ANNUAL QUALITY REPORT

April 28, 2006

SOUTHWEST COLORADO MENTAL HEALTH CENTER, INC.

Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution… Will A. Foster

SOUTHWEST COLORADO MENTAL HEALTH CENTER MISSION STATEMENT

Southwest Colorado Mental Health Center makes a meaningful difference by delivering the highest quality mental health service to the community in the most appropriate, affordable, educational, and accessible manner.

QUALITY IMPROVEMENT PROGRAM VALUES

We believe that quality improvement requires a continuous process of evaluating the impact of our programs/services/efforts on the lives of consumers, their families, friends and support systems, and the communities in which they live.

The assessment of the impact of our programs/services/efforts requires a joint effort of consumers, family members, friends, support systems and community stakeholders.

The structure of our services, their delivery and impact – and hence this plan, is guided by the Center's six core values (see Exhibit A).

INTENT OF THE QUALITY IMPROVEMENT PROGRAM

The intent of the Southwest Colorado Mental Health Center Quality Improvement Program is to objectively and systematically monitor and evaluate the appropriateness and quality of consumer care, pursue opportunities to continually improve consumer care and resolve identified problems. Included in these activities are those risk management functions related to clinical aspects of consumer care and safety issues. Consumers, family members and local agencies are critical parts of the evaluation of quality improvement activities and are involved in the evaluation of Center services and the design and implementation of best practice initiatives.

QUALITY IMPROVEMENT PROGRAM STRUCTURE AND RESPONSIBILITIES

Southwest Colorado Mental Health Center's Quality Improvement Program is continuous and involves activities under two headings;

- *Identification of Problems and Improvement Opportunities,* and
- *Mechanisms to Improve Quality*.

IDENTIFICATION OF PROBLEMS AND IMPROVEMENT OPPORTUNITIES

No system can rely upon a single source of input for improvement of service quality. Southwest Colorado Mental Health Center makes use of multiple mechanisms to ensure identification of problem areas of service and opportunities for improvement.

Quality Improvement Steering Committee (QISC). The QISC is the primary mechanism for identification of problem areas and improvement opportunities. The Chief Executive Officer (CEO) of the Center is the chair of the QISC which is made up of staff members strategically selected to bring different skills and perspectives to the committee. Though not included at inception, representatives from community agencies, consumers and family members have been invited to serve on the QISC. A consumer was a member of the QISC for a part of 2005 until work demands made it too difficult to continue. We are now recruiting another consumer representative.

The QISC meets monthly and reviews, at a minimum, the following:

a. Progress on prior months' assigned actions/activities

b. Grievances and Appeals (through to resolution)

c. Critical Incident Reports

d. New Policies and Procedures for approval

e. All such reports that are due or are available including Qualifacts reports, Access to Service, SPQM data on both the Center and CBHC/Center issues, Value Options quality reports, the State MHSIP Consumer Satisfaction and such other reports as may, from time to time, be requested or available (e.g., Community Agency Satisfaction Survey, work group reports, practice variance reports, quarterly record review reports, etc.)

f. Informal input from consumers, staff, or community members

g. The Center's Annual Quality Report

Customer Service. Southwest Colorado Mental Health Center recognizes that customer service is at the center of quality service and positive consumer outcomes – making a meaningful difference. The QISC evaluates the Center's performance on the MHSIP Consumer Satisfaction survey each year. Additionally the Center invests in training – in-service training, conference attendance, and trainers brought to the Center.

Regular Reports. Problem areas and opportunities for improvement are also identified through regular data-based reports designed in the Center's Qualifacts system and through Center contracts with other data providers. These reports (not yet complete) will be available to all staff (management, support and direct service), and relevant reports will be reviewed monthly at the QISC.

