The Guidance/Care Center
WestCare Florida
Performance Improvement Report
July – December 2015
FY 2015-2016

Overview

The Guidance/Care Center Performance Improvement Committee developed the Performance Improvement Work Plan for the 2015-2016 Fiscal Year on July 15, 2015. Based on data collected during the past Fiscal Year and overall performance on the objectives, the Performance Improvement Committee eliminated several indicators from the previous year's Work Plan since G/CC had consistent positive performance. Following is a summary of the progress G/CC made on the current Work Plan during the first Biannual Period (July - December 2015) of this Fiscal Year.

A. Program and Service Utilization

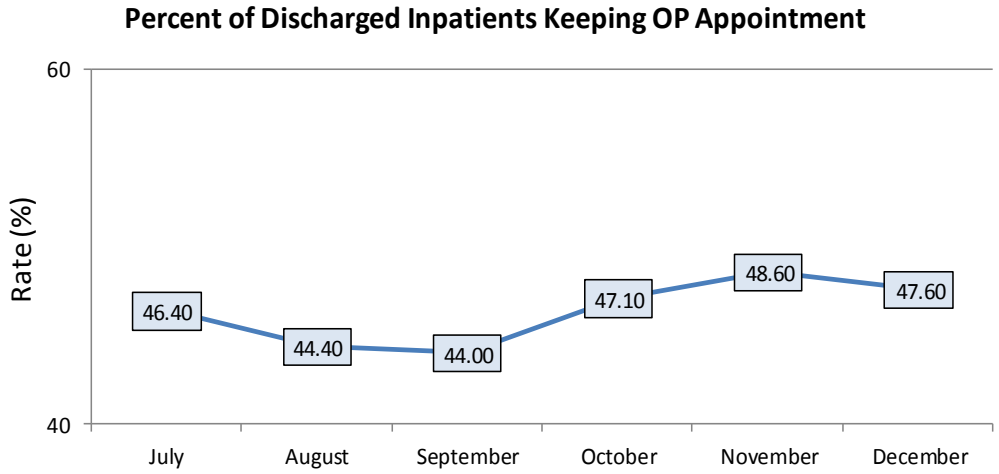
1. Attendance at first session of OP treatment following an IP discharge

Objective: 60% of all clients discharged from CSU will attend first OP appointment.

Type of Objective: *Performance Improvement: Efficiency*

Monthly, Quarterly, and Biannual
Overall, for this biannual period, 46.47% (N=79) of the clients discharged from the inpatient unit (N=170) and referred to outpatient kept their appointments. For the first quarter of the Fiscal Year, 45.0% (36/80) of the clients kept their outpatient appointment, and 47.8% (43/90) clients kept their outpatient appointments during the second quarter. The trend by month was:

Month	Percent	# Attended/# Referred
July	46.4%	13/28
August	44.4%	12/27
September	44.0%	11/25
October	47.1%	16/34
November	48.6%	17/35
December	47.6%	10/21
BIANNUAL	**46.47%**	**79/170**



Action: G/CC did not achieve its monthly or quarterly targets for the first biannual period of Fiscal Year 2015-2016. The Performance Improvement Committee continues to explore how data extraction and aggregation occurs for this indicator. It is possible, that data includes persons discharged within the timeframe, but the actual appointment date did not occur; in turn, creating an overestimate of clients not attending the first appointment.

2. Attendance at OP therapy sessions

Objective: 80% of clients will attend scheduled appointments.

Type of Objective: *Quality Assurance: Efficiency*

In order to obtain a truer picture of attendance at appointments, the analyses excluded non-preschedule appointments, including case management, activities on behalf of, IHOS, Outreach, CSU, and Detox.

The first set of analyses conducted examined the overall results for all appointments scheduled between July 1 and December 31, 2015.

Category	Total #	Kept % (#)	No Shows % (#)	Client Cancellations % (#)	Staff Cancellations % (#)
All Sites					
All Appointments*	10,726	69.0% (7,406)	18.0% (1,936)	6.2% (664)	6.7% (720)
Child	1,272	71.1% (904)	11.6% (147)	5.2% (66)	12.2% (155)
Adult	9,418	68.9% (6,488)	18.9% (1,778)	6.3% (595)	5.9% (557)

*Total appointments may be greater than Child + Adult, since not all appointments had an age associated with it.

Category	Total #	Kept % (#)	No Shows % (#)	Client Cancellations % (#)	Staff Cancellations % (#)
Key West					
All Appointments*	7,084	70.7% (5,007)	17.2% (1,215)	5.1% (363)	7.0% (499)
Child	1,058	73.5% (778)	11.7% (124)	4.9% (52)	9.8% (104)
Adult	5,999	70.3% (4,219)	18.1% (1,085)	5.1% (308)	6.5% (387)
Key Largo					
All Appointments*	1,948	68.7% (1,339)	15.9% (310)	7.9% (154)	7.4% (145)
Child	190	56.8% (108)	9.5% (18)	6.8% (13)	26.8% (51)
Adult	1,755	70.1% (1,230)	16.5% (290)	8.0% (141)	5.4% (94)
Marathon					
All Appointments*	1,694	62.6% (1,060)	24.3% (411)	8.7% (147)	4.5% (76)
Child	24	75.0% (18)	20.8% (5)	4.2% (1)	0.0% (0)
Adult	1,664	62.4% (1,039)	24.2% (403)	8.8% (146)	4.6% (76)

*Total appointments may be greater than Child + Adult, since not all appointments had an age associated with it.

The second set of analyses conducted examined only those appointments that clients kept or did not show. The analyses did not include client and staff cancellations since they technically are not "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	9,342	79.3% (7,406)	20.7% (1,936)
Child	1,051	86.0% (904)	14.0% (147)
Adult	8,266	78.5% (6,488)	21.5% (1,778)

Category	Total#	Kept % (#)	Now Shows % (#)
Key West			
All Appointments*	6,222	80.5% (5,007)	19.5% (1,215)
Child	902	86.3% (778)	13.7% (124)
Adult	5,304	79.5% (4,219)	20.5% (1,085)
Key Largo			
All Appointments	1,649	81.2% (1,339)	18.8% (310)
Child	126	85.7% (108)	14.3% (18)
Adult	1,520	80.9% (1,230)	19.1% (290)
Marathon			
All Appointments*	1,471	72.1% (1,060)	27.9% (411)
Child	23	78.3% (18)	21.7% (5)
Adult	1,442	72.1% (1,039)	27.9% (403)

*Total appointments may be greater than Child + Adult, since not all appointments had an age associated with it.

Action: G/CC had "Kept Appointment" rates lower than the 80% target for Adults in Marathon (72.1%) and Adults in Key West (79.5%). Marathon also had a "Kept Appointment" rate lower than 80% for Children (78.3%). The Performance Improvement Committee will work with the Site Directors and Research Assistants at each site to

identify potential barriers to consumers showing up for scheduled appointments. Based on these findings, the Team will develop and implement a Performance Improvement initiative. Staff cancellations were exceptionally high for children in Key Largo (26.8%). This is an unusual finding. G/CC will continue to monitor this rate to determine if it is an emerging trend or an anomaly.

3. Waiting Time from Initial Contact

Objective: 80% of clients will have a face-to-face appointment within 7 working days from initial contact.

Type of Objective: *Performance Improvement: Efficiency*

G/CC schedules all initial appointments for an assessment, not for specific services such as counseling or psychiatric appointments. This is to ensure that all potential clients are eligible for services and receive an assignment to the most appropriate service.

Overview – All Clients:
Biannual Results: During the first biannual period FY 2015-2016, G/CC received 711 contacts. The average number of days from Initial Contact to first appointment was 11 days, falling 4 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from the 1-29 days.

G/CC saw 70.3% of the clients within 14 days from the Initial Contact. G/CC saw 46.0% in seven (7) or fewer days.

Eighteen clients did not have the appointment status indicated. Therefore, the following analysis excluded their data.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=693)	52.2% (362)	30.0% (208)	11.3% (78)	6.5% (45)

Action: Only 52.2% of the clients attended the appointments and 30% did not "Show" for the initial appointment after making an initial contact with G/CC. G/CC will collect additional data to determine the barriers clients may experience in attending the initial appointment. Based on this information, G/CC will develop a performance improvement initiative to reduce the "No Show" rate.

Mental Health Clients:
Biannual Results: During the first biannual period of FY 2015-2016, G/CC received 322 contacts for mental health services. The average number of days from Initial Contact to first appointment was 11 days, falling 4 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 1-39 days.

G/CC saw 68.6% of the clients within 14 days from the Initial Contact. G/CC saw 46.9% in seven (7) or fewer days.

Eight clients (2.5%) did not have the outcome of their appointment status indicated in the database. Therefore, the following analysis excluded their data.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=314)	51.3% (161)	30.9% (97)	11.5% (36)	6.4% (20)

For the **adult clients (N=293)**, the average number of days from Initial Contact to first appointment was 11 days, falling 4 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 1-29 days.

G/CC saw 66.7% of the adult clients within 14 days from the Initial Contact. G/CC saw 47.8% in seven (7) or fewer days.

Six adult clients (2.0%) did not have the outcome of their appointment status indicated in the database. Therefore, the following analysis excluded their data.

For the **child clients (N=29)**, the average number of days from Initial Contact to first appointment was 10 days, falling 3 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 1-28 days.

G/CC saw 89.7% of the child clients within 14 days from the Initial Contact. G/CC saw 37.9% in seven (7) or fewer days.

Two children (2.9%) did not have the outcome of their appointment status indicated in the database. Therefore, the following analysis excluded their data.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=314)	51.3% (161)	30.9% (97)	11.5% (36)	6.4% (20)
Adults (N=287)	50.5% (145)	31.0% (89)	12.5% (36)	5.9% (17)
Children (N=27)	59.3% (16)	29.6% (8)	0.0% (0)	11.1% (0)

Substance Abuse Clients:

Biannual Results: During the first biannual period of FY 2015-2016, G/CC received 19 contacts for substance abuse services. The average number of days from Initial Contact to first appointment was 9 days, falling 2 days longer than the target of 7 days. Waiting times for an appointment from Initial Contact ranged from 2-21 days.

G/CC saw 84.2% of the clients within 14 days from the Initial Contact. G/CC saw 36.8% in seven (7) or fewer days.

All clients had the outcome of their appointment status indicated in the database.

The breakdown of Appointment Status is in the table below.

	APPOINTMENT STATUS			
	Attended	No Show	Cancelled by Client	Cancelled by Staff
All Clients (N=19)	63.2% (12)	15.8% (3)	15.8% (3)	5.3% (1)

ALL contacts during the second biannual period of FY 2014-2015 were for adults. There were no contacts for child substance abuse services.

4. Frequency of Outpatient Appointments

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

   Type of Objective: *Quality Assurance: Efficiency*

July 2015

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (3 clients)	25	0	75	0
TBOS – CMH (95 clients)	24	18	17	41
ASA (90 clients)	19	17	9	55
AMH (101 clients)	48	28	16	8
TBOS – AMH (0 clients)	--	--	--	--
CMH (2 clients)	25	0	75	0
CSA (0 clients)	--	--	--	--

August 2015

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (5 clients)	40	20	20	20
TBOS – CMH (99 clients)	25	28	13	34
ASA (88 clients)	11	16	8	65
AMH (104 clients)	53	28	10	9
TBOS – AMH (1 client)	100	0	0	0
CMH (1 client)	0	0	100	0
CSA (0 clients)	--	--	--	--

September 2015

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (6 clients)	49	17	17	17
TBOS – CMH (129 clients)	14	17	17	52
ASA (96 clients)	14	18	16	52
AMH (96 clients)	55	24	17	4
TBOS – AMH (1 client)	0	0	100	0
CMH (1 client)	100	0	0	0
CSA (0 clients)	--	--	--	--

October 2015

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (4 clients)	50	0	0	25
TBOS – CMH (132 clients)	11	17	18	54
ASA (86 clients)	22	12	8	58
AMH (92 clients)	55	21	13	11
CMH (0 client)	--	--	--	--
CSA (0 clients)	--	--	--	--

November 2015

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (4 clients)	50	50	0	0
TBOS – CMH (140 clients)	18	29	24	29
ASA (87 clients)	10	18	10	62
AMH (98 clients)	61	23	8	8
CMH (1 client)	0	100	0	0
CSA (0 clients)	--	--	--	--

December 2015

Program	% 1 Session/Month	% 2 Sessions/Month	% 3 Sessions/Month	% ≥ 4 Sessions/Month
TBOS CSA (3 clients)	66	0	34	0
TBOS – CMH (142 clients)	20	25	23	32
ASA (94 clients)	31	16	10	43
AMH (95 clients)	62	25	6	7
CMH (0 clients)	--	--	--	--
CSA (0 clients)	--	--	--	--

Action: Although the Managing Entity requires this indicator, it remains a challenging one to track accurately. The findings are misleading and most likely an underestimate. The current data base only tracks scheduled and kept appointments and does not track the frequency of appointments prescribed on the Wellness and Recovery Plan. The Performance Improvement and Clinical Committees, in collaboration with IT, attempted several times to develop a tracking system to no avail. The Committees decided to hold off on a solution until the implementation of an Electronic Health Record in 2016.

