



# ANNUAL QUALITY REPORT

May 19, 2008

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## 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 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 has established a customer satisfaction survey that can be completed electronically in the lobby of the Durango Bodo Park facility.

Record Reviews. To ensure identification of problem areas and opportunities in clinical documentation, the Center's record review team audits 200 records each year with regard to clinical services, documentation and/or medical necessity. 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.

Corporate Compliance. It is the policy of Southwest Colorado Mental Health Center, Inc. that all of its business and other practices be conducted at all times in compliance with all applicable laws and regulations of the United States, the State of Colorado, all other applicable local laws and ordinances, as well as the ethical standards/practices of the industry and the Center.

The Board of Directors of the Center, at its regular scheduled meeting on November 15, 2006, adopted the resolution and approved the formal revision of the Corporate Compliance Plan. A Corporate Compliance Committee was formed to review and modify the plan as appropriate. The Plan was approved and adopted by the Board of Directors on January 17, 2007.

The Corporate Compliance Plan serves as a guide to implement this policy of compliance with all applicable standards. The laws, regulations and ethical standards that govern behavioral healthcare are too numerous to list in the Plan. Fundamentally, all parties (as defined below) of the Center are expected to conduct all business activities honestly and fairly. Any form of lying, cheating, or misrepresentation is expressly prohibited.

The Plan applies to all employees, board members, clinical staff, independent contractors, consultants, and any others doing business with the Center. Each employee or contractor is responsible for his or her own conduct in complying with the Plan.

The Plan is distributed to all employees and contractors (to contractors only as requested)<sup>1</sup>. In addition, supplemental data dealing with specific topics may be distributed to employees and/or contractors in certain areas as deemed appropriate. A copy of the entire plan may be found on our website ([www.swcmhc.org](http://www.swcmhc.org)) in the "About Us" section.

The Plan is monitored on a regular basis and reviewed no less than annually by the Corporate Compliance Officer (CO). In coordination with the Deputy Corporate Compliance Officer (DCO) and the Quality Improvement Steering Committee (QISC), the CO may edit the Plan as warranted.

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.

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<sup>1</sup> The Plan with all current updates is available to all staff in the public folder, and available to everyone on the Center's website.

## 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 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.
- c. In December 2007, the Center contracted with Essential Learning for an on-line learning program to further support professional development of the staff. Implementation of the program began in January 2008, and rollout of a fully operational system began in March. The program incorporates many of the courses previously presented through New Employee Orientation and All Staff training days such as Corporate Compliance, Sexual Harassment, Safety, Confidentiality & HIPAA, Cultural Diversity, and Bloodborne Pathogens. There is a schedule of requirements for clinical staff based on the specific nature of their job. In addition to required trainings, the staff are able to take any of the courses within the Essential Learning library to further their own education and professional development plans.

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.

## QUALITY IMPROVEMENT ACTIVITIES AND FINDINGS – 2007

### QUALITY IMPROVEMENT STEERING COMMITTEE (QISC)

Complaints/Grievances/Appeals. In 2007, the QISC met on 12 occasions. A total of 41 grievances (from 38 individuals) were reviewed under Complaints/Grievances/Appeals and monitored to their conclusion. This represented an increase of 20 grievances from the previous year's total of 21. 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
<b>Crisis/Emergency</b>	0				5	5
<b>ATU</b>	0				1	1
<b>Mental Health</b>	2	2	0	(3)*	20	22
<b>Medical</b>	3	3			10	13
<b>TOTAL</b>	<b>5</b>	<b>5</b>	<b>0</b>		<b>36</b>	<b>41</b>

\*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 2007. While the number of grievances significantly increased, the number of founded grievances did not – increasing only by 1 (from 4 in 2006 to 5 in 2007). Given our increase in clients (the number of unduplicated clients increased 22,8% from FY '07 – FY '08) yet the consistently low number of substantiated grievances, it would appear that we are doing both a good job of delivering services and are actively encouraging clients to express concerns about treatment.

We continue to take great pains 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.

SWCMHC processed a total of 41 grievances: Five were substantiated (an increase of 1 from last year), 36 were unsubstantiated (an increase of 22 from last year), and 3 were withdrawn in favor of advocacy. Of the 5 substantiated grievances, all five were resolved to the client's satisfaction. Each of the five substantiated grievances was due to an inappropriate delay on our part. The two mental health grievances occurred on one day when the case manager did not show for appointments with two clients. The case manager had failed to attend the appointment as she was on vacation and had not adequately conveyed that to the clients. The clients were given an apology and the case manager counseled.

