Summary of Quality Improvement Activities

Fiscal Year 2019

MISSION

To be Allegan County's premier behavioral healthcare organization that promotes, protects, and advocates for the health and well-being of every member of the community.

VISION

To lead, collaborate, and succeed in making Allegan County among the healthiest counties in Michigan where all residents can thrive and prosper.

VALUES

- Holistic Person-Centered Care
- Dignity and Respect
- Respecting Choice
- Commitment to Excellence
- Community Collaboration
- Accessibility
- Responsiveness
- Diversity

PURPOSE

Allegan County Community Mental Health Services (ACCMHS) is committed to providing quality improvement throughout the mental health system of care. More specifically, ACCMHS is concerned with areas that limit access to services, quality of care, coordination of necessary services and supports, integrated care, and consumer satisfaction. Within each area are a set of performance indicators and program outcomes that are continuously tracked and analyzed.

The Purpose of the ACCMHS Quality Improvement Program is to:

- Continually evaluate and enhance quality management processes, program outcomes, and administrative efficiencies.
- Monitor and evaluate the systems and processes related to the quality of services that can be expected to affect the health status, quality of life, and satisfaction of persons served by ACCMHS.
- Identify and assign priority to opportunities for performance improvement as identified by stakeholders (e.g., staff, consumers, providers).
- Create a culture that encourages stakeholder input and participation in problem solving.
- Outline the structure for monitoring and evaluating ACCMHS and service providers' compliance with regulations and requirements.

GOALS

The ACCMHS Quality Improvement Program will:

1. Target improvement at all levels including management, administration, and programs to include: access, coordination of services, timeliness, safety, respect, effectiveness, appropriateness, and continuity.
2. Involve people served as well as those who care for them, in assessing and improving satisfaction of outcomes and services.
3. Develop performance indicators to ensure services are effective, safe, respectful, and appropriate.

4. Track key performance indicators, comparing performance to statewide or other comparable data when available.
5. Continuously monitor and analyze data related to program outcomes and consumer satisfaction to identify opportunities for improvement.
6. Ensure providers of service fulfill their contractual or employment obligations in accordance with applicable regulatory and accreditation standards.
7. Ensure providers of service are competent and capable of providing services through a system of competency evaluation and credentialing.

QUALITY IMPROVEMENT ACTIVITIES

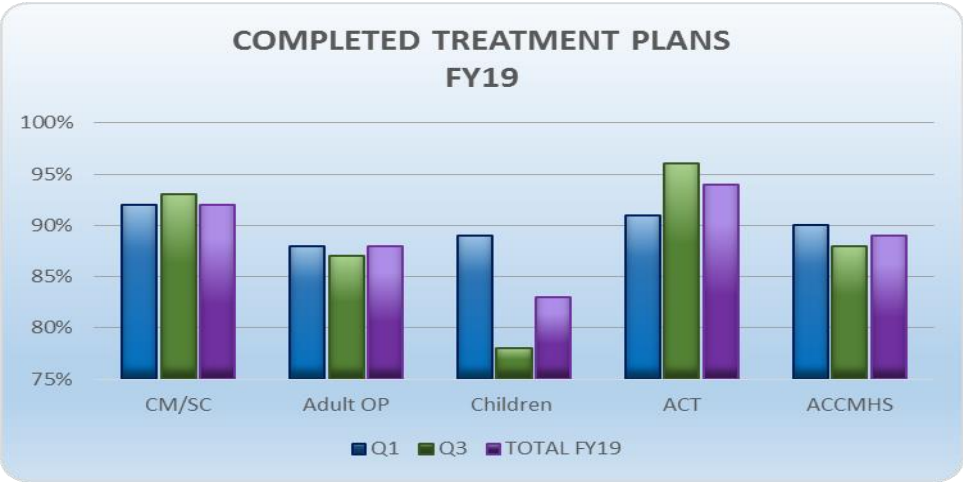
We, at ACCMHS, work to constantly improve our services. We monitor how our services are delivered and the ways our services help people in Allegan County through various internal quality monitoring reviews; input from consumers, stakeholders, and the community; and outside audits and reviews. The following report summarizes the quality improvement activities for Fiscal Year 2019.

SUMMARY OF QI GOALS FROM THE FY19 QUALITY IMPROVEMENT PLAN

GOAL 1: Maintain at least an overall 95% rate of current treatment plans for ACCMHS Programs.

A treatment plan is considered past due when any part of the entire treatment plan is past due (i.e., assessment, periodic review, or treatment plan). This goal was created to help improve overall services, as well as to ensure proper use of our resources. Keeping treatment plans current improves the quality of care for our consumers, because they most accurately reflect their present service needs and desires. In addition, any services provided after treatment plans are past due cannot be reported for Medicaid reimbursement.

