THE GUIDANCE/CARE CENTER
PERFORMANCE IMPROVEMENT WORK PLAN

FY 2017-2018
July 1, 2017 – June 30, 2018

Developed: **April 26, 2017**

Performance Improvement Work Plan

I. PURPOSE

The Performance Improvement Work Plan describes the goals and objectives for quality assurance and performance improvement activities for the Guidance/Care Center for Fiscal Year 2017-2018. The Plan consists of two (2) elements: (1) Quality Assurance – to ensure adherence to and sustenance of contractual, grant, and/or agency goals and objectives; and (2) Performance Improvement or Continuous Quality Improvement – to address objectives that currently are not achieving desired targets or the agency identified as needing enhancement. Indicators in the Plan consist of efficiency (process) and effectiveness (outcome) measures. The document also provides an organized, systematic schedule of performance improvement activities and details the persons or entities responsible for carrying out the activities.

II. SCOPE

The scope of the Performance Improvement Work Plan includes activities related to inpatient and outpatient care and services, prevention services, and agency-based administrative support services. The program addresses child, adolescent, and adult populations served at the Guidance/Care Center.

III. SELECTION OF WORK PLAN ACTIVITIES

Findings from the previous year's Work Plan, client demographic data, Consumer and Staff Perception Surveys, evaluation data, and attainment of contractual/grant goals and objectives are the basis for the selection of Work Plan activities. As a guideline, the Performance Improvement Committee and Leadership eliminate performance improvement items maintained at the targeted criterion for at least six (6) months during the previous Fiscal Year from the current Fiscal Year's Work Plan unless a contract or accrediting body requires continued, ongoing monitoring. The Performance Improvement Committee is responsible for developing the preliminary Work Plan and providing recommendations to The Keys Leadership Team. The Keys Leadership Team is responsible for final approval of the Work Plan.

IV. SYSTEMATIC MONITORING

The Performance Improvement Committee and/or its Subcommittees systematically monitor each of the areas listed according to the schedule recommended by the Performance Improvement Committee and approved by The Keys Leadership Team. The Keys Leadership Team, Program Directors, Program Coordinators, Community Action Council, and Board of Directors receive reports on a regularly scheduled basis as defined in the Work Plan.

V. GOALS AND STRATEGIES

Specific goals and objectives for Fiscal Year 2017-2018, strategies to achieve the goals and objectives, and timelines for data collection and reporting are below:

A. Program and Service Utilization

a. Increase attendance at the first outpatient appointment following discharge and referral from inpatient.
b. Monitor percent of consumers who do not show for or cancel the initial appointment, and the percent of initial appointments that staff cancels. This applies to adult, adolescent, and child Substance Abuse and Mental Health consumers.
c. Monitor the number of days from initial consumer contact for a request for service to the initial face-to-face appointment. This measure includes Adult and Child substance abuse and mental health and in-home onsite programs.
d. Increase the frequency of outpatient appointments, ensuring all clients have at least one service weekly unless justified in the clinical record. This measure pertains to Adult and Child substance abuse and mental health outpatient and in-home onsite programs.
e. Monitor enrollment of unduplicated clients into ORP.
f. Monitor enrollment of unduplicated clients into KIST.
g. Monitor enrollment of unduplicated clients in to MIND (N=65)
h. Monitor enrollment of unduplicated patients into the Center for Wellness (N=400)

B. Consumer, Staff, and Stakeholder Perception

a. Monitor Consumer Perception of Overall Program Quality for the CARF core programs to maintain a minimum positive perception of 80%. This measure includes adult substance abuse and mental health outpatient, child substance abuse and mental health outpatient, TBOS, adult and child case management, CSU/Detox, and criminal justice. Monitor Consumer Perception at Intake, midpoint of treatment, and at Discharge. Maintain a minimum positive perception of 80%.
b. Monitor Consumer Perception of Overall Program Quality for the new Primary Care Clinic in Marathon (The GC Center for Wellness). Monitor Consumer Perception at Intake, every 6 months, and at Discharge. Maintain a minimum positive perception of 80%.
c. Monitor Staff Perception of overall job satisfaction annually and maintain a minimum positive perception of 80%.
d. Monitor Stakeholder Perception of the agency and its services annually and maintain a minimum positive perception of 80%.
e. Monitor consumer satisfaction with GCC community-based transportation annually.

