

# **GRAHAM BEHAVIORAL SERVICES, INC.**



## **MARKETING & STRATEGIC PLAN – 2009/10**

**PROGRAM DEVELOPMENT AND IMPLEMENTATION SERVING CHILDREN,  
ADULTS AND OLDER ADULTS WITH BEHAVIORAL AND COGNITIVE CHALLENGES**



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The information and measurement variables recorded within this document are designed to be shared and coordinated with area agencies, in-kind services, the Department of Health & Human Services, and intra-state service agencies which share similar interests. The performance behaviors and related variables are designed to measure clinical and programmatic objective outcomes. This document may be reproduced upon notification to the writer (Agency) per design.

Prepared by Harold A Graham, MA, MA, QMRP, President/CEO

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Additional copies of this report may be requested from  
Graham Behavioral Services, Inc.  
PO Box 2075, Augusta Maine 04338  
207-626-0003 Fax 207-626-0004

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Marketing and Strategic Plan 2009/10  
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# **GRAHAM BEHAVIORAL SERVICES, Inc.**

## **GENERAL BUSINESS INFORMATION**

### **MISSION STATEMENT:**

It is the mission of Graham Behavioral Services, Inc. to be dedicated in providing the best quality of service for its customers and clients who have mental health and/or behavioral needs. This comprehensive service process is eclectic by design, and focuses services on the strengths and needs of each individual, family, and caregiver. This mission encompasses a holistic and performance based approach in assisting others to succeed and reach their full potential.

### **ETHICAL STANDARDS AND QUALITY OF LIFE:**

The quality of service is determined through the aligned vision of the customer/client, their families/care givers, natural supports, various support agencies, and through an individualized therapeutic process. Services and personnel managed by Graham Behavioral Services, Inc., will represent and demonstrate the ethical and professional standards established by the agency, and strive to promote and improve the quality of life for individuals and families living within our community.

### **EVIDENCE BASED PRACTICES:**

Evidence Based Practices is the cornerstone of Graham Behavioral Services, Inc. to provide effective treatment strategies, to efficiently measure improvement over time (outcomes), to improve service quality and customer satisfaction, and to implement and modify existing systems to appropriately support new service innovations (challenge conventional approaches). The GBS Inc. service model focuses on evidence based practices equally, through the promotion of organizational development (change) and to coordinate in collaboration with local agencies to sustain lasting overall improvement (quality of life).



# GRAHAM BEHAVIORAL SERVICES, INC.

*Service, Training, Consultation*

## AGENCY CORE VALUES

### The Core Values Serve to Support the Agency Mission and Philosophy of Service

**TO SERVE** our customers, clients, and consumers by providing ethically and clinically-based, safe, effective, innovative, and natural services of high quality.

**TO BUILD** relationships with our customers, clients, and consumers that encourages and promotes creativity and service ingenuity that focuses on individualized improvement with dignity and respect.

**TO RESPECT**, value, and serve not only our customers, clients, and consumers, but also our co-workers, owners, agents, and natural supports within the community; to be genuinely concerned about and contribute to their well-being, and to operate with integrity so as to be deserving of their trust and support.

**TO PROVIDE** meaningful employment, fair compensation, and a safe, healthy work environment that empowers and encourages genuine openness, creativity, self-discipline, personal growth and achievement.

**TO CONTRIBUTE** to and affirm a high level of commitment, competency, skill, and effectiveness, within the service community.

**TO RECOGNIZE**, encourage, support, and develop innovative treatment and service modalities to best accommodate individual needs and to appropriately serve customers, clients, and consumers.

**TO ACKNOWLEDGE** the value of each person's contribution to the GBS' goals and to foster teamwork in our various service tasks.

**TO BE DISTINCTIVE** in providing individualized treatment approaches, supporting effective qualitative methods in measuring improvement over time, and to develop and implement innovative methodologies which honor and sustain the natural culture.

**TO ADDRESS** community concerns in Maine, by devoting a portion of our time, talents, and resources to the community, addressing fundamental human needs, supporting the arts, and encouraging continued education.

**TO WORK TOGETHER** to contribute to the long-term ethical value, competency, and sustainability of GBS.

**TO BE HOLISTIC**, profitable, and a successful service agency, while acting in a socially ethical, and community responsible manner.



# GRAHAM BEHAVIORAL SERVICES, INC.

*Service, Training, Consultation*

## AGENCY CORE BELIEFS

### The Core Agency Beliefs Serve to Support the Agency Mission and Philosophy of Service

**WE BELIEVE** that the quality of service to our customers, clients, and consumers is directly correlated with the dedication, consistency, reliability, and the competency of the person's delivering the primary service.

**WE BELIEVE** in providing employees with a safe and fulfilling work environment, and the opportunity to improve personal competency, skills, and service accomplishment.

**WE BELIEVE** that the self-perceived overall well-being of the primary service employee is directly correlated with the quality of services being delivered to customers, clients, and consumers.

**WE BELIEVE** the role of management is to support, empower, and to reasonably accommodate the development of core competencies and skills to best serve the GBS' customers, clients, and consumers.

**WE BELIEVE** the role of management is to effectively and genuinely listen to the clinical and programmatic observations and recommendations that primary care employees encounter while providing services to customers, clients, and consumers and to invest reasonable resources to improve overall quality of service.

**WE BELIEVE** that management is required to encompass the educational, existential, and experiential competencies to effectively guide and direct GBS upon its mission and various service directives.

**WE BELIEVE** that employees and people directly associated with GBS, deserve to work and provide services to customers, clients, and consumers within an environment that is democratically and permissively directed, that encourages individualized development and improvement without tyranny, intimidation, exploitation, or fear.

**WE BELIEVE** that our agency and our services are unique and worthwhile, and that we can sustain these genuine qualities with an ongoing commitment to improvement, innovation, and creativity.

**WE BELIEVE** that we have the responsibility to cultivate the strongest and ethically-based relationships possible with our customers, clients, consumers, co-workers, owners, and service agencies within our community.

**WE BELIEVE** that our agency can be financially successful while behaving in a socially responsible and community sensitive manner.

## **HISTORY OF GRAHAM BEHAVIORAL SERVICES**

### **RELEVANT HISTORY:**

Graham Behavioral Services, Inc. (GBS, Inc.) was incorporated in August of 2005. The company is the direct descendant of Graham and Associates (G & A); a program and behavioral consulting group established in 1990. Consultation and services provided under G&A Inc. included the following:

- (1) evaluation and provided specific services for children with cognitive challenges and behavioral problems;
- (2) assessed adults with serious and persistent mental illness to improve service delivery and reduce recidivism;
- (3) evaluated environments for older adults with various dementia disorders to age in place;
- (4) designed and developed treatment processes and programs for various agencies to improve outcomes;
- (5) provided consultation to correctional officers regarding risk management;
- (6) provided public speaking and clinical and managerial consultation; and
- (7) provided independent root-cause analysis when sentinel events occur (intra-agency).

GBS Inc. is a private for-profit behavioral health, consulting, and service agency. Intended service of GBS Inc. has focused upon providing services for children, adults, care givers, and their families in addition to providing intra-agency consultation.

These services will include training specific in developing clinical competencies, clinical and managerial consultation, and program/service evaluation and support. Previous customers have been not-for-profit and for-profit agencies serving children and adults with developmental disabilities, university research pilot projects, nursing homes, clinical services, social service agencies, for-profit mental health agencies, independent family managed small businesses, and agencies organizing international speaking engagements.

### **CURRENT MACRO-REGIONAL ENVIRONMENT ASSESSMENT (culture):**

Each program has grown incrementally over the course of 2008. Specifics are identified within the Important Events and Accomplishments in 2008 (per section). There were many intra-agency changes within the 2008 community (Region II) for example; one agency closed their doors in November of 2007 which resulted in over 2,200 clients discharged without a substantiated coordination of service changes or transition period.

[Note: *Disclaimer, the unidentified area agencies within the State that are mentioned are for the purpose of describing the mental health environment and not a means for any other purpose*].

This resulted in over 60 (for GBS, Inc.) referrals for various services within five hours after this agency's capitulation. Referrals continue to be assessed, largely because of what appears to be hastily made plans and agencies reporting capacity without a thorough understanding of their own logistical support and organizational behavior (this organizational behavior practice is expected to continue in 2009).

Another area agency purchased what they thought was a "cash cow" in 2006 which rendered them financially viable, and also gave the appearance of 'blundering' the handling of another agency in capitulation in late 2007, although they have a significant endowment as a measure of 'safety' (to

most likely survive the executive decisions). Another agency within the region was investigated by MaineCare for financial malfeasance (whether they are in service is unknown at this time). Four other agencies were experiencing the difficulty to re-engineer their services to increase efficiency (not-for-profit agencies). This is in addition to the current State mandatory budget cuts due to deficits and stressed standardization of services (APS Health Care, 2008). Another agency has been cited for violations that may cause them to close (or significantly downsize) in 2008 which will impact general services in 2009 regarding two substantiated wage and hour violations within four years.

According to Moorhead, et. al, (2004) and Detert (2000) mastering organizational change can be extremely difficult. If there are not positive attitudes and perceptions (motivation) to change and development, participative management (Evan, et, al, 2002; Green, 2000; & French, 1995) then an agency is doomed to experience difficulty, resistance, disinvestment by employees, and at times overall performance failure. Performance behaviors are calculated carefully to include the employees to understand specific objectives that are not always dependent upon fiduciary budgets but on stringent performance measurement (Harbour, 1998; Graham, 1995).

The Agency continues to work conjunctively with other equally smaller providers to share resources and ideas, consult, and to develop a regional continuum of care therapeutic model. Inter/Intra agency continuum of care cooperation can have a significant impact in the delivery of mental health services (Graham, 1997; Graham, 1996; and Graham, 1995). Strategic processes and coordination with vendors are critical components to success whether in manufacturing or human services (Grant, 2002; David, 1995).

Within the current social service environment, is an element of what appears to be organizational chaos within the community and DHHS, despite budget constraints and the requirements for services or Consent Decree representatives to provide services for consumers within the current budgetary restraints (OAMHS Consent Decree, 2005 & 2006). Organizations, service agencies, and governmental departments are being held accountable to standards that emphasize a 'strategic' methodology across the United States (Graham, 2008; Graham, 2007; Grant, 2002). Within times of 'change' ... or in his words ... 'chaos' and the current environment Dr. Peters (1991) recommends involving 'everyone' within the systemic process, measure what's important, set conservative and long-term goals, and demand total integrity".

Current mandatory changes regarding State budgets have had a significant impact upon the social service fields, and other community services within the State. Our Agency will most likely efficiently weather the changes accordingly (through stringent fiscal management, programmatic accountability, and the continuous measurement of performance behaviors is implemented). The impact of APS HealthCare has been a frustrating process for many area agencies, especially those who do not have the infrastructure, organizational competency, and/or integrity to clinically document the need for continued services for their consumers.

Nevertheless, standardization of agency payments for services, accountability for services rendered; some agency fiscal and operations management practices have also forced a systemic change within the State to be on-line with other states (federal mandates). Many agencies, do not understand the impact of management ethics and their affects upon clinical outcomes – which indirectly and/or directly impact fiduciary outcomes (Graham, 2009; Olen & Barry, 2002).

The prevention of redundant management development (administrative over-layering), often found in certain types of not-for-profit agencies, has been a beneficial operations practice over the course of the past 3.5 years for the Agency. Many not-for-profit (and for-profit in certain situations)

agencies have been required to ‘down-size’ across the United States due to the systemic practices of CEO’s, boards, advisory councils, operational procedures, systemic processes, and in working within a tax-exempt environment (once implemented and established in the early 1960’s).

Although, implementing and managing a horizontal operations model with this Agency (within TQM & MBO protocols); this theoretical system has its shortcomings as documented within the literature if not implemented systemically and/or if there is no measure of accountability. The systemic process stresses, with appropriate oversight and accountability, can be considerably effective with start up agencies from a tactical and strategic perspective and provide a foundation for growth (Graham, 2007; Grant, 2002; Rollo, 2001; Meisenheimer, 1992; Muczyk, et al., 1989).

### **STRATEGIC MANAGEMENT & GBS, Inc. BUSINESS CULTURE:**

The Agency represents roughly 340 consumers/customers and over 125 employees, which does not include individual trainers, consultants, students completing their internship(s), or vendors. These variables are growing, as indicative of the responses to Human Resources in conjunction to current employee input. The opportunity to expand the Agency has been frequently reviewed during the past two years, and is expected to increase in 2009/10 through inquiries from other agencies, regional DHHS office personnel reports, inquiries within Region I, and with a number of out-of-state agency communication(s) of interest and collaboration.

2009 will most likely become a ‘fast-year’. Strategic alignments and internal logistics are going to influence the decision making process to determine the most effective delivery of services for each department within the Agency. Organizational performance behaviors (measurement & accountability) are critical to the success of each individual program. Failure to understand measurement can be catastrophic, “if you can’t measure it ... you can’t control it” (Dr. Levitt, 1960) (Inancevich, et. al, 2005; Davis, et. al, 2003).

The purpose of any strategic plan should focus on business ethics, recognizing the employee through empowerment, and through objective management of criterion (Graham, 2009; Graham, 2008; Graham, 2005; Grant, 2002; Detert, 2000); Schein, 1999; Hartman, 1998). In Dr. Hartman’s text (pg. 312-316), she comments about what makes for business success; “treating people right” and recognizes the importance (as is the trend over the past ten years) to recognize and acknowledge individual effort, teamwork, responsibility, courage, participatory management, etc. Quality management has a critical impact upon the perceptions of the employees who actually provide the service (Graham, 2009; Graham, 2008; Davis, et. al., 2004; Moorhead & Griffin, 2004; Graham, 1999; Edge & Groves, 1999).

In building high performance organizations, the Balanced Scorecard (BSC) has not always been supported in all longitudinal studies (Thompson et., al, 2008; Schien, 1990). However, Thompson (2008) recommended utilizing an “aligned” version (pg, 378). In essence, and with attempted practice, the Agency implements an aligned version of the BSC with an eclectic process to reduce the lack of understanding of the tactical and strategic process; and in the alignment of organizational goals with employees (Graham, 2008; Green, 2000).

Maine State Mental Health DHHS Licensing came to review the Agency’s protocols to validate the Mental Health License in late January of 2008. In summary, they expressed their astonishment regarding the milieu and culture of the office atmosphere, performance behaviors set as a measurement standard, operations, measurement variables, employee attitude, and client appreciation (see memo enclosed in Appendix I).

The Agency received a three year license, which was an unexpected event since the audit was the first official DHHS review. The CDC also conducted their annual audit in early 2008 and expressed their comments regarding quality (see memo enclosed in Appendix I). A number of other agencies have expressed appreciation regarding coordination of services and the quality of employees serving consumers jointly (i.e., Washington Manor, Cornerstone Behavioral Health, ASI-ME, and various clinicians and therapists within the area to name a few).

#### Strategic Management Communication & Resource Utilization:

During the late 1960's and 1970's resources were not always evaluated or calculated when employees were considered within the management or budgetary formulas other than as a static asset. Team concepts were considered 'units', especially within manufacturing. Eventually agencies (firms) started to develop a sense of pooling resources and capabilities to determine strategy and strategic management (Grant, 2002; Gadiesh & Gilbert, 1998). Many agencies based their strategic management and operational decisions, and subsequent communication, revolving around their mission statements in the 1980's and 1990's.

