West Michigan Community Mental Health
Annual Quality Measure Performance Analysis FY2018

Date: December 10, 2018

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)	LRE chart review?	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	LRE	*Not reported*
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
P. Suicide deaths and suicide attempts	*CIR / RE*	*Semi-Annual*

Annual Program Evaluation Includes:

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. A summary and description of areas needing improvement.
8. Recommendations and written action plans to address areas needing improvement.
9. Written follow up on actions taken and changes made to improve performance.

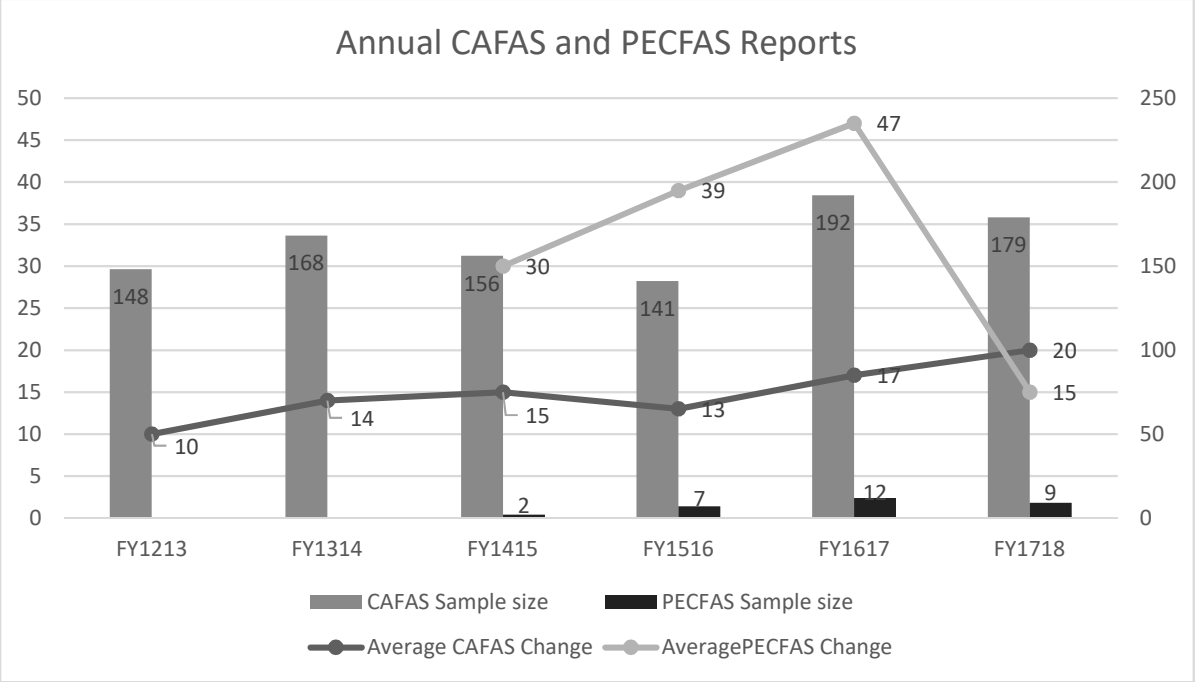
Documentation of the QAPIP annual review, its findings, and recommendations are forwarded to the Executive Team and the Board. The annual review may lead to:

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

FY 2018 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 6 fiscal years. Sample size for both CAFAS and PECFAS decreased slightly since FY17 but is still higher than previous years.

For CAFAS and PECFAS, a positive change value indicates improvement. The average change in CAFAS score over time remains fairly consistent year to year, with this year and last year indicating a positive trend. For PECFAS, average change in score is substantially lower than the past 4 fiscal years. It is noted that the PECFAS sample was 100% male. Maybe the change can be attributed to sampling.

This year's recommendations were:

- Continue participation in the CAFAS and PECFAS level of functioning project. Children's staff will continue to routinely monitor CAFAS and PECFAS data with a summary reporting coming to PIOC on an annual basis. The next summary report to PIOC will be in January/February 2020.
- 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 FY1718 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 2018 - CMH (all traditional MH)

Ind. 1 - PAS in 3 hours - 95% or greater

	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%

Ind. 2 - Request to Assessment in 14 days - 95% or greater

	1st Q	2nd Q	3rd Q	4th Q
MIC	100.00%	100.00%	100.00%	100.00%
MIA	100.00%	100.00%	100.00%	100.00%
DDC	N/A	0.00%	100.00%	100.00%
DDA	100.00%	100.00%	100.00%	100.00%
Total	100.00%	97.70%	100.00%	100.00%

Ind.3 - Assessment to start of care in 14 days - 95% or greater

	1st Q	2nd Q	3rd Q	4th Q
MIC	100.00%	95.00%	100.00%	100.00%
MIA	100.00%	96.77%	100.00%	100.00%
DDC	N/A	N/A	100.00%	100.00%
DDA	100.00%	100.00%	100.00%	100.00%
Total	100.00%	96.15%	100.00%	100.00%

Ind. 4a - Seen within 7 days of hosp discharge - 95% or greater

	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)

Ind. 10 - Readmitted to hosp within 30 days - 15% or less

	1st Q	2nd Q	3rd Q	4th Q
Children	0.00%	0.00%	50.00%	0.00%
Adults	6.25%	11.11%	7.69%	0.00%