C. Follow-Up

a. Maintain a minimum overall 80% GPRA and GAIN follow-up rate for the CSAT ORP grant at 3 and 6 months post admission.
b. Maintain a minimum 80% "in window" GAIN follow-up rate for the CSAT ORP grant at 3 and 6 months post admission.
c. Maintain a minimum overall 80% NOMS follow-up rate for the CSAT PBHCI grant at the 6-month post admission intervals.
d. Maintain a minimum 80% GPRA follow-up rate for the CSAT KIST grant at 6 months post admissions.
e. Increase collection of post-discharge follow-up surveys for the CARF core programs.

D. Clinical Records

a. Increase clinical records for CARF core programs to ensure compliance with 65D 30, CARF, CCISC, and agency policy and procedure to maintain an 80% adherence rate. **G/CC also uses this strategy to monitor fraud, waste, abuse and other potential wrongdoing.**
b. Conduct Utilization Management of clinical records in inpatient, adult and child substance abuse and mental health, in-home onsite, and prevention programs to ensure appropriate admission, continued stay, and discharge of clients in 95% of the cases.
c. Maintain consistency between invoice, clinical documentation, and data to ensure a 95% consistency rate for outpatient and case management services. This measure pertains to adult and child substance abuse and mental health, in-home onsite, and prevention programs. **G/CC also uses this strategy to monitor fraud, waste, abuse and other potential wrongdoing.**

E. Quality of Care and Service Provision

a. Identify number of consumers (SA & MH) identified as needing primary care in the outpatient and home-based treatment programs.
b. Monitor the number of successful linkages to primary care in the outpatient and home-based treatment programs for SA & MH consumers.
c. Monitor substance use frequency among adults discharged from substance abuse treatment.
d. Monitor completion rates for PRIME for LIFE
e. Monitor completion rate for Teen Intervene
f. Monitor completion rate for Project SUCCESS
g. Reduce alcohol use among youth completing Project SUCCESS
h. Increase attitudes and beliefs related to risk of harm associated with underage drinking among youth completing Project SUCCESS
i. Decrease favorable attitudes toward alcohol and drug use among youth completing Project SUCCESS

j. Decrease favorable attitudes toward alcohol, tobacco and drug use among youth completing PRIME for Life
k. Increase healthy behaviors and decrease use of ATOD or delay the age of onset for marijuana use among those youth completing TEEN Intervene.
l. Reduce symptoms and severity of symptoms among consumers completing Seeking Safety
m. Monitor fidelity of Project SUCCESS, Teen Intervene, PRIME for Life, Alcohol Literacy, Motivational Interviewing, Seeking Safety, Trauma-Informed CBT, and Relapse Prevention, ensuring staff maintain a minimum of 80% adherence to the evidence-based practice.

The following indicators apply ONLY to the MIND Program

n. Eighty percent (80%) of clients not having stable housing will have stable housing within 90 days from admission.
o. Eighty percent (80%) of program participants not having stable housing at admission will have stable housing one year following discharge.
p. Eighty percent (80%) of clients unemployed at admission who express a desire to work will have employment at 180 days post admission.
q. Seventy percent (70%) of clients unemployed at admission who express a desire to work will have employment within one (1) year post admission.
r. Seventy percent (70%) of clients who are eligible for benefits and entitlements will receive assistance with applying for them.
s. Eighty percent (80%) of clients will have reduced mental health symptoms at discharge.
t. Seventy percent (70%) of the clients will maintain the mental health improvements at 3-, 6-, and 12-months post discharge.
u. Seventy-five percent (75%) of clients will be substance free at discharge.
v. Seventy percent (70%) of clients will remain substance free at 3-, 6-, and 12-months post discharge.
w. Eighty percent (80%) of clients will have improved physical health at discharge.
x. Seventy percent (70%) of clients will maintain physical health improvements at 3-, 6-, and 12-months post discharge.

