Mission: To promote hope, recovery, resilience, quality of life and wellness in Washtenaw County by providing high quality, integrated services to eligible individuals.

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH (WCCMH)
PROGRAM-QUALITY COMMITTEE MEETING
AGENDA

https://zoom.us/j/99283662107

May 10, 2021

3:00-4:00pm

I. Roll Call (5 minutes)

II. Introductions (5 minutes)

III. Audience Participation (see guidelines below) (5 minutes)

IV. Budget-Finance and Program-Quality Combined Committee meeting minutes (5 minutes)
- Budget-Finance and Program-Quality Combined Committee Meeting Minutes and Actions from 3/8/21 (Attachment #1) **ACTION**

V. Discussion Items

VI. Old Business (10 minutes)
- CCBHC Updates

VII. New Business (25 minutes)
- Annual Performance Improvement Year End Report (Attachment #2) **– L. Higle ACTION**

VIII. Items for Future Discussions (5 minutes)

IX. Adjournment of Public Meeting

Please click this URL to join. https://zoom.us/j/99283662107

Or One tap mobile:
+13126266799, 99283662107# US (Chicago)
+16465189805, 99283662107# US (New York)

Or join by phone:
Dial(for higher quality, dial a number based on your current location):
US: +1 312 626 6799 or +1 646 518 9805 or +1 929 205 6099 or +1 267 831 0333

Webinar ID: 992 8366 2107

International numbers available: https://zoom.us/u/a2XTgVF3e

Effective March 17, 2021 the Washtenaw County Board of Commissioners has approved the continuation of all public meetings to be held virtually until December 31, 2021, per resolution #21-050.

Audience Participation Guidelines:
- Three (3) minutes are allowed per speaker
- Speakers are asked to bring a copy of their concerns/comments in writing
- Resolutions on issues will be brought to the appropriate committee as necessary

WASHTENAW COUNTY COMMUNITY MENTAL HEALTH AGENCY (WCCMH)

WCCMH BUDGET-FINANCE AND PROGRAM-QUALITY COMBINED COMMITTEE MEETING MINUTES *DRAFT*

Due to the recent State of Michigan legislature allowing public meetings and commissions to meet virtually, this meeting was held remotely

https://zoom.us/j/91553718568

March 8, 2021
1:00 pm

ROLL CALL: S. Antonow attending remotely from Ann Arbor, Washtenaw County, MI
A. Dusbiber attending remotely from Ann Arbor, Washtenaw County, MI
N. Graebner attending remotely from Chelsea, Washtenaw County, MI
B. Higman attending remotely from Ann Arbor, Washtenaw County, MI
R. Jefferson attending remotely from Ypsilanti Twp, Washtenaw County, MI
B. King attending remotely from Ann Arbor, Washtenaw County, MI
D. Strong attending remotely from Scio Twp, Washtenaw County, MI
K. Walker attending remotely from Cadillac, Wexford County, MI

MEMBERS ABSENT: K. Scott

STAFF PRESENT: N. Phelps, R. Dornbos, L. Higle. S. Ray, T. Cortes, K. Walker, M. Harding, S. Lefferts, H. Linky, K. Hoener, L. Gentz, M. Taylor, S. Amos O'Neal, M. Tasker, B. Hagaman

OTHERS PRESENT: L. Lutomski, G. Dill, K. Homan, K. Belknap, J. Martin, G. Nelson, M. Creekmore

K. Walker called the meeting to order at 1:01 pm

I. Introductions
- None

II. Audience Participation
- None

III. Board Response to Audience Participation
- None

IV. Budget-Finance Committee Meeting Minutes and Actions from 2/8/21
- Budget-Finance Committee Minutes and Actions of 2/8/21 were reviewed.

MOTION BY D. STRONG, SUPPORTED BY B. KING TO APPROVE THE MINUTES AND ACTIONS FROM THE FEBRUARY 8, 2021 BUDGET-FINANCE COMMITTEE MEETING.

ROLL CALL VOTE:

ANTONOW	**NOT ON BUDGET-FINANCE COMMITTEE**	**DUSBIBER**	**Y**
GRAEBNER	**Y**	**HIGMAN**	**NOT ON BUDGET-FINANCE COMMITTEE**
JEFFERSON	**Y**	**KING**	**Y**
SCOTT	**N/A**	**STRONG**	**Y**

WALKER	**NOT ON BUDGET-FINANCE COMMITTEE**		

MOTION CARRIED

V. Program-Quality Committee Meeting Minutes and Actions from 1/11/21

- Program-Quality Committee Minutes and Actions of 1/11/21 were reviewed.

MOTION BY N. GRAEBNER, SUPPORTED BY A. DUSBIBER TO APPROVE THE MINUTES AND ACTIONS FROM THE JANUARY 11, 2021 PROGRAM-QUALITY COMMITTEE MEETING.

ROLL CALL VOTE:

ANTONOW	**NOT PRESENT AT TIME OF THIS VOTE**	**DUSBIBER**	**Y**
GRAEBNER	**Y**	**HIGMAN**	**Y**
JEFFERSON	**NOT ON PROGRAM-QUALITY COMMITTEE**	**KING**	**NOT ON PROGRAM-QUALITY COMMITTEE**
SCOTT	**N/A**	**STRONG**	**NOT ON PROGRAM-QUALITY COMMITTEE**
WALKER	**Y**		

MOTION CARRIED

S. Antonow jointed the meeting at 1:10 pm.

VI. Finance Status Reports

- N. Phelps reviewed the financial status report for the month ending January 31, 2021.

MOTION BY B. KING, SUPPORTED BY A. DUSBIBER TO APPROVE THE FINANCIAL STATUS REPORT THROUGH JANUARY 31, 2021 AS PRESENTED.

ROLL CALL VOTE:

ANTONOW	**NOT ON BUDET-FINANCE COMMITTEE**	**DUSBIBER**	**Y**
GRAEBNER	**Y**	**HIGMAN**	**NOT ON BUDET-FINANCE COMMITTEE**
JEFFERSON	**Y**	**KING**	**Y**
SCOTT	**N/A**	**STRONG**	**Y**
WALKER	**NOT ON BUDET-FINANCE COMMITTEE**		

MOTION CARRIED

VII. Contracts and Leases

- There were no contracts and leases for this month.

VIII. Executive Director Authorizations
- There were no Executive Director Authorizations for this month.

IX. Regional Finance Update
- N. Phelps and T. Cortes presented the Regional Finance Update to the committee.
- PIHP is working with the State on how to handle prior year cost settlements.
- The $2 temporary direct care worker increase could potentially be extended until 9/30/2021.

X. Old Business
- CCBHC Update
  - o T. Cortes presented the CCBHC update to the committee.

- Staffing and Provider Discussion
  - o T. Cortes gave an update on the staffing and provider network to the committee.
  - o Keep this topic on the agenda but with CCBHC there are still a lot of questions around additional revenue and what we will need to staff clinically and administratively.

XI. New Business
- MDHHS Performance Quarterly Indicators FY2020 3rd and 4th Qtrs.
  - o T. Florence and L. Higle presented the MDHHS Performance Quarterly Indicators for the 3rd and 4th quarters of FY2020.

MOTION BY A. DUSBIBER, SUPPORTED BY B. HIGMAN TO ACCEPT THE MDHHS PERFORMANCE QUARTERLY INDICATORS FY 2020 3RD AND 4TH QUARTERS REPORT.

ANTONOW	**Y**	**DUSBIBER**	**Y**
GRAEBNER	**Y**	**HIGMAN**	**Y**
JEFFERSON	**NOT ON PROGRAM-QUALITY COMMITTEE**	**KING**	**NOT ON PROGRAM-QUALITY COMMITTEE**
SCOTT	**N/A**	**STRONG**	**NOT ON PROGRAM-QUALITY COMMITTEE**
WALKER	**Y**		

MOTION CARRIED

Request to have the full board notified on any public comments communications to close the loop on the process.

XII. Items for Future Discussions
- Diversion Council Update-Program-Quality Committee
- Bring to a future combined meeting the provider challenges with direct care staff wages and the County living wage ordinance.
- Career path for direct care workers with a goal to pay higher wage.
- Integrate the Millage, CCBHC and CMH Medicaid budgets into strategic planning.

MOTION BY B. KING, SUPPORTED BY B. HIGMAN TO ADJOURN THE BUDGET-FINANCE AND PROGRAM-QUALITY COMMITTEE COMBINED MEETING.

XIII. Meeting adjourned at 2:08 pm.

Washtenaw County Community Mental Health
Annual Year End Performance Improvement Report
Fiscal Year 20 (October 1, 2019 – September 30, 2020)

Introduction

Washtenaw County Community Mental Health (WCCMH) regularly reviews various indicators throughout the fiscal year. An annual comprehensive review and summary also occurs. Reviewing activities, status and performance indicators summarizes the past and directs the focus of the future. WCCMH also regularly reviews progress on our Five-Year Strategic Plan. This strategic plan is a foundation of improvement opportunities. Note that this report reflects the progress of CMH proper towards the strategic plan's goals developed in 2015. A separate Annual Report regarding Millage initiatives for Fiscal Year 2020 will be released at later date and are not reflected in this report. That report will be available on the CMH website upon release.

Strategic Plan and Organizational Focus FY 20

- Like FY 19, FY 20 was impacted by changes in the capitated funding model resulting in revenue changes and subsequent actions to minimize that impact. Continuing to work with the WCCMH Board, Washtenaw County's Board of Commissioners, and County Administration, WCCMH maintained a hiring freeze resulting in clinical and non-clinical administrative positions remaining vacant. This ongoing focus continued to pressure the ability to maintain high-quality services while also focusing on the Strategic Plan, during the COVID-19 pandemic. The impact on staffing positions is as follows:
  - 10 Vacant Administrative positions.
  - 48 vacated/ on hold CMH program positions (these positions do not include the 23 positions that were posted in FY 20).

- Strategic Plan Goal: Strengthen CMH capacity and consistency in delivery of core services. Achievements:
  - Due to COVID-19, operations were adjusted to safely provide and monitor services during the pandemic. The adjustments included:
    - During early months of the COVID-19 pandemic, we continued to provide services to individuals including health and wellness checks. We also adjusted to providing both telehealth and in person services while maintaining COVID-19 precautions.
    - Developed and implemented a schedule for emergency staff during the State of Emergency mandate until June 15, 2020. This ensured individuals were able to continue to receive services.
    - Navigated and created solutions that pertained to County building closures.
    - Developed and continually updated COVID-19 screening process for on-site staff members and individuals entering our physical sites for services.
    - Obtained, maintained, and monitored the supply and distribution of Personal Protection Equipment (PPE) for our staff members and providers.
    - Implemented and trained staff members on software processes to deliver telehealth services.
    - Developed and implemented rotating schedule of onsite and offsite staff members to minimize possible COVID-19 virus exposure and maximize services to individuals. This schedule required constant attention and revision as staff needs and/or requests changed.
    - Implemented, trained and monitored on the use of code procedure transaction (CPT) codes to reflect implementation of newly allowed various forms of telehealth services.

- Deployed a survey of telehealth utilization to identify future improvement opportunities.
- Increased mobile operations.
- Developed and performed remote management of operations.
- Developed and implemented a process to help manage and monitor work processes and productivity to replace normal "in person" processes.
- Monitored ongoing feedback and changes from accrediting organization (Joint Commission) while responding to new processes and demands due to the pandemic.

- Developed and launched the Black Lives Matter taskforce.
- Implemented Equity Training for all of WCCMH.
- Responded to and implemented processes to increase direct wage (by $2.00/ hour) for direct care staff as a "pass through" to provider organizations during the pandemic.

❖ Strategic Plan Goal: Pursue adequate Federal, State and Local resources for persons served by WCCMH. Achievements:
- Executive Director continued to meet with various State committees and leaders including the Community Mental Health Association of Michigan, Directors Forum, leaders from the Michigan Department of Health and Human Services (MDHHS), the Prepaid Inpatient Health Plan (PIHP) and Community Partners. Advocacy included addressing the multiple and changing needs driven by the pandemic the direct care worker crisis.
- Executive Director's advocacy and participation helped to ensure promote the $2.00/hour pass through rate increase for direct care workers.

❖ Strategic Plan Goal: Improve quality of life with a deeper integration of physical, behavioral and health/wellness services. Achievements:
- The 23 Hour Observation Center "750 Towner" opened. Due to limitations imposed by the pandemic social distancing requirements, the program operated with reduced capacity.
- WCCMH continues to serve and coordinate care for an average of 30 individuals via the State Innovative Model (SIM). Staff continue to actively participate in SIM and Washtenaw Health Initiative (WHI) meetings.

❖ Strategic Plan Objective: Develop and implement a process and service improvement plan for persons with substance use disorders, in partnership with Washtenaw Coordinating Agency. Achievements:
- The Program Administrator position overseeing this area of the plan was eliminated due to the response for FY 19 revenue challenges and has not been filled per the hiring freeze.
- Due to the pandemic, groups were suspended until we were able to deliver group therapy safely and effectively via telehealth while also meeting legal requirements for confidentiality.

❖ Strategic Plan Objective: Develop and implement a plan for enhanced services for youth. Achievements:
- Focused on developing a proposal for a Youth Assessment Center within Washtenaw County.
- Worked directly with the MDHHS to provide evidence-based practices via Telehealth.
- WCCMH has integrated Psychiatrists and Mental Health Professionals into the local Corner Health and outer County partners including Whitmore Lake, Chelsea, Dexter, and Manchester localities. Enhanced service connection and Juvenile Justice diversions by placing mental health professionals at key intercept points in Juvenile Court and the Youth Center.

- Strategic Plan Goal: Help increase access and availability of services across the community for recovery and quality of life through strategic partnerships. Achievements:
  - The State of Michigan was chosen as a Demonstration State for the federally driven Certified Community Behavioral Health Clinics (CCBHC). WCCMH was selected as an eligible CCBHC provider site.
  - The CCBHC Expansion Grant application was submitted and approved allowing an additional two years of programming. A targeted implementation date of May 2020 was identified.
  - WCCMH continued to partner with the Core Providers and Coordinating Agency to enhance a model of integrated SUD services for CCBHC service delivery.

- Strategic Plan Objective: Pursue resources to provide enhanced support for persons with co-occurring illnesses who are not currently served by CMH. Achievement:
  - Worked with the Core Providers and Coordinating Agency to develop a model of integrated SUD services for CCBHC service delivery.

- Strategic Plan Objective: Partner in a community initiative for early identification and preventions of serious mental illness. Achievements:
  - WCCMH met with Washtenaw Intermediate School District (WISD) and community partners to discuss Mental Health awareness initiatives through a "UMatter" week.
  - Youth-focused Anti-Stigma campaign was kicked off in June 2019 and continued through FY 20.
  - WCCMH provided trainings for WISD related to suicide assessment and resource/service connection.

- Strategic Plan Goal: Strengthen the quality, effectiveness, and efficiency of services through easy access to data and meaningful analysis. Achievements:
  - Continued to participate on statewide committees to further expand statewide sharing of behavioral health information.
  - WCCMH administration continues to monitor and evaluate the effectiveness of data-based reports.
  - Data-based reports are reviewed on a regular basis by the WCCMH Administration, the Mental Health Board, and staff members to assist with managing processes and identifying trends or patterns.

