THE CHILDREN'S CENTER OF WAYNE COUNTY, INC.
QUALITY IMPROVEMENT PLAN
&
QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT PLAN
FISCAL YEAR 2020-2021
October 1, 2020 – September 30, 2021

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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:

- <u>Client Focused:</u> Services should be designed to meet the needs of clients and their families.
- <u>Understanding work and system processes:</u> Understanding the service system and its key processes is vital to work to improve them.
- <u>Teamwork:</u> Because work is accomplished through processes and systems, it is essential to involve stakeholders, program, and process owners in the improvement process.
- <u>Data Driven:</u> 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 following the framework of Data Driven Decision Making:

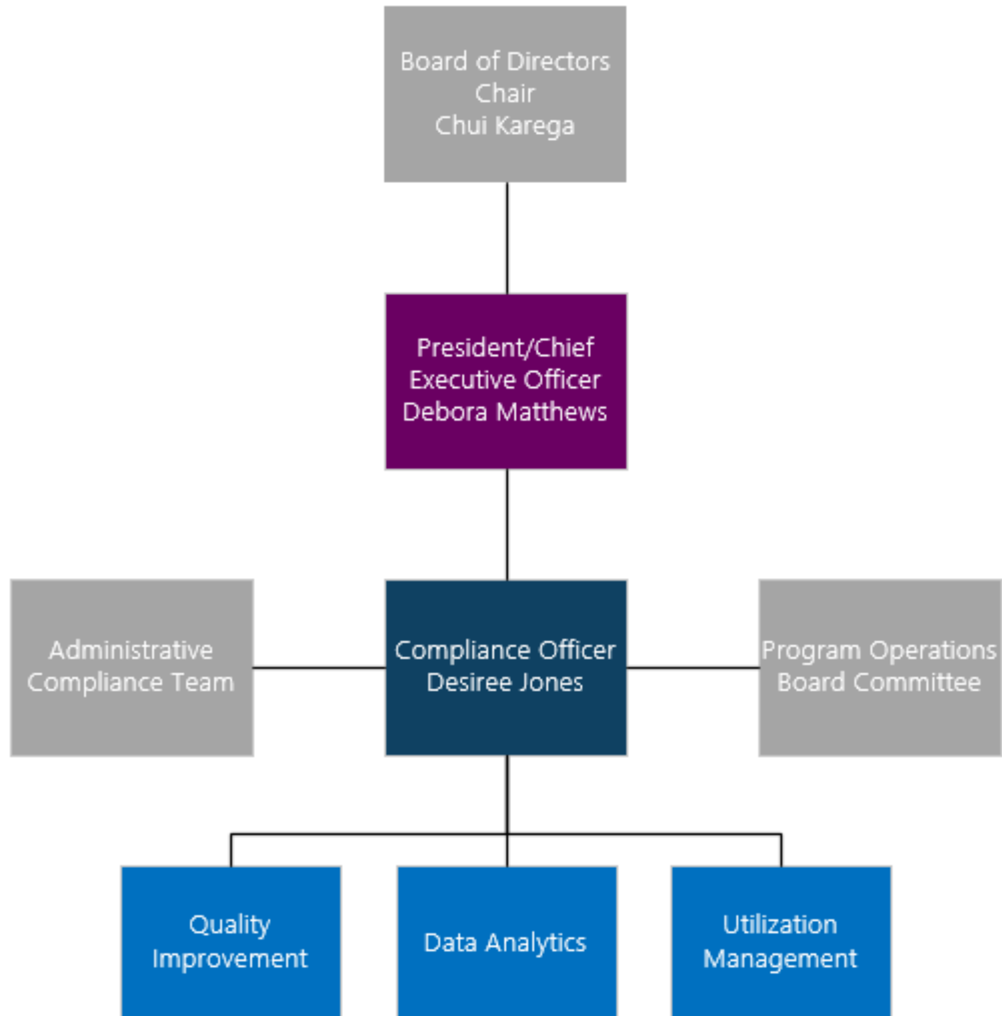
1) Strategy
2) Identify key areas
3) Data targeting
4) Collecting & analyzing data
5) Data presentation and validation
6) Garner insights
7) Turn actions and data into action

At the point of implementation, the data is continuously reviewed and collected (step 4) 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.