F. Safety and Security

a. Monitor incident reports at all facilities and programs to ensure accurate and appropriate reporting within the agency and to external sources (e.g., DCF, SFBHN, etc.) and to determine/identify trends or patterns related to type of incident, location, time of day, and/or day of week. This measure pertains to inpatient, adult and child substance abuse and mental health, in-home onsite, criminal justice, case management, and prevention programs.
b. Monitor medication errors, including wrong medication, wrong dose, wrong time of administration, and “missed” doses, in inpatient programs for SA & MH consumers. This measure pertains to CSU and Detox.
c. Conduct and monitor emergency drills on-time at all three locations.

d. Monitor the EOC/Safety Committee's enhanced roles and responsibilities, including the development, implementation, and monitoring of Security Program Plan (SSP).
e. Monitor the EOC/Safety Committee's enhanced roles and responsibilities, including compliance with the security-related requirements outlined in FDOT Rule 14.90.
    1. Security policies, goals, and objectives.
    2. Organization, roles, and responsibilities.
    3. Emergency management processes and procedures for mitigation, preparedness, response, and recovery.
    4. Procedures for investigation of events described under subsection 14-90.004(5), F.A.C.
    5. Procedures for the establishment of interfaces with emergency response organizations.
    6. Procedures for interagency coordination with local law enforcement jurisdictions.
    7. Employee security and threat awareness training programs.
    8. Security data acquisition and analysis.
    9. Emergency preparedness drills and exercises.
    10. Requirements for private contract transit providers that engage in continuous or recurring transportation services for compensation as a result of a contractual agreement with the bus transit system.
    11. Procedures for SPP maintenance and distribution.

G. Staff Development

a. Monitor training to all new hires within 30 days from hire date to ensure that a minimum of 95% of new employees receive appropriate training prior to assuming job duties and to ensure staff competency.
b. Monitor that staff receives a minimum of 20 hours of in-service training annually
c. Monitor employee turnover rates and maintain a rate of <20%.
d. Monitor use of overtime.

H. Accreditation – CARF

a. Conduct quarterly Committee Meetings to review and monitor CARF standards & to develop Action Plans for implementation of new standards. Committees include Performance Improvement, Care, Pharmacy, Seclusion/Restraint, and EOC/Safety.
b. Complete required Quality Improvement Plan (QIP) and submit to CARF.

I. Action Plans

a. Monitor ongoing implementation and maintenance of the Trauma-Informed Care initiative
b. Monitor ongoing implementation and maintenance of the Culturally and Linguistically Appropriate Services initiative
c. Monitor ongoing implementation and maintenance of the Integration of Behavioral and Primary Care Health initiative

A. Program and Service Utilization

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Increase attendance at the initial outpatient session after discharge and referral from inpatient treatment	PI	EFY	CDS	60% of clients referred after discharge from residential care will attend the first session	Clinical Directors and Chief Clinical Officer	R	X	X	X	X	X	R	X	X	X	X	X
Monitor percent of clients who do not appear for or cancel the initial appointment, and the percent of initial appointments that staff cancels. **SFBHN REQUIRED ACTIVITY (NO SHOWS, CLIENT CANCELLATIONS, & STAFF CANCELLATIONS)**	QA	EFY	CDS	80% of clients will attend scheduled appointments	Clinical Directors and Chief Clinical Officer	R	X	X	X	X	X	R	X	X	X	X	X
Monitor the number of days from initial client contact for a request for service to the initial face-to-face appointment. **SFBHN REQUIRED ACTIVITY**	PI	EFY	CDS	Average # of days ≥ 80% of clients will be seen within 7 working days	Site Directors, Office Managers, and Chief Clinical Officer	R	X	X	X	X	X	R	X	X	X	X	X
Increase the frequency of outpatient appointments, ensuring all clients have at least one service weekly unless justified in the clinical record	PI	EFY	CDA	≥ 90 of the clients will received 1 outpatient service weekly, unless justified in clinical record	Program Directors and Senior Clinical Officer	R	X	X	X	X	X	R	X	X	X	X	X
Monitor enrollment of unduplicated clients into ORP	QA	EFY	GPRA	Admit 45 unduplicated clients annually	Program Coordinator	R	X	X	X	X	X	R	X	X	X	X	X
Monitor enrollment of unduplicated clients into KIST	QA	EFY	GPRA	Admit 60 unduplicated clients annually	Program Coordinator	R	X	X	X	X	X	R	X	X	X	X	X