Record Reviews. To ensure identification of problem areas and opportunities in clinical documentation, the Center's record review team audits 10 records each month with regard to clinical services. This review process began in May 2005 and extended through October, when a staffing change interrupted the schedule. However, more than 120 records were reviewed in 2005. The following components are reviewed at a minimum:

a. Intake information - for thoroughness and appropriateness of diagnostic formulation

b. Service Plan - for appropriateness of diagnosis, progress on goals and objectives and consumer participation in its construction

c. Notes - in terms of their relation to Service Plan goals and objectives

Additional Mechanisms. The Center makes use of additional mechanisms to identify problem areas and opportunities. These include but are not limited to:

a. *Leadership Committee*. Leadership is made up of staff members who are informal leaders in the Center. These are staff who other staff turn to for professional guidance and who have demonstrated an investment in, and contributed to the growth and improvement of, the Center. Staff convey to Leadership members concerns within the Center. Any concerns arising are conveyed to QISC following each Leadership meeting.

b. *Supervision Structure.* The Center's formal supervision structure makes use of formal lines of responsibility from staff through management. Supervision occurs both regularly and informally. Concerns and opportunities for improvement identified by supervisors in the context of supervision are conveyed to the QISC.

c. *Informal Consumer Feedback.* The Center has several formal mechanisms for complaints, grievances and appeals related to services. These include a Grievance & Appeal process and the MHSIP Consumer Satisfaction Survey. To ensure that no informal communication related to problem areas or opportunities for improvement is lost, all staff are expected to convey all consumer comments related to services to the QISC.

MECHANISMS TO ENSURE CHANGES AND SUPPORT IMPROVED OUTCOMES

Southwest Colorado Mental Health Center has multiple mechanisms to ensure continual implementation of improvements in care and consumer outcomes.

Quality Improvement Steering Committee (QISC). The QISC ensures implementation of improvements in care and outcome through:

a. *Assignment of Work Groups*. Quality Improvement Project Work Groups are established by the QISC to address or investigate specific QI issues. These work groups are project specific and time limited. In addition to providing critical quality information, they offer staff the opportunity to engage more meaningfully with the Center, increase staff buy-in to continuous QI, improve morale/Center pride, and to develop staff leadership and vision.

b. *Ad Hoc Report Requests*. There are often issues identified through Grievances, Critical Incidents or staff input that can be addressed immediately and do not require a Work Group. In these instances, an individual or program will be asked to address the problem and provide either a written report to the QISC or verbal report at a subsequent meeting.

c. Assessment of implementation impacts through:
    - System reports
    - Feedback from Leadership Committee
    - Informal communication to staff and through supervision

Training. The Center supports both in-service and external training opportunities to ensure staff understand policies and procedures and have the skills necessary for their implementation.

a. The Center provides regular in-service training (through semi- annual All Staff Training) and irregular in-service training to staff on policies and procedures as well as skills necessary for continuous quality improvement. The Center makes maximum use of the skill sets of staff to provide in-service training opportunities for staff. Where skill sets are not present, the Center, from time to time and as need dictates, brings skilled outside trainers to the Center.

b. The Center includes in its annual budget such sum as is prudent and practical to pay for training opportunities outside of the Center

Reports. Regular and special data reports available through Qualifacts and other contract services are used by the QISC, management and supervisors to assess the impact of quality improvement efforts. This includes regular review of the Access to Care Report.

Leadership Committee. The Leadership Committee is available to follow up on quality improvement initiatives as appropriate for the specific initiative.

Supervision Structure. The supervision structure of the Center is critical for training, supervision and follow-up of quality improvement initiatives as appropriate.

Merit Bonus System. The Merit Bonus System provides a percentage bonus each year based upon specific Center performance indicators. In order to support continuous quality improvement, a minimum of 75% of the Merit Bonus performance indicators directly relate to improved care and consumer outcomes.

QUALITY IMPROVEMENT ACTIVITIES AND FINDINGS - 2005

QUALITY IMPROVEMENT STEERING COMMITTEE (QISC)

Complaints/Grievances/Appeals. In 2005, the QISC met on 12 occasions. A total of 32 cases were reviewed under Complaints/Grievances/Appeals and monitored to their conclusion. Below is a table listing the Complaints/Grievances/Appeals by service and status and resolution of complaints/grievances.

Service	Founded	Satisfactory Resolution	Unsatisfactory Resolution	*	Unfounded	TOTAL
Crisis/Emergency	1		1		3	4
Detox Services	2	2			1	3
Jail Services				(1)*		1
Mental Health	11	9	2		11	22
Residential					1	1
Other (Cx not related to Center)				(1)*		1
TOTAL	**14**	**11**	**3**		**16**	**30**

*Grievance withdrawn and shifted to advocacy – not included in TOTAL

The grievances referenced in this report are those which were closed/resolved in calendar year 2005. Of the 32 total initial grievances, 11 grievances pertained to clients on Medicaid or Medicare (five pertained to Medicaid-only clients while six pertained to clients on both Medicaid and Medicare). There were 21 grievances filed by clients who are either self-pay or private insurance.

