Focus Behavioral Health Services, LLC 2017 QI Work Plan

Objective / Goal	Required By	Monitoring Frequency	Monitoring Responsibility	Target	Outcome
QI Plan Focus Behavioral Health Services, LLC shall maintain an active QI work plan to outline improvements for provision of quality services	MCO Contracts Mission Statement Vision, Values APSM 30-1 APSM 45-2	Annually	LLT/QI Director LLT Owners	Plan reviewed, revised and or further developed Document improvements in annual outcomes report (December)	Ongoing
Endorsement – **Routine Provider Monitoring** – **Post Payment Review –** **DHSR Licensure Review –** **External Audits – Annual Licensure Monitoring** Licensure Reviews Medicaid Audits Reviews for "Cause" or client complaints MCO Reviews	LME Medicaid Requirements NCDHHS MCO, Medicaid Requirements NCDHHS DHSR Annual Licensure Monitoring APSM 30-1 APSM 45-2 NCDMA, NCDHHS MCO Contract – System monitoring	Every three years 2009 – 2012 Every two years 2015-2017 FY 2016 Annually As reports are received by Annually	LME's – VAYA Health PBHM MCO Cardinal MCO DHSR LME DSS MCO Medicaid DHHS Accountability	All required Enhanced Services shall receive 95% compliance with Endorsements. Any corrective action requests shall be developed and implemented to the satisfaction of the endorsing LME. All required routine provider monitorings shall receive 95% compliance with standards. Achieve 95% compliance in all service areas. Identify reasons for	**January 2017 - DHSR Annual Review Burkwell Facility:** There were minor deficiencies noted in the annual monitoring – a POC was submitted February 2017 **February 2017 – VAYA Post Payment Review IIH:** 100% **March 2017 - Cardinal Provider Monitoring:** 100% **May 2017 – DHSR Construction Survey Burkwell Facility:** There were minor deficiencies noted – a POC was submitted June 2017 and accepted. Awaiting follow-up review **June 2017 – VAYA Complaint based review:** Complaint unsubstantiated – POC required for documentation and policy update. POC accepted and an implementation desk review has been scheduled for September 18th 2017. **July 2017 – DHSR Complaint investigation and Annual Review**

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				"Cause" audits and develop corrective action / investigation for preventative action. Target: 100% of paybacks within 60 days. At least 90% compliance in sample audits.	**HDTX k-5 Facility:** Zero deficiencies and complaint unsubstantiated. **July 2017 – VAYA Routine Provider Monitoring.** No POC required. **August 2017 – PBHM Routine Provider Monitoring.** No POC required. Awaiting official results.
National Accreditation – Achieve and maintain 3 year National Accreditation through CARF. All facilities will begin planning for self-study during mid-year 2017 to achieve National Accreditation December 2017/January 2018	CARF	Every three years December 2017 – February 2018 –	CARF Accreditation Reviewers LLT Assigned Team Members	Achieve 3 years National CARF Accreditation.	Currently Accredited through CARF until February 2018 Ongoing
OSHA Compliance All facilities will be OSHA compliant Provide OSHA checklists that each safety representative shall complete at a minimum of two times per year to assess OSHA compliance. Monitor and document the number of OSHA deficiencies and fines paid in a calendar year	OSHA Regulations	Monthly – Safety representative will review the facility and complete (with facility Director) follow-up plans. Bi-Annually – track if any fines are paid	Facility Safety Representative	Target: All facilities will meet 90% of OSHA requirements. All items found out of compliance will have a corrective action completed by the facility supervisor and be corrected within 2 months. $0 per calendar year will be paid in OSHA fines.	2016 All facilities are currently OSHA compliant. **May 2017** – Received notification of OSHA complaint. Submitted requested Documents. Complaint was withdrawn.

