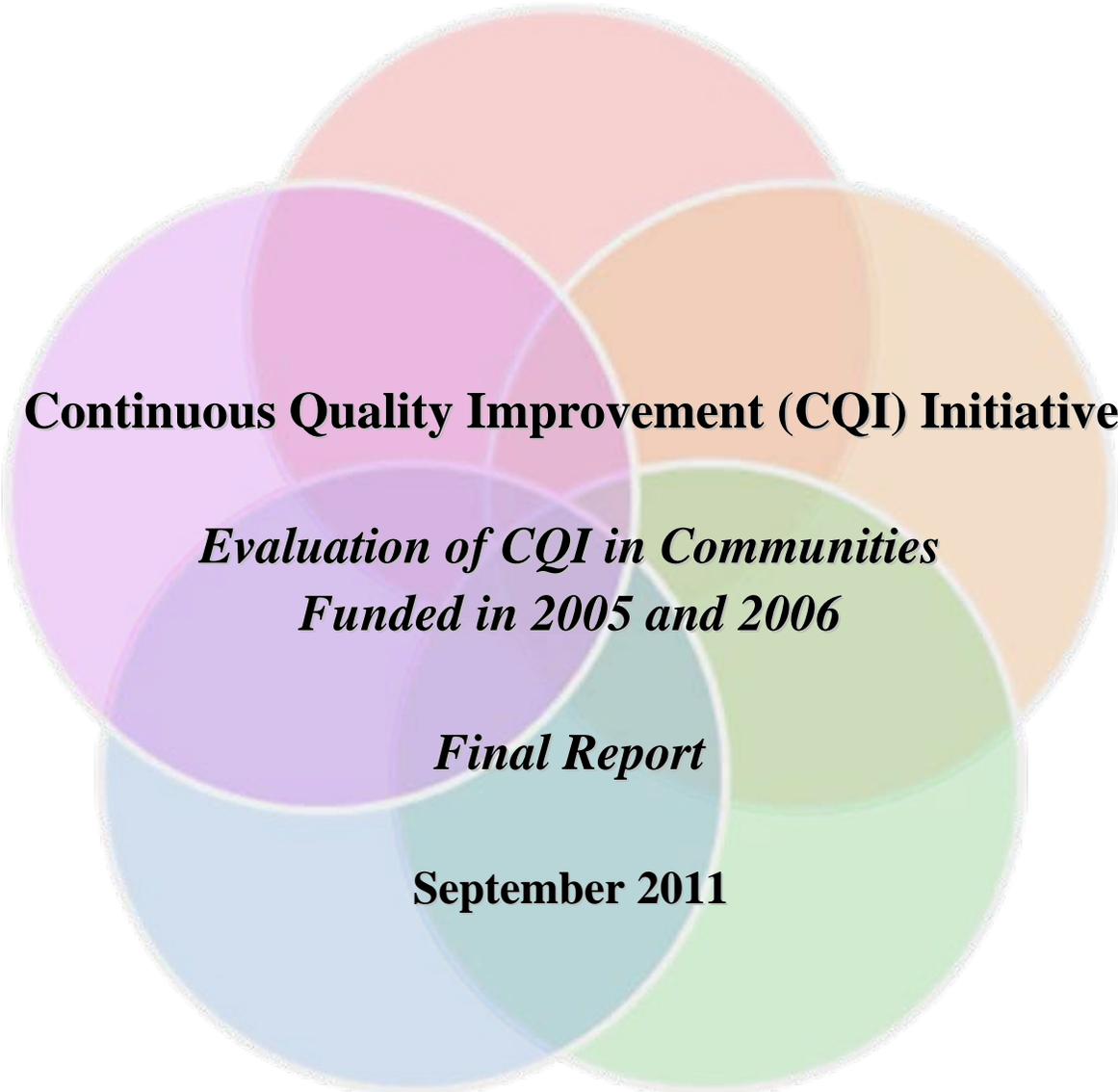


**Phase V of the National Evaluation of the Comprehensive Community Mental
Health Services for Children and Their Families Program**



Continuous Quality Improvement (CQI) Initiative

*Evaluation of CQI in Communities
Funded in 2005 and 2006*

Final Report

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Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
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EXECUTIVE SUMMARY

The Continuous Quality Improvement (CQI) Initiative is an integral component of the Comprehensive Community Mental Health Services for Children and Their Families Program (also referred to as the Children's Mental Health Initiative [CMHI]) funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, Division of Systems and Service Improvements, Child, Adolescent and Family Branch. The CQI Initiative for the CMHI was implemented in 2004 to support CQI efforts in funded system of care communities. As part of this Initiative, each community receives a *CQI Progress Report* several times per year that provides performance data for its system of care. Communities also receive an aggregate report that summarizes performance data across all communities funded in the same years. In addition, communities may access technical assistance (TA) from various national program partners to improve their performance in areas of challenge.

An evaluation of the CQI Initiative was conducted in 2009-2010 to assess CQI efforts in system of care communities funded in 2005 and 2006. The purpose of the evaluation was to examine how CQI is being implemented in funded communities, how communities are using evaluation data and TA in their CQI efforts, and how the CQI Initiative can be improved to further support CQI in system of care communities. Data collection for the evaluation involved three activities: (1) a Web-based survey of 109 key personnel in 27 funded communities; (2) telephone interviews with 30 people involved in CQI in five communities; and (3) discussion groups with 21 national TA providers. This report summarizes the primary findings of the evaluation and presents recommendations for improving the CQI Initiative.

Key Findings

Results from the evaluation of the CMHI CQI Initiative indicate that system of care communities have (1) implemented CQI in many different ways, (2) used a wide array of data to inform their CQI efforts, and (3) learned valuable lessons about the implementation of CQI. The following are key findings in each of these three areas.

CQI Efforts in System of Care Communities

- Most system of care communities had a CQI process, but communities varied greatly in their approaches to CQI. There also were differing conceptions of CQI within and across communities.
- All except one of the survey respondents either agreed (31.2%) or strongly agreed (67.5%) that CQI was essential for improving program delivery. A smaller percentage agreed (44.7%) or strongly agreed (34.2%) that their system of care was highly committed to CQI.
- Most of the respondents (58.3%) reported that their community had the resources needed to fully implement CQI. However, only about one-quarter (26.6%) of the

respondents thought that their community had sufficient resources to fully sustain CQI after SAMHSA funding ended.

- A majority of the respondents reported that their community had effective mechanisms in place to pursue CQI (72.0%) and that all the appropriate staff were involved in CQI (66.2%). However, less than one-half of the respondents (43.7%) thought that staff had been adequately trained in CQI.
- A majority of the respondents indicated that the CQI process had been helpful in identifying TA needs (65.7%) and improving their system of care (80.0%). More than three-quarters of the respondents (78.4%) said that the CQI process had resulted in changes to their system of care.
- Respondents indicated that their community's CQI process had led to changes in the following areas: staff training (90.4%), family and youth involvement (84.1%), strategic plan (82.7%), cultural and linguistic competence practices (80.7%), logic model (77.8%), staffing practices (66.7%), and recruitment / retention strategies (64.9%).

Resources Used in CQI Efforts

- Communities used a variety of data in their CQI efforts, including quantitative and qualitative data from local and national evaluations. Resources considered the most useful for CQI were experience and knowledge gained through program delivery, input from family members and youth, input from other local constituents, and local evaluation data.
- Seventy percent of the survey respondents agreed (58.6%) or strongly agreed (11.4%) that the *CQI Progress Report* was helpful in local CQI efforts. However, less than one-half of the respondents agreed (43.1%) or strongly agreed (0%) that the report was helpful in identifying TA needs.
- More than one-half of the respondents agreed (53.6%) or strongly agreed (2.9%) that the *CQI Progress Report* accurately reflected challenges faced by their systems of care. Slightly fewer than one-half agreed (43.5%) or strongly agreed (2.9%) that the report accurately reflected their successes.
- More than three-quarters of the respondents agreed (57.5%) or strongly agreed (23.3%) that the *CQI Progress Report* stimulated conversation about potential system of care improvements. However, only slightly more than one-half of the respondents agreed (47.9%) or strongly agreed (5.6%) that the report provided adequate information to aid in improvement.
- More than one-half of the respondents indicated that the *CQI Progress Report* provided timely information (66.3%) and was easy to understand (59.2%). However,

less than one-half of the respondents (44.4%) thought that the *CQI Progress Report* was easy to explain to people who were interested in the system of care's performance.

- A majority of the respondents reported that TA was provided in a timely manner (87.0%) and that TA was tailored to their system of care's unique needs (82.6%).

Lessons Learned by Communities in Implementing CQI

- Commonly reported challenges in implementing CQI were staff turnover; difficulty in involving constituents; lack of adequate resources and training; lack of commitment to CQI; data; and difficulty in identifying appropriate data, presenting data, and linking data to program changes.
- Successful strategies used in communities' CQI efforts included establishing a commitment to CQI, providing strong leadership for CQI, engaging various constituents, providing training in CQI and data analysis, incorporating key indicators into data collection, using evaluation data in decision making, sharing data with various constituents, and receiving TA from national TA providers.
- System of care communities offered the following advice for establishing and maintaining an effective CQI process:
 - Start CQI efforts early in the funding cycle
 - Provide consistent leadership that understands and emphasizes the importance of CQI
 - Foster buy-in from, and involvement of, a wide range of constituents, including staff, partners, family members, and youth
 - Provide training to all those involved in CQI efforts
 - Formalize the CQI process, in part by identifying goals and defining roles
 - Identify indicators relevant to various constituents
 - Clearly link data to system of care goals and changes in performance
 - Integrate quantitative and qualitative data from various sources
 - Garner input from varied constituents by presenting data in accessible formats
 - Celebrate successes as well as address challenges

Recommendations to Improve the CQI Initiative

The evaluation pinpointed some areas in which system of care communities have faced challenges and may benefit from additional TA. The following are recommendations for expanding TA support for CQI and facilitating the use of the *CQI Progress Report* in local CQI efforts.

- Early in each funding cycle, national TA providers should offer additional training in, and support for, establishing and maintaining a CQI process, including strategies for

fostering buy-in to data-driven CQI and involving a wide range of constituents in CQI efforts.

- On an ongoing basis throughout each funding cycle, national TA providers should offer additional training in, and support for, using data to inform CQI efforts, including strategies in the following areas:
 - Identifying indicators of interest to various constituents, and linking these indicators to specific goals, logic models, strategic plans, and evaluation plans
 - Assuring relevant data are collected in usable formats
 - Clarifying the types of data that can be used to inform CQI and how to use them
 - Presenting data in accessible formats and tailoring data presentations to various constituents
 - Translating findings into actionable recommendations and conveying those recommendations to people who can make the changes
 - Developing a plan to implement programmatic changes and assess their impact

- In future funding cycles, national TA providers should facilitate more extensive use of the *CQI Progress Report* as one resource to inform CQI efforts through the following actions:
 - Providing more detailed guidance on how to use the report in local CQI efforts, particularly how to identify indicators of interest and the role of TA providers in interpreting the report and addressing challenges reflected in the report

 - Automating the report and providing customization options that would allow communities to select indicators of interest, assess differences in performance across groups or service locations, view performance data at any follow-up point, choose whether to use cumulative data or data from a specified time period, and determine whether changes in performance over time are statistically and/or clinically significant

INTRODUCTION

The Continuous Quality Improvement (CQI) Initiative is an integral component of the Comprehensive Community Mental Health Services for Children and Their Families Program (also referred to as the Child Mental Health Initiative [CMHI]) funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, Division of Systems and Service Improvements, Child, Adolescent and Family Branch. CQI allows funded communities to identify and address areas of challenge in service coordination and delivery, thus resulting in better outcomes for the children, youth, and families served. The CQI Initiative for the CMHI was implemented in 2004 to support these efforts. As part of this Initiative, each community receives a *CQI Progress Report* several times per year that provides performance data for its system of care. Communities also receive an aggregate report that summarizes performance data across all communities funded in the same years. In addition, communities may access technical assistance (TA) from various national program partners to improve their performance in areas of challenge.

An evaluation of the CMHI CQI Initiative was conducted in 2009-2010 to assess CQI efforts in system of care communities funded in 2005 and 2006. The evaluation examined how CQI efforts are being implemented in system of care communities, how communities are using evaluation data in their CQI efforts, and how the CQI Initiative and associated reports can be improved to ensure that appropriate TA resources are allocated to those communities that most need this assistance to enhance their system of care services. Data collection for the evaluation included a Web-based survey of key personnel in funded communities, interviews with community-level respondents, and discussion groups with national TA providers. This report summarizes the primary findings from the evaluation and presents recommendations for improving the CQI Initiative.

CMHI CQI INITIATIVE

Evaluation and data-driven quality improvement have always been important aspects of systems of care. As noted in *The System of Care Handbook*, the concept of continuous quality improvement (CQI) provides a framework for identifying system- and service-level outcomes and informing efforts to improve them (Sheehan et al., 2008). Evaluation data have long been used to inform and improve systems of care at the local and national levels (Manteuffel et al., 2008). In particular, CMHI requirements have been revised to address areas of challenge, such as cultural competence in service provision and family involvement in service planning. Results from the national evaluation also have informed TA efforts, leading national TA providers to offer training and resources intended to assist communities in achieving sustainability and implementing evidence-based treatments.

