

Department of Behavioral Health & Developmental Disabilities



Quality Management Plan

Revised April 2013

**DBHDD Office of Quality Management
State of Georgia**

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I. Introduction

The DBHDD System of Care

The Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD) serves as the single state authority that provides direct service provision, administration, and monitoring of all facets of the state publicly funded behavioral health & developmental disabilities system. DBHDD's role as a direct service provider is limited to the operation of six state hospital campuses. Outpatient services are delivered by a network of private and public providers with whom DBHDD contracts. DBHDD Contractors are community-based organizations which administer behavioral health & developmental disabilities services throughout the state and are responsible for the provision of comprehensive services for children and adults with substance abuse disorders, serious and persistent mental illness (SPMI) and developmental disabilities.

The state is divided into six geographical service areas (see Appendix A) and is served by approximately 261 behavioral health (BH) and 343 developmental disabilities (DD) providers.

Program Vision, Mission and Goals

DBHDD's vision for the delivery of quality behavioral health & developmental disabilities services provides the foundation for all Quality Management (QM) activities. The DBHDD vision states:

Every person who participates in our services leads a satisfying, independent life with dignity and respect.

To support the DBHDD vision, the mission of the DBHDD Department of Quality Management is to:

- Improve the quality of care provided to all consumers with behavioral health & developmental disabilities;
- Improve customer satisfaction with behavioral health & developmental disability services received; and
- Improve outcomes for all consumers with behavioral health & developmental disabilities.

The DBHDD QM Plan is designed to achieve the goal of improved quality of care for BH and DD consumers utilizing evidence-based and best practices. Activities defined to support QM processes and program goals are outlined in the DBHDD QM Work Plan (Appendix B). These activities serve to direct and focus the DBHDD QM program and include goals, tasks, responsible parties, and target completion dates for activities.

II. Scope of the QM Program

The QM Plan includes all quality improvement activities conducted and managed by DBHDD. This includes monitoring of the quality of our hospital system as a direct provider of services as well as monitoring, collaborating with and supporting our contracted providers' own internal quality management systems. DBHDD uses analysis of hospital system and provider performance, feedback from recipients and stakeholders, and evidence based practices to drive the performance improvement activities.

The DBHDD QM Plan includes monitoring reports and quality improvement activities pertaining to the following treatment settings and service categories:

Treatment Settings

- Psychiatric Hospitals
- Skilled Nursing Facilities
- Immediate Care Facilities for Individuals with Mental Retardation
- Community Based Services and Clinics
- Behavioral Health and Developmental Disability Day Programs
- Residential Programs
- Community Based Crisis Services
- Mental Health Clubhouses

Service Categories

- Inpatient Services
- Treatment Services
- Rehabilitation Services
- Residential Support Services
- Crisis Intervention Services
- Developmental Disability Waiver Services

Annual Evaluation

DBHDD conducts an annual evaluation of the DBHDD QM Work Plan and reports the results to the Executive Quality Council. Evaluation of progress toward meeting the QM Program goals is used to determine the scope of the coming year's activities and in the development of QM processes and performance improvement activities.

III. Quality Management Administrative Oversight

Structural Framework and Communication

Quality is an organization-wide endeavor. The Department of Quality Management works collaboratively with all areas of DBHDD in the ongoing assessment and evaluation of the quality of services provided to BH and DD consumers. The DBHDD Executive Quality Council (EQC) and the three Program Quality Councils (PQCs) are utilized for decision making, development of performance improvement activities, performance monitoring, and as a mechanism for incorporating stakeholder and provider feedback into QM activities.

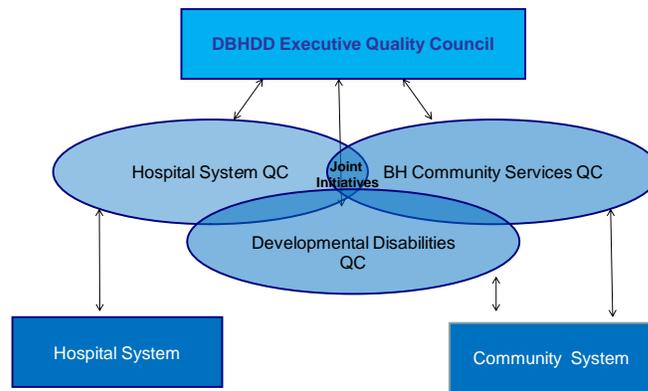


Diagram 1

Executive Quality Council QM Leadership Team

The EQC acts as the governing body for the QM program providing strategic direction and ultimate authority for the scope of DBHDD QM activities including the QM plan, the DBHDD work plan and the annual evaluation. The EQC is the highest-level quality committee in DBHDD. The EQC ensures integration of QM activities throughout the Department and provider network and ongoing communication between Program Quality Councils and DBHDD functional areas so that improvement activities are effective and ongoing. The EQC reviews and approves the DBHDD and Program Quality Council Key Performance Indicators no less than annually. The EQC receives feedback and recommendations for performance improvement activities from the Program Quality Councils. The EQC reviews, periodically modifies, and updates the QM program objective and procedures. As Diagram 1 indicates, the EQC is the final approval authority for all quality activities related to the DBHDD system of care.

EQC Membership: Assistant Commissioner & Chief Medical Officer - Chair
 Commissioner
 Deputy Commissioner for Programs
 Deputy Commissioner/COO
 Director, Office of Recovery Transformation
 Director of Regional Operations
 Assistant Commissioner for Behavioral Health
 Assistant Commissioner for Developmental Disabilities
 Settlement Coordination Director
 General Counsel
 Director of Quality Management

Regularly Invited
 Attendees: Director of Provider Network Management
 Information Technology Director
 Hospital Program Quality Council Chairperson
 Community Behavioral Health Program Quality Council Chairperson
 Developmental Disability Program Quality Council Chairperson
 Director Incident Management and Investigations
 Director of Forensic Services

Meeting Frequency: Six times a year

The EQC is chaired by the Assistant Commissioner & Chief Medical Officer (CMO) and vice-chaired by the Director of Quality Management.

Meeting minutes are taken at every meeting and disseminated to the membership. Sign in sheets are completed at all meetings.

Program Quality Councils (PQCs)

The EQC created and oversees three PQCs (hospital, community behavioral health and community developmental disability) based upon functional program area within the DBHDD. The purpose of the PQCs is to monitor quality management and improvement activities specific to their service area and facilitate the improvement of practices and services. Each PQC reviews data that includes performance measures, provider and consumer feedback, and outcomes measures.

Hospital System PQC

The hospital system PQC is chaired by the CMO and vice-chaired by the Director of Hospital System Quality Management. The purpose of this PQC is to monitor quality management and improvement activities specific to the hospital system services and improve procedures according to best practices. The hospital system PQC reviews, analyzes and makes recommendations regarding the key performance indicators (KPIs), Triggers and Thresholds report data, audit trends, incident trends and other quality of care and quality management issues. The Hospital System PQC also prioritizes performance improvement activities; provides oversight, direction and support to assure that effective QM programs are operated by all State hospitals; and supports the development of greater consistency of practice and design of processes among the hospitals in the Hospital System.

Hospital PQC

Membership: Assistant Commissioner & Chief Medical Officer – Chair
 Director of Hospital Systems Quality Management
 Hospital Nurse Executives Chairperson
 Regional Hospital Administrators
 Director of Forensic Services
 Director of Recovery Transformation
 Director of Quality Management
 Director of the Office of Transitional Services

Regularly invited

Attendees: Director Incident Management and Investigations
 Regional Hospital Quality Managers
 Patient/Consumer Representative

Meeting Frequency Monthly

The Hospital System PQC receives information and recommendations for performance improvement activities from various work groups and/or subcommittees as well as the quality councils of each of the State Hospitals. Sign in sheets are completed at all meetings. Meeting minutes are taken at every meeting and disseminated to the membership. Hospital System leadership then distributes information as

applicable within their areas. PQC reports and/or findings are presented to the EQC to provide recommendations and further action, as needed. For additional information about the quality management organizational structure, membership and primary functions at the Hospital level, see Appendix C.

Community Behavioral Health PQC

The community behavioral health PQC is chaired by the Assistant Commissioner for BH and vice-chaired by either the Director of Community Mental Health or the Addictive Diseases Division Director. The purpose of the Community Behavioral Health PQC is to monitor and improve the quality of community based services provided to DBHDD recipients and make recommendations for quality improvement initiatives and identify opportunities for training and/or technical assistance for DBHDD BH community providers/contractors.

The Community Behavioral Health PQC meets monthly and reviews, analyzes and makes recommendations regarding key performance indicators, quality of service issues identified through Fidelity, QM, and External Review Organization (ERO) monitoring reviews, mental health coalition and behavioral health consortium meeting feedback, satisfaction survey results, and incident trending. Additionally the CBH PQC reviews relevant information and makes recommendations specific to four child and adolescent BH programs: Care Management Entity (CME)/Community Based Alternatives for Youth (CBAY), Psychiatric Residential Treatment Facilities (PRTFs), Crisis Stabilization Units (CSUs) and Mental Health Clubhouses.

PQC Membership: Assistant Commissioner for BH – Chair
 Director of Addictive Disease Services
 Director of Community Mental Health Services
 Director of Recovery Transformation
 Director of Quality Management
 Director of Adult Mental Health Services
 Director of Child and Adolescent Services
 Assistant Commissioner & Chief Medical Officer
 Director of Regional Operations
 Settlement Coordination Director

Regularly Invited
Attendees: Director of Incident Management and Investigations
 Director of the Office of Transitional Services
 Suicide Prevention Manager
 Director of Forensic Services
 DD Director of Quality Management
 Assistant Director, Division of Addictive Diseases

Meeting Frequency Monthly

CBH Outcomes Framework

In FY 2013, the Community Behavioral Health PQC began the development of an outcomes framework to assess the impact of DBHDD programs and initiatives on outcomes. This framework will continue to be refined and developed going forward. It organizes indicators into categories such as:

- Access
- Safety
- Effective
- Efficient
- Experience of Care

Key performance indicators are reported in a series of scorecards that collectively form the Outcomes Dashboard. The dashboard quality management measures are developed by each of the program areas with stakeholder input and presented in the PQC for approval and review, as appropriate.

Developmental Disabilities PQC

The developmental disabilities PQC is chaired by the Assistant Commissioner for DD and vice-chaired by the DD Quality Management Director. The DD PQC meets at least quarterly and reviews, analyzes and makes recommendations regarding KPIs, strategic planning, system change, and continuous quality improvement.

DD PQC

Membership: Assistant Commissioner for DD – Chair
DD Quality Management Director
Director of Division DD Service Support
Director of Division DD Programs
DBHDD Director of Quality Management
Director of Regional Operations
DD Advisory Council Member
Settlement Coordination Director

Statewide Quality

Improvement Council: DD QM Director
Director of Division DD Service Support
Self Advocates
Family Member
DD Support Coordination Representative
ERO Advisory Member
Georgia Advocacy Office DD Director
State Director of ARC of Georgia

Regularly Invited

Attendees: DBHDD Director of Quality Management
Director of the Office of Incident Management and Investigations
State Office Staff

The Division of Developmental Disabilities also has six Regional Quality Improvement Councils, and a Developmental Disability Advisory Council. The Regional QI Councils are charged with reviewing regional

and statewide performance data (i.e. data collected through the Division's Quality Management System, critical incident/death data, and data collected through the National Core Indicator Survey) in order to provide ongoing guidance and feedback to DD Division leadership and staff regarding quality assurance and system improvement. The purpose of the Advisory Council is to advise the Department on matters relating to the care and service of people with developmental disabilities served by the Department.

Program Quality Council Additional Information:

See Appendix D for DBHDD Quality Management job descriptions, Appendix E for the DBHDD QM organizational chart and Appendix F for roles and responsibilities of the EQC and PQC members.

IV. Quality Management Plan Activities

This section describes DBHDD internal and Contractor (external) quality improvement activities and processes. See appendix G for reporting documents and data feeds and Appendix H for Key Performance Indicators.

Monitoring and Evaluation Activities – All DBHDD QM processes and activities are designed to foster positive clinical and social outcomes for BH and DD recipients. DBHDD conducts monitoring and evaluation of QM activities carried out by its hospitals and community provider networks through direct data reports from focused ad hoc reviews, multidisciplinary peer reviews in DBHDD hospitals, periodic administrative reviews, fidelity reviews, programmatic reviews and audits, and monthly data reports from settlement services contractors.

