The Guidance/Care Center
WestCare
Performance Improvement Report
January – June 2018

Overview

The Guidance/Care Center Performance Improvement Committee developed the Performance Improvement Work Plan for the 2017-2018 Fiscal Year on April 26, 2017. G/CC made several updates to this year's Work Plan based on the following: (1) the receipt of new grants and (2) areas for enhancement identified through monitoring visits. Following is a summary of the progress G/CC made on the current Work Plan during the second Biannual Period (January – June 2018) of this Fiscal Year. Key indicators also include data for the entire Fiscal Year.

A. Program and Service Utilization

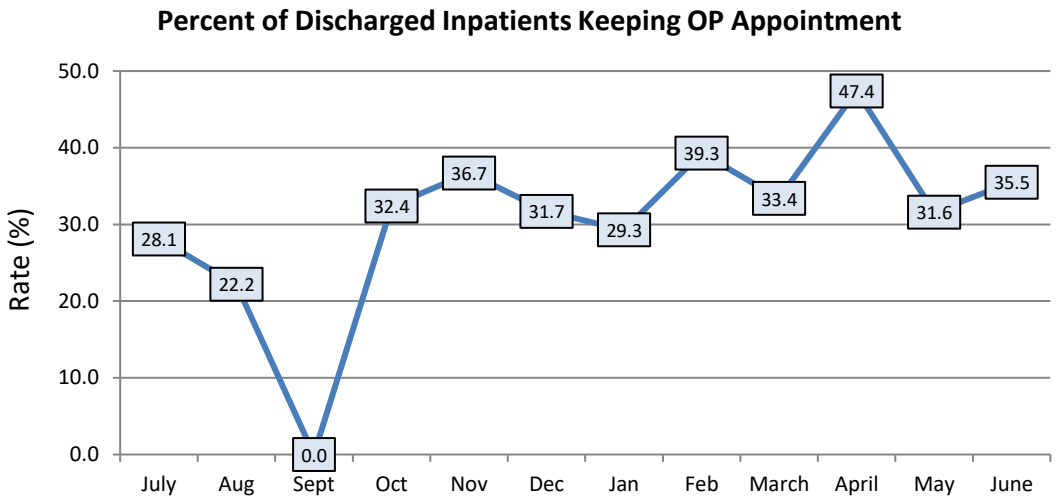
1. Attendance at first session of OP treatment following an IP discharge

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

Type of Objective: *Performance Improvement: Efficiency*

Monthly, Biannual, and Annual
Overall, for this biannual period, 29.3% (N=61) of the consumers discharged from the inpatient unit (N=208) and referred to outpatient kept their appointments. For the first quarter of the Fiscal Year, 22.9% (19/83) of the clients kept their outpatient appointment, and 33.6% (42/125) clients kept their outpatient appointments during the second quarter. The trend by month was:

Month	Percent	# Attended/# Referred
July	28.1%	9/32
August	22.2%	10/45
September	0.0%	0/6
October	32.4%	12/37
November	36.2%	17/47
December	31.7%	13/41
BIANNUAL	**29.3%**	**61/208**
January	29.3%	12/41
February	39.3%	11/28
March	33.3%	13/39
April	47.4%	9/19
May	31.6%	6/19
June	35.5%	11/31
BIANNUAL	**35.0%**	**62/177**
ANNUAL	**31.9%**	**123/385**



Biannual Rates by Location Referral Made

Location	B1 Percent	B1: # Attended/# Referred	B2 Percent	B2: # Attended/# Referred	Annual Percent	Annual: # Attended/# Referred
Key Largo	46.2	24/52	41.5	22/53	43.8	46/105
Marathon	20.0	8/32	27.5	14/51	26.5	22/83
Key West	25.0	29/116	35.6	26/73	29.1	55/189

Action: G/CC did not achieve its monthly or quarterly targets for either biannual period or for Fiscal Year 2017-2018.

Although not attaining the monthly rate, Key Largo had the highest rate of 43.8%.

Ensuring that clients discharged from Inpatient attend the first Outpatient appointment has been an ongoing struggle for G/CC the past two Fiscal Years. The Senior Scientist will discuss the finding with the Keys Leadership Team during the biannual Performance Improvement Committee meeting.

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 the consumer, TBOS, Outreach, CSU, and Detox.

The first set of analyses conducted examined the overall results for all appointments scheduled between January 1 and June 30, 2018. The numbers are slightly lower for this biannual period than previous biannual periods.

Category	Total #	Kept % (#)	No Shows % (#)	Client Cancellations % (#)	Staff Cancellations % (#)
All Sites					
All Appointments	11,581	82.1 (9,513)	8.5 (989)	4.9 (569)	510 (4.4)
Child	2,936	90.9 (2,669)	3.7 (108)	1.3 (38)	4.1 (121)
Adult	8,645	79.2 (6,844)	10.2 (881)	6.1 (531)	4.5 (389)

Category	Total #	Kept % (#)	No Shows % (#)	Client Cancellations % (#)	Staff Cancellations % (#)
Key West					
All Appointments	7,570	81.2 (6,149)	8.2 (619)	4.8 (367)	5.7 (435)
Child	1,420	84.3 (1,197)	5.6 (80)	1.7 (24)	8.4 (119)
Adult	6,150	80.5 (4,952)	8.8 (539)	5.6 (343)	5.1 (316)
Marathon					
All Appointments	1,409	80.5 (1,134)	10.6 (150)	6.8 (96)	2.1 (29)
Child	320	99.1 (317)	0.6 (2)	0.3 (1)	0.0 (0)
Adult	1,089	75.0 (817)	13.6 (148)	8.8 (96)	2.6 (28)
Key Largo					
All Appointments	2,601	85.7 (2,230)	8.4 (219)	4.1 (106)	1.8 (46)
Child	1,195	96.7 (1,155)	2.1 (25)	1.2 (14)	0.1 (1)
Adult	1,406	76.5 (1,075)	13.8 (194)	6.5 (92)	3.2 (45)

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	10,502	90.6 (9,513)	9.4 (989)
Child	2,777	96.1 (2,669)	3.9 (108)
Adult	7,725	88.6 (6,844)	11.4 (881)

Category	Total#	Kept % (#)	Now Shows % (#)
Key West			
All Appointments	6,768	90.9 (6,149)	9.1 (619)
Child	1,277	93.7 (1,197)	6.3 (80)
Adult	5,491	90.9 (4,592)	9.8 (539)

Category	Total#	Kept % (#)	Now Shows % (#)
Marathon			
All Appointments	1,284	88.3 (1,134)	11.7 (150)
Child	319	99.4 (317)	0.6 (2)
Adult	965	84.7 (817)	15.3 (148)
Key Largo			
All Appointments	2,449	91.1 (2,230)	8.9 (219)
Child	1,180	97.9 (1,155)	2.1 (25)
Adult	1,269	84.7 (1,075)	15.3 (194)

Action: No action needed. All sites had Kept Appointment rates that exceeded the 80% target.

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 of FY 2017-2018, G/CC received 319 contacts. The average number of days from Initial Contact to first appointment was 7.5 days, falling only slightly longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from the 0-24 days.

G/CC saw 87.5% of the clients within 14 days from the Initial Contact. G/CC saw 57.1% in seven (7) or fewer days. None of the consumers had to wait over 30 days for an appointment.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=319)	62.7 (200)	31.7 (101)	5.6 (18)	0.0 (0)

A subsequent analysis examined only those clients who either “Kept” or “Now Showed” for their appointments. The analysis did not include cancellations by clients or staff. This analysis examined the impact of days waiting before the initial contact.

APPOINTMENT STATUS	WAITING TIMES				
	0-7 Days	8-14 Days	15-30 Days	>30 Days	**0-30 days**
Kept	62.0% (124)	25.0% (50)	13.0% (26)	0.0% (0)	66.4 %(200)
No Show	47.5% (48)	40.6% (41)	11.9% (12)	0.0% (0)	33.6% (101)

Action: Overall, more than half the clients kept their initial appointments. An additional 5.6% were cancellations by the client. Almost 1/3 of the clients did not show up for their initial appointment. Clients waiting less than 15 days for an appointment were more likely to "No Show" for an appointment than clients who waited 15-30days (88.2% versus 11.9%).

Annual Results: During the FY 2017-2018, G/CC received 573 contacts. The average number of days from Initial Contact to first appointment was 9.0 days, falling slightly longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from the 0-56 days.

G/CC saw 85.5% of the clients within 14 days from the Initial Contact. G/CC saw 51.3% in seven (7) or fewer days. 2.4% of the consumers had to wait over 30 days for an appointment.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=561)	59.9% (336)	31.6% (177)	5.7% (32)	2.9% (16)

A subsequent analysis examined only those clients who either "Kept" or "Now Showed" for their appointments. The analysis did not include cancellations by clients or staff. This analysis examined the impact of days waiting before the initial contact.

APPOINTMENT STATUS	WAITING TIMES				
	0-7 Days	8-14 Days	15-30 Days	>30 Days	**0-30 days**
Kept	54.5% (183)	31.8% (107)	11.9% (40)	1.8% (6)	58.6% (336)
No Show	50.8% (90)	35.0% (62)	10.7% (19)	3.4% (6)	30.9 (177)

Action: Overall, more than half the clients kept their initial appointments. An additional 8.6% were cancellations by the client or staff. Almost 1/3 of the clients did not show up for their initial appointment. Clients waiting less than 15 days for an appointment were more likely to "No Show" for an appointment than clients who waited 15-30days (85.8% versus 14.1%).

Mental Health Clients:

Biannual Results: During the second biannual period of FY 2017-2018, G/CC received 152 contacts for mental health services. The average number of days from Initial Contact to first appointment was 7.6 days, falling at the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 0-24 days.

G/CC saw 86.8% of the clients within 14 days from the Initial Contact. G/CC saw 56.6% in seven (7) or fewer days. None of the clients had to wait over 30 days for an initial appointment.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=152)	61.8% (94)	32.2% (49)	5.9% (9)	0.0% (0)

For the **adult clients (N=119)**, The average number of days from Initial Contact to first appointment was 8.4 days, falling approximately slightly longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 1-24 days.

G/CC saw 84.0% of the clients within 14 days from the Initial Contact. G/CC saw 50.4% in seven (7) or fewer days. None of the clients had to wait over 30 days for an initial appointment.

For the **child clients (N=33)**, the average number of days from Initial Contact to first appointment was 4.8 days, falling 2 days sooner than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 0-15 days.

G/CC saw 97.0% of the child clients within 14 days from the Initial Contact. G/CC saw 78.8% in seven (7) or fewer days. None of the clients had to wait over 30 days for an initial appointment.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
Adults (N=119)	57.1% (68)	36.1% (43)	6.7% (8)	0.0% (0)
Children (N=33)	78.8% (26)	18.2% (6)	3.0% (1)	0.0% (0)

A subsequent analysis examined only those clients who either “Kept” or “Now Showed” for their appointments. The analysis did not include cancellations by clients or staff. This analysis examined the impact of days waiting before the initial contact.

APPOINTMENT STATUS	WAITING TIMES: ADULT				
	0-7 Days	8-14 Days	15-30 Days	>30 Days	**0-30 days**
Kept	55.9% (38)	26.5% (18)	17.6% (12)	0.0% (0)	100% (68)
No Show	41.9% (18)	44.2% (19)	14.0% (6)	0.0% (0)	100% (43)

APPOINTMENT STATUS	WAITING TIMES: CHILD				
	0-7 Days	8-14 Days	15-30 Days	>30 Days	**0-30 days**
Kept	76.9% (20)	19.2% (5)	3.8% (1)	0.0% (0)	100% (26)
No Show	83.3% (5)	16.7% (1)	0.0% (0)	0.0% (0)	100% (6)

Substance Abuse Clients:

Biannual Results: During the second biannual period for FY 2017-2018, G/CC received seven (7) contacts for substance abuse services. The average number of days from Initial Contact to first appointment was 5.6 days, falling sooner than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 0-12 days.

G/CC saw 100% of the clients within 12 days from the Initial Contact. G/CC saw 71.4% of the clients within 7 days.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=7)	85.7% (7)	14.3% (1)	0.0% (0)	0.0% (0)

For the **adult clients (N=3)**, the average number of days from Initial Contact to first appointment was 7.0 days, falling at the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 2-12 days.

G/CC saw 100% of the clients within 12 days from the Initial Contact. G/CC saw 66.7% of the clients within 7 days.

For the **child clients (N=4)**, the length of time from Initial Contact to first appointment was 4.5 days, falling 2.5 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 0-12 days.

G/CC saw 100% of the clients within 12 days from the Initial Contact. G/CC saw 75% of the clients within 7 days.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
Adults (N=108)	66.7% (2)	33.3% (1)	0.0% (0)	0.0% (0)
Children (N=1)	100.0% (4)	0.0% (0)	0.0% (0)	0.0% (0)

A subsequent analysis examined only those clients who either "Kept" or "Now Showed" for their appointments. The analysis did not include cancellations by clients or staff. This analysis examined the impact of days waiting before the initial contact.

APPOINTMENT STATUS	WAITING TIMES				
	0-7 Days	8-14 Days	15-30 Days	>30 Days	**0-30 days**
Kept	66.7% (4)	33.3% (2)	0.0% (0)	0.0% (0)	100% (6)
No Show	100% (1)	0.0% (0)	0.0% (0)	0.0% (0)	100% (1)

Co-Occurring Clients:

Biannual Results: During the second biannual period of FY 2017-2018, G/CC received 160 contacts for mental health services. The average number of days from Initial Contact

to first appointment was 7.5 days, falling near the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 0-24 days.

G/CC saw 87.5% of the clients within 14 days from the Initial Contact. G/CC saw 56.9% in seven (7) or fewer days. None of the clients had to wait over 30 days for an initial appointment.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=160)	62.5% (100)	31.9% (51)	5.6% (9)	0.0% (0)

The co-occurring classification did not separate the adults from the children in the database. Therefore, separate analyses for the target populations were not feasible.

A subsequent analysis examined only those clients who either "Kept" or "Now Showed" for their appointments. The analysis did not include cancellations by clients or staff. This analysis examined the impact of days waiting before the initial contact.

