FOHFS	Fountain of Hope Family Services Inc.		Policy and Procedures
	Policy Type:-	Aspire to Excellence	**Policy# ATE-150**
	Subject:-	Performance Improvement Plan	**Adopted:-05/06/2014**
	Section:-	**(1.N)**	**Effective:-06/11/2015**
	Approval By:-	**Michael Oladipo**	**Revised:-08/15/2020**

• Purpose

The purpose of (**FOHFS Agency**) Performance Improvement Plan (**PIP**) is to provide a **framework** for the (**FOHFS**) **continuous** agency-wide approach to achieving effective and efficient service delivery that is reflective of the identified **FOHFS** **mission**, **vision**, and **ethical values**, and supportive of the **long** and **short term** goals established for the **FOHFS Agency**.

• Philosophy

(**FOHFS Agency**) and its **leadership team**, and staff, place top priority on a performance Improvement Plan, (**PIP**) and structure to manage all areas of the **FOHFS Agency** to ensure delivery of the best **possible care** for **FOHFS** Clients. It is the goal of this policy to provide a mechanism and process designed to identify **opportunities to improve Client services**, outcome measures, community and stakeholder involvement, Client satisfaction, personnel satisfaction and retention, and environmental safety and security by measuring, assessing and improving these areas in a systematic and ongoing manner.
A well-defined, implemented, and continuously evaluated **PIP** plan enables **FOHFS** agency to develop **short** and **long** term **goals** that are **clear, flexible**, **responsive**, **pace setting**, and secure. **FOHFS** leadership team members and staff are committed to maintaining a **high** standard of values and personal accountability which are inclusive of all parts of the organization as well as its identified stakeholders. The **PIP** plan for **FOHFS** agency demands **evaluation** of every program and service against unbiased standards to measure organizational and programmatic innovation, methodology, execution and effectiveness.

• The Guiding Principles of the Agency's PIP Approach Include:

- **A strong** focus on Client centered care and services
- **Utilization** of an agency wide approach to improve important functions carried out by the agency by utilizing team efforts, stakeholder involvement and community resources.
- **Increasing the probability** of desired service outcomes, including Client satisfaction, by assessing and improving governance, managerial, Clinical and support processes that most affect those outcomes.

- **Identifying opportunities** to improve Client care and services provided.
- **Establishing priorities** for improving care and services that have the greatest impact on Client care outcomes and Client satisfaction.
- **Alignment** of practice with long-term and short-term planning
- **A strong emphasis** on data collection and the conversion of "data" to review ready information used in the on-going process of continuously modifying practice to meet stakeholder demands
- An agency **culture** of on-going learning and capacity development based on findings of PIP activities.
- **Coordinated** performance improvement activities and integrated efforts of all disciplines throughout the agency.
- **Increasing** the **safety** of Clients and staff by analyzing processes that **pose high** risk.

Goals and Objective

- The **GOAL** of Performance Improvement Planning is to **achieve** and **maintain** the **highest** level of service quality through present resources in each service area and administrative of **FOHFS** agency.
- The **OBJECTIVES** that support the goal and give direction to the Performance Improvement Planning activities are to ensure that:
- All **FOHFS** administrative and Clinical staff, as well as the agency conducts regular Performance Improvement reviews that monitor, **evaluate** and adjust/refine service components and treatment modalities.
- Policies and procedures are effectively designed to guide **FOHFS Agency** efforts to provide quality of care, evaluate staff performance, and identify necessary training programs.
- Mechanisms exist that monitor, evaluate and adjust/refine service delivery based on consumer and/or other stakeholder satisfaction feedback.
- There are efficient means to identify and resolve, in a timely fashion, problems that affect the quality of service to Clients.
- A strategic planning process is in place to align short and long-term goals and objectives with the values and mission of the agency.

The **Executive Director**, Leadership Team, Clinical staff, personnel, and other stake-holder groups have appropriate information necessary to understand the status of service delivery and to make changes to improve the quality of services.

Member of the Leadership Team Include:

- Executive Director
- Compliance/Safety Officer
- Clinical Director
- HR/Office Manager
- Biller Specialist Manager

The Leadership Team meets **quarterly** to identify and rectify issues resulting in suboptimal care and safety, and to require PIP reports from the systems necessary to facilitate identified improvement efforts.
Comprehensive reviews for analysis of PIP and risk management related data gathered by individual administrative staff within each department/program are completed quarterly. The PIP related data gathered by each department is submitted to the (**PIP**) Compliance Data Officer to be aggregated as part of the Performance Improvement Report.
This report is reviewed by the Leadership Team for improvement efforts, corrective action, and service change as appropriate.

