Welcome!

We know one of the advantages of an in-person event like this one is the opportunity to talk with colleagues doing similar work. Please spend a few minutes introducing yourself to those around you.
Tools to Support the Development of a Performance Driven Culture
Introduction & Housekeeping

Housekeeping:

- Slides are posted at MCTAC.org
- Questions not addressed today will be:
  - Reviewed and incorporated into future trainings and presentations
  - Added to Q&A resources when possible
- Feedback forms

Reminder: Information and timelines are current as of the date of the presentation
What is MCTAC?

MCTAC is a training, consultation, and educational resource center that offers resources to all mental health and substance use disorder providers in New York State.

**MCTAC’s Goal**
Provide training and intensive support on quality improvement strategies, including business, organizational and clinical practices to achieve the **overall goal of preparing and assisting providers with the transition to Medicaid Managed Care.**
Welcome!

- Introductions
- Outline for the day
- Tools and resources available to you
- Why would you want a performance driven culture?
- Continuing case study approach
Presenters

- CCSI’s Center for Collaboration in Community Health
  - Briannon O’Connor, Associate Director
- Community Technical Assistance Center/Managed Care Technical Assistance Center
  - Andy Cleek, Deputy Director, System Change Initiatives, McSilver Institute
  - Boris Vilgorin, Healthcare Strategy Officer, McSilver Institute
Outline for the day

‣ Why is data important?
‣ What is the impact of my services?
‣ What data should I collect and how?
‣ What do I do with the data once I have it?
‣ How do we work together?
Tools and resources available to you

‣ Expertise shared today
‣ Connections with other attendees
‣ Readiness assessment, guided brainstorming questions, excel workbook, online self-assessment, example dashboard will be available on the MCTAC Website
‣ What you can do when you leave here
  • “How can I get started?”
‣ Follow up webinars
How are you currently using data?

How is data important to your organization?
Why would you want a performance driven culture?

- Better for your staff
- Better for people receiving services
- Better for your bottom line
Case Study

Making Families Well Agency (MFWA)

Mission:
At Making Families Well Agency we strive to provide the highest quality of care to the children, adult and families we serve. For over 25 years we have been supporting children, adults and families in their time of need by empowering them with the skills and support to remain a family unit, attain their goals, and realize their full potential.
Case Study: MFWA

Who we serve: Youth 5-21 years old with Serious Emotional Disturbance, Adults and their families in NYC and LI

Services:

Outpatient clinic:
- Evaluation/Screening;
- Individual Psychotherapy;
- Group Therapy;
- Family Therapy;
- Crisis intervention;
- Medication Management;

Adult BH HCBS:
- CPST
- Peer/Empowerment
- Psychosocial Rehab
- Family Support

Crisis Intervention
Health Home CMA
Do You Know Your Area Demographics?

County
Town
Zip Code
Neighborhood

mctac
MFWA: Trends in service delivery

- Do you know your trends in services?
  - Referrals/Intakes
  - The average age of those in treatment
  - The average number of visits per year in the last year was
  - Length of Stay
  - Population/Demographic Changes
The state has expressed an interest in involving Managed Care Agencies more in the youth Medicaid service delivery system.

Conversations in the county are starting to mention network development.
MFWA: What do they need to know?

‣ Why is data important?
‣ What is the impact of my services?
‣ What data should I collect and how?
‣ What do I do with the data once I have it?
‣ How do we work together with other organizations?
Why is data important?
Why is Data Important?

Learning Objective:
Be able to describe the role/importance of data collection, analysis and data-sharing and how to develop an agency culture to support this work.

1. Why is data important?
2. Overview of the elements of a Performance Driven Culture
3. Tool: Performance Driven Culture Assessment
Why is Data Important?

- Supports the wise use of limited resources
- Encourages informed decision making
- Heightens accountability to make a difference/impact
- Important in supporting a more certain future during uncertain times
Why is Data Important?

‣ Encourages an organization to take on meaningful challenges

‣ Prepares an organization for greater accountability as new payers (MCOs, ACOs) emerge

‣ Positions an organization for the possibility of participating in Value Based Payment arrangements

‣ It’s the right thing to do for the children, youth and their families
What Are The Components of an Organization that Effectively Uses Data to Drive Performance?
Effective Internal Collaboration

Organizational Culture: Supports Data-Driven Decision Making

- Practice Development & Management
- Continuous Quality Improvement Practices
- Revenue Cycle Management
- Fiscal Management
- Data Collection & Processing
- Contracting/ Negotiations
- Training & Education
- Human Resources
- Corporate Compliance
- Marketing
- Financial Systems
- IT

Network Development

Processes
Infrastructure
Culture
Let’s Talk about the Culture of a Performance Driven Organization
What is a Culture?

- Culture is the way of thinking, behaving, or working that exists in a place or organization (such as a business).

- It is a belief system that impacts what is considered to be of “value” and how decisions are made.
What Does Culture Mean in a Performance Driven Organization?

Belief system ...from board to management to staff... that supports the concept of data-driven problem (opportunity) identification as a path to improved organizational and individual performance
How Might You Know Whether Your Organization has a Performance Driven Culture?
# Introducing: Performance Driven Culture Assessment Tool

## Performance Driven Culture Readiness Assessment

This tool was developed to assess organizational readiness to be Performance Driven, with a focus on the cultural elements that support heightened accountability. Please bring the Leadership Team together to respond to the questions collectively as the discussion that ensues will support the determination of next steps in enhancing the organizations’ Performance Driven Culture.

<table>
<thead>
<tr>
<th>Readiness Item</th>
<th>Not at True</th>
<th>Very True</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corporate Policy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a corporate policy (documentation) in place that reflects the value of performance driven leadership and the importance of continuously learning and improving</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>The policy is embraced as a shared vision by all leadership</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td><strong>Leadership Values</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership values data &amp; Information and routinely talks about agency performance</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Leadership is willing to conduct authentic agency program and service assessments using internal and/or external resources</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Leadership is always willing to take a “deeper dive” to better understand the meaning of the information</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Performance is an acceptable topic to talk about (discuss) at the staff, management and board levels of the organization</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Agency performance is reported out and discussed during board meetings</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Accountability for continuous improvement exists at all levels of the organization</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td><strong>Performance Dashboard</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency Performance Dashboard exists, is maintained and reviewed on a regular basis</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
<tr>
<td>Dashboard covers all areas of performance, financial, quality (ability to practice model), service impact, client satisfaction, payer satisfaction feedback</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Human Resources</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job descriptions reflect expectation of measurement and continuous improvement to assure best possible performance</td>
<td></td>
</tr>
<tr>
<td>Performance Appraisals incorporate aspects of measurable performance for staff members as well as management</td>
<td></td>
</tr>
<tr>
<td>Professional development driven by Identified areas for improvement</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Multiple forms of recognition exist and are tied to exceptional based practices</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td><strong>Continuous Learning</strong></td>
<td></td>
</tr>
<tr>
<td>The agency Invests in learning/training at all levels of the organization</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Continuous transformation is encouraged during trainings</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Ongoing research takes place to identify evidence based practices</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Investments are made in innovation</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td><strong>Communication</strong></td>
<td></td>
</tr>
<tr>
<td>Exceptional communication is routinely taking place across all areas of the organization</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Staff members see and hear leadership talk about and act in a manner consistent with the agency values</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Staff members are routinely given the opportunity to ask questions and share their thoughts about the work of the organization</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Both good news and bad news is shared and discussed</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Each staff members knows and supports the Agency Value Proposition and Values</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td><strong>Collaboration</strong></td>
<td></td>
</tr>
<tr>
<td>A work culture exists where joint communication and decision making among all members of the healthcare team is the norm</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>The work of the organization exhibits system thinking and team learning</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
Here is what Making Families Well Agency learned when they completed the Performance Driven Culture Readiness Assessment
Assessment Findings for MFWA

- Need to develop a Performance Dashboard that includes all areas of focus

- Need to take performance information (Dashboard) to the Board

- Need to invest in more training to support ongoing practice change
Assessment Findings for MFWA

› Need to improve routine, two-way communication with staff members, with a focus on sharing of performance information

› Need to invest in encouraging authentic collaboration within and among the various programs and support areas within MFWA
How Can I Get Started?

