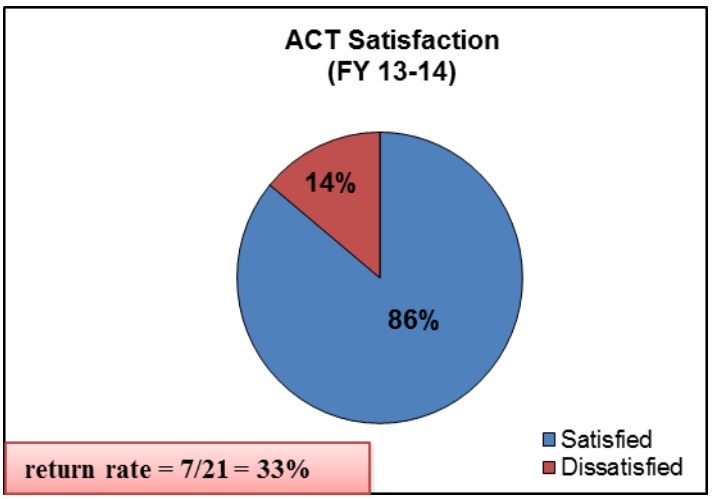
Satisfaction Survey Summary

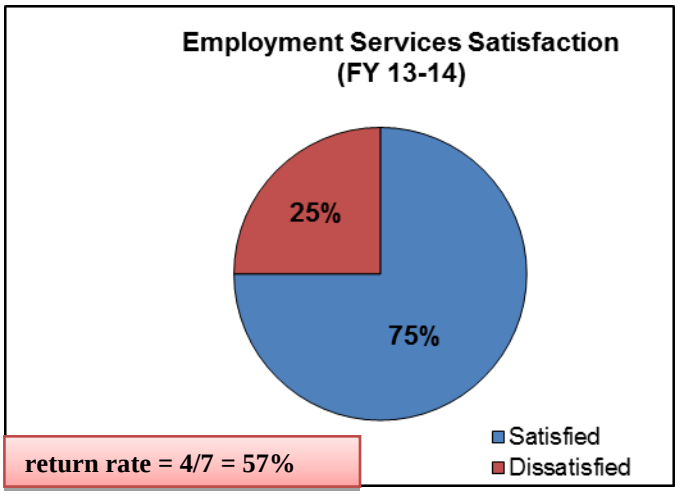
- Satisfaction surveys continued to be distributed monthly to consumers. Satisfaction data is reviewed by the CMH Board, the QI/UM Committee, the Consumer Advisory Council, and staff. An annual report is also shared with consumers/families/guardians; copies of the report are placed in the CMH lobby, in the Outpatient waiting area, and provided to the group homes.
- Starting with the January 2014 surveys, questions specific to 'recovery' were added to the monthly consumer satisfaction survey tool.
- The following graphs show satisfaction results for each CARF accredited program (Case Management, Assertive Community Treatment [ACT], Employment Services, Community Housing [Residential], and Crisis Intervention [Emergency Services]) and programs not CARF accredited (Outpatient, Home Based, Peer Support Specialists, Serenity Center).
- 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.