The graph below displays the percentage of treatment plans completed on time within each of the programs listed in the following chart for Q1 and Q3 of FY19 (as well as ACCMHS overall). Due to changes in staff and reporting responsibilities, we do not have data for Q2 and Q4 of FY19. The bottom three lines of the chart that follows display the average percent for each program and ACCMHS overall for FY19, FY18, and FY17.



Treatment Plans by Program: FY19 (% Complete)					
Quarter	CM/SC	Adult OP	Children	ACT	ACCMHS
Q1	92%	88%	89%	91%	90%
Q3	93%	87%	78%	96%	88%
TOTAL FY19	92%	88%	83%	94%	89%
TOTAL FY18	90%	88%	92%	93%	90%
TOTAL FY17	94%	93%	96%	98%	95%

We did not meet this goal for FY18 or FY19 (90% and 89%, respectively); however, we did meet our 95% goal for the agency during FY17. Factors influencing the outcome of the past two fiscal years include:

- Agency/Staff Layoffs (FY18)
- Staff Resignations (FY18)
- New Employees (learning curve/training)
- Changes in Staff & Reporting Responsibilities
- Revised Auditing & Monitoring (Quality Records Review) process

On a quarterly basis, the Quality Records Review Team (formerly known as the Auditing & Monitoring Team) randomly selects cases for chart review. Although data for the *Completed Treatment Plans* report was not collected for Q2 or Q4 of FY19, cases were still being reviewed through the Quality Records Review Team and supervisors were notified of the results.

The Quality Records Review process has succeeded in identifying barriers to meeting our 95% goal on a consistent basis. (Please see the section entitled "Additional Accomplishments in Quality Improvement in FY19" at the end of this report for further details regarding the Quality Records Review process.) Since the outcome impacts our finances as well as our quality of service, we retained this goal for FY20.

GOAL 2: Achieve and maintain all standards of the Michigan Mission-Based Performance Indicator System (MMBPIS).

MMBPIS Indicators focus on access/timeliness to services, continuity of care, efficiency, and outcomes. MMBPIS Standards are developed and monitored by the Michigan Department of Health and Human Services (MDHHS). Reports are provided to the Lakeshore Regional Entity (LRE) and to MDHHS on a quarterly basis. The LRE requires a *Plan of Correction* to be written whenever a standard is not met. ACCMHS monitors the following MMBPIS Indicators:

- **Indicator 1 (Standard - at least 95%):**
  Hospital preadmission screenings are completed within 3 hours.
- **Indicator 2 (Standard - at least 95%):**
  New persons requesting an intake appointment receive a face-to-face assessment with a professional within 14 calendar days of their request for service.
- **Indicator 3 (Standard - at least 95%):**
  New persons start their on-going service by meeting face-to-face with a professional within 14 days of their intake date.

- **Indicator 4a & 4b (Standard - at least 95%):**
  4a. Persons discharged from a psychiatric hospital are seen within seven days.
  4b. Persons discharged from a substance abuse detox unit are seen within seven days.
- **Indicator 12 (Standard – readmission rate of 15% or lower):**
  Persons discharged from a psychiatric hospital are not readmitted within 30 days of discharge.

The following table displays the MMBPIS scores reported to LRE & MDHHS for FY19:

FY19 ACCMHS MMBPIS REPORT

Indicator	Description	Population	Standard	1st Qtr FY19	2nd Qtr FY19	3rd Qtr FY19	4th Qtr FY19
1	Emergency Referrals Completed in 3 Hours	Children	>=95%	100	100	100	100
		Adults	>=95%	98	100	99	97
2	Assessment within 14 Days of First Request	SED Children	>=95%	68.2 (15/22)	100	100	100
		MI Adults	>=95%	91.3 (21/23)	100	100	100
		DD Children	>=95%	100	N.A.	100	100
		DD Adults	>=95%	100	100	100	100
		SUD	>=95%	100	97.2	100	95
3	Started Service within 14 Days of the Assessment	SED Children	>=95%	100	81.8 (9/11)	100	100
		MI Adults	>=95%	83.3 (15/18)	85.7 (12/14)	92.3 (12/13)	77.8 (7/9)
		DD Children	>=95%	N.A.	N.A.	100	100
		DD Adults	>=95%	66.7 (2/3)	50 (1/2)	100	75 (3/4)
		SUD	>=95%	100	100	100	97
4a	Seen within 7 Days of Discharge from Hospital	Children	>=95%	100	100	N.A.	100
		Adults	>=95%	100	100	93.8 (15/16)	100
4b	Seen within 7 Days of Discharge from SU Detox	SUD	>=95%	100	100	100	100
12	Readmitted to Inpatient within 30 Days of Discharge	Children	<= 15%	25 (1/4)	0	NA	0
		Adults	<= 15%	0	14.3	26.3 (5/19)	0

