South Peninsula
Behavioral Health Services, Inc.

Performance Improvement Plan CY 2015

Approved by the Board of Directors
Date March 19, 2015

Section 1 Introduction

Mission, Vision, Values and Scope of Service

This performance improvement plan serves as the foundational document in the expression of the commitment of South Peninsula Behavioral Health Services, Inc. (SPBHS) to continuously improve the quality of the treatment and services provided. The Mission of SPBHS is to partner with individuals, families and communities to enhance their health, productivity and social engagement by offering compassionate and evidence based services in the areas of mental health, developmental disabilities and co-occurring disorders. Our Vision is a dynamic organization committed to outstanding care with and for communities, valuing integrity and respect for all. Our values include:

1. The individual's right to self-determination.
2. The individual's right to be treated with dignity, respect and kindness.
3. In innovative response to obstacles.
4. That cooperation is founded on respect, honesty and forgiveness, as well as the opportunity to change.
5. In forging partnerships that create synergy within the community.
6. That diverse opinions enrich outcomes.
7. In collaboration, commitment, teamwork and problem solving.
8. That integrity and personal responsibility are core to ethical behavior.

Quality

Quality services are services that are provided in a safe, effective, person-centered, timely, equitable, and recovery-oriented fashion. SPBHS is committed to the ongoing improvement of the quality of care received by persons served, as evidenced by the outcomes of those care and services as well as the ongoing improvement of the performance of the organization. SPBHS continuously strives to ensure that:

- The treatment provided incorporates evidence based, effective practices;
- The treatment and services are appropriate to each individual person's or family's needs, and are available when needed.
- Risk to persons served, providers and others is minimized, and errors in the delivery of services are prevented.
- The individual needs and expectations of persons served are respected. Individuals or those whom they designate have the opportunity to participate in decisions regarding their treatment. Services are provided with sensitivity and caring.
- Procedures, treatments and services are provided in a timely and efficient manner, with appropriate coordination and continuity across all phases of care and all providers of care.

Performance Improvement Principles

Performance improvement is a systematic approach to assessing services and improving them on a priority basis. The SPBHS approach to improve performance is based on the following principles:

- **Customer Focus**. High quality organizations focus on their internal and external stakeholders or customers and on meeting or exceeding needs and expectations.

- **Recovery-oriented**. Services are characterized by a commitment to promoting and preserving wellness and to expanding choice. This approach promotes maximum flexibility and choice to meet individually defined goals and to support person-centered service delivery.

- **Employee Empowerment**. Effective programs involve people at all levels of the organization in improving performance.

- **Leadership Involvement**. Strong leadership, direction and support of performance improvement activities by the governing body, CEO and leadership team are key to performance improvement. This involvement of organizational leadership assures that performance improvement initiatives are consistent with our mission, vision, values and other foundational planning documents.

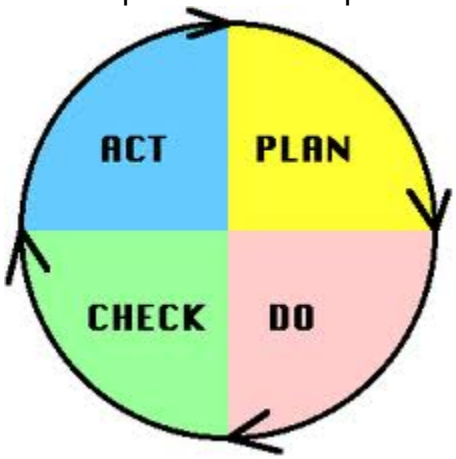
- **Data Informed Practice**. Successful performance improvement processes create feedback loops, use data to inform practice improvement initiatives and measure outcomes. Fact-based decisions are likely to be correct decisions.

- **Statistical Tools**. For continuous improvement of care, tools and methods are needed that foster knowledge and understanding. Continuous performance improvement organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information.

- **Prevention of Over-Correction**. Continuous performance improvement entities seek to design good processes to achieve excellent outcomes rather than fix processes after the fact.

- **Continuous Improvement**. Processes must be continually reviewed and improved. Small incremental changes do make an impact, and through our performance improvement work, we can almost always find improvement opportunities.

Cycle of Continuous Improvement
PDCA (Plan–Do–Check–Act) model of continuous improvement is an iterative four-step management method used for the control and continuous improvement of processes and products and the basis for the SPBHS performance improvement process.



