New Beginnings Behavioral Health Services, LLC

POLICY AND PROCEDURES **Policy # 5.1**

Performance and Quality Improvement	Title: Performance and Quality Improvement Plan

Adopted: __10/27/2014_____ Approval: 
Effective Date: __12/1/2014_____
Reviewed/Revised: __2/20/2015_____

PURPOSE

The purpose of New Beginnings Behavioral Health Services, LLC's (NBBHS) Performance and Quality Improvement (PQI) plan is to provide a framework for the continuous organizational-wide approach to achieving effective and efficient service delivery that is reflective of the identified organizational mission, vision, and ethical values, and supportive of the long and short term goals established for the agency.

PHILOSOPHY

New Beginnings Behavioral Health Services, LLC, (NBBHS) its leadership team, and staff, place top priority on a PQI plan and structure to manage all areas of the agency to ensure delivery of the best possible care for NBBHS clients. It is the goal of this policy to provide a mechanism and process designed to identify opportunities to improve client services, outcome measures, community and stakeholder involvement, client satisfaction, personnel satisfaction and retention, and environmental safety and security by measuring, assessing and improving these areas in a systematic and ongoing manner.

A well-defined, implemented, and continuously evaluated PQI plan enables NBBHS to develop short and long term goals that are clear, flexible, responsive, pace setting, and secure.

NBBHS leadership team members and staff are committed to maintaining a high standard of values and personal accountability which are inclusive of all parts of the organization as well as its identified stakeholders. The PQI plan for NBBHS demands evaluation of every program and service against unbiased standards to measure organizational and programmatic innovation, methodology, execution and effectiveness.

The guiding principles of the agency's PQI approach include:

- A strong focus on client centered care and services
- Utilization of an agency wide approach to improve important functions carried out by this organization by utilizing team efforts, stakeholder involvement and community resources.

- Increasing the probability of desired service outcomes, including client satisfaction, by assessing and improving governance, managerial, clinical and support processes that most effect those outcomes.
- Identifying opportunities to improve client care and services provided.
- Establishing priorities for improving care and services that have the greatest impact on client care outcomes and client satisfaction.
- Alignment of practice with long-term and short-term planning
- A strong emphasis on data collection and the conversion of "data" to review ready information used in the on-going process of continuously modifying practice to meet stakeholder demands
- An organizational culture of on-going learning and capacity development based on findings of PQI activities.
- Coordinated performance improvement activities and integrated efforts of all disciplines/departments throughout the organization.
- Increasing the safety of clients and staff by analyzing processes that pose high risk.

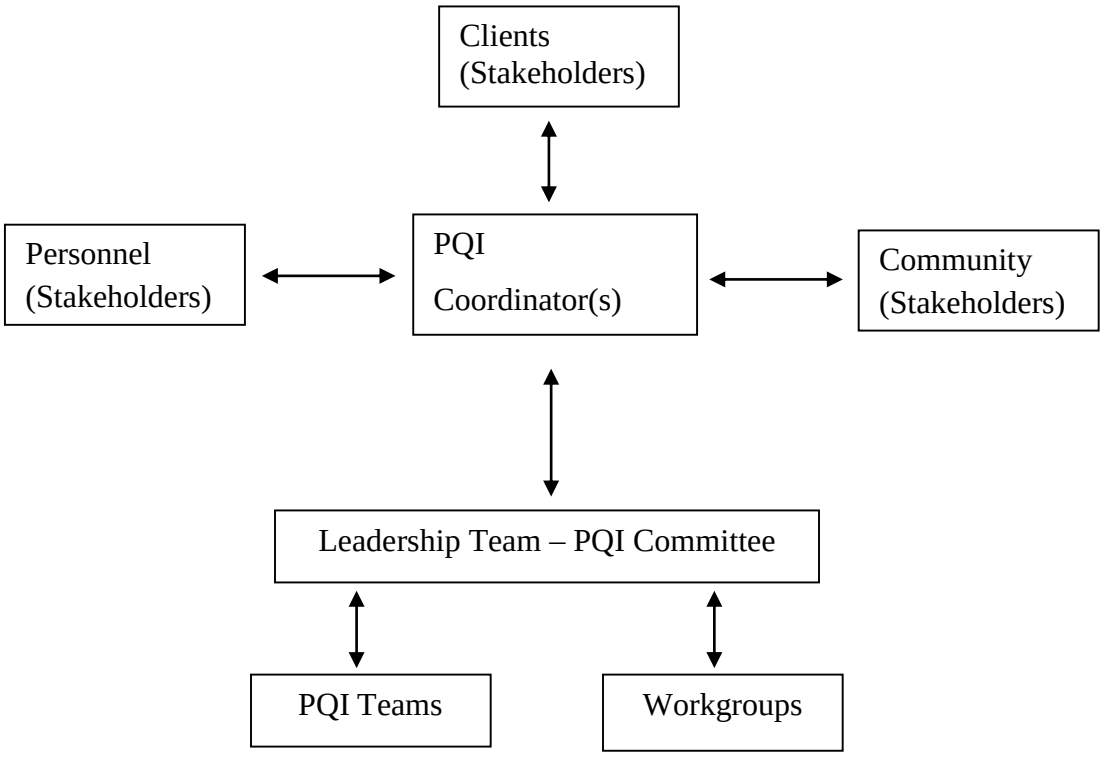
GOALS AND OBJECTIVES

The **GOAL** of Performance Quality Improvement Planning is to achieve and maintain the highest level of service quality through present resources in each service area and administrative department.