APPOINTMENT STATUS	WAITING TIMES				
	0-7 Days	8-14 Days	15-30 Days	>30 Days	**0-30 days**
Kept	62.0% (65)	25.0% (25)	13.0% (13)	0.0% (0)	100% (100)
No Show	47.1% (24)	41.2% (21)	11.8% (6)	0.0% (0)	100% (51)

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: *Performance Improvement: Efficiency*

   July 2017

Program	**% 1 Session/Month**	**% 2 Sessions/Month**	**% 3 Sessions/Month**	**% ≥ 4 Sessions/Month**
TBOS CSA (1 client)	0	100	0	0
TBOS – CMH (48 clients)	40	23	19	19
ASA (116 clients)	23	15	8	54
AMH (77 clients)	42	32	10	16
TBOS – ASA (10 clients)	20	40	30	10

August 2017

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (2 clients)	50	50	0	0
TBOS – CMH (71 clients)	17	23	20	41
ASA (115 clients)	18	11	8	63
AMH (63 clients)	33	32	16	19
TBOS – ASA (12 clients)	17	33	25	25

September 2017

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (1 client)	100	0	0	0
TBOS – CMH (43 clients)	63	23	9	5
ASA (72 clients)	44	18	24	14
AMH (41 clients)	88	7	5	0
TBOS – ASA (2 clients)	100	0	0	0

October 2017

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (1 client)	0	100	0	0
TBOS – CMH (83 clients)	14	20	10	55
ASA (88 clients)	20	10	6	64
AMH (52 clients)	50	29	15	6
TBOS – ASA (7 clients)	0	29	43	29

November 2017

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (2 clients)	50	50	0	0
TBOS – CMH (85 clients)	11	20	35	34
ASA (73 clients)	7	12	8	73
AMH (64 clients)	50	28	17	5
TBOS – ASA (8 clients)	50	0	38	13

December 2017

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (4 clients)	50	25	25	0
TBOS – CMH (97 clients)	31	21	21	28
ASA (76 clients)	16	9	11	64
AMH (65 clients)	57	17	17	9
TBOS – ASA (5 clients)	60	20	0	20

January 2018

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (8 clients)	38	25	25	13
TBOS – CMH (110 clients)	16	19	25	39
ASA (104 clients)	21	13	13	54
AMH (99 clients)	44	32	12	11
TBOS – ASA (10 clients)	10	30	20	40

February 2018

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (10 clients)	20	30	20	30
TBOS – CMH (110 clients)	8	23	16	53
ASA (109 clients)	28	13	12	47
AMH (89 clients)	44	29	17	9
TBOS – ASA (12 clients)	42	33	8	17

March 2018

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (9 clients)	22	33	33	11
TBOS – CMH (121 clients)	22	20	26	32
ASA (113 clients)	20	15	12	52
AMH (106 clients)	46	27	16	10
TBOS – ASA (12 clients)	42	25	25	8

April 2018

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (8 clients)	63	0	13	25
TBOS – CMH (122 clients)	12	20	34	34
ASA (106 clients)	14	18	8	59
AMH (105 clients)	40	28	18	14
TBOS – ASA (9 clients)	56	44	0	0

May 2018

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (10 clients)	30	60	0	10
TBOS – CMH (129 clients)	14	14	20	52
ASA (108 clients)	11	12	22	55
AMH (92 clients)	40	29	18	12
TBOS – ASA (9 clients)	0	100	0	0

June 2018

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (6 clients)	33	50	0	17
TBOS – CMH (78 clients)	44	24	15	17
ASA (106 clients)	12	20	8	59
AMH (115 clients)	47	21	18	14
TBOS – ASA (6 clients)	50	0	50	0

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. Currently, G/CC has a partial EHR. Wellness and Recovery Plans are not integrated into the system to date.

5. Unduplicated Enrollment in ORP

Objective: Admit 45 unduplicated clients annually (SAMHSA FY).

Type of Objective: *Quality Assurance: Efficiency*

To date for the SAMHSA Fiscal Year, The Other Side of the Fence admitted 45 unduplicated clients. This is 136.4% of its target (N=33). For the 6-month biannual period, the program enrolled 27 unduplicated clients, achieving 122.7% of its target (N=22).

Since inception, the program admitted 136 clients, attaining 106.3% of its enrollment target (N=128). The average grantee achieved 85.9% of its target.

6. Unduplicated Enrollment in KIST

Objective: Admit 65 unduplicated clients annually (SAMHSA FY).

To date for the SAMHSA Fiscal Year, the KIST Program admitted 42 unduplicated clients. This is 127.3% of its target (N=33). For the 6-month biannual period, the program enrolled 35 unduplicated clients, achieving 159.1% of its target (N=22).

Since inception, the program admitted 147 clients, attaining 114.8% of its enrollment target (N=128). The average grantee achieved 88.8% of its target.

Type of Objective: *Quality Assurance: Efficiency*

7. Unduplicated Enrollment in MIND

Objective: Admit 65 unduplicated clients annually (Calendar Year).
Type of Objective: *Performance Improvement: Efficiency*

For the second year of operation to date (Jan – June 2018), the MIND Program admitted 41 unduplicated clients. The program achieved 63.1% of its annual target.

8. Unduplicated Enrollment in the Wellness Center

Objective: Admit 400 unduplicated clients annually (SAMHSA FY).

Type of Objective: *Quality Assurance: Efficiency*

To date for the SAMHSA Fiscal Year, the Center for Wellness admitted 95 unduplicated clients. This is 31.7% of its target (N=300). For the 6-month biannual period, the Center enrolled 68 unduplicated clients, achieving 34% of its target (N=200).

Since inception, the program admitted 539 clients, attaining 35.9% of its enrollment target.

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).

NOTE: Since the length of stay generally is brief (several hours to only a few days), G/CC only conducts Discharge Surveys for the Inpatient programs: Crisis Stabilization and Detox.

Inpatient – Crisis Stabilization - DISCHARGE				
NUMBER COMPLETED: 75				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	75	86.0	1.3	2.7
I was treated with respect	75	86.0	4.0	0.0
I was seen for services on time	75	100	0.0	0.0
I received services when I needed them	75	87.3	2.7	0.0
If I had a complaint, it was handled well	70	94.2	2.9	2.9
If I were to have problems, I would return to this program	75	89.3	6.7	4.0
I would recommend this program to other people	75	93.3	6.7	4.0
The services focus on my needs	73	92.5	4.1	1.4
This program has helped me to feel better about myself	73	91.8	5.5	2.7

Inpatient – Detox - DISCHARGE				
NUMBER COMPLETED: 13				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	13	92.3	0.0	7.7
I was treated with respect	13	100	0.0	0.0
I was seen for services on time	13	100	0.0	0.0
I received services when I needed them	13	100	0.0	0.0
If I had a complaint, it was handled well	12	83.4	16.6	0.0
If I were to have problems, I would return to this program	12	91.7	8.3	0.0
I would recommend this program to other people	12	100	0.0	0.0
The services focus on my needs	12	100	0.0	0.0
This program has helped me to feel better about myself	12	100	0.0	0.0

Outpatient Adult – Mental Health - POINT IN TIME SURVEYS				
NUMBER COMPLETED: 103				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	102	92.2	6.8	1.0
I was treated with respect	103	93.2	5.8	1.0
I was seen for services on time	101	80.2	4.0	15.8
I received services when I needed them	100	95.0	4.0	1.0
If I had a complaint, it was handled well	93	93.5	5.4	1.1
If I were to have problems, I would return to this program	101	64.0	5.0	1.0
I would recommend this program to other people	103	91.2	6.8	2.0
The services focus on my needs	103	89.3	10.7	0.0
This program has helped me to feel better about myself	101	85.2	13.8	1.0

Outpatient Adult – Mental Health - DISCHARGE				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**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 Adult – Alcohol and Other Drugs/Addictions - POINT IN TIME SURVEYS				
NUMBER COMPLETED: 11				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	11	100	0.0	0.0
I was treated with respect	11	100	0.0	0.0
I was seen for services on time	11	100	0.0	0.0
I received services when I needed them	11	100	0.0	0.0
If I had a complaint, it was handled well	9	100	0.0	0.0
If I were to have problems, I would return to this program	11	90.9	0.0	9.1
I would recommend this program to other people	11	90.9	0.0	9.1
The services focus on my needs	10	90.0	10.0	0.0
This program has helped me to feel better about myself	11	90.9	9.1	0.0

Outpatient Adult – Alcohol and Other Drugs/Addictions - DISCHARGE				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**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	--	--	--	--

Outpatient Adult – Alcohol and Other Drugs/Addictions - DISCHARGE				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
I would recommend this program to other people	--	--	--	--
The services focus on my needs	--	--	--	--
This program has helped me to feel better about myself	--	--	--	--

Adult Case Management – POINT IN TIME SURVEYS				
NUMBER COMPLETED: 2				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	2	100	0.0	0.0
I was treated with respect	2	100	0.0	0.0
I was seen for services on time	2	50.0	50.0	0.0
I received services when I needed them	2	100	0.0	0.0
If I had a complaint, it was handled well	2	100	0.0	0.0
If I were to have problems, I would return to this program	1	100	0.0	0.0
I would recommend this program to other people	1	100	0.0	0.0
The services focus on my needs	1	100	0.0	0.0
This program has helped me to feel better about myself	1	100	0.0	0.0

Adult Case Management - DISCHARGE				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**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 – POINT IN TIME				
NUMBER COMPLETED: 5				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	5	100	0.0	0.0
I was treated with respect	5	100	0.0	0.0
I was seen for services on time	5	100	0.0	0.0
I received services when I needed them	5	100	0.0	0.0
If I had a complaint, it was handled well	5	100	0.0	0.0
If I were to have problems, I would return to this program	5	100	0.0	0.0
I would recommend this program to other people	5	100	0.0	0.0
The services focus on my needs	5	100	0.0	0.0
This program has helped me to feel better about myself	5	80.0	20.0	0.0

Community Integration - DISCHARGE				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**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: JIP – POINT IN TIME – KEY WEST ONLY				
NUMBER COMPLETED: 53				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	53	96.2	3.8	0.0
I was treated with respect	53	96.2	3.8	0.0
I was seen for services on time	53	98.1	0.0	1.9
I received services when I needed them	51	96.2	3.8	0.0
If I had a complaint, it was handled well	44	88.6	11.4	0.0
If I were to have problems, I would return to this program	49	***71.5***	16.3	12.2
I would recommend this program to other people	53	83.0	11.3	5.7
The services focus on my needs	52	82.7	17.3	0.0
This program has helped me to feel better about myself	53	88.7	7.5	3.8

Criminal Justice: JIP – DISCHARGE – KEY WEST ONLY				
NUMBER COMPLETED: 18				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	18	100	0.0	0.0
I was treated with respect	18	100	0.0	0.0
I was seen for services on time	18	100	0.0	0.0
I received services when I needed them	18	100	0.0	0.0
If I had a complaint, it was handled well	18	94.4	5.6	0.0
If I were to have problems, I would return to this program	17	***76.5***	17.6	5.9
I would recommend this program to other people	18	64.4	5.6	0.0
The services focus on my needs	18	100	0.0	0.0
This program has helped me to feel better about myself	18	94.4	5.6	0.0

Criminal Justice: ORP – POINT IN TIME – KEY WEST ONLY				
NUMBER COMPLETED: 17				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	17	100	0.0	0.0
I was treated with respect	17	100	0.0	0.0
I was seen for services on time	17	94.1	0.0	5.9
I received services when I needed them	17	100	0.0	0.0
If I had a complaint, it was handled well	17	94.1	5.9	0.0
If I were to have problems, I would return to this program	17	88.2	11.8	0.0

Criminal Justice: ORP – POINT IN TIME – KEY WEST ONLY				
NUMBER COMPLETED: 17				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
I would recommend this program to other people	17	88.2	11.8	0.0
The services focus on my needs	17	100	0.0	0.0
This program has helped me to feel better about myself	17	100	0.0	0.0

Criminal Justice: ORP – DISCHARGE – KEY WEST ONLY				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**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	--	--	--	--

FITT – POINT IN TIME				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**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	--	--	--	--

FITT – DISCHARGE SURVEYS				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**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 – POINT IN TIME				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**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 - DISCHARGE				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**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 – POINT IN TIME				
NUMBER COMPLETED: 8				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	8	100	0.0	0.0
I was treated with respect	8	100	0.0	0.0
I was seen for services on time	8	100	0.0	0.0
I received services when I needed them	8	100	0.0	0.0
If I had a complaint, it was handled well	8	100	0.0	0.0
If I were to have problems, I would return to this program	8	100	0.0	0.0
I would recommend this program to other people	8	100	0.0	0.0
The services focus on my needs	8	100	0.0	0.0
This program has helped me to feel better about myself	8	100	0.0	0.0

KIST - DISCHARGE				
NUMBER COMPLETED: 9				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	9	100	0.0	0.0
I was treated with respect	9	100	0.0	0.0
I was seen for services on time	9	100	0.0	0.0
I received services when I needed them	9	100	0.0	0.0
If I had a complaint, it was handled well	9	100	0.0	0.0
If I were to have problems, I would return to this program	9	100	0.0	0.0

KIST - DISCHARGE				
NUMBER COMPLETED: 9				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
I would recommend this program to other people	9	100	0.0	0.0
The services focus on my needs	9	100	0.0	0.0
This program has helped me to feel better about myself	9	100	0.0	0.0

Outpatient Children and Adolescents – Substance Abuse – POINT IN TIME				
NUMBER COMPLETED: 9				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	9	100	0.0	0.0
I was treated with respect	9	100	0.0	0.0
I was seen for services on time	7	100	0.0	0.0
I received services when I needed them	7	85.7	14.3	0.0
If I had a complaint, it was handled well	4	100	0.0	0.0
I get along better with family members	9	***66.7***	33.3	0.0
I am doing better in school	9	100	0.0	0.0

Outpatient Children and Adolescents – Substance Abuse - DISCHARGE				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**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	--	--	--	--

Outpatient Children and Adolescents – Mental Health – POINT IN TIME				
NUMBER COMPLETED: 28				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	28	96.4	0.0	3.6
I was treated with respect	28	96.4	0.0	3.6
I was seen for services on time	28	85.7	10.7	3.6
I received services when I needed them	28	96.4	0.0	3.6
If I had a complaint, it was handled well	25	92.0	4.0	4.0
I get along better with family members	27	***66.7***	25.9	7.4
I am doing better in school	27	***74.1***	25.9	0.0

Outpatient Children and Adolescents – Mental Health - DISCHARGE				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	--	--	--	--
I was treated with respect	--	--	--	--
I was seen for services on time	--	--	--	--

Outpatient Children and Adolescents – Mental Health - DISCHARGE				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
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	--	--	--	--

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

Alcohol Literacy Challenge DISCHARGE			
NUMBER COMPLETED: 242			
Item	**Number Responding**	**Agree (%)**	**Disagree (%)**
Program staff treats me fairly	237	99.2	0.8
Program staff here make the program exciting	236	84.3	15.7
The program helps me do better in school	236	90.3	9.7
This program helps me make healthy decisions	236	92.4	7.6
I enjoy coming here	236	84.3	15.7
I would tell my friends to come here	236	90.7	9.3
		Agree (%)	**Disagree (%)**
The Instructor was knowledgeable	242	91.7	8.3
The Instructor was well prepared	242	90.1	9.9
The participant worksheet was useful	232	***47.8***	52.2
I found the activities and commercials helpful in changing my expectations about alcohol	237	***61.6***	38.4

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

PRIME for Life - DISCHARGE			
NUMBER COMPLETED: 227			
Item	**Number Responding**	**Agree (%)**	**Disagree (%)**
Program staff treats me fairly	227	97.8	2.2
Program staff here make the program exciting	227	87.6	12.4
The program helps me do better in school	227	85.4	14.6
This program helps me make healthy decisions	227	91.7	8.3
I enjoy coming here	227	***73.6***	26.4
I would tell my friends to come here	227	88.1	11.9
	Number Responding	**Agree (%)**	**Disagree (%)**
Instructor 1 was knowledgeable about drug & alcohol issues	220	***78.2***	21.8
Instructor 2 was knowledgeable about drug & alcohol issues	40	87.5	12.5
Instructor 1 was well prepared for the sessions	220	***76.8***	23.2
Instructor 2 was well prepared for the sessions	40	80.0	20.0