The number of grievances has increased from last year. We believe this is due to two factors: SWCMHC is seeing more clients, and the processing of grievances has changed somewhat – including "informal" grievances as part of the total. Additionally, through staff experience and training, our staff members increasingly regard the grievance process as a positive process and have shown themselves more willing to help clients initiate the process.

SWCMHC processed a total of 32 grievances; 14 were substantiated, 16 were unsubstantiated, and 2 were withdrawn in favor of advocacy. Of the 14 substantiated grievances, 11 were resolved to the client's satisfaction, and three were resolved but not to the client's satisfaction. Every substantiated grievance resulted in a corrective action, with some resulting in multiple actions.

1. Three resulted in supervisory consultation and/or training.
2. Six initiated or impacted policy change.
3. In two instances, staff either resigned or were terminated.
4. In one instance, fees were waived and additional services were offered without charge.
5. Requested services were provided four times.
6. One grievance preceded the notification of a third party of a HIPAA violation.
7. Two initiated communication with a community partner.

Unsubstantiated grievances are taken very seriously. A situation handled correctly yet still resulting in a negative outcome offers opportunity for learning and improvement. The following actions are the result of steps taken relating to unsubstantiated grievances.

1. Eleven of the resolutions involved explanations and clarifications.
2. One resulted in supervisory consultation and staff training.
3. A client was assisted in changing their payeeship to a different entity.
4. A client was assisted in setting an appointment for a second opinion with an outside provider.
5. Two clients were referred to advocacy or other organizations for help.
6. Two situations resulted in policy or procedural changes.

Critical Incidents. In 2005, the Center had 56 Critical Incidents, all of which were reviewed at QISC. Three of the incidents involved the suicide death of a consumer. In each of the three suicide cases, the information was reviewed to determine if the Center could have foreseen the suicide and taken any steps to avert the suicide. There were no cases where we could reasonably have foreseen the suicides or expected staff to have been able to avert the suicide.

Of the 56 incidents, 13 involved medication errors. Ten of these errors occurred in the Detox facility and three in Stepping Stone. These errors led directly to changes in Detox medication policy and a revision of Stepping Stone medication administration policy as well as additional staff training.

The second highest incident count came from assaults on staff or between consumers. All 11 occurred either in the Detox (10) or the Stepping Stone (1) facility. Only one was preventable and the staff member involved contributed to the incident. That staff member's employment was terminated.

The incidents included eight unauthorized leaves (four from Detox, three from Stepping Stone, and one child slipped away from their group in Cortez). Seven incidents involved destruction of Center property (four at Detox, two at Stepping Stone, and one in Cortez). In the unauthorized leaves and destruction of property, the actions were not preventable given our facilities and supervisory availability.

Of the remaining 14 instances, seven involved medical conditions (seizures or illnesses), falls at the Detox (six) or a fall outside our Cortez office; two involved suicide attempts (with one attempt at the Detox leading to changes in observation schedules); and single incidents of unauthorized visitor (Stepping Stone), an off Center client injury (traffic accident), staff injury at the Detox (not client related), client possession of illegal drugs (appropriately discovered at Stepping Stone), and a threat from a client to a staff member (also appropriately addressed).

Of the 56 incidents reported, 36 occurred at the Detox facility and 14 at the Stepping Stone facility. Thus, 50 of 56 incidents occurred at one of these two acute residential facilities. The new Crossroads facility planned for October 2006 will contain a new Detox facility with much improved design, and a new Acute Treatment Unit addressing the acute needs currently being provided through the Stepping Stone program. These new facilities will support a substantive reduction of critical incidents.

Work Groups. In 2005, the QISC oversaw three work groups: one addressing Service Plans and related documentation; another to review and revamp triage, intake and enrollment for adults and children (separate approaches to each); and the third to improve the transition between crisis services and other internal and external programs.

The Service Plan Work Group's task was to ensure that all consumers had up-to-date service plans that were developed jointly with consumers, were strength based, and contained measurable goals appropriate to the diagnosis and presenting problem. The Work Group accomplished the following:

- A thorough review of service plans in 120 records;
- Development of consistent guidelines for managers in evaluating/accepting staff service plans;
- A presentation on strength based service planning by Larry Marsh, Division of Mental Health Services;
- Two special service planning clinics for clinicians;
- Updated Service Plan Workbook to assist clinicians develop service plans; and,
- Researched and secured service plans from model Colorado sites recommended by the Division of Mental Health Services and integrated those findings into training.

