Center for Youth and Families
2021 Performance Improvement Plan

Introduction: Center for Youth and Families (the Agency) is a community-based organization dedicated to filling gaps in services to the citizens of Maryland with mental health issues. Our intent is to engage in a performance improvement process every 3 years in which a variety of input and information is analyzed.

How We develop the Performance Improvement Plan-. We analyze our organization's strengths, and weaknesses and emerging opportunities and potential threats. We gather information from persons served, staff, and stakeholders about our agency's performance. Out of this process a performance improvement plan is formulated and the "critical issues" for the agency are developed and measurable goals are developed to address them.

We welcome your ideas and input as to improvements in services that we currently provide and new services that you think we should develop. Please email your suggestions to our CEO.

Mission
Center for Youth and Families strives to provide personalized, high-quality care on an as needed or preventative basis. We have created a practice that we believe in and choose for our own family member.

Vision Statement
Center for Youth and Families believes that people can and do recover from mental illness by using a Recovery and Person-Centered approach. The dedicated staff of Center for Youth and Families will assist you in your journey by focusing on your strengths, needs, abilities and preferences. Center for Youth and Families can help you find ways to manage and create a meaningful life..

Services
Center for Youth and Families provides an array of high quality services including:

- Psychiatric Rehabilitation Program -Adults and Youth
- Level II.I Substance Abuse Intensive Outpatient Program

This Quality Management Plan for 2021 outlines the overall quality management cycle, specific Quality Improvement outcomes to be achieved by the agency for 2021, and the measurement processes put in place to determine if clinical and operational outcomes have been met. This plan will be reviewed by the Quality Management Committee on a quarterly basis and will be used to improve the effectiveness, efficiency, accessibility of and satisfaction with service delivery and business functions.

Quality Management Committee

- The Agency will establish a Quality Management Committee**.** The Committee will be under the oversight of the Program Director and includes but is not limited to following members:

- CEO
- Corporate Compliance Officer (CCO)
- Clinicians
- Administrative Staff

- At a minimum, the Committee will ensure the:
    - Development of strategies to ensure effective implementation of policies and procedures for staff credentialing and supervision; monitoring of services, consumer safety, and effective outcomes; reviewing adverse events and identification of improvement opportunities
    - Development of strategies to ensure compliance with all documentation, staff qualification and all other state, federal and accrediting body requirements for the services being delivered.
    - Development of action plans to address the improvements needed to reach established or revised performance goals including actions taken to date to improve performance
    - Determining methods for monitoring and evaluating the quality and appropriateness of services, including input from staff, consumers and aggregate data to identify issues and opportunities for improvement.
    - Development of collaborative relationships between agencies, MCOs and other funding agencies through involvement in QM initiatives
    - Review all fatalities of active individuals served or individuals who have been served by the Agency within 90 days of death, when the agency is aware of the death.
    - Review employee termination trends
    - Review annual incident and grievance reports to determine trends, causes and actions for improvement
    - Ensure development of a culture of improvement across the entire agency with continuous staff involvement.

- The Quality Management Committee will:
    - Meet quarterly or on an as needed basis.
    - Prepare an annual outcome report to address the following:
        - Effectiveness of services
        - Efficiency of services
        - Service access
        - Satisfaction and other feedback from persons served and other stakeholders
        - Identification of areas needing performance improvement.
    - Prepare an annual Quality Management and Performance Improvement Plan to address the following:
        - Development of action plans to address the improvements needed to maintain or reach established or revised performance goals.
        - Outline of actions taken to date to improve performance

- Determine methods for monitoring and evaluating the quality and appropriateness of services, including input of staff and consumers and aggregate data to identify issues and opportunities for improvement.

Quality Management Cycle

- The QM Director will the draft or publish the following draft plans for review and commentary by all staff in January of each year and will used to identify areas needing improvement in business functions and the effectiveness, efficiency, accessibility and satisfaction with services.
    - Performance Improvement (aka QM/QI)
    - Training
    - Accessibility
    - Information Technology
    - Corporate Compliance
    - Risk Management
    - Disaster
    - Cultural Competency

- And all other previous year annual reports including
    - Reasonable Accommodations
    - Corporate Compliance Officer
    - Consumer Grievances
    - Employee Grievances
    - Incidents and Sentinel (Adverse) Events
    - Accessibility
    - External and Internal Inspection of Facilities
    - Training Needs
    - Risk Management
    - Clinical, Programmatic and Perception of Care Outcomes
    - Employee Satisfaction

- The Senior Management will formally approve the reports and plans in their January meeting.