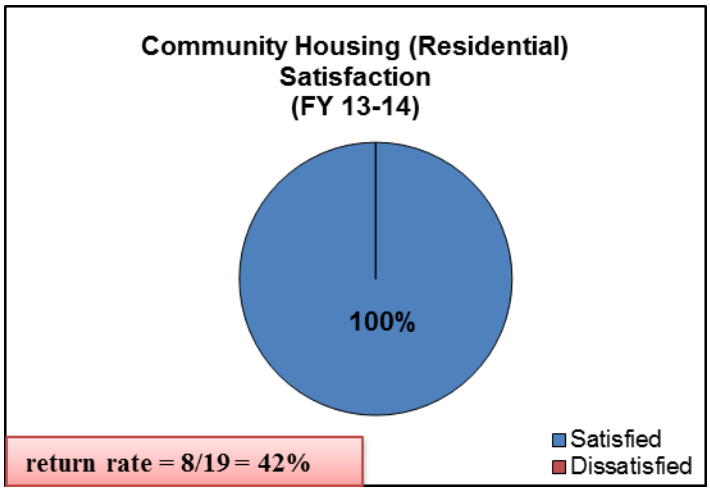
➢ *QI Plan*

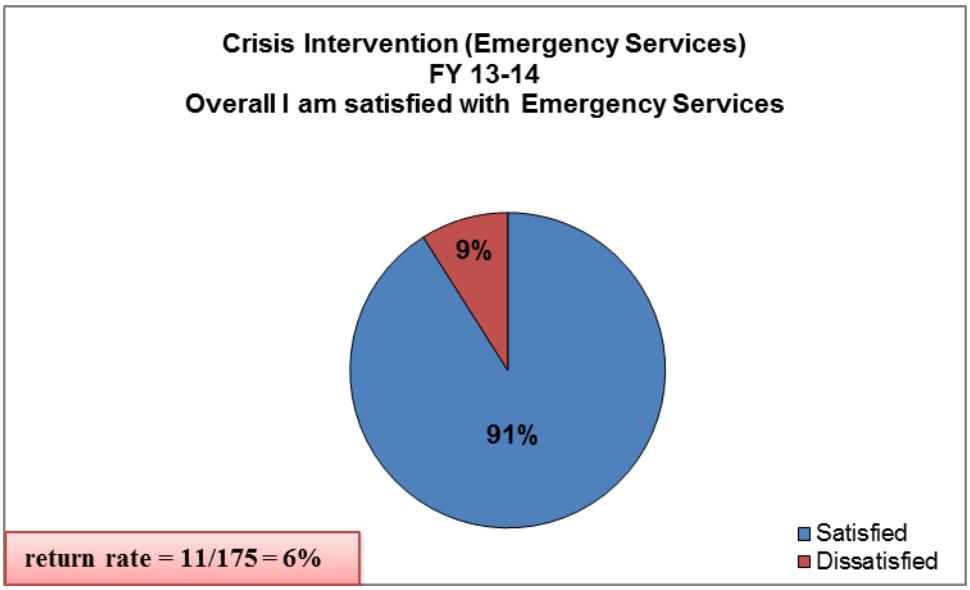
- Continue to assess satisfaction with CMH services and programs.