The rate of change of the business social service environment continues to accelerate, driven by increased fiduciary responsibility, the implementation of standardized service systems, new technology, and budgetary processes (Graham, 2009). Services are changing to a form resembling 'fee-for-service' across the State which requires more efficient communication and programmatic accountability. The basics of contemporary strategic analysis should be shared with all employees to assist with their understanding of operations management, service investment and treatment outcomes, and to process beyond the micro-therapeutic environment (Graham, 2009; Ivancevich, et. atl., 2005; Graham, 2003; Hartman, 1998; and Graham, 1996).

Our Agency's strategic framework views strategy as a link between other agencies, communication, sharing of intellectual property, efficient internal resource management, and the general coordination of services within the macro social service environment that would improve consumer services and align a greater strategic 'fit' (which includes intra-state services). This practice, in addition to empowering employees, is essential to effective service delivery (Graham, 2009, Hartman, 1998). In Grant's (2002) words, "lack of consistency between the strategy pursued by the firm and its external and internal environments is a common source of failure" (pg, 16). Strategy is a systemic process of objectives (goals) and the systems that are required to achieve these goals (defines what the Agency will become) (Porter, 1980) without creating the strategic phenomenon of 'hypercompetition' as defined by D'Aveni (1994).

One of the basics for strategic planning during the next two years would be in allocating resources to develop each program to efficiently meet programmatic and systemic need (resource based view of the Agency) and to maintain a 'competitive advantage' (see the articles from Collis & Montgomery, 1995; Peterlaf, 1993; and Barney, 1991). Tangible resources are fairly easily identified and evaluated. Intangible resources are much more difficult to measure, yet according to Grant (2002) have much more of an impact upon service and ultimately the balance sheet. The author commented that the "undervaluation or exclusion of intangible resources ... is a major reason for the large and growing divergence between companies" balance sheet valuations (pg. 141).

Strategic processing has become an instrumental component for business planning processes. "Game Theory", as explained by Porter (1980) along with other economists, stress the importance of stringent strategic management. Most agencies understand how to plan tactically, but at times fail to implement strategic methods for growth and development on a controlled and sustainable

scale (Graham, 2008). Controlled and incremental growth of this Agency allows the development of the agency framework and/or in making strategic decisions and; “it can predict the outcome of competitive situations and permit the selection of an optimal strategic choices” (Grant, 2002). Segmentation analysis is applicable to mental health agencies where there are demonstrated diversifications of services which impact the various customers need for services.

Thus a useful starting point to identify and recognize an agencies’ resources is to understand (or classify) the basic or principle types of resources into intangible, tangible, and with human resources. According to Grant (2002), “human resources are the ‘productive service’ that human beings offer to the firm in terms of their skills, knowledge, and reasoning and decision-making abilities” (pg. 143). Balance sheets do not represent human integrity, compassion, measure skill sets, assess the efficiency of operational management practices, ethics and integrity, or the individual investment of employees (Graham, 2009; Graham, 2008; Graham, 2007; Grant, 2002; Hartman, 1998; and Graham, 1995).

#### Core Competency & Distinctive Competence:

Core competency analysis is critical in measuring an agency’s capability to provide services as relevant to other firms or agencies within the area/region/country (Hamel & Prahalad, 1990). Competency is especially pertinent within social services which provide a milieu of services for consumers that have specific mental health needs, exhibit active or acute symptomology that could render the consumer to be prematurely institutionalized if not addressed, chronic conditions, and/or cognitive challenges (this is one of the reasons that the Agency measures employee experience and other performance variables). Core competencies can reflect “distinctive competence” for an agency (Selznick, 1957). Both competency distinctions direct the Agency’s vision toward competitive advantage relative to similar agencies within the State.

Through the measurement of performance variables, communication flow-charts, and related analysis of aggregate data allows the agency to conduct a ‘gap-analysis’ (Grant, 2002) to conventionally attend to resource building. Gaps are not necessarily considered a weakness; however, the tools should be considered as a means to build a stronger level of continuity of care (Graham, 2008). By developing individual employee competency, the process strengthens the Agency’s capability to more effectively and efficiently serve customers to live independently, to maintain symptom management, and/or reduce the frequency of premature relapse.

#### Knowledge Management:

Knowledge management (competencies) can be ‘tacit’ by nature which involves the skill-sets necessary to conduct the task or provide the service. This knowledge is conducted through observation, acquired through practice and often by experience within the Agency. Agencies that are ‘good’ at sharing information have an advantage over companies that are not (Davis, et. al., 2003; Grant, 2002; Hartman, 1998). This is the primary reason that GBS Inc. reaches to other agencies for conjunctive service coordination. The Agency has currently conducted knowledge measurement (by years of experience) as a valued and sustainable commodity.

This ‘knowledge management’ process will be provided through training to increase the understanding of ‘explicit’ knowledge of facts, theory, flow-charts, plan-do-check-act models, and in understanding procedures/protocols. Knowledge management regarding ‘communities of practice’ has been increasing (agencies) as a means to share information and agency group learning as demonstrated through clinical and team meetings. Knowledge integration can be the greatest challenge according to Edvinsson & Malone (1997) within systemic cultures. Executive

managers must be aware of their macro and micro cultures and how information is shared (Graham, 2008; Heneman, et. al., 1994; and Johnston, 1993).

There is an inherent importance regarding the investment from human resources that can impact quality, strategy, and the overall performance of the employees (this includes utilizing the individual quality and skill sets of employees). Recognizing the importance of ‘people’ allows the Agency to set ‘competency modeling standards’ that specify what skill-sets are required to implement services with consumers and manage systemic processes. According to Goleman (1995), ‘emotional intelligence’ reflects the importance of a firm to recognize employee values and social and emotional skills. Ignoring such; can have a long-term devastating impact upon clinical outcomes, morale, and employee service integrity (Graham, 2009).

The recognition of the employee’s emotional value has significant impact upon service delivery, ethical standards, and the overall organizational culture (Graham, 2009; Green, 2000; Fukuyama, 1995; Lawler, 1994; Barney, 1986). Dr. Green mentioned within his text and commented about five approaches that can assist managers to motivate their employees (pg. 213) using an informal loosely structured approach to the management of employees. Nevertheless, regardless of which management tool is utilized and implemented; it is the character of the CEO and the culture of the management team that ultimately cultivates performance (Graham, 2009; Green, 2000; Hartman, 1998; Graham, 1995; French, 1995; and Graham, 1989).

#### Continuous Improvement:

Johnston (1993) commented that continuous improvement is imperative to ‘busting bureaucracy’ and its related perceived negative components. The bureaucratic culture can be viewed by both micro and macro environments. The macro environment constitutes the greater service area that can include DHHS, aligned agencies, federal mandates, and various external vendor services. Whereas, the internal bureaucracy involves the culture of each individual employee’s experience added and the culture that is present upon employment. [Note: There can also exist internal-micro cultures (bureaucracy) within an agency’s micro culture – sometimes referred as niches or clicks (Graham, 2009; and Bridges, 1991)].

Regarding continuous improvement, both Johnston (1993) and Oddo (2007) exemplify the same premise to ‘plan-do-check-act’ systems to process for continuous improvement. Johnston stressed the importance to break complacent bureaucratic procedures and to change the culture of negative affects. In order to make a measureable difference within public health; systemic processes have to be evaluated and data trended (QA&I) in order to justify the delivery of services and/or to discharge customers who have completed their therapeutic objectives. The consciousness of continuous improvement reduces the phenomenon of bureaucratic mismanagement and cultures that hide inefficacy through systems of systemic ambiguity (Graham, 2009; Detert, 2000).

### **IMPORTANT EVENTS AND ACCOMPLISHMENTS IN 2008:**

#### Section 13 - Targeted Case Management Services– Children:

1. The contracted Targeted Children’s Case Management program which currently serves approximately seventy-four (74+) children with four experienced, mature, reliable, and dedicated case managers (and three interns – Thomas College, KVCC, and UMA during 2008). It should be noted that the University of Iowa is interested in sending graduate interns;

- a. The case managers were selected for their clinical and practical Quality Assessment experience and for their ability to complete tasks without minute-to-minute supervision;
- b. The DHHS Contract Review Committee (held in August 2008) noted the continuous improvement in services, communication, and regulatory requirements;
- c. DHHS Licensing agents provided a three year license based upon their audit conducted in January of 2008. There were no citations from DHHS;
- d. The case managers have demonstrated their versatility in working with customers with cognitive impairments (challenges) and various mental illnesses (including dual diagnosis);
- e. The case managers have demonstrated an eclectic methodology to effectively work with a variety of families and customers through empowerment and personal support;
- f. Discharged clients/consumers within the TCM program total 24%, largely due to the fact that they met their programmatic goals and did not require further services;
- g. Statistically it should be noted that one-of-five applicants for children's TCM (also CIS) has the skill sets, motivational consistency, and integrity for hire (it appears that case management employment complacency is rampant in the State);
- h. Customer compliment to complaint ratio for 2008 for Section 13, Targeted Children's Case Management was 14.9 to 1;

Section 17 – Community Support Services/Daily Living Support Services (DLSS):

2. The successful stabilization of the previous reengineering of the Section 17 Daily Living Support program serving adults with mental illness for persistent and prolonged treatment of thirty-nine (39+) customers (referrals continue, and some consumers have graduated, or were discharged for various reasons during 2008). The general results were as follows:
  - a. DHHS Licensing agents provided a three year license based upon their audit conducted in January of 2008. There were no citations from DHHS;
  - b. The DHHS Contract Review Committee (held in August 2008) noted the continuous improvement in services, communication, and regulatory requirements;
  - c. The intra-agency recognition regarding sustained quality of service resulting in an inundation of referrals (the practice of controlled growth continues to guide service development without compromising current service quality);
  - d. The inter-agency training and implementation of “Therapeutic Milieu” and how this clinical and programmatic practice improves quality of life, develops effective rapport with customers and service personnel, and reduces the likelihood that acute symptoms will result in recidivism or relapse has improved;
  - e. A Service Coordinator position was created to assist DLSS and Skills with APS (managed care) to reinstate services as needed by the consumer;
    - i. The clinical database system is being considered for Copywrite (inquiry pending);
    - ii. Representatives from APS came to the Agency to review designed protocols and measurement practices during 2008;
    - iii. Standardized processes, and procedures, have been finalized to accurately measure behavior and programmatic need;

- iv. A Quality Assurance (QA) department was developed in 2008 to monitor and audit client/consumer files and performance behaviors to meet and/or exceed regulatory requirements;
- v. The data collection, and Agency specific APS system, is pursuant of copy write regulations;
- f. Performance Behaviors:
  - i. 96.2% of the QA regulatory requirements regarding timeliness of document development and filing were met;
  - ii. 98.3% of the crisis plans met standards, were adjusted to more accurately meet changing needs of the consumers, and were implemented within Agency regulatory requirements as measured by signatures and completion dates (which are more stringent than standard DHHS regulatory requirements);
  - iii. 92.3% of the incident reports were reviewed (with signatures) in a timely manner within Agency standards as audited by QA&I and QA;
  - iv. 97.4% of the files reviewed were complete as measured by signatures and dates (random sample audit);
  - v. 99.8% of the comprehensive assessments, support plans, and incident report follow-ups were present (indicated by signatures and dates as the measurement variable);
  - vi. 83.5% of the DLSS service shifts were actively filled during the year (this includes the reduction of hours lost from client cancellations, staff call outs, weather, hospitalizations, and various relative incidental events);
  - vii. Customer compliment to complaint ratio for 2008 for Section 17 DLSS and Skills was 13.24 to 1 (The database was not programmed to separate DLSS from Skills);

Section 17 – Community Support Services/Skills Development Services (Skills):

- 3. The formal establishment of the Section 17 “Skills” program that provides a continuum of care for consumers who graduate from the DLSS and/or are from an outside referral source;
  - a. The Skills program currently serves 22 consumers, and additional referrals are being assessed (intake). It should be noted that nine (9) graduated from the program, three others decompensated;
  - b. DHHS Licensing agents provided a three year license based upon their audit conducted in January of 2008. There were no citations from DHHS;
  - c. Region I has been entertaining the option per the request of members of the CDC to develop a Skills program within the Portland area;
  - d. The recognition of the therapeutic value to implement a “continuum of care model” that coordinates services and clinical investment to improve overall quality of life from providers, the CDC, guardians, etc;
  - e. Performance Behaviors:
    - i. 86.3% of the QA regulatory requirements regarding timeliness of document development and filing;
    - ii. 97.1% of the crisis plans met standards and were implemented within regulatory requirements as measured by signatures and the completion dates with clinical need;
    - iii. 88.6% of the incident reports were reviewed (with signatures) in a timely manner within Agency standards as audited by QA&I;

- iv. 92.1% of the comprehensive assessments, support plans, and incident report follow-ups were present (indicated by signatures and dates as the measurement variable);
- v. 74.5% of the service shifts were actively filled during the year (this includes the reduction of hours lost from client cancelations, graduating from the program, staff call outs, weather, hospitalizations, and various relative incidental events);
- vi. Customer compliment to complaint ratio for 2008 for Section 17 DLSS and Skills was 13.76 to 1 (The database was not programmed to separate DLSS from Skills);

Section 17 – Community Support Services/ Community Integration Services (CIS):

- 4. The contract to provide CIS (adult case management) which currently serves one hundred and thirty six consumers (136+) within the Region is active. Referrals continue in early 2009. Results for 2008 are as follows:
  - a. There are currently a total of nine case managers who serve consumers (not including the Director, or intern). This will most likely grow in 2009/10 based upon the referral streams;
    - i. It was found that one-of-five case management managers demonstrate the caliber or quality standards to meet the Agency’s expectations (this primarily is pertinent to applications submitted during the year 2006, 2007, 2008);
    - ii. Many case manager applications vary from earning a MHRT-C (two-year) or a four-year degree. Two working toward their master’s degree in either human services or social services. Nevertheless, as was inferenced in ‘I’, do not possess the aptitude, organizational skills, and other necessary skill sets to manage a moderate case load.
  - b. There has been an expressed interest from individuals within various DHHS departments in serving more older adults (we currently have a number of older consumers who reside at Washington Manor);
    - i. The CEO/President will be providing a 42 hour course on Mental Health and Aging in the Spring of 2009;
    - ii. The CEO/President will be providing the MHRT-C Psychology of Aging course in 2009;
  - c. The CDC (Consent Decree Coordinator) came to review records (unannounced 2008 audit), and found no citations (see attached memo – Appendix);
  - d. Customer compliment to complaint ratio for 2008 for Section 17 CIS was 15.8 to 1.