PRIME for Life - DISCHARGE			
NUMBER COMPLETED: 227			
Item	**Number Responding**	**Agree (%)**	**Disagree (%)**
Instructor 1 was non-judgmental in presenting information and facilitating discussions	220	***69.5***	30.5
Instructor 2 was non-judgmental in presenting information and facilitating discussions	40	***67.5***	32.5
REVERSED SCORED (I.E. DISAGREE IS POSITIVE) Instructor 1 seemed to argue with the program participants	220	89.6	10.4
Instructor seemed to argue with the program participants	40	87.5	12.5
The participant workbook was useful	220	***47.7***	52.3
The program helped me make a decision about my alcohol and drug choices	220	***52.8***	47.2
I found the activities helpful in thinking about changes to my drug or alcohol choices	220	***45.5***	54.5
The videos were interesting to me	220	***45.0***	55.0

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

TEEN Intervene - DISCHARGE			
NUMBER COMPLETED: 44			
Item	**Number Responding**	**Agree (%)**	**Disagree (%)**
Program staff treats me fairly	40	95.0	5.0
Program staff here make the program exciting	40	90.0	10.0
The program helps me do better in school	40	95.0	5.0
This program helps me make healthy decisions	40	95.0	5.0
I enjoy coming here	40	82.5	17.5
I would tell my friends to come here	40	90.0	10.0
	Number Responding	**Agree (%)**	**Disagree (%)**
The Instructor was knowledgeable about alcohol and drug issues	44	95.5	4.5
The Instructor was well prepared for sessions	44	95.5	4.5
The Instructor was non-judgmental in presenting information and facilitating discussions	44	***75.0***	25.0
REVERSED SCORED (I.E. DISAGREE IS POSITIVE) The Instructor seemed to argue with program participants	44	81.8	18.2
The program helped me make a decision about my alcohol and drug choices	43	***76.7***	23.3
I found the activities helpful in thinking about changes to my drug or alcohol choices	43	***69.8***	30.2

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

Project SUCCESS - DISCHARGE			
NUMBER COMPLETED: 96			
Item	**Number Responding**	**Agree (%)**	**Disagree (%)**
Program staff treats me fairly	10	100	0.0
Program staff here make the program exciting	10	100	0.0
The program helps me do better in school	10	90.0	10.0
This program helps me make healthy decisions	10	100	0.0
I enjoy coming here	10	100	0.0
I would tell my friends to come here	10	100	0.0
		Agree (%)	**Disagree (%)**
The Instructor was knowledgeable about alcohol and drug issues	96	88.5	11.5
The Instructor was well prepared for sessions	96	89.6	10.4
The Instructor was non-judgmental in presenting information and facilitating discussions	96	***78.1***	21.9
REVERSED SCORED (I.E. DISAGREE IS POSITIVE) The Instructor seemed to argue with program participants	96	90.6	9.4
The program helped me make a decision about my alcohol and drug choices	96	***53.1***	46.9
I found the activities helpful in thinking about changes to my drug or alcohol choices	96	***50.0***	50.0
The videos were interesting to me	96	***35.4***	64.6

Case Management Children and Adolescents – POINT IN TIME				
NUMBER COMPLETED: 8				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
Overall, I am satisfied with the services I received	8	100	0.0	0.0
I was treated with respect	8	100	0.0	0.0
I was seen for services on time	8	***75.0***	25.0	0.0
I received services when I needed them	8	100	0.0	0.0
If I had a complaint, it was handled well	8	100	0.0	0.0
I get along better with family members	8	***75.0***	25.0	0.0
I am doing better in school	8	87.5	12.5	0.0

Case Management Children and Adolescents - DISCHARGE				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**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	--	--	--	--

Case Management Children and Adolescents - DISCHARGE				
NUMBER COMPLETED: NONE				
Item	**Number Responding**	**Satisfied (%)**	**Neutral (%)**	**Dissatisfied (%)**
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, 2018.

Action: The Center for Wellness staff will work with the Evaluator to develop and implement primary care specific perception surveys during FY 2018-2019.

3. Consumer Perception of Admission/Intake Process

Objective: 80% of the consumers will report satisfaction with the admission/intake process.

Type of Objective: *Quality Assurance: Efficiency*

Between January 1 and June 30, 2018, G/CC collected 189 Admission Surveys. One hundred eighty (180) were from adults and nine (9) were 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	**Number Responding**	**Satisfied (%)**	**Dissatisfied (%)**
When I walked into G/CC to ask about services…			
My questions were answered	180	98.3	1.7
I understood the information that was given to me	176	98.3	1.7
The information given to me was correct	177	97.7	2.3
It was easy to get an appointment for intake	177	95.5	4.5
During my intake assessment…			
The admission staff were welcoming	179	98.3	1.7
I was comfortable in the waiting area	177	96.1	3.9
My questions were fully answered	178	97.8	2.2
The admissions process was explained to me	177	96.0	4.0

Adult Admissions			
Item	**Number Responding**	**Satisfied (%)**	**Dissatisfied (%)**
I understood the explanation of the admission process	175	93.7	6.3
There was too much paperwork (reverse scored)	178	***20.7 (Disagreed)***	89.1
The Admission staff understood my needs	178	96.6	3.4
I felt the admission counselor listened to me	171	97.6	2.4
I thought the process took too long (reverse scored)	175	***37.7 (Disagreed)***	62.3
Thinking about the telephone contact and the intake assessment together, these helped me get prepared for treatment	167	95.8	4.2
G/CC could improve the admission process (reverse scored)	149	***46.3 (Disagreed)***	53.7

Would you refer friends with similar problems to yours to G/CC? Yes = 95.3%

Overall, were you satisfied with the admission process? Yes = 98.2%

Child/Adolescent Admissions			
Item	**Number Responding**	**Satisfied (%)**	**Dissatisfied (%)**
When I walked into G/CC to ask about services…			
My questions were answered	9	100	0.0
I understood the information that was given to me	8	100	0.0
The information given to me was correct	9	100	0.0
It was easy to get an appointment for intake	9	100	0.0
During my intake assessment…			
The admission staff were welcoming	9	100	0.0
I was comfortable in the waiting area	9	100	0.0
My questions were fully answered	9	100	0.0
The admissions process was explained to me	9	100	0.0
I understood the explanation of the admission process	9	100	0.0
There was too much paperwork (reverse scored)	9	***11.1 (Disagreed)***	88.9
The Admission staff understood my needs	9	100	0.0
I felt the admission counselor listened to me	8	100	0.0
I thought the process took too long (reverse scored)	9	***66.7 (Disagreed)***	33.3
Thinking about the telephone contact and the intake assessment together, these helped me get prepared for treatment	8	87.5	12.5
G/CC could improve the admission process (reverse scored)	2	***50.0 (Disagreed)***	50.0

Would you refer friends with similar problems to yours to G/CC? Yes = 100.0%

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

4. Staff Perception

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

Type of Objective: *Quality Assurance: Efficiency*

Type of Objective: *Quality Assurance: Efficiency*
G/CC conducted its Staff Perception Surveys during May 2018 using Survey Monkey. The questionnaire consisted of 10 questions. The survey went to 155 staff. Fifty-two (52) staff completed the survey. This is a response rate of 33.5%, which is a significant decrease from the previous Fiscal Year (55.2%). 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. For those having more than one symbol, each one indicates consecutive years of not meeting the criterion.

Question	**Percent Agreeing** **💎= Below 80% Criterion 💎 for every year Below Criterion** **↑ = Increase from last FY**
I know what is expected with me at work and am familiar with my job responsibilities	94.2% ↑
I have the materials and equipment I need to do my job right	**75.0% ↑ 💎💎💎💎**
I receive the level of supervision that is required	80.0% ↑
I feel respected and my ideas and input are valued	***78.4 % ↓ 💎***
Our agency's mission makes me feel like my job is important.	83.7% ↓
During the last year, I had opportunities at work to learn and grow	86.3% ↑
I received a thorough orientation to G/CC and my job duties when I began employment	**73.1% ↓ 💎💎**
I am familiar with the G/CC Health and Safety Plan	92.0% ↓
Overall, I am satisfied with my job	86.3% ↑
At my annual review, I was given the opportunity to contribute my input.	**52.9% ↓ 💎💎💎**

Action: Fifty (40%; N=4) of the items fell below the 80% criterion. Three (3) items fell below criterion for multiple consecutive years. 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.

5. Stakeholder Perception

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

Type of Objective: *Quality Assurance: Efficiency*

Type of Objective: *Quality Assurance: Efficiency*

G/CC conducted its Stakeholder Survey in May 2018 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. Forty-two (42) stakeholders completed the survey. Thirty-four (34) 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. For those having more than one symbol, each one indicates consecutive years of not meeting the criterion.

Question	**Percent** **👎= Below 80% Criterion 👎 for every year Below Criterion**
Knowledge of Service Provision • Detox • Crisis Stabilization • Child/Family Counseling • Free HIV Testing • Transportation • Substance Abuse Counseling • Psychiatric Services • Primary Care Services • Case Management • ALF	 • 81.0% ↑ • **85.7%** ↑ • **90.5%** ↑ • **47.6%** ↓ 👎👎👎👎👎 • **61.9%** ↑ 👎👎👎👎👎 • **78.6%** = 👎👎 • 95.2% ↓ • **38.1%** ↑ 👎👎 • 88.1% ↑ • **45.2%** ↑ 👎👎
How did you hear about us? • Received services • Word of mouth • Website/E-mail • Brochures • Other	 • 07.1% • 35.7% • 02.4% • 00.0% • 54.8%
To what extent do you find G/CC responsive with questions, concerns, or requests from you agency or family?	***73.2%*** ↓
To what extent do you feel G/CC is meeting your needs as a community partner or individual?	**73.8%** ↓ 👎👎👎
To what extent is G/CC providing services that are relevant to our community?	81.0% ↓
How would you rate G/CC's overall interaction with your agency or family?	***78.6%*** ↓
How would you rate G/CC's responses to you with regard to our being prompt and timely?	***76.2%*** ↓ 👎👎👎
How would you rate the overall quality of G/CC?	***76.2%***

Action: Seventy-five percent (75%; N=6) of the items fell below the 80% criterion. The Keys Leadership Team and Performance Improvement Committee will explore possible factors for the changes and develop a PI initiative based on the findings.

6. 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 2018. The questionnaire consisted of 13 questions. Seventy-seven (77) consumers completed the survey for the CTC across all providers. 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.

Monroe County CTC Survey	
Question	**Percent**
The van arrived at the scheduled time today	96.1% ↑
The time I am riding now is a convenient one for me.	90.9% ↓
The driver is pleasant and courteous.	98.7% ↑
The inside of the van is clean.	93.5% ↑
I have enough room to sit.	97.4% ↑
The seat is comfortable.	91.0% ↓
The ride did not take too long.	94.8% ↑
The driver does not drive too fast.	98.7% ↑
The driver does not make sudden movement in the van.	92.2% ↑
The person on the phone was polite and courteous.	***54.5%*** ↓ 👎👎
The person on the phone was helpful.	***51.9%*** ↓
I knew w/in 24 hours that I would be able to ride at the time I wanted.	***54.5%*** ↓
I would choose my provider even if there were another transportation company I could use.	**68.8%** ↓ 👎👎
Overall Responses	Positive : 83.2% ↓ Negative: 2.4% ↓ No Opinion: 14.3% ↑

Eleven (11) consumers completed the survey specifically for G/CC as a transportation provider.

G/CC as Provider Survey	
Question	**Percent**
The van arrived at the scheduled time today	100.0% =
The time I am riding now is a convenient one for me.	100.0% =
The driver is pleasant and courteous.	100.0% =
The inside of the van is clean.	100.0% =
I have enough room to sit.	100.0% ↑
The seat is comfortable.	90.9% ↓
The ride did not take too long.	100.0% =
The driver does not drive too fast.	100.0% ↑
The driver does not make sudden movement in the van.	100.0% =

G/CC as Provider Survey	
Question	**Percent**
The person on the phone was polite and courteous.	90.9% ↑
The person on the phone was helpful.	90.9% ↑
I knew w/in 24 hours that I would be able to ride at the time I wanted.	90.9% ↑
I would choose GCC even if there were another transportation company I could use.	81.8% ↑
Overall Responses	Positive : 95.8% ↑ Negative: 0.7% ↓ No Opinion: 3.5% ↑

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*

Scale	3-Month	6-Month	12-Month
GPRA	NA	80.9% ↑	NA
GAIN	69.0% ↑	61.0% ↑	30.0% ↑

The Guidance/Care Center 6-month follow-up rate for the GPRA is 80.9%. G/CC collected 89 out of 110 assessments. The G/CC follow-up rate is slightly higher than the average SAMHSA grantee rate of 72.5%.

Although remaining low, the GAIN follow-up rates increased since the last biannual period. The new Research Assistant successfully completed her GAIN Administrator certification during the last quarter.

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*

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	75.0% =	63.0% =	60.0% ↓

3. NOMS overall follow-up rate for the PBHCI (Primary Care) grant

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

Objective Type: *Performance Improvement: Efficiency*

Scale	6-Month Follow Up Rate				
TRAC	**Jan - March 2018**	**April – June 2018**	**Biannual Period**	**Fiscal Year**	**Cumulative**
	137/199 = 68.8%	94/220 = 42.7%	231/419 = 55.1%	377/741 = 50.9%	693/1,577 = 43.9% =

The Guidance/Care Center follow-up rate is below the required SAMHSA 80% rate.

Action: Staffing pattern contributed to the low rate. Currently, only one (1) Research Assistant is responsible for tracking consumers and collecting the follow-up data. This particular program handles large numbers of consumers, making it challenging for one person to do all of the work. G/CC, in collaboration with the Evaluation Team, is cross-training other staff (e.g. case managers) to assist with the data collection.

4. GPRA overall follow-up rate for TCE-HIV (KIST) grant

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

Objective Type: *Quality Assurance: Efficiency*

Scale	6-Month Follow Up Rate				
GPRA	**Jan – March 2018**	**April – June 2018**	**Biannual Period**	**Fiscal Year**	**Cumulative**
	9/7 = 128.6%	0/0 = N/A	9/7 = 128.6%	16/14 = 114.3%	91/114 = 79.8%↑

Action: The KIST program 6-month follow up rate (77.1%) currently is below the SAMHSA required 80%. This rate, however, is higher than the average grantee funded under the same initiative (60.5%).

5. Post Discharge Follow-Up Survey

Objective: ≥10 surveys completed quarterly

Objective Type: *Performance Improvement: Efficiency*

During the biannual period January 1 – June 30, 2018, G/CC collected no (0) 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
	--	--

Action: The Senior Scientist will work with the Regional VP and Research Assistants to establish a process for the G/CC programs to notify the Research Assistants of discharges. The Senior Scientist also will establish a process by which the Research Assistants will contact the discharged clients to request completion of the Post Discharge Survey.

