West Michigan Community Mental Health
Annual Quality Measure Performance Analysis FY2016

Report date: January 13, 2017

The following measures are reported to PIOC throughout the year at the frequency stated below. Additionally, these measures are reviewed as part of the annual effectiveness review.

Measure	Source	Reporting Frequency
A. CAFAS and PECFAS	Annual CAFAS and PECFAS reports	Annual
B. Access, efficiency, and outcomes as reported via the Michigan Mission-Based Performance Indicator System	MMBPIS	Quarterly
C. Care Coordination data (releases to PCPs, documents sent to PCPs)	Data draw	Annual
D. LRE Site Review	LRE	Annual
E. CARF Accreditation Summary	CARF	Triennial
F. Medicaid Verification Results	LRE	Semiannual
G. Provider Network Quality Oversight – Site Reviews (Pending LRE Action)	Network Coordinator / LRE	Annual
H. Physical Management and Behavior Treatment Review Committee Data	BTC report	Quarterly
I. Post-Discharge Monitoring	Customer Service	Semiannual
J. PIOC Self-Evaluation	PIOC	Annual
K. Walk-In Monitoring	PIOC	Semiannual
L. DD Proxy Completeness	SETeam	Annual
M. Accessibility Reporting	ACCC	Annual
N. UMUR Summaries	UMUR	Monthly
O. Satisfaction: West Michigan MHSIP and YSS	Customer Service	Annual

Annual Program Evaluation

1. A performance analysis of the above quality measures.
2. A review of the appropriateness and relevance of current measures (contained throughout this report).
3. A review of the Committee annual Self-Evaluation results (see indicator J.).
4. A review of QAPIP Goals of the previous year (See Attachment 4 of the QAPIP).
5. Identify QAPIP Goals for the coming year (to be determined by PIOC).
6. An overall performance summary including Improvements to Quality of Service Delivery, Trends in Service Delivery and Health Outcomes over Time, and Progress on Goals and Objectives.
7. Recommendations and next steps.

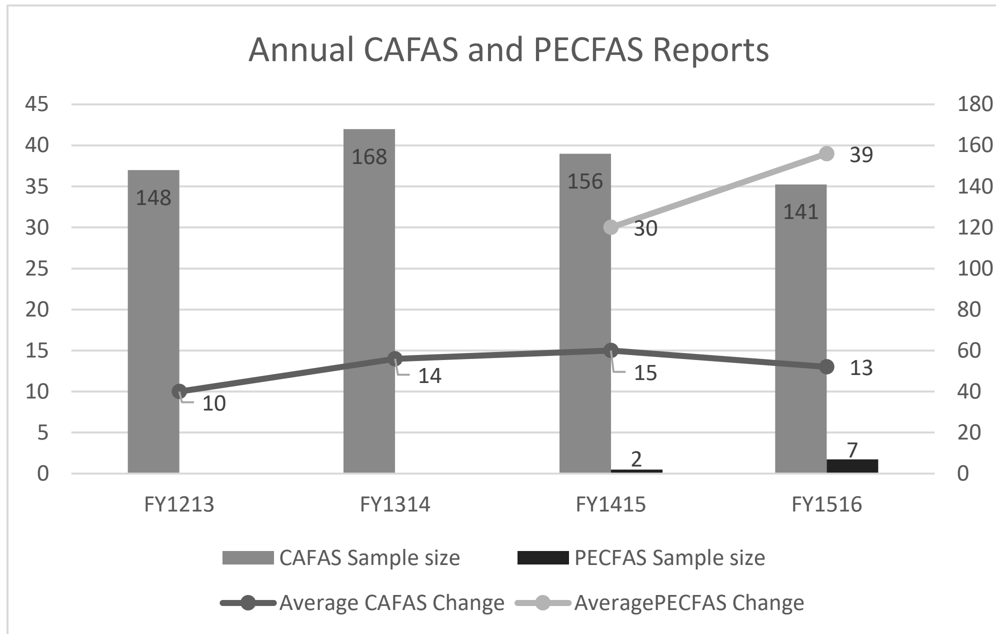
Documentation of the QAPIP annual review, its findings and recommendations are forwarded to the Executive Team and the Board. The annual review may lead to:

1. Identification of educational/training needs.
2. Establishment and revision of policies and procedures related to quality initiatives.
3. Recommendations regarding credentialing of practitioners.
4. Changes in operations to minimize risks in the delivery of quality services, and.
5. Development of objectives for the coming year.

FY 2016 Performance Analysis

Indicator A. CAFAS and PECFAS

Reported Annually



Analysis

CAFAS and PECFAS are functional assessment scales used for children and adolescents. The chart shows CAFAS and PECFAS sample size across the past 4 fiscal years. Sample size for CAFAS has remained fairly consistent, while PECFAS sample size has increased from 0 in the first two years, to 2, then 7 in FY1516.

For CAFAS and PECFAS, a positive change value indicates improvement. The average change in score over time remains fairly consistent year to year. For PECFAS, average change in score for FY1516 is greater than the previous year.

This year's recommendations were:

- Continue participation in the PECFAS level of functioning project. Children's staff will continue to routinely monitor PECFAS data with a summary reporting coming to PIOC on an annual basis. The next summary report to PIOC will be in January/February 2017.
- Children's staff will ensure that an exit PECFAS is being completed when a child reaches the age where CAFAS assessment is the more appropriate tool based upon the child's age.

Appropriateness of this Measure

This measure is required by MDHHS. It remains appropriate and relevant. Monitoring will be continued.

