Performance Improvement
Policy and Procedure Manual

Revised: 09/10/2024

TITLE: Performance Improvement	REFERENCE: PI.02.01.01
REVIEW AND APPROVAL: 09/10/2024	SUBJECT: PERFORMANCE IMPROVEMENT PLAN

1. **Jones Wellness Center Mission Statement**
    a. Jones Wellness Center changes lives by providing compassionate, client-centered, integrative, and evidence-based approaches to heal mental health and eating disorders. Through respect and best practices, Jones Wellness Center offers a continuum of care including assessment, intervention, and recovery services for teens, adults, and their families.
2. **Jones Wellness Center Vision**
    a. At Jones Wellness Center, we aim to address the needs of individuals by providing treatment for issues caused by mental health and eating disorders. Jones Wellness Center strives to utilize best practices while providing outpatient treatment services. We endeavor to guide individuals through a process of change, help them improve health and wellness, learn to live a self-directed life, and strive to reach their full potential by addressing and treating co-occurring mental health and eating disorders.
3. **Jones Wellness Center Values**
    a. Jones Wellness Center's core values constitute the framework of our performance improvement program.
        i. **Teamwork**
            1. Open communication, cooperation and collaboration.
            2. Staff members work together to achieve our vision.
            3. Managers create environments that encourage communication and support staff.
        ii. **Client Directed Services**
            1. To treat every client with respect and to provide individualized customer driven service in a dependable manner.
        iii. **Integrity**
            1. Pursue ethical practice, honesty and accountability.
        iv. **Empowerment**
            1. To create an environment in which all levels of management and staff take responsibility for promoting a positive work environment with positive attitudes, shared respect and enthusiastic contribution to and ownership of the Jones Wellness Center's mission.
            2. Remove barriers to outstanding performance.
        v. **Performance Improvement**
            1. To continually seek opportunities for improvement and to encourage the development of personal and professional competencies.
        vi. **Excellence**
            1. To perform with operational excellence by providing evidence-based care and by designing and implementing an efficient infrastructure.
        vii. **Technology & Innovation**
            1. To display flexibility, creativity and entrepreneurial spirit.
            2. Continue to support change as it encourages new ideas and approaches.
            3. We utilize data collection methodologies to track multiple data points across various areas where there is always an opportunity for improvement.
        viii. **Cultural Competence**
            1. To be sensitive to and value the diversity of cultural beliefs, perceptions, ethnicity, sexual preferences, language differences and religious practices of persons-served, their families and Jones Wellness Center staff, and to recognize the influence of culture on the effective delivery of behavioral healthcare.
        ix. **Safety**
            1. Services are provided in an emotionally and physically safe, compassionate, trusting and caring treatment/working environment for all persons served, family members and staff.

Jones Wellness Center's Philosophy:

1. Jones Wellness Center recognizes behavioral health issues are a primary issue.
2. The issue affects brain-functioning and physiology, mental health, social, and behavioral functioning and the totality of personal characteristics.
3. The illness if left untreated is a chronic, progressive, and fatal illness.
4. The illness is pervasive and affects not only the individual but has an impact on all who interact with them.
5. We believe each individual has the right to be treated with respect and dignity as they are valued by society.
6. We believe each individual has the right to treatment, the most appropriate level of treatment, regardless of creed, gender, race, sexual orientation, age, or origin and they have the inherent potential for change and growth.

Jones Wellness Center's Annual Company Goals:

1. Reduce the symptomology for patients as evidenced by:
    a. Reduce acuity level based off evidence based assessment tools (PCL5, GAD7, PHQ9, etc.)
    b. Clients' self-report based off surveys
2. Reduce high risk behavior responsible for infection as evidenced by:
    a. HCA/HIV, Hepatitis, STD risk assessment, education and referrals for testing
    b. Monitoring infection based practice
    c. Educating when necessary on infection control
3. Promote health equity as evidenced by:
    a. Treatment planning with emphasis on patient driven health equity measures
    b. Client's self-reported health equity survey data