The steps in each successive PDCA cycle are:

PLAN Establish the objectives and processes necessary to deliver results in accordance with the expected output (the target or goals). By establishing output expectations, the completeness and accuracy of the specification is also a part of the targeted improvement.

DO Implement the plan, execute the process, deliver the service. Collect data for charting and analysis in the following "CHECK" and "ACT" steps.

CHECK Study the actual results (measured and collected in "DO" above) and compare against the expected results (targets or goals from the "PLAN") to ascertain differences. Look for deviation in implementation from the plan and also look for the appropriateness and completeness of the plan to enable the execution, i.e., "Do". Charting data can make this much easier to see trends over several PDCA cycles and in order to convert the collected data into information.

ACT Request corrective actions on significant differences between actual and planned results. Analyze the differences to determine their root causes. Determine where to apply changes that will include improvement of the process or service. When a pass through these four steps does not result in the need to improve, the scope to which PDCA is applied may be refined to plan and improve with more detail in the next iteration of the cycle.

Continuous Performance Improvement Activities
Performance improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the governance and leadership, is understood, accepted and utilized throughout the organization, as a result of continuous education and involvement of staff at all levels in performance improvement. Performance improvement involves two primary activities:

1. Measuring and assessing performance through the collection and analysis of data and

2. Conducting performance improvement initiatives, taking action where indicated, including the design of new services and the improvement of existing services.

The tools used to conduct these activities are described in Appendix A, at the end of this Plan.

Section 2 Leadership and Organization

The ***Board of Directors*** provides leadership for the performance improvement process as follows:

- Supporting and guiding implementation of performance improvement activities across the organization and
- Reviewing, evaluating and approving the performance improvement plan annually.

Leadership is central to the success of the continuous performance improvement process. Leaders at SPBHS provide support for performance improvement activities through the planned coordination and communication of the results of measurement activities related to performance improvement initiatives and overall efforts to continually improve the quality of care provided. This sharing of data and information is an important leadership function. Leaders, through a planned and shared communication approach, ensure the board of directors, personnel, persons who receive services and family members have knowledge of and input into ongoing performance improvement initiatives as a means of continually improving performance.

The **Performance Improvement Team** provides ongoing operational leadership of continuous performance improvement activities across the organization. The team meets at least monthly or not less than ten (10) times per year, is facilitated by the Performance Improvement Specialist and consists of:

Performance Improvement Specialist
Chief Executive Officer
Representatives from Adult & Emergency Services, Child & Family Services, Intellectual/ Developmental Disability Services, Residential Services, Administrative Services and Quality Assurance.

The PI Team strives to include broad representation, and ideally, the representation of persons served and/or family members of persons served. The members of the performance improvement team act as champions of performance improvement and work as liaisons between their functional teams and the performance improvement team.

The charge to the performance improvement team is to:

1. Identify, monitor and analyze current performance indicators,
2. Share the findings of analyses and make recommendations on possible performance improvement initiatives to the leadership team and
3. Collect, analyze and report accurate and consistent data to support performance improvement goals

The responsibilities of the team include:

- Developing and approving the annual Performance Improvement Plan.
- Establishing measurable objectives based upon priorities identified through the use of established criteria for improving the quality and safety of services.
- Developing indicators of performance on a priority basis.
- Periodically assessing information based on the indicators, taking action as evidenced through performance improvement initiatives to solve problems and pursue opportunities to improve performance.
- Establishing and supporting specific performance improvement initiatives.
- Reporting to the Board of Directors on performance improvement activities annually.

This planned communication may take place through a variety of methods including but not limited to:

- Story boards and/or posters displayed in common areas
- Persons served participating in performance improvement activities and reporting back to others who receive services
- Distributing the annual outcomes report
- Sharing of the annual PI Plan evaluation
- Newsletters and or handouts

Section 3 Goals and Objectives

The performance improvement team identifies and defines goals and specific objectives to be accomplished each year. These goals can include training personnel regarding both continuous performance improvement principles and specific performance improvement initiatives. Progress in meeting these goals and objectives is an important part of the annual evaluation of the team's activities.

The following are the ongoing long term goals for the SPBHS performance improvement program:

- To implement quantitative measurement to assess key processes or outcomes;

- To bring managers, clinicians, and other staff together to review quantitative data and major clinical adverse occurrences to identify problems;
- To carefully prioritize identified problems and set goals for their resolution;
- To achieve measurable improvement in the highest priority areas;
- To meet internal and external reporting requirements;
- To provide education and training to managers, clinicians, and other staff;
- To develop, adopt or modify necessary tools, such as practice guidelines, survey instruments and performance indicators.

