



ANNUAL QUALITY REPORT

May 11, 2007

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 clients, 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 clients, 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 client care, pursue opportunities to continually improve client care, and resolve identified problems. Included in these activities are those risk management functions related to clinical aspects of client care and safety issues. Clients, 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, clients and family members have been invited to serve on the QISC. A client representative sits on and is an active member of our QISC.

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 regular reports including Access to Service, reports from our BHO QISC/CAUMC, and the State MHSIP Client Satisfaction report. Additionally and at irregular intervals the QISC reviews Qualifacts (management information system/electronic record) reports, data provided through our contract with David Lloyd on both the Center and CBHC/Center issues, Value Options quality reports, Community Agency Satisfaction Surveys, record review reports, and such other reports as may, from time to time, be requested or available.
- f. Informal input from clients, 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 client outcomes—making a meaningful difference. The QISC evaluates the Center's performance on the MHSIP Client Satisfaction survey each year. Additionally the Center invests in training—in-service training, conference attendance, and trainers brought to the Center.

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. In April 2007 we began auditing our records at enrollment to ensure all intake documentation is in the record and accurate. 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 client participation in its construction;

- c. Notes – in terms of their relation to Service Plan goals and objectives;
- d. Statements of medical necessity.

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

- a. *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.
- b. *Informal Client Feedback.* The Center has several formal mechanisms for complaints, grievances and appeals related to services. These include a Grievance & Appeals process and the MHSIP Client 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 client 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 client 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 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
 - 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.

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, the Merit Bonus performance indicators directly relate to improved care and client outcomes.

QUALITY IMPROVEMENT ACTIVITIES AND FINDINGS – 2006

QUALITY IMPROVEMENT STEERING COMMITTEE (QISC)

Complaints/Grievances/Appeals. In 2006, the QISC met on 11 occasions. A total of 21 cases were reviewed under Complaints/Grievances/Appeals and monitored to their conclusion. This represented a reduction of 11 grievances from the previous year's total of 32. 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	0		0		1	1
Detox Services	1	1	0		3	4
Mental Health	3	3	0	(3)*	9	12
Residential					1	1
Other (Cx not related to Center)						0
TOTAL	4	4	0		14	18

*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 2006. Of the 21 total initial grievances, 9 grievances pertained to clients on Medicaid or Medicare (six pertained to Medicaid-only clients while three pertained to clients on both Medicaid and Medicare). There were 12 grievances filed by clients who are either self-pay or private insurance.

The number of grievances decreased substantially from last year. We looked carefully to see if this was due to any barriers to filing of grievances or complaints that might have arisen. To the contrary, we found as strong if not stronger encouragement to file grievances or complaints as in past years. This is in large measure due to the great pains we have taken to make the process transparent to staff as a quality improvement mechanism. We have found that staff members have demonstrated a willingness to help clients initiate the process and actively participate in arriving at solutions.

What appears to be the case is that our efforts to improve customer service have been at play and effective. A large part of this has been in greater efforts at front-end communication with clients regarding their expectations, and the improved quality of those communications.

SWCMHC processed a total of 21 grievances: 4 were substantiated (a reduction of 10 from last year), 14 were unsubstantiated (a reduction of 2 from last year), and 3 were withdrawn in favor of advocacy (an increase of 1 from last year). Of the 4 substantiated grievances, all four were resolved to the client's satisfaction. Every substantiated grievance resulted in a corrective action, with some resulting in multiple actions.

1. One resulted in supervisory consultation and/or training.
2. Two initiated or impacted policy change.
3. In one instance, fees were waived.
4. Additional services were provided in one situation.

5. One grievance resulted in a successful meeting with SWCMHC staff to resolve concerns.
6. One initiated communication with and referral to 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. Four of the resolutions involved explanations and clarifications.
2. Three resulted in supervisory consultation and staff training.
3. A client was offered an apology.
4. Two clients were referred to advocacy or other organizations for help.
5. One situation resulted in policy or procedural change.

Critical Incidents. In 2006, the Center had 50 Critical Incidents (involving 37 clients), all of which were reviewed at QISC. One client was involved with 12 Incident Reports and two clients had two incidents apiece. The total of 50 Critical Incidents represented a 10.7% decrease from the 56 incidents in 2005. We were fortunate that there were no suicide deaths of clients this past year. We did have 8 client deaths due to automobile accidents or natural causes, 6 of which were past clients and 2 of which were active clients.

The highest number of incidents involved unauthorized absences (14). This was an increase from last year with 7 instances at Stepping Stone, 6 instances at Detox, and one at our Durango outpatient offices. With the new much more secure Detox facility at the Crossroads there have been no further Detox unauthorized absences. With the security of the ATU, fewer Stepping Stone clients have had unauthorized absences. Thus, next year's statistics should show a significant decline in these numbers.

Of the 50 incidents, 9 involved medication errors (a 30.8% reduction from last year). Seven of these errors occurred in the Stepping Stone facility and one each in Detox and the ATU. These errors led directly to changes in Stepping Stone medication policy and additional staff training in all three programs.

The third highest number of incidents was unusual illness. These were mostly seizures and in the Detox (6), with two incidents in the ATU.

Other incidents included 6 Detox incidents of property damage, 4 self-injuries (cutting by the same client across all three residential sites), 2 falls with injury, 2 physical assaults, and one verbal assault.

Of the remaining 4 instances, one involved an emergency evaluation for a Stepping Stone client, 1 instance of setting off the fire alarm in Detox, 1 identification of medications not turned over to Detox staff, and one inadvertent breach of confidentiality at our Durango Outpatient site.

Of the 50 incidents reported, 23 occurred at the Detox facility and 18 at the Stepping Stone facility. Thus, 41 of 50 incidents occurred at one of these two acute residential facilities. The new Crossroads facility that opened in October 2006 contains a new Detox facility with much improved design, and a new Acute Treatment Unit addressing the acute needs provided in part through the Stepping Stone program prior to October 2006. These new units are supporting a substantive reduction of critical incidents.

Work Groups

- In 2006, the QISC oversaw a work group which created a Customer Satisfaction Survey based upon the MHSIP but with an added *client engagement with services* component.
- In addition, the Work Group also addressed refinements to a Community Partner Survey based on the MHSIP structure but designed to gather input on the satisfaction of other community agencies with our services and access.