Through its contracts, DBHDD requires Contractors to conduct quality improvement and risk management activities. DBHDD and its Contractors participate in the continuous assessment and evaluation of system performance. Contractors are required to have a well defined QI plan and can demonstrate that: issues are identified, solutions are implemented, new or additional issues are identified and managed on an ongoing basis, internal structures minimize risks for individuals and staff, processes used for assessing and improving organizational quality are identified and the QI plan is reviewed/updated at least annually. Compliance with these requirements is monitored by DBHDDs Provider Performance Unit (for certain DD providers) and the Regional Offices. Contractors are also required to have performance indicators in place for assessing and improving organizational quality and can demonstrate:

- Indicators are established for each issue identified
- Outcome measurements for each indicator are reviewed quarterly
- Quality improvement findings are distributed on a quarterly basis to individuals served or their representative, organizational staff, the governing body and other stakeholders as determined by the governance authority
- Contractor participates in DBHDD consumer satisfaction and perception care surveys (i.e.: GMHCN)

Accurate and reliable data is imperative for the success of the DBHDD QM program. Contractors are required to maintain a health information system which includes data elements such as member demographics, service utilization, provider characteristics, episode of care status, outcomes measures,

individualized plans of care and diagnoses. Community behavioral health contractors who provide monthly programmatic reports including data for calculation of key performance indicators must use standardized report templates and methodology for the QM data reporting. The standardization of reporting ensures consistency in collection and reporting of critical data elements across contractors for improved analysis on a statewide level. These monthly programmatic data reports are each reviewed and validated by a program analyst prior to acceptance. Contractors are required to submit corrected reports when necessary and are provided technical assistance (TA) on an ongoing basis as needed. DBHDD's contracted ERO for community behavioral health is URAC-accredited and has established internal quality review processes to ensure the reliability and validity of their programmatic review and audit results. The external review organization for community DD services is a CMS-approved Quality Improvement Organization and as such must follow accepted standards and guidelines to ensure the quality of their work.

State Hospitals have Quality Management departments that are responsible for a number of quality management functions. Each hospital's quality management committee provides or facilitates the provision of training, data collection planning and data analysis activities. Each hospital also conducts inter-rater reliability tests for staff who perform many of the audits before data from those audits is utilized. Inter-rater reliability exercises are used to ensure consistency in staff interpretation of review questions and documentation ratings, thereby increasing the reliability of the review process. Once the inter-rater reliability standards have been met, the data is used for both intra-hospital and System-wide purposes.

Actions for Improvement - Each hospital within the DBHDD Hospital System develops corrective action plans in response to both internal and external findings. Examples of "internal" findings would include: the results of incident investigations or reviews, audits, root cause analyses or failure mode and effects analyses (FMEA). "External" findings would include: the result of accreditation surveys (TJC, CMS, etc.) or DBHDD Central Office investigations (Office of Incident Management and Investigations). Corrective action plans include the following elements:

- A statement of the problem or issue to be addressed,
- an action plan (set of actions planned),
- person(s) responsible for those action steps,
- time frames,
- the method by which a determination will be made as to when each action step has been completed and,
- most importantly, the means by which the effectiveness of that action plan can be determined (observation, audit results, etc).

Each Hospital's Quality Management Department is responsible for monitoring the status of completion of corrective action plans and assuring that Hospital leadership is apprised of the status of the implementation of those corrective action plans.

The following are descriptions of DBHDDs monitoring and evaluation QM activities.

Hospital System Mentoring/Peer Review

The Hospital System utilizes a mentor system for peer review in each of its six hospitals. The purpose of the mentoring system is to improve the quality of care provided to DBHDD recipients and provide oversight and

direction to professional staff. The mentors receive training on audit criteria and methodology in their respective areas of responsibility, are tested in order to achieve a minimum level of inter-rater reliability, and then perform audits. The criteria for those audits include system-wide criteria developed to be administered at all of the systems hospitals, as well as any that may be hospital-specific. Mentors in each of the disciplines (physicians, nurses, social workers and psychologists) perform record audits on the work of staff within their respective disciplines and then follow up with them to provide training and consultation, as needed, to address any quality issues. Data from those audits are also entered into a system-wide audit database that permits aggregation and analysis of data. Discipline specific monthly reports are generated and distributed to the respective discipline chiefs. Facility and Hospital System data is also aggregated and shared through the hospitals quality councils.

Hospital System Incidents

The DBHDD State Hospital System operates under a written policy, “Incident Management in DBHDD Hospitals, 03-515”. DBHDD State Hospitals support the DBHDD’s Incident Management system which is maintained to identify, classify, document, report, track and trend events that may have an adverse effect on the safety, care, treatment and rehabilitation of individuals served by each state hospital. That system also includes a database designed specifically for use in the Hospitals’ (Risk & Incident Management System—RIMS) to assist in complying with the provisions of the policy. It is also linked with and provides data for the DBHDD’s ROCI (Review of Critical Incidents) System. Each hospital system runs its own reports.

The system includes procedures for:

1. Taking immediate steps to ensure the health and safety of individuals,
2. A multi-level review process to ensure corrective actions are appropriate and effective, and to develop strategies to prevent reoccurrence,
3. Initiating the investigation, tracking corrective action plans (CAPs), and
4. Investigating incidents that involve allegations of abuse, neglect, or exploitation, (when the Hospitals are authorized to do so by the DBHDD Office of Incident Management and Investigations) and for protecting individuals while the investigation is being conducted.

For information about trend analysis see section entitled: DBHDD Incident Trending and Premature Mortality Reviews.

Hospital System Utilization Review

All System Hospitals maintain utilization review departments that monitor admissions, readmissions, continued stay criteria, unauthorized bed days, and a variety of other service utilization data. In addition, the Hospital System monitors and acts to improve several key utilization review measures. These data are utilized by the Hospital QM departments, their respective Hospital Quality Councils, and the Hospital System Program Quality Council for performance improvement activities. Reports vary in frequency from monthly to quarterly depending on the report. See Appendix H for the Hospital System key Utilization Review (UR) indicators.

Credentialing

Each hospital maintains a credentialing committee, which operates under the guidelines provided in the DBHDD Medical Staff Bylaws. Those committees, under the direction of the clinical director for each

hospital, are responsible for verifying medical staff credentials and granting privileges that are based on demonstrations of current competencies. That process operates under the direction of the DBHDD Medical Director and the Board of the DBHDD. Credentialing of practitioners who deliver community based services is performed by the provider. The Regional Offices periodically review community provider credentialing for appropriateness.

Community Behavioral Health Contracted ERO Reviews

Many of the functions and products provided by the contracted ERO for Behavioral Health contribute to the Department's quality management of the Provider Network. These elements include training, technical assistance, prior authorization for services, programmatic and compliance audits, and analysis of provider billing and service provision data.

The information that most informs management of the network are the programmatic and compliance audits. These are on-site audits conducted approximately twice per year for every community service provider. These audits are conducted by licensed clinicians and review provider's documentation specific to:

- Assessments
- Treatment planning
- Programmatic integrity
- Documentation
- Billing

Detailed and summary reports for these audits are provided to the provider, Regional Office and State Office leadership, and are posted to the EROs website and publicly accessible. In addition, for Medicaid providers, these reports are also provided to the Georgia Department of Community Health (DCH), the state's Medicaid agency.

Periodic summary reports for the network are generated by the ERO and reviewed by DBHDD's Department of Provider Network Management and concerns about provider audit performance are brought to the CBH PQC for review. Contracted BH providers who do not maintain compliance with their contract, the DBHDD/Medicaid provider manuals and/or who are low performers are subject to the provisions in Policy 01-113 (Noncompliance with Audit Performance, Staffing, and Accreditation Requirements for Community Behavioral Health Providers). The Office of Provider Network Management collaborates with the DCH to enforce the provider performance standards for Medicaid providers.

In addition to the quality audits conducted by DBHDD's ERO, the DCH has a contracted external review organization, the Georgia Medical Care Foundation, which performs less frequent but very in-depth audits of the community service boards. These audits occur approximately once every three years and are being expanded to all community behavioral health providers in 2013. DCH also conducts licensing reviews for certain residential providers and drug treatment programs and the DBHDD has requested that results of these reviews be provided so they may be incorporated into existing provider performance review processes. The DCH and the DBHDD are collaborating in a review of these audit processes to evaluate and identify opportunities for greater collaboration and improved effectiveness.

Community BH Fidelity Audits

Fidelity Reviews are conducted annually for all state contracted ACT and Supported Employment providers. Once a DBHDD Fidelity Review Team completes a review, results of the Fidelity Review are given to the provider, the regional office in which the team operates, the DBHDD Adult Mental Health Director, an external subject matter expert and other departmental leadership. The Fidelity Review teams offer technical assistance to both ACT and SE providers during and after these reviews and the Department has retained an expert in Supported Employment from the University of Georgia to provide ongoing trainings and on-site technical assistance to Supported Employment providers. When review items are found to be outside of the acceptable scoring range a corrective action plan is submitted to the regional and state offices and follow up and technical assistance are provided. Results of the reviews of trends or patterns are also reviewed at the CBH PQC and used to identify training and technical assistance needs.

Community BH Quality Management Service Reviews/Audits

As a component of DBHDD's quality management system, an audit of a sample of individuals with Serious and Persistent Mental Illness (SPMI) who have been identified as having been served in the State hospitals, who have been frequently readmitted to the State hospitals, who have been frequently seen in emergency rooms, who have been chronically homeless and/or who have been released from jails or prisons is conducted. The audits follow the care of an individual throughout the system of care as they transition between services and as they receive multiple ongoing services. As part of this quality service review, provider records are reviewed and interviews are conducted with individuals served and provider employees. Providers are given copies of their audit results and expected to utilize that information in their internal QM/QI processes to correct any concerns or issues identified. The Regional Office in which the provider operates is also given a copy of the audit results. At the end of each quality management audit cycle, a summary report is developed and shared with DBHDD senior leadership, the Regional Coordinators, the CBH PQC and key Central Office program leadership. The DBHDD's program leadership is informed about areas that have been identified in the review as having possible deficient practices or which require further analysis or review and/or may refer the issues to the contract manager for review and appropriate action.

Child and Adolescent Community Mental Health Programs (CAMH)

CAMH has established four stakeholder groups for four programs: CME/CBAY Quality Council, Psychiatric Residential Treatment Facilities (PRTF) Consortium, CSU Consortium and MH Clubhouse Consortium. Each group has all providers of those services, as well as other stakeholders, i.e. DFCS, DJJ, APS, Family Support Organizations, etc., as participants. In CY 2012, these stakeholder groups developed Quality Improvement Plans for each of the programs. Through a partnership with the Georgia State University Health Policy Center, CAMH has developed a Center of Excellence for Child and Adolescent Mental Health (COE) to provide research and evaluation, and training and technical assistance for the Georgia child and adolescent mental health system. The COE has incorporated those quality improvement plans and inputted data requirements into an online system, Qualtrix. Each provider group then submits the data to the COE for analysis according to the Quality Improvement plan. Clubhouses report data monthly, while all other programs report the data quarterly. The data is reviewed at the Stakeholder group meetings (quarterly) and Plan Do Study Act (PDSA) processes are used to address the issues or concerns that come from the

data. This information is reported bi-annually to the Community Behavioral Health PQC. See Appendix K for the Consortium and Quality Council meeting schedules.

Contracted Provider and Subcontractor Monitoring

The DBHDD monitors performance related to contract deliverables through its Regional and State Offices. Each Regional Office has staff designated to monitor contractor compliance for both behavioral health and developmental disability service providers and for some programs these duties are performed by state office program staff who are responsible for contract management. When providers are not meeting contract expectations, contract managers may provide technical assistance and/or require corrective action or quality improvement plans. DBHDD requires Contractors to demonstrate evidence of active oversight of subcontractor capacity and compliance and holds the Contractor responsible for the subcontractor's compliance. Evidence of active oversight includes, but is not limited to: compliance with licensure requirements, quality improvement and risk reduction activities, utilization of standards of practice, financial oversight and management of individual funds, staff competency and training, and mechanisms that assure care is provided according to the plan of care. Additionally, Contractors are required to submit quarterly reports to their Board of Directors regarding services delivered and the quality of subcontractor performance. Contractors are also required to submit bi-annual reports to the DBHDD Regional Offices (ROs) that include the name of the subcontractor, the authorized subcontractor name and contact information, disability groups served, specific service(s) provided, the number of persons in service and an annualized amount paid to the subcontractor.