‣ Consider using the Performance Driven Culture Assessment Tool to better understand your readiness for a world of heightened accountability for outcomes

‣ Complete the tool during a Leadership Team Meeting so that all may offer their perspectives. It is the conversation that will be very important

‣ Develop a work plan for addressing gaps in cultural readiness
What is the impact of my services?
Effective Internal Collaboration

Organizational Culture:
Supports Data-Driven Decision Making

- Practice Development & Management
- Continuous Quality Improvement Practices
- Financial Systems
- Contracting/Negotiations
- Data Collection & Processing
- Revenue Cycle Management/Fiscal Management
- Training & Education
- Marketing
- Human Resources
- Corporate Compliance

Network Development

Processes
Infrastructure
Culture
What is the impact of my services?

Learning Objective:
Be able to identify strategies to start measuring impact

1. Introduce strategies to measure impact (Brainstorming Activity)
   1. What do we do well?
   2. How do we know?
   3. What do we do with that information?

2. Measuring what you’re good at that aligns with state goals (Logic Model)

3. Tool: Brainstorming Activity
MFWA – Now What?

Finding from Performance Driven Culture Assessment:
Need to develop a Performance Dashboard that includes areas of focus

*In order to identify a performance dashboard, they need key pieces of information, including knowing their impact*
Thinking about your impact

Impact
Your value to your individuals served and the overall system of care

Context
- Accountability and reporting requirements
- Value Based Payments
- Marketing and recruitment
- Value proposition
Measuring my impact is important, but how do I do it?
How to determine your impact

1. Establish a workgroup
   i. Leadership
   ii. Representatives from all departments in the organization—direct service providers, finance, administrative support, etc.
   iii. Data experts

2. Use the Tool “Brainstorming Impact”
   i. Spend some time
   ii. All ideas are good ideas
How to determine your impact

‣ What does your organization do well?

‣ What impact does the service have on individuals/families/youth?

‣ What are the benefits of using the service?

‣ Why do individuals/families/youth seek out this service?

‣ Why do other service providers refer to you?
How to determine your impact

‣ What have other service providers told you about what you do well?

‣ What would the alternatives be if this service didn't exist (for individuals/families/youth/other service providers)?

‣ What outcomes are you most proud of?

‣ What do your staff and volunteers say about what they do well?
MFWA: Example Brainstorming Activity for Family Peer Support Services
MFWA: What are the benefits of this service?
MFWA: What would be the alternatives if this service didn’t exist?
What impact does your service have on individuals/families/youth?

What are the alternatives for your consumers/families/youth if your organization did not exist?
Where does this fit in the big picture changing environment?
Health Care System Reform Goals

- Improved individual health and behavioral health life outcomes
- Improved member’s experience of care
- Limiting use of high intensity and acute services, including emergency room and inpatient settings
- Culturally competent and trauma-informed services and providers
- Evidence-based, evidence-informed, and promising practices
- Transformation to a more community-based, recovery-oriented, person-centered, youth-guided, individualized service system
Fitting into the Big Picture

What we do well
Impact
Services provided

State Goals
Fitting into the Big Picture

What we do well
Impact
Services provided

State Goals

Start on the right
Ask the question how. How would this occur? How would you know?
MFWA: Example Logic Model for Family Peer Support Services
State Goals

Reduce avoidable ER/inpatient use

Improve Outcomes

Supports (natural/community)

Access Benefits
- Social services
- Healthcare
- Stable housing

Connections with social supports

Support use of de-escalation strategies

Access Mobile Crisis Services

Crisis plan in place

Family self-management wellness tools

Education about relapse prevention, identifying triggers

Attend family group sessions

Foster supportive relationships

Skill building

Identify barriers

Advocacy

Awareness of available community resources

Foster supportive relationships

Skill building

Identify barriers

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Improve Outcomes

Crises
State Outcomes

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Improve Outcomes

State Goals

Reduce avoidable ER/inpatient use

Improve Outcomes

Access Mobile Crisis Services

Crisis Services

Crises
State Outcomes

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Improve Outcomes

Crisis plan in place

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\downarrow Crises

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Crises
State Outcomes
Reduce avoidable ER/inpatient use
Improve Outcomes

State Goals
Reduce avoidable ER/inpatient use
Improve Outcomes

Crisis plan in place
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Education about relapse prevention, identifying triggers
Access Mobile Crisis Services
Support use of de-escalation strategies
↓ Crises

Family self-management wellness tools
Education about relapse prevention, identifying triggers
Support use of de-escalation strategies
Access Mobile Crisis Services
↓ Crises

State Goals
Reduce avoidable ER/inpatient use
Improve Outcomes
Data Opportunities:

- Number of education/relapse prevention sessions attended, by who (demographics)

- % of families attended relapse prevention session
State Goals
Reduce avoidable ER/inpatient use
Improve Outcomes

Data Opportunities:
- % of families that are introduced to self-management wellness tools
- % of families/individuals who report measurable progress on using self-management wellness tools
- % families who report measurable improvements in self-wellness
State Goals

Reduce avoidable ER/inpatient use

Improve Outcomes

↑ Supports (natural/community)
State Outcomes

State Goals
- Reduce avoidable ER/inpatient use
- Improve Outcomes

Connections with social supports

Supports (natural/community)

Access Benefits
- Social services
- Healthcare
- Stable housing
State Outcomes

Reduce avoidable ER/inpatient use

Improve Outcomes

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Skill building

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State Goals

Reduce avoidable ER/inpatient use

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- Improve Outcomes

Supports (natural/community)

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- Access Benefits
  - Social services
  - Healthcare
  - Stable housing

Identify barriers

- Identify barriers

Skill building

- Skill building

Foster supportive relationships

- Foster supportive relationships

Attend family group sessions

- Attend family group sessions

Awareness of available community resources

- Awareness of available community resources

Advocacy

- Advocacy

Connections with social supports

- Connections with social supports
State Goals

Reduce avoidable ER/inpatient use

Improve Outcomes

State Outcomes

Reduce avoidable ER/inpatient use

Improve Outcomes

Supports (natural/community)

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¶ Supports

Advocacy

Identify barriers

Skill building

Foster supportive relationships

Attend family group sessions

Awareness of available community resources
State Outcomes:

Reduce avoidable ER/inpatient use
Improve Outcomes

Supports (natural/community)

Access Benefits
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- Stable housing

Data Opportunities:

- % of families who attend at least 2 family group sessions
- % of families who received education on communication styles

Attend family group sessions

Foster supportive relationships

Skill building

Connections with social supports

Identify barriers

Advocacy

Awareness of available community resources

State Goals

Reduce avoidable ER/inpatient use
Improve Outcomes
Data Opportunities:

- % of clients who identify conflict resolution as a need
- % of clients with a skill-building goal on their individualized service plan
- % of clients who report measurable progress in conflict resolution skills
State Goals

Reduce avoidable ER/inpatient use

Improve Outcomes

Data Opportunities:

- % of families that attend a family engagement event
- % of youth with a family or support person involved in care
- Average # of contacts staff made with support person

Connections with social supports

Supports (natural/community)

Supports

\[ \text{Access Benefits} \]
- Social services
- Healthcare
- Stable housing

Advocacy

Identify barriers

Skill building

Foster supportive relationships

Attend family group sessions

Awareness of available community resources
We’ve brainstormed our impact and identified how our service supports system-wide goals.

How do we demonstrate it?
How do you know your impact?

‣ What data do you have that could demonstrate that impact (surveys, pre/post data, clinical outcomes, attendance, client satisfaction, referrals, etc.)?

‣ What information are you already tracking?

‣ What is included on intake forms or other paperwork?

‣ What is collected in an electronic health system or tracking spreadsheet?

