Quality Improvement Plan

for

Fiscal Year 2019/2020

INTRODUCTION

The Michigan Department of Health and Human Services (MDHHS) requires that each specialty Prepaid Inpatient Health Plan (PIHP) have a Quality Assessment and Performance Improvement Program (QAPIP), which meets the specified standards in the contract with MDHHS. The Regional Quality Improvement Plan documents the QAPIP for the Lakeshore Regional Entity (LRE), which includes Allegan County Community Mental Health Services (ACCMHS), HealthWest, Network 180 Community Mental Health and Substance Use Services, West Michigan Community Mental Health Services, and Ottawa County Community Mental Health Services.

In addition to the QAPIP, MDHHS requires each Community Mental Health Services Program (CMHSP) to have a Quality Improvement Program (QIP). Most of the requirements are met through the Regional Quality Improvement Plan. Areas where CMHSP distinctions are necessary have been included in this document. The distinct areas include:

1. Elements of the CMHSP Quality Improvement (QI) structure, and
2. Specific CMHSP QI goals and/or objectives.

MISSION

To be Allegan County's premier behavioral healthcare organization that promotes, protects, and advocates for the health and well-being of every member of the community.

VISION

To lead, collaborate, and succeed in making Allegan County among the healthiest counties in Michigan where all residents can thrive and prosper.

VALUES

- Holistic Person-Centered Care
- Dignity and Respect
- Respecting Choice
- Commitment to Excellence
- Community Collaboration
- Accessibility
- Responsiveness
- Diversity

COMMITMENT

ACCMHS is committed to providing quality improvement throughout the mental health and substance abuse system of care. Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by ACCMHS leadership, is understood, accepted, and utilized throughout the organization as a result of continuous education and involvement of staff at all levels in performance improvement.

Quality improvement involves two primary activities:

1. Measuring and assessing the performance of services through the collection and analysis of data, and
2. Conducting quality improvement initiatives and taking action where indicated, including the design of new services and/or improvement of existing services or processes that affect the quality of care at ACCMHS.

QUALITY IMPROVEMENT ASSUMPTIONS

The following assumptions are accepted:[1]

1. Health care is not an individual act between clinician and consumer, but a collective series of processes within a formal and informal system of care.
2. Most problems with quality in health care relate to defects in processes, not individual failings.
3. Measurement of crucial processes and outcomes play an important role in improving the quality of care. Through statistical analysis, processes can be compared to evidence-based treatment guidelines and outcomes can be compared to norms and benchmarks to identify opportunities for improvement.
4. Improvement efforts should be focused on the needs of the consumer.
5. Quality improvement draws upon the knowledge, expertise, and efforts throughout the entire agency.
6. The improvement process prioritizes key problems, utilizes hypotheses about the nature of these problems, and develops targeted interventions.
7. Many quality problems are multidimensional and the improvement process often occurs through incremental efforts.

PURPOSE

The purpose of the ACCMHS QI Plan is to establish a written description by which the specific structure, process, scope, and role of the quality improvement program is articulated. The ACCMHS Quality Improvement Program exists to improve the overall performance in the areas of access, clinical care, consumer protection, integrating care, and consumer satisfaction. The ACCMHS QI Plan will be evaluated at least annually and updated whenever necessary. The QI Plan is the responsibility of the QI Coordinator, in collaboration with staff and the Management Team.

The purpose of the ACCMHS Quality Improvement Program is to:

- Continually evaluate and enhance quality management processes, program outcomes, and administrative efficiencies.
- Monitor and evaluate the systems and processes related to the quality of services that can be expected to affect the health status, quality of life, and satisfaction of persons served by ACCMHS.
- Identify and assign priority to opportunities for performance improvement, as identified by stakeholders (e.g., staff, consumers, providers).

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[1] Adapted from "Selecting Process Measures for Quality Improvement in Mental Healthcare," Richard C. Hermann, M.D., M.S. H. Stephen Leff, Ph.D. and Greta Lagodmos, B.A. Center for Quality Assessment and Improvement in Mental Health

- Create a culture that encourages stakeholder input and participation in problem solving.
- Outline the structure for monitoring and evaluating ACCMHS and service provider's compliance with regulations and requirements.