Goals and Objectives

1. **Organizational Goals**
    a. To function as a mental health provider, by providing intensive outpatient/outpatient services to adults.
    b. To rapidly respond to the special needs of a diverse patient population, assessing needs and recommending appropriate action.
    c. To establish linkages with the professionals who serve adults and adolescents who share human and ethical values consistent with those of Jones Wellness Center.
    d. To employ experienced, committed, dedicated staff and support ongoing education and training opportunities to enhance their skills and abilities.
    e. To support creative patient centered/relapse prevention programs and services emphasizing goal oriented problem-solving assistance to meet individuals' needs.
    f. To operate, grow and develop within the perspective of a systems approach to the delivery of multi-level service options, design and coordinate for easy consumer access and utilization.
    g. To control utilization of resources such that appropriate care treatment is provided to effectively address individual needs using the least costly, least disruptive and least intensive approach.
    h. To support program and service directions which promote both short- and long-term financial success of Jones Wellness Center.
2. **Objectives**
    a. The objectives of the performance improvement plan are:
        i. To take advantage of new opportunities determined feasibly and likely to contribute to Jones Wellness Center ability to meet its mission and reach its financial objectives.
        ii. To conduct business affairs in compliance with applicable laws and regulations and with the highest regard for professional integrity.
        iii. To increase collection and use of patient feedback and measurement of outcomes.
        iv. To enhance operating efficiency, integration, and effectiveness through commitment to Total Quality Management principles.
3. Jones Wellness Center performance improvement's principal goal is to facilitate the improvement of those processes that most affect patient outcomes.
    a. This Performance Improvement Plan shall be established to serve as a blueprint for Jones Wellness Center-wide effort to assess and improve the quality of service delivery.
    b. To this end, Jones Wellness Center shall work toward:

        i. Improving the appropriateness and effectiveness of its services and outcomes.
        ii. Upgrading staff competency and performance.
        iii. Preventing or eliminating barriers to good patient care.
        iv. Resolving identified problems.
        v. Taking effective action when improvement is desired.
        vi. Creating a patient-focused culture.
4. The goals of the Performance Improvement Plan shall be established to accomplish the following:
    a. To respond to our patients with courtesy, respect and dignity at all times.
    b. To work as a team in the effective and efficient delivery of high-quality patient services.
    c. To provide the highest quality, patient friendly, cost-effective services to all patients.
    d. To empower employees to make recommendations for ongoing improvements for patient services.
    e. To provide the necessary education, training, and tools for continuous quality improvement processes.
    f. To increase Jones Wellness Center leadership role in assessing and improving patient outcomes for Jones Wellness Center.
    g. To effectively evaluate the quality of patient care through a continuous, coordinated and integrated process.
    h. To identify opportunities to improve patient care and outcomes by assessing those important functions related to good patient outcomes.
    i. To maximize the use of other quality-related feedback to identify opportunities for improvement, such as patient satisfaction or complaints, survey recommendations and outcome data.
    j. To ensure throughout Jones Wellness Center the provisions for a comparable level of care are disseminated.
    k. To maximize coordination and collaboration of communication among individuals, units and services of Jones Wellness Center.

Leadership Role:

1. Commitment:
    a. The governing body of Jones Wellness Center intends for the highest quality of service to be achieved and maintained throughout Jones Wellness Center and services.
    b. The Founder has assigned this responsibility to the Medical Director and the Leadership Team to develop and maintain optimal standards of patient care.
    c. A systematic, coordinated and continuous approach to assess and improve the performance of those functions and processes determined to be most directly related to good patient outcomes will be developed in a collaborative manner.
2. Statement of Commitment:
    a. Jones Wellness Center is committed to:
        i. Providing support, resources, and education for the Performance Improvement goals.
        ii. Multi-disciplinary involvement in the Performance Improvement process.
        iii. An empowerment management style congruent with the Performance Improvement philosophy.
        iv. A customer focused Performance Improvement process.

Purpose:

1. The purpose of the Performance Improvement Plan is to facilitate and foster Jones Wellness Center commitment to quality patient care.
    a. This will include providing support of the following activities essential for:
        i. Organizational strategic success.
        ii. Insurance that ethical standards of practices are met.
        iii. Encouraging cooperation, coordination, and communication among administration, supervisors, and staff.
2. In addition, the Performance Improvement Plan will provide a structured organization-wide process through which Jones Wellness Center can focus its efforts on accomplishing Performance Improvement in areas that are critical to its mission, vision, values, and strategic plan.
    a. Essential activities in the Performance Improvement Plan will be coordinated with the Leadership Team as well as outside agencies.
    b. Inherent in each of these purposes is the promotion of a positive organization that can improve the delivery of services offered to our patients through Performance Improvement activities.

c. A Four-Step Model (Plan-Do-Check-Act) (Appendix A) will provide the opportunity for input from line staff and patients as well as supervisors and administrators.
d. Jones Wellness Center Performance Improvement Plan is an on-going process of assuring quality service to the patients receiving treatment.
e. The Performance Improvement Plan addresses the necessary mechanisms and processes to ensure those processes occur.
f. The Performance Improvement Plan addresses the design, measurement, assessment, improvement, and re-design approach for important patient care and organizational functions.

