The Guidance/Care Center
WestCare Florida
Performance Improvement Report
January – June 2016
FY 2015-2016

Overview

The Guidance/Care Center Performance Improvement Committee developed the Performance Improvement Work Plan for the 2015-2016 Fiscal Year on July 15, 2015. Based on data collected during the past Fiscal Year and overall performance on the objectives, the Performance Improvement Committee eliminated several indicators from the previous year's Work Plan since G/CC had consistent positive performance. Following is a summary of the progress G/CC made on the current Work Plan during the first Biannual Period (July - December 2015) of this Fiscal Year. The report also includes FY 2015-2016 analyses for selected indicators.

A. Program and Service Utilization

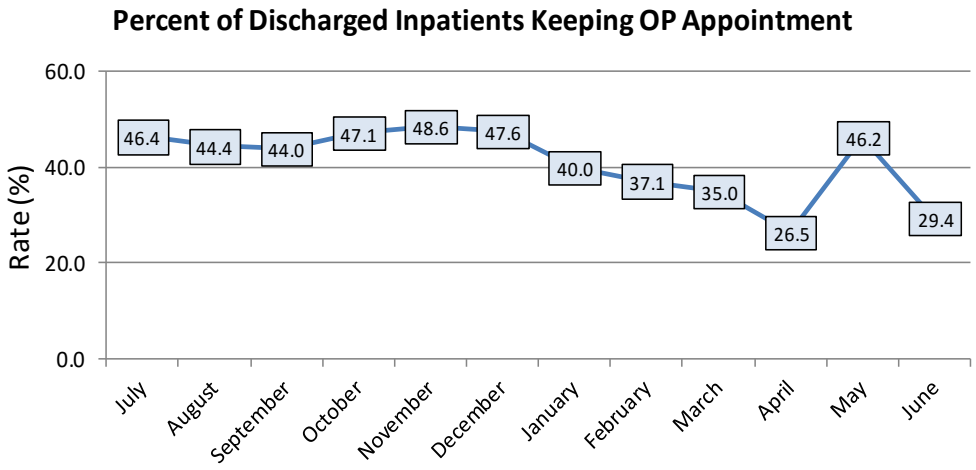
1. Attendance at first session of OP treatment following an IP discharge

Objective: 60% of all clients discharged from CSU will attend first OP appointment.

Type of Objective: *Performance Improvement: Efficiency*

Monthly, Quarterly, and Biannual
Overall, for this biannual period, 35.67% (N=56) of the clients discharged from the inpatient unit (N=157) and referred to outpatient kept their appointments. For the first quarter of the Fiscal Year, 45.0% (36/80) of the clients kept their outpatient appointment, 47.8% (43/90) clients kept their outpatient appointments during the second quarter, 37.5% (30/80) clients kept their appointments for the third quarter, and 33.8% (26/77) clients kept their appointments for the fourth quarter. For the Fiscal Year, 41.28% (135/327) clients kept their appointments. The trend by month was:

Month	Percent	# Attended/# Referred
July	46.4%	13/28
August	44.4%	12/27
September	44.0%	11/25
October	47.1%	16/34
November	48.6%	17/35
December	47.6%	10/21
January	40.0%	10/25
February	37.1%	13/35
March	35.0%	7/20
April	26.5%	9/34
May	46.2%	12/26
June	29.4%	5/17
ANNUAL	**41.28%**	**135/327**



Action: G/CC did not achieve its monthly or quarterly targets for the either biannual or the annual periods of Fiscal Year 2015-2016. The Performance Improvement Committee continues to explore how data extraction and aggregation occurs for this indicator. It is possible, that data includes persons discharged within the timeframe, but the actual appointment date did not occur; in turn, creating an overestimate of clients not attending the first appointment. There also was some discussion about changing policy and practice so that the assessment for outpatient occurs *prior* to discharge from inpatient. This would make the first outpatient appointment an appointment with the psychiatrist as opposed to an appointment for a comprehensive assessment. This in turn may increase the willingness of the clients to attend the outpatient appointment.

2. Attendance at OP therapy sessions

Objective: 80% of clients will attend scheduled appointments.

Type of Objective: *Quality Assurance: Efficiency*

In order to obtain a truer picture of attendance at appointments, the analyses excluded non-preschedule appointments, including case management, activities on behalf of, IHOS, Outreach, CSU, and Detox.

The first set of analyses conducted examined the overall results for all appointments scheduled between January 1 and June 30, 2016.

Category	Total #	Kept % (#)	No Shows % (#)	Client Cancellations % (#)	Staff Cancellations % (#)
All Sites					
All Appointments*	13,421	72.2% (9,691)	14.3% (1,924)	7.3% (980)	6.2% (826)
Child	1,686	63.7% (1,074)	10.5% (177)	5.9% (100)	19.9% (335)
Adult	11,714	73.5% (8,605)	14.9% (1,742)	7.5% (879)	4.2% (488)

*Total appointments may be greater than Child + Adult, since not all appointments had an age associated with it.

Category	Total #	Kept % (#)	No Shows % (#)	Client Cancellations % (#)	Staff Cancellations % (#)
Key West					
All Appointments*	9,690	75.2% (7,285)	12.4% (1,205)	7.6% (738)	4.8% (462)
Child	1,247	66.4% (828)	11.5% (144)	6.6% (82)	15.5% (193)
Adult	8,426	76.5% (6,445)	12.6% (1,058)	7.8% (655)	8.3% (156)
Key Largo					
All Appointments*	2,303	66.5% (1,532)	15.1% (348)	5.5% (127)	12.9% (296)
Child	416	55.3% (230)	7.0% (29)	4.1% (17)	33.7% (140)
Adult	1,887	69.0% (1,302)	16.9% (319)	5.8% (110)	8.3% (156)
Marathon					
All Appointments*	1,428	61.2% (874)	26.0% (371)	8.1% (115)	4.8% (68)
Child	23	69.6% (16)	17.4% (4)	4.3% (1)	8.7% (2)
Adult	1,401	61.2% (858)	26.1% (365)	8.1% (114)	4.6% (64)

*Total appointments may be greater than Child + Adult, since not all appointments had an age associated with it.

The second set of analyses conducted examined only those appointments that clients kept or did not show. The analyses did not include client and staff cancellations since they technically are not "No Shows" in the true sense of the term. These analyses, therefore, provide a more valid reflection of the No Show rate.

Category	Total #	Kept % (#)	No Shows % (#)
All Sites			
All Appointments	11,615	83.4% (9,691)	16.6% (1,924)
Child	1,251	85.9% (1,074)	14.1% (177)
Adult	10,347	83.2% (8,605)	16.8% (1,742)

Category	Total#	Kept % (#)	Now Shows % (#)
Key West			
All Appointments*	8,490	85.8% (7,285)	14.2% (1,205)
Child	972	85.2% (828)	14.8% (144)
Adult	7,503	85.9% (6,445)	14.1% (1,058)
Key Largo			
All Appointments	1,880	81.5% (1,532)	18.5% (348)
Child	259	88.8% (230)	11.2% (29)
Adult	1,621	80.3% (1,302)	19.7% (319)
Marathon			
All Appointments*	1,245	70.2% (874)	29.8% (371)
Child	20	80.0% (16)	20.0% (4)
Adult	1,223	70.2% (858)	29.8% (365)

*Total appointments may be greater than Child + Adult, since not all appointments had an age associated with it.

Action: G/CC had "Kept Appointment" rates lower than the 80% target for Adults in Marathon (70.2%). The Performance Improvement Committee will work with the Site

Directors and Research Assistants at each site to identify potential barriers to consumers showing up for scheduled appointments. Based on these findings, the Team will develop and implement a Performance Improvement initiative. Staff cancellations were exceptionally high for children in Key West (15.3%) and Key Largo (33.7%). This is the second biannual period having this finding for Key Largo. The Chief Clinical Officer will work with Children's Services Coordinator to identify possible reasons for this finding.

3. Waiting Time from Initial Contact

Objective: 80% of clients will have a face-to-face appointment within 7 working days from initial contact.

Type of Objective: *Performance Improvement: Efficiency*

G/CC schedules all initial appointments for an assessment, not for specific services such as counseling or psychiatric appointments. This is to ensure that all potential clients are eligible for services and receive an assignment to the most appropriate service.

Overview – All Clients:

Biannual Results: During the second biannual period FY 2015-2016, G/CC received 798 contacts. The average number of days from Initial Contact to first appointment was 13.7 days, falling almost 7 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from the 1-29 days.

G/CC saw 60.2% of the clients within 14 days from the Initial Contact. G/CC saw 27.3% in seven (7) or fewer days.

All clients had the appointment status indicated in the database.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=798)	54.4% (434)	36.1% (288)	3.3% (26)	6.3% (50)

Action: Only 54.4% of the clients attended the appointments and 36.1% did not "Show" for the initial appointment after making an initial contact with G/CC. G/CC will collect additional data to determine the barriers clients may experience in attending the initial appointment. Based on this information, G/CC will develop a performance improvement initiative to reduce the "No Show" rate.

Annual Results: For FY 2015-2016, G/CC received 1,509 contacts. The average number of days from Initial Contact to first appointment was 12.4 days, falling approximately 5 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from the 1-29 days.

G/CC saw 64.9% of the clients within 14 days from the Initial Contact. G/CC saw 36.1% in seven (7) or fewer days.

Eighteen clients did not have their appointment status indicated in the database. The analysis below excluded those clients.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=798)	54.4% (796)	33.3% (496)	7.0% (104)	6.4% (95)

Mental Health Clients:

Biannual Results: During the second biannual period of FY 2015-2016, G/CC received 386 contacts for mental health services. The average number of days from Initial Contact to first appointment was 13.8 days, falling approximately 7 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 1-29 days.

G/CC saw 59.8% of the clients within 14 days from the Initial Contact. G/CC saw 26.9% in seven (7) or fewer days.

All clients had the outcome of their appointment status indicated in the database.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=386)	54.1% (209)	36.3% (140)	3.4% (13)	6.2% (24)

For the **adult clients (N=320)**, the average number of days from Initial Contact to first appointment was 13.9 days, falling approximately 7 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 1-29 days.

G/CC saw 60.9% of the adult clients within 14 days from the Initial Contact. G/CC saw 25.9% in seven (7) or fewer days.

All adult clients had the outcome of their appointment status indicated in the database.

For the **child clients (N=66)**, the average number of days from Initial Contact to first appointment was 13.6 days, falling approximately 7 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 1-28 days.

G/CC saw 54.5% of the child clients within 14 days from the Initial Contact. G/CC saw 31.8% in seven (7) or fewer days.

All children had the outcome of their appointment status indicated in the database.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
Adults (N=320)	53.4% (171)	36.6% (117)	3.8% (12)	6.3% (20)
Children (N=66)	57.6% (38)	34.8% (23)	1.5% (1)	6.1% (4)

Annual Results: During FY 2015-2016, G/CC received 708 contacts for mental health services. The average number of days from Initial Contact to first appointment was 12.6 days, falling approximately 6 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 1-29 days.

G/CC saw 63.8% of the clients within 14 days from the Initial Contact. G/CC saw 36.0% in seven (7) or fewer days.

Eight (8) clients did not have the outcome of their appointment status indicated in the database. The analysis below excluded these clients.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=700)	52.9% (370)	33.9% (237)	7.0% (49)	6.3% (44)

For the **adult clients (N=613)**, the average number of days from Initial Contact to first appointment was 12.6 days, falling approximately 6 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 1-29 days.

G/CC saw 63.6% of the adult clients within 14 days from the Initial Contact. G/CC saw 36.4% in seven (7) or fewer days.

Six (6) adult clients did not have the outcome of their appointment status indicated in the database. The analysis below excluded them.

For the **child clients (N=95)**, the average number of days from Initial Contact to first appointment was 12.4 days, falling approximately 5 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 1-28 days.

G/CC saw 65.3% of the child clients within 14 days from the Initial Contact. G/CC saw 33.7% in seven (7) or fewer days.

Two (2) children did not have the outcome of their appointment status indicated in the database. The analysis below excluded them.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
Adults (N=607)	52.1% (316)	33.9% (206)	7.9% (48)	6.1% (37)
Children (N=93)	58.1% (54)	33.3% (31)	1.1% (1)	7.5% (7)

Substance Abuse Clients:

Biannual Results: During the second biannual period of FY 2015-2016, G/CC received 13 contacts for substance abuse services. The average number of days from Initial Contact to first appointment was 11 days, falling 4 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 1-27 days.

G/CC saw 69.2% of the clients within 14 days from the Initial Contact. G/CC saw 38.5% in seven (7) or fewer days.

All clients had the outcome of their appointment status indicated in the database.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=19) **ALL WERE ADULTS**	61.5% (8)	30.8% (4)	0.0% (0)	7.7% (1)

ALL contacts during the second biannual period of FY 2014-2015 were for adults. There were no contacts for child substance abuse services.

Action: No show rates for first appointments across all populations exceeded 30%. The Chief Clinical Officer will work with the Area Director and her teams to identify potential barriers the clients are experiencing to attend the first appointment after making contact with GCC.

Annual Results: During FY 2015-2016, G/CC received 32 contacts for substance abuse services. The average number of days from Initial Contact to first appointment was 10 days, falling 3 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 1-27 days.

G/CC saw 78.1% of the clients within 14 days from the Initial Contact. G/CC saw 37.5% in seven (7) or fewer days.

All clients had the outcome of their appointment status indicated in the database.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=19) **ALL WERE ADULTS**	62.5% (20)	21.9% (7)	9.4% (3)	6.3% (2)

ALL contacts during FY 2014-2015 were for adults. There were no contacts for child substance abuse services.

4. Frequency of Outpatient Appointments

Objective: ≥ 90 of the clients will received one (1) outpatient service weekly, unless justified in clinical record.