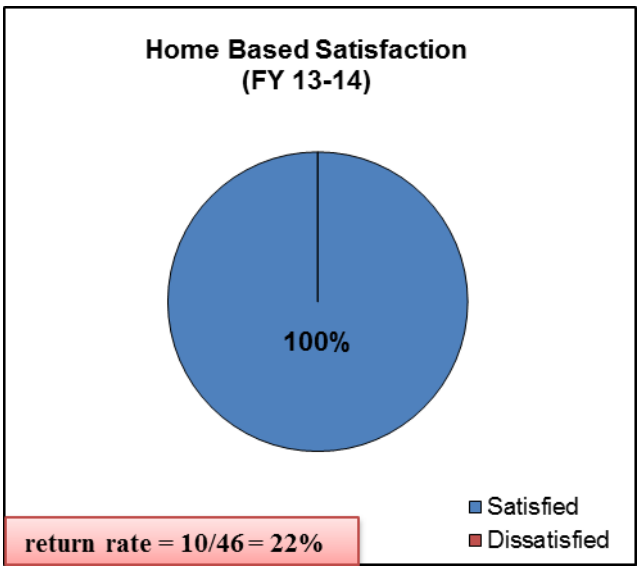


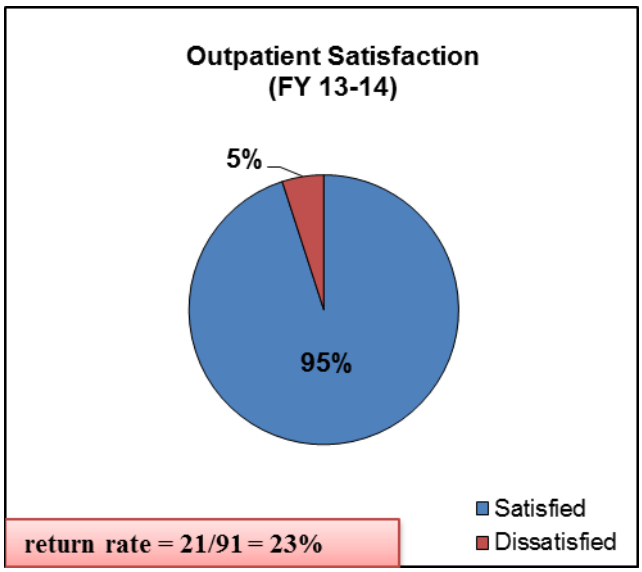


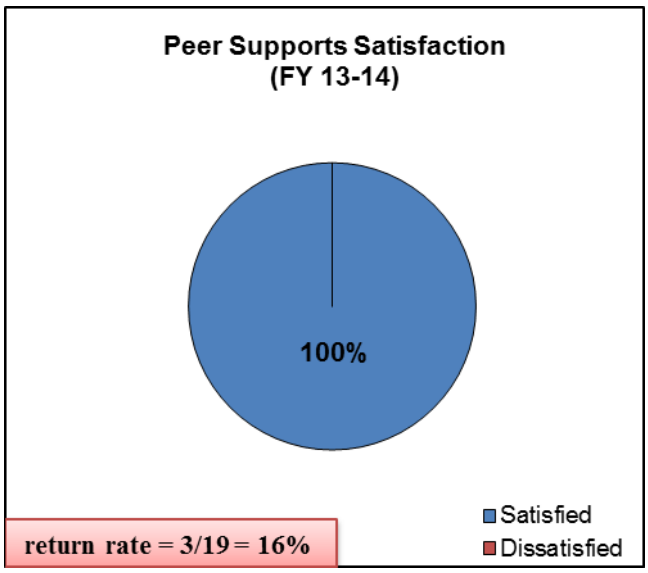

Employment Services Satisfaction
(FY 13-14)
25%
75%
Satisfied
Dissatisfied
return rate = 4/7 = 57%

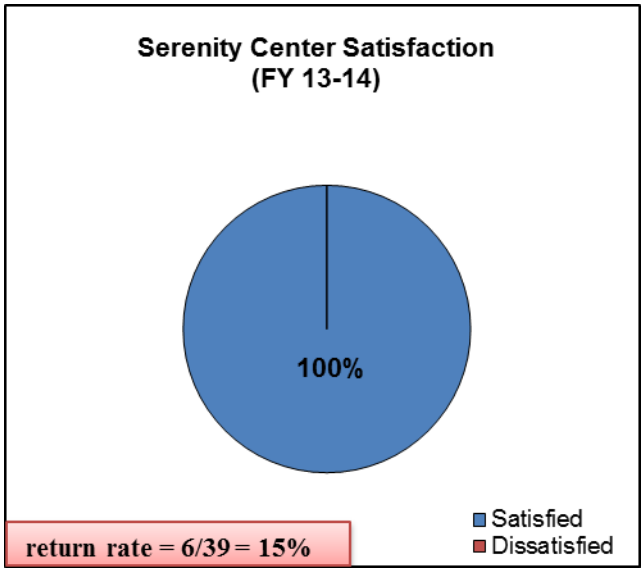

Community Housing (Residential)
Satisfaction
(FY 13-14)
100%
Satisfied
Dissatisfied
return rate = 8/19 = 42%

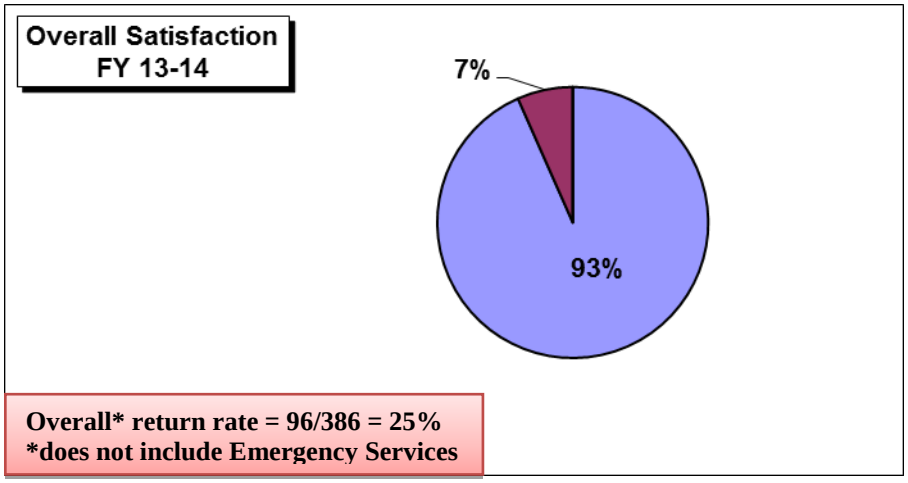

Crisis Intervention (Emergency Services)
FY 13-14
Overall I am satisfied with Emergency Services
9%
91%
Satisfied
Dissatisfied
return rate = 11/175 = 6%


Home Based Satisfaction
(FY 13-14)
100%
Satisfied
Dissatisfied
return rate = 10/46 = 22%