GOALS

The ACCMHS Quality Improvement Program will:

1. Target improvement at all levels including management, administration, and programs to include: access, coordination of services, timeliness, safety, respect, effectiveness, appropriateness, and continuity.
2. Involve people served, as well as those who care for them, in assessing and improving satisfaction of outcomes and services.
3. Develop performance indicators to ensure services are effective, safe, respectful, and appropriate.
4. Track key performance indicators, comparing performance to statewide or other comparable data when available.
5. Continuously monitor and analyze data related to program outcomes and consumer satisfaction to identify opportunities for improvement.
6. Ensure providers of service fulfill their contractual or employment obligations in accordance with applicable regulatory and accreditation standards.
7. Ensure providers of service are competent and capable of providing services through a system of competency evaluation and credentialing.

QUALITY IMPROVEMENT STRUCTURE AND ACTIVITIES

Board of Directors

The ACCMHS Board of Directors receives reports regarding performance indicators, program data, and consumer satisfaction data. The ACCMHS Board of Directors will regularly review outcome measurement data, consumer feedback activities, and improvement actions taken.

Management Team

The ACCMHS Management Team is comprised of the Executive Director, Director of Administrative Services, Director of Integrated Health Services, Director of Clinical Services, Director of Human Resources, and the Director of Quality and Compliance. The Management Team will demonstrate ACCMHS' commitment to continuous quality improvement by fulfilling the following responsibilities:

- Ensuring that all employees are aware of the organization's vision, mission, and values.
- Collaborating with the QI Coordinator and other staff members to identify improvement opportunities.
- Reviewing and taking action on reports from the QI Coordinator or other teams/committees on performance findings and recommendations.
- Reviewing and evaluating employee generated suggestions for quality improvement within the agency.
- Ensuring plans for improving systems are in place and effectively implemented, communicated, and monitored.
- Identifying staff training needs.

QI Coordinator
The Quality Improvement Coordinator is the author of the QI Plan and has the following additional responsibilities:

- Developing, managing and implementing activities stated in the QI Plan.
- Ensuring QI data is regularly presented to the Management Team and the ACCMHS Board of Directors.
- Identifying staff training opportunities related to quality improvement.
- Tracking improvement data and follow-up methods.
- Collaborating with Program Managers/Supervisors to implement and monitor QI goals.
- Coordinating data collection to and from committees, staff, and service teams.
- Collaborating with the LRE on regional quality improvement activities.

ACCMHS Supervisors/Leadership
ACCMHS Supervisors/Leadership help ACCMHS establish a culture of quality improvement and fulfill the following responsibilities related to quality improvement:

- Encouraging involvement of staff in the QI process.
- Collaborating with the QI Coordinator to implement ACCMHS QI Goals.
- Compiling/utilizing outcome measurement data for analysis.
- Communicating QI goals, activities, and results to staff.

ACCMHS Staff
ACCMHS staff play a key role in the quality improvement process and may conduct the following activities:

- Collecting and reviewing program data.
- Providing suggestions and recommendations for quality improvement.
- Collaborating with the QI Coordinator on performance improvement projects and recommendations.
- Serving on improvement committees/teams.

Subcontracting Agencies
Subcontracting Agencies may fulfill the following responsibilities related to the ACCMHS QI process:

- Participating in quality improvement activities (when mandated).
- Ensuring staff are compliant with appropriate credentials and training requirements.
- Implementing improvement actions and communicating improvement actions to ACCMHS.

Consumers/Other Stakeholders
ACCMHS consumers/other stakeholders may participate in the ACCMHS QI Process by conducting the following activities:

- Actively participating in quality improvement activities designed to obtain stakeholder input.
- Using the systems and procedures in place.

- Identifying improvement opportunities.
- Participating in teams, work groups, and committees.
- Providing feedback regarding agency changes and process improvement projects.

OVERVIEW OF COMMITTEES

Quality Improvement Council
- Supports the overall mission, vision, and values of ACCMHS
- Builds a culture of continuous quality improvement within ACCMHS
- Participates in the development of the annual Quality Improvement Plan
- Monitors key performance indicators compared to organizational goals and industry benchmarks
- Ensures conformance to accreditation and other external requirements
- Reviews and recommends revisions to quality/safety-related policies and standards
- Supports the ACCMHS Strategic Plan by collaborating with other agency teams/committees on quality improvement projects

Recipient Rights Advisory Committee
- Maintains compliance with Chapter 7 of the Michigan Mental Health Code
- Tracks and trends Office of Recipient Rights (ORR) data
- Provides recommendations for process improvements

