



**WASHTENAW COUNTY COMMUNITY MENTAL HEALTH
ADMINISTRATION**

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COMMUNICATION

TO: Suzanne Shaw, Chair
Board of Commissioners

THROUGH: Robert Guenzel
County Administrator

FROM: Mark Ptaszek, Interim Director
Community Mental Health

DATE: January 16, 2002

Re: Communication Regarding Community Mental Health's Quality
Improvement Plan and Structure

Attached to this memo you will find a copy of Community Mental Health's Annual Quality Improvement Report and the Annual Quality Improvement Plan for FY 2001-2002. As you are aware we are accredited by the Joint Commission on Accreditation for Healthcare Organizations (JCAHO). As part of that accreditation process the Board of Commissioners can expect to receive copies of the annual Quality Improvement Plan and an overview of the CMH Quality Improvement Structure each year.

If there are any questions, feel free to call me at 484-6620.

Washtenaw County Community Mental Health

PROGRAM EVALUATION AND QUALITY IMPROVEMENT SYSTEM 2001/2002 Annual Plan

I. Quality Improvement Program Mission and Values

The mission of the Quality Improvement Program at Washtenaw County Community Mental Health (WCCMH) is to improve the quality of life for those we serve. The Quality Improvement Program reviews, evaluates and monitors outcomes in order to ensure improvement and satisfaction of all stakeholders while insuring the health and safety of consumers and the community.

Based on the Deming model of Plan, Do, Check, Act the program values teamwork, consumer defined quality, systems thinking, empowerment, individual competence of staff and consumers, and community involvement.

II. Design and Model

The activities of the Quality Improvement Program fall in three areas: Operations, Clinical and Benchmarks. Reporting directly to the Senior Management Team and ultimately to the Board, each area has defined roles and responsibilities.

Operations:

Facilitated by a senior management staff person, that is also a member of the senior management team, the Operation Subcommittees address a series of mandated, day-to-day functions that require consistent monitoring. These committees develop annual work plans and report quarterly to the management team. Using the Plan, Do, Check, Act Model, each committee reviews the status of the organization in that area, defines potential areas for improvement and implements performance or process improvements as necessary. Below is a brief description of each committee.

Behavior Management Committee:

The Behavior Management Committee:

- Reviews, revises and approves or disapproves all use of medication when prescribed solely for the purpose of behavior control;
- Reviews, revises and approves or disapproves any intervention which utilizes any other restrictive, intrusive or aversive techniques.
- Reviews all previously approved interventions every ninety days from the date of initial approval;
- Recommends policies and procedures regarding behavior management practices.

A member of the Behavior Management Committee provides regular updates regarding significant trends, treatment practices and training needs to the Senior Management Team. The Medical Director participates in the committee.

Clinical Records Team

The Clinical Records team develops policies and procedures related to documentation of services, staff training on clinical documentation and coordinates the clinical record audit process. The team is comprised of representatives of each major program element. Programs complete an audit of records and submit the results to the Senior Management Team.

Grievance and Appeals

Consumers are routinely notified of changes in levels of care and provided with information on their grievance and appeal rights under federal and state law. The regional hearings officer provides training on grievance and appeal procedures to staff. The local hearings officer works collaboratively with the regional hearings officer in handling any appeals or grievances that are filed. The reports to management team include information on the number of appeals, the outcome of appeals and any actions needed to address the nature of the appeal.

Infection Control Committee:

The Infection Control Committee coordinates the activities of the Infection Control Program and provides an essential element for risk reduction and ongoing opportunities for practice improvement.

The Infection Control Committee:

- Develops policies and procedures regarding the prevention, identification and control of infection and communicable disease;
- Develops and monitors of a system for the reporting, evaluating and recording of infectious and communicable disease;
- Reviews the agency's response to documented reports of infectious or communicable disease and the potential for infection or communicable disease;
- Develops in-service programs to assist in increasing staff's awareness of, knowledge and skill in maintaining a safe and healthy environment;
- Provides a mechanism for staff to communicate concerns, issues and suggestions concerning the prevention and control of infectious and communicable disease

Person Centered Planning

The Person Centered Planning Committee is comprised of representatives from across the organization and monitors the implementation of Person Centered Planning. The committee routinely provides training for all new staff in the model, assists programs in problem solving issues as they rise and collects and analyzes data on the implementation process.