‣ Does data already exist “out there”?
How do you know your impact?

- If you don’t have current data, what information would you need to be able to know for sure that the service is having the impact described above (be as detailed as possible)?

- If you know mostly from anecdotes or personal testimonials, what types of information could you collect to get at the main themes from these stories?
MFWA: Example Brainstorming Activity for Family Peer Support Services
MFWA: What data do we have?

- Client Testimonials/Anecdotal data (verbal/written)
- Intake data (demographics)
- Units of Service/Attendance
- Surveys (varying types, pre/post)
- Testimonials from other agencies
- Hospitalization data
- Self-evaluation of family relationship (close, strained, etc.)
- Trauma history
- Housing status
MFWA: What data do we have?

Findings

‣ Data primarily stored on paper
‣ Not easy to aggregate data
  • A lot of anecdotal/qualitative data
  • Open ended questions/text format
‣ Minimal outcome data

Other thoughts

‣ Considering an EHR vendor
‣ Have Microsoft Excel available on all desktops
Recap…

So far, MFWA has:

- Completed Performance Driven Culture Assessment
- Developed a workgroup to address findings
- Identified impact of their services, mapped to state goals, and identified data sources/gaps

Next Step for MFWA:

- Having identified significant gaps in data, MFWA will need to review what data to start collecting and how
How Can I Get Started?

- Establish a Work Group
- Complete the Brainstorming Activity
- Connect the dots: how do your services connect with State Healthcare Reform Goals?
- Identify your data opportunities and data gaps
What data should I collect and how?
What Data Should I Collect and How?

Learning Objective:
Be able to identify key data elements valuable across systems (agencies, providers, counties, etc.)

1. Who is served? Understanding your population and demographics
2. How are they served? Looking at utilization data
3. How well are they served? Looking at outcome data
4. What is the cost of serving them? Looking at cost per unit and cost per episode data
5. Tool: Data summary and visualization workbook
MFWA – Now What?

- Remember, MFWA is still working to develop a performance dashboard.

- MFWA noticed gaps in data they currently collect.

- MFWA attended a few webinars recently and are aware of some basic best practices around data collection:
  - Keep the number of measures small (limit how much data you need to analyze).
  - Look at low-hanging fruit – what data do we already have?
  - Choose measures that are likely to show change and success.
MFWA – Now What?

- MFWA also knows that there are different types of measures out there and are aware of some standard data elements they should be capturing/collecting:

  1. **Demographics**: Understanding the basic characteristics of your consumer population
  2. **Utilization**: Quantifying the services you provide
  3. **Outcome**: Understanding the value of your service
  4. **Finance**: How effectively are you using your resources in support of your mission
Demographics: Why it’s important

- Provide a snapshot overview of your population
- Identify potential disparities in access to services
- Identify if the population you serve is representative of your community
- Help identify subgroups of interest or niche populations
- Identify targets for new markets or outreach

- Being able to easily summarize the population served is the foundation of measurement
  - Understanding your denominator
Utilization – Why it’s important

- Identify the services you provide and to whom
- Quantify how many services you provide and how those services are distributed across your population
- When collected, can identify who is providing the service and how often
  - Productivity
  - “How am I using my resources?”
- Identify if the service delivery pattern is consistent across services
Outcome – Why it’s important

- Determine if consumers are satisfied with the services
- Assess if consumers are engaged in the process
- Determine if consumers are accessing your services in a timely manner
- Identify if consumers are reaching their goals and/or making progress toward those goals
Finance – Why it’s important

› Compare your budget to actuals for:
  • Revenue
  • Costs
  • Revenue per Unit
  • Costs per Unit

› Look at your payer mix to determine variances in reimbursement
MFWA – Now What?

- MFWA has access to a tool through MCTAC that allows them to enter minimal data on their current roster, which the tool then auto-populates analyses and visualizations!

- Same tool you now have access to!
Introducing the Data Summary and Visualization Tool

In the tool, MFWA entered:

- Their roster/list of clients
  - Basic demographic, utilization and outcome data for each client
- Basic financial information
  - Revenue, costs, units of service (budget and actuals)

Tool auto-populates a real-time analysis of performance!

- Demographics
- Utilization
- Outcomes
- Finance
- Customizable!
Let’s see what MFWA found!
## Data Collection

**Report Period:** 1/1/17 - 5/31/17

<table>
<thead>
<tr>
<th>ID Number</th>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Age Group</th>
<th>Ethnicity</th>
<th>Race</th>
<th>Payor</th>
<th>Diagnosis/presenting condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000N</td>
<td>Mickey Mouse</td>
<td>Female</td>
<td>8</td>
<td>0-11 years</td>
<td>Not Hispanic</td>
<td>White</td>
<td>Medicaid</td>
<td>Autism spectrum disorder</td>
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<tr>
<td>10010N</td>
<td>Montana Max</td>
<td>Female</td>
<td>14</td>
<td>12-17 years</td>
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<td>White</td>
<td>Private Pay</td>
<td>Anxiety disorder</td>
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<td>28</td>
<td>18-64 years</td>
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<td>More than one Race</td>
<td>Medicaid</td>
<td>Depression</td>
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<td>67</td>
<td>65+ years</td>
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<td>Asian</td>
<td>Medicare</td>
<td>Depression</td>
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<tr>
<td>10140N</td>
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<td>Not Hispanic</td>
<td>American Indian or Alaskan Native</td>
<td>Medicaid</td>
<td>Bipolar Disorder</td>
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<tr>
<td>10200N</td>
<td>Minnie Mouse</td>
<td>Male</td>
<td>15</td>
<td>12-17 years</td>
<td>Hispanic</td>
<td>More than one Race</td>
<td>Commercial</td>
<td>Bipolar Disorder</td>
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<td>White</td>
<td>Commercial</td>
<td>Depression</td>
</tr>
<tr>
<td>15751N</td>
<td>Pappa Smurf</td>
<td>Transgender</td>
<td>13</td>
<td>12-17 years</td>
<td>Not Hispanic</td>
<td>White</td>
<td>Private Pay</td>
<td>Anxiety disorder</td>
</tr>
<tr>
<td>15351N</td>
<td>Jimmy Neutron</td>
<td>Male</td>
<td>14</td>
<td>12-17 years</td>
<td>Hispanic</td>
<td>White</td>
<td>Medicaid</td>
<td>Conduct Disorder</td>
</tr>
<tr>
<td>14789N</td>
<td>Doc McStuffins</td>
<td>Female</td>
<td>17</td>
<td>12-17 years</td>
<td>Not Hispanic</td>
<td>White</td>
<td>Medicaid</td>
<td>Anxiety disorder</td>
</tr>
<tr>
<td>12369N</td>
<td>Ben Ten</td>
<td>Male</td>
<td>19</td>
<td>18-64 years</td>
<td>Not Hispanic</td>
<td>White</td>
<td>Commercial</td>
<td>Depression</td>
</tr>
<tr>
<td>12458N</td>
<td>Robin Titan</td>
<td>Male</td>
<td>11</td>
<td>0-11 years</td>
<td>Not Hispanic</td>
<td>Black or African American</td>
<td>Medicaid</td>
<td>Conduct Disorder</td>
</tr>
<tr>
<td>15524N</td>
<td>Tweety Bird</td>
<td>Transgender</td>
<td>13</td>
<td>12-17 years</td>
<td>Not Hispanic</td>
<td>White</td>
<td>Medicaid</td>
<td>Depression</td>
</tr>
<tr>
<td>15987N</td>
<td>Bugs Bunny</td>
<td>Male</td>
<td>20</td>
<td>18-64 years</td>
<td>Not Hispanic</td>
<td>White</td>
<td>Commercial</td>
<td>Autism spectrum disorder</td>
</tr>
<tr>
<td>15963N</td>
<td>Daffy Duck</td>
<td>Male</td>
<td>12</td>
<td>12-17 years</td>
<td>Not Hispanic</td>
<td>White</td>
<td>Medicaid</td>
<td>Depression</td>
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<tr>
<td>13467N</td>
<td>Jerry Mouse</td>
<td>Female</td>
<td>6</td>
<td>0-11 years</td>
<td>Not Hispanic</td>
<td>White</td>
<td>Medicaid</td>
<td>Depression</td>
</tr>
<tr>
<td>14682N</td>
<td>Tom Cat</td>
<td>Male</td>
<td>8</td>
<td>0-11 years</td>
<td>Hispanic</td>
<td>More than one Race</td>
<td>Medicaid</td>
<td>Depression</td>
</tr>
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</table>
Demographics – understanding the basic characteristics of who you serve
What is our gender distribution? Does this make sense?
What is our race and ethnicity distribution?
What percentage of our population identifies as homeless?
Do we have a need to translate our documentation into multiple languages? If so, which languages?
What percentage of our population has a trauma history?
Example of customizing
<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>6</td>
<td>35.29%</td>
</tr>
<tr>
<td>Male</td>
<td>9</td>
<td>52.94%</td>
</tr>
<tr>
<td>Transgender</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.00%</strong></td>
</tr>
<tr>
<td>Gender</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>------------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
<td>35.29%</td>
</tr>
<tr>
<td>Male</td>
<td>9</td>
<td>52.94%</td>
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<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