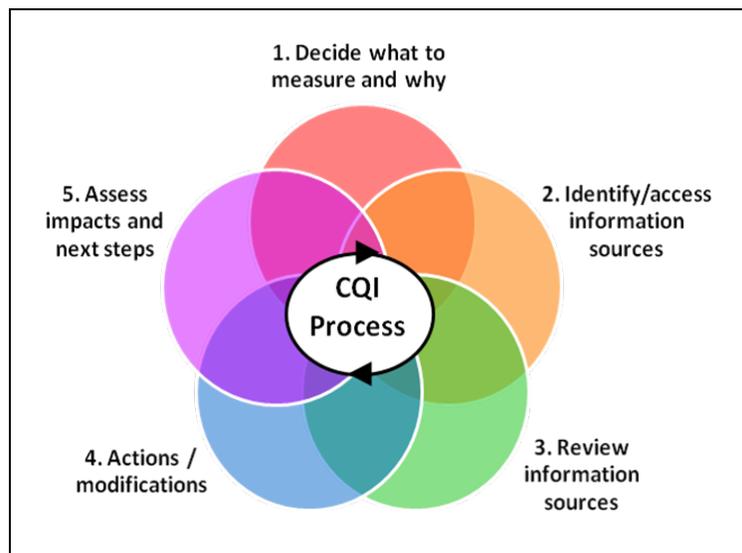
In 2004, the Child, Adolescent and Family Branch of the Center for Mental Health Services in SAMHSA reinforced its commitment to CQI by implementing a CQI Initiative for the CMHI. The purpose of the CQI Initiative is to support system of care communities in their efforts to conduct ongoing reviews and assessments that result in data-driven decision making related to service quality and improvement. There are three primary goals for the CQI Initiative: (1)

improve the implementation of systems of care; (2) support grant communities in their efforts to implement systems of care; and (3) aid communities in their CQI efforts by providing timely performance information and high-quality, data-driven TA. Three important components of the CQI Initiative are (1) modeling the CQI process; (2) providing evaluation data that communities can use to inform quality improvement efforts; and (3) offering TA to assist in these efforts.

A Model for CQI

One of the first activities of the CMHI CQI Initiative was to develop a model for CQI (see Figure 1). The model conveys the idea that communities should specify the outcomes they hope to achieve, identify information (especially evaluation data) that will allow them to assess their progress on attaining these outcomes, use those data to guide changes to their system of care, and assess the impact of these changes. The model portrays CQI as an ongoing process that should be repeated throughout the funding cycle.

Figure 1. CQI Model



The CQI model consists of five overlapping, cyclical steps:

1. **Decide what to measure and why**—Identify goals and priorities, and link them to measurable outcomes. One approach for doing this is a theory of change logic model developed by a community for their system of care.
2. **Identify / access information sources**—Link measurable outcomes to existing or new data sources. Data sources can include elements of the national evaluation or new measures that can be incorporated into the local evaluation.
3. **Review information sources**—Translate data into actionable recommendations, and convey the recommendations to people who can make changes.

4. **Actions / modifications**—Make changes intended to improve specific outcomes. Develop an implementation plan, including a timeline, assignment of responsibility for making and monitoring changes, and processes for evaluating the results of the changes.
5. **Assess impacts and next steps**—Monitor the results of the changes. Assess whether the actions / modifications had the desired effect. If they did not work, identify other approaches. If they did work, set new goals / priorities for quality improvement.

This model has been presented to system of care communities in numerous venues, including Webinars, conferences, and trainings. National-level TA providers also have participated in various training sessions designed to clarify their roles in facilitating community CQI processes and coordinating their TA efforts.

The CQI Progress Report and Technical Assistance (TA) Provision

One of the main objectives of the CMHI CQI Initiative is to provide a report that incorporates performance measurement and benchmarking to support the quality and continued improvement of systems of care. Both the *CQI Progress Report* and ongoing TA from national sources—which is based, in part, on the report—are designed to assist communities in continually improving service design and delivery.

The national evaluation began producing the *CQI Progress Report* in 2007, using data collected by communities funded in 2005 and 2006. Performance data from the national evaluation Cross-Sectional Descriptive Study and Longitudinal Child and Family Outcome Study are grouped into five domains: (1) system-level outcomes; (2) child and family outcomes; (3) satisfaction with services; (4) family and youth involvement; and (5) cultural and linguistic competence. Each domain contains several indicators, which measure performance in such areas as timeliness of services, school enrollment and attendance, family functioning, and caregiver and youth satisfaction. For each indicator, communities can assess their performance in several ways: (1) by comparing their performance to that of other communities in their funding cycle; (2) by examining whether the indicator score has changed since the last report; and (3) by comparing their score to the benchmark provided on the report. In combination, these three items enable communities to assess their performance in relation to their own past performance and in relation to other system of care communities.

The national evaluation begins producing a *CQI Progress Report* for a community when the community has submitted sufficient data to populate the report, usually in the second or third year of funding. Reports are produced three times per calendar year, in April, August, and December. Communities receive two versions of the *CQI Progress Report*: a community-specific report, which presents data for their community, and an aggregate report, which presents data for all communities in the same funding cycle. Appendix A contains a recent aggregate *CQI Progress Report*.

The *CQI Progress Report* is intended to stimulate conversations within each community about system development and service delivery, especially how to capitalize on existing strengths and

overcome ongoing challenges. In addition, the report is intended to facilitate and guide data-driven TA by providing information to help local system of care personnel and national TA providers identify and address communities' TA needs. By incorporating performance indicators and benchmarks, the report helps identify (1) specific areas of strength that can be highlighted as “best practices,” and (2) areas of challenge that can be targeted for improvement through TA and focused attention at the local level. Identifying these areas of strength and challenge is essential for developing and maintaining an effective communication feedback loop to support TA planning and resource allocation at the national level.

EVALUATION OF THE CQI INITIATIVE

Understanding how evaluation data are used is crucial to facilitating and maximizing their use (Blake and Ottoson 2009), including their incorporation into CQI processes. The evaluation of the CQI Initiative was conducted in 2009-2010 to assess CQI efforts in system of care communities funded in 2005 and 2006. The purpose of the evaluation was to examine how CQI efforts are being implemented in funded communities, how communities are using evaluation data (including the *CQI Progress Report*) and TA in their CQI efforts, and how the CQI Initiative can be improved to further support CQI in system of care communities. The evaluation also assessed communities' satisfaction with their CQI processes and their perceptions of the effectiveness and utility of the *CQI Progress Report* and TA provision. Table 1 provides a summary of the questions examined by the evaluation.

Table 1. CMHI CQI Initiative Evaluation Questions

Evaluation Questions
1. To what degree are communities engaged in CQI?
2. What do communities view as the purpose, role, rationale, and approach of CQI, both for the national program and for their community?
3. What mechanisms are being used by communities for CQI?
4. What challenges do communities face in implementing CQI efforts? How do they overcome these challenges?
5. How satisfied are communities with the <i>CQI Progress Report</i> and provision of TA?
6. What, if any, changes would communities like incorporated within the <i>CQI Progress Report</i> to make it more useful for improving the CQI efforts in their community?
7. Is the <i>CQI Progress Report</i> effective in identifying community-level strengths and challenges?
8. Is the <i>CQI Progress Report</i> effective in stimulating and guiding community-specific, data-driven TA?
9. What role, if any, has the <i>CQI Progress Report</i> and associated TA played in quality improvement efforts?
10. What types of changes occurred in systems of care as a result of their CQI efforts and their use of TA?

A mixed-methods approach was used for the evaluation, combining qualitative and quantitative data to provide a comprehensive assessment of CQI efforts. Data collection involved three activities: (1) a Web-based survey of key personnel in funded communities; (2) telephone interviews with community members from five systems of care; and (3) discussion groups with national TA providers.

Community Survey

Key personnel from 29 of the 30 communities funded in 2005 and 2006 were invited to participate in a Web-based survey. One community that ended its funding in 2009 was not invited to participate. In total, 157 people were invited to complete the survey, including the principal investigator, project director, lead evaluator, lead family contact, youth coordinator, social marketing / communications manager, and cultural and linguistic competence coordinator in each community. The survey contained 32 questions about local CQI efforts, including the ways in which CQI is being implemented in communities, challenges and successes in implementing CQI, resources used to support local CQI efforts, satisfaction with the TA provided by national program partners, and changes resulting from CQI. The survey contained several skip patterns to streamline the participation process. For example, respondents who indicated that their system of care did not have a CQI process were not asked additional questions about local CQI efforts. As a result, the number of respondents varied significantly across questions. The full survey is provided in appendix B.

A total of 109 people from 27 communities completed all or part of the survey, a 69 percent response rate. Two communities did not participate in the survey. Response rates varied across communities, ranging from a low of one respondent per community to a high of eight respondents. The most common (modal) numbers of respondents per community were three and five—in seven communities, three key personnel responded to the survey, and in seven communities, five key personnel responded. The largest group of respondents were evaluators, followed by project directors and principal investigators (see table 2). Due to the distribution of respondents, findings may be biased toward the roles and communities with greater numbers of respondents.

Table 2. Number of Survey Respondents by Role

Role	Number of Respondents	Percentage of Respondents	Number of Communities
Evaluator	32	29.4%	23
Project Director	25	22.9%	23
Principal Investigator	18	16.5%	17
Family Representative	13	11.9%	12
Social Marketer	8	7.3%	8
Youth Coordinator	8	7.3%	8
Cultural Competence Coordinator	5	4.6%	5
Total	109	100%	27

Community Interviews

Based on the results of the Web-based survey, five communities were selected from which to gather more in-depth data through interviews with system of care personnel and other community members. The communities were selected to represent various approaches to CQI and differing levels of use of the *CQI Progress Report*. Individuals in the selected communities were invited to participate in telephone interviews. They chose to participate in either one-on-one or group semi-structured interviews. Participants included key personnel who responded to the

Web-based survey, as well as other community members active in local CQI efforts. Interviews focused on each participant’s knowledge of and involvement in local CQI efforts, details of those efforts, the resources used to inform CQI, and challenges and successes in implementing CQI.

A total of 30 people from five communities participated in interviews. Participants included principal investigators, project directors, evaluators, social marketers, family representatives, cultural and linguistic competence coordinators, youth coordinators, clinical directors, and members of CQI workgroups.

Technical Assistance (TA) Provider Discussion Groups

Several organizations are contracted with SAMHSA to provide TA to system of care communities. Both the national evaluation and the Technical Assistance Partnership (TA Partnership) provide TA to support evaluation activities and data-driven CQI within communities. As part of the CQI Initiative evaluation, two discussion groups were conducted with these TA providers to better understand their experiences in working with funded communities. One discussion group was conducted with TA coordinators and resource specialists from the TA Partnership. Another discussion group was conducted with site liaisons from the national evaluation. Discussion topics included the coordination of TA provision, the role of TA providers in supporting local CQI efforts, and how evaluation data (including the *CQI Progress Report*) are used to guide TA. A total of 21 TA providers participated in the discussion groups.

FINDINGS FROM COMMUNITY SURVEYS AND INTERVIEWS

In total, 109 system of care personnel from 27 communities responded to the Web-based survey, and 30 people from five communities participated in telephone interviews. Most of the interview participants also completed the survey, but additional individuals involved in local CQI efforts participated in the interviews. These additional interviewees included family members, quality improvement experts, and representatives from partner agencies. Both quantitative and qualitative methods were used to analyze data from the survey and interviews—summary statistics were run on the survey items, and thematic analyses were conducted on the open-ended survey questions and the interview responses.

The following sections summarize the survey and interview results on several topics: CQI processes in system of care communities; resources used in local CQI efforts (including the *CQI Progress Report*); use and perceptions of TA provision; improvements resulting from CQI efforts; and lessons learned in implementing CQI.

CQI Processes in System of Care Communities

Survey respondents from all 27 communities indicated that their system of care had a CQI process in place. Within eight communities, individual respondents were in disagreement about whether a CQI process existed—this may reflect differing conceptions of CQI within a given community or differential involvement of staff in CQI efforts. Overall, the vast majority (91.1%) of the survey respondents indicated that their system of care had a CQI process in place. Nearly

90 percent (88.8%) of these respondents reported that they were involved in the CQI process. The composition of the 79 respondents who reported being involved in local CQI efforts was similar to the composition of the overall survey sample (see table 2 and appendix C, table C2).

Communities varied in their approaches to CQI. When asked to describe the CQI process in their system of care community, survey respondents mentioned several types of structures in place for the implementation of CQI. Some respondents reported having an organized CQI committee or subgroup, whereas others indicated that the CQI process was embedded in their regular staff meetings, management meetings, governance body meetings, or other committee meetings. The types of individuals involved in the CQI process also varied across communities. A majority of respondents referred to the evaluation team as the primary party responsible for their local CQI efforts. Others involved in the CQI process included CQI committee or subgroup members made up of various constituents, the management or administrative team, the governance board, family members, and youth.

To gain a better understanding of the importance of CQI within system of care communities, survey respondents were asked to assess 11 statements related to CQI. Responses, which ranged from 1 (strongly disagree) to 5 (strongly agree), were collected from the 92 respondents who reported that their community had a CQI process. A complete list of the 11 statements and the responses are provided in appendix C, table C3. The following is a summary of the results:

- All except one of the respondents either agreed (31.2%) or strongly agreed (67.5%) that CQI was essential for improving program delivery. A smaller percentage of the respondents agreed (44.7%) or strongly agreed (34.2%) that their system of care was highly committed to CQI.
- Most of the respondents (58.3%) reported that their community had the resources needed to fully implement CQI. However, only about one-quarter of the respondents (26.6%) thought that their community had sufficient resources to fully sustain CQI after SAMHSA funding ended.
- A majority of the respondents reported that their community had effective mechanisms in place to pursue CQI (72.0%) and that all the appropriate staff were involved in CQI (66.2%). However, less than one-half of the respondents (43.7%) thought that staff had been adequately trained in CQI.
- A majority of the respondents indicated that the CQI process had been helpful in identifying TA needs (65.7%) and improving their system of care (80.0%). More than three-quarters of the respondents (78.4%) said that the CQI process had resulted in changes to their system of care.
- Less than one-fifth of the respondents agreed (16.2%) or strongly agreed (1.4%) that the CQI process for their community was the best it could be. More than 60 percent of the respondents disagreed (51.4%) or strongly disagreed (10.8%) with this assessment.