Community Developmental Disabilities Quality Management Reviews

The Division of DD utilizes various audit processes to ensure that individuals served receive the highest quality of services. (See Appendix I for a flow diagram of the DD Quality Management System). The Georgia Quality Management System for DD (GQMS) as implemented by the contract external QIO utilizes two components in assessing quality of services. The first component is at the individual level and is called a Person-Centered Review (PCR). The PCR is designed to assess the overall quality of the supports and services a particular person receives through interviews with the individual and his or her provider(s), record reviews, and observations. The process explores the extent to which the system enhances the person's ability to achieve self-described goals and outcomes, as well as individuals' satisfaction with the service delivery system. Each PCR includes a face to face interview with a randomly selected individual using the National Core Indicator (NCI) individual survey tool and additional interview questions. The Division of DD has participated in the National Core Indicators (NCI) Survey since 2005.

In addition to the interviews with consumers and providers, records of the most recent twelve (12) months of services received by the person are reviewed and used to help determine the person's achievement of goals that matter most. On-site observations are conducted for individuals who receive day supports or residential services to observe the person in these environments, the individual's reaction to supports, and how well supports interact with the person. Interviews with the individual's support coordinator and provider/staff further assist the consultant in gathering information to help determine how the person is being supported and the person's knowledge of the supports and services being provided. A review of the

person's central record is also part of this process and includes a review of how well the person's Individual Support Plan (ISP) reflects the person, including goals, talents, strengths and needs. A total of 480 PCRs are completed each year of the contract. The results of the Person Centered Reviews are shared with the individual and their support team (support coordination, provider, family members, etc) and are used to improve the individual's supports and services. The results are also shared with Regional and State staff for monitoring and quality improvement purposes.

The other component of the GQMS is the Quality Enhancement Provider Review (QEPR). The QEPR is used to evaluate the effectiveness of the provider's supports and services, organizational systems, records, and compliance with the Division of DD policies and procedures as well as staff training and qualifications. Individual PCR and QEPR reports are regularly shared with the Regional Offices and the DD Director of QM. Quarterly aggregate reports of the results of PCRs and QEPRs are shared with the DD PQC and EQC.

Community Developmental Disabilities Support Coordination Monitoring

Support Coordination services are a set of interrelated activities for identifying, coordinating, and reviewing the delivery and quality of appropriate services for participants. Support Coordination services include the following:

- Assessment and Periodic Reassessment
- Development and Periodic Revision of the Individual Service Plan
- Referral and Related Activities
- Monitoring and Follow-up Activities

Support Coordination services are based on the needs and desires of the individual and are required to address any identified health and safety risks or service provider issues. Support Coordinators are responsible for monitoring the following: implementation of the Individual Support Plan (ISP), health and welfare of the participants, and the quality and outcome of services received by the individual. Monitoring includes direct observation, record reviews, and follow up to ensure that service plans have the intended effect. Support coordination also monitors approaches to address challenging behaviors, medical and health needs, and skill acquisition to determine that all are coordinated in their approach and anticipated outcome. Support Coordination Agencies are required to conduct their own internal quality assurance audits and submit quarterly benchmark reports to the Regional Offices and Division of DD. Support Coordinators are also responsible for the ongoing evaluation of the satisfaction of participants and their families with the ISP and its implementation.

Community Developmental Disabilities Standards Quality Reviews

DD promotes high quality services by establishing requirements for accreditation and the quality review of service standards. All DD providers are expected to meet Community Service Standards and have an organizational structure in place for quality assurance and compliance. Providers authorized by DBHDD to receive funding of \$250,000 or more per year are required to be accredited by one of the accreditation organizations approved by DBHDD. Proof of accreditation is monitored by the Regional Offices and Provider Network Management. Providers authorized by DBHDD to receive funding less than \$250,000 per

year are required to have a Standards Quality Review conducted by the DD Provider Performance Unit. Certification status is monitored by DD Provider Network Management.

There are two types of Quality Reviews, performed by the DD Provider Performance Unit, both utilizing the same processes. A Standards Quality Review is a review of a Provider to determine compliance with DBHDD Community Service Standards. A Special Standards Quality Review is a review conducted at the special request of the Division of Developmental Disabilities and/or Regional Office to assess a provider's compliance with community service standards. If during the standards quality review or a special standards quality review, critical concerns are identified, the contracting regional office(s) has the option to relocate the individual(s) immediately.

Data from each of these processes are compiled aggregately on a quarterly basis and are reviewed by the DD PQC and/or State QI Council. Data is shared with the EQC twice a year.

Regional DD Transition Quality Reviews

The Regional DD Transition Quality Review Team (RQR T) was established in 2013 to ensure that individuals with DD who transition out of state hospitals receive high quality services and achieve life goals in the community. The RQR Teams monitor the quality of services as well as providers' performance in meeting quality expectations. Periodically monitoring results will be reported to the DD PQC and the EQC.

The RQR Team consists of licensed clinicians as well as other professionals who have experience and expertise in DD services. The size of the RQR Team is based on the number of transitioned DD individuals in each Region. At a minimum, each RQR Team has the following professionals:

- RN
- Behavior Specialist
- Social Worker (MSW or LCSW)
- Other Team members may include a licensed physician, quality management staff, and others

After the RQR Team is established in each Region, all team members conduct an initial review of all transitioned DD individuals in the Region. The Team reviews the Individual Service Plan (ISP), observe individuals' activities and the living & service environment. The team members also use the High Risk Assessment Sheet (see Attachment 1) to assess each individual's risk factors. For the review process flow chart, see Appendix J.

Team members are required to complete a report on each visit. The report is based on the outcome of the audit tool. The report should document the current condition of the DD individual based on the following categories:

- **RED** – The individual or other individuals in the home and/or service area is/are in immediate danger.
- **YELLOW** – The individual or other individuals in the home and/or service area is/are in serious condition and have urgent support needs.

- **BROWN** -- The individual or other individuals in the home and/or service area have significant issues and problems.
- **GREEN** -- The individual or other individuals in the home and/or service area don't have significant issues and problems.

If a review falls into any category other than Green, the team member works with the provider to develop a Quality Improvement Plan (QIP). The Team Leader is required to notify the RC, DD RSA immediately when a Red or Yellow condition is found. Corrective Actions are taken based on the categories of reported conditions:

- **RED** – Remove the individuals at risk from the provider and move them to a safe placement. The RC or DD RSA will call the provider's top official immediately to notify them of the action taken by the Regional office and that a QIP should be in place within one (1) working day.
- **YELLOW** – The RC or DD RSA will call the provider's top official immediately to notify them of the findings of the RQR Team and that a QIP should be in place within one (1) working day.
- **BROWN** – The RC or DD RSA will meet with the provider's top official within three (3) working days of receiving the RQR team report to review the issues and problems and require a QIP by the provider within one (1) week after the meeting.
- **GREEN** – No corrective action needed.

The RQR Team members are required to have follow-up reviews until all identified issues/problems are addressed. If the providers QIP remains incomplete or has otherwise been determined to not meet the parameters of the QIP then the Regional Coordinator and Director of Provider Network Management make a joint decision concerning next steps to take, responsible parties and time lines. Monthly summary reports are provided to the DD Leadership Team and Programmatic Quality Council. Quarterly Summary reports are provided to the Department's External Quality Council.

Consumer Surveys

Hospital System consumer surveys

The Hospital System participates in the Inpatient Consumer Survey process administered through National Association of State Mental Health Program Directors (NASMHPD) Research Institute, a national organization that collects and reports performance data for mental health programs nationwide. Questionnaires are administered to individuals receiving services in the Hospitals and the data are submitted to National Research Institute (NRI) who creates reports that are posted on their website. The domains that are surveyed are clients perception of:

- Outcome of Care
- Dignity
- Rights
- Participation in Treatment
- Facility Environment
- Empowerment

Data from these measures are monitored and used to track effectiveness of quality improvement activities in each Hospital's QC as well as in the Hospital System's Dashboard and Program Quality Council.

Community BH consumer surveys

DBHDD utilizes the Mental Health Statistics Improvement Project (MHSIP) consumer survey to assess performance of the community BH service delivery system. DBHDD contracts with the Georgia Mental Health Consumer Network (GMHCN) to perform an annual perception of care survey for adults receiving mental health and/or addictive disease services in the community. This survey measures consumers' perceptions of access, quality and appropriateness of services, outcomes, participation in treatment planning, general satisfaction, social connectedness, and functioning. The GMHCN utilizes peers to conduct field interviews with a sample of about 5% of adults receiving services. Completed surveys are forwarded to the DBHDD Office of Decision Support & Information Management for data entry and analysis.

For child and adolescent services, the DBHDD has contracted with the Georgia Parent Support Network (GPSN) to perform a perception of care survey called the Youth Services Survey for Families (YSSF) with a large sample of parents/guardians of youth receiving DBHDD services. This survey measures perceptions of access, satisfaction, outcomes, participation in treatment, cultural sensitivity, social connectedness and functioning. Previously DBHDD contracted with the University of Georgia to perform this survey. Due to low response rates using mailed surveys, starting in 2013 and going forward, DBHDD changed its model from a mailed survey to a survey conducted by peers similar to the adult methodology through GPSN.

Aggregated results for both surveys are reported to the Federal government, the EQC, the BH PQC, the Regional Office and Central Office program staff. For the first time, the survey results are being published and publicly distributed in 2013. The survey results are incorporated into the CBH PQC's review of data related to quality, to identify how it may be used to improve consumer's perception of care, including evaluating the feasibility of distributing these results to providers for use in their own quality improvement projects.

Community BH settlement services consumer surveys

As an ongoing component of DBHDD's quality management system, a sample of community BH individuals meeting community settlement agreement criteria and who are enrolled in settlement funded services are interviewed. This consumer satisfaction component of the community BH QM audit is downloaded into a database by DBHDD QM staff and analyzed twice a year for trends or patterns and is reviewed by the Director of Quality Management and the CBH PQC.

DD consumer surveys

As stated above, a main component of the Georgia Quality Management System for Developmental Disabilities, is the Person Centered Review (PCR). The NCI is completed during the PCR. One purpose of the survey is to collect customer satisfaction data on developmental disability services. The data is used not only to improve service at the state level but also to add knowledge to the field, to influence state policy, and to inform strategic quality improvement planning initiatives the Division.

Other Stakeholder Involvement in Quality Management

In addition to obtaining input via the consumer surveys as noted above, the Divisions of Behavioral Health and Developmental Disabilities meets monthly with Georgia's Medicaid authority, the Department of Community Health (DCH), to discuss issues concerning the NOW and COMP waivers and community behavioral health care services. Standing agenda items include: policy changes, provider performance and management issues and program integrity.

The Division of DD also participates in quarterly meetings with DCH to discuss quality assurance and improvement efforts related to the waivers. Standing agenda items include: support coordination reports, monthly mortality reports, remediation reports, letter of agreement deliverables, and waiver performance measures.

The Division of DD Advisory Committee provides input on matters relating to the care and service of people with developmental disabilities served by the Department. The DD Advisory Committee:

- Assists the Division of DD in assuring the Department's services to people with developmental disabilities reflect adherence to the standard of "best practice."
- Assists the Division of DD in assuring the Department's programs for people with developmental disabilities provide quality services in a cost effective manner.
- Recommends improvements to the Division of DD for existing programs serving people with developmental disabilities.
- Recommends development and implementation of additional programs for people with developmental disabilities in Georgia.
- Reviews Division of DD policies, policy revisions, and make recommendations regarding the adherence to the Department's mission and the cost of proposed policies and amendments.
- Facilitates communication among Department staff, providers of services, service recipients, parents/guardians/advocates of people with developmental disabilities, and other public and private entities involved in delivering services to people with developmental disabilities.

