



THE CHILDREN'S CENTER OF WAYNE COUNTY, INC.
QUALITY IMPROVEMENT PLAN
&
QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN
FISCAL YEAR 2018-2019
October 1, 2018 – September 30, 2019

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INTRODUCTION

The Children's Center provides a comprehensive array of services for children and families in Wayne County. Services are designed to help develop strong children and successful families, focusing on preventative treatment, therapeutic interventions, fostering and provision of safe home environments, and linkage to other community resources. While a wide variety of services are offered, quality is a critical component and common underpinning amongst them all. This concept and philosophy are supported through the structure of the Quality & Compliance Department, the Quality Improvement Plan, and the Quality Assessment Performance Improvement Plan (QAPIP), which is detailed in section 2 of this document.

The Children's Center Quality Improvement Plan serves as the foundation of the commitment to continuously monitor and improve the quality of the treatment and service supports provided. We strive to deliver quality services that are provided in a safe, effective, client-centered, timely, equitable and a recovery-oriented fashion.

The purpose of the QAPIP is to provide Assessment that The Children's Center achieves alignment with healthcare reform and demonstrates to consumers, advocates, community organizations, health care providers, local and State policy makers that it has a distinct competency as a consumer-focused provider of Behavioral health services. The QAPIP is the vehicle for improving the quality of care to clients and families and improving methods of service delivery to ensure desired client health status, quality of life and client satisfaction.

SCOPE OF THE QI PLAN & QAPIP

The scope of the Quality Improvement activities includes The Children's Center, Contractors, and Student Interns. It identifies the important processes and aspects of care, both clinical and non-clinical, required to operate in accordance with fiduciary regulations, policies and procedures.

QUALITY IMPROVEMENT PROCESS

Quality Improvement is a systematic approach to assessing services and improving them on a priority basis. The Children's Center approach is based on the following principles:

- Client Focused: Services should be designed to meet the needs of clients and their families.
- Understanding work and system processes: Understanding the service system and its key processes is vital in order to work to improve them.
- Teamwork: Because work is accomplished through processes and systems, it is essential to involve stakeholders, program and process owners in the improvement process.
- Data Driven: Data is necessary to analyze processes, identify problems and measure performance. Needed changes can then be identified, tested, and analyzed to verify change effectiveness.

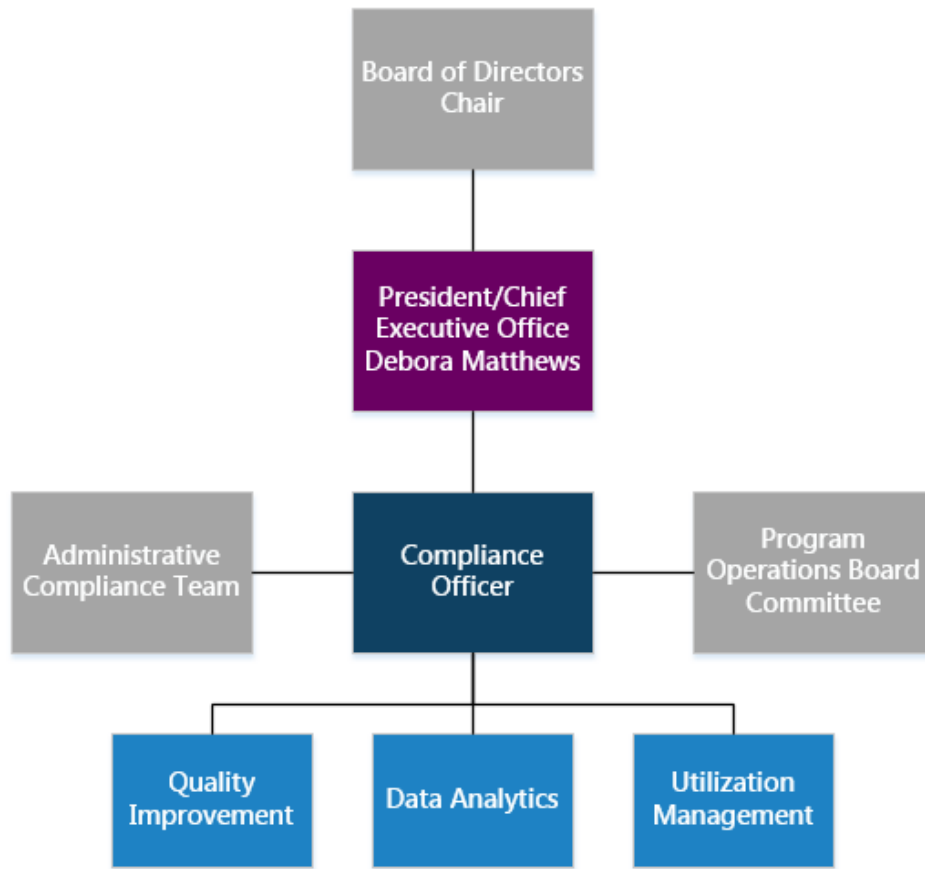
The development and implementation of the quality improvement initiatives is a collaborative effort that includes Quality & Compliance staff along with Program staff. This process transpires in a planned, systematic fashion. At the point of implementation, the data is continuously reviewed and collected over time to determine if these initiatives have had the hypothesized positive impact in the applicable area(s) of focus. If the data indicates that adjustments to the initiatives or development and implementation of additional initiatives

are necessary, then such changes will be made with subsequent indicators developed for ongoing measurement. Throughout the entire quality improvement process, sound data will be used to make informed decisions.

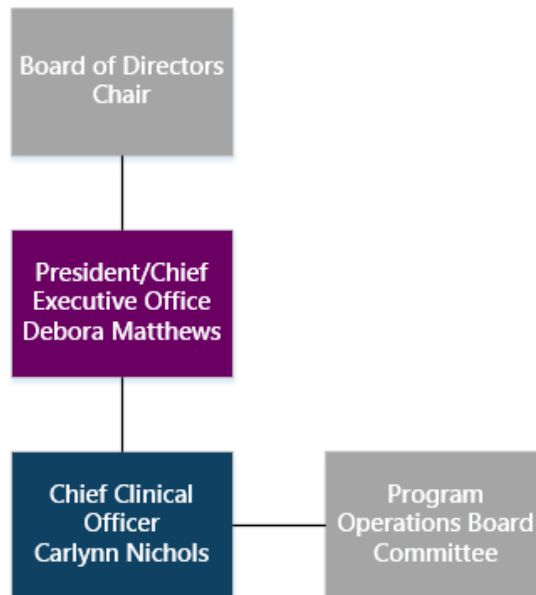
Access to valid data is crucial in the development of reliable quality indicators. However, data by itself is not enough to ensure that we measure what we need to measure; the data must be useful enough to answer important questions regarding specific areas of service delivery. For the purposes of ensuring comprehensive analysis of services, the indicators generally fall in one of four areas: effectiveness, efficiency, satisfaction, and contractual compliance.

LEADERSHIP & ORGANIZATION

The key to the success of the Quality Improvement process is leadership. The following describes how the leaders of The Children's Center provide support to Quality Improvement activities.



The following describes how the leaders of The Children’s Center provide support to the Quality Assessment Performance Improvement Plan.



The administration of compliance activities begins with the designation of a Compliance Officer. The Compliance Officer has direct access to the CEO and will be available to the Board of Directors, as they shall determine. The Compliance Officer, an internal Compliance Team and the Program Operations Committee of the Board shall oversee and monitor the implementation of the Quality Improvement Plan, Quality Assessment Performance Improvement Plan & the Compliance Plan. The Program Operations Committee is comprised of employees, Board members, and a Leadership Team member who will provide coordination, oversight and evaluation of this plan upon approval by the Board of Directors.