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, 2018, staff completed 263 Peer Reviews across the three (3) G/CC Locations: Key West, Marathon, and Key Largo. Staff reviewed a sampling of charts from all Core Programs. One hundred twenty-nine (129) records were for active clients, and 134 were for closed cases. The breakdown is as follows:

Core Program	Open Charts	Closed Charts	Number of Clinical Records
Adult Mental Health	19	23	42
Adult Substance Abuse	4	9	13
Child Mental Health	13	18	31
Child Substance Abuse	12	7	19
Diversion/Intervention	13	14	27
Level 2 Prevention	5	8	13
Adult Case Management	16	13	29
Child Case Management	12	5	17
CSU	1	2	3
Detox	0	0	0
Criminal Justice - JIP	6	8	14
Criminal Justice - ORP	4	2	6
Integrated	9	10	19
Community Integration	5	0	5
FITT	3	4	7
KIST	4	8	12
MIND	3	3	6
Total	**129**	**134**	**263**

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 ADULT TREATMENT PROGRAMS (Excludes ORP which uses the GAIN)

Section	Average Total Percent (100% highest possible score)
Legal Information	92.2% ↑
Screening and Admission	94.5% ↑
Psychosocial Assessment/In-Depth Evaluation	75.6% ↑
Initial/Preliminary Treatment Plan	74.1% =
Wellness & Recovery Plans and Reviews	83.0% ↑
Progress Notes	90.8% ↓
Medication Orders (if applicable)	--
Medical Plan & Progress Notes (if applicable)	79.2% ↑
Service Plans	51.9% ↑
Case Management Progress Notes	93.8% ↑
Disclosure Log	71.4% ↑
Discharge/Transition Reporting	85.5% =

Content Area	% Compliant
Immediate or Urgent Needs Documented	92.9% ↓
AST or Other Screening Completed	92.9% ↑
Consent to Treatment Signed	94.4% ↓
Information Regarding Rights/Responsibilities	95.7% =
Information Regarding Grievance Procedure	94.4% ↓
Information on HIPAA	94.4% ↓
SFBHN Sharing Agreement[1]	93.0% =
Screening Summary Provides Rationale for Level of Care	100.0% =
SMQ R 8 Completed	80.5% ↑
SNAP Form Completed	92.4% ↓
Evidence Results Shared with Client[1]	89.2% ↑
Interpretive Summary Complete	75.0% ↑
Preliminary Plan Completed at Admission	85.5% ↑
Life Goal in Client's Own Words	67.5% ↑
Wellness & Recovery Plan Reflects Interpretive Summary	56.4% ↓
Wellness & Recovery Plan Completed on Time	60.0% ↓
Plan Objectives are Behavioral & Measurable	65.0% ↑
Plan Reviews Include Client's Assessment of Progress	61.3% ↓
Plan Reviews Completed On-Time (for those having reviews due)	54.5% ↑
Medication Orders Indicate Primary MD*	66.7% ↓
Signed Consent for Medication	73.1% ↑
Copy of Prescriptions in Clinical Record*	79.2% ↑

[1]New item this Fiscal Year

ADULT MENTAL HEALTH	
Section	**Average Total Percent (100% highest possible score)**
Legal Information	100.0% ↑
Screening and Admission	94.4% ↓
Psychosocial Assessment/In-Depth Evaluation	79.5% ↑
Initial/Preliminary Treatment Plan	82.9% ↑
Wellness & Recovery Plans and Reviews	86.4% ↑
Progress Notes	100.0% =
Medication Orders (if applicable)	--
Medical Progress Notes (if applicable)	83.1% ↑
Service Plans	--
Case Management Progress Notes	--
Disclosure Log	61.7% ↑
Discharge/Transition Reporting	89.6% ↓

ADULT MENTAL HEALTH	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	95.8% ↑
AST or Other Screening Completed	100.0% =
Consent to Treatment Signed	91.7% ↓
Information Regarding Rights/Responsibilities	91.7% ↑
Information Regarding Grievance Procedure	91.7% ↓
Information on HIPAA	91.7% ↓
SFBHN Sharing Agreement[1]	91.7% ↑

ADULT MENTAL HEALTH	
Content Area	**% Compliant**
Screening Summary Provides Rationale for Level of Care	--
SMQ R 8 Completed	78.3% ↑
SNAP Form Completed	95.5% ↑
Evidence Results Shared with Clients[1]	87.0% ↑
Interpretive Summary Completed	83.3% ↑
Preliminary Plan Completed at Admission	91.7% ↑
Life Goal in Client's Own Words	83.3% ↓
Wellness & Recovery Plan Reflects Interpretive Summary	83.3% ↓
Wellness & Recovery Plan Completed on Time	66.7% ↓
Plan Objectives are Behavioral & Measurable	83.3% ↑
Plan Reviews Include Client's Assessment of Progress	55.6% ↓
Plan Reviews Completed On-Time (for those having reviews due)	44.4% ↓
Medication Orders Indicate Primary MD*	--
Signed Consent for Medication	70.0% ↑
Copy of Prescriptions in Clinical Record*	80.0% ↑

[1]New item this Fiscal Year

INPATIENT (CSU and Detox Combined)	
Section	**Average Total Percent (100% highest possible score)**
Legal Information	83.3%
Screening and Admission	91.1%
Psychosocial Assessment/In-Depth Evaluation	91.7%
Initial/Preliminary Treatment Plan	84.7%
Wellness & Recovery Plans and Reviews	72.8%
Progress Notes	--
Medication Orders (if applicable)	93.6%
Medical Progress Notes (if applicable)	91.7%
Service Plans	--
Case Management Progress Notes	--
Discharge/Transition Reporting	--

INPATIENT (CSU and Detox Combined)	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	100.0%
Consent to Treatment Signed	100.0%
Information Regarding Rights/Responsibilities	100.0%
Information Regarding Grievance Procedure	66.7%
Information on HIPAA	100.0%
SFBHN Sharing Agreement[1]	100.0%
Preliminary Plan Completed at Admission	50.0%
Wellness & Recovery Plan Completed on Time	0.0%
Plan Objectives are Behavioral & Measurable	0.0%
Medication Orders Indicate Primary MD*	66.7%
Signed Consent for Medication	100.0%
Copy of Prescriptions in Clinical Record*	100.0%

CRIMINAL JUSTICE - JIP	
Section	**Average Total Percent (100% highest possible score)**
Legal Information	100.0% =
Screening and Admission	97.3% ↓
Psychosocial Assessment/In-Depth Evaluation	87.6% ↓
Initial/Preliminary Treatment Plan	100.0% ↑
Wellness & Recovery Plans and Reviews	98.8% =
Progress Notes	100.0% =
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	NA
Case Management Progress Notes	NA
Disclosure Log	100.0% ↑
Discharge/Transition Reporting	95.1% =

CRIMINAL JUSTICE - JIP	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	100.0% =
AST or Other Screening Completed	NA
Consent to Treatment Signed	100.0% =
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
SFBHN Sharing Agreement[1]	100.0%
Screening Summary Provides Rationale for Level of Care	NA
SMQ R 8 Completed	100.0% ↑
SNAP Form Completed	100.0% =
Evidence Results Shared with Client[1]	100.0% =
Interpretive Summary Completed	83.3% ↑
Preliminary Plan Completed at Admission	100.0% ↑
Life Goal in Client's Own Words	100.0% =
Wellness & Recovery Plan Reflects Interpretive Summary	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)	83.3% ↓
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medication	NA
Copy of Prescriptions in Clinical Record*	NA

[1]New item this Fiscal Year

CRIMINAL JUSTICE - ORP	
Section	**Average Total Percent (100% highest possible score)**
Legal Information	93.7% ↓
Screening and Admission	91.3% =
Psychosocial Assessment/In-Depth Evaluation	84.7% =
Initial/Preliminary Treatment Plan	31.3% ↓

CRIMINAL JUSTICE - ORP	
Section	**Average Total Percent (100% highest possible score)**
Wellness & Recovery Plans and Reviews	99.3% ↑
Progress Notes	100.0% =
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	32.3% ↓
Case Management Progress Notes	94.3% ↓
Discharge/Transition Reporting	45.0% ↓

CRIMINAL JUSTICE - ORP	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	100.0% =
GAIN 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% =
SFBHN Sharing Agreement[1]	75.0% ↓
QRRS/GRRS Edited to Remove Prompts	NA
QRRS/GRRS Provides Rationale for Level of Care	NA
SMQ R 8 Completed	50.0% ↓
SNAP Form Completed	75.0% ↓
Evidence Results Shared with Client[1]	100.0% ↑
GRRS Edited to be Individualized	100.0% ↑
Preliminary Plan Completed at Admission	50.0% ↓
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

[1]New item this Fiscal Year

ADULT CASE MANAGEMENT	
Section	**Average Total Percent (100% highest possible score)**
Legal Information	82.5% ↑
Screening and Admission	96.8% ↑
Psychosocial Assessment/In-Depth Evaluation	65.0% ↓
Initial/Preliminary Treatment Plan	61.3% =
Wellness & Recovery Plans and Reviews	98.1% ↑
Progress Notes	--
Medication Orders (if applicable)	--
Medical Progress Notes (if applicable)	--

ADULT CASE MANAGEMENT	
Section	**Average Total Percent (100% highest possible score)**
Service Plans	52.0% ↑
Case Management Progress Notes	98.8% ↑
Disclosure Log	59.3% ↑
Discharge/Transition Reporting	75.2% ↓

ADULT CASE MANAGEMENT	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	100.0% ↑
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% ↑
SFBHN Sharing Agreement[1]	100.0% ↑
Screening Summary Provides Rationale for Level of Care	NA
SMQ R 8 Completed	84.6% ↑
SNAP Form Completed	92.3% ↓
Evidence Results Shared with Client[1]	84.6% ↓
Interpretive Summary Completed	50.0% ↓
Preliminary Plan Completed at Admission	84.6% ↑
Life Goal in Client's Own Words	NA
Wellness & Recovery Plan Reflects Interpretive Summary	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*	--
Signed Consent for Medication	--
Copy of Prescriptions in Clinical Record*	--

[1]New item this Fiscal Year

ADULT SUBSTANCE ABUSE	
Section	**Average Total Percent (100% highest possible score)**
Legal Information	0.0% ↓
Screening and Admission	100.0% ↑
Psychosocial Assessment/In-Depth Evaluation	50.0% ↓
Initial/Preliminary Treatment Plan	75.0% ↓
Wellness & Recovery Plans and Reviews	0.0% ↓
Progress Notes	51.0% ↓
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	NA
Case Management Progress Notes	NA
Disclosure Log	62.5% ↑
Discharge/Transition Reporting	89.7% ↑

ADULT SUBSTANCE ABUSE	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	100.0% =
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% =
SFBHN Sharing Agreement[1]	100.0% =
Screening Summary Provides Rationale for Level of Care	100.0%
SMQ R 8 Completed	100.0% =
SNAP Form Completed	100.0% =
Evidence Results Shared with Client[1]	75.0% =
Interpretive Summary Completed	75.0% =
Preliminary Plan Completed at Admission	100.0% ↑
Life Goal in Client's Own Words	66.7% =
Wellness & Recovery Plan Reflects Interpretive Summary	66.7% =
Wellness & Recovery Plan Completed on Time	66.7% ↓
Plan Objectives are Behavioral & Measurable	66.7% ↓
Plan Reviews Include Client's Assessment of Progress	66.7% ↑
Plan Reviews Completed On-Time (for those having reviews due)	66.7% ↑
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medication	NA
Copy of Prescriptions in Clinical Record*	NA

[1]New item this Fiscal Year

FITT	
Section	**Average Total Percent (100% highest possible score**
Legal Information	100.0% ↑
Screening and Admission	86.7% ↓
Psychosocial Assessment/In-Depth Evaluation	55.0% ↑
Initial/Preliminary Treatment Plan	72.3% ↑
Wellness & Recovery Plans and Reviews	44.5% ↓
Progress Notes	56.5% ↓
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	35.3% ↓
Case Management Progress Notes	50.0% ↑
Disclosure Log	66.7% =
Discharge/Transition Reporting	96.7% ↑

FITT	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	66.7% ↓
AST or Other Screen Completed	--
Consent to Treatment Signed	100.0% =
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =

FITT	
Content Area	**% Compliant**
SFBHN Sharing Agreement[1]	100.0% =
Screening Summary Provides Rationale for Level of Care	--
SMQ R 8 Completed	66.7% ↓
SNAP Form Completed	100.0% =
Evidence Results Shared with Client[1]	50.0% ↓
Interpretive Summary Completed	33.3% ↓
Preliminary Plan Completed at Admission	66.7% ↓
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	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

[1]New item this Fiscal Year

COMMUNITY INEGRATION	
Section	**Average Total Percent (100% highest possible score)**
Legal Information	100.0% =
Screening and Admission	96.0% ↓
Psychosocial Assessment/In-Depth Evaluation	76.0%
Initial/Preliminary Treatment Plan	50.0%
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
Disclosure Log	66.7% ↑
Discharge/Transition Reporting	NA

COMMUNITY INTEGRATION	
Content Area	**% Compliant**
Immediate or Urgent Needs	80.0% ↓
Consent for Treatment	NA
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
SFBHN Sharing Agreement[1]	80.0% ↓
Evidence Results Shared with Client[1]	100.0% =
Interpretive Summary Completed	80.0% ↑
Preliminary Plan Completed at Admission	60.0% ↑
Life Goal in Client's Own Words	75.0% ↓
Wellness & Recovery Plan Reflects Interpretive Summary	50.0% ↓

COMMUNITY INTEGRATION	
Content Area	**% Compliant**
Wellness & Recovery Plan Completed on Time	75.0% =
Plan Objectives are Behavioral & Measurable	50.0% ↓
Plan Reviews Include Client's Assessment of Progress	50.0% ↓
Plan Reviews Completed On-Time (for those having reviews due)	75.0% ↑
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medications	NA
Copy of Prescriptions in Clinical Record*	NA

INTEGRATED	
Section	**Average Total Percent (100% highest possible score)**
Legal Information	89.3% ↑
Screening and Admission	88.8% ↑
Psychosocial Assessment/In-Depth Evaluation	88.5% ↑
Initial/Preliminary Treatment Plan	58.3% ↓
Wellness & Recovery Plans and Reviews	28.8% ↓
Progress Notes	85.7% ↓
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	50.0% ↓
Service Plans	NA
Case Management Progress Notes	NA
Disclosure Log	100.0% ↑
Discharge/Transition Reporting	84.6% ↑

INTEGRATED	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	77.8% ↓
AST or Other Screen Completed	100.0% ↑
Consent to Treatment Signed	77.8% ↓
Information Regarding Rights/Responsibilities	88.9% ↓
Information Regarding Grievance Procedure	88.9% ↓
Information on HIPAA	77.8% ↓
SFBHN Sharing Agreement[1]	77.8% ↓
Screening Summary Provides Rationale for Level of Care	100.0 5
SMQ R 8 Completed	77.8% ↑
SNAP Form Completed	75.0% ↓
Evidence Results Shared with Client[1]	100.0% ↑
Interpretive Summary Completed	88.9% ↑
Preliminary Plan Completed at Admission	77.8% ↓
Life Goal in Client's Own Words	14.3% ↓
Wellness & Recovery Plan Reflects Interpretive Summary	100.0% ↑
Wellness & Recovery Plan Completed on Time	100.0% ↑
Plan Objectives are Behavioral & Measurable	14.3% ↓
Plan Reviews Include Client's Assessment of Progress	16.7% ↓
Plan Reviews Completed On-Time (for those having reviews due)	0.0% ↓
Medication Orders Indicate Primary MD*	NA