MMBPIS FY 2018 - PIHP (Medicaid only)

Ind. 1 - PAS in 3 hours - 95% or greater

	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%

Ind. 2 - Request to Assessment in 14 days - 95% or greater

	1st Q	2nd Q	3rd Q	4th Q
MIC	100.00%	100.00%	100.00%	100.00%
MIA	100.00%	100.00%	100.00%	100.00%
DDC	N/A	N/A	100.00%	100.00%
DDA	100.00%	100.00%	100.00%	100.00%
SUD	100.00%	100.00%	100.00%	100.00%
Total	100.00%	100.00%	100.00%	100.00%

Ind.3 - Assessment to start of care in 14 days - 95% or greater

	1st Q	2nd Q	3rd Q	4th Q
MIC	100.00%	94.74%	100.00%	100.00%
MIA	100.00%	96.43%	100.00%	100.00%
DDC	N/A	N/A	100.00%	100.00%
DDA	100.00%	100.00%	100.00%	100.00%
SUD	100.00%	100.00%	98.41%	100.00%
Total	100.00%	97.98%	99.21%	100.00%

Ind. 4a - Seen within 7 days of hosp discharge - 95% or greater

	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%

Ind. 4b - Seen within 7 days of detox discharge - 95% or greater

	1st Q	2nd Q	3rd Q	4th Q
SUD	87.50%	80.00%	100.00%	100.00%

Ind. 10 - Readmitted to hosp within 30 days - 15% or less

	1st Q	2nd Q	3rd Q	4th Q
Children	0.00%	0.00%	50.00%	0.00%
Adults	6.25%	11.11%	7.69%	0.00%

Analysis

After a performance low-point in Quarter 2, performance improved in the two remaining quarters to end the year at perfect performance. Performance this year, overall, is significantly better than last year. Improvement is likely due to intensive daily monitoring performed by Service Entry (indicators 2 and 3) and documentation changes in R3 plus training for providers (4b). Kudos, Team!

Appropriateness of this Measure

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

See Attachment B for FY18 Annual MMBPIS Reports

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

Reviewed at annual LRE audit

In FY1617, PIOC determined to discontinue semi-annual monitoring of this indicator when the plan of correction that prompted it had been achieved.

At last audit by the LRE, WM was found to be within standard for releases to PCPs and documents sent to PCPs. Therefore, monitoring was discontinued.

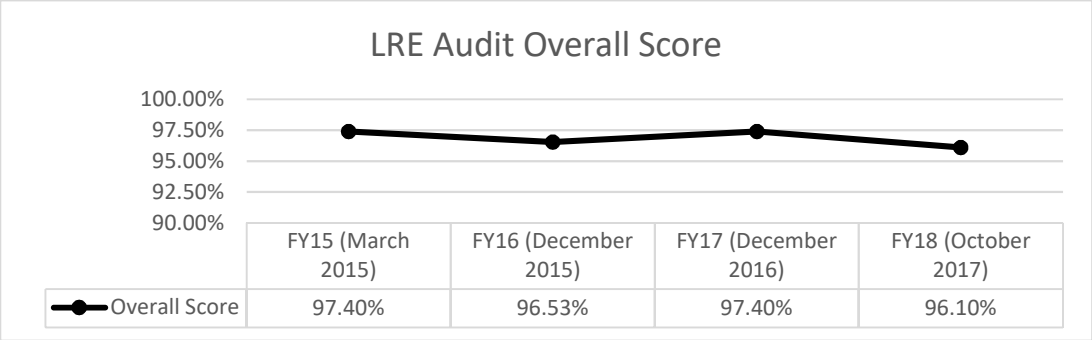
Last Year's Recommendations:
In FY 18, PIOC determined that workflow changes prompted by the transition to R3 are likely to have affected our compliance with this indicator. Monitoring will be reinstated with results brought to PIOC on a to-be-determined basis.

Status Update:
It was found that R3 does not have a built-in report to monitor performance on this indicator. The indicator was tabled due to other priorities.

Appropriateness of this Measure
PIOC will discuss and determine plan for monitoring this indicator in the future.

Indicator D. LRE Site Review

Reported Annually



Analysis

Due to administrative changes, the LRE did not perform a site review for Fiscal Year 18. It is anticipated that Beacon will perform a site review in the coming year.

Over the past 4 reviews, WM's score has remained relatively consistent. Out of 21 Plans of Correction, 16 have been completed at the time of this review. Below is a summary table of the status of plans of correction from the October 2017 site review:

Plan of Correction Short Title	Status
C&P is age and disability specific	Completed in FY17
Electronic device disposal	Completed in FY17
IT ongoing learning	Completed in FY17
IT Remote Access	Completed in FY17
IT Resource Acquisition	Completed in FY17
Mobile device management system	Completed in FY17
Provisional Credentials	Completed in FY17
UM LOC appropriateness	Completed in FY17
Work History in Application	Completed in FY17
Copy of Plan in 15 Days	Completed in FY18
No Pre-Plan	Completed in FY18
IT disaster recovery plan	Completed in FY18
Removable media encryption	Completed in FY18
Testing of IT disaster recovery plan	Completed in FY18
Encrypted devices	Completed in FY18
HSW missing IPOS training	Completed in FY19
Under- and Over-Utilization	In progress
Behavior Plans	In progress
ABA Hours Match	In progress
IT Risk Assessment	In progress
Autism Prior Auths	In progress

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 FY17 LRE Site Review report

Indicator E. CARF Accreditation Summary

Reported Every Three Years

Analysis

WMCMH's most CARF Survey was in February 2017. WMCMH received a 3-year accreditation with commendations for the board of directors, the executive director, long tenure of staff, solid working relationship with external stakeholders, enthusiastic and dedicated administrative support team, sound financial management, use of evidence based practices, focus on recovery, wellness, and healing, recovery philosophy reflected by staff, well-maintained facilities, consumer involvement, and the gathering sites.