B. Consumer, Staff, and Stakeholder Perception

1. Satisfaction with Program Quality

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

Type of Objective: *Quality Assurance: Efficiency*

The 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 are not included in the aggregate analysis for that item. In addition, although aggregated, the table does not include items not having responses. For the purpose of this report, the table only includes highlights that relate to overall program quality (as identified as an indicator in the PI Work Plan).

Inpatient Unit – Crisis Stabilization: One hundred (100) clients completed surveys between July 1 and December 31, 2015. **MARATHON ONLY – DISCHARGE SURVEYS**

G/CC only administers ***discharge*** surveys since the length of stay is only several days.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	89.7	5.2	5.2
I was treated with respect	89.9	7.1	3.0
I was seen for services on time	95.9	3.1	1.0
I received services when I needed them	91.9	6.1	2.0
If I had a complaint, it was handled well	91.1	6.7	2.2
If I were to have problems, I would return to this program	***77.7***	13.8	8.5
I would recommend this program to other people	82.0	12.8	5.3
The services focus on my needs	***76.6***	17.0	6.4
This program has helped me to feel better about myself	***79.1***	12.5	8.4

Detoxification: Sixty-five (65) clients completed surveys between July 1 and December 31, 2015. **MARATHON ONLY – DISCHARGE SURVEYS**

G/CC only administers ***discharge*** surveys since the length of stay is only several days.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	89.2	6.2	4.6
I was treated with respect	92.3	6.2	1.5
I was seen for services on time	95.4	3.1	1.5
I received services when I needed them	87.7	9.2	3.1
If I had a complaint, it was handled well	81.3	13.6	5.1
If I were to have problems, I would return to this program	80.0	10.8	9.2
I would recommend this program to other people	86.2	7.7	6.2
The services focus on my needs	89.0	6.3	4.7
This program has helped me to feel better about myself	80.0	15.4	4.6

Outpatient Adult – Mental Health: One hundred nine (109) clients completed Point in Time Surveys between July 1 and December 31, 2015. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect.	99.1	0.9	0.0
I was seen for services on time	95.4	2.8	1.8
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	99.0	1.0	0.0
If I were to have problems, I would return to this program	98.1	1.9	0.0
I would recommend this program to other people	97.2	1.8	1.9
The services focus on my needs	98.1	1.9	0.0
This program has helped me to feel better about myself	94.4	4.6	0.9

Twelve (12) clients completed **Discharge Surveys** between July 1 and December 31, 2015.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect.	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
If I were to have problems, I would return to this program	100.0	0.0	0.0
I would recommend this program to other people	100.0	0.0	0.0
The services focus on my needs	100.0	0.0	0.0
This program has helped me to feel better about myself	100.0	0.0	0.0

Outpatient Adult – Alcohol and Other Drugs/Addictions: Thirty-three (33) clients completed Point in Time Surveys between July 1 and December 31, 2014. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	97.0	3.0	0.0
I was treated with respect.	97.0	0.0	3.0
I was seen for services on time	94.0	3.0	3.0
I received services when I needed them	94.0	3.0	3.0
If I had a complaint, it was handled well*	80.0	16.0	4.0
If I were to have problems, I would return to this program	87.1	12.9	0.0
I would recommend this program to other people	90.3	6.5	3.2
The services focus on my needs	90.3	9.7	0.0
This program has helped me to feel better about myself	90.0	6.7	3.3

Twelve (12) clients completed **Discharge Surveys** between July 1 and December 31, 2015.

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect.	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	91.7	8.3	0.0
If I had a complaint, it was handled well*	91.7	8.3	0.0
If I were to have problems, I would return to this program	100.0	0.0	0.0
I would recommend this program to other people	100.0	0.0	0.0
The services focus on my needs	100.0	0.0	0.0
This program has helped me to feel better about myself	100.0	0.0	0.0

Case Management: Two (2) clients completed Point in Time Surveys between July 1 and December 31, 2015. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect.	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
If I were to have problems, I would return to this program	100.0	0.0	0.0
I would recommend this program to other people	100.0	0.0	0.0
The services focus on my needs	100.0	0.0	0.0
This program has helped me to feel better about myself	100.0	0.0	0.0

No (0) clients completed **Discharge Surveys** between July 1 and December 31, 2015.

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

Community Integration: No (0) clients completed Point in Time Surveys for this program between July 1 and December 31, 2015. **POINT IN TIME SURVEYS**

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

No (0) clients completed **Discharge Surveys** between July 1 and December 31, 2015.

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

Criminal Justice: Fifty-four (54) clients completed Point in Time Surveys between July 1 and December 31, 2015. **KEY WEST ONLY. POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	98.1	1.9	0.0
I was treated with respect.	100.0	0.0	0.0
I was seen for services on time	96.2	1.9	1.9
I received services when I needed them	98.1	1.9	0.0
If I had a complaint, it was handled well	98.1	1.9	0.0
If I were to have problems, I would return to this program	86.6	9.6	3.8
I would recommend this program to other people	94.4	5.6	0.0
The services focus on my needs	96.3	3.7	0.0
This program has helped me to feel better about myself	96.3	1.9	1.9

Six (6) clients completed **Discharge Surveys** between July 1 and December 31, 2015. **KEY WEST ONLY. DISCHARGE SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect.	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
If I were to have problems, I would return to this program	100.0	0.0	0.0
I would recommend this program to other people	100.0	0.0	0.0
The services focus on my needs	100.0	0.0	0.0
This program has helped me to feel better about myself	100.0	0.0	0.0

FITT: Two (2) clients completed Point in Time Surveys between July 1 and December 31, 2015.

POINT IN TIME SURVEYS

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect.	50.0	50.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
If I were to have problems, I would return to this program	50.0	50.0	0.0
I would recommend this program to other people	100.0	0.0	0.0
The services focus on my needs	100.0	0.0	0.0
This program has helped me to feel better about myself	100.0	0.0	0.0

No (0) clients completed **Discharge Surveys** between July 1 and December 31, 2015.

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

Heron House: Fifteen (15) clients completed Point in Time Surveys between July 1 and December 31, 2015. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	86.7	6.7	6.7
I was treated with respect.	80.0	13.3	6.7
I was seen for services on time	80.0	6.7	13.3
I received services when I needed them	80.0	13.3	6.7
If I had a complaint, it was handled well	80.0	13.3	6.7
If I were to have problems, I would return to this program	***73.3***	20.0	6.7
I would recommend this program to other people	85.8	7.1	7.1
The services focus on my needs	80.0	13.3	6.7
This program has helped me to feel better about myself	80.0	13.3	6.7

No (0) clients completed Discharge Surveys between July 1 and December 31, 2015.

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

Outpatient Children and Adolescents – Substance Abuse: Three (3) clients completed Point in Time Surveys between July 1 and December 31, 2015. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
I get along better with family members	100.0	0.0	0.0
I am doing better in school	100.0	0.0	0.0

No (0) clients completed Discharge Surveys for this program between July 1 and December 31, 2015.

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

Outpatient Children and Adolescents – Mental Health: Thirty-five (35) clients completed surveys between July 1 and December 31, 2015. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	93.9	6.1	0.0
I was treated with respect.	94.3	5.7	0.0
I was seen for services on time	90.9	9.1	0.0
I received services when I needed them	97.1	2.9	0.0
If I had a complaint, it was handled well	96.7	3.3	0.0
I get along better with family members	***73.9***	21.9	6.3
I am doing better in school	84.8	15.2	0.0

Eleven (11) clients completed Discharge Surveys between July 1 and December 31, 2015.

DISCHARGE SURVEYS

Item	Satisfied (%) [1]Indicates Below Criterion	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	***63.7***	36.3	0.0
I was treated with respect.	***63.7***	36.3	0.0
I was seen for services on time	***63.7***	36.3	0.0
I received services when I needed them	***54.5***	45.5	0.0
If I had a complaint, it was handled well	***50.0***	50.0	0.0
I get along better with family members	**72.7**	27.3	0.0
I am doing better in school	54.5	45.5	0.0

Prevention/Diversion: No (0) clients completed Point in Time Surveys between July 1 and December 31, 2015. **POINT IN TIME SURVEYS**

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

No (0) completed **Discharge Surveys** between July 1 and December 31, 2015.

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

Case Management Children and Adolescents: Four (4) clients completed surveys between July 1 and December 31, 2015. **POINT IN TIME SURVEYS**

Item	Satisfied (%)	Neutral (%)	Dissatisfied (%)
Overall, I am satisfied with the services I received	100.0	0.0	0.0
I was treated with respect	100.0	0.0	0.0
I was seen for services on time	100.0	0.0	0.0
I received services when I needed them	100.0	0.0	0.0
If I had a complaint, it was handled well	100.0	0.0	0.0
I get along better with family members	100.0	0.0	0.0
I am doing better in school	100.0	0.0	0.0

No (0) clients completed **Discharge Surveys** between July 1 and December 31, 2015.

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

2. Consumer Satisfaction with Primary Care Services

Objective: ≥ 80% of consumers will report satisfaction with primary care services at intake, every 6 months, and discharge.

Type of Objective: *Quality Assurance: Efficiency*

No (0) clients completed **Intake, 6-Month, or Discharge surveys** July 1 and December 31, 2015.

The Guidance/Care Center did not begin admitting consumers to the Center for Wellness until August 2015. Challenges hiring qualified staff delayed enrollment into the program. The initial focus, therefore, was identifying and enrolling potential consumers to the Center's enrollment goal.

The Center for Wellness staff will work with the Evaluator to develop primary care specific perception surveys during the third quarter of FY 2015-2016 and will implement the surveys by the fourth quarter.

3. Staff Perception

Objective: ≥ 80% of the staff will report job satisfaction.

Type of Objective: *Quality Assurance: Efficiency*

G/CC conducts Staff Perception Surveys annually using Survey Monkey. The next survey will occur in May 2016.

4. Stakeholder Perception

Objective: ≥ 80% of stakeholders will have a positive perception of G/CC and its services.

Type of Objective: *Quality Assurance: Efficiency*

G/CC conducts Stakeholder Surveys annually using Survey Monkey. The next survey will occur in May 2016

5. Transportation Perception

Objective: ≥ 80% of consumers have a positive perception of G/CC transportation services.

Type of Objective: *Quality Assurance: Efficiency*

G/CC conducts Transportation Perception surveys annually. The next survey will occur in May 2016.

C. Follow-Up

1. GPRA and GAIN overall follow-up rate for the ORP grant at 3, 6, and 12 months

Objective: 80% of the clients will complete the follow-ups

Objective Type: *Quality Assurance: Efficiency*

OLD ORP: The contract with SAMHSA began September 30, 2012 and ended on January 31, 2016.

Scale	3-Month	6-Month	12-Month
GPRA	NA	89.0%	NA
GAIN	89.0%	82.0%	76.0%

The Guidance/Care Center did very well with tracking clients for the 6-month GPRA follow-up. The SAMHSA requirement is a minimum of 80%.

NEW ORP: The contract with SAMHSA began September 30, 2015. G/CC began enrolling clients in October 2015. Therefore, the first GPRA 6-month follow-up assessments are due in April 2016.

Scale	3-Month	6-Month	12-Month
GPRA	NA	NONE DUE	NA
GAIN	72.0%	NONE DUE	NONE DUE

The Guidance/Care Center 3-month follow-up rate is below the SAMHSA expected rate of 80%. Of the five (5) assessments due, G/CC completed three (3). Although G/CC located four (4) clients, the fourth client dropped out of the study and refused to complete the follow-up assessment. One (1) client remains in the "active" window for data collection.