Survey respondents also were asked to indicate their level of satisfaction with the CQI process in their community. Responses ranged from 1 (very dissatisfied) to 5 (very satisfied). Although the majority of respondents were either somewhat satisfied (57.9%) or very satisfied (14.5%) with the local CQI process, nearly 15 percent were somewhat dissatisfied (7.9%) or very dissatisfied (6.6%). The remaining respondents indicated that they were neither satisfied nor dissatisfied with the CQI process in their community. Overall, evaluators reported lower levels of satisfaction than respondents in other roles.

Interview participants provided more detailed information about local CQI efforts, focusing heavily on two aspects of CQI—the overarching process and structure for CQI, and the use of data. Each of the five communities had established a different structure for CQI. One community approached CQI on a case-by-case basis, with project staff reviewing case records at weekly staff meetings to identify challenges and opportunities for improvement. This approach, which was feasible due to a relatively small number of active cases, allowed staff to apply insights from specific cases to the wider service-delivery system.

Other communities concentrated their CQI efforts within specific groups. In one community, the evaluation team was responsible for reviewing data and reporting key findings to various committees and constituents. One community had a CQI committee that dealt with CQI in all areas, whereas another community distributed responsibility for CQI among numerous committees focused on specific topics, such as cultural competence or youth involvement. Only one of the five communities vested primary responsibility for CQI in an external (i.e., non-staff) team. This community had a CQI committee comprised of quality improvement experts and family members. This group not only reviewed data collected as part of the local and national evaluations but also developed its own data collection tools. Group members reported their findings and recommendations back to system of care staff, who were then responsible for implementing any changes. Whereas the other communities interviewed encouraged involvement of staff members in CQI, this community emphasized the importance of having an external CQI team that was accountable to the governance board.

Although the structure for CQI varied greatly across system of care communities, the interviews also revealed some common elements. First, all of the communities described some process for reporting evaluation data and other relevant information back to their governance body. This was considered an important activity, both to highlight the successes of the system of care and to garner input on how to address challenges. Second, all the interview participants emphasized the importance of involving a wide array of constituents in CQI efforts, including family members and youth. This was viewed as an essential but challenging component of an effective CQI process. Third, all the communities noted that a wide array of information is used to inform CQI efforts, including quantitative and qualitative data from the local and national evaluations, feedback from staff, and informal input from family members and youth. In some cases, this approach created dissent within communities, with some individuals viewing quantitative evaluation data as the only legitimate basis for data-driven CQI. This related to a broader issue mentioned by several interview participants, namely differing conceptions of CQI. Whereas some people viewed CQI as the overall process of identifying challenges and making improvements, others focused more narrowly on the process of reviewing data. One community noted that it is essential to clarify the purpose of CQI and how it differs from evaluation.

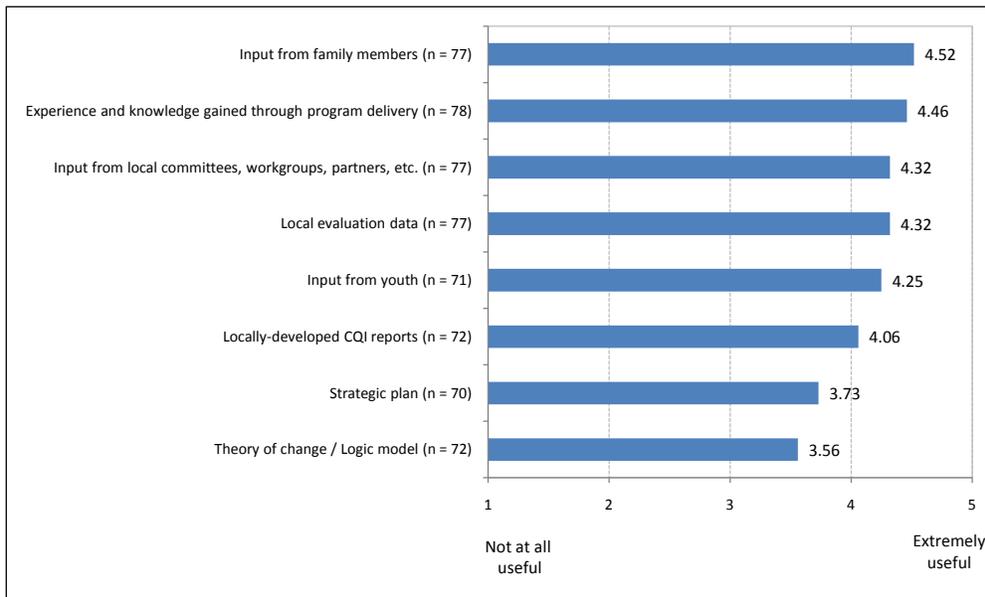
Resources Used in CQI Efforts

All funded communities are required to participate in the national evaluation and to develop a local evaluation. Survey respondents and interview participants emphasized that their communities used a wide array of resources in their CQI efforts, including quantitative and qualitative data from both evaluations. Local data collection activities included surveys, interviews, focus groups, and reviews of case records. In many cases, these activities were carried out by the evaluation team. However, local committees and workgroups affiliated with some systems of care also conducted data collection. In addition, a few communities mentioned obtaining data from other organizations through data-sharing agreements. Many communities also emphasized the importance of including input from staff, partners, family members, and youth in their CQI efforts—communities reported gathering such input both systematically, through feedback forms and case records, and more informally.

In combination, all these sources and types of data provided abundant, if sometimes overwhelming, information to inform CQI efforts. Many communities distilled information into summary reports that provided overviews of key findings from the national and local evaluations and other sources. Some of these locally produced reports presented information from the data reports provided by the national evaluation, such as the *CQI Progress Report*. System-level and client-level data from the national evaluation were often supplemented with data from the local evaluation, allowing a more in-depth look at various issues and outcomes relevant to the local community. Such data reports took various forms, including newsletters designed for distribution to a wide array of constituents. Some reports were explicitly intended to facilitate CQI efforts—survey respondents from 19 of the 27 communities indicated that their community had developed a local CQI report separate from the national evaluation *CQI Progress Report*. All the different types of reports were used to inform CQI efforts.

Survey respondents were asked to assess how useful various resources were in their CQI efforts. Responses ranged from 1 (not at all useful) to 5 (extremely useful). A list of resources and their average levels of usefulness are provided in appendix C, tables C4 and C5. Overall, respondents reported that various local resources were most useful in their CQI efforts, including experience and knowledge gained through program delivery, input from family members and youth, input from other local constituents, and local evaluation data (see figure 2).

Figure 2. Mean Ratings of Usefulness of Local Resources in CQI Efforts



Communities also indicated that various data reports produced by the national evaluation were useful in their CQI efforts. Survey respondents were specifically asked to assess the usefulness of three reports—the *Data Profile Report* was considered most useful (with an average rating of 3.61), followed by the *System of Care Assessment Report* (3.36), and the *CQI Progress Report* (3.07). These reports were either shared with constituents in their totality or incorporated into locally developed products, such as summary reports and newsletters. In most cases, the latter were viewed as being more effective, because such products allowed communities to focus on particular areas of interest and to tailor reporting formats to address the interests of different audiences. Some communities also incorporated measures from the national evaluation into their local evaluations, thus allowing them to continue collecting the selected information beyond the funding cycle.

Interview participants discussed several benefits of using national evaluation data and reports, as well as some limitations of these resources. Several participants noted that it was useful to compare local results with national trends—for example, some outcomes may appear unfavorable at the local level but actually exceed aggregate performance across all CMHI-funded communities. Participants also noted that national evaluation data could be useful for social marketing purposes, allowing communities to highlight the benefits of the system of care approach, something not possible before local data were available. In addition, national evaluation data often highlighted issues of concern that could be examined in more depth through the local evaluation.

In terms of limitations of national evaluation data and reports, several interview participants mentioned the following issues: the data only reflect a subset of children and youth served by each system of care; aggregate data do not facilitate analyses by geographic or service location, or across different subpopulations; data are not available in a timely manner; and the reports present too much information in formats that are not very user friendly. In combination, these issues sometimes made it challenging to use national evaluation data for CQI, because problems could not be tied to particular service providers and the impact of any improvements could not be easily assessed. All these critiques were also mentioned in relation to the *CQI Progress Report*, which is discussed in more detail below.

Interview participants also identified numerous challenges that arose when using any type of data for CQI, including selecting or identifying relevant indicators; collecting relevant data in usable formats; presenting results in clear, concise, and accessible formats; and providing different types of data and formats for different groups (e.g., line staff, topical workgroups, agency administrators, clients). Other challenges, as well as successful strategies, related to CQI are discussed more extensively in the “Lessons Learned” section below.

Overall, local and national evaluation data were used in several aspects of CQI, including assessing progress on specific goals, identifying priorities and the need for additional data, highlighting successes and challenges, and identifying TA needs. Evaluation data also were used to support social marketing and sustainability efforts and to facilitate data sharing across various child-serving systems. In most cases, it was clear that interview participants did not expect evaluation data to “speak for themselves.” Instead, they emphasized the importance of facilitating the use of evaluation data by interpreting results and tailoring presentations to various audiences.

Use of the CQI Progress Report

Survey respondents and interview participants were asked several questions about the *CQI Progress Report* produced by the CMHI national evaluation. Eighty of the 109 survey respondents (73.4%) indicated that they had seen a *CQI Progress Report* for their community. Fifty-four of these 80 respondents (67.5%) said that they personally reviewed the report. Across the different staff roles, evaluators most often reported reviewing the *CQI Progress Report*, followed by project directors and principal investigators (see table 3).

Table 3. Review of the *CQI Progress Report* by Role

Role	Number of Respondents	Seen a National Evaluation <i>CQI Progress Report</i>	Review the National Evaluation <i>CQI Progress Report</i>
Evaluator	32	30	26
Project Director	25	17	12
Principal Investigator	18	12	7
Family Representative	13	11	5
Youth Coordinator	8	5	2
Social Marketer	8	3	1
Cultural Competence Coordinator	5	2	1
Total	109	80	54

Overall, approximately three-quarters of the survey respondents were somewhat satisfied (60.3%) or very satisfied (16.4%) with the *CQI Progress Report*. To gain a better understanding of how the *CQI Progress Report* was being used within system of care communities, survey respondents were asked to respond to 11 statements about the report. Responses, which ranged from 1 (strongly disagree) to 5 (strongly agree), were collected from the 80 respondents who reported that they had seen a *CQI Progress Report* for their community. A complete list of the 11 statements and the responses are provided in appendix C, table C7. The following is a summary of the results:

- Seventy percent of the respondents agreed (58.6%) or strongly agreed (11.4%) that the *CQI Progress Report* was helpful in local CQI efforts. However, less than one-half of the respondents agreed (43.1%) or strongly agreed (0%) that the report was helpful in identifying TA needs.
- More than one-half of the respondents agreed (53.6%) or strongly agreed (2.9%) that the *CQI Progress Report* accurately reflected challenges faced by their system of care. Slightly fewer than one-half agreed (43.5%) or strongly agreed (2.9%) that the report accurately reflected their successes.
- More than three-quarters of the respondents agreed (57.5%) or strongly agreed (23.3%) that the *CQI Progress Report* stimulated conversation about potential system of care improvements. However, only slightly more than one-half of the respondents agreed (47.9%) or strongly agreed (5.6%) that the report provided adequate information to aid in improvement.
- More than one-half of the respondents indicated that the *CQI Progress Report* provided timely information (66.3%) and was easy to understand (59.2%). However, less than half of the respondents (44.4%) thought that the *CQI Progress Report* was easy to explain to people who were interested in the system of care’s performance.

- The majority of the respondents agreed (41.1%) or strongly agreed (24.7%) that it was useful to compare their performance to that of other funded communities.

Most of the 80 survey respondents who had reported seeing a *CQI Progress Report* stated that their community used the national evaluation *CQI Progress Report* to identify areas in need of improvement (88.7%), assess their system of care delivery (83.1%), and identify their TA needs (67.2%). Less than one-half of the respondents (44.6%) indicated that the report was used to adjust their project goals. (See table 4).

Table 4. Use of the CQI Progress Report

Our system of care uses the national evaluation <i>CQI Progress Report</i> to...	Yes	No
...identify areas in need of improvement (n = 71)	88.7%	11.3%
...assess our system of care delivery (n = 71)	83.1%	16.9%
...identify our technical assistance needs (n = 61)	67.2%	32.8%
...adjust our system of care goals (n = 56)	44.6%	55.4%

Survey respondents also were asked an open-ended question about other ways in which their community used the *CQI Progress Report*. They indicated that the report was used to provide feedback to constituents, stimulate conversations about program change, inform social marketing efforts, compare their progress to that of other communities, and monitor data collection activities.

Interview participants discussed how the *CQI Progress Report* was used within their communities. One of the five communities had not used the report much due to low enrollment numbers and a resulting lack of data in the report. The other four communities indicated that the report was used for various purposes, with three of the communities noting that they only focused on specific indicators that were of interest to their community. Two of the communities had incorporated these indicators of interest into their local evaluation and thus referred to the *CQI Progress Report* mainly for comparative purposes. Although some of the communities shared the entire report with various constituents, they also distilled key findings from the report into more accessible formats, such as newsletters and digests. Other specific uses of the reports mentioned by interview participants included

- identifying broad issues to examine in more depth through local evaluation data;
- comparing community performance to that of other communities;
- monitoring changes in performance over time;
- assessing the impact of quality improvement efforts; and
- comparing the report to local evaluation data to identify any discrepancies or data issues.