A work group was established at the April QISC meeting to set criteria for what is to be included in formal Center Policies and Procedures and criteria for procedures to be kept in program procedure manuals. This will keep the volume of formal Policies and Procedures manageable and readable and provide more ready access to guidance in program implementation.

Report Reviews

- Medicare Record Audit
- Annual Quality Improvement Report
- MHS 2006 Audit (and Plan of Correction)
- Access to Care
- Community Partners Survey (see Exhibit B)
- Pandemic Plan (see Exhibit C)
- Disaster Plan

Additional QISC Activities/Actions/Accomplishments

- Established an outpatient call-back system for clients on the waiting list.
- Refined record audit with addition of audit by exception structure and initiation of record audit at enrollment.
- Following CBHC Program and Standards Committee recommendation, trained staff center-wide in domain-based GAF scoring for state-wide consistency.
- Began preparation for *Catalytic Coaching* model of supervision and evaluation.
- Initiated move toward concurrent documentation.
- Began assessment of program/service fragmentation and prepared to address internal system-wide integration.
- Developed safety guidelines for Home Visits (see EXHIBIT D).
- Trained staff on the difference between Habilitative and Rehabilitative services.
- Created a Qualifacts Users Guide and Training Manual.
- Review and approval of update of, or new policies and procedures for, the following:
 - Changes to meet EQRO recommendations
 - Detox Voluntary Stay
 - Transitional Housing
 - Qualifacts Management Information System (13 related policies)
 - Adult mental health services (3 policies)
 - Internal complaint policy clarifying under what conditions the Board receives complaints
 - Fiscal Management of Medicare Co-Pays
 - Clinical Standards – Emergency fee waiver
 - Fee Collection Policy wording change
 - HUD incentive fund policy
 - Residential House rules
 - ATU policies and procedures

CUSTOMER SERVICE

Southwest Colorado Mental Health Center recognizes that customer service is at the center of quality service and positive client outcomes. In 2006 there were three customer service initiatives. The first was a review of the State implemented MHSIP. That customer service evaluation reflected substantive improvement in client's satisfaction with services at Southwest Colorado Mental Health Center. A summary report may be found in EXHIBIT E.

In addition to the MHSIP, the QISC Work Group refined our Community Partners Survey and our community agencies were surveyed in terms of their satisfaction with Center services. A copy of that report may be found in EXHIBIT B.

Finally, to augment the State administered MHSIP, we used that instrument as a base but added a client engagement component and plan to implement a broader based administration of this instrument Center-wide in 2007 using a web-based *Survey Monkey*.

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.

Qualifacts Reports. This has been another 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, Client Activity, and Complaint/Grievance) are operational. The Capacity Management Report was completed in the fall of 2006. This report is 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 on expected service ratios. This report supports our Merit Bonus system described below.

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 (CBHC) 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 clients, 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. This past year we began to schedule WebEx presentations by program—and this has proved remarkably valuable. Service volumes, productivity, practice variances, and crisis scheduling have all been addressed at these meetings.

Annual Quality Report. The Annual Quality Report was reviewed in June 2006. At that time we elected to focus in the coming year on customer service and on productivity.

Access to Care Report. Each month we review the Medicaid Access to Care report. Over the course of 2006, all Emergency contacts were made by phone within 15 minutes and in person within 2 hours, consistent with our contractual obligation. All urgent contacts were made in the prescribed 24 hours. In eight instances we did not offer a routine appointment within the specified 7 days. Corrective actions have been taken to streamline this process.

RECORD REVIEWS

In 2006 we audited approximately 150 adult and child records for documentation, appropriateness of the service plan, and evidence of appropriate treatment. In addition, we audited 218 Medicare records regarding documentation and medical necessity.

TRAINING

The Center supports both inservice 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:

- Review of our Corporate Compliance Plan
- Harassment and Safety policies and procedures
- Bloodborne Pathogen Training
- Customer Service

The Center provided a wide variety of training in 2006, as reflected in the following table:

Date of Training	Name of Training	Training Presenter
February 2006	DBT Training	Pam Wise-Romero
	ADAD Training	Marilyn Gaipa
March 2006	Case Mgmt Training Lunch	Don Raney
	Medication Administration	Vista Mesa Assisted Living
	Adult CPR & First Aid Course	American Red Cross
	Supportive Housing & Homeless Programs	CO Dept of Human Svcs
	Medication Administration	Vista Mesa Assisted Living
April 2006	Microsoft Excel	Fred Pryor Seminars
	National Council for Community Behavioral Healthcare	NCCBH
	DBT Training	Pam Wise-Romero
	Front Desk Seminar	Rockhurst University
	ES Training	Pam Wise-Romero
May 2006	Qualifacts, Sexual Harassment, Client Rights & Grievances & Fire Safety, CCARS & GAF Training	Roxann Stettler, Pat Roy, Ellis Miller & Ross Callender, Terry Brown & Pam Wise-Romero
	Risk Mgmt & Insurance Essentials	Various
June 2006	Medication Administration	Vista Mesa Assisted Living
	CCAR Training	Roxann Stettler
	Driving With Care Training	Timken & Assoc
	DECA-C Clinical (Devereux Early Childhood)	Devereux Foundation

Date of Training	Name of Training	Training Presenter
July 2006	Skills Training Manual	Gilford Publications Vista Mesa Assisted Living Residence
August 06	Medication Administration Managing Emotions & Thriving Under Stress USC Finance SkillPath Seminars Leadership Montezuma CFAS Class Hi-Fidelity Wraparound DC-03R Training Training for Implementing High-Fidelity Wraparound	SkillPath USC SkillPath Leadership Montezuma American Red Cross Jeff Co Family Support JFK Partners
September 2006	Columbia Project CBHC 2006 Annual Training 2006 DBT Training Forensic Training HUD Training EMDR Training - Albq	Jeff Co Family Support Columbia University CBHC Pam Wise-Romero Ed Henrie EMDR
October 2006	How To Deliver Accountable Care SPQM Quality Management Service Delivery & Clinical Standards Data Collection and Maximizing Service Nat'l Cert Step II Clinical Trials & Clinical Practice CPR Training	David Lloyd David Lloyd David Lloyd David Lloyd CTAT Robert Freedman, MD Heart Safe La Plata www.911trainer.com
December 2006	Crisis Intervention Skills for Call Taker Excel: Beyond the Basics Excelling as a First Time Supervisor QMAP Training	Fred Pryor Seminars Career Track CDPHE

BEST/EVIDENCE BASED PRACTICES

There has been increasing attention in the field to “best practices” and/or “evidence based practices”. These are treatment approaches which research has shown to have positive outcomes. However, the definitions of “evidence based” and “best practices” varies somewhat and the narrowness of the prescribed practices themselves is often limited, especially for rural applications.