INTEGRATED	
Content Area	**% Compliant**
Signed Consent for Medications	66.7%
Copy of Prescriptions in Clinical Record*	66.7% ↑

[1]New item this Fiscal Year

KIST	
Section	**Average Total Percent (100% highest possible score)**
Legal Information	100.0% ↑
Screening and Admission	100.0% ↑
Psychosocial Assessment/In-Depth Evaluation	79.0% ↓
Initial/Preliminary Treatment Plan	--
Wellness & Recovery Plans and Reviews	100.0% ↑
Progress Notes	100.0% =
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	100.0% ↑
Case Management Progress Notes	100.0% =
Disclosure Log	72.2% ↓
Discharge/Transition Reporting	72.0%

KIST	
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% =
SFBHN Sharing Agreement[1]	100.0% =
Screening Summary Provides Rationale for Level of Care	--
SMQ R 8 Completed	66.7% ↓
SNAP Form Completed	100.0% ↑
Evidence Results Shared with Client[1]	100.0% =
Interpretive Summary Completed	75.0% ↓
Preliminary Plan Completed at Admission	100.0% =
Life Goal in Client's Own Words	100.0% ↑
Wellness & Recovery Plan Reflects Interpretive Summary	75.0% ↑
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 Medications	NA
Copy of Prescriptions in Clinical Record*	NA

[1]New item this Fiscal Year

MIND – NEW PROGRAM THIS FISCAL YEAR	
Section	**Average Total Percent (100% highest possible score)**
Legal Information	100.0% =
Screening and Admission	97.7%
Psychosocial Assessment/In-Depth Evaluation	97.7% ↓
Initial/Preliminary Treatment Plan	75.0% ↑
Wellness & Recovery Plans and Reviews	96.3%
Progress Notes	100.0% =
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	100.0% =
Service Plans	NA
Case Management Progress Notes	NA
Disclosure Log	80.0%
Discharge/Transition Reporting	86.7%

MIND – NEW PROGRAM THIS FISCAL YEAR	
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% =
SFBHN Sharing Agreement[1]	100.0% ↑
Screening Summary Provides Rationale for Level of Care	--
SMQ R 8 Completed	100.0% =
SNAP Form Completed	100.0% =
Evidence Results Shared with Client[1]	100.0% =
Interpretive Summary Completed	100.0% =
Preliminary Plan Completed at Admission	100.0% ↑
Life Goal in Client's Own Words	100.0% ↑
Wellness & Recovery Plan Reflects Interpretive Summary	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)	66.7% ↑
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medications	100.0% =
Copy of Prescriptions in Clinical Record*	100.0% =

[1]New item this Fiscal Year

ALL CHILD TREATMENT PROGRAMS (Includes ORP which uses the GAIN)

Section	Average Total Percent (100% highest possible score)
Legal Information	92.5% ↑
Screening and Admission	91.9% =
Psychosocial Assessment/In-Depth Evaluation	83.0% ↑
Initial/Preliminary Treatment Plan	85.7% ↑
Wellness & Recovery Plans and Reviews	68.5% ↑
Progress Notes	88.0% ↓
Medication Orders (if applicable)	100.0% =
Medical Plan & Progress Notes (if applicable)	79.4% ↑
Service Plans	60.3% ↑
Case Management Progress Notes	63.4% ↓
Discharge/Transition Reporting	81.0% ↓

Content Area	% Compliant
Immediate or Urgent Needs Documented	97.7%
GAIN Complete	84.4%
Consent to Treatment Signed	93.2%
Information Regarding Rights/Responsibilities	95.5%
Information Regarding Grievance Procedure	93.3%
Information on HIPAA	95.6%
SFBHN Sharing Agreement[1]	93.3%
QRRS/GRRS Edited to Remove Prompts	76.0%
QRRS/GRRS Provides Rationale for Level of Care	87.5%
SMQ R 8 Completed	84.4%
SNAP Form Completed	88.9%
Evidence Results Shared with Client[1]	91.1%
GRRS Edited to be Individualized	83.3%
Preliminary Plan Completed at Admission	82.9%
Life Goal in Client's Own Words	65.6%
Wellness & Recovery Plan Reflects GRRS	66.7%
Wellness & Recovery Plan Completed on Time	63.6%
Plan Objectives are Behavioral & Measurable	72.7%
Plan Reviews Include Client's Assessment of Progress	51.9%
Plan Reviews Completed On-Time (for those having reviews due)	30.4%
Medication Orders Indicate Primary MD*	100.0%
Signed Consent for Medication	100.0%
Copy of Prescriptions in Clinical Record*	100.0%

[1]New item this Fiscal Year

CHILD MENTAL HEALTH	
Section	**Average Total Percent (100% highest possible score)**
Legal Information	100.0% ↑
Screening and Admission	95.4% ↑
Psychosocial Assessment/In-Depth Evaluation	93.0% ↑
Initial/Preliminary Treatment Plan	77.3% ↓
Wellness & Recovery Plans and Reviews	69.7% ↑
Progress Notes	92.5% ↑

CHILD MENTAL HEALTH	
Section	**Average Total Percent (100% highest possible score)**
Medication Orders (if applicable)	--
Medical Progress Notes (if applicable)	87.6% ↑
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	86.6% ↑

CHILD MENTAL HEALTH	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	100.0% ↑
GAIN Complete	88.9% ↑
Consent to Treatment Signed	100.0% ↑
Information Regarding Rights/Responsibilities	92.3% ↑
Information Regarding Grievance Procedure	100.0% ↑
Information on HIPAA	100.0% ↑
SFBHN Sharing Agreement[1]	100.0% ↑
QRRS/GRRS Edited to Remove Prompts	75.0% =
QRRS/GRRS Provides Rationale for Level of Care	75.0% ↑
SMQ R 8 Completed	92.3% ↑
SNAP Form Completed	100.0% ↑
Evidence Results Shared with Client[1]	100.0% ↑
GRRS Edited to be Individualized	100.0% ↑
Preliminary Plan Completed at Admission	92.3% ↑
Life Goal in Client's Own Words	69.2% ↑
Wellness & Recovery Plan Reflects GRRS	66.7% =
Wellness & Recovery Plan Completed on Time	66.7% ↑
Plan Objectives are Behavioral & Measurable	66.7% =
Plan Reviews Include Client's Assessment of Progress	66.7% ↑
Plan Reviews Completed On-Time (for those having reviews due)	33.3% ↑
Medication Orders Indicate Primary MD*	--
Signed Consent for Medication	--
Copy of Prescriptions in Clinical Record*	83.3% ↓

[1]New item this Fiscal Year

CHILD CASE MANAGEMENT	
Section	**Average Total Percent (100% highest possible score)**
Legal Information	100.0% ↑
Screening and Admission	86.5% ↓
Psychosocial Assessment/In-Depth Evaluation	58.7% ↓
Initial/Preliminary Treatment Plan	66.7% ↓
Wellness & Recovery Plans and Reviews	86.1% ↑
Progress Notes	--
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	48.2% ↓
Case Management Progress Notes	50.0% ↓
Discharge/Transition Reporting	92.7% ↓

CHILD CASE MANAGEMENT	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	90.0% ↓
GAIN Complete	80.0% ↓
Consent to Treatment Signed	90.0% ↓
Information Regarding Rights/Responsibilities	90.0% ↓
Information Regarding Grievance Procedure	90.0% ↓
Information on HIPAA	90.0% ↓
SFBHN Sharing Agreement[1]	90.0% ↓
QRRS/GRRS Edited to Remove Prompts	66.7% ↓
QRRS/GRRS Provides Rationale for Level of Care	66.7% ↓
SMQ R 8 Completed	80.0% ↓
SNAP Form Completed	80.0% ↓
Evidence Results Shared with Client[1]	66.7% ↓
GRRS Edited to be Individualized	55.6% ↓
Preliminary Plan Completed at Admission	70.0% ↓
Life Goal in Client's Own Words	66.7% ↑
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*	--
Signed Consent for Medication	100.0%
Copy of Prescriptions in Clinical Record*	--

[1]New item this Fiscal Year

CHILDREN'S SUBSTANCE ABUSE	
Section	**Average Total Percent (100% highest possible score**
Legal Information	78.4% ↓
Screening and Admission	84.4% ↓
Psychosocial Assessment/In-Depth Evaluation	86.5% ↓
Initial/Preliminary Treatment Plan	87.5% ↑

CHILDREN'S SUBSTANCE ABUSE	
Section	**Average Total Percent (100% highest possible score**
Wellness & Recovery Plans and Reviews	44.9% ↓
Progress Notes	90.0% ↓
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	67.1% ↓

CHILDREN'S SUBSTANCE ABUSE	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	100.0% =
GAIN Complete	85.7% =
Consent to Treatment Signed	81.8% ↓
Information Regarding Rights/Responsibilities	63.6% ↓
Information Regarding Grievance Procedure	81.8% ↓
Information on HIPAA	80.0% ↓
SFBHN Sharing Agreement[1]	80.0% ↓
QRRS/GRRS Edited to Remove Prompts	88.9% ↑
QRRS/GRRS Provides Rationale for Level of Care	88.9% ↓
SMQ R 8 Completed	81.8% ↓
SNAP Form Completed	100.0% ↑
Evidence Results Shared with Client[1]	100.0% ↑
GRRS Edited to be Individualized	81.8% ↓
Preliminary Plan Completed at Admission	90.9% ↑
Life Goal in Client's Own Words	60.0% ↑
Wellness & Recovery Plan Reflects GRRS	60.0% ↑
Wellness & Recovery Plan Completed on Time	60.0% ↑
Plan Objectives are Behavioral & Measurable	60.0% ↓
Plan Reviews Include Client's Assessment of Progress	37.5% ↓
Plan Reviews Completed On-Time (for those having reviews due)	25.0% ↓
Medication Orders Indicate Primary MD[*]	NA
Signed Consent for Medication	NA
Copy of Prescriptions in Clinical Record[*]	NA

[1]New item this Fiscal Year

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	91.3% ↑
Assessment	74.1% ↓
Initial/Preliminary Treatment Plan	58.3% ↓
Wellness & Recovery Plans and Reviews	45.1% ↑
Prevention Plan and Reviews	NA
Prevention Summary Notes	100.0%
Discharge/Transition Reporting	75.1% ↑

DIVERSION	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	100.0% =
GAIN Complete	66.7% =
Consent to Treatment Signed	100.0% ↑
Information Regarding Rights/Responsibilities	91.7% ↓
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
SFBHN Sharing Agreement[1]	100.0% =
QRRS/GRRS Edited to Remove Prompts	50.0% ↓
QRRS/GRRS Provides Rationale for Level of Care	50.0% ↓
SMQ R 8 Completed	84.6% ↑
SNAP Form Completed	83.3% ↑
Evidence Results Shared with Client[1]	69.2% =
GRRS Edited to be Individualized	58.3% ↓
Preliminary Plan Completed at Admission	75.0% ↓
Life Goal in Client's Own Words	61.5% ↑
Wellness & Recovery Plan Reflects GRRS	53.8% ↑
Wellness & Recovery Plan Completed on Time	58.3% ↑
Plan Objectives are Behavioral & Measurable	61.5% ↑
Plan Reviews Include Client's Assessment of Progress	33.3% ↓
Plan Reviews Completed On-Time (for those having reviews due)	30.0% ↓

[1]New item this Fiscal Year

PREVENTION LEVEL 2	
Section	**Average Total Percent (100% highest possible score)**
Screening and Admission	87.0% ↑
Assessment	100.0% ↑
Initial/Preliminary Treatment Plan	NA
Wellness & Recovery Plans and Reviews	NA
Prevention Plan and Reviews	60.0% ↑
Prevention Summary Notes	50.0% =
Discharge/Transition Reporting	56.5% ↓

PREVENTION LEVEL 2	
Content Area	**% Compliant**
Immediate or Urgent Needs Documented	100.0% ↑
Consent to Participate Signed	100.0% =
Information Regarding Rights/Responsibilities	--
Information Regarding Grievance Procedure	100.0% ↑
Information on HIPAA	100.0% =
SFBHN Sharing Agreement[1]	50.0% =
Plan Indicates Risk Factors	60.0% ↑
Plan Indicates Protective Factors	60.0% ↑
Plan Identifies Goals Specific to Client	60.0% ↑
Plan Objectives are Behavioral & Measurable	60.0% ↑
Summary Notes Include Risk & Protective Factors Addressed	50.0% =
Summary Notes Include Progress on Goals and Objectives	50.0% =

Staff reviewed 80 closed ***ADULT treatment charts***. Findings are as follows:

Content Area	% Compliant
Discharge Summary Completed	89.3% =
Discharge Report Includes Reason for Discharge	90.8% ↓
Discharge Report Includes Recommendations & Referrals	84.5% ↓
Discharge Report Includes Evaluation of Progress	88.0% ↑
Discharge/Transfer ASAM Completed	97.1% ↑
SISAR Completed	96.9% ↑
MH Outcome Completed	88.6% =
FARS/CFARS Completed	90.5% ↑
Wellness & Recovery Plans Closed	76.7% ↑
Service Plans Closed	100.0% =

Staff reviewed 32 closed ***CHILD treatment charts***. Findings are as follows:

Content Area	% Compliant
Discharge Summary Completed	91.2% ↑
Discharge Report Includes Reason for Discharge	94.1% ↓
Discharge Report Includes Recommendations & Referrals	90.9% ↓
Discharge Report Includes Evaluation of Progress	93.8% ↑
Discharge/Transfer ASAM Completed	70.0% ↓
SISAR Completed	75.0% ↓
MH Outcome Completed	87.0% ↓
FARS/CFARS Completed	87.0% ↑
Wellness & Recovery Plans Closed	57.9% ↓
Service Plans Closed	50.0% ↓

Staff reviewed 22 closed ***diversion and prevention charts.*** Findings are as follows:

Content Area	% Compliant
Discharge Summary Completed	63.6% ↓
Discharge Report Includes Reason for Discharge	81.8% ↑
Discharge Report Includes Recommendations & Referrals	71.4% ↓
Discharge Report Includes Evaluation of Progress	52.4% ↓
Discharge/Transfer ASAM Completed	85.7% ↑
SISAR Completed	88.9% ↑
Wellness & Recovery Plans Closed	68.4% ↑

2. Utilization Management

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

   Type of Objective: *Quality Assurance: Efficiency*

   The Senior Scientist completed the final version of the Utilization Management Review Forms. He 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 2017-2018, the VP and Senior Scientist delayed implementation because of numerous competing priorities.

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*

Although there have been improvement for the past year, many clients still do not have this information in the EHR. Therefore, results are only for those clients having the information available.

MENTAL HEALTH CLIENTS		
Covered Services	**Total Number of Clients**	**The number of behavioral health consumers identified as needing primary care**
Assessment	**80 (27 had data)**	**17 (63.0%)**
Crisis Stabilization Unit	**259 (169 had data)**	**108 (63.9%)**
In Home/On-Site	**105 (60 had data)**	**2 (3.3%)**
Medical Services	**417 (19 had data)**	**4 (26.7%)**
Outpatient Individual	**179 (21 had data)**	**7 (33.3%)**

SUBSTANCE USE CLIENTS		
Covered Services	**Total Number of Clients**	**The number of behavioral health consumers identified as needing primary care**
Assessment	**29 (7 had data)**	**5 (71.4%)**
Detoxification	**180 (77 had data)**	**60 (77.9%)**
In Home/On-Site	**90 (21 had data)**	**13 (61.9%)**
Medical Services	**--**	**--**
Outpatient Individual	**164 (47 had data)**	**38 (80.8%)**

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*

Although there have been improvement for the past year, many clients still do not have this information in the EHR. Furthermore, staff is not assisting clients who do not have a primary care physician because they deem them "to be in good health." Therefore, results are only for those clients having the information available.