NOTE:	When a standard is not met for a specific indicator, the process is analyzed and revised to improve outcomes. A plan of correction is also required to be submitted to the LRE.
GREEN	Indicates 95% Standard was met for Indicators 1,2,3, & 4a. Indicates 15% (or less) Standard was met for Indicator 12.
RED	Indicates 95% Standard was NOT met for Indicators 1,2,3, & 4a. Indicates 15% (or less) Standard was NOT met for Indicator 12.

When a standard was not met (numbers in **red**), the numbers within the parentheses show how the percentage was calculated. (For standards #1, #2, #3, 4a, and 4b: how many consumers met the standard / how many consumers were counted for that standard. For standard #12: how many consumers did **not** meet the standard / how many consumers were counted for that standard.)

As a region, we have struggled to meet Indicators 2 & 3 on a consistent basis. The regional QI group (QI ROAT) has quarterly MMBPIS meetings to discuss common issues and possible resolutions.

As an agency, the low number of consumers we service continue to have a negative impact on our percentages (e.g., for 7 out of the 13 standards that we missed during FY19, we were only one person away from meeting the goal). We have successfully met the standards for Indicators 1 and 12 the majority of the time during the last several FYs. Since FY18, we have improved on Indicators 2 and 4a; however, we still continue to struggle with meeting Indicator 3 on a consistent basis.

The QI Council MMBPIS Subcommittee has worked with supervisors, front desk staff, and clinical staff to identify barriers to meeting the Indicator #3 requirements. Scheduling and documentation issues were the primary barriers identified. Supervisors worked together to develop and implement a new tracking system to ensure new consumers will receive an assessment and ongoing services in a timely manner that will meet the MMBPIS requirements

The process continues to re-evaluated and revised as needed. Staff have been retrained on MMBPIS standards and documentation requirements for cases which have approved exceptions. The QI Council reviews our MMBPIS standings and communicates the results with the Management Team. Results are also included are included in our *FY19 Summary of QI Activities* report that is posted on our website.

Since MMBPIS reporting is required by both the LRE and the State of Michigan, we retained this goal for FY20.

GOAL 3: Receive at least a 90% overall satisfaction rating on all of the current ACCMHS Surveys.

Behavior Treatment Plan/Process Satisfaction Survey

The *Behavioral Treatment Plan/Process Satisfaction Survey* is a tool designed to evaluate the effectiveness of approved Behavioral Treatment Plans. During FY18, the LRE designed a new BTC survey to be used by all of the CMHs within the region on an annual basis. In September of 2019, we distributed the survey to the guardians and home managers of 57 consumers who are currently receiving Behavioral Services through ACCMHS. The recipients were provided with self-addressed stamped envelopes to return their surveys within a 2-week time period.

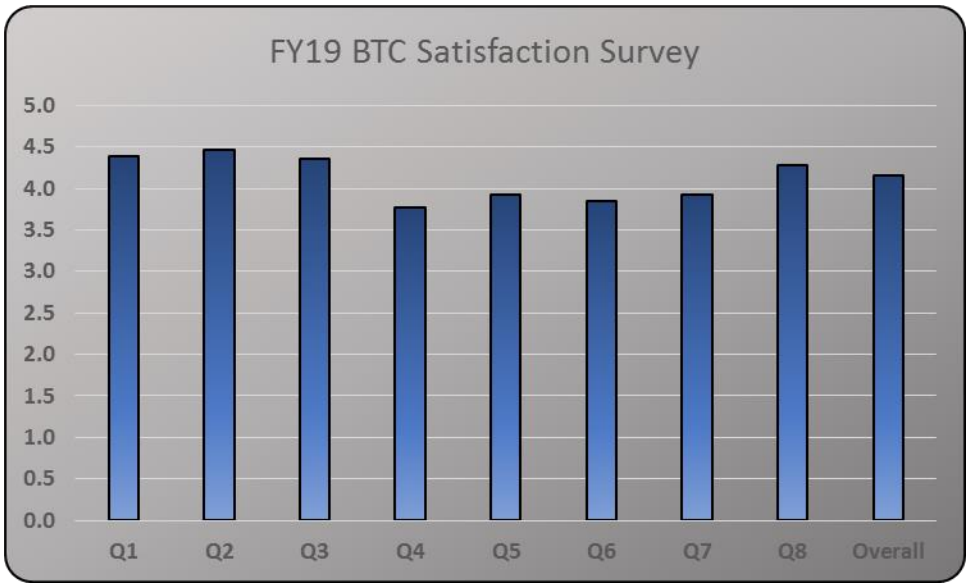
Survey Questions

Based on a scale of 1 (Strongly Disagree) to 5 (Strongly Agree), recipients rated the following areas:

1) My opinions were listen to during the development of the Behavior Treatment Plan.
2) The Behavior Treatment Plan was explained to me in a way that I understood.
3) The Behavior Treatment Plan is Person Centered.
4) The Behavior Treatment Plan is consistently implemented.
5) I know the Behavior Treatment Plan is being monitored.