(1.N.1):- PERFORMANCE IMPROVEMENT

1. **A performance analysis is completed:**
   a. Annually and is included in the Performance Review and Improvement Plan. The performance analysis is included in the Annual Management Summary.
   b.
   (1) **Business functions**: A comparison between the projected budget and actual performance will be used to analyze level of business functioning.
   (2) **Service delivery, including**:
   (a)
   The effectiveness of services: A Telephone **Survey Quarterly** Report and a Questionnaire Quarterly Report are used to identify effectiveness of service.
   (b)
   The efficiency of services: A Telephone Survey Quarterly Report and a Questionnaire Quarterly Report are used to identify efficiency of services. Efficiency is also measures by the Quarterly Clients Data Report where date of referral and date of intake can be assessed for services provided in a timely manner.
   (c)
   Service access is measured by the Quarterly Clients Data Report where person's served location is identified and compared to the service area of

providers. The Out of Office Referral Log is also used to identify areas of needs that **FOHFS** is not currently addressing.

(d)

Satisfaction and other feedback from:

(i)

The Clients: Quarterly telephone surveys or questionnaires will be used to access satisfaction of Clients. Reasons for discharge will also be access to gain information of satisfaction of Clients.

(ii)

Other stakeholders: Other stakeholders are encouraged to contact the Management Team with any questions or concerns. The stakeholders are also invited to participate in identifying the strengths, weakness, opportunities, and threats of **FOHFS Agency** each quarter during focus group sessions.

(3) **Extenuating of influencing factor:** When gathering and processing all data within the Agency, **FOHFS Agency** will be aware of all extenuating or influencing factors that may alter the outcome of any report.

C.That:

1. Analysis is used to identify areas of strength as well as areas needing performance improvement.
2. Action plans will be developed to address the improvements needed to reach **FOHFS Agency** goals this plan will be developed by the Management Team during quarterly meetings and included in the Performance Improvement Plan.
3. The Annual Management Summary will identify actions taken or changes made to improve performance.

• (1.N.2):- PERFORMANCE INDICATOR IS USED TO

a. During the annual meeting the Management Team reviews the implementation of the mission and goals of **FOHFS Agency.**

B. FOHFS Agency uses the information gathered to improve the quality of its program and services.

c. Facilitate:

The Management Team makes all agency decisions with the Clients and **FOHFS Agency** ability to continuously to provide services in mind. Strategic planning will include information from a variety of sources that include but are not limited to Clients, stakeholders, personnel, and the Management Team.

d. Review or update the (**FOHFS**)'s agency strategic plan: - The Management team will review the strategic plan

(1.N.3):- The Agency Communication Performance Information

(1) Persons served: Will have access to **FOHFS Agency** projected budget developed in percentages. The Annual Management Summary will be copied and made available to Clients along with an opportunity to provide feedback to the Management Team.

(2) **Personnel**: Will have access to **FOHFS'** projected budget developed in percentages. The Annual Management Summary will be copied and made available to Clients along with an opportunity to provide feedback to the Management Team

(3) **Other stakeholders**: Will have access to **FOHFS'** projected budget developed in percentages. The Annual Management Summary will be copied and made available to Clients along with an opportunity to provide feedback to the Management Team

(b) According to the need of the specific group including

1. **FOHFS Agency** has a performance improvement system that meets the needs of its organizational planning process.

2. **FOHFS Agency** has established a Performance Improvement system that addresses **satisfaction**, **effectiveness** and **efficiency** measures for its **Outpatient** Treatment service.

3. To manage this system and make it more effective and efficient, every person needing services enters the system in the most efficient and timely way possible. In addition, **FOHFS Agency** will provide services that demonstrate that Clients are showing progress in meeting their approved mental health treatment objectives.

(C.) That is accurate information

FOHFS Performance improvement, will including performance **measurement,** is the responsibility of all staff throughout the organization and aides in building organizational capacity for measurement and improvement. When necessary, individuals will be assigned by the PIP committee to performance improvement teams or work groups to carry out performance improvement activities including, but not limited to, collection of data and documentation/review of the necessary policies and procedures for the function assigned.

IMPORTANT PROCESSES AND OUTCOMES

FOHFS will compile data and analyze the following key **indicators** of performance through the risk management report and performance measures including:

- Evidence Based Practices
- Risk Management/Safety Report
- Clinical Record Review

- Service Utilization
- Program and Service Review
- Client Satisfaction Surveys
- Employee Satisfaction Surveys

• EVIDENCE BASED PRACTICES

(FOHFS agency) will provides evidence based practices by utilizing practices that are closely tied to evidence based studies such as: the **Cognitive Behavioral Model**, and those standard practices accepted by **SAMSHA**. The Master Treatment Plan Review/Treatment Plan Reviews (**MTPR/TPR's**) are used as a measure to evaluate Client progress on a minimum of every 90 days.