3. Goal:
    a. The goal of the Performance Improve Plan in conjunction with the Leadership Team is to streamline improvement-monitoring activities.
    b. The focus of the Performance Improvement Team is to establish priorities for improving Jones Wellness Center performance, utilizing resources more effectively and efficiently, while continuing to provide quality care and service.

Scope of Performance Improvement Activities

1. Appropriate services, contractual services, and disciplines will be involved collaboratively in the design, measurement, assessment, and improvement activities.
2. The term "Performance Improvement" encompasses activities that previously constituted quality assurance, as well as quality assessment and improvement.
3. The following important patient care and organizational functions are to be measured on a continuing basis:
    a. Patient-Focused Functions:
        i. Patient rights and organizational ethics
        ii. Areas for improvement defined by leaders, management, and staff
        iii. Patient Satisfaction
        iv. Evaluation of Patient Outcomes
    b. Organizational Functions:
        i. Improving organizational performance
        ii. Leadership
        iii. Culture of Safety
        iv. Management of the Environment of Care
        v. Management of Information
        vi. Management of Human Resources
        vii. Surveillance, Prevention and Control Infection
4. The patient care and organizational functions which are represented through the appropriate services, contractual services, and disciplines will be monitored and evaluated through the establishment of indicators, the collection of data, and aggregation of findings.
    a. The reporting of such findings will be under the direction of the Performance Improvement Chair, and/or the Founder. Reports which will be forwarded to the Leadership Team on a quarterly basis.
    b. In addition, the Leadership Team will regularly analyze data to reveal trends and patterns of performance or outcome, and implement corrective action/performance improvements when necessary, and evaluate the effectiveness of those actions.
5. A Priority Setting Grid (Appendix B) will be utilized to select and assess Performance Improvement activities.
    a. The priority grid card will compile and evaluate impact areas for the Division on a point value system.
    b. The impact areas will include life threatening (10 points); Potential for life threatening (8 points); Safety (8 points); Increased cost (S points); Decreased Customer Satisfaction (5 points); Potential Liability (5 points); Impact Regulatory Compliance (8 points); Ethical Impact (2 points); and Public Relations (2 points); Relationship to Mission/Vision/ Strategic Plan (8 points)

Communication & Collaboration

1. Jones Wellness Center's Performance Improvement Communication System (Appendix C, Performance Improvement Communication Flow Chart) illustrates the communication and collaboration of all parties involved in the improvement of organizational performance.
    a. The patient is a board term to define any person who uses or depends on the work provided by employees or who use Jones Wellness Center services (ex. patients, families, co-workers, physicians, referral sources,

etc.). Patients provide the information needed to assess quality and facilitate improvement efforts.

2. Jones Wellness Center's Leadership Team is responsible for implementing and coordinating the Performance Improvement Plan by serving as the clearinghouse for data, establishing organization-wide priorities for performance improvement projects, reviewing opportunities for improvement to insure consistency with organization-wide goals, and communicating progress reports to the Leadership Team, Founder and Clinical Management Team of Jones Wellness Center.
    a. The communication and collaboration among the Leadership Team, and Clinical Team is on an on-going basis. Modern will assure input from all groups regarding priority improvement projects as well as the results of projects.
3. In addition, performance improvement teams and sites design, measure, assess, and improve processes and outcome (See Appendix A).
    a. This ongoing process of assessment provides information to assist the Leadership Team to improve or may provide data to support the formation of improvement groups.
    b. The flow of communication may occur from the top down or the bottom up and may originate at any point in the process.
4. Jones Wellness Center's Performance Improvement FlowChart (Appendix C) exhibits the flow of data and the formulation of process improvement groups/teams.

