



Performance Improvement Plan

FY 2010

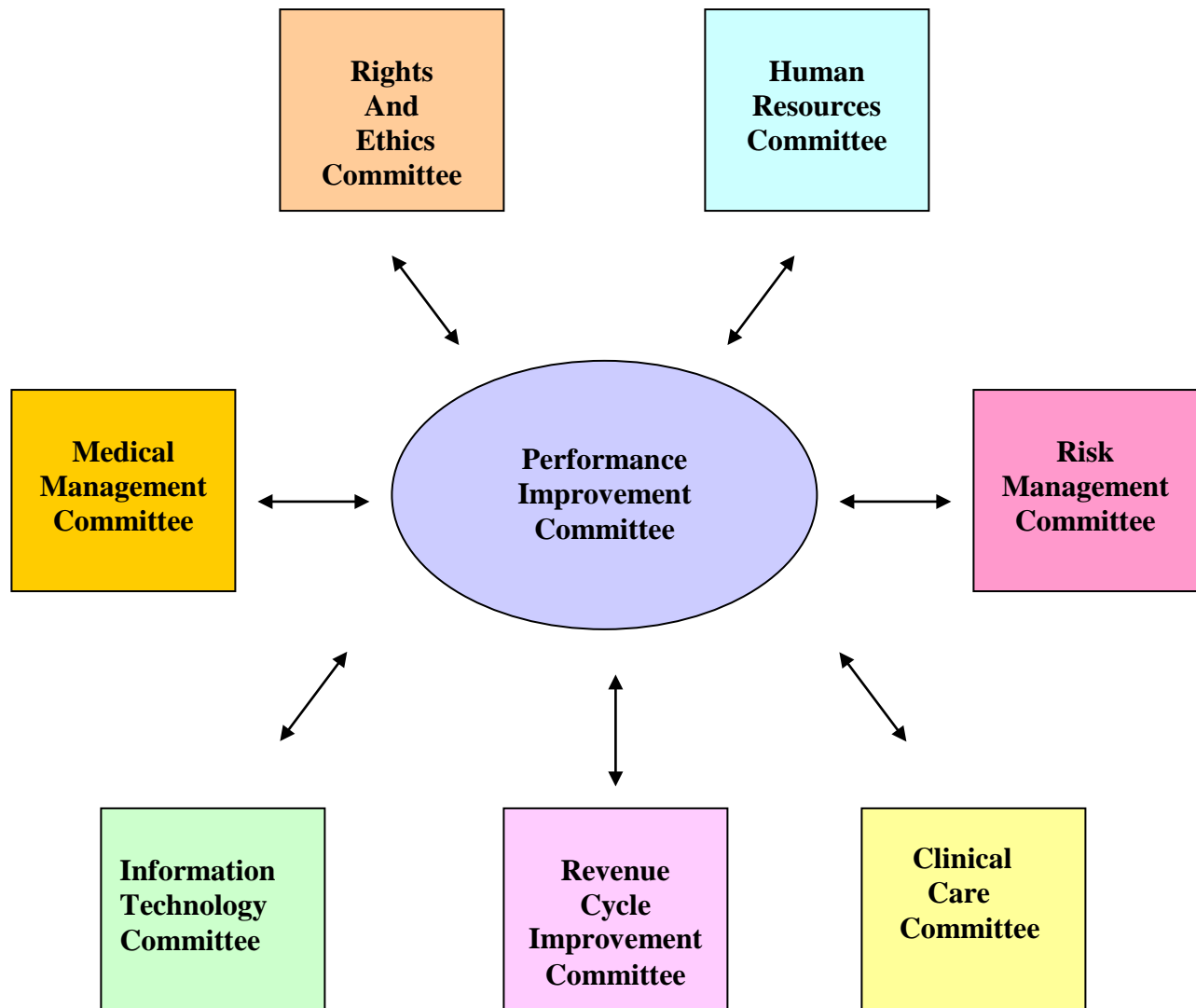
PHOENIX CENTER BEHAVIORAL HEALTH SERVICES

Performance Improvement Plan FY 2010

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Phoenix Center Behavioral Health Services Performance Improvement Committees FY 2010



The purpose of the Performance Improvement Plan is to improve our services and all things associated with those services; including, but not limited to, any risk to clients/staff/Center, treatment, safety/environment, medical concerns, client complaints, accreditations, financial and ethics violations.

Phoenix Center Mission Statement

To provide comprehensive behavioral health and developmental disability services that improve our consumer's psychological health, social functioning and quality of life.