CARF required 17 action plans; 9 have been complete. A summary of corrective action plans and status is below:

Plan Of Correction Topic	**Status**
Performance evaluations of contract providers	Completed in FY17
Management of students and interns	Completed in FY17
Assistive technology as part of the technology and systems plan	Completed in FY17
Model fidelity reviews for evidence based practices	Completed in FY18
Immunization records included in assessments for children and adolescents	Completed in FY18
Clinical supervision should address specific skills and issues	Completed in FY17
Code of ethics should address peer support services specifically	Completed in FY17
Assessment process should gather information about gender, sexual orientation, and gender expression; spiritual beliefs; and literacy level	Completed in FY18
Include a program of medication utilization evaluation	Completed in FY18
Cultural competency plan	In progress
Corporate compliance risk assessment	In progress
Risk Management	In progress
Bomb threat drills	In progress
Accessibility plan	In Progress
Business performance targets as part of performance measurement and management and included in annual performance analysis	In progress
Peer review of prescribing practices	In progress
Clinical records should be complete	In progress

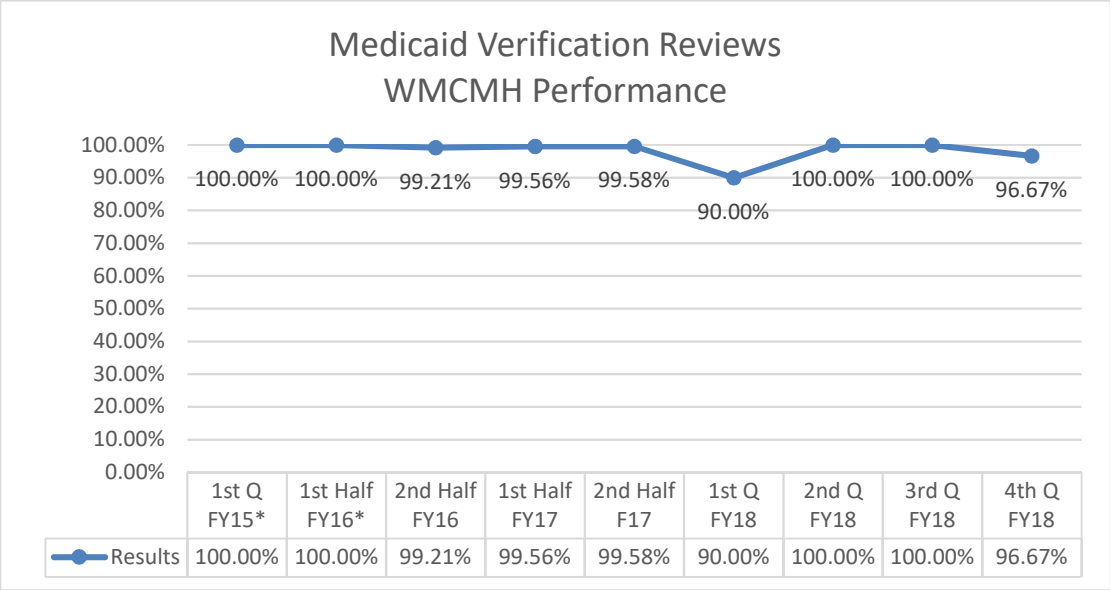
Appropriateness of this Measure

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

See Attachment E for full 2017 CARF Survey report

Indicator F. Medicaid Verification Results

Reported Quarterly



	1st Q FY15*	1st Half FY16*	2nd Half FY16	1st Half FY17	2nd Half F17	1st Q FY18	2nd Q FY18	3rd Q FY18	4th Q FY18
Results	100.00%	100.00%	99.21%	99.56%	99.58%	90.00%	100.00%	100.00%	96.67%

*Review completed by WMCMH staff

Analysis

For fiscal year 18, the LRE performed Medicaid claims verification on a quarterly basis. WMCMH's performance was above 95% for three out of 4 quarters in FY18. Plans of correction included recoupments, retraining staff, and correcting display of provider credentials in R3. All plans of correction were accepted by the LRE and completed.

