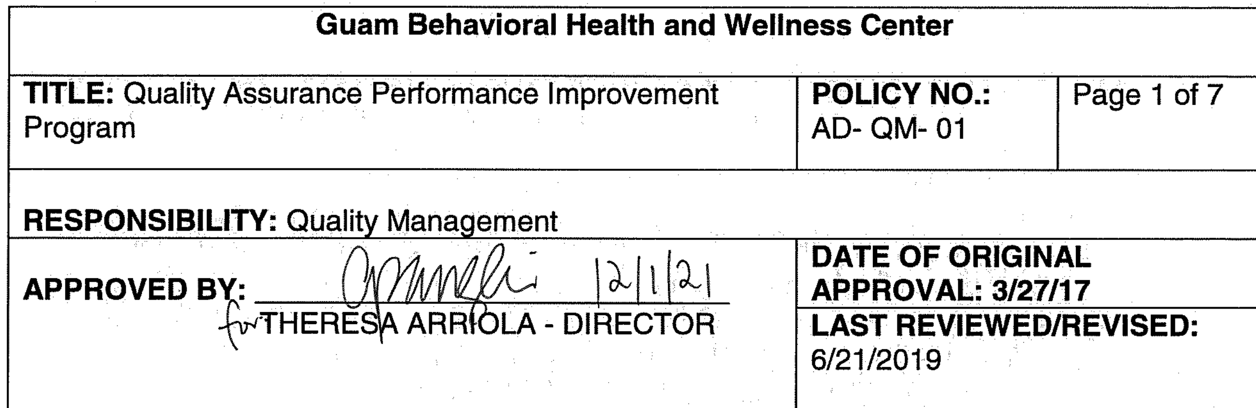

Guam Behavioral Health and Wellness Center		
TITLE: Quality Assurance Performance Improvement Program	**POLICY NO.:** AD- QM- 01	Page 1 of 7
RESPONSIBILITY: Quality Management		
APPROVED BY: [signature] 12/1/21 for THERESA ARRIOLA - DIRECTOR	**DATE OF ORIGINAL APPROVAL: 3/27/17**	
	LAST REVIEWED/REVISED: 6/21/2019	

PURPOSE:

A. To provide a Quality Assurance Performance Improvement (QAPI) program for the Guam Behavioral Health and Wellness Center (GBHWC) that supports its vision, mission, and organizational priorities.

POLICY STATEMENT:

A. The leadership and management of GBHWC support an environment that encourages the identification of improvement opportunities from all sources throughout the organization and the provision of care and services that are reflective of the organization's mission and vision (*see Mission, Vision and Core Value Policy AD-ORG 01).* It demonstrates its commitment to continuous quality improvement, through accreditation by Commission on Accreditation of Rehabilitation Services (CARF).

B. GBHWC 's quality improvement program is based on the principles of Continuous Quality Improvement (CQI). It provides a systematic, coordinated, continuous monitoring, collecting and analyzing data and make systems change to improve performance, focusing on processes and mechanisms of services that are provided in a safe, effective, consumer centered, timely, equitable and recovery-oriented fashion.

C. The Executive Management Council shall provide ongoing operational leadership of continuous quality improvement activities. Reviews the Quality Improvement Plan annually and establish measurable objectives based upon priorities identified through the use of establish criteria for improving the quality and safety of clinical services.

D. All clinical programs or divisions and Environments of Care Committee shall review quarterly performance data collected within their purview and shall initiate process improvement within their section.
   1. An Ad Hoc change team/quality improvement committee consisting of a diverse group representing an area of expertise will be created to facilitate any process improvement initiative or organizational change management.

RESPONSIBLITIES

A. Director/Deputy Director
   1. Provide oversight and leadership for all activities relative to GBHWC's Performance Improvement Plan.
   2. Shall support and guide implementation of quality improvement activities at GBHWC.

