THE GUIDANCE/CARE CENTER (G/CC)
PERFORMANCE IMPROVEMENT PROGRAM
QUALITY ASSURANCE AND CONTINUOUS QUALITY IMPROVEMENT
Plan Update: July 26, 2016

QA/CQI Officer - Frank A. Scafidi, Ph.D.

I. INTRODUCTION

G/CC, a subsidiary of WestCare Foundation, maintains a local Performance Improvement Program (PIP) that builds upon the guiding principles, structure, and intent of the WestCare Performance Improvement Plan. The G/CC PIP includes both ***Quality Assurance (QA) and Performance Improvement/Continuous Quality Improvement (PI/CQI)*** elements that addresses the specific aims and needs of its consumers and programs as well as the specific indicators identified in its contracts/grants. The PIP covers the three service locations: Key Largo, Marathon, and Key West.

Quality Assurance refers to the systematic monitoring and evaluation of various aspects of the agency to ensure achievement and maintenance of standards of quality. Contractual obligations (e.g. 65D-30, Exhibits of the DCF/SFBHN contracts, etc.), accreditation requirements, State/County Plans or Goals, and/or standards identified by the agency leadership may determine these standards.

Performance Improvement or Continuous Quality Improvement refers to the systematic identification of processes, procedures, and/or outcomes not achieving desired contract/agency targets; modifying the process or procedure to increase efficiency, effectiveness, or outputs; and monitoring the impact. G/CC applies these to clinical and administrative functions.

G/CC provides crisis and detoxification services, prevention, intervention, and outpatient services for adults, adolescents, children, and families who are suffering from substance use or mental health disorders or who have co-occurring disorders. The primary goal of these services is to promote the development of an alcohol and drug free lifestyle; reduce or eliminate the symptoms of mental health or co-existing disorders; and foster a personally effective and socially productive lifestyle. G/CC also provides primary care services for adults in its Center for Wellness. The primary goal of this service is to provide integrated primary care and behavioral health service that promote physical wellness and the prevention of disease/disease progression.

G/CC's goal is to provide services that are:

Safe – avoiding injuries or harm to consumers from the care and environment designed to help them

Effective – providing services based in “best-practices” and empirical evidence to those consumers who are likely to benefit from them and refraining from providing services to those who are not likely to benefit
Accessible/Available – reducing barriers to needed care and maintaining an appropriate scope of services to meet the needs of the consumers served;
Timely – reducing delays and waits for needed services
Efficient/Appropriate – using available resources in a cost-effective manner and providing only indicated and needed services
Client centered - providing care that is respectful of, and responsive to, individual consumer strengths, needs, abilities, and preferences and ensuring that consumer values guide all clinical and care decisions
Equitable – providing services that do not vary in quality because of personal characteristics such as gender, race, ethnicity, religious preference, sexual orientation, geographic location, or socioeconomic status

To achieve this goal, G/CC established a Performance Improvement Program (PIP) to ensure that consumers receive high quality care in an environment of minimal risk. Our performance improvement efforts focus on consumer care delivery processes and support processes and resources that promote optimal consumer outcome and effective business practices. All employees of G/CC participate in ongoing and systematic performance improvement efforts.

II. SCOPE OF THE PROGRAM

The PIP program encompasses a broad range of clinical and service issues related to the treatment of adults, adolescents, children, and families dealing with substance use, mental health, or co-occurring disorders. The PIP provides oversight of all aspects of clinical care and service provided to the consumers and is concerned with the continual improvement of clinical care performance. In its effort to promote healthy lifestyles, G/CC PIP utilizes nationally recognized resources such as, but not limited to, *Healthy People 2020, American Psychological Association, Centers for Disease Control and Prevention, and the Florida Department of Children and Families Long Range Plans and Priorities* when considering clinical studies and strategies and performance improvement initiatives.

G/CC PIP monitors and evaluates services and care provided throughout the agency; use and effectiveness of the services; and the availability and accessibility of the services. In addition, the PIP monitors consumer satisfaction and perception to improve the quality of services and to ensure the programs are addressing the consumers’ needs efficiently and effectively.

In addition to clinical care monitoring, the PIP also monitors and evaluates administrative functions related directly or indirectly to consumer care. These functions include, but are not limited to, utilization management, professional

growth and development, staff credentialing, consumer and/or staff incidents, sentinel events, and utilization of services.

The Performance Improvement Committee (PIC) amends the scope of the PIP program, the program description, and the PI Work Plans as needed but at a minimum annually. The changing needs of the clients served, evolving goals and objectives of the agency, input from stakeholders, and review of the successes and unfinished improvements from prior years guide amendments to the PI Work Plan.

Findings from the previous year's Work Plan, consumer demographic data, Consumer and Staff Perception Surveys, evaluation data, and attainment of contractual/grant goals and objectives are the basis for the selection of Work Plan activities. As a guideline, the Performance Improvement Committee and Leadership eliminate performance improvement items maintained at the targeted criterion for at least six (6) months during the previous Fiscal Year from the current Fiscal Year's Work Plan. The Performance Improvement Committee is responsible for developing the preliminary Work Plan and providing recommendations to The Keys Leadership Team. The Keys Leadership Team is responsible for final approval of the Work Plan.