The **OBJECTIVES** that support the goal and give direction to the Performance Quality Improvement Planning activities are to ensure that:

- All NBBHS administrative and clinical staff, as well as departmental leaders conduct regular Performance Quality Improvement reviews that monitor, evaluate and adjust/refine service components and treatment modalities.
- Policies and procedures are effectively designed to guide agency efforts to provide quality of care, evaluate staff performance, and identify necessary training programs.
- Mechanisms exist that monitor, evaluate and adjust/refine service delivery based on consumer and/or other stakeholder satisfaction feedback.
- There are efficient means to identify and resolve, in a timely fashion, problems that affect the quality of service to clients.
- A strategic planning process is in place to align short and long-term goals and objectives with the values and mission of the organization.
- The Chief Executive Officer, Leadership Team, Clinical staff, personnel, and other stake-holder groups have appropriate information necessary to understand the status of service delivery and to make changes to improve the quality of services.

PQI STRUCTURE



The PQI Committee is comprised of senior management from every department/program along with the PQI Coordinator(s). The Leadership Team is responsible to assign, implement, and review activities that guide and improve staff performance from client admission to client discharge. The Leadership Team is also responsible for management of the treatment service and program process. The focus of service reviews shall be to increase positive treatment outcomes. Each member has an equal vote and is required to attend committee meetings unless excused by the CEO. When a job related or personnel performance concern arises, procedures are in place for contact to be made with an immediate supervisor and/or any member of the Leadership Team.

Members of the Leadership Team include:

- Chief Executive Officer
- Corporate Compliance Officer/ PQI Coordinator
- Clinical Director
- Assistant Clinical Director
- PQI Data Manager/Coordinator
- Medical Records Librarian/Utilization Review
- Human Resources Director

- EOC/ Safety Manager
- Billing Specialist

The Leadership Team meets weekly to identify and rectify issues resulting in suboptimal care and safety, and to require PQI reports from the systems necessary to facilitate identified improvement efforts.

Comprehensive reviews for analysis of PQI and risk management related data gathered by individual administrative staff within each department/program are completed quarterly. The PQI related data gathered by each department is submitted to the PQI Data Manager to be aggregated as part of the Performance Quality Improvement Report.

This report is reviewed by the Leadership Team for improvement efforts, corrective action, and service change as appropriate.

Performance Improvement Teams and Work Groups

Performance improvement, including performance measurement, is the responsibility of all staff throughout the organization and aides in building organizational capacity for measurement and improvement. When necessary, individuals will be assigned by the PQI committee to performance improvement teams or work groups to carry out performance improvement activities including, but not limited to, collection of data and documentation/review of the necessary policies and procedures for the function assigned.

IMPORTANT PROCESSES AND OUTCOMES

NBBHS will compile data and analyze the following key indicators of performance through the risk management report and performance measures including:

- Evidence Based Practices
- Youth Outcome Questionnaire (YOQ)
- Risk Management/Safety Report
- Clinical Record Review
- Service Utilization
- Program and Service Review
- Client Satisfaction Surveys
- Employee Satisfaction Surveys

Evidence Based Practices

NBBHS provides evidence based practices by utilizing practices that are closely tied to evidence based studies such as: the Cognitive Behavioral Model, and those standard

practices accepted by SAMSHA. The Master Treatment Plan Review/Treatment Plan Reviews (MTPR/TPR's) are used as a measure to evaluate client progress on a minimum of every 90 days.

In addition, the agency participates in Arkansas' state evidence based project tool known as the Youth - Outcomes Questionnaire (Y-OQ) to track case response to treatment.

Youth Outcome Questionnaire

NBBHS will utilize the Youth Outcome Questionnaire (YOQ) for all clients ages four (4) to eighteen (18). The OQ-45.2 questionnaire will be utilized for adult clients. The Outcome Questionnaire (OQ) instruments are utilized at the initial client intake and a minimum of 90 days thereafter for all clients regardless of payer source. To maintain data integrity and consistency in data entry, all responses from OQ questionnaires will be entered into OQ Analyst by a designated administrative staff member that has been sufficiently training in the process.