Recipient Rights Committee:

The Office of Recipient Rights holds responsibility to protect the rights of recipients of service in compliance with the Michigan Mental Health Code and Department of Community Health Administrative Rules. The Recipient Rights Officer coordinates the activities of the Recipient Rights Committee which:

Assures that the Office of Recipient Rights prepares semi-annual data and an annual report of the rights protection system for dissemination to the Senior Management Team.

The report includes:

- Aggregate data regarding all reports of alleged violations including the number received, investigated, and resolved;
- Number of substantiated violation of rights by category;
- Sources of complaint,
- Remedial actions taken by type of action;
- Copies of minutes of the Recipient Rights Committee;
- Names of members of the committee;
- A summary of training activities;
- Other significant rights activities

The Office of Recipient Rights reviews and analyzes reports of unusual or critical incidents. The ORR identifies patterns, trends and high-risk incidents. Reports on data derived from Incident Reviews are presented to the Senior Management Team. Reports include trend reports by incident type, program and service provider. The ORR makes recommendations to Senior Management Team regarding service delivery, staff training and treatment protocols based upon analysis of Critical Incident Data. Individuals programs also review Critical Incident Data and submit recommendations addressing unusual trends to the Sr. Management Team.

- **Review of Deaths:** A member from the Office of Recipient Rights serves as a liaison between the Review of Deaths Workgroup and Senior Management Team. The workgroup meets on a formal basis to review all deaths that occur within WCCMH. The WCCMH Medical Director, the Medical Examiner and representatives from various program areas review all deaths and make recommendations based upon review. The liaison brings recommendations developed by this workgroup to the Senior Management Team to formulate strategies in implementing these recommendations.

Safety Committee:

The Safety Committee monitors department wide safety. The Committee, in conjunction with County Risk Management and Human Resources staff, develops recommendations for policies, procedures, training and work place practice which promotes a safe environment for all consumers and employees. The Safety Committee reports issues and areas of concern and overall status of the committee to the Senior Management Team.

Staff Development Committee:

The Staff Development Committee coordinates staff development activities throughout the agency and works in conjunction with the County Human Resources Department on county wide staff development initiatives. The Staff Development Committee identifies staff training needs/ interest and develops an annual plan of trainings to be coordinated through the Staff Development Committee.

The Staff Development Committee produces an annual schedule of trainings including training in Recipient Rights, confidentiality, health and safety, cultural diversity and other areas of interest and need related to the development of clinical knowledge and skills associated with service delivery.

Ad Hoc Committees:

Ad Hoc Operations Committees are appointed as needed. Examples of Ad Hoc Operations Committees include Ethical Practices, Accreditation, Strategic Mapping Team and HIPAA Compliance.

Clinical

Initiatives that address specific improvements in the quality of clinical care delivered by the organization are developed, reviewed and monitored by the Quality Innovations Committee (QIC). The Innovations Committee organizes its work around performance improvement initiatives, process improvement initiatives and sentinel events. Performance improvement initiatives are generally defined as those initiatives that will refine clinical care models or develop new approaches to services. Process improvement initiatives address needed changes in administrative processes that influence how clinical services are delivered. Sentinel events are defined as those events that result in a loss of life and/or the permanent loss of functioning of a body part. Review of these events includes the use of structured root cause analysis format.

Issues come to the attention of the QIC through QI suggestion forms, strategic planning processes, open agenda items, Innovations team member's ideas or by any other person or group contacting the team member. From these suggestions work groups are formed to address the issue. Each work group follows the same 12-step process to address the issue:

- What is the issue?
- Who are the stakeholders
- What do they want?
- What are the gaps between what they want and the current reality?
- Brainstorm solutions
- Agree upon criteria for solutions
- Evaluate solutions based on criteria
- Choose a solution
- Design an implementation plan including monitoring function
- Implement the solution
- Communicate the solution
- Celebrate success!

Each fiscal year several specific strategic planning areas are defined for Quality Innovations. Each strategic planning area is evaluated in terms of the outcomes desired for consumers, staff and program managers. Goals and objectives are defined for each stakeholder group and timeframes for completion of the task are set. The Quality Innovations Committee monitors the progress in each area, reporting back to the management team on a quarterly basis. The strategic planning areas for FY2002 is attached to this document.

Benchmarks

The benchmarks aspect of the Quality Improvement Program is actually an overlay for the total program and serves as the ultimate monitoring of the system. With a defined vision to be a world class behavioral health service provider Washtenaw CMH measures itself against national, state, regional and local indicators.

National Standards

The organization is currently using four sets of national standards as benchmarks: the Organizational Capability Study, the Child and Adolescent Functional Assessment Instrument (CAFAS), the Basis 32 and the Joint Commission on Accreditation of Health Care Organizations.