DBHDD's Adult Mental Health staff conducts monthly/bi-monthly provider Coalition meetings to facilitate open communication between the Department and providers of specific community services. These Coalition meetings are used to promote provider compliance with Fidelity models (as applicable) and DBHDD service definition guidelines. Coalition meetings are held for multiple provider types including but not limited to: Projects to Assist in Transitions from Homelessness (PATH), ACT, ICM/CM, CST, Supported Employment (SE), CSUs, and Medicaid Eligibility Specialists (MES). These meetings provide a forum in which to share updated DBHDD policy information, system changes, aggregate KPI data analysis with providers, and obtain their feedback and input regarding challenges or barriers to provision of services and programs. Additionally these coalition meetings bring providers together to discuss preferred practices and offer an opportunity for networking and problem solving. The Regional Offices are invited to participate in the

coalition meetings and receive copies of the resulting meeting minutes. See Appendix K for a schedule of coalition meetings.

Provider Network Analysis

The Regional Offices (ROs) are responsible for effective planning, purchasing and monitoring of community based behavioral health and developmental disabilities services that meet the needs of the citizens in the region. Service planning is unique to the needs of each community and includes significant input from community members and service recipients. In SFY 2013, each region underwent two planning activities to identify needs and gaps in their delivery system. The first activity, initiated by the regional planning board, was the annual Regional Planning Board Plan that identifies both service and funding priorities for the upcoming fiscal year. This activity involved gathering community input into needed services through public forums throughout each region's catchment area. That input was used by both the Regional Planning Board members and regional staff to determine where the regional office should concentrate its funding and services for the upcoming fiscal year. The second analytical activity was a Network Analysis. This analysis was an assessment of the availability of supports and services within each region. The Network Analysis was comprehensive in its scope and depth of reporting, analyzing and understanding facts and statistics of BH and DD services and how they impact services to the residents of each region.

The 2013 Network Analysis was developed through a collaborative process when DBHDD's central and regional office staff came together and decided upon a mutually agreed set of indicators that each region would look at during the development of their analysis. After determining the indicators or areas to be analyzed, information was obtained for the report from the appropriate resource or service. In addition, some of the information in the analysis came from the Annual Plan that was developed by each Regional Planning Board. This information and data was invaluable as the regions wanted to understand the service delivery system in the regions comprehensively. Lastly, information was obtained from various reports from DBHDD central offices as well as monthly reports submitted by providers. For SFY 2014 and annually going forward, a regional Network Analysis will be completed for community based BH and DD services. A summary of the network analysis results will be reviewed by the EQC and will be used for programming and budgeting, as applicable.

Medical Records and Communication

Contractors and DBHDD staff providing direct services must ensure effective and continuous care through medical record documentation of each individuals' health status, changes in health status, health care needs and services provided.

To protect the confidentiality of behavioral health recipients' medical information and ensure compliance with HIPAA requirements, all DBHDD staff, Contractors and sub-contractors must adhere to the requirements in Policy 23-100 entitled Confidentiality and HIPAA pertaining to the release of protected, confidential health information as mandated within this guidance document. DBHDD maintains policies and procedures regarding identification of breaches of HIPAA and reporting of breaches. Privacy Coordinators, in consultation with the Privacy Officer and/or the Office of Legal Services, determine whether violations also constitute breaches and ensure that notifications are made, as required by law.

Tracking and Trending of Complaints and Grievances

DBHDD defines a complaint as an expression of dissatisfaction with any aspect of care. Complaints are filed directly with DBHDD and may originate from the individual receiving services, family members/guardians, providers, or other stakeholders, including Legislators, or the Governor's Office.

Each hospital maintains its own complaint receipt and resolution process. At the present time those systems vary with respect to their structure, processes, data gathering and report capabilities. The prospect of establishing a more uniform system for the Hospital System is being discussed as a potential future initiative.

Additionally, the DBHDD Office of Public Relations (OPR) receives constituent complaints and grievances by fax, web-based electronic submission, email, telephone and U.S. mail. OPR staff triage and enter the complaint/grievance into a database, then assigns the case to a regional office, hospital or state office employee who has two business days to contact the complainant. A notification of receipt is sent to the complainant informing them that their complaint or grievance has been received and is being reviewed. OPR staff tracks and monitors each case. OPR and the complainant receives a status update within five business days. Once a resolution is received, OPR reviews the resolution and provides a summary of the resolution to the complainant within 24 hours. Reports of trends and patterns are periodically shared with the EQC, DBHDD leadership, Directors, Regional Coordinators, Hospital Administrators and QM staff.

DBHDD Incident Trending and Premature Mortality Reviews

DBHDD requires its Contractors to report incidents, accidents and deaths per Policy 04-106 (Reporting and Investigating Deaths and Critical Incidents in Community Services) and DBHDD hospitals per Policy 03-515 (Incident Management in Hospitals). Contractors and Hospitals are required to report significant and/or adverse incidents for all enrolled consumers. These reports are submitted to DBHDD, Office of Incident Management and Investigations. DBHDD Incident Management and Investigations staff review all submitted reports for identification of potential quality of care concerns. The quality of care concerns are triaged for investigation either at the State or Contractor level.

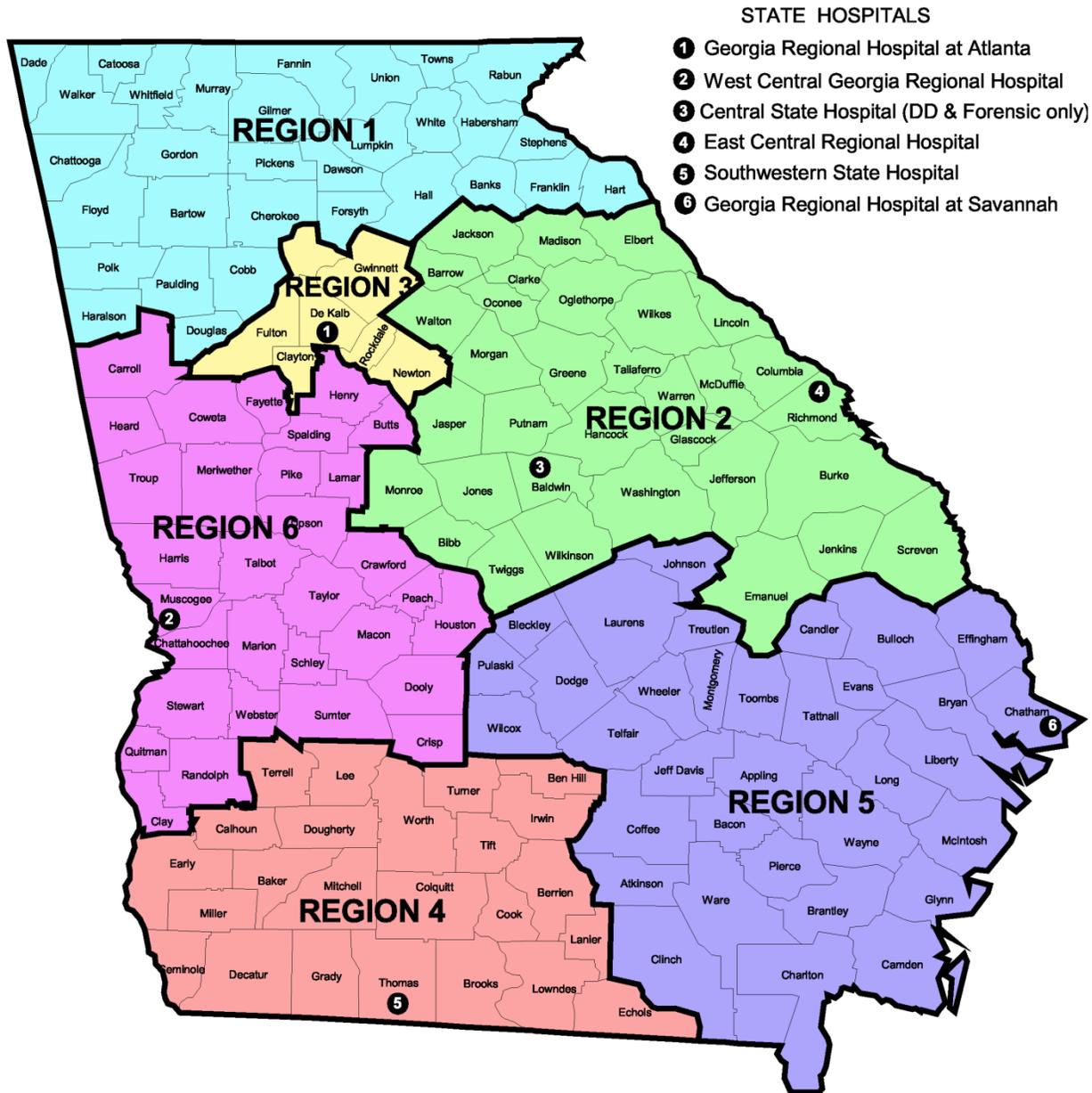
The Office of Incident Management and Investigations performs hospital and community based incident trending on a quarterly basis to identify patterns/trends and possibly mitigate further incidents. Identified trends and patterns are shared bi-annually at the EQC and at least quarterly at the PQC's and with DBHDD leadership and Director level staff as applicable.

Both the hospital Mortality Interdisciplinary Review Committee (MIRC) Policy 03-525 and Community Mortality Review Board (CMRB) are chaired by the DBHDD CMO. The hospital MIRC meets within 15 days of a death and the CMRB meets bi-monthly and performs a case review (including a review of the investigation) of deaths and follows up on recommendations from prior reviews. Through a review of each death by clinical and professional staff, deficiencies in the care or service provided or the omission of care or a service by DBHDD employees and/or Contractors may be identified and corrective action taken to improve services and programs. Trends, patterns and quality of care concerns are reviewed by the CMO and addressed with the applicable program leadership for resolution.

XII. Attachments

Appendix A DBHDD Regional Map

Georgia Department of Behavioral Health & Developmental Disabilities REGION MAP (Effective July 1, 2011)



Department of Behavioral Health and
Developmental Disabilities
Information Management Unit

Created: September 19, 2011

DBHDD

Appendix B DBHDD Quality Management Work Plan

Goal 1: Develop accurate, effective and meaningful performance indicators.

Tasks	Responsible Person	Target Completion Date	Status
Determine the criteria for developing the key performance indicators	Carol Zafiratos	June 2013	
Identify and assess current performance indicators for value and applicability	Carol Zafiratos, Steve Holton, Eddie Towson	June 2013	
Collaborate with stakeholders using the identified criteria to develop key performance indicators	Program Quality Councils	July 2013	
Develop and implement data collection plans for KPIs (identify responsible persons for data entry, collection, reporting, etc)	Carol Zafiratos, Steve Holton, Eddie Towson	August 2013	

Goal: 2 Educate stakeholders regarding QM (includes staff, providers and ultimately individuals and families).

Tasks	Responsible Person	Target Completion Date	Status
Update the current QM Training Plan and ensure inclusion of training for hospitals, CBH and DD – see Appendix L for current plan	Carol Zafiratos and Training Department	June 2013	
Continue development of web based training materials – three additional modules	Carol Zafiratos and Training Department	December 2013	
Develop and implement methodology to evaluate the effectiveness of the training	Carol Zafiratos and Training Department	December 2013	

Goal: 3 Assess and improve the effectiveness of the QM system and its various components. This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Implement the EQC approved outcomes framework (identify/revise KPIs as applicable, develop a data definition/collection plan for each measure and implement data collection).	Program Quality Council Chairpersons	June 2013	
Assess achievement levels of quality goals	Program Quality Council Chairpersons	March 2014	
Assess performance indicator achievement against target thresholds	Program Quality Council Chairpersons	March 2014	
Modify QM system and/or components as needed	Program Quality Council Chairpersons	March 2014	

Goal 4: Integrate QM Data Systems (have access to the data needed that is compatible with the hospital, community BH and community DD systems and which follows an individual and the services they receive across their lifetime, as applicable). This is a multi-year goal.

