Continuous Quality Improvement (CQI)/Performance Plan

ORIGINAL DATE: November 1, 2005
REVISION DATES: 10/2006, 09/2007, 05/2008, 09/2009, 10/2010, 09/2011
DEVELOPED BY: Annie Martinez-Esteve, LCSW, Director of Clinical Services
APPROVED BY: Board of Directors, Manny Fraga, Jr., CEO, Antonio Anguiano, LCSW-Director of Clinical Services, Luisa Ramirez, LCSW-CQI Officer, and Premysl Ulman, LMFT-Director of Outpatient/Prevention Services.

I. BACKGROUND

The following Performance Improvement Plan has been developed as Regis House, Inc.'s main tool in supporting Quality Assurance/Improvement initiatives. This Quality Assurance/Performance Improvement Plan is a narrative of the steps Regis House, Inc. will take to reach this goal. Regis House, Inc. will utilize this plan to promote continuous improvement in the provision of services to all persons served. Through the Performance Improvement Plan, all staff will work together to improve the delivery of care and all aspects of the organization that may impact services. To ensure the integrity of this Performance Improvement Plan, a Clinical Director was hired on July 25, 2005. The Clinical Director assumed the lead role in preparing Regis House, Inc. for CARF survey visit in 2006. As of March 19, 2007, the Clinical Director was re-hired on a part-time basis. Annie Martinez-Esteve resigned as of July 6, 2007, and Shana Cox, LCSW assumed the Clinical Director, QA/QI Officer position. As of October 1, 2009, Antonio Anguiano, LCSW, assumed the position of Acting Clinical Director while Shana Cox was in maternity leave. Mrs. Cox resigned later on December 2008 as Clinical Director. Luisa Ramirez, LCSW assumed the responsibilities of the CQI Officer, and Antonio Anguiano, LCSW became the Director of Clinical Services.

Regis House, Inc. was granted funding by the Health Foundation of South Florida specifically to cover the financial costs of pursuing CARF accreditation. This Quality Assurance/Performance Improvement Plan was born in response to the CARF Behavioral Health Standards 2005. During the fiscal year, (2005-2006) Regis House, Inc. focused its Quality Assurance Performance Improvement Plan on planning and implementing objectives for obtaining CARF accreditation.

The first objective for Regis House, Inc. was to submit the Intent to Survey (application) to CARF no later than December 31, 2005 for a scheduled survey to be determined by CARF during May or June 2006. Regis House, Inc. also hired an outside consultant, on an as needed basis, to assist the Clinical Director in this process. As per this plan, the ultimate goal during the fiscal year (2005-2006) was for Regis House, Inc. to obtain full accreditation (3 years) from CARF in the two program areas listed above. During June 2006, Regis House, Inc. was granted a Three-Year CARF Accreditation under the Behavioral Health Standards Manual 2005-2006 in the following two areas: Prevention and Outpatient.

After CARF, and for consequent years 2007, 2008, and 2009, the short term and long term objectives for Regis House, Inc. and its management team has been those of continuing serving those we served-children, adolescents, and adults-with a person-served centered, culturally competent, risk free environment, and with maintaining evidence-based high quality co-occurring psychiatric, and substance abuse programs.

Regis House, Inc. was re-accredited by CARF for three consecutive years (2009-2012) with commendations on September 2009.

II. QUALITY IMPROVEMENT COMMITTEE

To assist with implementation, the **Quality Improvement Committee (QIC, CQI)** was established (formerly the management/leadership committee) consisting of the Executive Director, Clinical Director and Program Directors. QIC meets on a quarterly basis in order to discuss strategic planning, quality assurance/improvement issues, overall agency compliance with CARF, AHCA, and CMS standards and feedback from subcommittees. Minutes are taken during each meeting and items, which require follow-up, are discussed during the following meeting. Each Program Director is responsible for providing an update regarding program goals and objectives. In addition, it is the responsibility of each Program Manager to disseminate all relevant information to their staff members. During QIC meetings, there is an annual formal review of grievances/complaints and incident reports-critical and non-critical reported to DCF as part of the annual risk analysis from persons served to determine trends, areas needing performance improvement, and corrective actions. Moreover, the results of all external and internal inspections are reviewed on a quarterly basis. The results of emergency disaster procedures will be discussed in QIC in order to analyze performance and improve or affirm satisfactory current practices.