2. GAIN "on-time" follow-up rate for 3, 6, and 12 months

Objective: 80% of the follow-ups completed will be within the "on-time" window

Objective Type: *Quality Assurance: Efficiency*

OLD ORP: The contract with SAMHSA began September 30, 2012 and ended on January 31, 2016. Although the overall follow-up rate is important, SAMHSA requires that staff complete majority of GAIN follow-ups within 2 week prior to or 2 weeks post the actual due date. This is the on-time window.

Scale	3-Month	6-Month	12-Month
GAIN	79.0%	71.0%	74.0%

NEW ORP: The contract with SAMHSA began September 30, 2015. G/CC began enrolling clients in October 2015.

Scale	3-Month	6-Month	12-Month
GAIN	100.0%	NONE DUE	NONE DUE

3. GPRA and GAIN overall follow-up rate for the PBHCI (Primary Care) grant at 3, 6, and 12 months

Objective: 80% of the clients will complete the follow-ups

Objective Type: *Quality Assurance: Efficiency*

Scale	3-Month	6-Month	12-Month
GPRA	NA	NONE DUE	NA
GAIN	53.0%	52.0%	0.0%

The Guidance/Care Center follow-up rate at the 3- and 6-month periods is below the required SAMHSA 80% rate. G/CC completed 60 of the 114 3-month assessments due.

Two (2) clients died at the time of follow-up. G/CC completed 16 of the 30 6-month assessments due.

4. GAIN "on-time" follow-up rate for PBHCI (Primary Care) grant at 3, 6, and 12 months

Objective: 80% of the follow-ups completed will be within the "on-time" window

Objective Type: *Quality Assurance: Efficiency*

Scale	3-Month	6-Month	12-Month
GAIN	59.0%	53.0%	0.0%

5. Post Discharge Follow-Up Survey

Objective: ≥10 surveys completed quarterly

Objective Type: *Performance Improvement: Efficiency*

During the biannual period July – December 2015, G/CC did not collect any post discharge follow-up surveys.

Employment	Full-Time	Part-Time	Seeking	Unemployed
Adults Only	--	--	--	--

Residential Status	Independent Living	Dependent Living	ALF	Nursing Home	Corrections Facility	Homeless	Other
	--	--	--	--	--	--	--

Discharge Plan Follow Up	Attending Appointment as prescribed	Attending Most Appointments	Attending NA/AA	Not Seeing Follow Up Practitioner	Taking Medication as Prescribed	Not Taking Medication as Prescribed
	--	--	--	--	--	--

SA or MH Readmission	Yes	No
	--	--

Followed Up with Referrals	Yes	No
	--	--

Criminal Justice Involvement	Yes	No
	--	--

Access To Primary Care	Yes	No
	--	--

ER Admissions	Yes	No
	--	--

Involvement with Community Activities	Church	AANA	Volunteer Work	Other
	--	--	--	--

Maintained Contact with GCC	Yes	No
	--	--

GCC/WestCare upholds the motto "Uplifting the Human Spirit"	Yes	No
	--	--

6. Intake Survey

Between July 1 and December 31, 2015, G/CC collected 193Admission Surveys. One hundred forty-four (144) were from adults, 46 from children/adolescents, and three (3) did not identify the population. The analyses below did not include those surveys not identifying the population.

The survey consists of 22 items. Six items are information only items rated as "Yes" or "No." The remaining 16 items evaluate the clients' perceptions of the admission process. Ratings for these items use a 4-point Likert scale, ranging from Strongly Agree to Strongly Disagree.

Adult Admissions

Item	Satisfied (%)	Dissatisfied (%)
When I walked into G/CC to ask about services…		
My questions were answered	98.6	1.4
I understood the information that was given to me	99.3	0.7
The information given to me was correct	96.5	3.5
It was easy to get an appointment for intake	94.3	5.7
During my intake assessment…		
The admission staff were welcoming	100.0	0.0
I was comfortable in the waiting area	98.6	1.4
My questions were fully answered	98.6	1.4
The admissions process was explained to me	97.1	2.9

I understood the explanation of the admission process	97.9	2.1
There was too much paperwork (reverse scored)	***78.0 (Agree)***	22.0 (Disagree)
The Admission staff understood my needs	99.3	0.7
I felt the admission counselor listened to me	98.4	1.6
I thought the process took too long (reverse scored)	***47.8 (Agree)***	52.2 (Disagree)
Thinking about the telephone contact and the intake assessment together, these helped me get prepared for treatment	94.7	5.3
G/CC could improve the admission process (reverse scored)	***44.3 (Agree)***	55.7 (Disagree)

Would you refer friends with similar problems to yours to G/CC? Yes = 95.6%

Overall, were you satisfied with the admission process? Yes = 99.3%

Child/Adolescent Admissions

Item	**Satisfied (%)**	**Dissatisfied (%)**
When I walked into G/CC to ask about services…		
My questions were answered	100.0	0.0
I understood the information that was given to me	100.0	0.0
The information given to me was correct	100.0	0.0
It was easy to get an appointment for intake	97.8	2.2
During my intake assessment…		
The admission staff were welcoming	100.0	0.0
I was comfortable in the waiting area	97.8	2.2
My questions were fully answered	100.0	0.0
The admissions process was explained to me	100.0	0.0
I understood the explanation of the admission process	100.0	0.0
There was too much paperwork (reverse scored)	***93.4 (Agree)***	6.6 (Disagree)
The Admission staff understood my needs	100.0	0.0
I felt the admission counselor listened to me	97.8	2.2
I thought the process took too long (reverse scored)	***69.1 (Agree)***	30.9 (Disagree)

Thinking about the telephone contact and the intake assessment together, these helped me get prepared for treatment	97.7	2.3
G/CC could improve the admission process (reverse scored)	***65.0 (Agree)***	35.0

Would you refer friends with similar problems to yours to G/CC? Yes = 97.6%

Overall, were you satisfied with the admission process? Yes = 100.0%

D. Clinical Records

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

Objective: ≥ 80% of treatment records will comply.

Type of Objective: *Quality Assurance: Efficiency*

Between July 1 and December 31, 2015, staff completed 226 Peer Reviews across three (3) G/CC Locations: Key West, Marathon, and Key Largo. Staff reviewed a sampling of charts from all Core Programs. One hundred forty (114) records were for active clients, and 102 were for closed cases. The breakdown is as follows:

Core Program	Number of Clinical Records	Open Charts	Closed Charts
Adult Mental Health	22	12	10
Adult Substance Abuse	10	3	7
Child Mental Health	32	17	15
Child Substance Abuse	23	12	11
Diversion	21	11	10
Level 2 Prevention	10	7	3
Adult Case Management	23	13	10
Child Case Management	25	12	13
CSU	7	1	6
Detox	8	3	5
Criminal Justice	30	15	15
Integrated	8	4	4
Community Integration	6	4	2
FITT	1	0	1
Total	**226**	**114**	**112**

Although the Peer Review Form is extensive and measures chart compliance and quality across all areas of 65D 30, CARF, Medicaid, and CCISC, the following are key findings from the audit. A 3-point scale measures each item, ranging from Not Compliant to Partially Compliant to Compliant. The tables below reflect the percent of charts that were fully compliant with each key item.

ALL TREATMENT PROGRAMS (Excludes Diversion & Prevention)

Section	Average Total Percent (100% highest possible score)
Legal Information	98.4% =
Screening and Admission	95.3% ↑
Psychosocial Assessment/In-Depth Evaluation	83.7% ↓
Initial/Preliminary Treatment Plan	84.3% ↓
Wellness & Recovery Plans and Reviews	86.7% ↑
Progress Notes	91.6% ↓
Medication Orders (if applicable)	97.5% =
Medical Plan & Progress Notes (if applicable)	94.4% ↑
Service Plans	71.8% ↓
Case Management Progress Notes	75.0% ↓
Discharge/Transition Reporting	81.9% ↓

Content Area	% Compliant
Immediate or Urgent Needs Documented	98.9% ↑
GAIN Q Complete	89.4% ↑
Consent to Treatment Signed	97.8% ↑
Information Regarding Rights/Responsibilities	95.7% ↓
Information Regarding Grievance Procedure	95.7% ↓
Information on HIPAA	95.7% ↑
QRRS Edited to Remove All Prompts	93.2% ↑
QRRS Provides Rationale for Level of Care	93.2% ↑
SMQ R 5 Completed	91.7% ↓
SNAP Form Completed	93.6% ↓
GRRS Edited to be Individualized	89.7% ↑
Preliminary Plan Completed at Admission	90.6% =
Life Goal in Client's Own Words	81.8% ↓
Wellness & Recovery Plan Reflects GRRS	78.7% ↓
Wellness & Recovery Plan Completed on Time	73.6% ↓
Plan Objectives are Behavioral & Measurable	86.0% ↓
Plan Reviews Include Client's Assessment of Progress	73.9% ↓
Plan Reviews Completed On-Time (for those having reviews due)	65.0% ↓
Medication Orders Indicate Primary MD*	100.0% =
Signed Consent for Medication	100.0% ↑
Copy of Prescriptions in Clinical Record*	100.0% =

ADULT MENTAL HEALTH

Section	Average Total Percent (100% highest possible score)
Legal Information	95.8% ↑
Screening and Admission	96.6% ↑
Psychosocial Assessment/In-Depth Evaluation	96.8% ↑
Initial/Preliminary Treatment Plan	83.6% ↓
Wellness & Recovery Plans and Reviews	71.5% ↓
Progress Notes	86.5% ↓
Medication Orders (if applicable)	100.0% =
Medical Progress Notes (if applicable)	98.6% ↑
Service Plans	100.0%
Case Management Progress Notes	NA
Discharge/Transition Reporting	90.9% ↑

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0%=
GAIN Q Complete	100.0% ↑
Consent to Treatment Signed	100.0% ↑
Information Regarding Rights/Responsibilities	100.0% ↑
Information Regarding Grievance Procedure	100.0% ↓
Information on HIPAA	100.0% ↑
QRRS Edited to Remove All Prompts	100.0% ↑
QRRS Provides Rationale for Level of Care	100.0% ↑
SMQ R 5 Completed	90.0% ↓
SNAP Form Completed	100.0% ↑
GRRS Edited to be Individualized	100.0% =
Preliminary Plan Completed at Admission	80.0% ↓
Life Goal in Client's Own Words	66.7% ↓
Wellness & Recovery Plan Reflects GRRS	66.7% ↓
Wellness & Recovery Plan Completed on Time	33.3% ↓
Plan Objectives are Behavioral & Measurable	66.7% ↓
Plan Reviews Include Client's Assessment of Progress	100.0% ↑
Plan Reviews Completed On-Time (for those having reviews due)	100.0% ↑
Medication Orders Indicate Primary MD*	100.0% =
Signed Consent for Medication	100.0% =
Copy of Prescriptions in Clinical Record*	100.0% =

*Only rated for clients receiving medication

CHILD MENTAL HEALTH

Section	Average Total Percent (100% highest possible score)
Legal Information	100.0% =
Screening and Admission	88.3% ↓
Psychosocial Assessment/In-Depth Evaluation	69.1% ↓
Initial/Preliminary Treatment Plan	67.1% ↓
Wellness & Recovery Plans and Reviews	85.4% ↓
Progress Notes	91.7% ↓
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	100.0% ↑
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	87.3% ↑

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% =
GAIN Q Complete	88.9% ↓
Consent to Treatment Signed	88.9% ↓
Information Regarding Rights/Responsibilities	83.3% ↓
Information Regarding Grievance Procedure	77.8% ↓
Information on HIPAA	83.3% ↓
GRRS Edited to Remove All Prompts	100.0% ↑
GRRS Provides Rationale for Level of Care	100.0% ↑
SMQ R 5 Completed	82.4% ↓
SNAP Form Completed	83.3% ↓
GRRS Edited to be Individualized	83.3% ↓
Preliminary Plan Completed at Admission	83.3% ↓
Life Goal in Client's Own Words	86.7% ↓
Wellness & Recovery Plan Reflects GRRS	73.3% ↓
Wellness & Recovery Plan Completed on Time	75.0% ↓
Plan Objectives are Behavioral & Measurable	87.5% ↓
Plan Reviews Include Client's Assessment of Progress	69.2% ↓
Plan Reviews Completed On-Time (for those having reviews due)	54.5% ↓
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medication	100.0% =
Copy of Prescriptions in Clinical Record*	NA

*Only rated for clients receiving medication

INPATIENT (CSU and Detox Combined)

