Management Summary

(Annual Performance Report)

October 1, 2016

~

September 30, 2017

Community Mental Health

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

COMMUNITY MENTAL HEALTH AUTHORITY BOARD

It is the mission of the Community Mental Health Authority (CMHA) 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 17 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, Contract Manager, Management Information Systems staff, the Human Resources Coordinator, and the Maintenance Coordinator.

Under the direction of the CMHA Board of Directors, the CEO is responsible for the overall administrative operations of the County-wide comprehensive community mental health system. The CEO executes and administers CMHA programs in accordance with all applicable procedures, regulations, and provisions outlined by the Michigan Mental Health Code as it exists or amended. The CEO is responsible for planning, budgeting, and general policy guidelines established by the Board as well as administration of the full master contract with the Department of Health and Human Services and other contracts and conditions as appropriate. The CEO supervises, coordinates, and directs work of the department directors as needed. The CEO oversees agency-wide strategic planning, program development, and Board Committee work as assigned. The CEO ensures compliance with all clinical and administrative policies, directives, and procedures of CMHA.

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 Administrative Service Professionals.

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 services to 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 chairs and the Safety and the Wellness committees and coordinates wellness activities for CMHA and the Serenity Center.
- 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 and contracted 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 sits on the Regional Provider Contract Workgroup (NorthCare committee) and the Regional Contract Manager Committee (consists of Northern Michigan below the bridge and the Upper Peninsula).

Human Resources (HR) Coordinator: The HR Coordinator assists the CEO in coordinating all areas of agency HR functions such as recruitment, employment, placement, wage and salary administration, union negotiations, and training concurrent with agency policies. The HR Coordinator is responsible for agency personnel matters including files, laws, policy/procedures, compensation/fringe benefit plans and the like as well as coordinating agency efforts toward EEOC, FMLA, ADA, FLSA, OSHA, COBRA, and HIPAA compliance. The HR Coordinator also monitors and facilitates the agency's health insurance, worker's compensation program, unemployment claims, other benefits administration, and maintains, develops, and implements all employee records and information as well as compiles, enters, and retrieves personnel data. In addition, the HR Coordinator co-manages the agency's training program and conducts new employee orientation and serves as an active participant on the Safety Committee.

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, assist with the development and implementation of agency policy and the maintenance of the 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 QI Coordinator also assists with the agency strategic planning and management reporting.

- 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, Clinical Services Director, 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.

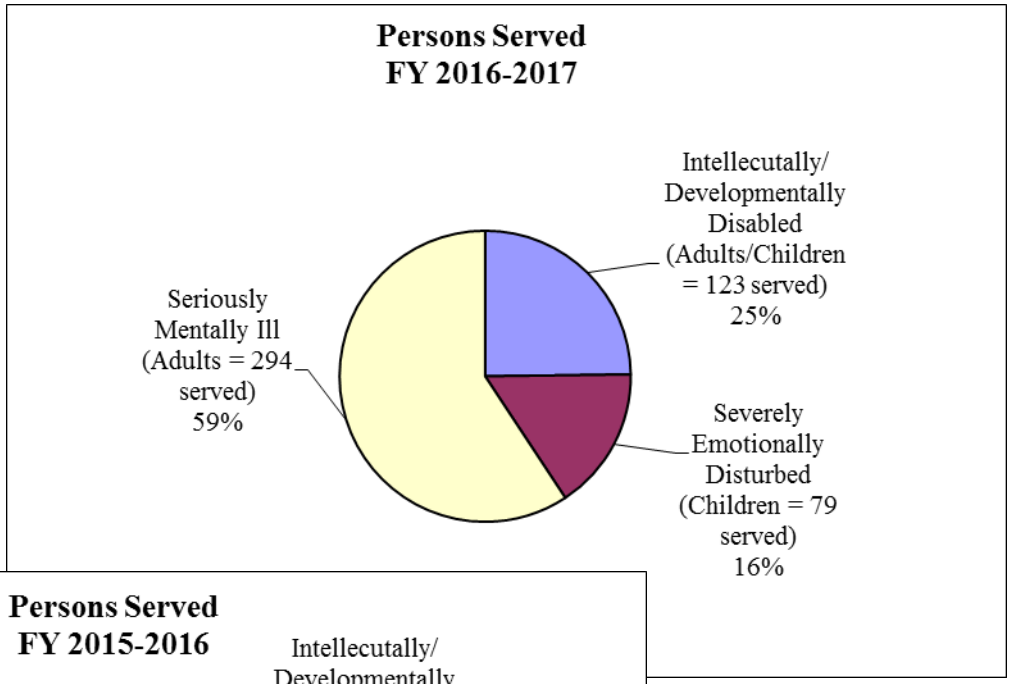
Maintenance Coordinator: The Maintenance Coordinator is responsible to perform repairs, snow shoveling/blowing/plowing, mowing grass, maintaining buildings and grounds, coordinating agency vehicle maintenance, assisting with building security and safety, and coordinating maintenance and repairs with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

