Management Summary

[Annual Performance Report]

October 1, 2019

~

September 30, 2020

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 in a trauma-informed culture of care, promoting person-centered planning, integrated healthcare, recovery, and community inclusion.

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/Building & Grounds. In addition, there is Board member representation on the agency's Recipient Rights Advisory Committee, the agency's Consumer Advisory Council, the agency's Anti-Stigma Committee, the NorthCare Network Governing Board, and the NorthCare Network Customer Services Committee. Board members also are members of the Great Lakes Rural Mental Health Association and the Community Mental Health Association of Michigan.

FY 20 Board members included Steve Thomas, (Chairperson), George Beninghaus, (Vice Chairperson), Bob Lynn, (Secretary/Treasurer), Patricia Crabtree, Valerie Swanberg, Dan Siirila, Ken Wegmeyer, Colleen Kichak, Carrie Braspenick, Margaret Rayner, Joe Bonovetz, and Donald Pezzetti.

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, Finance (Board Administration), and Community Services. The CEO also has direct supervision over the positions of CMHA Board's Administrative Assistant/Quality Improvement Coordinator/Compliance Liaison, Recipient Rights Officer/Contract Manager, Network Support Analyst, Information Systems Analyst, Human Resources Coordinator, and 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 Michigan Department of Health and Human Services, NorthCare Network PIHP-CMHSP Contract, and other contracts and conditions as appropriate. The CEO supervises, coordinates, and directs work of the Program 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, Data Coordinator, 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 Child and Family Clinical Supervisor, the Assertive Community Treatment Supervisor, the Adult Case Management/Community Supports Supervisor, outpatient therapy and assessments, and oversees contracted medical/specialty services including 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, Applied Behavior Analysis, Rehabilitation, and Residential Services programs, and staff working within those programs. The Community Services Director oversees the specialty contracts for Physical Therapy services, Occupational Therapy services, and Board-Certified Behavior Analyst services, and the Behavior Psychologist. 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 recipients 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 determination of whether an investigation was initiated immediately when there is an allegation of abuse, neglect, serious injury, or death of a recipient which involves an apparent or suspected rights violation, shall be based on the action by the rights office on receipt of the complaint. Steps to initiate an investigation in accordance with this standard shall be taken within 24 hours of the receipt of the complaint and shall be comprised of proactive rights activities. 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 conducts the quarterly Recipient Rights Advisory Committee meetings. The rights office is responsible for assuring rights protection is provided to all recipients of services in ALL service settings to include CMHA run services and contracted services.

- The RRO also chairs the Wellness Committee and coordinates wellness activities for CMHA and the Serenity Center.
- The RRO also serves as the Contract Manager (CM) who 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 sits on the regional Contract Management Committee and the Statewide Contract Managers Networking Committee.

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 organizes/ conducts new employee orientation and serves as an active participant on the Safety and Credentialing & Privileging Committees.

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, implementation, and maintenance of agency policies and forms, assist with the agency strategic planning and management reporting, 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 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 Committee has the responsibility to maintain a corporate culture based on continuing QI 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 is 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, UM Coordinator, the Recipient Rights Officer/Contract Manager/Safety Committee Rep, the Medical Records Coordinator, and representatives from the I/DD/MI Children/Adult populations. The Medical Director/designee participates in the meetings as needed. The QI/UM Committee meets as needed but not less than quarterly.

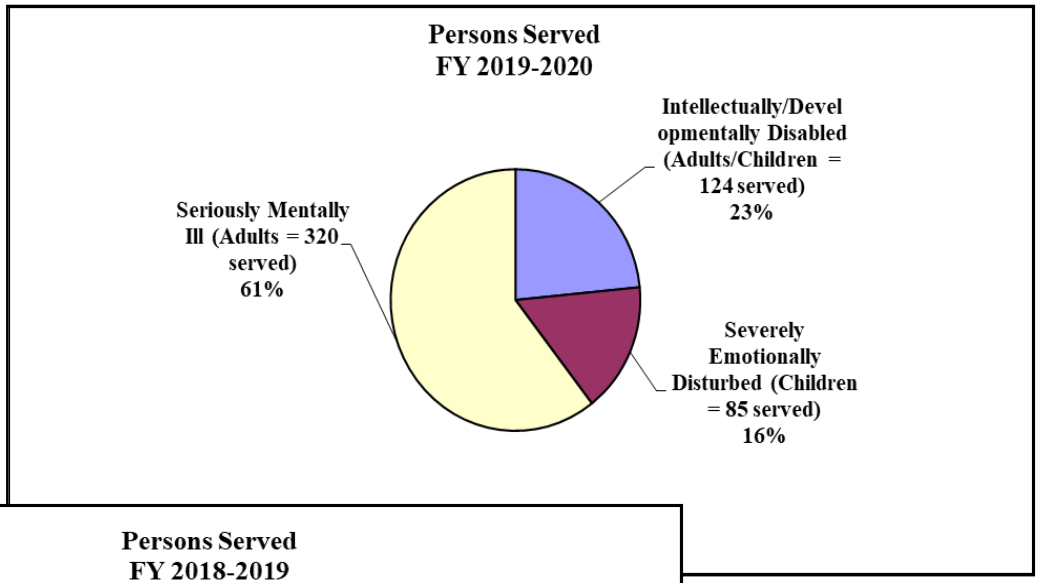
Maintenance Coordinator: The Maintenance Coordinator is responsible to perform repairs, snow shoveling/blowing/plowing, mowing grass, maintaining buildings and grounds, coordinating agency vehicle maintenance, assisting with building security and safety, and coordinating maintenance and repairs with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