Of the three substantiated med program grievances, two had to do with a wait for services of 15 minutes or more and one to a delay in sending a prescription from our Pagosa Office to our Durango office. Apologies were offered in all cases, staff counseled, and a new system of forwarding prescriptions from Pagosa to Durango was developed.

Critical Incidents. In 2007, the Center had 79 Critical Incidents (involving 76 clients), all of which were reviewed at QISC. One client was involved with 3 Incident Reports and 1 client had two incidents. The total of 79 Critical Incidents represented a 58% increase from the 50 incidents in 2006. Included in the 2007 total were 6 client deaths – three suicides, 1 undetermined and 2 accidental.

In 2006 the highest number of incidents involved unauthorized absences (14). In 2007, consistent with last year's expectation, we had only 4 unauthorized absences: three from the Stepping Stone program before its closure, and one from Detox during transport to the Emergency Department (ED).

The highest number of incidents in 2007 were medication errors at 17. Ten of these errors occurred at the ATU, three at Detox, three at Stepping Stone and one at our Pagosa Springs office. The Detox errors related to missing medication and in one instance was due to an unaccompanied release for a Detox client from the ED. The most troubling aspect of these incidents were the 10 at the ATU. In looking closer at these numbers, a pattern is instructive. In January 2007 we had 1 ATU med error, but in February we had 5 reported ATU med errors. This was addressed aggressively with each staff member involved with a combination of individual supervisory counseling, additional staff training, and in one case requiring that a nurse be supervised on all administrations for a period of time. This resulted in significant improvement with only 4 med errors at the ATU in the following 10 months. One of the four errors was a misread of the record resulting in a higher evening dose being administered during the day. The remaining three involved lost medication (1/2 tab, 1 tab, and meds given to a client in the ED that were not present on arrival at the ATU).

Unusual illnesses requiring treatment beyond that available in the program accounted for the next highest number of reported Critical Incidents at 14. Four of these occurred at the ATU, 9 at the Detox and 1 at our Durango outpatient offices. Assaults (8 incidents, of which 6 were in the Detox) accounted for the next most frequently reported Critical Incidents. We had 6 incidents of the destruction of property (all in the Detox), 5 falls (none serious), 5 verbal assaults with two requiring a duty to warn, 2 incidents of self-harm (minimal physical harm) and 2 admit decision errors. There were two additional incidents that were of a more serious nature. One was the report of an unsuccessful suicide attempt by a client at his home. The other was an instance where a male staff member, in violation of Center policy, invited a friend to a residential facility where two female clients reported sexual (verbal) harassment. That staff member was immediately terminated and additional services provided to the clients.

The remaining 10 reports were all minimal in risk and did not involve any sentinel events. They included such issues as missing Center cash, a client drinking on an outing, metal shavings found by a client, an inadvertent breach of confidentiality, etc.

Overall the largest number of incidents (62 or 78.5%) were reported in our residential programs (33 in Detox, 21 in the ATU, and 8 at Stepping Stone).

### Work Groups

At the January 22, 2007 QISC meeting a work group was assigned to organize all forms used at the Center and put them on the Public Folders to ensure consistent and universal use of the correct forms.

At the April 2 meeting a staff member was charged with investigating Survey Monkey to see if we could use this to begin a regular and ongoing client satisfaction survey. It proved feasible, and beginning in August a web-based client satisfaction survey has been piloted at the Durango office where it is available in the waiting room.

At the April 30 meeting, a work group was established to determine what constitutes a policy requiring QISC review and approval and what constitutes program guidelines that do not require QISC review and approval.

In June, the Evolution Team was established and given the task of leading an initiative to increase productivity.

### Report Reviews

- Annual Quality Improvement Report
- MHS 2007 Audit (and Plan of Correction)
- Access to Care
- Review of 2006 Community Partners Survey
- Review of the Center's Corporate Compliance Plan and strategy for training of management, support and direct services (i.e., all) staff
- During the first six months of 2007, QISC reviewed portions of the Disaster and Pandemic Plans and made modifications to both. At the September 2007 All Staff Training, the Pandemic Plan (see Exhibit B) was presented and discussed. Both the Disaster and Pandemic Plans have been placed in the Public Folders.
- MHSIP
- Youth Services Survey for Families – 2007