Overall, communities varied greatly in whether and how they used the *CQI Progress Report*. Among survey respondents, there was disagreement within communities about local use of the report. Part of this may be due to the fact that evaluation teams often reviewed the reports and

incorporated key findings into locally produced reports—therefore, some individuals may not have realized that they were using data from the *CQI Progress Report*. Interview participants provided clarification on other seemingly contradictory survey responses about the use of the report. For example, almost 90 percent of the survey respondents (88.7%) indicated that their community used the report to identify areas in need of improvement, but a much lower percentage of respondents (53.5%) thought the report provided adequate information to aid in improvement. Similarly, a larger percentage of respondents said their community used the report to identify TA needs (67.2%) than thought that it was helpful in identifying TA needs (43.1%). Interview participants clarified that the report often provided enough information to identify broad problem areas but not enough detail to pinpoint causes or potential solutions to specific problems. Communities were able to take this next step toward quality improvement by using local data to examine identified issues in more depth.

One of the primary purposes the *CQI Progress Report* is to stimulate conversation within each community about system development and service delivery. Although the survey results suggest that the report is serving this purpose, many communities emphasized some of the limitations of the report. In particular, interview participants noted that the data only reflected a subset of the children and youth served, that the reports were only produced three times per year, and that the reports were not user friendly. In addition, participants indicated the reports did not facilitate an assessment of differences in performance across various populations of focus or service locations and that the use of cumulative data made it difficult to identify changes in performance resulting from CQI efforts. Some communities also expressed that they would like to view performance beyond the 6-month follow-up period shown on the report and that it would be helpful to know whether changes in performance over time were statistically and/or clinically significant. In combination, these issues led some communities not to use the report at all or to do so to a very limited extent.

Among those communities that routinely reviewed the *CQI Progress Report*, there was confusion about exactly how they should be using it. One area of confusion was related to the number of indicators—people were unclear about whether they should be trying to maximize performance on all of the indicators in the report or choosing only a few on which to focus. The communities that found the report most useful tended to do the latter. Another source of confusion involved the issue of who should be looking at the report—some people thought this should be the purview of the evaluation team, whereas others believed it should be reviewed by a wider range of constituents. As noted above, the evaluation teams in some communities pulled key findings from the report to present to other groups in more accessible formats.

Assessment of Technical Assistance (TA)

To gain a better understanding of how satisfied system of care communities were with national TA providers, survey respondents were asked to assess three statements about TA provision. Responses ranged from 1 (strongly disagree) to 5 (strongly agree). A list of the three statements and the responses are provided in appendix C, table C9. The following is a summary of the results:

- A majority of the respondents agreed (48.2%) or strongly agreed (38.8%) that TA was provided in a timely manner.
- Most of the respondents agreed (51.2%) or strongly agreed (31.4%) that TA was tailored to their system of care’s unique needs.
- Fewer respondents felt that TA was tailored based on their *CQI Progress Report*—less than one-half of the respondents agreed (39.6%) or strongly agreed (3.8%) with this statement.

Survey respondents were also asked to provide an assessment of their satisfaction with national TA providers. Responses ranged from 1 (very dissatisfied) to 5 (very satisfied). Most respondents indicated that they were somewhat satisfied or very satisfied with their TA coordinator or community development specialist (81.5%), their national evaluation site liaison (77.0%), and other TA providers (63.3%-76.3%). Overall, respondents gave the highest satisfaction ratings to the TA coordinators (average score 4.32) and the national evaluation site liaisons (4.25) (see appendix C, table C10).

Interview participants provided more detailed information on their interactions with various TA providers. All five of the communities indicated that they maintained regular contact with their national evaluation site liaison and their TA Partnership TA coordinator. Communities also accessed TA from other national-level providers, such as the National Federation of Families for Children’s Mental Health, and from various local sources. Additional sources of TA mentioned by interview participants included Federal site visits, system of care training and conferences, Webinars, listservs, and other system of care communities. The intensity of interaction with TA providers and use of TA resources varied across communities and over the course of the grant period. In general, communities whose staff had previous experience in systems of care did not feel the need for much TA, and communities tended to need less TA toward the end of their funding cycle.

Interview participants also offered several suggestions for improving and expanding TA provision:

- Explain how the various TA resources can be beneficial, because many newly funded communities are not aware of what they don’t know
- Provide guidelines on when to request TA, because many communities are hesitant to ask for help until something goes wrong
- Compile a list of very basic “frequently asked questions” that people may be reluctant to ask during a teleconference call

- Coordinate TA provision to reduce redundancy and frequency of resources and events offered by the various TA providers
- Offer guidance on how to transform the mindset of staff from a case management perspective to a wraparound perspective
- Provide more guidance specific to CQI, including how to establish an effective CQI process, how to use data for CQI, and how to present data to various constituents

Improvements Resulting from CQI Efforts

Survey respondents provided information about changes that had occurred in their systems of care as a result of CQI efforts or associated TA (see table 5). More than one-half the respondents indicated that the following items or practices had undergone some revision due to CQI: staff training (90.4%), family and youth involvement (84.1%), strategic plan (82.7%), cultural and linguistic competence practices (80.7%), logic model (77.8%), staffing practices (66.7%), and recruitment / retention strategies (64.9%). Changes mentioned in the “other” category included training for family members and youth, revisions to sustainability plans, modifications in service-delivery models, and hiring new subcontractors.

Table 5. Changes Resulting from CQI Efforts and Associated Technical Assistance

	Yes	No
Staff training (n = 83)	90.4%	9.6%
Family and youth involvement (n = 82)	84.1%	15.9%
Strategic plan (n = 81)	82.7%	17.3%
Cultural and linguistic competence practices (n = 83)	80.7%	19.3%
Logic model (n = 81)	77.8%	22.2%
Staffing practices (n = 75)	66.7%	33.3%
Recruitment / retention strategies (n = 77)	64.9%	35.1%
Mission statement (n = 82)	34.1%	65.9%
Other (n = 12)	50.0%	50.0%

Interview participants also provided information about changes that had occurred in their systems of care as a result of CQI. Representatives from four of the five communities identified changes in training, particularly around the types of training offered and who received training. Another commonly identified change related to enrollment processes—four communities made modifications intended to ease the enrollment process for families. Other program improvements mentioned by interview participants included

- changes to service-delivery models to make services more accessible and individualized;
- increased outreach efforts to youth;
- changes in program staffing;
- more collaboration with other agencies and community partners;
- increased involvement of youth and family;
- modifications to cultural and linguistic competence practices;

- more use of evidence-based curriculum-driven programming;
- changes to locally produced reports; and
- increased use of data in discussions and decision making.

An example provided by interview participants from one community demonstrates how data from different sources can be used to identify and address issues of concern. A *CQI Progress Report* showed that the community ranked low compared to other funded communities on the timeliness of services indicator, which measures the average number of days between an assessment and the first date of service. Staff were concerned about this finding and used locally collected data, including case records and feedback from family members, to further explore the issue. These additional sources of information corroborated the data in the *CQI Progress Report*, thus prompting staff to discuss the enrollment process with various agencies. By working with these agencies, staff members were able to identify and reduce delays in the enrollment process and develop guidelines for when delays were acceptable. The community plans to monitor the effects of these changes using data from both the *CQI Progress Report* and local sources.

Some of the communities also discussed how feedback from constituents was incorporated into their CQI efforts. For example, interview participants from one community described how feedback received from family members led to changes in service provision. Family members reported to staff that they were having difficulty attending meetings due to challenges with transportation. Staff presented this feedback to the management team, and the management team reconfigured the project budget to allocate resources to offer transportation through a local cab company.

Lessons Learned: Challenges, Successful Strategies, and Advice

Both survey respondents and interview participants were asked about challenges and successful strategies related to implementing CQI efforts in their systems of care. Interestingly, several strategies that were identified as being challenging to implement, were also identified as contributing to successful CQI efforts. For example, communities reported that engaging family members and youth in CQI efforts was difficult but also essential for success. Table 6 presents the most common responses provided by community members—details about these responses are summarized in the sections following the table.

Table 6. Challenges and Successful Strategies in CQI Implementation

Challenges	Successful Strategies
Staff turnover	Establishing a commitment to CQI
Involving constituents	Providing strong leadership for CQI
Lack of adequate training, time, resources	Engaging various constituents
Lack of commitment to CQI	Providing training on CQI and data analysis
Insufficient quality or quantity of data	Incorporating key indicators into data collection
Identifying appropriate data to inform CQI	Using evaluation data in decision making
Presenting data to varied constituents	Sharing data with family members, youth, and program partner and stakeholder staff
Linking data to program changes	Receiving TA from national TA providers

Challenges in Implementing CQI

Survey respondents and interview participants were asked about the challenges their communities faced in implementing CQI. Both groups emphasized challenges in two areas—establishing and maintaining a structure for CQI, and using data effectively.

Many of the structural challenges mentioned by communities related to having a stable group of well-informed participants involved in CQI efforts. Staff turnover and burnout were among the most frequently mentioned challenges, along with the involvement of various constituents including family members and youth. In many cases, it was simply a matter of people not having time to participate in CQI efforts. Communities also indicated that involving constituents was difficult if people did not understand the importance of data or how to use it for CQI.

In addition, inadequate staff training on CQI and insufficient resources (including staff, time, and funding) to invest in CQI posed significant challenges for many communities. In some cases, there was also a general lack of understanding of CQI and participation in CQI efforts, as well as a lack of clarity about specific roles and responsibilities. Other reported challenges included differing conceptions of CQI at different levels of their system of care and establishing an effective local structure to support CQI.

Community members also identified several challenges related to the use of data, including lack of sufficient data, either in total number of cases or for specific populations; lag time between data collection and reporting; identifying data elements that are relevant and meaningful to various constituents; and presenting data to constituents in succinct, accessible formats. In terms of using data to identify or implement quality improvement measures, communities reported challenges in linking findings to specific program improvements, following up on issues identified, and assessing the impact of changes resulting from CQI efforts.

Successful Strategies in Implementing CQI

Survey respondents and interview participants also were asked about the types of practices that facilitated the development and maintenance of an effective CQI process within their community. As with the challenges discussed above, the successful strategies described by both groups fell into two broad categories—establishing and maintaining a structure for CQI, and using data effectively.

Some factors that were particularly helpful in implementing a CQI structure included fostering commitment and buy-in to CQI among staff and other constituents; providing strong leadership for CQI; and involving a wide range of constituents who can recommend and enact quality improvement activities, such as staff, partners, family members, and youth. Communities indicated that effective involvement of varied constituents was facilitated by providing training in CQI and data analysis, highlighting the importance of data-driven CQI, and explaining how CQI differs from evaluation. Community members also emphasized the importance of engaging the evaluation team in CQI efforts, establishing a clear CQI process, integrating CQI into the larger structure of work, and creating and regularly updating a CQI plan. In addition, communities noted that it was helpful to use several available resources to inform CQI efforts,

such as training and conferences, TA, internal expertise, and advice from other system of care communities.

Community members also reported several strategies that helped maximize the effective use of data. These included incorporating indicators of interest into local data collection efforts and providing training in data collection, analysis, and interpretation. The importance of using multiple sources and types of data—including both quantitative and qualitative data from both the national and local evaluations—was also emphasized by several communities. Other successful strategies related to the presentation of data, specifically presenting findings to various constituents in accessible and relevant formats, and tailoring reports and other materials to the interests of diverse audiences. Sharing data findings with family, youth, and program partner staff was useful for obtaining their suggestions for improvements, whereas sharing data with key stakeholder leaders was important to convince them to provide resources or to enact changes necessary for improvement.

Advice on Implementing CQI

In addition to discussing challenges and successful strategies related to CQI, survey respondents and interview participants offered several recommendations for establishing and maintaining an effective CQI process. Survey respondents were asked how their local CQI efforts could be improved, whereas interview participants were asked what advice they would give newly funded communities about CQI. There was substantial overlap in the two sets of answers, with both groups emphasizing the importance of the following elements:

- Starting CQI efforts early in the funding cycle
- Providing consistent leadership that understands and emphasizes the importance of CQI
- Fostering buy-in from, and involvement of, a wide range of constituents, including staff, partners, family members, and youth
- Providing training to all those involved in CQI efforts
- Formalizing the CQI process, in part by identifying goals and defining roles
- Identifying indicators relevant to various constituents
- Clearly linking data to system of care goals and changes in performance
- Integrating quantitative and qualitative data from various sources
- Garnering input from varied constituents by presenting data in accessible formats
- Celebrating successes as well as addressing challenges

FINDINGS FROM TA PROVIDER DISCUSSION GROUPS

In addition to the survey and interviews conducted with system of care personnel in funded communities, two discussion groups were conducted with national TA providers. A total of 21 TA providers participated in the discussion groups. Participants included site liaisons from the national evaluation as well as TA coordinators and resource specialists from the TA Partnership. These national TA providers were asked about the coordination of TA provision, their role in supporting local CQI efforts, and the types of information used to guide TA provision. The

discussions were recorded and analyzed to identify key themes. Many of the findings from the discussion groups confirmed information reported by community members in the survey and interviews.