Furthermore, the QIC has established the following three subcommittees:

A. Outpatient Subcommittee

An Outpatient Subcommittee has been established which consists mostly of clinicians who meet at minimum one time per month. The Outpatient Subcommittee is tasked with ensuring all applicable policies and procedures are in compliance, implemented and practiced at the outpatient programs. The subcommittee also reviews applicable clinical

forms and ensures clinical documentation is in accordance with CARF, AHCA, and CMS standards. Director of Clinical Services manages this process.

B. Prevention Subcommittee

A Prevention Subcommittee has been established consisting of outreach workers and after school counselors under the leadership of the Director of Prevention Services. This subcommittee meets to discuss changes in the program and identify areas which need improvement. The Prevention Subcommittee meets on a monthly basis and documents each meeting. The Director of Prevention Services is responsible for ensuring all information discussed during this meeting is disseminated to all Prevention staff.

C. Information Technology Subcommittee

An Information Technology (IT) Subcommittee has been established composed of Program Directors and a representative from PICT-Co in order to focus on IT issues which may include data collection, IT needs and analysis, system implementation and any other information management issues.

Regis House, Inc. had initially worked towards the implementation of the Knight Information System Software (KISS), but due to programmatic issues, the agency implanted the PICT-NewOrg management software system, which will allow Regis House, Inc.'s staff to generate reports at all management levels including data related to persons served, performance outcomes, and drawdowns and budgeting. In May 2008, the NewOrg management software became operational and particularly the Outpatient Dept benefited in ways of collecting and submitting data on all persons served to DCF and SFPC/SFBHN by interfacing with OneFamily, and KISS data systems chosen by the grantors.

With the implementation of the software, the agency encountered high levels of customization, and critical reporting issues with the DCF upload. The agency was able to surmount all hindrances and implemented the new software system. Efficiencies have been improved by reducing the amount of time spent waiting for technical assistance support from PICT-Co, decreased senior management time spent on collecting and inputting data, improved management oversight by increasing senior management ability to track and trend for analysis, produce more accurate reporting and billing, and increased direct service hours.

III. RECORD REVIEW

A. Compliance Review Team

The **Compliance Review Team** has been established to monitor the integrity of Regis House, Inc.'s clinical records. The Compliance Review Team consists of Program Directors including the Director of Clinical Services who at least one time per year will audit 30% of the active caseloads.

Regis House, Inc. has created a tool, which will help the program managers audit specific areas for each program in order to ensure compliance with CARF, Medicaid, Medicare, Department of Children & Families and all other funding sources or governing bodies. Once the program managers gather their findings, the results will be shared with each Program Director. Each Program Director will be given 14 days to correct all problem areas identified. The Clinical Director will maintain the data and audit tools utilized by the compliance review team each quarter.

B. Peer Review Team

A Peer Review process has been established in which clinicians from each of the programs audit the clinical records of a peer. This process will allow clinicians to learn about different programs within the agency as well as ensuring adequate integrity of clinical records. It is anticipated that this exercise will also result in informal learning opportunities for the clinicians. The peer review team will meet at minimum on a quarterly basis.

Regis House, Inc. has developed a peer review tool to guide clinicians in the process and identify content and quality issues in the clinical records. This will also contribute to compliance with CARF, Medicaid, Medicare, Department of Children & Families and all other licensing and funding sources or governing bodies. Once the clinicians gather the findings, the Director of Clinical Services will share the results with the respective Program Director. The Program Director will have 14 days to disseminate the findings to the clinicians/therapists and correct all problem areas identified. The Clinical Director will maintain the data and audit tools utilized by the peer review team each quarter. A summary of the findings will be discussed with all clinical staff and training will be offered in the following clinical staff meeting.