Tasks	Responsible Person	Target Completion Date	Status
Perform a comprehensive QM data management needs assessment	Director of IT and Carol Zafiratos, Steve Holton and Eddie Towson	January 2014	
Define and develop data sharing partnerships/agreements with other agencies (DCH, DJJ, DOE, DPH, DAS, etc)	DBHDD Leadership representative(s) [COO & Director of IT]	July 2014	
Create a QM information management plan (i.e.: policy and procedure development)	Director of IT	July 2014	
Develop a RFP to build a DBHDD Enterprise Data Systems (EDS)	Director of IT	July 2014	
Develop the DBHDD EDS	Director of IT	2015	
Evaluate the effectiveness and efficiency of the newly created system	Director of IT, Carol Zafiratos, Steve Holton and Eddie Towson	2016	

Annual Work Plans for each of the functional areas (Hospital System, Community BH and Community DD) will be developed and approved by the applicable PQC no later than 45 days after a revised or updated DBHDD Work Plan has been approved by the EQC, as applicable.

Appendix C Hospital System Quality Management Program

The Hospital System Program Quality Council is one of three PQC's described in the DBHDD Quality Management Plan. The following describes the organizational structure, membership and primary functions, of the Hospitals that comprise the DBHDD Hospital System.

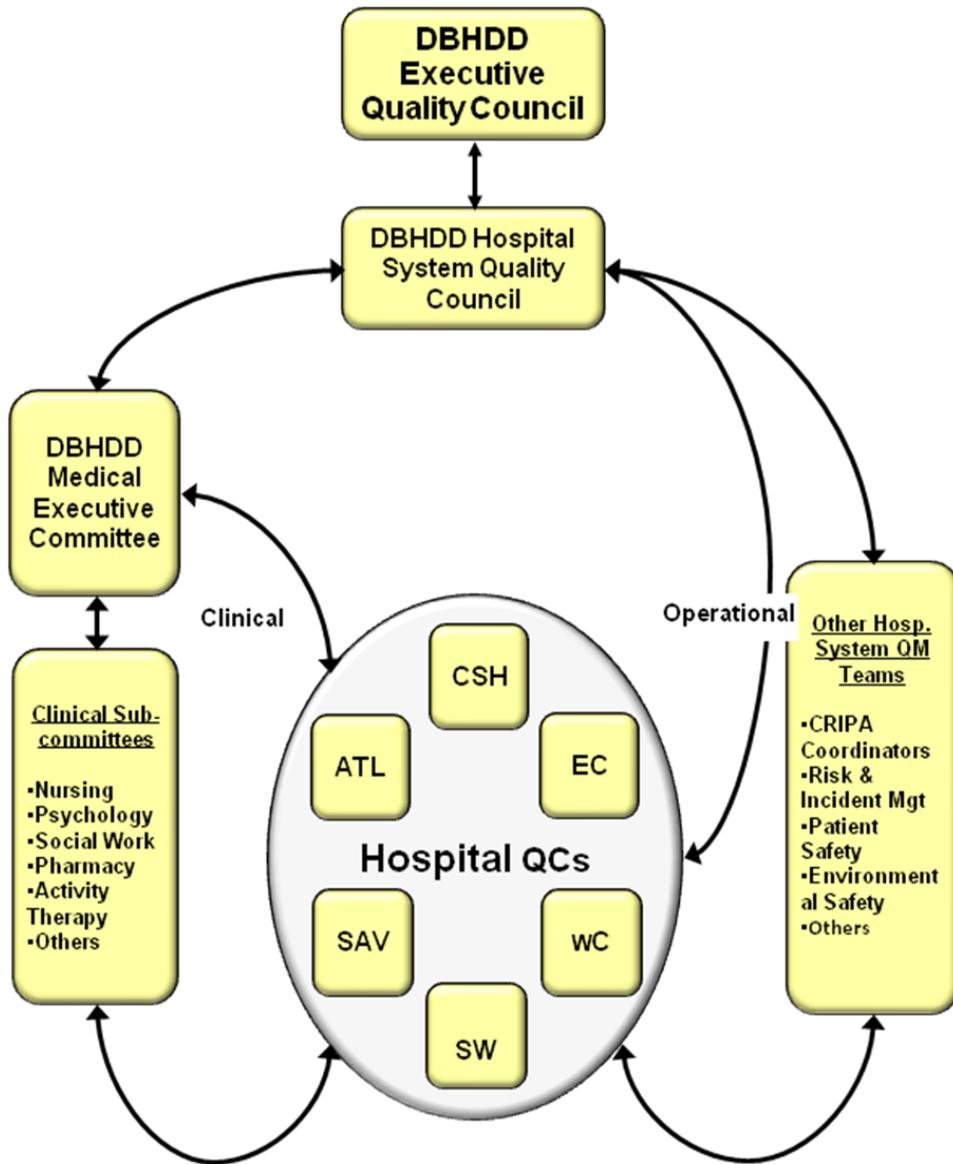
- **The DBHDD Hospitals:**
 - Maintain a quality management system consistent with the model established by the DBHDD Executive Quality Council and the Hospital System Program Quality Council and are compliant with all applicable accreditation and certification requirements
 - Report selected, performance measures directly to EQC and DBHDD Medical Executive Committee.
 - Report selected System-wide measures, Hospital-specific quality management activities, FMEAs and patient safety program reports.
 - Report all root cause analyses to the Director of Hospital Operations, the DBHDD Medical Director, the DBHDD Quality Management Director and the Director of Hospital System Quality Management.
 - Provide evidence of the effectiveness of quality improvement activities.

- **The DBHDD Medical Executive Committee**
 - **Functions:**
 - Reports to EQC on clinical performance measures and activities
 - Reviews, approves and oversees the development of all Hospital System-wide clinical policies and procedures
 - Reviews FMEAs and, as appropriate, communicates relevant information to other hospitals in the system that may benefit from recommendations.
 - Incorporates, as appropriate, systemic improvements into DBHDD policy
 - Assigns performance improvement teams to address systemic and other issues
 - Receives regular reports of clinical performance improvement activities from hospitals, subcommittees and teams
 - Reviews clinical risk management and other quality measurement reports
 - Provides oversight, direction and support to DBHDD Hospital System Professional practice subcommittees and other, multidisciplinary teams chartered for the purpose of improving clinical care.
 - **Membership includes**
 - DBHDD Chief Medical Officer —Chair
 - All state hospital clinical directors
 - Director of Hospital System Quality Management
 - Director of Hospital Operations
 - Chairs of Subcommittees
 - **Meeting frequency**—Monthly

- **The DBHDD Professional Practice Subcommittees of the Medical Executive Committee**
 - **Discipline subcommittees:**
 - Nursing
 - Psychology

- Social Work
 - Pharmacy
 - Activity Therapy
 - Others—to be determined
 - **Functions:**
 - Support the quality improvement goals of the DBHDD Medical Executive Committee and Hospital System
 - Create discipline-specific performance measures for the Hospital System
 - Plan, do, study and act to improve performance
 - Provide at least quarterly reports to the DBHDD Medical Executive Committee
 - Provide subject matter/process experts to assist in analysis and improvement of system-wide performance measurement
 - **Membership**
 - Chair: Appointed by DBHDD CMO and Director of Hospital Operations
 - Discipline chiefs from all state hospitals
 - **Meetings:** At least monthly
- **The DBHDD Quality Managers Committee**
 - **Functions:**
 - Supports the quality improvement goals of the Hospitals and Hospital System
 - Supports the development of performance measurement and improvement initiatives that are common for the Hospital System
 - Supports the development and improvement of the competencies and functioning of participants and contributors to the quality management processes in the hospitals (Quality managers, Clinical Risk Managers, CRIPA Coordinators, CRIPA Monitors)
 - Supports the quality measurement and improvement activities and goals of System-wide teams.
 - Provides quarterly reports to the DBHDD Quality Council
 - Leverages knowledge and skills committee members by facilitating the sharing with other hospitals within the System
 - **Membership**
 - Director of Hospital System Quality Management
 - Assistant Director of Hospital System Quality Management
 - All state hospital Quality Managers
 - **Meetings:** Monthly

Hospital System Quality Management Program – Flow Diagram



Atl = Georgial Regional Hospital, Atlanta
 EC = East Central Hospital
 SW = Southwestern State Hospital

CSH = Central State Hospital
 WC = West Central Georgia Regional Hospital
 SAV = Georgia Regional Hospital, Savannah

Appendix D Quality Management Job Descriptions

Commissioner is the DBHDD Commissioner. Reporting to the DBHDD Board, the Commissioner is responsible for setting policy for the DBHDD, and provides oversight and guidance to QM activities.

Chief Medical Officer is the DBHDD Chief Medical Officer (CMO) and is a Georgia licensed physician (Psychiatrist). The CMO is responsible for:

- Chairing the DBHDD EQC and the Hospital System PQC
- Providing clinical oversight of the quality of care processes (QOC)
- Working with DBHDD physicians on issues related to QOC and Peer Review
- Providing direction and input into DBHDD QM and Performance Improvement Projects

Assistant Commissioner for BH reports to the Deputy Commissioner for Programs. Responsibilities include ensuring ongoing communication and collaboration between DBHDD executive leadership and communication of QM program related issues and needs at the executive level. On a daily basis the Assistant Commissioner is responsible for:

- Administrative, executive-level leadership, guidance and support of the Office of QM
- Serves as a member for the DBHDD leadership team

Director of Quality Management is the Director of the Office of Quality Management and is responsible for administrative support and technical assistance to the EQC and the three PQCs (Hospital Systems, Community BH and Developmental Disabilities), and provides leadership for QM and PI efforts. On a daily basis the Director is responsible for:

- Focusing organizational efforts on improving clinical quality performance measures
- Co-Chairing the EQC with the Chief Medical Officer
- Overseeing the day-to-day operations of the Office of QM
- Providing technical assistance regarding DBHDD QM requirements, processes and operational matters
- Writing, revising and updating QM area reports, plans, policies and procedures
- Developing a DBHDD system wide QM training program

Quality Management Auditors report to the Director of Quality Management and their responsibilities include, but are not limited to:

- Designing audit/service review criteria and tools
- Completing field reviews/audits of settlement individuals receiving BH services in the community setting
- Compiling review/audit reports based upon on findings

Director of the Office of Information Management reports to the Deputy Commissioner/COO. The Information Management (IM) Director works with a team of staff to assist with quality and utilization management data needs, including:

- Providing data and reports related to consumers and services (Community & Hospital) to internal and external customers
- Producing required data and reports for federal block grants (MHBG and SABG)
- Management of the annual Adult and Youth/Family Satisfaction Surveys (data collection and reporting)
- Producing standardized monthly Hospital reports:
 - Hospital Utilization and Average Client Load (ACL) reports
 - Hospital 23 Hour Observation Unit Report
 - Hospital 30-Day Re-admissions Report
- Working with all parties to determine data and reporting needs (Ad Hoc and Routine)
- Working with all parties to understand data and reports
- Providing technical support as needed

DBHDD QM Operations Analyst reports to the Director of Quality Management. Responsibilities include but are not limited to:

- Developing charts and graphs for performance measures
- Assisting with database management

Director of Hospital System QM reports to the Director of QM and is responsible for oversight for hospital system QM. Responsibilities include:

- QM training and consultation
- Developing PI teams and committees
- Assisting with the development and monitoring of performance measures
- Assisting with accreditation survey preparations
- Assisting hospitals and system-wide teams to address quality issues
- Developing and supporting the implementation of the Hospital System Quality Management plan.