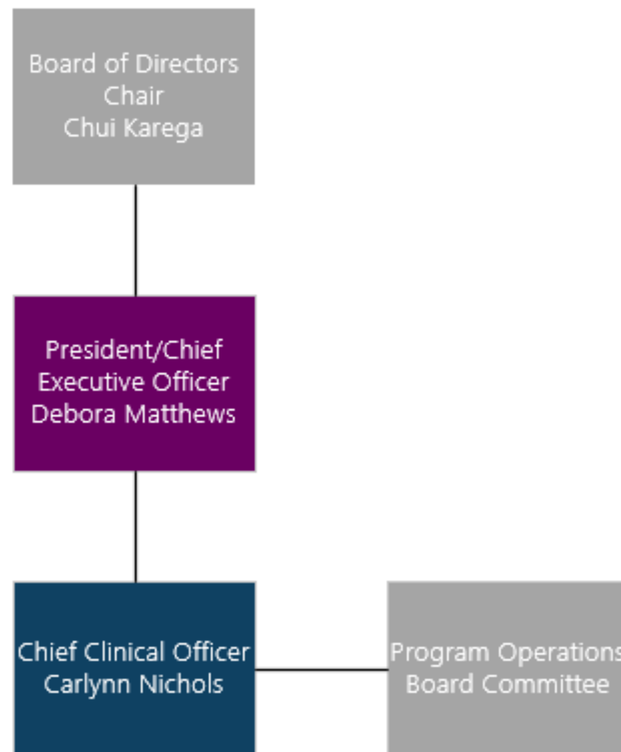
Access to valid data is crucial in the development of reliable quality indicators. However, data by itself is not enough to ensure that we measure what we need to measure; the data must be useful enough to answer important questions regarding specific areas of service delivery. For the purposes of ensuring 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 an Executive 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 effectives 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