Type of Objective: *Quality Assurance: Efficiency*

July 2015

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (3 clients)	25	0	75	0
TBOS – CMH (95 clients)	24	18	17	41
ASA (90 clients)	19	17	9	55
AMH (101 clients)	48	28	16	8
TBOS – AMH (0 clients)	--	--	--	--
CMH (2 clients)	25	0	75	0
CSA (0 clients)	--	--	--	--

August 2015

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (5 clients)	40	20	20	20
TBOS – CMH (99 clients)	25	28	13	34
ASA (88 clients)	11	16	8	65
AMH (104 clients)	53	28	10	9
TBOS – AMH (1 client)	100	0	0	0
CMH (1 client)	0	0	100	0
CSA (0 clients)	--	--	--	--

September 2015

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (6 clients)	49	17	17	17
TBOS – CMH (129 clients)	14	17	17	52
ASA (96 clients)	14	18	16	52
AMH (96 clients)	55	24	17	4
TBOS – AMH (1 client)	0	0	100	0
CMH (1 client)	100	0	0	0
CSA (0 clients)	--	--	--	--

October 2015

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (4 clients)	50	0	0	25
TBOS – CMH (132 clients)	11	17	18	54
ASA (86 clients)	22	12	8	58
AMH (92 clients)	55	21	13	11
CMH (0 client)	--	--	--	--
CSA (0 clients)	--	--	--	--

November 2015

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (4 clients)	50	50	0	0
TBOS – CMH (140 clients)	18	29	24	29
ASA (87 clients)	10	18	10	62
AMH (98 clients)	61	23	8	8
CMH (1 client)	0	100	0	0
CSA (0 clients)	--	--	--	--

December 2015

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (3 clients)	66	0	34	0
TBOS – CMH (142 clients)	20	25	23	32
ASA (94 clients)	31	16	10	43
AMH (95 clients)	62	25	6	7
CMH (0 clients)	--	--	--	--
CSA (0 clients)	--	--	--	--

January 2016

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (4 clients)	75	25	0	0
TBOS – CMH (150 clients)	23	27	17	33
ASA (90 clients)	16	11	17	57
ASA IHOS (13 clients)	46	23	8	23
AMH (90 clients)	50	24	16	10
CMH (0 clients)	--	--	--	--
CSA (0 clients)	--	--	--	--

February 2016

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (10 clients)	80	10	0	10
TBOS – CMH (154 clients)	15	19	21	45
ASA (101 clients)	14	7	13	66
ASA IHOS (9 clients)	33	22	22	22
AMH (112 clients)	45	28	19	9
CMH (0 clients)	--	--	--	--
CSA (0 clients)	--	--	--	--

March 2016

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (5 clients)	20	40	20	20
TBOS – CMH (153 clients)	18	22	20	41
ASA (110 clients)	16	11	8	65
ASA IHOS (5 clients)	10	20	0	20
AMH (97 clients)	42	35	4	19
CMH (0 clients)	--	--	--	--
CSA (0 clients)	--	--	--	--

April 2016

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (3 clients)	0	33	33	33
TBOS – CMH (159 clients)	17	23	22	38
ASA (97 clients)	10	6	5	78
ASA IHOS (5 clients)	40	40	20	0
AMH (79 clients)	39	29	10	22
CMH (0 clients)	--	--	--	--
CSA (0 clients)	--	--	--	--

May 2016

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (3 clients)	0	33	33	33
TBOS – CMH (162 clients)	18	22	19	41
ASA (115 clients)	14	6	5	75
ASA IHOS (7 clients)	29	29	29	14
AMH (119 clients)	51	31	9	8
CMH (0 clients)	--	--	--	--
CSA (0 clients)	--	--	--	--

June 2016

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (6 clients)	50	17	0	33
TBOS – CMH (147 clients)	35	26	9	30
ASA (112 clients)	12	11	12	66
ASA IHOS (7 clients)	57	43	0	0
AMH (118 clients)	38	29	19	14
CMH (5 clients)	100	0	0	0
CSA (0 clients)	--	--	--	--

Action: Although the Managing Entity requires this indicator, it remains a challenge to track accurately. The findings are misleading and most likely an underestimate. The current database only tracks scheduled and kept appointments and does not track the frequency of appointments prescribed on the Wellness and Recovery Plan. The Performance Improvement and Clinical Committees, in collaboration with IT, attempted several times to develop a tracking system to no avail. The Committees decided to hold off on a solution until the implementation of an Electronic Health Record in 2016.

B. Consumer, Staff, and Stakeholder Perception

1. Satisfaction with Program Quality

Objective: ≥80% on Overall Quality Rating for each program.

Type of Objective: *Quality Assurance: Efficiency*

The Guidance/Care Center currently uses an instrument consisting of items/questions rated on the following scale: Strongly Agree – Agree – Neutral – Disagree – Strongly Disagree – Not Applicable. For the purpose of these analyses, Strongly Agree and Agree are indicators of satisfaction. Respondents who identified an item as Not Applicable are not included in the aggregate analysis for that item. In addition, although aggregated, the

table does not include items not having responses. For the purpose of this report, the table only includes highlights that relate to overall program quality (as identified as an indicator in the PI Work Plan).

Inpatient Unit – Crisis Stabilization: One hundred five (105) clients completed surveys between January 1 and June 30, 2016. **MARATHON ONLY – DISCHARGE SURVEYS ONLY**

NOTE: Since the length of stay generally is brief (several hours to only a few days), G/CC only conducts Discharge Surveys for this program.

G/CC only administers ***discharge*** surveys since the length of stay is only several days.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	89.4	6.7	3.8
I was treated with respect	92.4	4.8	2.9
I was seen for services on time	91.4	4.8	3.8
I received services when I needed them	21.4	5.7	2.9
If I had a complaint, it was handled well	84.7	8.2	7.1
If I were to have problems, I would return to this program	83.7	8.7	7.6
I would recommend this program to other people	90.2	3.3	6.5
The services focus on my needs	84.5	13.3	2.2
This program has helped me to feel better about myself	80.4	13.0	6.5

Detoxification: Forty-six (45) clients completed surveys between January 1 and June 30, 2016. **MARATHON ONLY – DISCHARGE SURVEYS NOTE: Since the length of stay generally is brief (several hours to only a few days), G/CC only conducts Discharge Surveys for this program.**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	93.3	2.2	4.4
I was treated with respect	93.5	6.5	0.0
I was seen for services on time	86.9	8.7	4.4
I received services when I needed them	88.8	6.7	4.4
If I had a complaint, it was handled well	86.0	9.3	4.7
If I were to have problems, I would return to this program	90.7	4.7	4.7
I would recommend this program to other people	86.0	9.3	4.7
The services focus on my needs	85.4	14.6	0.0
This program has helped me to feel better about myself	93.0	2.3	4.7

Outpatient Adult – Mental Health: Sixty-eight (68) clients completed Point in Time Surveys between January 1 and June 30, 2016. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	98.5	1.5	0.0
I was treated with respect	95.5	1.5	3.0
I was seen for services on time	91.0	6.0	3.0
I received services when I needed them	95.5	3.0	1.5
If I had a complaint, it was handled well	89.6	6.9	3.4
If I were to have problems, I would return to this program	95.5	4.5	0.0
I would recommend this program to other people	95.5	1.5	3.0
The services focus on my needs	97.0	1.5	1.5
This program has helped me to feel better about myself	88.9	11.1	0.0

Seventeen (17) clients completed **Discharge Surveys** between January 1 and June 30, 2016.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
If I were to have problems, I would return to this program	100.0	0.0	0.0
I would recommend this program to other people	100.0	0.0	0.0
The services focus on my needs	100.0	0.0	0.0
This program has helped me to feel better about myself	100.0	0.0	0.0

Outpatient Adult – Alcohol and Other Drugs/Addictions: Twenty-two (22) clients completed Point in Time Surveys between January1 and June 30, 2016. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect	100.0	0.0	0.0
I was seen for services on time	95.5	4.5	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well*	100.0	0.0	0.0
If I were to have problems, I would return to this program	100.0	0.0	0.0
I would recommend this program to other people	100.0	0.0	0.0
The services focus on my needs	90.9	9.1	0.0
This program has helped me to feel better about myself	90.9	90.1	0.0

No (0) clients completed **Discharge Surveys** between January 1 and June 30, 2016.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	--	--	--
I was treated with respect	--	--	--
I was seen for services on time	--	--	--
I received services when I needed them	--	--	--
If I had a complaint, it was handled well*	--	--	--
If I were to have problems, I would return to this program	--	--	--
I would recommend this program to other people	--	--	--
The services focus on my needs	--	--	--
This program has helped me to feel better about myself	--	--	--

Case Management: Three (3) clients completed Point in Time Surveys between January 1 and June 30, 2016. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	***66.7***	33.3	0.0
If I were to have problems, I would return to this program	100.0	0.0	0.0
I would recommend this program to other people	100.0	0.0	0.0
The services focus on my needs	100.0	0.0	0.0
This program has helped me to feel better about myself	100.0	0.0	0.0

No (0) clients completed **Discharge Surveys** between January 1 and June 30, 2016.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	--	--	--
I was treated with respect	--	--	--
I was seen for services on time	--	--	--
I received services when I needed them	--	--	--
If I had a complaint, it was handled well	--	--	--
If I were to have problems, I would return to this program	--	--	--
I would recommend this program to other people	--	--	--
The services focus on my needs	--	--	--
This program has helped me to feel better about myself	--	--	--

Community Integration: Sixteen (16) clients completed Point in Time Surveys for this program between January 1 and June 30, 2016. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	93.7	0.0	6.3
I was treated with respect	93.7	6.3	0.0
I was seen for services on time	93.7	6.3	0.0
I received services when I needed them	87.5	12.5	0.0
If I had a complaint, it was handled well	86.7	6.7	6.7
If I were to have problems, I would return to this program	87.5	12.5	0.0
I would recommend this program to other people	93.7	6.3	0.0
The services focus on my needs	93.7	6.3	0.0
This program has helped me to feel better about myself	87.5	6.3	6.3

No (0) clients completed **Discharge Surveys** between January 1 and June 30, 2016.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	--	--	--
I was treated with respect	--	--	--
I was seen for services on time	--	--	--
I received services when I needed them	--	--	--
If I had a complaint, it was handled well	--	--	--
If I were to have problems, I would return to this program	--	--	--
I would recommend this program to other people	--	--	--
The services focus on my needs	--	--	--
This program has helped me to feel better about myself	--	--	--

Criminal Justice: Sixty-eight (68) clients completed Point in Time Surveys between January 1 and June 30, 2016. **KEY WEST ONLY POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	97.0	3.0	0.0
I was treated with respect	98.5	1.5	0.0
I was seen for services on time	97.1	2.9	0.0
I received services when I needed them	95.4	4.6	0.0
If I had a complaint, it was handled well	91.9	8.1	0.0
If I were to have problems, I would return to this program	93.6	6.4	0.0
I would recommend this program to other people	97.0	1.5	1.5
The services focus on my needs	94.1	5.9	0.0
This program has helped me to feel better about myself	94.1	4.5	1.5

Eight (8) clients completed **Discharge Surveys** between January 1 and June 30, 2016. **KEY WEST ONLY**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
If I were to have problems, I would return to this program	100.0	0.0	0.0
I would recommend this program to other people	100.0	0.0	0.0
The services focus on my needs	100.0	0.0	0.0
This program has helped me to feel better about myself	100.0	0.0	0.0

FITT: No (0) clients completed Point in Time Surveys between January 1 and June 30, 2016.

POINT IN TIME SURVEYS

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	--	--	--
I was treated with respect	--	--	--
I was seen for services on time	--	--	--
I received services when I needed them	--	--	--
If I had a complaint, it was handled well	--	--	--
If I were to have problems, I would return to this program	--	--	--
I would recommend this program to other people	--	--	--
The services focus on my needs	--	--	--
This program has helped me to feel better about myself	--	--	--

No (0) clients completed **Discharge Surveys** between January 1 and June 30, 2016.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	--	--	--
I was treated with respect	--	--	--
I was seen for services on time	--	--	--
I received services when I needed them	--	--	--
If I had a complaint, it was handled well	--	--	--
If I were to have problems, I would return to this program	--	--	--
I would recommend this program to other people	--	--	--
The services focus on my needs	--	--	--
This program has helped me to feel better about myself	--	--	--

Heron House: No (0) clients completed Point in Time Surveys between January 1 and June 30, 2016. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	--	--	--
I was treated with respect	--	--	--
I was seen for services on time	--	--	--
I received services when I needed them	--	--	--
If I had a complaint, it was handled well	--	--	--
If I were to have problems, I would return to this program	--	--	--
I would recommend this program to other people	--	--	--
The services focus on my needs	--	--	--
This program has helped me to feel better about myself	--	--	--

No (0) clients completed **Discharge Surveys** between January 1 and June 30, 2016.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	--	--	--
I was treated with respect	--	--	--
I was seen for services on time	--	--	--
I received services when I needed them	--	--	--
If I had a complaint, it was handled well	--	--	--
If I were to have problems, I would return to this program	--	--	--
I would recommend this program to other people	--	--	--
The services focus on my needs	--	--	--
This program has helped me to feel better about myself	--	--	--

KIST (TCE HIV): Two (2) clients completed Point in Time Surveys between January 1 and June 30, 2016. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
If I were to have problems, I would return to this program	100.0	0.0	0.0
I would recommend this program to other people	100.0	0.0	0.0
The services focus on my needs	100.0	0.0	0.0
This program has helped me to feel better about myself	100.0	0.0	0.0

No (0) clients completed **Discharge Surveys** between January 1 and June 30, 2016.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	--	--	--
I was treated with respect	--	--	--
I was seen for services on time	--	--	--
I received services when I needed them	--	--	--
If I had a complaint, it was handled well	--	--	--
If I were to have problems, I would return to this program	--	--	--
I would recommend this program to other people	--	--	--
The services focus on my needs	--	--	--
This program has helped me to feel better about myself	--	--	--

Outpatient Children and Adolescents – Substance Abuse: No (0) clients completed Point in Time Surveys between January 1 and June 30, 2016. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	--	--	--
I was treated with respect	--	--	--
I was seen for services on time	--	--	--
I received services when I needed them	--	--	--
If I had a complaint, it was handled well	--	--	--
I get along better with family members	--	--	--
I am doing better in school	--	--	--

Two (2) clients completed **Discharge Surveys** for this program between January 1 and June 30, 2016.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
I get along better with family members	100.0	0.0	0.0
I am doing better in school	100.0	0.0	0.0

Outpatient Children and Adolescents – Mental Health: Thirty-three (33) clients completed surveys between January 1 and June 30, 2016. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	81.8	18.2	0.0
I was treated with respect	84.8	15.2	0.0
I was seen for services on time	80.0	16.7	3.0
I received services when I needed them	87.5	12.5	0.0
If I had a complaint, it was handled well	87.5	12.5	0.0
I get along better with family members	97.0	0.0	3.0
I am doing better in school	***75.8***	21.2	3.0

Seven (7) clients completed Discharge Surveys between January 1 and June 30, 2016.

DISCHARGE SURVEYS

Item	Satisfied (%) [1]Indicates Below Criterion	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
I get along better with family members	100.0	0.0	0.0
I am doing better in school	100.0	0.0	0.0

Prevention/Diversion: Eight (8) clients completed Point in Time Surveys between January 1 and June 30, 2016. **POINT IN TIME**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect	100.0	0.0	0.0
I was seen for services on time	85.7	14.3	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	***66.7***	33.3	0.0
I get along better with family members	***75.0***	25.0	0.0
I am doing better in school	***66.7***	16.7	16.7

Five (5) clients completed **Discharge Surveys** between January 1 and June 30, 2016.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was seen for services on time	100.	0.0	0.0
I received services when I needed them	***60.0***	40.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
I get along better with family members	100.0	0.0	0.0
I am doing better in school	100.0	0.0	0.0

Alcohol Literacy Challenge: 427 youth completed the **Discharge Surveys** between January 1 and June 30, 2016.

NOTE: This is a one-session education curriculum. Therefore, youth only complete a discharge survey at the end of the session.

Item	Satisfied (%)	Dissatisfied (%)
Adults here treat me fairly	97.8	2.2
Adults here make the program exciting	91.0	9.0
I feel safe here	95.2	4.8
The program helps me do better in school	82.4	17.6
This program helps me stay active and healthy	***76.9***	23.1
This program helps me get along with other students	***77.6***	22.4
I enjoy coming here	82.4	17.6
I would tell my friends to come here	***77.9***	22.1

PRIME for Life: Thirty-two (32) youth completed the **Discharge Surveys** between January 1 and June 30, 2016.

NOTE: On the average, youth complete 4.5 sessions of the prevention curriculum. Therefore, youth only complete a discharge survey at the end of the session.