See Attachment A for FY1516 Annual CAFAS and PECFAS report

Indicator B. Access, efficiency, and outcomes as reported via the Michigan Mission-Based Performance Indicator System

Reported Quarterly

MMBPIS FY 2016 - PIHP (Medicaid only)

Indicator 1 - PAS in 3 hours

	1st Q	2nd Q	3rd Q	4th Q
Children	100.00%	100.00%	100.00%	100.00%
Adults	100.00%	100.00%	100.00%	100.00%

Indicator 2 - Request to Assessment in 14 days

	1st Q	2nd Q	3rd Q	4th Q
MIC	100.00%	100.00%	96.15%	97.14%
MIA	100.00%	100.00%	100.00%	98.59%
DDC	N/A	N/A	100.00%	100.00%
DDA	100.00%	100.00%	80.00%	100.00%
SUD	100.00%	100.00%	100.00%	97.62%
Total	**100.00%**	**100.00%**	**98.15%**	**98.03%**

Indicator 3 - Assessment to start of care in 14 days

	1st Q	2nd Q	3rd Q	4th Q
MIC	100.00%	100.00%	100.00%	100.00%
MIA	100.00%	100.00%	100.00%	94.60%
DDC	N/A	N/A	N/A	100.00%
DDA	100.00%	100.00%	50.00%	100.00%
SUD	96.80%	100.00%	100.00%	95.70%
Total	**98.80%**	**100.00%**	**98.70%**	**96.30%**

Indicator 4a - Seen within 7 days of hosp discharge

	1st Q	2nd Q	3rd Q	4th Q
Children	100.00%	100.00%	100.00%	100.00%
Adults	100.00%	100.00%	100.00%	100.00%

Indicator 4b - Seen within 7 days of detox discharge

	1st Q	2nd Q	3rd Q	4th Q
SUD	100.00%	100.00%	100.00%	93.75%

Indicator 10 - Readmitted to hosp in 30 days or less

	1st Q	2nd Q	3rd Q	4th Q
Children	0.00%	33.00%	0.00%	0.00%
Adults	0.00%	10.00%	5.56%	13.33%

MMBPIS FY 2016 - CMH (all traditional MH)

Indicator 1 - PAS in 3 hours

	1st Q	2nd Q	3rd Q	4th Q
Children	100.00%	100.00%	100.00%	100.00%
Adults	98.20%	100.00%	100.00%	100.00%

Indicator 2 - Request to Assessment in 14 days

	1st Q	2nd Q	3rd Q	4th Q
MIC	100.00%	100.00%	96.88%	97.14%
MIA	100.00%	100.00%	100.00%	98.72%
DDC	N/A	N/A	100.00%	100.00%
DDA	100.00%	100.00%	85.71%	100.00%
total	**100.00%**	**100.00%**	**98.21%**	**98.31%**

Indicator 3 - Assessment to start of care in 14 days

	1st Q	2nd Q	3rd Q	4th Q
MIC	100.00%	100.00%	100.00%	100.00%
MIA	100.00%	100.00%	100.00%	95.00%
DDC	N/A	N/A	N/A	100.00%
DDA	100.00%	100.00%	75.00%	100.00%
total	**100.00%**	**100.00%**	**98.50%**	**96.70%**

Indicator 4a - Seen within 7 days of hosp discharge

	1st Q	2nd Q	3rd Q	4th Q
Children	100.00%	100.00%	100.00%	100.00%
Adults	100.00%	100.00%	100.00%	100.00%

(Indicator 4b not reported)

Indicator 10 - Readmitted to hosp in 30 days or less

	1st Q	2nd Q	3rd Q	4th Q
Children	0.00%	33.33%	0.00%	0.00%
Adults	0.00%	8.33%	5.00%	11.76%

(Indicator B., continued)

Analysis
On average, there were more outliers in the second half of the fiscal year. WM's performance was strongest on Indicator 1 (PAS completed in 3 hours or less) and 4a (follow up care within 7 days after inpatient discharge). Indicators 2 (assessment within 14 days of request) and 3 (start of care within 14 days of assessment) had fewer quarters at 100%. Performance on indicator 10 (inpatient readmission within 30 days or less) was also spotty; however, none of the #10 outliers this year could have been prevented by WMCMH. Drilldown on Indicators 2 and 3 showed that staff scheduling and documentation errors accounted for the outliers. Plans of correction included retraining staff, developing a Quick Reference guide for Service Entry staff, developing a new process for rescheduling WMCMH-canceled appointments, retraining Detox providers on discharge planning, and monthly monitoring of performance as needed. Plans of correction were generally effective at preventing recurrence of specific errors that resulted in sub-standard performance.

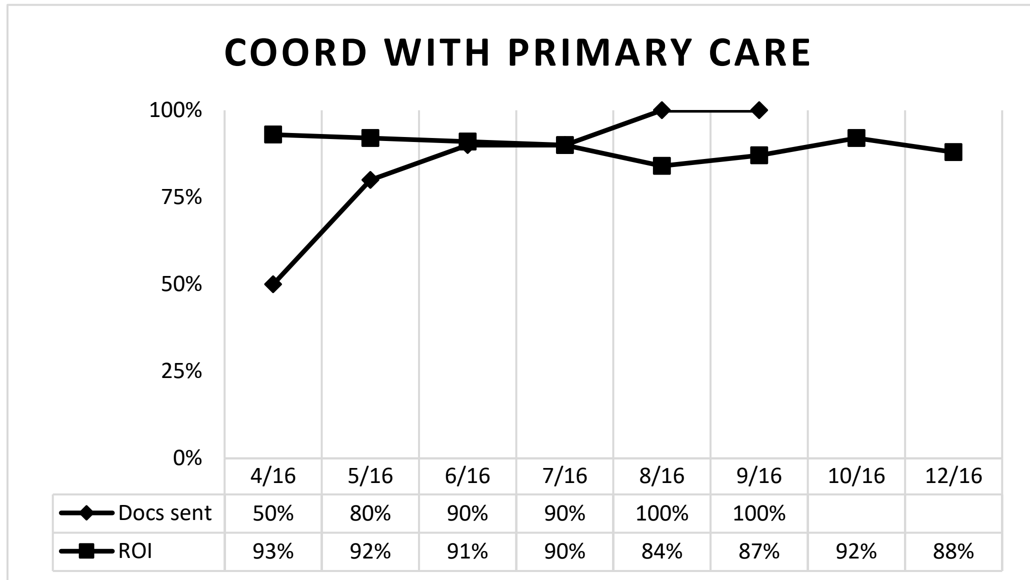
WM’s relatively low numbers of individuals served, especially in certain populations, makes meeting the performance targets challenging.

