QUALITY MANAGEMENT / PERFORMANCE IMPROVEMENT PLAN

2023

MISSION STATEMENT:

Life Recovery Services' mission is to create a world-class organization that sets the standard of excellence by providing innovative and comprehensive treatment for specialty behavioral health and addiction disorders. Our programs foster the health, happiness, longevity, and self-reliant, responsible behavior for those who wish to recover and begin the healing process. We welcome all clients having substance-related, addictive disorders, and co-occurring mental health conditions.

To our clients, we are committed to individualized and quality care that enables them to regain hope in a supportive, caring environment.

To our employees, we are committed to offering an environment that encourages and supports both professional and personal growth.

To our community, we are committed to developing partnerships with physicians, professionals, and payers within the community we serve through the delivery of high-quality specialty behavioral health services at affordable costs while always putting the client first.

PURPOSE:

This program is operated for the purpose of offering help and understanding to chemical dependent persons who will acknowledge their necessity for assistance. We are here to assist and encourage the physical and mental recovery of such people. Because of physical condition, financial circumstances and in many cases, the lack of family and friends, the chemical dependent person is not able to recover without outside help. We believe that chemical dependence is a chronic, relapse prone disease that if not arrested can result in death to the individual. It is our belief that recovery occurs over a span of years and some individuals will require a more structured setting to enhance this recovery potential.

We believe that there is no wrong door at this agency. We welcome people from all backgrounds, regardless of race, sex, sexual orientation, religion, disability, etc. It does not matter if there is a single addictive problem, bad behavior, or co-occurring disorders. We will do our best to provide the services that are needed specific to the case. If we cannot meet those needs, we will coordinate with other providers who can assist.

SCOPE:

The Quality Management/Performance Improvement Program monitors, evaluates, and improves the effectiveness of services, the efficiency of services, client's access to services, and stakeholder satisfaction in all its' programs:

1. Outpatient/Intensive Outpatient Substance Abuse/Mental Health Treatment (children and adults)
2. Medication Assisted Treatment for Opioid Users (adults)
3. Case Management (children and adults) and Peer Recovery Support Services (ages 16+)

For the goals and objectives of each of these programs, please see Service Program Descriptions. These goals and objectives are reviewed an updated annually and as needed.

The Quality Management and Performance Improvement program focuses on all key organizational activities including management as well as treatment and support services. Improving organizational and service quality is a job function of all employees and contractors of the organization.

ROLES AND RESPONSIBILITIES:

All persons affiliated with Life Recovery Services have a role in its Quality Management/Performance Improvement program:

1. Executive Director (Cody Shoemaker): It is the role of the Executive Director to set the organization's strategic direction and vision and ensure organizational commitment to quality and the Quality Management Program. The Executive Director is a member of the Quality Improvement Team and serves as the Director of Quality Improvement. It is the role of the Executive Director to ensure implementation of the Quality management/Performance Improvement and Strategic Plans, oversee the Quality Improvement Team's support and implementation of the Quality Management/Performance Improvement and Strategic Plans, and routinely update the Leadership team regarding program monitoring. The Executive Director creates and distributes the Quality Improvement Team agenda and facilitates its meetings. The Executive Director also ensures the design of useful monitoring indicators, data collection methods, analysis and reporting, facilitates external audits by payers, accreditation bodies, the State of Oklahoma, and ongoing compliance with CARF accreditation standards.

2. Advisory Board Members: The Advisory Board is made up of clients from all services and is run by Cody Shoemaker (Executive Director). The Advisory Board has the opportunity to give input concerning the accessibility, quality, and client satisfaction with services. They can offer recommendations.

