The Guidance/Care Center
Quarterly Performance Improvement Report

January – March 2010

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*

During the past quarter, GCC has been integrating its data management system with WestCare Foundation's system. The integration is not completed fully. With the previous IM system this objective was difficult to track and data was not captured efficiently. The new system should make this a more attainable measure.

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 January 1 and March 31, 2010.

Please **NOTE** that the separate analyses for the adults and children for the Key Largo and Key West sites include only a subsample of the entire population served. Ages were unable to be extracted from the data system for March 2010 as GCC continues its transition to the new WestCare client database.

Category	Total #	Kept % (#)	No Shows % (#)	Client Cancellations % (#)	Staff Cancellations % (#)
All Sites					
All Appointments	19,177	82.5% (15,830)	5.0% (954)	9.6% (1,840)	2.9% (553)
Child	4,178	95.0% (3,968)	2.6% (110)	1.1% (46)	1.3% (54)
Adult	8,486	69.3% (5,881)	7.1% (606)	19.9% (1,686)	3.7% (313)

Category	Total #	Kept % (#)	No Shows % (#)	Client Cancellations % (#)	Staff Cancellations % (#)
Key West					
All Appointments	11,542	89.9% (10,375)	5.3% (610)	1.5% (173)	3.3% (384)
Child	2,434	95.4% (2,322)	2.2% (54)	0.6% (14)	1.8% (44)
Adult	3,636	82.9% (3,014)	9.9% (359)	2.8% (100)	4.5% (163)
Key Largo					
All Appointments	3,306	92.9% (3,070)	3.1% (104)	3.7% (122)	0.3% (10)
Child	1,230	98.0% (1,205)	0.7% (9)	1.3% (16)	0.0% (0)
Adult	1,035	89.2% (923)	5.2% (54)	5.5% (57)	0.1% (1)
Marathon					
All Appointments	4,329	55.1% (2,385)	5.5% (240)	35.7% (1,545)	3.7% (159)
Child	514	85.8% (441)	9.1% (47)	3.1% (16)	2.0% (10)
Adult	3,815	51.0% (1,944)	5.1% (193)	40.0% (1,529)	3.9% (149)

Findings: The Key Largo and Key West locations achieved the targeted objective in all categories. The Marathon site, however, had a high incidence of Client Cancellations for the Adult Programs, in turn impacting the Appointment Kept rate.

Actions: The Regional Performance Improvement Coordinator will conduct additional analyses on the data to identify which program(s) had the highest rate of Client Cancellations. Based on these findings, he will meet with the Regional VP and Program Directors to identify potential factors related to the cancellations and develop a performance improvement initiative to reduce these factors or barriers using the NIATx rapid cycle strategy.

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 % (#)
All Sites			
All Appointments	16,784	94.3% (15,830)	5.7% (954)
Child	4,078	97.3% (3,968)	2.7% (110)
Adult	6,487	90.7% (5,881)	9.3% (606)
Key West			
All Appointments	10,985	94.4% (10,375)	5.6% (610)
Child	2,376	97.7% (2,322)	2.3% (54)
Adult	3,373	89.4% (3,014)	10.6% (359)
Key Largo			
All Appointments	3,174	96.7% (3,070)	3.3% (104)
Child	1,214	99.3% (1,205)	0.7% (9)
Adult	977	94.5% (923)	5.5% (54)
Marathon			
All Appointments	2,625	90.9% (2,385)	9.1% (240)
Child	488	90.4% (441)	9.6% (47)
Adult	2,137	91.0 % (1,944)	9.0% (193)

Findings: When examining No Shows and Kept Appointments only, all three locations achieved the desired target. In fact, the Kept Appointment rate exceeded the 80% target across all categories at each location.

Actions: None needed at this time.

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*

As with Objective 1, this objective has been difficult to adequately measure with the current data management system in use at GCC. Once integration with the WestCare Foundation system is complete, this objective should be more easily measured.

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*

As with Objective 1, this objective has been difficult to adequately measure with the current data management system in use at GCC. Once integration with the WestCare Foundation system is complete, this objective should be more easily measured.