6) The Behavior Treatment Plan has helped to reduce problematic or potentially harmful behaviors.
7) The Behavior Treatment Plan has improved the quality of life for the individual receiving services.
8) I know who to contact if I have questions regarding the Behavior Treatment Plan.

The following graph displays the results for the FY19 *BTC Satisfaction Survey*:



The following chart compares the FY19 and FY18 results:

ACCMSH/LRE BEHAVIOR TREATMENT PLAN SATISFACTION SURVEY									
FY	**Q1**	**Q2**	**Q3**	**Q4**	**Q5**	**Q6**	**Q7**	**Q8**	**Overall**
FY18	4.5	4.3	4.4	4.3	4.0	3.9	3.9	4.5	4.3
FY19	**4.4**	**4.5**	**4.4**	**3.8**	**3.9**	**3.8**	**3.9**	**4.3**	**4.1**

We received 14 of the 57 surveys back, for a 25% response rate. Our overall rating was 4.1 out of a possible 5.0 points (as compared to 4.3 in FY18). The drop from FY18 to FY19 was mainly due to a decrease in the rating of Question (Q) 4 (The Behavior Treatment Plan is consistently implemented). We surpassed our 90% goal for FY19 with an overall satisfaction rating of 100% (14/14), improving upon our 92% rating from FY18. Results are shared with the BTC Committee for QI purposes and are also included in our *FY19 Summary of QI Activities* report that is posted on our website.

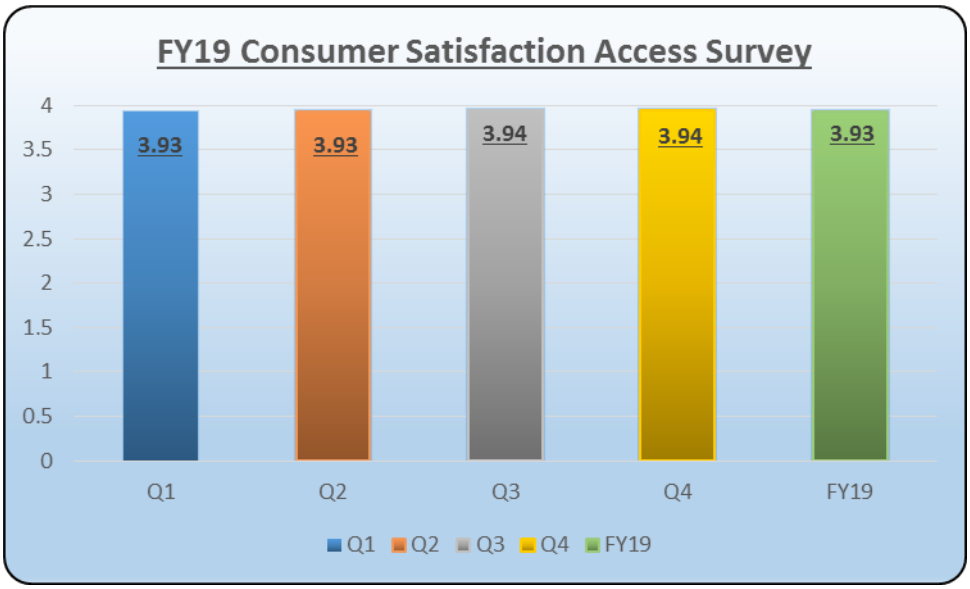
Consumer Satisfaction Access Survey

We encourage our new consumers to provide us with feedback regarding their intake process via the *ACCMHS Consumer Satisfaction Access Survey*. The survey consists of the following eight questions:

1. I felt welcomed at the agency.
2. I was treated in a respectful way.
3. The environment (offices and lobby areas) was clean, comfortable, and inviting.
4. The hours were convenient for me.
5. I understood the information discussed and provided by the finance staff (who talked about payment and other issues).

6. Staff stayed focused on my concerns.
7. I felt staff tried to make me feel comfortable.
8. I was provided with at least one (1) recommendation/suggestion to help me.