Outpatient Satisfaction
(FY 13-14)
5%
95%
Satisfied
Dissatisfied
return rate = 21/91 = 23%







Consumer Comments on Satisfaction Surveys

- A comprehensive service delivery system. Accolades to all!
- Dr. Rocco, Joe Hellman, nurse, and desk clerk are all very nice and supportive for all of my concerns and needs.
- All the staff take very good care of all the clients.
- Intake was comprehensive; at times not clear or a little confusing – office staff (Holly) outstanding.
- "Name" is well satisfied with the staff and services she receives. I know her program has helped her in many ways.
- Speaking as a guardian, the staff and Leah Nikula do an excellent job in my opinion.
- I love the people at CMH, thanks.
- I am a guardian for "name". I am 100% happy with her care and caregivers. All her needs are met and the care is top notch.
- Add more counselors to the services so people don't have to travel for one.
- We cannot ask for anything better than what "name" receives from you. His life is enriched because of how you treat him.
- I wish there was more socialization available.
- The services we receive are much appreciated and workers are very respectful and helpful. Thank you to all.
- I have to say I have great support from great people through CMH home-based program.

- Didn't do one helpful thing for my case. Terminate ACT program.
- My daughter is so lucky to have you people in her life. She is so happy and enjoys all her friends at Highline.
- Everyone there was wonderful and helped my daughter a great deal. I will never be able to thank you all enough.
- Cut backs in services have hurt. I have become very fond of all involved in my case. My team has been very helpful and supportive.
- Dr. Cummings was the best. She always made me feel that I and my family were very important to her. Dr. Cummings always returned phone calls in a timely manner which in a crisis (to me) was always so positive and really great.
- "Name" is 18 he would not be the man he is or I would not be the mom I am without CMH. Thanks Janet, without your support I would have lost my mind.
- "Name's" case workers have been a God send for our family. She always goes out of her way to help when issues arise. We would be lost without her; she takes in all my concerns, and provides excellent resources. Dr. Jan Cools has been the best doctor we have ever had. Love CMH and appreciate everything they do. I could not ever express my gratitude for everyone who contributes to "Name's" treatment and success.
- I was very happy coming in for my appointments, working with the receptionist, nurse, Joe H., my counselor, and Dr. Rocco. They all changed my life around for the better. Other medications weren't working for me. Before knowing about CMH, I was hopeless, didn't care about anything, and didn't want to leave the house. I isolated myself from friends and family. All people at CMH really help change my life around.
- If Joe wasn't there for me while I was in jail, making sure that I had my medications, I probably wouldn't be as stable as I am now and looking forward to my future and accomplishing my goals. I have co-occurring 1 on 1 with Amy once a week, Ellen 1 hour a week, and Joe is one of my biggest supports I call, or lean back on when times are good or bad. Thank you all.
- Joseph Hellman has been a great support in my recovery. Now I don't qualify for services, terminated, not sure what will happen. Dr. Cools was so very helpful and knowledgeable handling my medications. I feel at a loss and very upset. Both Mr. Hellman and Dr. Cools are exceptional in their jobs. I have severe mental health problems, which at times, with my physical disabilities, make it extremely difficult to function normally. I no longer qualify for CMH services, which were extremely useful in helping me maintain my symptoms from destroying my life. Thank you for all your help and good work and support.
- I was very satisfied with the way I was treated. Now that I've been cut from services of support from CMH I'm not sure about my future.
- I would still like to see a hoarding group started. I am very open about my hoarding and usually when I start talking about it someone will admit to having the same problem and don't usually talk about it because of shame, fear, and embarrassment. Once again I have a different case manager. In the last 3 years I have had Tess, Coleen, Bill, Ashley, and Laurie. They have all been great case managers, so I don't have a problem with any of them. It's like I have said before, I really just feel that I'm just plopped where you can squeeze me in. I try to look at it from the management view but if it wasn't for the consumers nobody would have a job. Thanks for letting me vent. You guys do great work.

Comments on Supported Employment Reviews 2013 - 2014

- When "name" needs guidance, it is given and she responds. Job coach does a great job with staying in touch.
- Would definitely continue to use the Supported Employment services. Would like to see more employers use the service and have more recipients become involved. Very beneficial and should continue to grow as possible.
- We enjoy "name"!
- "Name" is a wonderful person. Great work ethic and a joy to have on our team.
- The kids miss when "name" is unable to be here.
- Thank you for your supportive services.
- "Name" is a smiley person and we enjoy having him. Works well with his job coach.
- *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.