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, Adult and Child Outpatient services, case management services, residential treatment, and community integration 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 – Crisis Stabilization: A total of 52 surveys were administered between January 1 and March 31, 2010. **MARATHON ONLY**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	96.2	1.9	1.9
I was seen for services on time	90.4	9.6	0
I received services when I needed them	92.3	5.8	1.9
If I had a complaint, it was handled well	93.5	2.2	4.4
If I were to have problems, I would return to this program	87.5	6.3	6.3
I would recommend this program to other people	87.8	10.2	2.0
The services focus on my needs	87.8	10.2	2.0
This program has helped me to feel better about myself	81.6	16.3	2.0

Detoxification: A total of 32 surveys were administered between January 1 and March 31, 2010. **MARATHON ONLY**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	96.9	0	3.1
I was seen for services on time	96.9	3.1	0
I received services when I needed them	100	0	0
If I had a complaint, it was handled well	96.7	3.3	6.7
If I were to have problems, I would return to this program	93.5	0	6.5
I would recommend this program to other people	93.4	3.3	3.3
The services focus on my needs	90.0	6.7	3.3
This program has helped me to feel better about myself	93.7	3.3	3.3

Keys to Recovery – Residential Treatment: A total of 4 surveys were administered between January 1 and March 31, 2010.**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 – Mental Health: A total of 28 surveys were administered between January 1 and March 31, 2010. Results are reflective of consumers across all three locations: Key West, Key Largo, and Marathon.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	96.4	3.6	0
I was seen for services on time	96.3	3.7	0
I received services when I needed them	92.9	7.1	0
If I had a complaint, it was handled well	95.6	0	4.4
If I were to have problems, I would return to this program	100	0	0
I would recommend this program to other people	96.2	3.8	0
The services focus on my needs	96.2	0	3.8
This program has helped me to feel better about myself	88.5	7.7	3.8

Outpatient Adult – Alcohol and Other Drugs/Addictions: A total of 11 surveys were administered between January 1 and March 31, 2010. This survey was from the Marathon location.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100	0	0
I was seen for services on time	100	0	0
I received services when I needed them	100	0	0
If I had a complaint, it was handled well	100	0	0
If I were to have problems, I would return to this program	100	0	0
I would recommend this program to other people	100	0	0
The services focus on my needs	100	0	0
This program has helped me to feel better about myself	100	0	0

Case Management: A total of 8 surveys were administered between January 1 and March 31, 2010. Results are reflective of consumers across all three locations: Key West, Key Largo, and Marathon.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100	0	0
I was seen for services on time	100	0	0
I received services when I needed them	100	0	0
If I had a complaint, it was handled well	85.7	14.3	0
If I were to have problems, I would return to this program	100	0	0
I would recommend this program to other people	100	0	0
The services focus on my needs	100	0	0
This program has helped me to feel better about myself	100	0	0

Community Integration: A total of 7 surveys were administered between January 1 and March 31, 2010. **MARATHON ONLY**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	85.7	14.3	0
I was seen for services on time	100	0	0
I received services when I needed them	100	0	0
If I had a complaint, it was handled well	71.5	28.5	0
If I were to have problems, I would return to this program	85.8	14.2	0
I would recommend this program to other people	100	0	0
The services focus on my needs	71.5	28.5	0
This program has helped me to feel better about myself	71.5	28.5	0

Criminal Justice: A total of 43 surveys were administered between January 1 and March 31, 2010. **KEY WEST ONLY**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	90.7	9.3	0
I was seen for services on time	88.4	9.3	2.3
I received services when I needed them	88.4	7.0	4.6
If I had a complaint, it was handled well	80.5	17.1	2.4
If I were to have problems, I would return to this program	72.5	20.0	7.5
I would recommend this program to other people	95.1	4.9	0
The services focus on my needs	83.3	16.7	0
This program has helped me to feel better about myself	95.2	4.8	0

Findings: Overall, the programs exceeded the target for client satisfaction with the key indicators. The one exception was the Community Integration Program which had three (3) key indicators fall below the target 80% satisfaction rate.

Actions: No specific action is needed at this time since this is the first quarter that these indicators fell below the desired target. It is feasible that the result for this quarter is idiosyncratic

and not the emergence of an actual trend or pattern. During the upcoming quarter, the Regional Performance Improvement Coordinator will continue to monitor these indicators for the Community Integration Program using control charts. If the trend continues into the next quarter, Focus Groups will be conducted with the clients to determine the reasons for the ratings and to develop a performance improvement initiative as needed.