Each question uses a 4-point scale, with 4 as the highest rating. The following graph and chart display our results for the ACCMHS FY19 *Consumer Satisfaction Access Survey*:



FY19 ACCMHS ACCESS SURVEY RESULTS				
Q1	**Q2**	**Q3**	**Q4**	**FY19**
3.93	3.93	3.94	3.94	3.93

We received 100% overall satisfaction rating from our Access Surveys (all 283 respondents rated our Access process 3.0 or higher), surpassing our goal of 90%. Our average score was 3.93 (on a 4-point scale). Out of the 283 responses received, 80 replied with comments. The vast majority of the comments (69 of 80) were positive (e.g., "Awesome communication, very helpful and knowledgeable."); five comments were neutral (e.g., "It was ok"); and six comments were suggestions for improving the atmosphere of the waiting room. All of the comments were very supportive of staff and the access process. The waiting room suggestions are as follows:

1. Too early for Christmas music! After Thanksgiving please! ☺;
2. Music in the waiting room was loud and country;
3. Fix holes in wall in waiting room;
4. The waiting room was crowded even without people in it. Not an easy solution for finding the correct building;
5. More natural lighting in the children's waiting room; and
6. Have coffee out for your clients.

We always receive very high Access Survey results (in FY18 our average score was 3.94 with a 100% overall satisfaction rating). However, we are still able to utilize the comments to improve the intake process for our consumers. For example: 1) The music issues were addressed by

adding a sign stating "Please feel free to change the radio station and keep the volume reasonable. Thank you!"; 2) The "holes" in the waiting room were due to facilities installing a new control panel; the Clerical Supports Supervisor resolved the issue by submitting a work order to request repair of the wall; 3) The issues with the waiting room (needing more natural lighting and feeling crowded) will be resolved when we move into our new building; and 4) The request for coffee/beverages has been made before and will, again, be considered.

These results are shared with staff (e.g., Access Team, Front Desk Staff), and are also included in our *FY19 QI Summary of Activities* report that is posted on our website.

Follow-Up Survey

Customer Services mail out an *ACCMHS Follow-Up Survey* to consumers who are discharged from our services. A postage-paid envelope is provided for the return of the survey. From the 433 surveys sent out for FY19, we received 19 surveys back (for a response rate of 4.4%). The survey provides a place for comments and includes the following eight questions:

1. How much did services help you with resolving the problems that led you to seek help?
2. How much did services help you with improving your overall emotional state?
3. How much did services help you with improving your feelings about yourself (self-esteem)?
4. How much did services help you with improving your overall activity level?
5. How much did services help you to feel confident about handling problems as they come up?
6. How much did you feel involved in planning the course of your services/discharge?
7. Overall, how satisfied are you with the staff's treatment of your problem?
8. To what extent would you be willing to call again for services if the need should arise?

The questions are rated using the following scale:

- 0 = not at all
- 1 = a little bit
- 2 = somewhat
- 3 = quite a bit
- 4 = a lot
- NA = not applicable

The average ratings for the questions above (as well as the Overall rating) are displayed in the following chart for FY17, FY18, and FY19:

FY	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Overall
17	2.80	2.85	2.77	2.77	2.79	2.60	3.12	3.35	**2.83**
18	2.27	2.17	2.14	2.04	2.07	2.56	2.21	2.56	**2.21**
19	2.68	2.84	2.59	2.65	2.42	2.58	3.21	3.37	**2.80**

The chart demonstrates an overall satisfaction of consumers who are discharged from our services. If we consider a rating of 2.5 to be "satisfied" (half way between a "somewhat agree" rating of 2 and a "quite a bit agree" rating of 3), then our percentage of satisfied consumers for

the FY19 *Follow-Up Survey* is 84% (16/19), compared with 60% in FY18. This does not meet our goal of 90%; however, these results may be considered typical since most individuals who responded to the survey are consumers who were no longer eligible for the services that they would have liked to continue with. An increase in the overall satisfaction rating was noted from FY18 (2.21) as compared to FY19 (2.80). (The decline from FY17 to FY18 was most likely due to the intensified focus on utilization management during FY18.)

The survey also asks if the consumer would like Customer Services to contact them regarding the services that they received; 1 of the 19 respondents requested a follow-up phone call; however, the only comment was that they wanted their services to continue.