IV. PROGRAMMATIC QUALITY ASSURANCE/ IMPROVEMENT

A. Programmatic Staff Meetings

Regis House, Inc. conducts mandatory programmatic staff meetings on a monthly basis as a venue where staff discuss applicable administrative and clinical issues. Each Administrative Director keeps the meeting minutes.

B. Clinical Supervision

Regis House, Inc. acknowledges the importance of delivering the highest level of services to all persons served. All clinicians/therapists and clinical interns who provide therapeutic services are required to receive clinical supervision conducted by a licensed practitioner of the healing arts.

All clinicians/therapists registered with the State of Florida as Mental Health/Social Work/Marriage and Family and Interns receive clinical supervision from a staff Licensed

Clinical Social Worker, Licensed Marriage, and Family Therapist, and/or an Independent Licensed Contractor in groups or individual sessions per week. All clinical interns are required to sign-in and discussions are documented on the sign-in sheets.

All clinicians/therapists who provide clinical services through the Outpatient Program receive weekly group supervision. During the supervision sessions, specific cases are discussed and active discharge planning is a key component of supervision.

All after school counselors are required to attend team meetings at least one time per month. During these team meetings, the counselors are given relevant information regarding changes within the program. Also, counselors are encouraged to discuss cases which require special attention.

C. Record Integrity

In addition to the Compliance Review Team and Peer Review Team, all Program Directors are responsible for ensuring appropriate documentation within their program records. All persons served receiving individual, group, and/or family therapy are required to have individualized treatment plans, which include goals and measurable objectives. Interdisciplinary Treatment Plans are created utilizing input from the person served and includes the person's served strengths and abilities. Clinicians/therapists are required to initiate the development of the individualized treatment plan with the person served within thirty days from the date of the first session. Licensed practitioners are required to review and sign all treatment plans.

All clinicians are required to complete clinical progress notes which are reviewed by their supervisors on a weekly basis. In addition, all clinicians are required to conduct treatment plan reviews at least every three months. Active discharge is an important factor in treatment and begins during the initial sessions. All clinicians are required to document discharge plan goals on their treatment plans. Once a person served has been discharged from treatment, clinicians are required to complete a discharge summary thirty days from their last session.

V. PERFORMANCE OUTCOMES

Regis House, Inc. is actively working on establishing effective ways to gather performance outcomes. Regis House, Inc. implemented the PICT-NewOrg management software, which will facilitate the agency in collecting, monitoring, and analyzing outcomes and data. In the interim, there are internal methods for gathering, analyzing and interpreting outcome data. Moreover, Regis House, Inc. works with several independent evaluators-(The Thurston Group), via specific grants/contracts on performance outcomes, and grantors on specific grants conduct performance analysis.

Each program utilizes different tools in order to monitor the progress of persons served. The Outpatient Programs utilize various data collection forms including a Children's Functional Rating Score (CFARS), Substance Abuse and Mental Health (SAMH) data

form, and Substance Abuse Initial Immediate Evaluation Form in order to assess the person served prior to treatment. Those served within the Prevention Programs are given a pre-test prior to enrolling in the program, a mid-test during the course of the program, and a post-test upon termination of the program.

Moreover, Regis House, Inc. highly regards feedback from persons served, staff, student interns, and stakeholders by distributing satisfaction surveys. The surveys are analyzed and a report is produced and shared with the QIC Team to then disseminate the information to the staff and interns on the steps management is taken to resolve the issues. The results of the surveys are taken into consideration for Accessibility Planning, Quality Assurance/Performance Analysis planning, and Strategic Planning.

See Annual Quality Assurance/Performance Improvement Matrix-(2011-2012)