Appropriateness of this Measure
This measure is required by MDHHS. It remains appropriate and relevant. Monitoring will be continued.

See Attachment B for FY1516 Annual MMBPIS Reports

Indicator C. Care Coordination data (releases to PCPs, documents sent to PCPs)

Reported Semi-Annually



	4/16	5/16	6/16	7/16	8/16	9/16	10/16	12/16
Docs sent	50%	80%	90%	90%	100%	100%		
ROI	93%	92%	91%	90%	84%	87%	92%	88%

Analysis

This measure was implemented in a response to an LRE plan of correction from the December 2015 site visit. Documents sent to PCPs reached 100% for two consecutive reviews, and so monitoring was discontinued for the remainder of the year. Releases to primary care physicians has approached the 95% standard but has not yet met it. If this standard is cited by the LRE from the December 2016 site visit, the plan of correction will be revisited, with possible practice changes implemented, and intensive monitoring will continue. If it is not cited, PIOC will evaluate the ongoing reporting frequency of this standard.

Methods to improve performance have included:

- Team Leaders are provided a monthly list of persons served whose releases have expired.
- It was noted that performance at our December 2016 LRE site visit appeared better than our monitoring shows. This may be because of problems with the monitoring data set. In the next monthly monitoring cycle, we will pull a smaller random sample and drilldown as needed to ensure data is accurate.

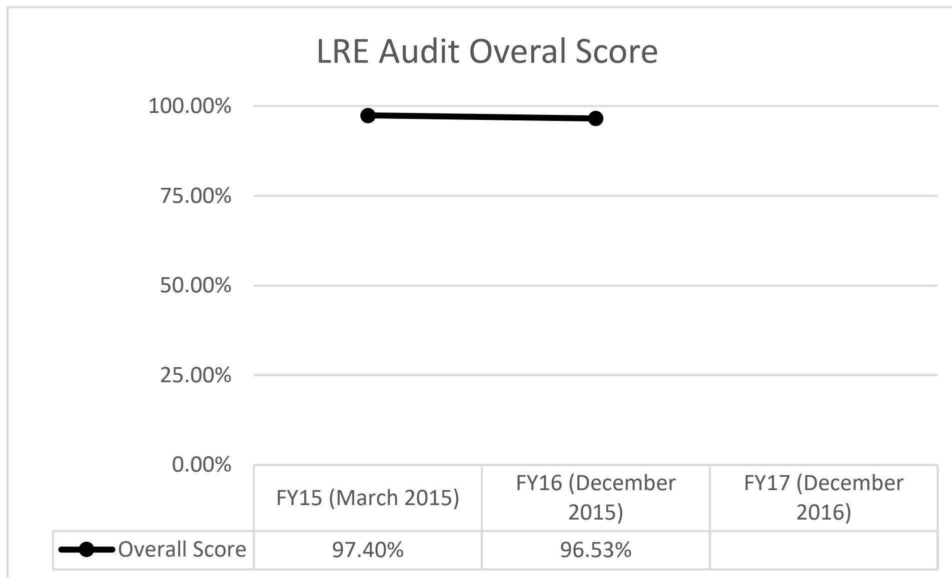
Appropriateness of this Measure

Coordination with Primary Care is a requirement of the LRE. Monitoring was implemented as part of a FY16 Plan of Correction to the LRE. It remains appropriate and relevant. Monitoring will be continued, with frequency to be determined.

See Attachment C for full FY1516 report on Care Coordination Data

Indicator D. LRE Site Review

Reported Annually



Analysis

WMCMH's FY1516 LRE Site Review (December 2015) resulted in overall 96.53% performance. Our score essentially the same as the previous year albeit slightly lower; the LRE communicated that the March 2015 review, being their first review of WMCMH, was not as detailed or comprehensive as the December 2015 review. Our strongest performance was the program specific standards, the majority of the administrative standards, and the staff training and credentialing standards. The majority of the citations were related to chart review. Plans of correction were submitted on time and accepted as written. As of January 2017 WMCMH has completed 14 of the 22 total plans of correction that were submitted.

Plans of correction that WM has not been able to complete include:

- Timeliness of IPOS, Copy of Plan to person served, and periodic reviews
- Clear and measurable goals and objectives
- Signatures on plans
- Services delivered according to plan
- Coordination with primary care (as evidenced by signed releases of information)
- Scripts for specialized services (Performance has been at 100% but the time period for completion is long due to the infrequent need for scripts)
- SUD issues noted in assessments are addressed in treatment plans

WMCMH's score for the December 2016 site visit has not yet been reported.

Appropriateness of this Measure

Site Visits are required by the LRE. It remains appropriate and relevant. Monitoring will be continued.