• STAKEHOLDER INVOLVEMENT IN THE PIP PROCESS

(FOHFS agency) has an extensive list of key stakeholders and values their participation in our PIP process. Key stakeholders include personnel, Clients, schools/community organizations, the Oklahoma health care authority.

- Clients participate in quarterly questionnaires which allow them to offer feedback and comments about the quality of service provided. Clients also receive a service follow-up questionnaire after discharge.
- The Oklahoma health Care Authority of Medicaid Services receives an annual attestation report, and all required ongoing Provider enrollment documentation.
- Central Oklahoma schools, community organizations, and **FOHFS** Community Advisory Committee, participate in questionnaires on an annual basis which allow them to offer feedback and comments based on their interactions with our organization.

(FOHFS agency) staff members participate in semi-annual surveys regarding supervisors, working environment, staff morale, and communication, knowledge of agency policy and procedures and evaluation of services. This survey is designed to give each employee an opportunity to offer comments and suggestions for improvement. PIP reports are presented at least quarterly during departmental staff meetings and employees have the opportunity to offer comments and suggestions. Staff members are also given opportunities to serve on departmental PIP teams and workgroups.

The Leadership Team review PIP reports as well as questionnaire results at quarterly meetings in order to identify trends based on empirical evidence. Suggestions and recommendations are

communicated to and among the Leadership Team, **PIP** Coordinator(s) and to the appropriate stakeholders. Corrective action is based on stakeholder feedback and improvement suggestions from departmental leaders and the Leadership Team. Changes in policies, procedures, or staff training are implemented as necessary by the Leadership Team.

FOHFS' PIP philosophy, PIP structure, stakeholder involvement, and a brief description of agency outcome measures are provided to all stakeholders in a PIP information packet and/or on the agency website. This information is maintained and updated as necessary by the PIP Coordinator(s).
All feedback and input from stakeholders is utilized by our Leadership Team to formulate strategic planning and to identify short-term and long-term goals and objectives.
Key stakeholders include **FOHFS** personnel, Clients, schools/community organizations, and the Oklahoma health care authority, **FOHFS** Audit and Finance Committee, and **FOHFS** Community Advisory Committee.

• Personnel

FOHFS facilitates monthly meetings/in-services with all administrative personnel, Mental Health Professionals (**MHPs**). During these meetings, staffs are informed of (**PIP**) efforts, support services and referral services available, as well as any changes in policy. This process enables **FOHFS** staff to voice concerns, recommend changes, ask questions, and offer feedback to leadership staff concerning issues of ongoing improvement, satisfaction and service delivery.

FOHFS personnel have a variety of opportunities to participate in the performance improvement process. Opportunities include providing feedback through staff meetings, performance evaluations, employee satisfaction surveys, and informal meetings with supervisors. **FOHFS** Personnel also receive both verbal and written communication on how to file a formal grievance. Results reported in the quarterly quality assurance meeting and actions taken by the PIP committee are communicated to all personnel.
MHPs and **MHPPs** are also trained and responsible for certain PIP efforts such as the continuation of care plan, monitoring of caseloads and Client service frequencies. **MHPs** have the additional responsibility of completing and documenting weekly supervision of **MHPPs.**

• Clients

Feedback from Clients and their family members involved in treatment is critical to the on-going evaluation of services. During the initial intake process, Clients' and their legal guardians (if applicable) receive both verbal and written communication of their rights including information on how to file a formal grievance.
Clients and parents are informed of company policies, PIP overview and agency improvement efforts, community support and referral services available, and service delivery details during the intake process. They are also made aware of any changes in policy, PIP procedures and

additional support services available during family therapy, family contact with Clinical staff, and during medication management appointments.
Formal client grievances are directed to the Grievance Officer. The total number of formal grievances filed is reported on a quarterly basis by the Grievance Officer to the PIP committee. In addition, satisfaction surveys are conducted with Clients, parents or guardians every quarter to obtain necessary feedback on service delivery. Results from these surveys are reported during the quarterly quality assurance meetings.

• Community Involvement and Support

FOHFS recognizes and values the role local churches, colleges/universities, and human service providers play in helping meet the behavioral and mental health needs of the community. **FOHFS** continues to improve Community Support efforts and Stakeholder Involvement by implementing a schedule of regular meetings with various representatives in the community for:

- Annual overview of agency Performance Improvement Efforts
- Pursuit of additional training opportunities
- Establishment of referral sources
- Fostering new relationships and partnerships
- Growth of referral opportunities for new **FOHFS** Clients
- Discussion with identified community stakeholders regarding available opportunities for collaborative efforts in providing better care to the community and the Clients that we serve.
- Implementation of Community Advisory Committee, attended by a broad array of community leaders, with a wealth of experience and knowledge of behavioral health needs and in serving Central Oklahoma City.