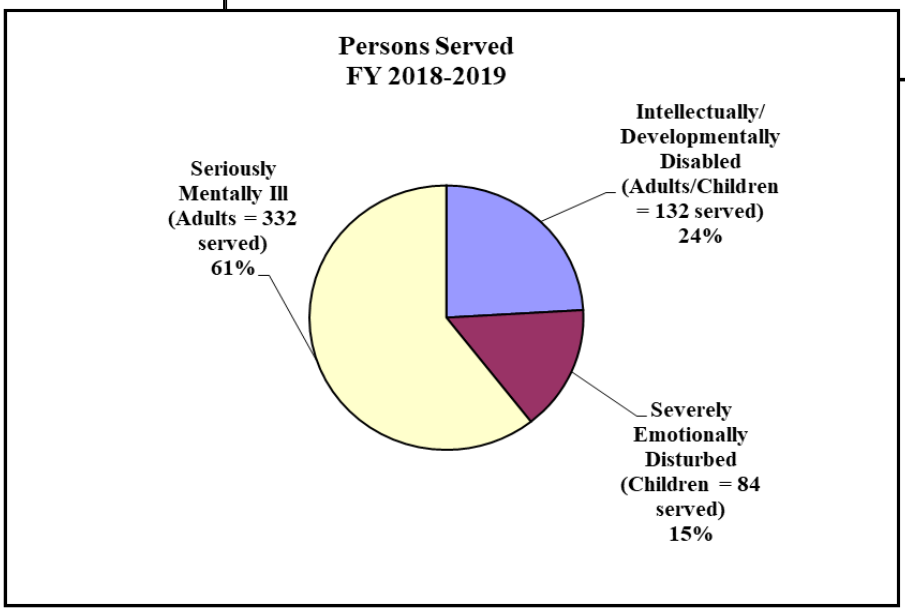
Available Services

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.

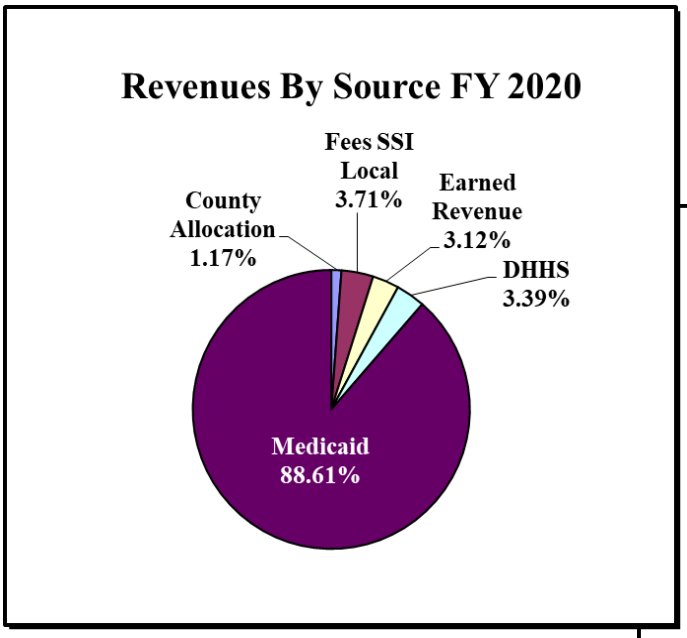
Persons Served

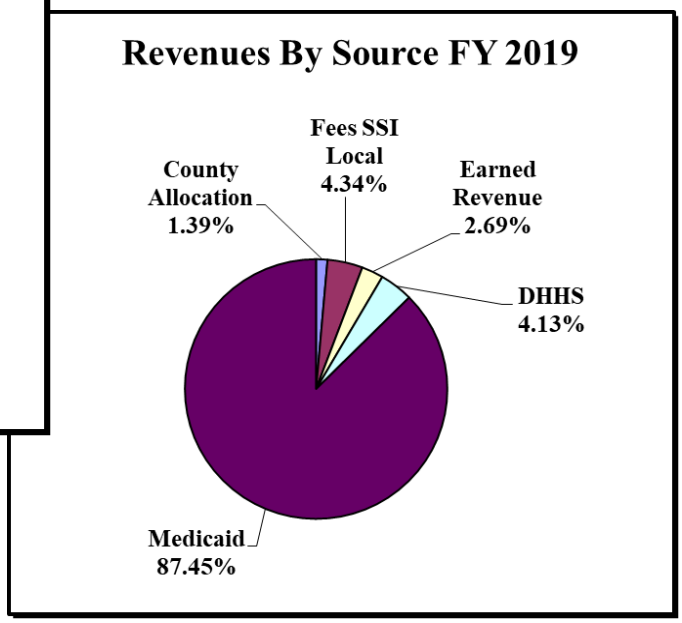
An unduplicated count of 529 individuals received reportable services during FY 2020; this is a decrease of 19 individuals served from last fiscal year. A break down per population is shown in the graph below, with a comparison to last fiscal year.