Performance Improvement

A systematic approach for enhancing employee and organizational performance that achieves results through a process that describes desired performance, identifies causes, selects, designs, and implements interventions to fix the causes and measures changes in performance.

The Goal of Performance Improvement

To solve performance issues and/or realize opportunities for improvement in performance at the organizational, system, process and employee levels in order to achieve desired organizational results of high quality, sustainable behavioral health services that increase positive outcomes for clients.

Phoenix Center Behavioral Health Services Performance Improvement Plan FY 2010

I. Purpose

The function of the Performance Improvement Plan is to enhance the quality of services provided and performance of the agency through the use of principles of performance and quality improvement. The purpose of the Performance Improvement Plan at Phoenix Center is to ensure that the Governing Body, clinical staff, and service staff demonstrate a consistent effort to deliver safe, effective, optimal client care and services in an environment respectful of the needs of the persons served.

The primary role of Phoenix Center's Performance Improvement Plan is to establish and manage a system that continuously measures, assesses, and improves the performance of our organization for optimal efficiency and effectiveness. This approach assists us in effectively meeting the stipulated goals of our mission statement to provide comprehensive services that improve our consumer's functioning and quality of life.

The Phoenix Center Community Service Board (CSB) collaborates with staff and clients in the development of the Performance Improvement Plan. The board's role in the Performance Improvement Plan is to provide policy direction, oversight and feedback to the Executive Director. The Management Team establishes a planned, systematic, coordinated and continuous approach to effectively assess and improve the performance of those functions and processes that most directly relate to positive individual outcomes and agency efficiency.

The Phoenix Center Plan is based on established standards for quality of client care and operations found in our Mission and Vision Statements, Policy and Procedure Manual, Operations Manuals for each Program and in the manuals and policies of our various governing bodies such as CARF, ORS and Department of Behavioral Health and Developmental Disabilities (DBHDD).

The Plan promotes quality of client care and operations through the ongoing and systematic assessment of our organizational structure, its policies, processes and procedures and the resolution of identified problems. This performance improvement process identifies service and service-delivery problems, recommends necessary changes, and monitors the changes to ensure satisfactory problem resolution. This process is accomplished using outcome measurements, quality assessments, and feedback from all internal and external customers.

Key elements of the philosophy of Performance Improvement at Phoenix Center include:

- Ensuring that new programs and services are planned, designed, assessed, and as indicated, changed, on an ongoing basis for maximum benefit to the consumer and most efficient utilization
- Ensuring that existing programs are meeting or exceeding expectations, that they are effective, and that they make needed changes to improve performance.
- Ensuring that changes to the system of care mandated by external payors are implemented in a method to provide maximum benefit to the client, minimum distress to the client, and most efficient utilization of resources.
- Including all organizational leaders in the development of the Performance Improvement Plan
- Setting aside adequate time for all staff to participate in the Performance Improvement Process
- Offering training and education to staff regarding the tools and techniques of Performance Improvement
- The Executive Director's direct and continuing participation on the Performance Improvement Committee

II. Input into the Performance Improvement Program

Phoenix Center seeks feedback from persons served in a number of ways. State law mandates that at least 50% of the CSB Board members be consumers, family members, or advocates. Phoenix Center consistently meets this mandate. We also have certified Peer Specialists that participate in the statewide Consumer Network organization. They provide

feedback and input to the CSB through liaison between the Peer Specialists and Outpatient Services Program Coordinators. The Peer Specialist also work with clients and advocate for their needs as well. Additionally, our staff is active participants and supporters of the local NAMI chapter. Clients give input into the program through suggestion boxes, the Community Needs Assessment Survey, Client Satisfaction Surveys, Accessibility Surveys, the Client Complaint Process and Post Discharge Follow-ups. They may also pass comments and concerns to any staff person, Program Coordinators, the Executive Director or any committee member.

Staff gives input into the program through Training Surveys, Employee Satisfaction Surveys, the Staff Grievance Process, the Problem Identification Report (in policy 8.3), staff meetings and through any Program Coordinators, the Executive Director or committee member.

Annually, Phoenix Center also completes a Community Needs Assessment survey of stakeholders such as School Districts, Sheriffs and Police Chiefs, County Commissioners, Department of Family and Children Services, Emergency Rooms, shelters, our state hospital and other service providers. This survey requests specific information regarding services provided needs and collaboration opportunities from other agencies in the community. The governing bodies and regular activities of the Committees also provide input into the PI Program through the Board's Annual Evaluation, Community Forums, reviews, and investigation of incidents, accreditation, clinical documentation and financial audits, the complaint process and through any Program Coordinators, the Executive Director or any committee member.