- Strategic Plan Objective: Expand the meaningful use of health, wellness, self-determination, and consumer satisfaction measures by the CMH team and provider network to support service excellence, well-informed consumer choice and transparency. Achievement:
  - The Performance Improvement Year End Report was presented to WCCMH Mental Health Board.
  - The Provider Dashboard was presented to the WCCMH Mental Health Board in 2nd quarter 2020.
  - The Program Committee Dashboards were presented to the Program Committee.

- Strategic Plan Goal: Build public awareness and trust, and support advocacy through clear, transparent communication and engagement. Achievements:
  - PIHP updated the Guide to Service which is distributed to all consumers at intake and available via the PIHP website.
  - Performance Improvement Year End Annual report was distributed and reviewed by the WCCMH Board.
  - Millage Annual Report published and distributed to the community.

- Communication plan completed and implemented. Achievements:
  - Social Media presence grew via Instagram and Facebook (>260 followers).
  - Virtual events included Facebook Live, Zoom and other platforms to engage with the community. Spring series implemented to engage with individuals during the Governor's "Stay Home Stay Safe" order.
  - WCCMH Millage engaged in numerous media contacts.
  - WCCMH and Consumer Advisory Council (CAC) invited members to present to the WCCMH Board quarterly on their lived experiences and engagement with the CAC.

❖ Strengthen shared learning and partnership between CMH and consumers.
- WCCMH completed the 2019 Satisfaction Survey. One question asked, "I know how to file a complaint" received a 76% response rate among our Adult MI population. Anything lower than 80% results in the need for a corrective action plan. Due to the challenges of the COVID-19 pandemic, a plan has not yet been developed.
- All other responses were above the 80% threshold.

❖ Strategic Plan Goal: Diversify revenue streams and increase flexibility of resources to support prevention, outreach, and equitable access. Achievements:
- WCCMH sought out and was awarded CCBHC 2 grant resulting in an additional $3.8M over two years.
- WCCMH continued to partner with Blue Cross Complete and Center for Healthcare, Research and Transformation (CHRT) on exploring sustainable public/private partnership.
- Maintained CCBHC 1 while implementing CCBHC 2.
- CCBHC 2 went live on May 1st, 2020.

❖ Strategic Plan Goal: Build a culture and the skills of engagement, appreciation, shared learning, and continuous improvement.
- Due to the COVID-19 pandemic, the Performance Improvement (PI) department shifted resources to help clinical teams manage and monitor clinical services during the pandemic. Reports were developed and distributed weekly and others were distributed monthly.
- Continued to monitor critical events and review deaths for possible trends and/or patterns.
- Received a thorough review of administrative and program processes by TBD Solutions which included:
  - Gathering, scheduling, and sharing requested documentation, datasets, interviews, and subsequent discussions with TBD Solutions.
  - Clarifying, responding, and assisting TBD Solutions staff as they performed their tasks.
  - Analyzed and considered TBD Solutions conclusions which included:
    - Despite a low number of administrative positions, WCCMH performs many functions very well.
    - Utilization Management processes may find areas to improve upon.

❖ Strategic Plan Goal: Develop WCCMH and the provider network into a well-integrated, effective provider entity with enhanced capacity to lead on quality, cost and innovation: Achievements:
- Shared learning through provider meetings continued to occur on a regular basis.
- Provider Advisory Meeting continued to occur on a bimonthly basis.
- Executive Director continued to provide information to the organization as it became available.

Overview of Indicator Monitoring

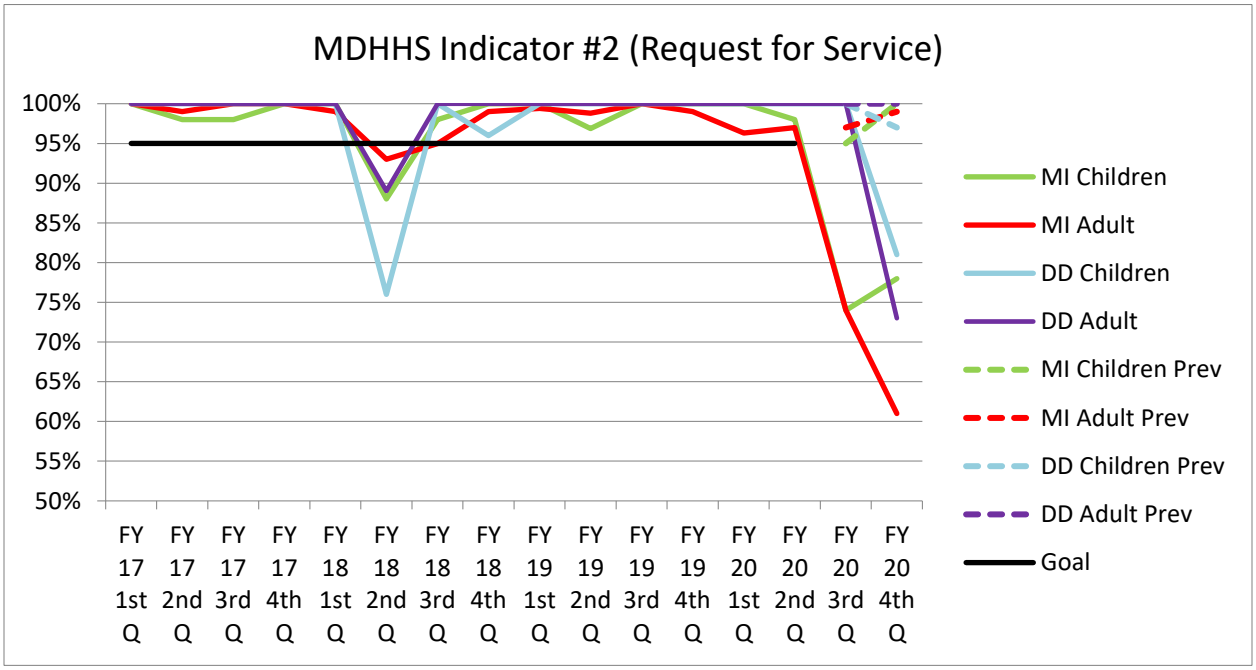
This is a final report of various measures compiled to assist stakeholders' understanding of WCCMH performance in some areas of efficiency and effectiveness. This is a summary review of our status.

Access and Services

WCCMH's Access Department responds to emergent, urgent, and routine requests for services. Routine requests result in an intake to determine eligibility. MDHHS Performance Indicators include monitoring access to services in a timely and efficient manner. Please note, for State Performance Indicators, all population naming follows the MDHHS population naming convention. MDHHS continues to identify adults who experience a developmental disability as "DD Adult" while our internal programming describes these individuals as experiencing an Intellectual and Developmental Disability (IDD).

As of April 1, 2020, the MDHHS changed the operational definitions for calculating Indicators #2 (14 days to Intake) and #3 (14 days to ongoing service) and removed the historical goal of 95% compliance. The major change in the operational definition does not allow accounting for individual choice. Individual choice is indicated when the individual requests an appointment outside of the 14-day window, reschedules, cancels and / or does not attend an appointment. An additional change that impacts indicator #3 includes eligible individuals declining our services would still be out of compliance. Because of these changes, the number of out of compliance cases has increased statewide. MDHHS is treating the first year as baseline collection.

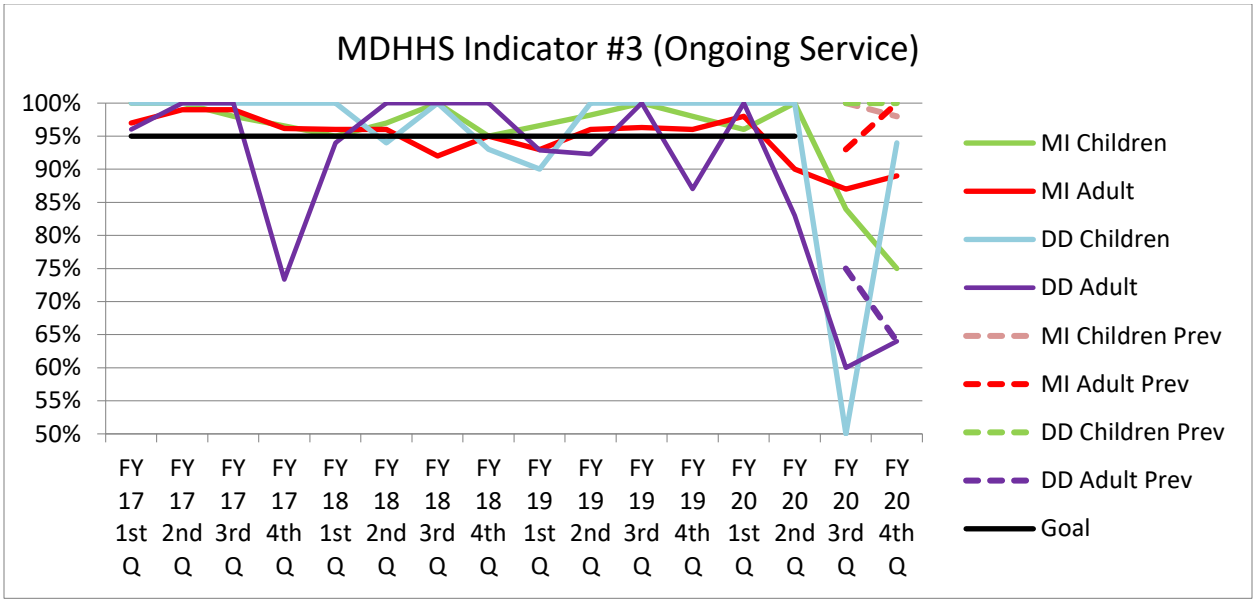
The third and fourth quarter data points are indicated on the graphs. The "dashed lines" indicate where our compliance would have been under previous definitions.



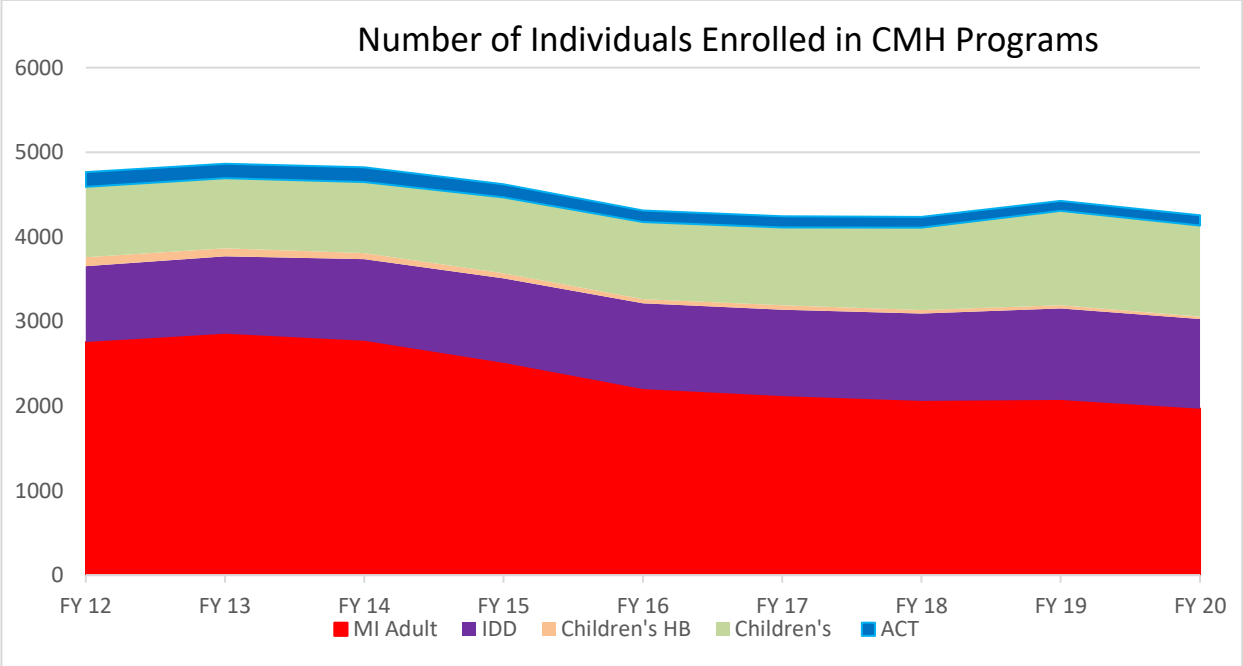
Overall, our response to request for services continues to meet expectations to offer appointments within 14 days indicating our capacity to respond to demands is sufficient. Additionally, our Access Department offers appointments as close to the request as possible hoping this will help the individual keep the appointment as a priority. However, as indicated in the third and fourth quarters, individuals seeking services often have competing priorities or other variables that prohibit them from attending appointments within 14 days. As

stated earlier, there is no MDHHS goal for quarters 3 and 4 as this is considered a statewide baseline collection period.

After the individual is found eligible to receive services, it is expected that ongoing services occur within 14 days. Again, the MDHHS operational definition changed for this indicator and does not account for individual choice when determining compliance.

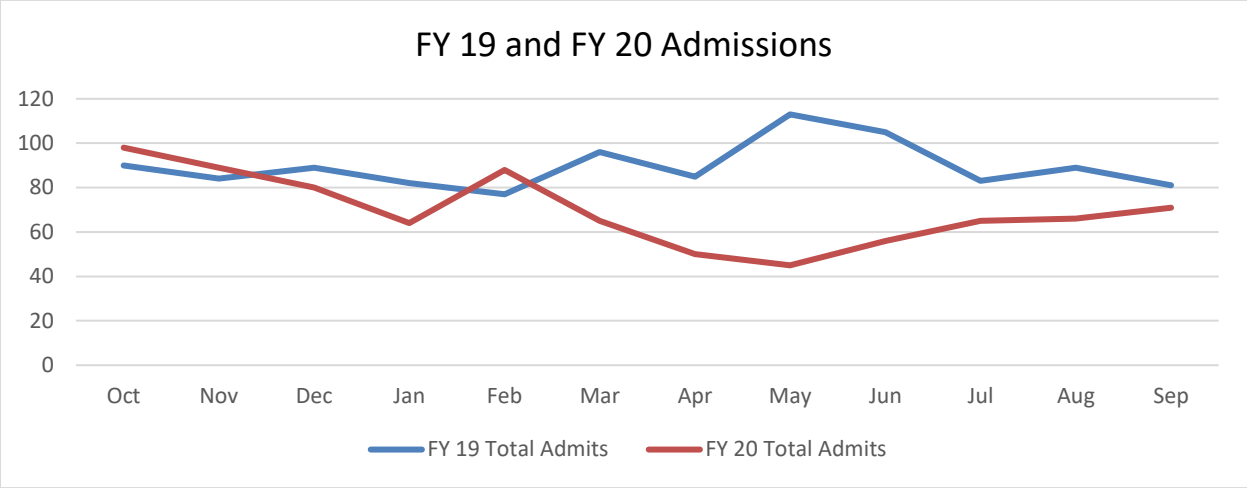


The following graph identifies the number enrolled in each of our core services by fiscal year. This helps identify the enrollment and trends/ patterns that may be occurring.