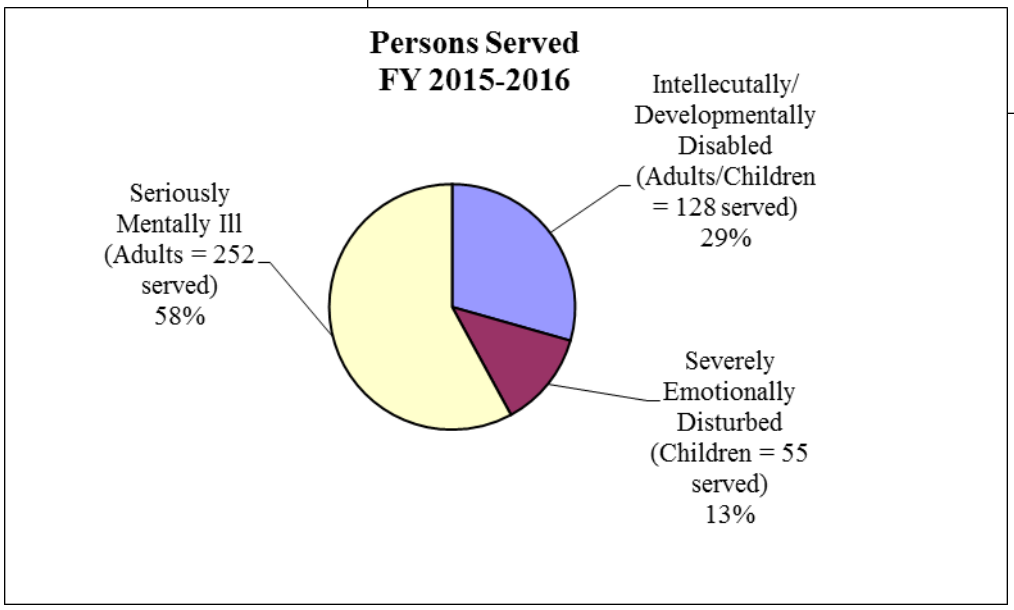
Available Services

CMHA provides a variety of services for individuals with serious mental illness, serious emotional disturbance, and/or co-occurring disorder, and/or intellectual/developmental disabilities. 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.

