The Guidance/Care Center
Quarterly Performance Improvement Report

July - September 2009

Overview

The Guidance/Care Center Performance Improvement Committee developed the original Performance Improvement Work Plan for the 2009-2010 Fiscal Year during July 2009. The PI Work Plan was updated in August 2009 to enhance the outcome/effectiveness indicators. .

A. Program and Service Utilization

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

Objective: 80% of all clients discharged from CSU will attend first OP appointment.

Type of Objective: *Quality Assurance: Efficiency*

Guidance/Care Center (GCC) IT staff, in collaboration with the Senior Clinical Officer, continues to enhance its data systems to capture and track the information related to this objective. Currently, the data cannot be withdrawn in a user friendly manner to aggregate the information in a meaningful and efficient manner.

2. Attendance at OP therapy sessions

Objective: 80% of clients will attend scheduled therapy sessions.

Type of Objective: *Quality Assurance: Efficiency*

The first set of analyses conducted examined the overall results for all appointments scheduled between April 1 and June 30, 2009.5

Category	Total #	Kept % (#)	No Shows % (#)	Client Cancellations % (#)	Staff Cancellations % (#)
Key West					
All Appointments	9,646	80% (7,721)	9.5% (917)	2.5% (239)	8.0% (769)
Child	2,614	93.3% (2,440)	4.4% (115)	1.2% (31)	1.1% (28)
Adult	6,798	74.2% (5,047)	11.8% (802)	3.1% (208)	10.9% (741)
Key Largo					
All Appointments	3.157	92.8% (2,931)	2.7% (85)	3.8% (119)	0.7% (22)
Child	1,224	94.7% (1,159)	1.5% (18)	3.4% (42)	0.4% (5)
Adult	1.933	91.7% (1,772)	3.5% (67)	4.0% (77)	0.8% (17)

Marathon					
All Appointments	7,141	69.7% (4,974)	2.6% (186)	25.4% (1,811)	2.4% (170)
Child	267	80.5% (205)	8.2% (22)	9.0% (24)	2.2% (6)
Adult	6,874	69.2% (4,759)	2.4% (164)	26.0% (1,787)	2.4% (164)

The second set of analyses conducted examined only those appointments that were either kept or for which the clients did not show. Client cancellations and staff cancellations were removed from these analyses since they technically cannot be considered "No Shows" in the true sense of the term. These analyses, therefore, provide a more valid reflection of the No Show rate.

Category	Total #	Kept % (#)	No Shows % (#)
Key West			
All Appointments	8,641	89.4% (7,721)	10.6% (917)
Child	2,555	95.5% (2,440)	4.5% (115)
Adult	5,849	86.3% (5,047)	13.7% (802)
Key Largo			
All Appointments	3,016	97.2% (2,931)	2.8% (85)
Child	1,177	98.5% (1,159)	1.5% (18)
Adult	1,839	96.4% (1,772)	3.6% (67)
Marathon			
All Appointments	5,160	96.4% (4,974)	3.6% (186)
Child	237	90.7% (205)	9.3% (22)
Adult	4,923	96.7% (4,759)	3.3% (164)

3. Wait times for OP Appointment

Objective: 80% of clients will be scheduled for first appointment within 2 weeks.

Type of Objective: *Quality Assurance: Efficiency*

The IT Department currently is enhancing its system to better capture this information and to make it more easily accessible for extraction and analysis.

4. Frequency of Outpatient Appointments

Objective: ≥ 90 of the clients will received 1 outpatient service weekly, unless justified in clinical record.

Type of Objective: *Quality Assurance: Efficiency*

Guidance/Care Center currently is enhancing its data system to more efficiently and effectively track this information.

B. Consumer Perception

1. Satisfaction with Program Quality

Objective: ≥ 80% on Overall Quality Rating for each program.

Type of Objective: *Quality Assurance: Efficiency*

Client Perception Surveys were administered during this quarter for the Detox and CSU units and for Outpatient services. In all instances, clients are surveyed upon discharge from the programs.

Guidance Care Center currently uses an instrument consisting of items/questions rated on the following scale: Strongly Agree – Agree – Neutral – Disagree – Strongly Disagree – Not Applicable. For the purpose of these analyses, Strongly Agree and Agree are indicators of satisfaction. Respondents who identified an item as Not Applicable were not included in the aggregate analysis for that item. In addition, although aggregated, items not having responses are not reflected in the table. For the purpose of this report, only highlights are presented that relate to overall program quality (as identified as an indicator in the PI Work Plan).