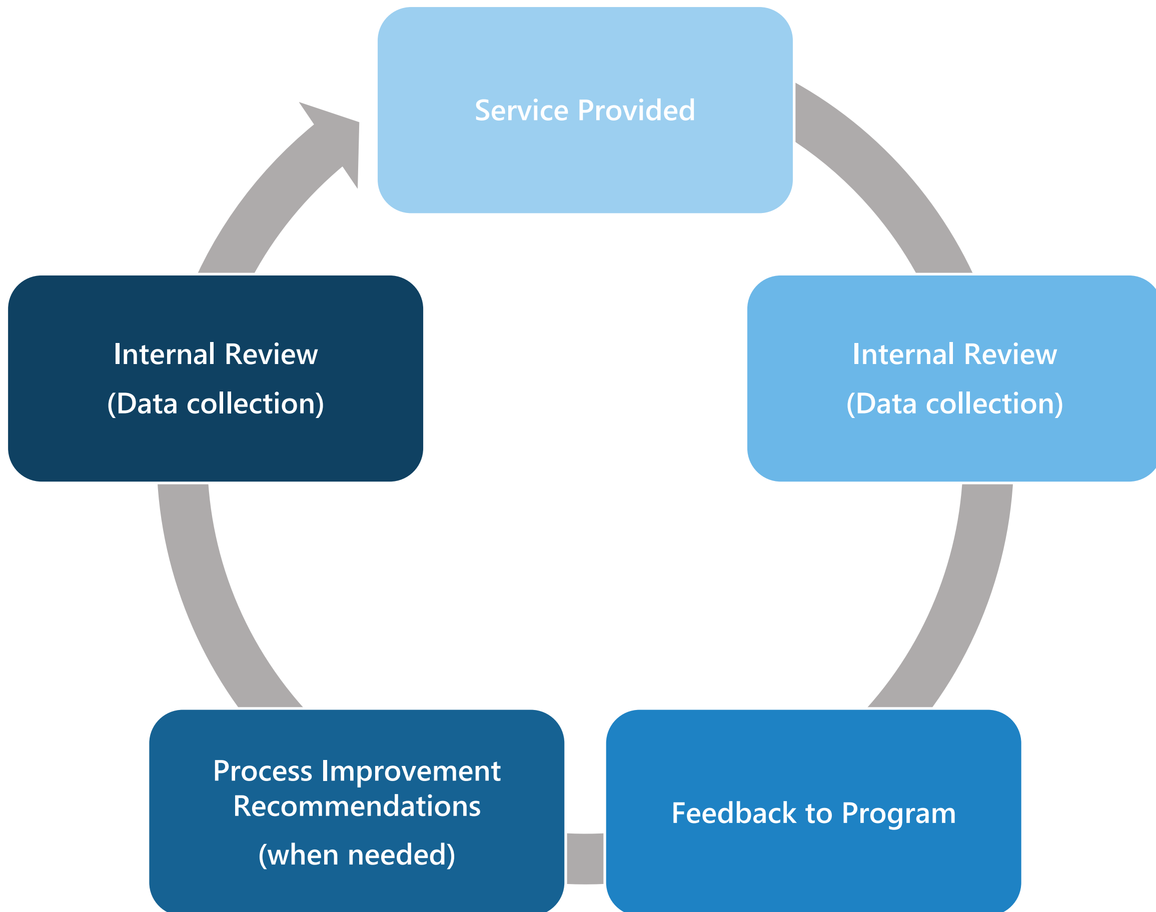
GOALS & OBJECTIVES

The Program Operations Committee identifies and defines goals and specific initiatives to be accomplished each year. The Fiscal Year 2020-2021 initiatives are as follows:

1) Serve as interface between TCC programs and Board of Directors.
2) Monitor and support internal activities that promote the reduction of health care disparities by assuring access to care for minority populations
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 consistent 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 involve:

- 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 regarding 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 because of the 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 responds accordingly. 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.

Glossary Guide

CCC: Crisis Care Center

CMH: Community Mental Health

CQI: Continuous Quality Improvement

CW: Child Welfare

DDS: Development Disability Services

DWIHN: Detroit Wayne Integrated Health Network

FROP: Formal Review of Progress

FY: Fiscal Year

HB: Home Based

I/DD: Intellectual or Development Disorder

ISEP: Implementation, Sustainability and Exit Plan

MDHHS: Michigan Department of Health and Human Services

MHWIN: Mental Health Wellness Information Network

MiSACWIS: Michigan Statewide Automated Child Welfare Information System

MISTICC: Management Information System of the Incredible Children's Center (TCC's Electronic Health Record)

QI: Quality Improvement

SED: Serious Emotional Disturbance

YASS: Young Adult Self Sufficiency

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 DWIHN. 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 DWIHN.
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 30th.	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 will begin to review subscale data of the CAFAS/PECFAS at the Quality Improvement meetings 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 the data TCC collects.
Assessment Frequency	The Quality & Compliance Department will assess information association with this indicator monthly and provide trending monthly at the QI meeting.

Performance Improvement Goal # 2	Target	Plan of Action	Responsible Program
1a) Decrease recidivism 1b) Monitor I/DD children	15% or less	Continual monitoring at internal QI meeting Identify occurrences for when special cases conferences are needed Q&C – monthly monitoring & reporting	Program Q&C Department

The statistics collected for hospital utilization and recidivism will continue to be tracked in the following areas:

Objectives	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP
Inpatient Data (from Hospital Liaison Log)												
1. SED Inpatient Admissions												
2. Average length of stay												
3. SED Recidivistic Admissions												
4. SED Percent Recidivism Target: <15%												
5. SED Total Discharged												
6. I/DD Inpatient Admissions												
7. I/DD Recidivistic Admissions												
8. I/DD Total Discharged												
9. SED and I/DD Aftercare Appts. (7 days)												
Crisis Center Data (from CC SED Monthly Log)												
10. Crisis Center Contacts (face to face)												
11. Crisis Center to Psych. Hosp.												
12. CC Diversion Rate Target>75%												
Overall Crisis Data (from MISTICC SALs)												
13. Psychiatrist Interventions (829 codes)												
14. H2011 codes billed												
15. 90839 codes billed												

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 1)**
Definition	Percentage of children receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours.
Data Collection	The data is collected through an internal file created by the Crisis Care Center.
Assessment Frequency	The Quality & Compliance Department pulls data from the internal report and reports monthly at BHS QI meeting.

Performance Improvement Goal # 1	Target	Plan of Action	Responsible Program
Maintain standard	Within 3 hours, 95% target	Q&C will provide data at the QI meeting	Family Assessment & Intervention Services Q&C Department

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 date 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 QI meeting.

Performance Improvement Goal # 2	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 new persons during the quarter starting any medically necessary on-going covered service within 14 days of completing a non-emergent biopsychosocial assessment.
Data Collection	The data is collected through MHWIN.
Assessment Frequency	The Quality & Compliance Department pulls data from MHWIN and reports monthly at BHS QI meeting.

Performance Improvement Goal # 3	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

MEASURE OF SERVICE EFFICIENCY	
Name	**Michigan Department of Health & Human Services - Access to Services (Performance Indicator 4a)**
Definition	Percentage of discharges from a psychiatric inpatient unit that were seen for follow-up care within 7 days.
Data Collection	The data is collected utilizing the hospitalization log and MISTICC.
Assessment Frequency	The Quality & Compliance Department pulls data from the log and MISTICC and reports monthly at BHS QI meeting.

Performance Improvement Goal # 4	Target	Plan of Action	Responsible Program
Maintain standard	Within 7 days, 95% target	Continual monthly monitoring & reporting	BHS SED & DDS Programs Q&C Department

CAFAS/PECFAS Completion and Overdue Rates:

Per our contract with DWIHN, 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 FY20 Annual Report, we met target for most of the year. We will continue to monitor this in FY21.

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 # 5	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 DWIHN, 100% of client entries into the FAS system must have the client's DWIHN 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 DWIHN 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 # 6	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 FY20 Annual Report, we met or exceeded target for the majority of the year, and this will continue to be the target for FY21.

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

Performance Improvement Goal # 7	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 Division 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 order to maintain a statistically significant response rate, we will continue to review proven practices and brainstorm new practices to gather responses.

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)	50% Response Rate	Q&C Department created a satisfaction survey	Client Services (survey distribution) Q&C Department (data collection)

Performance Improvement Goal # 3	Target	Plan of Action	Responsible Program
Monitor customer service satisfaction for foster parents	Continue to distribute the foster parent support group Conduct a focus group	Consistent distribution of the survey	Client Services (survey distribution) Q&C Department (data collection)

<u>Contractual Compliance</u>

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 FY20 Annual Report, Licensing and Adoptions met or exceeded target each quarter. Foster Care and YASS identified improvement areas for FY21. One of the actions, which has led to tremendous improvement, will continue for behavioral health services. This is the implementation of the internal and external chart review team. 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. DWIHN Autism Benefit Waiver Audit
4. DWIHN 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:

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. DWIHN 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 designee leads the process and incorporates the appropriate parties to participate. Any areas of improvement are 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 DWIHN 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 DWIHN 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 DWIHN. In either case, we would fully assist DWIHN 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 365 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 365 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
At least 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 FY20, 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 FY20, 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 FY20 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 FY20, we averaged 94%, which is higher than prior 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 INTERNAL TARGET	
Name	Child Welfare Licensed Homes – Viable Beds
Definition	# of Viable Beds
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
Increase the number of viable beds	30% net gain	Increase Recruiting Efforts	Child Welfare Program