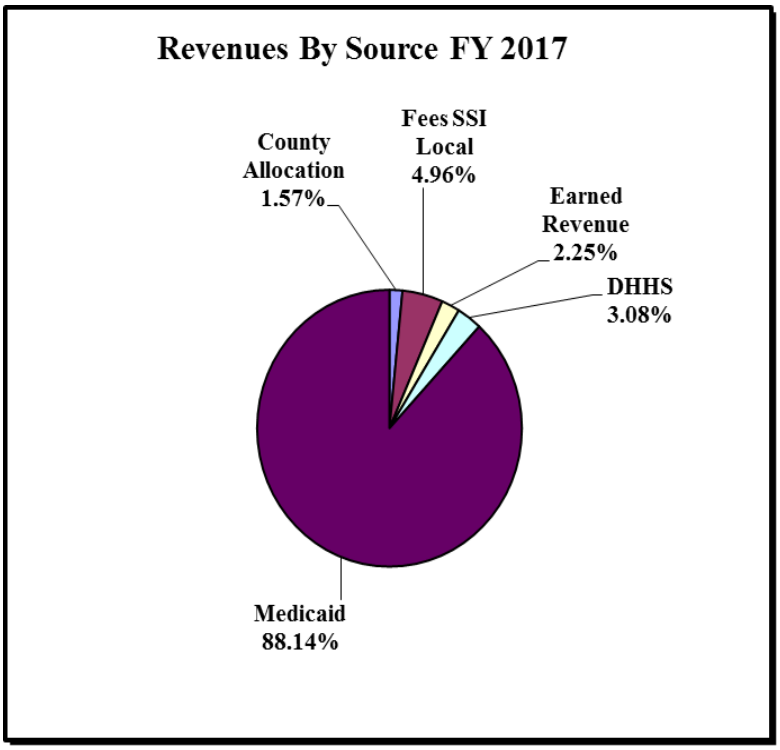
Persons Served

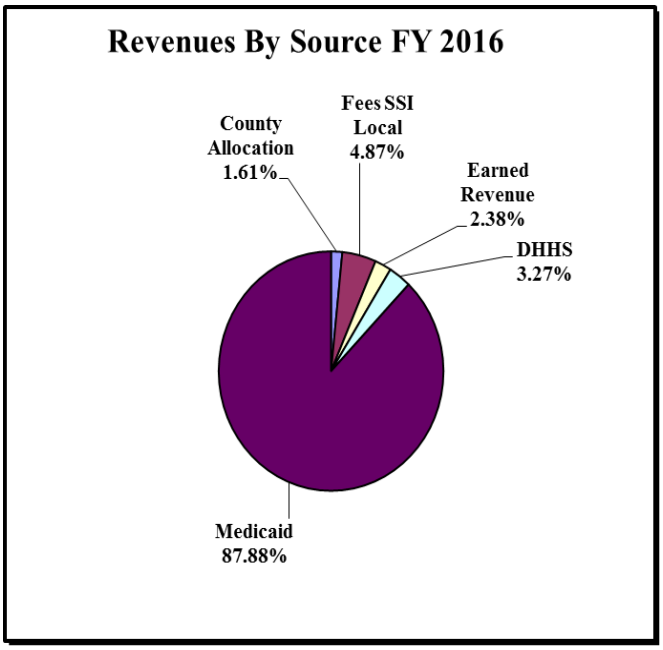
An unduplicated count of 496 individuals received reportable services during FY 2017; this is an increase of 61 individuals from last fiscal year. A break down per population is shown in the graph below, with a comparison to FY 2016.

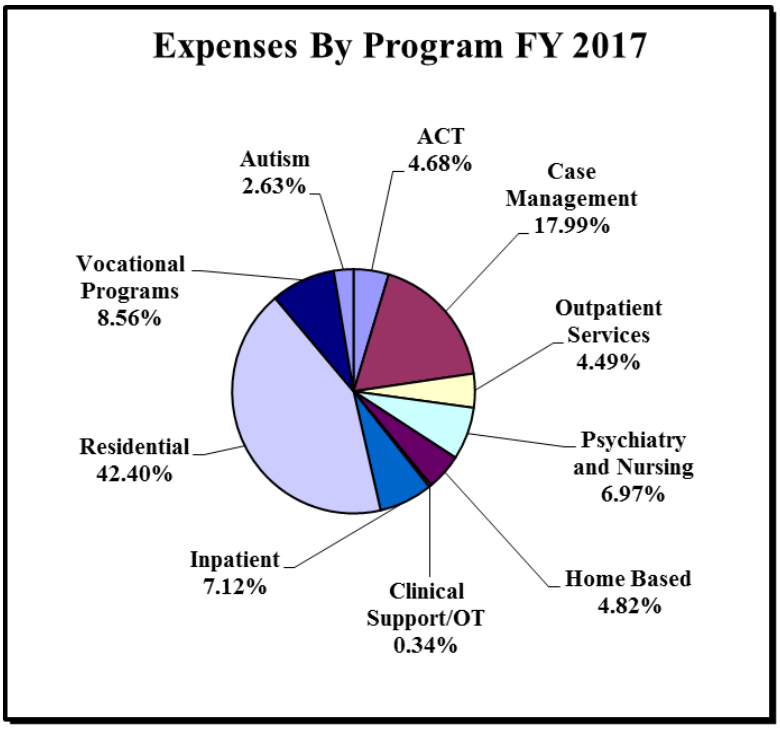


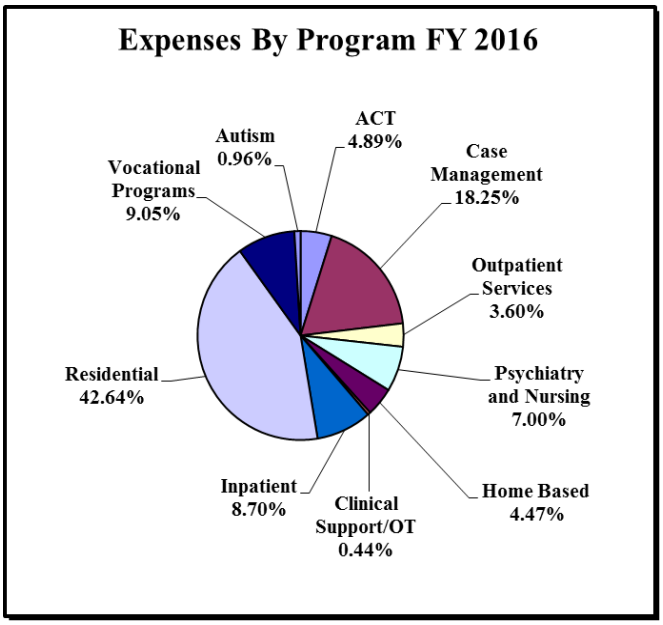


Financial Profile FY 2017
(with comparison to FY 2016)









Quality Assessment and Performance Improvement Program (QAPIP)
Outcomes Summary for FY 2017
(with Quality Improvement Plans for FY 2018)

Quality Improvement/Utilization Management (QI/UM) Committee

- The Committee continued to meet quarterly to review various QI and UM data (i.e., satisfaction, performance indicators, program outcomes, record review, incidents, 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)