Section	Average Total Percent (100% highest possible score)
Legal Information	100.0% =
Screening and Admission	97.5% ↑
Psychosocial Assessment/In-Depth Evaluation	NA
Initial/Preliminary Treatment Plan	100.0% ↑
Wellness & Recovery Plans and Reviews	100.0% ↑
Progress Notes	100.0% =
Medication Orders (if applicable)	97.5% =
Medical Progress Notes (if applicable)	100.0% ↑
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	97.5% ↑

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% =
Consent to Treatment Signed	100.0% ↑
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% ↑
Information on HIPAA	100.0% ↑
Preliminary Plan Completed at Admission	100.0% =
Wellness & Recovery Plan Completed on Time	50.0% ↓
Plan Objectives are Behavioral & Measurable	100.0% =
Medication Orders Indicate Primary MD*	100.0% =
Signed Consent for Medication	100.0% =
Copy of Prescriptions in Clinical Record*	100.0% =

*Only rated for clients receiving medication

Criminal Justice

Section	Average Total Percent (100% highest possible score)
Legal Information	9.3% ↓
Screening and Admission	95.0% ↑
Psychosocial Assessment/In-Depth Evaluation	93.4% ↓
Initial/Preliminary Treatment Plan	100.0% ↑
Wellness & Recovery Plans and Reviews	97.3% ↑
Progress Notes	100.0% ↑
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	78.8% ↑

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% ↑
GAIN Q Complete	80.0% ↑
Consent to Treatment Signed	100.0% =
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
GRRS Edited to Remove All Prompts	92.9% ↑
GRRS Provides Rationale for Level of Care	92.9% ↑
SMQ R 5 Completed	92.3% ↑
SNAP Form Completed	100.0% ↑
GRRS Edited to be Individualized	100.0% ↑
Preliminary Plan Completed at Admission	100.0% ↑
Life Goal in Client's Own Words	86.7% ↓
Wellness & Recovery Plan Reflects GRRS	92.9% ↑
Wellness & Recovery Plan Completed on Time	93.3% ↑
Plan Objectives are Behavioral & Measurable	93.3% ↑
Plan Reviews Include Client's Assessment of Progress	100.0% ↑
Plan Reviews Completed On-Time (for those having reviews due)	100.0% ↑
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medication	NA
Copy of Prescriptions in Clinical Record*	NA

*Only rated for clients receiving medication

ADULT CASE MANAGEMENT

Section	Average Total Percent (100% highest possible score)
Legal Information	100.0% =
Screening and Admission	96.1% ↑
Psychosocial Assessment/In-Depth Evaluation	83.0% ↑
Initial/Preliminary Treatment Plan	100.0% ↑
Wellness & Recovery Plans and Reviews	100.0% ↑
Progress Notes	100.0% ↑
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	51.0% ↓
Service Plans	80.0% ↑
Case Management Progress Notes	74.8% ↓
Discharge/Transition Reporting	60.1% ↓

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% =
GAIN Q Complete	100.0% ↑
Consent to Treatment Signed	100.0% ↑
Information Regarding Rights/Responsibilities	91.7% ↑
Information Regarding Grievance Procedure	100.0% ↑
Information on HIPAA	100.0% ↑
GRRS Edited to Remove All Prompts	100.0% ↑
GRRS Provides Rationale for Level of Care	100.0% ↑
SMQ R 5 Completed	100.0% ↑
SNAP Form Completed	90.9% ↓
GRRS Edited to be Individualized	88.9% ↑
Preliminary Plan Completed at Admission	69.2% ↓
Service Plan Completed	40.0%
Consent for Case Management	70.0%
Plan Objectives are Behavioral & Measurable	70.0%
Case Management Notes Indicate Progress Made on Goals & Objectives	50.0%
Medication Orders Indicate Primary MD*	100.0%
Signed Consent for Medication	100.0%
Copy of Prescriptions in Clinical Record*	100.0%

*Only rated for clients receiving medication

CHILD CASE MANAGEMENT

Section	Average Total Percent (100% highest possible score)
Legal Information	100.0% =
Screening and Admission	100.0% ↑
Psychosocial Assessment/In-Depth Evaluation	94.3% ↑
Initial/Preliminary Treatment Plan	85.7% ↓
Wellness & Recovery Plans and Reviews	92.8% ↑
Progress Notes	NA
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	58.0% ↓
Case Management Progress Notes	83.4% ↓
Discharge/Transition Reporting	95.6% ↑

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% =
GAIN Q Complete	83.3% ↓
Consent to Treatment Signed	100.0% =
Information Regarding Rights/Responsibilities	100.0% ↑
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% ↑
QRRS Edited to Remove All Prompts	100.0% ↑
QRRS Provides Rationale for Level of Care	100.0% ↑
SMQ R 4 Completed	100.0% ↑
SNAP Form Completed on Time	100.0% ↑
GRRS Edited to be Individualized	70.0% ↓
Preliminary Plan Completed at Admission	100.0% =
Service Plan Completed	80.0%
Consent for Case Management	70.0%
Plan Objectives are Behavioral & Measurable	77.8%
Case Management Notes Indicate Progress Made on Goals & Objectives	83.3%
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medication	NA
Copy of Prescriptions in Clinical Record*	NA

*Only rated for clients receiving medication

Adult Substance Abuse

Section	Average Total Percent (100% highest possible score)
Legal Information	100.0% ↑
Screening and Admission	100.0% ↑
Psychosocial Assessment/In-Depth Evaluation	64.0% ↓
Initial/Preliminary Treatment Plan	80.7% ↓
Wellness & Recovery Plans and Reviews	70.0% ↓
Progress Notes	92.0% ↓
Medication Orders (if applicable)	92.5%
Medical Progress Notes (if applicable)	100.0%
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	93.3% ↑

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% =
GAIN Q Complete	100.0% =
Consent to Treatment Signed	100.0% ↑
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
QRRS Edited to Remove All Prompts	100.0% =
QRRS Provides Rationale for Level of Care	100.0% =
SMQ R 5 Completed	100.0% ↑
SNAP Form Completed	100.0% ↑
GRRS Edited to be Individualized	100.0% ↑
Preliminary Plan Completed at Admission	100.0% ↑
Life Goal in Client's Own Words	100.0% =
Wellness & Recovery Plan Reflects GRRS	100.0% ↑
Wellness & Recovery Plan Completed on Time	100.0% =
Plan Objectives are Behavioral & Measurable	100.0% =
Plan Reviews Include Client's Assessment of Progress	100.0% ↑
Plan Reviews Completed On-Time (for those having reviews due)	100.0% ↑
Medication Orders Indicate Primary MD*	100.0%
Signed Consent for Medication	100.0%
Copy of Prescriptions in Clinical Record*	100.0%

*Only rated for clients receiving medication

Children's Substance Abuse

Section	Average Total Percent (100% highest possible score
Legal Information	100.0% ↑
Screening and Admission	96.6% ↑
Psychosocial Assessment/In-Depth Evaluation	75.4% ↓
Initial/Preliminary Treatment Plan	60.6% ↓
Wellness & Recovery Plans and Reviews	94.5% ↑
Progress Notes	80.0% ↓
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	66.1% ↓

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% ↑
GAIN Q Complete	71.4% ↓
Consent to Treatment Signed	100.0% =
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
GRRS Edited to Remove All Prompts	80.0% ↓
GRRS Provides Rationale for Level of Care	80.0% ↓
SMQ R 4 Completed	100.0% ↑
SNAP Form Completed	100.0% =
GRRS Edited to be Individualized	72.7% ↑
Preliminary Plan Completed at Admission	91.7% ↑
Life Goal in Client's Own Words	81.8% ↑
Wellness & Recovery Plan Reflects GRRS	81.8% ↑
Wellness & Recovery Plan Completed on Time	81.8% ↑
Plan Objectives are Behavioral & Measurable	81.8% ↑
Plan Reviews Include Client's Assessment of Progress	80.0% ↑
Plan Reviews Completed On-Time (for those having reviews due)	50.0% =
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medication	100.0%↑
Copy of Prescriptions in Clinical Record*	NA

*Only rated for clients receiving medication

FITT – Only one (1) Peer Review Occurred this Biannual Period so data was not included

Section	Average Total Percent (100% highest possible score
Legal Information	--
Screening and Admission	--
Psychosocial Assessment/In-Depth Evaluation	--
Initial/Preliminary Treatment Plan	--
Wellness & Recovery Plans and Reviews	--
Progress Notes	--
Medication Orders (if applicable)	--
Medical Progress Notes (if applicable)	--
Service Plans	--
Case Management Progress Notes	--
Discharge/Transition Reporting	--

Content Area	% Compliant
Immediate or Urgent Needs Documented	--
GAIN Q Complete	--
Consent to Treatment Signed	--
Information Regarding Rights/Responsibilities	--
Information Regarding Grievance Procedure	--
Information on HIPAA	--
GRRS Edited to Remove All Prompts	--
GRRS Provides Rationale for Level of Care	--
SMQ R 4 Completed	--
SNAP Form Completed	--
GRRS Edited to be Individualized	--
Preliminary Plan Completed at Admission	--
Life Goal in Client's Own Words	--
Wellness & Recovery Plan Reflects GRRS	--
Wellness & Recovery Plan Completed on Time	--
Plan Objectives are Behavioral & Measurable	--
Plan Reviews Include Client's Assessment of Progress	--
Plan Reviews Completed On-Time (for those having reviews due)	--
Medication Orders Indicate Primary MD*	--
Signed Consent for Medication	--
Copy of Prescriptions in Clinical Record*	--

*Only rated for clients receiving medication

G/CC uses a Peer Review Form that is more appropriate for the ***Diversion and Prevention Level 2*** clinical Records.

Diversion

Section	Average Total Percent (100% highest possible score)
Screening and Admission	96.0% ↑
Assessment	97.0% =
Initial/Preliminary Treatment Plan	79.7% ↓
Wellness & Recovery Plans and Reviews	45.2% ↓
Prevention Plan and Reviews	--
Prevention Summary Notes	--
Discharge/Transition Reporting	90.6% ↑

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0% ↑
GAIN Q Complete	90.9% ↑
Consent to Participate Signed	100.0% ↑
Information Regarding Rights/Responsibilities	100.0% =
Information Regarding Grievance Procedure	100.0% =
Information on HIPAA	100.0% =
QRRS Edited to Remove All Prompts	80.0% ↑
QRRS Provides Rationale for Level of Care	90.0% ↑
SMQ R 5 Completed	100.0% ↑
SNAP Form Completed	100.0% =
GRRS Completed	90.9% =
Preliminary Plan Completed at Admission	100.0% =
Life Goal in Client's Own Words	45.5% ↓
Wellness & Recovery Plan Reflects GRRS	54.5% ↓
Wellness & Recovery Plan Completed on Time	45.5% ↓
Plan Objectives are Behavioral & Measurable	54.5% ↓
Plan Reviews Include Client's Assessment of Progress	66.7% ↑
Plan Reviews Completed On-Time (for those having reviews due)	30.0% ↓

*Only rated for clients receiving medication

Prevention Level 2

Section	Average Total Percent (100% highest possible score)
Screening and Admission	77.0% ↓
Assessment	97.8%
Initial/Preliminary Treatment Plan	75.0%
Wellness & Recovery Plans and Reviews	91.0%
Prevention Plan and Reviews	50.0% ↓
Prevention Summary Notes	40.0% ↓
Discharge/Transition Reporting	87.7% ↓

Content Area	% Compliant
Immediate or Urgent Needs Documented	85.7% ↓
Consent to Participate Signed	71.4% ↓
Information Regarding Rights/Responsibilities	100.0% ↑
Information Regarding Grievance Procedure	85.7% ↓
Information on HIPAA	85.7% ↓
Preliminary Plan Completed at Admission	10.0% ↑
Plan Indicates Risk Factors	50.0% ↓
Plan Indicates Protective Factors	50.0% ↓
Plan Identifies Goals Specific to Client	50.0% ↓
Plan Objectives are Behavioral & Measurable	50.0% ↓
Summary Notes Include Risk & Protective Factors Addressed	40.0% ↓
Summary Notes Include Progress on Goals and Objectives	40.0% ↓

Community Integration

Section	Average Total Percent (100% highest possible score)
Legal Information	100.0% =
Screening and Admission	NA
Psychosocial Assessment/In-Depth Evaluation	NA
Initial/Preliminary Treatment Plan	NA
Wellness & Recovery Plans and Reviews	64.7% ↓
Progress Notes	100.0% ↑
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	NA
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	40.0% ↓