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 < 50%; 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 <75%; target is 95%	10% increase	Monitor the Book of Business Implement clerical support when needed	Child Supervisors & Manager Q&C Department

		Escalate case closing concerns to MDHHS CW QI Meeting agenda item	

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 – Viable Beds**
Definition	The Children's Center will increase the number of viable beds.
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 viable beds	Monitor monthly trends 30% increase	Supervisory monitoring 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. 40% of children in care will be discharged to permanency	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	75% 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	75%	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 throughout the fiscal year. The training is required for all staff and is being offered to agency board/committee members. 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
Continue strategy to report findings Continue training & report pre- & post-survey results	Outline data reporting methodology	Q&C Department Q&C Department will provide findings to Program Operations Committee	Q&C Department

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 case holder then monitors the client's progress. During the Quality Improvement meetings, the group determined to eliminate the "goal progress" report based on its subjectivity but to continue to monitor the compliance measure. As a result, this will be a targeted focus at the QI meetings in FY21.

MEASURE OF SERVICE EFFECTIVENESS	
Name	Treatment Plan Effectiveness
Definition	Identify methodology to collect qualitative and quantitative data.
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
Identify new methodology to track client progress	Utilize new tool to create a baseline and establish a target	Collaboration with Clinical Management Team Monthly monitoring	BHS Clinical Managers Q&C Department

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 # 4	Benchmark	Plan of Action	Responsible Program
Continue monitoring 30- 60- 90- statistics	Decrease in clients not seen in timely intervals	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 # 5	**Benchmark**	**Plan of Action**	**Responsible Program**
Increase 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 until FY19. Tremendous progress occurred regarding the content of the feedback provided because of the revised sampling process and question revision as well as the response rate. The target for FY21 will remain 15% response rate.

TCC's Big Hairy Audacious Goal (BHAG) is to be recognized as The Best Children's Service Provider in the Nation. One of the recognition measurements includes achieving an overall Net Promoter Score (NPS) of 75 with clients, donors, volunteers and other partners. NPS is focused on a single ultimate question: "How likely is it that you would recommend this company to a friend or colleague?"

In order to gear this questions towards other audiences aside from our clients, we tweaked the "ultimate" question for the audience being surveyed and increased the target for the follow-up survey to 80

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 # 1	Benchmark	Plan of Action	Responsible Program
Increase Response Rate	15% response rate	Q&C Department will coordinate with Client Services Supervisor to implement changes	Q&C Department

Performance Improvement Goal # 2	Benchmark	Plan of Action	Responsible Program
Monitor Positive Response %	80% (80 NPS)	Q&C Department will track percentages	Q&C Department

Contractual Compliance

Credential Committee:

The objective of The Children's Center Credential Committee is to operate in accordance with DWIHN 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 # 1	**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 Notice of Adverse Benefit Determination Audit.
Assessment Frequency	The Quality & Compliance department randomly selects charts and aggregates data on a monthly basis.

Performance Improvement Goal # 2	Benchmark	Plan of Action	Responsible Program
Increase compliance to 100% Identify systematic changes that will assist with compliance	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 monitor the alignment of service delivery and claims more closely, 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

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 # 3	Benchmark	Plan of Action	Responsible Program
Increase and maintain 100% compliance	100%	Continual monitoring & reporting Following the feedback loop for supervisors to monitor staff deficiencies	Q&C Department Program Supervisors

PHQ-9/A:

The PHQ-9/A is a questionnaire to measure the severity of depression in children and adolescents ages 11 – 17, 18-21 SED youth will complete the adult PHQ-9. If a client scores 10 or higher, a reassessment is due every 90 days. The administration of this screening is a requirement by our funder DWIHN. We monitor the compliance and proposed treatment actions at the monthly Quality Improvement meeting.

MEASURE OF CONTRACTUAL COMPLIANCE	
Name	PHQ-9/A
Definition	95% of clients will receive a timely PHQ-9/A
Data Collection	The data is collected through MISTICC
Assessment Frequency	The Quality & Compliance department collects the information and aggregates data on a monthly basis.