MENTAL HEALTH CLIENTS		
Covered Services	**The number of behavioral health consumers identified as needing primary care**	**Number of successful linkages to primary care**
Assessment	**17**	**9 (52.9%)**
Crisis Stabilization Unit	**108**	**35 (32.4%)**
In Home/On-Site	**2**	**1 (50.0%)**
Medical Services	**4**	**0 (0.0%)**
Outpatient Individual	**7**	**6 (85.7%)**

SUBSTANCE USE CLIENTS		
Covered Services	**The number of behavioral health consumers identified as needing primary care**	**Number of successful linkages to primary care**
Assessment	**5**	**5 (100.0%)**
Detoxification	**60**	**22 (36.7%)**
In Home/On-Site	**13**	**9 (69.2%)**
Medical Services	**--**	**--**
Outpatient Individual	**38**	**12 (31.6%)**

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 135 adult clients from substance abuse treatment from January 1 – June 30, 2018. Fifteen (15) clients had admission data but no discharge data in the system. Therefore, 120 clients (88.9%) had admission and discharge data available for analysis.

A significant number of clients reduced their substance abuse from admission to discharge ($Z = -2.757$, $p<.006$). Twenty-nine clients (29) reduced their substance use from admission to discharge, representing 24.2% of the discharges. Eight (8) clients increased use from admission to discharge, representing 6.7% of the discharges. Approximately 69.2% (N=83) continued to use substances at the same level at discharge as they did at admission.

Closer examination of the data revealed that 80 (66.7%) clients did not use any substances during the 30 days prior to admission. Therefore, a subsequent analysis excluded these clients using the 40 clients who reported use within the 30 days prior to admission.

For this analysis, a significant percent of clients also reduced their substance use from admission to discharge ($Z = - 3.718$, $p<.001$). Twenty-nine (29) reduced their substance use, representing 72.5% of the discharges who reported use at admission. Four (4) clients increased use, representing 10% of the clients. Seven (7) clients continued to use at the same level at discharge as at admission (17.5%).

Action: Even after eliminating those clients who did not use substances within the 30 days prior to admission, only 72.5% of the clients discharged reduced there substance use. This falls below the target of 80%. The Senior Scientist will reanalyze the data looking only at those clients who successfully completed treatment.

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*

During the second biannual period of the Fiscal Year, G/CC provided Prime for Life to 264 youth. Two hundred seventeen (217) youth completed the required number of sessions, representing 82.2% of the youth enrolled.

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*

From January 1 – June 30, 2018, G/CC discharged 48 youth from Teen Intervene. Forty-six (46) youth successfully completed the curriculum, representing 95.8% of the youth enrolled.

6. Completion Rates for Project SUCCESS

Objective: 85% of youth enrolled in Project SUCCESS will complete the required sessions.

Type of Objective: *Quality Assurance: Efficiency*

From January 1 – June 30, 2018, G/CC enrolled 10 youth into the Small Group Sessions. Nine (9) youth completed the required number of sessions (4-8), representing 90% of the youth enrolled.

From January 1 – June 30, 2018, G/CC enrolled 101 youth into the Prevention Education Series. All youth completed the required number of sessions (4-8), representing 100% of the youth enrolled.

7. Alcohol use among youth completing Project SUCCESS

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

Type of Objective: *Quality Assurance: Effectiveness*

G/CC utilizes the 19-item Project SUCCESS Survey to determine changes in the youths' behaviors, attitudes, and perceptions.

From January 1 – June 30, 2018, 10 youth from Project SUCCESS participating in the Small Groups completed a post-completion survey.

Based on this Survey, Nine (9) youth (90%) of the youth reported not using alcohol in the 30 days prior to completing Project SUCCESS. This falls above the target of 85%.

From January 1 – June 30, 2018, 101 youth from Project SUCCESS participating in the Prevention Education Series completed a post-completion survey.

Based on this Survey, 85 youth (84.2%) reported not using alcohol in the 30 days prior to completing Project SUCCESS. This falls slightly below the target of 85%.

Action: Since the attained rate (84.2%) fell only slightly below the target (85%) for this biannual period, the Senior Scientists will continue to monitor it during the next biannual period. If it falls below the target for two consecutive biannual periods, he will work with program staff to implement a PI initiative.

8. Attitudes and beliefs related to risk of harm associated with underage drinking among youth completing Project SUCCESS.

Objective: 85% of youth will increase attitudes and beliefs about risk of harm by curriculum completion.

Type of Objective: *Quality Assurance: Effectiveness*

G/CC utilizes the 19-item Project SUCCESS Survey to determine changes in the youths' behaviors, attitudes, and perceptions. There are two questions on the Survey that address risk of harm related to alcohol.

a) How much do you think people risk harming themselves (physically or in other ways) if they take one or two drinks of an alcoholic beverage nearly every day?
b) How much do you think people risk harming themselves (physically or in other ways) if they have five or more drinks of an alcoholic beverage once or twice nearly a week?

From January 1 – June 30, 2018, 10 youth from Project SUCCESS participating in the Small Groups completed a post-completion survey.

Prior to beginning the curriculum, 80% of the youth perceived a risk of harm related to having 1-2 drinks daily. By curriculum completion, none (0%) of the youth changed their perception, falling below the target of 85%.

A subsequent analysis examined only those youth reporting "no" or "slight" risk at admission. Neither youth's perception changed by curriculum completion.

Prior to beginning the curriculum, 80% of the youth perceived a risk of harm related to having five or more drinks once or twice weekly. By curriculum completion, 100% of the youth perceived a risk of harm. Only 20% of the youth changed their perception, falling below the target of 85%. This change, however, was almost significant statistically ($Z = -1.289$, $p=.19$).

A subsequent analysis examined only those youth reporting "no" or "slight" risk at admission. Both youth increased their perception of risk of harm to "moderate" or "great" risk.

From January 1 – June 30, 2018, 101 youth from Project SUCCESS participating in the Prevention Education Series completed a post-completion survey.

Prior to beginning the curriculum, 61.4% of the youth perceived a risk of harm related to having 1-2 drinks daily. By curriculum completion, only 49.5% of the youth changed perceived a "moderate" or "great" risk of harm, falling below the target of 85%. ***Nearly 35% of the youth decreased their perception of risk of harm following the curriculum.***

Prior to beginning the curriculum, 73.2% of the youth perceived a risk of harm related to having five or more drinks once or twice weekly. By curriculum completion, only 74.2% of the youth perceived a risk of harm. Only 1% of the youth changed their perception, falling below the target of 85%. ***Nearly 32% of the youth decreased their perception of risk of harm following the curriculum.***

Action: The Prevention Education Series resulted in findings that are contrary to the hypothesis. In fact, nearly 1/3 of the youth decreased their perception of the risk of harm. The Senior Scientist will explore this finding with the program in an attempt to ascertain why this may be.

9. Favorable attitudes toward alcohol and drug use among youth completing Project SUCCESS

Objective: 85% of youth will decrease favorable attitudes about alcohol/drugs by curriculum completion

Type of Objective: *Quality Assurance: Effectiveness*

G/CC utilizes the 19-item Project SUCCESS Survey to determine changes in the youths' behaviors, attitudes, and perceptions. The Survey only has one question that addresses this. It specifically related to alcohol use. There is no question relating to drug use.

From January 1 – June 30, 2018, 10 youth from Project SUCCESS participating in the Small Groups completed a post-completion survey.

Prior to beginning the curriculum, 70% of the youth did not have favorable attitude to people their age using alcohol regularly. By curriculum completion, only 60% of the youth did not have a favorable attitude. ***Nearly 20% of the youth decreased their perception of risk of harm following the curriculum.***

From January 1 – June 30, 2018, 101 youth from Project SUCCESS participating in the Prevention Education Series completed a post-completion survey.

Prior to beginning the curriculum, 63.3% of the youth did not have favorable attitude to people their age using alcohol regularly. By curriculum completion, only 66.3% of the youth did not have a favorable attitude. ***Nearly 32% of the youth decreased their perception of risk of harm following the curriculum.***

Action: The Prevention Education Series resulted in findings that are contrary to the hypothesis. In fact, numerous the youth decreased their perception of the risk of harm. The Senior Scientist will explore this finding with the program in an attempt to ascertain why this may be.

10. Favorable attitudes toward alcohol, tobacco and drug use among youth completing PRIME for Life.

Objective: 85% of youth who complete PRIME will decrease favorable attitudes towards alcohol, tobacco, and other drugs.

Type of Objective: *Quality Assurance: Effectiveness*

G/CC utilizes the 10-item Prime for Life Survey to determine changes. None of these items addresses favorable attitudes towards alcohol, tobacco, and other drug use. Therefore, G/CC cannot address this objective.

11. Healthy behaviors among youth completing Teen Intervene

Objective: 85% of youth who complete Teen Intervene will increase their healthy behaviors, decrease use of ATOD or delay the onset for marijuana use.

Type of Objective: *Quality Assurance: Effectiveness*

From January 1 – June 30, 2018, 40 youth completed a pre- and post-test for Teen Intervene. G/CC utilizes a 21-item Survey to determine changes in the youths' behaviors. The Survey uses three questions to assess alcohol, marijuana, and other drug use.

Upon completion of three sessions of Teen Intervene, how many times (if any):

a) Have you had alcoholic beverages?
b) Have you used marijuana or hashish?
c) Have you used drugs other than alcohol and marijuana?

At the time of enrollment, 43.9% of the youth reported using alcohol in the past 12 months. At the time of curriculum completion, only 5% of the youth reported drinking alcohol. This is a significant finding ($z = -3.381$, $p<.001$).

At the time of enrollment, 51.2% of the youth reported smoking marijuana or using hashish in the past 12 months. At the time of curriculum completion, only 5% of the youth reported smoking marijuana. This decrease was statistically significant ($z = -3.750$, $p<.001$).

At the time of enrollment, only 7.3% of the youth reported using other drugs in the past 12 months. At the time of curriculum completion, none (0%) of the youth reported using other drugs. Since there is limited variability in use, this change was not statistically significant.

12. 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 PCL-5 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 PCL-5 at discharge from the service.

PCL-5 : Ratings are on a Likert Scale: (1) Not at all; (2) A little bit; (3) Moderately; (4) Quite a bit; and (5) Extremely **RED = Significant at 95% Confidence Interval**			
Item	**Average Pre-Score**	**Average Post-Score**	**Significance**
Repeated, disturbing, and unwanted memories of the stressful experience	1.33	1.23	.103
Repeated, disturbing dreams of the stressful experience	1.16	1.04	.350
Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)	0.61	0.63	.899
Feeling very upset when something reminded you of the stressful experience	1.23	0.93	.088
Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)	0.91	0.93	.918
Avoiding memories, thoughts, or feelings related to the stressful experience	1.32	1.12	.268
Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)	1.23	1.05	.301
Trouble remembering important parts of the stressful experience	0.95	0.90	.817
Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)	1.21	1.00	.300
Blaming yourself or someone else for the stressful experience or what happened after it	1.39	0.89	**.026**
Having strong negative feelings such as fear, horror, anger, guilt, or shame	1.44	0.81	**.001**
Loss of interest in activities that you used to enjoy	1.00	0.75	.159
Feeling distant or cut off from other people	1.46	1.05	**.019**
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)	0.81	0.65	.350
Irritable behavior, angry outbursts, or acting aggressively	0.61	0.79	.336
Taking too many risks or doing things that could cause you harm	0.83	0.51	.083
Being “superalert” or watchful or on guard	1.35	0.93	.068
Feeling jumpy or easily startled	1.13	0.75	**.035**

PCL-5 : Ratings are on a Likert Scale: (1) Not at all; (2) A little bit; (3) Moderately; (4) Quite a bit; and (5) Extremely RED = Significant at 95% Confidence Interval			
Item	**Average Pre-Score**	**Average Post-Score**	**Significance**
Having difficulty concentrating	1.53	1.11	**.015**
Trouble falling or staying asleep	1.68	1.04	**.001**
TOTAL SCORE	22.79	17.47	**.027**

13. 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 2018 for progress on this item.

14. Stable Housing for MIND Clients

Objective 1: 80% of clients not having stable housing at admission will have it at 90 days post admission.

Objective 2: 80% of clients not having stable housing at admission will have it at 1 year post discharge.

Type of Objective: *Quality Assurance: Effectiveness*

During the biannual period, 25 clients did not have stable housing when enrolled in MIND. Within 90 days, 22 clients (88%) obtained stable housing.

None of the clients are one-year post discharge.

15. Employment for MIND Clients

Objective 1: 80% of unemployed clients wanting to work will have employment 180 days from admission.

Objective 2: 70% of unemployed clients wanting to work will have employment 1 year from admission.

Type of Objective: *Quality Assurance: Effectiveness*

Twenty-five (25) clients who did not have employment at the time of enrollment for this biannual period were in MIND for 180 days. . Of those, 22 obtained employment within 180 days, resulting in a 88% employment rate. This rate is slightly below the target of 80%.

None of the clients are one-year post discharge.

16. Benefits and Entitlements for MIND Clients

Objective: 70% of clients who are eligible for benefits will receive assistance applying.

Type of Objective: *Quality Assurance: Effectiveness*

At the time of admission, 25 clients, who were eligible, were not receiving benefits at enrollment. MIND assisted 100% of these clients with the applications.

17. Mental Health Symptoms of MIND Clients

Objective: 80% of clients will have reduced MH symptoms at discharge.

Type of Objective: *Quality Assurance: Effectiveness*

To date, MIND discharged 28 clients from the program who had mental health symptoms at admission. Of these, 25 clients (89.2%) exhibited reductions at discharge.

18. Mental Health Symptoms at Follow-Up

To date, none of the clients discharged are at the 3, 6, or 12-month follow up assessment periods.

19. Substance Use or Misuse of the MIND Clients

Objective 1: 75% of clients will be Substance free at discharge.

Objective 2: 75% will remain substance free at 3-, 6-, and 12-months post discharge.

Type of Objective: *Quality Assurance: Effectiveness*

To date, MIND enrolled 29 clients who had substance use issues. Of these, MIND discharged 28. Twenty-six (26) of the discharged clients were alcohol and drug-free at discharge, representing 92.9% of the discharged clients who had substance use issues.

To date, none of the clients discharged are at the 3, 6, or 12-month follow up assessment periods.

20. Physical Health of MIND Clients

Objective 1: 80% of clients will have improved physical health at discharge.

Objective 2: 70% will maintain the improvements at 3-, 6-, and 12-months post discharge.

Type of Objective: *Quality Assurance: Effectiveness*

This indicator is no longer in spreadsheet for Year 2 of grant.

F. Safety and Security

1. Incident Reports

Objective: G/CC will report 99% of reportable incidents to appropriate external entity.