Content Area	% Compliant
Life Goal in Client's Own Words	33.3% ↓
Wellness & Recovery Plan Reflects GRRS	33.3% ↓
Wellness & Recovery Plan Completed on Time	0.0% ↓
Plan Objectives are Behavioral & Measurable	33.3% ↓
Plan Reviews Include Client's Assessment of Progress	0.0% ↓
Plan Reviews Completed On-Time (for those having reviews due)	0.0% ↓
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medications	NA
Copy of Prescriptions in Clinical Record*	NA

*Only rated for clients receiving medication

Integrated – G/CC did not review any charts this Biannual Period

Section	Average Total Percent (100% highest possible score)
Legal Information	75.0%
Screening and Admission	97.0%
Psychosocial Assessment/In-Depth Evaluation	100.0%
Initial/Preliminary Treatment Plan	93.8%
Wellness & Recovery Plans and Reviews	100.0%
Progress Notes	100.0%
Medication Orders (if applicable)	NA
Medical Progress Notes (if applicable)	90.0%
Service Plans	NA
Case Management Progress Notes	NA
Discharge/Transition Reporting	95.5%

Content Area	% Compliant
Immediate or Urgent Needs Documented	100.0%
GAIN Q Complete	100.0%
Consent to Treatment Signed	100.0%
Information Regarding Rights/Responsibilities	100.0%
Information Regarding Grievance Procedure	100.0%
Information on HIPAA	100.0%
QRRS Edited to Remove All Prompts	NA
QRRS Provides Rationale for Level of Care	NA
SMQ R 4 Completed	100.0%
SNAP Form Completed	100.0%
GRRS Edited to be Individualized	NA
Preliminary Plan Completed at Admission	100.0%
Life Goal in Client's Own Words	100.0%
Wellness & Recovery Plan Reflects GRRS	100.0%
Wellness & Recovery Plan Completed on Time	100.0%
Plan Objectives are Behavioral & Measurable	100.0%
Plan Reviews Include Client's Assessment of Progress	100.0%
Plan Reviews Completed On-Time (for those having reviews due)	75.0%
Medication Orders Indicate Primary MD*	NA
Signed Consent for Medications	NA
Copy of Prescriptions in Clinical Record*	NA

*Only rated for clients receiving medication

Staff reviewed 99 closed ***treatment charts***. Findings are as follows:

Content Area	% Compliant
Discharge Summary Completed	91.5% ↑
Discharge Report Includes Reason for Discharge	93.6% ↓
Discharge Report Includes Recommendations & Referrals	93.3% =
Discharge Report Includes Evaluation of Progress	90.4% ↓
Discharge/Transfer ASAM Completed	55.8% ↓
SISAR Completed	55.8% ↓
MH Outcome Completed	84.5% ↓
FARS/CFARS Completed	82.8% ↓
Wellness & Recovery Plans Closed	63.5% ↑
Service Plans Closed	60.0% ↓

Staff reviewed 13 closed ***diversion and prevention charts.*** Findings are as follows:

Content Area	% Compliant
Discharge Summary Completed	91.7% ↑
Discharge Report Includes Reason for Discharge	84.6% ↑
Discharge Report Includes Recommendations & Referrals	92.3% ↑
Discharge Report Includes Evaluation of Progress	100.0% ↑
Discharge/Transfer ASAM Completed	90.0% ↑
SISAR Completed	92.3% ↑
Wellness & Recovery Plans Closed	66.7% ↑

2. Utilization Management

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

   Type of Objective: *Quality Assurance: Efficiency*

   The Chief Clinical Officer (CCO) completed the final version of the Utilization Management Review Form in February 2015 and sent it to staff for feedback. The CCO developed admission, continued stay, and discharge forms for Outpatient Mental Health, Outpatient Substance Abuse, and Residential Substance Abuse. G/CC will begin using the forms in Fiscal Year 2015-2016.

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 Peer Review process, clinical staff compares notes in the chart to the billing provided by accounting for each client under review. During this process, staff reviewed 1,319 services delivered from July 1, 2015 through December 31, 2015. 79.1% of the billed services had corresponding notes in the clinical record.

A subsequent analysis looked at the correspondence between the billing and notes in the clinical record at each location.

Location	Total Number of Notes	Billing with Corresponding Note %(N)
Key Largo	93	66.7% (62)
Marathon	242	81.4% (197)
Key West	984	79.7% (784)

Another analysis looked at correspondence between billing and notes for each program across all locations.

Program (Across All Locations)	Total Number of Notes	Billing with Corresponding Note %(N)
CMH OP	138	87.7% (121)
CSA OP	27	11.1% (3)
AMH OP	69	68.1% (47)
ASA OP	76	82.9% (63)
Case Management - Adult	194	78.4% (152)
Case Management - Child	109	67.0% (63)
JIP	342	95.0% (325)
Diversion	59	45.8% (27)
Community Integration	55	58.2% (32)
ORP	91	70.3% (64)
Integrated SA/MH	75	89.3% (67)
FITT	28	75.0% (21)
Prevention	56	85.7% (48)

The final set of analyses looked at the correspondence between billing and notes for each program at each location.

Program – KEY LARGO	Total Number of Notes	Billing with Corresponding Note %(N)
CMH OP	6	66.7% (4)
CSA OP	--	--
AMH OP	5	0.0% (0)
ASA OP	20	65.0% (13)
Case Management - Adult	39	66.7% (26)
Case Management - Child	14	85.7% (12)
Diversion	--	--
Integrated SA/MH	9	77.8% (7)
FITT	--	--
Prevention	--	--

Program - MARATHON	Total Number of Notes	Billing with Corresponding Note %(N)
CMH OP	28	89.3% (25)
CSA OP	--	--
AMH OP	--	--
ASA OP	5	20.0% (1)
Case Management - Adult	70	100.0% (70)
Case Management - Child	--	--
Diversion	--	--
Community Integration	55	58.2% (32)
Integrated SA/MH	--	--
FITT	28	75.0% (21)
Prevention	56	85.7% (48)

Program – KEY WEST	Total Number of Notes	Billing with Corresponding Note %(N)
CMH OP	104	88.5% (92)
CSA OP	27	11.1% (3)
AMH OP	64	73.4% (47)
ASA OP	51	96.1% (49)
Case Management - Adult	85	65.9% (56)
Case Management - Child	95	64.2% (61)
JIP	342	95.0% (325
Diversion	59	45.8% (27)
ORP	91	70.3% (64)
Integrated SA/MH	66	90.9% (60)
FITT	--	--
Prevention	--	--

Action: The Chief Clinical Officer will review the data with the Clinical Director, Clinical Coordinators, and Site Directors. Although none of the programs or locations achieved the 95% target, majority of the programs and locations significantly increased the corresponding documentation between billing and the clinical record compared to the previous Fiscal Year.

E. Quality of Care and Service Provision

1. Identify number of consumers (SA & MH) identified as needing primary care in the outpatient and home-based treatment programs.

Objective: G/CC will identify at least 95% of the consumers who need primary care.

Type of Objective: *Quality Assurance: Efficiency*

See ***CQI Annual Update Report*** (attached), Section V, submitted to SFBHN in January 2016 for progress on this item.

2. Number of consumers (SA & MH) linked to primary care

Objective: G/CC successfully will link 60% of consumers needing primary care to a provider

Type of Objective: *Quality Assurance: Efficiency*

See ***CQI Annual Update Report*** (attached), Section V, submitted to SFBHN in January 2016 for progress on this item.

3. Substance Use among Adults Discharged from Substance Abuse Treatment

Objective: 80% of adults discharged from SA treatment will reduce substance use from baseline

Type of Objective: *Quality Assurance: Efficiency*

G/CC discharged 94 clients from substance abuse treatment from July 1 – December 31, 2015. Seven (7) clients had discharge but no admission data in the system. Therefore, 87 clients had admission and discharge data available for analysis.

A significant percent of clients reduced their substance abuse from admission to discharge ($Z = -4.907$, $p<.001$). Thirty-three (33) clients reduced their substance use from admission to discharge, representing 37.9% of the discharges. One (1) client increased use from admission to discharge, representing 1.1% of the discharges. Approximately 61% (N=53) continued to use substances at the same level at discharge as they did at admission.

Closer examination of the data revealed that 51 clients did not use any substances during the 30 days prior to admission. Therefore, a subsequent analysis excluded these clients.

For this analysis, a significant percent of clients reduced their substance use from admission to discharge ($Z = - 5.119$, $p<.001$). Thirty-three (33) clients reduced their

substance use, representing 89.2% of the discharges. No (0) clients increased use. Four (4) clients continued to use at the same level at discharge as at admission (10.8%).

4. Completion Rates for Prime for Life

Objective: 85% of children enrolled in Prime for Life will complete the required sessions

Type of Objective: *Quality Assurance: Efficiency*

The Chief Clinical Officer, Area Director, Data Manager, and Chief Information Officer (CIO) will establish a database to track this measure. Currently, Prime for Life is a Prevention Level 1 service. G/CC currently does not enroll these clients in its centralized database.

5. Completion Rates for Children Receiving Teen Intervene

Objective: 85% of the children enrolled in Teen Intervene will complete the required three (3) sessions

Type of Objective: *Quality Assurance: Efficiency*

During the period from July 1 – December 31, 2015, G/CC discharged 4 youth from the Teen Intervene program. Four (4) youth completed the program, representing 100% of the discharges and exceeding the 85% target.

6. Reduce alcohol use and binge drinking among youth completing Project SUCCESS

Objective: 85% of youth will report no alcohol use in the past 30 days by curriculum completion

Type of Objective: *Quality Assurance: Effectiveness*

Between July 1 – December 31, 2015, G/CC discharged eight (8) youth from Project SUCCESS. Half (50%) of the youth completed the program successfully; one left voluntarily prior to completing; one left involuntarily prior to completing; and two did not complete the curriculum. The two youth who did not complete did not have alcohol or drug use recorded for the 30 days prior. Of those remaining (N=6), 100% reported no alcohol use in the 30 days prior to their discharge regardless of their discharge type.

7. Reduce the number of underage alcohol drinkers who report buying alcohol in a store among youth completing Project SUCCESS

Objective: 70% of youth will report not buying alcohol in a store in the past 30 days by curriculum completion

Type of Objective: *Quality Assurance: Effectiveness*

The eight (8) youth discharged from Project Success left the program prior to September 2015. These youth were part of the previous grant. Therefore, G/CC did not track this indicator for that grant.

8. Reduce alcohol use and binge drinking among youth completing PRIME for Life and/or Teen Intervene

Objective: 85% of youth will report no alcohol use in past 30 days by curriculum completion

Type of Objective: *Quality Assurance: Effectiveness*

Two (2) youth successfully completed the Teen Intervene curriculum. None (100%) of the youth reported not using alcohol during the 30 days prior to curriculum completion.

9. Clinical Outcomes for consumers receiving Seeking Safety

Objective: 70% of consumers will show decreased symptoms and severity

Type of Objective: *Quality Assurance: Effectiveness*

All consumers complete a Life Events Checklist and the PSSR as part of the intake packet. Based on these questionnaires, staff determines the appropriateness of the consumer for Seeking Safety. To ensure only appropriate consumers receive this service, the Treatment Team reviews the questionnaires prior to assigning them to Seeking Safety. Those completing the EBP also receive the PSSR at discharge from the service.

During this reporting period, only five (5) consumers completed a pre-PSSR, and only one consumer had a post-PSSR. Therefore, evaluation was unable to conduct analyses to determine reductions in symptoms. The Chief Clinical Officer currently is working with the Area Director to determine why a breakdown in the process occurred for data collection.

10. Fidelity of EBPs

Objective: 80% of staff will maintain fidelity to the EBPs

Type of Objective: *Performance Improvement: Efficiency*

See ***CQI Annual Update Report*** (attached), Section I, submitted to SFBHN in January 2016 for progress on this item.

F. 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 December 31, 2015, G/CC reported 100% of the reportable incidents to the appropriate external entity as required.

The status of the incidents is as follows:

Closed % (#)	Reviewed % (#)	Pending % (#)	Follow Up % (#)	Total
93.9 (93)	9.5 (11)	6.9 (8)	0.0 (0)	99

Facility	Closed % (#)	Reviewed % (#)	Pending % (#)	Total
Key Largo	100.0 (8)	0.0 (0)	0.0 (0)	8
Marathon	93.3 (70)	5.3 (4)	1.4 (1)	75
Key West	100.0 (9)	0.0 (0)	0.0 (0)	9
Heron	85.7 (6)	14.3 (1)	0.0 (0)	7

Overall, G/CC closed 93.9% of the incidents this biannual period. None of the reports required follow-up. Five (5) reports (5.1%) remain in review, indicating that an employee submitted a report but a supervisor did not review it. Majority of these (80%) are at the Marathon site. One (1) report is pending (1.0%), indicating that an employee wrote a report but did not submit it successfully. This report is at the Marathon site.