III. LONG-TERM STRATEGIC PROGRAM GOALS AND OBJECTIVES

The following statements describe the goals and objectives of G/CC Program Improvement Program.

1. To implement evidenced-based clinical practice guidelines which improve care and services for the most prevalent conditions of the consumers G/CC serves;

2. To ensure that all programs, departments, and processes within G/CC are co-occurring capable, trauma informed, culturally and linguistically appropriate, and integrate primary care into the case conceptualizations and services whether G/CC provides primary care directly or through referral and linkage;

3. To improve the utilization of care and treatment services;

4. To monitor, evaluate, and improve the clinical outcomes for the consumers served;

5. To monitor and evaluate multiple aspects of consumer satisfaction and perception with care delivery and service;

6. To support the implementation of activities to improve or enhance consumer safety and security in care delivery settings;

7. To monitor and improve when necessary, the accessibility and availability of services;

8. To ensure the continued growth and development of staff to support quality care and foster maximum clinical outcomes for the consumers;

9. To integrate Performance Improvement/Continuous Quality Improvement activities throughout the various operational areas of G/CC;

10. To enhance operations and reduce costs while maintaining and improving the quality of services; and

11. To ensure that adequate and appropriate resources are available to maintain an active Performance Improvement Program.

Measures and Outcomes for Fiscal Year 2016-2017 (Also detailed in the Annual PI Work Plan)

Specific goals and objectives for Fiscal Year 2015-2016, strategies to achieve the goals and objectives, and timelines for data collection and reporting are below:

A. Program and Service Utilization

a. Increase attendance at the first outpatient appointment following discharge and referral from inpatient.
b. Monitor percent of consumers who do not show for or cancel the initial appointment, and the percent of initial appointments that staff cancels. This applies to adult, adolescent, and child Substance Abuse and Mental Health consumers.
c. Monitor the number of days from initial consumer contact for a request for service to the initial face-to-face appointment. This measure includes Adult and Child substance abuse and mental health and in-home onsite programs.
d. Increase the frequency of outpatient appointments, ensuring all clients have at least one service weekly unless justified in the clinical record. This measure pertains to Adult and Child substance abuse and mental health outpatient and in-home onsite programs.

B. Consumer, Staff, and Stakeholder Perception

a. Monitor Consumer Perception of Overall Program Quality for the CARF core programs to maintain a minimum positive perception of 80%. This measure includes adult substance abuse and mental health outpatient, child substance abuse and mental health outpatient, TBOS, adult and child case management, CSU/Detox, and criminal justice.

Monitor Consumer Perception at Intake, midpoint of treatment, and at Discharge. Maintain a minimum positive perception of 80%.

b. Monitor Consumer Perception of Overall Program Quality for the new Primary Care Clinic in Marathon (The GC Center for Wellness). Monitor Consumer Perception at Intake, every 6 months, and at Discharge. Maintain a minimum positive perception of 80%.
c. Monitor Staff Perception of overall job satisfaction annually and maintain a minimum positive perception of 80%.
d. Monitor Stakeholder Perception of the agency and its services annually and maintain a minimum positive perception of 80%.
e. Monitor consumer satisfaction with GCC community-based transportation annually.

C. Follow-Up

a. Maintain a minimum overall 80% DCI and GAIN follow-up rate for the CSAT ORP grant at 3 and 6 months post admission.
b. Maintain a minimum 80% “in window” GAIN follow-up rate for the CSAT ORP grant at 3 and 6 months post admission.
c. Maintain a minimum overall 80% DCI and GAIN follow-up rate for the CSAT PBHCI grant at the 6-month post admission intervals.
d. Maintain a minimum 80% “in window” GAIN follow-up rate for the CSAT PBHCI grant at the 6-month post admission intervals.
e. Maintain a minimum 80% GPRA follow-up rate for the CSAT TCE HIV grant at 6 months post admissions.
f. Increase collection of post-discharge follow-up surveys for the CARF core programs.

D. Clinical Records

a. Increase clinical records for CARF core programs to ensure compliance with 65D 30, CARF, CCISC, and agency policy and procedure to maintain an 80% adherence rate. **G/CC also uses this strategy to monitor fraud, waste, abuse and other potential wrongdoing.**

b. Conduct Utilization Management of clinical records in inpatient, adult and child substance abuse and mental health, in-home onsite, and prevention programs to ensure appropriate admission, continued stay, and discharge of clients in 95% of the cases.

c. Maintain consistency between invoice, clinical documentation, and data to ensure a 95% consistency rate for outpatient and case management services. This measure pertains to adult and child substance abuse and mental health, in-home onsite, and prevention programs. **G/CC also uses this strategy to monitor fraud, waste, abuse and other potential wrongdoing.**