Item	Satisfied (%)	Dissatisfied (%)
Adults here treat me fairly	100.0	0.0
Adults here make the program exciting	90.3	9.7
I feel safe here	100.0	0.0
The program helps me do better in school	83.9	16.1
This program helps me stay active and healthy	93.5	6.5
This program helps me get along with other students	83.9	16.1
I enjoy coming here	***74.2***	25.8
I would tell my friends to come here	***71.0***	29.0

TEEN Intervene: Twenty-seven (27) youth completed the **Discharge Surveys** between January 1 and June 30, 2016.

NOTE: This is a three-session curriculum. Therefore, youth only complete a discharge survey at the end of the session.

Item	Satisfied (%)	Dissatisfied (%)
Adults here treat me fairly	100.0	0.0
Adults here make the program exciting	100.0	0.0
I feel safe here	100.0	0.0
The program helps me do better in school	100.0	0.0
This program helps me stay active and healthy	100.0	0.0
This program helps me get along with other students	100.0	0.0
I enjoy coming here	100.0	0.0
I would tell my friends to come here	100.0	0.0

Project SUCCESS: 436 youth completed the **Discharge Surveys** between January 1 and June 30, 2016.

NOTE: This is a four to eight-session curriculum. Therefore, youth only complete a discharge survey at the end of the session.

Item	Satisfied (%)	Dissatisfied (%)
Adults here treat me fairly	95.3	4.7
Adults here make the program exciting	80.0	20.0
I feel safe here	92.4	7.6
The program helps me do better in school	***67.7***	33.3
This program helps me stay active and healthy	***70.0***	30.0
This program helps me get along with other students	***67.2***	32.8
I enjoy coming here	***75.6***	24.4
I would tell my friends to come here	***71.1***	28.9

Case Management Children and Adolescents: Two (2) clients completed surveys between January 1 and June 30, 2016. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
I get along better with family members	0.0	100.0	0.0
I am doing better in school	100.0	0.0	0.0

No (0) clients completed **Discharge Surveys** between July 1 and December 31, 2015.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	--	--	--
I was treated with respect	--	--	--
I was seen for services on time	--	--	--
I received services when I needed them	--	--	--
If I had a complaint, it was handled well	--	--	--
I get along better with family members	--	--	--
I am doing better in school	--	--	--

2. Consumer Satisfaction with Primary Care Services

Objective: ≥ 80% of consumers will report satisfaction with primary care services at intake, every 6 months, and discharge.

Type of Objective: *Quality Assurance: Efficiency*

No (0) clients completed **Intake, 6-Month, or Discharge surveys** between January 1 and June 30, 2016.

The Guidance/Care Center did not begin admitting consumers to the Center for Wellness until August 2015. Challenges hiring qualified staff delayed enrollment into the program. The initial focus, therefore, was identifying and enrolling potential consumers to the Center's enrollment goal.

Action: The Center for Wellness staff will work with the Evaluator to develop and implement primary care specific perception surveys during the first biannual period of FY 2016-2017.

3. Staff Perception

Objective: ≥ 80% of the staff will report job satisfaction.

Type of Objective: *Quality Assurance: Efficiency*
G/CC conducted its Staff Perception Surveys during May 2016 using Survey Monkey. The questionnaire consisted of 10 questions. The survey went to 120 staff. Thirty-four (34) staff completed the survey. This is a response rate of 28.3%. G/CC uses an 80% criterion to determine staff satisfaction. The table below depicts the results. Those items having a symbol by the percentage fell below criterion.

Question	**Percent Agreeing** **👎= Below 80% Criterion 👎👎👎 3rd Year Below Criterion**
I know what is expected with me at work and am familiar with my job responsibilities	94.1%
I have the materials and equipment I need to do my job right	60.6%👎👎👎
I receive the level of supervision that is required	88.2%
I feel respected and my ideas and input are valued	85.3%
Our agency's mission makes me feel like my job is important.	85.3%
During the last year, I had opportunities at work to learn and grow	85.3%
I received a thorough orientation to G/CC and my job duties when I began employment	81.8%
I am familiar with the G/CC Health and Safety Plan	97.0%
Overall, I am satisfied with my job	81.8%
At my annual review, I was given the opportunity to contribute my input.	77.8%👎

Action: Twenty-percent (20%; N=2) of the items fell below the 80% criterion. The Clinical Care Committee, in collaboration with the HR Committee, will seek additional anonymous input from staff to identify specific reasons for staff endorsing these items in the negative direction. Based on the findings, the Committees will initiate a Performance Improvement initiative to improve situations or circumstances to increase staff perceptions.

4. Stakeholder Perception

Objective: ≥ 80% of stakeholders will have a positive perception of G/CC and its services.

Type of Objective: *Quality Assurance: Efficiency*
G/CC conducted its Stakeholder Survey in May 2016 using Survey Monkey. The questionnaire consisted of 10 questions. The person sending the survey did not indicate the total number of stakeholders who received it. Therefore, GCC could not calculate a response rate. Thirty-one (31) stakeholders completed the survey. Twenty-five (25) respondents were from the Lower Keys, four (4) from the Middle Keys, and two (2) from the Upper Keys. G/CC uses an 80% criterion to determine stakeholder perception. The table below depicts the results. Those items having a symbol by the percentage fell below criterion.

Question	**Percent** **= Below 80% Criterion = 3rd Year Below Criterion**
Knowledge of Service Provision • Detox • Crisis Stabilization • Child/Family Counseling • Free HIV Testing • Transportation • Substance Abuse Counseling	 48.4% 67.7% 83.9% 45.2% 32.3% 96.8%
How did you hear about us? • Received services • Word of mouth • Website/E-mail • Brochures • Other	 10.0% 33.3% 13.3% 6.7% 63.3%
To what extent do you find G/CC responsive with questions, concerns, or requests from you agency or family?	80.6%
To what extent do you feel G/CC is meeting your needs as a community partner or individual?	71.0%
To what extent is G/CC providing services that are relevant to our community?	77.4%
How would you rate G/CC's overall interaction with your agency or family?	83.9%
How would you rate G/CC's responses to you with regard to our being prompt and timely?	71.0%

How would you rate the overall quality of G/CC? • Superior • Very Good • Average • Poor • Unacceptable	 16.3% 32.3% 25.8% 25.8% 0.0%

Action: Forty percent (40%; N=4)) of the items fell below the 80% criterion. However, the responses received were significantly higher than last Fiscal Year (N=13). Overall, the "superior" rating decreased from 41.7% in FY 2014-2015 to 16.3% this Fiscal Year. In addition, during Fiscal Year 2014-2015, GCC had no "poor" ratings. It increased to 25.8% this fiscal year. The Keys Leadership Team and Performance Improvement Committee will explore possible factors for the changes and develop a PI initiative based on the findings.

5. Transportation Perception

Objective: ≥ 80% of consumers have a positive perception of G/CC transportation services.

Type of Objective: *Quality Assurance: Efficiency*

G/CC surveyed consumers regarding perceptions of G/CC transportation services in May 2016. The questionnaire consisted of 14 questions. One hundred sixteen (116) consumers completed the survey. G/CC uses an 80% criterion to determine staff satisfaction. The table below depicts the results. Those items having a symbol by the percentage fell below criterion.

Question	**Percent**
The van arrived at the scheduled time today	91.4%
The time I am riding now is a convenient one for me.	94.8%
The driver is pleasant and courteous.	96.6%
The inside of the van is clean.	95.7%
I have enough room to sit.	90.5%
The seat is comfortable.	86.2%
The ride did not take too long.	94.8%
The driver does not drive too fast.	94.0%
The driver does not make sudden movement in the van.	91.4%
The person on the phone was polite and courteous.	91.8%
The person on the phone was helpful.	91.4%
I knew w/in 24 hours that I would be able to ride at the time I wanted.	91.7%
I would choose GCC even if there were another transportation company I could use.	95.0%
Overall Responses	Positive : 75.5% Negative: 3.8% No Opinion: 20.7%

C. Follow-Up

1. GPRA and GAIN overall follow-up rate for the ORP grant at 3, 6, and 12 months

Objective: 80% of the clients will complete the follow-ups

Objective Type: *Quality Assurance: Efficiency*

OLD ORP: The contract with SAMHSA began September 30, 2012 and ended on January 31, 2016.

Scale	3-Month	6-Month	12-Month
GPRA	NA	89.0%	NA
GAIN	89.0%	82.0%	76.0%

The Guidance/Care Center did very well with tracking clients for the 6-month GPRA follow-up. The SAMHSA requirement is a minimum of 80%.

NEW ORP: The contract with SAMHSA began September 30, 2015. G/CC began enrolling clients in October 2015. Therefore, the first GPRA 6-month follow-up assessments occurred in April 2016.

Scale	3-Month	6-Month	12-Month
GPRA	NA	100.0%	NA
GAIN	92.0%	69.0%	NONE DUE

The Guidance/Care Center 6-month follow-up rate for the GPRA is 100%. G/CC collected 12 out of 12 assessments. The G/CC follow-up rate is higher than the average SAMHSA grantee rate of 64.4%.

The Guidance/Care Center 3-month follow-up rate is above the SAMHSA expected rate of 80%. The 6-month follow-up rate is below the expected 80%. G/CC had 13 6-month follow-ups due and collected nine (9). Two clients did not complete a follow-up. G/CC could not locate on of them. The other one, although G/CC located the client, refused to complete the follow-up GAIN. Two clients remain in the "active" window for data collection.

2. GAIN "on-time" follow-up rate for 3, 6, and 12 months

Objective: 80% of the follow-ups completed will be within the "on-time" window

Objective Type: *Quality Assurance: Efficiency*

OLD ORP: The contract with SAMHSA began September 30, 2012 and ended on January 31, 2016. Although the overall follow-up rate is important, SAMHSA requires that staff complete majority of GAIN follow-ups within 2 week prior to or 2 weeks post the actual due date. This is the on-time window.

Scale	3-Month	6-Month	12-Month
GAIN	79.0%	71.0%	74.0%

NEW ORP: The contract with SAMHSA began September 30, 2015. G/CC began enrolling clients in October 2015.

Scale	3-Month	6-Month	12-Month
GAIN	100.0%	100.0%	NONE DUE

3. GPRA and GAIN overall follow-up rate for the PBHCI (Primary Care) grant at 3, 6, and 12 months

Objective: 80% of the clients will complete the follow-ups

Objective Type: *Quality Assurance: Efficiency*

Scale	3-Month	6-Month	12-Month
GAIN	37.0%	38.0%	0.0%

The Guidance/Care Center follow-up rate at the 3- and 6-month periods is below the required SAMHSA 80% rate.

4. GAIN "on-time" follow-up rate for PBHCI (Primary Care) grant at 3, 6, and 12 months

Objective: 80% of the follow-ups completed will be within the "on-time" window

Objective Type: *Quality Assurance: Efficiency*

Scale	3-Month	6-Month	12-Month
GAIN	55.0%	51.0%	0.0%

5. Post Discharge Follow-Up Survey

Objective: ≥10 surveys completed quarterly

Objective Type: *Performance Improvement: Efficiency*

During the biannual period January 1 – Jun e30, 2016, G/CC did not collect any post discharge follow-up surveys.

Employment	Full-Time	Part-Time	Seeking	Unemployed
Adults Only	--	--	--	--

Residential Status	Independent Living	Dependent Living	ALF	Nursing Home	Corrections Facility	Homeless	Other
	--	--	--	--	--	--	--

Discharge Plan Follow Up	Attending Appointment as prescribed	Attending Most Appointments	Attending NA/AA	Not Seeing Follow Up Practitioner	Taking Medication as Prescribed	Not Taking Medication as Prescribed
	--	--	--	--	--	--

SA or MH Readmission	Yes	No
	--	--

Followed Up with Referrals	Yes	No
	--	--

Criminal Justice Involvement	Yes	No
	--	--

Access To Primary Care	Yes	No
	--	--
ER Admissions	**Yes**	**No**
	--	--

Involvement with Community Activities	Church	AA\NA	Volunteer Work	Other
	--	--	--	--

Maintained Contact with GCC	Yes	No
	--	--

GCC/WestCare upholds the motto "Uplifting the Human Spirit"	Yes	No
	--	--

6. Intake Survey

Between January 1 and June 30, 2016, G/CC collected 166Admission Surveys. One hundred forty-two (142) were from adults and 24 from children/adolescents.

The survey consists of 22 items. Six items are information only items rated as "Yes" or "No." The remaining 16 items evaluate the clients' perceptions of the admission process. Ratings for these items use a 4-point Likert scale, ranging from Strongly Agree to Strongly Disagree.

Adult Admissions

Item	Satisfied (%)	Dissatisfied (%)
When I walked into G/CC to ask about services…		
My questions were answered	100.0	0.0
I understood the information that was given to me	99.3	0.7
The information given to me was correct	98.6	1.4
It was easy to get an appointment for intake	94.7	5.3
During my intake assessment…		
The admission staff were welcoming	98.6	1.4
I was comfortable in the waiting area	92.5	7.5
My questions were fully answered	99.3	0.7
The admissions process was explained to me	97.1	2.9
I understood the explanation of the admission process	97.1	2.9
There was too much paperwork (reverse scored)	***84.8 (Agree)***	15.2 (Disagree)
The Admission staff understood my needs	97.9	2.1
I felt the admission counselor listened to me	99.3	0.7
I thought the process took too long (reverse scored)	***59.6 (Agree)***	40.4 (Disagree)
Thinking about the telephone contact and the intake assessment together, these helped me get prepared for treatment	99.3	0.7
G/CC could improve the admission process (reverse scored)	***43.7 (Agree)***	56.3 (Disagree)

Would you refer friends with similar problems to yours to G/CC? Yes = 95.6%

Overall, were you satisfied with the admission process? Yes = 97.8%

Child/Adolescent Admissions

Item	Satisfied (%)	Dissatisfied (%)
When I walked into G/CC to ask about services…		
My questions were answered	100.0	0.0
I understood the information that was given to me	100.0	0.0
The information given to me was correct	100.0	0.0
It was easy to get an appointment for intake	100.0	0.0
During my intake assessment…		
The admission staff were welcoming	100.0	0.0
I was comfortable in the waiting area	100.0	0.02
My questions were fully answered	100.0	0.0
The admissions process was explained to me	100.0	0.0
I understood the explanation of the admission process	100.0	0.0
There was too much paperwork (reverse scored)	***95.8 (Agree)***	4.2 (Disagree)
The Admission staff understood my needs	100.0	0.0
I felt the admission counselor listened to me	100.0	0.0
I thought the process took too long (reverse scored)	***95.8 (Agree)***	4.2 (Disagree)

Thinking about the telephone contact and the intake assessment together, these helped me get prepared for treatment	95.8	4.2
G/CC could improve the admission process (reverse scored)	***82.2 (Agree)***	17.8

Would you refer friends with similar problems to yours to G/CC? Yes = 95.8%

Overall, were you satisfied with the admission process? Yes = 100.0%

D. Clinical Records

1. Compliance of treatment program records with 65D 30 , CARF standards, and P & P

Objective: ≥ 80% of treatment records will comply.