3. Leadership Team (Quality Management/Performance Improvement Team): It is the role of the Leadership Team to perform those quality management functions that ensure the successful implementation of the Quality Management and Strategic Plans. Those functions include the collection of valid and reliable data, analysis and report writing, clinical case record review, billing verification, teamwork facilitation, and quality training. Training will be provided initially upon hire and updated annually. The Leadership Team consists of the Executive Director (Cody Shoemaker), the Clinical Director (Kirsten Lee), the Medical Director (Linda Ramer), the Nurse (Judith Young), the Compliance Director (Bobbie Hill), and the Care Coordinator (Daniel Marquez). The Leadership Team meets throughout the quarter and reviews any issues that may have occurred, the input from the clients, any behavior risk issues, clinical issues, billing issues, and other financial matters. The Leadership Team ensures the implementation of the Strategic and Quality Management/Performance Improvement Plans as well as other written plans. All members on the Leadership Team are considered equals. In the event of a tie decision, the vote of the Executive Director is considered the winner. The final decisions are made by this team.

4. Staff: It is the role of all staff and Contractors to participate in the Quality Management/Performance Improvement Program by sharing their expertise in the teamwork process and ensuring data collected is valid and reliable. Training will be provided initially upon hire and updated annually.

DATA VALIDITY, RELIABILITY, COMPLETENESS, AND ACCURACY:

This agency maintains a data driven Quality Management/Performance Improvement program. Performance improvement is based upon objective analysis of reliable data. Life Recovery Services uses evidence-based measurement tools such as the Addiction Severity Index/Behavioral Health Index for clinical outcomes. The data is pulled from completed assessments and analyzed by clinician, department, and diagnosis. Staff members are trained upon hire and refresher trainings are completed annually to assure reliability in scoring. Satisfaction forms are collected from clients, business partners, and staff via the agency's website or phone. This agency has used the same measurement tools to measure the same identified indicators each year accurately and consistently. The Quality Improvement Team routinely verifies the validity of data submitted for performance measurement purposes by asking

the question “Are we measuring what we claim to be measuring?” When issues with data validity are noted, the Quality Improvement Team acts to ensure resolution.

Data reliability is also tested by the following:

1. Comparison of the quality analysis against external analyses completed by payers, accreditation bodies, or other regulatory entities.

2. Comparison of data collection methods against standards established by the Oklahoma Department of Mental Health and Substance Abuse Services.

3. Monitoring of unexpected or unexplained apparent shifts in performance based upon data used.

4. At least annual monitoring and evaluation of data collection methods and sources for ongoing accuracy, completeness, and reliability.

This agency collects data about clients at the following intervals

1. The beginning of services

2. Appropriate intervals during services

3. The end of services

4. 1 year after discharge from services

This agency collects data about clients from the following sources:

1. Financial information (Leadership Team)

2. Accessibility Information (Advisory Board, Leadership Team)

3. Resource Allocation (Leadership Team)

4. Surveys (Performance Improvement Reports, Leadership Team)

5. Risk Management (Leadership Team)

6. Human Resource Activity (Staff satisfaction surveys)

7. Technology (Information Technology Plan and Outcome Report)

8. Health and Safety Reports

9. Strategic Planning and Outcome

10. Reports Service Delivery (Performance Improvement Outcomes)

11. Incident Reports

12. ASI/BHI Outcomes

This agency collects demographic type data on each client such as age, gender, ethnicity, etc. We use data from clients who have enrolled in the perspective programs.

Input from each department is gathered on the effectiveness, efficiency, access, and satisfaction of each program.

EXTENUATING AND INFLUENCING FACTORS:

This agency recognizes that there are sometimes factors that can have an impact on the collection of the data, the data itself, and/or the analyzation of the data. During this time when COVID-19 has been rampant, it definitely has affected the views of both clients and staff. What once may not have been much of a concern to some now has a significant impact on daily life functioning. This in return may raise assessment scores. We must take into consideration other illnesses, including both physical and mental. There has been a recent increase in mental health crises, depression, anxiety, etc. The impact on children has even been felt among the parents. This has created additional stress and unprecedented worry. We have seen many individuals who simply have gone into survival mode, giving up many luxuries so that they can provide for their basic necessities. The economy has significantly impacted numerous clients and staff. Some have lost employment completely, while others have had a reduction in wages or hours worked. Due to financial impacts, some clients have been forced to sacrifice regular internet and phone access. This has prevented some people from completing online surveys. Although the agency has made attempts to reach people by phone, there has been a decline in the amount of people in which we have been able to maintain consistent contact.