All of the discussion group participants emphasized the importance of collaboration and coordination among TA providers. Both the site liaisons and the TA coordinators hold regular calls with funded communities, but the calls are usually separate and information is not always shared between the two groups. In some cases, site liaisons join calls with the TA coordinator or vice-versa, but there is a lot of variation in whether and how frequently this occurs. Some participants noted that, although joint calls might be the ideal process for coordinating TA efforts, such calls would present significant challenges in terms of scheduling and keeping calls to a reasonable length. Therefore, it may be more practical for the different TA providers to consistently share relevant information among themselves. Currently, there is no established process in place for doing so. However, site liaisons and TA coordinators do frequently refer community members to each other, and resource specialists participate in calls, as needed, to address specific issues.

Both groups of TA providers work directly with staff in funded communities, but they typically focus on different aspects of systems of care. The support that site liaisons provide to communities often centers on the national evaluation protocol and instruments. Evaluators from funded communities usually participate in the monthly calls with their site liaison, and other staff join the calls on a more sporadic basis. Frequent topics of discussion include enrollment and retention, staffing changes, and specific technical issues related to data collection and reporting. When national evaluation reports are released, they are often discussed on a subsequent call. In contrast to the national evaluation site liaisons, the TA Partnership TA coordinators and resource specialists provide support to communities on a wide range of topics. TA coordinators hold monthly calls with funded communities, and resource specialists join the calls as needed. The discussion group participants noted that they do not often work with communities specifically on CQI, but that they provide TA that is usually aimed at quality improvement. They also emphasized that many communities are highly committed to data-driven decision making, frequently relying more heavily on locally developed sources of information than on data from the national evaluation.

All the TA providers were familiar with the *CQI Progress Report* and confirmed that communities vary greatly in whether and how they use the report. Some communities review the *CQI Progress Report* and discuss it during the calls with their site liaison—in these cases, discussion may focus on changes from the last report, missing data, and indicators of particular interest to the community. The communities that find the report most useful often focus on a few indicators and use local evaluation data to examine any problems identified in more depth. Other communities do not use the *CQI Progress Report* and are not interested in talking about it. Site liaisons indicated that most communities seem to understand the report and that there are various reasons that some communities do not use it. For example, one community has more than 200 service providers, and the report does not allow them to trace problems to particular locations. In addition, communities that focus more heavily on systems change than service delivery do not find the report very helpful. As is the case with the communities with which they work, some of the TA coordinators review the *CQI Progress Report* when it is released, whereas others do not.

The TA coordinators echoed the observation made by site liaisons that the communities that use the report most effectively typically focus on a few indicators relevant to their goals. Both groups of TA providers also indicated that they sometimes refer to *the CQI Progress Report* and other national evaluation reports when assessing communities' TA needs.

Discussions with the two groups of TA providers revealed that both communities and TA providers may benefit from guidance on how to use the *CQI Progress Report*. TA providers noted that some communities use the report in their data-driven decision making, but many communities rely more on locally developed information. TA providers suggested that offering specific guidance on how to use the reports might help facilitate more extensive use of the reports. They also conveyed uncertainty about their role in talking to communities about the *CQI Progress Report* and about how best to use the report to inform their TA efforts.

Participants in the discussion groups emphasized that many communities are highly committed to data-driven CQI. Site liaisons noted that several communities use both local and national evaluation data to assess their performance and identify areas in need of improvement. These communities often rely heavily on local evaluation data, because they know it will continue to be available after the end of the funding cycle. In addition, TA coordinators reported that communities commonly seek assistance in identifying indicators of interest to various constituents. TA coordinators frequently work with communities to identify or develop indicators of relevance to people involved in different child-serving sectors, such as juvenile justice, education, and child welfare.

Both groups of TA providers agreed that communities engage in CQI in a variety of ways. The site liaisons noted that an ideal CQI process would be one that emphasizes the use of data, such as the model developed as part of the CMHI CQI Initiative. The TA coordinators and resource specialists identified some common elements shared by communities with effective CQI processes: responsibility for CQI does not rest solely with the evaluation team; there is a conscious effort to share data with all constituents; and the evaluation team works to support the governing council and other constituents.

Although the two groups of national TA providers offer support that may ultimately lead to quality improvement within systems of care, they rarely talk to communities specifically about CQI. CQI is not a regular topic on call agendas, and several participants in the discussion groups indicated that communities are too diverse for any standard model of CQI to be effective. CQI was perceived as a local effort that TA providers supported by meeting the TA needs of communities. However, the discussion group participants agreed that communities may benefit from more specific and focused guidance on particular aspects of CQI, such as involving constituents and using data effectively.

DISCUSSION OF EVALUATION RESULTS

Results from the evaluation of the CMHI CQI Initiative highlight two facets of CQI in system of care communities—establishing and maintaining a CQI process and using data in CQI efforts. Survey respondents, interview participants, and national TA providers offered insights into both facets of CQI, including challenges and successful strategies in each area. This section briefly discusses key findings related to each facet of CQI and concludes with a comparison to issues raised in recent literature about CQI in the child welfare sector.

Establishing a CQI Process

CQI is clearly an important endeavor in system of care communities. The majority of survey respondents indicated that their community was highly committed to CQI, had effective mechanisms in place to pursue CQI, and had all the appropriate staff involved in CQI. However, survey respondents and interview participants alike reported that staff were often not adequately trained in CQI and that more resources were needed to implement CQI fully. In addition, less than one-quarter of the survey respondents thought that the CQI process for their community was the best it could be.

Communities face numerous challenges in establishing and maintaining a CQI process. Staff turnover and lack of buy-in make implementing a CQI process difficult. Involving a wide range of constituents, including family members and youth, was viewed as an essential aspect of CQI but also very challenging. Although CQI efforts often tend to fall under the purview of the evaluation team, several interview participants and national TA providers noted that this was not an ideal situation. The involvement of the evaluation team was seen as necessary for an effective CQI process, but it was also thought to be equally important to engage various constituents, including individuals who have the power to enact any recommendations for improvement.

In the face of such challenges, system of care communities have developed many successful strategies for establishing and maintaining an effective CQI process. These strategies are not dependent on a particular structure for CQI. Communities reported a diverse array of organizational schemes for pursuing CQI, from ongoing internal discussions among staff to external review boards comprised of various constituents. Both community members and national TA providers emphasized that there is not one structure for CQI that will work for all communities. However, there seem to be some essential elements that are necessary for an effective CQI process, based on examples of successful strategies used by funded communities. These strategies included emphasizing the importance of CQI to staff and other constituents, engaging a wide array of constituents in CQI efforts, providing training and support to all those involved in CQI, and incorporating CQI into the wider decision-making structure of the system of care. Several interview participants noted that these types of activities are often more complicated and challenging than just the process of reviewing data.

Using Data Effectively: The CQI Model Revisited

When asked about their conception of CQI, many survey respondents and interview participants immediately referred to the use of data. For some people, systematically collected quantitative evaluation data was the preferred basis for CQI efforts. Other individuals conceived of data more broadly, including sources such as informal feedback from staff, family members, and youth. Of course, the ability to use various types of data effectively requires having a process in place for doing so—even the most comprehensive and reliable data are essentially useless for CQI if there is not an established process for using the data.

The CQI model developed as part of the CMHI CQI Initiative is predicated on the existence of a CQI process and therefore focuses on how to use data in that process. System of care communities face challenges in each step of the CQI model, but they have developed successful strategies to address these challenges. Evaluation results related to the five steps of the CQI model are discussed below.

1. Decide What to Measure and Why

Several communities emphasized the importance of identifying the goals and priorities of their system of care and linking these to specific indicators. In a few cases, communities began this process too late in the funding cycle and realized that information they would have liked to have to assess their performance was not actually being collected as part of the national or local evaluations. Both interview participants and national TA providers emphasized that it is essential for communities to identify indicators of interest before data are available in order to assure that the appropriate data will be collected. An important aspect of this process is considering the interests and needs of various constituents and making sure that relevant data are collected to address their concerns. Communities indicated that one way to make all these connections is to link specific performance indicators to planning documents, such as the project logic model, strategic plan, and evaluation plan. A final strategy mentioned by interview participants and national TA providers is to limit the number of indicators reviewed as part of the CQI process. By focusing on a few essential indicators, communities may be able to monitor their performance more closely and assess the impact of any improvements more easily.

2. Identify/Access Information Sources

Several communities emphasized the importance of linking indicators of interest to specific data sources. In some cases, the desired data were collected as part of the national evaluation, whereas other data needed to be collected as part of the local evaluation. Some of the interview participants and national TA providers noted that communities should incorporate data elements from the national evaluation into their own local evaluation to ensure long-term sustainability of data collection—several communities indicated that they had included data from the *CQI Progress Report* and other national evaluation reports into local evaluation efforts. This strategy also allows communities to examine performance in more depth than is typically feasible with national evaluation data. Importantly, communities emphasized that both quantitative and qualitative data were useful in their CQI efforts and, in many cases, reinforced each other. In fact, survey respondents indicated that the most useful resources in their CQI efforts were experience and knowledge gained through program delivery, input from family members and

youth, and input from other local constituents. As noted by interview participants and TA providers, some people may not view informal feedback as a legitimate basis for CQI efforts, so it can be helpful to gather such input systematically and/or link it to quantitative data such as satisfaction measures.

3. Review Information Sources

Communities reported two major challenges related to this step of the CQI process: presenting data and translating findings into actionable recommendations. Part of the challenge in presenting data is simply the abundance of data. Interview participants indicated that national evaluation resources, such as the *CQI Progress Report*, contain much more information than is practical to present in many venues. The same is true of local evaluations, and there are also numerous other sources of information that could be used to inform decision making, including case records and shared management information systems. Community members and national TA providers indicated that it is essential to remain focused on identified indicators of interest while also recognizing when additional data may be needed. Both groups also noted that the diversity of constituents poses challenges in presenting data. Different constituents are interested in different indicators, so communities often develop several presentations for various audiences. Likewise, the format of presentations often needs to be tailored to different audiences, with some presentations being more technical and others summarizing complex quantitative data in ways that are easy to understand. In response to all these considerations, communities often cull from and/or repackage national evaluation data reports to better meet their needs.

Presenting data can certainly be a complex process, but it is not the end goal of CQI efforts. Instead, data serve as the basis for identifying areas for improvement. This involves translating findings into actionable recommendations and conveying those recommendations to the individuals or groups that can enact the changes. The fact that system of care communities struggle with this aspect of reviewing data is evident in the relative dearth of information collected about the process during the evaluation of the CQI Initiative. Although many communities mentioned the importance of identifying specific and feasible recommendations for improvement, few offered any concrete tips for doing so. One successful strategy that was mentioned by some interview participants was the inclusion of decision makers and those with the power to enact changes in the review process.

4. Actions / Modifications

Most system of care communities reported that they had a process in place for reviewing data, but few had an established process for implementing modifications aimed at quality improvement. This sometimes created delays and other barriers in enacting recommended changes. Communities indicated that the implementation of changes is complicated by many factors, including the existence of multiple service providers, lack of buy-in from those with the authority to make changes, and insufficient accountability for following through on recommendations. Making modifications to existing systems or practices is especially problematic when the group offering recommendations for change has no direct authority over the group(s) that would need to enact the changes. This is not an uncommon situation in many systems of care, including statewide systems comprised of thousands of service providers. In such cases, early planning about how to gain buy-in to CQI and include a wide range of

constituents in CQI efforts may help avoid stagnation at this stage. To facilitate the effective and timely implementation of recommendations for improvement, interview participants suggested assigning responsibility for making changes and specifying how to determine whether the changes had the intended effects. They also indicated that local and national TA providers could be helpful in identifying strategies for improvement in particular areas.

5. Assess Impacts and Next Steps

The final step in the CQI model is to assess the impacts of any changes and identify next steps. This may include both intended and unintended impacts, of course, both of which ideally should be examined. Interview participants from two communities described plans to continue monitoring performance on certain indicators in order to determine the effectiveness of changes to their enrollment and service-delivery processes. Another community specifically noted this as a weakness in their CQI efforts. Overall, neither community members nor national TA providers talked much about this aspect of CQI, but several participants did note the importance of assessing whether changes had the desired effects.

The Broader Context of CQI

Literature on CQI in other contexts reinforces many of the findings from the evaluation of the CMHI CQI Initiative, particularly the importance of establishing a structure for CQI and using data effectively. Three recent articles on CQI in the child welfare sector highlight some of the factors and activities that are essential to the success of any CQI effort.

Research by the National Child Welfare Resource Center for Organizational Improvement (NRCOI) found that child welfare agencies have been very successful in implementing certain aspects of an effective CQI system, particularly identifying outcomes and developing data collection systems (NRCOI 2010). However, these agencies have been less successful in using the data collected to identify opportunities for improvement and take actions to improve performance. Some key factors that have facilitated the use of data in child welfare agencies include leadership support, dedicated CQI staff, training and support for those involved in CQI, clear CQI structures and goals, accessible and usable reports, expectations for action, and support for improvements.

A 2005 panel of 28 CQI experts, assembled by Casey Family Programs and the NRCOI, identified several components necessary to the development and implementation of CQI systems in child welfare agencies (NRCOI 2005). Some of these components included organizational support for CQI and time for staff to engage in CQI efforts; identification of outcomes linked to the values and principles of the agency; involvement of stakeholders; provision of training to the various groups involved in CQI; collection of quantitative and qualitative data; review of these data by various groups; and the use of findings to improve policies, practices, and programs. The panel of CQI experts also highlighted key principles underlying CQI, including the usefulness of information collected both formally and informally, the need to support staff in their CQI efforts, and the importance of meaningful, active engagement of staff, children, families, and stakeholders.

Wulczyn (2007) provides another example of CQI efforts in the child welfare sector. He identifies major elements of a CQI process in child welfare systems, noting that these elements are the same in other areas of system design. An organization must begin the CQI process by identifying a set of core outcomes that reflect its central mission. The organization should then describe how well it currently performs on these outcomes and set goals for future performance. The final element of the CQI process is to assess whether intended changes are occurring and convey the resulting information to key actors and stakeholders. It is this last element, monitoring and feedback, that allows an organization to determine whether changes made to the system have been effective.