Type of Objective: *Quality Assurance: Efficiency*

Between January 1 and June 30, 2016, staff completed 172 Peer Reviews across three (3) G/CC Locations: Key West, Marathon, and Key Largo. Staff reviewed a sampling of charts from all Core Programs. Eighty-seven (87) records were for active clients, and 85 were for closed cases. The breakdown is as follows:

Core Program	Number of Clinical Records	Open Charts	Closed Charts
Adult Mental Health	30	16	14
Adult Substance Abuse	23	11	12
Child Mental Health	21	11	10
Child Substance Abuse	4	0	4
Diversion/Intervention	14	9	5
Level 2 Prevention	9	4	5
Adult Case Management	20	10	10
Child Case Management	15	8	7
CSU	4	0	4
Detox	2	0	2
Criminal Justice	10	5	5
Integrated	10	3	7
Community Integration	6	6	0
FITT	4	4	0
Total	**172**	**87**	**85**

Although the Peer Review Form is extensive and measures chart compliance and quality across all areas of 65D 30, CARF, Medicaid, and CCISC, the following are key findings from the audit. A 3-point scale measures each item, ranging from Not Compliant to Partially Compliant to Compliant. The tables below reflect the percent of charts that were fully compliant with each key item.

ALL TREATMENT PROGRAMS (Excludes Diversion & Prevention)

Section	Average Total Percent (100% highest possible score)
Legal Information	96.1% ↓
Screening and Admission	97.9% ↑
Psychosocial Assessment/In-Depth Evaluation	86.7% ↑
Initial/Preliminary Treatment Plan	74.1% ↓
Wellness & Recovery Plans and Reviews	83.9% ↓
Progress Notes	95.5% ↑
Medication Orders (if applicable)	96.0% ↓
Medical Plan & Progress Notes (if applicable)	94.4% =
Service Plans	82.3% ↑
Case Management Progress Notes	97.6% ↑
Disclosure Log	35.1%
Discharge/Transition Reporting	84.6% ↑

Content Area	% Compliant
Immediate or Urgent Needs Documented	91.7% ↓
AST or Other Screening Completed	79.2% ↓
Consent to Treatment Signed	91.9% ↓
Information Regarding Rights/Responsibilities	91.9% ↓
Information Regarding Grievance Procedure	94.6% ↓
Information on HIPAA	91.9% ↓
Screening Summary Provides Rationale for Level of Care	100.0% ↑
SMQ R 6 Completed	86.1% ↓
SNAP Form Completed	78.8% ↓
Interpretive Summary Complete	91.7% ↑
Preliminary Plan Completed at Admission	80.6% ↓
Life Goal in Client's Own Words	80.8% ↓
Wellness & Recovery Plan Reflects Interpretive Summary	80.8% ↑
Wellness & Recovery Plan Completed on Time	79.2% ↑
Plan Objectives are Behavioral & Measurable	79.2% ↓
Plan Reviews Include Client's Assessment of Progress	65.0% ↓
Plan Reviews Completed On-Time (for those having reviews due)	50.0% ↓
Medication Orders Indicate Primary MD*	100.0% =
Signed Consent for Medication	91.7% ↓
Copy of Prescriptions in Clinical Record*	100.0% =

ADULT MENTAL HEALTH

Section	Average Total Percent (100% highest possible score)
Legal Information	100.0% ↑
Screening and Admission	96.7% =
Psychosocial Assessment/In-Depth Evaluation	89.7% ↓
Initial/Preliminary Treatment Plan	92.8% ↑
Wellness & Recovery Plans and Reviews	98.5% ↑
Progress Notes	100.0% ↑
Medication Orders (if applicable)	100.0% =
Medical Progress Notes (if applicable)	89.0% ↓
Service Plans	100.0% =
Case Management Progress Notes	81.0%
Disclosure Log	30.0%
Discharge/Transition Reporting	84.3% ↓

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% =
AST or Other Screening Completed	66.7% ↓
Consent to Treatment Signed	80.0% ↓
Information Regarding Rights/Responsibilities	80.0% ↓
Information Regarding Grievance Procedure	90.0% ↓
Information on HIPAA	80.0% ↓
Screening Summary Provides Rationale for Level of Care	0.0% ↓
SMQ R 6 Completed	70.0% ↓
SNAP Form Completed	62.5% ↓
Interpretive Summary Completed	77.8% ↓
Preliminary Plan Completed at Admission	90.0% ↑
Life Goal in Client's Own Words	100.0% ↑
Wellness & Recovery Plan Reflects Interpretive Summary	100.0% ↑
Wellness & Recovery Plan Completed on Time	80.0% ↑
Plan Objectives are Behavioral & Measurable	80.0% ↑
Plan Reviews Include Client's Assessment of Progress	100.0% =
Plan Reviews Completed On-Time (for those having reviews due)	50.0% ↓
Medication Orders Indicate Primary MD*	100.0% =
Signed Consent for Medication	83.3% ↓
Copy of Prescriptions in Clinical Record*	100.0% =

*Only rated for clients receiving medication

CHILD MENTAL HEALTH

Section	Average Total Percent (100% highest possible score)
Legal Information	90.0% ↓
Screening and Admission	82.3% ↓
Psychosocial Assessment/In-Depth Evaluation	75.4% ↑
Initial/Preliminary Treatment Plan	61.6% ↓
Wellness & Recovery Plans and Reviews	70.3% ↓
Progress Notes	88.9% ↓
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	100.0% =
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	79.4% ↓

Content Area	% Compliant
Immediate or Urgent Needs Documented	90.9% ↓
GAIN Q Complete	80.0% ↓
Consent to Treatment Signed	81.8% ↓
Information Regarding Rights/Responsibilities	81.8% ↓
Information Regarding Grievance Procedure	81.8% ↑
Information on HIPAA	90.9% ↑
GRRS Edited to Remove All Prompts	80.0% ↓
GRRS Provides Rationale for Level of Care	80.0% ↓
SMQ R 6 Completed	90.9% ↑
SNAP Form Completed	90.9% ↑
GRRS Edited to be Individualized	80.0% ↓
Preliminary Plan Completed at Admission	90.0% ↑
Life Goal in Client's Own Words	72.7% ↓
Wellness & Recovery Plan Reflects GRRS	90.9% ↑
Wellness & Recovery Plan Completed on Time	81.8% ↑
Plan Objectives are Behavioral & Measurable	90.0% ↑
Plan Reviews Include Client's Assessment of Progress	80.0% ↑
Plan Reviews Completed On-Time (for those having reviews due)	40.0% ↓
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medication	100.0% =
Copy of Prescriptions in Clinical Record*	NA

*Only rated for clients receiving medication

INPATIENT (CSU and Detox Combined): G/CC did not conduct Peer Reviews for Open Charts during this Biannual Period.

Section	Average Total Percent (100% highest possible score)
Legal Information	--
Screening and Admission	--
Psychosocial Assessment/In-Depth Evaluation	--
Initial/Preliminary Treatment Plan	--
Wellness & Recovery Plans and Reviews	--
Progress Notes	--
Medication Orders (if applicable)	--
Medical Progress Notes (if applicable)	--
Service Plans	--
Case Management Progress Notes	--
Discharge/Transition Reporting	--

Content Area	% Compliant
Immediate or Urgent Needs Documented	--
Consent to Treatment Signed	--
Information Regarding Rights/Responsibilities	--
Information Regarding Grievance Procedure	--
Information on HIPAA	--
Preliminary Plan Completed at Admission	--
Wellness & Recovery Plan Completed on Time	--
Plan Objectives are Behavioral & Measurable	--
Medication Orders Indicate Primary MD*	--
Signed Consent for Medication	--
Copy of Prescriptions in Clinical Record*	--

*Only rated for clients receiving medication

Criminal Justice

Section	Average Total Percent (100% highest possible score)
Legal Information	100.0% ↑
Screening and Admission	100.0% ↑
Psychosocial Assessment/In-Depth Evaluation	82.0% ↓
Initial/Preliminary Treatment Plan	100.0% =
Wellness & Recovery Plans and Reviews	99.0% ↑
Progress Notes	100.0% ↑
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	62.6% ↓

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% =
GAIN Q Complete	NA
Consent to Treatment Signed	100.0% =
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
QRRS Edited to Remove All Prompts	NA
QRRS Provides Rationale for Level of Care	NA
SMQ R 6 Completed	100.0% ↑
SNAP Form Completed	100.0% =
GRRS Edited to be Individualized	100.0% =
Preliminary Plan Completed at Admission	100.0% =
Life Goal in Client's Own Words	100.0% ↑
Wellness & Recovery Plan Reflects GRRS	100.0% ↑
Wellness & Recovery Plan Completed on Time	100.0% ↑
Plan Objectives are Behavioral & Measurable	100.0% ↑
Plan Reviews Include Client's Assessment of Progress	100.0% =
Plan Reviews Completed On-Time (for those having reviews due)	100.0% =
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medication	NA
Copy of Prescriptions in Clinical Record*	NA

*Only rated for clients receiving medication

ADULT CASE MANAGEMENT

Section	Average Total Percent (100% highest possible score)
Legal Information	100.0% =
Screening and Admission	85.8% ↓
Psychosocial Assessment/In-Depth Evaluation	68.0% ↓
Initial/Preliminary Treatment Plan	43.8% ↓
Wellness & Recovery Plans and Reviews	99.8% =
Progress Notes	100.0% =
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	88.3% ↑
Case Management Progress Notes	79.4% ↑
Discharge/Transition Reporting	82.5% ↑

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% =
GAIN Q Complete	75.0% ↓
Consent to Treatment Signed	80.0% ↓
Information Regarding Rights/Responsibilities	100.0% ↑
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
GRRS Edited to Remove All Prompts	75.0% ↓
GRRS Provides Rationale for Level of Care	75.0% ↓
SMQ R 6 Completed	60.0% ↓
SNAP Form Completed	100.0% ↑
GRRS Edited to be Individualized	80.0% ↓
Preliminary Plan Completed at Admission	50.0% ↓
Service Plan Completed	100.0% ↑
Consent for Case Management	100.0% ↑
Plan Objectives are Behavioral & Measurable	100.0% ↑
Case Management Notes Indicate Progress Made on Goals & Objectives	60.0% ↑
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medication	NA
Copy of Prescriptions in Clinical Record*	NA

*Only rated for clients receiving medication

CHILD CASE MANAGEMENT

Section	Average Total Percent (100% highest possible score)
Legal Information	85.7% ↓
Screening and Admission	82.2% ↓
Psychosocial Assessment/In-Depth Evaluation	96.4% ↑
Initial/Preliminary Treatment Plan	100.0% ↑
Wellness & Recovery Plans and Reviews	64.3% ↓
Progress Notes	NA
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	99.0% ↑
Case Management Progress Notes	100.0% ↑
Discharge/Transition Reporting	66.4% ↓

Content Area	% Compliant
Immediate or Urgent Needs Documented	87.50% ↓
GAIN Q Complete	80.0% ↓
Consent to Treatment Signed	87.5% ↓
Information Regarding Rights/Responsibilities	87.5% ↓
Information Regarding Grievance Procedure	87.5% ↓
Information on HIPAA	87.5% ↓
QRRS Edited to Remove All Prompts	60.0% ↓
QRRS Provides Rationale for Level of Care	100.0% =
SMQ R 6 Completed	87.5% ↓
SNAP Form Completed on Time	87.5% ↓
GRRS Edited to be Individualized	83.3% ↑
Preliminary Plan Completed at Admission	83.3% ↓
Service Plan Completed	71.4% ↓
Consent for Case Management	100.0% ↑
Plan Objectives are Behavioral & Measurable	100.0% ↑
Case Management Notes Indicate Progress Made on Goals & Objectives	100.0% ↑
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medication	NA
Copy of Prescriptions in Clinical Record*	NA

*Only rated for clients receiving medication

Adult Substance Abuse

Section	Average Total Percent (100% highest possible score)
Legal Information	100.0% =
Screening and Admission	96.2% ↓
Psychosocial Assessment/In-Depth Evaluation	88.4% ↑
Initial/Preliminary Treatment Plan	90.6% ↑
Wellness & Recovery Plans and Reviews	81.6% ↑
Progress Notes	90.8% ↓
Medication Orders (if applicable)	92.0% =
Medical Progress Notes (if applicable)	94.3% ↓
Service Plans	NA
Case Management Progress Notes	NA
Disclosure Log	50.0%
Discharge/Transition Reporting	90.3% ↓

Content Area	% Compliant
Immediate or Urgent Needs Documented	81.3% ↓
AST or Other Screening Completed	100.0% =
Consent to Treatment Signed	100.0% =
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
Screening Summary Provides Rationale for Level of Care	100.0% =
SMQ R 6 Completed	90.9% ↓
SNAP Form Completed	88.9% ↓
Interpretive Summary Completed	100.0% =
Preliminary Plan Completed at Admission	90.9% ↓
Life Goal in Client's Own Words	90.9% ↓
Wellness & Recovery Plan Reflects GRRS	90.9% ↓
Wellness & Recovery Plan Completed on Time	90.9% ↓
Plan Objectives are Behavioral & Measurable	90.9% ↓
Plan Reviews Include Client's Assessment of Progress	50.0% ↓
Plan Reviews Completed On-Time (for those having reviews due)	62.5% ↓
Medication Orders Indicate Primary MD*	100.0% =
Signed Consent for Medication	100.0% =
Copy of Prescriptions in Clinical Record*	100.0% =

*Only rated for clients receiving medication

Children's Substance Abuse

Section	Average Total Percent (100% highest possible score
Legal Information	100.0% =
Screening and Admission	73.8% ↓
Psychosocial Assessment/In-Depth Evaluation	95.5% ↑
Initial/Preliminary Treatment Plan	68.8% ↑
Wellness & Recovery Plans and Reviews	92.0% ↓
Progress Notes	95.8% ↑
Medication Orders (if applicable)	100.0%
Medical Progress Notes (if applicable)	100.0%
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	NA

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% =
GAIN Q Complete	100.0% =
Consent to Treatment Signed	100.0% =
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
GRRS Edited to Remove All Prompts	33.3% ↓
GRRS Provides Rationale for Level of Care	33.3% ↓
SMQ R 6 Completed	33.3% ↓
SNAP Form Completed	50.0% ↓
GRRS Edited to be Individualized	100.0% ↑
Preliminary Plan Completed at Admission	100.0% ↑
Life Goal in Client's Own Words	100.0% ↑
Wellness & Recovery Plan Reflects GRRS	100.0% ↑
Wellness & Recovery Plan Completed on Time	75.0% ↓
Plan Objectives are Behavioral & Measurable	100.0% ↑
Plan Reviews Include Client's Assessment of Progress	100.0% ↑
Plan Reviews Completed On-Time (for those having reviews due)	25.0% ↓
Medication Orders Indicate Primary MD*	100.0%
Signed Consent for Medication	100.0% =
Copy of Prescriptions in Clinical Record*	100.0%

*Only rated for clients receiving medication

FITT

Section	Average Total Percent (100% highest possible score
Legal Information	100.0%
Screening and Admission	100.0%
Psychosocial Assessment/In-Depth Evaluation	100.0%
Initial/Preliminary Treatment Plan	100.0%
Wellness & Recovery Plans and Reviews	89.0%
Progress Notes	100.0%
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	88.0%
Case Management Progress Notes	100.0%
Disclosure Log	0.0%
Discharge/Transition Reporting	NA

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0%
AST or Other Screen Completed	100.0%
Consent to Treatment Signed	100.0%
Information Regarding Rights/Responsibilities	100.0%
Information Regarding Grievance Procedure	100.0%
Information on HIPAA	100.0%
Screening Summary Provides Rationale for Level of Care	NA
SMQ R 6 Completed	100.0%
SNAP Form Completed	100.0%
GRRS Edited to be Individualized	100.0%
Preliminary Plan Completed at Admission	100.0%
Life Goal in Client's Own Words	100.0%
Wellness & Recovery Plan Reflects GRRS	100.0%
Wellness & Recovery Plan Completed on Time	100.0%
Plan Objectives are Behavioral & Measurable	100.0%
Plan Reviews Include Client's Assessment of Progress	100.0%
Plan Reviews Completed On-Time (for those having reviews due)	0.0%
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medication	NA
Copy of Prescriptions in Clinical Record*	NA

*Only rated for clients receiving medication

G/CC uses a Peer Review Form that is more appropriate for the ***Diversion and Prevention Level 2*** clinical Records.