Behavioral Treatment Committee
- Monitors enrollment and exit from the Behavior Treatment Program for trend analysis
- Monitors and analyzes behavior modification techniques, including the emergency use of physical interventions

Community Opportunity Advisory Panel (COAP)
- Analyzes consumer feedback surveys/focus groups
- Identifies future consumer opportunities
- Provides ACCMHS with feedback regarding policy development and change
- Analyzes quality activity reports and provides feedback
- Identifies community opportunities for consumers and families

Utilization Management Committee
- Ensures consumers receive timely, quality, medically-necessary, cost-effective services in the most appropriate and least restrictive treatment setting
- Ensures ACCMHS has an effective mechanism to manage the utilization of clinical resources

Health and Safety
- Ensures compliance with OSHA/MIOSHA
- Develops infection control procedures
- Conducts staff training related to health and safety goals
- Updates required information for posting
- Inspects buildings/grounds/equipment

- Conducts safety drills
- Ensures physical accessibility
- Completes annual inspections

QUALITY MANAGEMENT / IMPROVEMENT SYSTEM

The ACCMHS Quality Management System combines the traditional aspects of quality assurance and adds the elements of continuous quality improvement. The Quality Management System helps ACCMHS achieve its mission, realize its vision, and live its values. It protects against adverse events and provides mechanisms to implement positive changes within the agency.

The *Quality Management System* includes:

- Predefined quality standards
- Formal assessment activities
- Measurement of outcomes and performance
- Strategies to improve performance that falls below standards

The various aspects of the system are not mutually exclusive to just one category, as an aspect can overlap into more than one category. The following table identifies some of the more common standards, assessment activities, measurements, and improvement strategies used by the ACCMHS Quality Management System.

ACCMHS QUALITY MANAGEMENT SYSTEM						
Quality Standards		**Assessment Activities**		**Performance Measurements**		**Improvement Strategies**
•Federal & State Rules/Regulations •Stakeholder Expectations •MDHHS/PIHP Contract •Provider Contracts •Practice Guidelines •Accreditation Standards •Affiliation Policies and Standards •Evidence-Based Practices	→	•Quality Records Reviews •Accreditation Surveys •Credentialing •Risk Management •Utilization Reviews •External Quality Reviews •Stakeholder Input •Sentinel Event Reports •Critical Event Reports •MDHHS Site Review Report •Behavior Treatment Analysis	→	•MDHHS MMBPIS •LRE Performance & Dashboard Reports •Benchmarking •Status Reports on Strategic Planning •Audit Reports •Grievances & Appeals •ACCMHS Dashboard Reports	→	•Corrective Action/ Improvement Plans •Improvement Projects •Improvement Teams • Strategic Planning •Adherence to Practice Guidelines •Organizational Learning •Staff Development and Training •Improvements through Root Cause Analysis

I. Quality Standards

Quality Standards provide the specifications, practices, and principles by which a process may be judged or rated. ACCMHS identifies and sets standards by reviewing, analyzing, and integrating such areas as:

- Performance expectations of stakeholders for both clinical services and administrative functions
- Accreditation standards
- Practice Guidelines
- Clinical pathway protocols and other authorization criteria
- Government requirements, regulations, and rules

ACCMHS quality standards are documented in policy and procedure, contracts with providers, and the quality review process. ACCMHS standards are evaluated, at least annually, to ensure continued appropriate and relevant application.

Confidentiality

ACCMHS is committed to maintaining the confidentiality of persons served by the organization. Specific details of this commitment are reflected in the LRE's policies and procedures related to confidentiality, as well as ACCMHS HIPAA Policies and Procedures.

II. Assessment Activities

Quality assessment consists of various strategically planned activities that help to identify the actual practices, attitudes, performance, and conformance to standards that are enhancing or inhibiting the achievement of quality. Obtaining stakeholder input is critical to quality assessment activities.

Stakeholder Input

ACCMHS recognizes that obtaining stakeholder input is a vital aspect of any system designed for continuous quality improvement. Typical stakeholders identified to provide input to ACCMHS include: service consumers, staff, contract service providers, families/advocates, and the local community.

Input is collected to better understand how ACCMHS is performing from the perspective of its stakeholders. Quantitative and qualitative assessments are conducted to address issues of quality, availability, and accessibility of care. The input is continually analyzed, and the analysis is integrated into the practices of ACCMHS.