Performance Improvement Goal # 4	Benchmark	Plan of Action	Responsible Program
Maintain 95% compliance	95%	Continual monitoring & reporting	Q&C Department Program Supervisors

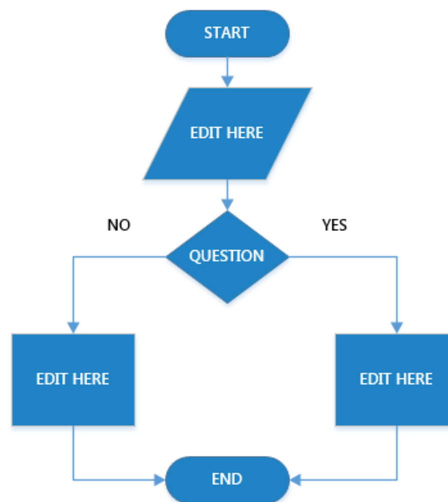
QI & QAPIP ANNUAL REPORT

The Annual Reports are compiled by the Chief 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

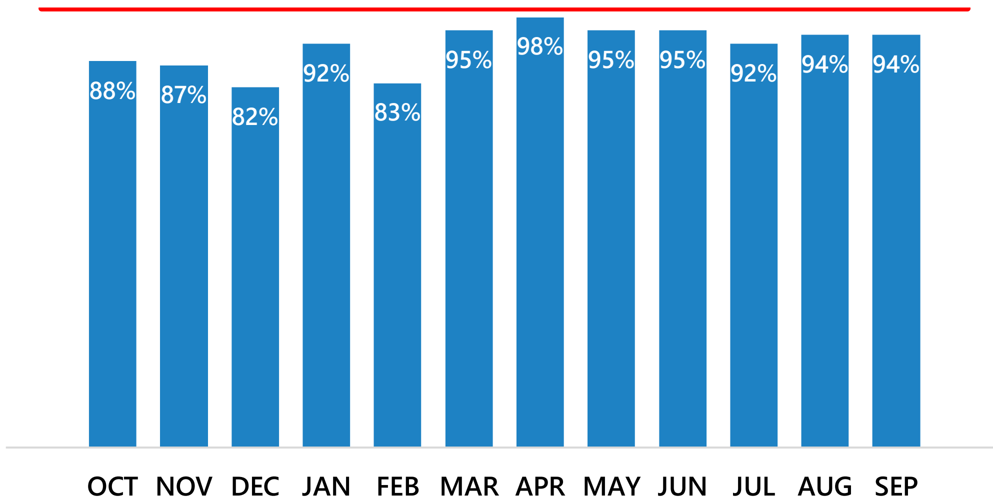
Following are some of the tools available to assist in the Quality Improvement process.

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



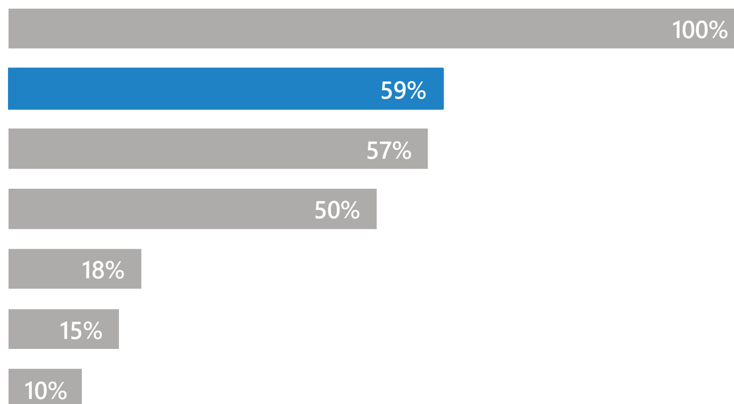
B. **Brainstorming:** A tool used by teams to bring out the ideas of each individual and present them in an orderly fashion to the rest of the team. Essential to brainstorming is to provide an environment free of criticism.

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.