3. Shall be the project sponsor of all QI initiatives and assist the change team in obtaining resources and overcoming barriers encountered when implementing improvements.
4. Shall review, and approve the Quality Improvement Plan annually.
5. Shall review reported QI data of all clinical programs, health and safety, risk management as well as business function data such as but not limited to financial reports, human resources and technology report.
6. Shall approve and prioritize performance improvement initiatives, system and process redesign or change as recommended by the change team or QI Committee to improve quality of care and consumer satisfaction.

B. The QI Committee (Change Team)

The Quality Improvement Committee/Change Team shall provide ongoing operational leadership of continuous quality improvement activities or organizational change management.

1. It shall be chaired by the designated change facilitator or quality improvement coordinator.
2. The membership of the QI Committee may vary based on the project undertaken. Standing member roles are as follows

Role / Function	Rationale for members inclusion	Job title
Project Sponsor	An individual with executive authority and serves as the link to the QI team and organization's senior management. Provides the resources.	Director or Deputy Director
Project Manager	Stands as a lead to the QI team and in a position to drive the project, ensuring completion of team's task. Also a subject matter expert.	
Change Facilitator	Has completed training on Change Facilitator Academy	
Clinical Leadership	Has the authority to test and implement a change and problem solve issues that may arise.	Division Administrators
Technical Expert	Has a deep knowledge of the system and processes of care or area or system in question.	QI/Accreditation specialist Data Analyst EBHR "Superuser" Section representative who knows the process or system in question

3. It shall meet at least monthly or as needed to review quarterly data gathered from each department and implement change.

4. It shall support improved consumer outcomes by identifying education and training opportunities for personnel and targeting areas in which improvement is needed by reviewing results, performance indicators, consumer feedback.

5. The responsibilities of the committee shall include but not limited to;
    a. Identifies mental health care aspects to be monitored and establishes thresholds

    b. Shall choose indicators, prioritize measures that include high risk and problem prone areas identified throughout the organization, which are trended and analyzed by departments.

    c. Periodically assess information based on the indicators, taking action as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.

    d. Formally adopting a specific approach to Continuous Quality Improvement e.g. Plan-Do-Study-Act (PDSA), as deemed appropriate.

C. Quality Improvement Coordinator or Research Statistical Analyst

The Quality Improvement Coordinator (QIC) shall guide the construction of performance measures, coordinate and monitor the performance indicator and the implementation of the quality improvement programs relating to patient care and support services. The responsibilities shall include but not limited to;

1. Develops and monitor the implementation of quality improvement program.
2. Coordinates program activities of the change team with the clinical staff, program or departmental heads.
3. Provide project management, data analysis and measurement of outcomes, document and report the results and accomplishments of quality improvement initiatives to the Clinical Committee and or the Executive Management Committee.
4. Evaluates the effectiveness of agency/departmental quality improvement programs and makes recommendations to identified problems.
5. Coordinates and participates in the quality improvement monitoring activities through chart review, gathering, and collecting data.
6. Gathers compiles and analyzes data from different program and prepare report and recommendation to the Clinical committee for review.
7. Conducts educational programs related to quality improvement methodologies and activities as required.
8. Monitors departmental compliance to established quality improvement policies and procedures and reporting calendar.
9. Maintains data records and prepare quarterly and annual trending reports.
10. Analyze Performance Measure annually and reports to the Clinical Committee and Executive Management Council.

The QAPI Program

A. The QAPI Program shall objectively and systematically monitor and evaluate the quality of care, the services provided to the consumer by assessing care delivery, its effectiveness and efficiency of service, consumer safety, and customer satisfaction.

1. Performance Measures, Data Collection and Analysis
    a. The organization shall choose indicators and data elements that measure high risk and problem prone areas identified throughout the organization.

    b. Data shall be collected on key systems, processes and clinical outcomes to monitor effectiveness, efficiency of service, access to care and consumer satisfaction in accordance with Commission on Accreditation for Rehabilitation Facilities (CARF) standards.

    c. Data collected shall be trended over time to display any variations, improvements and analyze annually so that GBHWC leadership can make informed assumptions and generalizations about what has happened, why this might vary from what was expected, and what corrective action might be required.