Feedback is also received from external review organizations such as American Psych Systems (APS), Office of Regulatory Services (ORS), Commission of Accreditation of Rehabilitation Facilities (CARF), the Regional Office, and Support Coordination for DD consumers. This feedback is used for goal setting and decision making related to service delivery.

III. Responsibilities of the Performance Improvement Committee

The PI Executive Committee is structured as a part of the administrative services provided by Phoenix Center. By the authority of the Community Service Board (CSB), the Executive Director has delegated to the PI Executive Committee, the responsibility of directing performance improvement activities. The committee is structured to receive wide support from service coordinators and service providers. Administrative staff on all levels will be supportive of the PI Executive Committee in its efforts towards compliance and its complete service to the mission, goals and objectives of Phoenix Center. Careful monitoring by the PI Executive Committee and other PI Committees will ensure that services are conducted in the most effective and efficient manner, at the lowest reasonable cost and in the least restrictive environment.

The purpose of the PI Executive Committee is to develop, administer and fully integrate the Performance Improvement Plan into consumer care and operations. It is to be responsible for directing and providing oversight of Performance Improvement initiatives and making recommendations, as well as, ensuring closure of Corrective Action Plans and implementation of improvements to client care and operations.

In order to accomplish this task efficiently, the PI Executive Committee will:

Create committees to be responsible for addressing the standards for quality of care and operations in our mission and vision statements, policy and procedure manual, operations manuals for each program and in the manuals and policies of our various governing bodies such as CARF, ORS, and DBHDD.

Communicate the PI plan to ensure ongoing awareness of PI principles and processes. New employees are introduced to PI during Phoenix Center Employee Orientation by distributing the PI Overview and the Membership of Committees. The Program Managers (or designee) are responsible for orienting new employees to the plan. Periodic updating and revision of the plan, overview and membership is communicated to staff by memo and/or in-service training sessions.

Operational lines of communication between the Executive Committee and the administrative body will be maintained in keeping with the organizational structure. The Executive Director serves in an administrative management capacity; the Program Directors & Program Coordinators serve under the Executive Director in a supervisory capacity of each service program, dealing with both clinical and management issues pertinent to the business agenda. Service staff will be directly responsible to the service managers for the delivery of both clinical and clerical performance.

It is the responsibility of the Executive Director to communicate with administrative channels of the Phoenix Center CSB and the Regional Office. The Executive Director may transfer this responsibility by official memorandum to a chosen designee.

Members of the Committees are to function as full representatives for their staff; being responsible for communicating fully to and from their staff members and functioning as liaisons with the Executive Committee.

The Chairperson will develop the Phoenix Center Performance Improvement Plan with input from the CSB Board, clients, staff and members of the Executive Committee. This plan will be reviewed and updated annually at the beginning of each fiscal year. It will be modified as needed and approved by the CSB Board, the Executive Director and the Medical Director. Changes or amendments to the plan will follow the same procedure. It is the responsibility of the individual Program Coordinators to identify areas of needed modification of the Plan that are germane to their respective programs.

IV. Performance Improvement Committee Membership

The Committee membership will include the following staff and/or representatives:

Executive Director	Coordinator of Outpatient Services (Peach, Crawford & Houston Counties)
Medical Director	Coordinator of DD Services
Chief Financial Officer	Coordinator of Crisis Services
Director of Information Technology	Risk Management Chair
Director of SA Services	Revenue Cycle Improvement Chair
Human Resources Manager	

The Committee Chairperson may add members to the Committee as appropriate for the success of the business agenda and processes upon approval of the Executive Director. For instance, if significant issues arise regarding business systems, management information system or other issues, the appropriate department staff will be included in the appropriate committee to promote inclusion, efficient problem identification and resolution.

V. Duties for Committees

Standing committees will be in the areas of Safety/ Risk Management, Medical Management, Clinical Care, Human Resources, Rights and Ethics, Information Technology and Revenue Cycle Improvement.

To efficiently address areas identified for improvement and approve follow-up actions the Committees will:

A. Identify issues within their areas of responsibilities that are; or potentially will, affect the quality of client care and operations at Phoenix Center and develop specific goals. Goals are defined as specific concerns identified through analysis of outcomes.