Section 4 Performance Measurement

Performance Measurement is the process of regularly assessing the results produced by the program. It involves identifying processes, systems and outcomes that are integral to the performance of the service delivery system, selecting indicators of these processes, systems and outcomes, and analyzing information related to these indicators on a regular basis. Continuous Performance Improvement involves taking action as needed based on the results of the data analysis and the opportunities for performance they identify.

The purpose of measurement and assessment is to:

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
- Identify problems and opportunities to improve the performance of processes.
- Assess the outcome of the care provided.
- Assess whether a new or improved process meets performance expectations.

Measurement and assessment involves:

- Selection of a process or outcome to be measured, on a priority basis.
- Identification and/or development of performance indicators for the selected process or outcome to be measured.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.

- Assessment of performance with regard to these indicators at planned and regular intervals.

- Taking action to address performance discrepancies when indicators indicate that a process is not stable, is not performing at an expected level or represents an opportunity for performance improvement.

- Reporting within the organization on findings, conclusions and actions taken as a result of performance assessment.

Selection of Performance Indicators
A performance indicator is a quantitative tool that provides information about the performance of an organization's process, services, functions or outcomes. Selection of a performance indicator is based on the following considerations:

- Relevance to mission - whether the indicator addresses the population served

- Importance - whether it addresses a clinically important process that is high volume, problem prone or high risk.

- Meets the performance indicator requirements of CARF International

SPBHS performance indicators are provided in Appendix B of this plan.

Characteristics of a Performance Indicator
Factors to consider in determining which indicator to use include:

- Scientific Foundation: the relationship between the indicator and the process, system or clinical outcome being measured

- Validity: whether the indicator assesses what it purports to assess

- Resource Availability: the relationship of the results of the indicator to the cost involved and the staffing resources that are available

- Consumer Preferences: the extent to which the indicator takes into account individual or group (e.g., racial, ethnic, or cultural) preferences

- Meaningfulness: whether the results of the indicator can be easily understood, the indicator measures a variable over which the program has some control, and the variable is likely to be changed by reasonable performance improvement efforts.

Assessment
Assessment is accomplished by comparing actual performance on an indicator with:

- Itself over time.
- Pre-established standards, goals or expected levels of performance.
- Information concerning evidence based practices.
- Benchmarked with other similar service providers.

Once the performance of a process has been measured, assessed and analyzed, the information gathered by the above performance indicator(s) is used to identify a continuous performance improvement initiative to be undertaken. The decision to undertake the initiative is based upon organizational priorities and utilizes the Plan-Do-Check-Act cycle.

Additional Areas for Review & Assessment
The Performance Improvement Team has identified some areas for PI Team on-going review and analysis that are important to SPBHS performance improvement but do not lend themselves to the definition of performance indicators or that would be subject to benchmarking, such as:

Quarterly and Annual Review of Critical Incident Reports and Use of Restrictive Intervention reports
Annual Review of Number of Involuntary Commitments,
Quarterly Review of Medication Errors Report (internal reporting),
Number of recipient and employee grievances (including resolution), and
Trends from Qualitative Records Reviews.

These reviews and analyses will be documented and included in the annual PI report for 2015.

Section 5 Evaluation

An evaluation is completed at the end of each calendar year. The annual evaluation is conducted by performance improvement team and kept on file by the performance improvement specialist. Findings from the annual evaluation are used to revise the performance improvement plan annually.

The evaluation summarizes the goals and objectives of the performance improvement plan, the performance improvement activities conducted during the past year, including the targeted process, systems and outcomes, the performance indicators utilized, the findings of the measurement, data aggregation, assessment and analysis processes, and the performance improvement initiatives taken in response to the findings. An instrument to support the annual evaluation with performance improvement team member self-reported input is included in Appendix C of this plan.