The responsibilities of the committee include the following:

- Review program outputs and outcomes and make recommendations
- Monitor progress and provide feedback of Quality Improvement initiatives by program
- Monitor effectiveness of programs by CAFAS/PECFAS scores (Child and Adolescent Functional Assessment Scale/ Preschool and Early Childhood Functional Assessment Scale)
- Monitor effectiveness of program by DDCGAS scores (Developmental Disabilities Children’s Global Assessment Scale)
- Review client satisfaction survey results
- Review agency Compliance Plan and monitor status
- Review results of external audits and make recommendations
- Monitor strategic plan initiatives related to quality improvement
- Review and monitor Quality Improvement Plan (QIP)
- Review and monitor Quality Assessment Performance Improvement Plan (QAPIP)
- Recommend approval of Compliance Plan, QIP, and QAPIP and annual reports

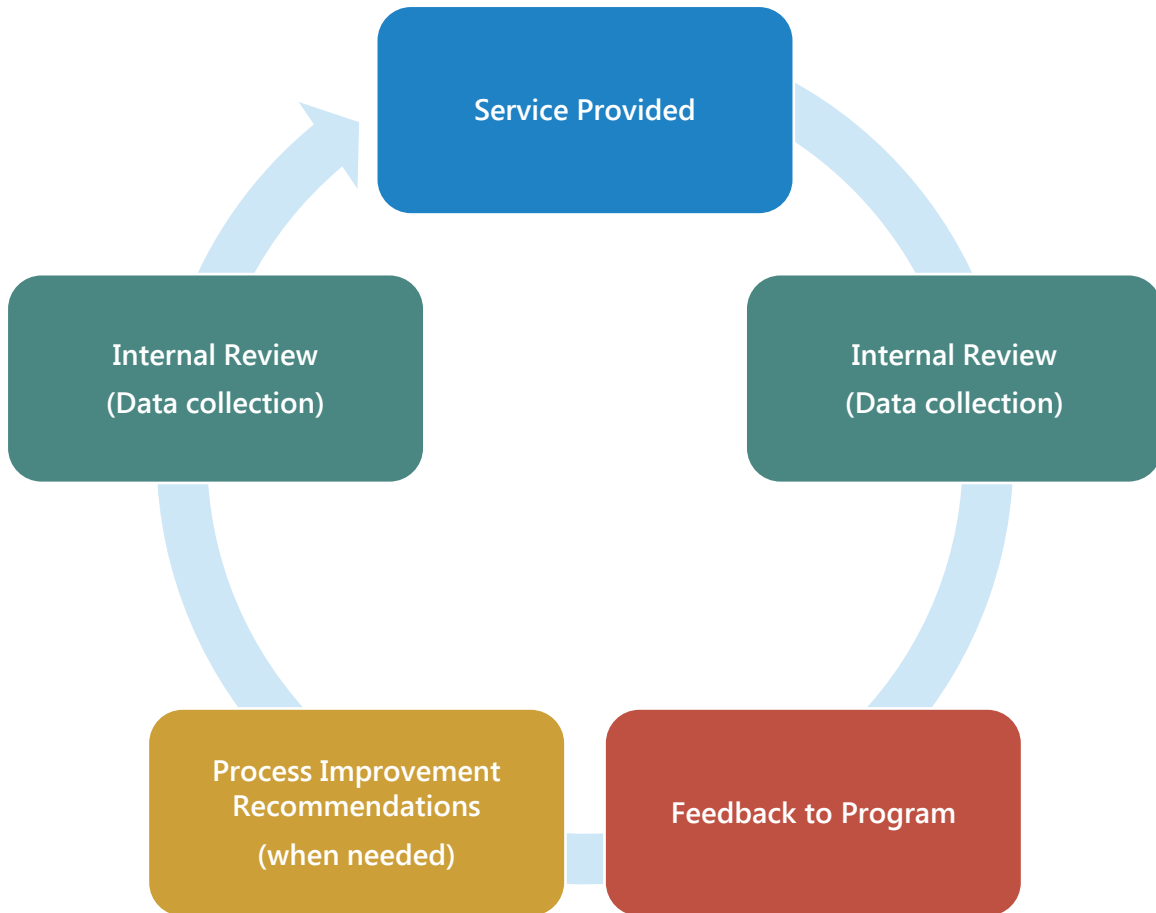
GOALS & OBJECTIVES

The Program Operations Committee identifies and defines goals and specific initiatives to be accomplished each year. The Fiscal Year 2018-2019 initiatives are as follows:

- 1) Serve as Interface between TCC programs and Board of Directors.
- 2) Reduce health care disparities by assuring access to care for minority populations (ethnic, racial, religious, and sexual).
- 3) Regular review of Program Outcomes & Outputs.

PERFORMANCE MONITORING

The Children's Center continuously monitors the services provided by employees, contractors, and student interns. The standards used to assess performance derive from Federal, State, and Local statutes, regulations and guidelines. The internal monitoring system transpires as follows:



PERFORMANCE MEASUREMENT

Performance Measurement is the process of routinely assessing the results produced by a program. It includes identifying processes, systems and outcomes that are integral to the performance of the service delivery system, selecting indicators, and analyzing data related to these indicators on a regular basis. A performance indicator is a quantitative tool that provides information about the performance of a process, service, function or outcome. The Performance Indicators are informed by current data and historical trends and are chosen based on relevance to the mission, qualitative and contractual mandates, areas that assist in monitoring risk, and Strategic Plan initiatives. Continuous Quality Improvement involves taking action, when needed, based on the results of the data analysis and the opportunities they identify.

The purpose of measurement and assessment is to:

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or failure to perform at an expected level.
- Identify problems and opportunities to improve the performance of processes.
- Assess the outcome of the care provided.
- Assess whether a new or improved process meets performance expectations.

Measurement and assessment involves:

- Selection of a process or outcome to be measured on a priority basis.
- Identification and/or development of performance indicators for the selected process or outcome to be measured.
- Determine sample size.
- Utilize RAND formula in Excel or COA's randomizer to pull a random sample.
- Clean data to ensure data integrity.
- Analyze results of the random sample.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.
- Assessment of performance with regard to these indicators at planned and regular intervals.
- Providing feedback to program staff and leadership.
- Taking action to address performance discrepancies when indicators specified that a process is not stable, is not performing at an expected level or represents an opportunity for quality improvement.
- Reporting within the organization on findings, conclusions and actions taken as a result of performance assessment.
- Implementing solutions to support the quality improvement process.

QUALITY IMPROVEMENT INITIATIVE

Once the performance of a selected process has been measured, assessed, and analyzed, The Children's Center Quality & Compliance Department takes action. The action taken is influenced by the findings and feedback is provided to the appropriate staff to:

- Develop and implement solutions
- Replicate good practice
- Recognize and motivate staff
- Improve organizational systems, processes, policies, and procedures
- Improve quality of services
- Eliminate or reduce identified deficiencies

The decision to spearhead a specific initiative is based upon current priorities and level of risk. The model utilized is called Plan-Do-Check-Act (PDCA).

- Plan – The first step involves identifying preliminary opportunities for improvement. The focus is to analyze data and identify concerns and determine anticipated outcome. Ideas for improving processes are shared with affected staff along with data compiled and solutions proposed. (Common tools utilized in APPENDIX A)
- Do – This step involves utilizing the proposed solution, and if proven successful through measuring and assessing, then implementing the solution.
- Check – Data is collected again to evaluate the results of the new process with those of the previous one.
- Act – This step involves making the changes a routine part of the targeted activity. Also, it means to involve others who will be affected by the changes. Documentation, reporting findings and follow up are integral to this area.

Effectiveness

Effectiveness indicators are developed to measure the impact services have on the quality of life of the clients and families we serve. Primarily, these indicators look at clinical improvement as evidenced by validated measurement tools and completion of family-centered treatment goals. In summary, effectiveness indicators are developed to ensure that the primary qualitative outcomes for our programs are being met.

Efficiency

Efficiency indicators are developed to measure the timeliness of service delivery, ensuring that quality services are delivered using only the resources necessary to facilitate such delivery. While effectiveness can be more of a qualitative measure of services, efficiency indicators are necessary to ensure maximum impact of services. For example, identification of appropriate clinical services at Intake is a crucial effectiveness indicator, yet such identification is severely limited if initial delivery of services is delayed in a significant way.