Structure & Procedure

1. Structure
    a. Functions of the governing body.
    b. Ensures and oversees the effectiveness of the Performance Improvement process.
    c. Ensures that appropriate levels of care are maintained throughout Jones Wellness Center.
    d. Responsible for reviewing and acting on the Performance Improvement endings and actions relevant to the management and clinical staff.
2. Functions of the Leadership Team
    a. Responsible for providing leadership for the assessment and improvement activities, and for ensuring that these activities are conducted in a collaborative, continuous and effective manner.
    b. Responsible for implementing the Quality Assurance Plan that may be called a Performance Improvement Plan.
    c. Responsible for designing and planning the Performance Improvement implementation system.
    d. Responsible for ensuring that all staff involved receive needed training/education regarding the tools to the Performance Improvement process.
    e. Responsible for screening, selecting and prioritizing areas of clinical services requiring improvement.
    f. Responsible for re-prioritizing issues in response to unusual or urgent events.
    g. Responsible for assigning or approving collaborative project/work teams.
    h. Develop formats for the documentation of team activity and results.
    i. Monitor the implementation and assess the effectiveness of changes made.
3. Membership of the Leadership Team
    a. Founder
    b. Performance Improvement Chair - Corporate Compliance Officer/Safety/Risk Manager Officer
    c. Others as appropriate, members of the Clinical Team

4. Meetings of the Performance Improvement Function
    a. Meetings are held each quarter and are conducted by the Performance Improvement Chair.
    b. Procedures and functions Performance Improvement meetings include, but are not limited to the following activities:
        i. The Leadership Team activities will be conducted by designated staff from Jones Wellness Center and reported to the appropriate Performance Improvement functions/ subcommittee monthly.
        ii. All reports to the Performance Improvement functions/subcommittee will be in writing.
        iii. To effectively utilize staff, monitoring functions will be conducted in a manner that complements existing reporting activities to local, state, and federal offices.
    c. Recommendations from the Performance Improvement functions/subcommittee will flow to the Leadership Team.

i. All decisions related to policy change or implementation require a vote.
ii. A simple majority of members present are required to implement any decision.

d. A quorum will consist of sixty percent (60%) of the membership of the Leadership Team.
e. All performance improvement reports are submitted to and reviewed by the Team and are considered a part of the minutes.
f. A detailed agenda is used for all function meetings, which serves to track the status of issues identified for improvement.
    i. Confidentiality of all performance improvement related reports and documents is maintained.
g. Members of the Leadership Team will review copies of the minutes prior to the meeting.
h. Copies of the minutes, logs and reports are maintained by the Performance Improvement Chair.
    i. It is the responsibility of the P.I. Chair to forward copies of all minutes to the Leadership Team members two days prior to the regularly scheduled monthly meeting.
i. The Leadership Team will establish improvement strategies that will focus upon systems/subsystems issues throughout Jones Wellness Center.
j. When a process has been implemented, but the issues have not been resolved, the Performance Improvement Chair and/or designee will direct responsible parties to implement additional actions and/or help form a quality improvement group or team to address the issue.
k. The Performance Improvement Chair and/or the Quality Improvement Chair will recommend performance improvement goals based upon quality assessment data and findings and actively participate in evaluation and planning.
l. Based upon the findings, the Performance Improvement Chair and/or the Quality Improvement Chair may choose a project improvement group to plan its performance improvement activities.
m. The Leadership Team will submit a summary report to the CEO on an annual basis.
n. Authority and Responsibility of the Performance Improvement Chair (P.I.C.).
o. The Leadership Team will maintain an ongoing collaborative relationship with services, programs and functions in order to support the facility's effort to improve performance of services.
    i. Support will include, but is not limited to:
        1. Collecting and aggregating data for Performance Improvement
        2. Team quarterly report
        3. Assisting with designing indicators
        4. Providing support of function activities
            a. Providing education of Performance Improvement methodology to supervisors and staff.
            b. Providing Performance Improvement activity summary reports.
            c. All participants and function members will be encouraged to use the Four-Step Model for Monitoring and Evaluation.
p. Performance Improvement indicators will be reviewed by the Founder to ensure their consistency and relevancy with the programs.
    i. The Leadership Team will share program strategies that reduce barriers to communication and proposed outcomes.
    ii. The Leadership Team may request reports, minutes, follow-up information, or any additional information from function chairpersons that will assist with assessing performance improvement indicators.

q. The Founder will serve as consultant to the Leadership Team in assessing appropriateness and effectiveness of the Performance Improvement activities.
r. Reporting of the Performance Improvement Team
s. Minutes are maintained for each meeting.
    i. All Performance Improvement reports submitted to and reviewed by the Leadership Team are considered a part of the minutes.
t. A detailed agenda is used for all function meetings, which serves to track the status of issues identified for improvement. Confidentiality of all Performance Improvement related reports and documents is maintained.
u. The Leadership Team submits a summary report on an annual basis.