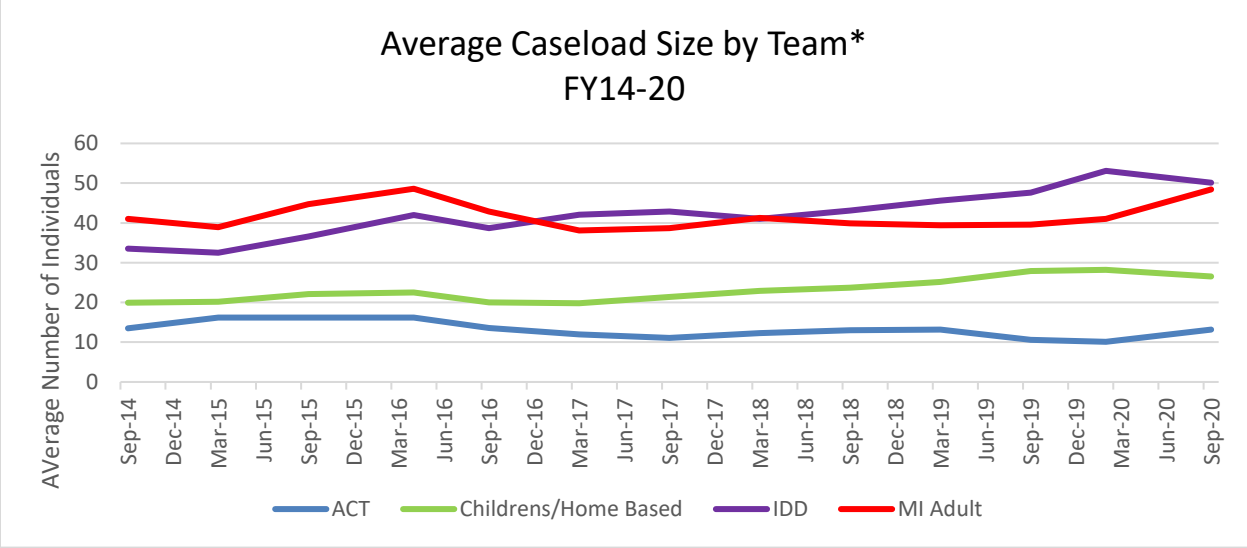
Overall cumulative enrollment has decreased since significant reduction of general funds at the State level in 2015 and has decreased in FY 20 from FY 19.

The change in enrollment numbers appear to be linked to a lower number of CMH Core Team admissions in FY 20:



The admission rate began declining in March and started to recover in June. This corresponds to the Executive Orders identifying a state of emergency from the Governor during this time period. Though our organization remained open and did admit individuals, the number of admits was much lower than in FY 19.

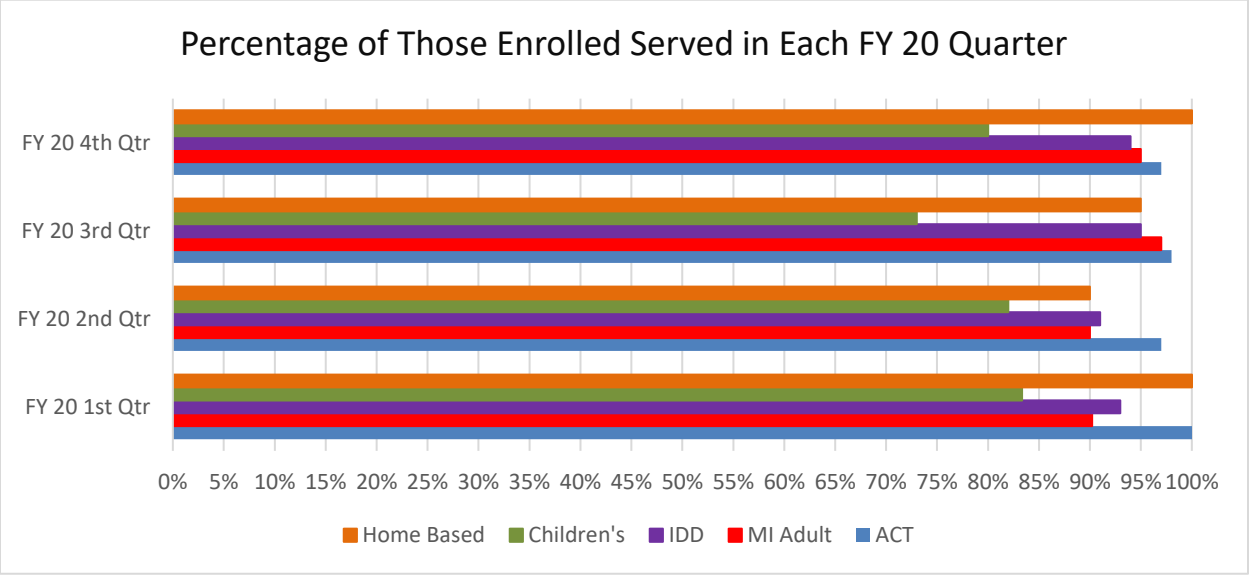
Given the hiring freeze and vacated positions, it is important to monitor caseload sizes. Caseloads vary depending on increased demand for services, turnover in staffing and most recently due to the hiring freeze which started in June 2019 (due to unexpected revenue changes which impacted the budget). Caseload sizes of primary staff members assigned to the cases are captured every month by the PI processes as part of the monthly management data sharing and review process. For this particular review, we captured caseload sizes at two points in time for every fiscal year and averaged those caseload sizes for their respective programs.



*Children's/ Home Based and Assertive Community Treatment (ACT) have much lower caseload sizes due to MDHHS and/or Medicaid mandates.

MI Adult has experienced a significant increase in caseload sizes. The IDD program has also witnessed an increase in caseload sizes with variance throughout the year.

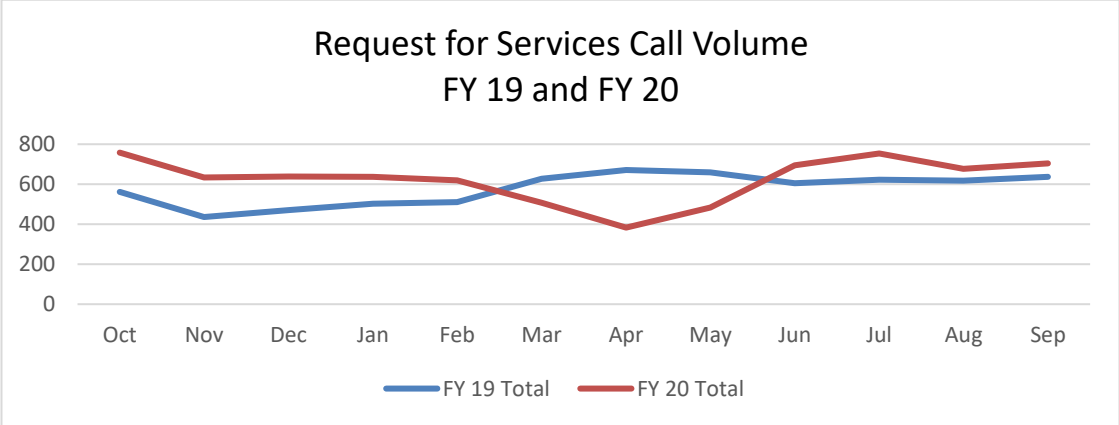
Of those enrolled, it is helpful to monitor the percentage receiving a service in the designated time period as indicated below:



This graph displays the percentage of individuals receiving at least one service in the corresponding time period.

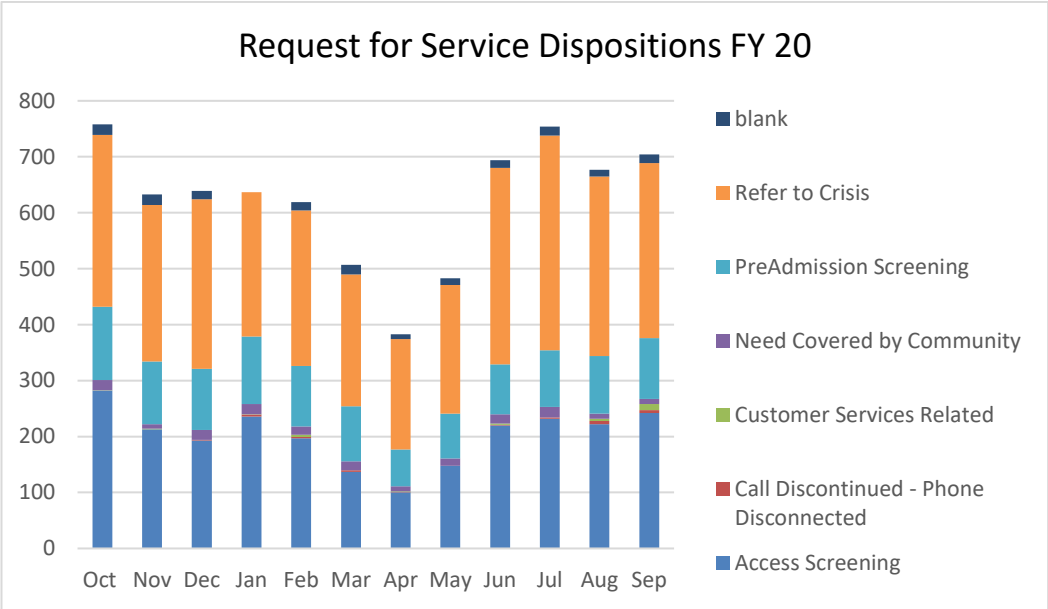
Access, Triage and Crises

As mentioned earlier, our Access Department responds to requests for services. Below is a graph depicting monthly volume of Request for Services documents in FY 20 compared to FY 19.



FY 20 request for services volume appears to be impacted by the pandemic in March, April and May and resumed to a higher volume from that point on.

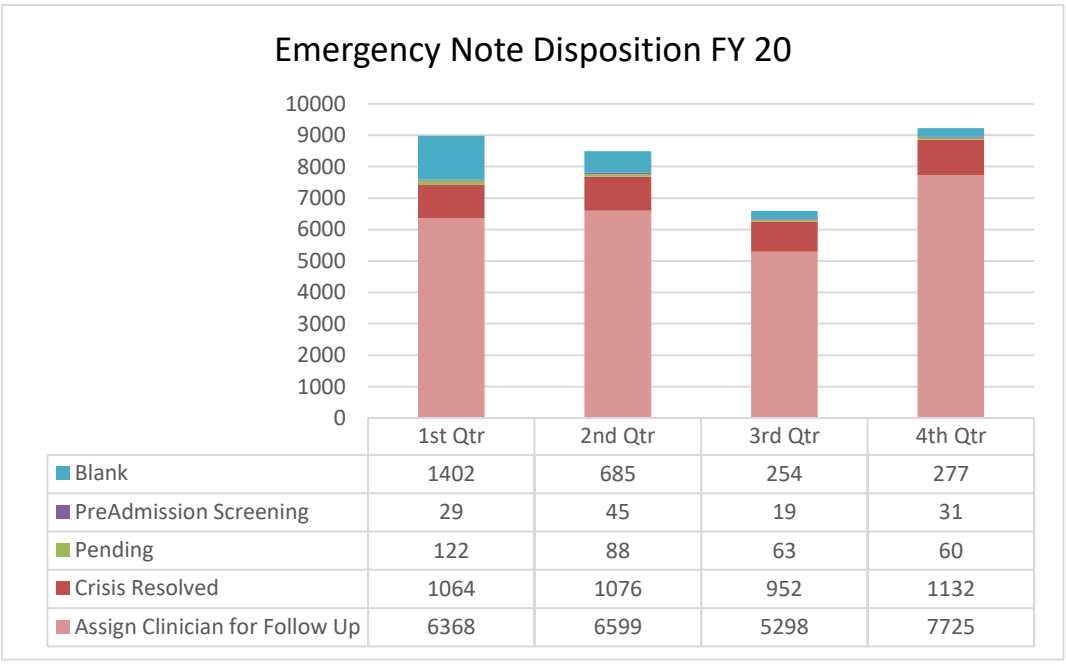
Calls are screened and those considered a request for service are routed according to individual needs and/ or requests. Emergent and Urgent requests are referred to the Crisis Team. Below is a graph identifying the number and type of telephonic requests in FY 20.



Though we remained open and available to serve individuals, the obvious decrease in request for services coincides with the Governor's Executive "shut down" orders.

Crisis Team

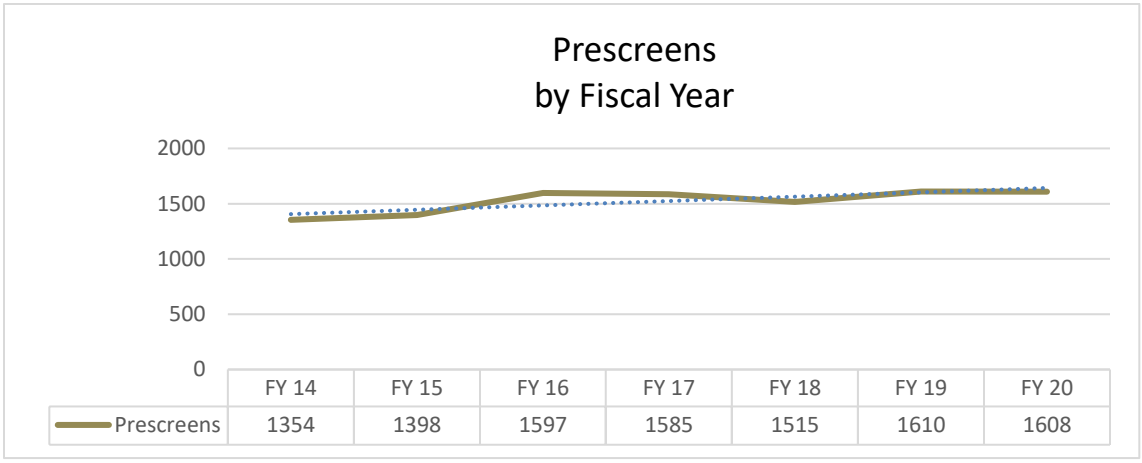
Our Crisis Team responds to emergent and urgent needs from both WCCMH recipients and the general public. Below are data points to help monitor the volume and nature of their work.



	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr
Blank	1402	685	254	277
PreAdmission Screening	29	45	19	31
Pending	122	88	63	60
Crisis Resolved	1064	1076	952	1132
Assign Clinician for Follow Up	6368	6599	5298	7725

Again, the decrease in emergency services coincides with the Governor's Executive orders due to the pandemic.

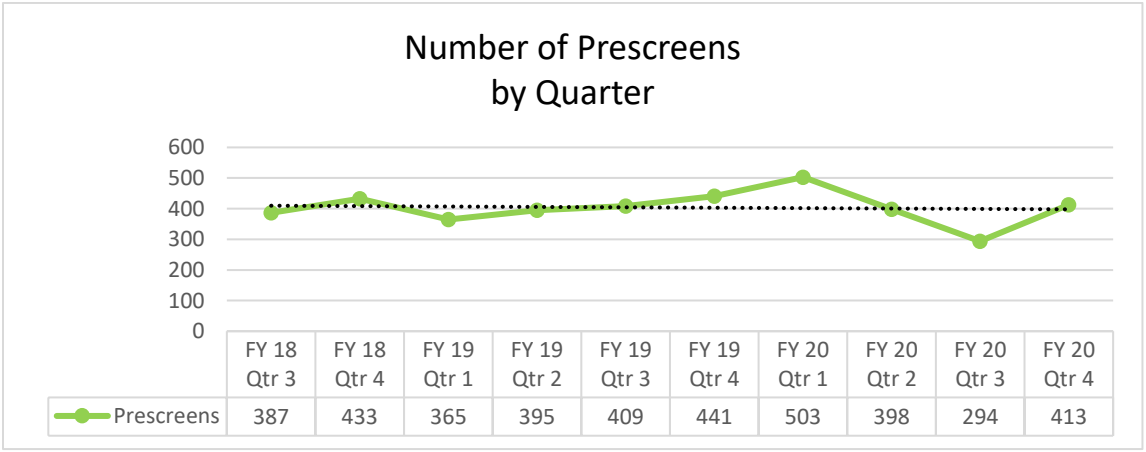
The Preadmission Screening results in either a face to face or telephonic evaluation of the individual's emergent needs. Below are the total number of Crisis Hospital Prescreens over a seven-year period:



	FY 14	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
Prescreens	1354	1398	1597	1585	1515	1610	1608

Overall, the number of Crisis prescreens in FY 20 was consistent with FY 19 and continues to be higher than in previous years. This continues to suggest possibly higher acuity in our communities or perhaps deeper penetration by WCCMH.