Client Satisfaction

Satisfaction indicators have been developed to assess client and family satisfaction with services delivered. The Children's Center prides itself on supporting clients and families in achieving their goals and objectives; services should be client-family centered. Effective services delivered in an efficient manner are hampered if the clients and families we serve are not satisfied with said services. Satisfaction surveys are a typical measure of client satisfaction. Measurement of client satisfaction can also be obtained conversely via client complaints.

Contractual Compliance

Contractual Compliance indicators are directly tied to contractual and legal requirements. Many of these requirements correlate to effectiveness, efficiency, and satisfaction; for the purposes of clarity, such indicators are included in the applicable sections of this plan. However, many contractual compliance indicators measure areas that are not directly related to the other three indicator types but are meant to facilitate and/or support achievement of indicators in these three areas. Examples of these processes or structure-focused indicators include quality improvement chart reviews and corporate compliance reviews of service activity logs to ensure appropriate coding and billing of services delivered.

Within each of these indicator sets, organizational indicators were identified that affect multiple programs or are tied to the overall mission and values of The Children's Center. Additionally, Program-specific indicators were developed to measure critical items that only can be found in one or a small set of programs. It should be noted that, in general, most indicators found in the clinical programs are organizational. While these programs may use different interventions and serve clients with differing diagnoses, they share the overarching task of assisting clients to achieve their goals via family-centered and youth driven planning processes.

QUALITY IMPROVEMENT PLAN INITIATIVES

Effectiveness

MEASURE OF SERVICE EFFECTIVENESS	
Name	CAFAS/PECFAS Progress
Definition	This includes the indicators set by DWMHA. The Target is to observe a 20-point decrease in total score for 60% of clients discharged each month to measure clinical progress.
Data Collection	The data is collected by Q&C monthly through FAS, and submitted to BHPI.
Assessment Frequency	The Quality & Compliance Department will assess information associated with the indicator on a quarterly basis as well as report trends at the Quality Improvement meeting.

CAFAS/PECFAS:

Performance Improvement Goal # 1	Target	Plan of Action	Responsible Program
Clients will exhibit improved functioning as evidenced by a decreased total CAFAS/PECFAS score	20-point decrease in total CAFAS/PECFAS score for 60% of clients discharged per month, reported as year-to-date Achieve 60% ending September 30 th .	Clinical Programs: ALL Behavioral Health SED Programs Q & C – monthly monitoring & reporting	BHS SED Programs Q&C Department

The CAFAS is the gold standard for assessing a youth's day-to-day functioning across critical life subscales and for determining whether a youth's functioning improves over time. The assessment yields a total score that categorizes a youth as having a serious emotional disturbance (SED). These are the totals that describe a youth as SED:

- A total score of 50 (using the eight subscale scores on the CAFAS), or
- Two 20s on any of the first eight subscales of the CAFAS, or
- One 30 on any subscale of the CAFAS, except for substance abuse only.

The CAFAS is used as a criteria to consider in determining the intensity of services needed, as an outcome measure (pre and post), as an aid to actively manage cases during a course of treatment, and for agency tracking and quality improvement. Additionally, it measures eight subscales; School, Home, Community, Behavior Towards Others, Moods/Emotions, Self-Harmful Behavior, Substance Use and Thinking/Communication. PECFAS has the same subscales except Substance Abuse and School is replaced with Preschool or Daycare.

The Children's Center is exploring looking at subscale data of the CAFAS/PECFAS at the Quality Improvement meetings in order to assess the specific improvement areas of the subscales.

Hospital Utilization:

MEASURE OF SERVICE EFFECTIVENESS	
Name	Michigan Mission Base Performance Indicator
Definition	% of readmissions of children to an inpatient psychiatric unit within 30 days of the discharge date from an inpatient psychiatric unit.
Data Collection	The data is collected by Q&C monthly utilizing TCC and BHPI's hospitalization log.
Assessment Frequency	The Quality & Compliance Department will assess information association with this indicator monthly and provide trending on a monthly basis at the BHS Output & Outcomes meeting.

Performance Improvement Goal # 2	Target	Plan of Action	Responsible Program
1a) Decrease recidivism 1b) Monitor ConsumerLink children	15% or less	Continual monitoring at internal QI meeting Refer high recidivistic children to HURT – High Utilization Review Team Q&C – monthly monitoring & reporting	HURT (High Utilization Review Team) Q&C Department

The statistics collected for hospital utilization and recidivism will continue to be tracked in the following areas as well as new areas related to ER data:

Objectives	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sep
Inpatient Data (from Hospital Liaison Log)												
1. CareLink Inpatient Admissions												
2. Average length of stay												
3. CareLink Recidivistic Admissions												
4. CareLink Percent Recidivism Target: <15%												
5. CareLink Total Discharged (inp.)												
6. ConsumerLink Inpatient Admissions												
7. ConsumerLink Total Discharged (inp.)												
8. All MCPN Aftercare Appointments (7 days)												
Crisis Center Data (from CC Monthly Log)												
9. Crisis Center Contacts (face to face)												
10. Crisis Center to Psyc. Hosp.												
11. CC Diversion Rate Target=65%												
Overall Crisis Data (from MISTICC SALs)												
12. Psychiatrist Interventions (829 codes)												
13. H2011 codes billed												
ER Data												
14. Children in ER, no bed available												
15. Children in ER, denied												
16. Count of children in ER												
17. Average length of stay in ER												

Child Welfare YASS (Young Adult Self – Sufficiency) Graduation %

Our Young Adult Self-Sufficiency Program (YASS) gives young people aging out of the foster care program a chance to find success. We empower these young adults with the life skills they need to become contributing members of society, and graduating from high school is a strong predictor of better health.

MEASURE OF SERVICE EFFECTIVENESS	
Name	% of YASS Clients Who Graduate High School/Receive a GED
Definition	This data point monitors TCC’s effectiveness in relationship to a social determinant of health.
Data Collection	The data is currently collected manually by the Child Welfare staff.
Assessment Frequency	The Quality & Compliance Department will collect the information from Child Welfare and report annual trends.

Performance Improvement Goal # 3	Target	Plan of Action	Responsible Program
% of YASS clients who graduate high school or receive a GED	95%	Annual data collection Annual monitoring & reporting Obtain & compare to local graduation rates	Child Welfare Q&C Department

Efficiency

Access to Behavioral Health Service Requests:

MEASURE OF SERVICE EFFICIENCY	
Name	Michigan Department of Health & Human Services - Access to Services (Performance Indicator 2)
Definition	# of days from Non-emergent request for Behavioral health service to day of Intake
Data Collection	The data is collected through MHWIN
Assessment Frequency	The Quality & Compliance Department pulls data from MHWIN and reports monthly at BHS Output & Outcomes meeting.

Performance Improvement Goal # 1	Target	Plan of Action	Responsible Program
Increase and maintain standard	Within 14 calendar days, 95% target Exceptions – clients who request appointment outside of 14 day timeframe, no show, or cancel scheduled appointment	Intake will continue to monitor calendar availability Q&C will review errant findings by BHPI to assess source of error	Family Assessment & Intervention Services Q&C Department

MEASURE OF SERVICE EFFICIENCY	
Name	Michigan Department of Health & Human Services - Access to Services (Performance Indicator 3)
Definition	# of days from Intake to first ongoing appointment
Data Collection	The data is collected through MHWIN
Assessment Frequency	The Quality & Compliance Department pulls data from MHWIN and reports monthly at BHS Output & Outcomes meeting.