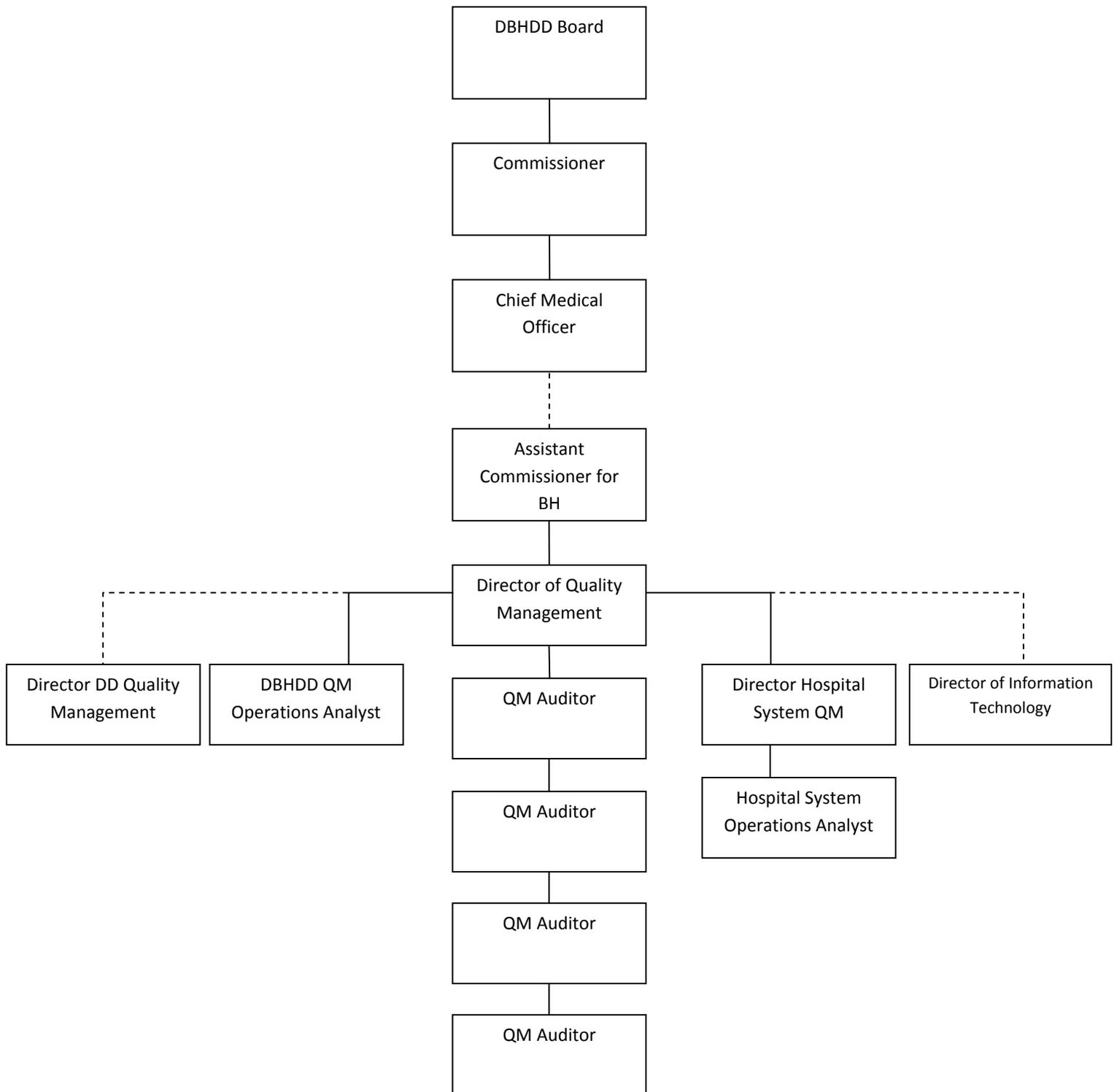
Hospital System Operations Analyst reports to the Director of Hospital System QM and is responsible for:

- Maintaining the Plato Data Analyzer audit system
- Creating quality management reports from data
- Maintaining and supporting the hospital systems NASMHPD Research Institute's performance measurement system
- Development and maintenance of performance measurement tools

DD Director of Quality Management reports to the DD Division Director of Service Support and is responsible for:

- Implementing, managing, monitoring and evaluating the Division of DD QM system
- Writing, revising and updating DD QM reports, plans policies and procedures
- DD ERO Leadership and oversight
- Performance Data Collection and analysis
- Special reviews as needed
- Provider education and training
- Development and coordination of regional and statewide DD QI councils
- Development and coordination of DD Human Rights committees
- Management and evaluation of the Georgia Crisis Response System for DD

Appendix E Quality Management Organizational Chart



Appendix F The Executive and PQCs Membership Roles

Assistant Commissioner and Chief Medical Officer	chair of the EQC and providers oversight and guidance to QM activities.
Commissioner	sets policy for the DBHDD, and provides oversight and guidance to QM activities.
Deputy Commissioner/Programs	oversees the provision of the Departments programs and activities related to behavioral health services/DD and provides guidance related to infrastructure and service delivery.
Deputy Commissioner/COO	responsible for the Departments fiscal management strategy and provides guidance to QM activities related to fiscal planning, budgeting, cash flow and other policy matters.
Director, Office of Recovery Transformation	provides input and guidance on the cultural shift towards recovery transformation, integration of persons with lived experience and practice guidelines for recovery.
Director of Regional Operations	provides a regional perspective on behavioral health and DD issues.
Assistant Commissioner for Behavioral Health	provides direction and guidance related to community behavioral health services and provides oversight for Quality Management.
Assistant Commissioner for Developmental Disabilities	oversees the provision of the Division of Developmental Disabilities programs and activities and provides guidance related to infrastructure and service delivery
Settlement Coordination Director	provides oversight for the settlement agreement for Community Mental Health & DD.
General Council	provides input regarding legal, ethical, risk management and HIPAA issues.
Director of Quality Management	oversees DBHDDs quality management system.

Hospital System PQC Roles

Assistant Commissioner & Chief Medical Officer	chair of the Hospital System PQC, sets policy and provides oversight to the hospitals.
Director of Hospital System Quality Management	coordinates and supports the Hospital System Quality management activities.
Chair of the Hospital Nurse Executives	provides oversight for nursing services and sets policy and practices in order to implement change to improve patient care.
Regional Hospital Administrators	chair their respective hospital's QCs and represents them on the Hospital System Program Quality Council.
Director of Forensic Services	directs and manages DBHDD's forensic programs and services and provides QM guidance related to forensic services.
Director, Office of Recovery Transformation	provides input and guidance on the cultural shift towards recovery transformation, integration of persons with lived experience and practice guidelines for recovery.
Director of Quality Management	oversees DBHDDs quality management system.
Director of the Office of Transitional Services	provides input related to consumers transitioning from inpatient to community settings and acts as an information resource for the Regional Offices and hospitals.

Community Behavioral Health PQC Roles

Assistant Commissioner for Behavioral Health	is chair of the Behavioral Health PQC and provides direction and guidance related to community behavioral health services.
Addictive Disease Services Executive Director	directs and manages DBHDDs addictive disease program and provides QM guidance related to AD services.
Director Community Mental Health Services	directs and manages DBHDDs adult and child community mental health programs and provides QM guidance related to community based services.
Director, Office of Recovery Transformation	provides input and guidance on the cultural shift towards recovery transformation, integration of persons with lived experience and practice guidelines for recovery.
Director Quality Management	oversees DBHDDs quality management system.
Director Adult Mental Health Services	provides administrative and clinical oversight for adult mental health services.
Director of Child and Adolescent Services	provides administrative and clinical oversight for children and adolescent mental health services.
Assistant Commissioner and Chief Medical Officer	provides clinical oversight and guidance to QM activities.
Director of the Office of Transitional Services	provides input related to consumers transitioning from inpatient to community settings and acts as an information resource for the Regional Offices and hospitals.
Director of Regional Operations	provides a regional perspective on behavioral health and DD issues.
Settlement Coordination Director	provides oversight for the settlement agreement for Community Mental Health & DD.

Developmental Disabilities PQC Roles

Assistant Commissioner for Developmental Disabilities	is the chair of the DD PQC and oversees the provision of the Division of Developmental Disabilities programs and activities and provides guidance related to infrastructure and service delivery.
DD Director of Quality Assurance	oversees the Division of Developmental Disabilities quality management system and crisis response system.
Director of Division of DD Service Support	provides direction and guidance related to quality management, provider performance, stakeholder input/involvement related to system change and policy and procedures.
Director of Division of DD Programs	provides direction and guidance related to community DD programming.
State Level DD Staff	assists with various duties related to areas such as training, provider compliance, supported employment, and others.
DBHDD Director of Quality Management	oversees DBHDDs quality management system.
Regional Director of Operations	provides a regional perspective on behavioral health and DD issues.
DD Advisory Council Member	provides a community and an end user perspective to services and programs.
Settlement Coordination Director	provides oversight for the settlement agreement for Community Mental Health & DD.

Appendix G Reporting Documents

DBHDD QM Reporting

- DBHDD QM Plan and Work Plan
- Annual PQC (Hospital, Community BH and DD) Work Plans
- Annual QM System Report
- Monthly Hospital System Triggers and Thresholds Report
- Quarterly Community BH Key Performance Indicator Matrix
- Periodic Community BH QM Audit Summaries
- Monthly Hospital System Dashboard
- Monthly Hospital System CRIPA work plan
- Quarterly DD Data Reports
- Annual DD Statewide QM Report
- Annual State National Core Indicator Report
- Quarterly DD Support Coordination Rating Summary Report
- Quarterly DD NOW and COMP Waiver Performance Indicator Report
- Annual DD Funding Utilization Report
- Annual DD QI Study
- DD Ad Hoc data reports

Data Feeds

DBHDD QM also reviews data reports from other DBHDD functional areas in QM committees and meetings.

The following are data feeds for DBHDD QM:

- Office of Public Relations Complaints/Grievance Reports
- Annual GMHCN Consumer Satisfaction Survey
- Office of Incident Management and Investigations Trend Reports
- Other data as identified

Appendix H Key Performance Indicators

All KPIs are accurate as of March 31, 2013 and are in the process of review and revision for FY 2014.

DBHDD acknowledges that mental health and physical health are inextricably linked and recognizes the importance of tracking key physical health indicators. Tracking physical health indicators will be one of the objectives/goals discussed for 2014.

Hospital System Key Performance Indicators

Measure	Definition	Target
Continuing care plan created overall. The measure definition is taken from NRI (NASMHPD Research Institute), a national organization that collects and reports performance data for mental health programs nationwide.	Percent of adult mental health patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan that contains all of the following: reason for hospitalization, principal discharge diagnosis, discharge medications and next level of care recommendations.	100%
Individualized Recovery Plan – Quality	Percent of criteria that were met on quality audits. Consumers in Adult Mental Health and Forensic inpatient programs.	100%
Consumer Satisfaction/Outcome of Care Domain	Percent of adult mental health clients at discharge or at annual review who respond positively to the outcome of care domain on the Inpatient Consumer Survey.	90%
Consumer Satisfaction/Empowerment Domain	Percent of adult mental health clients at discharge or at annual review who respond positively to the empowerment domain on the Inpatient Consumer Survey	90%

Hospital System Utilization Performance Indicators

All System Hospitals maintain utilization review departments that monitor admissions, readmissions, continued stay criteria, unauthorized bed days, and a variety of other service utilization data. In addition, the Hospital System monitors and acts to improve several key utilization review measures. They are:

Measure	Threshold
Percent of individuals returning to hospitals for admission within 30 days	5%
Percent of individual readmitted 3 or more times in a 12 month period	5%
Percent of individuals readmitted 10 or more times in their lifetime to state hospitals	10%

Community Behavioral Health Key Performance Indicators

Measure	Definition	Target
Housing Stability – Independence & Integration: (stability)	Percent of Georgia Housing Voucher Program (GHVP) adult mental health (MH) individuals in stable housing (greater than 6 months). Denominator = all consumers enrolled in the GHVP during the calendar month.	77%
Housing Stability – Independence & Integration: (reengagement)	Percent of GHVP adult MH individuals who have left stable housing under unfavorable circumstances & have been reengaged and reassigned vouchers. Denominator = all consumers who are and were enrolled in the GHVP during the calendar month.	10%
Supported Employment - Efficiency (caseload size)	Percent of adult MH supported employment providers that meet a caseload average of employment specialist staff to consumer ratio of 1:20. Denominator = Number of contracts DBHDD Community Mental Health holds for SE.	85% or more
Supported Employment - Effectiveness	Percent of unduplicated individuals who had 1 st contact with a competitive employer within 30 days of enrollment. Denominator = Number of settlement criteria consumers who started SE services during the quarter.	January 2012 – June 2013 = 50% or more July 2013 going forward = 75% or more
Assertive Community Treatment	The percent of ACT consumers who are enrolled within three	70% or more