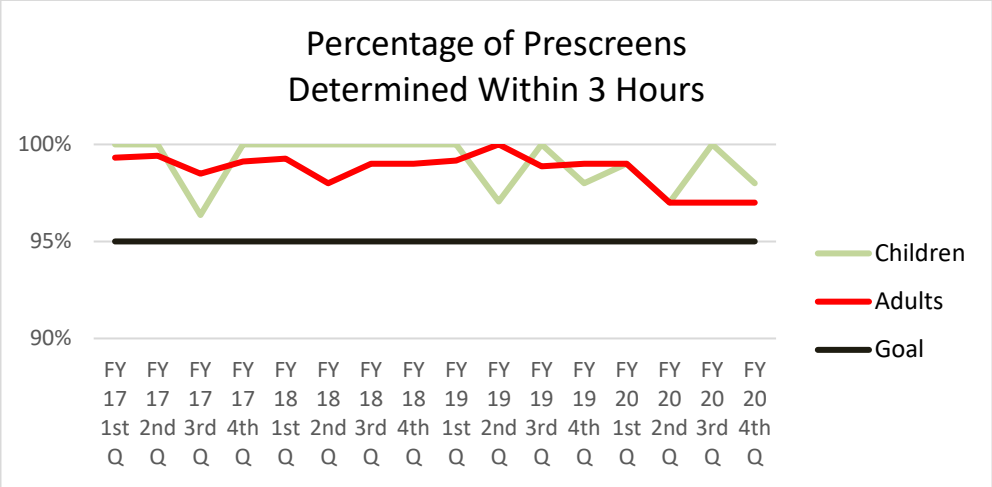
Sometimes it is helpful to monitor prescreens by quarter to see if there is a predictable pattern:



	FY 18 Qtr 3	FY 18 Qtr 4	FY 19 Qtr 1	FY 19 Qtr 2	FY 19 Qtr 3	FY 19 Qtr 4	FY 20 Qtr 1	FY 20 Qtr 2	FY 20 Qtr 3	FY 20 Qtr 4
Prescreens	387	433	365	395	409	441	503	398	294	413

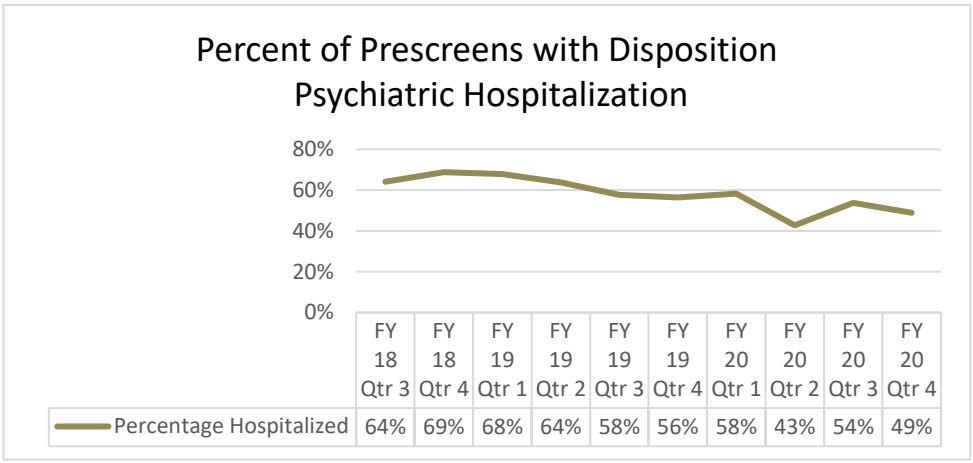
Quarter 1 had a much higher demand for services than in FY 19, Quarter 2 and 4 were consistent and Quarter 3 (April – May) had a decrease in demand.

During the hospital prescreen, the organization has three hours from the moment the individual is medically cleared to complete the disposition which includes identifying the level of service needed. Our ability to achieve higher than the expected 95% compliance is depicted below:



We continue to excel beyond this expectation.

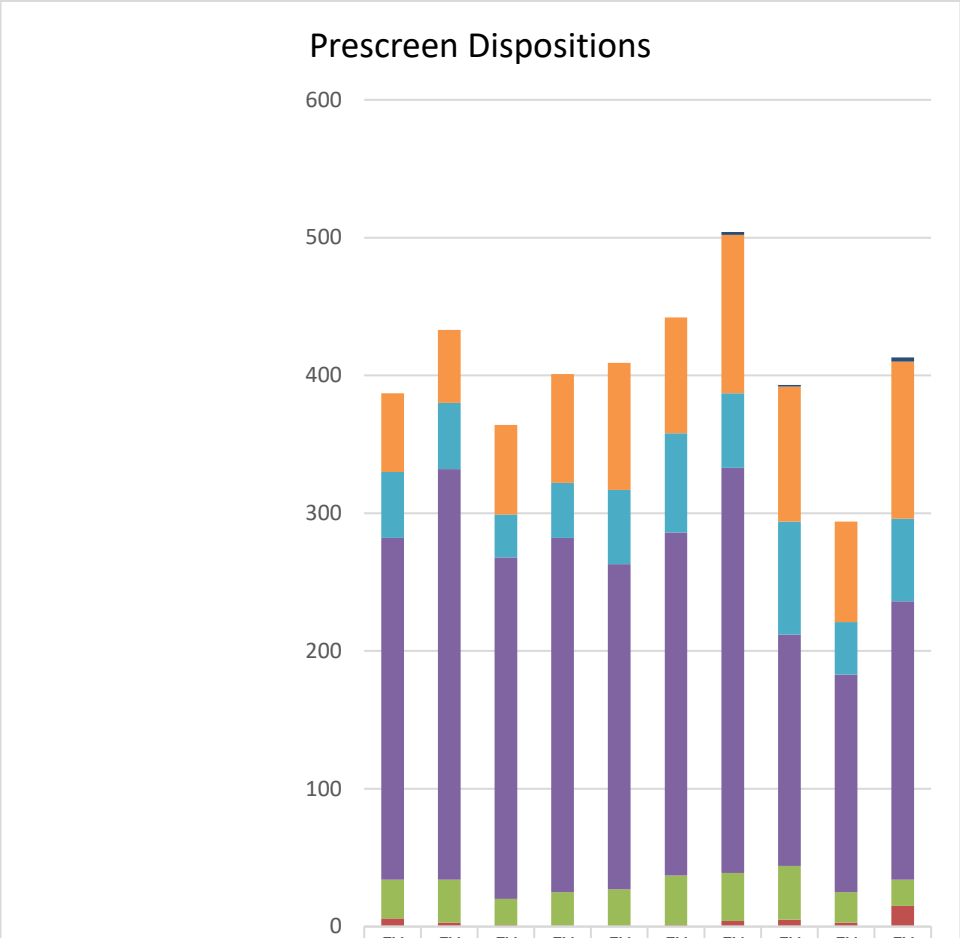
When an individual is in a psychiatric crisis, our crisis team evaluates the individual to determine their needs and assist with appropriate treatment in the medically necessary level of care. Monitoring the percentage of prescreens that result in dispositions of psychiatric hospitalizations reveals the following:



	FY 18 Qtr 3	FY 18 Qtr 4	FY 19 Qtr 1	FY 19 Qtr 2	FY 19 Qtr 3	FY 19 Qtr 4	FY 20 Qtr 1	FY 20 Qtr 2	FY 20 Qtr 3	FY 20 Qtr 4
Percentage Hospitalized	64%	69%	68%	64%	58%	56%	58%	43%	54%	49%

FY 20 dispositions continued the trend of fewer psychiatric hospitalizations, most likely due to the full implementation of the millage-funded CARES program and the 750 Towner location to assist with helping individuals in a psychiatric crisis. Appropriately resolving psychiatric crises without the possible trauma of a locked inpatient hospitalization can help an individual pursue and achieve recovery in a more accelerated manner.

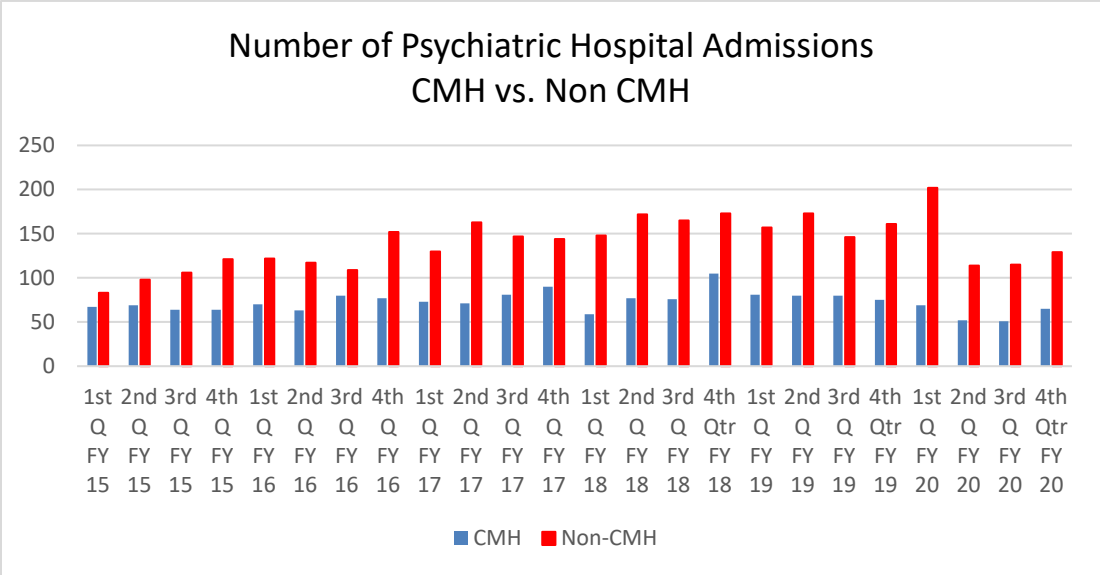
Of the Crisis Screenings, it is useful to look at all disposition categories that resulted from the screening. The following graph helps to pictorially represent these dispositions.



	FY 18 Qtr 3	FY 18 Qtr 4	FY 19 Qtr 1	FY 19 Qtr 2	FY 19 Qtr 3	FY 19 Qtr 4	FY 20 Qtr 1	FY 20 Qtr 2	FY 20 Qtr 3	FY 20 Qtr 4
Blank							2	1		3
Partial Hospitalization	57	53	65	79	92	84	115	98	73	114
Outpatient/ Support Services	48	48	31	40	54	72	54	82	38	60
Inpatient Admission	248	298	248	257	236	249	294	168	158	202
Crisis Residential	28	31	19	25	27	36	35	39	22	19
Crisis Outreach	6	3	1			1	4	5	3	15
Admission & Discharge Plan	0	0								

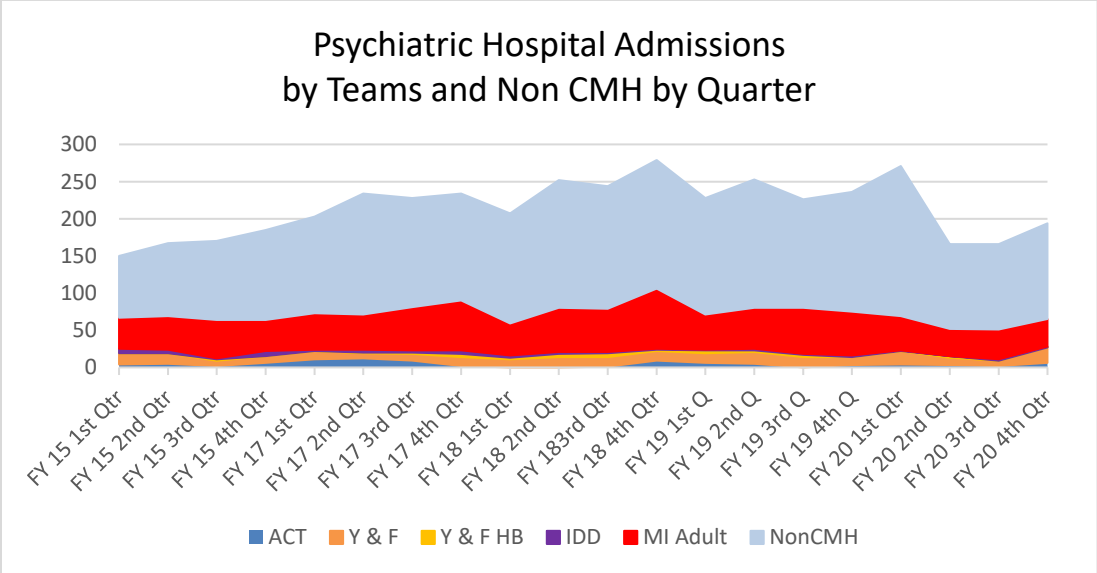
The number of third quarter prescreens follows the trend already identified that also coincided with the Governor's Executive Orders. Additionally, there is an overall higher use of Partial Hospitalization, Outpatient / Support Services and Crisis Outreach. The CARES and 750 Towner program referrals are included in the Outpatient / Support Services and Crisis Outreach dispositions.