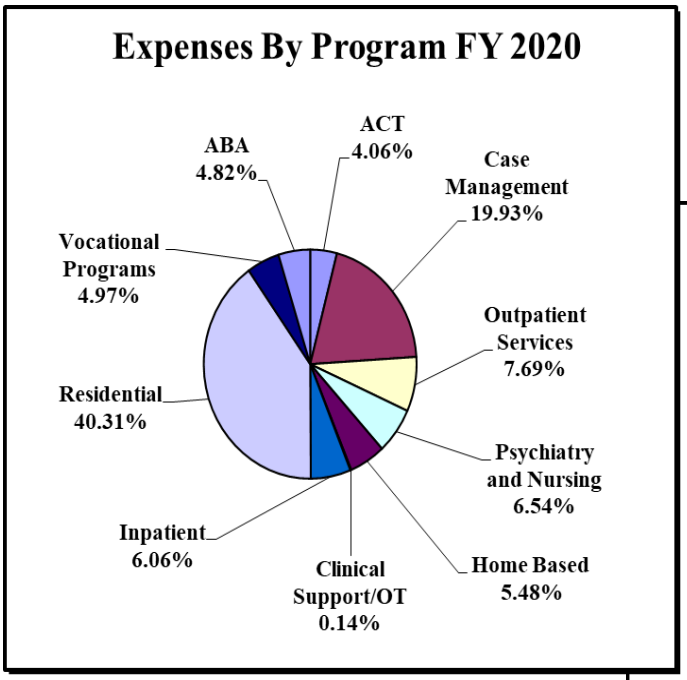


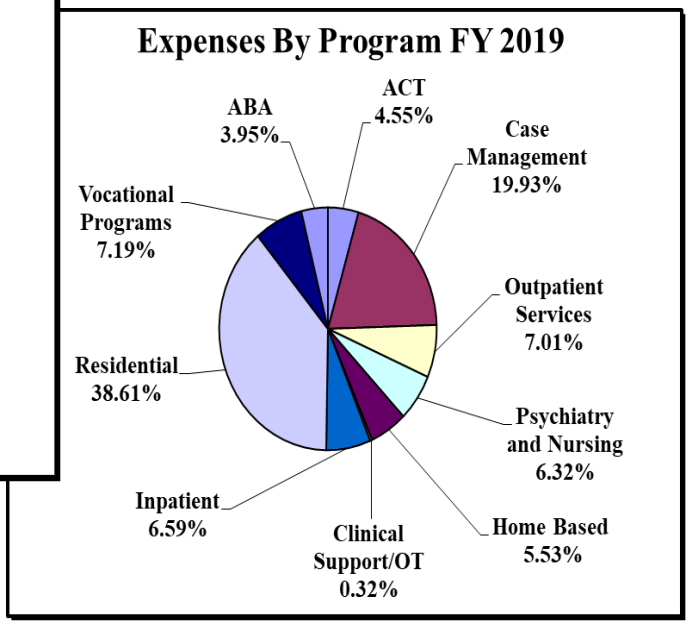


Financial Profile FY 2020
(with comparison to FY 2019)









Quality Assessment and Performance Improvement Program (QAPIP)
Outcomes Summary for FY 2020
(with Quality Improvement Plans for FY 2021)

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 data.

➢ *QI Plan*

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

Utilization Management (UM)

- The number of individuals participating in various Evidence Based Practices programs (i.e., Assertive Community Treatment, Infant Mental Health, etc.), approved/denied assessments, inpatient pre-admission screenings, and diversion data continued to be monitored and discussed during quarterly 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 modified the frequency of their meetings from monthly to quarterly for FY 2020. The Committee conducted numerous disaster drills in the CMHA main building throughout the fiscal year. There were no disaster drills conducted at the Serenity Center due to staffing issues and the Center being closed due to the COVID pandemic. There were a variety of drills and inspections conducted at the three CMHA-operated residential homes. Routine vehicle inspections were conducted throughout the fiscal year on agency fleet vehicles utilized at the CMHA main building and at the residential homes. The Maintenance Coordinator conducted internal building inspections at the CMHA main building. A Michigan Certified Building Inspector conducted the annual external building inspection on October 5, 2019 with no items of concern noted.
- The annual inspection of the First Aid bags located in agency vehicles and in the CMHA main building was conducted, with restocking of the supplies, as needed. The First Aid bags located in the residential homes and at the Serenity Center were also inspected by other CMHA staff and restocked with required supplies, as needed.
- There were 29 staff injuries (seven more than FY 19) resulting in six with lost time or need for accommodation (compared to three lost time or need for accommodation in FY 19). The Safety Committee reviewed all injuries and provided follow-up analysis and recommendations to minimize future injuries, as well as noting any trends/patterns in injury.
- There were 500 recipient incidents (duplicated count) for FY 20; this is a significant increase of 80 incidents from FY 19. Incidents can be coded for multiple categories, hence, some incidents are counted more than once (duplicated count); for example: a recipient experienced an (1) *accidental serious injury from fall*, which resulted in (2) *emergency medical treatment due to injury*, then it resulted in the recipient being (3) *hospitalized due to injury* (three different categories). The highest number of incidents is 105 for the category of "non-serious physical aggression"; the next highest is 66 for the category of "verbal aggression". Medication incidents decreased slightly from last fiscal year, from 67 (FY 19) to 63 (FY 20). 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. Applicable staff continued to address individual consumer risk for injuries with follow-up intervention as directed and recommended, 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, representatives from the Safety Committee provided safety-related quarterly progress reports for the Accessibility Plan, to include identifying and eliminating barriers, with reasonable accommodation, when identified.
- The Safety Committee reviewed agency policies and procedures relating to health, safety, and transportation to assure on-going compliance with indicators and standards established by CARF and other regulatory agencies.

➢ <u>QI Plan</u>
- Continue quarterly Safety & Risk Management Committee meetings.
- Continue to monitor the Strategic Plan's health and safety goals and objectives.
- Continue to monitor medication, health, and safety incidents, and implement prevention and pro-active plans, as needed.
- Continue quarterly reviews 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.

Pharmacy & Therapeutics/Medical Services Committee
- The Committee met quarterly and consisted of agency 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, conducts Peer Reviews, and discusses any infection control issues, as well as the Infection Control Committee, that also meets quarterly.