STAKEHOLDER INVOLVEMENT IN THE PQI PROCESS

New Beginnings Behavioral Health Services, LLC has an extensive list of key stakeholders and values their participation in our PQI process. Key stakeholders include personnel, clients, schools/community organizations, the Arkansas Division of Behavioral Health Services, the Division of Medicaid Services, NBBHS Audit and Finance Committee, and the NBBHS Community Advisory Committee.

- Clients participate in quarterly questionnaires which allow them to offer feedback and comments about the quality of service provided. Clients also receive a service follow-up questionnaire after discharge.
- The Arkansas Division of Behavioral Health Services receives an annual agency PQI report, and all required ongoing Certification compliance forms.
- The Arkansas Division of Medicaid Services receives an annual attestation report, and all required ongoing Provider enrollment documentation.
- Central Arkansas schools, community organizations, and NBBHS Community Advisory Committee, participate in questionnaires on an annual basis which allow them to offer feedback and comments based on their interactions with our organization.
- The NBBHS Audit and Finance Committee also receive monthly financial statements from our Chief Financial Officer.
- NBBHS staff members participate in semi-annual surveys regarding supervisors, working environment, staff morale, communication, knowledge of agency policy and procedures and evaluation of services. This survey is designed to give each employee an opportunity to offer comments and suggestions for improvement. PQI reports are presented at least quarterly during departmental staff meetings and employees have the opportunity to offer comments and suggestions. Staff

members are also given opportunities to serve on departmental PQI teams and workgroups.

The Leadership Team review PQI reports as well as questionnaire results at quarterly meetings in order to identify trends based on empirical evidence. Suggestions and recommendations are communicated to and among the Leadership Team, PQI Coordinator(s) and to the appropriate stakeholders. Corrective action is based on stakeholder feedback and improvement suggestions from departmental leaders and the Leadership Team. Changes in policies, procedures, or staff training are implemented as necessary by the Leadership Team.

NBBHS' PQI philosophy, PQI structure, stakeholder involvement, and a brief description of agency outcome measures are provided to all stakeholders in a PQI information packet and/or on the agency website. This information is maintained and updated as necessary by the PQI Coordinator(s).

All feedback and input from stakeholders is utilized by our Leadership Team to formulate strategic planning and to identify short-term and long-term goals and objectives.

Key stakeholders include NBBHS personnel, clients, schools/community organizations, the Arkansas Division of Behavioral Health Services, NBBHS Audit and Finance Committee, and NBBHS Community Advisory Committee.

Personnel

New Beginnings Behavioral Health Services, LLC (NBBHS) facilitates monthly meetings/in-services with all administrative personnel, Mental Health Professionals (MHPs), and Mental Health Paraprofessionals (MHPPs). During these meetings, staff are informed of PQI efforts, support services and referral services available, as well as any changes in policy. This process enables NBBHS staff to voice concerns, recommend changes, ask questions, and offer feedback to leadership staff concerning issues of ongoing improvement, satisfaction and service delivery.

NBBHS personnel have a variety of opportunities to participate in the performance improvement process. Opportunities include providing feedback through staff meetings, performance evaluations, employee satisfaction surveys, and informal meetings with supervisors. NBBHS Personnel also receive both verbal and written communication on how to file a formal grievance. Results reported in the quarterly quality assurance meeting and actions taken by the PQI committee are communicated to all personnel.

MHPs and MHPPs are also trained and responsible for certain PQI efforts such as the continuation of care plan, monitoring of caseloads and client service frequencies. MHPs have the additional responsibility of completing and documenting weekly supervision of MHPPs.

Clients

Feedback from clients and their family members involved in treatment is critical to the on-going evaluation of services. During the initial intake process, clients' and their legal guardians (if applicable) receive both verbal and written communication of their rights including information on how to file a formal grievance.

Clients and parents are informed of company policies, PQI overview and agency improvement efforts, community support and referral services available, and service delivery details during the intake process. They are also made aware of any changes in policy, PQI procedures and additional support services available during family therapy, family contact with clinical staff, and during medication management appointments.

Formal client grievances are directed to the Grievance Officer. The total number of formal grievances filed is reported on a quarterly basis by the Grievance Officer to the PQI committee.

In addition, satisfaction surveys are conducted with clients, parents or guardians every quarter to obtain necessary feedback on service delivery. Results from these surveys are reported during the quarterly quality assurance meetings.

School Officials/Personnel

NBBHS partners primarily with the Little Rock School District (LRSD), for service provision. MHPs and MHPPS are assigned to various schools within the LRSD. MHPs and MHPPs have daily and ongoing contact with school administrators and school staff at their assigned schools. The School District often requests Community Support services such as crisis interventions and trainings from NBBHS, these services are offered as "Pro-Bono". To date, all requests for support from the LRSD have been met.

Because of the ongoing involvement of MHPs and MHPPs in certain aspects of the PQI process, these staff members are able to inform the client, parent and LRSD administration of NBBHS PQI efforts and support resources. This information is provided either during face to face contact, in-service trainings, agency reports or specific meetings.

