

QUALITY MANAGEMENT PLAN 2009 – 02-16-09

XXX Forensic Treatment Center
Quality Management Plan 2009

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FORENSIC TREATMENT CENTER

QUALITY MANAGEMENT PLAN 2009

I. PURPOSE

XXX Forensic Treatment Center (XXX) is a 198-bed mental health treatment facility charged with responsibility for the care and treatment of adult residents who have been committed to the Department of Children and Families (DCF) after being determined by the courts to be Incompetent to Proceed to Trial or Not Guilty by Reason of Insanity. The facility is operated by XXX, Inc. under a contract with the XXX Department of Children and Families. XXX is accredited by The Joint Commission on Accreditation of Healthcare Organizations (The Joint Commission) under the Behavioral Health Care Standards. The facility's operation is governed by the laws of the state of XXX, as well as rules and regulations of various state and local agencies.

The Quality Management Plan outlines the philosophy, organizational structures, practices and operational processes that constitute the facility's Quality Management Plan, which is the vehicle for facilitating the highest quality, and continuous improvement of care, services, and outcomes for residents. The Plan:

- Describes the role of the Executive Management Team and Quality Management Team in providing leadership for the Quality Management Plan
- Defines the role of the Quality Management Teams, subcommittees and departments in the Quality Management Plan
- Describes the structure of the Quality Management Plan
- Promotes a consistent and systematic methodology for designing and improving processes
- Establishes mechanisms for reporting quality management activities
- Provides for evaluation, review and revision of the Quality Management Plan
- Establishes accountability for tracking data, measuring performance through data, preparing and presenting reports, and developing, implementing and monitoring improvements

II. QUALITY MANAGEMENT PLAN SCOPE

The overall goal of the Quality Management Plan is to ensure that the organization systematically monitors, measures, analyzes and improves performance, with the ultimate goal of improving outcomes for residents and other stakeholders. The program is comprehensive, encompassing all aspects of direct care, administrative and support services provided. It is a management-led effort and involves all levels of the organization.

The facility's leadership is accountable to the Governing Board for the systematic documentation, review and reporting of management information to assess and improve the facility's performance. Facility leadership will apply the principles and concepts of Continuous Quality Improvement (CQI) and performance

measurement in all areas in an effort to involve and empower the entire work force, as well as residents and family members.

Written policies and procedures provide specific guidance for the day-to-day implementation of the essential processes of the Quality Management Plan.

III. STRATEGIC PLANNING

XXX leaders engage in strategic planning annually to identify the facility's objectives and priorities for the year, the strategies to be employed to achieve them and performance measures for assessing progress. Through this process the organization's leaders annually review and revise the Strategic Plan (Appendix 1), the Implementation of which is a major focus of the Quality Management Plan. XXX utilizes XXX's Mission, Vision and Values to guide its planning, and it ensures its goals and objectives align to assist XXX to achieve its vision.

A. Mission

Optimizing individual potential through caring partnerships.

B. Vision

XXX is the leader in providing specialized treatment centers of excellence across the continuum of public.

C. Values

- **Continual Improvement/Innovation** – XXX strives to deliver the best care to those we serve and to exceed expectations of our partners.
- **Respect** – XXX treats every individual we serve, our colleagues and our partners with an appreciation of life experiences that have led our paths to cross.
- **Integrity** – XXX employees engage in relationships that are ethical, honest and sincere.
- **Stewardship** – XXX manages the resources entrusted to us by our partners with utmost efficiency and effectiveness.
- **Partnership** – XXX commits our team and resources to assure the success of our partners in making recovery happen.

D. Strategic Goals for 2009 and Beyond

Based on the evaluation of the 2008 performance, XXX has established six major goals/themes, shown below. Appendix 1 contains the XXX Strategic Plan, which describes objectives, strategies and measures for each goal.

1. XXX is the employer of choice with a staff that is fully engaged in the mission.
2. Create a mutually beneficial relationship with our community partners.
3. Provide the highest quality and cost effective care to the persons we serve.