Appropriateness of this Measure

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

Indicator G. Provider Network Quality Oversight – Site Reviews

Not Reported

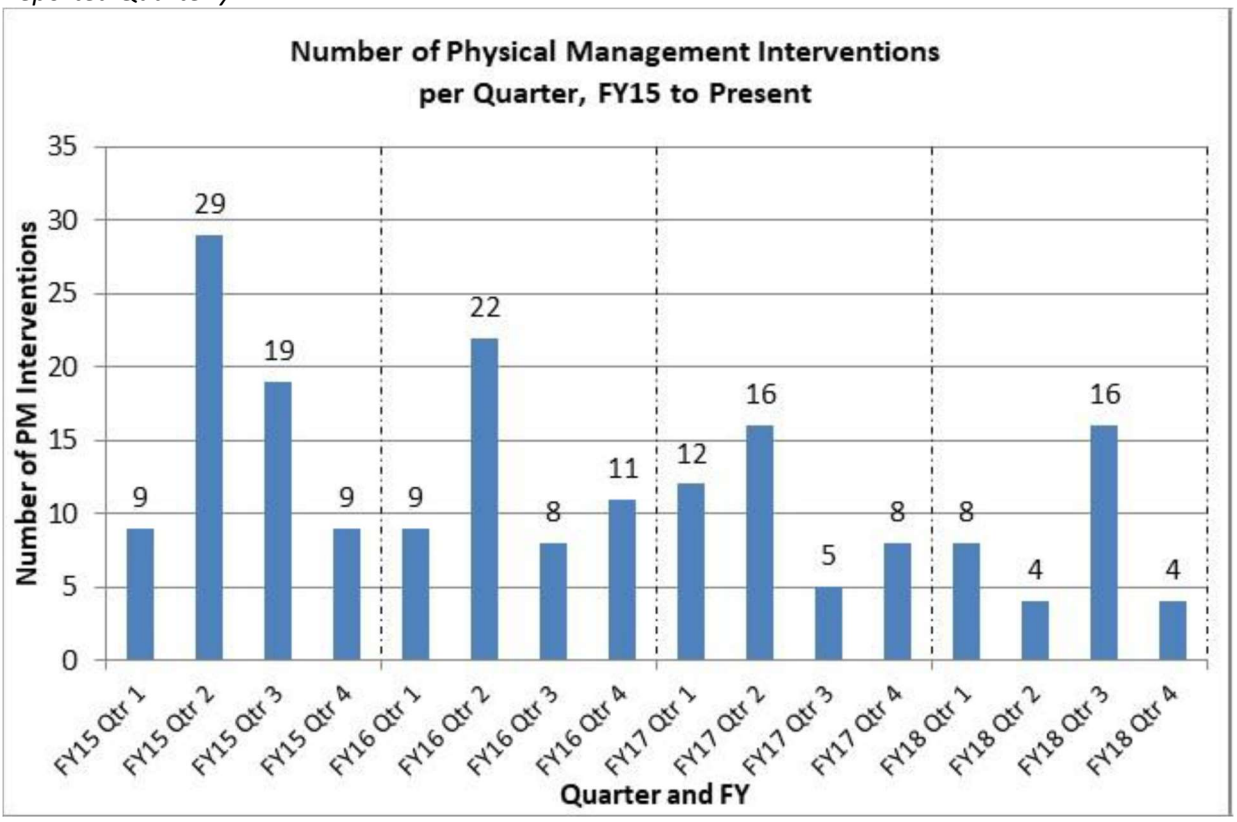
The LRE has not yet reported any provider network quality site review data to the CMHs. This indicator will be retained as a placeholder in case we receive data reports in the future, possibly from Beacon.

Appropriateness of this Measure

Provider Network Quality Oversight is required by the PIHP. Tracking performance has the potential to be appropriate and relevant.

Indicator H. Physical Management and Behavior Treatment Review Committee Data

Reported Quarterly



Analysis

The total FY18 year-end data represents a 21% decrease in the total number of physical management interventions compared to the FY17. Fourth quarter data in FY18 is the lowest quarter reported for this period when compared to 4th quarter data for the past years as well.

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 noted that contacts to Law Enforcement made by provider staff for the purposes of behavior-related emergencies has been up in the past year. This was discussed at both the Behavior Treatment Review Committee and PIOC, and it was determined to continue monitoring this closely to determine if it's a trend.