School officials/personnel receive a formal report on a monthly basis regarding the performance improvement process. School officials/personnel have also been instructed on the process to submit formal grievances that will be reviewed as part of the performance improvement process.

State Regulatory Agencies

The Division of Behavioral Health Services (DBHS) receives an annual agency PQI report, and all required ongoing state certification compliance forms. A recertification process is completed in concurrence with the accreditation cycle. Ongoing compliance is

maintained through timely notification of any changes within the agency that are monitored under the DBHS Rehabilitative Services for Persons with Mental Illness (RSPMI) Policy.

The Division of Medicaid Services (DMS) receives an annual attestation report, and all required ongoing Provider enrollment, and billing eligibility documentation as dictated by DMS RSPMI Rules and Regulations.

As part of ongoing compliance monitoring, NBBHS is required to complete on-site auditing procedures with a DMS contracted agency: Value Options, on an annual basis. Additional off site requirements are completed at the directive of DMS/Value Options.

NBBHS Audit and Finance Committee

The Audit and Finance Committee members are not employed with NBBHS, allowing for external control, feedback and oversight of the agency financial matters as well as assistance and support to the CEO in this area.

On a monthly basis, NBBHS' Chief Financial Officer completes a financial statement for review. Quarterly meetings are set with the CEO, Audit and Finance Committee, and CFO for additional financial discussions and planning. The CEO and CFO complete an annual budget with the assistance and feedback of the Audit and Finance Committee.

NBBHS Community Advisory Committee

New Beginnings Behavioral Health Services, LLC (NBBHS), invited parties in the community who have interests in NBBHS goals and projects to join the agency's efforts in providing quality behavioral health care to residents of Central Arkansas.

The parties who were approached were asked to serve on a committee to provide support, accountability and needed stakeholder involvement to NBBHS administration.

Because the agency's primary service demographic is with the child and adolescent populations, members with extensive knowledge and resources in this area were sought. The committee was formed with the intent of building a strong network of support and direction.

Quarterly meetings of the Community Advisory Committee are held and documented, as New Beginnings Behavioral Health Services, LLC pursues stronger community relationships and opportunities for community involvement.

Community Involvement and Support

NBBHS recognizes and values the role local churches, colleges/universities, and human service providers play in helping meet the behavioral and mental health needs of the community.

NBBHS continues to improve Community Support efforts and Stakeholder Involvement by implementing a schedule of regular meetings with various representatives in the community for:

- Annual overview of agency Performance Quality Improvement Efforts
- Pursuit of additional training opportunities
- Establishment of referral sources
- Fostering new relationships and partnerships
- Growth of referral opportunities for new NBBHS clients
- Discussion with identified community stakeholders regarding available opportunities for collaborative efforts in providing better care to the community and the clients that we serve.
- Implementation of Community Advisory Committee, attended by a broad array of community leaders, with a wealth of experience and knowledge of behavioral health needs and in serving Central Arkansas.
- Monthly attendance of Provider Alliance meetings, over 14 state Providers represented – Discussions ranging from State and Federal legislative issues, to common problem solving regarding issues faced in day to day agency operations.
- Short Term and Long Term Departmental goals are reflective of ongoing efforts to offer supportive services to the community, foster good relationships and build partnerships, as well as encourage stakeholder involvement and feedback.

DATA REVIEW, ANALYSIS, AND COMMUNICATING RESULTS

PQI data, reports, and stakeholder feedback is reviewed at least quarterly by the Leadership Team. PQI reports and data are presented to all staff at least quarterly at departmental staff meetings. The Community Advisory Committee receives a quarterly report and are updated on PQI efforts and issues at monthly meetings.

An overview of PQI efforts, data, and improvement goals is generated into a stakeholder report on an annual basis. Clients, parents, guardians, school personnel, and community organizations/partners are informed of NBBHS PQI structure, plan and process as well as short term and long term goals, in the annual report.

Analysis of data is conducted by the PQI Data Manager and Leadership Team based on targeted goals specified on the quarterly report and corrective action report, as well as by identifying trends in outcomes documented on departmental Performance Quality Improvement Reports. Stakeholder feedback is considered and incorporated into on-going agency improvement efforts.

Corrective Action Plans are developed and recommendations are made to the Leadership Team, leading to modification to policies, procedures, training, supervision, or other programmatic change in order to ensure achievement of goals and client outcomes. Improvements that have occurred as a result of PQI corrective action plans and plans are implemented and communicated through an annual Performance and Quality Improvement Narrative Report. The PQI Narrative Report is provided to all staff and is included in stakeholder information packets and/or on the agency website.

MEASURES AND OUTCOMES

NBBHS acknowledges that meaningful performance improvement can only occur through an environment in which leaders develop a culture committed to continuous improvement. NBBHS aims to achieve and maintain effective communication, collaboration, and planning within the organization. This expectation of continuous improvement and excellence in customer service are cornerstones of the NBBHS performance improvement processes.