Performance Improvement Plan and Continuous Quality Improvement Procedures *(Data Collection and Evaluation)*

1. The Performance Improvement activities will include:
    a. Providing ongoing monitoring and evaluation of important aspects of care.
    b. Solicitation and evaluation of patients (patients, family members / significant others) needs and expectations to improve delivery systems and performance patterns.
2. Performance Improvement Plan activities will include but not be limited to the following functions:
    a. Infection Control Function:
        i. The Infection Control Representative is appointed by the Founder.
        ii. The Infection Control Representative is a member of the Leadership Team.
        iii. The Medical Director will designate an Infection Control Coordinator.
        iv. The Infection Control Coordinator responsibilities include various tasks related to infection control activities.
        v. The Infection Control Coordinator will serve on the Leadership Team.
        vi. The functions of the Infection Control Representative/Coordinator will include:
            1. Compiling and reviewing Performance Improvement reports for:
                a. Outcome of regular and special surveillance activities.
                b. Providing communication of conclusions, recommendations, and actions to the Leadership Team quarterly.
                c. Instituting surveillance, prevention, and control measures when there is a reason to believe there is a danger to patients or staff.
    b. Safety/Risk Management Function:
        i. The Safety/Risk Management Representative is appointed by the Founder.
        ii. Safety/Risk Management include those functions related to safety and risk management activities as defined in the safety management plan.
        iii. The Safety/Risk Management Representative will be on the Leadership Team.
        iv. The functions of the Safety/Risk Management chair will include:
            1. The compiling and reviewing of Performance Improvement reports.
                a. Safety: compiled by the Safety Coordinator and/or Risk Manager.
                b. Security: compiled by the Safety Coordinator and/or Risk Manager.
                c. Emergency Preparedness: compiled by Safety Coordinator and/or Risk Manager.
                d. Utilities Systems: compiled by Safety Coordinator and/or Founder.
                e. Education: compiled by Founder.
            2. Providing communication of conclusions, recommendations, and actions to the Leadership Team quarterly.
    c. Utilization Management/Quality Assurance Function:
        i. The Utilization Management/Quality Assurance Representative is appointed by the Founder.
        ii. The Utilization Management/Quality Assurance Representative includes those functions related to Utilization Review activities including appropriateness of admissions and continued treatment and other data needed to support the review process.
        iii. The Utilization Management/Quality Assurance Function Representative will serve on the Leadership Team.
            1. The functions of the Utilization Review Representative will include:
                a. Compiling, reviewing and analyzing data submitted through Utilization Management activities:
                    i. Quality Control: monitoring and evaluation.
                    ii. Clinical Services: monitoring and evaluation.
                    iii. Utilization Review: monitoring and evaluation.
                    iv. Medical Records: timeliness, completion and clinical pertinence.
                b. Conducting peer review when indicated.
                c. Recommending performance assessment and improvement corrective plan.
                d. Providing communication of conclusions, recommendations, and actions to the Leadership Team monthly.
    d. Staff Training/Competency and Educational Development Function:
        i. The Staff Training/Competency and Educational Development Representative is appointed by the Founder.

1. A member of the Leadership Team will be designated as the Staff Training Chair/Coordinator.

ii. Staff Training/Competency and Educational Development include tasks related to ensuring staff training and education and orientation of staff.
    1. The Staff Training/Competency and Educational Development Chair/Coordinator will serve on the Leadership Team.
    2. The functions of the Staff Training/Competency and Educational Development will include:
        a. Ensuring coordination and scheduling of all staff training and education on a yearly basis.
        b. Reviewing staff training and education needs, patient and staff suggestions.
        c. Reviewing competency evaluations for contracted services on a yearly basis
        d. Conducting reviews when indicated related to training, competency and education issues.

e. Grievance/Ethics Team
    i. The Grievance/Ethics Team and chair is appointed by the Founder.
    ii. The Grievance/Ethics Team's responsibilities include tasks related to ensuring patient grievances are addressed and resolved.
    iii. The Grievance/Ethics Team's Representative will serve as on the Leadership Team.
    iv. The functions of the Grievance/Ethics Team and Representative will include:
        1. Meeting on an as needed basis.
        2. Ensuring staff and patient grievances/ethics are reviewed and resolved.
        3. Ensuring staff and patient suggestions are reviewed: compiled by the Founder and forwarded to the appropriate function.