Performance Improvement Goal # 2	Target	Plan of Action	Responsible Program
Maintain standard	Within 14 calendar days, 95% target Exceptions – clients who request appointment outside of 14 day timeframe, no show, or cancel scheduled appointment	Continual monthly monitoring & reporting	BHS SED & DDS Programs Q&C Department

CAFAS/PECFAS Completion and Overdue Rates:

Per our contract with CareLink, The Children’s Center is responsible for monitoring overdue CAFAS/PECFAS rates. Monitoring the number of overdue CAFAS/PECFAS assessments is necessary to help create and sustain ongoing and timely evaluations of clients, which is critical when monitoring clinical outcomes. The threshold is that no more than 10% of expected assessments are overdue system-wide. Additionally, it is required to have 100% of our clients entered into the FAS system.

As reported in the FY18 Annual Report, we struggled to consistently meet the target. Thus, this will be closely monitored in FY19.

MEASURE OF SERVICE EFFICIENCY	
Name	CAFAS/PECFAS Timeliness
Definition	% Overdue CAFAS/PECFAS must be below 10%
Data Collection	The data is collected utilizing FAS system
Assessment Frequency	The Quality & Compliance Department calculates this measure monthly and reports it at the Quality Improvement meeting.

Performance Improvement Goal # 3	Target	Plan of Action	Responsible Program
CAFAS/PECFAS Timeliness completion	CAFAS/PECFAS scores will be completed within 90 days of previous assessment; less than 10% overdue target	Continual monthly monitoring & reporting	BHS SED Programs Q&C – monthly monitoring and reporting

Client Entries into FAS:

The CAFAS/PECFAS related requirement from DWMHA, 100% of client entries into the FAS system must have the client’s DWMHA ID number entered. Without this number, client specific data will not be included in count-wide aggregate reports leading to unsound reporting of qualitative outcomes.

CAFAS Third Party ID Entry											
Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep

MEASURE OF SERVICE EFFICIENCY	
Name	CAFAS/PECFAS Data Entry
Definition	% of clients with DWMHA IDs in FAS system
Data Collection	The data is collected through FAS
Assessment Frequency	The Quality & Compliance Department monitors this on a monthly basis and reports the data at the Quality Improvement meeting.

Performance Improvement Goal # 4	Target	Plan of Action	Responsible Program
Maintain standard	100%	Continual monthly monitoring & reporting	Q&C Department

Treatment Plan Completion:

Timely completion of a treatment plan is essential to help identify treatment needs, initiate ongoing services, and authorize services based on medical necessity. A preliminary plan is required to be completed within 7 days and a comprehensive treatment plan within 30 days of Intake.

As reported in FY18 Annual Report, we averaged 95% for the majority of the year and this will continue to be the target for FY19.

MEASURE OF SERVICE EFFICIENCY	
Name	Treatment Plan Completion
Definition	# of days to completion of treatment plan from Intake
Data Collection	The data is collected through MISTICC
Assessment Frequency	The Quality & Compliance Department monitors this on a monthly basis.

Performance Improvement Goal # 5	Target	Plan of Action	Responsible Program
All clients will have their Treatment Plan completed within 30 days of Intake and annually	95%	Continual monthly monitoring & reporting	BHS SED & DDS Programs Q&C Department

Client Satisfaction

Satisfaction Survey:

The Children’s Center clients and families receive several satisfaction surveys to assess how pleased or displeased they are with the services they receive as well as areas for improvement. Surveys are administered addressing all service areas of TCC: Behavioral Health, Child Welfare, and Enrichment as well as campus environment.

In FY18, we hit target for the first time. We will continue with the practices we implemented last fiscal year in order to maintain a statistically significant response rate.

MEASURE OF SERVICE SATISFACTION	
Name	Satisfaction Survey
Definition	5 point scale % strongly disagree→ strongly agree
Data Collection	The data was collected utilizing non treating staff to deliver and collect surveys
Assessment Frequency	The Quality & Compliance Department aggregates collected data annually.

Performance Improvement Goal # 1	Target	Plan of Action	Responsible Program
Maintain statistically significant response rate of 20% or higher	20%	TCC will maintain the expanded window for the survey and utilize Interns.	Q&C Department

While most surveys yielded positive response regarding treatment and progress of clients, foster parents reported less satisfaction with staff interactions, although very few foster parents responded.

Performance Improvement Goal # 2	Target	Plan of Action	Responsible Program
Monitor Parent Satisfaction (New Foster Parent & Birth Parent)	50% Response Rate	Q&C Department created a satisfaction survey	Child Welfare (survey distribution) Q&C Department (data collection)

Performance Improvement Goal # 3	Target	Plan of Action	Responsible Program
Monitor customer service satisfaction for foster parents	Implement foster parent survey to be distributed at the foster parent support group	The group at QI Child Welfare a satisfaction survey	Client Services (survey distribution) Q&C Department (data collection)

Contractual Compliance

Quality Improvement Chart Review:

All programs at The Children’s Center will be reviewed quarterly through our internal Quality Improvement chart review process. Aggregate reports are provided to the director of the program and discussed at Quality Improvement meetings.

As mentioned in FY18 Annual Report, all services except Licensing have identified improvement areas as Licensing consistently met or exceeded target. In FY19, one of the actions that will continue for behavioral health services will be the internal and external chart review team. The implementation of these teams are directly correlated to the significant improvement in the clinical chart reviews. Additionally, the Quality & Compliance department will continue to focus on clarifying the feedback loop with program areas and collaborating on improvement initiatives to increase chart compliance.

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	Quality Improvement Chart Review
Definition	% of chart compliance, 95% target
Data Collection	The data is collected through a myriad of ways: randomization of Excel reports from MISTICC, MHWIN, MiSACWIS, etc.
Assessment Frequency	The Quality & Compliance department randomly selects charts monthly and aggregates data on a quarterly basis.

Performance Improvement Goal # 1	Target	Plan of Action	Responsible Program
Maintain and increase chart compliance to 95% for all quarters	95%	Maintain internal chart review team Monitor corrective action plans in place Continual monitoring & reporting, creating additional internal reviews	Q&C Department

Additional Reviews Overseen by Quality & Compliance Department:

1. Division of Child Welfare Licensing Audit
2. Customer Service Site Reviews
3. DWMHA Autism Benefit Waiver Audit
4. DWMHA SEDW Audit
5. Michigan Department of Health & Human Services Audits
6. Office of Recipient Rights Audit

7. Quarterly MHWIN Chart Reviews
8. Other Reviews as requested

Incident Report Review/Root Cause Analysis:

Whenever an incident of an atypical nature involving a client occurs, staff are to complete an Incident Report (IR) documenting the details of the incident that gets forwarded to the Quality & Compliance Department. The process and monitoring of IRs will ensure that any necessary treatment or procedural changes will occur to best prevent reoccurrence of the incident. With regards to establishing a target for this indicator, a quantitative measurement is insufficient as an increase or decrease in the number of IR's completed. However, aggregate reporting of incidents by program are reported on a monthly basis to determine if trends requiring action exist. If such trends are noted, then global interventions will be developed and implemented by the Leadership Team or at the Quality Improvement meetings.

When injuries and behavioral concerns are reported and cross the threshold of a Critical Incident, it is entered into MHWIN. The Authority notifies us if the Critical Incident is a Sentinel Event. These events are reviewed through our Root Cause Analysis process when necessary. The Compliance Officer or Chief Medical Officers leads the process and incorporates the appropriate parties to participate. Any deficiencies noted during the review, even those determined as to not have contributed to the occurrence of the incident, result in a formal Process Improvement Plan, identifying the areas requiring improvement, the necessary action steps to improve, the staff responsible, and the timeframe for completion.

Grievances and Recipient Rights Complaints:

The inverse indicator to the satisfaction rate is the number of service-related complaints received during the year. Complaints are generally taken in the form of Grievance or Recipient Rights complaint. The Quality & Compliance Department investigates the grievances by speaking with the client/family to obtain a full understanding of their concerns; reviewing the documentation at hand; interviewing the staff involved, their supervisors, HR staff (if necessary), and any other staff or leadership as applicable; and developing a plan of action that best meets the client/family's needs within reason. All grievances and their follow-up notes are entered into the DWMHA MHWIN system, with resolution expected within 60 days of receipt of initial complaint.