As a result of input from stakeholders, ACCMHS:

A. Takes specific action on individual cases as appropriate
B. Identifies and investigates sources of dissatisfaction
C. Outlines systemic action steps to follow up on findings

D. Utilizes stakeholder input in decision making
E. Informs practitioners, providers, persons served, and the ACCMHS Board of Directors of the results of assessment activities

The following table summarizes some of the various methods and sources ACCMHS uses to obtain stakeholder input.

STAKEHOLDER INPUT-METHODS & SOURCES

Type of Input	Consumer	Staff	Providers	Family/ Advocates	Community
Interviews	*MDHHS Site Reviews, Accreditation, Individual Assessments, Evaluations*	*Performance Evaluations, Termination/Exit Interviews*	*ORR Site Visit , Quality Review of Providers*	*MDHHS Site Reviews*	
Suggestions	*Case Management/ Supports Coordination Contacts or Customer Service Contacts*	*Supervision, Quality Improvement Ideas*	*Quality Monitoring Reviews, Case Management Contacts*	*Case Management/ Supports Coordination Contacts*	*Contacts to ACCMHS*
Forums	*Consumer Advisory Committees, Board Meetings*	*Team/Unit Meetings*	*MDHHS Reviews, Contract Negotiations, Meetings*	*MDHHS Reviews, Advisory Council*	*MDHHS Reviews, Open Forums at Board Meetings, Advisory Council*
Surveys	*Consumer Surveys*	*Staff Surveys*	*Provider Surveys, Accreditation surveys*	*Satisfaction Surveys*	
Planning	*Service Planning Meeting*	*Program Planning*	*Budget Planning*	*Service Planning Meeting*	
Assessment	*Pre-planning Information, Progress Notes Reviews, Discharge Summary*	*Performance Evaluations*	*Quality Review of Providers.*	*Surveys assessing family/advocate satisfaction level/needs*	*Community Needs Assessment*
Grievances /Appeals	*Grievance Systems to File a Grievance, Appeal, or Recipient Rights Complaint*	*Staff Grievance*	*Provider Grievance, Placement Reconsideration for Inpatient Requests*	*Grievance Systems*	*Contact to Customer Services*
Complaints	*Recipient Rights Complaint, Complaints Discussed with Customer Services*	*Employee Complaint*	*Recipient Rights Complaint*	*Recipient Rights Complaint*	*Recipient Rights Complaint*

Quality Records Reviews

ACCMHS has a Quality Records Review Team comprised of staff that are very knowledgeable in external compliance standards and reimbursement practices. The team meets to complete random and/or focus reviews depending on present issues. Formal reports are generated from these reviews and are shared with the staff providing the service, managers/supervisors, the Clinical Director, and the QI Team. The Quality Records Review Team notifies the Corporate Compliance Committee when an issue warranting further investigation is identified.

In addition, ACCMHS will follow the LRE policy on Provider Network Monitoring, which describes additional mechanisms for monitoring and assessing compliance with contract, state, and federal requirements of service providers.

MDHHS Site Reviews

MDHHS conducts reviews of the quality of ACCMHS administrative and clinical services. In response to the reviews, improvement plans are developed and implemented. The LRE will monitor affiliate member performance on site reviews conducted by MDHHS. ACCMHS will draft remedial action for all citations for which ACCMHS has been identified as out of compliance. The LRE completes the overall response, provides consultation for affiliate members, and oversees the implementation of improvement actions.

LRE Site Reviews

As part of a delegated model, the LRE completes annual site visits that include reviewing administrative standards and clinical practices. Any areas of noncompliance receive a written Corrective Action Plan (C.A.P.) from the LRE. The C.A.P. is submitted to the LRE for its approval of the quality improvement process to addresses the area(s) of concern.

External Quality Reviews

The Balanced Budget Act (BBA) of 1997 requires that states contract with an External Quality Review Organization (EQRO) for an annual independent review of each Pre-paid Inpatient Health Plan to evaluate the quality, timeliness of, and access to health care services provided to Medicaid enrollees. MDHHS contracts with the Health Services Advisory Group (HSAG) to conduct the reviews within the state of Michigan. ACCMHS participates in the HSAG Review as a CMHSP of the Lakeshore Regional Entity.