Action

The Chief Clinical Officer will provide a detailed list to each Site Director of the Incident Reports numbers remaining under review or pending. The Site Directors will close the remaining incidents within 30 calendar days from receiving the report.

The breakdown of the incident reportable type for this quarter is below:

Immediately Reportable % (#)	Reportable % (#)	Non-Reportable % (#)	Total
22.2 (22)	62.6 (62)	15.2 (15)	99

Facility Breakdown

	Immediately Reportable % (#)	Reportable % (#)	Non-Reportable % (#)	Total
Key Largo	7.0 (7)	2.0 (2)	0.0 (0)	9
Marathon	11.1 (11)	52.5 (52)	12.1 (12)	75
Key West	2.0 (2)	5.1 (5)	1.0 (1)	8
Heron	2.0 (2)	3.0 (3)	2.0 (2)	7

Marathon had the highest rate of "Immediately Reportable" incidents, accounting for 11.1% of all incidents and 50% of all "Immediately Reportable" incidents. This is a typical finding, since most of these incidents occur on the CSU and Detox units.

Incident Category Breakdown

Incident Category	Number	Percent of Total
Abuse/Neglect	4	4.0
Alcohol/Drugs	1	1.0
Behavior, Other	17	17.2
Client Grievance	4	4.0
Contraband	1	1.0
Confidentiality	1	1.0
Criminal	0	0.0
Contraband	1	1.0
Death	5	5.1
Disaster	0	0.0
Illness	11	11.1
Injury	5	5.1
Left Treatment/Elopement	12	12.1
Medication Error	3	3.0
Medication Reaction	0	0.0
Motor Vehicle/Transportation	2	2.0
Operations	8	8.1
Other	11	11.1
Safety	2	2.0
Sexual	3	3.0
Staff	0	0.0
Suicide/Self Harm	7	7.1
Violence	2	2.0

Nine (9; 81.8%) of the ***Illness incidents*** occurred in Marathon, with 66.7% of these occurring on the Inpatient unit. The remaining Illness incidents occurred in Key West (1; 9.1%) and at the Heron (1; 9.1%). 100% of the incidents required medical services, with 90.9% requiring emergency services and 9.1% requiring non-emergency services. Eighty percent (80%) of the ***Injury incidents*** occurred in Marathon, with 100% of these occurring on the Inpatient unit. Twenty percent (20%) of the injury incidents occurred at Heron. Only 10% of the incidents required emergency medical services, and 80% requiring no medical attention. 28.5% of the ***Suicide/Self Harm incidents*** occurred in Key Largo, 42.8% occurred in Key West, and 28.5% occurred in Marathon. All (100%) were suicidal ideations or threats. Staff took precautionary measures to keep the client safe in 100% of the cases. Sixty percent (60%) of the ***Death incidents*** occurred in Key Largo, 20% occurred in Marathon, and 20% occurred at the Heron. Twenty percent (20%) related to an accidental death, 40% resulted from natural causes, and 40% related to death by violence. None of the incidents occurred on WestCare property. Two-thirds (66.7%) of the ***Sexual incidents*** occurred in Marathon on the CSU, involving inappropriate sexual relationships between clients. The other incident (33.3%) involved a adolescent client reporting past sexual abuse by a cousin.

Twenty-five percent (25%) of the ***Abuse/Neglect incidents*** occurred in Key West, with the incident reported in the Intervention program. Twenty-five percent (25%) occurred in Marathon, with the report occurring during an assessment. Half (50%) occurred in Key Largo, with both occurring in TBOS. None of the incidents occurred on agency property, and none involved agency staff. Staff reported all incidents/allegations to the appropriate and required authorities. One ***Alcohol/Drug*** incident occurred in Key West in the TBOS program. The incident related to staff receiving a call from a school counselor concerned that a client reported using drugs and was exhibiting "withdrawal" behavior. 62.5% of the ***Operation incidents*** occurred in Marathon, 12.5% occurred in Key West, and 25% at the Heron. One quarter (25%) related to funding/licensing agencies conducting announced on-site reviews, 37.5% related to unannounced site visits, 25% related to a community concern (a call from Marathon Code Enforcement about a possible violation), and 12.5% related to poor supervision of clients. There were two (2) only ***Motor Vehicle incidents*** this biannual period, with both occurring in Marathon. One incident involved a WestCare operated vehicle and one (1) involved an employee vehicle. The incident involving the WestCare owned vehicle included an injury that did not require medical attention. One-hundred percent (100%) of the ***Left Treatment/Elopement incidents*** involved clients leaving the CSU or Detox against medical advice (AMA). All (100%) of the ***Violence incidents*** occurred in Marathon. One occurred on the Inpatient unit and involved combative, aggressive, or assaultive behavior of a client. The other occurred in the FITT program, with a female client reporting her male partner becoming violent during an altercation resulting in an injury requiring treatment in the emergency room.

Fifty percent (50%) of the ***Grievance incidents*** occurred in Marathon, with one occurring in the primary care clinic and one occurring in the outpatient program. Twenty-five percent (25%) occurred in Key West, with a client complaining about her interaction with a psychiatrist. Twenty-five percent (25%) occurred at the Heron and related to a client calling police because her children could not visit her. The one ***Confidentiality incident*** occurred in Key West in the FITT Program, involving the theft of a staff car that contained an appointment book with client names.

From January 1 through June 30, 2015, the Inpatient Unit in Marathon (CSU + Detox) had 59 incidents. Of these, two (2) incidents related to ***medication errors***, accounting for 3.4% of all incidents on the inpatient unit. This rate is lower than last biannual period. Both incidents related to a documentation error.

There were no ***Medication Reaction*** incidents this biannual period.

There were 17 incidents of ***seclusion and/or restraint*** use this biannual period. All (100%) occurred on the Inpatient unit. Approximately 35% involved seclusion only, and 35% involved restraint only. Nearly 12% involved seclusion with chemical restraint, and 17.6% involved seclusion with mechanical restraint. Nearly 59% of the incidents related to clients becoming verbally aggressive and threatening; 23.5% related to clients becoming physically aggressive; and 17.6% related to staff being unsuccessful using verbal de-escalation techniques.

Hours of Day Breakdown

Time of Day	Number	Percent Total
Morning (12 am – 11:59 am)	39	39.4
Afternoon (12 pm – 4:59 pm)	39	39.4
Evening (5 pm – 11:59 pm)	21	21.2

Fewer incidents occurred during the evening hours than the morning and afternoon hours. This finding is typical since most services occur during traditional working hours (9 am – 6 pm), except for the inpatient units.

Day of Week Breakdown

Day of Week	Number	Percent Total
Sunday	7	7.1
Monday	19	19.2
Tuesday	15	15.2
Wednesday	19	19.2
Thursday	14	14.1
Friday	21	21.2
Saturday	4	4.0

Approximately 32% of the incidents occurred on the weekend (Friday-Sunday). Mondays and Wednesdays had the highest occurrence of incidents during the weekday, accounting for 38.4% of all incidents occurring from Monday through Thursday.

2. Medication Errors on Inpatient

Objective: Maintain medication error incident reports at less than 2%

Type of Objective: *Quality Assurance: Efficiency*

From July 1 through December 31, 2015, the Inpatient Unit in Marathon (CSU + Detox) had 55 incidents. Of these, three (3) incidents related to ***medication errors***, accounting for 5.4% of all incidents on the inpatient unit. This rate is higher than the target.

One-third (33.3%) of the incidents involved a documentation error, 33.3% involved a client taking the wrong medication, and 33.3% involved a client taking the wrong number of pills of his prescribed medication.

G. Staff Development

1. New Hire Training

Objective: 95% of new hires will complete the e-learning courses within 5 days from hire date

Type of Objective: *Quality Assurance: Efficiency*

All (100%) of the new employees completed the required e-learning courses within the identified timeframe.

2. Annual In-Service Training

Objective: 85% of staff will complete the required 20 hours of training annually

Type of Objective: *Performance Improvement: Efficiency*

Currently, the database includes training hours for 113 employees. As of December 31, 2015, G/CC had 117 active employees. Therefore, four (4) employees most likely did not take any training from July 1 – December 31, 2015.

As a rough estimate, G/CC expects that most employees will complete 10 hours of training by mid-year. Through December 31, 2015, the average employee has 16.4 hours of training completed. Training hours ranged from one (1) to 56 hours.

Nearly 65% of the employees completed 10 or more hours of training, with 32.8% having 20 or more hours completed. Approximately 17% of the employees had less than five (5) training hours completed.

3. Verbal De-Escalation Training

Objective: 100% of Receiving Facility staff will receive verbal de-escalation training annually.

Type of Objective: *Performance Improvement: Efficiency*

Currently, the training database does not contain a training entitled "Verbal De-Escalation." It is unclear whether no staff actually took the training or whether the training has a different name in the database.

4. CPR Training

Objective: 100% of Receiving Facility staff will have CPR training and active certificates

Type of Objective: *Performance Improvement: Efficiency*

As of December 31, 2015, 18 employees completed CPR training. However, the database does not contain position title or program. Therefore, it is unclear whether the staff that completed the training is Receiving Facility staff or not.

5. Affidavit of Good Moral Character

Objective: 100% of Receiving Facility staff will have a signed Affidavit of Good Moral Character in their personnel file

Type of Objective: *Performance Improvement: Efficiency*

Data was not available for the reporting period. A full analysis will occur for the Fiscal Year.

6. Performance Evaluations

Objective: 100% of Receiving Facility staff will have annual Performance Evaluations in their personnel files

Type of Objective: *Performance Improvement: Efficiency*

Data was not available for the reporting period. A full analysis will occur for the Fiscal Year.

7. Training Database

Objective: Develop and implement a more comprehensive training database

Type of Objective: *Performance Improvement: Efficiency*

To date, the Human Resources Director and Chief Clinical Officer identified the necessary elements to include in the database. However, an update of the database did not occur during this biannual period.

8. Employee Turnover

Objective: <20% turnover rate

Type of Objective: *Quality Assurance: Efficiency*

For the biannual period of July 1 – December 31, 2015, the average turnover rate was 4.51%, falling significantly below the target of 20%. The monthly turnover rate for G/CC is below.

Month	Turnover Rate
July	0.0%
August	8.0%
September	8.0%
October	5.1%
November	2.57%
December	3.41%

9. Overtime

Objective: NA

Type of Objective: *Quality Assurance: Efficiency*

For the first biannual period of Fiscal Year 2015-2016, G/CC had a total of 1,167.54 hours in overtime, averaging 194.59 hours monthly. This resulted in a total cost of $30,865.04. The average cost per month was $5,144.17.

The monthly trend is below.

Month	Hours	Cost
July	130.49	$2,869.28
August	114.89	$3,124.44
September	114.26	$3,317.09
October	131.84	$3,823.77
November	419.31	$11,004.45
December	256.75	$6,726.01
Total	1,167.54	$30,865.04

H. Accreditation – CARF

1. Committee Meetings

Objective: Committees will meet at least one time quarterly

Type of Objective: *Quality Assurance: Efficiency*

See ***CQI Annual Update Report*** (attached), Section VI, submitted to SFBHN in January 2016 for progress on this item.

2. Annual QIP

Objective: Complete required QIP annually and submitted to CARF on time

Type of Objective: *Quality Assurance: Efficiency*

See ***CQI Annual Update Report*** (attached), Section I, submitted to SFBHN in January 2016 for progress on this item.

I. Additional Monitoring Items

1. Trauma Informed Care

Objective: Conduct walk though of each program and process

Type of Objective: *Performance Improvement: Efficiency*

See ***CQI Annual Update Report*** (attached), Section III, submitted to SFBHN in January 2016 for progress on this item.

2. Cultural and Linguistic Competence

Objective: Conduct walk though of each program and process

Type of Objective: *Performance Improvement: Efficiency*

See ***CQI Annual Update Report*** (attached), Section IV, submitted to SFBHN in January 2016 for progress on this item.

3. Integration of Behavioral and Primary Healthcare

Objective: Conduct walk though of each program and process

Type of Objective: *Performance Improvement: Efficiency*

See ***CQI Annual Update Report*** (attached), Section II, submitted to SFBHN in January 2016 for progress on this item.