- **Female**: 35.29%
- **Male**: 52.94%
- **Transgender**: 11.76%
MFWA Findings
<table>
<thead>
<tr>
<th>Race</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaskan Native</td>
<td>1</td>
<td>5.88%</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>5.88%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>1</td>
<td>5.88%</td>
</tr>
<tr>
<td>More than one Race</td>
<td>3</td>
<td>17.65%</td>
</tr>
<tr>
<td>White</td>
<td>11</td>
<td>64.71%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.00%</strong></td>
</tr>
<tr>
<td>Race</td>
<td>Number</td>
<td>Percentage</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------</td>
<td>------------</td>
</tr>
<tr>
<td>American Indian or Alaskan Native</td>
<td>1</td>
<td>5.88%</td>
</tr>
<tr>
<td>Asian</td>
<td>1</td>
<td>5.88%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>1</td>
<td>5.88%</td>
</tr>
<tr>
<td>More than one Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
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</table>

Low compared to county demographics
<table>
<thead>
<tr>
<th>Trauma History</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>29.41%</td>
</tr>
<tr>
<td>Unknown</td>
<td>11.76%</td>
</tr>
<tr>
<td>Yes</td>
<td>58.82%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

![Bar chart showing trauma history percentages]
60% of current clients have a trauma history – are we trauma-informed?
Utilization – quantifying the services you provide
### Diagnosis/presenting concern

<table>
<thead>
<tr>
<th>Diagnosis/Presenting Concern</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorder</td>
<td>3</td>
<td>17.65%</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td>Depression</td>
<td>8</td>
<td>47.06%</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

### Number of Primary Services by Type

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>9</td>
</tr>
<tr>
<td>Counseling</td>
<td>42</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>51</strong></td>
</tr>
</tbody>
</table>

### Number of Support Services by Type

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination</td>
<td>19</td>
</tr>
<tr>
<td>Medical Referral</td>
<td>4</td>
</tr>
<tr>
<td>Medication Management</td>
<td>20</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>43</strong></td>
</tr>
</tbody>
</table>

### Number and type of Primary Services by Presenting Problem

<table>
<thead>
<tr>
<th>Anxiety disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
</tr>
<tr>
<td>Counseling</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
</tr>
<tr>
<td>Counseling</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
</tr>
<tr>
<td>Assessment</td>
</tr>
<tr>
<td>Depression</td>
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<tr>
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</tr>
<tr>
<td>Conduct Disorder</td>
</tr>
<tr>
<td>Assessment</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
</tr>
</tbody>
</table>

### Number and type of Support Services by Presenting Problem

<table>
<thead>
<tr>
<th>Anxiety disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination</td>
</tr>
<tr>
<td>Medical Referral</td>
</tr>
<tr>
<td>Medication Management</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
</tr>
<tr>
<td>Care Coordination</td>
</tr>
<tr>
<td>Medical Referral</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
</tr>
<tr>
<td>Care Coordination</td>
</tr>
<tr>
<td>Medication Management</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Care Coordination</td>
</tr>
<tr>
<td>Medication Management</td>
</tr>
<tr>
<td>Conduct Disorder</td>
</tr>
<tr>
<td>Care Coordination</td>
</tr>
<tr>
<td>Medication Management</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
</tr>
</tbody>
</table>
Do I have the right training for my staff?

### Diagnosis/presenting concern

<table>
<thead>
<tr>
<th>Diagnosis/presenting concern</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorder</td>
<td>3</td>
<td>17.65%</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td>Depression</td>
<td>8</td>
<td>47.06%</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>17</td>
<td>100.00%</td>
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</tbody>
</table>

### Number of Primary Services by Type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>9</td>
</tr>
<tr>
<td>Counseling</td>
<td>42</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>51</td>
</tr>
</tbody>
</table>

### Number of Support Services by Type

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number of services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination</td>
<td>19</td>
</tr>
<tr>
<td>Medical Referral</td>
<td>4</td>
</tr>
<tr>
<td>Medication Management</td>
<td>20</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>43</td>
</tr>
</tbody>
</table>

### Number and type of Primary Services by presenting concern

<table>
<thead>
<tr>
<th>Presenting concern</th>
<th>Number of Services</th>
</tr>
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<tbody>
<tr>
<td>Anxiety disorder</td>
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<tr>
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</tr>
<tr>
<td>Counseling</td>
<td>6</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
<td>8</td>
</tr>
<tr>
<td>Counseling</td>
<td></td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>3</td>
</tr>
<tr>
<td>Assessment</td>
<td>2</td>
</tr>
<tr>
<td>Counseling</td>
<td>28</td>
</tr>
<tr>
<td>Depression</td>
<td>3</td>
</tr>
<tr>
<td>Assessment</td>
<td>2</td>
</tr>
<tr>
<td>Counseling</td>
<td></td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>3</td>
</tr>
<tr>
<td>Assessment</td>
<td>3</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>51</strong></td>
</tr>
</tbody>
</table>
Is my staff distribution appropriate?
Are we using best practices?
MFWA Findings
<table>
<thead>
<tr>
<th>Diagnosis/Presenting Concern</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorder</td>
<td>3</td>
<td>17.65%</td>
</tr>
<tr>
<td>Autism Spectrum Disorder</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td>Depression</td>
<td>8</td>
<td>47.06%</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

![Pie chart showing the distribution of diagnoses]
Why are there no PTSD diagnoses when 60% of our population has a trauma history?
<table>
<thead>
<tr>
<th>Disorder</th>
<th>Number of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorder</td>
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<td>Assessment</td>
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</tr>
<tr>
<td>Counseling</td>
<td>6</td>
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<tr>
<td>Autism spectrum disorder</td>
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<tr>
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<tr>
<td>Bipolar Disorder</td>
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<td>Depression</td>
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<td>Assessment</td>
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<tr>
<td>Counseling</td>
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<tr>
<td>Conduct Disorder</td>
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<tr>
<td>Assessment</td>
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</tr>
<tr>
<td>Grand Total</td>
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</tr>
<tr>
<td>Disorder</td>
<td>Service</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td>Assessment</td>
</tr>
<tr>
<td></td>
<td>Counseling</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
<td>Counseling</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>Assessment</td>
</tr>
<tr>
<td>Depression</td>
<td>Assessment</td>
</tr>
<tr>
<td></td>
<td>Counseling</td>
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<tr>
<td>Conduct Disorder</td>
<td>Assessment</td>
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<td>Disorder</td>
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<tr>
<td>Medication Management</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>43</strong></td>
</tr>
</tbody>
</table>
### Number and type of Support Services by Presenting Problem