New Beginning's Performance Quality Improvement (PQI) approach includes, but is not limited to the following areas, processes and outcomes:

Personnel

- Employee Performance Reviews
- Employee Satisfaction Reviews
- Employee Incentive to Engage in Improvements for Program Excellence
- Initial and Ongoing Training
- Grievance Procedures
- Exit Surveys

Clients

- Quarterly Client Satisfaction Surveys
- System for Suggestions for Program Improvement
- Community Support Information
- Grievance Process
- Youth - Outcomes Questionnaire (Y-OQ) Participation
- Clinical Record Review

Community Relationships

- Maintenance of Community Liaison Responsibilities
- Formal Notification of Improvement Projects
- Invitation to the Public and Stakeholders to Provide Suggestions for Improvements for the agency
- Grievance Process

Facility Risk Management and Safety

- Maintenance of an Environmental/Safety Director Position to Manage Threat Responses
- Quarterly Facility Inspection Process
- Quarterly Safety and Disaster Drills
- Transportation Maintenance and Inspection
- Incident Reports

Financial Assessment

- Contracted Services with CPA for Annual Financial Reporting
- Ongoing review of Accounting Processes

Information and Technology Security

- Initial and Ongoing Training HIPPA/Confidentiality
- Quarterly Inspection Report
- Improvement Review
- Incident Reports
- Private Contract with an Information Technology Security Technician to Upgrade and Improve Internet Security.

MANAGEMENT/OPERATIONAL PERFORMANCE

The Leadership Team represents the agency's supervision and responsibilities for finance, human resources, programs and services, communications, and overall safety, risk and facility management. For PQI purposes, the following areas are monitored and analyzed for performance and operational excellence.

Financial Viability

The CEO, CFO, and the Audit and Finance Committee have a close working relationship. Financial reports and other data are reviewed and analyzed monthly. Copies of financial statements are provided to the Audit and Finance Committee for their review on a monthly basis.

The Audit and Finance Committee participates in the budget process and approves the final proposed budget each year. NBBHS adheres to financial policies and procedures which render transparent and sound financial reporting to all appropriate parties.

Cost analysis of service data is analyzed for ongoing monitoring of revenue and expenditures for budget reporting, as well as providing information for funders and governmental agencies. Aggregated cost and revenue data related to programs and services is included in the annual PQI report. Aggregated cost of service and revenue data, which includes targeted goals for each area of service, is also tracked and reviewed

on a quarterly basis during the Audit and Finance Committee meetings. Personnel turnover is also aggregated and reviewed at this time.

Workforce Stability

The Director of Human Resources, in cooperation with Leadership Team members, conducts a workforce analysis annually in preparation for the budget process. The analysis also includes a review of demographic information in relation to how NBBHS employees match the demographics of the surrounding communities in the areas of the state where they work.

The information gathered is analyzed for internal workforce adjustments related to projected job openings such as retirements, turnover, demographic equity, and growth/decrease in service needs in accordance with the agency's annual plans.

These factors are used for strategic planning, short-term goals related to workforce planning, and or corporate visioning by the CEO and the Leadership Team.

Employee Satisfaction surveys are conducted twice a year, and employees respond anonymously through an outsourced on-line service. The response information is reviewed by the Leadership Team for the purpose of creating improvement goals and objectives related to over-arching themes from employee feedback.

Final reports are made available for all employees to review. Annual performance evaluations of all staff are conducted in January and July of each year prior to the budget planning process.

Safety and Risk Management

The EOC/Safety Manager reviews all accident and incident data, facility safety, and transportation requirements and inspections, security of facility and information, and then recommends corrective action steps for prevention and/or improvement based on trends or compliance standards related to the areas of responsibility.

Reports of findings are submitted to the Leadership Team for their quarterly PQI review. The PQI Data Manager aggregates data related to serious incident reports, worker's compensation injuries, vehicle accidents, grievances, and other risk elements as outlined in COA's Risk Prevention Standards.

The data is analyzed to identify safety and risk trends and methods for improvement and prevention. Revisions in policies and procedures as well as corrective action steps involving training and supervision may be developed and distributed to the Leadership Team for implementation throughout the agency.

Quarterly PQI and Risk Management reports, including aggregated data and corrective action steps for improvement and prevention, are submitted to the CEO, as well as the Leadership Team.

PROGRAM RESULTS/SERVICE DELIVERY QUALITY

New Beginnings Behavioral Health Services, LLC chooses to measure the following dimensions of service quality on a quarterly basis. Following data collection and analysis by the PQI Data Manager, aggregated data is reviewed by the Leadership Team to identify patterns and trends.