- During the fiscal year, the Clinical Director transitioned UM Coordinator responsibilities to the Intake Coordinator/Outpatient Therapist and both individuals continued to participate in CMHA QI/UM Committee meetings and 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 CMHA main building throughout the fiscal year. Disaster drills were conducted on a monthly basis at the Serenity Center and Home Managers conducted disaster drills at all CMHA-operated residential homes, as well. Routine vehicle inspections were conducted throughout the fiscal year on agency fleet vehicles utilized at the CMHA main building and vehicles utilized at the residential homes. Internal building inspections were conducted quarterly at the CMHA main building by the Maintenance Coordinator; Home Managers conducted quarterly inspections at the residential homes; and the Serenity Center Coordinator conducted building inspections at the Center.
- First Aid bags located in agency vehicles, in the CMHA main building, in the residential homes, and at the Serenity Center were all inspected and restocked with required supplies, as needed.
- There were 20 staff injuries (six more than last fiscal year) with six resulting in lost time or need for accommodation, compared to zero lost time last fiscal year. The Safety Committee reviewed all staff injuries and provided follow-up analysis and recommendations/strategies to minimize future injuries.
- There were 453 consumer incidents (32 less than 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). 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. 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 Chairperson provided safety-related quarterly progress reports for the Accessibility Plan, to include identifying and eliminating 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 CMHA's RNs, Clinical Services Director, Psychiatrist/ Medical Director, and Physician. The Committee reviews and monitors all pharmacy and therapeutic related data (i.e., medication incidents), applicable policies and procedures, and conducts Peer Reviews. Infection Control meetings were also held on a quarterly basis.

➢ *QI Plan*
- Continue to monitor the Strategic Plan's health and safety goals and objectives.
- Continue to monitor incidents pertaining to medication, 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 70% overall compliance, a significant increase from 50% last fiscal year (includes access standards but does not include satisfaction or Customer Services data) – see *Satisfaction Surveys* 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 2018.
- *Michigan Mission-Based Performance Indicators* ~ Of the five indicators monitored, four have an established compliance rate of 95%; compliance *exceeded* the established standard (scoring 100%) every quarter for each indicator except for two indicators that scored less than 100% for one quarter. One indicator has a '15% or less' standard which monitors children and adults who are readmitted to an inpatient psychiatric unit within 30 days of discharge. CMHA was in compliance at 0% (0 readmissions within 30 days of discharge) for three quarters and was non-compliant for one quarter, scoring 33% (out of three discharges, there was one readmission within 30 days of discharge).
- *Pre-paid Inpatient Health Plan (PIHP) Performance Indicators* ~ The indicators monitored mirror those for the *Michigan Mission-Based Performance Indicators*; however, they focus solely on *Medicaid* beneficiaries served. For the four indicators having an established compliance rate of 95%, compliance *exceeded* the established standard (scoring 100%) every quarter for each indicator except for one indicator that scored less than 100% for one quarter.

For the indicator having a '15% or less' standard, CMHA was in compliance at 0% (0 readmissions within 30 days of discharge) for three quarters and was non-compliant for one quarter, scoring 33% (out of three discharges, there was one readmission within 30 days of discharge).

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

State Performance Improvement Projects (PIP) ~ Standards published by the Centers for Medicare and Medicaid Services (CMS) require that the PIHP "conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction." Two PIPs are required, one project topic typically mandated by the State and one project topic chosen by the PIHP that takes into account the prevalence of a condition among, or need for a specific service by the organization's consumers, consumer demographic characteristics and health risks and the interest of consumers in the aspect of service to be addressed. In addition, NorthCare is 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** (continued from 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 was provided for when health and safety concerns are identified in the BPS.
  - This project was complete in December 2016 with the overall goals met. A key finding throughout this PIP, however, was the need to retrain staff bi-annually on the "Golden Thread" system of documentation, which directs clinicians to trace the 'golden thread' (chart documentation) from assessment through treatment planning and on through the progress being made in services, keeping the focus on measurements that are critical to coordination of care.

- **PIP #2** (continued since FY 2014): Engagement in Service ~ This project 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.
  - As a way to measure engagement in service, NorthCare tracked consumers who were eligible for services and who were discharged within 90 days. The number of consumers discharged within 90 days averaged 10% across the region during the baseline phase of data collection. Gogebic data showed out of 119 admissions, 7 were

discharged within 90 days for 5.88% (below the region's average). Out of the 7 discharges, 5 dropped out of treatment for 71% (slightly higher that the region's average of 62.9%). NorthCare is working with the regional UM Committee to implement strategies to increase engagement across the region.
    - Barriers to engagement included lack of transportation, appointments being forgotten or cancelled, inconvenient appointment times, and poor rapport with the clinician.

- **PIP #3** (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 medical nutritional therapy (MNT) or counseling from their primary health care provider or dietician.
    - FY 17 regional data shows 31 out of 1,091 individuals (unduplicated count) had a MNT service from a primary health care provider, scoring 2.84% which exceeds the regional goal of 2.4%, verifying the region is maintaining a statistically significant improvement from baseline data.
    - All regional staff continued to be reminded to discuss a MNT referral with those consumers meeting the criteria for this project.