B. Measure by developing mechanisms for the collection and analysis of information which will indicate success or lack of regarding the desired outcome.

C. Analyze the problem identified to determine causes, trends and indicators, reporting results to the Executive PI committee on a regular basis.

D. Improve the quality of client care and operations as a result of the identified causes and trends by developing Corrective Action Plans (CAP). Corrective Action Plans are specific, measurable, achievable and time limited documents that describe actions/solutions implemented and initial results

E. Monitor the ongoing results, lessons learned plans to maintain improvement, and identify the individuals responsible to ensure problem resolution. CAPs will continue to be monitored for an appropriate period of time to ensure the issues identified are resolved.

In addition Committees will:

F. Incorporate accreditation standards (CARF, ORS, DHR, etc.), the MHDDAD Provider Manual standards, DHR policies and other regulatory edicts as they relate to their Committee ensuring that all Phoenix Center programs, services and policies meet applicable standards.

G. Review Phoenix Center Policies and Procedures applicable to their Committee on an annual basis according to the established schedule and participate in the review, revision, addition or deletion of all policies and forms as described in Policy 1.1 (attachment 2).

H. Report on the analysis of any program audits, including any changes recommended regarding policies, procedures and/or services.

I. Provide consultation to the Executive Committee pertaining to their expertise.

J. Inform the Executive Committee, Phoenix Center Staff and the CSB Board of committee activities through monthly minutes, monthly summarizations. Annual summarizations will include an analysis of activities, goals, outcomes, improvements, as well as, recommendations for improvements and goals for the next year.

K. The Committees will be as follows:

1. Risk Management Committee focuses on:

Promoting a safe, healthy and physically accessible environment for staff, clients and visitors by: conducting regular safety and health awareness communications; developing educational material and sponsoring appropriate training; by initiating and conducting projects related to promoting safety, health, and physical accessibility, infection control and disaster preparedness; coordination of health and safety drills, and fire safety and health inspections, and by conducting risk assessments.

The committee will determines accessibility of services in administrative and programmatic area, assess liability issues in administrative and programmatic areas as well as, areas beyond Center control or influence and monitor liability insurance and claims issues.

Reviewing all incident reports and tracking the completion of Final and Follow-up Reports within 30 days or by the extension date granted by the Division Investigations Section or the Risk Management Committee for internal reporting. The committee also makes certain that there is a Closing Report that notes the completion of monitoring and the implementation of needed improvements to Quality of Care, Services or Operations.

Monitoring risks and risk exposure to the Center, our clients or staff; including those from the delivery of services, administrative and programmatic areas, as well as, areas beyond Center control or influence

Trending data related to incident reports, health and safety inspections, vehicle inspections and emergency procedure drills by written reports quarterly and annually to PI Committee in the PI Goal Outcome.

2. Clinical Care Committee focuses on:

Providing oversight for clinical functions and clinical documentation, ensuring clients are provided Quality of Care according to the standards of Phoenix Center and other regulatory bodies. Ensures staff is trained in Evidenced Based Best Practices. In this effort, the Committee will identify and address quality and appropriateness of treatment concerns, coordinate clinical staff development, clinical form development and training. In addition, the committee will be accountable for developing, revising, conducting and monitoring Clinical Documentation Audits, thus ensuring services are provided to the client in the most effective and efficient manner, at the lowest reasonable cost and in the least restrictive environment. Monthly trending, analysis and results of all audit results will be presented to Clinical Care and PI Committees.

The committee will ensure compliance with the Phoenix Center Clinical Documentation Manual standards, Phoenix Center Policies and Procedures and other requirements as outlined by HIPAA and other governing bodies. In this effort, the Committee will promote person centered/strength based planning and SMART (specific, measurable, attainable, time limited) documentation that justifies services; developing educational material, awareness communications, sponsoring appropriate training and initiating, conducting projects related to clinical documentation. The Phoenix Center Clinical Documentation Manual standards will be updated annually and as other requirements are received.

The Private Home Care Program will be monitored through this committee; the Developmental Disabilities (DD) Coordinator will provide oversight, staff supervision & auditing for outcomes. The (DD) Coordinator will complete the Private Home Care Audit Checklist quarterly. A report will be presented to this committee & the PI Executive Committee quarterly.