See Attachment D for full FY1516 LRE Site Review report (to be included when received from LRE)

Indicator E. CARF Accreditation Summary

Reported Every Three Years

Analysis

WMCMH's last CARF Survey was in February 2014. WMCMH received a 3-year accreditation with commendations for community relations, community collaboration, involvement of individuals served by the organization, satisfaction of the individuals served, welcoming facilities, passionate staff / employee retention, EHR, and strategic partnership. Corrective action plans were required in the areas of:

- Policies reviewed and/or updated annually – complete
- Cultural competency plan additions – complete
- Ethics policy additions
- Policy on search warrants and investigations – complete
- Fiscal review of records of persons served– complete
- Health and Safety tests and inspections – complete
- Critical incident debriefing
- Staff training on promoting wellness – complete
- Performance Appraisals
- Rights information provided annually – complete
- Program level performance measures – complete
- Annual performance analysis – complete
- Program plans reviewed annually – complete
- Clinical supervision – complete
- Goals in words of persons served
- Transition plans include referral information – complete
- Med training for staff – complete
- Prescriber peer review process
- Signatures on clinical record documents – complete
- ACT staff supervision – complete

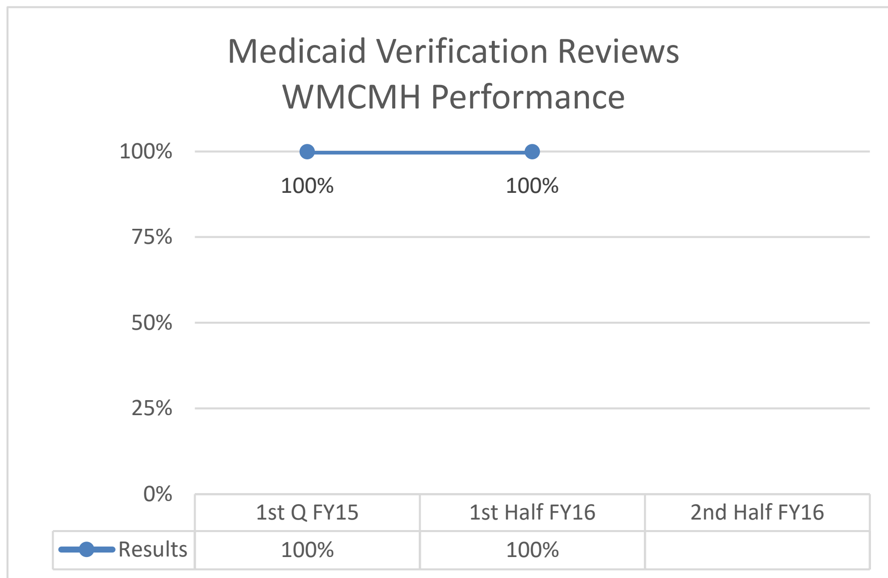
Appropriateness of this Measure

Accreditation is required by multiple payer sources. This measure remains appropriate and relevant. Monitoring will be continued.

See Attachment E for full 2014 CARF Survey report

Indicator F. Medicaid Verification Results

Reported Semi-Annually



Analysis

After the initial quarterly review in FY2015, the LRE has implemented Medicaid Verification Reviews every 6 months, looking at a sample of claims during the previous 6-month period. WMCMH's performance has been at 100%, indicating excellent compliance with requirements. Results from the 2nd half of FY16 are not yet available from the LRE.

Appropriateness of this Measure

This measure is required by the LRE. It remains appropriate and relevant. Monitoring will be continued.

See Attachment F for full FY1516 Medicaid Verification report from the LRE

Indicator G. Provider Network Quality Oversight – Site Reviews

Reported Annually

Analysis

FY 1516 was a transition year, with the following new processes and procedures:

- LRE took over network provider site visits
- LRE used new site visit tools while reviewing providers
- Providers were newly required to use the Lakeshore Learning Management System for staff training
- Providers were newly required to train all staff in Mandt

Revisions to the site visit tools will be on the table in the near future. WMCMH has worked with the LRE to develop a process for immediately notifying WMCMH of any health and safety issues so that they can be addressed timely. Very few emergent issues have come forward.