Type of Objective: *Quality Assurance: Efficiency*

Between January 1 and June 30, 2018, 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
80.3 (98)	10.6 (13)	6.6 (8)	2.4 (3)	122

Facility	Closed % (#)	Reviewed % (#)	Pending % (#)	Follow-Up % (#)	Total
Key Largo	81.8 (9)	0.0 (0)	0.0 (0)	18.2 (2)	11
Marathon	69.2 (45)	20.0 (13)	10.8 (7)	0.0 (0)	65
Key West	97.0 (33)	0.0 (0)	3.0 (1)	0.0 (0)	34
Heron	91.7 (11)	0.0 (0)	0.0 (0)	3.1 (1)	12
Primary Care	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	0
Total	**98**	**13**	**8**	**3**	**122**

Overall, G/CC only closed 80.3% of the incidents this biannual period. Three (3) reports required follow-up. Approximately 11% of the reports remain in review, indicating that an employee submitted a report but a supervisor did not review it. Marathon (100%) had the highest proportion of these incidents. Eight (8) reports are pending (6.6%), indicating that an employee wrote a report but did not submit it successfully.

Action
The Senior Scientist will provide a detailed list to each Site Director/Office Manager of the Incident Reports numbers remaining under review or pending. They 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
21.3 (26)	65.6 (80)	13.1 (16)	122

Facility Breakdown

	Immediately Reportable % (#)	Reportable % (#)	Non-Reportable % (#)	Total
Key Largo	54.5 (6)	36.4 (4)	9.1 (1)	11
Marathon	12.3 (8)	67.7 (44)	20.0 (13)	65
Key West	35.3 (12)	61.8 (21)	2.9 (1)	34
Heron	0.0 (0)	91.7 (11)	8.3 (1)	12
Primary Care*	0.0 (0)	0.0 (0)	0.0 (0)	0
Total	**26**	**80**	**16**	**122**

*__Note:__ Primary Care is part of the Marathon location

Key West had the highest rate of "Immediately Reportable" incidents, accounting for 9.8% of all incidents, and 46.2% of all "Immediately Reportable" incidents. Nearly 55% of all incidents occurring in Key Largo were "Immediately Reportable," the highest site specific rate of any location.

Incident Category Breakdown

Incident Category	Number	Percent of Total
Abuse/Neglect	12	9.9
Alcohol/Drugs	4	3.3
Behavior, Other	6	4.9
Client Grievance	3	2.4
Confidentiality	0	0.0
Contraband	0	0.0
Criminal	1	0.8
Death	4	3.3
Disaster	0	0.0
Illness	7	5.7
Injury	7	5.7
Left Treatment/Elopement	4	3.3
Medication Error	19	15.6
Medication Reaction	0	0.0
Motor Vehicle/Transportation	5	4.1
Operations	12	9.9
Other	7	5.7
Restraint, Seclusion, Therapeutic Holds	2	1.6
Safety	2	1.6
Self-Harm/Psychiatric Emergencies	16	13.1
Sexual	2	1.6
Staff	0	0.0
Violence	9	7.4
Total	**122**	**100**

All (7) of the ***Illness incidents*** occurred in Marathon, with 85.7% of these occurring on the Inpatient unit and 14.3% occurring at PGC. All (100%) of the incidents required medical services, with 85.7% of these requiring emergency services and 14.3% requiring

non-emergency services. Approximately 86% of the ***Injury incidents*** occurred in Marathon, with 71.4% of these occurring on the Inpatient unit. The remaining ***Injury incidents*** occurred in Key West (1; 14.3%). Only 28.6% of the incidents required non-emergency medical attention. The remaining 71.4% required no medical attention. Seventy-five percent (75%) of the ***Self-Harm/Psychiatric Emergency incidents*** occurred in Key West and 25% occurred in Key Largo. Seventy-five percent (75%) of the incidents were suicidal ideations or threats. Nearly 19% were self-abuse, and 6.3% were suicide attempts. The attempt did not occur on WestCare property. *Staff took precautionary measures to keep the client safe in 100% of the cases.* Seventy-five percent (75%) of the ***Death incidents*** occurred in Key Largo, and 25% occurred in Key West. All (100%) resulted from natural causes. G/CC made requests in all cases to the Medical Examiner to receive reports related to the cause of death. *None (0%) of the incidents occurred on WestCare property.* There were two (2) ***Sexual incidents*** this biannual reporting period. Both incidents occurred in Key West and involved sexual abuse of a minor. *None of the incidents involved G/CC staff, and none occurred on WestCare property. Staff reported all allegations to DCF as required.* There were no ***Contraband incidents*** this biannual period. There were two (2) ***Safety incidents***, with 50% occurring in Marathon on the Inpatient unit, and 50% occurring at The Heron. One incident involved a staff member losing her keys that open the front door, office, and staff area to facility. The other involved a staff member accidentally sticking herself with a lancet she used on a client to draw blood.

There were 12 ***Abuse/Neglect incidents.*** Two-thirds (66.7%) occurred in Key West, 16.7% occurred in Marathon, and 16.7% occurred in Key Largo. *None (0%) of the incidents occurred on agency property, and none involved agency staff. Staff reported all incidents/allegations to the appropriate and required authorities.* There were four (4) ***Alcohol/Drug*** incidents. Half (50%) occurred in Key West, and 50% occurred in Marathon. Two (2; 50%) incidents related to clients bringing substances on the property, one (1; 25) related to a client using on the facility, and one (1; 50%) related to a client having a positive urine screen. There were 12 ***Operation incidents.*** More than half (58.3%) occurred at Marathon, and 41.7% occurred at the Heron. Approximately 83% related to funding/licensing agencies conducting on-site reviews, with 60% of these relating to announced visits, and 40% relating to unannounced visits. Approximately 8% related to mechanical failures, and 8% related to falsified documentation. There were five (5) ***Motor Vehicle incidents*** this biannual period, with 100% occurring in Marathon. All (100%) involved a WestCare operated vehicle. Sixty percent (60%) involved property damage only, and 40% involved collision damage only. None resulted in injury. There were four (4) ***Left Treatment incidents*** this biannual reporting period. Two (2; 50%) occurred in Key West, one (1; 25%) occurred in Marathon, and one (1; 25%) occurred at the Heron. Half (50%) of the incidents were self-discharges. There were nine (9) ***Violence incidents*** this biannual period, with 55.5% occurring in Key West, 33.3% occurring in Marathon, and 16.7% occurring in Key Largo. Approximately 44% involved only combative and threatening behavior; 44.4% involved homicidal ideation; and 11.2% involved physical aggression. There was one (1) ***Criminal incident*** this biannual period, which occurred in Marathon. It involved the arrest of a staff member while driving a WestCare vehicle. There was no ***Confidentiality incident*** this biannual reporting period.

There were three (3) ***Grievance incidents.*** Two-thirds (66.7%) occurred in Key West, and 33.3% occurred in Marathon. Half (50%) of the incidents were about staff. All (100%) related to clients complaining about a staff member. ***Two (2) of the incident descriptions were vague and did not clearly explain what the grievance about the staff was.*** The remaining incident related to a father complaining that the therapist should have spoken to him about his child's threatening behavior PRIOR to informing school personnel, resulting in the child's arrest.

There were 2 incidents of ***seclusion and/or restraint*** use this biannual period. Both occurred on the Inpatient unit. Both (100%) involved seclusion with mechanical and chemical restraint. None (0%) involved injury. Fifty percent (50%) of the incidents occurred between midnight – 1:00 am, and 50% occurred between 11:00 –11:59 PM. Both incidents occurred on Wednesday.

Hours of Day Breakdown

Time of Day	Number	Percent Total
Morning (12 am – 11:59 am)	53	43.4
Afternoon (12 pm – 4:59 pm)	51	41.8
Evening (5 pm – 11:59 pm)	18	14.8
Total	**122**	**100**

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	11	9.0
Monday	19	15.6
Tuesday	20	16.4
Wednesday	27	22.1
Thursday	21	17.2
Friday	18	14.8
Saturday	6	4.9
Total	**122**	**100**

Approximately 15% of the incidents occurred on the weekend (Saturday-Sunday). Wednesday had the highest occurrence of incidents during the weekday, accounting for 25.7% of all incidents occurring from Monday through Friday.

Action
Information only

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, 2018, there were 19 ***Medication Error incidents***. Fourteen (14; 73.7%) occurred on the Inpatient Unit (CSU + Detox, and five (5; 26.3%) occurred at the Heron.

Closer examination of the medication errors revealed the following. For those incidents occurring on the Inpatient Unit (N=14), one (1; 7.1%) related to a counting error, three (3; 21.4%) were documentation errors, one (1; 7.1%) involved a client receiving a wrong dose, two (2; 14.2%) involved a client receiving the incorrect medication, four (4; 28.6%) involved a client receiving a medication at the wrong time; one (1; 7.1%) involved a client being out of medication; and one (1; 7.1%) involved the facility receiving the incorrect amount of medication. For those incidents occurring at the Heron (N=5), four (4; 80%) related to clients not showing up for medication, and one (1; 20%) related to a client being out of medication.

3. Emergency Drills

Objective: 98% of emergency drills will occur on time at all locations

Type of Objective: *Quality Assurance: Efficiency*

The following "Drills" were due this biannual period.

	MARCH	APRIL	MAY
			
Location	**Workplace Violence**	**Active Shooter**	**Natural Disaster**
	DRILL	**DRILL**	**DRILL**
Key Largo	✓	✓	✓
Marathon	--	--	✓
Key West	✓	✓	✓
The Heron	✓	--	✓

G/CC did not complete the required drills at all locations during this biannual period. All (100%) of the sites completed the Natural Disaster drill in May 2018. Only 75% of the sites completed the Workplace Violence drill in March, with Marathon not completing it.

Half (50%) of the sites completed the Active Shooter drill in April. Neither Marathon nor the Heron completed this drill.

Action: The Senior Scientist notified the Site Director that the required drills were missing from the online system.

4. System Safety Program (SSP)

Objective: A biannual review of the SSP will occur 100% of the time

Type of Objective: *Quality Assurance: Efficiency*

Discussion occurred during the January 30, 2018 meeting.

5. Compliance with the security-related requirements outlined in FDOT Rule 14.90

Objective: 100% of Meeting minutes will reflect discussion of the security-related items; Biannual analysis of IRs for security-related incidents

Type of Objective: *Quality Assurance: Efficiency*

The January 30, 2018 EOC minutes reflect discussion and action on the security-related items. The biannual incident report analysis is in this report. The EOC Committee will review the findings in the next meeting.

Action
The Chief Clinical Officer will provide this biannual report, which includes the incident report analyses, to the EOC Committee for the next meeting.

6. Safety and Security inspections

Objective: 100% of Meeting minutes will reflect discussion of Safety and Security Inspections conducted

Type of Objective: *Quality Assurance: Efficiency*

The January 30, 2018 minutes reflect discussion of the available reports.

G. Staff Development

1. New Hire Training

Objective: 95% of new hires will complete the e-learning courses within 30 days from hire date

Type of Objective: *Quality Assurance: Efficiency*

During this biannual period (January – June 2018), 98.49% of the new hires completed the e-learning courses within the required 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*

The expectation is that staff will complete approximately 10 hours of training each biannual period. On average, staff completed 18.5 hours of training from January 1 – June 30, 2018, ranging from 1 to 81 hours.

3. Employee Turnover

Objective: <20% turnover rate

Type of Objective: *Quality Assurance: Efficiency*

For the biannual period of January 1 – June 30, 2018, the average turnover rate was 2.967%. The average turnover rate for FY 2018 was 3.335. These rates fall falling below the target of 20%. The monthly turnover rate for G/CC is below.

Month	Turnover Rate %
July	0.881
August	3.367
September	5.021
October	7.080
November	0.889
December	4.979
Biannual Average Rate	**3.703**
January	1.594
February	2.410
March	4.878
April	3.320
May	2.251
June	3.347
Biannual Average Rate	**2.967**
Annual Average Rate	**3.335**

4. Overtime

Objective: NA

Type of Objective: *Quality Assurance: Efficiency*

For the second biannual period of Fiscal Year 2017-2018, G/CC had a total of 788.83 hours in overtime, averaging 131.47 hours monthly. This resulted in a total cost of $19,457.60. The average cost per month was $3,242.93.

The monthly trend is below.

Month	Hours	Cost
July	848.7	$20,249.39
August	702.49	$17,149.11
September	413.32	$9,770.86
October	655.05	$16,196.27
November	562.09	$14,495.22
December	384.13	$9,600.23
Biannual Total	**3,565.78**	**$87,461.08**
January	236.49	$6,881.07
February	299.13	$9,165.99
March	207.22	$6,355.87
April	350.69	$10.542.69
May	302.39	$8,381.29
June	401.1	$10,123.87
Biannual Total	**1,797.53**	**$51,450.78**
Annual Total	**5,363.31**	**$138,911.86**

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 2018 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 2018 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 2018 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 2018for 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 2018 or progress on this item.

CQI Semiannual Update
Guidance/Care Center, Inc.
Date of Update: June 30, 2018

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; PCL-5 pre- and post-test measures **Progress:** During the biannual reporting period, G/CC staff completed two (2) fidelity checks for two (2) clinicians. The fidelity checks occurred for the topics: Setting Boundaries in Relationships & Red and Green Flags.

Seeking Safety: BIANNUAL	
Fidelity Content Area	**% Compliant**
Check-In	100%
Quotation	50%
Handouts	100%
Check Out	50%
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%
Case Management	100%
Absence of Graphics Details of Trauma or SA	100%
Warmth/Caring	100%
Depth	50%
Management of Crisis and Extreme Emotion	50%
Power Dynamics	50%
Listening	100%
Level of Engagement	100%
Absence of Intervention that Conflicts with Manual	100%
Building Group Cohesion	100%
Overall Performance: Average Score = 2.00	Done A Lot

CQI Semiannual Update
Guidance/Care Center, Inc.
Date of Update: June 30, 2018

PCL-5 : Ratings are on a Likert Scale: (1) Not at all; (2) A little bit; (3) Moderately; (4) Quite a bit; and (5) Extremely RED = Significant at 95% Confidence Interval			
Item	**Average Pre-Score**	**Average Post-Score**	**Significance**
Repeated, disturbing, and unwanted memories of the stressful experience	1.33	1.23	.103
Repeated, disturbing dreams of the stressful experience	1.16	1.04	.350
Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)	0.61	0.63	.899
Feeling very upset when something reminded you of the stressful experience	1.23	0.93	.088
Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)	0.91	0.93	.918
Avoiding memories, thoughts, or feelings related to the stressful experience	1.32	1.12	.268
Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)	1.23	1.05	.301
Trouble remembering important parts of the stressful experience	0.95	0.90	.817
Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)	1.21	1.00	.300
Blaming yourself or someone else for the stressful experience or what happened after it	1.39	0.89	**.026**
Having strong negative feelings such as fear, horror, anger, guilt, or shame	1.44	0.81	**.001**
Loss of interest in activities that you used to enjoy	1.00	0.75	.159
Feeling distant or cut off from other people	1.46	1.05	**.019**
Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)	0.81	0.65	.350
Irritable behavior, angry outbursts, or acting aggressively	0.61	0.79	.336
Taking too many risks or doing things that could cause you harm	0.83	0.51	.083
Being “superalert” or watchful or on guard	1.35	0.93	.068
Feeling jumpy or easily startled	1.13	0.75	**.035**
Having difficulty concentrating	1.53	1.11	**.015**
Trouble falling or staying asleep	1.68	1.04	**.001**
TOTAL SCORE	22.79	17.47	**.027**

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.