Outpatient Children and Adolescents – Mental Health: A total of 5 surveys were administered between January 1 and March, 31, 2010. Results are reflective of consumers across all three locations: Key West, Key Largo, and Marathon.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100	0	0
I was seen for services on time	100	0	0
I received services when I needed them	100	0	0
If I had a complaint, it was handled well	100	0	0
I get along better with family members	40.0	60.0	0
I am doing better in school	80.0	20.0	0

Outpatient Children and Adolescents – Substance Abuse: A total of 3 surveys were administered between January 1 and March 31, 2010. Results are reflective of consumers from Key West.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100	0	0
I was seen for services on time	100	0	0
I received services when I needed them	100	0	0
If I had a complaint, it was handled well	100	0	0
I get along better with family members	100	0	0
I am doing better in school	100	0	0

Prevention/Diversion: A total of 7 surveys were administered between January 1 and March 31, 2010. Results are reflective of consumers across all three locations: Key West, Key Largo, and Marathon.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	71.4	28.6	0
I was seen for services on time	100	0	0
I received services when I needed them	100	0	0

If I had a complaint, it was handled well	66.7	33.3	0
I get along better with family members	85.7	14.3	0
I am doing better in school	100	0	0

Case Management: A total of 2 surveys were administered between January 1 and March 31, 2010. Results are reflective of consumers from Marathon.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100	0	0
I was seen for services on time	100	0	0
I received services when I needed them	100	0	0
If I had a complaint, it was handled well	0	100	0
I get along better with family members	0	100	0
I am doing better in school	94.28	5.8	0

Findings: Overall, the programs exceeded the target for client satisfaction with the key indicators. The one exception was the Prevention Program which had two (2) key indicators fall below the target 80% satisfaction rate.

Actions: No specific action is needed at this time since this is the first quarter that these indicators fell below the desired target. It is feasible that the result for this quarter is idiosyncratic and not the emergence of an actual trend or pattern. During the upcoming quarter, the Regional Performance Improvement Coordinator will continue to monitor these indicators for the Community Integration Program using control charts. If the trend continues into the next quarter, Focus Groups will be conducted with the clients to determine the reasons for the ratings and to develop a performance improvement initiative as needed.

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*

During the quarter, a total of 30 clinical records were reviewed. Twenty-six (27) were from active cases and three (3) were from closed cases. The breakdown of clinical records reviewed is detailed below:

Program	Number of Clinical Records
Prevention	8
Criminal Justice	3
Outpatient Adult – Mental Health	3
Outpatient Adult – Substance Abuse	2
Outpatient Child – Mental Health	5
Outpatient Child – Substance Abuse	1
Case Management – Adult	5
Case Management – Child	0
Community Reintegration	0
Residential Treatment	0
Crisis Stabilization	0
Detoxification	0
Closed Records	3

Findings: Although 30 clinical records were reviewed this quarter, a representative sample of the Core Programs was not completed. Similarly, a representative sample of closed clinical records also was not completed across the programs. Key Largo, however, did have the most representative sample across all of the services provided at that location.

Actions: The Regional Performance Improvement Coordinator, in collaboration with the Regional VP, Site Managers, and Program Directors will develop and establish a tracking system to ensure that a representative sample of active and closed clinical records is reviewed for each program quarterly. In addition, based on the size of the program at each location, target numbers or percents will be established.

Active Record Findings

Indicator	% of Records
Primary clinician is identified clearly	100%
Immediate/Urgent Needs are identified	96.0%
Consent Signed	92.3%
Client Oriented to Program (documented)	76.9%
Knowledge of Grievance Procedure	76.9%
Knowledge of HIPAA	84.6%
Aware of Rights and Responsibilities	100%
Assessment if Thorough and Complete	84.6%
Client Involved in Selection of Services	100%
Wellness & Recovery Plan, Prevention Plan, Medication Plan Completed timely	92.3%
Client Provided Input into Plan	92.3%
Goal in Client's Words	92.3%
Goals & Objectives Relate to Assessment	80.8%
Services Relate to Goals and Objectives	80.8%
Objectives are Measurable (SMART format)	38.5%

Services Documented as Required	100%
Reviews Occurred as Required	83.3%
ASAM Completed (SA Clients Only)	80.0%
ASAM Narrative Adequate	0%