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Number of Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorder</td>
<td>6</td>
</tr>
<tr>
<td>Care Coordination</td>
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<tr>
<td>Medical Referral</td>
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<td>Medication Management</td>
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</tr>
<tr>
<td>Autism spectrum disorder</td>
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<td>Medical Referral</td>
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</tr>
<tr>
<td>Conduct Disorder</td>
<td>3</td>
</tr>
<tr>
<td>Care Coordination</td>
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</tr>
<tr>
<td>Medication Management</td>
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</tr>
</tbody>
</table>

**Grand Total**: 43

Are we using best practices?
Outcome – understanding the value of your service
What are the priority outcomes in your agency?
### Severity of symptoms measure

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderately improved</td>
<td>23.53%</td>
</tr>
<tr>
<td>No Improvement</td>
<td>17.65%</td>
</tr>
<tr>
<td>Significantly improved</td>
<td>11.76%</td>
</tr>
<tr>
<td>Slightly improved</td>
<td>35.29%</td>
</tr>
<tr>
<td>Slightly worse</td>
<td>11.76%</td>
</tr>
</tbody>
</table>

**Grand Total**: 100.00%

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
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<tbody>
<tr>
<td><strong>Anxiety disorder</strong></td>
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<tr>
<td>No Improvement</td>
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</tr>
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<td>Slightly improved</td>
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<td><strong>Autism spectrum disorder</strong></td>
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<tr>
<td>Significantly improved</td>
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<td>Slightly worse</td>
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<td>Slightly worse</td>
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</tr>
<tr>
<td><strong>Conduct Disorder</strong></td>
<td></td>
</tr>
<tr>
<td>Moderately improved</td>
<td>1</td>
</tr>
<tr>
<td>Slightly improved</td>
<td>1</td>
</tr>
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</table>

**Grand Total**: 17

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderately improved</td>
<td>6</td>
</tr>
<tr>
<td>No Improvement</td>
<td>3</td>
</tr>
<tr>
<td>Slightly improved</td>
<td>2</td>
</tr>
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</table>

**Counseling**: 11

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderately improved</td>
<td>1</td>
</tr>
<tr>
<td>No Improvement</td>
<td>2</td>
</tr>
<tr>
<td>Slightly improved</td>
<td>2</td>
</tr>
<tr>
<td>Slightly better</td>
<td>4</td>
</tr>
<tr>
<td>Slightly worse</td>
<td>2</td>
</tr>
</tbody>
</table>

**Grand Total**: 17
What percentage of my current clients have improved in their functioning scores since their first assessment?
Are there differences between outcomes by diagnosis/presenting concern?
Are there differences between outcomes by primary service?

<table>
<thead>
<tr>
<th>Severity of symptoms measure</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modestly improved</td>
<td>23.53%</td>
</tr>
<tr>
<td>No Improvement</td>
<td>17.65%</td>
</tr>
<tr>
<td>Significantly improved</td>
<td>11.76%</td>
</tr>
<tr>
<td>Slightly improved</td>
<td>35.29%</td>
</tr>
<tr>
<td>Slightly worse</td>
<td>11.76%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of Cases</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorder</td>
<td></td>
</tr>
<tr>
<td>No Improvement</td>
<td>2</td>
</tr>
<tr>
<td>Slightly improved</td>
<td>1</td>
</tr>
<tr>
<td>Autism spectrum disorder</td>
<td></td>
</tr>
<tr>
<td>Significantly improved</td>
<td>1</td>
</tr>
<tr>
<td>Slightly worse</td>
<td>1</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td></td>
</tr>
<tr>
<td>Moderately improved</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td></td>
</tr>
<tr>
<td>Moderately improved</td>
<td>1</td>
</tr>
<tr>
<td>No Improvement</td>
<td>1</td>
</tr>
<tr>
<td>Significantly improved</td>
<td>1</td>
</tr>
<tr>
<td>Slightly improved</td>
<td>4</td>
</tr>
<tr>
<td>Slightly worse</td>
<td>1</td>
</tr>
<tr>
<td>Conduct Disorder</td>
<td></td>
</tr>
<tr>
<td>Moderately improved</td>
<td>1</td>
</tr>
<tr>
<td>Slightly improved</td>
<td>1</td>
</tr>
<tr>
<td>Grand Total</td>
<td>17</td>
</tr>
</tbody>
</table>
Outcome

MFWA Findings
More than 50% of current clients show little to no improvement
66% of those clients showing little to no improvement identify having a trauma history.
Finance – how effectively are you using your resources in support of your mission
# Data Entry Requirements

<table>
<thead>
<tr>
<th>Number fiscal year months reported:</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program1</strong></td>
<td><strong>Program2</strong></td>
</tr>
<tr>
<td>Total Cost Budget</td>
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<tr>
<td>Total Revenue Budget</td>
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<tr>
<td>Surplus/(Loss)</td>
<td>5,614</td>
</tr>
<tr>
<td>Units of Service Budget</td>
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</tr>
<tr>
<td>Total Cost Actual</td>
<td>236,514</td>
</tr>
<tr>
<td>Total Revenue Actual</td>
<td>239,411</td>
</tr>
<tr>
<td>Surplus/(Loss)</td>
<td>2,897</td>
</tr>
<tr>
<td>Units of Service Actual</td>
<td>1,880</td>
</tr>
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</table>

**Key:**
- Input fields
- Calculated field
### Payor Summary

<table>
<thead>
<tr>
<th>Payor</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>4</td>
<td>23.53%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>10</td>
<td>58.82%</td>
</tr>
<tr>
<td>Medicare</td>
<td>1</td>
<td>5.88%</td>
</tr>
<tr>
<td>Private Pay</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

### Fiscal Summary by Program

#### Program 1

<table>
<thead>
<tr>
<th>Category</th>
<th>Budget</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expense</td>
<td>235,813</td>
<td>236,514</td>
<td>701</td>
</tr>
<tr>
<td>Revenue</td>
<td>238,153</td>
<td>239,411</td>
<td>1,258</td>
</tr>
<tr>
<td>Surplus/(Loss)</td>
<td>2,340</td>
<td>2,897</td>
<td>557</td>
</tr>
<tr>
<td>Units</td>
<td>1,887</td>
<td>1,880</td>
<td>(7)</td>
</tr>
<tr>
<td>Cost per unit</td>
<td>124.97</td>
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<tr>
<td>Revenue per unit</td>
<td>126.21</td>
<td>127.35</td>
<td>1.14</td>
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</tbody>
</table>

#### Program 2

<table>
<thead>
<tr>
<th>Category</th>
<th>Budget</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expense</td>
<td>112,131</td>
<td>113,028</td>
<td>897</td>
</tr>
<tr>
<td>Revenue</td>
<td>107,880</td>
<td>108,441</td>
<td>561</td>
</tr>
<tr>
<td>Surplus/(Loss)</td>
<td>(4,251)</td>
<td>(4,587)</td>
<td>(336)</td>
</tr>
<tr>
<td>Units</td>
<td>731</td>
<td>812</td>
<td>81</td>
</tr>
<tr>
<td>Cost per unit</td>
<td>153.39</td>
<td>139.20</td>
<td>(14.19)</td>
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<tr>
<td>Revenue per unit</td>
<td>147.58</td>
<td>133.55</td>
<td>(14.03)</td>
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</table>

#### Program 3

<table>
<thead>
<tr>
<th>Category</th>
<th>Budget</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expense</td>
<td>285,468</td>
<td>289,741</td>
<td>4,273</td>
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<tr>
<td>Revenue</td>
<td>287,380</td>
<td>298,712</td>
<td>11,332</td>
</tr>
<tr>
<td>Surplus/(Loss)</td>
<td>1,912</td>
<td>8,971</td>
<td>7,059</td>
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<td>3,213</td>
<td>158</td>
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<tr>
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<td>93.44</td>
<td>90.18</td>
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<tr>
<td>Revenue per unit</td>
<td>94.07</td>
<td>92.97</td>
<td>(1.10)</td>
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</table>
What is my payor mix?