2. Data Collection
   Data collection shall be done concurrently and on a monthly basis. The methods in which data will be collected shall be determined by the departments and stated in Performance Improvement plans, with guidance from QI Coordinator and the QI Change Team Committee.

    a. The organization shall take steps to ensure that data are reliable; by training new and existing personnel on recording each data element they are responsible for collecting.
    b. Indicators are explained and periodically reviewed.
        i. Indicators are defined with detail, data elements and the type of numerical value to be used to express the indicator e.g. percentage, rate, number of occurrence etc.
        ii. Data collection shall be described; how the data will be collected as well as method and frequency of collection, and who will collect the data.
    c. The organization shall take steps to ensure that data used for decision making are complete. Database is checked for completeness of records before final analyses are run and decisions made.

    d. Collected data shall be submitted to the Quality Improvement Coordinator every 10th of the month and will be reported quarterly to the different committees.

3. Guidance for continuing or discontinuing monitoring
    a. Standards based measures or mandated indicators from regulatory bodies (e.g. CARF) shall continually be monitored, reflected on one's PI plan, trended, analyzed and reported.

b. Monitoring activities can be decreased or eliminated for other PI indicators that sustained 95% compliance for a period of 6 consecutive months.

   i. Reporting of this data to QI committee can be discontinued after informing the QIC; reporting will ensue as needed when significant concerns surface or negative trends arise.
   ii. Monitoring activities can be decreased in frequency from monthly to quarterly and reduced to random spot audits. If compliance is sustained, the measure or indicator may be dropped from monitoring activities and the PI plan must be updated accordingly.

4. Priorities for Monitoring- Standards Related Indicators
   a. In accordance with CARF performance measurement and management standard, the following indicators shall be monitored and analyzed.
      i. Services delivery performance indicators for each program area such as effectiveness of service, efficiency of service, service access satisfaction and other feedback from persons served and stakeholder.
      ii. The organization collects data about the consumer at the beginning of services, appropriate intervals during services, at the end of services and points in time following the services.

   b. The data collected shall address the needs of the persons served, the needs of the other stakeholders and the business needs of the organization. The data collected by the organization shall also include but not limited to;
      i. Financial information,
      ii. accessibility status reports,
      iii. risk management,
      iv. human resources activities,
      v. technology,
      vi. health and safety reports,
      vii. satisfaction surveys
   c. The data collected are used to set written business function and written service delivery, objectives, performance indicators and performance targets.

5. Reports
   a. Annual narrative reports:
   Narrative reports from department will primarily focus on the PI indicator that did not meet goals. These reports shall be submitted to the QI Coordinator every second (2nd) Friday of October prior to the first FY EMC Committee meeting.

   b. Trending Sheets
   Trending sheets reflect the performance of all measures/indicators being monitored by departments (based on their PI Plans) over the course of

the calendar year. Trending graphs shall be included in the annual analysis report.

c. Action Plans
Action Plans should accompany the trending sheets and annual narrative reports when measures/Indicators do not meet expected target goals. The format of action plans may vary, but the following components must be included (*See Attachment I).*
   i. WHAT – describe the improvement actions undertaken
   ii. WHEN – indicate the dates of when the actions will be completed
   iii. WHO – identify those responsible for completing the actions

6. Performance Improvement Model
An interdisciplinary, continuous, performance improvement approach is recognized across GBHWC organization continuum of care and service areas utilizing **FOCUS PDSA model.** Process improvement will be undertaken by the change team.