Section 21 – Home and Community Benefits for Members with Mental Retardation or Austistic Disorder:

- 5. The successful and recognized reengineering and development of the Section 21 Comprehensive Waiver program (initiated in late 2006) serving adults with cognitive challenges and serving thirteen (13+) customers; The general results for 2008 were as follows:
  - a. DHHS continues to recognize and verbally stated the dramatically improved quality of services that were initially initiated in 2006 (infancy) to the present;

- i. The Program Director attends quarterly service meetings with DHHS to review status and quality of care; all of which have proven satisfactory (or better);
  - ii. The PCP Coordinator continues to assess consumers, monitor progress, and support employees implementing the plans;
  - iii. The previous PCP Coordinator continues to provide consultation services as she was promoted at another agency;
  - iv. State budgetary restraints had forced all agencies in the State to consolidate services for consumers (evaluation and analysis will be pending in 2009/10);
- b. The improved and recognized understanding of the importance in developing and establishing a “Therapeutic Milieu (culture)” as a programmatic practice that improves quality of life, establishes an environment to develop self esteem (Graham, 2003), develops effective culture and rapport with customers and service personnel, and reduces the likelihood that acute symptoms will result in recidivism, crisis intervention, or relapse (Graham, 2001; French, et. al., 1995);
  - i. The development of therapeutic cultures has reduced the frequency of noxious target behavior (inversely related) by 62%, reduced the level of risk to consumers and employees, and improved environmental safety;
  - ii. Although there is at least one ‘heavy-hitter’; intervals (measured in days) between incidents has increased in length of duration for all consumers (with the exception around the holidays);
- c. 94.3% of the service shifts were actively filled during the year (this includes the reduction of hours lost from hospitalizations and/or various relative incidental events), acute hospitalizations and family holiday events, and/or bi-weekly visits were primary regarding service contracted shifts being unfilled;
- d. Customer compliment to complaint ratio for 2008 for Section 21 was 14.6 to 1 (this ratio does not include employee complaints pertinent to scheduling challenges (*department*));
- e. A consultant was hired in late 2008 to assist in developing the program to serve adults with cognitive challenges case management services;
- f. The agency was reviewing the possibility of implementing a small ISO model to serve adults with cognitive impairments (challenges) and to support the “family living model” in 2007;
  - i. The ISO model is temporarily ‘on-hold’ until the time can be invested to complete a Rider (for the record there have been many families who have requested assistance);
- g. The Agency has obtained Section 29 consumers under it’s contract;
- h. The Agency is in pursuit of obtaining Adult MR Case Management (current) in 2009;

#### Section 24 – Children’s Habilitation Services

- 6. The re-engineering process begun in late 2006 has been successfully rooted and in 2009 we expect to see an increase in clients served
  - a. The program continues to receive referrals as requested from Central Enrollment and independent sources (that are re-routed through Central Enrollment);
  - b. The program has had three interns work with assisting the Program Director, learning how to complete assessments, and tallying behavioral data;

- c. The re-engineering process allowed the Agency to hold families accountable to follow the treatment plan (vs. a baby-sitting or errand service). This resulted in the discharge of two consumers;
  - d. DHHS provided standardized training for all area agencies regarding comprehensive assessments processes;
  - e. Functional Behavioral Analysis Training was provided;
  - f. Clinical supervision is provided for employees (despite that this is not required by DHHS regulations);
7. 2008 also saw an increase in the percentage of clients “fully served”. Meaning served the the number of hours the client was approved to be served.
- a. There were two consumers who graduated from the program;
  - b. There is a need to develop a transitional process from children's to adults (discussions with DHHS pending);
  - c. Agency served 68.4% of the contracted hours within the children's program. However, there are conditions that are beyond the Agency's control;
    - i. Parents call out;
    - ii. Holidays are not generally served;
    - iii. Some families call for an intermission of services (i.e., vacation, summer, etc);
    - iv. Two families were discharged based upon inappropriate conduct with employees (Graham, 2008);
  - d. The program implemented a service group to increase communication (socialization) with the girls program (craft based);
  - e. It is recommended that all employees who serve children in Section 24 receive Behavioral Health Professional training (this is an Agency requirement, not a requirement from DHHS or the Agency's regulatory body);

Community Out Reach:

- 8. The Agency provides “community out reach” which includes continued DHHS contacts and intra-agency correspondence for service development and in-kind service coordination with other agencies:
  - a. The community outreach includes educational development and administration support within the region;
    - i. The CEO/President provided “Boundary Training” for the employees of Washington Manor;
    - ii. The Program Director for TCM visits local schools and area agencies regarding what case management services are available for children;
    - iii. The Program Director for CIS represents the Agency during the monthly CRS DHHS meetings and has been asked to participate on various intra-agency committees (i.e., ESN, CSN);
    - iv. The CEO/President will be presenting at the Minnesota Social Service Conference in March and June of 2009 (Topic - Management Ethics and

- the Impact upon Clinical Outcomes; Environmental Assessment; Validation Therapy; and Reminiscing & Life Review Therapy);
- v. The CEO/President will be conducting a 42 hour Psycho/Educational training regarding Sex Offenders for DHHS guardians and case managers (currently the course is being implemented at the office for case managers, directors, and related personnel and will be implemented again in February of 2009);
- vi. MHRT-C classes are being developed by the Employee Development Coordinator (most courses have been approved);
- vii. The Employee Development Coordinator teaches communication classes at KVCC;
- viii. The CEO will be presenting to various health & human services students regarding systemic mental health processes and issues (03/03/09);
- ix. CRMA, First-Aid, BBP, and various other trainings are held at the office which are also offered to area Fire Departments;
- b. Community outreach is represented by the coordinated efforts of employees to work with area agencies for the common good of all;
- c. Community outreach includes attending seminars, consultation, resource management, presentation(s) and training, and other various activities;
- d. Community outreach includes providing support and donations to entities that serve others in need (i.e., local food bank, shelters, Alzheimer's Association, Knights of Columbus, etc.);
- e. The Agency conducts and initiates 'idea-generating-sessions' with the local chapter of the Alzheimer's Association which visited the Agency in February, 2009;
- f. A coordinated collaborative effort in working with Crisis and Counseling is ongoing to better serve consumers in need (a presentation was held at the office in y February, 2009).

Internships – Graduate & Undergraduate:

- 9. The Agency has a regionally scholastically recognized undergraduate and graduate internship program (since the Agency's inception, eighteen "18" interns have completed their programs, two "2" are currently working under Section 24 while another one "1" is within the Section 17 programs, one "1" is shadowing QA&I and HR, and three "3" others are in the process of developing educational goals and objectives with their advisors and the Agency);
  - a. Internships are paid (at minimum wage) at the Agency;
  - b. Contracts (with goals) are developed with the intern and can include, but are not limited to, the following tasks;
    - i. Shadow case managers, directors, clinicians, etc to learn about intake assessments and family (consumer) dynamics;
    - ii. Learn how to develop a comprehensive service plan and treatment plan;
    - iii. Participate in regulatory meetings or sessions regarding client care;
    - iv. Participate in forensics assessments (including acute/chronic issues) behavioral management;
      - 1. Learn about the dynamics of Juvenile Fire-Setter behavior;
      - 2. Learn about the psycho/educational information regarding registered sex offenders (including profiles);

- v. Learn how to trend behavioral data (aggregate data analysis for clinical QA&I purposes) with high profile clients/consumers (Cooper, 2007; Ramsey, 2002; Brassard & Ritter, 1994);
- vi. Learn the difference between qualitative and quantitative data analysis (clinical and programmatic) with practice (guided by the text from Cooper, et. al., 2007; Brassard & Ritter, 1994; Meisenheimer, 1992);
- vii. Participate in the CRC and QA&I clinical meetings (committees);
- viii. Participate in clinical sessions (group) with colleagues and the clinicians;

QA&I & QA:

10. The agency focuses on an established clinically based programmatic process and service that effectively individualizes each customer's treatment plan that emphasizes best practices, and realistically assesses clinical outcomes (objectively);
  - a. The recognition in measuring behavioral and programmatic data was understood by the DHHS licensing review (January, 2008), various members of the CDC, and the current licensing consultant (*conducting a mock-audit*) as a significant benefit to provide efficient services (these variables will be measured using the fundamental techniques as outlined by Babbie (2002) and other authors);
  - b. Introducing a clinical balance of professionals to provide employee supervision and training (on-going and improving since 2006);
    - i. Standardization of behavioral variables is critical to the measurement of services rendered (Graham, 2003; Graham, 2002; Meisenheimer, 1992);
    - ii. Standardization of performance variables is currently being processed and refined initially implemented in late 2006 and grew to other programs in 2007/2008. This systemic process will continue to through 2009 to extend threshold markers and behavioral/programmatic comparisons audits;
    - iii. Reliability of assessment criterion and objective measurement, to increase inter-rater reliability among employees and QA&I staff is stressed. Additional training will be implemented with QA&I, QA, and collegiate interns (see Blank, 2004; Blank, 1999, for basic definition review).
    - iv. Within two years, QA&I in the Agency, will pursue the potential to utilize the fundamentals of Six Sigma as it applies to mental health services (see Stamatis, 2004).
  - c. [Note – Eventually employees will be trained to develop and implement the LOGIC model in treatment planning, service development, implementation, and measurement in 2010. The Logic Model has shown a consistent measure of performance with a variety of populations (Listiak, 2003; Graham, 2002; Graham, 2002; Graham, 2001; Kellogg Foundation, 2001)];
  - d. Measure established Agency thresholds to continue to improve consistently, assess therapeutic cultures, and develop a unified organizational practice (as evident and described within the following text: Collins, 2001; Collins & Porras, 1994 who stress “home grown management” (pg 169-184));

Human Resources:

11. Introduced and established a full-time position of a Employee Development Coordinator (actually started on 12/10/07, but was not fully integrated until 2008);

- a. Recording training data from staff “shadowing” has increased training hours (see ‘c’). Current Orientation hours have increased for new employees by 62%;
  - b. In 2009, training will separate employees that work within more than one program, which may or may not require clinical supervision or specific training topics;
  - c. Prior to 2008, the time employees spent shadowing other staff was not able to be tracked (time) without time spent to cross reference from the scheduling department (billing);
  - d. See performance indicators (behaviors) outlined within the Appendix;
  - e. The practice of ‘front-loading’ direct care personnel has been effective in identifying invested employees and those few who may be solely invested in themselves (Graham, 2008);
12. The introduction and establishment of a full-time QA and QA&I department (previously stated). In the beginning of 2006 this was a fragmented process until an infrastructure could be built over time, hiring the necessary personnel capable of tracking and trending aggregated data, and not until financial reimbursement for client services increased to the level where QA and QA&I could be segmented within each department (rather than multi-tasked);
13. Introducing and establishing a full-time Payroll Specialist to augment the financial department (completed);
14. TQM and MBO (Evans, et., al., 2002; Muczyk, et., al., 1989) standards and a horizontal management practice (democratic-permissive model) continue to allow employees to succeed, develop, feel empowered and comfortable, and provide accurate and objective performance accountability. As indicated by the last MH DHHS licensing review and DHHS contract review there were no citations, and many commented about the healthy atmosphere for employees, consumers, visitors, and vendors.
15. These practices allow the Agency to recognize the employees who are invested in their service delivery and level of professionalism (within an environment that is healthy, non-punitive, and “fun”). Turnover for the first six months of 2008 was 9 (final results are within another section);
- a. One was expecting, and resigned to develop her own day-care business;
  - b. One resigned due to a medical condition;
  - c. One position elimination;
  - d. One finished her internship;
  - e. Two left the State for graduate school;
  - f. One had boundary issues;
  - g. Two never showed up for work (background checks nullified employment);
16. The introduction and establishment of contracted services for consulting and programmatic support to improve quality: Nursing, PCP Consultant, Behavioral Analyst, Occupational Therapy Consultant, Training, Finance, Clinical Services, Specialized & Individualized Assessment, IT, and Technological Support Services;

Communication and Benefits:

17. The establishment of the Agency newsletter, “The Graham Gazette” – initiated in July, 2007 continues and is supplied to all employees and many (109) vendors and associates;
18. Improvement of the Group Health Insurance Plan (2007) and implementation of a 401k Retirement Plan, and a Group Dental Plan (2008) for employees;
19. The continued review of employee mileage to increase the rate from \$0.42 per mile to \$0.51 per mile;
20. The continued review of adding one additional holiday for employees and administrative staff (results pending);

Activities (results):

21. The Agency sponsored summer softball team won more games in 2008 than 2007;
22. The Activity Committee organizes and hosts bi-weekly card games, bingo night(s), pot-luck dinners, and related community activities for consumers (evenings at office) – on-going;
23. Many of the consumers/customers earned medals during both the winter and summer Special Olympics (2009 winter Olympics are being planned by the Special Olympics Coordinator);
24. There is a weekly juvenile male and female social group (separate groups) who work on skill building, socialization, and the reduction of symptoms of anxiety;
25. The Agency offers the local Peer Recovery Group conference room space to conduct weekly meetings (support group – mental health) on Mondays from 02:00pm to 04:00pm;
26. The Agency regularly communicates with members from the State Chapter Alzheimer’s Association;
27. Employees and consumers regularly attend the scheduled ‘fire-safety’ and fire extinguisher class provided by the Augusta and Chelsea Fire Departments;

**QUALITY ASSESSMENT & IMPROVEMENT (Statistical Findings & Goals):**

Employees:

1. A total of 313 recorded applications were received in 2008 (There were a total of 167 in 2007, and 202 in 2006) [Note: The systems to track applications had not become sensitive enough until 2008. However, there is a margin of error of 8%; thus the number of applicants in 2008 would most likely be around 337].
  - a. A total of eighteen (18) interns, in addition to four current, have either successfully completed their scholastic programs (collegiate & graduate), or are in the process of completing their internships (including four others pending);
  - b. Of the current 130 employees and consultants (12/31/08), five (4.8%) either have or are working toward completing their Ph.D. (this will increase in 2009);

- c. Of the current 130 employees and consultants (12/31/08), nineteen (15.0%) either have or are working toward completing their Master's degree;
  - d. Of the current 130 employees and consultants (12/31/08), eighty-three (83.2%) either have or are working toward completing their Bachelor's or associates degree and/or have an advanced degree or other formal continuing education experience. [QA&I Note: This figure does not represent students who have either relocated, are attending graduate school, or have taken different positions with other agencies];
2. Employee turnover decreased in 2008 to 0.000039 per billable hours. Turnover was 0.000041 per billable hours in 2006, and 0.000063 per billable hours in 2007. Which is still recognized as negligible within the industry;
- a. Seventy-three percent (73.7%) of employees who resigned were for the following reasons: seasonal employees, left for graduate school, left for other jobs (personal development or promotion), marriage, had health issues that prevented them from working, were interns completing their internships, graduation, child-birth, divorce, left the State, death of a family member, military service, retirement, and various other miscellaneous reasons;
    - i. This is a 6.67% percent improvement in turnover rates as they relate to non-disciplinary action terminations;
    - ii. The Agency implemented a small investment in advertisement and recruitment that focused on specific positions and/or unique client needs;
    - iii. The majority of the applications received were the result of community discussion and the Agency's performance standards as an attraction to applicant interest (this is significant);
  - b. Twenty-six percent (26.3%) were terminated for the following reasons: poor attendance and/or call-outs, boundary issues, failed background checks; no-shows for services; and other related breaches in ethics and/or policy standards;
    - i. There were no incidences of 'theft' investigated during 2008;
    - ii. There were no incidences of unauthorized or inappropriate sexual contact in 2006, 2007, or 2008;
    - iii. There were no incidents that required significant DHHS involvement to investigate allegations in 2008;
    - iv. Adult Protective and Child Protective have authorized the Agency's internal investigator to conduct investigations (based upon integrity);
3. Average age of employees in 2008 was 40.5 years (with a standard deviation of 2.25 years). [Note: The average age of employees in 2006 was 37.5 years, and the average age of employees in 2007 was 39.0 years].
- a. A randomized statistical analysis was completed in early 2006, 2007, and 2008 which revealed that on average the Agency's employees tend to be 14.31 years older than the norm average age of employees for a standard mental health agency (normed data collected over 16 years, standard deviation =  $\pm$  1.27 years). The inference, based upon a randomized statistical analysis of years of experience leaves the interpretation that the agency's employees are considerably experienced as a whole;

- b. After the 2008 audit regarding experience, it was found that current employee average 14.65 years of experience working with consumers with SPMI or cognitive challenges;
4. “Hannah” continues to be an active member of the organization because of the following (Hannah is a three-year old Husky mix, and monitors the office activities, social parties, and training, on a daily basis): She greets consumers, families, and customers, clients, and other canines (no cats allowed); she assists employees in quality food and treat testing during lunch time; she leaves her toys around the office areas for the Health & Safety Officer to justify his position; attends training and various individual and clinical sessions; she monitors the parking lot and the sea-gulls in the park adjacent to the office; opens doors with her paws and she respectfully introduces herself into each office with her tail wagging;
5. One GBS, Inc. employee is a local volunteer fire-fighter (Chelsea). Previously in 2007/08 there had been four; however, one was hired for the Gardiner Rescue (which also serves Chelsea), another was hired for Augusta (which also serves Chelsea), and the third resigned due to personal issues (however will most like return in 2009).
6. The Agency is represented by one member who is one of the two Kennebec County Juvenile Fire-Setter Intervention Specialist – II; and Disaster Behavioral Health responder volunteer;