Of those who are psychiatrically hospitalized, some are already enrolled and active in our WCCMH service system (CMH) while some are county residents who are not enrolled in our service system (Non CMH). Data regarding the hospitalization trends between these two categories is depicted below:

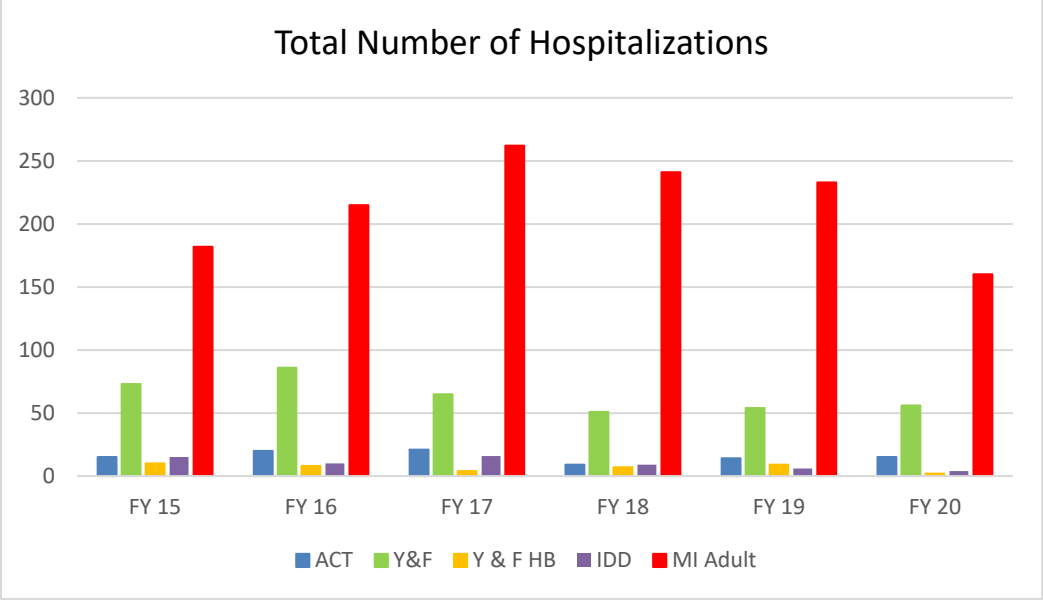


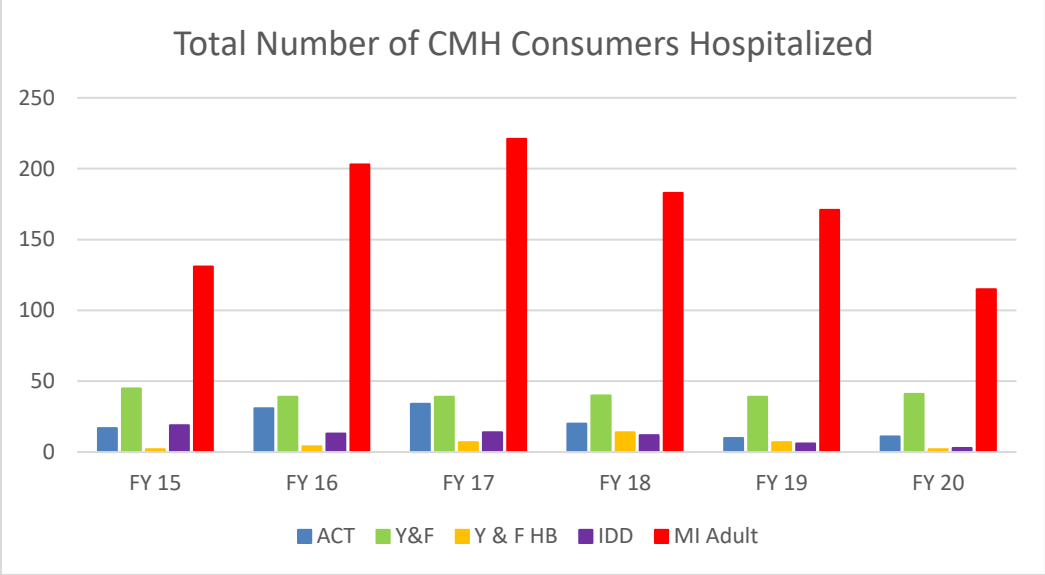
Psychiatric hospitalizations of CMH-served individuals (open cases) have decreased in FY 20. Non-CMH individuals (not open to CMH) also show a decrease in hospitalizations. This may be due to the full implementation of the millage-funded CARES program and the 750 Towner crisis center, which opened in the Spring of 2020. The CARES program also responds to crises which might also be impacting the decrease in hospitalizations for individuals open to CMH. Both measured values may also reflect the impact of the pandemic. It is important to note level of care recommendations are always the least restrictive service while addressing the medical necessity of the individual's presenting symptoms. Having less restrictive options for medically necessary services is recovery focused and less traumatic for the individuals we serve.

A stacked chart graph helps convey the cumulative number of hospital admissions.



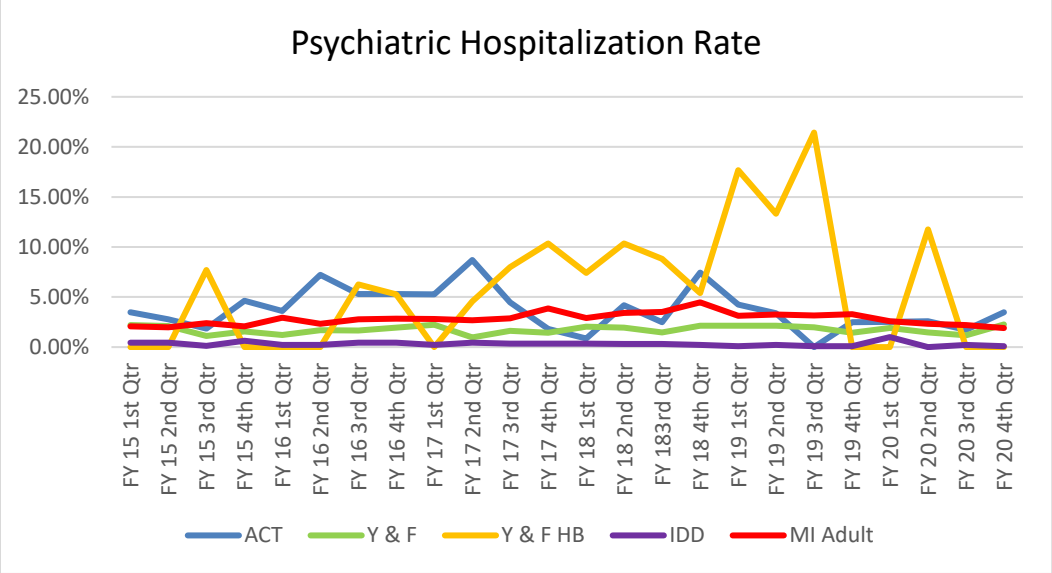
Below are two graphs. The first graph displays the total number of hospitalizations (individuals may be duplicated in these numbers if they had multiple admissions). The second graph delineates the number of enrolled individuals (individuals who are receiving CMH services through one of our core programs) who experienced a psychiatric hospitalization. These are unduplicated individuals.





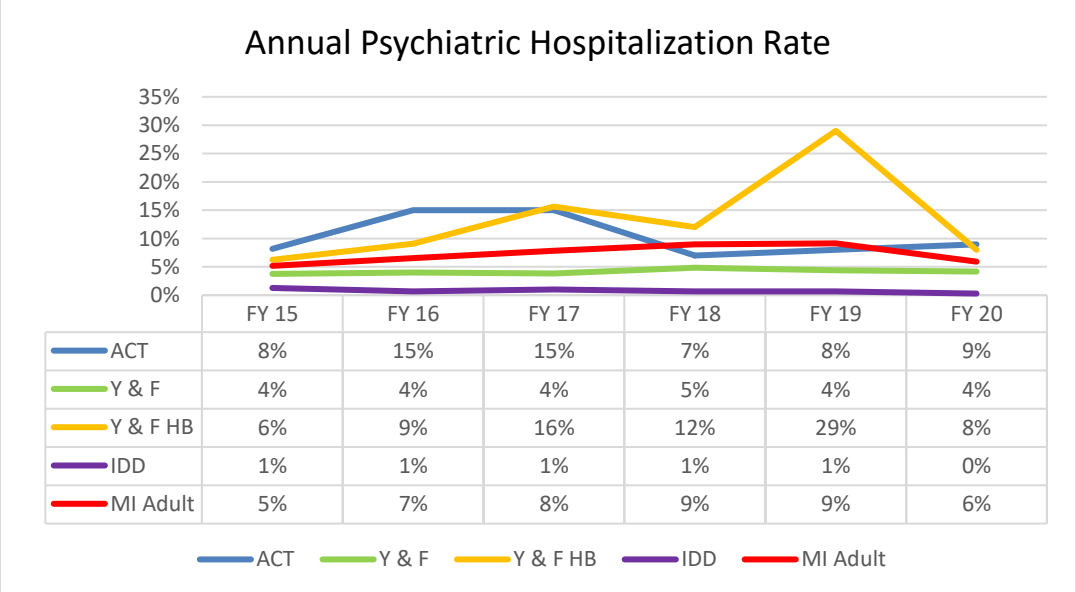
The total number of individuals psychiatrically hospitalized can be a helpful measure of outcomes and/or trends and/or patterns over the course of five years. The MI Adult team has an ongoing trend of fewer psychiatric hospitalizations. Overall, most other teams had fewer hospitalizations than in FY 19, and FY 18. It is important to note these psychiatric hospitalizations do not include Medicare funded psychiatric hospitalizations.

Considering a psychiatric hospitalization rate (number of individuals hospitalized compared to number of individuals served as an open case) can be a very useful measure to monitor as it helps identify the percentage of admissions per those served. The following graph helps depict these rates and possible trends:



The Youth and Family Home Based team had no hospitalizations except for second quarter suggesting an overall decrease in hospitalizations. The ACT team saw a decrease in hospitalization as well. The MI Adult Team experienced a steady decrease. The IDD team remained at baseline and the Youth and Family team has an overall slight decrease.

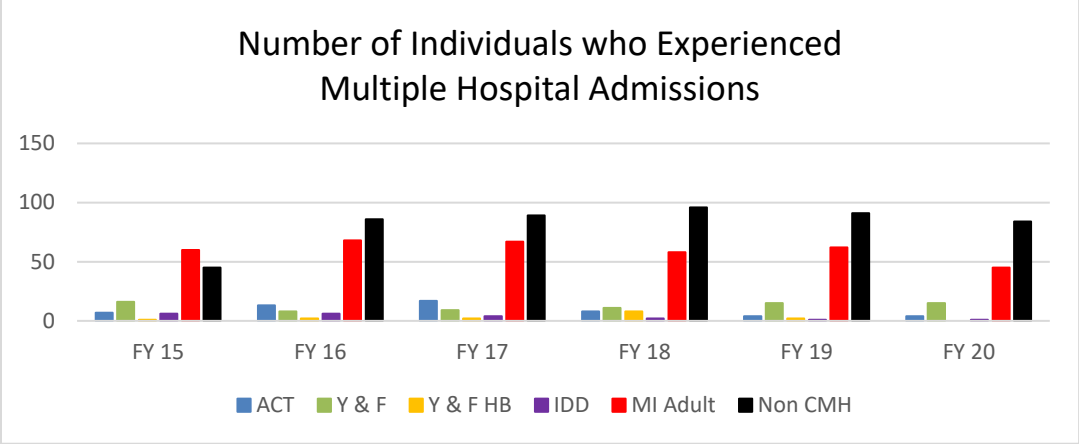
A macro view of psychiatric hospitalization trends / patterns may also be helpful.



	FY 15	FY 16	FY 17	FY 18	FY 19	FY 20
ACT	8%	15%	15%	7%	8%	9%
Y & F	4%	4%	4%	5%	4%	4%
Y & F HB	6%	9%	16%	12%	29%	8%
IDD	1%	1%	1%	1%	1%	0%
MI Adult	5%	7%	8%	9%	9%	6%

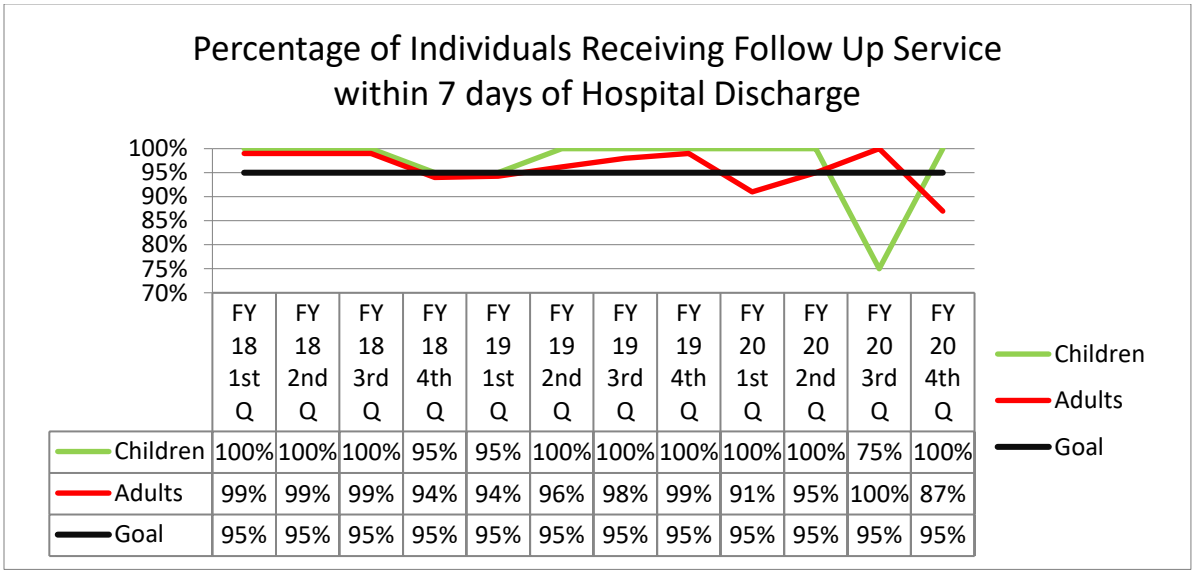
ACT experienced a great deal of variance in hospitalization rates over the years though overall shows a lower rate of hospitalizations. The Youth & Family and IDD teams are overall at baseline. The Youth & Family Home Based team experiences a great deal of variance which is easily influenced by the small number of people enrolled in the program which results in a very low denominator and therefore an easily impacted percentage rate. The MI Adult team has a decreasing trend in the percentage rate from FY 18 though is very closely equal to the FY 15 rate

Sometimes an increase in psychiatric hospital admissions is driven by individuals enrolled in services with CMH who experience multiple hospital admissions within the fiscal year due to the severity of their illness. Below is a bar chart showing how many individuals experienced more than one psychiatric hospitalization over the course of the fiscal year.



MI Adult experienced significantly fewer repeat hospitalizations in FY 20. The Youth and Family Home Based team had no repeat hospitalizations which is also less than the year before. The "Non CMH" individuals are individuals who are not open to a core team with WCCMH whose hospitalization is sponsored by WCCMH. There was the same number of repeat hospitalizations for these individuals in FY 20 as in FY 19.

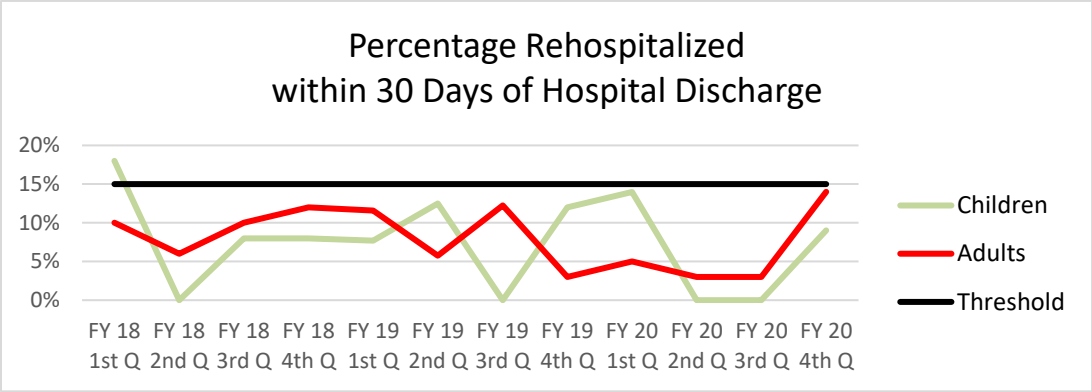
Below are graphs of the MDHHS Performance Indicator monitoring children and adults who were psychiatrically hospitalized and received a face-to-face service within 7 days of their discharge.