E. Quality of Care and Service Provision

a. Identify number of consumers (SA & MH) identified as needing primary care in the outpatient and home-based treatment programs.
b. Monitor the number of successful linkages to primary care in the outpatient and home-based treatment programs for SA & MH consumers.
c. Monitor substance use frequency among adults discharged from substance abuse treatment.
d. Monitor completion rates for PRIME for LIFE
e. Monitor completion rate for Teen Intervene
f. Reduce alcohol use among youth completing Project SUCCESS
g. Increase attitudes and beliefs related to risk of harm associated with underage drinking among youth completing Project SUCCESS
h. Decrease favorable attitudes toward alcohol and drug use among youth completing Project SUCCESS
i. Decrease favorable attitudes toward alcohol, tobacco and drug use among youth completing PRIME for Life
j. Increase healthy behaviors and decrease use of ATOD or delay the age of onset for marijuana use among those youth completing TEEN Intervene
k. Reduce symptoms and severity of symptoms among consumers completing Seeking Safety
l. Monitor fidelity of Project SUCCESS, Teen Intervene, PRIME for Life, Alcohol Literacy, Motivational Interviewing, Seeking Safety, Trauma-Informed CBT, and Relapse Prevention, ensuring staff maintain a minimum of 80% adherence to the evidence-based practice.

F. Safety and Security

a. Monitor incident reports at all facilities and programs to ensure accurate and appropriate reporting within the agency and to external sources (e.g., DCF, SFBHN, etc.) and to determine/identify trends or patterns related to type of incident, location, time of day, and/or day of week. This measure pertains to inpatient, adult and child substance abuse and mental health, in-home onsite, criminal justice, case management, and prevention programs.
b. Monitor medication errors, including wrong medication, wrong dose, wrong time of administration, and “missed” doses, in inpatient programs for SA & MH consumers. This measure pertains to CSU and Detox.
c. Conduct and monitor emergency drills on-time at all three locations.
d. Enhance the EOC/Safety Committee roles and responsibilities to include the development, implementation, and monitoring of Security Program Plan (SSP).

e. Enhance the EOC/Safety Committee roles and responsibilities to include compliance with the security-related requirements outlined in FDOT Rule 14.90.

1. Security policies, goals, and objectives.
2. Organization, roles, and responsibilities.
3. Emergency management processes and procedures for mitigation, preparedness, response, and recovery.
4. Procedures for investigation of events described under subsection 14-90.004(5), F.A.C.
5. Procedures for the establishment of interfaces with emergency response organizations.
6. Procedures for interagency coordination with local law enforcement jurisdictions.
7. Employee security and threat awareness training programs.
8. Security data acquisition and analysis.
9. Emergency preparedness drills and exercises.
10. Requirements for private contract transit providers that engage in continuous or recurring transportation services for compensation as a result of a contractual agreement with the bus transit system.
11. Procedures for SPP maintenance and distribution.

f. Enhance the EOC/Safety Committee roles and responsibilities to include review of all Safety and Security Inspections conducted.

G. Staff Development

a. Monitor training to all new hires within 5 days from hire date to ensure that a minimum of 95% of new employees receive appropriate training prior to assuming job duties and to ensure staff competency.
b. Monitor that staff receives a minimum of 20 hours of in-service training annually
c. Monitor that 100% of Receiving Facility staff receive verbal de-escalation training annually
d. Monitor that 100% of Receiving Facility staff receive CPR as required and have active certificates
e. Monitor that 100% of Receiving Facility staff have a current, signed Affidavit of Good Moral Character in the personnel file
f. Monitor that 100% of Receiving Facility staff have annual Performance Evaluations in the personnel file
g. Develop and implement a more comprehensive database for training that has all necessary elements to produce accurate reports.
h. Monitor employee turnover rates and maintain a rate of <20%.
i. Monitor use of overtime.

H. Accreditation – CARF

a. Conduct quarterly Committee Meetings to review and monitor CARF standards & to develop Action Plans for implementation of new standards. Committees include Performance Improvement, Care, Pharmacy, Seclusion/Restraint, and EOC/Safety.
b. Complete required Quality Improvement Plan (QIP) and submit to CARF.

I. Action Plans

a. Monitor ongoing implementation and maintenance of the Trauma-Informed Care initiative
b. Monitor ongoing implementation and maintenance of the Culturally and Linguistically Appropriate Services initiative
c. Monitor ongoing implementation and maintenance of the Integration of Behavioral and Primary Care Health initiative

IV. OVERSIGHT OF THE LOCAL PROGRAM

The G/CC Leadership Team designated the Performance Improvement Committee (PIC) as the body responsible for the design and implementation of the local Performance Improvement Program.

PIC Composition: The PIC is a multidisciplinary committee. The Chief Clinical Officer (CCO) is the chairperson of the PIC and acts as the Quality Assurance/PI/CQI Officer for the agency. Additional members of the PIC include the Director of Children & Family Services, the Children's Services Coordinator, Adult Services Coordinator, and the Site Directors from Key Largo, Marathon, and Key West. The Medical Director, Controller, and Data Manager act as consultants to the PIC. The PIC meets at least quarterly, although the PIC may schedule meetings more frequently as needed or as deemed appropriate by the Chairperson of the PIC or The Keys Leadership Team. The PIC also includes consumers of substance use and/or mental health services (e.g. consumers, family members, and/or other community-based consumers).

