Introduction

The development of this submission has provided the Community Mental Health Partnership of Southeastern Michigan (CMHPSM) with a framework to develop forums that encouraged consumers, staff, advocates, community members, providers, and natural supports to embrace a vision of what quality services should look like and how to insure this becomes a reality. Input was obtained through a variety of formats, locations, and times that stakeholders found most convenient. This included community forums, town hall meetings, committee and council meetings, networking fairs, Clubhouse meetings, juvenile justice stakeholder group discussions (including members from the courts, law enforcement, DHS, and community representatives), discussion with a consumer criminal justice stakeholder group, and a confidential internet-based "Zoomerang" survey to determine strengths, weaknesses, and QI plan ideas for the environmental scan. All input was recorded on flip charts, paper, or in electronic format. Accommodations were provided to stakeholders when needed including access to interpreters for non-English speakers and the deaf. Anyone who was unable to fill out the survey online was offered neutral party face-to-face assistance with its completion. We also gathered information from various sources (including, but not limited to, PPGs, and EQR needs assessment data as well as contract, PI data, and AFP responses). Additionally, after each QI plan was developed, we held an ARR Retreat for various stakeholders from all four Affiliate counties to give input on the plan design. This draft was then sent to the Regional Performance Improvement Committee and the Regional Consumer Advisory Council for further feedback. The CMHPSM Affiliation Executive Committee has had final approval on all of the QI plans.

While comprehensive, it is the goal of the CMHPSM to make sure the QI plans are not static but instead operate as "living" improvement plans open to new ideas, directives, and challenges that develop over time. To accomplish this, WCHO and CMHPSM used the aforementioned ARR retreat to identify recurrent themes for improvement, which included: additional training and development, resource allocation (or lack of), use of technology and data collection, and the expanded use of Evidence-based Practice.

Additional Training and Development

In many of the improvement plans, the need for ongoing training and development were identified as a means to maintaining continuous learning. This need not only touches our own staff, but also provider staff, consumers, consumer advocates, and natural supports. Ongoing and consistent education and coaching was identified as the best way meet these needs, rather than a one time, segmented or annual trainings. Underlying this culture of coaching and support, is the intent to educate and develop a system founded in hope, recovery, and

gentleness. Only by doing this can we further enhance the knowledge and participation of our stakeholders and ultimately the service experience of the people we serve.

Resource Allocation

In these difficult times, efficient and effective resource allocation (both clinical and administrative) is key to maximizing resources. Seeking additional funding, such as grants, may assist in this endeavor. However, ultimately it is only through embracing the quality improvement process that we will be able to adapt and develop our services. Therefore shifting resources, creative dismantling of outdated or redundant ways of providing services, and better management of demand will be vital to implementing these plans.

We have learned, and the ARR process has reinforced, a thoughtful approach to collaboration is the key to meaningful partnerships. Given the current economic climate it is essential, now more than ever, that collaboration be used as a force multiplier to guarantee services of the highest quality.

Use of Technology

Accurate monitoring of processes and ease of data collection can be achieved with an investment in technology. The CMHPSM has made significant investment into computer based technology to enhance quality improvement, clinical, and administrative operations. These investments have paid off by allowing user interface and associated workflows to be as intuitive as possible resulting in low cost and reliable data collection. We will continue to leverage computer-based technology for the improvement of processes which generate reliable and valid actionable information.

Evidence-Based Practice

Consumers and staff alike, reported value in using evidence-based practices (EBP), and where not available, promising and/or best practices. We have made considerable progress since the days of staff and consumers resisting the incorporation of EBP's into services. Despite this progress there is the need to be thoughtful about the implementation and use of EBP's. Failure to do this will undermine any progress made and invite consumers to interpret EBP's as mandated, expert enforced services instead of the beneficial options they are. Fidelity to the person-centered process will support the perception of what EBP should be, an option for overcoming the struggle of mental illness, substance use disorders, and/or developmental disabilities.

In conclusion, this process has truly been an energizing recommitment by our staff and those they serve, their families, advocates, providers, and community representatives. The ARR process has produced a wealth of new information and new plans for creating a system of care

that will have more informed stakeholders, better allocation of resources, a continued commitment to the creative use of technology, and implementation of evidence-based, best and promising practices.