Monitoring and evaluating steps occur with the following activities:

- Accuracy of case records – Case records are reviewed randomly by Mental Health Professional staff for self and peer audit activities to measure errors and compliance. Issues, trends, noted areas of needed improvement are discussed in monthly staff meetings facilitated by the Clinical Director staff.
- Clinical Audit of case records – Case records are reviewed on an ongoing basis by a Clinical Auditor to measure errors and compliance. A case record review document is used to aggregate data and identify trends.
- Paper Prescription Management – The Medical Records Receptionist reviews paper prescription pick-up logs for accuracy and checks paper prescriptions for expiration dates, following appropriate destruction methods for expired prescriptions. Results are aggregated and reviewed by Medical Records Librarian or Medical Director, to identify patterns and trends.
- Assessment of services -- use of family conferences, family visitation, and parent groups are reviewed by Clinical Director staff and MHPs on a case-by-case basis; aggregated data is reviewed by Clinical Director Staff and Leadership Team to identify patterns and trends.
- Client feedback – Surveys are utilized to collect feedback from consumers regarding their experiences with organizational programs and to solicit their ideas about areas needing improvement. Responses are aggregated by the PQI Data Manager, and reviewed by the Leadership Team.
- Non-client stakeholder feedback -- Surveys are utilized to collect feedback from non-client stakeholders regarding their experiences with organizational programs and to solicit their ideas about areas needing improvement. Responses are aggregated by the PQI Data Manager, and reviewed by the Leadership Team.

CLIENT AND PROGRAM OUTCOMES

New Beginnings Behavioral Health Services, LLC has well established outcome expectations within all of its departments to measure the effectiveness of services and the impact on consumers.
Staff members at all levels are involved in the development of outcomes and outputs using quarterly Performance Quality Improvement Plans from each department as well as

stakeholder feedback. Client and program outcomes tracked include but are not limited to:

- Evaluation of level and intensity of care - for provision of consistent, medically necessary services
- The health, welfare, and safety of our clients
- Improving effectiveness of services through ongoing monitoring and improvement, community resources, and referral relationships
- Positive Stakeholder and community perception
- Financial Viability
- Personnel satisfaction and retention
- Compliance
- Safety and Risk Management

An analysis of outcome data is conducted by the PQI Data Manager as well as by the Leadership Team and aggregated data is shared at departmental staff meetings quarterly and with the Community Advisory Committee and State Regulatory agency on an annual basis. Corrective action plans are developed as needed based on the monitoring of these outcomes.

COMPLIANCE: EXTERNAL REGULATORY REQUIREMENTS

NBBHS is a State Certified Provider of Medicaid reimbursable services in the outpatient behavioral health field in Central Arkansas. The following regulatory agencies manage, monitor and provide oversight to the agency as a component of ongoing compliance requirements.

The Division of Behavioral Health Services (DBHS) receives an annual agency PQI report, and all required ongoing state Certification compliance forms. A recertification process is completed in concurrence with the accreditation cycle.

Ongoing compliance is maintained through timely notification of any changes within the agency that are monitored under the DBHS Rehabilitative Services for Persons with Mental Illness (RSPMI) Policy.
Additional mandated processes and procedures include:

- Use and completion of the YOQ at initial intake and every 90 days thereafter
- Quarterly completion of clinical record review (random sample of 10% open cases)
- Annual reporting/ ongoing reporting of any changes in administrative structure, services provided or location

The Division of Medical Services (DMS) receives an annual attestation report, and all required ongoing Provider enrollment, and billing eligibility documentation as dictated by DMS RSPMI Rules and Regulations.

As part of ongoing compliance monitoring, NBBHS is required to complete on-site auditing procedures with a DMS contracted agency: Value Options, on an annual basis. Additional off site requirements are completed at the directive of DMS/Value Options.

PQI DATA MANAGEMENT PROCEDURES

NBBHS has assigned the responsibility of completing the data sources for each department to the departmental leader. Each departmental leader is to manage the completion of each listed data source for their area, and submit the information to the PQI Data Manager on a monthly basis.

The PQI Data Manager analyzes and aggregates relevant data into a generated report for review by the Leadership Team. Follow up action, or corrective action is communicated to each department leader as necessary.

Needed improvements, updates, additions or removal from the tracking tool list is at the discretion of the Leadership Team. The Leadership Team determines the rationale for data collection and use of information as a part of ongoing PQI efforts.

Recommendations and action plans are discussed and submitted for vote by all members of the Leadership Team.

DATA COLLECTION AND AGGREGATION

Case Record Review

Case records are reviewed randomly by Mental Health Professional staff for self and peer audit activities to measure clinical appropriateness, technical errors, and regulatory compliance. Issues, trends, noted areas of needed improvement are discussed in monthly staff meetings facilitated by the Clinical Director staff.

A sample of 10% of open cases are selected ~~at~~ randomly for quarterly review. A case record review report form is used for each record that incorporates specific review elements as deemed appropriate to that program.