3. Reviewing of Patient and Staff surveys: compiled by designated person.
    a. We will also measure this against poor outcomes measurements.

QUALITY ASSURANCE & MANAGEMENT

Purpose:

1. The purpose of this policy is to establish a measurable quality assurance and improvement program.
2. While it is essential to follow the established policies and procedures, it is also important to create an internal process that continuously evaluates these policies and procedures to improve their effectiveness and efficiency.
3. The four primary goals of the Quality Management program are to ensure:
    a. That quality services are provided.
    b. That the services are provided to eligible clients.
    c. That the payments are based on properly documented service.
    d. That performance is assessed and outcomes are monitored, achieved, and documented properly.
4. The objectives associated with these goals are:
    a. To provide the assurance that the program is being implemented with fidelity.
    b. To identify exemplary performance and shore up weaknesses.
    c. To strengthen internal consistency.
    d. To propose and implement improvements that increase effectiveness.
    e. To provide personnel training and technical assistance on quality assurance practices and processes.
    f. To continuously monitor subcontractor programs and operations.
    g. To create a team of QA staff to act as a peer review to identify exemplary performance, assist with desk reviews and QA monitoring, and improve the QA methodologies, tools, policies and procedures.
    h. To strengthen systemic consistency of the QA processes.
    i. To foster a culture that proposes and implements changes.

Responsibility:

1. The Governing Body is responsible for overseeing the Quality Management policies and procedures.
2. They will ensure that each team member follows the roles and responsibilities listed on the table below.

Policy:

1. The Quality Management policy serves as a mechanism to review, analyze, and document processes at modern times to identify areas where quality is not optimal, and implement corrections to ensure compliance with our standards of care.
2. It is the policy to follow the Plan, Do, Check, Act.

Scope:

1. The scope of the QA Plan will include the following topics:

Incident Reports	Client Satisfaction Surveys	Discharge Coordination
Grievance Reports	Therapeutic Value of Program	Life Skills Curriculum
AMA Reports	Implementation of EBP	Utilization Review
Client Records	PI/Corrective Action MOS	Employee Surveys
Outcomes Tools	EOC Reports	Emergency & Fire Drills

2. The QA Plan will be monitored to ensure continuous quality improvement and be assessed and reviewed on a bi-monthly basis for the first 12 months by the Governing Body via telephonic and in person leadership and QA meetings.
3. Thereafter, the meetings will occur on a monthly basis for an additional 12 months.

Team Members	Roles	Responsibilities
Compliance Committee	Monitoring and Technical Development	1. Develops an annual QA plan. 2. Coordinates internal monitoring plan with supervisors. 3. Coordinates with the State Program Office. 4. Conducts internal QA monitoring. 5. Writes reports of internal monitoring findings, recommendations, and proposes CAP/PIPs. 6. Tracks CAP/PIPs and reports progress to supervisors. 7. Conducts at least one quality improvement (QI) project per year. 8. Submit proposed changes based on QI project findings. 9. Conducts monitoring of QA/QI programs. 10. Writes reports of QA monitoring findings, recommendations and proposes CAP/PIPs. 11. Track implementation of QA/QI CAP/PIPs. 12. Coordinates QA/QI Workgroups. 13. Provides at least 2 training workshops QA/QI processes and best practices. 14. Provides technical assistance as needed. 15. Writes and submits to the Governing Body, Founder, and Compliance Officer a summary report of QA/QI.
Compliance Officer	Oversight	1. Reviews the annual plan and submits it to the Founder for approval. 2. Meets with a Compliance Specialist for regular status reports. 3. Reviews reports and CAP/PIPs and submits to the Founder for approval. 4. Approves QI projects and training curriculum. 5. Reviews proposed changes to policies and procedures. 6. Coordinates with HHS Program Office. 7. Reviews summary report and submits to Founder for approval.
Supervisor/s	Coordination	1. Review the annual plan and submit comments to the Founder. 2. Cooperates with QA monitoring of the program by making records available.