<table>
<thead>
<tr>
<th>Payor</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>4</td>
<td>23.53%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>10</td>
<td>58.82%</td>
</tr>
<tr>
<td>Medicare</td>
<td>1</td>
<td>5.88%</td>
</tr>
<tr>
<td>Private Pay</td>
<td>2</td>
<td>11.76%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>17</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

**Fiscal Summary by Program**

<table>
<thead>
<tr>
<th>Program</th>
<th>Budget</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Revenue per unit</td>
<td>126.21</td>
<td>127.35</td>
</tr>
<tr>
<td>Program2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expense</td>
<td>112,131</td>
<td>113,028</td>
</tr>
<tr>
<td></td>
<td>Revenue</td>
<td>107,880</td>
<td>108,441</td>
</tr>
<tr>
<td></td>
<td>Surplus/(Loss)</td>
<td>(4,251)</td>
<td>(4,587)</td>
</tr>
<tr>
<td>Program3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Expense</td>
<td>285,468</td>
<td>289,741</td>
</tr>
<tr>
<td></td>
<td>Revenue</td>
<td>287,380</td>
<td>298,712</td>
</tr>
<tr>
<td></td>
<td>Surplus/(Loss)</td>
<td>1,912</td>
<td>8,971</td>
</tr>
</tbody>
</table>

**Agency Fiscal Summary**

<table>
<thead>
<tr>
<th></th>
<th>Budget</th>
<th>Actual</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expense</td>
<td>633,412</td>
<td>639,283</td>
<td>5,871</td>
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<tr>
<td>Revenue</td>
<td>633,412</td>
<td>646,564</td>
<td>13,152</td>
</tr>
<tr>
<td>Surplus/(Loss)</td>
<td>0</td>
<td>7,281</td>
<td>7,281</td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th>Units</th>
<th>Cost per unit</th>
<th>Revenue per unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expense</td>
<td>5,673</td>
<td>111.65</td>
<td>111.65</td>
</tr>
<tr>
<td>Revenue</td>
<td>5,905</td>
<td>108.26</td>
<td>109.49</td>
</tr>
<tr>
<td>Surplus/(Loss)</td>
<td>7,281</td>
<td>232</td>
<td>(2.16)</td>
</tr>
</tbody>
</table>
How are each of my programs doing fiscally, comparing actual YTD to budget?
How is my agency as a whole doing fiscally, YTD compared to budget?
What are my cost per unit and revenue per unit? Both budgeted and actual YTD
Finance

MFWA Findings
One of MFWA’s programs is operating at a current deficit.
MFWA – Recap Findings

Demographics
› Serve low % of Black/African-American pop. compared to county
› 60% of current clients have a trauma history

Utilization
› No PTSD diagnoses, yet 60% of population with a trauma history
› Are we using best practices?

Outcomes
› >50% of current clients show little to no improvement in symptoms
› Of those, 66% identify a trauma history

Finance
› One of MFWA’s programs is operating at a current deficit
How Can I Get Started?

‣ Go to the MCTAC website for access to the Data Summary and Visualization Workbook

‣ Follow the instructions, enter your current roster, basic demographic and utilization data, and basic financial information

‣ Play, play, play!!

‣ What questions do you want/need to know about demographics, utilization, outcomes and finance?

‣ What findings do you come up with?
Data Collection - Tips

‣ Know your definitions
‣ Pay attention to Spelling
‣ Check for completeness and accuracy of your data
  • Check ID numbers
  • Check data categories
‣ Determine if the data you collect is meaningful
  • Does collecting Housing Status make sense for my agency/service?
  • What information is critical to know?
‣ Pay attention to the Time Period
Questions?
What do I do with the data once I have it?
Effective Internal Collaboration

- Continuous Quality Improvement Practices
- Practice Development & Management
- Financial Systems
- Data Collection & Processing
- Contracting/Negotiations
- Revenue Cycle Management/Fiscal Management
- IT
- Training & Education
- Corporate Compliance
- Human Resources
- Planning

Organizational Culture: Supports Data-Driven Decision Making

Network Development

Processes
Infrastructure
Culture
Continuous Quality Improvement
What is CQI?

A philosophy that focuses on improving the systems and processes of an organization

‣ Asks:
  • How are we doing?
  • How do we know?
  • Can we do better?

‣ By using methodology that is:
  • Specific
  • Objective
  • Data-Driven
  • Cyclical
Why CQI?

- Helps any organization become better at improving the lives of those they serve
- Foundation of a performance driven culture and organization
- Facilitates alignment with State and Federal Policy goals
  - Triple Aim
    - Improve the quality of care
    - Reduce costs
    - Improve Population Health
PDSA Cycle

Plan

Act

Do

Study
How to begin using PDSA?

▶ **Who? Workgroup:**
  - Need buy-in!
  - Individuals that may be impacted by PDSA cycle for their input
  - Those with the data
  - Leadership that has authority to make decisions on PDSA findings AND can ensure implementation of the “DO”

▶ **What?**
  - PDSA cycle on **ONE** step at a time
    - Ensures you are attributing change to the correct variable
  - PDSA cycle on a Pilot group first

▶ **Timeline?**
  - Short Cycles (2 weeks) for rapid decision making
    - This can be a challenge in the Behavioral Healthcare field
### Overall Results

The following tables represent how your organization scored on the assessment based on the 10 domains of the assessment and is reported accordingly. There are two tables: one depicting leadership and the other frontline and support staff. The mean score is on a scale of one (1) to five (5) and is calculated by summing the total number of responses for each item and domain then dividing by the total number of responses.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Frontline &amp; Support Staff</th>
<th>Leadership</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Score</td>
<td>Ranking</td>
<td>Mean Score</td>
</tr>
<tr>
<td>Governance &amp; Leadership</td>
<td>1.79</td>
<td></td>
<td>1.79</td>
</tr>
<tr>
<td>Policy</td>
<td>4.33</td>
<td></td>
<td>4.33</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>3.75</td>
<td></td>
<td>3.75</td>
</tr>
<tr>
<td>Engagement &amp; Involvement</td>
<td>4.25</td>
<td></td>
<td>4.25</td>
</tr>
<tr>
<td>Screening, Assessment &amp; Treatment</td>
<td>4.77</td>
<td></td>
<td>4.77</td>
</tr>
<tr>
<td>Cross Sector Collaboration</td>
<td>1.38</td>
<td></td>
<td>1.38</td>
</tr>
<tr>
<td>Training &amp; Workforce Development</td>
<td>0.87</td>
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<td>0.87</td>
</tr>
<tr>
<td>Progress Monitoring &amp; Quality Assurance</td>
<td>1.50</td>
<td></td>
<td>1.50</td>
</tr>
<tr>
<td>Financing</td>
<td>3.88</td>
<td></td>
<td>3.88</td>
</tr>
<tr>
<td>Evaluation</td>
<td>4.93</td>
<td></td>
<td>4.93</td>
</tr>
</tbody>
</table>

#### Legend

- **Low**: 0.00 - 3.50
- **Medium**: 3.51 - 4.00
- **High**: 4.01 - 5.00
Plan

This is the detail planning part of the cycle!

Considerations

‣ What is the question this PDSA cycle is trying to answer?

‣ What is the goal?

What MFWA did specifically

‣ **Question**: Are we providing adequate trauma training and workforce development opportunities to all staff?

‣ **Goal**: Ensure all staff at all levels have received foundational training and general education about Trauma Informed Care
Plan

**Details, Details, Details…**

**Considerations**
- Who will enact the PDSA cycle?
- What data points are needed?
  - Who will collect the data?
  - How will it be collected?
  - Who will be aggregating/analyzing?
- When to reconvene to look at data?

**What MFWA did specifically**
- PDSA will be piloted in outpatient MH clinic
- Create a Survey to:
  - Identify who has been trained and who has not
  - Identify any barriers to training
  - Are there differences in who is being trained?
- Will reconvene two weeks after deployment of the survey
Do

Go forth and “do” the work!