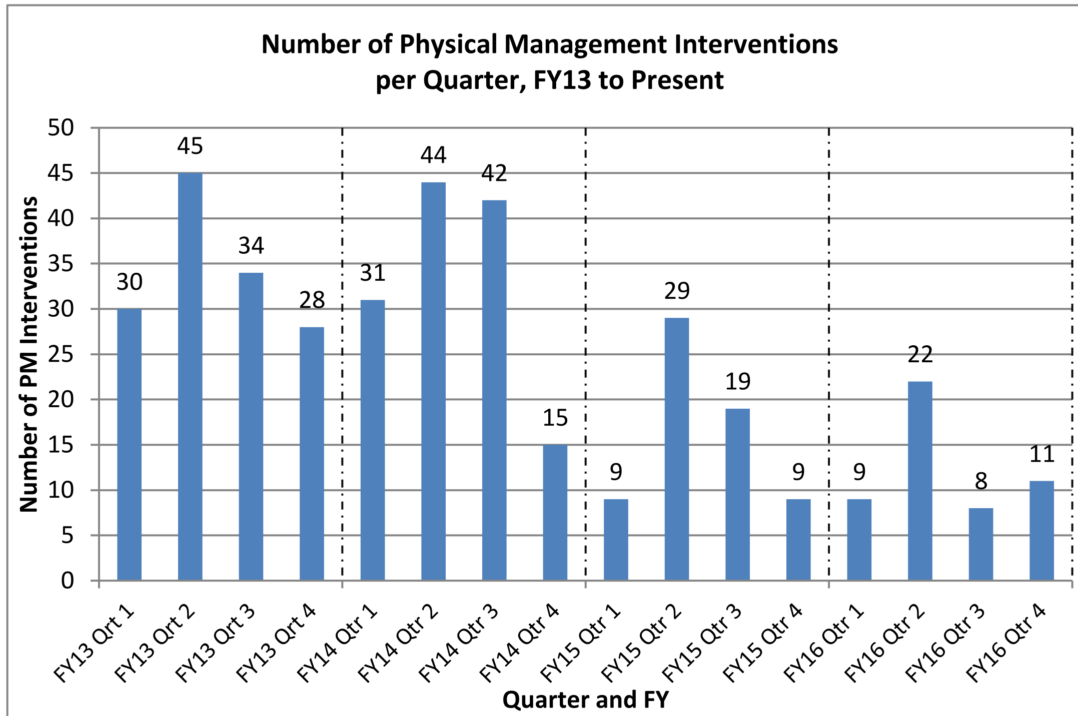
As a result of the LRE Site Visits of Providers, WMCMH was found to have partial responsibility for some citations, including repairs to facilities owned by WMCMH, monthly monitoring of individuals served by WMCMH staff, Person Centered Plans meeting requirements, and copy of Person Centered Plan being on site at the home. Plans of correction were submitted and all were completed timely.

Appropriateness of this Measure

Provider Network Quality Oversight is required by the LRE. Tracking performance remains appropriate and relevant. Monitoring will be continued.

Indicator H. Physical Management and Behavior Treatment Review Committee Data

Reported Quarterly



Analysis

The use of physical management has continued to trend downward over the past 4 fiscal years. Use of physical management in FY16 was 55% lower than the average use over the past 3 fiscal years. This decrease may be associated with less risk and better quality of care. Tracking and of physical management use continues to be thorough and consistent.

It is further noted that contacts to Law Enforcement made by provider staff for the purposes of behavior-related emergencies has been trending downward since the start of FY16. This suggests that providers are not relying on Law Enforcement involvement to replace physical management for the purposes of behavior control.

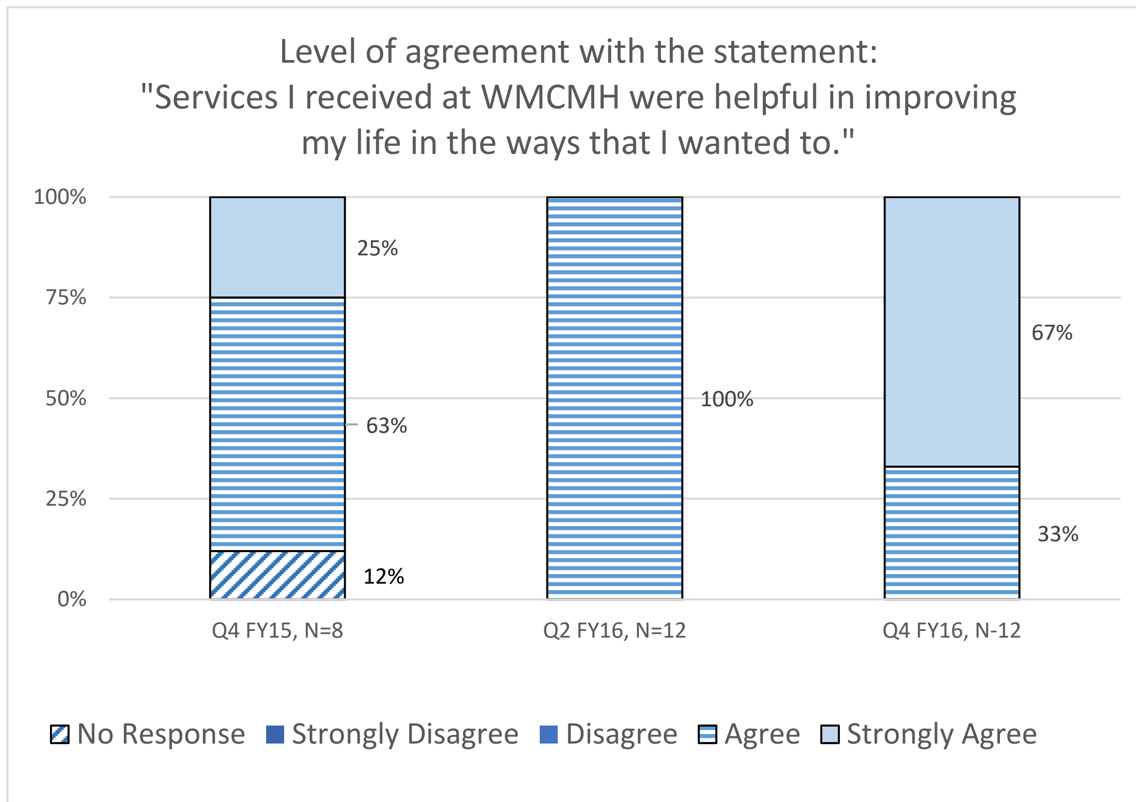
Appropriateness of this Measure

This measure is required by MDHHS and the LRE. It remains appropriate and relevant. Monitoring will be continued.

See Attachment H for full FY1516 Physical Management and Law Enforcement Data Report

Indicator I. Post-Discharge Monitoring

Reported Semi-Annually



Analysis

In both reporting periods of FY16, 100% of respondents agreed that WMCMH services were helpful in improving their lives. In the most recent reporting period, the majority of respondents strongly agreed. Additionally, a majority of respondents reported that they had a stable living situation, were employed or in school, and had not used drugs or alcohol in the past 30 days. Comments received were highly positive.