Closed Record Findings

Indicator	% of Records
Discharge Summary Completed	100%
Transitional Plan Completed	66.7%

Findings: Several areas for improvement were identified during the clinical record review this quarter. These included: (1) Although the Program Directors verified that all clients are oriented to the program, the clinical record did not clearly document this; (2) The clinical record did not clearly indicate whether the client received information related to the Grievance Procedures; (3) Although the Wellness and Recovery, Prevention, and Medication Wellness and Recovery Plans included objectives, the objectives were not measurable or behavioral. This is a repeat finding, and a finding identified during a recent monitoring by the South Florida Provider Coalition; (4) Although the ASAM PPC 2 R was completed on the substance abuse clients, in some instances the incorrect version was used and some charts did not contain the monthly updates; and (5) Many of the ASAM PPC 2 forms did not include a narrative. Those that did include a narrative had narratives that did not link back directly to the ASAM dimensions or justify the level of care. This is a repeat finding, and a finding identified during a recent monitoring visit by the South Florida Provider Coalition.

Actions: (1) GCC currently is using revised forms that will indicate clearly the client's orientation to the program. Clients also are receiving Client Handbooks. (2) GCC currently is using revised forms that will indicate clearly that the client received information related to the Grievance Procedure. (3) By June 2010, the Regional Senior Clinical Officer will conduct a workshop for all staff on writing measurable and behavioral objectives that are strength-based. This will be followed by coaching and mentoring. (4) and (5) By June 2010, the Senior Clinical Officer will conduct a workshop for all substance abuse staff re-educating them on the ASAM, the appropriate forms to use for which service, and how to write a narrative that justifies the level of care placement, the need for continued treatment, and/or the appropriateness for transfer or discharge.

2. Utilization Management

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

Type of Objective: *Quality Assurance: Efficiency*

During the quarter, only one (1) Utilization Management Review was conducted. The client was placed in the appropriate level of care.
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 July 2010.

3. Billing, Documentation and Data Consistency

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

Type of Objective: *Performance Improvement: Efficiency*

Based on the most recent Report Card from SFPC, the Guidance/Care Center had less than a 5% error rate.

Based on a recent monitoring by the South Florida Provider Coalition, GCC had two areas for improvement related to billing. These were:

a. An error rate of 37.09% was noted in the Validation of Service Events reviewed resulted in noncompliance in demonstrating that the Provider maintains service documentation for services billed to the Managing Entity pursuant to this contract.

b. According to the Invoice Validation Desk Review, data reported to the SFPC KIS Database does not reflect the number of units invoiced to SFPC for the months of November 2009 and December 2009. Error rate of November 2009 Year to Date average is 59.66% incorrect, and December 2009 Year to Date average 32.59% incorrect.

A Corrective Action Plan was submitted to and accepted by the South Florida Provider Coalition.

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*

100% of the clinical records reviewed during the quarter for those clients receiving medications contained a Medication Wellness and Recovery Plan and were reviewed in accord with agency policy and procedure.

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, 90% 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 completed the annual scoring of the COMPASS for its programs in December 2009. COMPASS scoring for this year will begin during the upcoming quarter.

2. School Attendance

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

Type of Objective: *Performance Improvement: Effectiveness*

Twenty-two (22) school days were available during the past month prior to admission with the children attending, on the average, 15 of the available school days. More specifically, 67.6% of the children attended 15 or more days of the available school days prior to admission. Similarly, 22 school days were available during the month prior to discharge with the children attending, on the average, 17 days or more of the available school days. More specifically, 88.4% of the children attended 15 or more days of school during the month prior to discharge. An additional analysis was conducted comparing the number of days attended at intake to the number of days attended at follow-up. A significant increase in school attendance occurred between intake and follow with the

average child increasing attendance from 15 days at admission to 19 days at follow-up [$t(78) = -1.480$, $p<.05$].

3. Employment

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

Type of Objective: *Performance Improvement: Effectiveness*

For this analysis, clients who were disabled, retired, and/or incarcerated were removed since they cannot be considered employment eligible. Between January 1 and March 31, 2010, 73.8% of the clients discharged from substance abuse treatment were employed at discharge, with 49.2% having full-time employment and 24.6% having part-time employment. An additional 9.8% were full-time homemakers.