➢ <u>QI Plan</u>
- Continue to monitor medical and medication incidents and implement prevention and pro-active plans, as needed.
- Continue to conduct annual Peer Reviews.
- Continue Pharmacy & Therapeutics/Medical Services Committee and Infection Control Committee meetings and responsibilities.
- Review agency policies/procedures relating to medical/medication services to assure continued compliance with applicable CARF standards and other regulatory agencies.

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

➢ *<u>QI Plan</u>*
- Maintain quarterly monitoring of the Strategic Plan goals and objectives, encouraging input from CMHA Board and staff.

Outcomes Management System (OMS)
- The OMS is a systematic procedure for determining the effectiveness and efficiency of results achieved by the persons served during service delivery or following service completion and of individual satisfaction with those results. The function of the OMS is to collect and monitor outcome goals and objectives developed by QI work groups for the agency's CARF accredited programs. Although not CARF accredited, goals and objectives for Customer Services continued to be monitored, as well. OMS data for the fiscal year shows 65% overall compliance, a significant decrease from 75% last fiscal year (includes

access goals 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.

- *Michigan Mission-Based Performance Indicators* ~ Four of the five indicators monitored have an established compliance threshold of 95%. All four indicators were compliant for the entire fiscal year, scoring 95% or above for all quarters except for one quarter, where one indicator scored 79.17%. The fifth indicator monitored has a '15% or less' compliance threshold and monitors children and adults who are readmitted to an inpatient psychiatric unit within 30 days of discharge. CMHA was compliant with this indicator for three of the four quarters in the fiscal year; the one quarter not compliant scored 25% (2 of 8 individuals were readmitted to a psychiatric unit within 30 days of their 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. Compliance for these indicators was the same as the Michigan Mission-Based Performance Indicators, as noted above, except the one indicator not compliant scored 78.26%. Compliance for the indicator with a 15% or less compliance threshold was the same as listed above.

➢ *QI Plan*

- Continue to monitor and maintain the OMS, making modifications to increase compliance, as needed.
- OMS work groups to review and modify the goals and objectives and the Program Descriptions and Plans, as needed for FY 21.
- Continue to monitor all performance indicators.

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 is typically mandated by the State and one project topic is chosen by the PIHP that must address integration of physical and behavioral health. 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 recipient safety for the population served.

- PIP #1 ~ *Documentation/Supported Employment/Skill Building*: This project continued from FY 19. Progress continued throughout the entire fiscal year with creating the electronic contract provider progress notes in ELMER. In September 2020, CMHA staff provided ELMER training to Highline staff regarding such; Highline staff were completing vocational progress notes in the ELMER 'training mode'; it is anticipated that transitioning to ELMER 'live' will happen in November 2020 (1st quarter FY 21).

- PIP #2 ~ *Engagement in Service*: This clinical project focuses on increasing the number of persons served by reducing the number of individuals discharged from services due to no-shows (not showing up for their appointment). This project is monitored by the regional UM Committee and they continue to discuss and implement strategies to keep individuals involved/increase engagement in services across the region. FY 20 data was not received from NorthCare regarding this project.

- PIP #3 ~ *Follow-Up After Inpatient Psychiatric Hospitalization Discharge - 7 Days (the percentage of discharged enrollees age six (6) and older who were hospitalized for treatment*

of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven (7) days of discharge): This PIP is on-going from prior years. Per the June 2020 report, baseline data was corrected for Calendar year 2018 for both children and adults, which resulted in establishing new goals. Calendar year 2019 data shows 61.53% of children received follow-up care within seven days of discharge (3.96% below *2018 baseline*, 13.75% below *2018 goal*, and 16.35% below *2019 goal*). Calendar year 2019 shows 61.96% of adults received follow-up care within seven days of discharge (1.67% above *2018 baseline*, 0.02% below *2018 goal*, and 4.4% below the 2019 goal). Some of the lack of follow-up is due to discharge planning, especially with individuals who chose not to follow-up with CMHs, which should start at the time of admission. NorthCare staff conducted training and provided documents to clinicians across the region; they were also working on a report to track contacts from date of admission forward to help monitor discharge planning. It is anticipated that Calendar year 2020 data will not be available for comparison until Q2 FY 21.

- <u>*QI Plan*</u>
  - Continue to participate in the regional PIPs as required.

Record Review and Service Verification

- For FY 20, the Record Review Checklist and the procedure for such was modified. A total of 13 records were reviewed per quarter with 56 indicators monitored. Data analysis reports were developed from the quarterly record reviews that were conducted. For FY 20, a total of 50 records were reviewed. Of the 56 indicators, 5 indicators were not applicable for the entire fiscal year. Of the 51 applicable indicators, 41 scored as "met" (95% or higher) for an overall compliance score of 80%; of the 41 compliant indicators, 30 scored a perfect 100%. A trend continued with one indicator being non-compliant for multiple fiscal years; observations were provided to the (service) Program Directors, along with any trends regarding individual provider non-compliance. A compliance comparison to FY 19 cannot be made due to the modification of the Checklist and record review procedure.
- CMH's Service Verification process was modified for FY 20. The new process, which mirrors NorthCare's process, shows all four quarters scoring 100% compliance for the 10 Service Activity Logs (SALs) and the 10 Claims selected for review each quarter. CMH's Service Verification, however, includes *all* services where NorthCare's is specific to *Medicaid* only.
- NorthCare's quarterly Service Verification audits focus only on *Medicaid* services. Q2 FY 20 data shows no invalid SALs or Claims for the 10 that were reviewed. Data for Qs 1, 3, and 4 was not received.
- Highline Service Verification was also conducted quarterly. FY 20 overall compliance was 99%, a very small decrease from FY 19's overall compliance score of 100%.