The second category that a complaint may fall under is as a Recipient Rights complaint. These complaints are specific to perceived Recipient Rights violations. They may be submitted by the client/family directly or by someone assisting the client/family with the submission. If we are made aware of a complaint, the process for investigation would proceed as described above for grievances, except that the complaint form would also be forwarded directly to the DWMHA Office of Recipient Rights for their review, during which they may decide to open an investigation at the county level. A county-level investigation may also be opened without our direct initial involvement if the client chooses to submit the complaint directly to DWMHA. In either case, we would fully assist DWMHA with their investigation and implementation of any requested corrective action plans.

Child Welfare Social Work Contacts – 85 -95%:

As part of the ISEP (Implementation, Sustainability, and Exit Plan), our Foster Care children are required to receive monthly contacts:

- Child & Worker – 95% Target
- Worker & Parent – 85% Target
- Worker & Supervisor – 95% Target
- Parent & Child – 85% Target

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	Child Welfare Social Work Contacts
Definition	Children will receive monthly social work contacts in accordance with the ISEP
Data Collection	MiSACWIS
Assessment Frequency	The Quality & Compliance Department will monitor this monthly and report at the Quality Improvement meeting.

Performance Improvement Goal # 2	Target	Plan of Action	Responsible Program
Children in Foster Care will receive monthly social work contacts	85 – 95%	Monitor through chart review Monthly reports utilizing MiSACWIS	Child Welfare Program Q&C Department

Child Welfare Adoption Timeliness:

When a child cannot reunify with their birth family, the courts may terminate parental rights. This may occur after the child has been in the foster care program for 12 months, with the next 12 months focused on facilitating a successful finalized adoption for the child. The compliance target is 80% within 240 days which is dictated by the DHHS contract.

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	Child Welfare Adoption Timeliness
Definition	80% of children who have a goal of adoption, shall have their adoption finalized within 240 days
Data Collection	Manual process tracked in Excel
Assessment Frequency	The Quality & Compliance Department will monitor this monthly and report at the Quality Improvement meeting.

Performance Improvement Goal # 3	Target	Plan of Action	Responsible Program
Not less than 80% of children with a goal of adoption shall have a finalized adoption	80%	Monitor through chart review Monthly reports utilizing MiSACWIS	Child Welfare Program Q&C Department

Child Welfare Sibling Visits:

Based on contractual regulations, siblings who are not placed in the same home must be able to visit their sibling each month. Since we did not meet this target in FY18, we will continue to monitor the compliance in this area and look at internal communication and reporting channels to ensure mandates are being met and reports are accurate.

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	Child Welfare Sibling Visits
Definition	% of children in Foster Care who receive monthly sibling visits
Data Collection	The data is collected through MiSACWIS
Assessment Frequency	The Quality & Compliance Department will monitor this monthly and report at the Quality Improvement meeting.

Performance Improvement Goal # 4	Target	Plan of Action	Responsible Program
Children separated from siblings will visit them once a month	85%	Monitor through chart review Monthly reports utilizing MiSACWIS	Child Welfare Program Q&C Department

Child Welfare YASS (Young Adult Self-Sufficiency) – Productive Activity Involvement:

One of the expectations for the youth served in the YASS program is to either be involved in obtaining an education, obtaining a vocational training, or be employed; thus, engaged in “productive” activities. YASS staff work closely with the clients in the program to develop the skills necessary to achieve these markers of independent living. The target for the program is 100%, with data reported by the YASS staff to the Quality & Compliance department on a monthly basis. Since we did not meet this target in FY18, we will continue to monitor this indicator.

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	Child Welfare YASS Client Productive Activities
Definition	% of YASS clients involved in productive activities
Data Collection	The data is collected through a monthly reporting process
Assessment Frequency	The Quality & Compliance Department will monitor this monthly and report at the Quality Improvement meeting.

Performance Improvement Goal # 5	Target	Plan of Action	Responsible Program
Clients will be involved in productive activities	100%	Staff assessment of opportunities for productive activities	Child Welfare Program

Child Welfare YASS Clients in a Safe Living Environment:

Additionally, the YASS staff are tasked with working with the clients to ensure that they are in a safe living environment. Without acquisition of stable housing, any gains made by the youth are in jeopardy. For the purposes of measurement, “free from abuse and neglect and having basic safety and utility needs met” is defined as an absence of incident reports and substantiated special evaluations for all YASS staff specific to abuse, neglect, and health and safety. We met this target in FY18, and will continue to monitor for ongoing compliance.

Performance Improvement Goal # 6	Target	Plan of Action	Responsible Program
Clients will be involved in a safe living environment	100%	Staff assessment of opportunities for productive activities	Child Welfare Program

Child Welfare YASS Clients Connected to a Mentor:

All young adults in the YASS program should be connected with a community support person who can be of assistance to them, provide a mentoring relationship and help the youth adjust to societal expectations. The target is 100%. In FY18, we averaged 81%, which is significantly higher than the previous two fiscal years. We will continue to monitor this indicator.

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	Child Welfare YASS Clients Connected to a Mentor
Definition	% of YASS clients who have a mentor
Data Collection	The data is collected manually by YASS staff
Assessment Frequency	The Quality & Compliance Department will monitor this monthly and report at the Quality Improvement meeting.

Performance Improvement Goal # 7	Target	Plan of Action	Responsible Program
Clients will be connected with a mentor	100%	Staff assessment of mentor pool	Child Welfare Program

Child Welfare Licensing Target:

The Licensing Department of the Child Welfare programs is tasked with the licensing and monitoring of new foster parent homes, responding accordingly to any findings. As part of this process the Licensing Department monitors the number of licensed foster settings, with the expectation of having 10% more homes than the previous fiscal year. Economic challenges within the community continue to have an impact on the ability of the program to license new foster parents and have also resulted in the loss of licenses, as foster parents must be employed as a condition of their license. Data is manually recorded and aggregated quarterly.

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	Child Welfare Licensed Homes
Definition	# of Licensed Homes
Data Collection	The data is collected manually by Licensing staff as well as from MISTICC and information from the State
Assessment Frequency	The Quality & Compliance Department will monitor this monthly and report at the Quality Improvement meeting.

Performance Improvement Goal # 8	Target	Plan of Action	Responsible Program
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Maintain net gain of licensed homes	10% net gain	Increase Recruiting Efforts	Child Welfare Program
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Child Welfare Medical & Dental Timeliness:

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	Child Welfare Medical & Dental Timeliness
Definition	Children in Foster Care will receive medical and dental assessments on time
Data Collection	The data is collected through MiSACWIS
Assessment Frequency	The Quality & Compliance Department will monitor this monthly and report at the Quality Improvement meeting.

Performance Improvement Goal # 9	Target	Plan of Action	Responsible Program
Increase compliance, current average < 70%; target is 95%	10% increase	Supervisory monitoring CW QI Meeting agenda item	Child Welfare Program Q&C Department

Child Welfare Documentation Timeliness:

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	Child Welfare Documentation Timeliness
Definition	The required documents will be completed on time
Data Collection	The data is collected through MiSACWIS
Assessment Frequency	The Quality & Compliance Department will monitor this monthly and report at the Quality Improvement meeting.

Performance Improvement Goal # 10	Target	Plan of Action	Responsible Program
Increase service plan completion compliance, current average <81%; target is 95%	10% increase	Monitor the Book of Business Implement clerical support when needed Escalate case closing concerns to MDHHS	Child Supervisors & Manager Q&C Department

		CW QI Meeting agenda item	
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Additional Indicators

At the Child Welfare Quality Improvement meeting, the group decided to focus on a few additional quality improvement initiatives that will positively impact the staff as well as clients.

Child Welfare Host Provider Increase:

MEASURE OF ADDITIONAL INDICATORS	
Name	Child Welfare Host Providers
Definition	The Children’s Center will increase the number of foster homes and host providers
Data Collection	The data is manually collected by Child Welfare staff
Assessment Frequency	The Quality & Compliance Department will monitor this monthly and report at the Quality Improvement meeting.