Case review items include but are not limited to:

- PCP Referral
- Appropriate Consents
- Appropriate Assessment tool Completion
- Youth Outcomes Questionnaire (YOQ) Completion
- Master Treatment Plan
- Primary Diagnosis
- Progress Notes

- Incident Reports
- Treatment Plan Reviews (every 90 days)
- YOQ Completion (every 90 days)
- Length of time in care
- Aftercare plan
- Discharge Summary

Clinical Audit of case records are completed on an ongoing basis by an appointed Clinical Auditor who has demonstrated no conflict of interest and is an objective reviewer of the case record. Clinical case audits measure technical errors, treatment components, intervention effectiveness, and service appropriateness as well as regulatory and professional compliance. A case record review document is used to aggregate data and identify trends.

The data collected from the clinical audit report is aggregated to identify trends and implement necessary improvement plans. Summarized results and corrective action plans are documented on the quarterly Quality Assurance/ Performance Quality Improvement Report.

Review of Risk Management Data

The EOC/Safety Manager reviews all accident and incident data, facility safety, and transportation requirements and inspections, security of facility and information, and then recommends corrective action steps for prevention and/or improvement based on trends or compliance standards related to the areas of responsibility.

Reports of findings are submitted to the Leadership Team for their quarterly PQI review. The PQI Data Manager aggregates data related to serious incident reports, worker's compensation injuries, vehicle accidents, grievances, and other risk elements as outlined in COA's Risk Prevention Standards.

The data is analyzed to identify safety and risk trends and methods for improvement and risk prevention. Revisions in policies and procedures as well as corrective action steps involving training and supervision may be developed and distributed to the Leadership Team for implementation throughout the agency.

Quarterly PQI and Risk Management reports, including aggregated data and corrective action steps for improvement and prevention, are submitted to the CEO, as well as the Leadership Team.

Client Involvement/Satisfaction

Client Involvement/Satisfaction is evaluated quarterly by the Leadership Team. Client feedback questionnaires are part of the quarterly service plan review. Comprehensive client satisfaction surveys are disseminated annually to all clients, parents/guardians.

Service follow-up questionnaires are mailed by Medical Records staff following all discharges.
Client grievance reports are tracked on a quarterly basis. Summarized results and corrective action plans are documented on the quarterly Performance Quality Improvement Report.

Client Outcomes Data

Client Outcomes Data is collected, utilizing the State mandated outcomes measurement tool: Youth Outcomes Questionnaire (YOQ). Data is aggregated and reported on a quarterly basis by the PQI Data Manager, and reviewed by the Leadership Team. This data is used to evaluate the health, safety and welfare of our clients, behavioral changes, permanency of life situations, and changes in functional status.

The Youth Outcome Questionnaire must be administered to all individuals over the age of four and under age 21 except the persons age 18-21 who have been certified as seriously mentally ill. This administration should be within the first 14 days of service and must be repeated at a minimum of every 90 days. *(The Y-OQ®, including the Arkansas Indicators, can be used every time a child or youth is seen, but must be used at least every 90 days).*

The UR/Medical Records Librarian manages the comprehensive review of 10% of all open client charts on a quarterly basis. Purpose of review:

a. To assess and document care and services meet client needs
b. Identify unmet behavioral health needs
c. Establish and implement plans to address unmet needs

The UR/ Medical Records Librarian tracks and reports "client satisfaction/self-assessment" portion of the Treatment Plan Review (TPR) which is administered every 90 days. This portion of the TPR will address:

d. Client, or parent/guardian assessment of progress
    i. Achieved
    ii. Making good progress
    iii. Making minimal progress
    iv. No progress
    v. Getting worse
    vi. Comments
e. Client or parent/guardian level of satisfaction with services
    i. Extremely Satisfied
    ii. Satisfied
    iii. Neutral
    iv. Dissatisfied
    v. Extremely Dissatisfied

vi. Comments

Medical Records staff will keep record and report on a monthly basis the following:

f. Number of Referrals
g. Number of Admissions
h. Discharges
i. Reasons for discharge

Data is analyzed by the PQI Data Manager, and a report to the Leadership Team for PQI/QA review is provided quarterly.

Quarterly Review meetings address areas of improvement, needs for improvement, program modification needs, areas of change, or trends.
Follow up action to the findings in these reports and processes are assessed/implemented by members of the Leadership Team as appropriate.

Summarized results and corresponding corrective action plans are documented on the quarterly departmental/program Performance Quality Improvement Report.

DATA REVIEW AND ANALYSIS

NBBHS recently appointed a dedicated PQI Data Manager to assist in PQI Coordination responsibilities and to compile all aggregation of reporting data from all agency departments. Data timelines are managed by the PQI Data Manager. All data is received, analyzed and aggregated on a monthly basis with quarterly, and annual reports (at a minimum) submitted to the Leadership Team for review.