A. Program and Service Utilization

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Monitor enrollment of unduplicated clients into MIND	QA	EFY	CDS	Admit 65 unduplicated clients annually	Program Coordinator	R	X	X	R	X	X	R	X	X	R	X	X
Monitor enrollment of unduplicated patients into the Center for Wellness	PI	EFY	CDS	Admit 400 unduplicated clients annually	Program Director	R	X	X	R	X	X	R	X	X	R	X	X

NOTE: X=Date Collection R=Report Out

B. Consumer, Staff, and Stakeholder Perception

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Monitor Consumer Perception of Overall Program Quality for adult and child programs	QA	EFY	Consumer Perception Survey (Rating of 3 or higher)	≥ 80% on Overall Quality Rating for each program	Clinical Staff	R	X	X	X	X	X	R	X	X	X	X	X
Monitor Consumer Perception of Overall Quality for the Primary Care Clinic	PI	EFY	Consumer Perception Survey (Rating of 3 or higher)	≥ 80% on Overall Quality Rating for each program	Primary Care Staff	R	X	X	R	X	X	R	X	X	R	X	X
Monitor Staff Perception of job satisfaction annually	PI	QA	Staff Perception Survey (rating of 3 or higher)	≥ 80%	RE	R										X	X
Monitor Stakeholder Perception of satisfaction with agency and services	QA	EFY	Stakeholder Perception Survey (rating of 3 or higher)	≥ 80%	RE	R										X	X
Monitor consumer satisfaction with GCC community-based transportation annually	QA	EFY	Client Perception Survey (Rating of 3 or higher)	≥ 80% on Overall Quality Rating for each program	Transportation Director	R										X	X

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C. Follow-Up

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
GPRA and GAIN follow-up rate for the CSAT ORP grant at 3 and 6 months post admission	QA	EFY	Evaluation Data Base	≥ 80% of clients	Program Director & Data Specialist	R	X	X	X	X	X	R	X	X	X	X	X
GAIN "on-time" follow-up for CSAT ORP grants at 3 and 6 months post admission	QA	EFY	Evaluation Data Base	≥ 80% of clients	Program Director & Data Specialist	R	X	X	X	X	X	R	X	X	X	X	X
NOMS follow-up rate for the CSAT PBHCI grant at 6-month intervals post admission	PI	EFY	Evaluation Data Base	≥ 80% of clients	Program Director & Data Specialist	R	X	X	X	X	X	R	X	X	X	X	X
GPRA follow-up rate for the CSAT TCE HIV grant at 6 months post admission	QA	EFY	Evaluation Data Base	≥ 80% of clients	Program Director & Data Specialist	R	X	X	X	X	X	R	X	X	X	X	X
Increase collection of post discharge follow-up survey for all programs	PI	EFY	Evaluation Data Base	≥ 10 surveys completed quarterly	Research Assistants	R	X	X	X	X	X	R	X	X	X	X	X

