SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

ADMINISTRATIVE PROCEDURE

NUMBER: DA1090

NAME: INTERNAL PERFORMANCE OUTCOMES DATA REVIEW (IPOD)

INITIAL APPROVAL DATE:	10/11/2017	BY: QI Committee
(LAST) REVISION DATE:	02/16/2023	BY: CIO/EAA
(LAST) REVIEW DATE:	01/16/2025	BY: Policy Committee
DISCONTINUED DATE:	N/A	REPLACED BY: N/A

I. PURPOSE

The purpose of this procedure is to outline the basis for the IPOD (Internal Performance Outcomes Data Review); outline the process of the review; provide for closer review if the standards are not maintained and provide for review and re-evaluation of any Performance Data Set if necessary.

II. APPLICATION

Populations: All
Programs: **Direct - All**
Contracted – When applicable

III. PROCEDURE

A. The IPOD is a set of data elements pulled from Performance Indicators, National Outcome Measurement Sets (NOMS), CCBHC Goals and Measurements and BH TEDS that relate to domains of efficiency, effectiveness, satisfaction and access; that apply to the entire Agency and are monitored on a quarterly basis.

B. A report regarding maintenance of these standards is prepared quarterly by the Data Management Department and shared with the COO, Administration and the QI Committee.

IV. DEFINITIONS

A. Access: Barriers or lack thereof for persons in obtaining services. May apply at the level of the individual persons served (timeliness or other barriers) or the target population for the organization.

B. Effectiveness: Results achieved and outcomes observed for persons served. Can apply to different points in time (during, at the end of, or at points in time following services). Can apply to different domains (e.g., change in disability or impairment, function, participation in life's activities, work and many other domains relevant to the organization).

C. Efficiency: Relationship between resources used and results or outcomes obtained. Resources can include, for example, time, money, or staff/FTEs. Can apply at the level of the person served, program or groups of persons served or at the level of the organization as a whole.

D. Performance Data Sets: The standard by which the Agency is monitored in relation to an established baseline.

- Standard is MET: The Agency is in FULL COMPLIANCE with the established Performance Data Sets standard and baseline.
- Standard is SUBSTANTIALLY MET: There are identified minor issues within a subset of the Agency but no trends in the application of the Performance Data Sets standard and baseline.
- Standard is PARTIALLY MET: There are significant or minor issues along with trends being noted within a subset of the Agency as the Performance Data Sets standard and baseline is applied.
- Standard is NOT MET: The Performance Data Sets standard and baseline is not met at all and there have been continuous, significant trends noted.

E. Satisfaction: The satisfaction of the individual served during service delivery or following service completion.

V. STANDARDS

Each Performance Data Set will have its own established standards for compliance that shall be monitored by the QI Committee. Each Data Set will be assigned a point system for rating purposes to be used with the following scale:

- Performance Data Sets that meet the established standards shall be deemed MET by the QI Committee.
- Performance Data Sets that have minor issues meeting the established standards and have no trends in this area shall be deemed as SUBSTANTIALLY MET and monitored by the QI Committee.
- Performance Data Sets that have minor or significant issues meeting the established standards and have a trend in this area shall be deemed as PARTIALLY MET and will require the respective subset of the Agency to respond with the rationale for why the situation is occurring to the QI Committee.
- Performance Data Sets that do not meet the established standards at all shall be deemed as NOT MET and will require the specific subset of the Agency to respond with the rationale for why the situation is occurring along with a Corrective Action Plan (CAP) to bring the Data Set back to the appropriate level to the QI Committee.

VI. CORRECTIVE ACTION PLAN (CAP)

In addition to supplying the rationale as outlined above, the CAP should also indicate:

a. Whether or not the Data Set needs to be re-evaluated; and
b. If the data collection methodology is correct.
c. Also subsets need to include what measures they will take to improve performance for the specific data set if the above are not an issue.

The Data Management Department shall monitor these reports to track for trends and provide status reports on any outstanding CAPs to the QI Committee.

VII. ATTACHMENTS

None

VIII. REFERENCES

Sanilac CMH CARF Standards Manual and Review 2017