The QISC initiated a Work Group to review and revamp our intake/enrollment process. This work group, headed by the Senior Vice President for Outpatient and Emergency Services, was charged with improving access to Center services. The Group:

- Refined and redefined the triage function center-wide and assigned specific staff to this function at each outpatient service location;
- Developed a triage "script" to ensure consistency in our message to clients regarding the information required for assessment;
- The Group also developed a triage database to track access to care and ensure timely triage follow-up calls;
- Developed and implemented a new child/adolescent assessment instrument and protocol to replace old intake procedures;
- Developed a new Adult Assessment instrument and protocol to replace old intake procedures; and
- Initiated a protocol to assign a therapist to follow (stay in regular contact regarding status and needs) any client whose services are delayed.

The QISC had a third Work Group to improve the transition between crisis services and other internal and external programs. That group identified a number of barriers to effective communication between programs. The group addressed specific barriers (through cross-training) that had led to the initiation of this Work Group, but also recognized a larger system need for integration of services. As a result, a management group was established to investigate and plan for a system-wide integration of services led by a single point of entry model.

Report Reviews

- Customer Service Action Plan
- Annual Quality Improvement Report
- MHS 2004 Audit (and Plan of Correction)
- Access to Care
- Catalytic Coaching (from MHCD)
- Community Partners Survey (see Exhibit B)
- MHSIP & CCAR Indicators Report
- Employee Retention Survey

Additional QISC Activities/Actions/Accomplishments.

- Assembled an inventory of current staff participation in community projects, summits and committees to ensure adequate community representation.
- Creation of a wallet-sized fold-down handout for crisis services and access to services in general.
- Reviewed all published material to ensure crisis numbers were included.
- Reviewed expected protocol with answering service.
- Reviewed new information on Ombuds program.
- Admission process to Stepping Stone was revised to ensure clients and families understand the implications of voluntary admission.
- Developed a system to reduce/eliminate self-administration errors for consumers living independently.
- Developed a new Treatment Summary form to be of greater use to other organizations requesting client information (with authorization) and Center staff.
- Investigation of SPQM Outlier Reports as companion to random/select record reviews.
- Review of article: Can Your Organization Sustain An Audit?
- Initiated policy to ensure all clients requesting services are contacted immediately following their request and receive a follow-up status phone call within a week.
- Review and approval of update of, or new policies and procedures for, the following:
    - Corporate Structure and Values
    - Availability and Accessibility of Services
    - Critical Incidents (and subsequent revision)
    - Fraud & Fiscal Abuse
    - Identification of Problem Areas and Opportunities
    - Mechanisms to Implement Improvements
    - All Fiscal Policies and Procedures
    - Infection Control
    - Front Desk Operation
    - Residential Standards
    - IT Policies and Procedures (and subsequent modification)
    - All Clinical Standards
    - Vocational Services
    - Emergency Services
    - Fee Policy
    - Modification to Deposit of Funds
    - Documentation for Medicare Part B
    - Substance Abuse
    - Red Cross Disaster and fee waiver
    - Payeeships
- A thorough revision of triage and enrollment for outpatient services for adults and for children.
- Identification and follow-up on new policy and procedure regarding medications at the Detox.

CUSTOMER SERVICE

Southwest Colorado Mental Health Center recognizes that customer service is at the center of quality service and positive consumer outcomes. In 2005, the Center monitored progress on the previous year (revised) Customer Service Plan and sponsored two trainings through national organizations: *Customer Service for Health Care Professionals*, and *Win-Win*

Negotiations (to help staff in working with clients). The QISC also reviewed the Community Partners Survey (Exhibit B), a community customer satisfaction instrument that was administered in October 2005.

REGULAR REPORTS

Problem areas and opportunities for improvement are also identified through regular data-based reports designed in the Center's Qualifacts system and through Center contracts with other data providers. These reports (not yet complete) will be available to all staff (management, support, and direct service).