Diversion

Section	Average Total Percent (100% highest possible score)
Screening and Admission	100.0% ↑
Assessment	100.0% ↑
Initial/Preliminary Treatment Plan	34.7% ↓
Wellness & Recovery Plans and Reviews	NA
Prevention Plan and Reviews	100.0%
Prevention Summary Notes	--
Discharge/Transition Reporting	83.3% ↓

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% =
GAIN Q or Biopsychosocial Completed	100.0% ↑
Consent to Participate Signed	100.0% ↑
Information Regarding Rights/Responsibilities	87.5% ↓
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
QRRS Edited to Remove All Prompts	71.4% ↓
QRRS Provides Rationale for Level of Care	71.4% ↓
SMQ R 6 Completed	57.1% ↓
SNAP Form Completed	57.1% ↓
GRRS or Interpretive Summary Completed	62.5% ↓
Preliminary Plan Completed at Admission	62.5% ↓
Life Goal in Client's Own Words	62.5% ↑
Wellness & Recovery Plan Reflects GRRS	50.0% ↓
Wellness & Recovery Plan Completed on Time	50.0% ↑
Plan Objectives are Behavioral & Measurable	50.0% ↓
Plan Reviews Include Client's Assessment of Progress	20.0% ↓
Plan Reviews Completed On-Time (for those having reviews due)	20.0% ↓

*Only rated for clients receiving medication

Prevention Level 2

Section	Average Total Percent (100% highest possible score)
Screening and Admission	77.0% =
Assessment	100.0% ↑
Initial/Preliminary Treatment Plan	--
Wellness & Recovery Plans and Reviews	--
Prevention Plan and Reviews	47.0% ↓
Prevention Summary Notes	100.0% ↑
Discharge/Transition Reporting	100.0% ↑

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% ↑
Consent to Participate Signed	100.0% ↑
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
Preliminary Plan Completed at Admission	--
Plan Indicates Risk Factors	50.0% ↓
Plan Indicates Protective Factors	50.0% =
Plan Identifies Goals Specific to Client	50.0% =
Plan Objectives are Behavioral & Measurable	25.0% ↓
Summary Notes Include Risk & Protective Factors Addressed	100.0% ↑
Summary Notes Include Progress on Goals and Objectives	100.0% ↑

Community Integration

Section	Average Total Percent (100% highest possible score)
Legal Information	100.0% =
Screening and Admission	100.0%
Psychosocial Assessment/In-Depth Evaluation	NA
Initial/Preliminary Treatment Plan	NA
Wellness & Recovery Plans and Reviews	100.0% ↑
Progress Notes	100.0% =
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	--

Content Area	% Compliant
Life Goal in Client's Own Words	100.0% ↑
Consent for Treatment	100.0%
Information Regarding Rights/Responsibilities	100.0%
Information Regarding Grievance Procedure	100.0%
Information on HIPAA	100.0%
Wellness & Recovery Plan Reflects GRRS	NA
Wellness & Recovery Plan Completed on Time	NA
Plan Objectives are Behavioral & Measurable	NA
Plan Reviews Include Client's Assessment of Progress	NA
Plan Reviews Completed On-Time (for those having reviews due)	NA
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medications	NA
Copy of Prescriptions in Clinical Record*	NA

*Only rated for clients receiving medication

Integrated

Section	Average Total Percent (100% highest possible score)
Legal Information	100.0% ↑
Screening and Admission	100.0% ↑
Psychosocial Assessment/In-Depth Evaluation	86.0% ↓
Initial/Preliminary Treatment Plan	75.0% ↓
Wellness & Recovery Plans and Reviews	11.0% ↓
Progress Notes	78.0% ↓
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	100.0% ↑
Service Plans	NA
Case Management Progress Notes	NA
Disclosure Log	50.0% ↓
Discharge/Transition Reporting	84.8% ↑

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% =
AST or Other Screen Completed	100.0% =
Consent to Treatment Signed	100.0% =
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
Screening Summary Provides Rationale for Level of Care	NA
SMQ R 6 Completed	100.0% =
SNAP Form Completed	100.0% =
Interpretive Summary Completed	100.0%
Preliminary Plan Completed at Admission	100.0% =
Life Goal in Client's Own Words	33.3% ↓
Wellness & Recovery Plan Reflects Interpretive Summary	33.3% ↓
Wellness & Recovery Plan Completed on Time	33.3% ↓
Plan Objectives are Behavioral & Measurable	33.3% ↓
Plan Reviews Include Client's Assessment of Progress	0.0% ↓
Plan Reviews Completed On-Time (for those having reviews	0.0% ↓

due)	
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medications	100.0%
Copy of Prescriptions in Clinical Record*	100.0%

*Only rated for clients receiving medication

Staff reviewed 75 closed ***treatment charts***. Findings are as follows:

Content Area	% Compliant
Discharge Summary Completed	93.8% ↑
Discharge Report Includes Reason for Discharge	96.9% ↑
Discharge Report Includes Recommendations & Referrals	96.9% ↑
Discharge Report Includes Evaluation of Progress	93.8% ↑
Discharge/Transfer ASAM Completed	100.0% ↑
SISAR Completed	100.0% ↑
MH Outcome Completed	81.8% ↓
FARS/CFARS Completed	80.0% ↓
Wellness & Recovery Plans Closed	70.0% ↑
Service Plans Closed	NA

Staff reviewed 13 closed ***diversion and prevention charts.*** Findings are as follows:

Content Area	% Compliant
Discharge Summary Completed	91.7% ↑
Discharge Report Includes Reason for Discharge	84.6% ↑
Discharge Report Includes Recommendations & Referrals	92.3% ↑
Discharge Report Includes Evaluation of Progress	100.0% ↑
Discharge/Transfer ASAM Completed	90.0% ↑
SISAR Completed	92.3% ↑
Wellness & Recovery Plans Closed	66.7% ↑

2. Utilization Management

   Objective: ≥ 95% of clinical records score ≥ 95% on the UM Review Form.

   Type of Objective: *Quality Assurance: Efficiency*

   The Chief Clinical Officer (CCO) completed the final version of the Utilization Management Review Form in February 2015 and sent it to staff for feedback. The CCO developed admission, continued stay, and discharge forms for Outpatient Mental Health, Outpatient Substance Abuse, and Residential Substance Abuse. Although G/CC intended to begin using the forms in Fiscal Year 2015-2016, the CCO delayed implementation because of numerous competing priorities.

3. Billing, Documentation and Data Consistency

Objective: ≥ 95% of the clinical documentation will support the service tickets

Type of Objective: *Performance Improvement: Efficiency*

During the Peer Review process, clinical staff compares notes in the chart to the billing provided by accounting for each client under review. During this process, staff reviewed 1,207 services delivered from January 1 through June 30, 2016. 68.1% of the billed services had corresponding notes in the clinical record.

A subsequent analysis looked at the correspondence between the billing and notes in the clinical record at each location.

Location	Total Number of Notes	Billing with Corresponding Note %(N)
Key Largo	430	66.7% (287) =
Marathon	397	69.8% (277) ↓
Key West	380	679% (258) ↓

Another analysis looked at correspondence between billing and notes for each program across all locations.

Program (Across All Locations)	Total Number of Notes	Billing with Corresponding Note %(N)
CMH OP	191	51.8% (99) ↓
CSA OP	8	100.0% (8) ↑
AMH OP	53	60.4% (32) ↓
ASA OP	95	87.4% (83) ↑
Case Management - Adult	177	71.2% (126) ↓
Case Management - Child	1	0.0% (0) ↓
JIP	149	81.2% (121) ↓
Diversion	137	67.9% (93) ↑
Community Integration	206	77.2% (159) ↑
ORP	66	50.0% (33) ↓
Integrated SA/MH	67	46.3% (31) ↓
FITT	30	75.0% (21)
Prevention	27	76.7% (23) ↑

The final set of analyses looked at the correspondence between billing and notes for each program at each location.

Program – KEY LARGO	Total Number of Notes	Billing with Corresponding Note %(N)
CMH OP	134	67.2% (90) ↓
CSA OP	1	100.0% (1)
AMH OP	46	69.6% (32) ↑
ASA OP	43	95.3% (41) ↑
Case Management - Adult	85	48.2% (41) ↓
Case Management - Child	--	--
Diversion	93	65.6% (61)
Integrated SA/MH	28	75.0% (21) ↓
FITT	--	--
Prevention	--	--

Program - MARATHON	Total Number of Notes	Billing with Corresponding Note %(N)
CMH OP	32	25.0% (8) ↓
CSA OP	--	--
AMH OP	7	0.0% (0)
ASA OP	44	79.5% (35) ↑
Case Management - Adult	49	93.9% (46) ↓
Case Management - Child	--	--
Diversion	35	65.7% (23)
Community Integration	206	77.2% (159) ↑
Integrated SA/MH	24	25.0% (6)
FITT	--	--
Prevention	--	--

Program – KEY WEST	Total Number of Notes	Billing with Corresponding Note %(N)
CMH OP	25	4.0% (1) ↓
CSA OP	7	100.0% (7) ↑
AMH OP	--	--
ASA OP	8	87.5% (7) ↓
Case Management - Adult	43	90.7% (39) ↑
Case Management - Child	1	0.0% (0) ↓
JIP	149	81.2% (121) ↓
Diversion	9	100.0% (9) ↑
ORP	66	50.0% (33) ↓
Integrated SA/MH	15	26.7% (4)
FITT	30	76.7% (23)
Prevention	27	51.9% (14)

Action: The Chief Clinical Officer will review the data with the Clinical Director, Clinical Coordinators, and Site Directors. Although most of the programs or locations failed to achieve the 95% target, majority of the programs and locations significantly increased the corresponding documentation between billing and the clinical record compared to the previous Fiscal Year.

E. Quality of Care and Service Provision

1. Identify number of consumers (SA & MH) identified as needing primary care in the outpatient and home-based treatment programs.

Objective: G/CC will identify at least 95% of the consumers who need primary care.

Type of Objective: *Quality Assurance: Efficiency*

See ***CQI Annual Update Report*** (attached), Section V, submitted to SFBHN in July 2016 for progress on this item.

2. Number of consumers (SA & MH) linked to primary care

Objective: G/CC successfully will link 60% of consumers needing primary care to a provider

Type of Objective: *Quality Assurance: Efficiency*

See ***CQI Annual Update Report*** (attached), Section V, submitted to SFBHN in July 2016 for progress on this item.

3. Substance Use among Adults Discharged from Substance Abuse Treatment

Objective: 80% of adults discharged from SA treatment will reduce substance use from baseline

Type of Objective: *Quality Assurance: Efficiency*

G/CC discharged 105 adult clients from substance abuse treatment from January 1 – June 30, 2016. Thirteen (13) clients had discharge but no admission data in the system. Therefore, 92 clients had admission and discharge data available for analysis.

A significant percent of clients reduced their substance abuse from admission to discharge ($Z = -3{,}989$, $p<.001$). Thirty-two (32) clients reduced their substance use from admission to discharge, representing 34.8% of the discharges. Six (6) clients increased use from admission to discharge, representing 6.5% of the discharges. Approximately 59% (N=54) continued to use substances at the same level at discharge as they did at admission.

Closer examination of the data revealed that 51 clients did not use any substances during the 30 days prior to admission. Therefore, a subsequent analysis excluded these clients.

For this analysis, a significant percent of clients reduced their substance use from admission to discharge ($Z = -5.055$, $p<.001$). Thirty-two (32) clients reduced their substance use, representing 78.0% of the discharges. No (0) clients increased use. Nine (9) clients continued to use at the same level at discharge as at admission (22.0%).

4. Completion Rates for Prime for Life

Objective: 85% of children enrolled in Prime for Life will complete the required sessions

Type of Objective: *Quality Assurance: Efficiency*

Since inception of the program, G/CC enrolled 44 youth in Prime for Life. Thirty-one (31) youth completed the required number of sessions, representing 70.4% of the youth. This completion rate falls below the required target of 85%.

Action: The Chief Clinical Officer will meet with the Program Coordinator and Research Assistant to discuss and identify potential challenges or barriers to youth completing the curriculum.

5. Completion Rates for Children Receiving Teen Intervene

Objective: 85% of the children enrolled in Teen Intervene will complete the required three (3) sessions

Type of Objective: *Quality Assurance: Efficiency*

Since inception of the program, G/CC enrolled 32 youth in Teen Intervene. Twenty-nine (29) youth completed the program, representing 90.6% of the discharges and exceeding the 85% target.

6. Reduce alcohol use and binge drinking among youth completing Project SUCCESS

Objective: 85% of youth will report no alcohol use in the past 30 days by curriculum completion

Type of Objective: *Quality Assurance: Effectiveness*

From January 1 – June 30, 2016, G/CC discharged 33 youth from Project SUCCESS. Twenty-eight (28; 84.8%) of the youth completed the program successfully; and five (5; 15.2%) did not complete the curriculum. The two youth who did not complete did not have alcohol or drug use recorded for the 30 days prior. Of those remaining (N=28), 100% reported no alcohol use in the 30 days prior to their discharge regardless of their discharge type.

7. Reduce the number of underage alcohol drinkers who report buying alcohol in a store among youth completing Project SUCCESS

Objective: 70% of youth will report not buying alcohol in a store in the past 30 days by curriculum completion

Type of Objective: *Quality Assurance: Effectiveness*
G/CC no longer tracks this indicator. It is not in the current Scope of Work.

8. Reduce alcohol use and binge drinking among youth completing PRIME for Life and/or Teen Intervene

Objective: 85% of youth will report no alcohol use in past 30 days by curriculum completion

Type of Objective: *Quality Assurance: Effectiveness*

Twenty-eight (28) youth completed Teen Intervene from January 1 – June 30, 2016. Twenty-seven (27; 96.4%) of the youth completed successfully, and one (1; 3.6%) left the program voluntarily before completing services.

At admission, nine (9; 32.1%) youth reported using alcohol or drugs in the past month (1-3 times). At discharge, only one (1) youth reported using alcohol or drugs in the past month (1-3 times). This represents a significant change from admission to discharge ($Z = -2.828$, $p<.005$).

G/CC discharged 44 youth from PRIME for Life from July 1, 2015 – June 30, 2016. Thirty-two (32; 72.7%) completed the program.

For change in alcohol use, the analysis included only those youth who did not respond, "I don't know" to either the admission or discharge alcohol question, resulting in 17 cases. Alcohol use in the past 30 days did not significantly change from admission to discharge ($t(16) = -1.456$, $p=.165$). In fact, although not significant, there was a slight increase in alcohol use during the past 30 days from less than 1 day at admission to 2 days at discharge.