Consumer Involvement: Aside from consumers being active members of the PIC, the PIC also uses consumer input and feedback to identify strengths and barriers; enhance program functioning, efficiency, and effectiveness; and increase program performance. The PIC uses two primary processes to achieve these goals.

A. *Consumer Perception Surveys:* G/CC administers Consumer Perception Surveys to active and/or discharged consumers on a regularly scheduled timeframe. The timeframes include intake, point in time (during services), discharge, and within 6 months post service completion. The primary purpose of these Surveys is to determine the consumers' overall perception of care and program quality, perception of and satisfaction with programming specific services, perception of involvement in Wellness and Recovery Planning, and perception of and satisfaction with staff respectfulness, and availability.

   The PIC Chairperson is responsible for aggregating the data. The PIC reviews the data from these surveys to identify areas and/or factors that the consumers perceive as being useful and/or helpful and areas and/or

factors that consumers perceive as needing improvement or enhancement. The PIC uses a minimum criterion of 80% to define satisfaction and/or positive perceptions.

B. *Consumer Focus Groups:* Either following the administration of the Consumer Perception Survey, following a series of consumer complaints related to the same issue, or following a staff member's or PIC member's observation, the PIC may conduct a Focus Group with the consumers of a particular program or service. Consumer participation in the Focus Group is voluntary. The primary purpose of the Focus Group is to obtain detailed information related to the areas identified by consumers and/or staff as being of concern or needing improvement.

   Information from the Focus Groups is anonymous and only presented in aggregate format. The PIC utilizes this information to help the G/CC Leadership and program staff to design and implement performance improvement activities.

Responsibilities of the PIC include:

1. Review and approval of the local PI program description and PI Work Plan;

2. Selection of clinical and service indicators and performance improvement initiatives related to the indicators;

3. Evaluation of the effectiveness of the PIP with input from appropriate staff;

4. Review and analysis of aggregate trend reports and analysis of clinical and service indicators;

5. Establishment of benchmarks or performance goals for each indicator;

6. Evaluation of clinical and service indicators against performance goals;

7. Ensuring that system-wide trends are identified and analyzed, and that focused interventions are implemented to improve performance issues;

8. Ensuring that performance improvement efforts are prioritized, resources are appropriate, and resolution occurs;

9. Approval and oversight of the design of PI initiatives undertaken by component programs;

10. Development and empowerment of committees, including the

development of charge statements and committee member selection;

11. Determining the need for training and education regarding performance improvement;

12. Review and approval of procedures, activities, and recommendations presented by PI committees; and

13. Submitting Performance Improvement reports to the Leadership Team, Community Action Council, Board of Directors, and funding agencies as required or requested.

Committees

Including the Performance Improvement Committee, four (4) committees support the PI Program. The structure and need for each committee enhances the ability of the PI Program to operate functionally within G/CC. Each committee may call special meetings on an as needed basis. Each committee has an identified chairperson or co-chairpersons. The chairperson or co-chairpersons are responsible for scheduling committee meetings, providing leadership, developing agendas, and maintaining minutes.

The following committees support the PI Program:

Clinical Care Committee

The primary focus of the Clinical Care Committee incorporates objectives that relate directly or indirectly to the quality of individual care, treatment, and service standards. The Clinical Care Committee consists of members representing adult, adolescent, and child substance use and mental health prevention, intervention and treatment services. The Clinical Care Committee meets at least quarterly.

Responsibilities of the Clinical Care Committee include:

1. Provision of input on practice guidelines, including the identification of potential evidence-based practices to enhance or improve agency and program functioning and to maximize consumer-level clinical outcomes;

2. Provision of input on clinical record standards, including the adoption or adaptation of evidence-based documentation practices and processes;

3. Oversight of client record maintenance procedures to ensure adherence to state, licensing, contract, and accreditation standards and regulations as well as adherence to agency policy and procedure ;

4. Oversight of the Peer Review process to ensure quality and integration of documentation;

5. Oversight of the Utilization Management Review process to ensure appropriate admission, continued stay, and/or discharge of consumers;

6. Provision of input on assessment guidelines to ensure adherence to standards and regulations set-forth by accrediting, funding and other regulatory bodies and to ensure adequate and appropriate assessment of mental health and substance use, including the utilization of evidence-based assessment instruments; Oversight of quality of assessment information collected;

7. Provision of input on accessibility and availability of services, and the continuum of care;

8. Monitoring of the utilization of the continuum of care, including referral to and utilization of the step-down programs (residential/CSU/Detox to outpatient/continuing care);