	FY 18 1st Q	FY 18 2nd Q	FY 18 3rd Q	FY 18 4th Q	FY 19 1st Q	FY 19 2nd Q	FY 19 3rd Q	FY 19 4th Q	FY 20 1st Q	FY 20 2nd Q	FY 20 3rd Q	FY 20 4th Q
Children	100%	100%	100%	95%	95%	100%	100%	100%	100%	100%	75%	100%
Adults	99%	99%	99%	94%	94%	96%	98%	99%	91%	95%	100%	87%
Goal	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Both programs were challenged at various times throughout the year to meet the indicator expectations.

The following MDHHS Performance indicator helps to monitor our effectiveness of avoiding repeat hospitalization within 30 days of discharge from the hospital. This graph is comprised of adults and children who are enrolled in and receive services from WCCMH, were hospitalized and then re-hospitalized within 30 days of discharge.



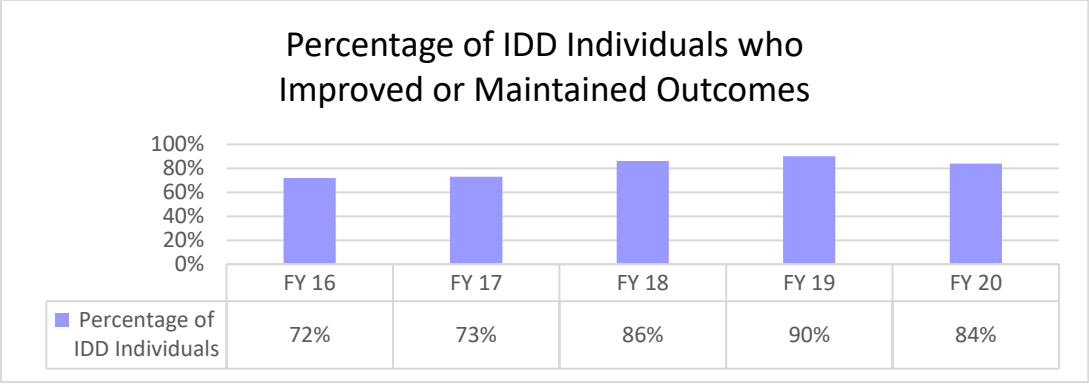
The organization continues to remain below the MDHHS threshold of 15%.

Program Outcomes

IDD Program Outcomes

Adults with an Intellectual or Developmental Disability are continually assessed with the standardized "DD Outcome" tool. The tool was developed in 2007 to quantify the status of an individual's life domains and needs. The tool was then implemented to achieve a standardized manner of collecting outcome data. The tool focuses on the individual's status and/or level of independence in factors of Self Determination (Work, Community Living, Choice & Decision Making, Relationships, Housing) and Health and Welfare (Safety, Safety Education, Health Access, and Wellness). Their status in each of these items is assigned a quantitative designation. The range of assigned number is from 1 – 5. "1" reflects extreme need while "5" reflects that specific area is addressed and in place. Based on the sum of completed items, an average for all items is determined. This tool continues to be used in a standardized manner by WCCMH.

Identifying aggregated results of maintaining status or improving are developed based on calculating differences between the average scores of the most recent assessment and the initial assessment.



IDD shows an overall outcome improvement from FY 17, 18 and 19. However, FY 20 shows an overall lower percentage of individuals increased or maintained their outcome. It is not clear if this may be due to COVID - 19 impact.

Youth and Family Program Outcomes

The Youth and Family program uses the Child, Adolescent Functional Assessment System (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) as valid and reliable outcome measures for children who experience a serious emotional disorder. The CAFAS is used for children who are in school and are between 7 and 18 years old. The PECFAS is used for children 3 years old and under 7 years old.

The CAFAS Total Score is the sum of the impairment ratings for the 8 subscales for the youth. For each subscale, the rater selects the item(s), which are true for the youth, which in turn, determines the youth's level of impairment for that subscale. There are 4 levels of impairment based on the score (indicated parenthetically): Severe Impairment (30), Moderate (20), Mild (10), and No or Minimal (0) Impairment.

Reviewing this outcome for FY 20 indicates the program has made a significant difference in the individuals they serve. For this administrative report, CAFAS Total Scores are aggregated across youths and a comparison is made between the scores for the initial and most recent assessments. A lower score at the most recent assessment indicates a positive change. The difference in scores is also calculated: a positive number indicates improvement in functioning, 0 indicates no change, and a negative number indicates greater functional impairment. The findings are broken down between inactive episodes of care (closed cases) and for both inactive and active episodes of care (closed and open cases).

FY 20 Child and Adolescent Functional Assessment Scale (CAFAS)

Difference Between Average CAFAS Youth Total Score for Initial and Most Recent Assessments (for inactive episodes of care with a sample size of 204): **28** Average CAFAS Youth Total Score on Initial Assessment: **99** Average CAFAS Youth Total Score on Most Recent Assessment: **71**

Difference Between Average CAFAS Youth Total Score for Initial and Most Recent Assessments (for both active and inactive episodes of care with a sample size of 567): **23** Average CAFAS Youth Total Score on Initial Assessment: **100** Average CAFAS Youth Total Score on Most Recent Assessment: **77**

The finding for inactive cases identifies a significant improvement (a score greater than 20 indicates a statistically significant change) and an impressive difference between initial and most recent assessment. The significant improvement is consistent with previous year's findings however, FY 20 indicates a stronger significant difference.

The finding that includes both active and inactive cases indicate a statistically significant change in CAFAS score reflecting positive improvement for the children suggesting the program model is effective. Typically, we do not see a statistically significant change in this category because the active cases are still receiving interventions and may not have experienced a significant change yet. However, in FY 19 and FY 20, we did see statistically significant improvement in the category that includes both the open and the closed cases

The PECFAS is a "preschool" version of the CAFAS, assesses the child's functioning over relevant life domains and overall improvement. The PECFAS Total Score is based on the same subscales as the CAFAS

and also includes information from the Caregiver (Material Needs, Family / Social Support). The four levels of impairment are the same as the CAFAS.

For this administrative report, PECFAS Total Scores are aggregated across youths and a comparison is made between the scores for the initial and most recent assessments. A lower score of the most recent assessment indicates a positive change. The difference score is also calculated: a positive number indicates improvement in functioning, 0 indicates no change, and a negative number indicates greater functional impairment. The findings are broken down between inactive episodes of care (closed cases) and for both inactive and active episodes of care (closed and open cases).

Preschool and Early Childhood Functional Assessment Scale (PECFAS)

Difference Between Average PECFAS Youth Total Score for Initial and Most Recent Assessments (for inactive episodes of care with a sample size of 24: **21**

Average PECFAS Youth Total Score on Initial Assessment: **86**

Average PECFAS Youth Total Score on Most Recent Assessment:**65**

Difference Between Average PECFAS Youth Total Score for Initial and Most Recent Assessments (for both active and inactive episodes of care with a sample size of 64): **14**

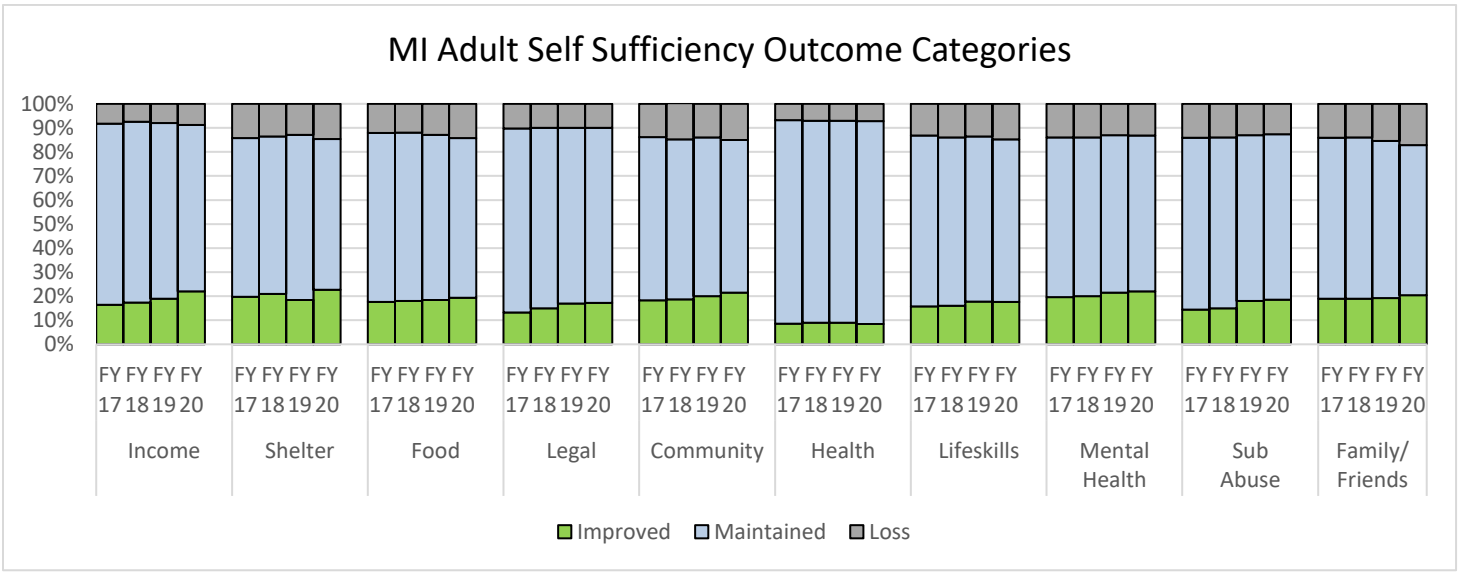
Average PECFAS Youth Total Score on Initial Assessment: **86**

Average PECFAS Youth Total Score on Most Recent Assessment: **72**

Like the findings from the CAFAS, reviewing this outcome for FY 20 indicates the program has made a significant difference in the individuals they serve for inactive (closed cases). When reviewing outcomes for both inactive and active (closed and open) cases we observe a positive impact with children and their families occurred, though it is not considered to be significant.

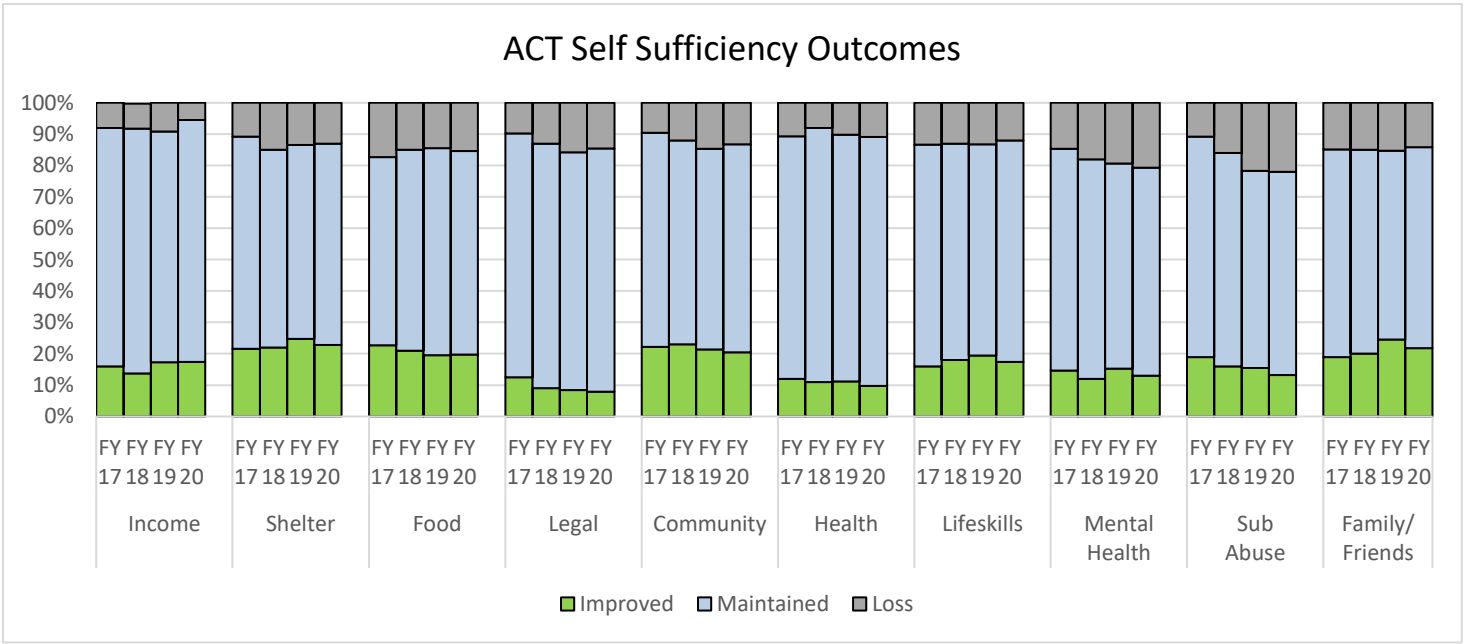
MI Adult and ACT Program Outcomes

Adults with a Mental Illness are continually assessed with the standardized outcome tool called the Self Sufficiency Matrix. The Self Sufficiency tool reviews an individual's status on 13 indicators (Income, Shelter, Education, Healthcare, Mental Health, Family / Friends, Community, Employment, Food, Legal, Life Skills, Substance Abuse and Mobility). However, for purposes of efficient display, education, employment, and mobility are not included in the graph. Values can include In Crisis, Vulnerable, Safe, Building Capacity or Empowered. Aggregated results of improving, maintaining or loss of status are developed based on calculating differences between the initial and most recent item score, categorizing for each item and each case if there was an improvement, loss or maintained and then subsequent percentages for the overall program.



The graphs identify percentages of Improvement, Maintained, and Loss over a four-year time period. Sometimes there will be a percentage that Improved and a percentage that experienced Loss, sometimes on the same domain. This can occur because the aggregated data may reflect individuals who moved from "Maintained" and either moved to "Improved" or "Loss".

MI Adult continued to improve in eight of the ten categories (Income, Shelter, Food, Legal, Community, Mental Health, Substance Abuse and Family/ Friends) while a higher percentage show a Loss in six categories (Income, Shelter, Food, Community, Life Skills and Family/Friends).



ACT did not have an improvement in outcomes in FY 20, though a higher percentage maintained their outcome status in nine areas (Income, Shelter, Legal, Community, Health, Lifeskills, Mental Health, Substance Abuse and Family Friends). Individuals receiving ACT services tend to experience more severe impairments

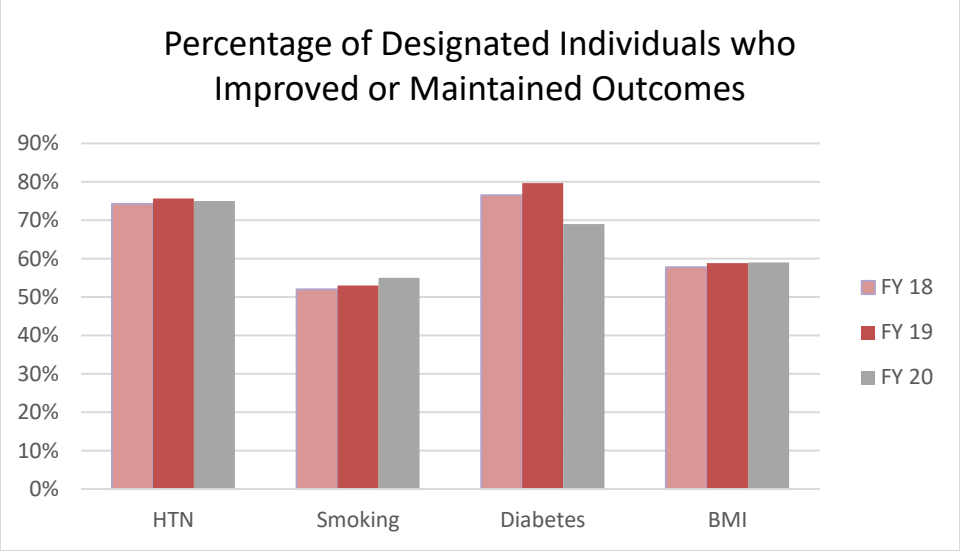
and require a higher level of care to minimize impact of these impairments. Therefore, higher outcomes of maintaining functioning is considered a good outcome.