The committee will serve as a forum for the coordination with the Utilization Management Department to assist with and implement:

- Developing, monitoring and revising processes for ordering and authorizing services that ensure payment
- Making certain that services are neither under utilized nor over utilized according to medical necessity guidelines and reporting utilization patterns
- Ensuring compliance with all External Review Organizations, payor source utilization guidelines and authorization processes. Provide training in all areas as needed

3. Rights and Ethics Committee focuses on:

Promoting clients rights through advocacy and education of staff and stakeholders and resolving client complaints that are presented according to policy and procedures. The Committee will encourage open communication between staff and consumers in order to resolve consumer issues in a therapeutic, informal supportive manner and promote client's rights according to policy and procedures. The Committee provides staff education on consumer rights, trends and analyzes complaints, grievances and client deaths monthly and report to PI Committee. The Committee will also present an annual report that analyzes trends of all complaints and deaths. All allegations of abuse, neglect and exploitation will be included in analysis, as well as, difficulties accessing services.

Implementing the Corporate Compliance Plan according to policy and procedure and investigating violations that are reported to the committee. The Committee will promote an atmosphere of open communication that encourages staff participation in the Corporate Compliance Plan. When appropriate the Committee will develop material that increases awareness of the principles of Corporate Compliance.

Schedules annual community forums and ensures the completion of the Annual Needs Assessments and trends data and reports to PI after each forum. Monitors suggestion boxes feedback monthly and reports findings and follow-up actions to PI committee monthly. Trends results of client satisfaction surveys and reports data to PI quarterly and annually.

4. Human Resources Committee focuses on:

This committee reviews issues related to employment and recommends policies related to employment, and develops the Employee Handbook. It also develops criteria for staff credentials, designs applications, and reviews applications for credentials. Also, ensures that clinical and programmatic activities of physicians and other professional staff are consistent with their training, licensure, and credentials and meet all applicable standards. The committee develops training program for the agency staff and monitors staff training needs and attendance; they trend hiring data to include staff turnover, EEO reports quarterly and reports to PI committee. In addition, the committee develops employee recognition programs, ensures annual completion of Employee Satisfaction Surveys and trends data with report to PI Committee.

5. Information Management and Technology Committee focuses on:

Assesses IT needs throughout the agency; researches, analyzes and recommends solutions to problems related to IT; recommends or provides training to staff members, and develops and recommends policies relates to IT issues. The committee is responsible for developing processes and standard operating procedures for staff that use the agency's electronic clinical information system. Once approved, the committee should assure that approved procedures are documented and communicated to the staff and to the PI committee for compliance monitoring. Should periodically gather input from users of the system to identify desirable changes to the system and possible new features to be reviewed and prioritized by PI.

The committee ensures compliance with the Medical Records Guidelines as outlined in the Policies and Procedures as required by HIPAA and other governing bodies. In this effort, the Committee will develop educational material & awareness communications, sponsor appropriate training at orientation (ongoing, & initial) and conduct projects related to confidentiality.

In addition, the Medical Records Department will be accountable for developing, revising, conducting, analyzing and monitoring results of all Medical Records Audits in collaboration with the Clinical Care Committee and Utilization Management. Audits will be completed monthly, trended and analyzed. The analysis & scores will be presented to the PI Committee quarterly and annually in the PI Goal Outcome report.

6. Revenue Cycle Improvement Committee focuses on:

Develop ways to increase revenue and resources. Analyzes financial data and recommend actions to maintain financial stability. The committee reviews all aspects of revenue cycle, managed care processes and indicators used by the agency to gauge performance and to ensure proper payment for all services provided. In addition the committee analyzes the billing and collection functions for effective and efficient practices, analyzes and trends monthly reports related to billing, collections, denials and revenues from all payor sources with recommendations for operational improvements.

7. Medical Management Committee focuses on:

Medical risks and risk exposure to the Center and safe and effective medical services for our clients and staff; including those pertaining to medical and pharmacotherapy concerns, delivery of services, administrative and programmatic areas, as well as, areas beyond Center control or influence.

The committee will serve in an evaluative, educational and advisory capacity to the staff and administration in all matters pertaining to the use of medications and medical procedures/processes.

The committee will promote evidenced based best practices and manage all medically related polices, procedures and forms.

The committee will promote a safe and healthy environment for staff and clients by developing educational material, health awareness communications, sponsoring appropriate training and by initiating and conducting projects related to promoting health.

VIII. Goals for FY 2010

All goals will be reported monthly in each committee's minutes and to the PI Committee quarterly, with results & efforts made to accomplish the goal and a 4th quarter/annual summarization on the Performance Improvement Report.