Considerations

- Enact the PDSA cycle
- How will staff be notified about the workgroup and its aims?
- How will it be disseminated?
- Set Start and End Dates

What MFWA did specifically

- Took advantage of an upcoming all staff meeting to introduce the project
- Assigned the admin assistant to create the survey in SurveyGizmo and send to staff
- SurveyGizmo will analyze the results and they will be discussed in the next CQI group meeting by identified data person of the workgroup
- Staff will have 1 week to complete the survey
Study

*This is the “did it work?” portion of the cycle*

**Considerations**

- What does the data show?
- Were the changes meaningful?
- Was there enough information to make a decision?
- What changes occurred as a result of the PDSA cycle?
- Barriers?

**What MFWA did specifically**

- Results:
  - 50% of program managers;
  - 35% of clinical staff;
  - 0% of administrative staff and board members received training
- Past Trainings were optional and only targeted toward clinical staff
- Feedback indicated the need for multiple trainings to allow for shift and caseload coverage
Act

So what are you going to do with this new information? Here are some options…

Considerations
- Implement a policy/workflow change
- Expand the PDSA cycle to a larger group/department
- Disseminate the findings
- A new PDSA cycle with a different variable
- Stop doing an action/behavior
- Solicit additional input from other stakeholders

What MFWA did specifically
- Trainings will now be made mandatory and offered to all staff
- Multiple trainings will be offered to allow staff attendance
- Will now deploy the PDSA cycle agency wide to increase percentage of all staff trained
Are we there yet?
How Can I Get Started?

- Establish a workgroup
- Pilot a PDSA cycle in your organization
- Seek outside expertise to facilitate and sustain future CQI efforts
Questions?
How do we work together?
Effective Internal Collaboration

Organizational Culture: Supports Data-Driven Decision Making

Processes:
- Planning
- Human Resources
- Corporate Compliance
- Marketing
- Financial Systems
- IT
- Data Collection & Processing
- Contracting/Negotiations
- Revenue Cycle Management/Fiscal Management

Infrastructures:
- Practice Development & Management
- Continuous Quality Improvement Practices

Culture:
- Training & Education

Network Development
How do we work together?

Learning Objective:
Understand why external collaboration is important (especially in the children’s system of care) and become aware of models/approaches being used to support collaboration among service providers and other support systems.

1. Demonstrate models showing what cross-systems data-sharing can accomplish
2. How to establish and maintain collaborative relationships
3. Tool: “Systems” Dashboard Demo
Question

Have you ever attempted to work more closely with other providers or other systems, but met with limited success… and a fair amount of frustration?

During this session, we will talk more about such opportunities
Why is Collaboration with other providers (or client support systems) important?

- A team approach causes the largest change in outcomes for patients
- Reduces silos
- Promotes a holistic approach to care
- Reduces fragmentation in care and service gaps
- Supports working towards solutions that may not be specific to any one provider or system, such as self-care or management of interpersonal relationships
Why is Collaboration with other providers (or client support systems) important?

- Creates value and respect among participants from an array of disciplines, and it has elevated the level of care of the patient.
- Impact: When nurses collaborate as equals with other health care providers, patient outcomes and quality of care tend to improve.
- It also improves the coordination and communication between the healthcare professionals and thus in turn, improves the quality and safety of patient care.
What are the fears and challenges of collaboration?

- Trust among participants
- Lack of understanding roles
- Use of different professional languages (or Jargon) from one program to the next
- Concerns about confidentiality
- No clearly articulated measurable outcome or impact that drives the work
- Fear of change
What are the fears and challenges of collaboration?

- Lack of success with intra-agency (within) collaboration for one or more of the partners
- Financial incentives exist to remain the same, including the fee for service payment model
- Maintaining the motivation and investment from the stakeholders
- Ability to keep focused on those values that are mutually shared
What are the changes taking place in the healthcare delivery system that may offer an added push/incentive towards real collaboration with the behavioral health system and with other systems?

- Managed Care transformation
  - Health Homes
- Development of Behavioral Health Care Collaboratives
  - Introduction of Value Based Payment models
The State’s Managed Care for Children Vision

Proposed 2016 Children’s Medicaid Managed Care Model
For all children 0-21 years old

Mainstream Medicaid Managed Care Organization: Benefit Package*
- All Health & Pharmacy expanded Benefits
- Behavioral Health State Plan Services and New State Plan Services
- Aligned HCBS Services for children meeting LOC and LDC criteria (transition of existing children’s 1915c Waivers - OMH, B2H & CAH I/II)

Service Provider Network
- Children’s Care at Home IVV Providers
- Children’s Behavioral Health Providers
- Foster Care Providers
- Community Based Providers (e.g., family support/peer services)
- Community Services & Supports (non-Medicaid)
- School Districts & CSEs
- Regional Planning Consortiums
- Local Government (LDSS, LGUs, SPOA, Probation)

Care Management for All
Care Management will be provided by a range of models that are consistent with a child’s needs (e.g., Managed Care Plans, Patient Centered Medical Homes and Health Homes). Most children’s care and services will be coordinated through Health Homes.

*MCOs may opt to contract with other entities (e.g., BHOs) to manage behavioral health benefits
Techniques/models that have been used to support effective provider or cross-system collaboration

- Collaboration and Teamwork to Better Serve Young People (Pathways Transition Training Collaborative)
- Principles that Guide Stakeholder Collaboration (Building Systems of Care: A Primer for Child Welfare)
Collaboration and Teamwork to Better Serve Young People (Pathways Transition Training Collaborative)

Intended use: A cross-system collaborative approach for reaching across fragmented services and systems to build constructive working relationships that will assist young people to achieve their goals.
Collaboration and Teamwork to Better Serve Young People (Pathways Transition Training Collaborative)

Have specific policies, procedures and structures in place, including:

- Regular meetings to resolve any tensions that may arise between providers
- Written interagency agreements and practice guidelines to coordinate referral and service delivery across the system
- Clearly defined roles
- Clear agreements about confidentiality

Source: Pathways Transition Training Collaborative
Have specific policies, procedures and structures in place, including:

- Release of information form in place to allow information flow across the relevant system
- Liaisons or coordination specialists assigned to service users
- Regular cross training of staff to clarify expectations
- Reduced caseloads to allow time for collaboration

Source: Pathways Transition Training Collaborative
Collaboration and Teamwork to Better Serve Young People:

Attitudes, knowledge, skills and relationships that support collaboration:

‣ Define the needs of the young person and clearly specify roles and leadership

‣ Include providers from all systems: youth/adult systems, housing, vocational rehab, child welfare, juvenile justice, school, etc.

‣ Obtain informed consent

‣ Communicate and share information with other systems involved in supporting the youth

Source: Pathways Transition Training Collaborative

mctac
Collaboration and Teamwork to Better Serve Young People:

Attitudes, knowledge, skills and relationships that support collaboration:

- Hold Joint case conferences or wraparound type meetings
- Take the time to clarify roles and resolve any boundary issues
- Practice demonstrating mutual respect for each other’s knowledge, skills, and roles
- Maintain regular contact
- Follow through with commitments
- Be friendly, interested and open to suggestions

Source: Pathways Transition Training Collaborative
Collaboration and Teamwork to Better Serve Young People:

Skills needed for collaboration and teamwork:

- Cooperation: Acknowledging and respecting one another
- Responsibility: accept and share responsibility
- Communication among the team so that important information is shared
- Autonomy of the team
- Coordination of work
- Leadership: Recognizing group dynamics, respecting different cultures of members (including professional cultures)

Source: Pathways Transition Training Collaborative
Reducing Readmissions through Cross Continuum Process Redesign
Institute for Healthcare Improvement-STAAR
STAAR Initiative: Team-to-team collaboration across organizational boundaries resulting in reduced readmissions

- A model that encourages providers to work together to improve the transition to the next setting (example: inpatient to community) by creating partnerships between “senders” and “receivers.”