Despite these limitations, Southwest Colorado Mental Health Center has initiated the following evidence based practices, a number of what we would consider best practices, and is about to initiate several promising practices:

State Defined Evidence Based Practices

- Supported Housing – through our Valle de Merced partnership with Mercy Housing Southwest
- Matrix Model substance abuse treatment (ADAD evidence based practice)
- Integrated Dual Diagnosis Treatment (IDDT will begin at the Center 7/1/2007)

Best Practices

- Adult and Adolescent Dialectical Behavior Therapy (DBT)
- Columbia Model child/adolescent treatment
- Televideo Psychiatry – remote televideo linkage to substantively improve access to psychiatric services
- Crisis Intervention Teams – we were the third CIT in Colorado and the very first rural CIT site in the Nation.

Promising Practices

- High Fidelity Wrap-around – scheduled to begin 6/1/2007
- Parent Child Interaction Therapy – scheduled to begin 7/1/2007
- Nurturing Parent – scheduled to begin 8/1/2007

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 2005 for the 2006 Merit Bonus are directly or indirectly related to improved care and client outcomes. The same domains were selected in 2006 for 2007 performance assessment. They are Client Satisfaction (as measured by the State administered and nationally standardized MHSIP), cancellation/no show rates as measured on the Qualifacts Capacity Management Report, and productivity (number of direct service and qualifying hours per staff compared to expected hours) as measured on the Qualifacts Capacity Management Report.

Each of the three domains noted above directly or indirectly addresses service quality. Each of the three domains accounts for one-third 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 clients, 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 Clients 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 clients 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* clients 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.

Client Partnership

The value of client 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 settled on, 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 client/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 Partnership Survey – 2006 N=20

The Community Partners Survey was first administered in 2004 and again in 2005. At the request of the Southwest Colorado Mental Health Center (SWCMHC) Quality Improvement Steering Committee (QISC), the survey instrument was revised significantly in 2006.

The 2006 survey measures four domains, those being: 1) perception of SWCMHC image in the community; 2) access to services; 3) quality/appropriateness of services; and 4) responsiveness. Responses were solicited via a 5-point Likert scale with 1 being the most positive response and 5 the most negative. The option of an additional “Not Applicable” response was also offered. Contact locations are included along with a filtering question to ensure respondents have accessed SWCMHC services within the past year. Respondents were given the opportunity to offer comments.

The survey was administered by email to 212 recipients, 197 of which were delivered. There were 20 responses to the survey, which is a decline from an n of 33 in 2005. Eleven respondents indicated contact at Durango, Bodo Park, nine in Cortez, three in Pagosa Springs, two with Emergency Services, and one each at New Day, Crossroads and Stepping Stone. Conspicuously absent from the response pool are Social/Human Services (all counties) and Law Enforcement (all cities and counties).

SWCMHC Community Partners Survey 2006 N = 20

Domain	Average Score
Community Image	2.5
Access to Services	2.4
Quality / Appropriateness of Services	1.9
Response	2.2

81% of those who responded to the question would refer a friend or family member to SWCMHC.

Because of the revision of the 2006 survey, the only domain comparable with previous years is the perception of the image of SWCMHC in the community. The community image domain has improved by .5 points on a scale of 1-5 between 2004 and 2005, and again by .5 points between 2005 and 2006. Coupled with the fact that the 2006 survey shows all domains scoring above neutral indicates that SWCMHC continues to move forward in being perceived positively as a key community resource.

Quality and appropriateness of service emerged as the strongest domain. SWCMHC staff is held in high regard with ratings of 1.9 for staff qualification and competency and for front desk staff being pleasant and helpful. There were two comments specifically praising the front desk staff at the Cortez location. The highest scoring question (1.7) concerned protection of client confidentiality. A close second at 1.8 pertained to SWCMHC making a meaningful difference in the community and in the lives of people receiving services.

Perceptions around access to services remain a challenge. The question regarding routine client appointments available in a timely manner scored lowest on the entire survey with an average of 2.6. Availability of services to people with minimum resources scored 2.4, and prompt response to phone calls and emails scored 2.3. Comments indicate continued concern with SWCMHC staff turnover and communications issues.

Information from the survey point to some possible courses of action:

1. Continue to refine communication procedures between Crossroads and other locations, including managing family and client contacts and contacts with Community Partners.
2. Revisit email and phone etiquette as pertains to communication with Community Partners.
3. Continue efforts to communicate with the community including mitigation of false information and clarification of SWCMHC status as a private non-profit corporation.
4. Continue efforts to maximize client time with clinical staff.
5. Continue efforts to refine and improve the intake process.
6. Consolidation of meetings/staffings involving clients being served by multiple agencies by bringing staff from other agencies into the process.
7. Establish a specific contact person at SWCMHC for each Community Partner agency or individual staff where appropriate.