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Employee Accidents and Injuries Attempt to have safety program that assists employees in maintaining a safe environment so as to prevent all employee injuries on the job.	OSHA Regulation	Quarterly	Program Director Human Resources	The number of on-the-job injuries will be no more than 4 in calendar year.	Ongoing Accidents occurring in 2017 to date: **2**
Employee Evaluation System Implement a more measurable employee evaluation system – job description functions being evaluated twice yearly –	Agency Policies and Procedures CARF	Quarterly	HR Director	October/November 2014	10 evaluations are still outstanding in 2017. HR Director looking into this.
Electronic Personnel Database With the continued growth of FBHS – tremendous need for tracking of personnel information – supervision, evaluations, trainings, employee actions and change forms, etc.	Program Director Personnel Policies and Procedures	New Implementa-tion	HR Director & QI Director	Begin implementation during 4th quarter 2016	1/2017 – working toward implementation. 6/2017 50% of records scanned into EPD.
Employee Satisfaction and Turnover Rates Conduct bi-annual employee satisfaction surveys & accept feedback from employees. Review and conduct strategic plan with owners around further improvement of employee benefits, retention, and salary survey for same type of service.	Personnel Policies and Procedures Employee Handbook Benefits package Pay scale	Bi-annually	QI Director Administrative Director	Target: Improved staff satisfaction with working conditions, training, and input into agency management, 50% improvement in satisfaction Increase agency	**April 2017 survey conducted:** Overall satisfaction is median range primarily being most dissatisfied with pay range and benefits – see strategic plan for specific criteria that staff identified. Added 401K as a result. **October 2017:** Distribute surveys **Current Benefits:** medical, dental, vision, life insurance, 401K STARTING July 1st 2017

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Implement Employee Recognition Program through Employee of the Month and Bonus Incentives				Holidays Improve benefits package or comparable to other similar providers. **Reviewed:** Health Insurance Supplementary Insurance Dental Insurance Vacation Days Sick Days Holidays Life Insurance Researching 401K/IRA Work on decreased turnover rates – satisfaction surveys for employees	Holidays – New Years Day, Memorial Day, Independence Day, Thanks Giving, Christmas Vacation & Sick – based on # years Bereavement – added additional family to bereavement leave – 1/2015 Life Insurance added 09/2014 Added AFLAC benefits package 2012 Added MetLife benefits package 2014 **Staff Turnover rates:** 2010: 6 2011: 14 2012: 31 2013: 27 2014: 32 2015: 30 2016: 46 2017: ____ Rates have increased for the following reasons: 1) Increase in hiring due to adding additional services. 2) Recruited by agencies with higher wages and better benefits.
Service Records Review Service Records for service delivery staff will be in compliance with all state and federal requirements. Internally audit a 20% sample quarterly. Record reviews will demonstrate compliance with standard elements in Medicaid documentation and HIPAA requirements.	HIPAA requirements Medicaid requirements APSM 45-2 APSM 30-2 MCO	Quarterly	Service Records Select agency QP's and LP's shall participate in peer review a minimum of 2x's per year QI Director, Medical Records Staff	Target: 90% to 100% Compliance with standard elements in Medicaid documentation and HIPAA requirements	Audits conducted by Medical Records staff – 90% compliance with all service record requirements. Developed and Implemented New Medication Management Peer Review in 2016 – Identified areas of improvement regarding documentation of patient education and consistently monitoring requirements for controlled substances and side effects of antipsychotics.