### Additional QISC Activities/Actions/Accomplishments

- Bern met with Shane Benjamin of the Durango Herald to request more sensitive treatment of interactions with mentally ill clients in the "Police Blotter"
- Review, plans and input regarding integrated Behavioral Health/Primary Care
- Establishment of the *Evolution Team* – a group of young and new staff with long-term potential for the Center
- Coordination of services for a dementia patient in the community
- Review and input on major revisions to our Center website
- Review and recommendations regarding management of the waiting room during the open access clinic
- Review and approval of update of, or new policies and procedures for, the following:
  - Admission and Assignment to Clinical Services
  - Clinical/Medical Records
  - Safety Policy (changes requested by the Fire Department)
  - Stepping Stone Charges
  - Fiscal Management Policy (enhanced internal controls)
  - Claims Development, Submission, Billing and Collections
  - Clinical Standards – Medical Necessity
  - Safety and Infection Control – universal precautions
  - Crossroads evacuation, fire drill and safety program
  - Notification regarding relocation
  - Protocol for monitoring
  - Third party payer
  - Residential standards for Stepping Stone
  - Provision for forensic evaluations for the 6<sup>th</sup> Judicial District
  - Medical staff orders for the ATU
  - Lab testing and follow-up
  - Telepsychiatry

- Medication ordering and tracking – ATU
- Crossroads program description
- Admission and Assignment to Clinical Services
- Front Desk Point of Entry
- Crossroads maintenance
- ATU Fee Collection
- Corporate Structure & Values
- Availability and Accessibility of Service
- Critical Incidents
- Fraud and Fiscal Abuse
- Deposit of Funds
- Payroll Policy (due to new Paid Time Off structure)
- Injectable Drugs
- Storage and Distribution of Onsite Medications
- Medicaid Eligibility Determination (for front desk)
- Minimum Necessary

## **CUSTOMER SERVICE**

Southwest Colorado Mental Health Center recognizes that customer service is at the center of quality service and positive client outcomes. In 2007, there were two customer service initiatives. The first was a review of the State implemented MHSIP. That customer service evaluation reflected substantive improvement in clients' satisfaction with services at Southwest Colorado Mental Health Center. A summary report may be found in EXHIBIT C.

To augment the State administered MHSIP, we used that instrument as a base but added a client engagement component. We began piloting that instrument via web-based *Survey Monkey* on a computer in the Durango office. Results are not yet compiled and available.

A companion consumer satisfaction survey to the MHSIP, Youth Services Survey for Families – 2007, was also administered to youth and families in 2007 with a report developed on Medicaid youth and families in March of 2008. On the 26 items of this survey, not only did the Center have higher levels of satisfaction than the State average on all but three items (87.5%), but the Center was ranked either highest or second highest in satisfaction on 19 (73%) of the items among the eight CHN mental health center partners.

## **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.

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. We 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 2007 Annual Quality Report was reviewed at the QISC meeting on June 4, 2008.

Access to Care Report. Each month we review the Medicaid Access to Care report. Over the course of 2007, 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 three instances (all in the first two calendar quarters) we did not offer a routine appointment within the specified 7 days. Corrective actions have been taken to address this problem and we have had no exceptions for more than a year (since April 2007).

#### CHN/QISC Meetings.

- Review of BHO EQRO
- Follow-up on the five top diagnoses and treatment patterns
- Quality management and care work plan
- Utilization management summary
- Deficit Reduction activities
- Changes to CHN Treatment Guidelines
- Medicaid and the Deficit Reduction Act
- Quality Report
- Enhanced Case Management

#### **Corporate Compliance**

The Corporate Compliance Officer makes regular quarterly reports to the CEO and Board of Directors since the Plan's inception in January of 2007. In 2007 there were six violations of our Corporate Compliance Policy:

1. Colorado Medicaid client residing in New Mexico – we notified them we would accept only self-pay
2. Inaccurate billing to Medicaid fee-for-service – employee was terminated
3. Lack of adherence to Medicaid Injectable Medications Policy – a follow-up audit was done on this complicated issue with subsequent training
4. Medicaid eligibility questions and inaccurate reporting of encounters – Inadvertent. Encounters were corrected and resubmitted. Training materials and procedures were updated.
5. Inaccurate service coding by clinical staff – coding corrected and supervision to ensure it does not happen again.
6. Missing money (Center funds) at the Detox – instituted procedural changes.

## RECORD REVIEWS

In 2007 we audited approximately 100 adult and child records for documentation, appropriateness of the service plan, and evidence of appropriate treatment. In addition, we audited 100 Medicare records regarding documentation and medical necessity.

