CONSUMER QUALITY
TEAM OF MARYLAND

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THE CONSUMER QUALITY TEAM OF MARYLAND
THE FIRST YEAR

CQT is proud to report the results of the first year of operation. We have held confidential, qualitative interviews with more than 200 consumers and have been the catalyst for changes that will help them on their journey toward recovery.

The CQT Director was hired in June 2006. Programs in other states were investigated and evaluated, and with the cooperation of the CQT Workgroup, the protocols for this program were developed. A training curriculum was designed along with a training manual. Job descriptions were written, personnel policies were defined and staff was hired. Training for these jobs is an ongoing process. In this year, over 100 hours were spent on training.

After careful review of available resources, we realized that we would not be able to visit every public mental health facility in the pilot jurisdictions of Anne Arundel and Howard Counties and Baltimore City. The Workgroup was consulted and the decision was made to begin with site visits to Psychiatric Rehabilitation Programs (PRPs). These programs afford the CQT the opportunity to reach the largest number of consumers.

Consumer programs in other states disclosed that they often have a difficult relationship with mental health providers. To avoid this problem, the team made 18 introductory visits to the various PRPs in the pilot area, in order to introduce the team and the program to the provider's staff. We stressed that we see ourselves as helping to facilitate partnerships between consumers and providers, and that we recognize and appreciate the important role providers play in recovery process. As a result, we have been very well-received on all site visits.

Site visits began in January 2007. The first three visits to a site are scheduled, so consumers and staff can become comfortable with the team. Subsequent visits are unannounced, and each site is visited three to six times each year. Twenty-two site visits were conducted. After a brief introduction to the team and description of what we do at a consumer meeting, team members meet with consumers individually for confidential interviews. We explain to consumers that we want to hear what they want to tell us, that we aren't there to conduct a survey. We have developed a list of "ice breaker" questions, such as "How do you like this program?" and "Are you getting what you need to help you recover?" and we use the answers to these questions to elicit further information.

We let the consumer set the direction of the interview. This differs from other programs, in that we are not using a survey of pre-set questions. We are not compiling data to report overall consumer response; rather, we are focusing on the individual consumer. We hear about the concerns of particular consumers, creating the opportunity to have these concerns immediately addressed. After each interview, we

give the consumer our contact information, and tell them to let us know if their concerns are not resolved. At the conclusion of each interview, the team gives a brief verbal report to the program director. Many problems are immediately resolved after these discussions.

Standardized forms were developed to record consumer comments and to report them back to the provider, the Core Service Agency and the Mental Hygiene Administration (MHA). CQT hosted four Feedback Meetings with representatives from provider associations, the CSAs and the MHA. At these monthly meetings, each report from the prior month is discussed, the concerns raised by consumers are reviewed and updates are provided regarding these concerns. The CSAs provide a written report to the CQT on issues raised at the prior month's meeting, stating how the concerns have been addressed. Prior to return visits to a site, the CQT team reviews the report from the previous visit. When we see the consumers who have previously reported concerns, we can ensure that their concerns have been addressed.

In consultation with the Workgroup, five questions from the MHSIP were selected to be asked at the end of each consumer interview. The purpose of this is to investigate whether or not CQT gets the same response trends as the formal MHSIP, as well as to help track the levels of consumer satisfaction reported to the CQT on subsequent program visits. We have frequently noted a disparity between what the consumers tell us about their program experiences, and the answers they give to our brief survey. This was discussed with University of Maryland researchers and it was decided that the CQT will try and determine the reason for this disparity on future site visits.

The majority of consumers have reported general satisfaction with their program; however, on each visit, suggestions for improvement have been made. These suggestions have been well-received by the providers, and program staff have indicated that they will use them as part of their own quality improvement programs. CQT's findings have included the following:

- At most sites, specific suggestions have been made to improve the educational programming. One provider took this information and formed a committee of consumers and staff to review and revamp the entire educational curriculum. Other providers have added classes to the schedule. In some cases, the programs were already offered, but this information wasn't clear to the consumers. Efforts were made by program staff to correct this problem.

- At most sites, consumers indicated confusion and/or a lack of knowledge about entitlements. Some consumers gave us permission to use their names with program staff, so their individual concerns could be addressed immediately. Some providers have decided to add educational classes for consumers about entitlements to address the concern more generally. Additionally, many of the

direct care staff had incorrect or no information about entitlements. Providers indicated they would use this information to better educate staff.

- At most sites, CQT found consumers who were having a problem they had previously shared with staff and which was already being addressed. The consumers, however, were not aware of the status of their problem or what actions had been taken by staff. Providers indicated they would use this information to improve the communication between consumers and staff.

- At the majority of sites, consumers complained about the elimination of social/recreational programming. These programs can be a crucial element of the consumers' recovery and return to the workforce. In the cases of the elderly or infirmed consumers, these programs improved their quality of life. This need could possibly be met by other consumer-run programs, but many of the people are not aware of these programs, or do not have transportation to get to the other site.

- At some sites, consumers told CQT about small needs that would improve their quality of life while attending the programs. At one site, it was to have a working coffee pot. In response to the report, this was purchased by program staff. CQT has had similar results at other programs.

- At one site, consumers told CQT about abuse by staff and their fear of retribution for reporting it. Program staff repeatedly violated the confidentiality of the consumer interviews, so CQT terminated the visit and immediately reported this information to the CSA. Two days later, the program director phoned the CQT and told us corrective measures had been taken; a follow-up visit was scheduled for two weeks later. On the subsequent visit, consumers reported that the abusive staff had been replaced, the program curriculum had been improved, and the facility was cleaned.

CQT has also developed marketing materials, including a brochure and a website. Brochures are distributed at each PRP visited and contact information is given to each consumer interviewed. As a result, CQT has been contacted by consumers and family members who are not in the PRPs and/or the pilot jurisdiction.

- One consumer called with concerns about his RRP. This information was given to the CSA who investigated the report. After CQT obtained permission from the consumer to use his name, the CSA met with the consumer and is working on a different placement to better serve this consumer's needs.

- A mother, from within the CQT pilot area, called to report an abusive situation with her daughter in residential treatment in another jurisdiction. Working with the MHA, the problem was directed to the correct office and resolved.

- A sister of a consumer in a jurisdiction outside the pilot area called to report a problem with cleanliness in a RRP. This was directed to the proper agency, and the problem was resolved.

In the coming year, CQT will begin visiting inpatient facilities. An initial visit was made to the first inpatient facility to discuss logistical concerns with facility staff. The first site visit will be made in August 2007.

Consumers and providers in other Maryland jurisdictions are asking when the CQT will begin visiting their jurisdictions. Plans and a budget have been developed to increase the staff and expand the program to cover the state of Maryland over a two year period.