The Organizational Capability study is a biennial survey of all staff and provides data on job satisfaction and work environment issues. The results for CMH are compared against leading private sector corporations.

The CAFAS and Basis 32 are national functional assessment tools that provide us information on how well consumers are functioning based on standardized instruments. The organization tracks scores on these instruments over time to evaluate outcomes of service.

The Joint Commission establishes national standards for the quality of care provided by healthcare organizations. Achieving accreditation benchmarks the organization against other providers in the country.

State Performance Standards

The Michigan Department of Community Health measures the organization's performance on over 30 performance indicators in the areas of access, effectiveness and efficiency. Quarterly reports are issued to all stakeholders by MDCH comparing the level of performance of each Community Mental Health Center in the State. The organization strives to achieve 100% compliance with all performance standards.

Regional Performance Standards

Washtenaw County Community Mental Health participates in the regional Community Mental Health Partnership of Southeast Michigan, which includes two other contiguous Mental Health Centers. The regional affiliation uses the statewide data to prepare a document that compares the cumulative performance level of the affiliation with all other Boards in the State. The goal for the affiliation is to exceed the median level of performance of all other Boards.

Local Performance Standards

Within Community Mental Health, each major program proposes a program specific Outcomes Evaluation Plan. The program specific system addresses all services or programs offered and is tailored to the scope and nature of services provided by the program. Programs are responsible for:

- Recommending appropriate measures of efficiency, effectiveness and consumer satisfaction for each program/service area
- Collecting and analyzing data on the chosen measures
- Suggesting quality improvement projects that address trends in the data
- Reporting quarterly to the management team on these issues

The Quality Innovations Committee reviews the plans and the outcomes reports and develops recommendations for areas of improvement. The reports are made available to staff and incorporated into the consumer newsletter.

The organization also collects productivity data on staff providing direct services to consumers. The productivity data is reviewed quarterly at the management team and is used to determine needed resource adjustments to programs.

III. Accountability

The Executive Director is responsible and has authority for the overall development and implementation of the Program Evaluation and Quality Improvement System and provides regular reports on Program Evaluation and Quality Improvement activities to the Board. The Executive Director ensures that the goals and objectives of evaluation and improvement activities are aligned with the agency mission. The Executive Director provides key leadership in expressing values and principles of Quality Improvement.

The Medical Director participates in the Quality Improvement System including membership on the Quality Innovations Committee and membership on the ongoing activities that ensure quality services are being delivered. This includes, but is not limited to the following: Behavior Management Committee, Review of Deaths and sentinel event reviews. The Medical Director is actively involved in the programmatic elements of service delivery.

Program Managers provide active leadership in the development and implementation of all elements of the Program Evaluation and Quality Improvement System. Managers insure access of all staff and consumers to quality improvement mechanisms, provide opportunities for involvement in program evaluation activities, and identify and develop resolutions to barriers to participation. Managers insure that the results of program evaluation and quality improvement activities are included in the service planning and delivery process.

Employees participate in the Program Evaluation and Quality Improvement System, including the development of systems and mechanisms, the development of specific indicators, the gathering and analyzing of data and the development of recommendations. Employees participate in the identification of specific problems, development of solutions or improvements and review progress toward improvement strategies.

Consumers are encouraged to participate in the development of improvements, in the development of objectives and outcome indicators, including the analysis of data and making recommendations to enhance service delivery.

Washtenaw County Community Mental Health
Quality Improvement Innovations Team
2001 – 2002 Performance Improvement Plan

I. Background

The Quality Improvement Innovations Team, a group of staff and consumers dedicated to service improvements at Washtenaw County Community Mental Health, met and conducted an annual planning process to identify goals for this fiscal year. This document will delineate their process with the goals that they will be working on this year.

II. Purpose

The purpose of the planning session was to identify goals that are meaningful to our customers. Thus, group members consider the following as critical pieces of information in their planning process: a) organizational context b) organizational capability study c) data currently available to the Innovations Team d) Washtenaw County Community Mental Health's strategic plan.

III. Goal Areas

The group identified the following as goal areas that they would like to address in the upcoming year: a) quality improvement professional development b) consumer leadership c) staff retention d) quality improvement membership diversity.

a. Quality Improvement Professional Development

Purpose: The purpose of this goal area is to provide staff and consumers with concrete knowledge of quality improvement processes. For example, two arenas the group recommends further training in are 1) Quality Improvement problem-solving and b) Facilitating work-groups. This will help ensure that a true 'learning organization' culture flourishes within mental health services, leaving people empowered to improve services and create innovative solutions to service delivery challenges because they have been provided with the tools to do so.