The stated objective of the annual evaluation is to provide meaningful information that MDHHS and the LRE can use for:

- Evaluating the quality, timeliness, and access to mental health and substance abuse care
- Identifying, implementing, and monitoring system interventions to improve quality
- Evaluating one of the two performance improvement projects of the LRE

- Planning and initiating activities to sustain and enhance current performance processes

Critical Incidents, Risk Events, Complaints, & Sentinel Events

The ACCMHS QI Coordinator is responsible for tracking critical incidents, risk events, and sentinel events reported to ACCMHS via incident reports. The Office of Recipient Rights (ORR) is responsible for reviewing consumer incidents and all complaints that may violate the rights of consumers. In combination of efforts from the ACCMHS QI Program and the Office of Recipient Rights, the critical incidents, complaints, and sentinel events review processes includes:

- Investigating complaints of rights violations
- Reviewing incident reports, conducting follow-up activities and investigations
- Monitoring incidents for the identification of sentinel events
- Analyzing for trends and providing suggestions to prevent recurrence
- Reviewing consumer death reports and investigating any unexpected death to identify potential system improvements
- Sharing and discussing information with the Recipient Rights Committee, Sentinel Events Review Committee, the ACCMHS Board of Directors, and Management Team

The QI Coordinator notifies the Sentinel Event Review Committee of issues that are determined to be a sentinel event. The QI Coordinator reports sentinel events as required by MDHHS following the LRE's Sentinel Event Review Reporting Process. When appropriate, the QI Coordinator conducts a Root Cause Analysis and submits the findings to the Sentinel Event Review Committee for further process improvement recommendations.

Credentialing

The ACCMHS Credentialing Team will ensure services and supports are consistently provided by staff that are properly and currently credentialed, licensed, and qualified. ACCMHS will follow ACCMHS and LRE Credentialing and Re-Credentialing Policies, which outlines the guidelines and responsibilities for credentialing and re-credentialing for CMHSPs of the LRE and their contract service providers.

Accreditation

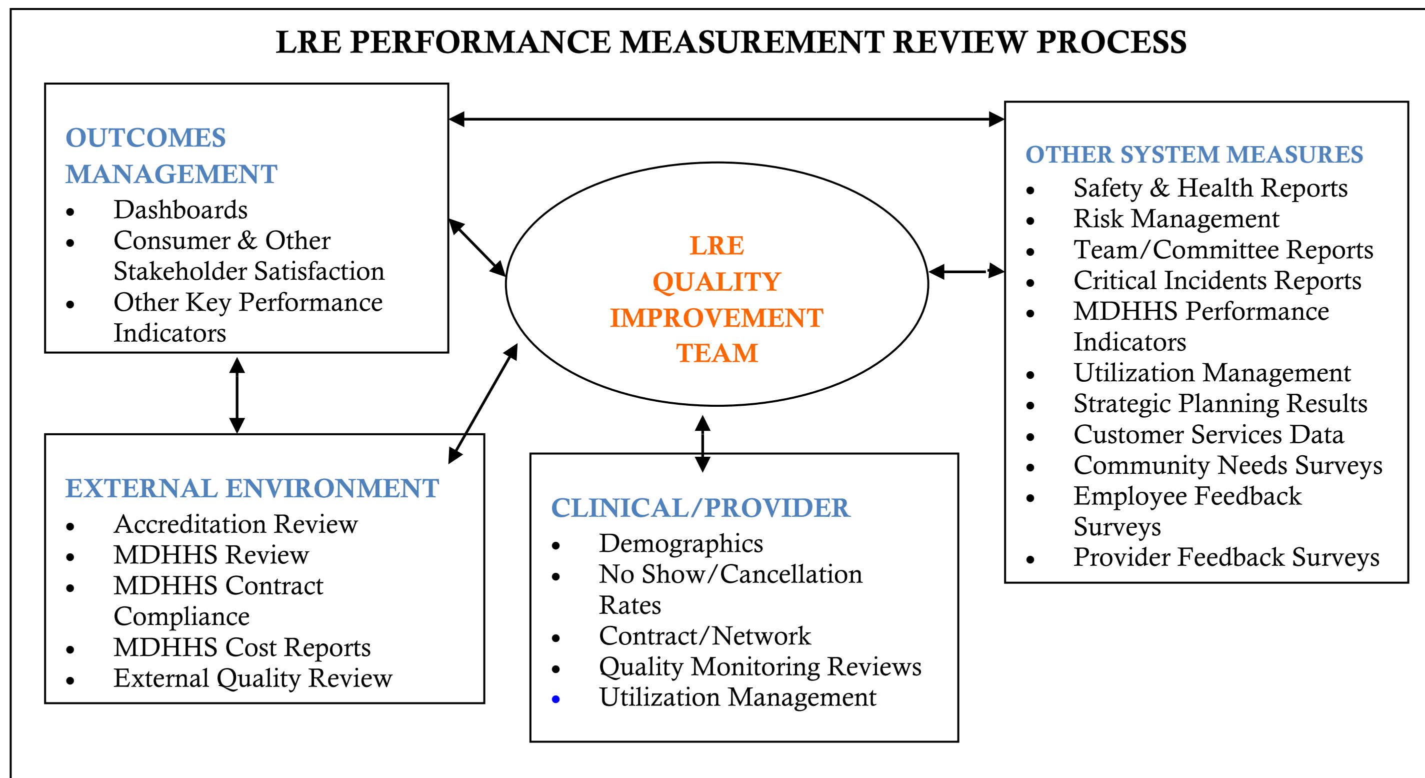
The Director of Quality and Compliance serves as the CARF Liaison and chairs the CARF/QI Team. The Director of Quality and Compliance organizes the CARF survey process and offers extensive consultation to the Management Team and Managers/Supervisors on meeting and exceeding CARF standards. Other members of the CARF/QI Team also assist with the preparation process, as well as provide consultation to staff on how best to meet standards. ACCMHS uses the results of the survey to implement improvements within the agency. On an ongoing basis, the Director of Quality and Compliance remains familiar with CARF changes and reports information to staff members as appropriate.