9. Dosage of services in outpatient and home-based programs, including no show rates and frequency of sessions;

10. Review of aggregate clinical data;

11. Implementing and monitoring of the Trauma-Informed Care initiative;

12. Implementing and monitoring of the Cultural and Linguistically Appropriate Services initiative;

13. Implementing and monitoring the Integrated Behavioral and Primary Health Care initiative.

In addition to the aforementioned, the Clinical Care Committee also focuses on issues related to the ***Rights, Privileges, and Responsibilities*** of the consumers. These responsibilities include:

1. Review of Consumer Rights, Privileges, and Responsibilities;

2. Review of staff professional code of ethics;

3. Review, development, and implementation of Informed Consent forms and Disclosure forms;

4. Establishment of a review procedure for consumer complaints

(grievances), alleged violations of consumer rights; staff complaints, and violations of consumer confidentiality;

5. Review of trend data concerning consumer and staff grievances; and

6. Monitor the effectiveness of existing and proposed methods and procedures for protecting consumer rights and confidentiality.

Environment of Care and Safety Committee

The Environment of Care and Safety Committee functions as a joint committee since many of the issues and tasks for these committees overlap. The Committee consists of representatives from each of G/CC's facilities. The Environment of Care and Safety Committee meets at least four times annually.

Responsibilities of the Environment of Care and Safety Committee include:

1. Provide input into the development of maintenance and housekeeping policies and procedures;

2. Train staff on security and safety issues, including fire safety, disaster plans, fire extinguisher use, fire drills, etc.;

3. Conduct facility inspections to reduce and control environmental hazards and risks and to maintain safe conditions for clients, staff, and visitors;

4. Conduct vehicle inspections to reduce and control hazards and risks and ensure appropriate, routine maintenance to maintain safe vehicular conditions for consumers and staff;

5. Evaluate the effectiveness of existing risk management plans and emergency plans;

6. Ensure performance of regular safety and evacuation drills (i.e. bomb threats, utility failures, natural disasters, etc.) to ensure adherence to procedures, timeliness of response, and timeliness of evacuation of staff and clients;

7. Analyze aggregate incident data related to security and safety issues for staff and consumers and examine trends within the agency. Trend examination also includes the appropriate reporting of incidents to DCF/SFBHN within the required timeframes; and

8. Analyze aggregate data from fire drills to ensure adherence to procedures, timeliness of response, and timeliness of evacuation of staff

and consumers.

Pharmacy Committee

The primary focus of the Pharmacy Committee is objectives related to medication. The Pharmacy Committee consists of members representing medical and nursing care. The Pharmacy Committee meets at least quarterly.

Responsibilities of the Pharmacy Committee include:

1. Monitoring regulatory compliance;

2. Reviewing and approving the drug formulary;

3. Reviewing and monitoring developments in medication assisted substance abuse treatment (e.g. Suboxone, Vivitrol, etc.);

4. Monitoring and reviewing incidents related to medication errors.

Seclusion and Restraint Committee

The primary focus of the Seclusion and Restraint Committee is to reduce the use of seclusion and restraint on the Inpatient Units (CSU and Detox). Committee members represent medical, nursing and administrative staff. The Seclusion and Restraint Committee meets at least quarterly.

Responsibilities of the Seclusion and Restraint Committee include:

1. Review and monitor incidents related to *seclusion and restraint*;

2. Develop action plans and make recommendations to enhance processes that will reduce the use of seclusion and restraint

Task Forces and Time-Limited Work Groups

The PIC may convene task forces and time-limited work groups, which include groups of individuals who meet to accomplish a specific and focused task, to develop and implement various aspects of the PI Program, or a PI initiative.

Scope of Task Forces and Time-Limited Work Groups. The scope of activities shall include issues regarding the improvement of the quality of service to consumers, organization efficiency, cost effectiveness, and general well-being of employees. Examples of those issues include the following dimensions of performance: appropriateness, availability, continuity, effectiveness, efficacy, efficiency, respect and caring, safety, and timeliness.

A more macro level of analysis would include issues related to: reliability of service to those we serve; process control and improvement; design of new processes or technology; improvement of systems; reducing operating costs; reducing re-work; internal operations; improvement in communications, attitudes, and morale; equipment performance; scheduling; and education.

Selection of Task Force or Time-Limited Group Members. The PIC shall select task force and time-limited work group members who are familiar with the process under study and who represent those components or activities within a component that will affect or be affected by the outcome. Furthermore, members will be representative of the racial and cultural diversity of the population that will be affected by the outcome. Task forces and time-limited work groups will not have more than 10 members, including the Chairperson. The PIC will charge tasks forces and time-limited work groups with the responsibility and authority to address specific and focused projects within an assigned timeframe. All task forces and time-limited work groups will submit written reports to the PIC as defined in their charter.

Change in Appointment of Members.

Resignation. Any member may resign from a task force or time-limited work group. That person, however, must remain an active member until the identification of a suitable and appropriate replacement.

In order for a member to resign, the supervisor, program director, or department head of the member shall contact the chairperson of the task force or time-limited work group to discuss the need for or appropriateness of the proposed resignation prior to it being accepted.