9. Clinical Outcomes for consumers receiving Seeking Safety

Objective: 70% of consumers will show decreased symptoms and severity

Type of Objective: *Quality Assurance: Effectiveness*

All consumers complete a Life Events Checklist and the PSSR as part of the intake packet. Based on these questionnaires, staff determines the appropriateness of the consumer for Seeking Safety. To ensure only appropriate consumers receive this service, the Treatment Team reviews the questionnaires prior to assigning them to Seeking Safety. Those completing the EBP also receive the PSSR at discharge from the service.

During this reporting period, 11 consumers completed a pre-PSSR, and only five (5) consumers had a post-PSSR.

PSSR - NOTE – Sample size is too small to report significance
Ratings are on a Likert Scale ranging from 1-5: (1) Not at all; (2) A little bit; (3) Moderately; (4) Quite a bit; and (5) Extremely

Item	Average Pre-Score	Average Post-Score	Significance
Upset thoughts Frequency	1.60	1.00	NA
Upset thoughts Severity	2.20	1.00	NA
Bad dreams Frequency	1.80	1.00	NA
Bad dream Severity	1.60	1.00	NA
Reliving trauma Frequency	1.40	1.00	NA
Reliving trauma Severity	1.40	1.00	NA
Emotionally upset Frequency	1.80	1.00	NA
Emotionally upset Severity	2.20	1.00	NA
Trying not to think about, talk about, or have feelings about the trauma Frequency	2.60	1.00	NA
Trying not to think about, talk about, or have feelings about the trauma Severity	2.60	1.00	NA

Avoid activities Frequency	2.00	1.00	NA
Avoid activities Severity	1.60	1.00	NA
Not being able to remember an important part of the trauma Frequency	2.00	1.40	NA
Not being able to remember an important part of the trauma Severity	1.60	1.20	NA
Having much less interest or participating much less often in important activities Frequency	1.40	1.00	NA
Having much less interest or participating much less often in important activities Severity	1.60	1.00	NA
Feeling distant or cut off from people around you Frequency	2.00	1.40	NA
Feeling distant or cut off from people around you Severity	2.00	1.20	NA
Emotionally numb Frequency	2.20	1.00	NA
Emotionally numb Severity	2.60	1.00	NA
Feeling as if future plans or hopes will not come true Frequency	1.60	1.00	NA
Feeling as if future plans or hopes will not come true Severity	1.80	1.00	NA
Having trouble falling or staying asleep Frequency	1.60	1.40	NA
Having trouble falling or staying asleep Severity	1.80	1.40	NA
Feeling irritable or having fits of anger Frequency	1.60	1.40	NA
Feeling irritable or having fits of anger Severity	1.80	1.20	NA
Having trouble concentrating Frequency	2.40	1.40	NA
Having trouble concentrating Severity	1.80	1.20	NA
Being over alert Frequency	1.60	1.00	NA
Being over alert Severity	1.80	1.00	NA
Being jumpy or easily startled Frequency	1.60	1.00	NA
Being jumpy or easily startled Severity	1.80	1.00	NA
Experiencing PHYSICAL reactions when you were reminded of the trauma Frequency	1.60	1.00	NA
Experiencing PHYSICAL reactions when you were reminded of the trauma Severity	1.80	1.00	NA

10. Fidelity of EBPs

Objective: 80% of staff will maintain fidelity to the EBPs

Type of Objective: *Performance Improvement: Efficiency*

See ***CQI Annual Update Report*** (attached), Section I, submitted to SFBHN in July 2016 for progress on this item.

F. Safety and Security

1. Incident Reports

Objective: 99% of reportable incidents will be provided to appropriate external entity.

Type of Objective: *Quality Assurance: Efficiency*

Between January 1 and June 30, 2016, G/CC reported 100% of the reportable incidents to the appropriate external entity as required.

The status of the incidents is as follows:

Closed % (#)	Reviewed % (#)	Pending % (#)	Follow Up % (#)	Total
77.4 (119)	20.8 (32)	0.6 (1)	1.2 (2)	154

Facility	Closed % (#)	Reviewed % (#)	Pending % (#)	Total
Key Largo	100.0 (7)	0.0 (0)	0.0 (0)	7
Marathon	64.1 (59)	33.7 (31)	1.1 (1)	92
Key West	100.0 (36)	0.0 (0)	0.0 (0)	36
Heron	85.7 (16)	0.0 (0)	0.0 (0)	16
Primary Care	33.3 (1)	33.3 (1)	33.3 (1)	3

Overall, G/CC closed 77.4% of the incidents this biannual period. Two (2) reports required follow-up. Nearly 21% of the reports remain in review, indicating that an employee submitted a report but a supervisor did not review it. Majority of these (96.8%) are at the Marathon site. Two (2) reports are pending (1.2%), indicating that an employee wrote a report but did not submit it successfully.

Action
The Chief Clinical Officer will provide a detailed list to each Site Director of the Incident Reports numbers remaining under review or pending. The Site Directors will close the remaining incidents within 30 calendar days from receiving the report.

The breakdown of the incident reportable type for this quarter is below:

Immediately Reportable % (#)	Reportable % (#)	Non-Reportable % (#)	Total
22.7 (35)	54.5 (84)	22.7 (35)	154

Facility Breakdown

	Immediately Reportable % (#)	Reportable % (#)	Non-Reportable % (#)	Total
Key Largo	3.2 (5)	1.3 (2)	0.0 (0)	7
Marathon	8.4 (13)	29.9 (46)	21.4 (33)	92
Key West	9.1 (14)	13.6 (21)	0.6 (1)	36
Heron	1.3 (2)	8.4 (13)	0.6 (1)	16
Primary Care	0.6 (1)	1.3 (2)	0.0 (0)	3

Key Largo had the lowest rate of “Immediately Reportable” incidents, accounting for 3.2% of all incidents and 14.3% of all “Immediately Reportable” incidents. Approximately 71% of all incidents occurring in Key Largo were “Immediately Reportable.”

Incident Category Breakdown

Incident Category	Number	Percent of Total
Abuse/Neglect	11	7.1
Alcohol/Drugs	1	0.6
Behavior, Other	21	13.6
Client Grievance	19	12.3
Contraband	4	2.6
Confidentiality	0	0.0
Criminal	1	0.6
Death	7	4.5
Disaster	0	0.0
Illness	12	7.8
Injury	9	5.8
Left Treatment/Elopement	8	5.2
Medication Error	9	5.8
Medication Reaction	0	0.0
Motor Vehicle/Transportation	4	2.6
Operations	12	7.8
Other	14	9.1
Safety	2	1.2
Sexual	1	0.6
Staff	0	0.0
Suicide/Self Harm	16	10.4
Violence	2	1.2

Eight (8; 66.7%) of the ***Illness incidents*** occurred in Marathon, with 75% of these occurring on the Inpatient unit. The remaining Illness incidents occurred in Key West (1; 8.3%) and at the Heron (3; 25%). 100% of the incidents required medical services, with 91.7% requiring emergency services and 8.3% requiring non-emergency services. Two-thirds (66.7%) of the ***Injury incidents*** occurred in Marathon, with 83.3% of these occurring on the Inpatient unit and 16.7% occurring in the Transportation Department. One-third (33.3%) of the injury incidents occurred at Heron. Approximately 44% of the incidents required non-emergency medical services, and 55.6% requiring no medical attention. None (0%) of the incidents required emergency medical attention. 6.25% of the ***Suicide/Self Harm incidents*** occurred in Key Largo, 81.2% occurred in Key West, and 12.6% occurred in Marathon (with one of these occurring in the Center for Wellness). Most of the incidents (93.5%) were suicidal ideations or threats. Only one (1; 6.5%) were an actual attempt. Staff took precautionary measures to keep the client safe in 100% of the cases. 28.6% of the ***Death incidents*** occurred in Key Largo, 28.6% occurred in Marathon, 28.6% occurred in Marathon. One incident (1; 14.3%) occurred in the Center for Wellness. 85.7% resulted from natural causes, with 33.3% being expected and 66.7% being unexpected. None of the incidents occurred on WestCare property. The one (1) ***Sexual incident*** occurred in Key West on the Prevention Program. This incident involved a youth reporting previous inappropriate touching by a mother's boyfriend. All (100%) of the ***Contraband incidents*** occurred in Marathon on the CSU. Seventy-five percent (75%) related to non-illegal contraband with clients possessing cigarettes and medications. One incident related to a client having marijuana in his possession when admitted to the unit. There were two (2) ***Safety incidents***, with 50% occurring in Marathon and 50% in Key

West. One incident related to a client wanting to leave the Detox Unit and drive home while inebriated. The other incident related to a trespasser on GCC property who would not leave.

Nearly 73% of the ***Abuse/Neglect incidents*** occurred in Key West. Twenty-five percent (25%) occurred in Assessment. 25% in TBOS, 25% in Prevention, 12.5% in Intervention, and 12.5% in Outpatient. Approximately 27% occurred in Key Largo, with 66.7% occurring in TBOS and 33.3% occurring in Intervention. None of the incidents occurred on agency property, and none involved agency staff. Staff reported all incidents/allegations to the appropriate and required authorities. One ***Alcohol/Drug*** incident occurred in Key West in Outreach. The incident related to a client passing out following completion of his detox screening. Fifty percent (50%) of the ***Operation incidents*** occurred at Heron, 33.3% occurred in Marathon, 16.7% occurred in Key West. One hundred percent (100%) related to funding/licensing agencies conducting on-site reviews, with 333.3% related to unannounced site visits and 66.7% related to announced visits. There were four (4) ***Motor Vehicle incidents*** this biannual period, with 50% occurring in Key West, 25% in Key Largo, and 25% at the Heron. Half (50%) of the incident involved a WestCare operated vehicle and 50% involved an employee vehicle. None of the incidents results in injury. There only was damage to the vehicles. Seventy-five percent (75%) of the ***Left Treatment/Elopement incidents*** involved clients leaving the CSU or Detox against medical advice (AMA). The remaining 25% were clients self-discharging from Intervention or the Personal Growth Center. Half (50%) of the ***Violence incidents*** occurred in Marathon, and 50% occurred at the Heron. The incident at Heron involved a client reporting command hallucinations to assault someone, although there was not actual violence. The incident in Marathon on the CSU involved a client attacking another client without provocation.

All (100%) of the ***Grievance incidents*** occurred in Marathon, with 94.7% occurring on the Inpatient Unit and 5.3% occurring in the Transportation Department. Thirteen grievances (13; 68.4%) were about nurses not permitting clients to do certain things, not giving them forms requested, and not allowing them to make phone calls. Two grievances (2; 10.5%) related to limited access to telephones.

There were 17 incidents of ***seclusion and/or restraint*** use this biannual period. Approximately 94% occurred on the Inpatient unit, and one (1; 5.9%) occurred in Key West. Approximately 35% involved seclusion only. Nearly 12% involved seclusion with chemical restraint, and 47.1% involved seclusion with chemical/mechanical restraint. There also were four (4) ***Therapeutic Hold incidents.*** All (100%) occurred on the Inpatient Unit and none (0%) involved injury.

Hours of Day Breakdown

Time of Day	Number	Percent Total
Morning (12 am – 11:59 am)	61	39.6
Afternoon (12 pm – 4:59 pm)	47	30.5
Evening (5 pm – 11:59 pm)	46	29.9

Fewer incidents occurred during the evening hours than the morning and afternoon hours. This finding is typical since most services occur during traditional working hours (9 am – 6 pm), except for the inpatient units. This pattern is consistent from quarter to quarter.

Day of Week Breakdown

Day of Week	Number	Percent Total
Sunday	10	6.5
Monday	29	18.8
Tuesday	23	14.9
Wednesday	22	14.3
Thursday	29	18.8
Friday	24	15.6
Saturday	17	11.0

Approximately 33% of the incidents occurred on the weekend (Friday-Sunday). Mondays and Thursdays had the highest occurrence of incidents during the weekday, accounting for 37.7% of all incidents occurring from Monday through Thursday.

2. Medication Errors on Inpatient

Objective: Maintain medication error incident reports at less than 2%

Type of Objective: *Quality Assurance: Efficiency*

From January 1 through June 30, 2016, there were nine (9) ***Medication Error incidents***. Eight (8; 88.9%) occurred on the Inpatient Unit (CSU + Detox), and 11.1% occurred in the Center for Wellness.

Closer examination of the incident details revealed that 22.2% of the incidents involved a documentation error, 33.3% related to a counting error by staff, and 11.1% related to a client being out of medication. Three incidents (33.3%) involved client-related medication errors, with 11.1% involving the client taking the incorrect number of pills and 22.2% involving the client taking the wrong medication.

G. Staff Development

1. New Hire Training

Objective: 95% of new hires will complete the e-learning courses within 5 days from hire date

Type of Objective: *Quality Assurance: Efficiency*

All (100%) of the new employees completed the required e-learning courses within the identified timeframe.

2. Annual In-Service Training

Objective: 85% of staff will complete the required 20 hours of training annually

Type of Objective: *Performance Improvement: Efficiency*

56.4% of the staff completed 20 hours of CEUs this Fiscal Year.

3. Verbal De-Escalation Training

Objective: 100% of Receiving Facility staff will receive verbal de-escalation training annually.

Type of Objective: *Performance Improvement: Efficiency*

100% of the staff received TACT training.

4. CPR Training

Objective: 100% of Receiving Facility staff will have CPR training and active certificates

Type of Objective: *Performance Improvement: Efficiency*

98.5% of the staff completed CPR training on-time and have active certificates.

5. Affidavit of Good Moral Character

Objective: 100% of Receiving Facility staff will have a signed Affidavit of Good Moral Character in their personnel file

Type of Objective: *Performance Improvement: Efficiency*

100% of the staff has the signed Affidavit of Good Moral Character in their personnel file.

6. Performance Evaluations

Objective: 100% of Receiving Facility staff will have annual Performance Evaluations in their personnel files

Type of Objective: *Performance Improvement: Efficiency*

100% of the staff had Performance Evaluations as of August 8, 2016.

7. Training Database

Objective: Develop and implement a more comprehensive training database

Type of Objective: *Performance Improvement: Efficiency*

To date, the Human Resources Director and Chief Clinical Officer identified the necessary elements to include in the database. However, an update of the database did not occur during this biannual period.

8. Employee Turnover

Objective: <20% turnover rate

Type of Objective: *Quality Assurance: Efficiency*

For the biannual period of July 1 – December 31, 2015, the average turnover rate was 4.51%, falling significantly below the target of 20%. The monthly turnover rate for G/CC is below.

Month	Turnover Rate
July	0.0%
August	8.0%
September	8.0%
October	5.1%
November	2.57%
December	3.41%
January	1.70%
February	3.41%
March	2.65%
April	5.41%
May	0.0%
June	Data Not Available

9. Overtime

Objective: NA

Type of Objective: *Quality Assurance: Efficiency*

For the first biannual period of Fiscal Year 2015-2016, G/CC had a total of 1,167.54 hours in overtime, averaging 194.59 hours monthly. This resulted in a total cost of $30,865.04. The average cost per month was $5,144.17.

The monthly trend is below.