## 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:

- 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 2007, as reflected in the following table:

<b>Month</b>	<b>Name of Training</b>	<b>Presenter</b>
January	Front Desk Training HIPAA/Corporate Compliance Addictions Counseling Skills	Roxann Stettler Pam Wise Romero, Pat Roy West Slope Casa
February	ATU Staff In-service, Food Safety CAC II CPR, First Aid QMAP Training Driving with Care	San Juan Basin Health Dept. West Slope Casa Heart Safe La Plata CDPHE Center for Impaired Driving Research & Evaluation
March	Fire Safety Infection Control CCARs: Good, Bad & Ugly Medical Necessity News Update Disaster Recovery Plan Cultural Competency ATU Staff In-service, Med Administration NCCBH National Conference American College of Mental Health Admin. Summit Legal Issues in Behavioral Health in CO Excel Training CRS WRAP Training	Pat Roy, Durango Fire Dept. Kris Kozak Terry Brown Roxann, Pam, Lori Ellis Miller Lori Raney Marian Riggert NCCBH ACMHA  MEDS-PDN DGO Adult Education Center Ellis Miller

<b>Month</b>	<b>Name of Training</b>	<b>Presenter</b>
April	CIT Training PCIT Training  EMD Training Children's Mental Health Coalition Conf. QMAP Training CPR and First Aid Detox Program Training High Fidelity Wraparound HUD/SHHP Training How to Delivery Exceptional Customer Service	Linda Lute Mayerson Center for Safe and Healthy Children Molly Gierasch CMHC CDPHE American Red Cross ADAD John Vandenberg Terry Larson Fred Pryor Seminars
May	DBT Training EMDR Training HQS 101 Training Infectious Diseases Ethics & Jurisprudence PCIT Training  CPR Training – CPR Pro Group Counseling Skills	Pam Wise Romero Molly Gierasch Travis Winger West Slope Casa West Slope Casa Mayerson Center for Safe and Healthy Children CPR Pro Linda Lute
June	CCAR Training MCD Policy Training MH Train the Trainer DBT Training EMDR for Children First Aid Training Revenue Cycle Best Practices Principles of Addiction PCIT	Diane Fox Roxann Stettler Project Bloom Girelley Gregory Smith American Red Cross McBee Associates West Slope Casa SWCMHC
July	Non-activity invoice training HR Skills Training PCIT Training Addictions Counseling Skills DBT Training	Roxann Stettler DAHR SWCMHC West Slope Casa (Spear) Pam Wise Romero
August	Advanced Counseling Skills EMDR Training Continuity of Care (Discharge Planning) Advanced Counseling Skills First Aid and Adult CPR Differential Assessment for DD Train the Trainer Elite Software Training	West Slope Casa (Humble) Molly Gierasch CHN West Slope Casa (Humble) American Red Cross West Slope Casa (Armour) ADAD Elite Software

<b>Month</b>	<b>Name of Training</b>	<b>Presenter</b>
September	DBT Individual Coaching Training Minimum Necessary HIPAA Req. Pandemic Flu 42 CFR Part II Strategies for Self-improvement and Change Colorado Works State Conference Driving with Care  Western Colorado Psychiatry Symposium QMAP Training Summit Leadership Series	Pam Wise Romero Pam Wise Romero Ellis Miller, Patsy Ford Tom Bonde, Stacey Foss West Slope Casa (O'Neill)  Colorado Works Center for Impaired Driving Research and Evaluation West Slope Casa CDPHE Dolores/Montezuma County Community Summit
October	Double Trouble Colo. Behavioral Healthcare Council Annual Conference EMDR Ergonomics Training Internal Audit/Risk Management Comm. Mental Health Assoc. Workshops Infectious Diseases Bridges out of Poverty	Tom Bonde, Linda Lute CBHC  Molly Gierasch Pinnacle Assurance McBee Associates CCMHA West Slope Casa (Humble) Colorado Works
November	EMDR Level II Training Collaborative Family Healthcare Association Conference SW Colorado Worksite Wellness Clinic EMDR Study Group Addiction Counseling Skills High Fidelity Wraparound Facilitator Training Sensory Integration	Molly Gierasch  CFHA Healthy Lifestyle La Plata Molly Gierasch Linda Lute Laurie Beckel  Barry Chaloner
December	Disaster Recovery Strategies Budgeting and Rate Setting CPR – American Red Cross EMDR Study Group De-escalation Skills Training	Symantec McBee Associates American Red Cross Gierasch Linda Lute

## **BEST/EVIDENCE BASED PRACTICES**

There continues to be substantive 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” vary 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 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)
- Driving with Care in our DUI program
- Strategies for Self Improvement and Change (SSIC) for our jail groups

#### 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.
- IMPACT Depression Care Management Program (used in our Integrated Care sites)

#### Promising Practices

- High Fidelity Wrap-around
- Parent Child Interaction Therapy
- Nurturing Parent

# 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

## 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](http://www.pandemicflu.gov) [www.cdc.gov](http://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.