THE QUALITY CYCLE

PHILOSOPHY:

This agency practices a continuous quality improvement cycle which consists of planning, monitoring, reporting, and responding.

PLANNING:

The quality cycle is driven not only by this Quality Management/Performance Improvement Plan but also by the Strategic Plan. These plans provide a basis that focuses efforts and activities and delineates clear goals and timelines to be achieved.

MONITORING:

The quality cycle is informed by the continuous collection of valid and reliable performance data. Each performance indicator describes the data necessary for measurement, their source and the method utilized to analyze the data.

REPORTING:

Data collected are analyzed to routinely inform the organization. Reporting provides clarity around the areas that are working well, as well as areas that present opportunities for improvement.

RESPONSE:

The quality cycle is fueled by data driven, quality improvement response. Responses include not only the quality improvement teamwork process, but also working in partnership with the Oklahoma Health Care Authority, the Oklahoma Department of Corrections, and other payers toward systemic change. We work to inform stakeholders and gather their input, and systematically improve organizational treatment processes, policies, and business practices. Response addresses areas for improvement, re-indicators for effect, and standardizes practices across the organization.

ANNUAL REVIEW:

The Quality Management/Performance Measures Improvement Plan is reviewed annually and updated as needed for continued efficacy. The review includes the following:

1. Current accuracy of the descriptions of the program structure and Quality Improvement Committee Membership.

2. The efficacy of performance indicators (Does the Quality Improvement plan monitor what it should, at the frequency it should, and in the way it should?)

3. The achievement of each performance indicator.

4. Recommendations of revisions to the program structure and performance monitoring plan.

Once a final report has been completed (in January), it shall be made available to the Board of Directors within 7 days. The Board will review the document. If no errors, objections, or revisions need to be made, the document will be made available online within 30 days of the findings.

QUALITY PERFORMANCE IMPROVEMENT PARTNERSHIPS:

This agency is committed to partnering with other organizations within the substance abuse and mental health treatment continuum of care to ensure clients receive the highest quality service. These partnerships include the following:

1. Facilitation of external audits

2. Thoroughly addressing requests for improvement

3. Participation in quality improvement efforts

4. Assistance and cooperation with audits performed by ODMHSAS

5. The establishment/maintenance of CARF accreditation

6. Implementation of best practices and other activities identified as improving quality of care

STRATEGIC PLANNING:

On an annual basis, the Executive Director and the organization's leadership and management teams engage in strategic planning. Strategic planning is the process of determining the organization's long-term goals. Strategic planning begins with an environmental scan which includes the following elements:

1. Review of the organization's performance measurement data, including input from all stakeholder groups.

2. Review of the results of external audits performed during the previous year.

3. Review of the organization's financial status.

4. Review of the organization's written vision statement.

5. Review of the organization's written mission statement.

6. Review of the organization's written corporate values.

7. Review of the progress on the previous year's strategic plan.

8. Analysis of the organization's current ability to meet its contracts and serve its clients.

9. Review of all plans and outcome reports

This agency utilizes the information collected as a part of the environmental scan to complete an analysis. This includes brainstorming of the organization's current strengths, weaknesses, opportunities, and threats identified through discussing their relevance, immanence, and their ability to be generalized across the organization; evaluating the continued relevance of the current plan and evaluate whether the fundamental strategic vision for the agency has changed.

STAKEHOLDER INPUT:

This agency routinely solicits, collects, analyzes, and uses input from stakeholders to create and continuously improve its services. These stakeholders include persons served, personnel, contractors (including payers and service providers), and community members in general. This agency utilizes a variety of mechanisms to gather stakeholder input, including customer satisfaction surveys, an Advisory Board, routine meetings with contract managers representing payers, client/family input, and monitoring of online activity and comments from our website.

1. Customer Satisfaction Surveys: Customer satisfaction surveys are continuously available on our website. Clients are urged to complete one at various intervals of the treatment process. Data is analyzed periodically at least once per quarter.

2. Payer contract management meetings: On a regular basis the Executive Director and/or other Leadership Team personnel participate with representatives of payer organizations in a review of our contractual performance. Feedback provided by the payer is integrated into the Quality Management/Performance Improvement Program and Strategic Planning process.