ADULT	
Content Area	**% Compliant**
Evidence that Assessments Results are Shared with the Person Served	89.7 ↑
Life Goal in the Person's Served Own Words	72.7 ↑
Wellness & Recovery Plan includes Barriers	72.7 ↑
Wellness & Recovery Plan includes Strengths	68.2 ↑
Wellness & Recovery Plan Objectives are Specific to the Needs of the Person Served	72.7 ↑
Wellness & Recovery Plan includes Stage of Change for Each Objective	71.4 ↑
Plan Reviews Include Client's Assessment of Progress	75.0 ↑

CHILD	
Content Area	**% Compliant**
Evidence that Assessments Results are Shared with the Person Served	88.9 ↓
Life Goal in the Person's Served Own Words	50.0 ↓
Wellness & Recovery Plan includes Barriers	50.0 ↓
Wellness & Recovery Plan includes Strengths	50.0 ↓
Wellness & Recovery Plan Objectives are Specific to the Needs of the Person Served	50.0 ↓
Wellness & Recovery Plan includes Stage of Change for Each Objective	50.0 ↓
Plan Reviews Include Client's Assessment of Progress	60.0 ↓

Relapse Prevention Therapy	**Measure:** Observation using RPT Fidelity Checklist **Progress:** GCC collected two (2) RPT Fidelity Checklists this biannual reporting period for two (2) clinicians. The Observation occurred for the session topics: Identifying High Risk Scenarios & Coping with High Risk Scenarios.

BIANNUAL	
Fidelity Content Area	**% Compliant**
Check-In	50.0%
Handouts	50.0%
Focus on skills learned to prevent relapse	50.0%
Safe coping	50.0%
Topic discussion and rehearsal	50.0%
Focus on Current, Specific, Important Client Problems	50.0%
Balance of Support & Accountability	50.0%
Absence of Graphics Details of SA	50.0%
Assign New Task	50.0%

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BIANNUAL	
Fidelity Content Area	**% Compliant**
Encourage Practice	50.0%
Warmth and Caring	50.0%
Depth	50.0%
Management of Crisis and Extreme Emotion	50.0%
Power Dynamics	50.0%
Listening	50.0%
Level of Engagement	50.0%
Absence of Intervention that Conflicts with Manual	50.0%
Building Group Cohesion	50.0%
Overall Performance: Average Score = 3.00	Done a Little

MRT	**Measure:** Observation using the MRT Checklist **Progress:** During the biannual reporting period, G/CC conducted two (2) fidelity checks for one (1) clinician.

BIANNUAL	
Fidelity Content Area	**% Compliant**
Facilitator Handbook Present	100%
All Participants have an MRT Handbook	100%
Participants without an MRT Book are NOT Allowed to Present a Step	--
Participants State the Essence of the Step They are Presenting	100%
Facilitator Does Not Allow Specific Questions Related to Crime	100%
Facilitator Does Not Allow Participants to Ramble when Presenting	100%
Facilitator used the Freedom Ladder Acknowledging and Reinforcing Positive Recognition for Accomplishment	100%
Facilitator Encourages How to Complete Steps – Indicates They are Confident the Client can Complete the Work	100%
Step 1 Testimony is Presented while the Client Stands and Guidelines are Followed	100%
Step 3 Part 1 Guidelines are Followed	100%
Step 3 Part 2 Guidelines are Followed	100%
Facilitator Directs no Value Judgements	100%
Facilitator Directs Participants to Follow Rules of Each Step	100%
Praise is Consistent with the Offender's Presentation	100%
Step 4 Reality is Maintained	100%
Feedback is Concrete and Specific	100%
Step 5 Important Relationship is Related to the Client's Current Circumstance	100%
Step 6 All Public Service Hours are Pre-Approved	100%
Step 7 Facilitator Assists Clients to Follow Instructions on Master Goal Plan	100%
Step 7 Facilitator Operates as a "Broker of Reality" when Reviewing 1, 5, and 10-Year Goals and Assists with Analyzing Them	100%
Participant Commits to What Step S/he will be Working On and Presenting in the Next Group	100%
Review Time is Provided at the End of Group	100%
Facilitator Does Not do Therapy	100%
Were Group Rules and Expectations for Participation Reviewed for New Group Members	100%
If Step Summaries are Required, were Summaries Passed that Showed that the Client Made an Effort to Read the Step	100%
Were Exercises Passed that Complied with the Instructions in the Book	100%

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BIANNUAL	
Fidelity Content Area	**% Compliant**
When an Exercise was not Passed by the Group Facilitator, was the Client Told Clearly what Changes were Necessary to Pass the Exercise Next time	--
Were Group Members Encouraged to Seek Clarification about Anything They did not Understand in Another Group Member's Testimony	100%
Was the 2/3 Voting Rule Adhered to for Steps 1, 2, and 3	100%
Were Testimonies Passed that Complied with the Instructions in the Book	100%
When a Testimony did not Pass, was the Client Told Clearly what Changes were Necessary to Pass the Testimony Next Time	100%
Did the Group Facilitator Avoid Lengthy Processing of Steps and Adhere to the Structured Format Associated with MRT	100%
Did the Group Facilitator Respond Effectively to Behavioral Disruptions	100%
Were Steps, including Summaries, Written Assignments, Drawings, and Testimonies, Kept to less than 15 Minutes	100%
Did the Group Facilitator Maintain a Good Pace so that Interest from Clients was Sustained	100%
Was Extra Time Used Effectively	100%
Did the Group Facilitator Manage Pre and Post Arrival of Clients, Ensuring that Client Communication was Appropriate and Kept to a Minimum	100%
Were Clients Praised for Efforts to Participate and Complete the Steps	100%

Community Reinforcement Approach	**Measure:** Observation and supervision **Progress**: During the previous Biannual period, the trainer was on a maternity leave. She completed her training certification with Chestnut Health Systems during the current Biannual period. Data was not available for the current Biannual period.

Teen Intervene	**Measure:** Observation using the Teen Intervene Checklist **Progress:** G/CC did not complete any fidelity check for Teen Intervene.

PRIME for Life	**Measure:** Observation using the PFL Checklist **Progress:** For the Biannual reporting period, G/CC completed four (4) observations for one (1) clinician.

BIANNUAL	
Content Area	**% Compliant**
Instructor conveys understanding of major concepts without confusion	100%
Instructor follows manual in proper order and does not overlook relevant segments in manual	100%
Instructor uses video materials at the correct time and is able to transition between video and lecture comfortably	100%
Instructor uses participant workbook exercises as indicated and pauses to solicit feedback about them	100%
Instructor is able to complete lectures and exercises without relying excessively on the manual	100%
Instructor avoids material not included in the manual	100%

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Alcohol Literacy Challenge	**Measure:** Observation using the ALC Checklist **Progress:** During the Biannual reporting period, G/CC completed three (3) fidelity checklists for one (1) clinician.

BIANNUAL	
Content Area	**% Compliant**
Presenter read ALC lesson narration while viewing the corresponding slides	66.7%
Presenter used the appropriate videos at the correct time points	66.7%
Presenter adhered to the ALC Talking Points	66.7%
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:** For the Biannual reporting period, G/CC completed three (3) fidelity checks for one (1) clinician for the topic: Being an Adolescent & Skills for Coping.

BIANNUAL	
Content Area	**% Compliant**
TOPIC 1: BEING AN ADOLESCENT	
Discuss the changing attitudes and feelings they are experiencing	100%
Identify the physical, social, emotional, and intellectual changes that occur during adolescence	100%
Identify support systems for adolescent years	100%
What is a teenager?	100%
Growing Up	100%
Agree/Disagree Activity	100%
How do you feel?	100%
What is normal?	100%
The Adolescent Brain	100%
Answer Sheet	100%
Getting Support	100%
TOPIC 4: SKILLS FOR COPING	
Identify stressors that students face	100.0%
Discuss what stress feels like	100.0%
Examine healthy ways to cope with stress	100.0%
Discuss peer pressure	100.0%
Identify passive, aggressive, and assertive response styles	--
Practice refusal skills	--
Identifying Stressors - Handout 23	100.0%
Signs of Stress - Handout 24	100.0%
Stress Fact Sheet - Handout 25	100.0%
Healthy Responses to Stress - Handout 26	100.0%

BIANNUAL	
Content Area	**% Compliant**
Ways to Reduce Stress - Handout 27	100.0%
Relaxation Exercises - Handout 28	100.0%
How to Refuse - Handout 29	--
Refusal Scenarios 1 & 2 = Handouts 30 & 31	--

II. Integrated Care	
(b) Evidence of the implementation of integrated care, including progress on the implementation of the integrated care action plan.	**Criterion 3: Wellness Plans for primary care and behavioral/mental health care are integrated** Although G/CC implemented an EHR in October 2016, the system currently uses separate Plans for Behavioral Health and Primary Care. There also is a separate Plan for Medication Management. The Area Director and Senior Scientist met to discuss options for having an integrated plan. The Senior Scientist finished the development of the integrated plan. The Area Director and Senior Scientist met with IT to have the plan added to the EHR. Once IT adds the form to the EHR, the Area Director and Senior Scientist will train staff. Random review of the integrated Wellness and Recovery Plans is set to begin August 2018. **Criterion 4: Patient care is based on (or informed by) best practice evidence for BH/MH and primary care.** G/CC currently uses several EBPs for BH/MH including Motivational Interviewing, Seeking Safety, Relapse Prevention Treatment, Community Reinforcement Approach, CLEAR, and Moral Reconation Therapy. G/CC also uses numerous EBPs for substance use prevention including Project Success, Prime for Life, Teen Intervene, and Alcohol Literacy Challenge. G/CC continues to explore and implement best practices and standards of care to reduce blood pressure, cholesterol, etc. In October 2017, G/CC implemented an EBP called NewR for Wellness. **Criterion 5: Consumer and family, when appropriate, participate and collaborate in the development of the Wellness Plan** Although the action steps for this criterion were to begin in

	January 2018, this was delayed due to other priorities from Hurricane Irma. . **Criterion 6: Staff educates and communicates with consumers about integrated care** Action steps for this criterion did not begin in FY 2018. G/CC postponed this until FY 2019. **Criterion 7: Follow-up occurs on assessments, tests, treatment, referrals and other services** Action steps for this criterion did not begin in FY 2018. G/CC postponed this until FY 2019. **II. Organizational Supports for Practice Change Toward Integrated Services** **Criterion 3: Providers engaged and enthusiastic about integrated care** WestCare identified Kathy Paxton, Senior VP for Government Relations and Business Development, and Dr. Denzil Hawkinberry, Medical Director, as the leads in this initiative across WestCare. **Criterion 4: Continuity of care between primary care and behavioral/mental health** The Senior Scientist and Area Director were unable to address this Action Item to date. They will work with Kathy Paxton and Dr. Hawkinberry to develop training for staff. **Category 5: Coordination of referrals and specialists** Currently, G/CC continues to request consents from the clients to permit two-way communication between G/CC and all external specialists/care providers. **Category 6: Data systems/patient records document integrated care** G/CC did not address this during FY 2018. Beginning in August 2018, G/CC will monitor medications the client received in

	Inpatient with those currently received in Outpatient to ensure the transition occurred smoothly. G/CC will use the Discharge Summary in the EHR to accomplish this. **Category 7: Consumer and family input to integration management** The Senior Scientist and his evaluation team currently are exploring the most efficient and effective ways to obtain information from consumers and their families. The Team is exploring such avenues as online surveys, focus groups, committee membership, etc. **Category 8: Physician, team and staff education and training for integrated care** The Area Director and Senior Scientist are developing a standardized training for all staff. The first training did not occur as planned in March 2018. They are revisiting this action and will develop new targets for FY 2019. **Category 9: Funding sources/resources support integrated care** On August 14, 2017, G/CC received its Medicaid number and health care clinic exemption for licensure for the Primary Care Clinic. NO FURTHER ACTION NEEDED ON THIS ITEM

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 agency-wide self-assessment tool and the activities listed below: i. An overview of the Network Provider's TIC capabilities with regard to service	G/CC is involved with the TIC initiative since its inception in the State. G/CC representatives consistently attend TIC meetings as required by SFBHN. **Domains 1A-E Criterion 1: Program Review for:** • **Safety** • **Trustworthiness** • **Choice** • **Collaboration** • **Empowerment** G/CC completed the walk through for treatment and discharge process. Although G/CC did administer the Staff Perception

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;	Survey, it did not add questions related to Safety. G/CC did not include these questions since WestCare intended to develop an agency wide survey that would address this. WestCare did not develop the survey. **Domain 2: Formal Service Policies** **Criterion 4: De-Escalation Policy** Policy update occurred. CEO signed the Policy in February 2018. **Domain 3: Trauma Screening, Assessment, and Service Planning** **Criterion 3: Trauma Screening Process** The Senior Scientist will update the Intake Perception Survey to include items related to stress of the screening/assessment process. Originally, the Senior Scientist planned to complete the action step by March 2018. However, because of the continued impacts resulting from Hurricane Irma, he postponed the action step until FY 2019. **Domain 4: Administrative Support for Program-Wide Trauma Informed Services** **Criterion 3: Administrative Participation in and Oversight of Trauma-Informed Approaches** G/CC continues to collect data to determine the efficacy of its trauma-specific services (Seeking Safety). G/CC currently shares with analyses with the Leadership Team but not with all G/CC staff and consumers. G/CC also does not routinely use the data to enhance or improve it implementation or delivery of Seeking Safety. The Area Director and Senior Scientist currently are developing processes to share the data agency wide and to use the data more effectively for program planning. **Annual Fallot TIC Assessment** G/CC completed the assessment upon 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.	**III. Communication and Language Assistance** **Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.** The Research and Evaluation Department are in the process of developing a survey for consumers and staff to assess awareness of the services available and their knowledge of how to access them when needed. Research and Evaluation postponed this action until FY 2019. **Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.** G/CC will design a consumer pamphlet that explains clearly the availability of the services and how to access them. All consumers will receive the pamphlet. No progress was made on this during the Fiscal Year. **Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.** Research and Evaluation is in the process of developing a Consumer Perception Survey specifically for the interpretation services. Any consumer using these services will receive a Survey. Research and Evaluation postponed this action until FY 2019. **Annual CLC Action Plan** Update for Fiscal Year 2018-2019 will occur no later than August 31, 2018.

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 Senior Scientist 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? The Senior Scientist downloads and analyzes data biannually (January and April) to ensure compliance and to determine trends. For this Biannual Period, 37.4% of the clients enrolled in all programs across G/CC were asked if they had a primary care provider. Of these, 50.6% indicated that they did not have one. Of those indicating that they did not have a primary care provider, 43% received a referral to one.

IV. 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.	G/CC has been working on the QIP for CARF. G/CC also attends the WestCare National Accreditation calls monthly. This allows G/CC to keep abreast of any changes that occur in CARF standards or in the interpretation of the standards. It also allows uniformity across WestCare in the implementation of the standards.