Termination. The Chairperson of a task force or time-limited work group may dismiss any member for general non-participation, frequent absence or tardiness, and/or failure to complete assigned tasks. Prior to dismissal, the committee chairperson will discuss this aspect of job performance with the team member's supervisor who, in turn, will address this as a supervisory issue. Subsequently, if the chairperson decides to dismiss a team member, the chairperson shall communicate this decision to the team member's supervisor. The Chairperson shall handle the dismissal of a team member in a tactful manner. The Chairperson shall provide documentation detailing the process and reasons for the dismissal to the PIC and the Director of Human Resources. The Director of Human Resources shall include a copy of the documentation in the member's personnel record.

V. PERFORMANCE IMPROVEMENT MONITORING AND EVALUATION

G/CC PIP has evolved over time and will continue evolving based on PI/CQI issues identified in the population served, emerging technologies, and changing practice standards. To ensure the PIP remains dynamic and achieves its desired objectives, evaluation of the program occurs annually and revisions occur as necessary. Responsibility for evaluation of the PIP lies with the Keys Leadership Team, the Performance Improvement Committee, Program Directors, and Committee Chairpersons.

A. *Role of G/CC Leadership Team (KLT)*

The Keys Leadership Team (KLT) shall determine the strategic direction and vision for overall performance improvement activities within the agency. One meeting of the KLT per quarter shall address performance improvement issues. The Chairperson of the PIC shall prepare reference materials for the meeting and will coordinate agenda items.

The Chairperson of the PIC also will submit a written annual Performance Improvement report to the KLT detailing performance improvement activities, accomplishments and achievements of the Committees, an analysis of the attainment of the annual PI Work Plan, emerging trends within the agency, and comparison data. Based on the findings in the report, the KLT shall revise the PIP, if necessary.

B. *Role of the Performance Improvement Committee (PIC)*

In carrying out its monitoring and evaluating functions, it is the responsibility of the PIC, either directly or through assignment, to state explicitly important areas of consumer care, to identify indicators related to important aspects of care, and to develop objective criteria and methods with which performance in the areas identified are measured.

The PIC shall see that the criteria and measures selected are objective and based on published findings and/or on information obtained from formal and informal surveys. When such information is not available, clinical experience shall guide the selection of criteria and measures.

The PIC shall set priorities for the Performance Improvement Program that align with and support the strategic plans and vision of G/CC when determining important aspects of care to monitor and evaluate. In determining priorities, the PIC shall consider:

1. The importance of the identified aspect of consumer care (e.g. high-volume, high-risk, and problem prone areas) and its potential impact

on the consumer population or staff;

2. The feasibility of investigating the potential indicator (e.g. does the indicator lend itself to study?) and the availability of resources within the agency to carry out the investigation; and/or

3. The feasibility of implementing changes, if necessary, and the availability of resources (financial, staff, etc.) to make the changes

C. *Role of the Program Directors and Department Chairpersons*

Every Program Director and Department Chairperson is responsible for implementing performance improvement activities for their component or department. These activities are part of the agency-wide Performance Improvement Program. The ultimate goal of the activities is to improve the quality of care or cost-effectiveness of services within their component or department.

Guidelines for developing and implementing performance improvement activities within a component or department include:

1. Development of a performance improvement plan for the component or department, including a description of the population served, scope of services, core processes, quality indicators, desired outcomes, and objective measures;

2. Submission of the completed performance improvement plan to the PIC for review and approval of the plan prior to initiating the project;

3. Provision of updates to the PIC at least quarterly through written reports; and

4. Submission of a final report to the PIC within 90 days from project completion that provides an analysis of improvements demonstrated, the costs of the project, and the benefits derived from the project.

VI. DATA COLLECTION AND AGGREGATION

The PIC, its Committees and Task Forces, and G/CC programs use a variety of strategies and methodologies to collect and aggregate data.

A. *Data Collection*

1. *Qualitative Date* is information that describes the attributes, qualities, or properties that an object or event possesses (e.g.

gender, race, ethnicity, etc.). For evaluation and performance improvement purposes, one can categorize the data into classes by assigning “random” numeric values. However, there is no inherent significance to the data values other than simply representing attributes.

G/CC collects a variety of qualitative data to monitor and evaluate processes or to describe populations, events, etc. The type of data collected depends on the process or descriptor G/CC is monitoring of evaluating. The G/CC Annual PI Work Plan clearly identifies the data collected for each indicator in the Plan.