– Accessibility (enrollment)	days of referral. Denominator = Total number of consumer enrollments (consumers who started services) during the month.	
Assertive Community Treatment – Effectiveness (admissions)	The percent of ACT consumers admitted to a Psychiatric hospital within the past month. Denominator = Census on the last day of month minus the number of enrollments during month.	7% or less
Assertive Community Treatment – Effectiveness (incarceration)	Average number of jail/prison days utilized per enrolled consumer. Denominator = Number of discharges during the month plus the census on the last day of the month.	1.00 or less
Intensive Case Management – Effectiveness (admissions)	Percent of ICM consumers with a Psychiatric Inpatient Admission within the past month. Denominator = Census on the last day of month minus the number of enrollments during month.	January 2012 to June 2013 = 10% or less July 2013 going forward = 5% or less
Intensive Case Management - Housing	Percent of ICM consumers housed (non-homeless) within the past month. Denominator = Number of consumers by living arrangement on the last day of the month.	90% or more
Intensive Case Management - Effectiveness (incarceration)	Average number of jail/prison days utilized per enrolled consumer. Denominator = Number of discharges during the month plus the census on the last day during the month.	January 2012 to June 2013 = .50 days or less July 2013 going forward = .25 days or less

Community Support Teams - Effectiveness (admissions)	Percent of CST consumers with a Psychiatric Inpatient Admission within the past month. Denominator = Census on the last day of month minus the number of enrollments during month.	10% or less
Community Support Teams - Housing	Percent of CST consumers housed (non-homeless) within the past month. Denominator = Number of consumers by living arrangement on the last day of the month.	90% or more
Community Support Teams – Effectiveness (incarceration)	Average number of jail/prison days utilized per enrolled consumer. Denominator = Number of discharges during the month plus the census on the last day of the month.	.75 days or less
Case Management - Effectiveness (admissions)	Percent of CM consumers with a Psychiatric Inpatient Admission within the past month. Denominator = Census on the last day of month minus the number of enrollments during month.	January 2012 to June 2013 = 10% or less July 2013 going forward = 5% or less
Case Management - Housing	Percent of CM consumers housed (non-homeless) within the past month. Denominator = Census on the last day of the month.	90% or more
Case Management - Effectiveness (incarceration)	Average number of jail/prison days utilized per enrolled consumer. Denominator = Number of discharges during the month plus the census on the last day of the month.	.25 days or less

Addictive Disease	Percent of adult Consumers discharged from crisis/ detoxification who receive follow-up services. Follow up is defined as an authorization for a BH service which demonstrates a connection.	To Be Determined
Addictive Disease	Percent of adult Consumers remaining active in treatment for 90 days after beginning non-crisis stabilization services. Non crisis is defined as a service that is not a CSU admission.	To Be Determined
Consumer Satisfaction with Services	Percent of individuals meeting community settlement agreement criteria who are enrolled in settlement funded services who state they are satisfied with the services they are receiving. Denominator = random sample of consumers chosen to be included in an onsite QM audit who are actively receiving services for 30 days or more. * Will be expanded to other populations as resources allow.	90%
Consumer Satisfaction – Quality of Life	Percent of individuals meeting community settlement agreement criteria who are enrolled in settlement funded services who feel their quality of life has improved as a result of receiving services. Denominator = random sample of consumers chosen to be included in an onsite QM audit who are actively receiving services for 30 days or more.* Will be expanded to other	90%

	populations as resources allow.	
Child and Adolescent BH Programs - Effectiveness	Percent of youth with an increase in functioning as determined by a standardized tool. Denominator = individuals between the ages of 4 -21 who have a severe emotional diagnosis and are active in the program.	80%
Child and Adolescent BH Program - Effectiveness	Percent of youth with an increase in functioning as determined by their parent or legal guardian (CIS). Denominator = parents or legal guardians of individuals between the ages of 4 -21 who have a severe emotional diagnosis and are active in the program.	80%

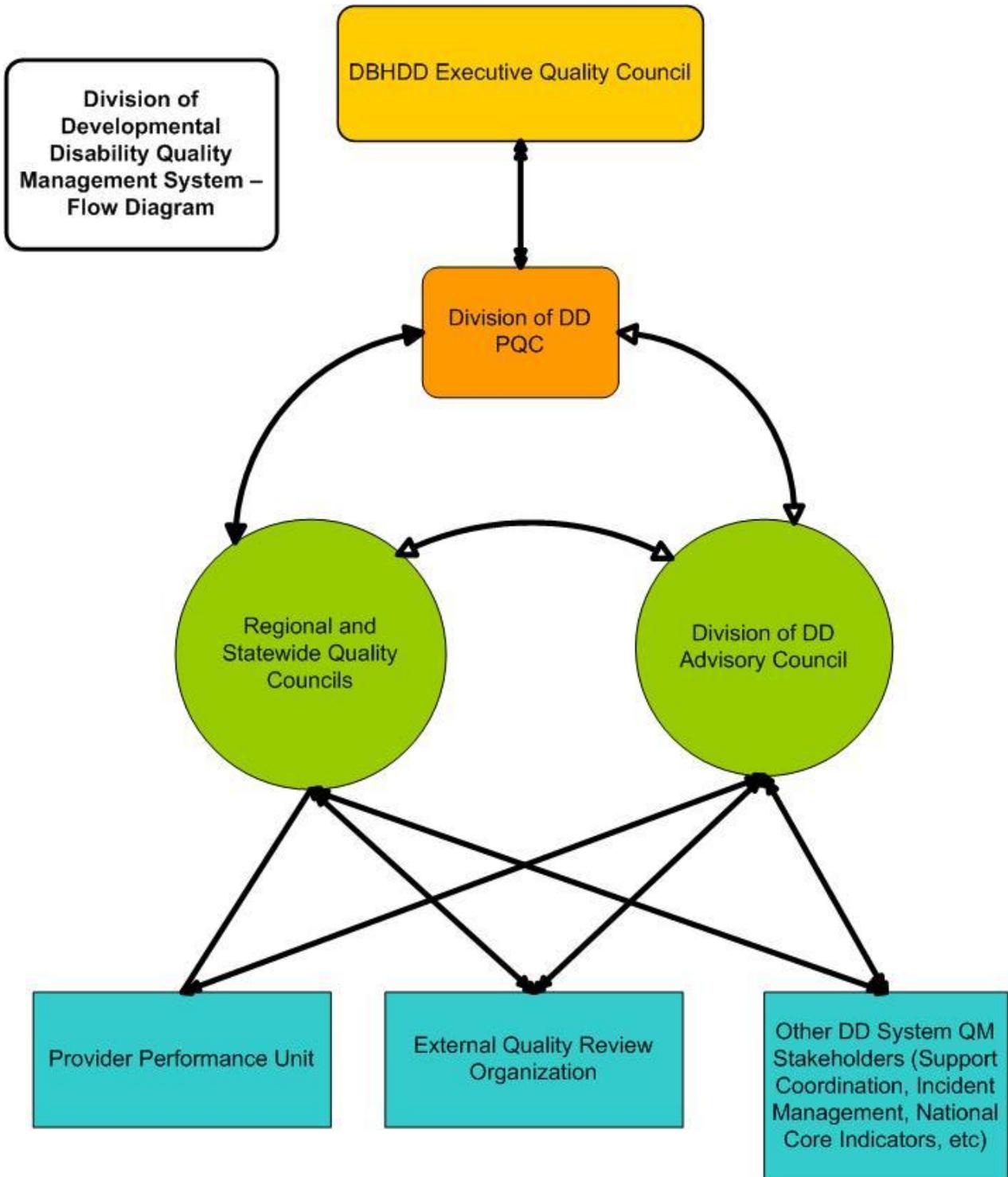
Developmental Disabilities Key Performance Indicators

Measure	Definition	Target
Individual Support Plan	<p>The percent of ISPs written to support either a Service Life, Good but Paid Life, or Community Life. Denominator = the number of waiver supported individuals who completed an ISP QA Checklist form</p> <p>Service Life means the individuals uses paid supports and services and has little to no connection with the community.</p> <p>Good but Paid Life means the plan supports life in the community, but real community connections are lacking. The individual has both paid and unpaid supports.</p> <p>Community Life means the ISP is written to move people toward a community life as the person chooses.</p>	90%
Crisis Response System	<p>The Percent of Crisis Incidents that resulted in intensive –home supports. Denominator = number of Mobile Crisis Team dispatches</p> <p>The Percent of Crisis incidents that resulted in placement of the individual in a crisis home. Denominator = Number of Mobile Crisis Team dispatches.</p>	<p>20%</p> <p>15%</p>
Health	<p>Percentage of individuals who had a flu vaccine in the last year. Denominator = Number of individuals in a random sample who answered either yes or no to this question on the National Core Indicator Survey.</p> <p>Percentage of Individuals who has a routine dental examine in the past year. Denominator = Number of individuals in a random sample who answered either yes or no to this question on the National Core Indicator Survey.</p>	<p>75%</p> <p>80%</p>

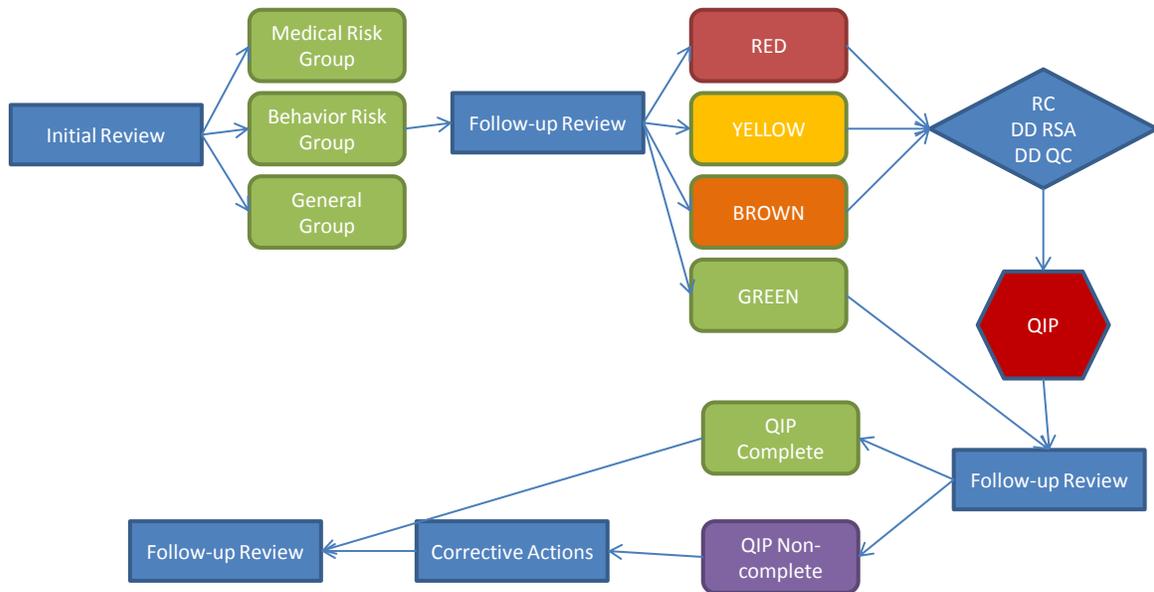
	Percentage of Individuals who have had an annual physical in the past year. Denominator = Number of individuals in a random sample who answered either yes or no to this question on the National Core Indicator Survey.	92%
Safety	Percentage of Individuals who state they feel safe in their home. Denominator = Number of individuals randomly sampled to undergo a Person Centered Review.	90%
Rights and Choice	Percentage of Individual who report they are treated with respect and dignity. Denominator = Number of individuals randomly sampled to undergo a Person Centered Review.	100%
	Percentage of individuals who stated they have a choice of supports and services. Denominator = Number of individuals randomly sampled to undergo a Person Centered Review.	95%
Transition (Additional indicators will be added as the new monitoring process is implemented)	Percentage of Individuals who are included in the larger Community. Denominator = Number of individuals randomly sampled to undergo a Person Centered Review.	75%
	Percentage of individuals who report they were involved with the development of their service plans. Denominator = Number of individuals randomly sampled to undergo a Person Centered Review.	85%
	Percentage of individuals on psychotropic / anti-convulsive medications who have a signed conformed consent. Denominator = Number of transitioned individuals required to have a signed informed consent form.	100%
	Percentage of transitioned individuals who were categorized being in a level green condition. Denominator = Number of transitioned individuals that were assessed by the RQR teams.	75%

A DBHDD QM Data Definition document for KPIs is being developed and has an anticipated completion date of May 2013.