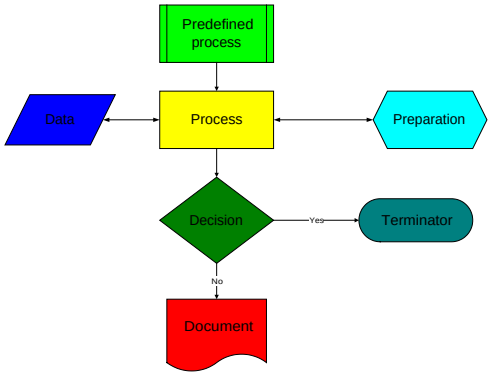
APPENDIX A.
Performance Improvement Tools

Following are some of the tools available to assist in the performance improvement process.

a. Flow Charting: Use of a diagram in which graphic symbols depict the nature and flow of the steps in a process. This tool is particularly useful in the early stages of a project to help the team understand how the process currently works. The "as-is" flow chart may be compared to how the process is intended to work. At the end of the project, the team may want to then re-plot the modified process to show how the redefined process should occur. The benefits of a flow chart are that it:

1) Is a pictorial representation that promotes understanding of the process
2) Is a potential training tool for employees
3) Clearly shows where problem areas and processes for improvement are.

FLOW CHART SYMBOLS



Flow charting allows the team to identify the actual flow-of-event sequence in a process.

b. Brainstorming: A tool used by teams to bring out the ideas of each individual and present them in an orderly fashion to the rest of the team. Essential to brainstorming is to provide an environment free of criticism. Team members generate issues and agree to "defer judgment" on the relative value of each idea. Brainstorming is used when one wants to generate a large number of ideas about issues to tackle, possible causes, approaches to use, or actions to take. The advantages of brainstorming are that it:

1) Encourages creativity
2) Rapidly produces a large number of ideas
3) Equalizes involvement by all team members
4) Fosters a sense of ownership in the final decision as all members actively participate
5) Provides input to other tools: "brain stormed" ideas can be put into an affinity diagram or they can be reduced by multi-voting.

c. Decision-making Tools: While not all decisions are made by teams, two tools can be helpful when teams need to make decisions.

1) Multi-voting is a group decision-making technique used to reduce a long list of items to a manageable number by means of a structured series of votes. The result is a short list identifying what is important to the team. Multi-voting is used to reduce a long list of ideas and assign priorities quickly with a high degree of team agreement.
2) Nominal Group technique-used to identify and rank issues.

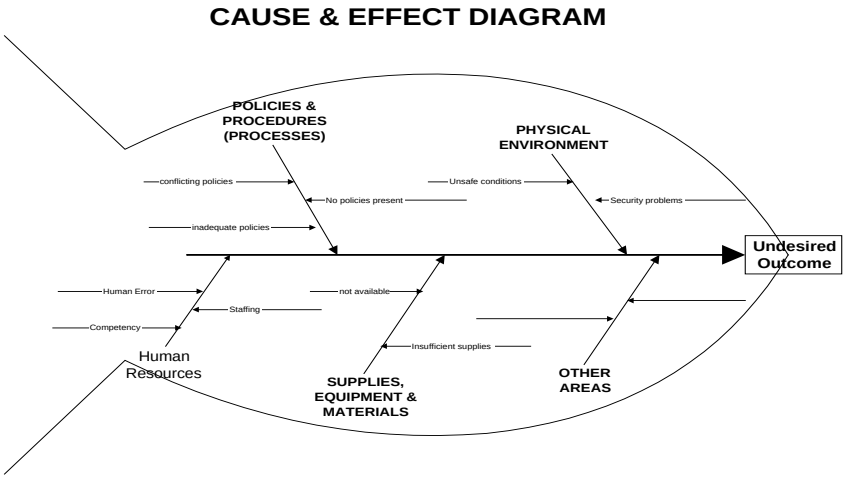
d. Affinity Diagram: The Affinity Diagram is often used to group ideas generated by brainstorming. It is a tool that gathers large amounts of language data (ideas, issues, opinions) and organizes them into groupings based on their natural relationship. The affinity process is a good way to get people who work on a creative level to address difficult, confusing, unknown or disorganized issues. The affinity process is formalized in a graphic representation called an affinity diagram. This process is useful to:

1) Sift through large volumes of data.
2) Encourage new patterns of thinking.

As a rule of thumb, if less than 15 items of information have been identified, the affinity process is not needed.

e. Cause and Effect Diagram (also called a fishbone or Ishakawa diagram): This is a tool that helps identify, sort, and display. It is a graphic representation of the relationship between a given outcome and all the factors that influence the outcome. This tool helps to identify the basic root causes of a problem. The structure of the diagram helps team members think in a very systematic way. The benefits of a cause-and-effect diagram are that it:

1) Helps the team to determine the root causes of a problem or performance characteristic using a structured approach
2) Encourages group participation and utilizes group knowledge of the process
3) Uses an orderly, easy-to-read format to diagram cause-and-effect relationships
4) Indicates possible causes of variation in a process
5) Increases knowledge of the process
6) Identifies areas where data should be collected for additional study.