In combination, these three articles mirror many of the insights provided by the survey respondents, interview participants, and national TA providers during the evaluation of the CMHI CQI Initiative. In particular, several of the core elements of an effective CQI process, such as the involvement of a wide range of constituents, were emphasized in both contexts. In addition, it is notable that both system of care communities and child welfare agencies have been more successful in developing data systems and collecting data than in using the resulting data to guide quality improvement efforts. The three articles also demonstrate the importance of the two aspects of CQI discussed in the preceding section, namely establishing a CQI process and using data effectively. To date, the CMHI CQI Initiative has largely focused on the use of data, but it is clear that system of care communities may also benefit from guidance on how to establish and maintain a structure for CQI.

RECOMMENDATIONS TO IMPROVE THE CQI INITIATIVE

The CMHI CQI Initiative was established in 2004 to support system of care communities in their efforts to implement data-driven CQI. Since that time, national TA providers have offered guidance on how to use data in decision making, and the national evaluation has produced a report specifically intended to provide data to inform CQI efforts. In addition, the CQI model developed as part of the CQI Initiative outlines how to use data in the CQI process. To a large degree, the model is predicated on the existence of a structure or process for CQI within communities. However, the evaluation results clearly indicate that communities face numerous challenges in implementing a CQI process and may benefit from additional support and guidance in doing so. Therefore, the following recommendations address both aspects of CQI—establishing a CQI process and using data, including the *CQI Progress Report*, effectively.

As noted by communities and TA providers alike, there is no one structure or process for CQI that would fit all system of care communities. However, there are some key elements that often underlie a successful CQI process. The first recommendation emphasizes these elements.

- Early in each funding cycle, national TA providers should offer additional training in, and support for, establishing and maintaining a CQI process, including strategies for fostering buy-in to data-driven CQI and involving a wide range of constituents in CQI efforts

After communities establish a CQI process, they are faced with numerous challenges related to data collection, analysis, presentation, and application. The following recommendation addresses these challenges.

- On an ongoing basis throughout each funding cycle, national TA providers should offer additional training in, and support for, using data to inform CQI efforts, including strategies in the following areas:
 - Identifying indicators of interest to various constituents, and linking these indicators to specific goals, logic models, strategic plans, and evaluation plans
 - Assuring relevant data are collected in usable formats
 - Clarifying the types of data that can be used to inform CQI and how to use them
 - Presenting data in accessible formats and tailoring data presentations to various constituents
 - Translating findings into actionable recommendations and conveying those recommendations to people who can make the changes
 - Developing a plan to implement programmatic changes and assess their impact

The *CQI Progress Report* was developed as a resource to inform CQI efforts in system of care communities. Although many communities are using the report for this purpose, survey respondents and interview participants noted several limitations of the report. The final recommendation focuses on increasing the utility of the report.

- In future funding cycles, national TA providers should facilitate more extensive use of the *CQI Progress Report* as one resource to inform CQI efforts through the following actions:
 - Providing more detailed guidance on how to use the report in local CQI efforts, particularly how to identify indicators of interest and the role of TA providers in interpreting the report and addressing challenges reflected in the report
 - Automating the report and providing customization options that would allow communities to select indicators of interest, assess differences in performance across groups or service locations, view performance data at any follow-up point, choose whether to use cumulative data or data from a specified time period, and determine whether changes in performance over time are statistically and/or clinically significant

Results from the evaluation of the CMHI CQI Initiative indicate that system of care communities funded in 2005 and 2006 are highly committed to CQI. They have a diverse array of structures in place to pursue CQI and use various data to inform their quality improvement efforts. Although they have faced numerous challenges in establishing CQI processes and using data effectively, they have also identified strategies to overcome many of these challenges. As these communities approach the end of their funding cycles, their experiences provide valuable insights into the implementation of CQI that will inform future efforts of grantees and national TA providers alike.

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APPENDIX A
AGGREGATE CQI PROGRESS REPORT

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**Comprehensive Community Mental Health Services for Children and Their Families Program
CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRESS REPORT
National Aggregate Report for Grant Communities Funded in 2005 and 2006
December 31, 2010**

Date Services Started: Aug-06

Number Enrolled in the Descriptive Study: 10,499

Number Enrolled in the Outcome Study: 4,668

	Change from Previous Report ¹	Previous Cumulative Raw Score	Current Cumulative Raw Score	Performance Mark ²	Current Period Raw Score	Benchmark ³	How to Interpret Raw Score
System Level Outcomes							
Service Accessibility							
1. Number of Children Served (with descriptive data)		9,396	10,129		739	n/a	Community defined
2. Linguistic Competency Rate		88.9%	88.5%		84.6%	94.7%	Closer to 100% better
3. Agency Involvement Rate-Service Provision		77.6%	77.5%		76.0%	85.9%	Closer to 100% better
4. Caregiver Satisfaction Rate-Access to Services		4.25	4.25		4.21	4.38	Closer to 5 better
5. Timeliness of Services (average days) *		14.64	14.44		11.48	6.00	Lower # better
Service Quality							
6. Agency Involvement Rate-Treatment Planning		33.1%	33.2%		33.7%	54.6%	Closer to 100% better
7. Informal Supports Rate		40.0%	40.8%		47.1%	51.8%	Closer to 100% better
8. Caregiver Satisfaction Rate-Quality of Services		4.01	4.01		4.05	4.18	Closer to 5 better
9. Youth Satisfaction Rate-Quality of Services		3.90	3.91		4.02	4.02	Closer to 5 better
10. Caregiver Satisfaction Rate-Outcomes		3.52	3.54		3.64	3.77	Closer to 5 better
11. Youth Satisfaction Rate-Outcomes		3.84	3.84		3.89	3.97	Closer to 5 better
Service Appropriateness							
12. Individualized Education Plan (IEP) Development (% at 6 mos)		57.6%	57.2%		53.8%	67.2%	Community defined
13. Substance Use Treatment Rate		58.8%	59.8%		68.4%	73.1%	Closer to 100% better
Child and Family Outcomes							
Caregiver Report							
Child Level							
14a. School Enrollment Rate		95.9%	96.1%		96.9%	99.8%	Closer to 100% better
14b. School Enrollment Rate (Preschool)		97.3%	97.6%		100.0%	100.0%	Closer to 100% better
15a. School Attendance Rate (80% of the time)		81.2%	81.9%		87.6%	87.2%	Closer to 100% better
15b. Daycare or After-School Care Program Attendance Rate		79.0%	80.0%		89.4%	81.4%	Closer to 100% better
16. School Performance Improvement Rate (intake to 6 mos)		33.2%	33.5%		35.9%	39.1%	Closer to 100% better
17. Stability in Living Situation Rate (intake to 6 mos)		79.5%	79.7%		82.0%	84.7%	Closer to 100% better
18. Inpatient Hospitalization Days per Child (intake to 6 mos) *		2.88	2.87		2.77	0.80	Lower # better
19. Suicide Attempt Reduction Rate-Caregiver Report **		-45.5%	-45.5%		-44.4%	-50.0%	More negative % better
20a. Emotional and Behavioral Problem Improvement Rate-Age 6-18 (intake to 6 mos)		28.1%	29.4%		40.9%	33.6%	Closer to 100% better
20b. Emotional and Behavioral Problem Improvement Rate-Age 1.5-5 (intake to 6 mos)		33.5%	34.0%		38.3%	35.6%	Closer to 100% better
20c. Socialization or Communication Problem Improvement Rate (intake to 6 mos)		23.0%	22.0%		12.0%	33.5%	Closer to 100% better

¹ The change from previous report is represented by the following symbols: : Score Worsened : No Change : Score Improved

² Performance marks are not reported for the aggregate report.

³ The benchmark represents the 75th percentile score across all Phase IV and Phase V communities as of April 11, 2009.

* For these indicators, smaller average days represent positive outcomes. The smaller the raw score the better the outcome.

** For these indicators, a negative raw score represents a positive outcome. The more negative the raw score the better the outcome.

**Comprehensive Community Mental Health Services for Children and Their Families Program
CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRESS REPORT
National Aggregate Report for Grant Communities Funded in 2005 and 2006
December 31, 2010**

Date Services Started: Aug-06
Number Enrolled in the Descriptive Study: 10,499
Number Enrolled in the Outcome Study: 4,668

	Change from Previous Report ¹	Previous Cumulative Raw Score	Current Cumulative Raw Score	Performance Mark ²	Current Period Raw Score	Benchmark ³	How to Interpret Raw Score
Child and Family Outcomes (continued)							
Caregiver Report (continued)							
Family Level							
21. Average Reduction in Employment Days Lost (intake to 6 mos) **		-1.47	-1.32		0.07	-2.92	More negative # better
22. Family Functioning Improvement Rate (intake to 6 mos)		2.7%	2.9%		4.2%	5.7%	Higher % better
23. Caregiver Strain Improvement Rate (intake to 6 mos)		25.7%	25.7%		26.3%	32.1%	Closer to 100% better
Youth Report							
24. Youth No Arrest Rate (intake to 6 mos)		5.6%	5.8%		8.1%	17.6%	Higher % better
25. Suicide Attempt Reduction Rate-Youth Report (intake to 6 mos) **		-34.2%	-33.8%		-25.0%	-50.0%	More negative % better
26. Anxiety Improvement Rate (intake to 6 mos)		17.2%	17.9%		24.4%	18.5%	Closer to 100% better
27. Depression Improvement Rate (intake to 6 mos)		11.0%	11.6%		16.7%	14.3%	Closer to 100% better
Satisfaction with Services							
28. Caregiver Overall Satisfaction		4.01	4.03		4.24	4.16	Closer to 5 better
29. Youth Overall Satisfaction		3.92	3.93		4.00	4.00	Closer to 5 better
Family and Youth Involvement							
30. Caregiver Satisfaction Rate-Participation		4.24	4.24		4.23	4.30	Closer to 5 better
31. Youth Satisfaction Rate-Participation		3.66	3.67		3.82	3.73	Closer to 5 better
32. Caregiver and Other Family Involvement in Service Plan		96.9%	96.7%		94.5%	99.4%	Closer to 100% better
33. Youth Involvement in Service Plan		88.7%	89.0%		92.0%	94.8%	Closer to 100% better
Cultural and Linguistic Competency							
34. Caregiver Satisfaction Rate-Cultural Competency		4.44	4.44		4.44	4.56	Closer to 5 better
35. Youth Satisfaction Rate-Cultural Competency		4.25	4.25		4.25	4.37	Closer to 5 better

¹ The change from previous report is represented by the following symbols: : Score Worsened : No Change : Score Improved

² Performance marks are not reported for the aggregate report.

³ The benchmark represents the 75th percentile score across all Phase IV and Phase V communities as of April 11, 2009.

* For these indicators, smaller average days represent positive outcomes. The smaller the raw score the better the outcome.

** For these indicators, a negative raw score represents a positive outcome. The more negative the raw score the better the outcome.

**Comprehensive Community Mental Health Services for Children and Their Families Program
CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRESS REPORT
National Aggregate Report for Grant Communities Funded in 2005 and 2006
December 31, 2010**

Number and Standard Deviation Table for CQI Progress Report Indicators

CQI Progress Report Indicators	Cumulative Number of Cases at National Level*	Number of Sites with Complete Data to Calculate Indicator	Cumulative National Standard Deviation	Number of Cases at National Level for Current Period*	Data Source
1. Number of Children Served (with descriptive data)	10129	30	250.77	739	EDIF**
2. Linguistic Competency Rate	165	5	0.13	13	Caregiver
3. Agency Involvement Rate-Service Provision	2604	29	0.16	275	Caregiver
4. Caregiver Satisfaction Rate-Access to Services	2484	29	0.21	263	Caregiver
5. Timeliness of Services (average days)	8357	30	13.39	564	EDIF**
6. Agency Involvement Rate-Treatment Planning	7609	30	0.22	528	EDIF**
7. Informal Supports Rate	2616	29	0.19	278	Caregiver
8. Caregiver Satisfaction Rate-Quality of Services	2491	29	0.28	263	Caregiver
9. Youth Satisfaction Rate-Quality of Services	1324	22	0.27	130	Youth
10. Caregiver Satisfaction Rate- Outcomes	2480	29	0.28	260	Caregiver
11. Youth Satisfaction Rate- Outcomes	1320	22	0.23	131	Youth
12. Increase in Individualized Education Plan (IEP) Development (intake to 6 mos)	2203	29	0.16	247	Caregiver
13. Substance Use Treatment Rate	244	10	0.16	19	Caregiver
14a. School Enrollment Rate	2710	29	0.06	287	Caregiver
14b. School Enrollment Rate (Preschool)	252	7	0.03	31	Caregiver
15a. School Attendance Rate (80% of the time)	2475	29	0.09	266	Caregiver
15b. Daycare or After-School Care Program Attendance Rate	480	19	0.13	47	Caregiver
16. School Performance Improvement Rate (intake to 6 mos)	1421	24	0.09	153	Caregiver
17. Stability in Living Situation (intake to 6 mos)	2793	29	0.13	300	Caregiver
18. Inpatient Hospitalization Days per Child (intake to 6 mos)	2793	29	4.63	302	Caregiver
19. Suicide Attempt Reduction Rate-Caregiver Report	2752	20	0.49	287	Caregiver
20a. Emotional and Behavioral Problem Improvement Rate-Age 6-18 (intake to 6 mos)	2202	26	0.08	232	Caregiver
20b. Emotional and Behavioral Problem Improvement Rate-Age 1.5-5 (intake to 6 mos)	471	8	0.05	47	Caregiver
20c. Socialization or Communication Problem Improvement Rate (intake to 6 mos)	498	7	0.10	58	Caregiver
21. Average Reduction in Employment Days Lost (intake to 6 mos)	1240	26	3.53	123	Caregiver
22. Family Functioning Improvement Rate (intake to 6 mos)	2782	29	0.03	299	Caregiver
23. Caregiver Strain Improvement Rate (intake to 6 mos)	2736	29	0.08	300	Caregiver
24. Youth No Arrest Rate (intake to 6 mos)	1377	23	0.10	138	Youth
25. Suicide Attempt Reduction Rate-Youth Report (intake to 6 mos)	1361	19	0.60	135	Youth
26. Anxiety Improvement Rate (intake to 6 mos)	1343	23	0.09	135	Youth
27. Depression Improvement Rate (intake to 6 mos)	1381	23	0.04	144	Youth
28. Caregiver Overall Satisfaction	2491	29	0.30	263	Caregiver
29. Youth Overall Satisfaction	1321	22	0.22	131	Youth
30. Caregiver Satisfaction Rate-Participation	2490	29	0.20	263	Caregiver
31. Youth Satisfaction Rate-Participation	1321	22	0.28	130	Youth
32. Caregiver and Other Family Involvement in Service Plan	7910	30	0.10	581	EDIF**
33. Youth Involvement in Service Plan	4752	25	0.19	325	EDIF**
34. Caregiver Satisfaction Rate-Cultural Competency	2427	28	0.14	255	Caregiver
35. Youth Satisfaction Rate-Cultural Competency	1298	22	0.17	128	Youth

* Numbers reported as "0" represent less than 10 cases.