Process or Descriptor	How Collected
Consumer demographics, including gender, race, ethnicity, sexual orientation, veteran status, etc.	Categorical data (e.g. Male =1; Female=2) from data in the WestCare Clinical Data System
Needing Primary Care & Referral/Linkage	Categorical data (e.g. No=0; Yes=1) from data in the WestCare Clinical Data System
Consumer Perceptions	Likert Scales (e.g. Strong Agree=1; Strongly Disagree=4) on Surveys Process notes/transcripts from Focus Groups
Program Implementation	Documentation of barriers, challenges, solutions, and successes
Services Received	Service data from data in the WestCare Clinical Data System
Appointment Status, including (No Shows, Cancellations, etc.)	Categorical data (e.g. Kept=1; No Show=2) from data in the WestCare Clinical Data System
Employee and Stakeholder Perceptions	Likert Scales (e.g. Strong Agree=1; Strongly Disagree=4) on Surveys Process notes/transcripts from Focus Groups
GPRA, TRAC & GAIN Follow-Up	Ratio data
Clinical Documentation and Utilization Management	Ordinal data (Complete=2; Partially Complete=1; Incomplete=0) from Peer Review and Utilization Management Forms
Consistency Between Invoices & Documentation	Billing and documentation data from WestCare Clinical Data System and Peer Review Forms
Completion Rates	Categorical data (e.g. Successful Completion=1; ASA=2) from data in the WestCare Clinical Data System
EBP Fidelity	Ordinal data from standardized Fidelity Checklists
Incident Reports & Medication Errors	Ratio data from the WestCare Intranet Reporting System
Staff Training	Frequency and ratio data from Training database
Staff Turnover	Ratio data from HR database
Staff Overtime	Frequency data from Accounting database and payroll reports
Action Plans	Qualitative review of each Action Plan with indicators of targets met and not met

2. *Quantitative Data* is information that one can count or express numerically, and the number naturally has a specific or "real" meaning (e.g. height, weight, age, etc.). This type of data easily lends itself to manipulation and statistical analysis.

   G/CC collects a variety of quantitative data to monitor and evaluate consumer outcomes The type of data collected depends on the outcome G/CC is monitoring of evaluating. The G/CC Annual PI Work Plan clearly identifies the data collected for each indicator in the Plan.

Outcome	How Collected
Substance Use in past 30 Days	Number days each consumer used alcohol or drugs from the WestCare Clinical Data System and/or Consumer-Level Surveys such as the GPRA, Project SUCCESS Survey, PRIME Survey, etc.
Trauma Symptoms and Severity	Total scores from the PSSR pre- and post-tests
Knowledge	Total scores from standardized knowledge assessment pre- and post-tests
Primary care variables for the Center for Wellness, including glucose and lipid levels, weight, blood pressure, etc.	Lab and vital sign data in the WestCare Clinical Data System

B. *Data Aggregation and Analyses*

The Chief Clinical Officer, the Director of Evaluation and Quality for the Eastern and Caribbean Region, and Research Assistants primarily are responsible for cleaning and aggregating the data.

G/CC maintains most of the data in the WestCare Clinical Data System, an SPSS database, or an online database such as the SAMHSA SAIS or TRAC systems. Oftentimes, G/CC maintains data for a single consumer across these databases to prevent double entry and increase efficiency (e.g. demographics and service data in the WestCare Clinical Data System and GPRA data in the SAMHSA SAIS system). In these instances, the Chief Clinical Officer or designee uploads the information from the WestCare Clinical Data System and the SAMHSA SAIS System to an SPSS database. After uploading each database separately, database merging occurs, linking the information by the unique consumer. The Chief Clinical Officer or designee reviews the merged database to ensure that merging and linking occurred correctly prior to conducting data analyses.

G/CC uses a variety of statistical strategies to analyze data, depending on whether data is qualitative or quantitative.

Data/Outcome	Analysis
Consumer demographics, including gender, race, ethnicity, sexual orientation, veteran status, etc.	Frequency counts and ratio analyses
Needing Primary Care & Referral/Linkage	Frequency counts and ratio analyses
Consumer Perceptions	Ratio analyses
Program Implementation	Qualitative analysis of barriers, challenges, solutions, and successes
Services Received	Frequency counts for each type of service
Appointment Status, including(No Shows, Cancellations, etc.	Frequency counts and ratio analysis
Employee and Stakeholder Perceptions	Ratio analysis
DCI & GAIN Follow-Up	Ratio analysis
Clinical Documentation and Utilization Management	Ratio analysis
Consistency Between Invoices & Documentation	Ratio analysis
Completion Rates	Ratio analysis
EBP Fidelity	Ratio analysis
Incident Reports & Medication Errors	Ratio analysis and qualitative analysis
Staff Training	Frequency counts and ratio analysis
Staff Turnover	Ratio analysis
Staff Overtime	Frequency count of hours and associated dollar value
Action Plans	Qualitative analysis of actions met and challenges, barriers, and solutions for those unmet
Substance Use in past 30 Days	Ratio analysis; Repeated measures analysis across time
Trauma Symptoms and Severity	Ratio analysis; Repeated measures analysis across time
Knowledge	Ratio analysis; Repeated measures analysis across time
Primary care variables for the Center for Wellness, including glucose and lipid levels, weight, blood pressure, etc.	Ratio analysis; Repeated measures analysis across time

VII. PERFORMANCE IMPROVEMENT PROCESSES AND METHODOLOGY

The PIC uses a prospective, as well as concurrent and retrospective monitoring process in order to objectively and systematically monitor and evaluate information about important aspects of client care. This process identifies areas of satisfactory performance as well as potential problem areas that have an impact on consumer care and clinical performance.