III. Performance Measurement

Through monitoring and evaluating expected performance on operational activities, the efforts and resources of ACCMHS can be redirected to obtain the desired outcomes.

By using performance indicators, the variation between the target desired and current status of the item(s) being measured can be identified. Indicators are used to alert the LRE and CMHSPs of issues that need to be addressed immediately, to monitor trends and contractual compliance, and to provide information to consumers and the public.

The following figure displays many of the performance indicators that are monitored and reviewed by the LRE to determine significant trends and to plan, design, measure, assess, and improve services, processes, and systems. If performance does not meet the standard established by the LRE, an improvement strategy will be determined and implemented by ACCMHS.



Performance indicator results are used to guide management decision making related to:

- Strategic planning
- Resource allocation
- Modification of service delivery
- Process improvements
- Staff training
- Marketing and outreach activities
- Other activities identified by consumers and/or other stakeholders

The LRE monitors and reviews significant sets of performance indicators, including: Michigan Mission-Based Performance Indicator System, Utilization Management, and the Verification of the Delivery of Medicaid Services.

A. **Michigan Mission-Based Performance Indicator System (MMBPIS)**
The Michigan Mission-Based Performance Indicator System (MMBPIS) was fully implemented by MDHHS on October 1, 1998 and is in its 6th revision. There are both Affiliation and CMHSP level indicators within the system. The Affiliation and each of the affiliate members submits data to MDHHS on a quarterly basis. MDHHS collects, aggregates, trends, and publishes the MMBPIS information on the indicators MDHHS has determined would best monitor the implementation of managed care throughout the state. The LRE and the Information Systems Coordinators ensure the reliability and validity of the data across the affiliation and that the indicators conform to the "Validation of the Performance Measures" of the Balanced Budget Act protocols. The LRE will review MMBPIS results. If ACCMHS is out of compliance with MDHHS standards, ACCMHS will work with the LRE to ensure the implementation of an effective improvement plan.

B. **Utilization Management**
The ACCMHS Utilization Management Process is guided by the LRE's Utilization Management Policy and Procedure and annual Utilization Management Plan. ACCMHS conducts utilization management activities to ensure the appropriate delivery of services. Utilization mechanisms identify and correct under-utilization as well as over-utilization. Utilization reviews include the review/monitoring of individual consumer records, specific provider practices, and system trends.

C. **Verification of the Delivery of Medicaid Services**
The Michigan Department of Health and Human Services (MDHHS) requires each PIHP to complete reviews that meet the Verification of the Delivery of Medicaid Services (VDMS) requirements. The purpose of the process is to verify that adjudicated claims are for services identified by MDHHS as Specialty Mental Health and/or Substance Abuse Services, and that the services are sufficiently supported by case record documentation. ACCMHS will follow the LRE's policy and procedure for the VDMS.