- *QI Plan*
    - Continue to participate in the regional PIPs as required.

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 17. Twenty-three (23) indicators were monitored (one more than last fiscal year). Of the 23 indicators, 21 scored as "met" (95% or higher) for 91% compliance, the same as 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, 11 scored as "met" (95% or higher) for an overall fiscal year compliance score of 73%, an increase from 67% last fiscal year. It is noteworthy that all 11 compliant indicators scored a perfect 100% throughout the 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 four Record Review indicators that are utilized for service verification; however, one was implemented in the 3rd quarter and not monitored for the entire fiscal year. 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; 81% compliance for Indicator 2.09 (*Frequency of FTF contacts identified in the IPOS match services received or documented why not*), an increase from 69% last fiscal year; and 89% for Indicator 2.10 (*IPOS is reviewed/updated per agency policy [frequency of periodic reviews occurs as noted in IPOS]*), a decrease from 97% last fiscal year. The new indicator (*Program Directors will review three CLS services to verify the use of the code matches the service documented*) was compliant at 100% for both the 3rd and 4th quarters.
- 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 17 audit, 30 services and claims were reviewed; the results are shown below. Supported documentation was submitted to NorthCare for the one Claim that scored less than 100%.

- Service Activity Logs
  - Beneficiary is eligible on the date of service: 100%
  - Service is include in the IPOS: 100%
  - Documentation 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: 100%
- Claims
  - Beneficiary is eligible on the date of service: 100%
  - Service is include in the IPOS: 100%
  - Documentation 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: 100%

- Highline Service Verification: For FY 17, there were 14 charts reviewed with a total of 432 sections scored; overall compliance was 99%, the same as last fiscal year.
- 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 18.
  - Continue CMH quarterly record reviews and qualitative reviews and develop data analysis reports with recommendations to increase compliance, as applicable.
  - Continue to calculate individual (provider) record review and indicator compliance on a quarterly basis and provide results to the Clinical and the Community Services Program Directors for the purpose of including "Findings of Documentation Review" on individual performance evaluations.
  - Continue to provide record review data to the Clinical and Community Services Directors and to providers to review, discuss, and 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 ways, such as the suggestion box, satisfaction surveys, grievances via Customer Services, and representation on the CMHA Board and various committees. There was one suggestion received via the suggestion box; the CEO provided a response and the suggestion and the response were posted throughout the agency and the group homes. There were seven grievances received via Customer Services (one less than last fiscal year) and all were resolved within the required 60-day time frame. There were four (informal) inquiries that the Customer Services representative received and assisted with resolution; all four were resolved within 60 days. Suggestions and grievances were also reviewed by the Consumer Advisory Council (CAC) and the QI/UM Committee with 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.
- CMHA staff presentations continued to be provided to the CMHA Board of Directors during their monthly meetings. These presentations focused on CMHA programs and services, staff

responsibilities, and topics relating to mental health and/or intellectual/developmental disabilities; question and answer sessions followed each presentation.

- For Calendar Year 2017, CMHA staff provided and/or sponsored 19 trainings in/for the community, various topics included: suicide prevention; reducing stigma; anti-bullying; recipient rights; trauma; non-violent crisis intervention; CMH programing for children and families; self-determination; and Mental Health First Aid (both youth and adult versions).

➢ *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.
- 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 28, 2017. Out of the 160 applicable indicators reviewed, 153 indicators scored as "met", five scored as "partially met", and two scored as "not met", for an overall compliance score of 97.2% (an increase from 94% last fiscal year). Plans of Correction (POC) were developed for the seven indicators that scored "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 2018 site review.

- **Department of Health and Human Services (DHHS)**: DHHS was on-site in August 2017 to conduct a site review of the Habilitation Supports Waiver and the Children's Waiver Programs; both programs scored 100% compliance with no plans of correction needed. DHHS also conducted a site review at the Lakeview group home during September, with no citations received.

➢ *QI Plan*

- On-going monitoring of program indicators to assure on-going compliance.

- **CARF**: CMHA's current 3-year accreditation expires June 2019, hence, CARF will not be on-site until 2019. The five Plans of Correction from the 2016 survey are complete. During the years between surveys, an Annual Conformance to Quality Report must be submitted to CARF; CMHA was in compliance with submitting the report to CARF in June 2017 and it was approved by CARF, resulting in CMHA receiving the Year 2 Gold Seal of Accreditation which was placed on the Accreditation Award Certificate located in the CMHA foyer.

➢ *QI Plan*

- Continue to order CARF standards manuals annually to assure on-gong compliance with all applicable CARF standards.