The process for ensuring data integrity and reliability:

- All data is given to the PQI Data Manager in raw forms, without any initial analysis that could influence future interpretations.
- All client identifying information is redacted for confidentiality. If there is a need to refer to a specific chart or client, only their medical record (MR) number is used.

Types of data analysis ~~being~~ used:

- Analysis/measures of central tendency
- Graphical representation of numbers
- Z-Scores, T-Test(s), Chi-Squares and other analyses of correlation
- Analysis of variance, if applicable

Report formats:

- Reports are formatted with Tables of raw numbers, Figures giving graphical representations of the raw data, then narratives summarizing the data, noting trends, and making recommendations for the Leadership Team's consideration.
- The narrative takes the form of a heavily modified CRAF Reporting format

Timeframes for dissemination and review:

- Full PQI Reports, covering all track able data, are compiled each quarter for review by the Leadership Team, with review done within 15 days of the end of the quarter
- The four Quarterly Reports are then aggregated into an Annual Report
- Timeframes for implementation of proposed changes and follow-up reporting are set by the Leadership Team during the report review.
- Any pressing ad hoc issue confronting the PQI staff results in a report generated for discussion during the next weekly scheduled Leadership Team meeting, where the issue will be reviewed, and alterations to practice proposed, and the timeline for follow up reporting set. This process is followed when pressing issues are discovered, necessitating timely review and response prior to the Quarter Report process.

Review procedures including detailed procedures for stakeholder review:

- The PQI staff prepares a condensed version of the Quarterly and Annual Reports, designed to be brief and easily reviewed by all stakeholders.
- These reports are given to clinical staff during staffing meetings, to representatives of the Little Rock School District, provided to the CEO to disseminate to the Community Advisory Committee, and other community support/referral sources. This information is also posted on the agency website for review by current or potential clients, or other providers within the community.
- Each format of the PQI report includes simple instructions for providing feedback to the agency, whether by phone or by email, including who to address the comments to, as well as the option to be included in follow up contact when improvements and changes are implemented.

Analysis of stakeholder feedback:

- Comments from all stakeholders who reviewed and responded to the PQI report are collected by the individual identified as the point of contact on the report.
- That individual redacts any client identifying information, and comments if necessary, and forward them on to the PQI Data Manager.
- The Data Manager will code all of the subjective responses given, and perform all appropriate factor analyses to look for patterns and trends in the data
- All the data gathered from feedback is compiled into a report, following the format of the above documents, to be disseminated to the Leadership for discussion and planning in practice/policy improvements, or changes.

IMPLEMENTING IMPROVEMENT AND ASSESSMENT OF THE EFFECTIVENESS OF THE PQI PROCESS

An evaluation of the PQI Process is completed each year at the annual PQI Planning Meeting. Recommendations for improvement are made from stakeholder feedback, clinical and administrative staff, the Community Advisory Committee, and the Audit and Finance Committee, to the PQI Coordinator, and Leadership Team based on the annual agency PQI report. Assessment of the PQI structure, responsibilities, and procedures are also completed by the Leadership Team at this time.

Each departmental leader reports all PQI tracking tools, indicators, reason for measurement, frequency of use, and data sources for review on an annual basis. Needed improvements, updates, additions or removal from the tracking tool list will be at the discretion of the Leadership Team. Rationale for data-collection and its use is a part of the ongoing PQI effort.

Recommendations regarding data repots are discussed and submitted for vote by all members of the Leadership Team.

Changes made to the existing Performance and Quality Improvement Plan, structure, policy and process are based on these recommendations. Any changes made, are communicated to the appropriate staff or stakeholders.

Planning Ahead

The Leadership Team is responsible for ensuring that corrective action plans are implemented and that timeframes are maintained. The Leadership Team and departmental leaders are responsible for monitoring the results of the implementation of corrective action plans, and setting reasonable timelines for completion and review of corrective action results.

The impacts of the corrective action plans are monitored through measurement of improvement of stakeholder satisfaction, personnel retention rates, incident reports, reductions in non-compliance items reviewed during case record reviews and risk management reviews, and enhanced achievement of client outcomes.

Review of all holdover issues from prior reports or inclusion of goals and activities to the updated report are voted on by all members of the Leadership Team.

Each departmental leader completes an annual short term and long term goal report. The departmental goals are reviewed by the Leadership Team for implementation in the agency's Strategic Plan on an annual basis.

Development of the agency's annual strategic plan is completed in three stages:

- Stakeholder feedback and involvement
- Departmental short and long term goals

- Leadership Team review, discussion and implementation

Administrative revisions in policies and procedures as well as corrective action steps involving training and supervision may be developed and distributed to the Leadership Team for implementation throughout the agency.

Improvements that occur as a result of PQI corrective action plans and any plans that are in the implementation stages, including the agency strategic plan, are communicated through an annual Performance and Quality Improvement Narrative Report which is provided to all staff and is included in stakeholder information packets and/or on the agency website.