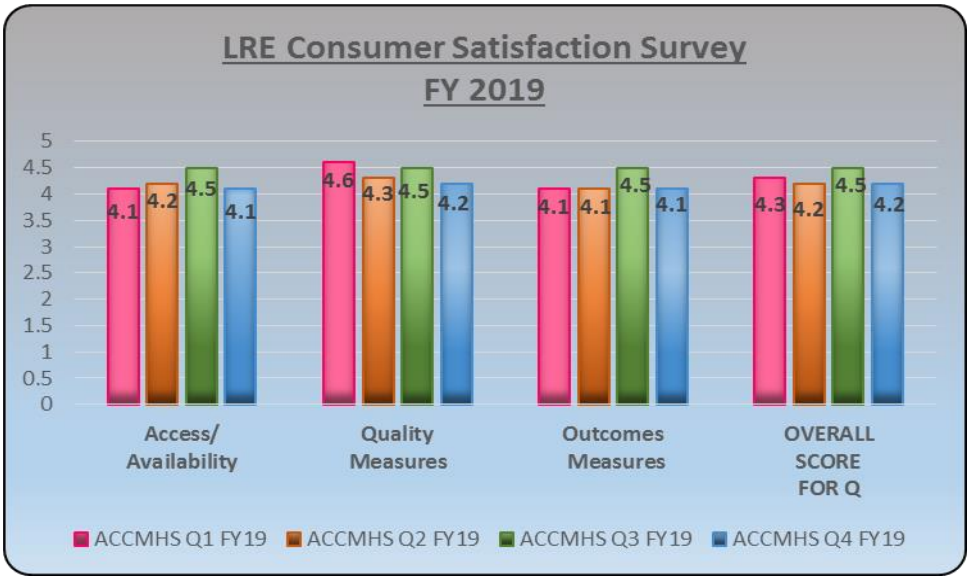
Results are shared with Customer Services and the QI Committee, and are included in our *FY19 Summary of QI Activities* report that is posted on our website.

LRE Consumer Satisfaction Survey

During FY17, the LRE developed a Consumer Satisfaction Survey to be used throughout the region. This survey is comprised of ten questions designed to collect data from the following domains: Access, Quality, Outcome, and Overall. The back page of the survey has a "Comment Section" where the consumer is asked to identify what they liked, did not like, or thought was missing from the services that they received. There is also an area for the consumer to provide their phone number if they would like to be contacted by a Customer Services Representative.

During FY19, data was collected from 107 different respondents, which included several service groups (e.g., Outpatient, Case Management, Autism, Homebased, ACT).

The following graph and chart compare the ACCMHS results for each quarter in FY19. A "4" or a "5" represents satisfaction with "5" being the highest possible score. A "3" is neutral, and a "2" or "1" represents dissatisfaction. The "Overall" category represents the average satisfaction rate for the categories of Access, Quality, and Outcome.



FY19 LRE CONSUMER SATISFACTION SURVEY RESULTS				
AGENCY/Q FY	Access/ Availability	Quality Measures	Outcomes Measures	OVERALL SCORE FOR Q
ACCMHS Q1 FY19	4.1	4.6	4.1	**4.3**
ACCMHS Q2 FY19	4.2	4.3	4.1	**4.2**
ACCMHS Q3 FY19	4.5	4.5	4.5	**4.5**
ACCMHS Q4 FY19	4.1	4.2	4.1	**4.2**
AVERAGE SCORE PER CATEGORY FOR FY19	**4.3**	**4.4**	**4.3**	**4.3**

In previous years, we were provided with regional (LRE) results for the fiscal year. However, that data is not yet available for FY19. The following chart shows the LRE FY18 results, as well as the ACCMHS results for FY18 and FY19. Comparatively, our agency results were equivalent with the average regional results, as the LRE and ACCMHS had an overall score of 4.3 for each fiscal year represented in the following chart:

FY18 & FY19 LRE CONSUMER SATISFACTION SURVEY RESULTS				
AGENCY/FY	Access/ Availability	Quality Measures	Outcomes Measures	OVERALL SCORE
ACCMHS FY19	4.3	4.4	4.3	**4.3**
ACCMHS FY18	4.3	4.3	4.3	**4.3**
LRE FY18	4.2	4.3	4.3	**4.3**

With a 98% overall satisfaction rating (105 of 107 respondents were satisfied overall with our services), we surpassed our goal of 90%.

We received a total of 29 "Disagree" ratings (out of a possible 1,070), with the most (6 of the 29) for the Access/Availability Measures statement "Staff returned my calls within 24 hours." We received the second most "Disagree" ratings (5 of the 29) for the Quality Measures statement "I, not staff, decided my goals." These results are shared with ACCMHS staff, the QI Council, and are also included in our *FY19 QI Summary of Activities* report that is posted on our website. They will also be discussed during a regional QI ROAT meeting.

GOAL 4: Initiate an annual Employee Satisfaction Survey to measure satisfaction and engagement, per the FY2018-FY2022 Strategic Plan.