- <u>*QI Plan*</u>
  - Continue CMH quarterly record 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 (service) Program Directors for the purpose of including "*Findings of Documentation Review*" on individual performance evaluations, as required by NorthCare.
  - Continue to provide record review data to the CEO, (service) Program Directors, and to providers to review and discuss ways to assure compliance.
  - Continue quarterly Service Verification reviews.
  - 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 which pertained to agency COVID procedures. There were four grievances received via Customer Services (four less than FY 19) and all were resolved within the required 90-day time frame. All information was reviewed by the QI/UM Committee, with no trends or patterns 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 until March 2020 when the COVID pandemic hit and the CMHA Board meetings began to be held virtually. The staff presentations provided 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.
- There were no CMHA staff provided/sponsored trainings in/for the community for Calendar Year 2020 due to the COVID pandemic.

➢ *QI Plan*

- Continue to implement NorthCare's '*Member CMHSP Trainings*' 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, as allowable due to COVID.

Site Surveys

- **CARF**: The CARF resurvey was conducted in May 2019 which resulted in another 3-year Accreditation Award. The Year-2 Quality Improvement Plan (QIP) was submitted to and accepted by CARF in June 2020.
- **NorthCare**: The NorthCare annual site review was conducted remotely, in July 2020 and the overall score was 99.1%. Although there were three indicators scored as "partially met", the compliance score is considered 'full compliance'. A Plan of Correction (POC) was submitted to and accepted by NorthCare for the three indicators that scored "partially met". FY 20's score is an increase from FY 19's score of 98.18%.

➢ *QI Plan*

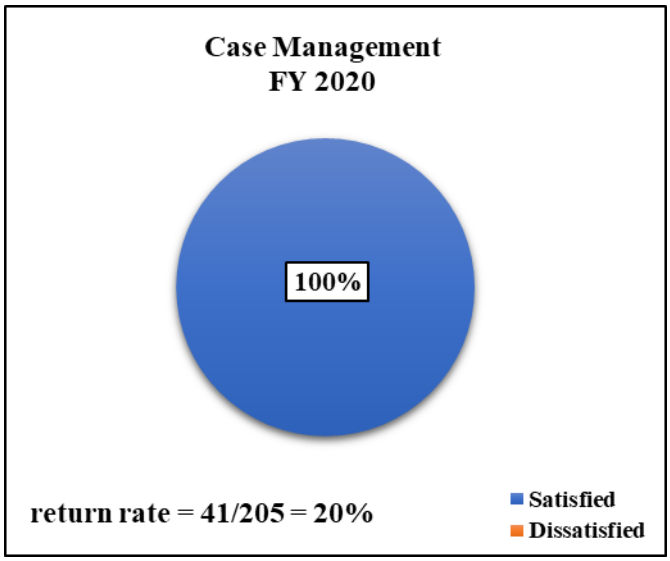
- All items on the CARF QIP were completed. Assure on-going compliance with applicable CARF standards. Submit the Annual Conformance to Quality Report as required by CARF.
- All items on the NorthCare POC were completed. Assure on-going compliance with applicable NorthCare protocols. Prepare for FY 21 site review.

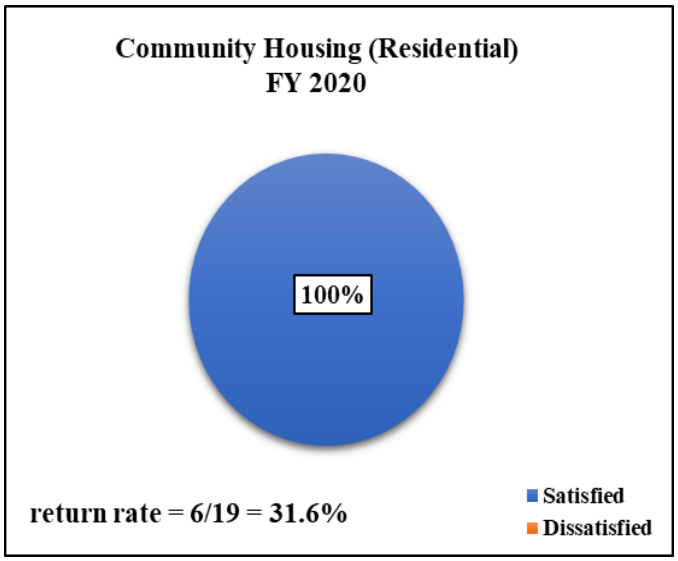
- ***Other Surveys***
  - Throughout the fiscal year, CMHA's three residential group homes experienced various safety reviews (fire safety inspection by the State Fire Marshall/Department of Licensing and Regulatory Affairs, annual fire extinguisher inspection/service [J.F. Ahern], smoke alarms/sprinkler systems). The Department of Licensing and Regulatory Affairs conducted a licensing inspection at the Lakeshore and Greenbush group homes with no concerns or issues identified and the Adult Foster Care licenses were renewed for another two years at both homes. The Lakeshore and Greenbush group homes also experienced a virtual Home and Community Based Services Heightened Scrutiny audit in August 2020; results have not yet been received.
  - CMHA staff conducted annual site reviews (virtually, due to COVID) at CMHA's residential homes and at Highline Corporation; all four sites received an overall compliance score of 100%.