The data collection, monitoring, and evaluation process is systematic, both in the sense of being related to the agency operation as a single system, and in the sense of being planned and ongoing. The Performance Improvement methodology utilized for monitoring and evaluation shall be PDSA. This PDSA

cycle dictates a dynamic process for improvement.

PLAN (P) the improvement.

- Identify the opportunity for improvement
- Define the objective
- Ask, “Why are we doing this and how can we do it differently to make it better?”
- Identify the performance indicators

DO (D) the improvement process.

- Collect and analyze data
- Implement the change strategies

STUDY (S) the result.

- Understand the source of errors
- Review the re-measurement data
- Determine whether the results were better, worse or lateral

ACT (A) to hold the gain and to improve the process.

- Follow up with documentation and report to the PIC and to other people involved in the process.

Rapid Cycle Testing

G/CC adopted the use of Rapid Cycle Testing of changes. This method of testing ensures efficiency in testing and implementation and reduces the risk of changes based on theories, hunches, and ideals. It also ensures that only those changes that make a “real “difference are maintained.

The basic tenets of Rapid Cycle Testing include:

1. Using planned, sequential multiple cycles;
2. Changing only one factor or element at a time in each cycle;
3. Implementing change on a small scale (i.e. one program, one component, etc.);
4. Testing each change/cycle rapidly (3-4 weeks);
5. Maintaining or sustaining only those changes that work; and
6. Eliminating those changes that do no produce the desired result

Identification of Opportunities for Improvement. Problems identified and/or opportunities for improvement of consumer care or administrative processes may come to the PIC through:

1. The prospective monitoring process, whether through direct monitoring and evaluation by the PIC or through reports to the PIC

by a Committee or an identified individual responsible for monitoring an aspect of consumer care;

2. Formal written or informal verbal communication to the PIC from a staff member or consumer;

3. Observations made by Committee members during the course of their extra-committee activities;

4. Consumer complaints or grievances;

5. Individual or aggregate reviews of consumer care monitoring;

6. Annual staff performance and/or competency evaluations;

7. Reports and/or audits of external monitoring bodies; or

8. A retrospective review of minutes and reports of the PIC or Committees

VII. COMPARATIVE DATABASES, BENCHMARKS AND PROFESSIONAL PRACTICE STANDARDS

G/CC uses comparative databases to incorporate a process for continuous assessment with similar organizations, populations, standards of care, and best practices. The comparative assessment leads to action for improvement as necessary. Databases that G/CC utilizes on an ongoing, routine basis include:

- Rule 65D-30
- Florida Youth Substance Abuse Survey
- National Survey on Drug Use & Health
- Healthy People 2020
- Drug Abuse Warning Network
- CDC Surveillance Summaries
- CARF Accreditation Manual
- Trauma-Informed Care Checklist
- CLAS Assessment
- Integrated Care Readiness Assessment

VIII. EDUCATION

G/CC gives the responsibility and authority to participate in the Performance Improvement Plan to all staff. To accomplish this fully, G/CC educates all staff

on the PI Plan, including a description of the plan, how they fit into the plan, and the PI/CQI methodology. As needed, Chairpersons receive training in team dynamics, performance improvement concepts, tools and techniques, and effective meeting skills.

IX. COMMUNICATION PROCESSES FOR PERFORMANCE IMPROVEMENT ACTIVITIES

Reports of Performance Improvement activity shall be developed and distributed as follows:

A. The PIC Chairperson or designee shall prepare a biannual report to the Keys Leadership Team, Community Action Council, and Board of Directors. The report shall include:

- An overview of relevant monitoring activities
- An overview of Committee and Task Force results and project status
- A benefit/cost analysis of Performance Improvement monitoring activities
- Results of monitoring of any key indicators the Management Team and/or Board of Directors may request

B. Each Chairperson of a Committee, Task Force, or Time-Limited Group shall submit a quarterly progress report to the PIC for ongoing projects.

C. Each Chairperson of a Committee, Task Force, or Time-Limited Group shall submit a written report to the PIC prior to initiating a project, when the project charge statement has changed, when the improvement cycle begins, and within 90 days of project completion.

X. ANNUAL EVALUATION

The PIC evaluates G/CC's PI Work Plan annually to ensure adequate achievement of the goals and objectives identified. The PIC will compile an annual written report of a summary of activities, improvements made, care delivery processes modified, projects in progress, and recommendations for changes in the PI Plan. The PIC Chairperson will provide the report to the Keys Leadership Team, Community Action Council, and Board of Directors.

The annual evaluation report for the PI Work Plan covers the period from July through June, aligning it with G/CC's Fiscal Year.

XI. CONFIDENTIALITY

The Performance Improvement Committee Chairperson shall ensure that the PI Program operations protect the confidentiality and dignity of the consumers and staff members. To the extent permitted by law, the records and reports generated from these activities are confidential. Information presented in reports or analyses are in aggregate format and never utilize the individual names of consumers and/or staff members without the expressed consent of those persons. G/CC maintains all records in a manner consistent with the Confidentiality Policies of G/CC.