4. Provide a safe and therapeutic environment of care.
5. XXX will have a sound contract compliance program and internal quality control program.
6. XXX will add value to XXX, Inc.

IV. COMPLIANCE WITH CONTRACT, ACCREDITATION, AND REGULATORY STANDARDS

XXX has incorporated the facility's Compliance Plan (Appendix 2) as a key strategy in the Quality Management Plan. The Compliance Plan outlines a comprehensive and coordinated approach to achieving and maintaining continuous compliance with contract requirements, accreditation, legal and regulatory standards. It includes performance factors as prescribed by the Department of Children and Families and XXX corporate headquarters. XXX complies with all regulatory requirements of the Sarbanes Oxley Act. XXX participates in XXX processes regarding the Sarbanes Oxley Act and has incorporated various aspects of the law into its Corporate Compliance Program.

The Corporate Compliance and Quality Management Coordinator has overall responsibility for ensuring that the facility maintains continuous compliance with Joint Commission Accreditation Standards. This is most effectively achieved through the consistent implementation, monitoring and improvement of treatment, care, and support processes, using the systems outlined throughout the Quality Management Plan. Annually the facility performs a Periodic Performance Review as required by the Joint Commission. Any elements of performance that are determined to be not fully compliant are identified as priorities for improvement and corrective action plans are developed, implemented and monitored by the appropriate committees and the Corporate Compliance and Quality Management Coordinator until full compliance is achieved and sustained.

V. ORGANIZATIONAL STRUCTURE AND ACCOUNTABILITY

A. Governing Board

The Governing Board has ultimate responsibility for the quality of care and services provided at the facility, and have delegated to XXX management the responsibility for developing and implementing the Quality Management Plan. XXX leaders report to the Governing Board on the implementation and effectiveness of the Quality Management Plan.

B. XXX Corporate Leadership

XXX corporate leaders provide management and leadership oversight to XXX. They establish corporate policies and guidelines under which XXX operates, and they establish certain performance standards for the center. XXX maintains primary responsibility for corporate functions including liaison with key leaders of state of XXX.

C. Executive Management Team

The Executive Management Team (EMT) is responsible for the operation of the facility. It identifies membership of the Quality Management Team and provides oversight to it.

D. Quality Management Team

The Quality Management Team (QMT) is responsible for the implementation of the Quality Management Plan. The QMT meets monthly, and it has the same membership as the Senior Management Group.

Interdepartmental and interdisciplinary collaboration and cooperation are facilitated through standing committees, which have been assigned responsibility for specific functions and operate according to charters. A committee reporting structure is established whereby committees report regularly to the Quality Management Team, Clinical Operations Committee, Professional Staff Organization, and Administration and Operations Committee. The Quality Management Team structure is shown in detail in Appendix 3, and includes the following:

1. **Clinical Operations Committee:** (Specialized Behavioral Management Sub-Committee, Infection Control Sub-Committee, SROC/Critical Incidents Sub-Committee, Utilization Management Sub-Committee, and Clinical Peer Review Sub-Committee)
2. **Professional Staff Organization:** (Medical Peer Review Sub-Committee, Pharmacy and Therapeutics Sub-Committee, Credentialing & Privileging Sub-Committee)
3. **Administration and Operations Committee:** (Medical Records Review Sub-Committee, Environment of Care and Safety Sub-Committee, Human Resources and Development Sub-Committee, Business and Technology Sub-Committee, Strategic Planning Sub-Committee, and Ethics/Resident Rights/Grievance Sub-Committee)
4. **Corporate Compliance Committee:**

The Quality Management Team and Standing Committees establish multidisciplinary quality management teams to work on specific projects that have been identified as priorities for improvement, based on performance results and factors such as whether the issue is high risk, problem prone, occurs frequently, and affects or involves several processes and/or departments.