Area	#	Goal	Committee
A. Input from Clients & Stakeholders	1.	20% increase in the number of "Community Needs Assessments" surveys collected from our community partners by 6/30/10	Rights & Ethics (RE)
	2.	Develop & implement 5 methods to increase communication between Supervisors & Employees by 12/31/09	Human Resources (HR)
	3.	Quarterly, each program will conduct a "recognition of employees' work efforts" event	
B. Effectiveness of Services	1.	Implement an effective "On-the-Job" training program for Staff by 6/30/2010	Medical Management (MM)
	2.	Eliminate prescriptions given for Benzodiazepines for all clients with an SA diagnosis and reduce the use of Benzodiazepines for other clients by 50 % (with the exception of CSP) by 6/30/10	
	3.	20% reduction in the number of repeat admission to the CSP by 6/30/10	
	4.	100% of clinical and medical staff will receive training sessions on Addictive Diseases by 6/30/10	
	5.	Implement the Evidenced Based Best Practice "CENAPS Model of Relapse Prevention Therapy" for the treatment of Substance Abuse/Dependence clients by 1/31/10	Clinical Care (CC)
	6.	Each of the 9 audits (medical records, billing & clinical) on the <u>Phoenix Center Audit Protocol</u> will have 90% compliance each month on the "Audit Summary" sheets by 6/30/10.	
C. Efficiency of Services	1.	90% of direct service staff will meet 100% of their productivity goal, monthly by 6/30/10	Information Technology (IT) w/CC w/CC w/MM w/MM w/RM
	2.	Complete the scanning of the "closed" paper medical records by 9/30/09	
	3.	Re-arrange information in the <u>Electronic Medical Record</u> to reflect the Tabs in the hard copy chart format, as recommended by Clinical Care by 6/30/10	
	4.	Revise the content of the Assessment Tab in the <u>Electronic Medical Record</u> in a user-friendly manner as recommended by the Clinical Care Committee by 9/30/09	
	5.	Complete development of the Physician electronic Progress notes by 9/30/09	
	6.	Develop a system to enable the doctor to fill out prescriptions in the Electronic Medical Record by 10/30/09	
	7.	Re-program the Center's Incident Reporting entry and tracking program per revised instructions by 9/30/09	
	8.	Twenty-five or fewer Medication Errors will occur within the Center for the year ending 6/30/10.	Risk Management (RM)
	9.	95% of the combined total of initial and investigative incident reports will be completed within the Division & Center Guidelines by 6/30/10	Revenue Cycle Improvement
	10.	10% reduction of claims "adjusted off" in the three Medicaid Managed Care Programs from the baseline of the first quarter of FY10 by 6/30/10	
	11.	A process of checks and balances will be developed and implemented to insure all services provided for the three Medicaid Managed Care programs have been billed and then paid or denied by 12/31/09	

	12. 50% reduction of the Center-wide deficit of FY09 by 6/30/10	
D. Access to Services	1. 10% increase in the number of SA clients for SCS. for whom encounter data is submitted by 6/30/10	Clinical Care
	2. 50% Decrease in the time between scheduled appointments & time seen by staff by 6/30/10	
	3. 25% increase in the number of clients in the court ordered programs; Anger Management, SA & MOP (DUI) by 6/30/10	
	4. 10% increase in TANF clients at the STAR Program; enrolled & attending at least 7 (5 aftercare) treatment contacts per month by 6/30/10	

VII. Evaluation

Performance Improvement goals and projects are selected by committees through a process of identifying opportunities for improvement, collecting data, analyzing the data, and making recommendations to leadership. The Performance Improvement Committee also selects improvement projects which require multi-committee participation and coordination. All projects are approved by Leadership to ensure that they are in keeping with the mission, vision and values of the organization.

An annual report is provided which reviews the progress on goals and makes recommendations based on the performance of the agency.

The Performance Improvement Plan is reviewed annually. The Evaluation identifies ways the assessment and improvement process can be improved to assure that Phoenix Center Community Service Board provides the best possible consumer care. The evaluation also addresses the effectiveness of these activities by reviewing the improvements that have been made in the provision of client care as well as those processes and/or outcomes that were difficult or unsuccessful. Any portion of the plan may be modified at any time to maintain compliance with external standards and to improve the effectiveness of the performance improvement process.

Approved by:

Ken Pritchard
CSB Board Chairperson

James E. Singleton M.S.
Executive Director

Dan Ioanitescu, M.D.
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