<b>Goal # 1: Establish initial planning, response and coordinating mechanisms</b>						
<b>Objective # 1: Establish internal SWCMHC mechanisms for planning and response</b>						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			
<b>Objective # 2: Establish appropriate interagency and intergovernmental presence</b>						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			

<b>Goal # 2: Develop alternative policies, procedures and practices to be activated in event of pandemic</b>						
<b>Objective # 1: Develop policies, procedures and practices in anticipation of diminished service delivery by SWCMHC</b>						<b>Priority:</b>
<b>Priority</b>	<b>Strategy</b>	<b>Responsible Party</b>	<b>Action Steps</b>	<b>Start Date</b>	<b>Complete Date</b>	<b>Status</b>
	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.			
<b>Objective # 2: Develop policies, practices and procedures to minimize potential for spread of infection</b>						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			
<b>Objective # 3: Develop policies, practices and procedures to maintain adequate revenue and general solvency</b>						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).

<b>Goal # 1: Contain or delay spread to possibly avert a pandemic, and to gain time to implement response measures.</b>						
<b>Objective # 1: Implement appropriate containment measures</b>						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			
<b>Objective # 2: Operationalize external and internal communications mechanisms</b>						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.

<b>Goal # 1: Maintain maximum service delivery possible within established safety parameters.</b>						
<b>Objective # 1: All aspects of pandemic plan are fully operationalized</b>						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.			
<b>Objective # 2: Continue to assess impact of pandemic on agency staff and clients and develop recovery model.</b>						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 C**

**2001 – 2006 MHSIP COMPARATIVE EVALUATION  
SOUTHWEST COLORADO MENTAL HEALTH CENTER**

**July, 2007**

**Prepared by:**

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

# 2000 – 2006 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 information as well 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). Until 2005, the survey offered 28 customer satisfaction questions. In 2006, the number of items was increased to 39. 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: Fifteen of the 39 items do not factor into any domain. Additionally, one item assesses the perceived provider sensitivity to the cultural/ethnic backgrounds of consumers.

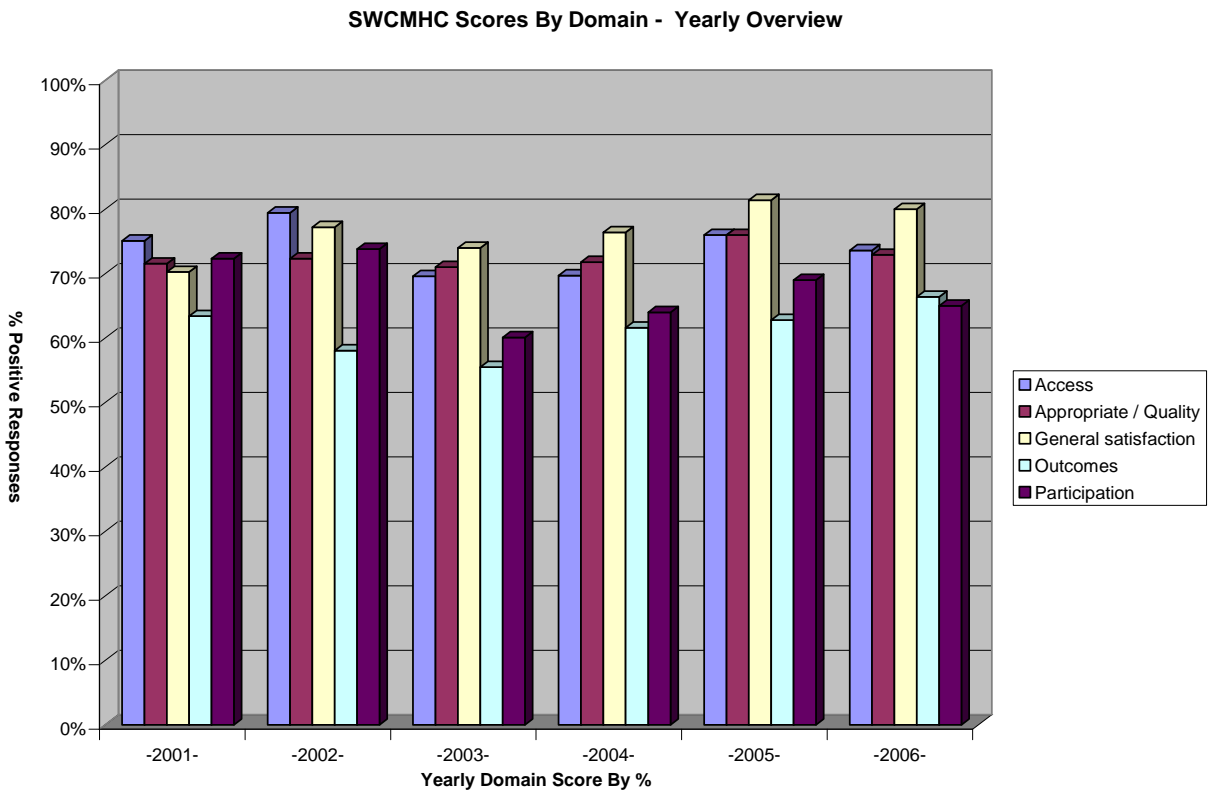
### A Brief Analysis:

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. 2) July 2004 marked the beginning of an aggressive customer service effort at the Center paralleling in a rise in MHSIP scores in 2005 to a point exceeding State averages overall and in each individual domain.

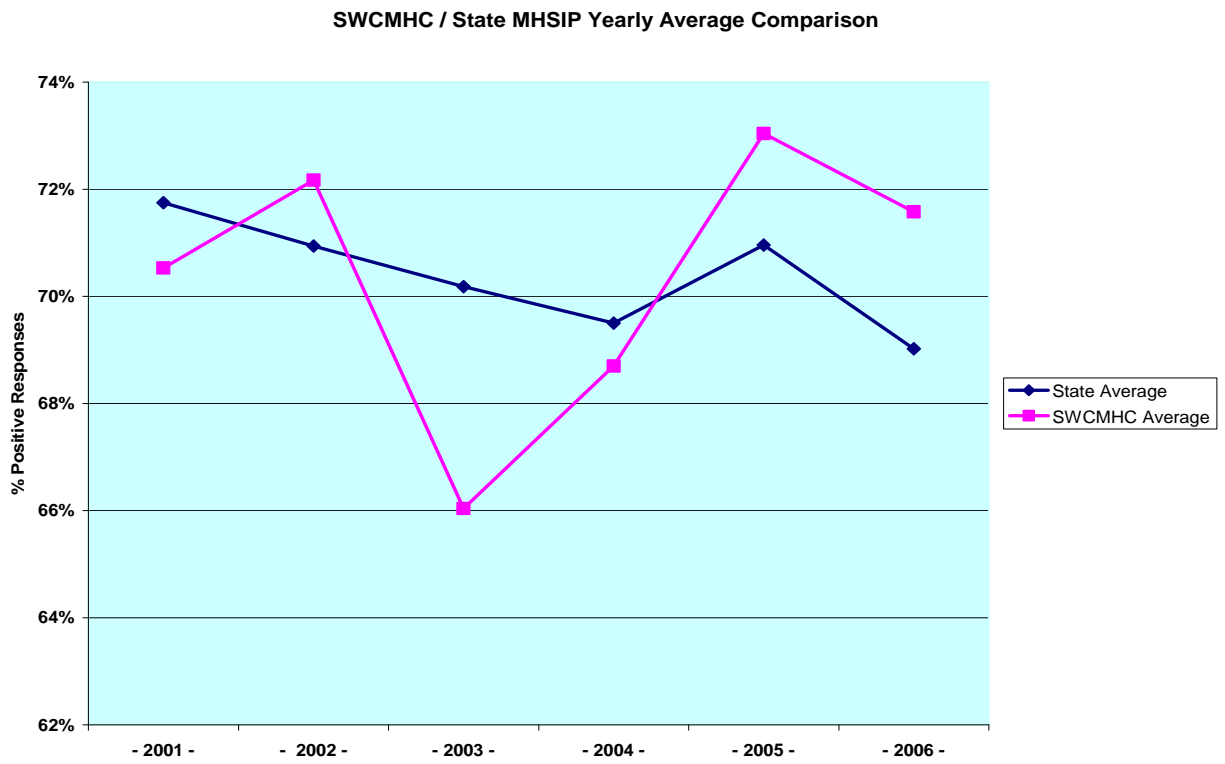
The 2006 survey results show a drop in the State overall average and across all domains. This trend is echoed by SWCMHC with the exception of the outcomes domain. While the state scores dropped by 2% in the outcomes domain, the SWCMHC score increased by 3.6%. SWCMHC MHSIP scores continue to exceed state scores in all domains and in the overall average.