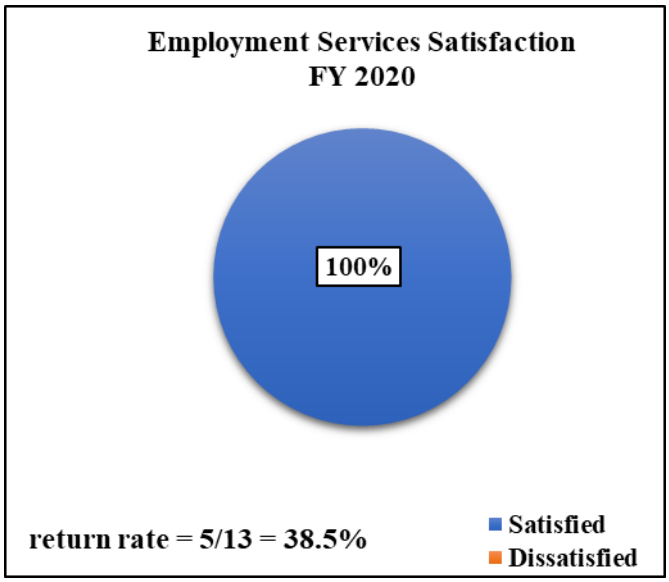
➢ *QI Plan*
- Assure on-going compliance with applicable standards and indicators specific to the licensed residential group homes.
- Assure annual site reviews are conducted at the CMHA-owned residential group homes and at Highline Corporation.

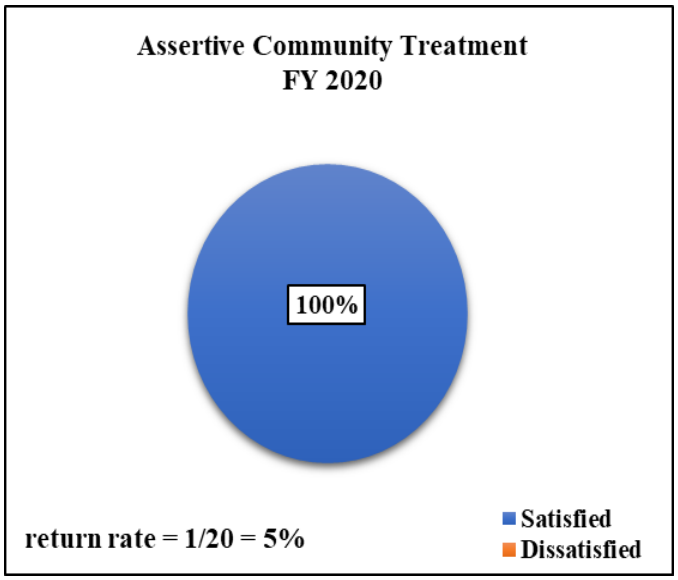
Consumer Satisfaction Surveys
- Satisfaction surveys were distributed monthly to various recipients. Data is reviewed by the CMHA Board, the QI/UM Committee, the Consumer Advisory Council, and staff.
- The following graphs show satisfaction results for each CARF accredited program (Case Management, Assertive Community Treatment [ACT], Employment Services [Supported Employment], Community Housing [Residential], and Crisis Intervention [Emergency Services]), along with satisfaction results for programs not CARF accredited (Outpatient, Home Based, Peer Supports, Applied Behavior Analysis, and Serenity Center).

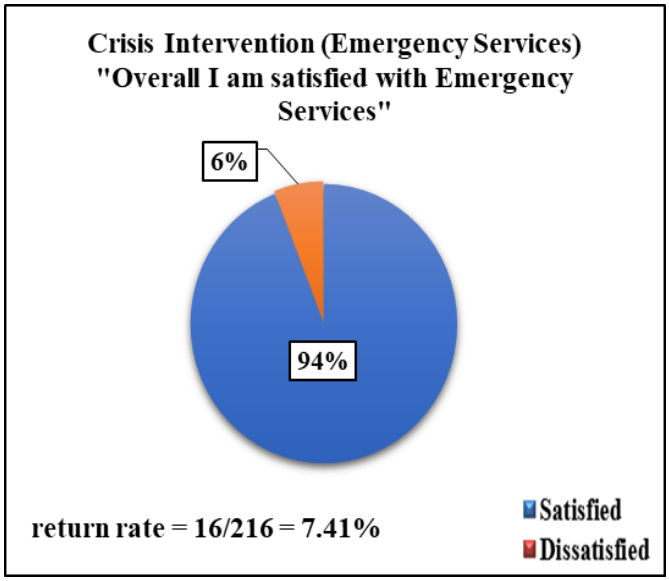
➢ *QI Plan*
- Continue to assess satisfaction with CMHA services and programs.