A subsequent analysis was conducting examining only those clients who completed treatment. Based on this analysis, 83.8% of the clients discharged were employed, with 60.5% having full-time employment and 23.3% having part-time employment. An additional 9.3% were full-time homemakers.

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*

Nearly 92% of the adults were in the community for more than 15 days during the 30 days prior to admission with, 77.1% of them being in the community for 30 days. The average number of days in the community was 27 days. 85.5% of the adults were in the community for 30 days during the 30 days prior to discharge. Although 8.4% of the adults increased their number of days in the community at discharge, the result is not significant since majority of the adults were in the community for 30 days at admission, resulting in minimal variance.

5. CGAS Scores

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

Type of Objective: *Performance Improvement: Effectiveness*

Average CGAS scores increased from 60 at admission to 64 at discharge. The increase, however, was not significant [$t (80) = -1.464$, $p=.17$].

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 January 1 and March 31, 2010, 87.9% of the clients discharged from substance abuse treatment reduced the frequency of alcohol and/or drug use, with 79.9% having no use during the 30 days prior to discharge and an additional 8.0% reducing their frequency of use from admission to discharge.

A subsequent analysis examined only those clients who completed treated or were referred to another provider after completing substance abuse treatment. Based on this analysis, 93.6% of the clients reduced the frequency of alcohol and/or drug use, with 89.1% having no use during the past 30 days and an additional 4.5% reducing their frequency of use from admission to discharge.

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 January 1 and March 31, 2010, 100% of reportable incidents were reported to the appropriate external entity and within the required timeframe.

GCC continues to conduct its quarterly detailed analysis of incidents. These analyses examine incidents by category type, program, time of day, and day of week. The purpose of these analyses is to isolate trends that may be occurring or to identify significant increases in types of incidents. This information is used to identify and develop performance improvement initiatives as needed.

Findings: See Attached Detailed Report

Total Incidents:
From January 1 to March 31, 2010, 44 incidents occurred across the three (3) GCC locations. Twelve (12; 27.27%) were immediately reportable, 22 (50%) were reportable, and 10 (22.73%) were not reportable and for external use only.

Proportion of Incidents Across Sites: Of these incidents, 5 (11.36%) occurred in Key Largo, 31 (70.45%) occurred in Marathon, and 8 (18.18%) occurred in Key West. The distribution of incidents across the locations is not an unexpected or unusual finding. Since the Marathon location has the most diversity of programs, including Detoxification, CSU, and Residential Treatment, it is expected that there would be a higher volume of incidents at this location. In contrast, since the Key Largo and Key West locations consist primarily of outpatient, school-based, and home-based programs; a lower volume of incidents are expected.

Reportable Incidents Across Sites: Similarly, it is anticipated the Marathon location would have the highest proportion of immediately reportable and reportable events (24 total: 6 immediately reportable and 18 reportable), especially since the Detoxification, CSU, and Residential Treatment Program are housed at this location.

An analysis of the reportable incidents by location revealed: (1) 60% of the Key West incidents were reportable, with 20% being immediately reportable and 40% being reportable; (2) 77.4% of the Marathon incidents were reportable, with 19.35% being immediately reportable and 58.06% being reportable; (3) 87.5% of the Key Largo incidents were reportable, with 62.5% being immediately reportable and 25% being reportable.

Actions: None needed at this time.

Incidents by Program: As expected, the CSU had the highest volume of incidents. In total, the CSU had 19 incidents, with 2 (4.55% of the total and 10.56% of those occurring on the CSU) being immediately reportable and 12 (27.27% of the total and 63.16% of those occurring on the CSU) being reportable. Incidents across the remaining programs were equivocal, with no trend emerging. Similarly, no trend emerged for the immediately reportable and reportable incidents across the programs. The proportions of these incident types were similar across all remaining programs.

Actions: None needed at this time.

Incidents by Category: Overall, "Other" had the highest proportion of incidents, accounting for 27.27% of the total incidents across locations. This finding is expected, since "Other" primarily includes minor, internal and non-reportable incidents. This pattern, however, was not consistent across locations. At the Key West location, "Other" accounted for the highest proportion of incidents (40%). At the Marathon location, "Other" and "Illness/Injury" occurred in equal proportions (19.35%). At the Key Largo location, "Abuse/Neglect" accounted for the highest proportion of incidents (37.5%).