Month	Hours	Cost
July	130.49	$2,869.28
August	114.89	$3,124.44
September	114.26	$3,317.09
October	131.84	$3,823.77
November	419.31	$11,004.45
December	256.75	$6,726.01
January	193.75	$4,856.00
February	283.50	$6,762.22
March	926.90	$23,746.44
April	598.29	$14,815.47
May	462.25	$11,831.49
June	Data Not Available	
Total	3632.23	$92,876.66

H. Accreditation – CARF

1. Committee Meetings

Objective: Committees will meet at least one time quarterly

Type of Objective: *Quality Assurance: Efficiency*

See ***CQI Annual Update Report*** (attached), Section VI, submitted to SFBHN in July 2016 for progress on this item.

2. Annual QIP

Objective: Complete required QIP annually and submitted to CARF on time

Type of Objective: *Quality Assurance: Efficiency*

See ***CQI Annual Update Report*** (attached), Section I, submitted to SFBHN in July 2016 for progress on this item.

I. Additional Monitoring Items

1. Trauma Informed Care

Objective: Conduct walk though of each program and process

Type of Objective: *Performance Improvement: Efficiency*

See ***CQI Annual Update Report*** (attached), Section III, submitted to SFBHN in July 2016 for progress on this item.

2. Cultural and Linguistic Competence

Objective: Conduct walk though of each program and process

Type of Objective: *Performance Improvement: Efficiency*

See ***CQI Annual Update Report*** (attached), Section IV, submitted to SFBHN in July 2016 for progress on this item.

3. Integration of Behavioral and Primary Healthcare

Objective: Conduct walk though of each program and process

Type of Objective: *Performance Improvement: Efficiency*

See ***CQI Annual Update Report*** (attached), Section II, submitted to SFBHN in July 2016 for progress on this item.

CQI Semiannual Update
Guidance/Care Center, Inc.
Date of Update: July 31, 2016

Performance Measure	**Action Plan and/or Opportunities for Improvement**
I. Evidence-Based Practices	
(a) Evidence-based practices (EBPs) utilized by the agency and how these EBPs are monitored to ensure fidelity to the model. **Provide information on progress, etc.**	
List EBP	**Fidelity Measure**
Seeking Safety	**Measure:** Observation using Seeking Safety Fidelity Checklist; Life Events Checklist (LEC); PSSR pre- and post-test measures **Progress:** During the reporting period, GCC staff completed five (5) fidelity checks across three (3) clinicians. These fidelity checks occurred across four (4) topics. All consumers complete a Life Events Checklist and the PSSR as part of the intake packet. Based on these questionnaires, staff determines the appropriateness of the consumer for Seeking Safety. To ensure only appropriate consumers receive this service, the Treatment Team reviews the questionnaires prior to assigning them to Seeking Safety. Those completing the EBP also receive the PSSR at discharge from the service. During this reporting period, 11 consumers completed a pre-PSSR, and only five (5) consumers had a post-PSSR.

Fidelity Content Area	% Compliant
Check-In	100%
Quotation	75%
Handouts	100%
Check Out	80%
Focus on Trauma	100%
Focus on SA	100%
Safe Coping	100%
Topic Discussion and Rehearsal	100%
Focus on Current, Specific, Important Client Problems	100%
Balance of Support & Accountability	100%
Absence of Graphics Details of Trauma or SA	80%
Warmth/Caring	100%
Depth	100%
Management of Crisis and Extreme Emotion	100%
Power Dynamics	100%
Listening	100%
Level of Engagement	100%
Absence of Intervention that Conflicts with Manual	100%
Building Group Cohesion	100%
Overall Performance: Average Score = 2.60	Done A Lot

CQI Semiannual Update
Guidance/Care Center, Inc.
Date of Update: July 31, 2016

PSSR - NOTE – Sample size is too small to report significance
Ratings are on a Likert Scale ranging from 1-5: (1) Not at all; (2) A little bit; (3) Moderately; (4) Quite a bit; and (5) Extremely

Item	Average Pre-Score	Average Post-Score	Significance
Upset thoughts Frequency	1.60	1.00	NA
Upset thoughts Severity	2.20	1.00	NA
Bad dreams Frequency	1.80	1.00	NA
Bad dream Severity	1.60	1.00	NA
Reliving trauma Frequency	1.40	1.00	NA
Reliving trauma Severity	1.40	1.00	NA
Emotionally upset Frequency	1.80	1.00	NA
Emotionally upset Severity	2.20	1.00	NA
Trying not to think about, talk about, or have feelings about the trauma Frequency	2.60	1.00	NA
Trying not to think about, talk about, or have feelings about the trauma Severity	2.60	1.00	NA
Avoid activities Frequency	2.00	1.00	NA
Avoid activities Severity	1.60	1.00	NA
Not being able to remember an important part of the trauma Frequency	2.00	1.40	NA
Not being able to remember an important part of the trauma Severity	1.60	1.20	NA
Having much less interest or participating much less often in important activities Frequency	1.40	1.00	NA
Having much less interest or participating much less often in important activities Severity	1.60	1.00	NA
Feeling distant or cut off from people around you Frequency	2.00	1.40	NA
Feeling distant or cut off from people around you Severity	2.00	1.20	NA
Emotionally numb Frequency	2.20	1.00	NA
Emotionally numb Severity	2.60	1.00	NA
Feeling as if future plans or hopes will not come true Frequency	1.60	1.00	NA
Feeling as if future plans or hopes will not come true Severity	1.80	1.00	NA
Having trouble falling or staying asleep Frequency	1.60	1.40	NA
Having trouble falling or staying asleep Severity	1.80	1.40	NA
Feeling irritable or having fits of anger Frequency	1.60	1.40	NA
Feeling irritable or having fits of anger Severity	1.80	1.20	NA
Having trouble concentrating Frequency	2.40	1.40	NA
Having trouble concentrating Severity	1.80	1.20	NA
Being over alert Frequency	1.60	1.00	NA
Being over alert Severity	1.80	1.00	NA
Being jumpy or easily startled Frequency	1.60	1.00	NA
Being jumpy or easily startled Severity	1.80	1.00	NA
Experiencing PHYSICAL reactions when you were reminded of the trauma Frequency	1.60	1.00	NA
Experiencing PHYSICAL reactions when you were reminded of the trauma Severity	1.80	1.00	NA

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Motivational Interviewing	**Measure:** Clinical Record Review **Progress:** Staff conducting the reviews examines the Wellness & Recovery Plans to ensure that each objective has an identified "stage of change." The also ensure that the Goal is written in the client's own words. Reviewers also examine the Wellness & Recovery Plan Reviews to ensure that the client provided a statement, in his/her own words, about the progress he/she made since the last review.

Content Area	% Compliant
Life Goal in Client's Own Words	80.8% ↓
Wellness & Recovery Plan includes Barriers	73.1% ↓
Wellness & Recovery Plan includes Strengths	73.1% ↓
Wellness & Recovery Plan includes Stage of Change for Each Objective	75.0% ↓
Plan Reviews Include Client's Assessment of Progress	65.0% ↓

Relapse Prevention Therapy	**Measure:** Observation using RPT Fidelity Checklist **Progress:** GCC collected two (2) RPT Fidelity Checklists this reporting period. Observations occurred for two (2) clinicians across two session topics.

Fidelity Content Area	% Compliant
Check-In	0%
Handouts	50%
Focus on skills learned to prevent relapse	50%
Safe coping	50%
Topic discussion and rehearsal	100%
Focus on Current, Specific, Important Client Problems	50%
Balance of Support & Accountability	50%
Absence of Graphics Details of SA	50%
Assign New Task	50%
Encourage Practice	50%
Warmth and Caring	100%
Depth	50%
Management of Crisis and Extreme Emotion	100%
Power Dynamics	50%
Listening	100%
Level of Engagement	50%
Absence of Intervention that Conflicts with Manual	50%
Building Group Cohesion	100%
Overall Performance: Average Score = 2.50	Done A Little

MRT	**Measure:** Observation using the MRT Checklist **Progress:** During the reporting period, the supervisor conducted two (2) fidelity checks. Both observations had a 100% fidelity rating across the 38-item checklist.
Community Reinforcement Approach	**Measure:** Observation and supervision **Progress**: The trained therapists receive approximately 3-4 hours of supervision monthly on the EBP. Two FITT and three KIST therapists completed and passed the procedures needed for their certificate of proficiency in CRA. GCC hired a new therapist in April who completed the 5-hour training. The therapists turn in recordings of procedures with consumers at least once per month to verify fidelity. In addition, each therapist participates in a supervision call at least once per month. They discuss cases and appropriate use of procedures based on consumer needs. The trainer/supervisor also conducts role-plays to help therapists practice skills (including those procedures not passed in recordings). They also name and describe the procedure(s) in their progress notes.
Teen Intervene	**Measure:** Observation using the Teen Intervene Checklist **Progress:** From January 1 – June 30, 2016, GCC completed three (3) fidelity checks for Teen Intervene: 1 for Session #1, 1 for Session #2, and 1 for Session #3. For Session #1, the counselor received a score of 3 out of 4 on 13 of 14 items on the checklist. On the remaining item, the counselor received a 4. The average rating was an “Agree.” For Session #2, the counselor received a score of 3 out of 4 on 13 of 14 items on the checklist. On the remaining item, the counselor received a 4. The average rating was an “Agree.” For Session #3, the Parent Session, the counselor received a score of 3 (Agree) out of 4 on 8 of the items (57.1%) and a score of 2 (Disagree) (42.9%) on the remaining 6 items. The supervisor will be working with the counselor to increase these ratings to a minimum of 3.
PRIME for Life	**Measure:** Observation using the PFL Checklist **Progress:** From January 1 – June 30, 2016, GCC completed two (2) fidelity checks for the counselors. The observations took place at the same location for the same counselor.

Content Area	% Compliant
Instructor conveys understanding of major concepts without confusion	100.0%
Instructor follows manual in proper order and does not overlook relevant segments in manual	100.0%
Instructor uses video materials at the correct time and is able to transition between video and lecture comfortably	100.0%
Instructor uses participant workbook exercises as indicated and pauses to solicit feedback about them	100.0%
Instructor is able to complete lectures and exercises without relying excessively on the manual	100.0%
Instructor avoids material not included in the manual	0.0%

Alcohol Literacy Challenge	**Measure:** Observation using the ALC Checklist **Progress:** From January 1 – June 30, 2016, GCC completed two (2) fidelity checks for the counselor. The observations took place at the same location for two different counselors.

Content Area	% Compliant
Presenter read ALC lesson narration while viewing the corresponding slides	100.0%
Presenter used the appropriate videos at the correct time points	100.0%
Presenter adhered to the ALC Talking Points	100.0%
Presenter addressed comments and questions appropriately and within the context of the lesson	100.0%
Presenter correctly operated the audiovisual equipment	100.0%
Presenter adhered to the time allotted and finished on schedule	100.0%
Presenter spoke clearly and at appropriate volume	100.0%

Project SUCCESS	**Measure:** Observation using Checklist developed by G/CC and WestCare Evaluation Department **Progress:** The WestCare Evaluation Department in collaboration with the Clinical Director and Research Assistant finalized the fidelity measures for use with each of the four (4) topics. Data collection will begin during the first quarter of Fiscal Year 2016-2017.
II. Integrated Care	
(b) Evidence of the implementation of integrated care, including progress on the implementation of the integrated care action plan.	**I. Integrated Services for Patient and Family Centered Care** **Criterion 1: Co-location of treatment for primary care and mental/behavioral health care** In August 2015, GCC opened a primary healthcare clinic in Marathon through a PBHCI grant received from SAMHSA. Services are available to all GCC consumers currently receiving SA or MH services in the Behavioral Health Clinic. To date, GCC has 286 consumers enrolled in the Center for Wellness. **Criterion 2: Primary care needs are assessed as part of the screening/intake process** ALL potential consumers for the Behavioral Health Clinic complete the CAT and a Medical Screening form to determine appropriateness and need for enrollment in the Center for

	Wellness. In addition, all consumers in the CSU or Detox facility receive screening for medical need prior to their discharge. Consumers having medical needs and not having a primary care provider receive an appointment in the clinic prior to discharge. **Criterion 3: Wellness Plans for primary care and behavioral/mental health care are integrated** The Center for Wellness currently uses a Comprehensive Wellness & Recovery Plan that integrates the consumer's primary and behavioral healthcare needs. As of 06/30/2016, the Center for Wellness Program Coordinator attends all outpatient staff treatment team meetings to provide and receive information about consumers receiving care from the Behavioral and Healthcare Clinics. This ensures that the teams share information, allowing integration of all of the consumer's needs. **Criterion 5: Consumer and family, when appropriate, participate and collaborate in the development of the Wellness Plan** Consumers currently participate in the development of the Wellness Plan and in the Wellness Plan Review for both the Behavioral Health and Primary Care clinics. G/CC has not made any progress on this item during the Fiscal Year. **Criterion 6: Staff educates and communicates with consumers about integrated care** GCC created a brochure for the Center for Wellness that educates consumers on the importance of primary care and integrated care. Outpatient programs distribute these brochures to the behavioral health consumers. As of June 30, 2016, Center for Wellness staff began attending treatment team meetings for the adult programs so that staff has the necessary information to relay to their clients. **Criterion 7: Follow-up occurs on assessments, tests, treatment, referrals and other services** No progress made to date. The focus has been on enrolling consumers to meet the required target for SAMHSA.