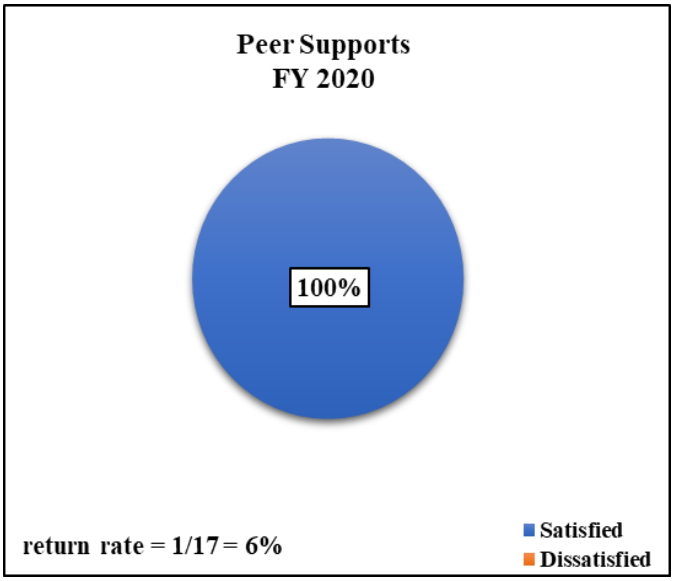


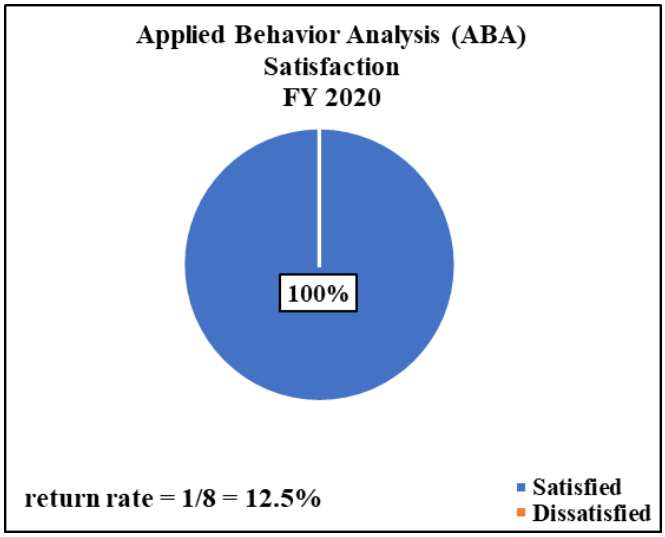


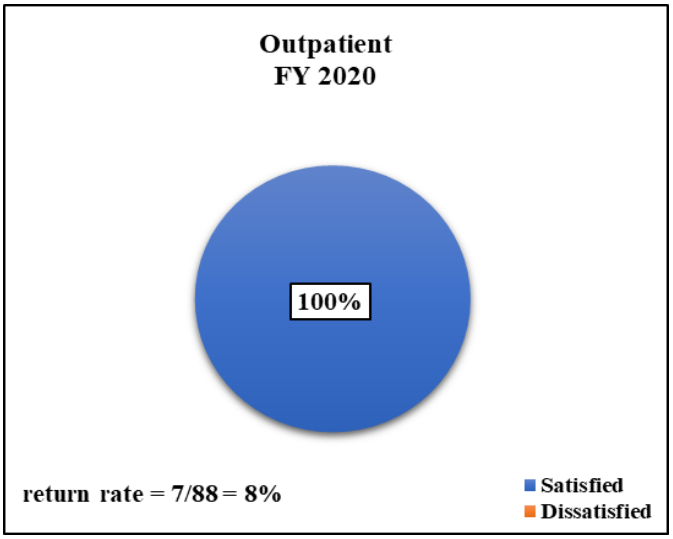

Employment Services Satisfaction
FY 2020
100%
return rate = 5/13 = 38.5%
Satisfied
Dissatisfied

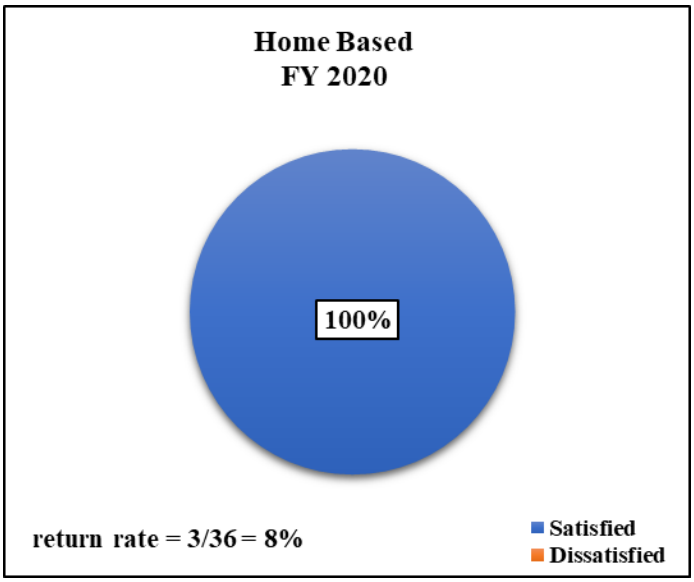

Assertive Community Treatment
FY 2020
100%
return rate = 1/20 = 5%
Satisfied
Dissatisfied

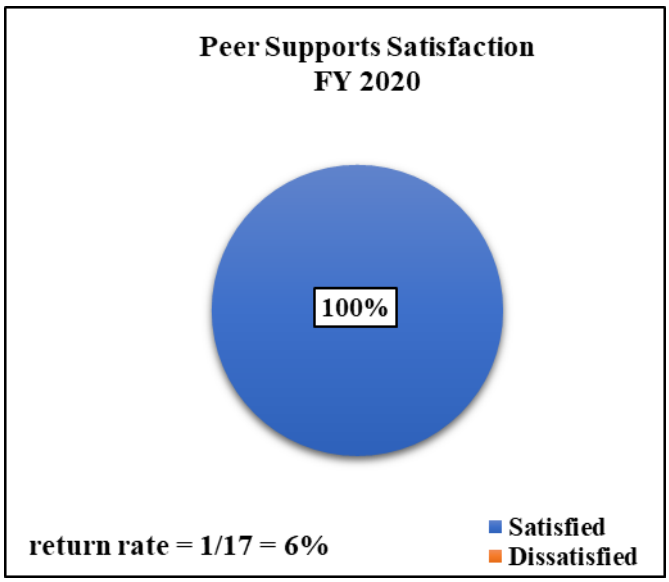

Crisis Intervention (Emergency Services)
"Overall I am satisfied with Emergency Services"
6%
94%
return rate = 16/216 = 7.41%
Satisfied
Dissatisfied