In July of 2019, ACCMHS conducted an online, anonymous Employee Climate Survey through an independent third party (uSPEQ). The purpose of the survey was to measure the satisfaction level of current ACCMHS employees, and to utilize the data collected to implement changes that will improve employee retention by building positive employee relations and a positive work environment (as described in the FY2018-2022 Strategic Plan).

Respondents were categorized by gender, agency longevity, age group, and job category. The response rate was an impressive 85.5% (n=94).

Questions were asked regarding the following areas:

- Organization Climate (Organizational Culture and Outlook, and Communication, Leadership);
- Workgroup (Teamwork and Manager Support);
- Staff Support (Work Environment, Staff Development, and Compensation and Recognition);
- Overall Job Satisfaction; and
- Open Ended Questions:
  1. What do you like best about working at ACCMHS?
  2. If you could change on thing about your job, what would it be?
  3. What could ACCMHS do differently to help you in your job?

Survey Results:

Top Five Items with Positive Responses:

1. Work well with co-workers.
2. Encouraged to work as part of a team.
3. Supervisor interested in me as a person.
4. Supervisor respects me.
5. Understand job responsibilities.

Top Five Items for Improvement:

1. Concerns taken seriously/follow-up occurs.
2. ACCMHS managed effectively by senior management.
3. Senior management informed of staff concerns.
4. Asked for input on job decisions.
5. Informed about plans/progress at ACCMHS.

The results of the survey were shared at an All Staff Meeting and with the ACCMHS Board. The Management Team has utilized this information to incorporate staff input in agency-wide projects, such as the design of our new building and the revision of our current Vision Statement (to fulfill the Mission/Vision/Values update, per our FY2018-FY2022 Strategic Plan).

GOAL 5: Initiate a Quality Improvement (QI) Team, per the FY2018-FY2022 Strategic Plan.

One of the stated goals on ACCMHS 2018-22 Strategic Plan was to form a Quality Improvement Committee that would help foster a continuous quality improvement culture which engages staff in identifying quality improvement opportunities and generating creative solutions. The data-driven committee serves to support the overall mission, vision, and values of ACCMHS by

ensuring the quality of clinical care, promoting health & safety, improving organizational performance, and ensuring conformance to accreditation standards and compliance with other external requirements.

In the beginning of FY19, a team charter was drafted to outline the committee responsibilities, membership roles, decision-making process, and reporting structure of the Quality Improvement Council (QIC). The Quality Improvement (QI) Team will meet a minimum of 6 times a year. Members will include: QI Director, QI Coordinator, Utilization Management Coordinator, Residential Services Coordinator, Integrated Health Services Director, Human Resources Manager, Reimbursement Coordinator, and the Clinical Director.

The QIC began meeting in December of 2018 and has taken on several projects including Policy & Procedure review, CARF preparation, and Annual Site Reviews (as well as any resulting Corrective Action Plans). Subcommittees have had success by focusing on specific areas such as "MMBPIS" and "The Unnecessary Use of General Funds".

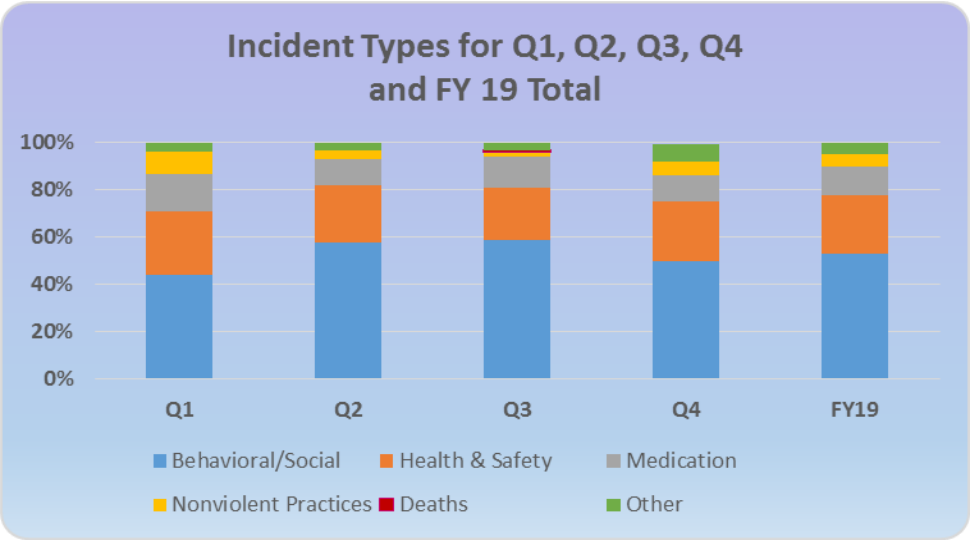
INCIDENT REPORTS

Incident Reports are monitored to: ensure that incidents are appropriately responded to in an effective, timely manner; determine specific trends or patterns of incidents; and to create mechanisms (based on specific trends) designed to prevent or minimize the negative impact that these incidents have on the lives of those we serve.