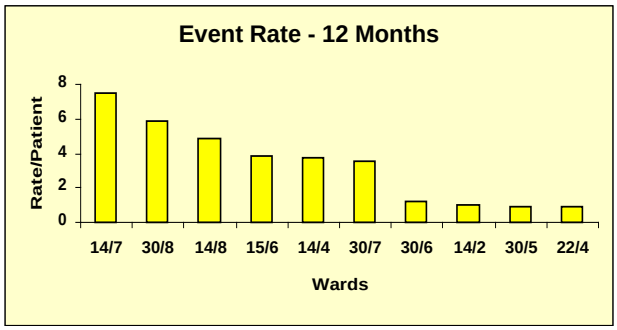
Cause and effect diagrams allow the team to identify and graphically display all possible causes related to a process, procedure or system failure.

f. Histogram: This is a vertical bar chart which depicts the distribution of a data set at a single point in time. A histogram facilitates the display of a large set of measurements presented in a table, showing where the majority of values fall in a measurement scale and the amount of variation. The histogram is used in the following situations:

1) To graphically represent a large data set by adding specification limits one can compare;
2) o process results and readily determine if a current process was able to produce positive results assist with decision-making.

g. Pareto Chart: Named after the Pareto Principle which indicates that 80% of the trouble comes from 20% of the problems. It is a series of bars on a graph, arranged in descending order of frequency. The height of each bar reflects the frequency of an item. Pareto charts are useful throughout the performance improvement process - helping to identify which problems need further study, which causes to address first, and which are the "biggest problems." Benefits and advantages include:

1) Focus on most important factors and help to build consensus
2) Allows for allocation of limited resources.

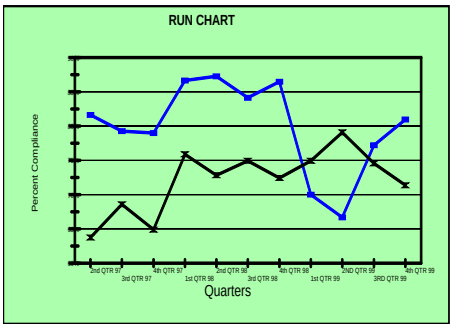


The "Pareto Principle" says 20% of the source causes 80% of the problem. Pareto charts allow the team to graphically focus on the areas and issues where the greatest opportunities to improve performance exist.

h. Run Chart: Most basic tool to show how a process performs over time. Data points are plotted in temporal order on a line graph. Run charts are most effectively used to assess and achieve process stability by graphically depicting signals of variation. A run chart can help to determine whether or not a process is stable, consistent and predictable. Simple statistics such as median and range may also be displayed.

The run chart is most helpful in:

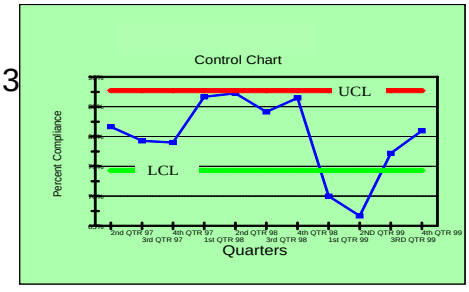
1) Understanding variation in process performance
2) Monitoring process performance over time to detect signals of change
3) Depicting how a process performed over time, including variation.



Allows the team to see changes in performance over time. The diagram can include a trend line to identify possible changes in performance.

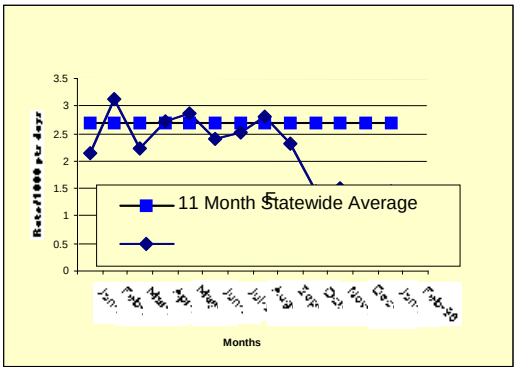
i. **Control Chart:** A control chart is a statistical tool used to distinguish between variation in a process resulting from common causes and variation resulting from special causes. It is noted that there is variation in every process, some the result of causes not normally present in the process (special cause variation). Common cause variation is variation that results simply from the numerous, ever-present differences in the process. Control charts can help to maintain stability in a process by depicting when a process may be affected by special causes. The consistency of a process is usually characterized by showing if data fall within control limits based on plus or minus specific standard deviations from the center line. Control charts are used to:

1) Monitor process variation over time
2) Help to differentiate between special and common cause variation
3) the effectiveness of change on a process
4) Illustrate how a process performed during a specific period.