Programmatic & Clinical:

1. Four licensed psychologists, four L.C.P.C.’s, and one licensed clinical social worker provide clinical and programmatic supervision and support for the employees;
  - a. The months of January through December do not include the daily supervision from the CEO/President (Harold Graham, MA, MA, QMRP – hours are recorded in the next section), however, clinicians will review minutes and document clinical supervision when necessary;
  - b. The additional contracted clinicians over the past three years have added a diverse clinical experience for the employees who attend clinical supervision that more soundly matches clinicians to meet their needs and addresses acute and chronic daily issues;
  - c. Clinical supervision is regulated by the DHHS Licensing Division for Section 17 and 13, case management, and Section 65m/n; however and not required through regulation, the agency also provides clinical supervision for employees working in Section 21 and 24;
  - d. The primary goal for 2008 was to increase the employee competencies (knowledge) regarding the processes of behavioral redirection, applied behavioral analysis, FMEA, identifying and implementing symptoms management techniques, and to increase the understanding of various diagnoses through training and retention (see text Wetzler, 1989) regarding measuring mental illness;
  - e. Sensory integration was also included regarding the specific trainings of Stephanie Truman for adults and children with Autism;
  - f. See total monthly hours of clinical supervision provided below:

2007 & 2008 Clinical Supervision Hourly Tallies:

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Hours 2007	388.25	294.75	382.75	418.25	451.25	326.00	249.25	255.25	299.25	249.75	219.75	196.25
Hours 2008	358.25	275.75	263.75	285.50	240.25	270.50	288.25	218.75	219.50	289.50	265.25	237.25

2. The eight Program Directors provide administrative support and supervision for their employees;
  - a. The process and practice of documenting face-to-face administrative (programmatic) supervision was (is) a new experience for the Program Directors;
  - b. As observed during the day, Program Directors meet with their employees on a regular basis; however, documenting the meeting or discussion falls considerably short of the hours identified below (meaning encounters with employees that are work specific are not always documented) – as witnessed by the technique ‘management by walking around’ (Allen, 1987);
  - c. The Program Directors that provide “face-to-face” meetings with their employees can be considered administrative supervision, client status reviews, team meetings, and/or training. [Note: If a licensed clinician is present and providing feedback for employees, the encounter is considered and documented as clinical supervision].
  - d. The primary goal for 2008 regarding administrative supervision was to develop a system to more accurately record what activities are already being implemented;
  - e. See total monthly hours of administrative supervision provided below:

2007 & 2008 Administrative Supervision Hourly Tallies (Training calculated separately):

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Hours 2007	112.00	87.25	121.50	80.25	208.50	235.75	266.25	105.25	138.50	195.50	155.50	203.75
Hours 2008	283.75	274.00	288.75	272.75	362.00	346.50	273.50	386.75	429.25	431.00	397.75	343.25

3. Employees received 13,809.75 hours of training in 2008 (employees received 7,755.50 hours of training in 2007 – however scholastic and extra-curricular training hours pertaining to mental health were not always recorded accurately within the database for 2007 or 2008) within the Human Resources files;
  - a. Training provided to visiting agency employees were not included within the total training tally of hours:
    - i. This would include scholastic hours from formal education);
    - ii. The Employee Development Coordinator allows 25 to 35 hours of documented training per pertinent course work applicable to services;
    - iii. Graduate courses are honored for 35 hours of training per class;
  - b. Administration hours (documented) increased from 1,910.00 in 2007 to 4,089.50 in 2008 (increase of over 100%);
    - i. It was found that the Clinical Director, or clinical consultant (internal or external), would ‘sit-in’ on treatment team meetings, meetings with case management, and/or individually consult with employees and administrative staff and at times failed to document the supervision;
      1. During the fall of 2008, there was a change in Clinical Director positions (personnel) to increase organizational competence;

2. During the summer, the position of Children's Services Director was eliminated due to redundancy of services (no need or justification for the elimination of the redundant position);
  - ii. Thus, an estimated 30% (S.D. of 4%) of the administration hours documented and recorded would most likely fall within DHHS licensing clinical parameters;
  - iii. Upon observation and implementing of the process of 'management by walking around' (Allen, 1987; Heneman, et. al, 1994) revealed that the total administrative supervision represents roughly 66% of the guidance that Directors provide their employees (as documented);
- c. Total training hours did not include the 4,089.50(+) administrative hours from the supervisors, or the 3,217.5 clinical hours for 2008;
  - i. Employees' reading of consumer files (i.e., psychological reports, social histories, etc) were not always recorded within training within the total monthly tallies based upon a random audit. This information was recorded through finance based upon un-billable forms submitted (goal for 2009);
  - ii. Employees 'shadowing' other employees for training purposes were also not always included within the total training tally (goal for 2009);
- d. The primary goal for 2008 was to increase training opportunities that will continue to improve the knowledge base and competencies of all employees;
  - i. Implementing the MHRT-C and various other programs continue to be in practice (will be initiated in 2009 as each course is approved – only one pending);
  - ii. The initial leadership training for executive and administrative staff was an unexpected failure in 2008 (*poor content validity of the primary assessment, presentation of the material that was more designed for the generalist, and was presented in a passive religious tone*);
  - iii. Arrangements are being made to implement a stronger matched leadership training for employees in 2009;
- e. The Training department is reviewing the implementation to have an on-campus MHRT-C course to support case management and the skills programs along with the pursuit of an effective ACT team to improve community continuity of care (*meeting set for 02/27/09 with DHHS to initiate the process*);
- f. As previously mentioned, the goal is to increase the overall competencies of the employees through training and retention;
- g. See Human Resource goals attached in appendix 2;

QA&I & QA (best practices):

4. Target behavior statistical analysis (*quantitative aggregate data has not been analyzed quantitatively or interpreted to date as an overall Agency practice – task for 2008 with the augmentation of QA&I*). However, individual data tallies have been recorded for 'heavy-hitters' that require more attention than the average consumer;
5. Overtime reduction: The goal for 2008 was to reduce the overall agency overtime by a minimum of 33% as compared to billable hours. [Note: Calculations to determine a measurable change must be compared as a ratio for each year]. Overtime includes service-shifts, training, clinical supervision, team meetings, etc;

- a. Administration Overtime (*does not apply to salaried employees*): 1,379.75 hours in 2007;
  - b. Administrative Overtime (*does not apply to salaried employees*): 883.25 hours in 2008
  - c. Direct Care or Consumer Support Overtime: 7,082.25 hours in 2007;
  - d. Direct Care or Consumer Support Overtime: 9,854.75 hours in 2008 (however, billable service specific hours increased by 231% in 2008. Thus there was a reduction in overall service overtime hours by 37% (*which met the objective to decrease overtime by 33%*);
6. Community Development (Philanthropic): Since inception, the agency and various members volunteer or provide services and/or donations to local and regional agencies who serve individuals in need;
- a. NAMI of Maine;
  - b. American Cancer Society;
  - c. Pine Tree Camp;
  - d. Maine Special Olympics;
  - e. Maine State Troopers Association;
  - f. Good Shepherd Food Bank;
  - g. Autism Society of Maine;
  - h. Muscular Dystrophy Association;
  - i. Knights of Columbus (Council 5612);
  - j. Lung Association Bike Trek;
  - k. Alzheimer's Association;
  - l. Girl Scouts of Maine;
  - m. Chelsea Fire Department;

Agency Affiliations:

- 1. Maine Association of Mental Health Services;
- 2. Better Business Bureau;
- 3. National QRMP Association;
- 4. NAMI of Maine;
- 5. Autism Society (of Maine);
- 6. Maine Personal Assistance Service Association;
- 7. Chelsea Fire Department (training & in-kind services);

**BUSINESS GOALS (General):**

The fundamental goal is to implement mental health services within Evidence Based Practices, Total Quality Management (TQM), and Management by Objectives (MBO) into various service programs for the purpose of improving the quality of care and the efficient delivery of programmatic, behavioral, and clinical support for customers in need with employee support and empowerment (see appendix one for brief description).

This was achieved through the utilization of objective outcome measures of individuals, quantitative system reviews, and qualitative process analysis (*aggregate data mining*). The primary goal of GBS Inc. is to effectively serve children and adults within an optimal therapeutic culture with efficiency (horizontal management).

Section 13 (Children's Targeted Case Management) and Section 17 (CIS) adult case management were initiated within the second business year (serving approximately over 200 clients combined). Section 17 Skills was also contracted with the State in 2008 (higher functioning and end-state consumer support - Skills). Consultation and presentation is a continuation of Graham & Associates. The 2008 GBS Inc. business goals and performance behavioral goals constitute the following:

Global Strategic Business Goals (Performance Variables see Appendix II):

1. Section 24 – Children's Day Habilitation:
2. Section 65m/n – Children's Behavioral Health Services
3. Section 13 – Children's Targeted Case Management
4. Section 17 – Adult Mental Health DLSS
5. Section 17 – Skills Development
6. Section 17 – Community Integration Services
7. Section 21 – Home and Community Benefits for Members with Mental Retardation or Autistic Disorder:
8. Clinical Team – Clinical Review Committee & QA&I Committee
9. Pursuit – Adult MR Case Management
10. Pursuit – ACT team Case Management – SPMI
11. Pursuit – Out Patient Clinical and Co-Dependency Services - SPMI

Children & Adult Behavioral Services (goals) – Section 24 and Section 21:

Historical Context: Section 24 has been the initial cornerstone for the agency resulting in the first program approved to conduct services (2005). Regulatory standards continue to be postulated; however, remain at the 1990 programmatic quality standards (presently there are no clinically standardized regulatory processes governing services within the State.

Currently, the Section 24 children's program is being reengineered for the following improvements: communication, continued staff development, family support, and customer on-site support, staff on-site support, programmatic integrity, leadership and organization, clinical supervision, scheduling, and quality of service. QA&I performance variables (behaviors) were established in early 2007 (see appendix). It should be noted that DHHS began standardizing the requirements of Section 24 during the first quarter of 2008 and continuing through 2009.

1. Children served under Section 24 (cognitive impairment, autism, and pervasive developmental disorders) will improve their ADL's and IADL's as measured during the initiation of in-home support services until successful discharge using the Woodvale ISAS and PSMS scales (Baldus, 2005) with a cognitive/behavioral treatment philosophy. The Woodvale assessments are applicable for pre-teens (*pre-teens to older adults with dementia*) who do not fall below the profound range of cognitive and/or physical challenges – this objective continues to be worked on.
2. Children served under Section 24 will effectively manage target behaviors in order to focus on developing independent living skills more effectively as evaluated by using the CABC-E and other tally (charts) systems through QA&I.
3. Children served under Section 65m/n (behavioral mental health) will reduce the frequency, intensity, and duration of aggressive and/or social non-compliant target behaviors as evaluated by using the CABC-E and other tally (charts) systems through QA&I (Ramsey, et. al 2002 for clarification of behavioral management techniques).

4. Children served under Section 24, 21, and 65m/n will complete their scholastic education or maintain their age appropriate scholastic achievement upon discharge from GBS.
5. Children served under Section 24, 21, and 65m/n will require less frequent hospitalizations as compared to the state and national averages per clinical diagnosis.
6. The program will meet 95(+) percent of the QA&I performance behaviors that have been implemented and aligned with the program strengths to reengineer service delivery, provide measurable criteria to assure programmatic integrity, and sustain quality of services.
7. Increase the billable service hours to more effectively match each individual consumer's is weekly budget.
8. Administrative and support personnel attended the DHHS training in early 2008 that is mandatory for all agencies to attend (standardization of procedures and assessment).
9. Gradually develop an understanding (including training) to implement the "Logic Model" as implemented in mental health (Kellogg, 2001; Graham, 2002);

Community Support Services for Adults (goals) – Section 17 DLSS, Skills, and 21:

Historical Context: Adult services have emerged in an environment of "controlled growth". Competing and collaborative agency changes within the State have provided opportunities and inquiries to grow considerably (primarily under Section 17, adult mental health). The strategic management decision has been to support the Directors' choice to increase the volume of consumers served per month incrementally, and only when employees have been matched, trained, and supported to initiate service with a new referral. The current State budget constraints and systematic service re-evaluation changes are likely to influence the direction of the State and the need for intra-agency collaboration (i.e., QA&I, training, support, sharing of ideas, etc).

1. Adults served under Section 17 (mental health/behavioral) and 21 (cognitive challenges, autism, and pervasive developmental disorders) will improve their ADL's and IADL's as measured during the initiation of in-home support services until successful discharge using the Woodvale ISAS and PSMS (Baldus, 2005) scales with a cognitive/behavioral treatment philosophy;
2. Each program has their goals and objectives (performance behaviors) located within appendix 2 (DLSS, Skills, and 21);
3. Adults served under Section 17 and 21 will effectively manage target behaviors and symptoms in order to focus on developing independent living skills more effectively and to establish the therapeutic milieu needed to sustain quality of services and reduce acute recidivism or relapse.
4. Adults served under Section 17 and 21 will reduce the frequency, intensity, and duration of aggressive target behaviors;
5. Adults served under Section 17 and 21 will require less frequent hospitalizations due to symptom management, therapeutic milieu development, and subsequently reduce the rate of recidivism as compared to the State and national averages per clinical diagnosis;
6. Inquiries have been initiated per the request of various individual providers to initiate and support the ISO service model for Section 21 consumer and their families (currently on hold due to logistics);
7. It has already been initiated to inquiry about developing an ACT team (on-going) based upon concerns expressed by families, consumers, case managers, and various governmental experiences regarding the current programs (see Dr. Yoe, January DHHS QA&I 2008 audit report);
8. It is also the intent of the Agency to develop mental health services for geriatric consumers regarding a service rich continuum of care model. This is an evident need as our populations grow older (see Scheidt, 1998; Sherwood, et. at., 1997; Buckingham, 1994; Coons, 1991;

Graham, 1988; Graham, 1989; Kermis, 1986) regarding the population of older adults needing services will significantly increase by 2010 (including dementia).

#### Section 13 Children's Targeted Case Management (goals):

Historical Context: Children's Targeted Case Management was approved and initiated on 06/16/07. There are currently three case managers and a Director who carries a small caseload.

1. Improve (provide guidance for) the treatment of children and families with fairness, respect, politeness, and compassion using standardized pre-and-post assessment measures;
2. Identify and empower family strengths and natural supports;
3. Identify and empower family culture, and foster natural and community based supports;
4. Improve and collaborate with area agencies regarding overall service delivery and to correctly align services to individual needs;
5. Maintain the regulatory requirements established by the State;
6. Review the performance behaviors located within the Appendix;

#### Section 17 Adult Mental Health – CIS Case Management (goals):

Historical Context: Adult case management was approved and initiated on 05/01/07. There was a total of six case managers and a Director who divided her time between QA&I, a small case load, and CIS program operations and regulatory management. Now, as noted before, there are over 120 clients, with 8 case managers. Consumers fall within Section 17 CIS.