EXHIBIT C

PANDEMIC PLAN DRAFT CHECKLIST

Planning Phase

1. Designate pandemic coordinator and team with defined roles and responsibilities
 - a. Disaster Response Coordinator and team are in place with Terry Brown as alternate. Team members, roles and responsibilities may need to be revised for pandemic situation, subject to input from team members and SWCMHC management.
2. Identify services required to meet essential client needs by location and function.
 - a. Emergency Services identified by QISC as priority one.
 - i. Expand ES coverage list with qualified alternative personnel.
 - ii. Train and prepare alternate ES personnel.
3. Investigate steps necessary to access State or Federal emergency aid and funding.
4. Establish reliable sources of pandemic information and mechanism for distributing information to staff and clients.
 - a. SJBHD, American Red Cross, Office of Emergency Management identified as resources
 - b. Disseminate information regarding the prevention of influenza spread, i.e., periods of contagion, social distancing strategies, respiratory and personal hygiene, and prophylaxis.
 - c. Websites: www.pandemicflu.gov www.cdc.gov
5. Forecast and allow for employee absences during a pandemic.
 - a. Consider temporary alterations to personnel policy to accommodate illness, family member illness, community containment or quarantines, school and/or business closures and others.
 - b. Consider policy for immediate mandatory sick leave in instances of suspected illness or known exposure.
6. Implement guidelines to modify the frequency and type of face-to-face contact among employees and clients.
 - a. Develop guidelines, infrastructure and training for working at home.
 - b. Develop guidelines for increased home visits and phone consults including medical.
 - c. Stagger employees' work hours (shifts) to minimize contact.
7. Maintain awareness of vaccination availability and priority.
8. Identify employees and clients with special or acute needs.
 - a. Case managers identify clients with limited access or mobility.
9. Set up authorities, triggers and procedures for activating and terminating response plan.
 - a. Recommendation or declaration by SJBHD
 - b. Notification by CEO using snow day call-down list.

Alert Phase

1. Issue memo to staff advising of alert status and providing information about pandemic preparedness plan and that said plan is in place.
2. Provide sufficient and accessible infection control supplies (e.g., hand-hygiene products, tissues and disposal receptacles) at all business locations.
 - a. Obtain from SJBHD or otherwise as needed.
3. Enhance communications and information technology infrastructures as needed to support employee telecommunicating, working from home and remote client access.

4. Develop and disseminate programs and materials covering pandemic fundamentals (e.g., signs and symptoms of influenza, modes of transmission), personal and family response strategies (e.g., hand-hygiene, coughing/sneezing etiquette, contingency plans).
 - a. Encourage use of email as means of communication with employees working from home.
 - b. Use of SWCMHC website for timely updates and links to other information sites.
 - c. Anticipate employee fear and anxiety, rumors and misinformation.
 - d. Ensure clear and culturally appropriate communication to clients, with outreach to those who are more remote or isolated or with more acute symptoms.
 - i. Handouts by staff during encounters or group mailings as appropriate.
5. Collaborate with federal, state, and local public health agencies and/or emergency responders to participate in their planning processes, share pandemic plans and keep apprised of available resources.
6. Implement community outreach offering complementary services as appropriate or as resources allow.

Pandemic Period Phase (attached)

Recovery Phase

1. Continue to monitor informational sources for status changes and reoccurrence.
2. Assess impact of pandemic on agency staff and clients and develop recovery model.
3. Continue to position agency to assess and access any state and federal, etc., funding or relief available.

SWCMHC PANDEMIC PREPAREDNESS WORKPLAN

Pandemic Period (Planning Phase)

The Interpandemic Period includes the first two designated phases of a pandemic, those being:

- Phase 1: No new virus subtypes in humans. Virus subtype that has caused human infection may be present in animals. Risk of human infection is low.
- Phase 2: No new influenza virus subtypes in humans. A circulating animal influenza subtype poses substantial risk of human disease.

Goal # 1: Establish initial planning, response and coordinating mechanisms						
Objective # 1: Establish internal SWCMHC mechanisms for planning and response						Priority:
Priority	Strategy	Responsible Party	Action Steps	Start Date	Complete Date	Status
	Assessment of current SWCMHC preparedness Development of appropriate response staff and mechanisms	Disaster Coordinator	Designate Coordinator and team Assessment of current SWCMHC staff trained in disaster response Staff training as appropriate or as compliance dictates			
Objective # 2: Establish appropriate interagency and intergovernmental presence						Priority:
Priority	Strategy	Responsible Party	Action Steps	Start Date	Complete Date	Status
	Collaborate with federal, state, and local public health agencies and/or emergency responders to participate in their planning processes, share pandemic plans and keep apprised of available resources.	Disaster Coordinator Executive Mgmt	Establish contact with responding agencies and entities throughout service area Assess current compliance status Sign Memoranda of Understanding with other responding entities as appropriate Implement steps necessary to access State and/or Federal aid and funding			

Goal # 2: Develop alternative policies, procedures and practices to be activated in event of pandemic						
Objective # 1: Develop policies, procedures and practices in anticipation of diminished service delivery by SWCMHC						Priority:
Priority	Strategy	Responsible Party	Action Steps	Start Date	Complete Date	Status
	Forecast and allow for employee availability during a pandemic	Disaster Coordinator Executive Mgmt Vice Pres. OPT/ES	Identify services and staffing required to meet essential client needs by location and function Prioritize Services and functions according to level of need and/or expendability, i.e., emergency services and medical services Cross train staff to fill anticipated absences in high priority services. Expand high priority coverage lists with qualified alternative personnel Consider temporary alterations to personnel policy to accommodate illness, family member illness, community containment or quarantines, school and/or business closures and others.			ES has been identified as high priority
	Forecast and allow for diminished services to SWCMHC clients	VP OPT/ES Clinical Dir Case Mgrs IT Front Desk Mgr.	Establish criteria for determining high priority clients Identify clients with high priority needs Develop alternative contact mechanisms i.e. phone Develop alternative treatment venues for less acute clients Develop mechanisms to decrease frequency of or to cancel appointments according to priority			
	Anticipate the need to scale down or temporarily suspend residential services, Detox, and ATU	Clinical Dir. Detox & ATU supervisors	Identify alternative treatment venues and services Respective supervisors/managers to develop plans and procedures.			