Appendix I Developmental Disabilities Quality Management System – Flow Diagram



Appendix J RQR Team Review Process Flow Diagram



Appendix K Community BH Coalition and Consortium Meeting Schedules

AMH Coalition Meeting Schedule: 1/2013 - 6/2013

Group	Date	Time	Location	Contact
ACT	January 17, 2013	2:00pm – 4:00pm	Macon Training Center	Kimberly Miller
CST/ICM/CM	January 23, 2013	10:00 am - 11:00am	2 Peachtree	Charley Bliss
SOAR	January 28, 2013	10:00am - 11:00am	United Way	Charley Bliss
PATH	February 13, 2013	2:00pm - 3:30pm	United Way	Charley Bliss
CSU	February 15, 2013	10:00am - 2:00pm	Macon Training Center, Atlanta Room	Carla Givens
SE	February 20, 2013	1:00pm - 2:30pm	Macon Training Center, Savannah Room	Vernell Jones
CST/ICM/CM	February 27, 2013	10:00am - 11:00am	2 Peachtree	Charley Bliss
ACT	March 21, 2013	2:00pm – 4:00pm	Macon Training Center, Macon Room	Kimberly Miller
SOAR	March 25, 2013	10:00am - 11:00am	United Way	Charley Bliss
CST/ICM/CM	March 27, 2013	10:00am - 11:00am	2 Peachtree	Charley Bliss
MES	April 8, 2013	1:00pm- 2:00pm	2 Peachtree 25-375	Charley Bliss
PATH	April 10, 2013	2:00pm - 3:30pm	United Way	Charley Bliss
SE	April 17, 2013	1:00pm – 2:30pm	2 Peachtree Suite 24-389	Vernell Jones
CST/ICM/CM	April 24, 2013	10:00am - 11:00am	2 Peachtree	Charley Bliss
MES	May 13, 2013	1:00pm – 2:00pm	2 Peachtree 25-375	Charley Bliss

ACT	May 16, 2013	2:00pm – 4:00pm	Macon Training Center, Savannah Room	Kimberly Miller
SOAR	May 20, 2013	10:00am - 11:00am	United Way	Charley Bliss
CST/ICM/CM	May 22, 2013	10:00am - 11:00am	2 Peachtree	Charley Bliss
MES	June 10, 2013	1:00pm – 2:00pm	2 Peachtree 25-375	Charley Bliss
PATH	June 12, 2013	2:00pm - 3:30pm	United Way	Charley Bliss
CST/ICM/CM	June 26, 2013	10:00am - 11:00am	2 Peachtree	Charley Bliss

Child and Adolescent Community BH Program Consortium and Quality Council Meetings

The Psychiatric Residential Treatment Facilities Consortiums and Crisis Stabilization Unit Consortiums meet every other month. The Care Management Entity Quality Council meets quarterly on the 1st Tuesday of each quarter (January, April, July and October).

Appendix L QM Learning Plan - 2012



Department of Behavioral Health &
Developmental Disabilities

December 2012

**DBHDD Office of Quality Management
State of Georgia**

DBHDD Quality Management Learning Plan

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DBHDD Quality Management Learning Plan, Continued

Introduction

This document provides information about the plan to developed and deliver learning on relevant Quality Management concepts to DBHDD staff and contracted services providers.

Originator of Learning Program Request

The Originator of the learning is shown below

Location	Office/Department	Name(s) and title of Originator
DBHDD State Office	<input type="checkbox"/> Addictive Diseases	Carol Zafiratos, Director, Quality Management
East Central Regional Hospital	<input type="checkbox"/> Advocacy	
Central State Hospital	<input type="checkbox"/> Budget & Finance	
Georgia Regional Hospital-Atlanta	<input type="checkbox"/> Commissioner	
Georgia Regional Hospital-Savannah	<input type="checkbox"/> Compliance	
Southwestern State Hospital	<input type="checkbox"/> Contracts & Procurement	
West Central Georgia Regional Hospital	<input type="checkbox"/> Developmental Disabilities	
	<input type="checkbox"/> Human Resources	
	<input type="checkbox"/> Mental Health	
	<input type="checkbox"/> Learning & Organization Development	
	<input type="checkbox"/> OIT	
	<input type="checkbox"/> Policy	
	<input checked="" type="checkbox"/> Quality Management	
	<input type="checkbox"/> Other _____	

Continued on next page

DBHDD Quality Management Learning Plan, Continued

Learning Program Executive Sponsors

Who makes the final decisions on this project?

Name:	Title:	Email address
Carol Zafiratos,	Director, Quality Management	cazafiratos@dhr.state.ga.us

Project Manager

Who will plan, organize, and control project activities to ensure successful outcome?

Name:	Title:	Email address
Ann Rogers	Learning Systems & Development	anrogers@dhr.state.ga.us

Business Case for Learning

Why is the learning necessary for the business?

One of the underlying principles of DBHDD is to provide quality services to customers. Employees need to understand the expectations of the Department as it relates to integrating quality concepts into daily activities to deliver quality care to the individuals served by the Department.

Staff or other service delivery personnel have never received any education concerning the Department's approach to continuous quality improvement. It is necessary to provide learners with an understanding of DBHDD's approach to quality and provide examples to tools that can be used at various levels of the continuous quality improvement model. To deliver quality services, staff must understand what quality is and what it means to the individuals we serve.

DBHDD Quality Management Learning Plan, Continued

Stakeholders Involved

- Individuals served
- DBHDD staff

Who will be impacted by the success or failure of the project?

Supporting Policies

List relevant policies that are applicable to this learning

Policy Title & ID	New	Update
None		

Learning Overview

Briefly describe what the learning is about

The quality management learning program consists of ten (10) learning modules. Each module will provide information about quality management concepts and techniques. The module will provide information about the quality initiatives DBHDD is undertaking and the organization’s approach to providing quality care to individuals served.

The modules are being developed, piloted and rolled out in phases:

Modules	Target Development and Testing timeline	Tentative Rollout Schedule
1, 2, 3	September 2012- February 2012 <ul style="list-style-type: none"> - Building a Customer-Focused QM Program - DBHDD’s Approach to QM - Introduction to Project Selection 	March 15, 2013
4, 5, 6	March 2012 - September 2013	October 2013

	<ul style="list-style-type: none"> - Introduction to Quick Wins & Rapid Improvement Events - Project Documentation & Project Meeting - Voice of the Customer & Stakeholder Analysis 	
7, 8, 9,10 & 11	<p>October 2012- April 2014</p> <ul style="list-style-type: none"> - Introduction to Establishing Measures - Introduction to Measurement Selection - Introduction to Sampling - Measurement Systems Analysis - Continuous Improvement 	June 2014

Continued on next page

DBHDD Quality Management Learning Plan, Continued

Learning Platform

E-Learning

One-on-One

Virtual

How will the learning be delivered?

Blended Learning

Instructor led

Multimedia

Read and Sign

Self-Instructional Package (SIP)

OTHER (please specify): _____

The course will be delivered 100% e-learning platform. Learners will log into the DBHDD Learning Management System (LMS) to complete the modules.

Resource Needs

What resources (subject matter experts, funding, etc) will be needed to successfully implement this plan?

	Personnel	Funding	Hardware	Software
	SME			Computer
	Instructional Designer/Developer	OLOD		
	Other			

Location/Venue: This e-learning program will be delivered online through the DBHDD Learning Management System (LMS).

Where will the learning be delivered?

Learning Goals

What do you want to accomplish by implementing this learning?

The goals of the course are to

- educate staff about DBHDD’s focus on consumer- oriented care and services.
- increase awareness among DBHDD staff and contracted providers regarding the delivery of quality care, and Provide a framework for developing and monitoring a quality management program.

Continued on next page

DBHDD Quality Management Learning Plan, Continued

Learning objectives

What specific knowledge, skills, and attitudes would you like to impart during the learning to accomplish your learning goals?

Module Title and Objectives	Estimated Length of Module
Module 1: A Customer- Focused Approach to Quality	
<ul style="list-style-type: none"> • Identify consumers of DBHDD services- our customers • Define quality as it relates to providing services to our customers • Explore quality management processes from the customer-supplier perspective • Provide information about DBHDD’s Quality Management philosophy 	30 minutes
Module 3: DBHDD’s Approach to Quality	
<ul style="list-style-type: none"> • Provide an overview of the mission and core values of DBHDD • Describe the services DBHDD offers, and • Provide information on the structure and processes of the DBHDD Quality Management System. • Gain awareness of the role and function of the Program Quality Councils (PQC) and the following areas: <ul style="list-style-type: none"> ▪ The PQCs cycle and structure? ▪ The quality monitoring processes? ▪ the key performance indicators that are currently being used to track outcomes 	45 minutes

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DBHDD Quality Management Learning Plan, Continued

What specific knowledge, skills, and attitudes would you like to impart during the learning to accomplish your learning goals?
(continued)

Module Title and Objectives	Estimated Length of Module
Module 3: Selecting Quality Improvement Projects	
<ul style="list-style-type: none"> • review basic tools and methods for selecting improvement projects • gain awareness of project selection tools and methods as a foundation for formal project selection • Identify potential continuous improvement projects 	30 minutes

Note: Modules 4-10 have not yet been developed.

Continued on next page

DBHDD Quality Management Learning Plan, Continued

Learning Platform

E-Learning

Instructor led

Read and Sign

How will the learning be delivered?

Self-Instructional Package (SIP)

Blended Learning

Multimedia

Virtual

One-on-One

OTHER (please specify): _____

The course will be delivered 100% e-learning platform. Learners will log into the DBHDD Learning Management System to complete the modules

Learning Audience

Who will be participating in the learning?

Audience	Check✓ if applicable	Select Service Area
All DBHDD Staff	✓	<input checked="" type="checkbox"/> All <input type="checkbox"/> Forensics <input type="checkbox"/> Mental Health <input type="checkbox"/> Addictive Diseases <input type="checkbox"/> Developmental Disabilities
Executive Staff (Executive Directors and Above)		
Nurse- Limited or No Contact		
Nurse- Routine Contact		
Direct Care- Nurse		
Direct Care- HSTs/FSTs, CNAs		
Direct Care- Other Clinical		
Support Staff - Limited or No Contact		
Support Staff -Administrative		
Support Staff- Routine Contact		

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DBHDD Quality Management Learning Plan, Continued

Learning Design

The course is designed to provide relevant information on all the course objectives in digestible format. There are reviews and knowledge checks designed to measure learning throughout the module. A pre and post test is designed into each module.

How is the learning designed to accomplish the objectives?

The modules are designed based on the needs of different target audiences.

A pilot of the modules will be used to gather feedback from a cross section of DBHDD employees. The feedback obtained will provide information about target audience for each module, appropriateness of the learning content, e-learning delivery format, recommended changes, etc.

A survey will be linked to each module to gather feedback specific to each module.

Learning Development

How will the learning be developed?

Story boards will be developed and submitted to SME for review and approval.

Once approval is given from the SME the developer will develop a module and submit it to SME and project manager for approval.

Adobe Captivate v 5.5 is the designated e-learning development tool that will be used to develop the modules.

Learning Communication

How will learners know that the learning is available?

The Director will announce the pilot of the quality management modules and request pilot participants.

The project managers will communicate with pilot participants and provide instructions for accessing the assigned courses in the LMS.

The Quality management Director will encourage leadership to ensure their employees complete the assigned modules.

Continued on next page

DBHDD Quality Management Learning Plan, Continued

Learning

The modules will be assigned to specific target audience via the LMS after modifications are complete and SME approval is obtained.

Implementation

How will the learning be delivered?

Learners will be given three weeks to complete each set of modules. Reminders will be sent after two weeks to learners and supervisors who have not completed the modules. Targeted emails will be sent to specific target groups, as needed.

Learning

Each module contains a pre and post. Learners are waived from completing the course if they score 80% or higher on the pre test.

Evaluation

How will you know that you have accomplished the objectives?

Learners are given three attempts to pass the post test. After three unsuccessful attempts, a failure is recorded. Learners who have failed are allowed to re enroll in the course.

Continuous Improvement Plan

What actions will you take to improve learning outcomes?

Employees who do not pass will be given another chance to retake the modules.

The test items will be evaluated to ensure they are valid and reliable. A bank of questions will be developed to ensure random assignment can occur.

The course content will be evaluated and modified to ensure that the objectives and content are aligned.

Reporting

The Quality Management Director will receive periodic scheduled programmatic reports. The Director will disseminate the results to stakeholders, as needed.