Objectives:

1. Offer training organization-wide in QI problem-solving and team facilitation.
2. Ensure that at least one person from each program or unit is trained in Quality Improvement.

Target: Quarterly training offered beginning February 28, 2002.

b. Consumer Education, Consumer Leadership and Customer Service

Purpose: To ensure that consumers receive excellent service and that they are able to advocate for improved services.

Objectives:

1. Ensure that performance indicators are useful by conducting a review of current indicators.

2. Adopt a conceptual model that will assist guide us as we conduct this process.

Target: April 28, 2002

c. Staff Retention

Purpose: To increase staff retention at the supports coordinator level.

Objectives:

Monitor the progress of the recommendations of the QI work-group that was created to solve this issue.

Target: March 30, 2002.

d. Quality Improvement Membership Diversity

Purpose: As the Quality Innovations Team is responsible for the design and implementation of an agency-wide plan, it is critical that a variety of voices are heard. Thus, the group emphasizes the importance not simply of the management level staff, but of staff who work directly with consumers in different areas and with the consumers themselves.

Objectives:

1) Write policy describing membership

2) Review current membership for compliance with policy.

Target: May 30, 2002.

Review of Performance Improvement Activities 2000/2001

Washtenaw County Community Mental Health Department

The Senior Management Team is responsible for a quality program that is integrated with the day to day functioning of the organization; one in which consumers play a vital role, and provides staff below the management level a meaningful way to participate in quality issues. Performance Improvement activities include Operations, Clinical, and Benchmarking.

Operations

The Senior Management Team is responsible for reviewing and analyzing the data collected and reported by Staff Development, Behavior Management Committee, Grievance and Appeals, Person Centered Planning Implementation, Clinical Record Audits, Safety, Infection Control and Recipient Rights. This year these reports are presented first to the CMH Leaders for their review and suggestions and improved communication. This group includes supervisors, service coordinators, Deputy Directors and management staff.

Summary

Behavior Management Committee monitors and approves the use of restrictive, aversive, or intrusive interventions, or a combination of these interventions. The Behavior Management Policy was revised to be consistent with JCAHO standards. Review of premedication/restraints for dental care with persons with developmental disabilities was implemented successfully. Lack of current consents for treatment was identified and corrected.

Clinical Record Audits were completed this year using a revised format. The format allows for a review of the completeness of the paper forms, and also for a review that includes clinical content. Youth and Family Services report well documented clinical information throughout the case records. There are clear connections between assessments, needs are reflected in Person Centered Plans and periodic reviews and termination summaries reflect the progress and future needs of the client. Community Services (services for persons with developmental disabilities) noted strengths in the area of Rights and Consent and Health. Adult Services noted improvement in the presence of progress notes in the charts. Both Adult Services and Children's services mentioned improvement needed for documentation of Aims and lab tests in the records.

Grievance and Appeal. There was a variety of activity over the past year. The most frequent category was request for Local Dispute Resolution Meetings at 10 requests. Two of these requests resulted in action to meet the clients' needs. Most requests were withdrawn, two requests were resolved through the person center planning process or other clinical intervention. There were two requests for second opinions, one was for denial of hospitalization. The decision to deny hospitalization was upheld. The other request for second opinion was withdrawn. Of the four requests for DCH Administrative Hearing, one was dismissed for failure of the client to show, and the others were withdrawn.

The Grievance & Appeal process will be modified to a regional model in the coming year.

Infection Control is a combined committee of Community Mental Health and Public Health staff. They implemented a surveillance and identification system for signs, symptoms and reports of illness or infection, as well as for "serious communicable disease" that requires immediate reporting to the Public Health /Disease Control unit. A quarterly review was implemented to assure staff use standard prevention oriented practices related to the use of sharps, needles, or other potentially infectious material. One blood borne pathogen incident was reported.

Person Centered Planning committee has continued to monitor the implementation of the person centered planning guidelines. Training for adult services staff included Essential Life Style Plan and Family Oriented Therapy. A person centered planning coordinator for adult services was hired and has begun a special training effort with adult services staff. Staff attended an annual conference in Lansing. Staff for services for persons with developmental disabilities work with Self Determination Initiative coordinator on skill building sessions. Senior Management Team requested the committee pull together the numbers of clients with completed person centered plans, and data on the satisfaction of clients with

their plans. Although no unit has achieved 100% implementation of person – centered plans, the average completion rate is around 85%. Even with client requests to postpone the planning process, and the difficulties posed by consumers who move frequently, 90 % completion is a realistic goal. Customer satisfaction among those who complete the survey remains high at approximately 90%.