1. Continue to improve (guidance) the treatment of adults and their natural supports with fairness, respect, politeness, and compassion using standardized pre-and-post assessment measures and developing appropriate rapport that is therapeutically beneficial to the consumers and their natural supports;
2. Identify and empower customer, family strengths and natural supports;
3. Identify and empower family culture, and foster natural and community based supports
4. Improve and collaborate with area agencies regarding overall service delivery and to correctly align services to individual needs;
5. Identify the populations that can be considered older adults (with a diagnosis of mental illness, including dementia) and assist in providing the coordination for appropriate housing and services to age in place (see the text from Scheidt & Windley (1998); Pastalan, 1995; and Williams (1991);
6. See performance behaviors as identified within the Appendix;

#### Clinical & Programmatic Consultation and Training (goals):

Historical Context: Individual management employees have provided local, state, regional, national, and international presentations to various target audiences during their careers. Competencies range from adult and children's mental health, psychology, management, QA&I, aging, system evaluation, communication, corrections, and social work.

1. Provide consultation to agencies that are developing programs to serve the following: children afflicted with cognitive challenges and/or mental illness; Adults with serious and persistent mental illness; adults with Alzheimer's Disease and related dementia; and juveniles and adults who are involved within the correctional system (members of the Alzheimer's Association local chapter visited with the Agency in early February, 2009);

2. Provide clinical diagnostic assessment for children, adolescents, and adults who are in need and/or are ordered to receive an evaluation under the judicial system;
3. Provide clinical and programmatic consultation and training to improve the delivery of services for human services and State managed services (contract based);
4. Provide clinical consultation for the Kennebec County Juvenile Fire-Setter Intervention program (as coordinated with the Augusta Fire Department when events occur (completed));
5. Assist by volunteering with the State's Disaster Behavioral Health Response Team (completed);
6. Increase the opportunity that GBS Inc. may participate in various State sponsored "pilot service projects" and/or other scholastically coordinated research projects to improve and maintain service. [Note: Inquiries have been initiated per the request of Dr. Mollie Marty (University of Iowa) and Maxim Health Care (Boston)].

Program Evaluation & Development (goals):

Historical Context: The agency possesses individuals with the expertise and experience to effectively provide consultation, evaluation, program reengineering, root-cause analysis, and general program development.

1. Provide independent consultation and evaluation for agencies that may have experienced a sentinel event or a series of critical events requiring a Failure Mode Effect Analysis or Root Cause Analysis. Under confidential contract, these evaluations are designed to determine effect from events, identify and reduce risk, and improve the system integrity for the purpose of proactive preventative management. [Incrementally increase the number of clients served].
2. Increase the opportunity to evaluate the implementation of various mental health services to determine objectively and the efficiency based upon the assessment of potential barriers, allocation of resources and overall programmatic cost to outcomes.
3. Increase the opportunity to collaboratively provide services that protect the community and individuals needing services (i.e., crisis management, and community corrections, which includes the pursuit to develop an Agency ACT team).

Professional Presentation and Training:

Historical Context: Individual management employees have provided local, state, regional, national, and international presentations to various target audiences during their careers. Competencies range from adult and children's mental health, psychology, management, QA&I, aging, system evaluation, communication, corrections, and social work.

1. Increase the opportunities to provide professional training and presentations to local, regional, and international audiences.
2. Increase the opportunity to provide specialized training for mental health agencies serving children, adults, and older adults within the community.
3. Increase the competency of GBS Inc. service and clinical staff.
4. Develop a workplace-wellness program.

**INITIAL AND FUTURE SERVICE LOCATION:**

The initial office location has been established at 76 Eastern Avenue in Augusta, Maine. The site was chosen based upon the residence of various clients and that the building also serves agencies directly associated with serving children and adults with mental health, psychiatric, neuropsychiatry, dental, dietary, and various physical ailments.

The office is located within ½ mile of Riverview Hospital, a major psychiatric State-managed residence serving adults. Future service site location(s) may require additional office and conference space to support administration, clinical staff, and provide space to efficiently deliver training and development seminars. Exploration of satellite service locations was initiated during the last quarter of 2007, and is currently being reviewed on a monthly basis as the macro-industry climate continues to change.

#### **EMPLOYEES & CONSULTANTS:**

Employees will vary from direct-line staff who may have a MHRT-1, MHRT-C, DSP, BHP, etc, and other related certifications to implement services under regulatory guidelines. [Note: See previous sub-section regarding the educational status of the agency's employees]. Consultants attend to the clinical, nursing, educational, regulatory, and training needs of the agency's employees. [Note: It is recommended that the pursuit of a clinical psychiatrist be reviewed as the agency expands and a full-time QA&I Director is in place].

### **2009 Management Team Profiles**

#### **Harold Graham – President/CEO:**

Harry was born and raised in Iowa and moved to Maine in 2004. He received his BA in Psychology in 1987 from Loras College (Dubuque, IA). He went to Minnesota for graduate school receiving his MA in Psychology of Aging in 1992 and a second MA in Management tailored to mental health service assessment, both from the College of St. Scholastica (Duluth, MN).

He is presently working toward a Ph.D. from Warren National University. He has over twenty years experience working with children and adults with cognitive impairments (challenges); as well as children and adults with serious and persistent mental illness. He also provides private program evaluation and system improvement processes consultation; and has provided presentations for target audiences to local, state, regional, national and international audiences.

Harry is a member of the Chelsea Fire Department (5 years), and also served 5 years as a fire fighter in Buhl, MN driving apparatus and the ambulance. Harry is part of the Kennebec County Juvenile Fire-Setter Intervention program (JFSI-II) and serves as one of the clinical consultants. He also completed the Disaster Behavioral Health course along with other clinicians, to be a mental health/crisis first responder. Harry has been a member of the Knights of Columbus since 1993 (Chapter 5612).

#### **Carol Graham – Vice President – Administration & Finance**

Carol was born in the Bronx, grew up in Westchester County, NY and moved to Maine in 1987. Carol graduated from SUNY Purchase, in Purchase, NY with a BFA. Her career in business began at Hanover Insurance Company in Portland, ME where she was a Surety Underwriter for 12.5 years. She then moved to Augusta, ME where she spent 6 years in the Human Resources department at NRF Distributors. Since the inception of GBS in 2005, she has headed the Administration side of the company, overseeing HR, Payroll, Purchasing, QA, IT and other administrative needs of the company. Outside of work, Carol is a landscape painter, exhibiting her work in summer sidewalk art shows. Carol serves the agency as Vice President.

### **Mascot**

**Hannah Graham** – Hannah is an instrumental part of the GBS Inc. office environment. She is a smart, alert, 3 year old, 35 pound Husky mix. She frequently attends directors meetings, clinicals, trainings, and monitors the whereabouts of Harry and Carol Graham. During the spring, summer and fall months, she monitors the seagull and gray squirrel populations in the park next to the office. [Note: An unrecognized talent of Hannah's ... is in catching mice ... not one mouse has gotten into the home office – old ranch].

Hannah also plays a vital role in employee and client/customer morale and as a learning therapy dog. Her charm and grace are well received by all those who visit the office. Greeting staff and children is one of the areas of her expertise. Often, Hannah peaks her head in the offices of staff to make sure they are alert and aware of her presence with her tail wagging. She knows when they offer her well deserved treats. Hannah knows that many of the administrative staff keeps treats for her on hand. [Note: She has demonstrated her capability to open door handles, much to the amazement of employees].

Hannah reports to Harry Graham, CEO/President of GBS Inc. and to Carol Graham, Vice President of Administration and Finance. She is also attentive (sensitive) to the fire-department codes when the tone for service is activated over the Fire Department radio (dispatch). Hannah is probably the most 'happy' employee (Mascot) as in her mornings she jumps close to five feet by the front door, wags her tail, 'talks', as the Jeep is getting warmed up to come to work. She also enjoys taking Harry's son to school because of the turkeys that are in the middle of the road and an occasional peacock (Hallowell Road – Chelsea).

## **Clinical**

### **Tara Mullins, LMSW-CC, Clinical Director**

Tara graduated *Cum Laude* in 1999 from the University of Maine at Presque Isle with a Bachelor's Degree in Social Work. She then was accepted that same year into the advanced standing program at the University of New England, Biddeford and completed her Master's Degree in Social Work in 1 year, graduating in 2000 with her MSW.

Tara has had extensive experience in the MR field. She has previously worked in an MR waiver home, been a member of a State of Maine MR Crisis Team for 4 years, worked as a clinical therapist with children, adolescents and adults for 3 years, was the DHHS Intensive Case Management Supervisor for the State of Maine Region III (Penobscot, Piscataquis, Washington, Hancock and Aroostook Counties) for 2 years, and Director of Forensics at Riverview Psychiatric Hospital (Lower Saco) for 2 years. She was also the Director of Social Workers at Riverview Psychiatric Hospital for 1 ½, and has been the Director of Mental Health Services at another community based agency prior to becoming Clinical Director at GBS in 2008. Tara reports to Harry Graham.

## **Programs**

### **Section 13 – Targeted Case Management**

#### **Elayne Richard – Director of Children's Targeted Case Management.**

With a Bachelors degree in Sociology, Elayne was a Vista Volunteer in Montana. Her experience was to take MR adults out of State institution and place them into group homes. After, she went to Houston, Texas, where she worked with MR Adults as a case manager and job placement

coordinator. She started at GBS in April of 2007, as our first Children's Case Manager. Her skills were apparent, in therefore; she was promoted to the Directors positions in June of 2008. Since taking on her role, she has increased the population that we service from 50 to 74 children. Her team is exceptional and all work well together. Elayne is truly dedicated to children and to GBS, Inc. Elayne reports to Harry Graham.

## **Section 17**

### **Jennifer Raymond – Program Director Section 17 CIS**

Jennifer Raymond is a 2002 graduate from the University of Maine. She earned her BA in Social Science and completed her social work licensure. Her career in mental health began working with special needs children, as a case manager. Jennifer transitioned into a supervisory position for adult case management.

Jennifer became part of the Graham Behavioral Services family in 2007. She was hired to develop a Community Integration Program and as the Interim QA&I Officer.

The Community Integration Program began serving client's in May 2007. Jennifer was the sole case manager and administrator while growing the program. CIS now serves 100+ clients. Jennifer continues to immerse herself in ensuring the delivery of quality services and providing management oversights for the Community Integration Program. In addition, Jennifer is a State investigator and manages 75% of the Agency's APS systems.

### **Michelle Staples – Program Director, Section 17 Skills**

Michelle was hired at GBS Inc. in July of 2007. She began building the Skills Development Program in October 2007. She currently supervises 6 staff members. Section 17 Skills currently has 22 clients. She is a 1997 Graduate of University of Maine, in Presque Isle, Maine, with a BS in Behavioral Science and a minor in Criminal Justice. She's been in management in the mental health field since 2003. She has a wide-range of experience working within the mental health field as an in-home support worker, Behavioral Specialist 1, adults with mental illness, assistant team leader. In her current role Michelle reports to Harry Graham.

### **Sabrina Doe – Program Director, Section 17 DLSS**

Sabrina has been working in the mental health field for approximately five years. She began as a direct care staff providing in-home support to children with disabilities along with supported employment to adults in the community. She has been working at Graham Behavioral Services for over three years. During the last three years Sabrina has had various role changes within the agency which include providing in-home support to children, assisting with secretarial needs prior to a receptionist being hired, becoming the Assistant of Section 24 Children's Habilitation Services, then a Community Integration Specialist and now her newest position as Program Director for Daily Living Support Services.

Sabrina has been going to college for seven years and has obtained the MHRT/C certification, an Associate's Degree in Social Services and will be obtaining a Bachelor's Degree in Mental Health and Human Services in May of 2009. Sabrina reports to Harry Graham.

### **Denis Wood – Service Coordinator**

GBS hired Denis in the summer of 2006. Since he started with us, he has contributed to our growth and understanding of the business. With Denis' support, GBS Inc. went from serving 12 clients to over 50. Denis has been working in the MR field since 1976, when he transitioned into the Mental Health field in 1992 and is still employed in the industry today. Some of his past roles

include working in the day program as a case manager, job coach, shift supervisor, and team leader. Additionally, he has served the community as a volunteer and direct support worker.

Denis is enrolled in UMA to complete his BA in Human Services. He has furthered his education by acquiring a MHRT/C certification. He's attended Kennebec Technical College for Supervision trainings and has attending various workshops and in-services classes. Denis became an instructor for the Residential Care Specialist training, which is now known as the Mental Health Rehabilitation Tech course; and was actively involved with area committees for the development of course curriculums for different employers. Denis reports to Harry Graham.

## **Section 21 – Adult Waiver Services**

### **Mary Parks – Program Director, Adults**

Mary attended Framingham State College in Framingham, MA. She specialized in early childhood Psychology and computer science. Her professional work experience has been working with adults with developmental disabilities in a variety of capacities. Her first position was working direct care on a self injurious behavior unit at the Glavin Regional Center in Shrewsbury, MA. After that she worked at *The Bridge* located in Northboro, MA with adults in a supported living model. Two years later, Mary moved to Arizona and worked as a team leader/program manager for A.I.R.E.S in both a children's group home and a young adult group home. She moved to Maine and worked for JF Murphy Homes in 2 ICF/MR programs. She then worked as a team coordinator/Staff Supervisor for 16 ½ years at Motivational Services. In January of 2007, she began to work for GBS Inc. as the Program Director working with adults under the comprehensive waiver program (Section 21) Mary reports to Harry Graham, President and CEO of GBS.

### **Brendan Casey- PCP Coordinator**

Brendan has a Bachelor of Science in Psychology from Acadia University in Nova Scotia, Canada. He started at GBS Inc. in Section 24 in August 2007. He then moved into Section 21 and began working for Mary Parks. In November 2008, he was promoted to PCP coordinator for Section 21. Since becoming the PCP coordinator, he has spend his time in the office writing and coordinating PCP plans that help our consumers achieve the things that are most important to them. He still works 10-15 hours in the field and loves the change of pace it provides to his work week. Since joining GBS Inc. qualifications he has acquired a BHP (Behavioral Health Professional), CRMA (Certified Residential Medication Aide), DSP (Direct Support Professional), MHSS (Mental Health Support Specialist), MHRT-1, MHRT-C, and most recently QMRP(Qualified Mental Retardation Professional). Brendan reports to Mary Parks, Program Director

## **Section 24 – Children's Habilitation**

### **Elaine Wilson - Program Director**

Elaine currently serves as the Program Director for Section 24, Elaine earned her B.S. in Elementary Education; M.S. in Vocational Rehabilitation Counseling; Employment Specialist; Certified in Rehabilitation Management Provider from the University of Hartford. She has over Twenty years experience working in the social service field as a direct support professional for Adults with Developmental Disabilities; manager of a day program for Adults with DD; Counselor for Disabled Students Services with SD Community College system; State of Maine Case Manager for Adults with Mental Retardation; Director of Supported Employment Programs for Adults with Mental Retardation; MST Therapist working with families with "at risk" children; and , Community Support/Case Manager for Adults with Persistent Mental Health Illness. She is a published writer for a national publication for direct services workers.

## **Administration Department**

### **Mathew Gauvin - Information Systems Coordinator**

Mathew attended Kennebec Valley Technical College (now Community College) where he completed an associate's degree in computer applications. He has worked in the mental health field for over six years. In another agency, Mathew worked hands on with consumers as an in-home support. Then he was promoted to scheduling assistant where he was able to develop new schedule patterns and utilize his analytical skills.

At Graham Behavioral Services, he works as a computer and network technician as well as with quality assessment and improvement. He used his experience in scheduling to develop a schedule system that is easy to use and maintain. He has also streamlined some of our procedures that have enabled us to be more efficient and improve on the way we deliver services with QA&I. Upon completion, GBS staff will be able to utilize this training and provide a greater measure of quality service to our clients. Mathew reports to Carol Graham, Vice President of Administration and Finance.