Appropriateness of this Measure

This measure is required by CARF. It remains appropriate and relevant. Monitoring will be continued.

See Attachment I for FY1516 Post Discharge reports.

Indicator J. PIOC Self-Evaluation

Reported Annually

Members of the Performance Improvement Oversight Committee complete an annual survey regarding the performance of the committee. The table below presents average aggregate scores on the 4 sections of the survey.

Rating Scale: 4=Very Good; 3=Good; 2=Fair; 1=Poor

Summary Data	FY 2015	FY 2016
Mission Planning & Oversight	3.61	3.71
Quality Oversight	3.50	3.52
Committee Effectiveness	3.63	3.76
Individual Self-Assessment	3.67	3.93
Overall Rating	**3.60**	**3.73**

Analysis

All committee members responded to the survey. Aggregate scores in each section showed improvement over the previous year. The highest rated sections were the Individual Self-Assessment and Committee Effectiveness. The lowest rated section was Quality Oversight, in which the lowest questions were regarding reviewing feedback from outside sources and communicating performance data with outside sources. These may be areas to consider for FY17 annual goal setting.

Appropriateness of this Measure

This measure is required by MDHHS and the LRE. It remains appropriate and relevant. Monitoring will be continued.

See Attachment J for FY1516 PIOC Self-Evaluation Report

Indicator K. Walk In Monitoring

Reported Semi-Annually

Review #	Review Period	Average Amount of Time Spent Waiting in Lobby	Percent seen in 30 minutes or less	Met 95% DCH standard?
1	4/25/11 – 5/6/11	26 min. (Range: 3-62 minutes)	**68%** (13 of 19)	No
2	7/25/11 – 8/5/11	22.7 min. (Range: 0-71 minutes)	**78%** (18 of 23)	No
3	10/31/11 – 11/11/11	11.25 min. (Range: 2-36 minutes)	**96%** (27 of 28)	**Yes**
4	1/30/12 – 2/10/12	9.46 min. (Range: 0-25)	**100%** (28 of 28)	**Yes**
5	8/13/12 – 8/24/12	21.15 min. (Range 0-65 minutes)	**77%** (23 of 30)	No
6	10/22/12 – 10/26/12	27 min. (Range 0-103 minutes)	**75%** (12 of 16)	No
7	11/12/12 – 11/16/12	18 min. (Range 1-90 minutes)	**89%** (17 of 19)	No
8	1/28/13 – 2/1/13	24 min. (Range 1-75 minutes)	**77%** (10 of 13)	No
9	2/17/14 – 2/21/14	15.5 min. (Range 2-90 minutes)	**85%** (11 of 13)	No
10	11/3/14 – 11/4/14	27.6 min. (Range 4-67 minutes)	**64%** (7 of 11)	No
11	6/1/15 – 6/5/15	11.7 min. (Range 2-25 minutes)	**100%** (16 of 16)	**Yes**
12	12/14/15 – 12/18/15	19.83 min. (Range 5-49 minutes)	**92%** (11 of 12)	No
13	6/6/16 – 6/10/16	16 min. (Range 7-30 minutes)	**100%** (12 of 12)	**Yes**

Analysis

The performance standard is that 95% of people who "walk in" to request services (without a scheduled appointment) are seen/triaged within 30 minutes. In the past 13 reporting periods, WMCMH has met the performance standard 4 times. In the most recent period, WM performed above the 95% standard. In the past, corrective action has included reviewing procedures with Service Entry and support staff and implementing a Daily On-Call schedule. Performance in the last three period has been better than it had been for a couple years. If the improvement proves sustainable, PIOC may decide to reduce monitoring frequency.