- ***Other Surveys***
  - Throughout the fiscal year, the residential group homes experienced various safety reviews (i.e., Fire Marshall, fire extinguishers, smoke detectors, fire panels, sprinkler system and alarm system, etc.) with no concerns or issues identified.
  - 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

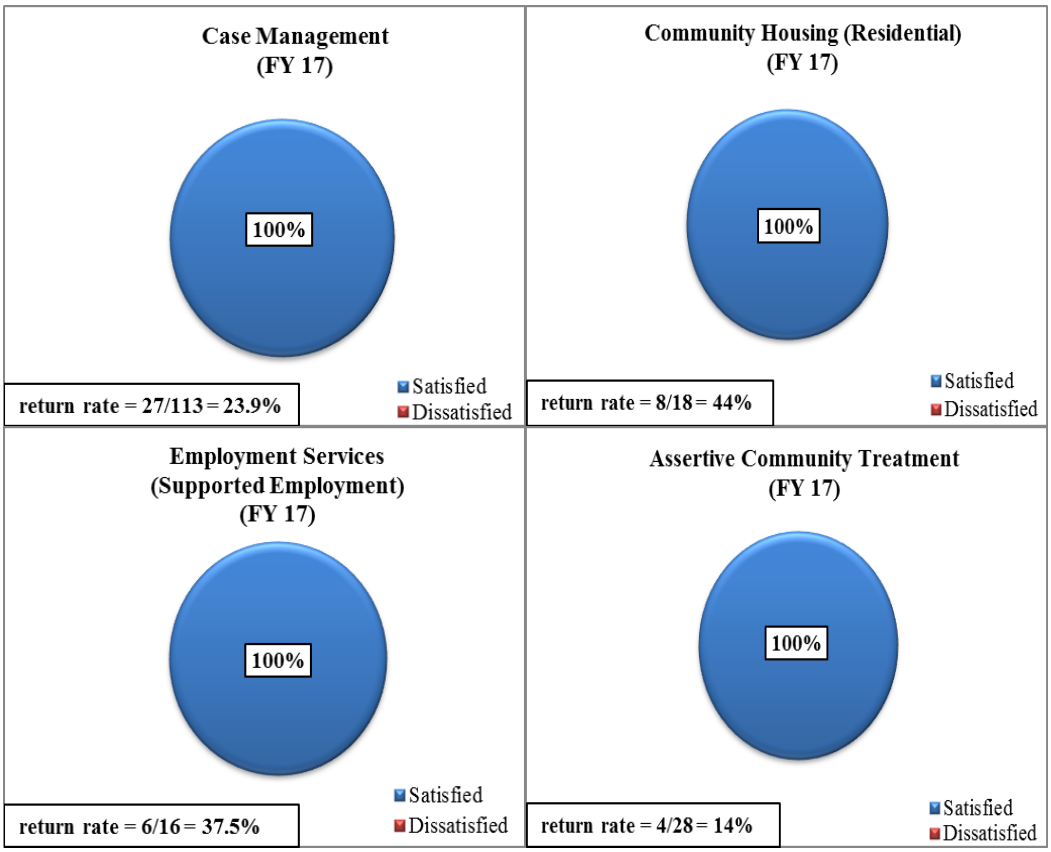
compliance with all applicable rules and statutes and the Licensing Consultant recommended issuance of a regular license to all group homes.
    - All three group homes experienced the annual internal site review in May 2017; all three group homes were 100% compliant with all indicators.
    - CMH staff conducted an annual site review at Highline Corporation in May 2017; they were in compliance with 108 out of 110 indicators for an overall compliance score of 98%.

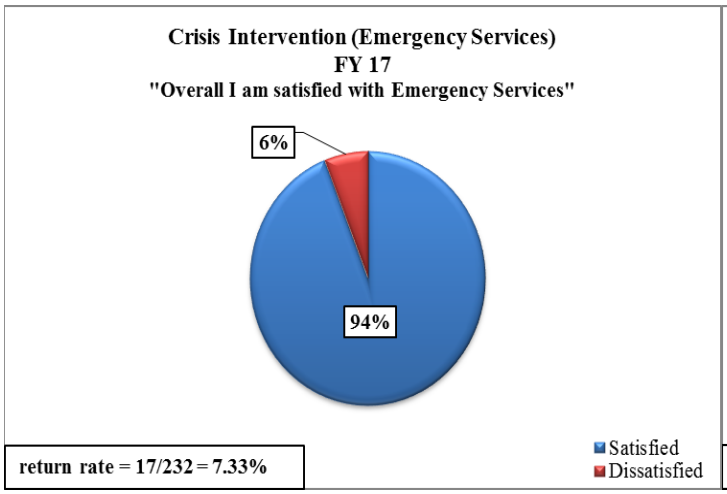
➢ *QI Plan*
- Assure on-going compliance with applicable standards and indicators pertaining to the licensed residential group homes.