Recipient Rights continues to report aggregate data semi-annually. Program analysis of incident reports is very useful in identifying trends or negative patterns and implementing modifications in procedures or training to staff as needed. Staff training was emphasized this year. Work continued on developing a regional rights network as well.

Safety committee assures that the elements of security, hazardous materials and wastes, emergency preparedness, life safety, equipment, utility systems, and physical environment meet the JCAHO standards for accreditation. Of the 11 areas reported quarterly, only the percent of staff wearing proper identification and completion of the RAMS security recommendations were below the target.

Staff development team continues to organize All Staff meetings. This year the focus was on mental illness and recovery. Presentations by the group Mentality at one meeting and a presentation by Dr. Fred Frese at another were very engaging. Much work this year has been devoted to new staff orientation and to assessing clinical competencies.

Beginning in October, the chair of staff development committee has been assigned to other duties. Sr. Management Team will review the committee functions and make new assignments.

Sentinel events reviews, using a root cause analysis model were conducted this year. Recommendations are made to the Sr. Management Team for implementation and follow up.

Other

HIPAA. In addition to these efforts, a collaborative effort between WCCMH, Washtenaw County Information Technology Services, Risk Management and the Washtenaw Health Organization began to implement necessary measures to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA). This group will conduct a risk assessment, revise and implement policies

Productivity has been measured and monitored by Senior Management Team for a year. Efficiency continues to improve and is approaching the 60% Professional Standard. After twelve months of monitoring productivity the following yearly averages were reported:

Adult Services:	58%	
Youth & Family:		51%
DD Services:	51%	
Doctors:	82%	

Training has been provided to all clinical staff on why productivity is critical to the agency's success and how to record services accurately. Sr. Management Team will continue to monitor productivity quarterly. Follow up training and opportunities to identify process improvements will be provided to staff.

National Benchmarks

Washtenaw County has surveyed its employees using the Organizational Capability Survey three times now using a nationally recognized consulting firm. The questions have been tested and our results compared to large private companies. Community Mental Health improved in these targeted areas from the last survey:

Reduce tolerance of poor performance	+16%	52% favorable
Improve communication	+10%	57% favorable
Improve management of change	+6%	36% favorable

The results showed improvement in all three areas. Activities that contributed to the improved scores included participating in the County Initiatives of the Leadership Academy, which provided training to all managers and supervisors in the fair application of policy, and the Communication Strategic Plan. In addition, the Community Mental Health Department implemented the supervision policy, used work plans and provided training for all staff on performance and productivity issues.

A new action plan will be developed for the coming year.

Clinical Outcomes

Each of our major programs develops objectives and measures for outcomes and prepares a summary report each quarter. Over the past several years the Washtenaw County Community Mental Health Program Evaluation and Outcome Measurement has been evolving to allow for the evaluation of a variety of aspects of programs. Programs identified measures of effectiveness, efficiency and consumer satisfaction. Once these measures were identified, data has been collected and evaluated for trends, areas that need improvement or strengths of different programs. This information presented in the attached reports reflects the data collected this year.

QUALITY INNOVATION REPORT

2000 – 2001

Washtenaw County Community Mental Health Department

The Community Mental Health (CMH) Quality Innovation Team (QIT) is a multi-disciplinary group responsible for identifying and designing improvement strategies to address clinical quality of care issues ensuring the provision of world-class service. Its underlying emphasis is to develop and sustain the organization's capacity to effectively use teams to solve organizational problems and issues. For example, the productivity work group reported upon herein emerged from discussions at both the operations and management level.

The QIT conducted a planning process in August of 2000. The planning session resulted in:

- The identification of goal areas for the 2000/2001 fiscal year.
- The adoption of a specific model of quality innovation activity providing an overarching framework in which to hold strategies and plans for service improvement.
- The development of a regular reporting schedule to CMH senior management and the larger organization to assure a consistent and effective method for feedback; a mechanism for appropriate organizational change (e.g., policy and procedure modification); and, alignment with other organizational and County goals and activity.

The three (3) goal areas identified for 2000/2001 were:

- Consumer Representation and Participation in Quality Improvement Activities.
- Improved Quality Improvement Education.
- Improved Communication Regarding Quality Improvement Activities.