Inpatient Unit: A total of 20 surveys were administered between July 1 and September 30, 2009. **MARATHON ONLY**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	95.0	5.0	0
I was seen for services on time	95.0	5.0	0
I received services when I needed them	95.0	5.0	0
If I had a complaint, it was handled well	94.1	5.9	0
If I were to have problems, I would return to this program	94.1	5.9	0
I would recommend this program to other people	88.9	11.1	0
The services focus on my needs	88.9	11.1	0
This program has helped me to feel better about myself	88.9	11.1	0

Keys to Recovery: A total of 2 surveys were administered between July 1 and September 30, 2009.**MARATHON ONLY**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0	0

I was seen for services on time	100.0	0	0
I received services when I needed them	100.0	0	0
If I had a complaint, it was handled well	100.0	0	0
If I were to have problems, I would return to this program	100.0	0	0
I would recommend this program to other people	100.0	0	0
The services focus on my needs	100.0	0	0
This program has helped me to feel better about myself	100.0	0	0

Outpatient Adult:

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Marathon (N=15)			
Overall, I am satisfied with the services I received	73.4	26.7	0
I was seen for services on time	60.0	40.0	0
I received services when I needed them	100.0	0	0
If I had a complaint, it was handled well	50.0	50.0	0
If I were to have problems, I would return to this program	86.7	13.3	0
I would recommend this program to other people	86.7	13.3	0
The services focus on my needs	66.7	33.3	0
This program has helped me to feel better about myself	73.3	26.7	0
Key West (N=12)			
Overall, I am satisfied with the services I received	75.0	25.0	0
I was seen for services on time	66.7	33.3	0
I received services when I needed them	66.7	33.3	0
If I had a complaint, it was handled well	75.0	25.0	0
If I were to have problems, I would return to this program	54.5	45.5	0
I would recommend this program to other people	72.7	27.3	0

The services focus on my needs	72.7	27.3	0
This program has helped me to feel better about myself	72.7	27.3	0

Outpatient Child: A total of 33 surveys were administered between July 1 and September 30, 2009.**MARATHON ONLY**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	75.8	24.2	0
I was seen for services on time	63.6	36.4	0
I received services when I needed them	72.7	27.3	0
If I had a complaint, it was handled well	66.7	33.3	0

C. Clinical Records

1. Compliance of treatment program records with 65D 30 , CARF standards, and P & P

Objective: ≥ 95% of treatment records will comply.

Type of Objective: *Quality Assurance: Efficiency*

Nearly 70% of the records reviewed had a score of 95% of higher on the review form, with scores ranging from 32.7% to 100%. Two areas scoring particularly low were the Wellness and Recovery Plans and Reviews and the Progress Notes. More specifically, 100% of the charts in Key Largo had a score of 95% or above, 85.7% of the charts in Marathon had a score of 95% or above, and 0% of the charts in Key West had a score of 95% or above.

The Guidance/Care Center currently is revamping its documentation system to align all three locations since the GCMK and Care Center officially merged. The Guidance/care Center also is intensely preparing for its CARF re-accreditation and is ensuring that all clinical records across all three locations align with the CARF standards. The Guidance/Care Center is confident that the merger and CARF preparation will increase the compliance of clinical documentation and charting across all three locations.

2. Utilization Management

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

Type of Objective: *Quality Assurance: Efficiency*

The Senior Clinical Officer is in the process of revising and finalizing the Utilization Management Review Form. After completion of the form, the Senior Clinical Officer will train Program Directors and Coordinators on use of the form. The Research and Evaluation Department also will develop a statistical database to capture the data. The first utilization review was planned for January 2009. However, due to a delay in finalizing the form and competing priorities, the first review will occur in December 2009.

3. Billing, Documentation and Data Consistency

Objective: ≥ 95% of the clinical documentation will support the service tickets

Type of Objective: *Performance Improvement: Efficiency*

During the past quarter, the Guidance/Care Center has increased the consistency between submitted invoices and data. Based on the most recent Report Card from SFPC, the Guidance/Care Center achieved a 95% or greater accuracy rating for this item.

4. Wellness and Recovery Plans and Reviews

Objective: ≥ 95% of clinical records will contain a Medication Wellness & Recovery Plan and the associated review

Type of Objective: *Performance Improvement: Efficiency*

Approximately 79.8% of the clinical records reviewed across the 3 site locations contained the required Wellness and Recovery Plan and the associated Wellness and Recovery Plan Review. More specifically, 100% of the clinical records in Marathon, 89.5% of the clinical records I Key Largo, and 50% of the records in Key West contained the required documents.