Performance Improvement Goal # 1	Target	Plan of Action	Responsible Program
Increase the number of host providers	Monitor monthly trends 30% increase	Supervisory monitoring CW QI Meeting agenda item	Child Welfare Program Q&C Department

Child Welfare Staff Retention:

MEASURE OF ADDITIONAL INDICATORS	
Name	Child Welfare Staff Retention
Definition	The Children’s Center Child Welfare department will implement initiatives to positively affect the staff retention rate.
Data Collection	The data is collected by Human Resources
Assessment Frequency	The Quality & Compliance Department will obtain this information monthly and report at the Quality Improvement meeting.

Performance Improvement Goal # 2	Target	Plan of Action	Responsible Program
Implement initiatives to positively affect the staff retention rate	Review staff turnover Identify and implement retention initiatives.	Publish calendar of events Implement engagement opportunities CW QI Meeting agenda item	Child Welfare Program Q&C Department

Child Welfare Achieve Permanency:

MEASURE OF ADDITIONAL INDICATORS	
Name	Child Welfare Achieve Permanency
Definition	The Children’s Center Child Welfare department will implement initiatives to achieve permanency of foster youth.
Data Collection	The data is collected utilizing MiSACWIS
Assessment Frequency	The Quality & Compliance Department will monitor this monthly and report at the Quality Improvement meeting.

Performance Improvement Goal # 3	Target	Plan of Action	Responsible Program
Achieve permanency	Monitor reunification, guardianship/adoption & transition timelines.	Supervisory monitoring CW QI Meeting agenda item	Child Welfare Program Q&C Department

QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN INITIATIVES

Effectiveness:

Crisis Care Center:

The Crisis Care Center’s purpose is to provide Wayne County families with a walk in alternative to the local emergency room when experiencing a psychiatric crisis. When families present at an emergency room, they are required to be screened and medically cleared by a physician before a staff social worker meets with the family to discuss the reason that the family has presented. This process requires that families presenting for psychiatric emergencies endure longer waits and procedures that are unnecessary for their immediate needs. Our Crisis Care Center is intended to reduce the wait time of families’ immediate needs being met. Additionally, because local emergency rooms do not have psychiatric or behavioral health staff, the medical social worker and physicians are more likely to recommend hospitalization for these children. Our staff works with the family to identify stressors contributing to their crisis as well as utilizing natural supports to reduce any risk factors in hopes of stabilizing the crisis, maintaining the family unit, and helping the family increase their skills in coping with future crises.

When families are screened by our staff, we have seen a greater likelihood of them being able to safely return to their home following the crisis and/or be placed in an out of home setting that is less intense than an inpatient stay (e.g. Crisis Residential, Partial Hospitalization). This, again, allows the family to remain together during a crisis and hopefully increase their ability to cope with future crises. It also decreases the amount of dollars expended by the system of care on children's inpatient services. The target diversion rate is 65%. This means that our goal is to divert the child from the highest level of care by stabilizing the crisis and sending the child home or utilizing crisis residential or partial hospitalization.

MEASURE OF SERVICE EFFECTIVENESS	
Name	Crisis Care Center Diversion
Definition	65% Diversion from Highest Level of Care
Data Collection	The data is collected by Q&C monthly utilizing MISTICC and Crisis Care Center logs
Assessment Frequency	The Quality & Compliance Department will assess information association with this indicator monthly and provide trending on a quarterly basis.

Performance Improvement Goal # 1	Benchmark	Plan of Action	Responsible Program
Maintain internal diversion rate	65%	Q&C Department will monitor and report percentages	Q&C Department

Behavioral Health Equity:

The Children’s Center will continue to implement the Behavioral Health Equity for Children and Families training. Three training dates have been selected during quarters two through four. The training is recommended for all staff and will be made mandatory for all clinical staff. Training facilitators will continue to make improvements on the training. The Children’s Center continue to engage in conversations with staff at the Ruth Ellis Center. The EDI (Equity, Diversity & Inclusion) Committee will discuss how this work will be continued through initiatives the committee takes on.

MEASURE OF SERVICE EFFECTIVENESS	
Name	Behavioral Health Equity
Definition	Collect quantitative and qualitative data
Data Collection	The data will be collected through a pre and post survey
Assessment Frequency	The Quality & Compliance Department will utilize the information collected to establish a baseline and parameters around ongoing monitoring

Performance Improvement Goal # 2	Benchmark	Plan of Action	Responsible Program
Implement strategy to report findings	Outline data reporting methodology	Q&C Department	Q&C Department
Continue training		Q&C Department will provide findings to Program Operations Committee	

Treatment Plan – Progress and Treatment Effectiveness:

Within our clinical programs, children and their families are involved in the development of their treatment goals and objectives in order to formulate an individualized, strength-based family-centered plan. Once the treatment plan has been completed, the clinician then monitors the client’s progress on the treatment plan on a regular basis through the completion of a Formal Review of Progress (FROP) review. As part of this review, the clinician documents whether or not, in their clinical judgment, the client has exhibited progress with a particular treatment plan goal or needs additional assistance and/or interventions to complete. For each goal listed in the treatment plan the clinician provides a narrative and marks the goal progress using one of five descriptors: “no progress,” “little progress,” “average progress,” “significant progress,” and “goal completed.” In turn, these reviews can be monitored on an aggregated basis via reports generated from MISTICC to determine both within a particular program and across the agency to see whether or not we are successfully assisting clients and their families in completing their treatment goals. “Exhibiting progress” is defined as those goals which were marked as having “average progress,” “significant progress,” or “goal completed.”

During the Quality Improvement meetings, significant dialogue transpires on assessing if the current fields in the FROP are adequately measuring effectiveness. As a result, this will be a targeted focus at the QI meetings in FY19.

MEASURE OF SERVICE EFFECTIVENESS	
Name	Treatment Plan Effectiveness
Definition	Progress on Treatment Plan Goals
Data Collection	The data is collected by Q&C monthly utilizing MISTICC
Assessment Frequency	The Quality & Compliance Department will assess information association with this indicator monthly and provide trending on a quarterly basis.

Performance Improvement Goal # 3	Benchmark	Plan of Action	Responsible Program
Monitor data to create baseline	Utilize baseline to establish a target	Full implementation of indicator in MISTICC Monthly monitoring	BHS Clinical Supervisors Q&C Department

Successful Discharge:

During the Quality Improvement meetings, there is a gap concerning the subjectivity of a successful discharge. We monitor quite a few external data points related to “successful discharge”, leading us to identify the need to reduce some of the subjectivity and connect it to our electronic health record. Through open discussion, the group defined it as such:

Successful Discharge: Client satisfaction with treatment progress as evidenced by 1) client satisfaction and 2) progress towards treatment goals or 3) improvement in outcome measures.

MEASURE OF SERVICE EFFECTIVENESS	
Name	Successful Discharge
Definition	Successful discharge of clients
Data Collection	The data is collected by Q&C monthly utilizing MISTICC
Assessment Frequency	The Quality & Compliance Department will work with program staff and the electronic health record to construct a method to assess this information monthly and provide trending on a quarterly basis.

Performance Improvement Goal # 4	Benchmark	Plan of Action	Responsible Program
Increase the number of successful discharges	Outline data reporting methodology	Train staff on successful discharge Implement strategies to monitor success	Q&C Department

		Correlate definition to EMR	
		Monthly monitoring & reporting	

Client Engagement:

A vital part of successful treatment is engaging the client and family in the treatment process. Several factors can indicate if the client is engaged and some are easier to measure than others. As part of the continuous quality improvement process, the group at the Quality Improvement meeting decided to focus on monitoring 30 day and 60 day time intervals of no service utilization. The prior indicator illustrates the presence of a strong therapeutic relationship between the staff and clients. Since this is more of a qualitative measure, communication will transpire between Quality & Compliance and clinical staff when concerning trends materialize.