3. External Audit Reports: This agency routinely receives audits from various organizations/regulatory bodies (including ODMHSAS, OHCA, DOC, and third-party insurance carriers). At the conclusion of each external audit, the agency receives an audit report, which details audit findings and recommendations. These audit reports generally require a response in the form of a Corrective Action Plan. There are three phases to the corrective action plan development process:

   a. Phase I: Corrective Action Planning: identification of problems and administrative/service delivery policies and procedures affected by potential system changes made.

   b. Phase II: Corrective Action Description: writing a precise and clear plan of correction that describes the changes to be made; expected results of those changes; monitoring currently in place or to be developed to ensure changes have the desired effect. An effective corrective action plan must validate the effectiveness of the corrective action to ensure that the problem does not reoccur.

c. Phase III: Corrective Action Implementation: Managing a corrective action project to resolution is essential. Phases I and II of the corrective action plan development process must be completed with attention to implementation. For each corrective action plan developed, the developer must consider: who will be responsible for implementation of the corrective action plan; what policies and procedures must be revised/developed in order to effectively implement the corrective action proposed; what are the timelines for effective corrective action; who must receive training/retraining in the proposed corrective action; how will the agency know that the planned corrective action has been effective in addressing/improving the identified issue?

ENVIRONMENT OF CARE/ACCESSIBILITY:

This agency promotes accessibility and the removal of barriers for the persons served and other stakeholders. Life Recovery Services addresses accessibility issues to the following:

1. Enhance the quality of life of clients served in our programs.
2. Implement non-discriminatory employment practices.
3. Meet legal and regulatory requirements.
4. Meet the expectations of stakeholders in the area of accessibility.

At every meeting, the Quality Management/Performance Improvement Team reviews inspection reports on the facility. These reports identify barriers in the following areas:

1. Architecture
2. Environment or location
3. Transportation
4. Attitudes
5. Finances
6. Employment
7. Communication

Barriers identified because of these reports are addressed at each meeting with follow up occurring at subsequent meetings and included in an annual Accessibility outcome report.

CRITICAL INCIDENT/SENTINEL EVENT REVIEW:

This agency continually reviews and acts upon adverse occurrences that take place in clients' lives while receiving services. This review process must evaluate the extent to which:

1. Services and/or staff were involved in precipitating events/circumstances to the critical incident/sentinel event.

2. Additional precautions that could have prevented the critical incident/sentinel event.

3. Procedural changes that might prevent the critical incident/sentinel event from occurring in the future.

This critical incident/sentinel event review utilizes a root cause analysis process. This root cause analysis process takes place at the Leadership level and is augmented by routine clinical record reviews and service utilization review processes. The root cause analysis process requires that staff complete incident reports within 24 hours of the occurrence.

CLINICAL RECORD REVIEW:

Comprehensive, accurate and timely record of individualized services provided to our clients is paramount to the organization's success. Not only do payers require adherence to medical records standards, but also the maintenance of superb clinical records is necessary to achieve high quality care for our clients. Recovery Technology is committed to an internal record review procedure that continually ensures client records are comprehensively and accurately maintained. On an annual basis, the Quality clinical record review process ensures that a representative sample of each program's client population is reviewed. Reviews are completed using a standardized, objective data collection tool, which address the standards and requirements of payers.

PERFORMANCE MEASUREMENT

PERFORMANCE MEASURES:

Performance measures are developed to monitor the implementation, use and outcomes of organizational functions and service delivery. These performance measures have been developed to measure:

1. The effectiveness of services (addressing the quality of care and service outcomes)

2. The experience of services received and other feedback from clients (satisfaction/feedback)

3. The experience of services received and other feedback from stakeholders (satisfaction/feedback)

4. The resources used to achieve results for clients (efficiency) (administratively oriented measures)

5. Service access

Performance measures are continuously monitored to effectively identify areas for improvement. Measures are established under each of the four domains.