IV. Improvement Strategies

Establishing and successfully carrying out strategies to minimize statistical performance outliers, incorporate best practices, and optimize consumer outcomes is key to continuous quality improvement. The particular strategy or sets of strategies used vary according to the situation and the kind of improvement that is desired. ACCMHS will develop improvement strategies based on performance reviews, evaluation methods, and stakeholder input.

The ACCMHS Quality Improvement Program utilizes the Plan-Do-Check-Act (PDCA) process as a problem solving approach, commonly used in quality control efforts. The

process can be repeated indefinitely until the desired outcome is achieved. The four-step process includes:

1. **Plan:** Design (or revise) a process to improve results.
2. **Do:** Implement the plan and measure its performance.
3. **Check:** Measure and evaluate the results to determine if the results met the desired goals.
4. **Act:** Decide if changes are needed to improve the process. If so, begin the PDCA process again.

ACCMHS QUALITY IMPROVEMENT GOALS FOR FISCAL YEAR 2019/2020

Goal #1	Reasoning	Actions	Target Date
Maintain at least an overall 90% rate of current treatment plans for ACCMHS Programs	-Services provided after treatment plans are past due cannot be reported for Medicaid reimbursement. - ACCMHS is working to ensure the best use of General Fund dollars. -Ensuring treatment plans are current also provides better service to ACCMHS consumers, since current plans most accurately reflect consumers' needs and desires. -This goal was created to help improve overall services, as well as to ensure proper use of ACCMHS funds.	-The Quality Records Review team will provide supervisors with treatment plan data on a quarterly basis. -The QI Council General Funds Workgroup will create a work plan to address the barriers for this standard. -Managers/Supervisors will ensure treatment plans remain current by monitoring reports and reviewing completion/timeliness issues with staff during one-on-one supervision meetings.	September 30, 2020

Goal #2	Reasoning	Actions	Target Date
Achieve and maintain all standards of the Michigan Mission-Based Performance Indicator System (MMBPIS)	-The MMBPIS indicators collect data to monitor the quality of care for consumers in Michigan's public mental healthcare system. -MMBPIS Indicators focus on: access/timeliness to services, continuity of care, efficiency, and outcomes. -ACCMHS values all of these concepts and, as a quality mental health provider, endeavors to improve upon them. -MDHHS places great value on these indicators. -Whenever a standard is not met, the LRE requires a written *Plan of Correction* detailing the steps to be taken to improve processes and outcomes. A status update on the progress toward meeting the standard is also required by the LRE.	-The QI Coordinator will work with IT staff to ensure reports are available and accurate from the EMR. -The QI Council will oversee MMBPIS quality improvement efforts to ensure that MMBPIS Indicators are being met. -ACCMHS Managers/Supervisors will oversee the activities related to MMBPIS standards and will encourage staff to strive to meet them on a consistent basis. -Managers/Supervisors will be responsible to write the *Plan of Correction* for their department, when one is required by the LRE. -When a *Plan of Correction* is required, the QI Coordinator will submit it in a timely manner to the LRE.	September 30, 2020

Goal #3	Reasoning	Actions	Target Date
Ensure an Engaged and Empowered Workforce, per the FY2018-22 Strategic Plan.	- To ensure a systematic approach is used for employee reviews. - To ensure job descriptions are current, representing the responsibilities of each staff position. -The "Threads Culture" approach to Performance Reviews strengthens organization culture by: 1) defining an organization's core values and, 2) engaging staff by improving communication and accountability. -To improve employee satisfaction and retention rates.	-In coordination with the Management Team, HR will implement the "Threads Culture" Job Description and Performance Review System. (Initial trainings to be completed in October of 2019). -Supervisors will work with their staff to ensure that job descriptions are accurate. -Supervisors will ensure the Threads System captures relevant data for Performance Review. -Data will be used to communicate cultural expectations and provide accountability measures.	September 30, 2020
Goal #4	**Reasoning**	**Actions**	**Target Date**
Receive a 3-year accreditation from CARF.	-CARF accreditation ensures that internationally recognized standards are being met. CARF accreditation demonstrates our commitment to providing quality services for our consumers.	-The QI Council members will serve as the CARF team. -The CARF Team Lead will assign sections for review. -Mock Surveys will be conducted to identify gaps and address issues.	May 2020