MEASURE OF SERVICE EFFECTIVENESS	
Name	Client Engagement
Definition	Engagement of clients and families with clinical staff
Data Collection	The data is collected by Q&C monthly utilizing MISTICC
Assessment Frequency	The Quality & Compliance Department will work with program staff and the electronic health record to construct a method to assess this information monthly and provide trending on a quarterly basis.

Performance Improvement Goal # 5	Benchmark	Plan of Action	Responsible Program
Identify reports needed to track and report data	Outline data reporting methodology	Implement & maintain data collection methods Monthly monitoring & reporting	Q&C Department

Utilization Management: Retrospective Chart Review:

Unlike the current Quality Improvement chart review process, the items reviewed will be of a qualitative, clinical nature. Utilization Management is the process of evaluating the medical necessity, appropriateness and efficiency of health care services against established guidelines and criteria. Ultimately, these chart review items when viewed as a whole should allow for clinical staff to determine whether or not the appropriate clinical interventions are being delivered to a particular client, as evidenced by the presentation of the client’s needs, the content of the intervention, the congruency between these two items and the level of care established for the client. Feedback from the reviewer will be given to both the applicable case holder and their supervisor, allowing for informed changes to intensity and type of services when necessary. In order to improve the

efficiency of this process and make it more clinically valuable, we revised the audit tool and the sample selection process.

A random sample of client charts will be reviewed each month. The overall sample size is 50 per quarter. 75% of that sample will focus on one department, while the remaining 25% is a sample of smaller departments. As with most reviews, the target is 95%.

MEASURE OF SERVICE EFFECTIVENESS	
Name	UM Chart Review
Definition	% UM Chart Compliance
Data Collection	The data is collected by Q&C department reviewing charts in MISTICC
Assessment Frequency	The Quality & Compliance Department will assess information association with this indicator monthly and provide trending on a quarterly basis.

Performance Improvement Goal # 6	Benchmark	Plan of Action	Responsible Program
Maintain 95% compliance for all quarters	95%	Q&C will implement and monitor progress	Q&C Department

Efficiency

Periodic Formal Review of Progress:

In addition to the timely completion of an IPOS, clients also need periodic and timely review of their progress towards completion of treatment plan goals and objectives. This is facilitated via completion of our Formal Review of Progress (FROP) document. As with timely completion of the Treatment Plan, a target of 95% compliance is set for all Programs.

MEASURE OF SERVICE EFFICIENCY	
Name	Formal Review of Progress Completion
Definition	% of FROPs completed on time
Data Collection	The data is collected through MISTICC
Assessment Frequency	The Quality & Compliance Department monitors this on a monthly basis.

Performance Improvement Goal # 1	Benchmark	Plan of Action	Responsible Program
All clients will have their FROP completed within the appropriate time frames	95%	Continual monthly monitoring & reporting	BHS SED & DDS Programs Q&C Department

Satisfaction

Follow Up Survey:

The Children’s Center has been able to obtain feedback via our client satisfaction survey process. In addition to satisfaction surveys, follow-up surveys are utilized to survey behavioral health clients who are no longer active in services. The main purpose of the follow-up survey is to determine if our interventions were successful and/or if the client was linked to the appropriate aftercare services. Completion of the follow-up surveys is facilitated by the Client Services Department.

A random sample of closed cases are called each month and the targeted return rate is 15%. Since the follow up survey was implemented in 2013, this target has been difficult to reach. However, in FY18 tremendous progress occurred regarding the content of the feedback provided because of the revised sampling process and question revision. The target for FY19 will remain 15% response rate.

MEASURE OF SATISFACTION	
Name	Follow Up Survey
Definition	Positive Responses Observed – 80%
Data Collection	The data is collected by Q&C monthly utilizing MISTICC
Assessment Frequency	The Quality & Compliance Department will assess information association with this indicator monthly and provide trending on a quarterly basis.

Performance Improvement Goal # 5	Benchmark	Plan of Action	Responsible Program
Increase Response Rate	15% response rate	Q&C Department will coordinate with Client Services Coordinator to implement changes	Q&C Department

Performance Improvement Goal # 6	Benchmark	Plan of Action	Responsible Program
Identify Positive Response Indicator	80%	Q&C Department will track percentages	Q&C Department
Monitor Positive Response %			

Contractual Compliance

Credential Committee:

The objective of The Children’s Center Credential Committee is to operate in accordance with DWMHA Credentialing/Re-Credentialing policy as a CVO (Credential Verification Organization) ensuring the oversight and management of the credentialing and re-credentialing processes. These responsibilities include the development and review of credentialing criteria, making recommendations for approval of clinical responsibilities, and oversight of the implementation of appeal processes for adverse decisions specific to credentialing/re-credentialing.

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	Credential Committee Compliance
Definition	100% Compliance of Staff Credentialing
Data Collection	The data is collected through an internal spreadsheet that monitors staff’s credentials related to Aide, CMHP, QIDP, QMHP, QBHP , PSP, YPSS, etc.
Assessment Frequency	The Quality & Compliance department participates on the credential committee and gathers the annual average.

Performance Improvement Goal # 2	Benchmark	Plan of Action	Responsible Program
Increase credentialing compliance to 100% within 60 days of hire	100%	Implement yearly reports to monitor training hours for clinical staff Monitor corrective action plans in place Continual monitoring & reporting, creating additional internal reviews	Credential Committee

Action Notices:

In the CMH system, Medicaid Beneficiaries are afforded “Rights”. These rights include receiving a Notice of Action when a service is reduced, terminated, suspended or denied. The denial of services typically happens at the point of initial assessment and through our internal audits have observed deficiencies in this area.

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	Action Notice Review
Definition	100% of clients denied services due to criteria will receive an Adequate Notice and offered a Second Opinion. 100% of clients will receive an appropriate notice of action.
Data Collection	The data is collected through the Action Notice Internal Audit
Assessment Frequency	The Quality & Compliance department randomly selects charts and aggregates data on a monthly basis.

Performance Improvement Goal # 3	Benchmark	Plan of Action	Responsible Program
Increase compliance to 100%	100%	Q&C department implement corrective action plans Continual monitoring & reporting, creating additional internal reviews	Family Assessment Integration Service Department Q&C Department

Internal Claims Audit:

As a result of the PIHP (Pre-paid Inpatient Health Plan) requiring the providers to more closely monitor the alignment of service delivery and claims, we have implemented an internal claims audit. The internal claims audit assesses factors such as:

- Valid Treatment Plan
- Credentials of staff providing the service
- CPT code matching the service provided

The target is 100%.

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	Internal Claims Audit
Definition	100% of claims submitted for payment are appropriate
Data Collection	The data is collected through the Internal Claims Audit Sample
Assessment Frequency	The Quality & Compliance department randomly selects charts and aggregates data on a monthly basis.

Performance Improvement Goal # 4	Benchmark	Plan of Action	Responsible Program
Increase and maintain 100% compliance	100%	Continual monitoring & reporting Following the feedback loop for coordinators to monitor staff deficiencies	Q&C Department Program Coordinators

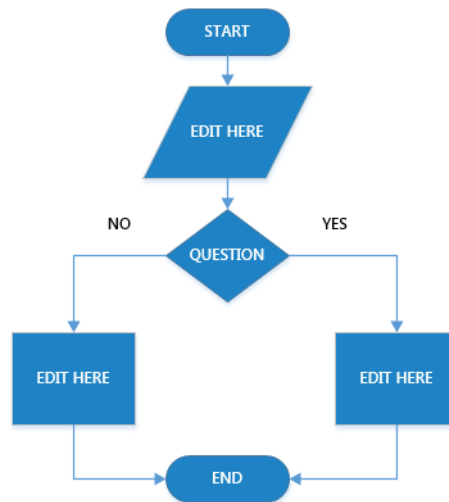
QI & QAPIP ANNUAL REPORT

The Annual Reports are compiled by the Director overseeing the Quality & Compliance Department. The Annual Report summarizes the goals and objectives of the plans, the quality improvement activities conducted the previous fiscal year, including targeted processes, systems and outcomes, the performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes, and the quality improvement initiatives taken in response to the findings. This report is reviewed and approved by the Administrative Compliance Team, Program Operations Committee and the Board of Directors.