5. State Required Mental Health and Substance Abuse Forms

Objective: ≥ 95% of the required State Forms will be completed within the appropriate timeframes and will be accurate

Type of Objective: *Performance Improvement: Efficiency*

Currently, the Guidance/Care Center is developing a tracking system to more efficiently capture and analyze this information.

6. Prescriptions

Objective: ≥ 95% of the clinical records will have prescription copies as required

Type of Objective: *Quality Assurance: Efficiency*

During the previous quarter, 100% of the clinical records at all three locations contained copies of the prescriptions as required by policy and procedure.

D. Quality of Care and Service Provision

1. CCISC participation

Objective: 100% of programs will score COMPASS by end of year.

Type of Objective: *Quality Assurance: Efficiency*

Guidance/Care Center remains actively involved in the CCISC initiative sponsored by the Florida Department of Children and Families. A representative has participated in all meetings and activities.

Guidance/Care Center is in process of completing the COMPASS for its programs. All assessment instruments will be completed as required by the end of the year.

2. School Attendance

Objective: 86% of the children receiving mental health services will increase attendance at school

Type of Objective: *Performance Improvement: Effectiveness*

Data for this objective for the reporting period, July 1 to September 30, 2009, is not yet available since any children discharged from the programs during the reporting period were on summer vacation or had just began the school year.

3. Employment

Objective: 78% of the clients will be employed at discharge.

Type of Objective: *Performance Improvement: Effectiveness*

Between July 1 and September 30, 2009, 29.8% of the clients discharged from substance abuse treatment were employed at discharge. A subsequent analysis was conducted removing clients who were disabled, retired, and/or incarcerated since they cannot be considered employment eligible. Based on the subsequent analysis, 56.5% of the clients were employed at discharge.

4. Days in Community

Objective: Adults receiving mental health services will increase the number of days in the community by discharge.

Type of Objective: *Performance Improvement: Effectiveness*

Approximately 90% of the adults were in the community for 30 days. The average number of days in the community was 27.8 days.

5. CGAS Scores

Objective: 74% of the children discharged from mental health services will show improvement

Type of Objective: *Performance Improvement: Effectiveness*

A significant improvement occurred in the GGAS score from admission to discharge ($t = -9.79$, $p<.001$). Average CGAS scores increased from 30 at admission to 55.9 at discharge.

6. Alcohol and Drug Use

Objective: 75% of clients will reduce alcohol/drug use from admission to discharge

Type of Objective: *Performance Improvement: Effectiveness*

Between July 1 and September 30, 2009, 80.7% of the clients discharged from substance abuse treatment reduced the frequency of alcohol and/or drug use.

7. Social and Emotional Functioning

Objective: 75% of children will show improved functioning.

Type of Objective: *Performance Improvement: Effectiveness*

The Guidance/Care Center currently is in the process of designing and implementing an evaluation database that will accurately capture the data related to this objective in collaboration with WestCare's Research and Evaluation Department. Data will be available for the next reporting period.

E. Safety and Security

1. Incident Reports

Objective: 99% of reportable incidents will be provided to appropriate external entity.

Type of Objective: *Quality Assurance: Efficiency*

Between July 1 and September 30, 2009, 100% of the reportable incidents were reported to the appropriate external entity as required. All submissions occurred within the required timeframe. Since this is the first quarter of the Fiscal Year, trend data will not be available until the upcoming quarter.

2. Emergency Drills

Objective: 95% compliance rate with the drill schedule

Type of Objective: *Quality Assurance: Efficiency*

WestCare implemented a new emergency drill schedule in July 2009 for all of its regions and facilities. During this quarter, all sites, including the Guidance/Care Center, were to conduct medical emergency drills across all of the sites and locations. All (100%) of the required drills were completed in Key West, 100% were completed in Marathon, and 100% were completed in Key Largo.

F. Staff Development

1. Annual Training

Objective: ≥95% of all staff will complete 20 hours of annual training

Type of Objective: *Quality Assurance: Efficiency*

Between July 1 and September 30, 2009, the Guidance/Care Center had numerous on-site training sessions and E-Learning sessions available to staff. The table below provides a detailed description of training completed during this time period:

Training Topic	**% Staff Completing**
Corporate Compliance	97.8
Code of Ethics	95.6
HIV	82.6
CPR	21.7
ACT	15.2
Health	89.1
OSHA	43.5
Civil Rights	10.9
Co-Occurring Disorders	17.4
Person-Centered Care and Treatment	95.6