Summary of Agency efforts in the following quality management domains

- Staff credentialing, training and supervision- The agency has published the credentials, training and supervision requirements for each position in Job Descriptions, Program Descriptions, Policy and Procedure, and Training Plans. The Job Descriptions, Program Descriptions, and Training Plan are reviewed and updated annually, or as needed, and approved by Senior Management. Staff's credentials and training plan are approved by the HR Director prior to starting work. All staff credentials shall be reviewed shall include:

- Review of staff qualifications compared to the level of skill needed for position;
- Verification of educational credentials, experience, licensure, knowledge and competencies;
- Professional supervision, as required by licensure.

Agency supervisors shall conduct job performance evaluations and develop performance improvement plans for each staff at least annually

- Monitoring of services and compliance with all documentation requirements- The agency employs a Corporate Compliance Officer (CCO) to monitor services through medical records audits. In addition, a professional peer review process is in place under the direction of the Qualified Professionals. The agency has standardized medical and personnel/training record audit tools that detail the monitoring of services. Local offices have real time information about medical records audits, crisis service utilization, and incidents. The Clinical Director monitors the fidelity of services through documented supervision.

- Consumer safety- The CEO and CCO monitor safety and accessibility issues, incidents that involve safety issues, disaster planning and other safety related issues.

- Review of adverse events- The CEO and CCO review all incident reports including allegation of abuse, neglect and exploitation within 24 hours of the incident. The CCO conducts quarterly trend analysis of all incidents to the QM Committee to be used for performance improvement activities. Level II and III incidents are reported to the MCO and State through the IRIS system. The agency has a corporate compliance plan that details investigatory processes and reporting procedures.

- Accrediting body requirements- The QM Committee meets at least annually to review accrediting requirements and make necessary changes. The CEO and CCO keep abreast of MCO and state requirements through attendance at MCO and state meetings and monitoring pertinent websites.

- Restrictive Interventions Monitoring – the agency does not allow restrictive interventions.

- Grievances and Complaints- The agency has complaint and grievance procedures for consumers and employees. The CCO is the point person for grievances. The CCO reports quarterly to the to the PI Committee for performance improvement activities.

- Accreditation body survey results and funding source audits/plans of correction - Via at least an annual report from Corporate Compliance Officer.

- Development of collaborative relationships between agencies and MCOs and other funding agencies through involvement in QM initiatives - The CEO develops relationships with their counterparts in the MCO and other community stakeholders through regular participation in meetings and projects.

- Determining methods for monitoring and evaluating the quality and appropriateness of services, including input from staff, consumers and aggregate data to identify issues and opportunities for improvement. - Data about the following performance indicators will be collected and analyzed. The data collection system will include measures of the business functions and the effectiveness, efficiency, accessibility and satisfaction with services from the perspective of persons served and other stakeholders. The following outcomes will be collected and compared to state or national normative outcomes:

    - Business Functions
        - Monthly analysis of financial statements under the direction of the CFO. Specifically, utilization, productivity and collections will be trend analyzed and compared to budgeted income and expenses.

    - Service Delivery and Consumer Satisfaction:
        - The agency has contracted with Retrospect Consulting Group, a regional consulting practice that specializes in outcome and satisfaction measures, to administer and analyze participatory evaluations of satisfaction and personal outcomes to a representative sample of persons receiving services.
        - Service outcomes and satisfaction will be measured by an adaption of the Program Indicators- Mental Health Statistics Program- American College of Mental Health Administration (ACMHA) –2010. Additional survey questions will be added to accessibility and medical care In the last month of each year all persons receiving services will be asked take the survey. In addition, surveys will be sent via email at six month intervals after discharge to determine the long-term effectiveness of the program.
        - Persons served will be given the option to participate electronically on a computer, tablet or smart phone or complete paper versions of the survey. The surveys will be anonymous to preserve the integrity of the data. The reliability of the data will be ensured by internal controls on the electronic version that prevented “ballot stuffing”. The paper versions were faxed directly to the survey consultant who manually entered the data so ensure the anonymity, integrity and reliability of the data. A comparative analysis will be presented at least annually for key indicators to the QM Committees to address the efficiency, effectiveness, satisfaction with and accessibility of services for performance improvement purposes.
        - The efficiency, effectiveness, satisfaction with and accessibility of services will be compared to industry performance for like agencies

providing like services in the past 5 years based on the aggregate data collected by the consulting group in multiple states.