Using upper control limits (UCLs) and lower control limits (LCLs) that are statistically computed, the team can identify statistically significant changes in performance. This information can be used to identify opportunities to improve performance or measure the effectiveness of a change in a process, procedure, or system.

j. Bench Marking: A benchmark is a point of reference by which something can be measured, compared, or judged. It can be an industry standard against which a program indicator is monitored and found to be above, below or comparable to the benchmark.



k. Root Cause Analysis: A root cause analysis is a systematic process for identifying the most basic factors/causes that underlie variation in performance.

APPENDIX B.

South Peninsula Behavioral Health Services
Performance Monitoring Indicators for CY 2015

Domain	Objective	#	Indicator	Program(s) Applied To	Target	Frequency of Measurement
BUSINESS	Employee Safety	1	OSHA- Summary of Work-Related Injuries and Illnesses: Number of Recordable Cases	All Programs	0	Annually
	Regulatory Efficiency	2	Grant fund reporting requirements are submitted timely and accurately	DD Grant BH Grant	100%	Quarterly
	Financial Sustainability	3	Funds on hand for days of SPBHS operations	Agency Wide	90 days	Quarterly
	Regulatory Compliance	4	AKAIMS Data Integrity Minimal Data Set Report- DBH required data set	BH Adults & Youth	98%	Quarterly
EFFECTIVENESS	Suicide Prevention	5	Number of completed suicides by persons served	BH Adults[1] BH Youth[2] DD[3]	0	Annually
	Serious Adverse Outcome Prevention	6	Number of sentinel events[4] involving persons served	BH Adults BH Youth DD	0	Annually
	Improved Life Domains	7	Percent of clients reporting improvement in life domains[5] between first and second Client Status Review (RBA Dashboard #8)	BH Adults & Youth	90%	Quarterly
	Improved Quality of Life	8	Percent of clients reporting improvement in quality of life domains[6] between first and second Client Status Review (RBA Dashboard #9)	BH Adults & Youth	90%	Quarterly
	Satisfaction with Quality of Life	9	Percent of clients reporting being "satisfied" or better regarding their quality of life on their second Client Status Review (RBA Dashboard #11)	BH Adults & Youth	90%	Quarterly
EFFICIENCY	CSR Timeliness	10	Percent of clients with an open case (Case that was open at any time during the selected time period) who were "due" at least one follow-up CSR and the CSR was completed. (AKAIMS)	BH Adults & Youth	100%	Quarterly
	Frequency of Contact	11	Number of active BH recipients who have not been seen for a face-to-face contact for at least 135 days (RBA Dashboard #7.b)	BH Adults & Youth	0	Quarterly

	Objective	#	Indicator	Program(s) Applied To	Target	Frequency of Measurement
	Documenta-tion Completeness	12	Percent of BH Adults and Youth who will experience Alaska Screening Tool (AST) to first service response elapse time of less than 30 days on average. (RBA Dashboard #3)	BH Adults & Youth	95%	Quarterly
	Clinician Productivity	13	Measure full-time Clinicians' "direct patient care" hours to meet NHSC requirements [7]	BH Adults & Youth	21 of 40 hours weekly	Quarterly
	Timely Submission of Documenta-tion of Services	14	Percent of full-time staff who are current (less than one-week out) with their documentation for the services provided in the preceding week.	Agency wide	90%	Quarterly
	Accuracy of Service Documenta-tion of Services	15	Percent of full-time staff documentation that is returned by billing for correction each week. (measurement TBD)	Agency wide	*<5%*	Quarterly
ACCESS	Timely Initial Clinical Assessment	16	Average # of days between request and appointment for Adults and Youth who present for non-emergent BH services (and # of initial clinical assessments completed).	BH Adults & Youth	<7	Quarterly
	Timely Initial Psychiatric Evaluation	17	Percent of initial psychiatric evaluations completed within 30 days of internal written referral for persons who present for non-emergent psychiatric services (and # of initial psychiatric evaluations completed).	BH Adults & Youth	95%	Quarterly
	Measure client no-show rate(s)	18	Percent of BH recipients who no-show their appointments- BH Adults & Youth Psychiatric services (TBD)	BH Services	Estab base line	Quarterly
	Initial Clinical Engagement	19	Percent of BH adults and youth who receive treatment services within 30 days of enrollment. (RBA Dashboard #7.a)	BH Adults & Youth	90%	Quarterly
STAKEHOLDER INPUT	Satisfaction of Persons Served	20	Percent of persons served who Agree or Strongly Agree that services are built around what they and/or their family want	DD	85%	Annually
	Satisfaction of Persons Served	21	Percent of persons served and family members who Agree or Strongly Agree that they are satisfied with their care providers	DD	85%	Annually
	Satisfaction of Persons Served	22	Percent of persons served who report being "Satisfied" or better regarding getting services and being treated with respect on their second CSR (RBA Dashboard # 10)	BH Adults & Youth	80%	Quarterly