Qualifacts Reports. This has been a frustrating year trying to complete the designed reports Qualifacts has contracted to provide. Three reports were completed in 2004, but were at various times corrupted due to new Qualifacts structures. We believe that now, these reports (Outpatient Census, Consumer Activity, and Complaint/Grievance) are operational. The Capacity Management Report is still under construction. This report will be the primary supervisory report. It contains a section on Kept/Canc/NS with percentages, a section on service cost, a section on hours of service provided, and a section of expected service ratios. This report supports our Merit Bonus system described below.

Another report essential to the Merit Bonus system, and to the increasing demands on outcome data, is our Outcome Report. It, too, is under construction and required a revision to our Service Plan in order to capture progress on service plan objectives.

We plan for these five reports to be available in 2006 and for the data they provide to be reviewed in QISC and as indicated with direct service staff.

SPQM Reports. Southwest Colorado Mental Health Center contracts directly with David Lloyd and MTM Services for monthly Center data reports, and through the Colorado Behavioral Healthcare Council (CBCH) indirectly with MTM Services for an additional set of data reports. Center reports provide data on service volumes, activities, payers, appointment codes, staff time, diagnoses and practice variance variables. Reports through CBHC allow the Center to compare its services and performance against the other 16 Colorado mental health centers in terms of payer profiles, ethnicity, age, diagnoses, and gender of consumers, service volumes, appointment codes and General Assessment of Functioning (GAF). Crisis Service volumes by time of day allowed us to develop a better Crisis Service staffing pattern. The CBHC reports are providing the Center information on possible ways to serve diagnostic groups more effectively.

These reports are reviewed monthly at an SPQM WebEx meeting. Service volumes, productivity, practice variances, and crisis scheduling have all been addressed at these meetings.

RECORD REVIEWS

In 2005, more than 120 records were reviewed. These reviews assessed the quality and appropriateness of service plans. Beginning in May 2005, the Center's record review team audited 10 records each month with regard to clinical services to ensure identification of problem areas and opportunities in clinical documentation.

TRAINING

The Center supports both in-service and external training opportunities to improve the quality of our services and ensure that staff understand policies and procedures and have the skills necessary for their implementation. Training at the Center begins with Orientation. Orientation is an all-day event that provides new employees with an orientation to the entire Center and exposure to all programs and services. Included in the orientation process is a review of ethical obligations and the Center's policies and procedures, including:

- SAS 99 requirements
- Harassment and Safety policies and procedures

The Center provided a wide variety of in-service training in 2005. In-service training provided in 2005 is shown in the following table:

January 2005	Columbia Manualized Treatment for Children with Disruptive Behavior Disorders
	Attachment Disorders and Interventions – Kenny Miller
February	Dialectical Behavioral Therapy – 2 full days
	Attachment Disorders and Interventions – Kenny Miller
	Web-Ex – Management Training
March	Dialectical Behavioral Therapy – 8 hours
	Web-Ex – Management Training
April	Law Enforcement Crisis Intervention Team Training
May	Web Ex Management Training
June	Attachment Disorders and Interventions – Kenny Miller
	Web-Ex – Management Training
	Juvenile Intake Screening
July	Juvenile Intake Screening
August	Dialectical Behavioral Therapy – 2 full days
September	Emergency Services Team Training – 9/9 and 9/30
	Attachment Disorders and Interventions – Kenny Miller, 2 full days
	All Staff Training – 9/21 full day
	Web-Ex – Management Training
October	Dialectical Behavioral Therapy – 2 full days
	Juvenile Intake Screening
	Web-Ex – Management Training
	Emergency Services Training
	Columbia Manualized Treatment for Disruptive Behavior Disorders Part II
	Psychotropic Medications
November	Strength-based, Consumer Focused Service Planning
	Juvenile Intake Screening
	Psychotropic Medications
	Community Intervention for Methamphetamine Abuse – 2 full days
	Web-Ex – Management Training
	EMDR Training – two staff for 3 days
	EMDR Level Two Training for 3 days
December	Management Training – 2 full days
	Web-Ex – Management Training
	Service Planning Training
	Columbia Manualized Treatment for Disruptive Behavior Disorders Part III

In addition to in-service training, and as presented in the Customer Service section, in 2005 the Center sponsored two trainings (at the semi-annual All Staff Trainings) through national organizations: *Customer Service for Health Care Professionals*, and *Win-Win Negotiations* (to help staff in working with clients). Roxann Stettler also provided regular training on use of our Qualifacts Management Information System.