Integrated Care

WCCMH continues to maintain a strong focus of integrated care. We monitor indicators of Hypertension, Smoking, Diabetes and Body Mass Index (BMI) for improvements. These definitions are:

Hypertension: the percentage of individuals diagnosed with Hypertension who either improved or maintained their health based on their blood pressure.
Smoking: the percentage of individuals who either smoked in the past or currently smoke who either improved or maintained their health based on their smoking status.
Diabetes: the percentage of individuals who have a Diabetes diagnoses and a current laboratory value (within 12 months of the end of the fiscal year) who either improved or maintained their health as indicated by an improvement or maintained level of their A1C.
BMI: the percentage of individuals who either improved or maintained their health by a static or decrease in their BMI.

The graph below depicts the percentage of individuals who either improved or maintained on measures of health:



Diabetes has a lower percentage of individuals that improved or maintained in FY 20. A deeper review of the data revealed the denominator (comprised of individuals who had a diabetes diagnosis and an A1C lab value that was less than 12 months old) was much lower this year than in year's past and those who did have a lab value had a change that was not maintaining or improving from their initial A1C value.

Health and Mortality

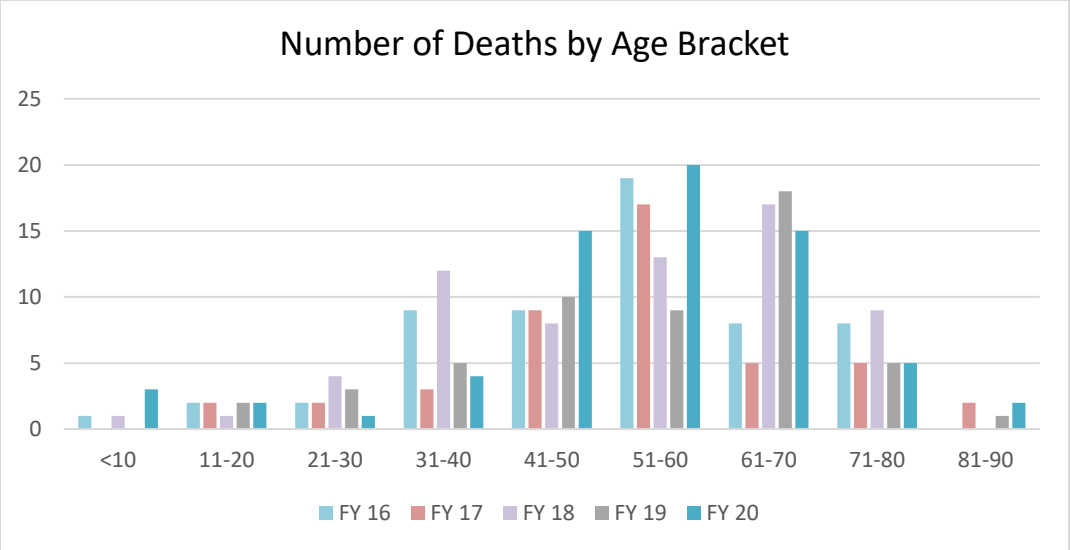
Research and industry trends identify that individuals who experience a severe mental illness tend to die much younger than their counterparts. We monitor our mortality rate, as well as the average age of the individual at the time of death. The data below are commensurate with research identified trends. For every reported individual death, WCCMH process includes reviewing the chart, obtaining the death certificate (if available) and presenting this information and the death report to the Medical Director. The Medical Director then classifies the cause of death. Below are the aggregated categories of cause of death and the average age at the time of death for each category.

Mortality

Cause of Death	**FY 16**	***Age FY 16***	**FY 17**	***Age FY 17***	**FY 18**	***Age FY 18***	**FY 19**	***Age FY 19***	**FY 20**	***Age FY 20***
Accident (Drowning)			1	26						
Cancer	10	59	10	54	8	63	9	57	7	57
Cardiovascular	16	56	8	76	13	59	14	61	14	60
Dehydration					1	76				
Drug Abuse	8	36	6	47	12	38	5	40	8	45
Environmental Hypothermia							1	51		
Gastrointestinal	1	70							3	60
Hip Fracture Complications					1	60				
Inanition									2	60
Homicide			1	33	3	30				
Infection			4	61	3	72	1	61	4	70
Kidney Disease	2	53	1	42	1	62			1	80
Liver Disease			1	57	2	63			2	49
Metabolic							1	61		
Muscular Dystrophy	1	20								
Natural/Other			3	47	1	38				
Neurological	5	56	2	47	2	34	1	81	3	50
Respiratory	6	63	4	61	5	66	10	52	10	51
Sturge Weber Syndrome	1	41								
Suicide	2	40	3	47	2	44	2	22	6	45
Trauma	1	39			1	53	2	68		
Unknown	5	44	3	51	9	52	9	52	7	44
Grand Total	**# of Deaths 58**	***Avg Age 52***	**# of Deaths 47**	***Avg Age 56***	**# of Deaths 65**	***Avg Age 53***	**# of Deaths 55**	***Avg Age 54***	**# of Deaths 67**	***Avg Age 53***

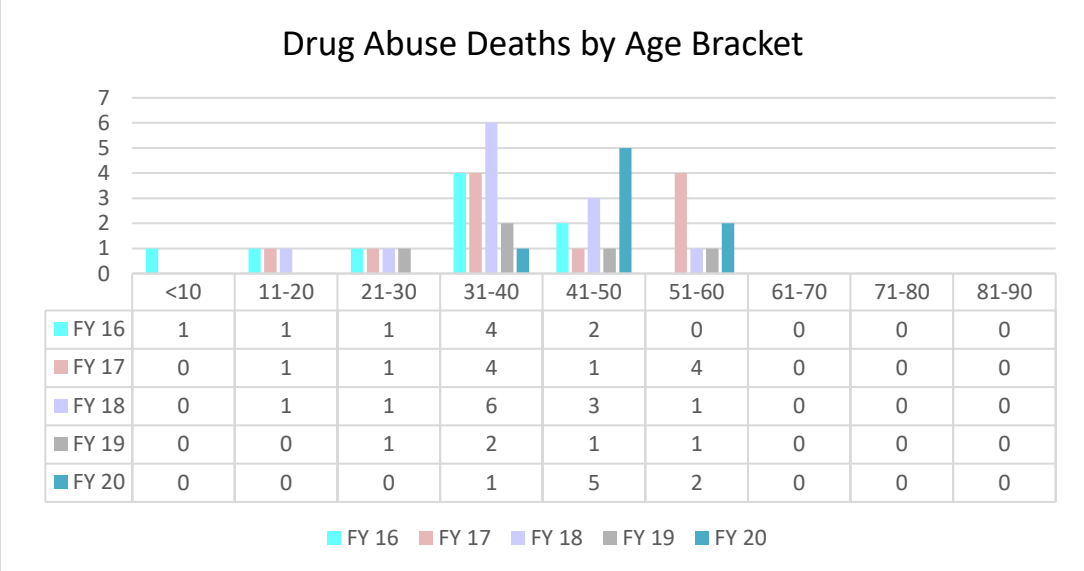
Mortality data is based on death certificates from the Washtenaw County Medical Examiner. If an individual dies out of county, we do not receive that death certificate. WCCMH has been tracking COVID-19 testing of the individuals we served. Seven hundred seventeen tests were negative (some of these tests may be duplicated individuals) and forty-four individuals tested positive for COVID-19. Two of those have passed away due to COVID-19 (categorized as "Infection").

Reviewing the relationship of the total number of CMH served individuals who had open cases and passed away in Fiscal Year 2020 between frequency of deaths per bracketed age categories helps monitor and review baseline data and possible trends/ patterns.



Not surprisingly, a higher frequency of deaths occurs in the older decades. We hope that helping individuals with their health will result in the frequency of deaths moving to the right on the graph, i.e., occurring in older age. Fiscal years 17, 18 and 19 did show a decrease in the 51-60 age group and an increase in the 61-70 age group suggesting individuals are dying at later stages in their life. FY 20 shows an increase in the 51 – 60 age group and a decrease in the 61-70 age group. Nationwide trends indicate average age of deaths were lower in 2020. Trends also indicate individuals are not pursuing medical services in person and this may result in untreated medical concerns.

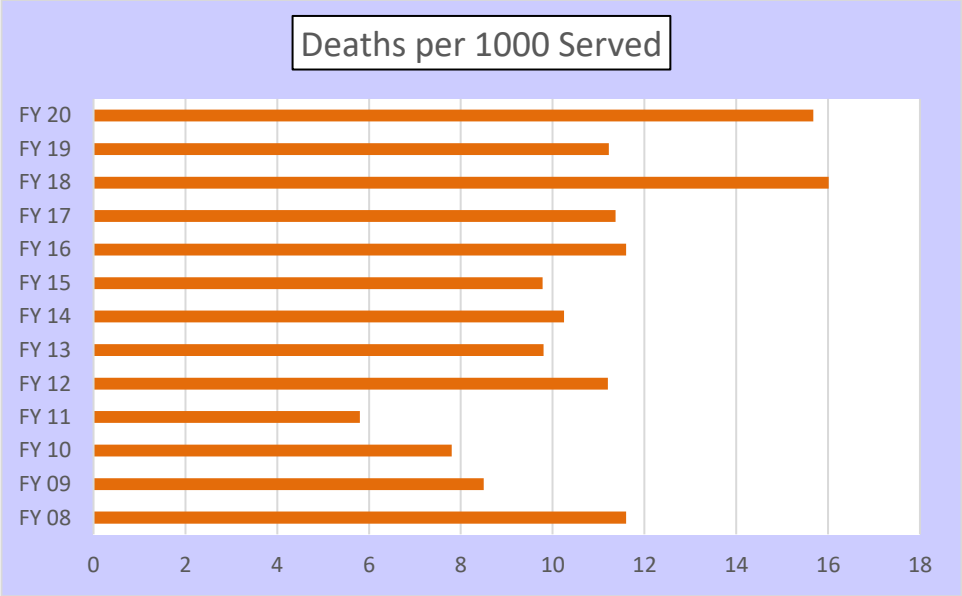
Of the deaths that occurred due to accidental overdose (Drug Abuse), it may be interesting to understand if there are age groups where this occurs more often and what those age groups are. The following graph charts this over time:



	<10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90
FY 16	1	1	1	4	2	0	0	0	0
FY 17	0	1	1	4	1	4	0	0	0
FY 18	0	1	1	6	3	1	0	0	0
FY 19	0	0	1	2	1	1	0	0	0
FY 20	0	0	0	1	5	2	0	0	0

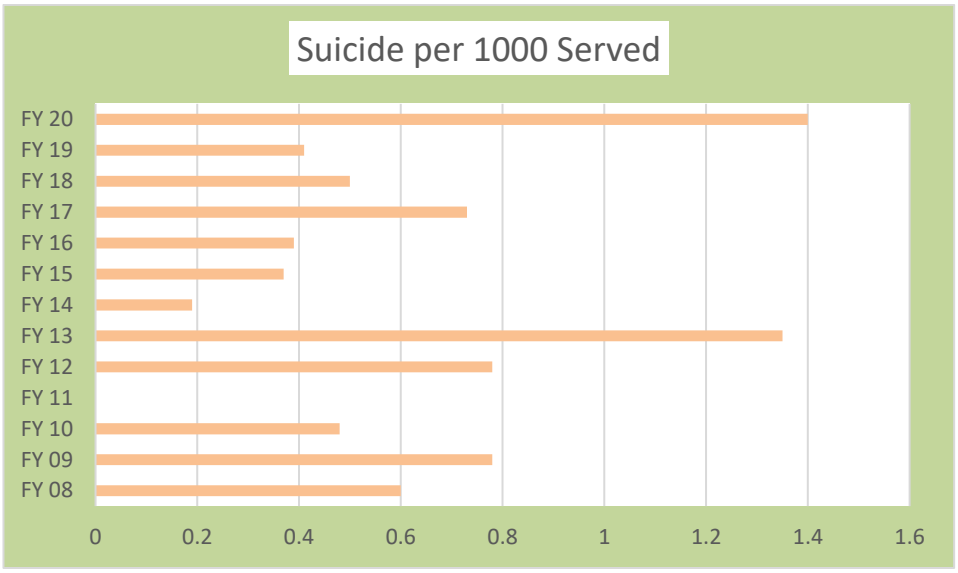
Identifying age groups that have a higher frequency of drug abuse deaths can suggest age groups to target with specific interventions. In FY 20, we see the modal value in the 41 – 50 year old age range. There has been a nationwide increase in the number of deaths due to overdose in 2020. The (Heroin) Opioid Task Force within Washtenaw County continues to review, analyze and attempt to tackle this problem.

Reviewing deaths over the past thirteen years has helped us identify the number of deaths compared to the number of individuals served. Please note, the accuracy and robustness of deaths in fiscal years 2008 – 2011 is unknown due to concerns about reporting processes in that time frame. Reporting processes are much more robust and monitored so there is credibility to the number of deaths from 2012 – 2020.



The ratio of deaths / individuals served this past year is high when compared to past years (except FY 18). There are no identified systemic mental health treatment factors contributing to these deaths. As mentioned before, the COVID-19 pandemic may have inadvertently resulted in less access or willingness to access medical interventions which may have resulted in a higher number of deaths. To the best of the organization's ability, we know of only two deaths of an individual whose COVID-19 test results was positive.