Appropriateness of this Measure

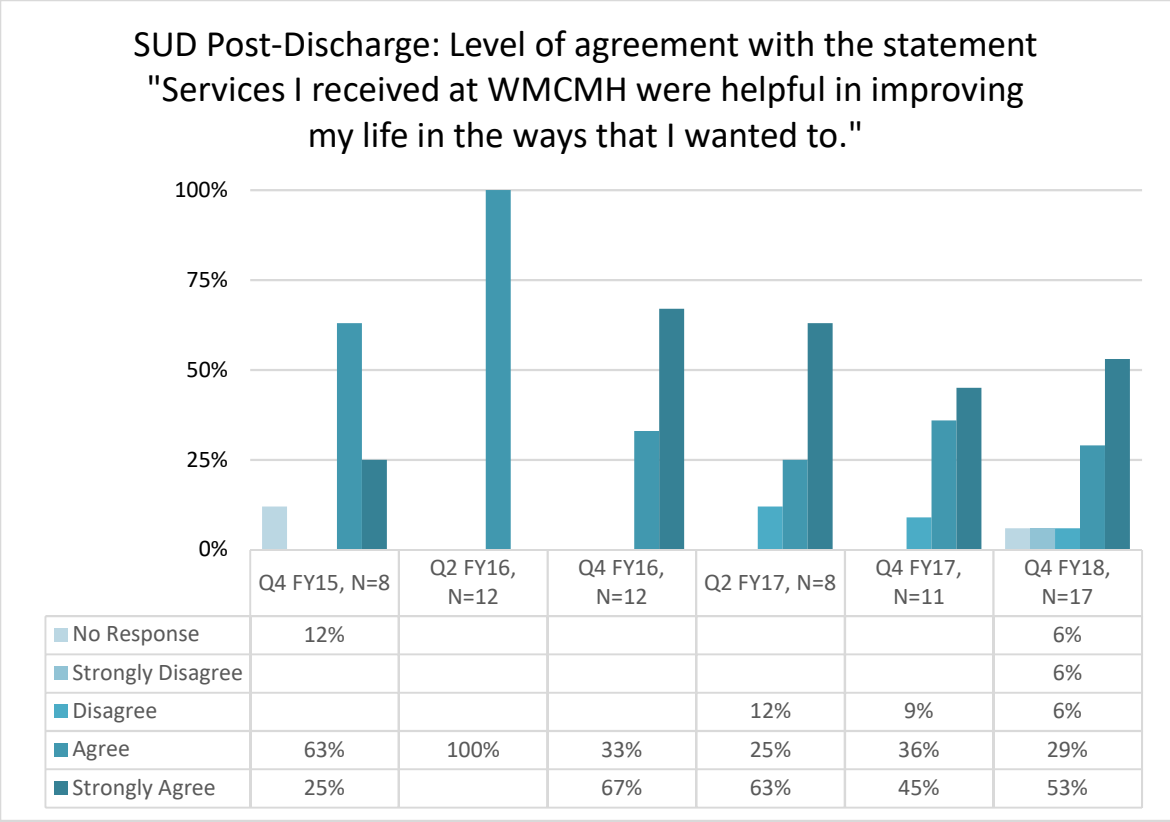
This measure is required by MDHHS and the LRE. It remains appropriate and relevant. Monitoring will be continued.

See Attachment H for full FY18 Physical Management and Law Enforcement Data Report

Indicator I. Post-Discharge Monitoring

Reported Semi-Annually

SUD POST-DISCHARGE

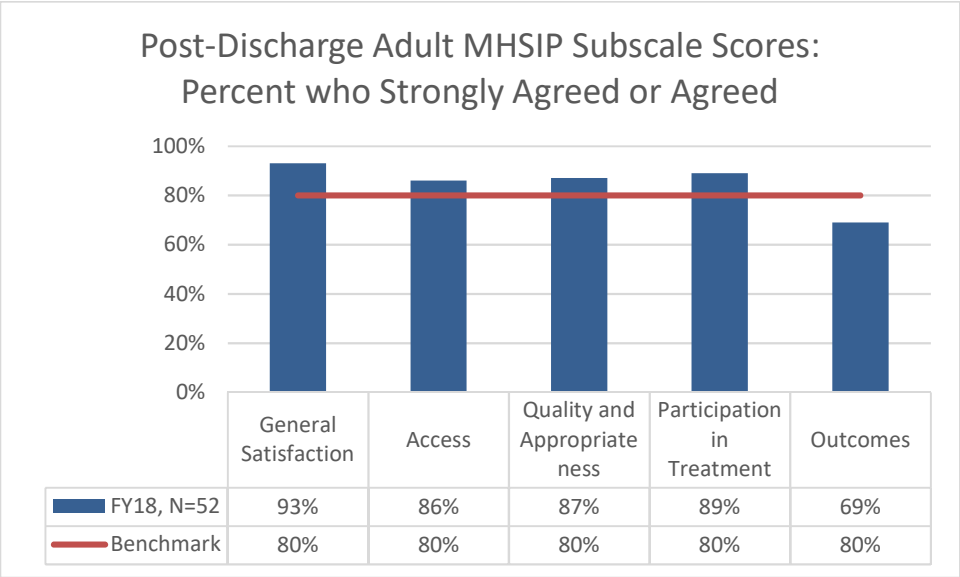


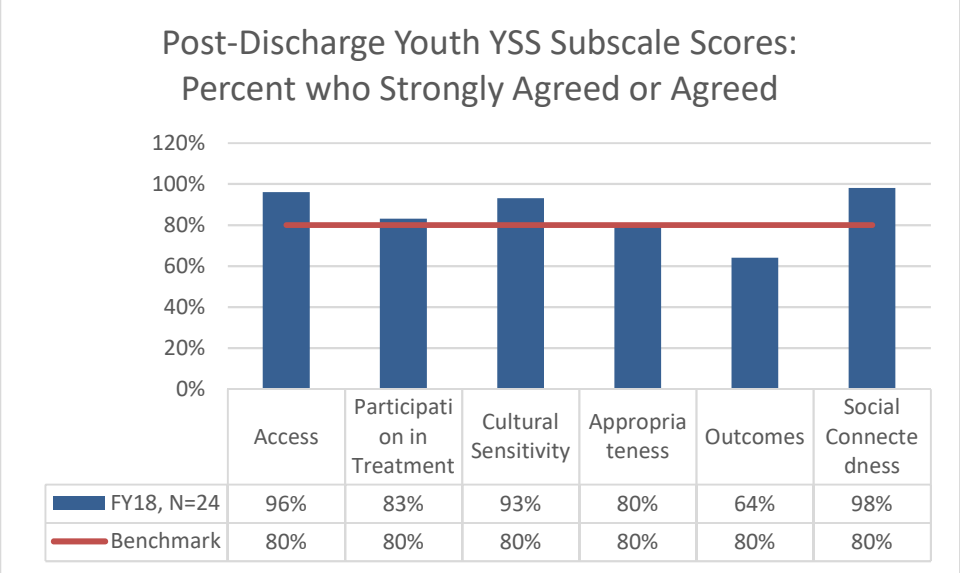
	Q4 FY15, N=8	Q2 FY16, N=12	Q4 FY16, N=12	Q2 FY17, N=8	Q4 FY17, N=11	Q4 FY18, N=17
No Response	12%					6%
Strongly Disagree						6%
Disagree				12%	9%	6%
Agree	63%	100%	33%	25%	36%	29%
Strongly Agree	25%		67%	63%	45%	53%