Through our BHO and partnership with Value Options, Dr. Pam Wise-Romero and Marc Fallon-Cyr, M.D. (child psychiatrist on staff at the Center), have continued a specialized training through Columbia University. These two staff members have completed the training and are now in the train-the-trainers model and involved in two days of intense training followed by an every-other-week phone consultation/supervision. Training of other Center staff using this model continues.

MERIT BONUS SYSTEM

The Southwest Colorado Mental Health Center Merit Bonus System is presented as part of the Annual Quality Report because it supports quality individual performance on the part of staff, and serves as a mechanism to focus the Center's attention and efforts on key quality variables. The Merit Bonus System provides a percentage bonus each year based upon specific Center performance indicators. The domains selected in 2004 for the 2005 Merit Bonus are directly or indirectly related to improved care and consumer outcomes. The same domains were selected in 2005 for 2006 performance assessment. They are Consumer Satisfaction (as measured by the State administered and nationally standardized MHSIP), cancellation/no show rates as measured on the Qualifacts Capacity Management Report, productivity (number of direct service and qualifying hours per staff compared to expected hours) as measured on the Qualifacts Capacity Management Report, and consumer outcomes as measured on the Qualifacts Outcome Report. Though this latter report has not been completed, the components that will feed the report have been established in the system.

Each of the four domains noted above directly or indirectly addresses service quality. Each of the four domains will account for 25% of the maximum merit bonus established as available at the start of the year.

EXHIBIT A

SOUTHWEST COLORADO MENTAL HEALTH CENTER
Six Core Values

Making a Meaningful Difference

The sole purpose of our Center is to support our communities through the full and equal participation of all our residents in the quality of life available here. We do this by *Making a Meaningful Difference* in the lives of those who seek our assistance. The value of *Making a Meaningful Difference* requires that we measure the development of our resources, the delivery of our services and the organization of our Center against our capacity to *Make a Meaningful Difference*.

It is our responsibility to constantly modify and adapt our resources to make the greatest possible impact on consumers, family members of those with a substance abuse problem or mental illness, and those in the community for whom mental illness or substance abuse is limiting their capacity to fully participate in the quality of life.

Supporting Family, Job and Intimate Relationships

Greater therapeutic impact happens outside of the Center and its resources than within it. Families, job settings and intimate relationships provide the greatest therapeutic impact and enhance the impact of our service resources. A substantial portion of our resources should be committed to providing this support, which should not be limited to crisis support, but should extend to preventive and early interventive support.

Engaging All Consumers and Family Members to the Best of Our Ability

ALL persons challenged with a mental illness, their families, and others who work and live with them are our responsibility. Our responsibility extends beyond enrolled consumers and enrolled family members.

We have an obligation to the broader community that requires us to work closely with, and serve as a resource for, all aspects of our community, including but not limited to health, public safety, economic development, education, and other human service resources.

Engaging *all* consumers and family members to the best of our ability requires a specific commitment to cultural competency and proficiency. This extends beyond minority language expertise to an active effort to make all groups feel comfortable and welcomed. Where possible we will employ staff at all levels with ethnic and cultural backgrounds consistent with those served by our Center. Where this is not feasible, we will make concerted efforts to train and educate our staff so that they may represent and deliver our services in as effective, acceptable and user-friendly a manner as possible.

Consumer Partnership

The value of consumer partnership means that we approach our services with respect for those challenged with a mental illness or substance abuse problem and with respect for their families. We take pride in our resources and their professional application but we recognize that that application must be guided and tailored in partnership with those we serve.

Culture of Change

Change is not our enemy, nor is it an obstacle. Change is not something we will get past, have settle down, or need to endure. ***Change is our opportunity***.

We will embrace change as the opportunity to make a more meaningful difference. We are the temporary stewards of our Center, its resources and its capacity to serve our community. Staff will change, demands on our system will change, technology will change (note web based applications decreasing center based operations), our community is constantly changing and our understanding of best practices will change. Only those who accept the constant nature of change and can use it to advantage will thrive in our environment.

Commitment to Excellence

Excellence is the achievement of outcome making best/most creative use of resources within professional and ethical guidelines. Excellence requires a commitment to the highest professional best practice standards, highest ethical standards, and the integrity to recognize when those standards are not met.