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D. Clinical Records

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Increase compliance of CARF core program records with 65D 30, CARF standards, CCISC, and P & P. **NOTE:** G/CC also uses this strategy to monitor fraud, waste, abuse and other potential wrongdoing	PI	EFY	Biannual monitoring of treatment records with Peer Review and QA Checks	≥ 80% of treatment records will comply	Clinical Directors, Clinical Staff & RE	R						R					
Conduct Utilization Management Quality of Care	PI	EFY	Biannual monitoring of randomly selected clinical records from each program	≥95% of clinical records score ≥95% on the UM Review Form	Program staff and Chief Clinical Officer	R	X	X	X	X	X	R	X	X	X	X	X

D. Clinical Records

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Maintain consistency between invoice, clinical documentation, and data **NOTE:** G/CC also uses this strategy to monitor fraud, waste, abuse and other potential wrongdoing	PI	EFY	Biannual monitoring of central IT database	≥ 95% of the clinical documentation will support billing	Clinical Directors, Program Staff & RE	R	X	X	X	X	X	R	X	X	X	X	X

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E. Quality of Care and Service Provision

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Identify number of consumers (SA & MH) needing primary care **SFBHN REQUIRED ACTIVITY**	PI	EFY	Centralized database	# of consumers needing primary care	Chief Clinical Officer, Program Coordinators, Program Staff	R	X	X	X	X	X	R	X	X	X	X	X
Number of consumers (SA & MH) linked to primary care **SFBHN REQUIRED ACTIVITY**	PI	EFY	Centralized database	60% of consumers needing primary care linkages will have the linkage	Chief Clinical Officer, Program Coordinators, Program Staff	R	X	X	X	X	X	R	X	X	X	X	X
Monitor substance use among adults discharged from substance abuse treatment	QA	EFC	Consumer IM System	80% of adults discharged from substance abuse treatment will reduce substance use from baseline use	Clinical Directors, Clinical Staff, and Chief Clinical Officer	R	X	X	X	X	X	R	X	X	X	X	X
Monitor completion rates for Prime for Life	QA	EFY	Consumer IM System	85% of the youth will complete at least the required 4.5 sessions of Prime for Life curriculum	Prevention Coordinator, Prevention Staff	R	X	X	X	X	X	R	X	X	X	X	X

E. Quality of Care and Service Provision

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Monitor completion rates for Teen Intervene	QA	EFY	CDS	85% of youth referred to Teen Intervene will complete the three (3) Required sessions	Prevention Coordinator, Prevention Staff	R	X	X	X	X	X	R	X	X	X	X	X
Monitor completion rates for Project SUCCESS	QA	EFY	CDS	85% of youth referred to Project SUCCESS will complete the Required sessions	Prevention Coordinator, Prevention Staff	R	X	X	X	X	X	R	X	X	X	X	X
Reduce alcohol use among youth completing Project SUCCESS	QA	EFC	Pre- and post-tests (Project SUCCESS Survey)	85% of youth will report no or reduced alcohol use in past 30 days by curriculum completion	Prevention Coordinator, Prevention Staff	R	X	X	X	X	X	R	X	X	X	X	X
Increase attitudes and beliefs related to risk of harm associated with underage drinking among youth completing Project SUCCESS	QA	EFC	Pre- and post-tests (Project SUCCESS Survey)	85% of youth will increase attitudes and beliefs about risk of harm by curriculum completion	Prevention Coordinator, Prevention Staff	R	X	X	X	X	X	R	X	X	X	X	X
Decrease favorable attitudes toward alcohol and drug use among youth completing Project SUCCESS	QA	EFC	Pre- and post-tests (Project SUCCESS Survey)	85% of youth will decrease favorable attitudes about alcohol/drugs by curriculum completion	Prevention Coordinator, Prevention Staff	R	X	X	X	X	X	R	X	X	X	X	X
Decrease favorable attitudes toward alcohol, tobacco and drug use among youth completing PRIME for Life	QA	EFC	Pre- and post-tests (BSRI and Program Specific tools)	85% of youth who complete PRIME/Teen will decrease favorable attitudes towards alcohol, tobacco, and other drugs.	Prevention Coordinator, Prevention Staff	R	X	X	X	X	X	R	X	X	X	X	X