Analysis

It was determined in FY17 to move this survey to an annual frequency. In both 4th quarter FY17 and in the FY18 administration, 81% and 82% of respondents (respectively) agreed that services they received at WMCMH were helpful in improving their lives in the ways they wanted to. Additionally, in both periods the majority of respondents reported a stable living condition. About 64% or 65% of respondents said they had not used drugs or alcohol in the past 30 days. This is lower than previous years, which was in the high 80s to 100%. Just under half (45% and 47%) of respondents reported that they were employed or in school. This was a big drop from previous years. Comments received were mostly positive. At the time of this report, these results and next steps are scheduled to be discussed at the next PIOC meeting.

WM POST-DISCHARGE (MHSIP)





Analysis

The 2nd Quarter administration results were disturbing. The majority of subscales did not meet the 80% benchmark. In response to this and results from the annual MHSIP, the PIOC designated a subcommittee for next steps. The subcommittee recommended focus groups to gather more information on low-scoring questions. Results should be reported to PIOC in February 2019.

Appropriateness of this Measure

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

See Attachment I(a) and I(b) for FY1617 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	FY 2017	FY 2018
Mission Planning & Oversight	3.61	3.71	3.67	3.68
Quality Oversight	3.50	3.52	3.05	2.89
Committee Effectiveness	3.63	3.76	3.64	3.66
Individual Self-Assessment	3.67	3.93	3.76	3.57
Overall Rating	**3.60**	**3.73**	**3.60**	**3.45**

Analysis

Out of 11 committee members, 9 responded to the survey. PIOC discussed results at the October 2018 meeting. Discussion focused on low ratings for sharing performance data with staff and stakeholders. This continues to be an annual goal for the organization's QAPIP. Ideas for meaningful sharing and appropriate involvement of stakeholders will be discussed at the January PIOC meeting.

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 FY18 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**
14	1/9/17 – 1/13/17	16 min. (Range 6-29 minutes)	**100%** (8 of 8)	**Yes**
15	7/10/17-7/14/17	15 min. (Range 1-29 minutes)	**100%** (7 of 7)	**Yes**
16	7/30/18-8/3/18	22 min. (Range 3-24 minutes)	**100%** (9 of 9)	**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 16 reporting periods, WMCMH has met the performance standard 7 times. In the past 4 periods, WM performed above the 95% standard. In August 2017, PIOC agreed to reduce the frequency of monitoring to annual. In 2018 it was determined to discontinue monitoring this indicator.