Excellence is not a specific practice, nor a specific application of resources. Excellence is determined by the unique outcome dictated through consumer/family identification of need, desired outcome, resources and limitations combined in partnership with the application of Center resources brought creatively to bear by staff and staff teams.

Excellence is not to be confused with perfection, which takes no risks. Excellence requires both risk and failure to be achieved.

EXHIBIT B

COMMUNITY PARTNERS SURVEY REPORT

12/12/2005

The Survey:
The Community Partners Survey was administered via email on October 12, 2005. The 207 recipients of the survey included school administrators and counselors, county and city law enforcement, departments of social or human services, county health departments, Southern Ute and Ute Mountain Ute Tribes, BOCS, probation departments, Mercy and Southwest Memorial Hospitals. Non-profits and other organizations such as The Pinon Project, Colorado Work Force, NAMI, Advocacy for La Plata, Four Corners Child Advocacy Center and others were also surveyed. Total responses numbered 33; however, respondents often did not answer all the survey questions.

Overview of Responses:

1. Schools: Responses were received from all school districts in the SWCMHC service area except San Juan County. Responses generally ranked positive to neutral with the exception of two negative responses. Responses indicated a general lack of awareness of SWCMHC and available services.
2. Law Enforcement: It is notable was that there were no responses from law enforcement.
3. Social/Human Services: Also notable that there were no responses from any of the Social/Human Service agencies.
4. San Juan Basin Health Dept. There were two responses, one neutral noting improvement, and one negative.
5. Montezuma County Health Department: One response - negative.
6. Dove Creek Community Health Clinic: Positive response from Director.
7. Community Connections: One person responded on behalf of the organization citing improvement with a need for continued efforts toward collaboration.
8. Non Profits and Miscellaneous: Generally positive responses from these areas, except Durango Adult Education Center as noted below.

Responses indicating possible areas of needed improvement:

1. Montezuma County Health Department: The only response (the Director) from the Montezuma County Health Department was negative, citing inability to access services, non-responsiveness to crisis situations, and most of the money staying in La Plata County.
2. Pagosa Intermediate School: Noted improvement; however, expressed frustration with staff turnover and poor follow-through.
3. Montezuma Cortez High School: Inability to see clients on a regular basis and SWCMHC staff talking about clients.
4. Pagosa Springs High School: (there was also a positive response) Frustration with past turnover and inconsistency.
5. San Juan Basin Health Dept: (there was also a positive response) Delayed response, no sense of urgency when suicide is a concern, staff turnover.
6. Hilltop House: Response from Director with a very negative tone suggesting poor communications, inability to get appointments, triage “worthless”, meds being reused. Viewed SWCMHC as a “last resort”.

7. Durango Adult Education Center: General negativity. No Spanish speaker, no sliding scale, no response to situation involving a murder with children on scene, service delivery secondary to bottom line. Some misinformation (sliding scale) was corrected. Respondent sent a follow-up email praising SWCMHC involvement in the vested program and appreciation of sliding scale.

Analysis:
The Community Partners Survey offers three questions with responses solicited on a 1-5 Likert scale. These questions are: Overall satisfaction with SWCMH, satisfaction with primary contact, and image of SWCMHC in the community. Survey results show significant improvement of 20%, 34% and 15% respectively. Each question offered the opportunity for narrative comment. Comments regarding overall satisfaction and satisfaction with primary contact ran approximately 50% positive, 25% negative and 25% neutral. The perceptions of community image did not fare as well with 24% positive comments, 38% negative and 38% neutral.

The significant improvement in all areas measured indicates that efforts to establish better communication and improve the community image of SWCMHC have been effective and should be continued. Information in the narrative responses indicates some specific areas that can be marked for improvement.

1. The lack of a Spanish speaking employee or access to interpreter services is a legitimate concern.
2. Staff turnover and resulting inconsistency was referenced repeatedly.
3. SWCMHC community image appears weakest in areas other than La Plata County. Historical animosity lingers in Archuleta and Montezuma Counties.
4. While misinformation has been mitigated significantly, it remains a concern. Perceptions linger that SWCMHC does not treat people without resources, is unresponsive in crisis situations, and that access to services is very difficult.
5. There remains a general lack of awareness throughout the entire service area. As distance from Durango increases, awareness appears to decrease. Two of the three responses from Dolores County mentioned a lack of awareness, as did the single response from Mancos. There were no responses whatsoever from San Juan County.