Procedure:

1. Frequency of Monitoring:
    a. The Compliance Specialist will perform quality assurance monitoring of the program.
    b. Monitoring should utilize the SWOT analysis when looking at how processes and outcomes are working.
2. Scope of the Monitoring:
    a. The Compliance Specialist will monitor all of the systems that implement the program.
3. Methodologies for Conducting Monitoring:
    a. The Compliance Specialist shall use three techniques to conduct their quality assurance monitoring.
    b. The first involves reviewing a sample of documents using a set of checklists.
    c. This component of the review must be completed every 15 days for the first 12 months.
    d. The second involves conducting a data flow analysis.

    e. The purpose of the analysis is to determine if the information is being properly reviewed and approved, if

there are backlogs, if it represents all of the data, and if there are any inefficiencies with the "flow" of the data.

f. The data flow analysis must be performed at least bi-annually.
g. Additional reviews are only required, if corrective action/performance improvement was necessary.
h. The frequency of the follow-up reviews will be based on the corrective action/performance improvement plan.
i. The last technique consists of structured staff interviews.
j. The purpose of staff interviews is to determine if staff is trained both on the procedures and the content of the information they are responsible for collecting, transmitting, or inputting, if they have problems completing their tasks, and if they have suggestions for improving the procedures.
k. These interviews must be performed at least once a year.
l. Additional follow-up is only required, if corrective action/performance improvement was necessary.
m. The frequency of the follow-up reviews will be based on the corrective action/performance improvement plan.

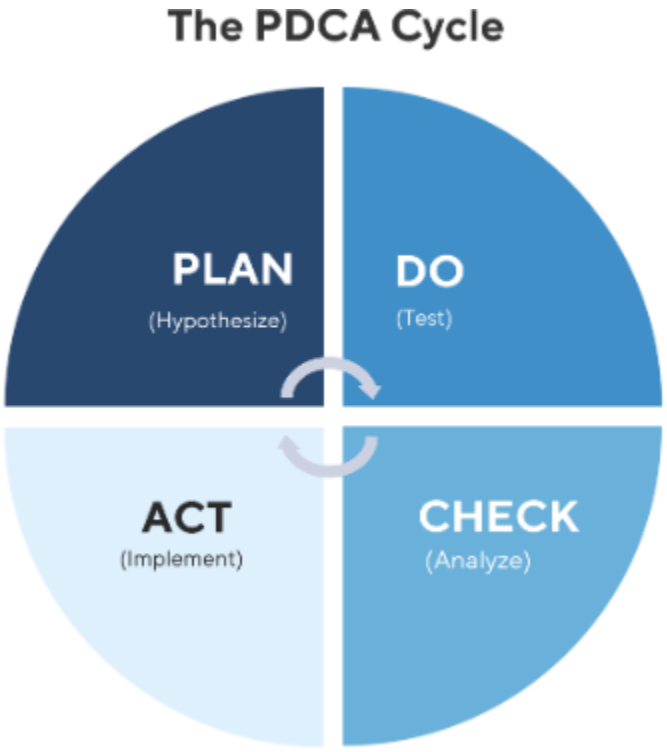
4. Time Frames for Submitting Quality Assurance Monitoring Reports:
    a. Reports on Quality Assurance Reviews are due to the Compliance Specialist and Founder 10 working days after each quarter.
5. Format of Quality Assurance Monitoring Report:
    a. All Quality Assurance Monitoring Reports will be formatted in the same way.
        i. The report consists of three parts.
            1. The first part is an executive summary of each of the six (6) systems.
                a. Each summary will describe the most significant findings in terms of strengths, weaknesses, and most importantly material weaknesses.
                    i. Weaknesses and material weaknesses will be subdivided into two types:
                        1. Those that require corrective action/performance improvement.
                        2. Those that require a change in policy.
            2. The second part is a detailed analysis of each of the six (6) systems.
                a. The analysis consists of five (5) sections:
                    1. Positive and Negative Findings.
                    2. Conclusions including the identification of weaknesses, material weaknesses, and potential weaknesses or material weaknesses.
                    3. Recommended Corrective action/performance improvements.
                    4. Responsible Persons/Offices.
                    5. Completion Dates.
                b. Table 2 describes each of these 5 sections.
                    i. This analysis is to be organized in accordance with the order of the systems described in Table below.
                c. Required Tasks:
                    i. The method to change or communicate a new process or policy must include documentation that addresses:
                        1. WHAT was changed
                        2. WHEN this change will be implemented
                        3. WHERE this change will be implemented
                        4. WHO the change affects
                        5. WHY the change has been made
                        6. HOW this change has improved the process/policy
            3. The third part consists of the documentation generated by the Quality Assurance Monitoring.
                a. The checklists, data flow analyses, and interview questionnaires are included in this section.
                b. This material is to be organized in accordance with the order of the systems described below.