Domain	Objective	#	Indicator	Program(s) Applied To	Target	Frequency of Measurement
STAKEHOLDER INPUT	Satisfaction of Persons Served	23	Percent of persons served who report overall satisfaction with SPBHS BH services as reported on the statewide MHSIP survey	BH Adults & Youth	85%	Annually
	Satisfaction of Full Time Staff	*24*	The percent of staff who agree or strongly agree that everyone is treated fairly at this organization	All full time staff	75%	Annually
	Satisfaction of Part Time Staff	*25*	The percent of staff who agree or strongly agree that they are paid fairly for the work they do	All part time staff	75%	Annually
	Increase Validity of Staff Survey	26	Increase % of staff who complete and submit annual all-employee survey	All SPBHS staff	75%	Annually
HR	Maintain adequate staffing levels to provide services	27	# of new hires for the quarter	All SPBHS staff	Establish Baseline	Quarterly
	Maintain adequate staffing levels to provide services	28	# of re-hires for the quarter (staff returning after less than 1 year of separation)	All SPBHS staff	Establish Baseline	Quarterly
	Maintain adequate staffing levels to provide services	29	# of employees who voluntarily terminated in the quarter	All SPBHS staff	Establish Baseline	Quarterly
	Maintain adequate staffing levels to provide services	30	# of employees who were involuntarily terminated in the quarter	All SPBHS staff	Establish Baseline	Quarterly
	Assure timely performance evaluations for all staff	31	% of employee performance evaluations that were completed timely during the quarter	All SPBHS staff	100%	Quarterly
	Ensure all staff are adequately trained	32	% of employees completing assigned initial training within 14 days of hire	All SPBHS staff	100%	Quarterly
	Ensure all staff are adequately trained	33	% of employees completing annual training within assigned timeframe	All SPBHS staff	100%	Annually

Definitions

TBD= Manner of data collection to be developed.

[1]BH Adult	Adults age 18 and older who receive community mental health services for serious mental illness or emotional disturbance.
[2]BH Youth	Youth up to age 18 who receive community mental health services for serious emotional disturbance or emotional disturbance.
[3]DD	Youth and adults with intellectual or developmental disabilities who receive home and community-based services through the SPBHS Pride Program.
[4]Sentinel Event	An unexpected occurrence resulting in death or serious physical or psychological injury or risk thereof. Serious injury specifically includes loss of limb or function. The phrase 'or risk thereof' includes any process variation for which a recurrence would carry a significant chance of significant adverse outcome. Such events are called 'sentinel' because they signal the need for immediate investigation and response. The terms 'sentinel' and 'error' are not synonymous; not all sentinel events occur because of an error; not all errors result in sentinel events.
[5]Life Domains	The Client Status Review (CSR) tracks six life domains including financial/basic needs, housing situation, meaningful activities/employed, mental/emotional health, physical health and thoughts of self harm.
[6]Quality of Life Domains	The Client Status Review (CSR) tracks nine quality of life domains including productivity, physical health, mental/emotional health, thoughts about self harm, family and social support for recovery, feeling safe, sense of connectedness, well-being and spirituality, financial security and housing situation.
[7]*NHSC*	*The National Health Service Corps offers loan repayment and scholarships to professional healthcare providers for serving at NHSC sites in communities with limited resources. SPBHS is a qualified NHSC site to enhance clinician recruitment. Presently, several clinicians are enrolled for loan repayment. NHSC clinician requirements are: "Clinician works a minimum of 40 hours/week, for a minimum of 45 weeks/service year. At least 21 hours/week are spent providing direct patient care at the approved service site(s). The remaining 19 hours/week are spent providing clinical services for patients or teaching at the approved site(s), providing clinical services in alternative settings (e.g., hospitals, nursing homes, shelters) as directed by the approved site(s), or performing practice-related administrative activities (practice-related administrative time is limited to 8 hours)."*

APPENDIX C.