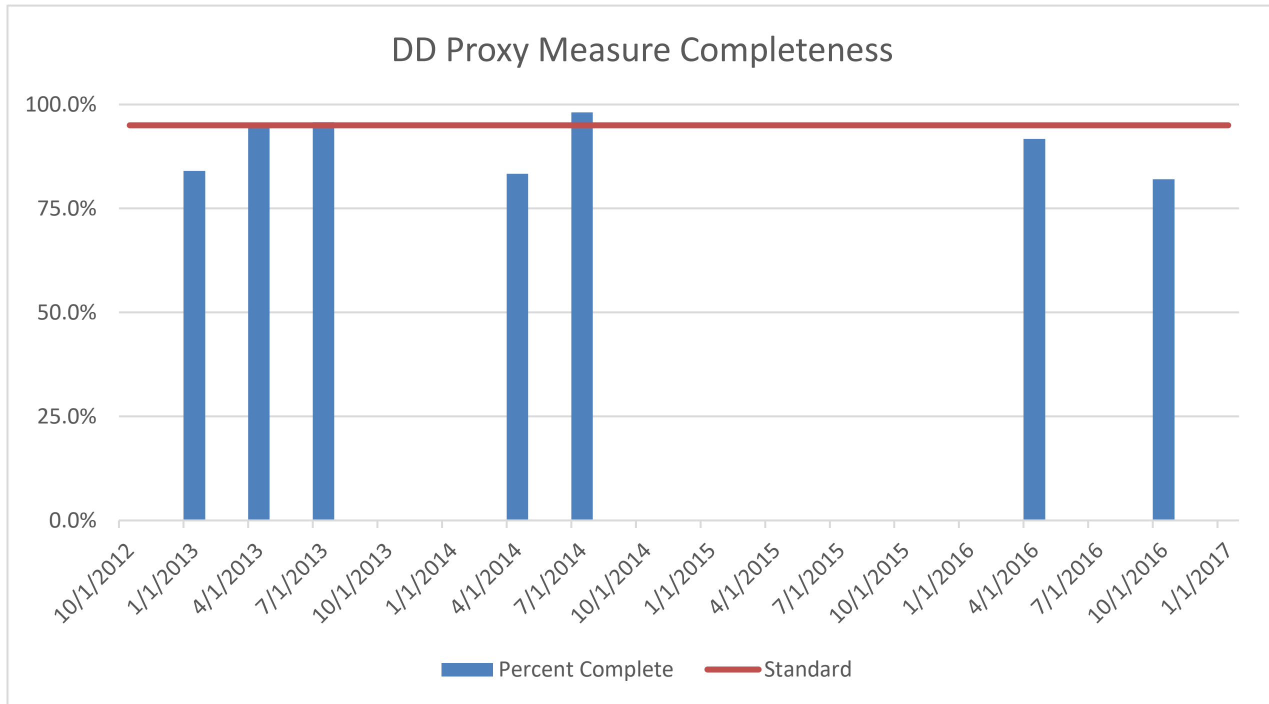
Appropriateness of this Measure

This standard is required by the MDHHS Contract. It remains appropriate and relevant. Monitoring will be continued at this time. If satisfactory performance is maintained, PIOC may determine to discontinue this measure.

See Attachment K for FY1516 Walk In Monitoring Reports

Indicator L. DD Proxy Measure Completeness

Reported Annually



Analysis

In March 2016, completeness of DD Proxy Measures was below the 95% standard at 91.7%. By the end of FY2016, completeness had dropped to at 82%. This drop is attributed to the fact that regular clean-up was not completed after the mid-year report. Clean up is not being performed at this time because it's too late to submit FY2016 data to MDHHS. It was determined that FY2017 mid-year data will be reviewed in April 2017, and mid-year clean-up will be performed at that time.

Because DD Proxy measures are now collected in MI Adult assessments, compliance will hopefully be closer to the standard even prior to clean up. Clean up will be performed as needed and this measure will continue to be tracked until the PIOC determines it is no longer needed.

Appropriateness of this Measure

Compliance with DD Proxy Measure completeness is required by MDHHS. Monitoring will be continued at this time.

Indicator M. Accessibility Reporting

Reported Annually

Analysis

Indicator data for FY1415 was similar to previous reporting periods; however, access to transportation was reported to be lower than in previous periods. The ACCC committee performed drilldown and found that fewer adults reported having access to transportation than in previous years. This information was shared with the Deputy Director for Clinical Services. WMCMH continues to provide persons served with public transportation tokens for scheduled appointments. No plans of correction were recommended.

Appropriateness of this Measure

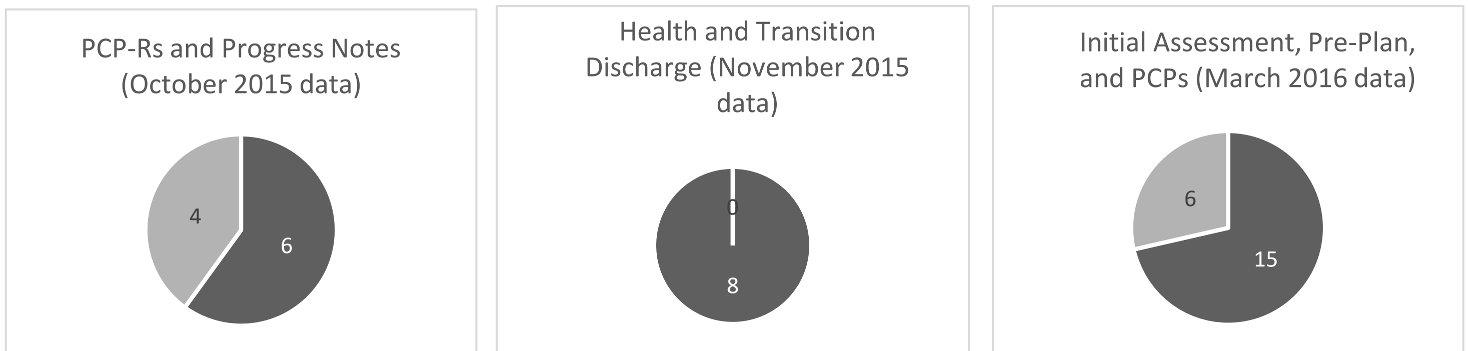
This measure is required by CARF. It remains appropriate and relevant. Monitoring will be continued.

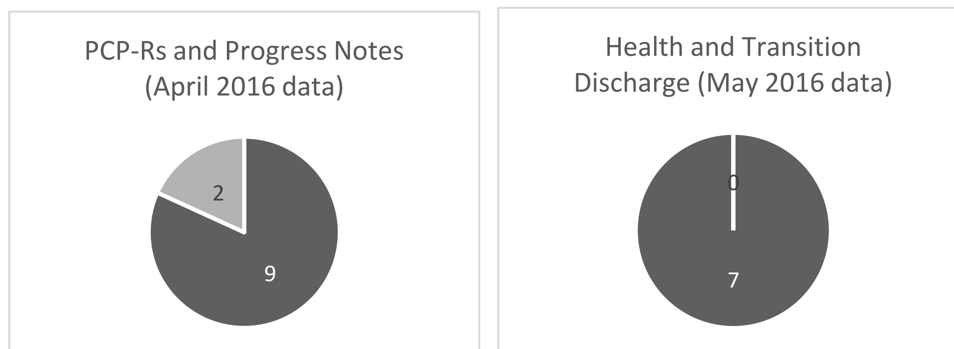
See Attachment M for FY1516 Accessibility report

Indicator N. UMUR Review Summaries

Reported Monthly

UMUR Summary Charts:
These charts are designed to give an overview of performance on the 5 UMUR reviews completed during fiscal year 2016. For UMUR, WMCMH has set the standard that 70% of records reviewed should be in compliance with each indicator (question) on the tool. For this analysis, performance was summarized by comparing the number of questions for which 70% or more of records were reviewed were in compliance to number of questions for which less than 70% of records reviewed were in compliance.