GOALS:

The following goals and objectives have been established for the Quality Improvement Program to be achieved by December 31, 2023:

1. Goal #1: BUSINESS FUNCTION-This agency will continue to market ourselves in a way that increases public awareness and understanding of behavioral health conditions (Intellectual Disabilities, Mental Health and Substance Use Disorders) and how to access treatment and supports available through the agency (High Priority/Ongoing).

Objective #1: The agency will provide ongoing opportunities for community education related to behavioral health conditions, available treatment options, and how to access recovery-oriented services and supports.

Objective #2: The agency will review marketing strategies and tools (website, LED sign, etc.) and look for ways to incorporate additional information regarding the importance of substance use and mental health treatment and recovery.

Objective #3: The agency will participate in community events to further promote substance abuse and mental health awareness and recovery.

Objective #4: The agency will increase awareness by observing and recognizing events such as the following: Alcohol Awareness Month, International Overdose Awareness Day, Mental Health Month, National Drug and Alcohol Facts Weeks, National Impaired Driving Prevention Month, National Prescription Take Back Day, National Recovery Month, National Substance Abuse Prevention Month, National Suicide Prevention Week, Nurses Day, Red Ribbon Week, Stress Awareness Month, World Mental Health Day, and World No Tobacco Day.

2. Goal #2: EFFECTIVENESS; EFFICIENCY-This agency will continue to strengthen a healthy work environment (High Priority/Ongoing)

   Objective #1: The Leadership Team will continue to use the skills we teach in all interactions with staff, clients, and other stakeholders to create a healthy workplace environment.

   Objective #2: The Leadership Team will host events periodically throughout the year that will simply be a time of connecting with people and sharing successes and acknowledging staff for their accomplishments.

   Objective #3: The agency will use an employee satisfaction survey to determine the effectiveness of this goal.

3. Goal #3: EFFECTIVENESS; EFFICIENCY This agency will assure that all staff consistently receive their annual trainings in a meaningful way that will improve their clinical practices and strengthen the workplace (High Priority/Ongoing).

   Objective #1: The Leadership Team will continue to strive for 100% compliance for all staff in all required trainings.

   Objective #2: The agency will offer relevant trainings internally to our staff on subjects that will benefit them in their work with clients.

   Objective #3: The agency will continue to both in-house and online trainings.

   Objective #4: The Leadership Team will maintain a workforce of knowledgeable, skilled, and culturally respectful staff.

4. Goal #4: EFFECTIVENESS; EFFICIENCY-On an annual basis, regulatory audits will demonstrate

superior organizational performance (Low Priority/Ongoing).

Objective #1: This agency will score 85% or better on all audits.

5. Goal #5: EFFECTIVENESS; SATISFACTION OF STAKEHOLDERS; SATISFACTION OF CLIENTS-At least 60% of discharges will be described as successful discharges (Low Priority/Ongoing).

   Objective #1: Discharges will be totaled at the end of the fiscal year. Successful discharge will be described as completion of treatment or discharged for reasons beyond our control.

   Objective #2: Discharge data will be analyzed by the agency.

6. Goal #6: EFFECTIVENESS; SATISFACTION OF STAKEHOLDERS; SATISFACTION OF CLIENTS-This agency will use ASI/BHI scores to measure clinical improvement in all services (Low Priority/Ongoing).

   Objective #1: Clinical outcomes for Outpatient/Intensive Outpatient Treatment will be at least a 15% overall improvement in functioning.

   Objective #2: Clinical outcomes for Medication Assisted Treatment will be at least a 15% overall improvement in functioning.

   Objective #2: Clinical outcomes for Case Management and Peer Recovery Support Services will be at least a 15% overall improvement in functioning.

7. Goal #7: SERVICE ACCESS; SATISFACTION OF STAKEHOLDERS; SATISFACTION OF CLIENTS -This agency will create a positive experience for those accessing our services.

   Objective #1: Stakeholders will report satisfaction/ease of making referrals to the agency.

   Objective #2: Clients will report satisfaction/ease of beginning treatment with the agency.

   Objective #3: Clients will have numerous options concerning the method in which they access treatment (tele-health, in-office, in-home, etc.).