	Anticipate shortages of essential supplies, including medication.	Medical Dept supervisors	Assessment and plan by appropriate medical staff.			
	Anticipate need for alternative emergency communication and supervisory structure	Disaster Coordinator Ex Mgmt	Develop emergency in house communication structure Develop alternate supervisory structure to accommodate absence of supervisory personnel.			
Objective # 2: Develop policies, practices and procedures to minimize potential for spread of infection						Priority:
Priority	Strategy	Responsible Party	Action Steps	Start Date	Complete Date	Status
	Plan for the need to diminish work place contact and modify the frequency and type of face to face contact	Ex Mgmt Front Desk Department supervisors	Consider policy for immediate mandatory sick leave in instances of suspected illness or known exposure Develop guidelines, infrastructure and training for working at home Develop guidelines for increased home visits and phone consults including medical services Develop guidelines for staggering employees work hours (shifts) to minimize contact			
	Plan for stockpiling or immediate access to Personal Protection Equipment (PPE)	Disaster Coordinator Ex. Mgmt	Prioritize personnel to have access to PPE on the basis of most critical need and likelihood of contact. Stockpile or have access to enough PPE for 10 people over a period of 6 weeks			
Objective # 3: Develop policies, practices and procedures to maintain adequate revenue and general solvency						Priority:
Priority	Strategy	Responsible Party	Action Steps	Start Date	Complete Date	Status
		CFO				

Pandemic Alert Period (Preliminary activation)

The Pandemic Alert Period includes pandemic phases three, four and five:

- Phase 3: Human infection(s) are occurring with a new subtype. No human-to-human spread, or at most rare instances of spread to a close contact.
- Phase 4: Small cluster(s) of human infection with limited human-to-human transmission. Spread is highly localized suggesting that the virus is not well adapted to humans.
- Phase 5: Larger cluster(s) of human infection but human-to-human spread is localized, suggesting that the virus is becoming increasingly better adapted to humans. Virus may not yet be fully transmissible (substantial pandemic risk).

Goal # 1: Contain or delay spread to possibly avert a pandemic, and to gain time to implement response measures.						
Objective # 1: Implement appropriate containment measures						Priority:
Priority	Strategy	Responsible Party	Action Steps	Start Date	Complete Date	Status
	Implement staff and workplace containment measures as appropriate	Ex Mgmt Dept Supervisors All Staff	Implement mandatory sick day policy where possibility of exposure or infection exists Implement guidelines, technology and infrastructure for working at home as situation dictates Implement guidelines for alternative means of contact such as phone consult Provide sufficient and accessible infection control supplies and personal protection equipment. (e.g. hand-hygiene products, tissues and disposal receptacles) to staff and clients at all business locations. Implement guidelines for staggering employees work hours (shifts) to minimize contact			
Objective # 2: Operationalize external and internal communications mechanisms						Priority:
Priority	Strategy	Responsible Party	Action Steps	Start Date	Complete Date	Status
	Participate in federal, state and local emergency management.	Disaster Coordinator Med staff	Engage in federal and state emergency management structures including Incident Command System (ICS) and National Incident Management System (NIMS) including information and media management			

		Ex and Sr. Mgmt staff as appropriate	Maintain awareness of vaccination availability and priority Identify, document and report possible cases of infection			
	Implement intensive communications process to include staff, clients and community	CEO All Mgmt staff Disaster Coordinator All Staff IT staff Case Mgrs	Issue memo to staff advising of alert status and providing information about pandemic preparedness plan and that said plan is in place Implement in house emergency communications and supervisory structure. Establish reliable sources of pandemic information. Anticipate and monitor fear, rumors, and misinformation and address immediately Develop and disseminate programs and materials covering pandemic fundamentals (e.g. signs and symptoms of influenza, modes of transmission), personal and family response strategies (e.g. hand-hygiene, coughing/sneezing etiquette, contingency plans). Dedicate portion of website to education/prevention and pandemic updates. Outreach to clients who are more distanced and isolated or with more acute symptoms.			

Pandemic Period

Phase 6: Pandemic is declared. Increased and sustained transmission in the general population.

Goal # 1: Maintain maximum service delivery possible within established safety parameters.						
Objective # 1: All aspects of pandemic plan are fully operationalized						Priority:
Priority	Strategy	Responsible Party	Action Steps	Start Date	Complete Date	Status
	Implement alternative policies, procedures and practices as established in the Interpandemic and Alert Periods	CEO Ex Mgmt	CEO issues declaration to staff and clients subsequent to declaration by SJBHD and/or Red Cross			
	Continued participation in State, Federal, and local ICS and NIMS	Disaster Coordinator Ex Mgmt CFO	Continue to position agency to access any state and federal, etc funding or relief available.			
Objective # 2: Continue to assess impact of pandemic on agency staff and clients and develop recovery model.						Priority:
Priority	Strategy	Responsible Party	Action Steps	Start Date	Complete Date	Status
	Situation monitoring	Mgmt staff	Effectiveness of plan and execution monitored by CEO and appropriate staff and adjusted as appropriate Continue to monitor informational sources for status changes and reoccurrence			
	Restore services and staffing as the situation and availability allow	Mgmt staff				

EXHIBIT D

Practice Recommendations for Home-Based Services

Training Needed: CPR/First Aid
Meth Awareness and Recognition
* Recommend Rocky Mtn. HIDTA Clandestine Lab Training Program by Lynn Reimer

1. Medical Emergency:
 - Call 911 and begin CPR if needed.
 - Ensure adequate supervision of minor children.
 - Complete an incident report form.
2. Substances:
 - If a client is under the influence of a substance, reschedule session.
 - If another person in the home is under the influence, relocate the session, request that the other person leave during the session, or reschedule the session.
 - If signs of a meth lab are present, leave the home and inform a supervisor. If children are living in the home, report to DHS. Complete an incident report form.
3. Firearms:
 - If firearms are in plain sight, request client unload and relocate them or reschedule session if client refuses.
 - Staff should never bring a weapon of any type to a session.
4. Violence:
 - If you witness physical or sexual abuse of a child, attempt to redirect to more appropriate actions and report abuse to DHS. Inform a supervisor of report.
 - If the client or other person refuses to redirect abusive actions, call police to ensure child's safety. Inform a supervisor and complete an incident report.
 - If you witness domestic violence, attempt to calmly redirect actions.
 - If client or other refuses to redirect actions or becomes hostile toward you, leave the home and call the police to ensure safety if needed.
5. Pets:
 - If a dog is loose in front of or in a home and their level of safety is unclear, request the owner relocate the pet or leash him while present.
6. Attire:
 - If a client or other person in the home is not dressed upon arrival, request they put on clothing prior to entering the home or reschedule.
 - Staff clothing should be comfortable but not distracting.
7. Personal Safety:
 - Always have on your schedule where you will be (client's home, community location, etc.) and inform another staff person of your whereabouts.