LEGEND

- ■ Number of indicators (questions) for which 70% or more records were in compliance
- ■ Number of indicators (questions) for which less than 70% of records were in compliance

(Analysis is continued on the next page)

(Indicator N., continued)

Recommendations on UMUR Summaries included:

- Reminding / retraining CTLs to standards
- Drilling down on outliers
- Revising clinical record templates to better support compliance
- Possibility of additional data reports to assist clinicians in tracking treatment planning and review timeliness

Appropriateness of this Measure

Quality Record Review is required by CARF and other bodies, and has been determined good business practice by WMCMH. This measure remains appropriate and relevant. Monitoring will be continued.

See Attachment N for FY1516 UMUR Summaries

Indicator O. West Michigan MHSIP and YSS

For a one-week period, all individuals seen for services were provided with the opportunity to complete a MHSIP survey (adults) or a YSS survey (for parents/guardians of children under 18). Individuals seen "in office" during the period were offered the opportunity to complete the survey while they were in the office. Those seen "out of office" during the period were offered the opportunity to complete the survey by phone.

The MHSIP survey was not designed to be used with people who have developmental disabilities; therefore, individuals in this population were excluded. Also, people who were very new to services (defined as those who received a Service Entry assessment during the period) were excluded.

For the study period, approximately X individuals had scheduled appointments. There were a total of X surveys completed (X% response rate).

- There were approximately X people who declined the opportunity to complete the survey, were not available by phone, or were not offered the survey (for the reasons indicated above).

Of the X completed surveys for the period:

- X were adult surveys
- X were youth surveys

OVERALL CONCLUSIONS AND RECOMMENDATIONS:
ENTER HERE

See Attachment O for FY1516 MHSIP Summary

2016 Performance Summary

*Add analysis of WM MHSIP

Excellent Performance

In 2016, WMCMH demonstrated very good performance in the following areas:

- Functional Improvement of young children as demonstrated by PECFAS score change.
- Timely access to inpatient screening, with nearly 100% of all PASes completed within 3 hours throughout the year.
- Timely follow up after hospitalization, with 100% of all individuals discharged from inpatient being seen within 7 days of discharge.
- Coordination with primary care; with monitoring showing that for 100% of the sample reviewed, critical clinical information was shared with primary care providers.
- General performance on the LRE site visit, with overall score above 95% and a particularly strong performance on program specific standards.
- Medicaid Verification reviews, with 100% compliance.
- Reduction in the use of Physical Management, with the total number of PM incidents in FY 2016 being the lowest in the past 3 years.
- Post-discharge Satisfaction, with 100% of respondents endorsing agreement that the services they received at WMCMH were helpful in improving their lives.
- Accessibility, with the most recent complete review showing no areas for improvement identified.
- Health and Transition/Discharge UMUR review, with both reviews this year fully meeting the 70% standard.

Opportunities for Improvement

The following areas are noted as challenges in WMCMH's overall performance. Please note that performance was often very good for many of these areas; they are noted only for being below standard at least at some point in the year:

- Timeliness from request to assessment
- Timeliness from assessment to start of care
- Releases of information to primary care physicians
- Timeliness of person-centered plan documents
- Signatures on plans
- Clear and Measurable objectives
- Services delivered according to amount, scope, and duration specified in the plan
- SUD issues noted in assessments are addressed in treatment plans
- Timeliness of service for walk-ins, with the 95% standard being met in one of the two reviews during the fiscal year.
- DD Proxy Measure completeness.
- PCP-R and Progress Notes, and Initial Assessment, Pre-plan, and PCP UMUR reviews, which fell below the 70% standard.

Overall Analysis of Performance – DRAFT FOR PIOC INPUT

West Michigan performed excellently in many areas in fiscal year 2016, notably during high-risk points in care such as timely inpatient screening, timely follow up after inpatient care, and reduction in use of physical management. West Michigan also performed excellently on Medicaid Verification, which is notable because sub-standard performance can lead to take-backs of Medicaid dollars. It is also noted that persons served reported high levels of satisfaction with services.

Areas of challenge mostly fit into the categories of timely and complete care planning and documentation, and timely access to care. These areas pose risk to persons served as they do have an impact on quality of care and engagement into treatment. These areas are monitored closely by our payers, MDHHS and the LRE.

Other areas of challenge which potentially pose risk to the organization are services provided according to plan and DD proxy measure completeness. Failure to provide services according to plan is grounds for appeal by persons served. It is noted that WMCMH received no appeals in FY16 for failure to provide services according to plan. As far as DD proxy measures, data less than 95% complete fails to meet MDHHS standards. MDHHS has suggested there may be funding take-backs for this specific offense, though as far as we know this has not been implemented.

Recommendations

1. It is recommended that this report be shared with personnel and Board.
2. It is recommended that applicable staff teams be congratulated on excellent performance in the areas noted in this report.
3. It is recommended that WMCMH's FY17 Quality Assurance and Performance Improvement goals are designed to focus on the areas of challenge noted in this report.