- Created by Amy E. Boutwell, MD, MPP Co-founder, STARR (State Action on Avoidable Rehospitalizations), Initiative Collaborative Healthcare Strategies, Lexington, MA (part of the Institute for Healthcare Improvement).
The transition from the hospital to home and other post-acute care settings, has emerged as an important cornerstone in IHI’s work to reduce avoidable rehospitalizations and it is a major focus of this How-to Guide.

As Dr. Steve Jencks, notes, “Although the care that prevents rehospitalization occurs largely outside of the hospital, it starts in the hospital.”
STAAR Approach

- Know your data
- Form a cross-continuum team
- Review transitions across settings
- Four guides available (www.ihi.org)
  - How to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations
  - How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations
  - How-to Guide: Improving Transitions from the Hospital to Home Health Care to Reduce Avoidable Rehospitalizations
  - How-to-Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations
Key Changes

1. Partner with Patient and Family to Determine Post-Hospital Needs in completing a needs assessment of the patient’s home-going needs.
   i. Reconcile medications upon admission.

2. Provide Effective Teaching and Facilitate Learning
   i. Involve all learners in patient education.
   ii. Always use Teach Back throughout the hospital stay to assess the patient’s and family caregivers’ understanding of discharge instructions and ability to perform self-care
Key Changes

3. Create and Activate Post-Hospital Care Follow-up
   i. Review daily the patient’s medical and social risk for readmission and finalize the customized post-hospital follow-up plan.
   ii. Prior to discharge, schedule timely follow-up care and initiate clinical and social services as indicated from the identified post-hospital needs as well as the capabilities of patients and family.

4. Provide Real-Time Handover Communications
   i. Give patient and family members a patient-friendly, post-hospital care plan which includes a clear medication list.
   ii. Provide customized, real-time critical information to the next clinical care provider(s)
Out of the Box Thinking… What about Collective Impact and How It Might Help?
What is Collective Impact?

- A framework to tackle deeply entrenched and complex social problems
- An innovative and structured approach to making collaboration work across government business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change
- The approach is premised on the belief that no single policy, government department, organization or program can tackle or solve the increasingly complex social problems we face as a society.
What is Collective Impact?

- Calls for multiple organizations or entities from different sectors to abandon their own agenda in favor of a common agenda, shared measurement and alignment of effort

- Unlike collaboration or partnership, Collective Impact initiatives have centralized infrastructure – known as a backbone organization - with dedicated staff whose role is to help participating organizations shift from acting alone to acting in concert
More about Collective Impact

Requires:

- Common agenda for change: includes a shared understanding of the problem and a joint approach to solving it through agreed upon actions
- Collecting data and measuring results consistently across all the participants ensures shared measurement for alignment and accountability
- A plan of action that outlines and coordinates mutually reinforcing activities for each participant
More about Collective Impact

Requires:

- Leadership comes from the team, not the one selected individual
- Open and continuous communication is needed across the many players to build trust, assure mutual objectives, and create common motivation
- A backbone organization with staff and specific set of skills to serve the entire initiative and coordinate participating organizations and agencies
How is Collective Impact being used today?

- Bringing organizations together in support of anti-poverty initiatives (Rochester Monroe Anti-Poverty Initiative)
- Reducing teenage substance abuse (Communities That Care in Coalition of Franklin County: MA)
- Addressing childhood obesity (Shape up Somerville Campaign: MA)
Does the Collective Impact framework have potential to support your work?
Cross Cutting Themes in Developing a Collaborative Model

What aspects do these three approaches share?

- Need for Trust among participants
- Common purpose. Clear shared understanding of the desired impact/outcome of the work that is measurable
- Respect: assuming best intentions
- Communication that is meaningful, regular and creates motivation to continue on
Cross Cutting Themes in Developing a Collaborative Model

What aspects do these three approaches share?

‣ Shared values
‣ Clarity concerning how decisions are to be made
‣ Shared training so that each participant understands and appreciates the work done by others
‣ Ability to identify and address issues among participants (differences of opinions, actions taken without support) in a very timely and open manner
How cross-systems data sharing is important to effective collaboration and what data sharing can accomplish

- Helps to define the clarity of purpose of the collaboration
- Provides ability to measure impact of work over time
- By taking a deeper dive, data will assist in better understanding a problem are.
  - Example- Are there differences by age, gender or race/ethnicity
How do you start the conversation?
How do you start the conversation?

Ask the question:

◦ What can we accomplish by working together that we cannot accomplish alone?
So… What about Making Families Well Agency

- MFWA have been invited to be part of an emerging Behavioral Health network… a Behavioral Health Care Collaborative.
So… What about Making Families Well Agency

- Recognizing that the success of the network will require effective cross-provider collaboration, they are taking the following steps:

  - Practice internal, cross-department collaboration. Successful intra-agency collaboration improves the chances for successful interagency collaboration.
  - Development of a MFWA values statement so that they may clearly articulate what is important to them as they begin to work with others.
  - Begin to review internally generated data, as well as data provided to them by their LGU to better understand the system opportunities for improvement.
The MFWA Vision

The Vision of MFWA is to be part of a system of care network that is positioned to create quarterly system dashboard reports much like the one shown here…
Domingo County System Dashboard

- Access
- Engagement
- System Collaboration
- Continuity of Care
- Family-Driven Values
- Linkages to Services
Percentage of those using services with reduced Juvenile Justice Involvement

<table>
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<tr>
<th>Quarter</th>
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<tr>
<td>Q3</td>
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<tr>
<td>Q4</td>
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### Quarter
- Q3: 14.8%
- Q4: 15.3%

### YTD
- 2015: 17.0%
- 2016: 15.0%
Domingo County System Dashboard

- Access
- Family-Driven Values
- Linkages to Services
- Continuity of Care
- System Collaboration
- Engagement
Domingo County System Dashboard

- Access
- Family-Driven Values
- Linkages to Services
- Continuity of Care
- Engagement
- System Collaboration

- Percentage of programs demonstrating competency in Trauma Informed Care
- Percentage of Residential Programs engaging families in supporting their children/youth
- Percentage of youth unified or reunified with families from Residential facilities
Domingo County System Dashboard

Access

Engagement

System Collaboration

Family-Driven Values

Linkages to Services

Continuity of Care

Percentage of those using services enrolled in a Health Home

Percentage of those using services referred to a SPA service
Percentage of mental health inpatient discharges followed by an outpatient visit for mental health treatment within 7 and 30 days.
Domingo County System Dashboard

Percentage of mental health inpatient discharges followed by 2 or more mental health outpatient visits within 30 days
How Can I Get Started?

- Pay attention to what’s happening around the development of Care Collaboratives in your region
- Explore data that already exists
- Making relationships with your referral sources and discharge resources
How can I get started? Review

1. Performance Driven Culture Assessment
   - Use the Performance Driven Culture Assessment Tool to better understand your readiness for a world of heightened accountability for outcomes
   - Complete the tool during a Leadership Team Meeting so that all may offer their perspectives.
   - Develop a work plan for addressing gaps in cultural readiness

2. Brainstorming Activity
   - Establish a Work Group
   - Complete the Brainstorming Activity
   - Connect the dots: How do your services connect with State Healthcare Reform Goals? Consider a logic model
   - Identify what data opportunities you have
How can I get started? Review

3. Data Summary and Visualization Tool
   - Go to the New York State Success website for access to the Data Summary and Visualization Workbook
   - Follow the instructions, enter your current roster, basic demographic and utilization data, and basic financial information
   - Look at your data, what questions come up?
How can I get started? Review

5. CQI/PDSA
   ◦ Consider implementing a PDSA cycle; use guidance from today’s presentation

5. Systems Collaboration
   ◦ Pay attention to what’s happening around the development of Care Collaboratives in your region
   ◦ Explore data that already exists
   ◦ Make relationships with your referral sources and discharge resources
Thank you for your participation!
Questions and Discussion

Please send questions to: mctac.info@nyu.edu

Logistical questions usually receive a response in 1 business day or less.

Longer & more complicated questions can take longer.

We appreciate your interest and patience!

Visit www.ctacny.org to view past trainings, sign-up for updates and event announcements, and access resources.