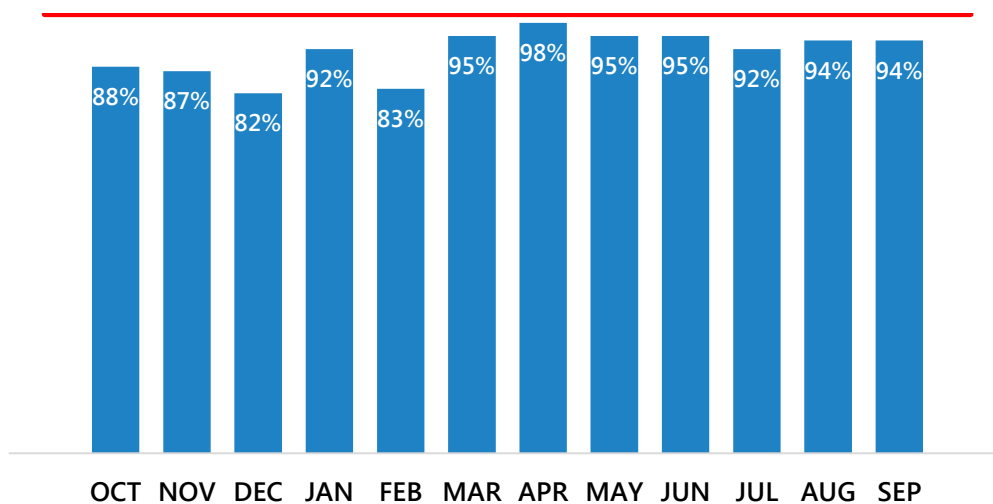
APPENDIX A. Quality Improvement Tools

Following are some of the tools available to assist in the Quality Improvement process.

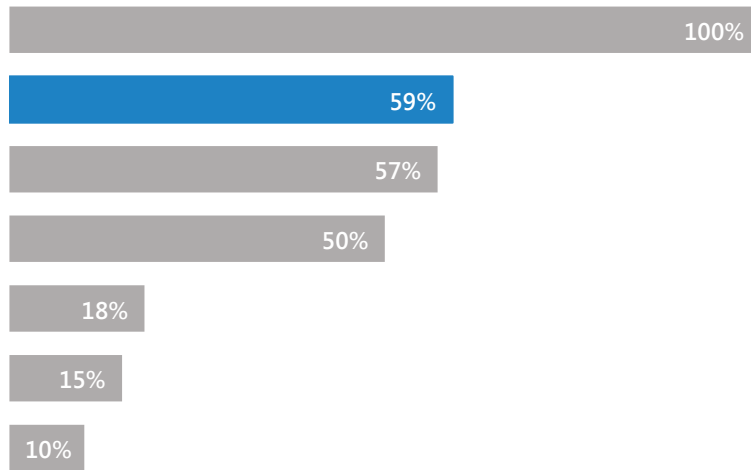
- A. Flow Charting/Process Mapping: Use of a diagram in which symbols depict the nature and flow of the steps in a process.



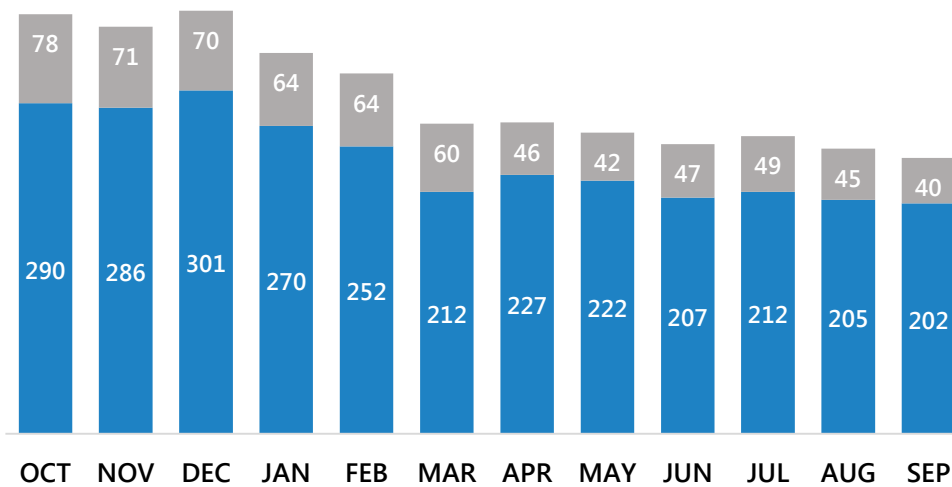
- B. Brainstorming: A tool used by teams to bring out the ideas of each individual and present them in an orderly fashion to the rest of the team. Essential to brainstorming is to provide an environment free of criticism.
- C. Bench Marking: A Target is a point of reference by which something can be measured, compared, or judged. It can be an industry standard against which a program indicator is monitored and found to be above, below, or comparable.



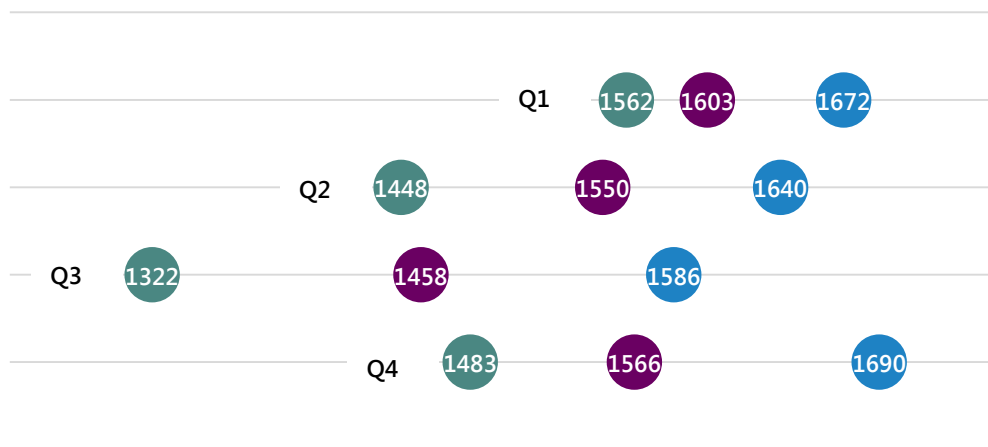
D. Bar Chart: A bar chart is a way of summarizing a set of categorical data. It displays the data using a number of bars of the same width, each of which representing a particular category.



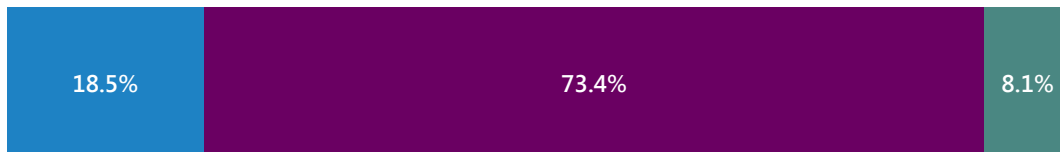
E. Combo Chart: A combo chart is a way of summarizing multiple variables of data. It displays the data using multiple bars and/or lines.



F. Dumbbell Dot Plot: A dumbbell dot plot is a way of summarizing how two or more numbers are alike or not. It displays the data using dots connected either vertically or horizontally.



G. Stacked Bar: A stacked bar is a way of showing comparisons of data, such as survey responses or parts of a whole. Each bar in the chart represents a whole, and segments in the bar different parts or categories of that whole.



H. Small Multiples: A series of similar graphs or charts using the same scale and axes, allowing them to be easily compared.