Monitoring the ratio of suicides per 1,000 individuals served is also important. Again, it is not known how robust or accurate our historical death reporting process was. That is, there may have been more historical suicides than are listed in the following chart. This is the data trend over the past thirteen fiscal years:

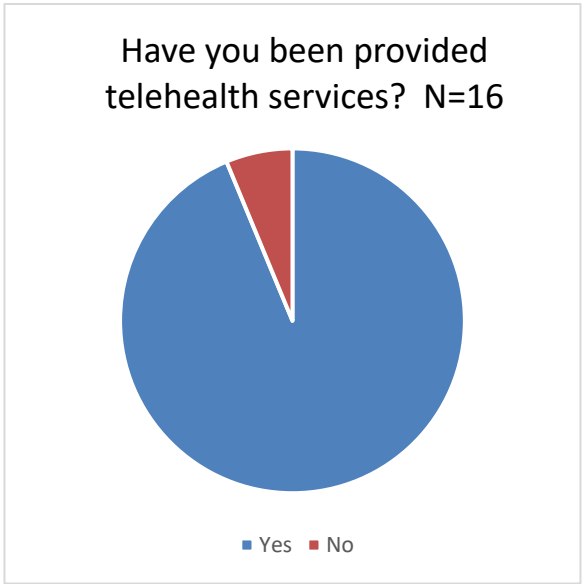


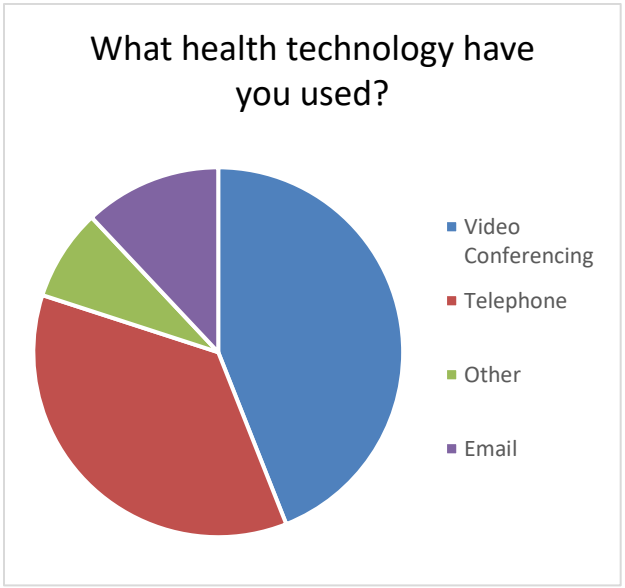
It should also be noted that all suicides are reviewed with a root cause analysis. This is a very thorough and thoughtful review process beyond the normal death review process. The ratio for FY 20 is the highest ratio. There were no practice-of-care issues in these suicides and no systemic patterns or trends identified.

Satisfaction Survey Results

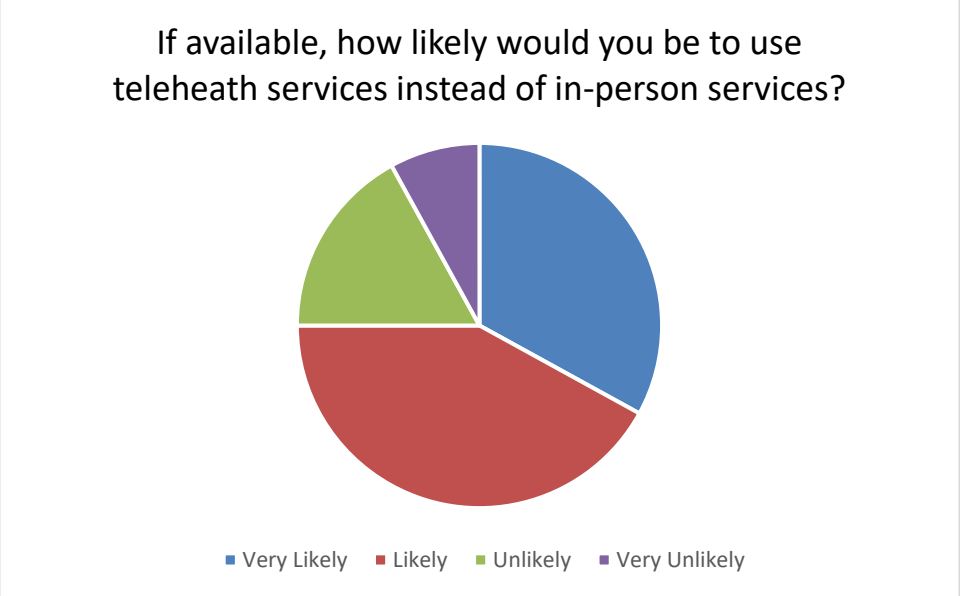
Due to the change in service delivery, the Regional Customer Service Committee did not survey all populations with the satisfaction surveys as in the past. Instead, early in the pandemic, the WCCMH participated with 19 others state wide CMHSPs Telehealth Satisfaction Survey. Surveys were distributed to both individuals served and providers. The results are below.

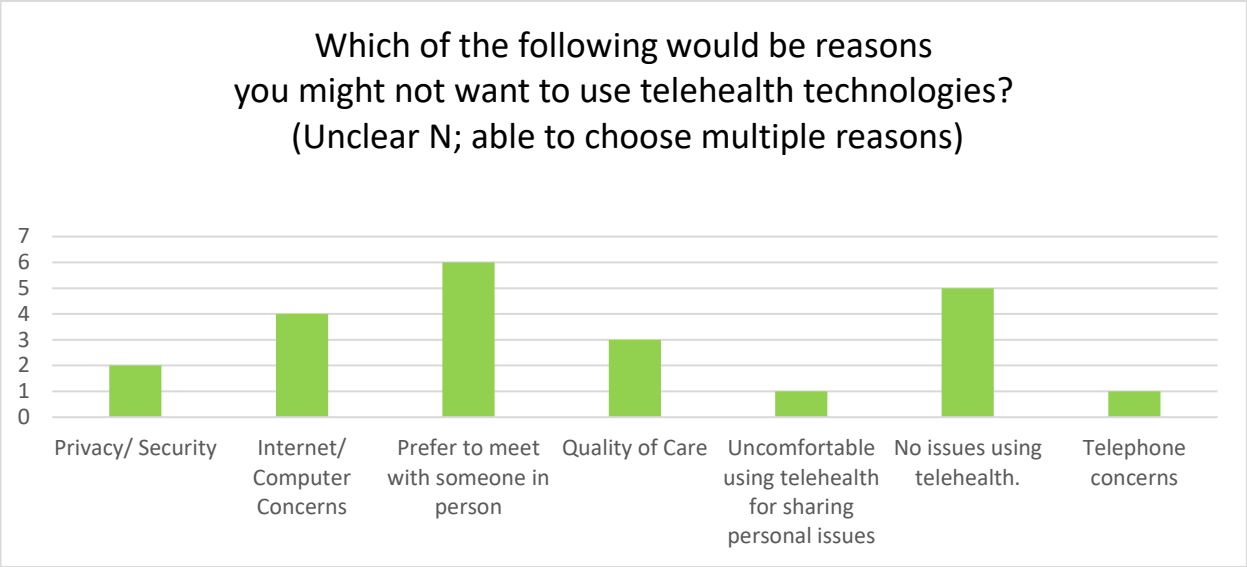
Survey Results from Those Who Receive Services

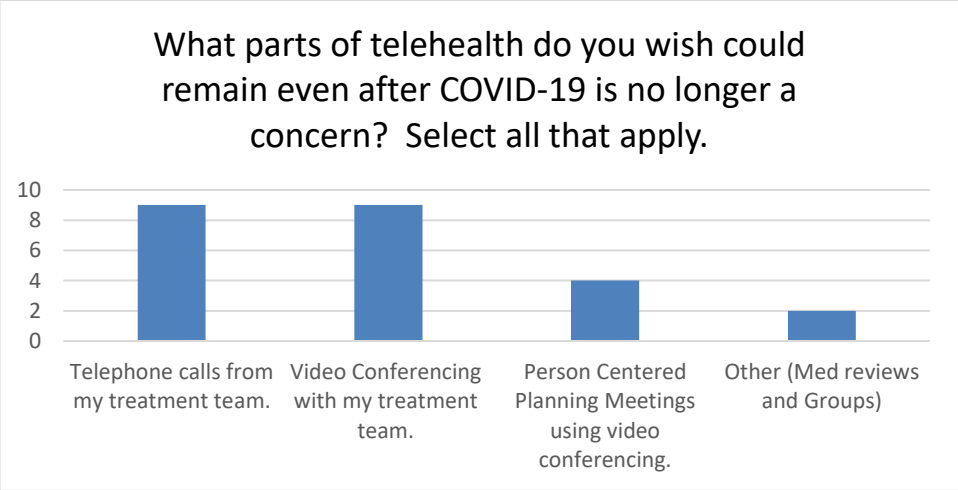




What do you like about using telehealth?
Not driving to the office.
It's simple. It's nice to not have to leave the house/office if you don't have to.
I don't like it!
It's okay for the more moderate mentally ill but it's not appropriate for those with severe mental illness like schizophrenia.
Not much, but when there are no alternatives, it is better than nothing.
Can still meet with therapist without having to go out.
I am able to get a hold of some of my clients this way and hear presentations, but not as good as face to face.
I don't have support to get to office.
Didn't need to go anywhere.
Same thing as regular therapy.
Safe during pandemic. Saves time and I don't have to worry about packing up all my other kids.
Easy and don't have to drive and if I forget it is ok.







Survey Results for Those Providing Telehealth Services

WCCMH made the decision to survey staff regarding their experience providing telehealth services. Thirty-seven individuals participated in the survey. Their responses indicated:

- 46% felt telehealth allows them to be as effective,
- 32% experience telehealth to be less effective and
- 22% reported telehealth is more effective.

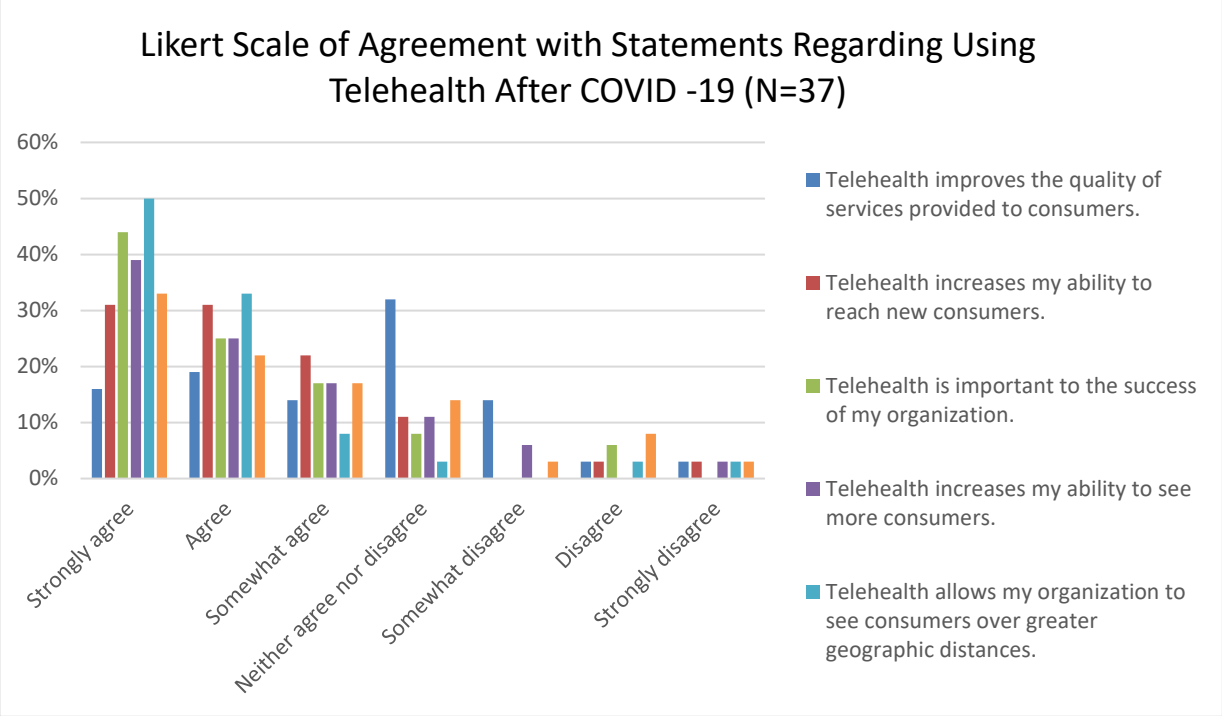
Their narrative responses to "less effective" and "more effective" are below.

WCCMH Response to Telehealth Survey Regarding Effectiveness	
If less effective, why?	If more effective, why?
No support staff.	*Able to complete more in a shorter period of time.*
Build rapport, trust kinesthetic, EMDR	*Telehealth has removed many barriers for consumers who have health issues, mobility issues, transportation issues, and scheduling issues. I have found using a virtual therapy platform has reduced the amount of missed appointments overall.*
Hard to do therapy with children over the phone.	*Less distractions than when performed in an agency setting.*
MEND often doesn't work (or staff don't know how to use it)	*I can deliver MORE case management services to more clients than ever before.*
Miss the interaction with the patient face to face and being able to assess them in that way.	*Families with transportations issues are not limited. Also able to do more sessions because it feels more efficient.*
It affects therapeutic rapport.	*Folks who would not be able to come into the office can be engaged easier.*
No ability to physically assess someone (AIMS exam, etc.) and limited ability to evaluate non-verbal cues.	*Have even been able to provide needed services to families that have transportation issues.*
Lose the value of face to face.	*I am able to see more clients as the show rate is higher with telehealth.*
Requires lot of up-front work, once set-up and rolling could be good.	
Live face to face is more personal. Also, internet issues are problematic.	
Difficult for Psychiatric Evaluations, getting to know someone psychiatrically.	
Unable to complete effective types of therapy via telehealth. At times it is useful but other times not.	

What issues, if any, have you experienced in using telehealth technology? Select all that apply.	
Service availability/ connectivity	22
Consumer engagement	16
Privacy / Security Concerns	5
Other	6

What aspects of telehealth do you wish would remain after COVID-19 is no longer a concern (select all that apply).	
Video Conferencing (Zoom, Teams, etc.)	35
Telephone	31
Email	13
Other	10
Written in: Social media platforms, MEND, Texting	

Have your "no show rates" or missed appointments…	
…..been less frequent	66%
…..remained the same	28%
…..been more frequent	6%



What are the positive things about working remotely? (Similar responses were categorized.)	Number of Comments
Higher efficiency	16
Less distractions and interruptions	16
No commute	14
Protection from germs and therefore improvement on health	14
Flexible	13
Calmer environment to work in	9
Clients with transportation issues find it easier to receive the service	4
Lower stress	4
Better for environment	2
Clients prefer	1
Privacy	1
Sleep in	1
Weather not an impact on service delivery	1
"No pants"	1
Better impact on no show rates	1
Feel safer when speaking with agitated clients	1
Beneficial to see patients environment while they're on Zoom	1
Less workplace drama	1
Minimizes unnecessary meetings	1
Childcare not as much of an issue	1

What are the negative reasons about working remotely? (Similar responses are categorized.)	Number of comments
Loss of collaboration with others	11
Loss of in person service impacts rapport	7
Technology Issues (accessing M drive, server crashes, needing immediate assistance, etc.)	6
Difficult to maintain boundaries between work and home	5
Remote working is lonely and isolating	4
Consumers do not have adequate resources	4
Home Office not set up	3
Meeting the needs of your children while working	3
Low observation / interpretation/ assessment of client	3
Difficult to focus	3
Difficult to maintain privacy	2
Not know pulse of "office" and assisting as needed	2
Negative impact on Play Therapy/ other therapy	2
Cannot conduct Abnormal Involuntary Movement Scale (AIMS)	2
Distractions	2
Mend is very difficult	2
Logging tasks is redundant and lowers efficiency	1
No access to passwords	1
Managing anxiety around change	1
Need supplies at home	1
No paper forms on hand	1
No Support Staff	1
Signatures on paperwork are difficult to obtain	1
Cannot gather labs from consumers	1
Coordinating injections	1
No childcare	1
Nothing	1

Summary

The industry of Community Mental Health services is a complex, demanding and high-risk environment seeking to service individuals who experience poverty, disabilities and severe symptoms that impact on functioning. CMH Organizations must manage this complexity while also improving lives and families as an important component of community responsibility. The organization continues to make systemic improvements. We continue to seek out ways to strengthen our organization in a manner that will help to improve the lives of those we are honored to serve.