- Service access

The Agency collects data about the following to identify barrier to treatment

- Wait list for services - via in-house tracking system as a method of determining program accessibility.
- Wait times for admission- via in-house tracking system as a method of determining program accessibility.
- No show rates for OPT- via in-house tracking system as a method of determining program accessibility

- Stakeholder Satisfaction

- The agency has contracted with Retrospect Consulting Group, a regional consulting practice that specializes in outcome and satisfaction measures, to administer and analyze participatory evaluations of satisfaction to a representative sample of stakeholders.
- The surveys are proprietary and have been tested in a multi-state market over hundreds of stakeholders.
- All stakeholders were invited to participate in the stakeholder satisfaction survey via e-mail. Stakeholders were given the option to participate electronically on a computer, tablet or smart phone or complete paper versions of the survey. The surveys were anonymous to preserve the integrity of the data. The reliability of the data was ensured by internal controls on the electronic version that prevented "ballot stuffing". The paper versions will be faxed directly to the survey consultant who manually entered the data so ensure the anonymity, integrity and reliability of the data.
- A comparative analysis will be presented at least annually for key indicators to the QM Committees to address the efficiency, effectiveness, satisfaction with and accessibility of services for performance improvement purposes.
- The efficiency, effectiveness, satisfaction with and accessibility of services will be compared to industry performance for like agencies providing like services in the past 5 years based on the aggregate data collected by the consulting group in multiple states.

- Employee satisfactions surveys

- The agency contracted with Retrospect Consulting Group, LLC to administer the employee satisfaction surveys and analyze the data. All staff will be invited to participate in the employee satisfaction survey at staff meetings and via e-mail. Staff were given the option to participate electronically on a computer, tablet or smart phone or complete paper versions of the survey.

- The surveys are proprietary and have been tested in a multi-state market over thousands of employees.
- The surveys will be anonymous to preserve the integrity of the data. The reliability of the data was ensured by internal controls on the electronic version that prevented "ballot stuffing". The paper versions will be faxed directly to the survey consultant who manually entered the data so ensure the anonymity, integrity and reliability of the data.

- Information will be shared with:
  - Persons served
  - Personnel
  - Other stakeholders

Specific Performance Improvement Initiatives to continuously develop, strengthen, and improve services in 2021

Priority	Goal	Resources needed	Measure	Cost	Who	By When
Top	Become CARF accredited and licensed to provide behavioral healthcare services.	Contract with CARF consultant	Successfully accredited and licensed	$5000	CEO	12/31/21
High	Technology acquisition- The agency will develop a user-friendly website The agency will buy 2 new laptops.	Contact with a website designer. Contract with a webmaster. Online ordering from Dell business systems.	85% of staff, persons served and stakeholder will report the website as being user friendly. Purchase of 2 laptops	$2000 for website developer $50 / year for domain hosting $25 / year for	CEO	12/31/21

				domain name. ~$ 1000 /year ongoing support by webmaster. ~$400 for laptop		
Moder-ate	Technology maintenance- The agency will have sufficient knowledge and resources to maintain existing technology.	Contract with an IT consultant.	IT equipment will be able to be repaired in house 50% of the time	~$1000 / year for IT consultant	CEO	12/31/21
Moder-ate	Technology replacement- The agency will replace 2 desktop computers with new models	Online ordering from Dell business systems.	Replacement of 2 desktop computers	~$800	CEO	12/31/21
High	Develop HIPAA complaint company intranet including online training for staff.	Contract with training consultant.	Successful development of online training. Training records audit will show	~$2000	CEO	12/31/21

			100% compliance with requirements			
High	To **improve the effectiveness** of the PRP, OPT, IOP, and residential programs the agency will focus of clinical skill development	Contract with training and fidelity monitoring consultant	Training record audits will show 100% compliance with the training requirement. Fidelity monitoring will show at least 85% conformance with EBP standards.	~$2000	CEO	12/31/21
High	To **improve the efficiency** of the PRP, OPT, IOP, and residential programs the agency will have wait times from referral to first day of service with an average of 5 days.	Purchase of EHR	The agency EHR will be mined for data to calculate wait times.	~1% of revenue	CEO	12/31/21
High	Persons served and stakeholders will report high level of **satisfaction** with the PRP, OPT, IOP, and residential programs.	Develop satisfaction surveys for persons served and stakeholders	85% of survey respondents will report being satisfied or very satisfied on the 2021 satisfaction surveys	$ 99 / years for survey software	CEO	12/31/21
High	PRP, OPT, IOP, and residential programs will be **assessable** to persons served.	Purchase EHR to track no show rates	The no show rate for PRP, OPT and IOP will be less than 20% measured over the quarter. Residential census will be	~1% of revenue	CEO	12/31/21

			90% measured over the quarter.			
High	To **reduce risk** to the agency in due to potential paybacks or plans of correction the PRP, OPT, IOP, and residential the agency will contract with a Certified Forensic Healthcare Auditor to conduct formal audits and routinely review service documentation.	Contract with Certified Forensic Healthcare Auditor	Internal self-audits will show at least 90% compliance with standards as aggregated over the quarter.	$1200 per quarter	CEO	12/31/21