This report highlights progress, accomplishments, and future needs based on our activity throughout the 2000/2001 calendar year.

GOAL AREA #1: Consumer Representation

As of August 2000, there was no representation of consumers on the Quality Innovation Team (QIT). The QIT had recently undergone a transformation in both philosophy and membership. Philosophically, the Team broadening from a quantitative model to an "innovation through ideas" model inclusive of, but not limited to, quantitatively driven methods and analysis.

Membership was restructured to include consumers in addition to varying levels of staff. The QIT recruited three (3) consumers for membership with a possible fourth joining the Team in fall of 2001. Membership changes have enriched the synergy of Team efforts and ensure that consumer "voice" is present in planning and implementation processes.

GOAL AREA #2: Improved Quality Improvement Education

Education remains a goal "in-process". To date, effort has focused on specific trainings and use of work groups as a "training laboratory" for learning the improvement process while addressing actual organizational issues.

Specific training has included the following initiatives:

- Training in the quality innovation problem solving process for staff serving Persons with Developmental Disabilities and Youth and Children.
- Training of all new employees at monthly new staff orientation sessions. This training includes introduction to the annual goals, defining quality and our improvement structure, and explaining how to communicate with the QIT with questions or ideas.

Work groups have addressed electronic communication, staff productivity and retention utilizing our adopted quality improvement model.

Remaining identified training will include:

- Training in the quality innovation problem-solving process to staff serving Adults with a Severe and Persistent Mental Illness, and any other staff not yet trained.
- Training for selected staff in the “skill sets” necessary to:
 - Support the quality innovation process including, but not necessarily limited to data collection, quality improvement problem-solving, and quality improvement values.
 - Build the capacity of CMH to engage in continuous improvement at all levels and service areas.

GOAL AREA #3: Improved Communication Regarding Quality Improvement Activities

This goal area has resulted in a number of activities:

- The Quality Innovation Plan for this year, along with the model the plan is based upon, is available on the employee web site.
- To create opportunities for employee feedback and suggestions, an interactive feedback form is available to all staff, also on the employee web site.
- QIT members now act as “ambassadors” for Quality Innovation, explaining efforts, soliciting ideas, and providing information in their various roles and collaborative work groups within the organization.
- Quality Innovation bulletin boards have been created and placed in each of three (3) population sites.
- Quality Innovation activities are shared in the staff newsletter.
- A regular reporting process has been implemented to assure timely and accurate reporting of quality innovation progress and activity to the management team.
- QIT has developed a linkage with the consumer-driven Fresh Start Clubhouse which has resulted in the development and implementation of a “consumer leadership program” which will be offered to all consumers of CMH services.

SERVICE ISSUES (Work Groups)

In the past year, the following work groups have addressed service issues:

- E-Mail Work Group: This group reviewed e-mail and confidentiality issues resulting in a new policy delineating correct and clinically appropriate use of electronic communication where consumers are involved.
- Productivity Work Group: As CMH transitions to a managed care environment, this group convened to:
 - Ensure clear communication regarding agency requirements of professional productivity standards.
 - Increase staff support for these standards.
- Staff Retention Work Group: This work group convened for its first time in August 2001, targeting completion for mid-September. The work group will address how to retain staff on a long-term basis and how to support

NEEDS AND OPPORTUNITIES

The Quality Innovations effort has identified and/or recognizes the following organizational needs:

- Alignment of the CMH Quality Innovation process with the County Business Improvement process.
- Improved knowledge, by all levels of staff, on the principles and practices of quality improvement.
- Improved communication and feedback from staff and consumers regarding suggestions for areas of focus for improvement.
- Development of a model to establish priorities for outcome measurement
- An established model for information (data) collection, interpretation and use based on consumer input.

ANNUAL PLANNING

The QIT will conduct a planning session in September with a review of the issues stated above. Annual goals will be constructed based on these areas, the organizations larger planning process, and the County's Business Improvement process.

QUALITY IMPROVEMENT TEAM MEMBERSHIP

Leslie Hall, Facilitator

Jan Baltzell, Senior Management Analyst

Paula Burdelski, Deputy Director

Jeff Capobianca, Client Services Manager

David, Consumer

Louise Hayward, Placement Coordinator

Pat, Consumer

Linda Mavrinac, Court Liaison

Mary Parker, Care Manager

Raymond, Consumer

Doris A. Peoples, Chief Clerk

Dawn-Rachelle Smith, Client Services Manager

Robert D. Strozier, Coordinator of Member Services