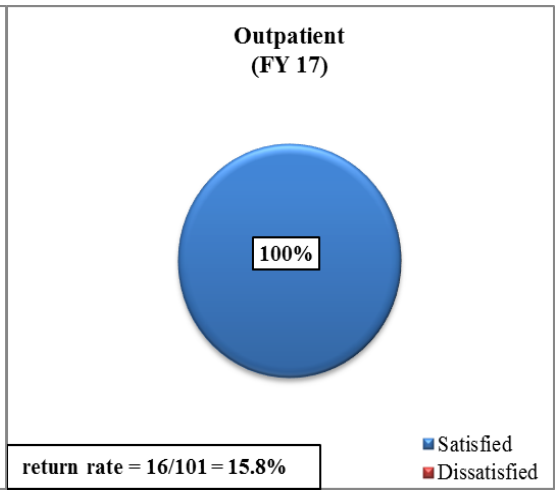
Satisfaction Surveys

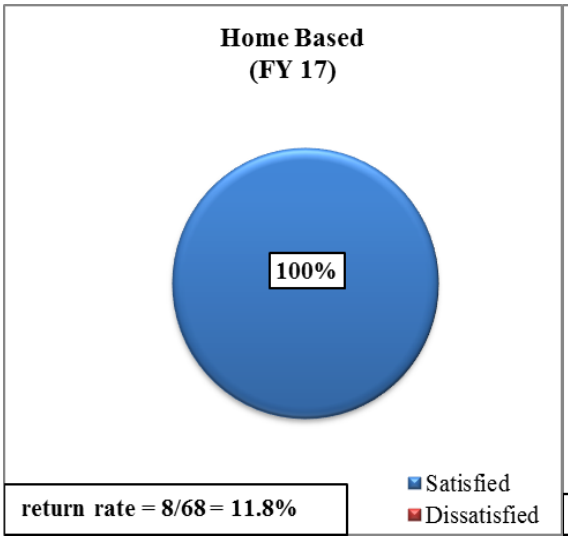
- Satisfaction surveys were distributed monthly to consumers. Satisfaction data is reviewed by the CMHA Board, the QI/UM Committee, the Consumer Advisory Council, and staff.
- The following graphs show satisfaction results for each CARF accredited program (Case Management, Assertive Community Treatment [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 Supports, Serenity Center).
- For the last 10 years, CMHA 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 2016 and 2017 State-wide satisfaction surveys have not yet been received.

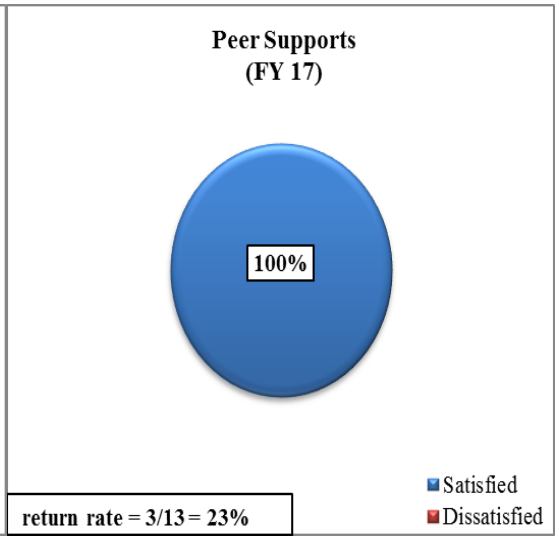
➢ *QI Plan*
- Continue to assess satisfaction with CMHA services and programs.