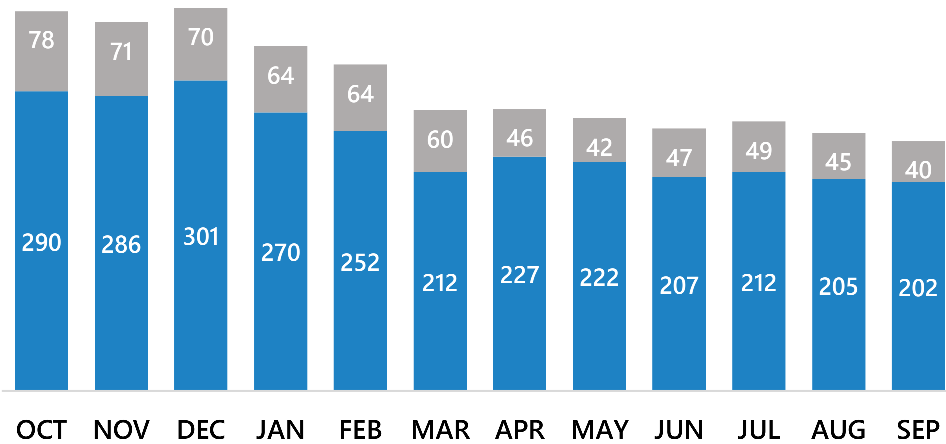


D. **Back to Back Chart:** A back to back chart is a way of summarizing the overall shape of datasets. It displays the data using back to back bars that start from the same axis point.

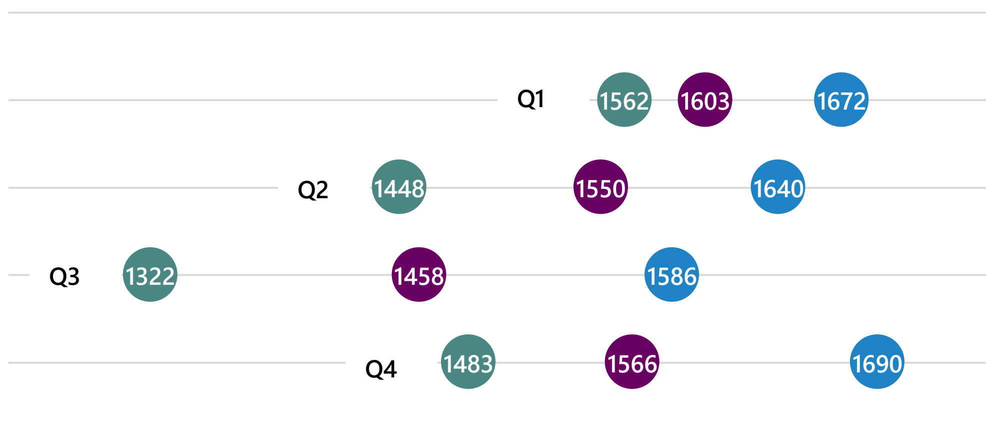
E. **Bar Chart:** A bar chart is a way of summarizing a set of categorical data. It displays the data using a number of bars of the same width, each of which representing a particular category.



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

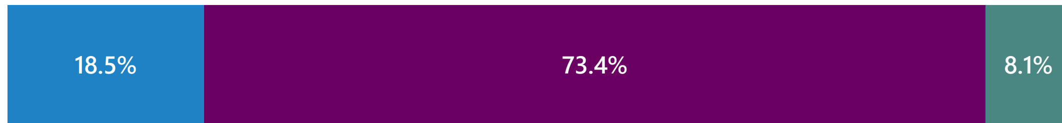


G. **Dumbbell Dot Plot:** A dumbbell dot plot is a way of summarizing how two or more numbers are alike or not. It displays the data using dots connected either vertically or horizontally.



H. **Lollipop Chart:** A lollipop is another way to visualize a dataset that would typically be made into a bar chart that is less visually overwhelming. It displays the data using dots connected either vertically or horizontally.

I. **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.



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