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			Medical Director		
Credentialing All service delivery staff will be appropriately credentialed and documentation will be filed within 60 days of employment or notification of the need for an update.	APSM 30-1 MCO – contracts Service Definition Requirements	Monthly	Human Resources Clinical Director Credentialing Specialist	Target: Documentation of credentialing will be on file in the Human Resources Coordinator office within 60 days of employment.	2017 – All credentialing submitted and up to date.
Training/Competencies Proposed Division competencies will be operationalized into curricula and criteria. Document competencies in job descriptions in HR files. Document curricula in training files. Audit files to verify competencies and curricula are in place and match. Develop Training Manual for all Leadership and Case Managers	APSM 30-1 MCO Contracts Service Definition Requirements Focus	Annually	LLT Human Resources QI Director Program Director Clinical Director	Target: Competencies will be identified by the state for each service program (DTX, RES, DTX, TFC, OP, IIH) and each position and a curriculum plan will be documented for each current position.	10% non-compliance due to employees and limited availability of certain trainings
Cultural Proficiency All providers will assess and include clients and families cultural preference in the development of PCP's Hire culturally diverse staff in order to have ability to serve clients across all cultural areas. Do cultural diversity training at	State Plan Mission Statement CARF	At time of hire and review every two years Ongoing	Peer Review Team Quality Improvement Human Resources	Target: All staff will be trained in cultural diversity at the time of hire and annually thereafter. Training will be developed by the LLT. Printed materials will be available in	Brochures printed in Spanish during November 2008. Added interpreter to access to care unit 2013 All staff trained in cultural competency during NEO and updates through agency memos annually. During 2017

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the time of orientation.				English and Spanish. Hire 2nd interpreter 100% of plans reviewed show evidence that person's cultural preferences were addressed.	
HIPAA Compliance Facilities will be in compliance with HIPAA requirements within two weeks of notification. File a copy of all written notifications. Complete onsite inspections, using HIPAA checklist to document compliance and date.	Federal Regulations APSM 45-2 New HIPAA regulation 45CFR – Parts 160, 162, & 164 1996, Omnibus 2013, HiTech Act 2009	Monthly	HIPAA Service Records Sub-Committee LLT	Target: IT staff develop new IT plan to ensure compliance with regulations around EMR, PHI, Electronic e-mail, Cellular Phone Usage, Flash drives, etc.	All facilities HIPAA compliant Zixmail – 1/2014 Encryption1/2014 Secured Server 1/2014 Firewall purchased 7/2015
Policies & Procedures P & P will be updated based on standard criteria within 3 months and piloted (when feasible) within 5 months of changes in the organization or standards that occur. Recommendations will also be taken from the program members for Policy change.	Mission Statement APSM 30-1 APSM 45-2 APSM 95-2 State and Federal regulations National Accreditation Standards	Monthly	LLT	Target: 100% of criteria for P & P are met. Procedures are drafted within 3 months of changes in State and Federal regulations, agency requested changes. Piloting (when feasible) shall take place within 5 months of notification that change has occurred.	Policies and Procedures reviewed during 2014/2015 and updated according to State, Federal and National Accreditation Standards. **Policy updates during 2015:** ▪ Health and Safety Emergency Medical Plan and Response 3-110 ▪ Restrictive Intervention 4-120 ▪ Transition and Discharge Criteria 7-030 ▪ Safeguards Pertaining to Medication Administration 4-150 **Working on new protocol during**

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				If policy changes only – the Directors will be notified within 3 months.	**2017**: ▪ Change protocol for Medication Peer Review – Check sheet – 7-100, 7-070, 7-150, 7-170 ▪ Restrictive Intervention 4-120 – Review use of seclusion
Client Services: Survey of Satisfaction Administer the Client Satisfaction Surveys, consistent with DHHS standards and submit data received according to DHHS guidelines. Submitted to the LME and currently conducted through the LME Administer Client Satisfaction surveys for 100% of caseloads.	DHHS/LME Contract .	Bi-Annually (Fall) survey conducted in late October to early November. Data is returned to the MCO within 2 weeks of the close of survey.	Client Outcomes Evaluation LLT & AMT	Target: 90% of expected surveys are completed as required and received by the due date. 85% of respondents will indicate satisfaction with the elements of client service found in the Client Satisfaction Survey (see website).	**April 2017 Results:** Residential Level III – 100% Satisfaction Residential Level II – 100% Satisfaction Day Treatment – 89% Satisfaction. • Areas of improvement: cleanliness of facility, comfortable making a complaint IIH – 94% Satisfaction Outpatient – 88% Satisfaction • Areas of improvement: comfortable making a complaint **Services with a low response rate:** Residential Level III – less than 10% Outpatient – less than 10%
Client, Family / Legally Responsible Person Program Specific Satisfaction Administer Program Specific Client & Family / Legally responsible person satisfaction surveys for 100% of caseloads.	QI Policy and Procedures	Bi-Annually (Winter) and (Summer) survey conducted. Data is returned to NCMT and LLT within 2 weeks of the close of survey	Client Outcomes Evaluation LLT	Target: 90% of expected surveys are completed as required and received by the due date. 85% of respondents will indicate satisfaction with the elements of client service found in the survey.	**April 2017 Results:** Residential Level III – 100% Satisfaction Residential Level II – 100% Satisfaction Day Treatment – 99% Satisfaction. IIH – 99% Satisfaction Outpatient – 94% Satisfaction Medication Management – 97% Satisfaction **Services with a low response rate:** Residential Level III – less than 10%
Suggestion Boxes Located at each nonresidential	FOCUS	Monthly	LLT	Review all suggestions and	