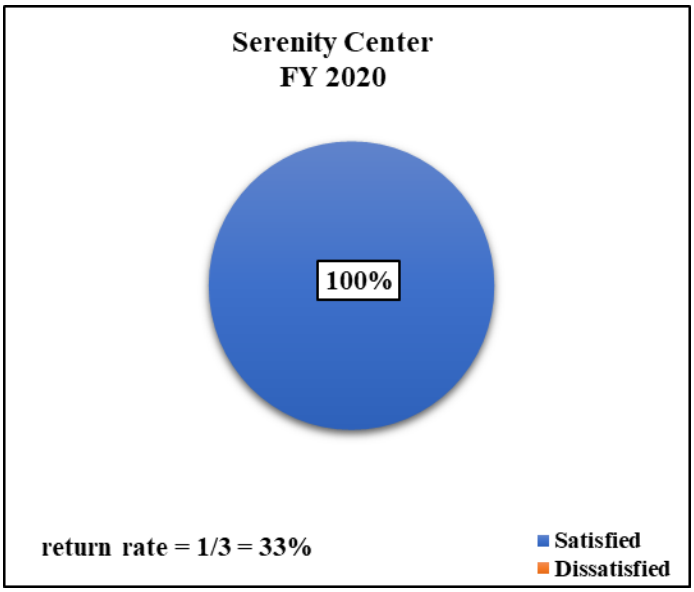

Peer Supports
FY 2020
100%
return rate = 1/17 = 6%
Satisfied
Dissatisfied

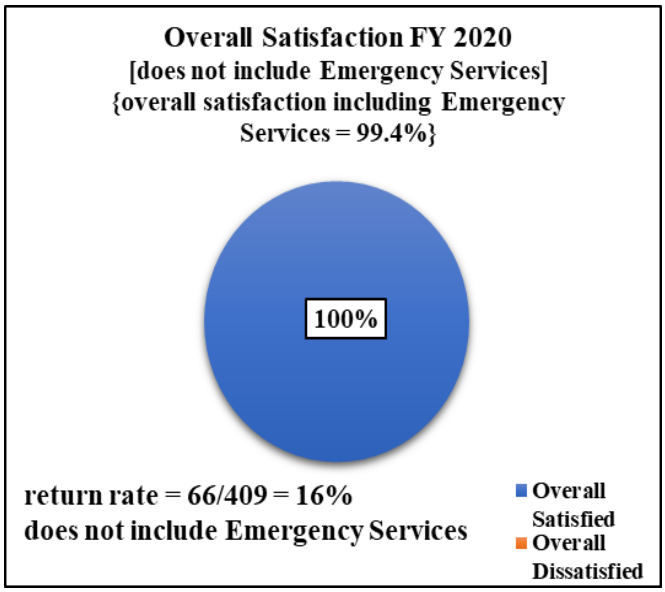

Applied Behavior Analysis (ABA)
Satisfaction
FY 2020
100%
return rate = 1/8 = 12.5%
Satisfied
Dissatisfied


Outpatient
FY 2020
100%
return rate = 7/88 = 8%
Satisfied
Dissatisfied









Consumer Comments on Satisfaction Surveys

- "Name" is doing very well. He is given opportunity to achieve his goals. He loves his work and the group activities.
- Tara and Kristina are amazing. They have helped us tremendously with our daughter. We are super thankful for them and CMH.
- Wendy Krall has always been in our corner and is an awesome advocate for our son and us! She is kind, caring, and a wonderful friend to us! We know we can always count on Wendy for help and advice.
- Everyone is friendly and professional and provides the optimal support for me on my treatment plan. I appreciate all my support team. Would love opportunity to be hired as peer support specialist while I'm obtaining my RN license to practice part-time in Michigan.
- Although he is unable to speak, "name" will try to indicate that he needs help with some things such as dressing.
- Joe Hellman is so kind and caring. He responds quickly to voicemail.

- ❖ The meaning for question 3 is I want to go to online college, but I may have to use the loan also for online college. I need help with learning more about my career I want, if I decide to go. I enjoy the services I'm provided. The staff are awesome there.
- ❖ Still too early to see much change. Some services are not yet started. It's a very slow process getting access to services. Punctuality could be improved.
- ❖ My case manager is awesome. She is very caring when it comes to (consumer). We could not have asked for a better person. Nicole Nasi.
- ❖ I feel better since I have let me be a writer instead of a speech pathologist.
- ❖ Case manager Nicole Nasi is wonderful to work with. A great asset to your team.
- ❖ We love Karin and Dr. Burrows and Stephanie at the front desk.
- ❖ (consumer) CMH team is amazing. They know him very well and meet all of his needs. I am grateful to everyone for providing his services compassionately.
- ❖ Most excellent case manager! Many thanks.
- ❖ We have Janet as our case manager and she is awesome. Great communication. Helps with everything we question. I never worry about the care my niece receives. Keep up the great job. Janet has a big heart of gold. We are happy to have CMH in our community. Keep up the great work and again we need more like Janet. She is awesome.
- ❖ Laurie has been there for me through thick and thin. She is like family in my eyes. I would be lost without her. She is awesome.
- ❖ We are very pleased with the services and help we received from our case worker Leah Nikula. She is very understanding and willing to work with us in every situation or issue we have.
- ❖ Keep Katie!
- ❖ CMH really helped us with our foster child. Your support was very appreciated during some trying times. Thank you for your help!
- ❖ It's been almost a year of services and haven't seen much happen yet. It's very slow process.

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 (6 of 12) by employers indicated 100% satisfaction with SE services they received. Satisfaction with the individual's job performance at their place of work was 100%.

Comments on Supported Employment Reviews

- ❖ "Name" has been doing a great job. We have had a couple issues, but I was able to resolve them. Overall, "Name" has shown much improvement since June.
- ❖ "Name" is great.
- ❖ "Name" is great to work with. Sometimes I need to push a little harder to keep on track. He has been doing a really good job.
- ❖ "Name" is more limited in the tasks she is able to do compared to other associates in the department. For instance, we don't have her completing price changes. She also has a tendency to get off task, but we realize she has limitations and try to task accordingly.

*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.