### **Danielle Nemeth, PHR, - Human Resources Manager**

Danielle has over 10 years of experience in the human resources field working as a HR Generalist, HR Recruiter, Account Executive, HR Coordinator and HR Assistant. She earned her Bachelors Degree in Human Resources Management with a minor in Business Management at Wilmington University located in New Castle, Delaware. Recently, she obtained her Professional Human Resources (PHR) certificate. Danielle started working for GBS Inc. in October of 2008. Danielle specializes in leadership, employee morale, coaching and development. Although new to GBS, Danielle has already contributed to the organization in many positive ways. Danielle reports to Carol Graham.

### **Brenda Radel – Employee Development Coordinator:**

Brenda has a BA in Communication with a second major in Child Development and Family Relations, MA in Communication (UMO). Brenda has over 17 years experience working with children and adults with developmental disabilities and mental health. She has 10 years experience teaching at the University of Maine, Orono, Husson College in Bangor, and Kennebec Valley Community College in Fairfield. She has also worked for two years as a case manager in Bangor and as a Therapeutic House Parent with Spurwink. After leaving Spurwink, Brenda worked for another agency providing daily living support and eventually came to GBS in 2006. She is now coordinating all trainings for GBS, Inc. and is in the process of finishing the Non-Academic Mental Health Rehabilitation Technician (MHRT/C) Curriculum. Brenda reports to Carol Graham, Vice President of Administration and Finance.

### **Amy Speck – Executive Assistant to the President**

Amy is working toward completing her BA in Human Resources Management and has earned her MHRT-C; she has ten years working with adults with mental illness. She has experience reviewing and updating MAR's for medication accuracy, reviewing quarterly reports and other administrative duties. Amy currently serves as the Executive Assistant to Harold Graham, President/CEO.

### **George Speck – Health and Safety Officer**

George has been with GBS since 2007. He has successfully worked with a wide range of clients in his MHRT-1 capacity. He is currently working toward his MHRT/C certification. He has recently taken on the role of Safety Officer. His responsibilities include safety inspections of the office and

clients residences. He also heads the Activity Committee which plans a variety of events for clients, such as BINGO night, trivia night, and this year a Chili cook-off,

**Billie-Jo Cookson – Scheduling Coordinator**

Billie-Jo has 14 years of experience working in the MH/MR field. She came to Graham Behavioral Services in November of 2006 and primarily worked in Section 21 (MR) but was qualified to work in Section 17 (MH) as well. She attended the University of Maine in Augusta for two years majoring in Mental Health. In November of 2008, Billie-Jo took on the responsibility of Scheduling Coordinator for GBS. Her duties include scheduling direct support staff for shifts, trainings, supervisions, staff meetings and clinical supervisions.

**Administration - Quality Assurance Department**

**Christa Bickford – Quality Assurance Manager**

Christa has an Associate Degree in Business Administration from the University of Maine in Augusta. Christa began her career in the mental health field as a Records Specialist at Richardson Hollow Mental Health Services in Augusta Maine. Her current responsibilities include billing preparation, quality control, and quality assurance and improvement. Her past experience in customer service and attention to detail are her greatest assets. Christa reports to Carol Graham, Vice President of Administration and Finance

**Mark McNeff – QA Analyst**

He has many accomplishments in various departments throughout his career in the mental health field. He started working with children at the elementary level. Then he expanded into agency services for the MR population. Opportunities opened up through the years to continue in the mental health services. Mark has had the opportunity to be a MH director for another agency, and was glad to come to GBS Inc. and expand his involvement as the business has grown. He continues to keep all required certifications to be able to do in home supports for clients and has attended much training to enhance insight in this field. After working in the field, he was recognized by GBS Inc. as an asset and was promoted into Quality Assurance as well as assist in the MH department. He continues to focus on quality of services and business practices for GBS Inc. Mark reports to Christa Bickford, QA Manager.

**Regina Griffin, MHRT/C, - QA Analyst.**

Regina (Gina) Griffin has been an employee with Graham Behavioral Services since September, 2007. After high school, she furthered her education through KVCC in order to obtain her MHRT/C certification. Since November, 2002, she has worked in the mental health field providing a variety of services.

Regina started as a DLSS employee with Richardson Hollow Mental Services (RHMHS), and upon earning her MHRT/C certification in 2005, started a Skills program for RHMHS. While building the Skills program, she started providing case management services part time until she had a full case load. Afterward, she proceeded to open the coast via providing case management services through RHMHS. In September of 2007, RHMHS closed, at that time, Regina became an employee of Graham Behavioral Services providing case management for their Community Integration Services program.

Her current position is that of a Quality Assurance Analyst in the QA department of Graham Behavioral Services where her duties include but are not limited to, monitoring and tracking case management documentation, filing and assisting with monitoring and tracking section 17 records. At this time, she finds her present position to be very rewarding and she is able to utilize her

strengths to ensure that the highest regard for quality of service and accurate records is done as proficiently as possible. Gina reports to Christa Bickford, QA Manager.

### **Administrative & Reception**

#### **Lorena Cunningham- Records Clerk/Intern**

Lorena has been employed with Graham Behavioral Services since the Fall of 2006. She began in the children's program and expanded her position to include records clerk in the office a year and a half later. As a records clerk her duties include processing paperwork for payroll, overseeing document integrity of client's files, answering phones and covering the receptionist desk, and directing and assisting clients and consumers. In addition, Lorena has been working as an intern fulfilling the requirement of her Bachelors degree. She is in her senior year of the Mental Health & Human Service program at UMA. Lorena reports to Amy Speck.

#### **Kathy Rondone – Receptionist**

Kathy has a Bachelor's Degree plus 39 units Graduate Work in Human Services. She has worked in a variety of positions such as a Kindergarten and Special Education Teacher for 11 years, and a Travel Agent and Customer Service Representative for 2 different airlines. As receptionist for Graham Behavioral Services, her duties include greeting visitors to the office, answering phones, taking messages, forwarding faxes, making copies, assisting the CEO, Payroll and Human Resources, and helping staff and clients in any way she can. She is a valuable team player, and adds professionalism to our organization since 2007. Kathy Reports to Amy Speck.

### **Organizational Chart:**

*(see Appendix III)*

### **Consultants:**

Dr. Lewis Lester: Independent Consulting Psychologist – Valley Associates (Augusta, ME).  
Val Morin: Independent Consulting L.C.P.C. – Morin Enterprises (Augusta, ME).  
Dr. Barda Leavitt: Independent Consulting Psychologist (Hallowell, ME).  
Stephanie Truman: Consulting Clinician and Trainer – Amethyst Consulting (Gardiner, ME).  
Bernice “Bunny” Mansir: (employee) RN & CRMA Trainer (Gardiner, ME).  
Greg DeWitt: Independent Seasonal Consulting L.C.P.C. - (Litchfield, ME).  
C.H. “Skip” Spurling, ESQ: Independent Consulting Attorney (Gardiner, ME).  
Mike Anderson: Consulting Finance/Retirement – Choice Investments (Waterville, ME).  
Mike Dunn: Consulting Accountant – McDonald Page & Company (Augusta, ME).  
Elaine Hansen: AFLAC Consultant & Benefit Analyst (Augusta, ME).  
Patricia Gardner CIC, AAI: Cross Insurance (Augusta, ME).  
Barbara Shorette: Independent Consulting RN & CRMA Trainer (Dresden, ME).  
Peter Mauro: Independent Consultant, LSW (Lewiston, ME).  
Dr. Fred White: Independent Licensed Consulting Psychologist (Augusta, ME)

### **Mentors:**

Dan Graham: Attorney – Funkhouser Vegosen Lieban & Dunn, LTD (Chicago, IL).  
James E. Graham: Attorney – Graham Land Acquisition Design (Nevada, IA).  
Dr. Allen Lystiack: Licensing of S.O. Treatment - MN Department of Corrections (St Paul, MN).

Christos Petsoulis, MA, LP: Independent Licensed Psychologist (Duluth, MN)  
Dr. Bambenac: Independent Licensed Psychiatrist – Waterstone Clinic (Duluth, MN)  
Robert McAllister, MA, LP: Licensed Psychologist – Range Mental Health (Virginia, MN)  
Barb Thorne, MA, LP: Licensed Psychologist – Range Mental Health (Virginia, MN).  
Bill Prepodnick, LISW: Case Manager – LeSueur County DHHS (LeCenter, MN).  
Tom Wondowlkowski: Financial Consultant – Weddell & Reed Financial Services (Superior, WI).  
Joey Freyberg: Director Harry Merring Center (Mankato, MN).  
Angie NewHouse: QA&I Riverview Psychiatric Center (Augusta, ME).  
Tom Aaronson: MBA & LCSW Director of Social Work & Spiritual Care (Boise, OI).  
Steve Gunn, MA: QA&I – KidsPeace (Allentown, PA).

#### **Advisory Board:**

Angie Newhouse: Training & Development – Riverview Psychiatric Center (Augusta, ME).  
Allen French: Parent (Madison, ME).  
Ann Marie Fitzpatrick: Parent (Augusta, ME).  
C.H. “Skip” Spurling, ESQ: Independent Consulting Attorney (Gardiner, ME).  
George Russell, MSW: AIDS Center (Ellsworth, ME) *pending*

## **SERVICE DESCRIPTION(S)**

### **CHILDREN’S BEHAVIORAL SERVICES:**

Children’s Behavioral Services fall under three state regulated programs under GBS Inc.; (1) Section 24 (mental retardation, Autism and related Pervasive Developmental Disorders); (2) child waiver under Section 21, and (3) Section 65m/n for behavioral and family support issues. All three service programs provide in-home support staff, either Behavioral Health Professional or Habilitation Specialist, to implement individualized service plans for children between the ages of 5 and 20 utilizing a cognitive behavioral treatment approach. [Note: Special consideration can be provided for children under 5 years of age if appropriate resources are available at the time of the referral]. Services may include goals and objectives to assist children to improve their abilities to function independently, assist and guide children to learn more effective coping skills, to develop and sustain healthy and appropriate relationships, and to teach skills that enable them to reach their full potential.

### **ADULT BEHAVIORAL AND MENTAL HEALTH SERVICES:**

Adult Mental Health and Behavioral Services fall under three state regulated programs under GBS Inc.; (1) Section 21 (adult cognitively impaired (challenged), Autism and related Pervasive Developmental Disorders); (2) Section 17 adult skills development, and (3) Section 17 for mental health and behavioral issues (DLSS). Each service program provides in-home support staff to implement individualized service plans for adults between the ages of 18 to 99. Services may include goals and objectives to assist adults to improve their abilities to function independently, monitor medications more effectively, reduce recidivism and/or relapse, to learn more effective personal coping skills, and to teach skills that enable them to reach and maintain their full potential.

### **CHILDREN’S TARGETED CASE MANAGEMENT:**

Children’s Targeted Case Management Services is the cornerstone in a “wrap-around” service delivery service that encompass the context that both the child receiving services and the family

are centered within the treatment or service process. Case managers assist and empower families to augment their personal strengths through self-determination to independently improve the family structure and dynamics therapeutically. CTCMS, is a comprehensive and therapeutic process. It is required to collaboratively review and support natural strengths, assess and align community resources, and to encourage the therapeutic process to be centralized within the family. Case management services promote the building and fostering of natural and community based supports.

### **ADULT MENTAL HEALTH – CIS CASE MANAGEMENT:**

Adult Mental Health Case Management Services is the cornerstone in a “wrap-around” delivery service that encompasses the context that both the adult receiving services and the natural supports to be centered within the treatment or service process, including in-home supports. Case managers assist and empower families, caregivers, guardians, and natural supports to augment the adult’s personal strengths through self-determination and therapeutically support improvement in quality of life (continuity of care). CIS, is a comprehensive and therapeutic process. It is required to collaboratively review and support natural strengths, assess and align community resources, and to encourage the therapeutic process to be centralized within the treatment modality. Case management services promote the building and fostering of natural and community based supports.

### **CLINICAL AND PROGRAMMATIC CONSULTATION AND TRAINING:**

GBS Inc. is able to provide clinical and programmatic consultation for agencies serving children and adults with cognitive challenges, serious and persistent mental illness, and older adults who have a dementia related illness. GBS Inc. has experience in designing and developing programs and service systems to best serve clients within various environments (residential, assisted living, group-home, nursing home) and to assist those to age in place as deemed applicable.

### **PROGRAM EVALUATION AND DEVELOPMENT:**

GBS Inc. has the demonstrated ability to comprehensively evaluate the effectiveness of services(s) provided to various population groups (i.e., mental retardation, mental illness, corrections, and aging related disorders). Programmatic and service delivery evaluations and assessments are designed to measure desired change over time, programmatic integrity, objectively evaluate sentinel events after they occur, and to provide recommendations to improve the quality of services and the lives of individuals.

### **PROFESSIONAL PRESENTATION & TRAINING (Non-conclusive summary):**

GBS Inc. will be providing specialized presentations and training for local, regional, and international audiences on a variety of topics. [Note: GBS Inc., is the direct descendent of Graham and Associates, a consulting group initially established in 1990]. Some of the presentation topics are provided below:

#### Training Topics:

Mental Health and Aging  
Reminiscence, Life Review, & Self Esteem  
Grief, Depression, Suicide in Aging

Small Business Development (social services)  
Measuring Programmatic and Service Effectiveness  
Root Cause Analysis – Sentinel and Critical Events

Counseling Interventions (Oriented Adults)	How to Develop a Healthy Business Process
Counseling Interventions (Disoriented Adults)	Environmental Assessment (service delivery)
Crisis Prevention & Behavioral Management	Social Service Programmatic Outcome Evaluation
Restraint Free Environments	Strategic Planning for Small Business
Dementia & Alzheimer's Disease	Treatment Plan Development: Objective Measures
Reminiscence through Sensory Stimulation	Quality Assessment & Improvement Planning
Programming for Stages of Dementia	Management of the Sex Offender in the Community
Validation Therapy (communication with the disoriented older adult)	Sex Offender Psycho/Education for Case Managers
Management Ethics & Clinical Outcomes	

## **AGENCY CHALLENGES**

### **COMPETING AGENCIES:**

There are approximately twenty-four service providers who serve children within the Region. There are more than forty-seven providers who serve adults with either cognitive challenges or mental illness within the State. These statistics do not include all of the “mom-and-pop” agencies that either chose not to be included in the state database, or are too small (1 ct +) to be considered an agency.

Currently, there are over 180 children not being served within the state of Maine. This statistic does change as assessed each month and is deemed to under-estimate the true need. There is an overall lack of coordinated services for adults with serious and persistent mental illness (this phenomenon continued in 2008, and will most likely continue through 2009 during the strains of budget cuts and agency organizational behavior. Many clients continue to remain within the state’s psychiatric mental health system.

### **STATE SYSTEMS AND PROCESSES:**

The primary State managed system processes that can impact the start-up of small businesses are the problems associated with cash-flow computer issues (2005/2006). Typically, MaineCare’s reimbursement payment process is 30-days after the service was provided by the agency. However, the reimbursement process can increase to 45-days contingent upon computer problems.

The State of Maine’s social services has been involved in three primary lawsuits, the last being the AMHI Consent Decree which forces the State to provide adequate mental health services for adults with mental health issues and to improve the quality of services. The Pineland Consent Decree and French Lawsuits also were implemented to improve overall services for children. The current statutes of these suits with mandates assist class members to receive timely, appropriate, and quality mental health and support services.

## **MANAGEMENT PLAN (brief)**

### **OPERATIONS MANAGEMENT:**

The CEO/President will oversee operations as programs develop and expand with controlled growth. An Operations Manager will eventually be considered to oversee all operations as programs continue to grow. A Human Resources Manager was hired in 2007 who manages the day-to-day HR regulatory requirements, policy development, and related employee concerns. An administrative assistant will be hired to manage scheduling and another for payroll and other fundamental office needs (i.e., answering the telephone, dictating clinical notes, etc.).