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:

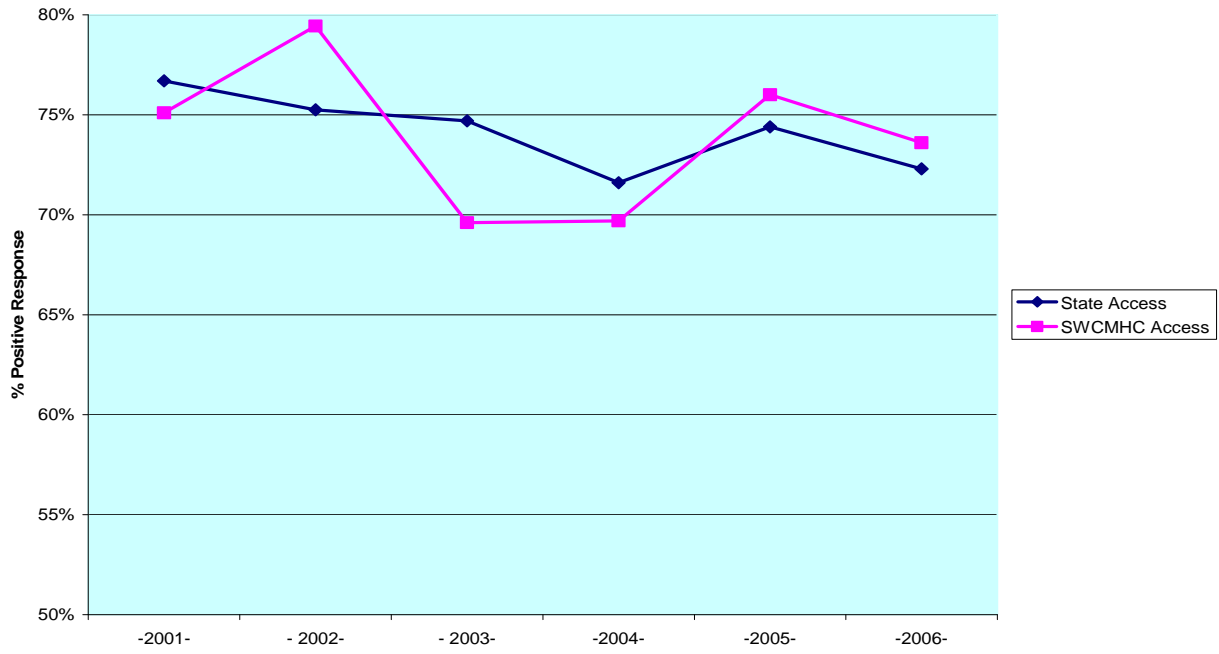


**Chart 2:**



**Chart 3:**

**Year by Year Domain Comparison:  
Access**

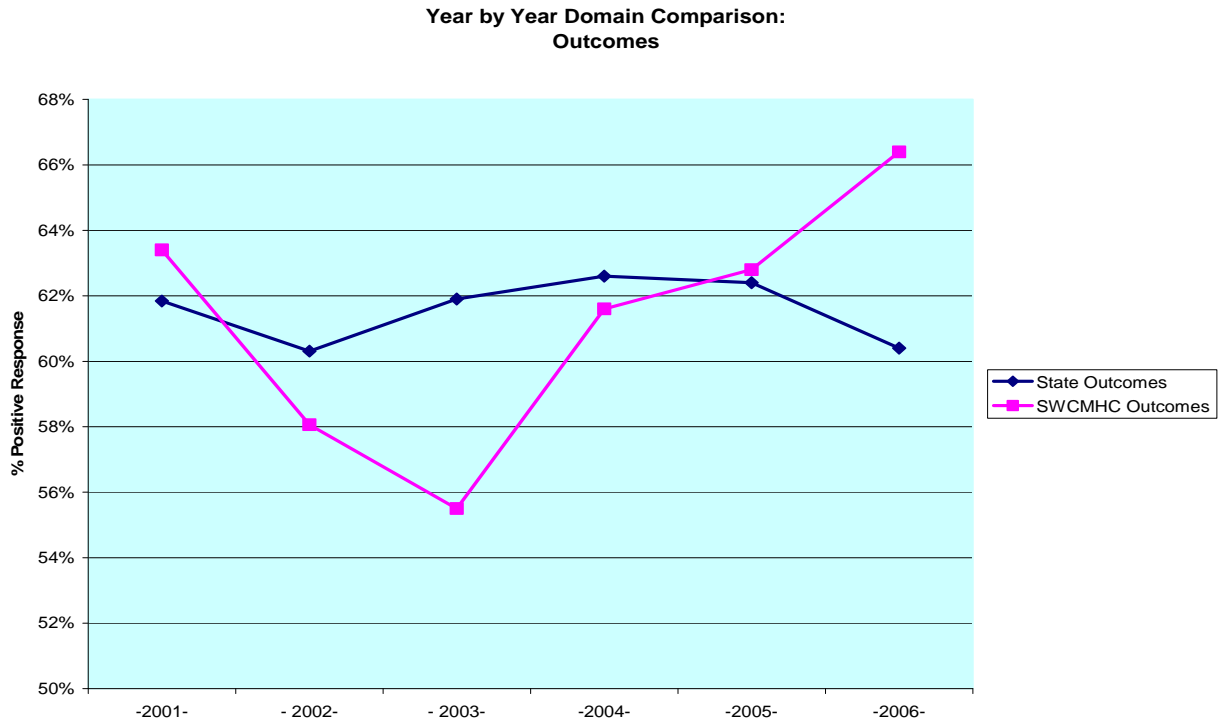


**Chart 4:**

**Year by Year Domain