E. Quality of Care and Service Provision

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Increase healthy behaviors and decrease use of ATOD or delay the age of onset for marijuana use among those completing TEEN Intervene.	QA	EFC	Pre- and post-Tests (BSRI and Program Specific tools)	85% of youth who complete Teen Intervene will increase their healthy behaviors, decrease use of ATOD or delay the onset for marijuana use.	Prevention Coordinator, Prevention Staff	R	X	X	X	X	X	R	X	X	X	X	X
Monitor clinical outcomes of those consumers receiving Seeking Safety	QA	EFC	Pre- and post-tests (PCL-5)	70% of consumers will show decreased symptoms and severity	Program Coordinators, Chief Clinical Officer	R	X	X	X	X	X	R	X	X	X	X	X
Fidelity of EBPs	PI	EFY	Fidelity Checklists	80% of staff will maintain fidelity to EBPs	Program Coordinator & Chief Clinical Officer	R	X	X	X	X	X	R	X	X	X	X	X
Stable housing for MIND clients	QA	EFC	CDS	80% of clients not having stable housing at admission will have it at 90 days post admission **AND** 80% of clients not having stable housing at admission will have it at 1 year post discharge	Program Coordinator, Care Coordinators	R	X	X	X	X	X	R	X	X	X	X	X

E. Quality of Care and Service Provision

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Employment for MIND clients	QA	EFC	CDS	80% of unemployed clients wanting to work will have employment 180 days from admission **AND** 70% of unemployed clients wanting to work will have employment 1 year from admission	Program Coordinator, Care Coordinators	R	X	X	X	X	X	R	X	X	X	X	X
Benefits and Entitlements	QA	EFY	CDS	70% of clients who are eligible for benefits will receive assistance applying	Program Coordinator, Care Coordinators	R	X	X	X	X	X	R	X	X	X	X	X
Mental Health Symptoms	QA	EFC	Modified Mini Screen, PCL-5	80% of clients will have reduced MH symptoms at discharge	Program Coordinators, Therapists	R	X	X	X	X	X	R	X	X	X	X	X
Improvements at follow-up	QA	EFC	Modified Mini, PCL-5, CDS	70% of clients will maintain improvements at 3-, 6-, and 12-months post discharge	Research Assistant, Evaluator	R	X	X	X	X	X	R	X	X	X	X	X

E. Quality of Care and Service Provision

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Substance use/misuse	QA	EFC	CDS	75% of clients will be Substance free at discharge **AND** 75% will remain substance free at 3-, 6-, and 12-months post discharge	Program Coordinator, Therapists, Research Assistant, Evaluator	R	X	X	X	X	X	R	X	X	X	X	X
Physical health	QA	EFC	NOMS, CDS	80% of clients will have improved physical health at discharge **AND** 70% will maintain the improvements at 3-, 6-, and 12=months post discharge	Program Coordinator, Therapists, Research Assistant, Evaluator	R	X	X	X	X	X	R	X	X	X	X	X

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F. Safety and Security

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Monitor Incident Reports to ensure accurate and appropriate reporting and identify trends	QA	EFY	• Centralized database • Aggregate data	Unusual trend patterns	• Performance Improvement Committee • Safety Committee • Keys Leadership Team	R	X	X	X	X	X	R	X	X	X	X	X
Monitor medication errors on CSU and Detox units **SFBHN REQUIRED ACTIVITY**	QA	EFY	Incident Reports	Maintain medication errors at </= 2%	Medical Director, CSU & Detox staff, CCO	R	X	X	X	X	X	R	X	X	X	X	X