   a. **FOCUS** is defined as:
      i. **FIND** a process that needs improvement
      ii. **ORGANIZE** a team that knows the process
      iii. **CLARIFY** the current knowledge of the process
      iv. **UNDERSTAND** the process and learn the causes of variation
      v. **SELECT** a strategy for continued improvement; start the PDCA cycle

   b. **PDSA** cycle is defined as:
      i. **PLAN -** is based on the result of data collection or the assessment process. The plan should include how the process will be improved and what will be measured to evaluate the effectiveness of the proposed process change.
      ii. **DO -** includes the implementation of the process changes. These changes may be tested before changing policies and procedures or conducting extensive education.
      iii. **STUDY-** evaluates the effect of the action taken at a given point in time
      iv. **ACT-** is to maintain and hold the gain and to continue to improve and implement the process

7. Performance Improvement Plans
Performance Improvement Plan is a list of all measures/indicators that department choose to monitor over the course of the fiscal year. Format for PI plan shall follow the Performance Plan template (*see Attachment II)*
   a. It shall undergo review and approval by the Executive Management Council.
   b. Evaluated PI plans and newly created PI plan shall be submitted to the appropriate Division Heads, prior to year-end, at a date specified by QIC,
   c. All PI Plans shall be collected by the Quality Improvement Coordinator

DEFINITIONS:

1. Performance Measure: The process of regularly assessing the results produced by the program. It involves identifying processes, systems and outcomes that are integral to the performance delivery system, selecting indicators of these processes, systems and outcomes, and analyzing information related to these indicators on a regular basis.
2. Performance Indicator: A quantitative tool that provides information about the performance of a clinic's or program's process, services, functions or outcomes.

REFERENCES:

CARF. (2020). Behavioral Health Standards Manual. Tucson, Arizona: CARF International.

White, S. V. (2012). Quality and Performance Improvement Q Solutions. Glendale Illinois: National Association for Healthcare Quality.

ATTACHMENTS:

I. *Performance Improvement Action Plan*
II. *2021 GBHWC Performance Improvement Plan Indicators*

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CORRECTIVE ACTION PLAN REPORT

Clinical Program: ______________________ **Date :** ______________

Program Supervisor or manager ______________________ **QI Team members:** ______________

____

Division Administrator ______________________ ______________

1. **Description summary of issues:** significant findings/problems that your department identified based on the PI data? (Of all the indicators, which is more significant to address now?

2. What is the problem or issue to be addressed? ______________________

Corrective Action for each root cause of the problem identified

Root Cause #1		
Actions to be taken/Strategy	**Responsibility**	**Completion Date**
1.		
2.		
1.		
Root Cause #2		
Actions to be taken/Strategy	**Responsibility**	**Completion Date**
1.		
2.		
3.		
Root Cause # 3		
Actions to be taken/Strategy	**Responsibility**	**Completion Date**
1.		

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REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

Policy Title: Quality Assurance Performance Improvement Program FY2022
Policy No: AD-RM-01
Initiated by: Regulatory Compliance

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11/18/21	[signature]

Barsen Adelbai
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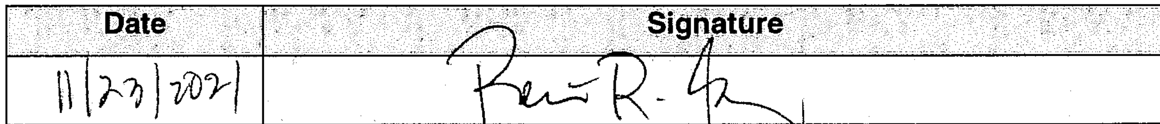

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11/23/2021	

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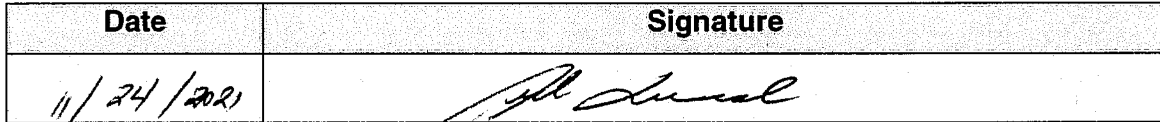

Date	Signature
11/24/2021	

Dr. Ariel Ismael
Medical Director

Date	Signature
12/1/21	

Carissa Pangelinan
Deputy Director