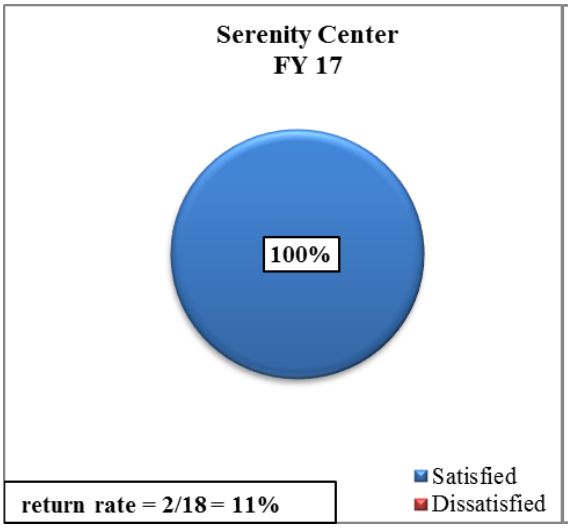


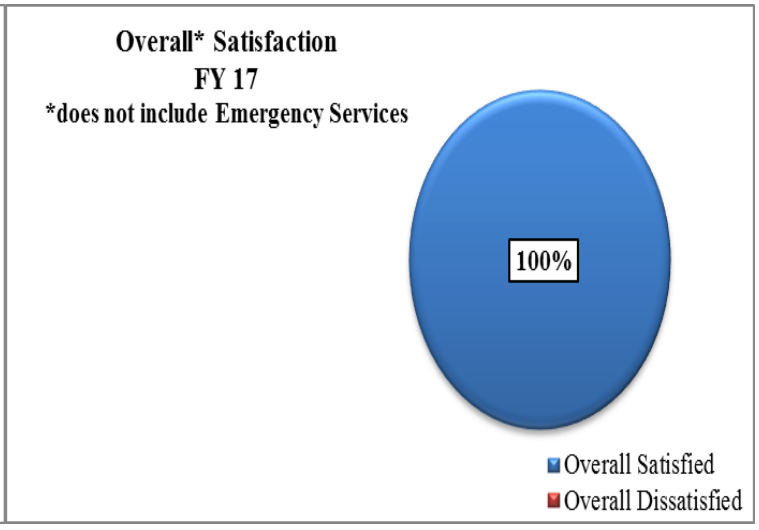

Crisis Intervention (Emergency Services)
FY 17
"Overall I am satisfied with Emergency Services"
6%
94%
return rate = 17/232 = 7.33%
Satisfied
Dissatisfied


Outpatient
(FY 17)
100%
return rate = 16/101 = 15.8%
Satisfied
Dissatisfied


Home Based
(FY 17)
100%
return rate = 8/68 = 11.8%
Satisfied
Dissatisfied


Peer Supports
(FY 17)
100%
return rate = 3/13 = 23%
Satisfied
Dissatisfied


Serenity Center
FY 17
100%
return rate = 2/18 = 11%
Satisfied
Dissatisfied


Overall* Satisfaction
FY 17
*does not include Emergency Services
100%
Overall Satisfied
Overall Dissatisfied

Consumer Comments on Satisfaction Surveys

- Great staff, very helpful.
- Great team!
- "Name" received excellent services for over 17 years through CMH. In September 2016, with the help and support of CMH, "Name" was placed in GMCF, and no longer needs CMH services.
- Thanks so much for always putting "Name's" needs ahead of all others, including ours. Sometimes it takes an outside perspective.
- As a guardian I am very happy with the services provided and the work done by Community Mental Health.
- Wendy Krall is always ready to give help, listen to our problems and concerns, and share in our good news. She is not only the best case manager we could ever hope for, but she is a great friend to us. She is super.
- I feel my daughter wasn't ready to be discharged!!! She feels like they didn't want to help her any longer.
- Stacey is an important part of my life even though she isn't a part of my ACT team. She is very helpful to me.
- Colleen, Rosa, and Robin are very helpful. I have learned a lot about how I can help myself in times of need. I think that the crisis line should get in touch with ACT counselors sooner. I am much better off since I have been a part of ACT.
- I enjoy working with my case worker. I moved from another state leaving my services to be able to continue over here in a new state. I am grateful for all the services so far.
- I am the wife of a consumer filling out this out. So far we appreciate everyone and my husband stated he likes Dr. Burrows. He feels like she cares and is trying to help him at this point. Thank you.
- We are currently trying different medication and some counseling so we are taking one day at a time. We are just starting out.
- I feel very comfortable calling or coming into CMH due to Stacey's calming and very concerning attitude. Thank you Stacey. I look forward to the group that has started to help me deal with my future. I have become a very much happier person with the help of CMH.
- The ACT counselors have helped me move forward to my recovery in many ways. I truly believe without the ACT staff I would (wouldn't?) be living today. The staff has helped me with my relationships with my significant other and children. This is a very important part of my life. I didn't think I would ever have. I just want to say a big thank you.
- Staff provides a complete plan of action. They are aware of resident's needs. Very good care is provided at this AFC facility.
- A big thank you to everyone working with *Name* at Lakeshore. Especially thankful for supporting him to the live the best life possible.
- I'm comfortable taking with Caitlin.
- *Name* will never recover or change from Down's Syndrome but this program at Highline is very helpful to him in other aspects of his life.
- Everyone in the house is (except my daughter) is being worked with in our home-based program. She really needs some help with PTSD and feeling like the rest of us. We are a family-that means we are not being worked with in this family home-based program.
- We are blessed to have all people involved in *Name's* life. He is happy and loved boy (young man) by all. Thank you so much.

- *Name's* support coordinator, Leah, is nothing but helpful, courteous, caring, efficient, easy to address any issue with, and kind. *Name* is a lucky client. She does a fantastic job for him.
- Laurie Niemi is the best.

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 (14 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

* Very good employee. Happy to have her!
* "Name" is very pleasant to have around the dogs. She's very compassionate.
* "Name" fits is very well with our kitchen staff.
* "Name" is always willing to cover extra shifts. If we are slow, she finds things to do on our cleaning list, even the tasks other employees avoid. We are very pleased with what you do! This is a wonderful program and we are grateful you offer it.
* "Name" is doing a very good job.
* "Name" and "ETS" work well as a team.
* "Name" is fun to be around, does pretty much whatever you ask of her. We work well together.

* *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.