** The sources of information used to complete the EDIF include: caregiver, staff-as-caregiver, youth, and case record review.

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APPENDIX B
CQI INITIATIVE EVALUATION SURVEY

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CONTINUOUS QUALITY IMPROVEMENT INITIATIVE SURVEY



Systems of Care

This study is authorized by Section 565 of the Public Health Service Act. Public reporting burden for this collection of information is estimated to average 30 minutes per respondent. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0257), OAS, 1 Choke Cherry Road, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0280 (expiration date 11/30/2012).

PHASE V OF THE NATIONAL EVALUATION
CONTINUOUS QUALITY IMPROVEMENT INITIATIVE
INFORMED CONSENT FORM

The Center for Mental Health Services of the United States Department of Health and Human Services is sponsoring a national evaluation of system of care programs that are funded to improve community-based mental health services for children and families. Part of the evaluation is examining the continuous quality improvement (CQI) process in system of care communities.

You are being invited to participate in this survey because your community received funding from the Center for Mental Health Services to develop a system of care to improve community-based mental health services for children and families. Participation entails completing a Web-based survey that will document your participation in, and perceptions of, the CQI process for your program. **Your input is important to helping us understand how to improve the CQI process.**

Here are some things you may want to know about completing the survey:

- Your participation in completing the survey is totally voluntary.
- If you agree to participate in the survey, you will be mailed a \$20 pre-paid credit card within 60 days of participating in the survey. You will receive this credit card regardless of whether you answer all the questions on the survey.
- If you decide not to complete the survey, this will in no way affect your program funding or the services that the families in the program are receiving or will receive in the future.
- You may choose not to answer any question and you may stop the survey at any time, for any reason.
- Completing the survey will take about 30 minutes. After you have completed the survey, you may be contacted by email or telephone to participate in a telephone interview. However, by participating in this survey, you are not obligated to participate in an interview. If you should choose to participate in an interview, there will be an additional incentive.
- Any information that you provide will be kept strictly private. No one other than national evaluation project staff will know who you are or know what answers you gave. Any reports from this survey will report results in group form. Your name or the names of anyone you mention will not be used in any reports about this survey. In addition, authors of quotes will not be identified.
- There are no risks or direct benefits associated with your participation in the survey.
- A report that combines what is learned from all of the completed surveys will be sent to each participating community and to the Center for Mental Health Services.

Any questions you may have concerning the study, at any time, can be answered by Trena Valado or Katrina Bledsoe at Walter R. McDonald & Associates, Inc. at (301) 881-2590 or (800) 570-0837.

Please indicate whether you will participate in this survey by checking the appropriate box below:

I choose to participate in this survey.

I choose not to participate in this survey

Continuous Quality Improvement Initiative Survey

Thank you for participating in this survey. It is part of the national evaluation of the Comprehensive Community Mental Health Services for Children and Their Families Program (CMHI), which is the program that funds the system of care in your community. In this survey, we are trying to understand the continuous quality improvement (CQI) process in system of care communities.

Because you are an important member of your system of care, your perspective on CQI and the CQI process in your community is very important to us. Please fill out the survey based on **your** experiences with CQI. Thank you for your help toward understanding CQI in systems of care.

The following terms will be used throughout the survey:

Continuous Quality Improvement (CQI) / CQI Process

The continuous quality improvement process involves using evaluation data to identify program areas that may benefit from technical assistance. For example, data indicating that youth are not often involved in developing their treatment plans may demonstrate the need to explore ways of encouraging youth involvement in treatment planning.

CQI Progress Reports

The *CQI Progress Reports* are prepared by the National Evaluation Team and are released to communities three times per year in December, April and August. Each system of care community receives two separate CQI Progress Reports: one compiled from its own data and one that combines data from all system of care communities. The reports contain data on numerous indicators divided into five major categories: system level outcomes; child and family outcomes; satisfaction of services; family and youth involvement; and cultural and linguistic competence. The reports are intended to provide data that will allow communities to assess the performance of their program and target areas that may benefit from technical assistance.

Technical Assistance (TA)

Several groups partner to provide technical assistance, including the National Evaluation Team, the Technical Assistance Partnership, the National Federation of Families for Children's Mental Health, the National Indian Child Welfare Association, the University of South Florida, Portland State University, and Vanguard Communications. Technical assistance to support system of care communities is provided through several sources, such as National Evaluation Team liaisons, Technical Assistance Partnership technical assistance coordinators and resource specialists, and other expert consultants.

Continuous Quality Improvement Initiative Survey

I. PROGRAM INFORMATION

1. Please provide the location and name of your system of care: _____
2. Which of the following best describes your *primary* role with your system of care?
 - ___ Principal Investigator
 - ___ Project Director
 - ___ Lead Evaluator
 - ___ Cultural Competence Coordinator
 - ___ Youth Coordinator
 - ___ Family Representative
 - ___ Social Marketer
 - ___ Other (*please specify*): _____

II. CQI PROCESS

3. Please describe your understanding of CQI.

4. Does your system of care have a CQI process?
 - ___ Yes
 - ___ No (*☞ Go to question 16*)
 - ___ Don't know / Not sure (*☞ Go to question 16*)
5. Does your system of care have an individual or team to oversee the CQI process?
 - ___ Yes
 - ___ No
 - ___ Don't know / Not sure

6. Are you involved in the CQI process for your system of care?

___Yes

___No (☞ Go to question 16)

___Don't know / Not sure (☞ Go to question 16)

7. Please describe the CQI process for your system of care.

--

8. How useful are each of the following resources in your CQI process?

<i>Responses range from 1 (not at all useful) to 3 (very useful). Use "don't know / not sure" if you are not familiar with the resource or if you are not sure whether the resource is used by your system of care. Use "not applicable" if your system of care has not used the resource in its CQI process.</i>	1 = Not at all useful	2 = Somewhat useful	3 = Neutral / No opinion	4 = Very useful	5 = Extremely useful	Don't know / Not sure	Not applicable
National Resources							
National evaluation <i>CQI Progress Reports</i>	1	2	3	4	5	DK	NA
National evaluation <i>System of Care Assessment Reports</i>	1	2	3	4	5	DK	NA
National evaluation <i>Data Profile Reports</i>	1	2	3	4	5	DK	NA
Technical assistance from National Evaluation Team liaison	1	2	3	4	5	DK	NA
Technical assistance from technical assistance coordinator or community development specialist	1	2	3	4	5	DK	NA
Technical assistance from Resource Specialist/s	1	2	3	4	5	DK	NA
Technical assistance from University of South Florida (theory of change logic models)	1	2	3	4	5	DK	NA
Technical assistance from other national sources	1	2	3	4	5	DK	NA
Local Resources							
Logic model	1	2	3	4	5	DK	NA
Strategic plan	1	2	3	4	5	DK	NA
Locally developed CQI reports	1	2	3	4	5	DK	NA
Local evaluation data	1	2	3	4	5	DK	NA
Experience and knowledge gained through program delivery	1	2	3	4	5	DK	NA
Input from local committees, workgroups, partners, etc.	1	2	3	4	5	DK	NA
Input from family members	1	2	3	4	5	DK	NA
Input from youth	1	2	3	4	5	DK	NA

9. Please list any other resources used in your CQI process:

10. Has your system of care developed a local CQI report separate from the national evaluation *CQI Progress Reports*?

- Yes
 No
 Don't know / Not sure

11. How much do you agree or disagree with the following statements about CQI?

<i>Responses range from 1 (strongly disagree) to 5 (strongly agree).</i>	1 = Strongly Disagree	2 = Disagree	3 = Neither	4 = Agree	5 = Strongly Agree	Don't know / Not sure
CQI is essential for improving program delivery	1	2	3	4	5	DK
System of care staff have been adequately trained in CQI	1	2	3	4	5	DK
Our system of care is highly committed to CQI	1	2	3	4	5	DK
We have effective mechanisms in place to pursue CQI	1	2	3	4	5	DK
We have the resources needed to implement CQI fully	1	2	3	4	5	DK
We have all the appropriate staff involved in CQI	1	2	3	4	5	DK
Our CQI process is the best it can be	1	2	3	4	5	DK
The CQI process has been helpful in identifying our technical assistance needs	1	2	3	4	5	DK
The CQI process has been helpful in improving our system of care	1	2	3	4	5	DK
The CQI process has resulted in changes to our system of care	1	2	3	4	5	DK
We have sufficient resources to sustain CQI fully after SAMHSA funding	1	2	3	4	5	DK

12. What factors have helped your system of care to implement a CQI process (for example, advice from a technical assistance provider, support from family organizations, etc.)?

13. What challenges has your system of care faced when implementing a CQI process (for example, staff turnover, lack of relevant data, etc.)?

14. Overall, how satisfied are you with the CQI process for your system of care?

- Very satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Very dissatisfied
- Don't know / Not sure

15. How could the CQI process for your system of care be improved?

III. CQI PROGRESS REPORTS

16. Have you ever seen a national evaluation *CQI Progress Report* for your system of care?

- Yes
- No (*☞ Go to question 26*)
- Don't know / Not sure (*☞ Go to question 26*)

17. Do you personally review the national evaluation *CQI Progress Reports* for your system of care?

- Yes
- No
- Don't know / Not sure

18. Our system of care uses the national evaluation *CQI Progress Reports* to...

	Yes	No	Don't know / Not sure
...assess our system of care delivery	Y	N	DK
...adjust our system of care goals	Y	N	DK
...identify areas in need of improvement	Y	N	DK
...identify our technical assistance needs	Y	N	DK

19. In what other ways does your system of care use the national evaluation *CQI Progress Reports*? Please describe.

20. When identifying areas in need of improvement, how often does your system of care consult national evaluation data such as the *CQI Progress Reports*?

- Always
- Most of the time
- Sometimes
- Rarely
- Never
- Don't know / Not sure

21. How much do you agree or disagree with the following statements about the national evaluation *CQI Progress Reports* (CQI PRs)?

<i>Responses range from 1 (strongly disagree) to 5 (strongly agree).</i>	1 = Strongly Disagree	2 = Disagree	3 = Neither	4 = Agree	5 = Strongly Agree	Don't know / Not sure
The CQI PRs are helpful in the local CQI process	1	2	3	4	5	DK
The CQI PRs are easy to understand	1	2	3	4	5	DK
The CQI PRs are easy to explain to people who are interested in the system of care's performance	1	2	3	4	5	DK
The CQI PRs provide timely information	1	2	3	4	5	DK
The CQI PRs stimulate conversation about potential system of care improvements	1	2	3	4	5	DK
The CQI PRs accurately reflect the successes of our system of care	1	2	3	4	5	DK
The CQI PRs accurately reflect the challenges of our system of care	1	2	3	4	5	DK
The CQI PRs provide adequate information necessary to aid in	1	2	3	4	5	DK

<i>Responses range from 1 (strongly disagree) to 5 (strongly agree).</i>	1 = Strongly Disagree	2 = Disagree	3 = Neither	4 = Agree	5 = Strongly Agree	Don't know / Not sure
system of care improvement						
The CQI PRs are helpful in identifying our technical assistance needs	1	2	3	4	5	DK
Including an indicator related to evidence based practices in the CQI PRs would be helpful	1	2	3	4	5	DK
Including a national benchmark for each indicator in the CQI PRs would be helpful	1	2	3	4	5	DK
Comparing our system of care's performance with that of other systems of care is helpful	1	2	3	4	5	DK
National TA providers are helpful in interpreting the CQI PRs	1	2	3	4	5	DK

22. Which indicator on the national evaluation *CQI Progress Reports* are most useful in assessing your system of care's performance?

(Click here to see a sample CQI Progress Report).

23. Which indicator on the national evaluation *CQI Progress Reports* could be improved to make them more useful to your system of care? How would you improve these indicators to make them more useful to your system of care?

(Click here to see a sample CQI Progress Report).