An eclectic ten-phase operations management system has been incorporated utilizing TQM and MBO (*copyright pending*). [Note: See section identifying new hires and logistical positions, pg.5 and review the Organizational Chart in Appendix III].

Measurement Criterion (Goals 2009/10):

1. Continue to implement an agency wide definition of quality as indicated by QA&I performance behaviors (see appendix). This includes the following;
  - a. Increase the utilization of specific performance measurement techniques in 2009/10 (for example – Performance Measurement (Harbour, 1997; Graham, 2003; Ewen, 1982);
  - b. Improve quality auditing of performance behaviors and consumer behaviors through the use of FMEA (McDermott, et al., 1996);
  - c. Improve the overall competency of the employees and staff knowledge (as illustrated in Arthur's (2008) article in Organizational Dynamics, and in strengthening employee leadership skills (Kouzes, et. at., 1997). During 2008 this Agency contracted with KVCC to provide a course of Leadership Training. During 2009 another different segment of Leadership training will be provided to a variety of employees to ensure ongoing improvement in this area;
2. Implement the agency and individual program strategic goals (performance behaviors located within appendix II);
3. Continue to develop methods that improve consumer, client, and customer focus;
4. Continue to implement methods to improve inter-organizational communication (previously reengineered human resources which has had a dramatic impact over the past quarter);
5. Continue to encourage employee involvement and empowerment throughout the development of systems and programs;
6. Continue to implement and maintain a horizontal management structure to maintain employee trust and investment;
7. Continue to provide employees with strategic and tactical information sharing regarding regional changes, policy, State practices, and intra-agency protocol and practices;
8. Implement quality measures gradually (not a quick fix) per program at a rate that is sustainable and measurable (Fogiel, 2000; and Moore, 2004);
9. Continue to streamline inter-organization systems to reduce waste for long-term programmatic improvements;
10. Continue to support coordination of services with other area and regional agencies, institutions, and scholastic centers (i.e., Thomas College, KVCC, UMA, etc);
11. Review and initiate qualifications to determine eligibility in obtaining CARF certification under Behavioral Health (*this is in review*);

12. Further reduce disciplinary turnover by five percent (5%) in 2009;
13. Implement a positive process to reduce disciplinary action through the strategies provided referenced within Grote's (2006) and Stiff's (1995) text (*currently being implemented with employees and administrative staff in 2009*);
14. Increase management competencies in programmatic evaluation and aggregate data analysis (including 'Failure-Mode-Effect-Analysis' and trending behavior/operations);
15. Develop "Critical To Quality" (CTQ) assessment with identified criterion by which consumers, clients, and customers evaluate the quality of the agency's service and to measure their perception of service (also implement the use of the DMAIC method for standardization);
16. Pursue the potential possibility to develop an Agency ACT team; (*as previously stated*)
17. Pursue the potential of having a Vocational Specialist on staff to assist consumers in obtaining active employment (*in process starting in 11/2008*);
18. Increase the competency of employees working with older adults with SPMI to understand the implications of aging upon the symptomology of mental illness including dementia (Storandt & VandernBos, 1995; Smyer, M., & Gatz, M. 1983; Ebersole, 1989)

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## **Appendix I**

### **Total Quality Management & Management by Objectives**

**GRAHAM BEHAVIORAL SERVICES, Inc.**  
76 Eastern Avenue, Augusta, Maine 04330

**CEO to QA&I & Management**

**Memo To:** Management & QA&I (and employees) - ☺

**Cc:** Joe Feero, Human Resources Manager  
Carol Graham, Finance & Human Resources

**Memo From:** Harold Graham, CEO & Interim QA&I Director

**Date:** 08/04/07

**Regarding:** Total Quality Management (TQM) & Management by Objectives (MBO) - ☺

-----  
The purpose of this memo is to acknowledge the frequent inquiry from our fellow employees, colleagues, and supervisory staff regarding the understanding of what is Total Quality Management (TQM) and Management by Objectives (MBO). Briefly stated:

TQM combines the ideas of job enrichment and socio-technical theory. Managers who implement TQM design jobs that empower individuals to make important decisions about product/service quality. The empowerment process encourages participative management, team-oriented task modules and autonomy (Detert, 2000). Leadership style for TQM attempts to move managers toward a certain style – open, supportive, and group centered that encourages the development of collaboration, trust, accountability, and personal existential growth (Graham, 1995).

MBO is a management process that can be interwoven within TQM which superiors and subordinates jointly set goals for a specific time period and then meet again to evaluate the subordinates' performance of those previous goals (Evans & Dean, 2002). It is a philosophy of management which reflects a proactive rather than reactive approach to managing. The intended consequences of the MBO approach include improved contribution to the organization, improved attitudes and satisfaction of participants, and greater role clarity. The MBO model is highly developed and widely used in business, health care, and governmental organizations (Muczyk & Reimann, 1989; Inancevich, Konopaske, & Matteson, 2005).

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References:

Detert, J. (2000, October). A Framework for Linking Culture and Improvement Initiatives in Organizations. Academy of Management Review, 25, no 4, pp. 850-864.

Evans, J. & Dean J. (2002). Total Quality Management. Cincinnati, OH: South-Western University.

Graham, H. (1995, May). Personal Motivation: Factors that Motivated and Unmotivated Individual Care-givers Within the Health Care Industry. Paper presented in the graduate course of Motivation & Management. College of Saint Scholastica, Duluth, MN.

Inancevich, J., Konopaske, R., & Matteson, M. (2005). Organizational Behavior and Management (7<sup>th</sup> ed). McGraw-Hill/Irwin Companies Inc. New York, NY.

Muczyk, J. & Reimann, B. (1989, May). MBO as a Compliment to Effective Leadership. Academy of Management Executive, pp. 131-138.

-----  
**Cc: QA&I Committee**

**GRAHAM BEHAVIORAL SERVICES, Inc.**  
76 Eastern Avenue, Augusta, Maine 04330

**CEO to Agency Employees & Counsel**

**Memo To:** Employees ☺  
Administration ☺  
Program Directors ☺  
Advisory Board ☺

**CC:** Mat Gauvin, Quality Assessment Analyst  
Lana Bickim, Quality Assurance Specialist  
Christa Bickford, Quality Outcomes Analyst

**Memo From:** Harold Graham, CEO/Interim QA&I Director

**Date:** 01/24/08

**Regarding:** DHHS Mental Health Licensing Review (Audit Results) ☺

-----  
The purpose of this memo is to acknowledge your efforts regarding our most recent DHHS licensing review. Two State licensers reviewed our various programs over the past couple days; the exit interview was yesterday. They were very impressed with our services, quality incentives and measurement, and our agencies' method of management. We received no citations. From what information I have, this has not occurred within this region in at least 20 years. Kudos' to all of you. ☺

Some of the licenser's comments:

"This agency is definitely consumer centered";  
"The atmosphere is wonderful!"  
"You have a great team!!"  
"Employees laugh and the consumers know you";  
"There are so many positives ... it was hard to find anything negative";  
"You guys do a great job!"  
"I am impressed on how you set your ... performance behaviors within each program's objectives ... and it seems they are measurable!"  
"Can we share your ideas with other agencies"; *(the answer is 'yes')*  
The Marketing and Strategic Plan: "this is wonderful ... and you actually collect the data you say you are ... wow ... I am impressed!"  
"The charts are incredibly neat and orderly";  
"Very impressed with the implementation of QA&I and the documentation of supervision ... no one else is collecting data or documenting as you are that we've seen anywhere";  
"I really like the idea of teaching safety to consumers ... this is really great";  
"Can you provide training on the benefits of a consistent therapeutic milieu?" *(the answer is 'yes')*  
"Hannah is awesome!!!"

Credit goes to you. I have always stated, service is only as good as the person providing the service and their support. Thank you again. Keep up the great work!! ☺

---

Cc: Dr. Lewis Lester, Consulting Psychologist

**GRAHAM BEHAVIORAL SERVICES, Inc.**  
76 Eastern Avenue, Augusta, Maine 04330

**CEO to Department(s)**

**Memo To:** Denis Wood, Program Director – Section 17 DSP  
Michelle Staples, Program Director – Section 17 Skills  
Jennifer Raymond, Program Director – Section 17 CIS  
Mark McNeff, Senior Rehabilitation Specialist

**CC:** Joe Feero, Human Resources Assistant & Training Coordinator

**Memo From:** Harold Graham, CEO/Interim QA&I

**Date:** 02/28/08 g

**Regarding:** Exceptional Performance (Washington Manor Residence) - ☺ ☺ ☺ ☺

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The primary purpose of this memo is to document the appreciation about the comments expressed to me this morning regarding the performance while serving consumers (customers) at the Washington Manner. Linda André (Director) called me personally to thank us for the reliable and genuine support and service you provide their clients, and the level of comfort and support from case management as many are served under this agency.

Linda stated, “we are happy that you are serving with us ... you are very accommodating and flexible ... the support staff are ‘top-notch’ (meaning James and James) ... Gina is so calm ... and I like the new case manager ... you guys are very good and in my opinion the best company we’ve worked with in ten years”. She will be submitting additional referrals for both case management and daily living supports. Credit goes to your investment and efforts.

Personally (and as previously stated in other kudos submitted today), I very much appreciate that there are employees that have invested their efforts to serve our consumers (customers), and that they enjoy what they are doing consistently. This is what I mean by developing a “therapeutic milieu” for all to benefit and grow. Again; kudos to all of you and your employees, and keep up the great work!!! ☺

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**Cc:** QA&I Team  
Personnel File(s)

**During 2008 we have been very pleased to receive a variety of positive comments from our clients, consumers, guardians, state agencies and other agencies we work with. Shown below are just a sampling of those comments received in 2008**

11/10/08: "I know Sabrina was a great intern, but I didn't know she was employed by your agency. That's great. I am glad that you are enjoying Lorena's work, too. She seems to be learning lots." "It's great to have an ongoing good relationship with your agency." Leslie Ann Costello, Ph. D., UMA Bangor.

10/08/08: "Toni Richard is the best case manager we have joint clients with". " She goes above and beyond". From David Lawrence, LSW at Crisis and Counseling

6/28/08: Thank you for your assistance in developing their APS system. Donna Rubel, Cornerstone, Inc.

6/28/08: Thank you for your willingness to work with us when one of our clients is hospitalized. Thayer Unit, Waterville, Maine.

6/20/08: I am very impressed with the information, statistical inferences and relation recommendations in the FMEA report for our client. Barda Leavitt, Ph.D

3/24/08: (Our employee) "takes things in stride, she is wonderful". A parent of a child client.

2/28/08: "this is the best file I have ever seen...your plans actually target to meet the consumers goals... and I can see that the case managers are following protocols". He was very impressed. Brian Gallagher, Maine CDC

2/28/08: Thank you for the reliable and genuine support and service you provide our mutual client. Linda Andrei, Director. Washington Manor.

### **Organizational Development & Leadership MBO**

**Organizational Development:** A system-wide application of behavioral science knowledge to the planned development and reinforcement of organizational strategies, structures and process for improving an organization's effectiveness (Cumming & Worley, 1993).

**Autocratic & Directive:** This MBO type is clearly best suited for the directive autocrat. Here the supervisor sets goals for the subordinate, gets actively involved in the construction of action plans, and conducts very frequent reviews of goal progress. The leader also maintains complete control of the performance appraisal process, including not only the goals but also the means to accomplish them. Through the autocratic aspect of this version, the leader provides the goals that followers need for overall direction, and through the directive aspect employees are given the detailed structure they need for attaining their goals. [Note: Used when tasks require quick action, no time for active participation, inexperienced or under-qualified subordinates who need extensive follow-up and coaching, when there is an adversarial relationship, staff that may lack significant initiative].

**Autocratic & Permissive:** A leader practicing this MBO version sets goals and objectives independently, but permits followers a great deal of latitude in attaining the goals. Subordinates are permitted to select the means for attaining their goal and objectives and to construct their own action plans with little or no supervision. Periodic reviews are conducted infrequently. The supervisor still guides the performance appraisal process, but concentrates on the degree of achievement, not the means by which progress is made [Note: Suitable for individuals who can create their own structure for attaining goals, but need their supervisor to establish the general work focus that goals provide. Good for employees who have low expectations of involvement in goal setting and decision making and do not need extensive coaching].

**Democratic & Directive:** The supervisor or leader in this MBO invites full participation in goal setting, expecting subordinates to be willing and able to contribute in setting the general direction of their work. However, direction is still used to provide task structure for subordinates. Situations in which this MBO version is appropriate include those with employees who lack the will or follow-through to carry out all the tasks needed to achieve their goals and need the constant feedback control provided by follow-up more than they do the less frequent feed-forward from goal setting. [Note: Democratic and directive MBO is appropriate when employee involvement is important to the decision process, such as in a very complex undertaking involving many interdependent activities].

**Democratic & Permissive:** In a sense, this combination constitutes the textbook ideal, since it allows employees to participate in goal setting as well as enjoy a high degree of autonomy regarding the means by which goals are actually attained. The subordinate guides the performance appraisal process, which emphasizes on degree of goal achievement. There is little need in this type of MBO to focus on the means through which goals are attained. Able, well-trained, experienced and motivated employees who expect to be involved in goal setting and decision making are ideally suited for democratic and permissive MBO. These subordinates can function with a minimum of feed-forward or feedback control, since they already possess internal mechanisms that align their behavior with the organizational objectives. [Note: This version of MBO is appropriate for any organization in which employee involvement has both informational and motivational benefits. However, it requires highly qualified employees, some effective substitutes for personal direction, as well as time to reach consensus. The leader must value the democratic process and have faith in subordinates' abilities, judgments, and motives]. Also allows the systematic development of a personalized business culture that acknowledges individualized accomplishments and exposes/identifies early onset management development needs effectively (with a strong QA&I contingency).

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Source: Muczyk, J. & Reimann, B. (1989). *Management By Objectives as a Complement to Effective Leadership*. The Academy of Management EXECUTIVE, Vol III, No 2. pp 131-138

## **Appendix II**

### **Performance Behaviors (Indicators)**

## **HR Goals for 2009**

Improve job descriptions

Specify job functions and physical restriction requirements  
Write, define and clarify roles of new positions as we experience growth

Increase staff retention rates/lower attrition rate

Dedicate additional funds towards improving recognition

New Hire Thank you cards, condolence cards

Recognize and award employees for outstanding achievements by giving them certificate, praise and other tokens of appreciations

Continue to utilize the HR database (APEX)

Send performance review notices on the monthly bases through APEX

Work with APEX software to develop new reports

Review current documentation forms and redevelop them to be used across the organization to promote consistency and productivity across the organization

Update and write company policies for clarity and documentation of policies.

Update and add specific language and additional information to the employee handbook 2010.

Support front-line staff and Directors

Be available to hear their comments and concerns

Coach directors and employees on professional conduct, disciplinary situations, performance reviews

Improve ongoing knowledge of updated and constantly changing MaineCare Regulations

## **Employee Development Goals for 2009**

1. MHRT/C. In 2009 the entire course of study, with instructors, will be approved and ready to offer. At least two sections will be offered in 2009.
2. Leadership training. The next section will be 12-15 hours over a three month period for administrative staff only. This will be taught on site by Dr White, PhD. Details should be finalized in the first quarter of 2009.
3. Sex Offender Training. This will be a 24 hour course and be taught on site by CEO.
4. Peter Mauro will provide on-site trainings for office staff. With a goal of 3 trainings per year at 1-2 hours each.
5. Outside Providers. We will increase utilization of Barda Leavitt, Ph.D this year to 48 hours of on-site training on a variety of topics applicable mainly to direct care staff (MHRT-1, DSP, CSS etc.)
6. Stephanie Truman will provide 48 hours of on-site training on a variety of topics applicable mainly to direct care staff (MHRT-1, DSP, CSS etc.)
7. This Agency contracts with Maine General for our EAP program. They offer trainings on a variety of topics with the cost included in contract. We will explore their offers and may offer those as appropriate to our needs.