Quality Management committees brainstorm, review processes, research alternatives and solutions and report the findings to the originating committee. The originating committee has the responsibility of monitoring and tracking implementation and effectiveness of new or re-designed processes. QMT functions include:

- Screen, select and prioritize areas for improvement
- Re-prioritize issues in response to unusual or urgent events
- Assign or approve collaborative quality management teams based on high risk, high frequency or problem prone areas
- Establish time frames for progress reports on quality management activities.
- Approve formats for the documentation of team activities and results
- Receive reports of subcommittees, departments and quality management teams
- Evaluate the effectiveness of the Quality Management Plan annually and determine quality management priorities for the coming year.

E. Departmental Groups

Facility departments participate in quality management activities specific to services provided. Each department identifies quality management priorities and selects performance indicators to continuously monitor and assess processes and the effectiveness of improvement efforts. Representatives of these departments are also included as members of subcommittees and participate in quality management teams.

F. Corporate Compliance and Quality Management Coordinator

The Corporate Compliance and Quality Management Coordinator coordinates the development and implementation of the continuous quality improvement system and provides support for the day-to-day operation of the Quality Management Plan, including, but not limited to:

- Ensure proper and effective use of problem-solving methods and statistical tools
- Provide needed training regarding the tools and approaches to the quality management process to all staff involved
- Facilitate the development and implementation of corrective action plans when deficiencies or deviations from acceptable standards are recognized for a particular program or process involving one or more programs
- Develop operating procedures for specific aspects of the Quality Management Plan and monitor outcomes.

G. Accountability

XXX places accountability for implementation of the Quality Management Plan and related activities on all employees. Primary accountability is placed on the members of the Quality Management Team, which has the same representation as the Senior Management Group, and on the chairpersons of the Quality Management sub-committees.

Each member of the Executive Management Team and other management personnel has specific position responsibilities regarding quality of care and administrative services matters. In addition, certain management personnel have direct position responsibilities for carrying out tasks associated with the

Quality Management Plan, including data collection, measuring performance through data, report generation and presentation, development and implementation of improvements, and monitoring of improvements. These employees include:

Corporate Compliance and Quality Management Coordinator
Chief Operating Officer
Medical Executive Director
Forensic Psychology Services Coordinator
Director of Risk Management
Director of Security
Director of Nursing

VI. CONTINUOUS QUALITY IMPROVEMENT METHODOLOGY

The quality management process is built around the key concepts of dedication to quality and customer value, a scientific approach to continuous improvement and fostering an environment of teamwork and cooperation. Quality is the central focus of the program. Quality is defined in terms of the needs of the facility's primary customers as expressed in the mission statement. Customers are broadly defined to include external customers (primarily residents served, families, Department of Children and Families, community mental health providers) and internal customers (staff).

The facility has selected specific performance approaches, methods and tools to be used by management and staff in order to ensure a systematic approach. Quality management activities focus on process planning, design, and process management. Priorities are set as part of the process.

The P-D-C-A is a cycle based upon the premise that to always meet customer's needs you must continuously improve. The model is utilized by all levels of staff when designing, managing, and improving processes.

- Plan:** Assign responsibility for measurement and assessment
Identify targets of performance and customer expectations
Describe and review current processes
Analyze the data
Use data to measure performance
- Do:** Implement corrective actions
Identify barriers, and improvement areas
Develop countermeasures and corrective action
- Check:** Review the results
Assess the effects of the actions and document the improvement
- Act:** Act upon findings
Improve/communicate results to relevant individuals

VII. PERFORMANCE MEASUREMENT AND REPORTING

To measure, assess and continuously improve performance, departments, facility committees and quality management teams develop observable, measurable performance indicators. The Executive Management Team has prioritized these indicators and established standards for data collection, analysis and reporting. Direct service indicators have been selected to ensure that all dimensions of performance are measured. That allows the facility to determine whether it is “doing the right thing and doing the right thing well.” The departments, committees and the Executive Management Team monitor performance indicators.

Appendix 4 contains a comprehensive list of quality management indicators separated into major categories. Descriptions of the categories are shown below.