Comparison:  
Appropriate / Quality of Services**

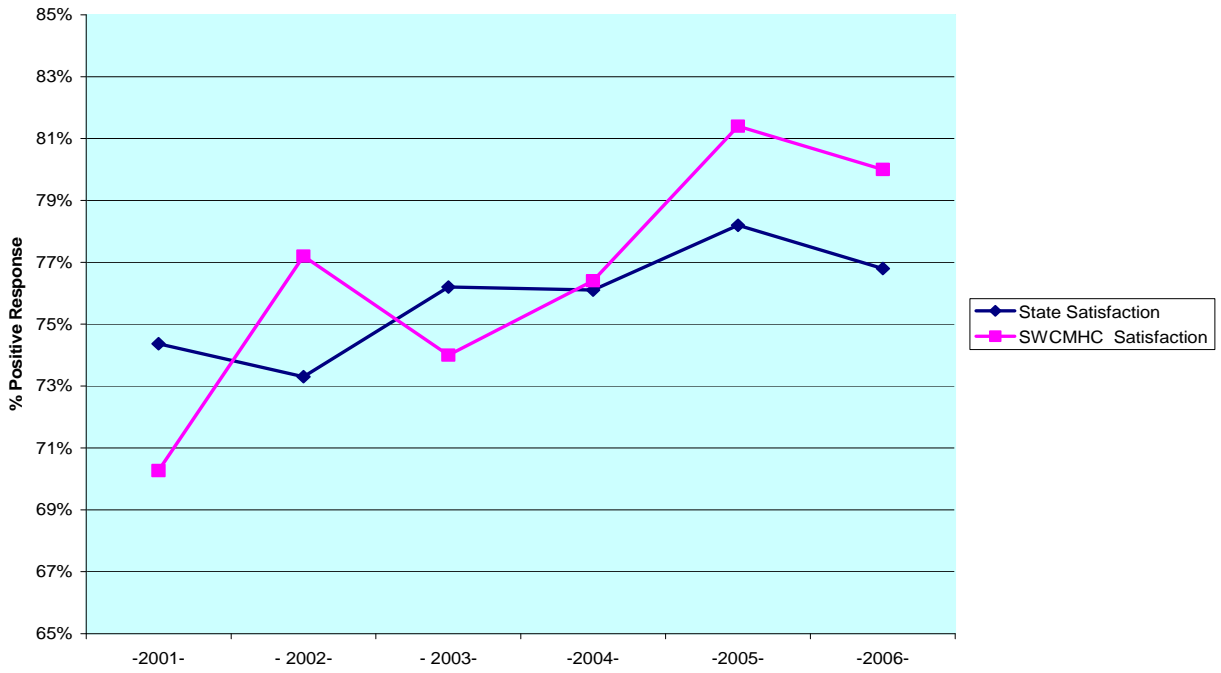


**Chart 5:**



**Chart 6:**

**Year by Year Domain Comparison:  
General Satisfaction**



**Chart 7:**

**Year by Year Domain Comparison:  
Participation in Treatment**