Performance Improvement Team
Annual Self-Evaluation

There are three basic reasons for teams in health and human service organizations to perform periodic self-evaluation. The first is that today's environment demands nothing less than excellence in care and services. The second is that a well-developed self-evaluation process can help a team improve its performance and achieve or maintain excellence in performance improvement. The third is that regulatory standards specifically require that teams evaluate their own performance.

Self-evaluation provides a team with a structured opportunity to look at its past performance and to plan ahead. The process allows the team to ask itself such questions as: What are we doing well? What could we be doing better? What are our objectives? How well did we achieve our objectives, or, why did we not achieve our objectives? The team may then use the answers to develop an action plan to improve its performance and establish new goals.

The aggregate responses of the performance improvement team self-evaluation questionnaire and the analysis report will be used to facilitate discussion among team members. It is this discussion that provides the real value of the self-evaluation process.

The action plan is the key to both improving the performance of the team as well as to satisfying regulatory and accreditation requirements.

The development of the action plan and strategies for its implementation mark the end of the team self-assessment discussion. It is then up to the team and SPBHS performance improvement specialist to implement the action plan.

Section 1: MISSION AND PLANNING OVERSIGHT

A. Recommendations brought before our performance improvement team are evaluated to ensure that they are consistent with SPBHS mission statement.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

B. Each performance improvement team member understands our team charge statement.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

C. We periodically review, discuss, and if necessary amend our performance improvement team's charge statement to ensure that it remains current and relevant.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

D. Our performance improvement team has a comprehensive, system-wide performance improvement plan.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

E. Our performance improvement team assesses the extent to which our team is adhering to its values.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

F. Our performance improvement team members are active and effective in communicating SPBHS interests.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

Section 2 - PERFORMANCE OVERSIGHT

A. We review and carefully discuss performance reports that are part of an agency-wide performance improvement plan which provides comparative statistical data about our agency's services and performance.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

A. We periodically receive reports which review and assess the attitudes and opinions of those who work in the organization to identify our strengths, weaknesses and opportunities for improvement.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

C. We fully understand our responsibilities and relationships with the agency staff, and have effective mechanisms for communicating with them.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

Section 3 - LEADERSHIP RELATIONSHIP

A. Our performance improvement team recommends initiatives for the agency that are consistent with the SPBHS mission and vision.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

B. Our performance improvement team supports and assists the agency performance improvement specialist to achieve our team's charge.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

Section 4 – PERFORMANCE IMPROVEMENT TEAM EFFECTIVENESS

A. Our performance improvement team evaluates its own performance.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

B. All members of the performance improvement team understand and fulfill their responsibilities.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

C. All members of the performance improvement team participate in an orientation program and opportunities for continuing education in performance improvement.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

D. The frequency and duration of performance improvement team meetings are adequate to conduct the team's responsibilities.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

D. The performance improvement specialist exercises a firm and fair hand with individual members to ensure that all have equal opportunity to participate, time is not monopolized by a few, and agenda items are dispatched after reasonable discussion.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

F. The performance improvement team members receive the agenda and back-up materials well in advance of meetings.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

G. Our performance improvement team members come to meetings well prepared to discuss agenda items.
Our Rating: ___ Excellent ___ Good ___ Fair ___ Poor

Section 5 -INDIVIDUAL SELF-ASSESSMENT

A. **Continuing Education:** I participate in education opportunities to remain current on changing trends and issues affecting our performance.
My Performance: __ Excellent __Good __Fair __Poor

B. **Demonstrated Interest.** I prepare for, attend, participate and assume a fair workload at performance improvement meetings.
My Performance: __ Excellent __Good __Fair __Poor

C. **Interpersonal Relations.** I deal fairly and appropriately with other performance improvement team members.
My Performance: __ Excellent __Good __Fair __Poor

D. **Community Representation.** As a performance improvement team member, I strive to represent SPBHS mission and share the agency's performance improvement needs and concerns with other staff members.
My Performance: __ Excellent __Good __Fair __Poor