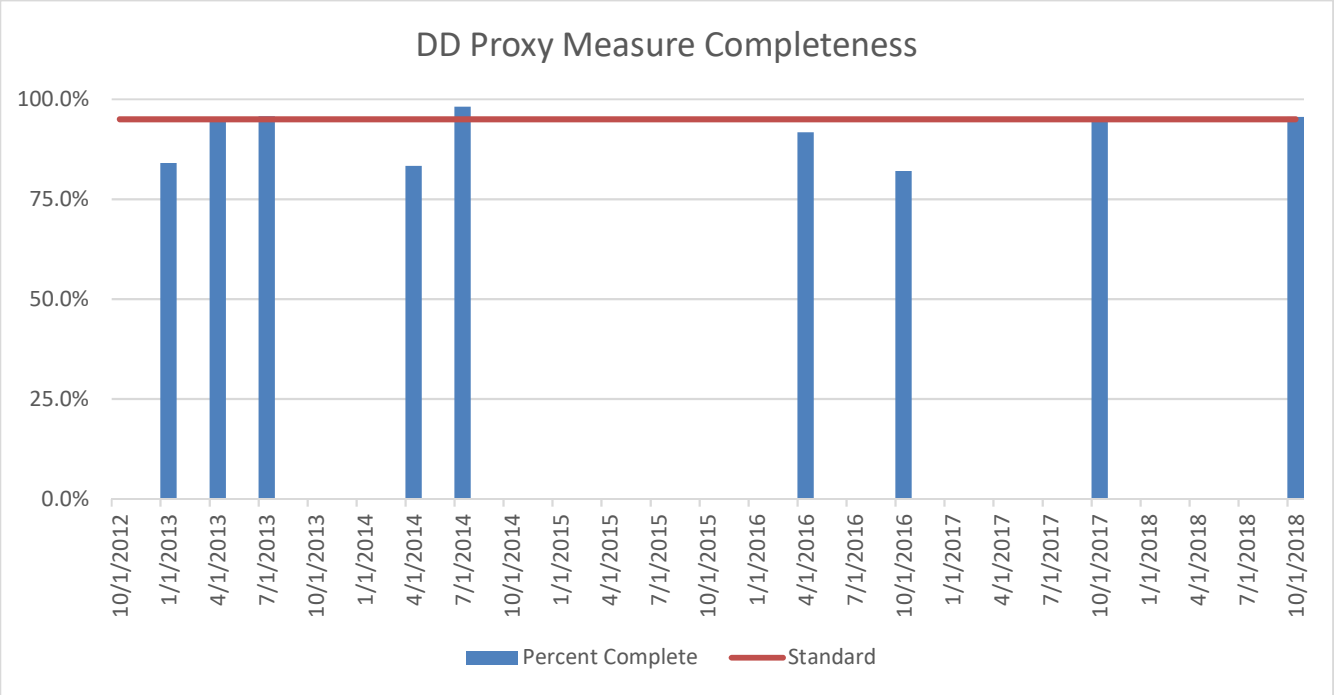
Appropriateness of this Measure

It was determined to discontinue this measure because performance has been consistently excellent. If in the future there is concern about performance, monitoring can be reinstated.

See Attachment K for FY18 Walk In Monitoring Report

Indicator L. DD Proxy Measure Completeness

Reported Annually



Analysis

FY18 closed out with DD Proxy measures over the 95% standard for data completeness. Improved performance was likely attributable to the new assessment process in the R3 system, which includes prompts and checks to support complete data collection.

Appropriateness of this Measure

Compliance with DD Proxy Measure completeness is required by MDHHS. Last review, it was recommended that data be gathered for at least one more fiscal year. Because we now have a reliable system to support compliance, and performance is good, PIOC should consider discontinuing this measure.

Indicator M. Accessibility Reporting

Reported Annually

The Accessibility Committee developed a new process for assessment and reporting. The first round of assessment and steps should be performed and reported to PIOC in mid FY19.

Appropriateness of this Measure

This measure is required by CARF and will be continued.

Indicator N. UMUR Review Summaries

Reported Monthly

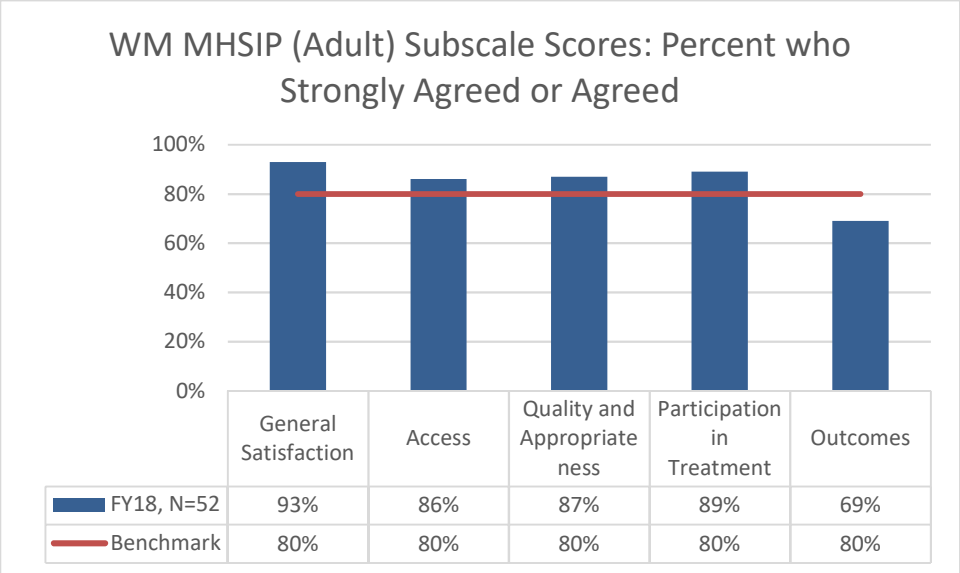
The UMUR process was overhauled in FY18. At the time of this report, the first UMUR summary is being compiled for review by the UMUR committee and later by PIOC.

Appropriateness of this Measure

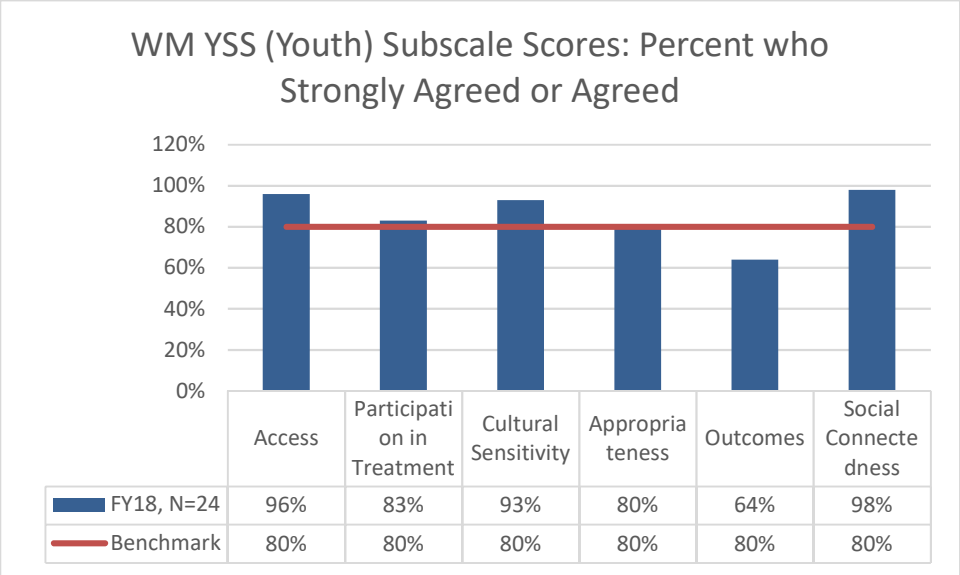
Quality Record Review is required by CARF and other bodies, and has been determined good business practice by WMCMH. This measure will be continued.