As part of the incident report monitoring process, incident reports are categorized into six areas:

- Behavioral/Social
- Health & Safety
- Medication
- Nonviolent Practices
- Deaths
- Other

The following graph and chart display the total percentages of Incident Reports received within each category for Q1, Q2, Q3, Q4, and FY19:



CATEGORY	Q1	Q2	Q3	Q4	FY19
Behavioral/Social	44%	58%	59%	50%	**53%**
Health & Safety	27%	24%	22%	25%	**25%**
Medication	16%	11%	13%	11%	**12%**
Nonviolent Practices	9%	4%	2%	6%	**5%**
Deaths	0%	0%	1%	0%	**0%**
Other	4%	3%	3%	8%	**5%**

An increase in the Behavior/Social category from Q1 to Q2 (44% to 58%) was noted, while there was a decrease in the Medication category during that same time period (16% to 11%). This is partially due to the fact that our present Incident Reporting system can only record one type of incident code per Incident Report form. For example, "Medication Refusals" can be recorded as an M1: *Missed Medication* (which are recorded in the **Medication** category) or as a B8: *Disruption of a Service Routine* (which are recorded in the **Behavioral/Social** category). Sometimes these incidents can be coded as both; however, the system will only allow for the incident to be included in one or the other of these categories (thus causing the "shift" we see when comparing Q1 to Q2).

Nonviolent Practices went from a high of 9% during Q1 down to a low of 2% during Q3, mainly due to a decrease in the amount of "Emergency Use of Physical Management" needed for one particular consumer during Q3.

The following chart displays the Incident Reporting for FY16, FY17, FY18, and FY19.

CATEGORY	FY16 (n=2447)	FY17 (n=2443)	FY18 (n=2002)	FY19 (n=2310)
Behavioral/Social	46%	49%	53%	53%
Health & Safety	28%	25%	23%	25%
Medication	13%	11%	12%	12%
Nonviolent Practices	6%	7%	6%	5%
Deaths	1%	1%	1%	0%
Other	6%	7%	5%	5%

The only significant change noted between FY18 and FY19 was the increase in received Incident Reports (from n=2,002 in FY18 to n=2,310 in FY19). However, the number of Incident Reports received in FY19 more closely reflects those of FY16 and FY17 (as well as the overall average of 2,300 from FY16-FY19).

Our Recipient Rights Officer provides ongoing training to providers on the Incident Reporting process. As previously mentioned, our current Incident Reporting database isn't able to adequately accommodate all of the events recorded on our Incident Reports. We are hoping to enhance or replace our current system with a more robust program with increased recording, reporting, and analysis capability.

ADDITIONAL QUALITY IMPROVEMENT ACCOMPLISHMENTS IN FY 19

Quality Records Review

The Quality Records Review process has been restructured to review, on a quarterly basis, random cases from the following five departments: Adult CSM, ACT, Child Outpatient, Adult Outpatient, and Adult SC. The following four areas of the chart are reviewed: 1) Assessment; 2) Person Centered Plan/Plan of Service; 3) Service Delivery; and 4) Service Specific Requirements. In addition, the Finance Team reviews the same charts to ensure billing criteria is being met.

The quarterly report includes: Review Scores, Areas of Strengths, Opportunities for Improvement, and Next Steps (e.g., Review Schedules, modifications to the Monitoring Tool).The forms and process are revised as needed (e.g., to more closely monitor process improvement recommendations and/or service-specific requirements). The final reports are shared with the appropriate supervisors and clinician, as well as the Clinical Director.

Mission/Vision/Values Update

ACCMHS is in the process of updating our current Mission, Vision, and Values statements (per the FY2018-FY2022 Strategic Plan). As part of the Management Team's commitment to offering more opportunities for employee input and engagement (Strategic Plan and the Staff Climate Survey), two cohort teams met to propose a set of values that: 1) reflect the character of the agency we have today and/or 2) help point us to the character/values we need to strengthen ACCMHS to be able to be the best agency that we can possibly be, while providing the best service possible for our consumers/community.

ACCMHS Relocation – New Building Plans

One of the items that consistently receives lower ratings on our consumer satisfaction surveys is our location. To better serve our consumers as well as our community, ACCMHS plans to renovate a building and relocate to a place that can accommodate our current and future service needs. The Management Team has incorporated staff input in the building plans/process to ensure that individual team areas are designed to meet the specific needs of both ACCMHS consumers and staff members.