- If a client or other person is aggressive toward you in the home, do not continue the session and leave the situation. Inform your supervisor and law enforcement if necessary.

8. Client Safety:

- If a client or other individual in the home is suicidal, assess the safety of the individual and the environment.
- If client cannot be safe in their home have a family member or law enforcement transport the individual to the hospital.
- If the individual can agree to safety, develop a safety plan before leaving the situation and provide follow-up services through yourself or Emergency Services.
- Inform an Emergency Services staff person or Supervisor of the incident and the outcome immediately following.

Prior to the first session in a home please inform client of the following:

1. No substances are to be present during the session. No one present at the session or participating in the session may be under the influence of substances.
2. No firearms are to be present during a session.
3. If anyone other than clients are present in the home at the time of the session, the session will either need to be relocated or clients will need to provide consent for others in attendance.

EXHIBIT E

2001 – 2005 MHSIP COMPARATIVE EVALUATION SOUTHWEST COLORADO MENTAL HEALTH CENTER

February 2006

Prepared by:

**Ellis Miller
Director of Consumer/Family Affairs
Southwest Colorado Mental Health Center**

2000 – 2005 MHSIP COMPARATIVE EVALUATION

Overview of MHSIP Survey

The Mental Health Statistical Improvement Program (MHSIP) survey is administered yearly by the Colorado Division of Mental Health as part of the 16-State Performance Indicator Pilot and the current Data Infrastructure Grant. Southwest Colorado Mental Health Center has incorporated the MHSIP results as a performance measure in yearly customer service evaluations and work plans as well as the merit bonus system used as a staff incentive.

The MHSIP consumer survey consists of demographic items and 28 customer satisfaction items which are each rated on a 5-point Likert scale (1-strongly agree to 5-strongly disagree; a “not applicable” option is also included).

The MHSIP is scored along five domains with the survey items applied as follows:

Consumer Perception of Access

The location of services was convenient.
Staff was willing to see me as often as I felt it was necessary.
Staff returned my calls within 24 hours.
Services were available at times that were good for me.

Consumer Perception of Quality/Appropriateness

Staff here believe I can grow, change and recover.
I felt free to complain.
Staff told me what side effects to watch for.
Staff respected my wishes about who is, and is not to be given information about my treatment.
Staff was sensitive to my cultural/ethnic background.
Staff helped me obtain information so that I could take charge of managing my illness.

Participation in Service/Treatment Planning

I, not staff, decided my treatment goals.
I felt comfortable asking questions about my treatment and medication.

Consumer Perception of Outcomes

I deal more effectively with daily problems.
I am better able to control my life.
I am better able to deal with crisis.
I am getting along better with my family.
I do better in social situations.
I do better in school and/or work.
My symptoms are not bothering me as much.

General Satisfaction

I like the services that I received here.
If I had other choices, I would still get services from this agency.
I would recommend this agency to a friend or family member.

Note: Five of the 28 items do not factor into any domain.

A Brief Analysis:

The SWCMHC MHSIP scores reflect two significant events that took place during the time period considered: 1) 2003 marked the full impact of budget cuts at the State level, requiring SWCMHC to reflect those budget cuts operationally; and 2) July 2004 marked the beginning of an aggressive customer service effort at the Center paralleling a rise in MHSIP scores in 2005 to a point exceeding State averages overall and in each individual domain.

The following charts offer an overview of SWCMHC MHSIP scores and comparisons with State results in overall average scores and each MHSIP domain.

Chart 1:

SWCMHC MHSIP Scores by Domain - Yearly Overview

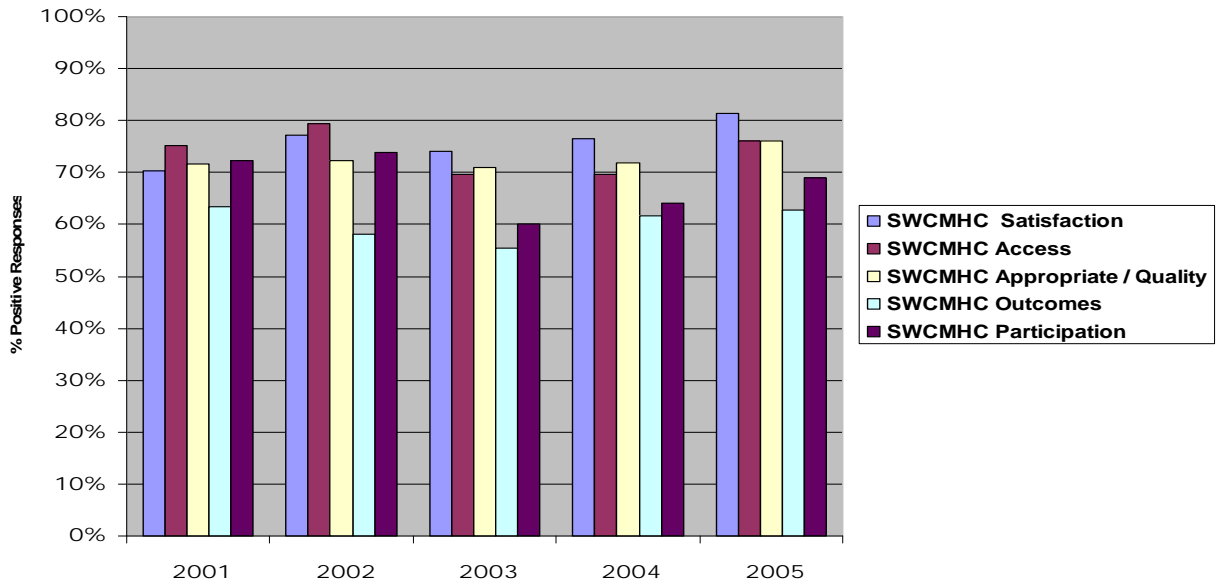


Chart 2:

SWCMHC / State MHSIP Yearly Average Comparison

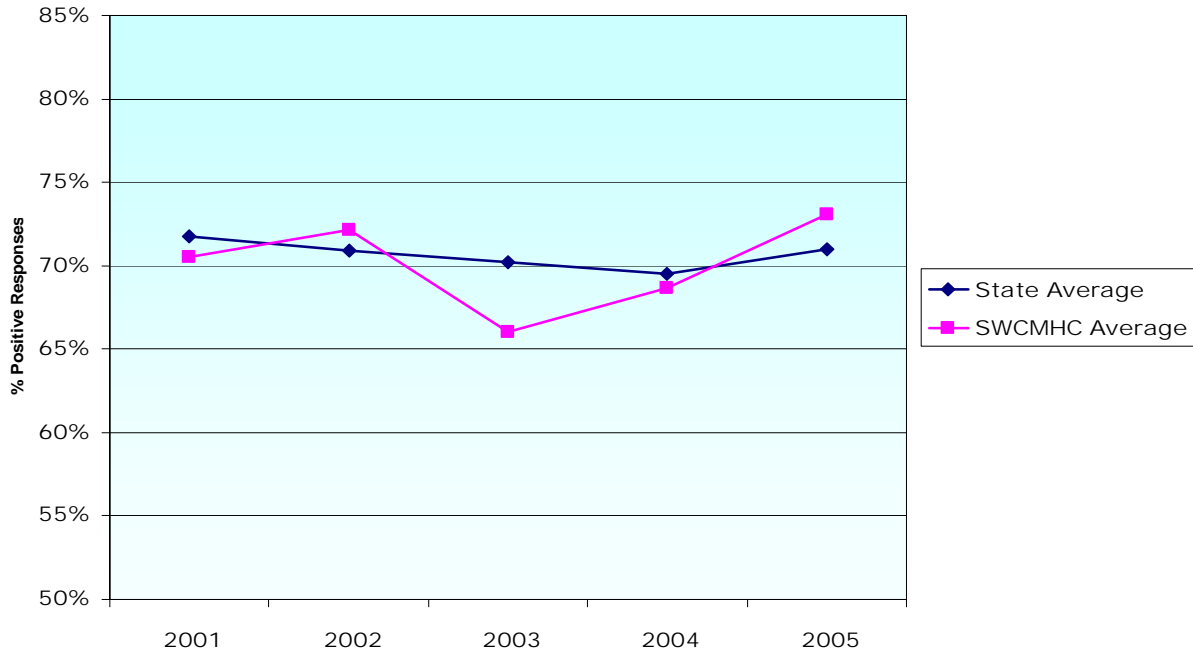


Chart 3:

**SWCMHC / State MHSIP Yearly Comparison by Domain:
Access**

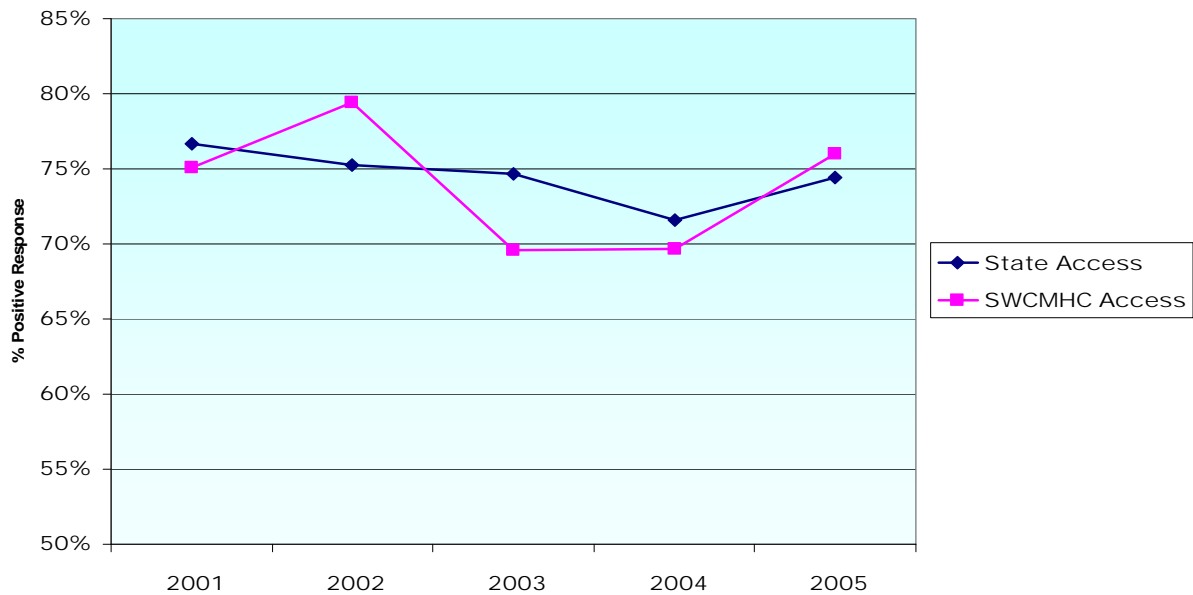


Chart 4:

**SWCMHC / State MHSIP Yearly Comparison by Domain:
Appropriate / Quality**

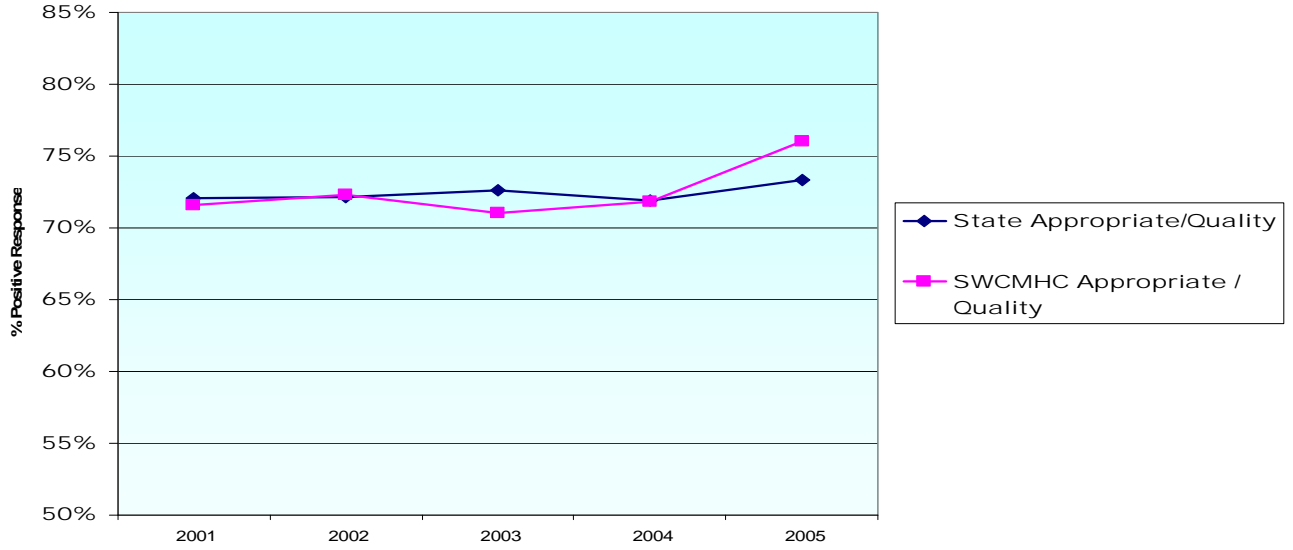


Chart 5:

**SWCMHC / State MHSIP Yearly Comparison by Domain:
Outcomes**

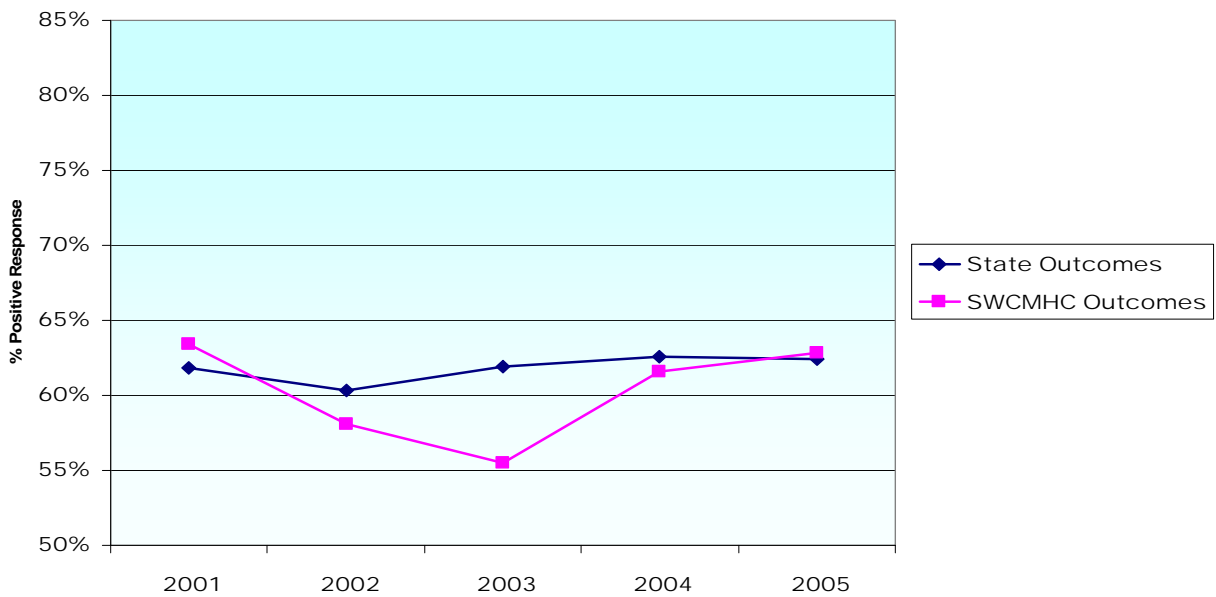


Chart 6:

**SWCMHC / State MHSIP Yearly Comparison by Domain:
General Satisfaction**

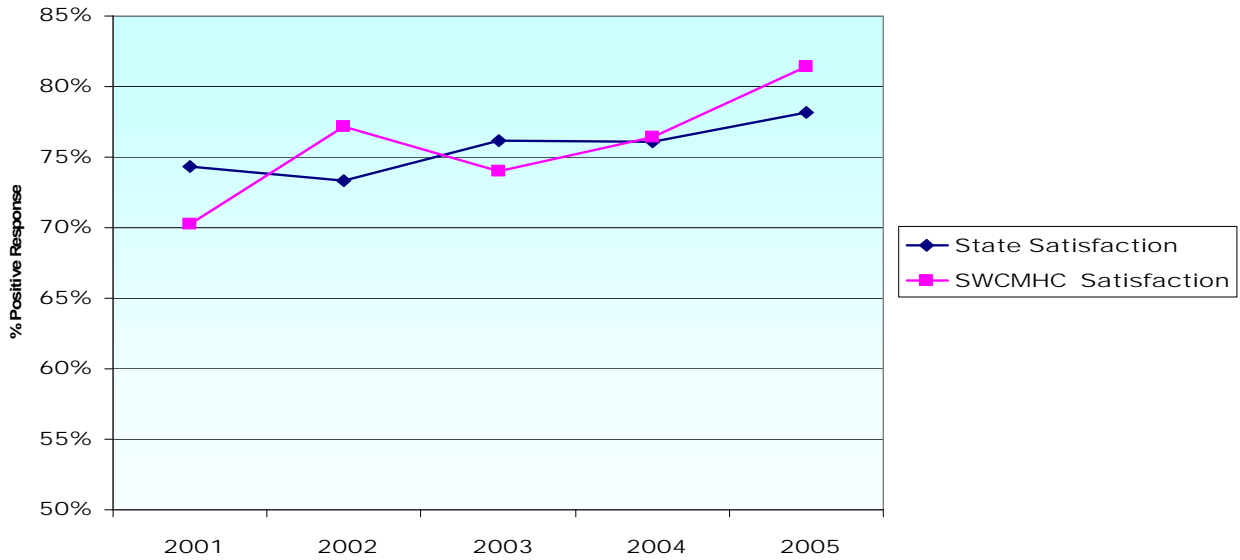


Chart 7:

**SWCMHC / State MHSIP Yearly Comparison by Domain:
Participation in Treatment**