A. Dashboard Indicators

The Quality Management Team has identified certain performance indicators as crucial metrics to be reported through the use of a XXX Dashboard. The Dashboard is considered a key metrics management tool and contains important indicators related to resident safety, DCF contract and XXX corporate metrics. The indicators are measured, reported and evaluated frequently, normally at least on a weekly basis. They are derived from indicators shown in other categories below.

B. External/Corporate/DCF Indicators

The External Indicators are required by XXX Corporate and/or Department of Children and Families (DCF) in order to monitor facility performance related to contract compliance and XXX strategic objectives. Indicator results are reported electronically to XXX Corporate on a weekly basis and to DCF monthly.

C. Quality Management Team Indicators

The Quality Management Team Indicators have been selected by the various committees in order to provide close monitoring, analysis and improvement opportunities for processes that have been identified as priorities for improvement. These indicators also provide valuable customer input into the quality management process. Departments responsible for collecting and analyzing indicator data submit reports to the Corporate Compliance and Quality Management Coordinator and the designated committee monthly. Committee chairs report quarterly to the Quality Management Team.

D. Departmental Indicators

The Departmental Indicators have been selected by the departments in order to monitor improvement efforts specific to services provided by each of these groups. The departments have identified these processes as priorities with the goal of improving outcomes for their specific customers. The Departmental Indicators are reported monthly in department meeting.

Departmental indicators are reported quarterly to the Quality Management Team.

E. Standards of The Joint Commission on Accreditation of Healthcare Facilities

XXX has incorporated standards for Performance Improvement and Leadership of The Joint Commission throughout its Quality Management Plan and Leadership Plan. The Joint Commission guidance focuses in part, "...on improving organizational performance is effectively reducing factors that contribute to unanticipated adverse events and/or outcomes. Unanticipated adverse events and/or outcomes may be caused by poorly designed systems, system failures, or errors. Reducing unanticipated adverse events and/or outcomes requires an environment in which clients, their families, and organizational staff and leaders can identify and manage actual and potential risks to safety." The Joint Commission's relevant standards in the performance improvement area include:

- The organization collects data to monitor its performance.
- Data are systematically aggregated and analyzed.
- Undesirable patterns or trends in performance are analyzed.
- Processes for identifying and managing sentinel events are defined and implemented.
- Information for data analysis is used to make changes that improve performance and client safety and reduce the risk of sentinel events.
- An ongoing, proactive program for identifying and reducing unanticipated adverse events and safety risks to clients is defined and implemented.

The Joint Commission's relevant standards addressed in the center's Leadership Plan, which are also related to quality management, include, but are not limited to:

- The leaders engage in both short-term and long-term planning.
- Communication is effective throughout the organization.
- The organization plans for appropriate care, treatment, and services of clients under legal or correctional restrictions.
- The leaders set expiations, plan, and manage processes to measure, assess, and improve the organization's governance, management, clinical and support activities.
- The leaders assure that an integrated client safety program is implemented throughout the organization.
- The leaders set performance improvement priorities and identify how the organization adjusts priorities in response to unusual or urgent events. The leaders allocate adequate resources for measuring, assessing, and improving the organization's performance and improving client safety.
- The leaders measure and assess the effectiveness of the performance improvement and safety improvement activities.

XXX also uses The Joint Commission's Periodic Performance Review (PPR) assessments as a method to evaluate and manage quality.

F. The Joint Commission and National Research Institute Performance Indicators

XXX collects and analyzes data related to nine indicators identified as important by the National Association of State Mental Health Program Directors (NASMHPD) Research Institute (NRI) Performance Measurement System. The Joint Commission, through the ORYX System, also utilizes these indicators to benchmark performance against similar psychiatric facilities. Although XXX does not report these indicators to NRI, it is able to benchmark them against XXX's South XXX Forensic Treatment Center's results. The comparative data are utilized to identify improvement opportunities. The Corporate Compliance and Quality Management Coordinator presents comparative data to the Quality Management Team on a quarterly basis. The nine performance indicators are shown in Appendix 4.