The high proportion of "Illness/Injury" incidents in Marathon is not an unexpected finding. Seventy-five percent (75%) of the incidents occurred on the CSU/Detox units. One-third (66.7%) of the incidents involved clients needing medical attention for detoxification symptoms, and 33.3% of the incidents involved staff members incurring minor injuries.

The high proportion of "Abuse/Neglect" incidents in Key Largo largely is related to medical neglect (33.3%) and possible physical/sexual abuse (66.7%). None of the incidents occurred on the facility. None of the incidents were observed by staff but reported by minor aged clients. The Abuse Hotline was notified in all instances.

Actions: None needed at this time.

Days of the Week: Overall, most incidents (N=14) occurred on a Tuesday, accounting for 31.82% of all incidents. Slightly more incidents also occurred on Mondays (N=7; 15.91%), Wednesdays (N=7; 15.91%), and Fridays (N=8; 18.18%).

In Marathon, the pattern of incidents was the same as for all locations aggregated. Most incidents (N=8) occurred on Tuesdays, accounting for 25.81% of them. Slightly more incidents also occurred on Fridays (N=7; 22.58%). The fewest incidents occurred on Sundays and Thursdays (N=1 each), accounting only for 6.45% of all incidents at this location.

In Key Largo, the pattern was similar, with most incidents occurring on a Tuesday (N=3; 37.5%) or Wednesday (N=3; 37.5%). No incidents were reported on a Thursday. As expected, incidents were not reported over the weekend, since the facility is not open.

In Key West, most (N=3) incidents occurred on a Tuesday, accounting for 60% of all incidents. No incents were reported on Wednesdays or Fridays. As expected, incidents were not reported over the weekend, since the facility is not open.

Comparing analyses for the individual locations revealed that incidents occurred most frequently on Tuesdays at each location. Similarly, across all three locations, few, if any, incidents occurred on Thursdays.

Actions: This pattern of incidents will be monitored during the upcoming quarter using control charts to determine if it is a distinct and consistent trend. If the finding persists, additional analyses will be conducted to identify potential factors related to most incidents occurring on Tuesdays and the least incidents occurring on Thursdays.

Time of Day: Overall, the majority of incidents (N=17) occurred during the afternoon hours (Noon to 5 PM), accounting for 38.64% of all incidents. The second time period for the highest proportion of incidents (N=16) was the morning hours (5 AM to Noon), accounting for 36.36% of all incidents. Seventy-five percent (75%) of the incidents occurred between 5 AM and 5 PM. Only 3 (6.82%) of the incidents were reported during the very early morning hours (Midnight to 5 AM).

In Marathon, the pattern was the same as the overall pattern. Majority of incidents (13) occurred from Noon to 5 PM, accounting for 41.94% of the incidents at that location. The second time period for the highest proportion of incidents (N=10 was from 5 AM to Noon, accounting for 32.26% of the incidents. Together, 74.2% of the incidents occurred from 5 AM to 5 PM. The fewest incidents (N=3) occurred from Midnight to 5 AM (9.68%). All of these incidents occurred at the Marathon location, as expected, since it is the only location that has 24-hour programs.

In Key Largo, most incidents occurred between 8 AM and 5 PM, with 3 (37.5%) occurring between 8 AM and Noon and 2 (25%) occurring between Noon and 5 PM. This pattern is expected since the facility is operational during these hours. Key Largo, however, did have 3 incidents (37.5%) occur after hours during on-call shifts, with 2 (25%) occurring between 6-7 PM and 1 (12.5%) occurring between 8-9 PM.

In Key West, 100% of the incidents occurred during the hours of operation (8 AM to 5 PM). Three (3; 60%) incidents occurred during the early hours of operation (9-11 AM) and 2 (40%) occurred during the late hours of operation (3-5 PM).

Actions: This pattern of incidents will be monitored during the upcoming quarter using control charts to determine if it is a distinct and consistent trend. If the finding persists, additional analyses will be conducted to identify potential factors for the emerging pattern.

2. Emergency Drills

Objective: 95% compliance rate with the drill schedule

Type of Objective: *Quality Assurance: Efficiency*

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*

The Regional Human Resources Director currently is completing a comprehensive audit of the personnel files for staff working at all three (3) location. This audit includes ensuring that staff receives the required training and ensuring that the files contain all certificates. Data analysis for this objective was postponed until the HR Director completes her audit.