Section	Description

Findings	1. Findings related to documentation reviews are to be a statement of the facts as expressed in quantitative terms, i.e., counts, percentages, averages, medians, modes, moving averages, and standard statistics. a. Tables, charts, and graphs may also be used to analyze the data. 2. Findings related to data flow are primarily expressed in qualitative terms, e.g., no backlog was observed; supervision ensured accuracy, completeness, and timeliness; process did not appear to include unnecessary steps, etc. a. However, quantitative analyses also can provide important findings, e.g.,20% of the records reviewed were misplaced for 5 months. b. Data from 15 percent of the reporting units did not indicate supervisory review, etc. 3. Findings related to staff interviews are expressed in both quantitative and qualitative terms, e.g., 25% of the staff answered question #7 related to his or her understanding of policy "X".
Conclusions	1. Conclusions represent a reasoned deduction or inference from the findings. a. There are three (3) general conclusions: 1. The process reviewed was materially compliant. 2. The process reviewed was materially out of compliance, and if so, corrective action/performance improvement is necessary. 3. The findings were inconclusive and additional review is necessary. a. Additionally, each conclusion should be accompanied by an explanation of the logic used to arrive at the conclusion.
Corrective Action/ Performance Improvement	1. When the conclusion calls for corrective action/performance improvement, the quality assurance coordinator restates what needs to be corrected and proposes actions or changes necessary to effectively correct the problem(s).
Responsible Person/s	1. The Compliance Specialist specifies the person or office responsible for the corrective action/performance improvement. a. Many corrective action/performance improvements require a coordinated effort of a number of individuals and approval from different supervisors. b. In these cases, the quality assurance coordinator should list all individuals and offices but the responsible or lead person/office should be listed first.
Due Dates	1. The quality assurance coordinator proposes the date that the corrective action/performance improvement should be completed. 2. The length of time should be based on the risk of continuing non-compliance. 3. Client and financial risks that result in endangerment to the client or disallowed services and costs are top priorities and should be corrected in no less than 10 working days or less.

6. Tracking of Corrective action/performance improvements:
    a. The Founder shall maintain a spreadsheet that contains a list of all the corrective action/performance improvements, and a folder with documentation that the corrective action/performance improvement has been taken.
    b. For example, if the corrective action/performance improvement involved training, the notebook would contain copies of the training attendance log and/or copies of the certificates of completion; if the corrective action/performance improvement involved a change in policy, a copy of the revised policy, signed and dated by the authorized staff would be available; etc.
    c. Every two weeks or once a month depending on the risk factors on noncompliance, the QA coordinator will review the notebook and compare it to the corrective action/performance improvement plan (CAP/PIP).
    d. The Compliance Specialist will ensure that CAP/PIP's are completed in a timely manner.

Appendix A


The PDCA Cycle
PLAN
(Hypothesize)
DO
(Test)
ACT
(Implement)
CHECK
(Analyze)

Appendix B

Example of Priority Setting Grid.

Priority Setting Grid

Project Name	Life Threatening (10 points)	Potential for Life Threatening (8 points)	Safety (8 points)	Increased Cost (5 points)	Decreased Customer Satisfaction (5 points)	Potential Liability (5 points)	Impact Regulatory Compliance (8 points)	Ethical Impact (2 points)	Public Relations (2 points)	Relationship to Mission/ Vision/ Strategic Plan (8 points)	Total
											0
											0
											0
											0
											0
											0
											0
											0
											0

Priority Matrix

Importance (Based on Consensus)	Urgency (Based on Percentage)									
	1	2	3	4	5	6	7	8	9	10
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Appendix C

Performance Improvement Communication Flow Chart