Indicator O. West Michigan MHSIP and YSS

Reported Annually



	General Satisfaction	Access	Quality and Appropriateness	Participation in Treatment	Outcomes
FY18, N=52	93%	86%	87%	89%	69%
Benchmark	80%	80%	80%	80%	80%



	Access	Participation in Treatment	Cultural Sensitivity	Appropriateness	Outcomes	Social Connectedness
FY18, N=24	96%	83%	93%	80%	64%	98%
Benchmark	80%	80%	80%	80%	80%	80%

Analysis

For FY18, PIOC set a benchmark that 80% or more of respondents would agree or strongly agree with the statements in each tool. In terms of the subscale totals, both adult and youth respondents were below the benchmark for outcomes. For specific questions, adults were below 80% on "I was able to see a psychiatrist when I wanted to," "I felt free to complain," and all the outcomes questions. Youth were below 80% on "The services my child and/or family received were right for us," "My family got the help we wanted for my child," and "My family got as much help as we needed for my child," plus all the outcomes questions. After much discussion it was decided to gather more information from people served via focus groups. Focus groups will be held in early 2019, with recommendations for next steps to be brought to PIOC in March 2019.

Appropriateness of this Measure

Satisfaction surveying is required by payors and CARF, and is important to WMCMH's performance improvement program. Monitoring will be continued.

2018 Performance Summary

Progress on Areas Identified for Improvement in 2017

Area for Improvement	Actions taken	Results
MMBPIS performance.	Revised Plans of Correction	Marked improvement throughout FY18, with the year ending at perfect performance for 4th quarter
WM needs a new Accessibility plan that is more meaningful and results in improved access to services.	Accessibility Plan and policy revisions with new plan for assessment and action plans	Plan and policy revisions have been drafted by the committee; will be finalized in early 2019 with new assessment to begin after CCBHC implementation
Revised and expanded UM Model, with performance standards that match industry standard and actionable plans for improvement in performance when standards are not met.	UM Model was revised and expanded as indicated.	First UM review under the new model was completed in November 2018 and will be reviewed by the UMUR committee in December 2018.
PIOC Self-Evaluation scores need improvement.	QAPIP goals were set to address low-scoring items in the self-evaluation	Goals to meaningfully share performance data with staff and to involve stakeholders in QAPIP were not able to be completed in FY18; self-evaluation scores were lower for 2018 than for 2017. More action needed. Barriers to success included competing organizational priorities.
CARF has recommended that this annual performance analysis include indicators for business performance improvement.	Executive team is in the process of drafting a risk management plan to include performance targets.	This analysis has not been updated as indicated. Barriers to success included competing organizational priorities.

2018 Areas of Strength:

- Functional Improvement of children and adolescents as demonstrated by CAFAS and score change.
- MMBPIS Results
- Medicaid Verification reviews; problems identified early in the FY were corrected and performance was above standard following that.
- Reduction in the use of Physical Management, with the total number of PM incidents steadily trending downward for 5 consecutive years. Totals for FY 2018 are the lowest in the past 5 years.
- Walk In Monitoring, with the past 4 review periods at 100%. Due to sustained good performance, this measure was discontinued by PIOC.
- DD Proxy Indicators, with FY18 just above standard.

2018 Areas for Improvement:

- Develop a plan to monitor valid signed PCP releases and determine if performance improvement is needed.
- More progress on CARF Plans of Correction (next audit is February 2020).
- Satisfaction results have shown decline; more information must be gathered and action steps must follow.
- PIOC self-evaluation results continue to drop; related goals need to be prioritized differently this coming year.
- Progress on Accessibility must continue to move forward.
- Progress on adding business indicators to the performance summary must move forward.

Overall Analysis of Performance

West Michigan performs excellently in many areas, notably at high-risk points in care such as timely access to services and follow up after inpatient and detox, and reduction in use of physical management. This year, WM made progress on some areas identified last year as needing improvement

Competing organizational priorities is a common barrier to the areas that are either moving slowly or have stalled. Since higher-priority projects will continue to be priorities, and since it is unlikely that staffing capacity for these areas will increase, WM should consider a different approach to making progress in the areas identified in this report. In FY18, Leadership staff received training and consultation with Jeff Lawrence that offered some insight about getting things done in an environment with increasing demands and flat capacity. It is recommended that these insights be applied to the areas that continue to need improvement.

Recommendations

1. It is recommended that this report be shared with personnel, the Board, and the general public.
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 appropriate staff / teams develop action plans for areas noted for improvement.