It is anticipated that the Joint Commission will implement mandatory Core Measures for freestanding psychiatric facilities in mid-2009. XXX will review the core measures to determine whether any should be incorporated as metrics.

VIII. ORGANIZATIONAL COMMUNICATION

Several avenues have been created for management to communicate with staff, and for receiving and utilizing staff feedback for identifying opportunities for improvement. These are shown in Appendix 5, and include:

A. Executive Management Team

The Executive Management Team is responsible for facilitating two-way communication between the management, supervisory staff, and line staff. The Executive Management Team meets twice per month and members are responsible for receiving and transmitting information through supervisory staff, departmental/unit meetings and other appropriate forms of communication.

B. Senior Management Group

The Senior Management Group, which is comprised of members of the EMT and department heads, meets bi-monthly. The meeting is chaired by the Facility Administrator, and is used to share information between the EMT, QMT and department heads. Department heads present department-specific reports; metrics are reviewed; corporate initiatives are presented; and other relevant material presented and discussed.

C. Department/Unit Meetings

Department heads are required to conduct meetings with their staff monthly, in order to share information from leadership and committee meetings and provide staff with the opportunity to participate as a team in quality management at the department level.

D. Quarterly General Staff Meetings

The Executive Management Team conducts general staff meetings quarterly to communicate with staff about major decisions, policy changes, upcoming activities, improvement opportunities and projects, and to give staff the opportunity to ask questions and give feedback.

E. Staff Satisfaction Survey

At least once per year staff have the opportunity to complete a satisfaction survey. The results are analyzed and presented to staff, along with a report on the actions that are being implemented and others that are being considered to address the priority issues identified through the survey responses. Employees are also given the opportunity to provide input on other issues through a variety of other surveys administered at general staff meetings or otherwise.

F. Administrative Bulletins, Newsletters & Calendars

The facility utilizes Administrative Bulletins/Newsletters to ensure proper notification and publication of data and information to all employee levels. These are produced and distributed electronically and/or in hard copy.

G. Feedback from External Customers

Feedback from external customers is actively solicited through dialogue with families, Department of Children and Families, community providers, advocates, and other business partners and stakeholders. Feedback on resident needs and perceptions is provided through the Resident Government system and the complaint and grievance process as well as the Satisfaction Survey, which each resident has the opportunity to complete at least once per year and upon discharge. This feedback is utilized for the improvement of treatment and services.

IX. QUALITY MANAGEMENT TRAINING

Quality management orientation is provided for all new employees. Departmental heads or their designees provide on-going quality management training. A program of ongoing training will be provided for leadership. Specific training in the team process and quality management methods and tools is provided to team leaders and members as new quality management teams are launched.

X. EVALUATION OF THE QUALITY MANAGEMENT PLAN

The Executive Management Team evaluates the effectiveness of the Quality Management Plan on an ongoing basis and provides quarterly reports and a complete annual evaluation report to the Governing Board. The evaluation measures how the facility performs relative to the specific processes that are outlined in the Quality Management Plan and the effectiveness of the quality management process as reflected in processes and outcomes related to care and services facility-wide.

The Corporate Compliance and Quality Management Coordinator reports regularly to the Quality Management Team and Executive Management Team on the overall implementation of the substantive components of the program. Effectiveness of the program is assessed through review of data relating to performance and outcome of processes and services.

Quality management priorities are determined from internal data analysis, comparative data and customer input. This information is incorporated into a SWOT analysis, which is performed as part of the strategic planning process.

Respectfully submitted to the Board of Directors for approval.

QUALITY MANAGEMENT PLAN 2009

Approved By:

Appendix 1

XXX Strategic Plan

Appendix 2

XXX Compliance Plan

Appendix 3

XXX Quality Management Team Structure

Appendix 4

XXX Performance Indicators, Outcome Measures and Other Metrics