**Section 13**  
**Children's Targeted Case Management**

**Management Variables (Performance Behaviors)**

Management Variable	Expected rate or percentage
<b>Supervision:</b>	
Clinical: 4 hours/month(clinical director provides)	90%
Administrative: 2 hours/month(director provides)	90%
<b>Continuing Training</b> 20 hours/annually	95%
<b>Maintain Productivity standards</b> 2 contacts/monthly; 20-24 billable hours/weekly	95%
<b>Maintain Wait List (director)</b> Report to DHHS monthly	100%
<b>Compliment to Complaint Ratio</b>	8 to 1
<b>Complete Intake Packet as referred (director)</b> Intake, referral, comp assessment, CAFAS EFS, HIPPA, Releases, Evals, CHAT	100%
<b>Complete initial paperwork as referred</b> Comp, ISP, Releases, Safety plan within 30 days	95%
<b>Action Notes / Billing</b> Completed and submitted weekly	100%
<b>90 day reviews for each client / annual reviews</b>	95%
<b>APS registration and continued stay reviews (director)</b> Enrollment, prior authorization continued stay review as needed to maintain client eligibility	100%
<b>Assure completion and accuracy of case manager work prior to clinical review (director)</b>	100%
<b>Assure productivity standards are maintained (director)</b>	100%
<b>Provide individual supervision to assure expectations are met and staff is supported; provide substitution for case managers when needed(director)</b>	100%

**Section 17**  
**Daily Living Support Services**

**Management Variables (Performance Behaviors)**

Management Variable	Expected rate or percentage
<b><u>Employee Variables:</u></b>	
Employees meet clinical supervision	90% (supervision hours determined by total hours)
Employees meet admin supervision	90% (at least 1 hour per month)
Attendance clinical and QA	100% (Clinical team)
Attendance of staff scheduled	95% (staff attendance, aggregate data analysis)
Employees meet training requirements	95% (CPR/FA, MANDT, CRMA, MHSS=MHRT1)
<b><u>Client Specific Variables:</u></b>	
Referral packet	100% (diagnosis, locus, problem need statement)
In Home Support Plan	100% (completed during intake, service agreement)
Comprehensive Assessment	100% (completed within 30 days of intake)
Crisis plans implemented	95% (completed as part of intake)
Quarterly Service Plan meetings	95% (report completed and signed on time)
Case note completion	90% (networking note completed)
Follow-up incident reports	95% (timeliness and monthly summary)
<b><u>Program Specific Variables:</u></b>	
Master files (up to date)	95% (based upon the DHHS checklist)
APS/Managed Care data entry	100% (complete and timely, PA & CSR)
<b><u>Quality Assurance Indicators</u></b>	
QA&I Monthly Incident Report	95% (summary monthly)
QA&I trending data analysis	95% (QA&I requirement)
Compliment to Customer Complaints	8 to 1

## Adult Section 17 Skills Development

### Management Variables (Performance Behaviors)

Management Variable	Expected rate or percentage
<b><u>Employee Variables:</u></b>	
Employees meet clinical supervision	90% (supervision hours determined by total hours)
Employees meet admin supervision	90% (at least 1 hour per month)
Attendance clinical and QA	100% (Clinical team)
Attendance of Staff Scheduled	95% (staff attendance, aggregate data analysis)
Employees meet training requirements	(95% (CPR/FA, MANDT, CRMA, MHSS = MRHT-1
<b><u>Client Specific Variables:</u></b>	
Referral packet	100% (diagnosis, locus, problem need statement)
In Home Support Plan	100% (completed during intake, service agreement)
Comprehensive Assessment	100% (completed within 30 days of intake)
Crisis plans implemented	95% (completed as part of intake)
Quarterly Service Plan meetings	95% (report completed and signed on time)
Case note completion	90% (networking note completed)
Follow-up incident reports	95% (timeliness and monthly summary)
<b><u>Program Specific Variables:</u></b>	
Master files (up to date)	95% (based upon the DHHS checklist)
APS/Managed Care data entry	100% (complete and timely, PA & CSR)
<b><u>Quality Assurance Indicators</u></b>	
QA&I Monthly Incident Report	95% (summary monthly)
QA&I trending data analysis	95% (QA&I requirement)
Compliment to Customer Complaints	8 to 1

**Section 17  
Community Integration Services**

**Management Variables (Performance Behaviors)**

<b>Categories</b>	<b>Expected/Desired</b>
<b>Supervision; clinical and administrative:</b> Based on data collection; supervision log	90%
<b>CIS Meet Training Requirements:</b> MHRT-C on staff is current	95%
<b>CIS Continuing Credits 20 Annually</b> CIS met requirements via training, on file with HR	20 hours
<b>Maintain Productivity Standards</b> 2 Contacts, 24 contact hours	94%
<b>On Call Hospital Coordination</b> Coordinate supports via on call	100%
<b>Hospital Discharge Coordination</b> Participate in discharge, contact client	95%
<b>Manage Wait List/Status report</b> Report Monthly to DHHS	100%
<b>Complement to Complaint Ratio</b>	8 to 1
<b>Complete Intake Packet, as referred</b> Locus, DHHS Enrollment, Intake Assessment	100%
<b>Complete Initial Paperwork, as referred</b> Hippa, Rights, Comp, EFS, ISP, Crisis	90%
<b>Action Notes/Billing Calendar</b> Turned in Weekly	100%
<b>Incident Reports</b> Internal and DHHS	96%
<b>DHHS Status Report, Quarterly</b> Quarterly reports completed and forwarded To Jerrold Melville @ DHHS, by the 10 <sup>th</sup> .	100%
<b>APS authorization and continued stay review</b> Enrollment, prior authorization and continued stay to be maintained, as needed.	95%

## Section 21 Goals for 2009

- Consumer, guardian & DHHS satisfaction of services provided by DSP's and GBS
- Census – number of consumers satisfactory for financial stability
- Employee specific
  - Staff meet continuing education requirements
  - All certifications are current
  - Administrative supervision completed and documented
  - All staff have DSP and CRMA certifications within 1 yr of employment
  - Employees are matched well with consumers
  - Improved employee attendance to shifts, staff meetings etc.
- Consumer specific
  - Monthly action plan progress notes completed within 2 weeks of month end
  - Quarterly meetings scheduled for required consumers and minutes written up and disseminated.
  - Annual PCP's held timely and written up with signatures within 30 days.
  - Ensure medical and ancillary appointments are current
  - Employee schedules meet consumers needs

**Section 24  
Childrens Day Habilitation**

**Management Variables (Performance Behaviors)**

<b>Management Variable</b>	<b>Baseline</b>	<b>Expected Rate or Percentage</b>
Employees Meet Clinical Supervision	80% (Jan, 07)	90% (employees meet clinical supervision)
Employees Meet Admin Supervision *	75%	90% (at least 1 hour per month – same as office)
Direct Employee Supervision (on-site)	50%	90% (at least 1 hour per employee per month)
Direct Employee Supervision (office)	(Until 10/08) 75%	90% (at least 1 hour per employee per month)
Employees Meet Training Requirements	100%	95% (CRP, BHP, CPR, First/Aid, etc.)
Panel Reports Submitted on Time	100%	92% (12) (Panel reports due by the 10 <sup>th</sup> )
DHHS Quarterly Report(s) on Time	100%	100% (4) (QA reports due 30-days after quarter)
Budget Mailed within 30 days	100%	100% (mailed within 2 wks from CE referral)
Completed Referral Packet (submitted)	100%	100% (CHAT, Budget, SP, Psychological)
Behavioral Plans Implemented **	N/A	95% (new criterion based upon intern hire)
QA&I Trending Data Analysis ***	N/A	95% (QA&I requirement)
Quarterly Service Plan Meetings	90%	95% (quarterly report completed & signed on time)
Case Note Completion ****	90%	90% (case note completed after meeting – wk agenda)
Attendance CR (clinical supervision)	100%	100% (Dr. Lester, Val Morin, Rick Condon, etc.)
Meet Annual Continuing Ed rq	150%	150% (Must meet regulatory requirements)
Follow-up – Incident Reports *****	N/A	95% (Timeliness & monthly summary to QA&I)
QA&I – Monthly Incident Report	N/A	92% (Submit Monthly Incident Report Summary)
Staff Scheduled Attendance *****)	N/A	96% (staff attendance – aggregated data analysis)
Master Files (Up-To-Date) *****)	100%	95% (based upon the DHHS Checklist)
Compliment to Complaint Ratio	TBD	8:1 (ratio documented – 87.5 approval rate)

**Section 24**  
**Childrens Day Habilitation**

**Management Variables (Performance Behaviors)**  
**Continued**

\* Indicates administrative supervision provided by the Program Director. Office administrative supervision can be allocated to this tally. Staff meeting hours do count for administrative supervision; however, only for the total administrative support. The Program Director needs to provide a minimum of 1 hour of one-to-one (face-to-face) documented contact with their employees in regard to the consumer being served per month.

\*\* A graduate level intern will be developing behavioral plans specific to Section 24 consumers. Baselines will be assessed accordingly. Evaluation criterion is based upon the actual implementation and monitoring of the behavioral plans (are employees implementing the plan correctly? Is data being collected? How is the data being analyzed? Are recommendations being developed and implemented to meet the changing programmatic needs?). Plans are required to be implemented continuously. Measurement interval is each week (data review).

\*\*\* Presently, the director's assistant is completing the programmatic trending data analysis. Trending and behavioral representation patterns should be within a graph format/template and included within the quarterly service plan meetings. The measurement interval is each month (data review). [Note: Some consumers may require a measurement interval of a week contingent upon the acuity of the behavioral symptoms and/or level of safety risk (clinical team decision)].

\*\*\*\* Case notes are required to be completed after any significant "type" of meeting which includes, but may not be limited to the following: PET, Quarterly ISP, Behavioral Meeting, Monthly Meeting with Team, Emergency Meeting, Clinical Meetings pertaining to a served consumer, Treatment Team Meetings, IDT Meetings, Serious Incident Events (report), and/or a meeting with Family or other treatment team members regarding the status of the child being served. [Note: Case Notes are also required when a significant event or shared information that would impact services is communicated over the telephone to the Program Director].

\*\*\*\*\* Incident report follow-up has not been previously tracked through computer for 2006. However, each Program Director must develop a monthly tracking system to present to QA&I that summarizes the number, type of event, and the frequency per consumer per month (due within the first 10 days of the month for analysis). It is the responsibility of the Program Director to inquire about developing and utilizing a data base with QA&I (Matt Gauvin).

\*\*\*\*\* Staff attendance data is collected; however, as of January 2007 this information was not computerized and/or collected systematically. Staff "call-outs" are considered a hit for what ever reason. Call-outs are calculated to the overall service shifts per month. Consumer cancelled shifts are not considered a "call-out". It is the responsibility of the Program Director to inquire about developing and utilizing a data base with QA&I (Matt Gauvin).

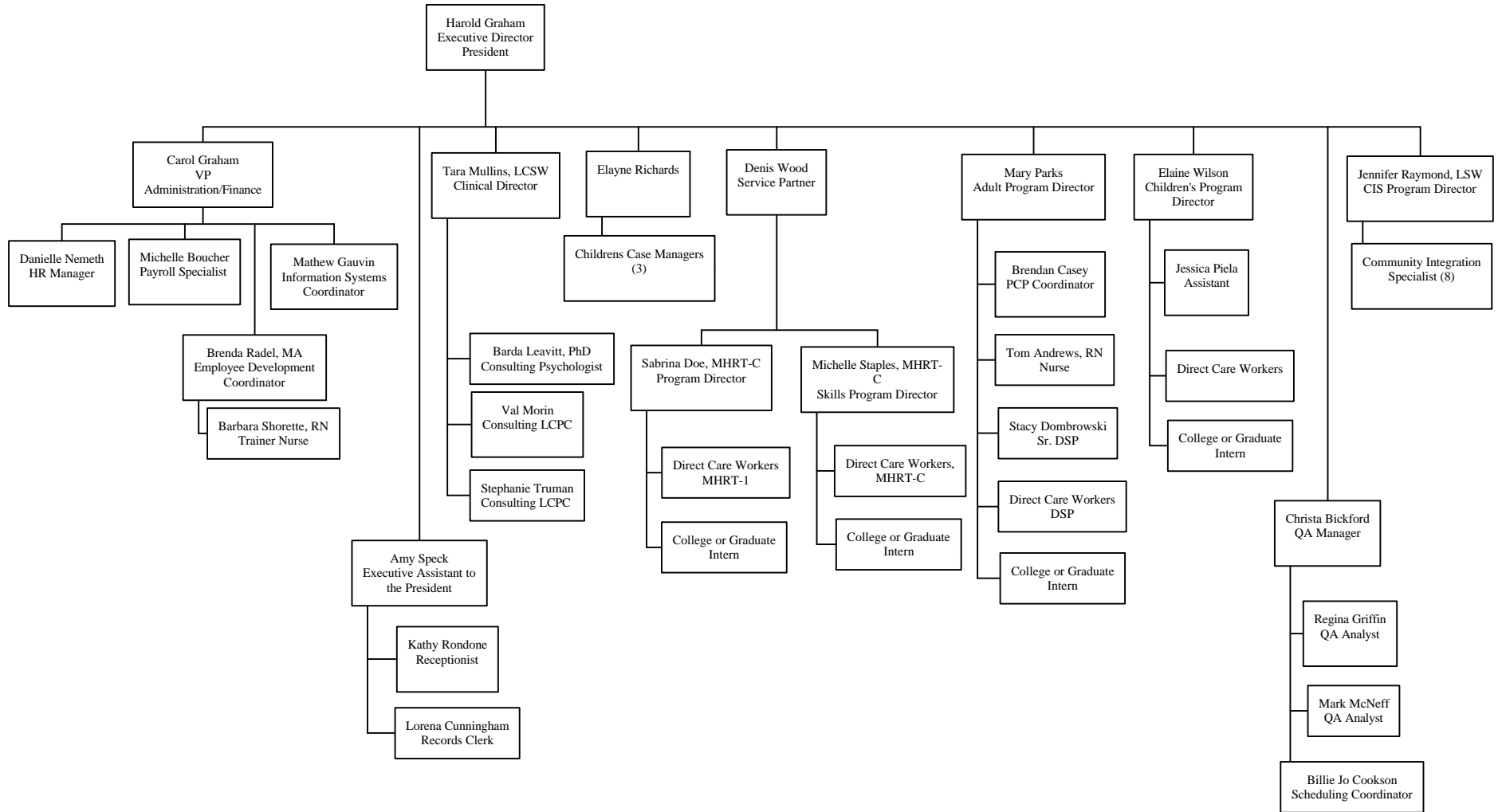
\*\*\*\*\* The determination of Master File regulatory requirements will be assessed either by a DHHS pre or actual file audit reviews, and through random QA&I audits completed by the agency by designated personnel. Document investment is determined by the previously supplied "check-list" as submitted by Mike Austin (DHHS-QA) in April, 2006. Copies of the checklist have been supplied and are available.

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## **Appendix III**

### **Organizational Chart**

## Graham Behavioral Services, Inc. Organizational Chart



Specific vertical location on this chart does NOT denote supervisory responsibility. Only relationship lines denote supervisory function over that person.  
Current information as of 3/27/09

## Appendix IV

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