	Criterion 8: Consumers' access to social supports for primary care is addressed GCC updated brochure and handbook to include wellness resources on January 9, 2016. **Criterion 9: Linking consumers to community resources for primary care** No progress made to date. The focus has been on enrolling consumers to meet the required target for SAMHSA. **II. Organizational Supports for Practice Change Toward Integrated Services** **Criterion 1: Organizational leadership supports integrated care – <u>Focus on staff time and resources</u>** Discussed staff time and resources at the January 12, 2016 Keys Leadership Team Meeting **Criterion 2: Consumer care team implements integrated care** GCC has taken no action currently. GCC postponed this action item until FY 2016-2017. **Criterion 3: Providers engaged and enthusiastic about integrated care** WestCare identified Christine Gibson, Director of Quality and Risk Management, to assist Dr. Frank Scafidi in the integration initiative occurring throughout WestCare. Ms. Gibson and Dr. Scafidi currently are working on the training for staff and will select a date to begin the training once thy complete the curriculum. **Criterion 4: Continuity of care between primary care and behavioral/mental health** The Chief Clinical Officer and Area Director were unable to address this Action Item during the current Fiscal Year. GCC postponed the action until Fiscal Year 2016-2017. **Category 5: Coordination of referrals and specialists** WestCare identified Christine Gibson, Director of Quality and Risk Management, to assist Dr. Frank Scafidi in the integration initiative occurring throughout WestCare. Ms. Gibson and Dr. Scafidi currently are working on the training for staff and will

	select a date to begin the training once thy complete the curriculum. **Category 6: Data systems/patient records document integrated care** The internal EHR received Phase 1 in February 2016. WestCare IT now is building the fields, forms, etc. into the system for Phase 1 of the testing. Staff training also is occurring to pilot the system. IT expects piloting to begin in September 2016. **Category 7: Consumer and family input to integration management** GCC welcomes feedback from consumers and community based providers. Through some of its Federally funded programs, WestCare Research & Evaluation conducts Focus Groups in the community to elicit feedback from past and current consumers about GCC services. GCC currently is examining processes and practices to expand Focus Groups beyond federally funded projects. Consumers also complete Perception Surveys at Intake, within 3 months post-admission, discharge, and within 6-months post-discharge. **Category 8: Physician, team and staff education and training for integrated care** No additional actions occurred since the last update. **Category 9: Funding sources/resources support integrated care** GCC began working on the AHCA licensing for primary care. Once application completion occurs, GCC will submit it to AHCA. Once licensed, GCC will have additional avenues to bill for services, specifically primary care services. **Annual MeHas Assessment** GCC will complete at request from SFBHN
III. Trauma Informed Care	
(c) Evidence of the implementation of the TIC initiative throughout the agency, including progress on the implementation of a TIC action plan that shall include incorporated results of the	The GCC is involved with the TIC initiative since its inception in the State. GCC representatives consistently attend TIC meetings as required by SFBHN. **Domains 1A-E Criterion 1: Program Review for:** • **Safety** • **Trustworthiness**

agency-wide self-assessment tool and the activities listed below: i. An overview of the Network Provider's TIC capabilities with regard to service structure (assessment, stabilization, treatment, support, and other services); ii. Networking capacities with local providers in the community for persons with trauma; iii. Strategies and activities to develop or improve TIC service capability;	• **Choice** • **Collaboration** • **Empowerment** i. All staff receives TIC training annually with an emphasis on the difference between trauma informed care and trauma specific treatment. The Chief Clinical Officer developed a questionnaire to assess staff attitudes, beliefs, and competencies related to TIC. First distribution of the survey was to occur in April 2016. The CCO needed to delay distribution because of other employee survey distribution, did not want to overburden staff and wanted to ensure adequate response rates. GCC provides a comprehensive system of care, including assessment, stabilization, treatment, prevention, and intervention. GCC designed the system so that consumers easily can transition from one service to another or receive multiple services simultaneously. GCC continues to try to streamline paperwork to decrease the burden on consumers and to eliminate duplication of information. Motivational Interviewing is the cornerstone of the services, ensuring a person-centered, strength-based approach/strategy to service delivery. GCC also encourages consumers to collaborate in the development of the Wellness and Recovery Plans and in the design of their treatment. GCC consistently works with the consumer to minimize barriers to care and increase accessibility to services. GCC completed its walk through assessments for first contact, intake assessment, and biopsychosocial assessment in all programs. Research and Evaluation currently is compiling the data and producing a report on the findings. **Domain 2: Formal Service Policies** **Criterion 4: De-Escalation Policy** In October 2015, GCC submitted an updated policy for approval to amend the current de-escalation policy to ensure it minimizes re-traumatization and to update policy to include a statement regarding consumer's crisis response preference. GCC did not receive feedback from the WestCare Executive Team regarding the changes. The Chief Clinical Officer, Area Director, and Director of Accreditation currently are following up on this Action item to determine where it is in the approval process.

	Domain 4: Administrative Support for Program-Wide Trauma Informed Services **Criterion 3: Administrative Participation in and Oversight of Trauma-Informed Approaches** ii. The Keys Leadership Team is extremely active in the initiative and reviews progress at least quarterly. The last meetings addressing the initiative plans were January 12, and February 10, 2016. iii. The Chief Clinical Officer, Area Director and other agency leaders continually scan GCC services to identify ways to increase TIC capability and capacity. They also attend various webinars through HRSA, SAMHSA, and the National Council to increase their knowledge and skills related to TIC. GCC completed its walk through assessments for first contact, intake assessment, and biopsychosocial assessment in all programs. Research and Evaluation currently is compiling the data and producing a report on the findings. **Criterion 5: Trauma Survivor Consumer Involvement** Since 2014, GCC has an active TIC Advisory Board that includes community members. The Board meets at least quarterly. The last meeting occurred on April 16, 2016. Consumers also complete Perception Surveys. GCC uses this data to improve or enhance its services as necessary. **Domain 1A Criterion 4: Staff Ratings** GCC is working in collaboration with WestCare to re-implement a national employee satisfaction survey that assesses staff's perception of safety. The Human Resources Director addressed this during the National HR Committee meeting on January 14, 2016. The Director of Accreditation developed a WestCare-wide survey but has not distributed to date. **Domain 6: Human Resource Practices** **Criterion 2: Staff Performance Reviews** GCC Supervisors completed annual Performance Reviews in June 2016. The Human Resources Director, Chief Clinical Officer, and Area Director completed updates to the Performance Review

	templates for clinical staff to ensure it include TIC competencies and will update as needed. **Annual Fallot TIC Assessment** GCC completed the assessment in March 2016. GCC will submit the new assessment at request from SFBHN.
IV. Cultural and Linguistic Competence	
(d) Evidence of the implementation of Cultural and Linguistic Competence, including progress on the implementation of the Cultural and Linguistic Competence Action Plan.	**I. Policy & Governance** **The composition of your agency's Board of Directors or its governing board reflects the consumers that it serves within the system of care.** GCC added female and fait-based representation to the Community Action Council to increase the diversity of its members. The last CAC meeting was June 18, 2016. **Your agency provides mechanisms that give youth and family the opportunity to review all pertinent materials- including written documents, oral and symbolic communications- to ensure that they are culturally and linguistically appropriate.** GCC updated its website on January 11, 2016 to include its new brochures and handbooks. GCC welcomes feedback from consumers and community based providers. Through some of its Federally funded programs, WestCare Research & Evaluation conducts Focus Groups in the community to elicit feedback from past and current consumers about GCC services. **II. Organizational Values & Resources** **The annual budget includes a line item specifically dedicated to the development and continued support of culturally and linguistically competent services.** The Controller indicated that although there is not a line item labelled CLAS, the system does have an expenditure item to use for all expenses related to CLAS (e.g. interpretation, brochures, etc.). The Controller suggested using this item moving forward and training all staff. **There is a cultural competence committee/other group/person responsible for cultural competence within the agency.** The GCC Clinical Care Committee also has the charge of ensuring and reviewing cultural competence. The Committee meets at least quarterly. The last meetings were on January 12 and April 15, 2016.

	III. Human Resources & Development **Regularly review and modification of job descriptions to ensure that they include requirements for the ongoing development of cultural knowledge and cross-cultural practice skills** **The Chief Clinical Officer and Human Resources Director currently are reviewing all job descriptions for content related to cultural competence. They will update the job descriptions as needed.** The Human Resources Director, Chief Clinical Officer, and Area Director are in the process of reviewing the Job Descriptions for all positions to ensure they include appropriate CLAS language and will update as needed. **Staff at all agency levels receives in-service training activities on culturally and linguistically competent health care** The Chief Clinical Officer and Area Director completed the annual training plan. The Plan includes CLAS training for non-clinical and non-direct care staff. **Youth and family members have a mechanism to participate in the development and delivery of cultural and linguistic competency training activities.** GCC welcomes feedback from consumers and community based providers. Through some of its Federally funded programs, WestCare Research & Evaluation conducts Focus Groups in the community to elicit feedback from past and current consumers about GCC services. Consumers also complete Perception Surveys at Intake, within 3 months post-admission, and within 6-months post-discharge. GCC also is looking at other options and strategies to include consumers in training activities. **IV. Facilitation of Broad Service Array** **The agency uses Wellness Plans that include family preferences for culturally/ethnically traditional healers, alternative healers, spiritual healers, natural supports, bilingual services, self-help groups, etc.** No progress made to date. **Work environment contains décor reflecting the culturally and diverse groups in your service areas** The Chief Clinical Officer and Area Director are developing a

	strategy to conduct a walk through in each program and service to obtain data on diversity in décor in the environment. Based on these findings, they will develop an Action Plan for improvement as needed. **The agency posts signs and materials such as brochures, fact sheets, etc. in languages other than English** GCC displays posters at each location in English, Spanish, and Creole. GCC continues to work on a plan to translate all its materials, brochures, and forms into Spanish. **VI. Youth, Family, and Community Participation** **Provide incentives to youth and families to encourage their service on organizational boards, committees, conducting advocacy, conducting outreach, and the development of the service array** No progress made to date. **The agency uses health/ and mental health promotion and disease prevention activities to reach out to places of worship, traditional healers, providers of alternative care, media, child advocates, etc.** GCC consistently participates in Health Fairs when the opportunity arises. GCC attended the last Health Fairs on January 30, 2016 in Big Pine and March 19, 2016 in Marathon. **VII. Planning, Monitoring, & Evaluation** **Conduct a needs assessment regularly to gather information on the community it serves** The Chief Clinical Officer completed a Disparity Impact Statement in November 2015. The Chief Clinical Officer updates the DIS annually, if needed, in October. **Annual cultural and linguistic competence self-assessment** GCC completed the annual assessment in March 2016. GCC will complete this year's annual assessment when instructed by SFBHN. **Evaluate the quality and effectiveness of interpretation and translation services, in particular** No progress made to date. **Communicate the organization's progress in implementing and**

	sustaining the CLAS standards to all stakeholders, constituents and the general public No progress made to date. **Develop formal partnerships, with cultural community agencies, faith-based entities, traditional cultural providers, and other culturally relevant organizations** ALL MOUs are up-to-date for 2016. **Annual CLC Action Plan** Plan updated and submitted for Fiscal Year 2015-2016. Update for next Fiscal Year will occur no later than August 31, 2016.
V. Referrals and Linkage	
(e) Evidence of tracking and ensuring the successful referrals and linkages of consumers of behavioral health services to primary care services.	The Chief Clinical Officer and GCC Data Manager worked with WestCare IT to include primary care variables in the intranet Clinical Data System These variables include: • Does client have a primary care doctor or has client seen a doctor while in the program? • If No, then was a linkage to primary care made? • If Referral made, then to What/Whom? • If No, the reason for no linkage? **If FITT Client** • Name of Client • Name of Child • Does child have primary care physician? • If not, primary care linkage made? • Linkage to what and or whom? Tracking of this information began during January 2016.
VI. Accreditation	
(f) Evidence of the progress on steps to taken towards meeting the requirement to become an accredited provider (i.e. TJC, CARF, COA, etc.) or meet the CARF Standards for Unaccredited Providers.	GCC received a 3-year accreditation renewal in 2016. GCC completed its annual report for CARF and submitted by the deadlines. The Keys Leadership Team updated all Plans in July 2016.

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Performance Measures for Continuous Quality Improvement Plans

I. Mental Health Services (Admission type):

Covered Services

01-Assessment	19- Residential Level 2
03- Crisis Stabilization Unit	20- Residential Level 3
06 Day/Night	21 Residential Level 4
08- In Home/ On-Site	34- FACT
09-Inpatient	35- Outpatient Group
12- Medical Services (psychiatric)	39-Short-term Residential Treatment
14-Outpatient Individual	

Must be tracked for any of the covered services listed in the table above and which are funded by the contract.

(A) NOTE: G/CC schedules all initial appointments for an assessment, not for specific services such as counseling or psychiatric appointments. This is to ensure that all potential clients are eligible for services and receive an assignment to the most appropriate service.

Covered Services	Average # of calendar days between a request for services and the date of initially scheduled face-to-face appointment
Assessment	**ALL** clients = 13.8 days (386 contacts) **ADULT** clients = 13.9 days (320 contacts) **CHILD** clients = 13.6 days (66 contacts)
Crisis Stabilization Unit	**ADULTS Only** = 0 days
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Outpatient Group	**NA**

(B)

Covered Services	% of persons who do not appear for their initial appointment
Assessment	**ALL** clients = 36.2% **ADULT** clients = 36.6% **CHILD** clients = 34.8%
Crisis Stabilization Unit	**ADULTS Only** =0.0%
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Outpatient Group	**NA**

(C)

Covered Services	% of appointments cancelled by client for all initial appointments
Assessment	**ALL** clients = 3.4% **ADULT** clients = 3.8% **CHILD** clients = 1.5%
Crisis Stabilization Unit	**ADULTS Only** =0.0%
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Outpatient Group	**NA**

(D)

Covered Services	% of appointments cancelled by staff for all initial appointments
Assessment	**ALL** clients = 6.2% **ADULT** clients = 6.3% **CHILD** clients = 6.1%
Crisis Stabilization Unit	**ADULTS Only** =0.0%
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Outpatient Group	**NA**

(E)

Covered Services	Medication Error % (*for Inpatient/CSU and residential settings*)		
	Wrong Medication	Wrong Dose	Wrong Time of Administration
Crisis Stabilization Unit	**2**	**1**	**0**

(F)

Covered Services	The number of behavioral health consumers identified as needing primary care
Assessment	**3 (37.5%)**
Crisis Stabilization Unit	**161 (88.5%)**
In Home/On-Site	**7 (50.0%)**
Medical Services	**5 (50.0%)**
Outpatient Individual	**11 (78.6%)**
Outpatient Group	**Combined with Outpatient Individual since There**

	is No Separate Designation

(G)

Covered Services	Number of successful linkages to primary care
Assessment	**2 (66.7%)**
Crisis Stabilization Unit	**150 (93.2%)**
In Home/On-Site	**2 (28.6%)**
Medical Services	**5 (100%)**
Outpatient Individual	**7 (63.6%)**
Outpatient Group	**NA**

II. Substance Abuse Services (Admission type):

Covered Services

01-Assessment	21-Residential Level 4
06 Day/Night	24-Detoxification
08- In Home/On-Site	35- Outpatient Group
12- Medical Services (psychiatric)	
14-Outpatient Individual	
18- Residential Level 1	
19- Residential Level 2	
20- Residential Level 3	

Must be tracked for any of the covered services listed in the table above and which are funded by the contract.*

(A)

Covered Services	Average # of calendar days between a request for services and the date of initially scheduled face-to-face appointment
Assessment	**ALL** clients = 13.0 days (11 Contacts) **ADULT** clients = 13.0 days (11 Contacts) **CHILD** clients = No Contacts this Biannual Period
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Detoxification	**ADULTS Only** = 0 days
Outpatient Group	**NA**

(B)

Covered Services	% of persons who do not appear for their initial appointment
Assessment	**ALL** clients = 30.8% **ADULT** clients = 30.8% **CHILD** clients = No Contacts this Biannual Period
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Detoxification	**ADULTS Only** = 0.0%
Outpatient Group	**NA**

(C)

Covered Services	% of appointments cancelled by client for initial appointment for assessments and counseling
Assessment	**ALL** clients = 0.0% **ADULT** clients = 0.0% **CHILD** clients = No Contacts this Biannual Period
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Detoxification	**ADULTS Only** = 0.0%
Outpatient Group	**NA**

(D)

Covered Services	% of appointments cancelled by staff, tracked by initial appointment, counseling/psychotherapy and psychiatric appointments
Assessment	**ALL** clients = 7.7% **ADULT** clients = 7.7% **CHILD** clients = No Contacts this Biannual Period
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Detoxification	**ADULTS Only** = 0.0%
Outpatient Group	**NA**

(E)

Covered Services	Medication Error % (*for JARF/Detox and residential settings*)		
	Wrong Medication	Wrong Dose	Wrong Time of Administration
Detoxification	0	0	0

(F)

Covered Services	The number of behavioral health consumers identified as needing primary care
Assessment	0 (0.0%)
In Home/On-Site	No Data Available
Medical Services	0 (0.0%)
Outpatient Individual	25 (78.1%)
Detoxification	76 (90.5%)
Outpatient Group	Combined with Outpatient Individual since There is No Separate Designation

(G)

Covered Services	Number of successful linkages to primary care
Assessment	NA
In Home/On-Site	No Data Available
Medical Services	NA
Outpatient Individual	(2) 13.3%
Detoxification	70 (92.1%)
Outpatient Group	NA