F. Safety and Security

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Conduct emergency drills on-time at all three locations	QA	EFY	Emergency drill forms	98% of emergency drills will occur on time at all locations	EOC Committee	R	R	R	R			R			R		
Monitor EOC/Safety Committee's enhanced roles & responsibilities, including development, implementation, and monitoring of the SSP	QA	EFY	Committee Meeting minutes Updates to SSP	A biannual review of the SSP will occur 100% of the time	Area Director, EOC/Safety Committee	R	X	X	X	X	X	R	X	X	X	X	X
Monitor EOC/Safety Committee's enhanced roles and responsibilities, including compliance with the security-related requirements outlined in FDOT Rule 14.90	QA	EFY	Committee Meeting Minutes Incident Reports	• 100% of Meeting minutes will reflect discussion of the security-related items • Biannual analysis of IRs for security-related incidents	Area Director, EOC/Safety Committee	R	X	X	X	X	X	R	X	X	X	X	X

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G. Staff Development

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Monitor appropriate training and competence of new hires	QA	EFY	E-Learning Training Logs	≥95% of new hires will complete the e-learning courses within 30 days from hire date	Human Resources Director, Training Committee	R	X	X	X	X	X	R	X	X	X	X	X
Monitor that staff receives a minimum of 20 hours of in-service training annually	PI	EFY	E-Learning Training Logs	At least 85% of staff will have 20 hours of training annually	Human Resources Director, Training Committee	R	X	X	X	X	X	R	X	X	X	X	X

G. Staff Development

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Monitor employee Turnover	QA	EFY	Human Resource reports	<20% turnover rate	Human Resources Director GCC Leadership Team	R	X	X	X	X	X	R	X	X	X	X	X
Monitor Overtime	QA	EFY	Human Resource reports	<20% turnover rate	Human Resources Director GCC Leadership Team	R	X	X	X	X	X	R	X	X	X	X	X

H. Accreditation - CARF

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Conduct quarterly Committee Meetings to review and monitor CARF standards & to develop Action Plans for implementation of new standards	QA	EFY	CARF Standards Manual Committee Meeting Minutes	Committees will meet at least 1 time quarterly	Keys Leadership Team, Chief Clinical Officer, Committee Chairpersons	R			R			R			R		
Complete required QIP annually and submit to CARF	QA	EFY	CARF Standards Manual Committee Meeting Minutes	Completed required QIP and submission to CARF	Keys Leadership Team, Chief Clinical Officer, Committee Chairpersons										R		

I. Action Plans

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Monitor ongoing implementation and maintenance of the Trauma-Informed Care Initiative	PI	EFY	Walk Through Minutes	Conduct walk through for each facility and service	Program Directors Chief Clinical Officer Keys Leadership Team	R	X	X	X	X	X	R	X	X	X	X	X

I. Action Plans

Topic	Objective Type	Measure	Method	Measurable Objective	Accountability	July 2017	Aug 2017	Sept 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	May 2018	June 2018
Monitor ongoing implementation and maintenance of the Cultural and Linguistically Appropriate Service Initiative	PI	EFY	Walk Through Minutes	Conduct walk through for each facility and service	Program Directors Chief Clinical Officer Keys Leadership Team	R	X	X	X	X	X	R	X	X	X	X	X
Monitor ongoing implementation and maintenance of the Integration of Behavioral and Primary Care Health initiative	PI	EFY	Walk Through Minutes	Conduct walk through for each facility and service	Program Directors Chief Clinical Officer Keys Leadership Team	R	X	X	X	X	X	R	X	X	X	X	X

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VI. ABBREVATIONS

QA	**=**	Quality Assurance
PI	**=**	Performance Improvement
LOS	=	Length of Stay
R	=	Report
RE	=	Research and Evaluation
X	=	Data Collection
EFY	=	Efficiency
EFC	=	Effectiveness

VII. OVERSIGHT AND DIRECTION

A. The Performance Improvement Committee (PIC) is the body in which responsibility for the overall Work Plan resides.
B. The PIC quarterly meeting is held and exercises oversight through a standing agenda item of the Work Plan
C. The Keys Leadership Team provides overall accountability of the PI Work Plan
D. The PI Chairperson provides quarterly reports to the Board of Directors and Community Council

VIII. REVIEW AND APPROVAL

The Performance Improvement Committee Review and Recommendation for Approval Date of Approval

_____ _____

Keys Leadership Team Review and Approval Date of Approval

_____ _____