Performance Measure	**Action Plan and/or Opportunities for Improvement**
I. Evidence-Based Practices	
(a) Evidence-based practices (EBPs) utilized by the agency and how these EBPs are monitored to ensure fidelity to the model. **Provide information on progress, etc.**	
List EBP	**Fidelity Measure**
Seeking Safety	**Measure:** Observation using Seeking Safety Fidelity Checklist; Life Events Checklist (LEC); PSSR pre- and post-test measures **Progress:** To date, supervisors have not completed the fidelity checklists. GCC currently is establishing a process and protocol to ensure timely completion of the checklists at least quarterly. All consumers complete a Life Events Checklist and the PSSR as part of the intake packet. Based on these questionnaires, staff determines the appropriateness of the consumer for Seeking Safety. To ensure only appropriate consumers receive this service, the Treatment Team reviews the questionnaires prior to assigning them to Seeking Safety. Those completing the EBP also receive the PSSR at discharge from the service. During this reporting period, only 5 consumers completed a pre-PSSR, and only one consumer had a post-PSSR. Therefore, evaluation was unable to conduct analyses to determine reductions in symptoms. The Chief Clinical Officer currently is working with the Area Director to determine why a breakdown in the process occurred for data collection.
Motivational Interviewing	**Measure:** Clinical Record Review **Progress:** Staff conducting the reviews examines the Wellness & Recovery Plans to ensure that each objective has an identified "stage of change." The also ensure that the Goal is written in the client's own words. Reviewers also examine the Wellness & Recovery Plan Reviews to ensure that the client provided a statement, in his/her own words, about the progress he/she made since the last review.

Content Area	% Compliant
Life Goal in Client's Own Words	88.9% ↓
Wellness & Recovery Plan includes Barriers	88.9% ↓
Wellness & Recovery Plan includes Strengths	83.3% ↓
Wellness & Recovery Plan includes Stage of Change for Each Objective	88.9% ↓
Plan Reviews Include Client's Assessment of Progress	75.0% ↓

Relapse Prevention Therapy	**Measure:** Observation using RPT Fidelity Checklist **Progress:** GCC did not collect any RPT Fidelity Checklists this reporting period. This partly was due to staff changes and the resignation of the Adult Clinical Director. The Chief Clinical Officer currently is working with the Area Director to ensure re-implementation of the data collection protocols.
MRT	**Measure:** Observation using the MRT Checklist **Progress:** During the reporting period, the supervisor conducted two (2) fidelity checks. Both observations had a 100% fidelity rating across the 38-item checklist.
Community Reinforcement Approach	**Measure:** Observation and supervision **Progress**: All therapists completed a one-day training of CRA, including the two new hires. Two (2) of three (3) FITT therapists passed ½ the procedures needed for their certificate of proficiency in CRA. The therapists turn in recordings of procedures with consumers at least once per month to verify fidelity. In addition, each therapist participates in a supervision call at least once per month. We discuss cases and appropriate use of procedures based on consumer needs. We also conduct role-plays to help therapists practice skills (including those procedures not passed in recordings). They also name and describe the procedure(s) in their progress notes.
Teen Intervene	**Measure:** Observation using the Teen Intervene Checklist **Progress:** From July 1 – December 31, 2015, GCC completed three (3) fidelity checks for Teen Intervene: 1 for Session #1, 1 for Session #2, and 1 for Session #3. For Session #1, the counselor received a score of 3 out of 4 on all 14 items on the checklist. The average rating was an "Agree." For Session #2, the counselor received a score of 3 out of 4 on all 14 items on the checklist. The average rating was an "Agree." For Session #3, the Parent Session, the counselor received a score of 3 (Agree) out of 4 on 8 of the items (57.1%) and a score of 2 (Disagree) (42.9%) on 6 of the items. The supervisor will be working with the counselor to increase these ratings to a minimum of 3.

PRIME for Life

Measure: Observation using the PFL Checklist
Progress: From July 1 – December 31, 2015, GCC completed two (2) fidelity checks for the counselors. The observations took place at the same location for two different counselors during different sessions.

Content Area	% Compliant
Instructor conveys understanding of major concepts without confusion	100.0%
Instructor follows manual in proper order and does not overlook relevant segments in manual	50.0%
Instructor uses video materials at the correct time and is able to transition between video and lecture comfortably	100.0%
Instructor uses participant workbook exercises as indicated and pauses to solicit feedback about them	100.0%
Instructor is able to complete lectures and exercises without relying excessively on the manual	50.0%
Instructor avoids material not included in the manual	50.0%

Alcohol Literacy Challenge

Measure: Observation using the ALC Checklist
Progress: From July 1 – December 31, 2015, GCC completed two (2) fidelity checks for the counselor. The observations took place at two different locations for the same counselor during different sessions.

Content Area	% Compliant
Presenter read ALC lesson narration while viewing the corresponding slides	100.0%
Presenter used the appropriate videos at the correct time points	100.0%
Presenter adhered to the ALC Talking Points	100.0%
Presenter addressed comments and questions appropriately and within the context of the lesson	100.0%
Presenter correctly operated the audiovisual equipment	100.0%
Presenter adhered to the time allotted and finished on schedule	100.0%
Presenter spoke clearly and at appropriate volume	100.0%

Project SUCCESS

Measure: Observation using Checklist developed by G/CC and WestCare Evaluation Department
Progress: The WestCare Evaluation Department in collaboration with the Clinical Director drafted a potential fidelity measure for use. Currently, it is under review for finalization.

II. Integrated Care

(b) Evidence of the implementation of integrated care, including progress on the implementation of the integrated care action plan.

I. Integrated Services for Patient and Family Centered Care
Criterion 1: Co-location of treatment for primary care and mental/behavioral health care
In August 2015, GCC opened a primary healthcare clinic in Marathon through a PBHCI grant received from SAMHSA. Services are available to all GCC consumers currently receiving SA or MH services in the Behavioral Health Clinic. To date, GCC has 151 consumers enrolled in the Center for Wellness.

	Criterion 2: Primary care needs are assessed as part of the screening/intake process ALL potential consumers for the Behavioral Health Clinic complete the CAT and a Medical Screening form to determine appropriateness and need for enrollment in the Center for Wellness. In addition, all consumers in the CSU or Detox facility receive screening for medical need prior to their discharge. Consumers having medical needs and not having a primary care provider receive an appointment in the clinic prior to discharge. **Criterion 3: Wellness Plans for primary care and behavioral/mental health care are integrated** The Center for Wellness currently uses a Comprehensive Wellness & Recovery Plan that integrates the consumer's primary and behavioral healthcare needs. The Center for Wellness Program Coordinator attends all outpatient staff treatment team meetings to provide and receive information about consumers receiving care from the Behavioral and Healthcare Clinics. This ensures that the teams share information, allowing integration of all of the consumer's needs. **Criterion 5: Consumer and family, when appropriate, participate and collaborate in the development of the Wellness Plan** Consumers currently participate in the development of the Wellness Plan and in the Wellness Plan Review for both the Behavioral Health and Primary Care clinics. The Chief Clinical Officer is in the process of updating Policies and Procedures to include primary care and integration language. **Criterion 6: Staff educates and communicates with consumers about integrated care** GCC created a brochure for the Center for Wellness that educates consumers on the importance of primary care and integrated care. Outpatient programs distribute these brochures to the behavioral health consumers.

	Criterion 7: Follow-up occurs on assessments, tests, treatment, referrals and other services No progress made to date. The focus has been on enrolling consumers to meet the required target. **Criterion 8: Consumers' access to social supports for primary care is addressed** GCC updated brochure and handbook to include wellness resources on January 9, 2016. **Criterion 9: Linking consumers to community resources for primary care** No progress made to date. The focus has been on enrolling consumers to meet the required target. **II. Organizational Supports for Practice Change Toward Integrated Services** **Criterion 1: Organizational leadership supports integrated care – <u>Focus on staff time and resources</u>** Discussed staff time and resources at the January 12, 2016 Keys Leadership Team Meeting **Criterion 2: Consumer care team implements integrated care** GCC has taken no action currently. The target date for completion is June 30, 2016. **Criterion 3: Providers engaged and enthusiastic about integrated care** Training postponed from November 2015 due to the VP of Integration and WC Medical Director resignations from WestCare, leaving the Chief Clinical Officer as the only member of the team. Training will be complete by original target date. **Criterion 4: Continuity of care between primary care and behavioral/mental health** The Chief Clinical Officer and Area Director, in collaboration with Key staff from the primary care and behavioral health clinics, are updating all Policies and Procedures to reflect integration. Updates will be complete by the original target date. **Category 5: Coordination of referrals and specialists** Training postponed from November 2015 due to the VP of Integration and WC Medical Director resignations from

	WestCare, leaving the Chief Clinical Officer as the only member of the team. Training will be complete by original target date. **Category 6: Data systems/patient records document integrated care** WestCare currently is in the process of certifying its internal EHR. The Chief Information Officer indicated that Phase 1 certification would be complete by February 29, 2016. **Category 7: Consumer and family input to integration management** GCC welcomes feedback from consumers and community based providers. Through some of its Federally funded programs, WestCare Research & Evaluation conducts Focus Groups in the community to elicit feedback from past and current consumers about GCC services. Consumers also complete Perception Surveys at Intake, within 3 months post-admission, and within 6-months post-discharge. **Category 8: Physician, team and staff education and training for integrated care** Chief Clinical Officer did team building with the Center for Wellness staff on October 12, 2015 to create a unified team and assist the various disciplines (nursing, medical, care coordinators, and peers) to understand their roles and contribution to an integrated model. Chief Clinical Officer conducted Wellness Plan training for the Clinic on October 21, 2015. **Category 9: Funding sources/resources support integrated care** Chief Clinical Officer, Area Director, Controller, and Clinic Team currently are working on financial sustainability plan to include Medicaid, Medicare, and Private Insurance funding streams. GCC currently is exploring licensing requirements for a primary care clinic to expand billing options. **Annual MeHas Assessment** GCC will complete at request from SFBHN
III. Trauma Informed Care	
(c) Evidence of the implementation of the TIC	The GCC is involved with the TIC initiative since its inception in the State. GCC representatives consistently attend TIC meetings

initiative throughout the agency, including progress on the implementation of a TIC action plan that shall include incorporated results of the agency-wide self-assessment tool and the activities listed below: i. An overview of the Network Provider's TIC capabilities with regard to service structure (assessment, stabilization, treatment, support, and other services); ii. Networking capacities with local providers in the community for persons with trauma; iii. Strategies and activities to develop or improve TIC service capability;	as required by SFBHN. **Domains 1A-E Criterion 1: Program Review for:** • **Safety** • **Trustworthiness** • **Choice** • **Collaboration** • **Empowerment** i. All staff receives TIC training annually with an emphasis on the difference between trauma informed care and trauma specific treatment. The Chief Clinical Officer developed a questionnaire to assess staff attitudes, beliefs, and competencies related to TIC. First distribution of the survey will occur in April 2016. GCC provides a comprehensive system of care, including assessment, stabilization, treatment, prevention, and intervention. GCC designed the system so that consumers easily can transition from one service to another or receive multiple services simultaneously. GCC continues to try to streamline paperwork to decrease the burden on consumers and to eliminate duplication of information. Motivational Interviewing is the cornerstone of the services, ensuring a person-centered, strength-based approach/strategy to service delivery. GCC also encourages consumers to collaborate in the development of the Wellness and Recovery Plans and in the design of their treatment. GCC consistently works with the consumer to minimize barriers to care and increase accessibility to services. GCC currently is scheduling a walk through for all its programs and services. GCC plans to complete 50% of them by June 30, 2016. **Domain 2: Formal Service Policies** **Criterion 4: De-Escalation Policy** In October 2015, GCC submitted an updated policy for approval to amend the current de-escalation policy to ensure it minimizes re-traumatization and to update policy to include a statement regarding consumer's crisis response preference. GCC currently is scheduling a walk through for all its programs and services. GCC plans to complete 50% of them by June 30, 2016.