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facility by 2018				implement relevant improvements within reason	
Client Rights: Due Process All client complaints and grievances, denial, reduction, suspension or termination of services will be communicated to the Client or legally responsible person on the designated form and be accompanied by information about due process for an appeal or hearing to ensure compliance with Agency Mission, Policies and Procedures, DHHS and MCO criteria	MCO Contract Mission Statement APSM 95-2 APSM 30-1	Quarterly CR Committee meetings Annual report is due every December.	Client Rights NCMT	Target: Continue with current community provider Client Rights Committee. Focus BHS and Carolina Residential Services to partner 100% fully functioning Client Rights Committee in accordance with DHHS standards and LME Contract. Recruit at least one new community member in 2017	Client Rights Committee continuing to meet quarterly. See 2016/2017 minutes Collaboration between three agencies on all Client Rights Committee Functions: ▪ RePay, Inc. ▪ Focus Behavioral Health Services, LLC ▪ Carolina Residential Services, LLC **January 2017:** Two new community members approved by committee.
Critical Incidents Analysis of number of critical incidents per person served in the following categories: suicide attempts, suicides, deaths, abuse, neglect, exploitation, serious injuries, other critical incidents Review of the agency quarterly reports on critical incidents and actions taken will include: data analysis to ID patterns and trends, strategies developed to address problems, actions taken,	MCO Contract APSM 30-1 APSM 95-2 Mission Statement	Client Rights Committee LP that attends RIAC Reviews and summarizes recommendations and information on a quarterly basis for review by LLT and QI Director.	Client Rights Committee LP that attends RIAC Residential Coordinator	Target: 100% of cases reviewed indicate adequate response and follow-up. Minimum: 85% of cases reviewed indicate adequate response and follow-up.	**1st Quarter Trends:** Majority of critical incidents occurred at the two K-5 DTX facilities. Over 95% of reports were restrictive interventions. 100% of cases reviewed indicate adequate follow up. **2nd Quarter Trends:** Majority of critical incidents occurred at the two K-5 DTX facilities. Restrictive interventions, however, decreased from the 1st quarter. 100% of cases reviewed indicate adequate follow up.

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evaluation of results, and recommendations for next steps. LME will review reports for evidence of effective incident review process.					
NC-TOPPS -	MCO Contracts VAYA, PBHM & Cardinal APSM 30-1 Policy and Procedure	Monthly All NC-TOPPS are due within two weeks of initial billable visit and updated within NC-TOPPS guidelines.	QI Director LLT	Target: 100% of cases reviewed indicate completion MCO Target: 95% of cases reviewed indicate completion.	Cited in November 2016 for 2 facilities not meeting compliance for on time submission or follow up rate. POC was implemented to increase performance. However, there are limitations. In many cases receiving providers fail to request NCTOPPS transfers resulting in Focus being penalized. Focus will continue to report other agencies that fail to have cases transferred to the relevant MCOs.

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This 2017 QI work plan has been updated, reviewed and approved and adopted by the Ownership and Area Management Team:

Administrative Director	Date
Quality Improvement Director	Date
Clinical Director	Date
Medical Director	Date