24. Overall, how satisfied are you with the national evaluation *CQI Progress Reports*?

- Very satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- Somewhat dissatisfied
- Very dissatisfied
- Don't know / Not sure

25. How could the national CQI Progress Reports be improved?

IV. TECHNICAL ASSISTANCE FOR CQI

26. How are technical assistance needs identified for your system of care? Please describe.

27. How satisfied or dissatisfied are you with the following sources of technical assistance from national TA providers?

<i>Responses range from 1 (very dissatisfied) to 5 (very satisfied).</i> <i>Use "don't know / not sure" if you are not familiar with the source or if you are not sure whether the source is used by your system of care.</i> <i>Use "not applicable" if your system of care has not used the source in its CQI process.</i>	1 = Very Dissatisfied	2 = Somewhat Dissatisfied	3 = Neither	4 = Somewhat Satisfied	5 = Very Satisfied	Don't know / Not sure	Not applicable
National Evaluation Team liaison	1	2	3	4	5	DK	NA
Technical assistance coordinator or community development specialist	1	2	3	4	5	DK	NA
Resource specialist/s	1	2	3	4	5	DK	NA
University of South Florida (theory of change logic models)	1	2	3	4	5	DK	NA
Portland State University	1	2	3	4	5	DK	NA
Webinars	1	2	3	4	5	DK	NA
Other (please specify): _____	1	2	3	4	5	DK	NA

28. How much do you agree or disagree with the following statements about the technical assistance (TA) from national TA providers?

<i>Responses range from 1 (strongly disagree) to 5 (strongly agree).</i>	1 = Strongly Disagree	2 = Disagree	3 = Neither	4 = Agree	5 = Strongly Agree	Don't know / Not sure
Our system of care has received requested TA from its National Evaluation Team liaison	1	2	3	4	5	DK
Our system of care has received requested TA from its technical assistance coordinator or community development specialist	1	2	3	4	5	DK
Our system of care has received requested TA from other national TA providers	1	2	3	4	5	DK
TA was provided in a timely manner	1	2	3	4	5	DK
TA has been tailored based on our system of care's unique needs	1	2	3	4	5	DK

<i>Responses range from 1 (strongly disagree) to 5 (strongly agree).</i>	1 = Strongly Disagree	2 = Disagree	3 = Neither	4 = Agree	5 = Strongly Agree	Don't know / Not sure
TA has been tailored based on our <i>CQI Progress Reports</i>	1	2	3	4	5	DK
The CQI process has helped identify technical assistance needs	1	2	3	4	5	DK

29. How could the technical assistance from national TA providers be improved?

V. PROGRAM IMPROVEMENT AS A RESULT OF CQI

30. Which of the following, if any, have undergone at least some revision as a result of your system of care's CQI process or the associated technical assistance from national TA providers?

<i>Use "don't know / not sure" if you are not sure whether the following has undergone revision as a result of the CQI process or associated technical assistance for your system of care.</i>	Yes	No	Don't know / Not sure
Logic Model	Y	N	DK
Mission Statement	Y	N	DK
Strategic Plan	Y	N	DK
Recruitment / retention strategies	Y	N	DK
Staff training	Y	N	DK
Staffing practices	Y	N	DK
Cultural and linguistic competence practices	Y	N	DK
Family and youth involvement	Y	N	DK
Other (<i>please specify</i>): _____	Y	N	DK

31. If applicable, how has your system of care been changed as a result of the CQI process or the associated technical assistance from national TA providers? Please describe.

VI. FINAL THOUGHTS

- 32.** Do you have any other feedback about the CQI process or the associated technical assistance from national TA providers?

Thank you for completing this survey – your input is very valuable to us.

*If you have any questions, please contact Trena Valado or Katrina Bledsoe
at (301) 881-2590 or (800) 570-0837.*

APPENDIX C

CQI SURVEY DATA TABLES

Table C1. Number of Survey Respondents by Role

Table C2. Involvement in the CQI Process by Role

Table C3. Assessment of the CQI Process

Table C4. Usefulness of Local Resources in the CQI Process

Table C5. Usefulness of National Evaluation Reports in the CQI Process

Table C6. Review of the *CQI Progress Report* by Role

Table C7. Assessment of the *CQI Progress Report*

Table C8. Use of the *CQI Progress Report*

Table C9. Assessment of Technical Assistance Provision

Table C10. Satisfaction with Technical Assistance Provision

Table C11. Changes Resulting from CQI Efforts and Associated Technical Assistance

Table C12. Challenges and Successful Strategies in CQI Implementation

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Table C1. Number of Survey Respondents by Role

Role	Number of Respondents	Percentage of Respondents	Number of Communities
Evaluator	32	29.4%	23
Project Director	25	22.9%	23
Principal Investigator	18	16.5%	17
Family Representative	13	11.9%	12
Social Marketer	8	7.3%	8
Youth Coordinator	8	7.3%	8
Cultural Competence Coordinator	5	4.6%	5
Total	109	100%	27

Table C2. Involvement in the CQI Process by Role

Role	Total Number of Respondents	Number of Respondents Involved in the CQI Process	Percentage of Respondents
Evaluator	32	26	32.9%
Project Director	25	21	26.6%
Principal Investigator	18	14	17.7%
Family Representative	13	12	15.2%
Social Marketer	8	2	2.5%
Youth Coordinator	8	2	2.5%
Cultural Competence Coordinator	5	2	2.5%
Total	109	79	100%

Table C3. Assessment of the CQI Process

	Strongly Disagree (1)	Disagree (2)	Neither (3)	Agree (4)	Strongly Agree (5)	Rating Average
CQI is essential for improving program delivery. (n = 77)	1.3%	0%	0%	31.2%	67.5%	4.64
Our system of care is highly committed to CQI. (n = 76)	2.6%	9.2%	9.2%	44.7%	34.2%	3.99
The CQI process has been helpful in improving our system of care. (n = 75)	2.7%	5.3%	12.0%	57.3%	22.7%	3.92
The CQI process has resulted in changes to our system of care. (n = 74)	2.7%	5.4%	13.5%	59.5%	18.9%	3.86
We have effective mechanisms in place to pursue CQI. (n = 75)	2.7%	5.3%	20.0%	66.7%	5.3%	3.67
We have all the appropriate staff involved in CQI. (n = 74)	1.4%	18.9%	13.5%	55.4%	10.8%	3.55
The CQI process has been helpful in identifying our technical assistance needs. (n = 70)	5.7%	8.6%	20.0%	58.6%	7.1%	3.53
We have the resources needed to implement CQI fully. (n = 72)	1.4%	26.4%	13.9%	50.0%	8.3%	3.38
System of care staff have been adequately trained in CQI. (n = 71)	4.2%	29.6%	22.5%	33.8%	9.9%	3.15
We have sufficient resources to sustain CQI fully after SAMHSA funding ends. (n = 64)	18.8%	40.6%	14.1%	20.3%	6.3%	2.55
Our CQI process is the best it can be. (n = 74)	10.8%	51.4%	20.3%	16.2%	1.4%	2.46

Table C4. Usefulness of Local Resources in the CQI Process

TA Resource	Not at all Useful (1)	Somewhat Useful (2)	Neutral/ No Opinion (3)	Very Useful (4)	Extremely Useful (5)	Rating Average
Input from family members (n = 77)	0%	6.5%	2.6%	23.4%	67.5%	4.52
Experience and knowledge gained through program delivery (n = 78)	0%	5.1%	0%	38.5%	56.4%	4.46
Local evaluation data (n = 77)	0%	9.1%	0%	40.3%	50.6%	4.32
Input from local committees, workgroups, partners, etc. (n = 77)	0%	11.7%	1.3%	29.9%	57.1%	4.32
Input from youth (n = 71)	0%	11.3%	8.5%	23.9%	56.3%	4.25
Locally developed CQI reports (n = 72)	0%	13.9%	8.3%	36.1%	41.7%	4.06
Strategic plan (n = 70)	1.4%	17.1%	8.6%	52.9%	20.0%	3.73
Theory of change / logic model (n = 72)	1.4%	27.8%	9.7%	36.1%	25.0%	3.56

Table C5. Usefulness of National Evaluation Reports in the CQI Process

TA Resource	Not at all Useful (1)	Somewhat Useful (2)	Neutral/ No Opinion (3)	Very Useful (4)	Extremely Useful (5)	Rating Average
National evaluation Data Profile Reports (n = 74)	0%	24.3%	12.2%	41.9%	21.6%	3.61
National evaluation System of Care Assessment Reports (n = 74)	2.7%	31.1%	9.5%	40.5%	16.2%	3.36
National evaluation <i>CQI Progress Reports</i> (n = 68)	2.9%	36.8%	17.6%	35.3%	7.4%	3.07

Table C6. Review of the CQI Progress Report by Role

Role	Number of Respondents	Seen a national evaluation <i>CQI Progress Report</i>	Review the national evaluation <i>CQI Progress Report</i>
Evaluator	32	30	26
Project Director	25	17	12
Principal Investigator	18	12	7
Family Representative	13	11	5
Youth Coordinator	8	5	2
Social Marketer	8	3	1
Cultural Competence Coordinator	5	2	1
Total	109	80	54

Table C7. Assessment of the CQI Progress Report

	Strongly Disagree (1)	Disagree (2)	Neither (3)	Agree (4)	Strongly Agree (5)	Rating Average
The CQI PRs stimulate conversation about potential system of care improvements. (n = 73)	1.4%	6.8%	11.0%	57.5%	23.3%	3.95
The CQI PRs are helpful in the local CQI process. (n = 70)	1.4%	7.1%	21.4%	58.6%	11.4%	3.71
National TA providers are helpful in interpreting the CQI PRs. (n = 57)	1.8%	3.5%	33.3%	47.4%	14.0%	3.68
Comparing our system of care's performance with that of other systems of care is helpful. (n = 73)	6.8%	13.7%	13.7%	41.1%	24.7%	3.63
The CQI PRs provide timely information. (n = 74)	2.7%	13.5%	17.6%	64.9%	1.4%	3.49
The CQI PRs are easy to understand. (n = 71)	2.8%	19.7%	18.3%	49.3%	9.9%	3.44
The CQI PRs accurately reflect the challenges of our system of care. (n = 69)	1.4%	23.2%	18.8%	53.6%	2.9%	3.33
The CQI PRs provide adequate information necessary to aid in system of care improvement. (n = 71)	2.8%	21.1%	22.5%	47.9%	5.6%	3.32
The CQI PRs are easy to explain to people who are interested in the system of care's performance. (n = 72)	4.2%	18.1%	33.3%	37.5%	6.9%	3.25
The CQI PRs accurately reflect the successes of our system of care. (n = 69)	1.4%	21.7%	30.4%	43.5%	2.9%	3.25
The CQI PRs are helpful in identifying our technical assistance needs. (n = 65)	4.6%	21.5%	30.8%	43.1%	0%	3.12

Table C8. Use of the CQI Progress Report

Our system of care uses the national evaluation CQI Progress Reports to...	Yes	No
...identify areas in need of improvement (n = 71)	88.7%	11.3%
...assess our system of care delivery (n = 71)	83.1%	16.9%
...identify our technical assistance needs (n = 61)	67.2%	32.8%
...adjust our system of care goals (n = 56)	44.6%	55.4%

Table C9. Assessment of Technical Assistance Provision

TA Provider	Strongly Disagree (1)	Disagree (2)	Neither (3)	Agree (4)	Strongly Agree (5)	Rating Average
TA was provided in a timely manner (n = 85)	1.2%	0%	11.8%	48.2%	38.8%	4.24
TA has been tailored based on our system of care's unique needs (n = 86)	0%	4.7%	12.8%	51.2%	31.4%	4.09
TA has been tailored based on our <i>CQI Progress Reports</i> (n = 53)	3.8%	22.6%	30.2%	39.6%	3.8%	3.17

Table C10. Satisfaction with Technical Assistance Provision

TA Provider	Very dissatisfied (1)	Somewhat dissatisfied (2)	Neither (3)	Somewhat satisfied (4)	Very satisfied (5)	Rating Average
Technical assistance coordinator or community development specialist (n = 81)	0%	4.9%	13.6%	25.9%	55.6%	4.32
National Evaluation Team liaison (n = 87)	1.1%	2.3%	19.5%	24.1%	52.9%	4.25
Resource specialist/s (n = 67)	0%	4.5%	19.4%	38.8%	37.3%	4.09
University of South Florida (theory of change logic models) (n = 72)	0%	4.2%	25.0%	29.2%	41.7%	4.08
Webinars (n = 93)	2.2%	5.4%	16.1%	54.8%	21.5%	3.88
Portland State University (n = 49)	2.0%	2.0%	32.7%	34.7%	28.6%	3.86

Table C11. Changes Resulting from CQI Efforts and Associated Technical Assistance

	Yes	No
Staff training (n = 83)	90.4%	9.6%
Family and youth involvement (n = 82)	84.1%	15.9%
Strategic plan (n = 81)	82.7%	17.3%
Cultural and linguistic competence practices (n = 83)	80.7%	19.3%
Logic model (n = 81)	77.8%	22.2%
Staffing practices (n = 75)	66.7%	33.3%
Recruitment / retention strategies (n = 77)	64.9%	35.1%
Mission statement (n = 82)	34.1%	65.9%
Other (n = 12)	50.0%	50.0%

Table C12. Challenges and Successful Strategies in CQI Implementation

Challenges	Successful Strategies
Staff turnover	Establishing a commitment to CQI
Involving constituents	Providing strong leadership for CQI
Lack of adequate training, time, resources	Engaging various constituents
Lack of commitment to CQI	Providing training on CQI and data analysis
Insufficient quality or quantity of data	Incorporating key indicators into data collection
Identifying appropriate data to inform CQI	Using evaluation data in decision making
Presenting data to varied constituents	Sharing data with various constituents
Linking data to program changes	Receiving TA from national TA providers