	Domain 4: Administrative Support for Program-Wide Trauma Informed Services **Criterion 3: Administrative Participation in and Oversight of Trauma-Informed Approaches** ii. The Keys Leadership Team is extremely active in the initiative and reviews progress at least quarterly. The last meeting was January 12, 2016. iii. The Chief Clinical Officer, Area Director and other agency leaders continually scan GCC services to identify ways to increase TIC capability and capacity. They also attend various webinars through HRSA, SAMHSA, and the National Council to increase their knowledge and skills related to TIC. The Chief Clinical Officer and Area Director are developing a strategy to conduct a walk through in each program and service to obtain data on how trauma informed it is. Based on these findings, they will develop an Action Plan for improvement as needed. **Criterion 5: Trauma Survivor Consumer Involvement** Since 2014, GCC has an active TIC Advisory Board that includes community members. The Board meets at least quarterly. The last meeting occurred on October 23, 2015. Consumers also complete Perception Surveys. GCC uses this data to improve or enhance its services as necessary. **Domain 1A Criterion 4: Staff Ratings** The Human Resources Director currently is working to re-implement the agency-wide Staff Perception Survey for Safety. **Domain 6: Human Resource Practices** **Criterion 2: Staff Performance Reviews** GCC Supervisors completed annual Performance Reviews in June 2015. The Human Resources Director, Chief Clinical Officer, and Area Director are in the process of reviewing the Performance Review template to ensure it include TIC competencies and will update as needed. **Annual Fallot TIC Assessment** GCC completed the assessment in March 2015. GCC will submit the new assessment at request from SFBHN.

IV. Cultural and Linguistic Competence	
(d) Evidence of the implementation of Cultural and Linguistic Competence, including progress on the implementation of the Cultural and Linguistic Competence Action Plan.	**I. Policy & Governance** **The composition of your agency's Board of Directors or its governing board reflects the consumers that it serves within the system of care.** GCC currently is seeking new members for its Community Action Council to increase the diversity of its members. GCC hopes to have additional members by its next meeting on March 2, 2016. **Your agency provides mechanisms that give youth and family the opportunity to review all pertinent materials- including written documents, oral and symbolic communications- to ensure that they are culturally and linguistically appropriate.** GCC updated its website on January 11, 2016 to include its new brochures and handbooks. GCC welcomes feedback from consumers and community based providers. Through some of its Federally funded programs, WestCare Research & Evaluation conducts Focus Groups in the community to elicit feedback from past and current consumers about GCC services. **II. Organizational Values & Resources** **The annual budget includes a line item specifically dedicated to the development and continued support of culturally and linguistically competent services.** The Area Director and Controller met to review the agency budget and its inclusion of a line item for CLAS. The Controller will be meeting with the WestCare CFO to ensure inclusion of this line item in the annual budget for FY 2016-2017. **There is a cultural competence committee/other group/person responsible for cultural competence within the agency.** The GCC Clinical Care Committee also has the charge of ensuring and reviewing cultural competence. The Committee meets at least quarterly. The last meeting was on January 12, 2016. **III. Human Resources & Development** **Regularly review and modification of job descriptions to ensure that they include requirements for the ongoing development of cultural knowledge and cross-cultural practice skills** **The Chief Clinical Officer and Human Resources Director**

	currently are reviewing all job descriptions for content related to cultural competence. They will update the job descriptions as needed. The Human Resources Director, Chief Clinical Officer, and Area Director are in the process of reviewing the Job Descriptions for all positions to ensure they include appropriate CLAS language and will update as needed. **Staff at all agency levels receives in-service training activities on culturally and linguistically competent health care** The Human Resources Director, Chief Clinical Officer, Area Director, and WestCare Training Director currently are working on the annual training plan. The Plan will include CLAS training for non-clinical and non-direct care staff. **Youth and family members have a mechanism to participate in the development and delivery of cultural and linguistic competency training activities.** GCC welcomes feedback from consumers and community based providers. Through some of its Federally funded programs, WestCare Research & Evaluation conducts Focus Groups in the community to elicit feedback from past and current consumers about GCC services. Consumers also complete Perception Surveys at Intake, within 3 months post-admission, and within 6-months post-discharge. GCC also is looking at other options and strategies to include consumers in training activities. **IV. Facilitation of Broad Service Array** **The agency uses Wellness Plans that include family preferences for culturally/ethnically traditional healers, alternative healers, spiritual healers, natural supports, bilingual services, self-help groups, etc.** No progress made to date. **Work environment contains décor reflecting the culturally and diverse groups in your service areas** The Chief Clinical Officer and Area Director are developing a strategy to conduct a walk through in each program and service to obtain data on diversity in décor in the environment. Based on these findings, they will develop an Action Plan for improvement as needed. **The agency posts signs and materials such as brochures, fact**

	sheets, etc. in languages other than English GCC displays posters at each location in English, Spanish, and Creole. GCC is working on a plan to translate all its materials, brochures, and forms into Spanish. **VI. Youth, Family, and Community Participation** **Provide incentives to youth and families to encourage their service on organizational boards, committees, conducting advocacy, conducting outreach, and the development of the service array** No progress made to date. **The agency uses health/ and mental health promotion and disease prevention activities to reach out to places of worship, traditional healers, providers of alternative care, media, child advocates, etc.** GCC consistently participates in Health Fairs when the opportunity arises. GCC attended the last Health Fair on December 12, 2015 in Tavernier. **VII. Planning, Monitoring, & Evaluation** **Conduct a needs assessment regularly to gather information on the community it serves** The Chief Clinical Officer completed a Disparity Impact Statement in November 2015. **Annual cultural and linguistic competence self-assessment** GCC completed the annual assessment last year as requested by SFBHN. GCC will complete this year's annual assessment when instructed by SFBHN. **Evaluate the quality and effectiveness of interpretation and translation services, in particular** No progress made to date. **Communicate the organization's progress in implementing and sustaining the CLAS standards to all stakeholders, constituents and the general public** No progress made to date. **Develop formal partnerships, with cultural community agencies, faith-based entities, traditional cultural providers, and other culturally relevant organizations**

	ALL MOUs are up-to-date for 2016. **Annual CLC Action Plan** Plan updated and submitted for this Fiscal Year. Update for next Fiscal Year will occur no later than August 31, 2016.
V. Referrals and Linkage	
(e) Evidence of tracking and ensuring the successful referrals and linkages of consumers of behavioral health services to primary care services.	The Chief Clinical Officer and GCC Data Manager worked with WestCare IT to include primary care variables in the intranet Clinical Data System These variables include: • Does client have a primary care doctor or has client seen a doctor while in the program? • If No, then was a linkage to primary care made? • If Referral made, then to What/Whom? • If No, the reason for no linkage? **If FITT Client** • Name of Client • Name of Child • Does child have primary care physician? • If not, primary care linkage made? • Linkage to what and or whom? Tracking of this information began during January 2016.
VI. Accreditation	
(f) Evidence of the progress on steps to taken towards meeting the requirement to become an accredited provider (i.e. TJC, CARF, COA, etc.) or meet the CARF Standards for Unaccredited Providers.	GCC received a 3-year accreditation renewal in 2013. GCC completed its annual report for CARF and submitted by the deadlines. The Director of Accreditation files the Intent in October 2015. GCC currently is preparing for its reaccreditation-monitoring visit in April or May 2016. CARF has not provided the final dates. The Keys Leadership Team updated all Plans in August 2015. The Chief Clinical Officer and Area Director are meeting on February 9, 2016 to review the CARF Preparation List and discuss any outstanding items prior to the monitoring visit.

CQI Semiannual Update
SFBHN
Guidance/Care Center, Inc.
Date of Update: January 30, 2016

Performance Measures for Continuous Quality Improvement Plans

I. Mental Health Services (Admission type):

Covered Services

01-Assessment	19- Residential Level 2
03- Crisis Stabilization Unit	20- Residential Level 3
06 Day/Night	21 Residential Level 4
08- In Home/ On-Site	34- FACT
09-Inpatient	35- Outpatient Group
12- Medical Services (psychiatric)	39-Short-term Residential Treatment
14-Outpatient Individual	

Must be tracked for any of the covered services listed in the table above and which are funded by the contract.

(A) **NOTE:** G/CC schedules all initial appointments for an assessment, not for specific services such as counseling or psychiatric appointments. This is to ensure that all potential clients are eligible for services and receive an assignment to the most appropriate service.

Covered Services	Average # of calendar days between a request for services and the date of initially scheduled face-to-face appointment
Assessment	**ALL** clients = 11.4 days (322 contacts) **ADULT** clients = 11.3 days (293 contacts) **CHILD** clients = 9.8 days (29 contacts)
Crisis Stabilization Unit	**ADULTS Only** = 0 days
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Outpatient Group	**NA**

(B)

Covered Services	% of persons who do not appear for their initial appointment
Assessment	**ALL** clients = 30.1% **ADULT** clients = 30.4% **CHILD** clients = 27.6%
Crisis Stabilization Unit	**ADULTS Only** =0.0%
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Outpatient Group	**NA**

(C)

Covered Services	% of appointments cancelled by client for all initial appointments
Assessment	**ALL** clients = 11.2% **ADULT** clients = 12.3% **CHILD** clients = 0.0%
Crisis Stabilization Unit	**ADULTS Only** =0.0%
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Outpatient Group	**NA**

(D)

Covered Services	% of appointments cancelled by staff for all initial appointments
Assessment	**ALL** clients = 6.2% **ADULT** clients = 5.8% **CHILD** clients = 10.3%
Crisis Stabilization Unit	**ADULTS Only** =0.0%
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Outpatient Group	**NA**

(E)

Covered Services	Medication Error % (*for Inpatient/CSU and residential settings*)		
	Wrong Medication	Wrong Dose	Wrong Time of Administration
Crisis Stabilization Unit	**1**	**1**	**0**

(F)

Covered Services	The number of behavioral health consumers identified as needing primary care
Assessment	**GCC Updated its Clinical Data System and began tracking this information in January 2016**
Crisis Stabilization Unit	
In Home/On-Site	
Medical Services	
Outpatient Individual	
Outpatient Group	

(G)

Covered Services	Number of successful linkages to primary care
Assessment	GCC Updated its Clinical Data System and began tracking this information in January 2016
Crisis Stabilization Unit	
In Home/On-Site	
Medical Services	
Outpatient Individual	
Outpatient Group	

II. Substance Abuse Services (Admission type):

Covered Services

01-Assessment	21-Residential Level 4
06 Day/Night	24-Detoxification
08- In Home/On-Site	35- Outpatient Group
12- Medical Services (psychiatric)	
14-Outpatient Individual	
18- Residential Level 1	
19- Residential Level 2	
20- Residential Level 3	

Must be tracked for any of the covered services listed in the table above and which are funded by the contract.

(A)

Covered Services	Average # of calendar days between a request for services and the date of initially scheduled face-to-face appointment
Assessment	**ALL** clients = 9.3 days (19 Contacts) **ADULT** clients = 9.3 days (19 Contacts) **CHILD** clients = No Contacts this Biannual Period
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Detoxification	**ADULTS Only** = 0 days
Outpatient Group	**NA**

(B)

Covered Services	% of persons who do not appear for their initial appointment
Assessment	**ALL** clients = 15.8% **ADULT** clients = 15.8% **CHILD** clients = No Contacts this Biannual Period
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Detoxification	**ADULTS Only** = 0.0%
Outpatient Group	**NA**

(C)

Covered Services	% of appointments cancelled by client for initial appointment for assessments and counseling
Assessment	**ALL** clients = 15.8% **ADULT** clients = 15.8%

	CHILD clients = No Contacts this Biannual Period
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Detoxification	**ADULTS Only** = 0.0%
Outpatient Group	**NA**

(D)

Covered Services	% of appointments cancelled by staff, tracked by initial appointment, counseling/psychotherapy and psychiatric appointments
Assessment	**ALL** clients = 5.3% **ADULT** clients = 5.3% **CHILD** clients = No Contacts this Biannual Period
In Home/On-Site	**NA**
Medical Services	**NA**
Outpatient Individual	**NA**
Detoxification	**ADULTS Only** = 0.0%
Outpatient Group	**NA**

(E)

Covered Services	Medication Error % (*for JARF/Detox and residential settings*)		
	Wrong Medication	Wrong Dose	Wrong Time of Administration
Detoxification	**0**	**0**	**0**

(F)

Covered Services	The number of behavioral health consumers identified as needing primary care
Assessment	**GCC Updated its Clinical Data System and began tracking this information in January 2016**
In Home/On-Site	
Medical Services	
Outpatient Individual	
Detoxification	
Outpatient Group	

(G)

Covered Services	Number of successful linkages to primary care
Assessment	**GCC Updated its Clinical Data System and began tracking this information in January 2016**

In Home/On-Site	
Medical Services	
Outpatient Individual	
Detoxification	
Outpatient Group	