• DATA REVIEW, ANALYSIS, AND COMMUNICATING RESULTS

PIP data, reports, and stakeholder feedback is reviewed at least quarterly by the Leadership Team. PIP reports and data are presented to all staff at least quarterly at departmental staff meetings. The Community Advisory Committee receives a quarterly report and is updated on PIP efforts and issues at monthly meetings.
An overview of **PIP** efforts, data, and improvement goals is generated into a stakeholder report on an annual basis. Clients, parents, guardians, school personnel, and community organizations/partners are informed of **FOHFS** PIP structure, plan and process as well as short term and long term goals, in the annual report.
Analysis of data is conducted by the PIP Compliance Data Officer and Leadership Team based on targeted goals specified on the quarterly report and corrective action report, as well as by identifying trends in outcomes documented on departmental Performance Quality Improvement Reports. Stakeholder feedback is considered and incorporated into on-going agency

improvement efforts.

- **Corrective Action Plans** are developed and recommendations are made to the Leadership Team, leading to modification to policies, procedures, training, supervision, or other programmatic change in order to ensure achievement of goals and Client outcomes. Improvements that have occurred as a result of PIP corrective action plans and plans are implemented and communicated through an annual Performance Improvement Narrative Report. The PIP Narrative Report is provided to all staff and is included in stakeholder information packets and/or on the agency website.

- **MEASURES AND OUTCOMES**

FOHFS acknowledges that meaningful performance improvement can only occur through an environment in which leaders develop a culture committed to continuous improvement. **FOHFS** aims to achieve and maintain effective communication, collaboration, and planning within the organization. This expectation of continuous improvement and excellence in customer service are cornerstones of the **FOHFS** performance improvement processes. **FOHFS** Performance Improvement Plan (**PIP**) approach includes, but is not limited to the following areas, processes and outcomes:

Personnel

- Employee Performance Reviews
- Employee Satisfaction Reviews
- Employee Incentive to Engage in Improvements for Program Excellence
- Initial and Ongoing Training
- Grievance Procedures
- Exit Surveys

- **Clients**
- Quarterly Client Satisfaction Surveys
- System for Suggestions for Program Improvement
- Community Support Information
- Grievance Process
- Clinical Record Review

- **Community Relationships**

- Maintenance of Community Liaison Responsibilities
- Formal Notification of Improvement Projects
- Invitation to the Public and Stakeholders to Provide Suggestions for Improvements for the agency
- Grievance Process

- **Facility Risk Management and Safety**
- Maintenance of an Environmental/Safety Director Position to Manage Threat Responses
- Quarterly Facility Inspection Process
- Quarterly Safety and Disaster Drills
- Incident Reports

- **Financial Assessment**
- Contracted Services with **CPA** for Annual Financial Reporting
- Ongoing review of Accounting Processes

- **Information and Technology Security**
- Initial and Ongoing Training **HIPPA**/Confidentiality
- Quarterly Inspection Report
- Improvement Review
- Incident Reports

- **MANAGEMENT/OPERATIONAL PERFORMANCE**

The Leadership Team represents the agency's supervision and responsibilities for finance, human resources, programs and services, communications, and overall safety, risk and facility management. For PIP purposes, the following areas are monitored and analyzed for performance and operational excellence.

- **Financial Viability**

The **Executive Director**, **Clinical Director** reviewed and analyzed monthly copies of financial statements on a monthly basis.
The **Executive Director** participates in the budget process and approves the final proposed budget each year. **FOHFS** adheres to financial policies and procedures which render transparent and sound financial reporting to all appropriate parties.

Cost analysis of service data is analyzed for ongoing monitoring of revenue and expenditures for budget reporting, as well as providing information for governmental agencies. Aggregated cost and revenue data related to programs and services is included in the annual PIP report. Aggregated cost of service and revenue data, which includes targeted goals for each area of service, is also tracked and reviewed on a quarterly basis during the agency Auditing meetings. Personnel turnover is also aggregated and reviewed at this time.

- **Workforce Stability**

The **HR/Office Manager** in cooperation with Leadership Team members conducts a workforce analysis annually in preparation for the budget process. The analysis also includes a review of **demographic** information in relation to how **FOHFS** employees match the demographics of the surrounding communities in the areas of the state where they work.
The information gathered is analyzed for internal workforce adjustments related to project job openings such as retirements, turnover, demographic equity, and growth/decrease in service needs in accordance with the agency's annual plans.
These factors are used for strategic planning, short-term goals related to workforce planning, and or corporate visioning by the **Executive Director** and the **Leadership Team**.
Employee Satisfaction surveys is conducted twice a year, and employees respond anonymously through an outsourced on-line service. The response information is reviewed by the Leadership Team for the purpose of creating improvement goals and objectives related to over-arching themes from employee feedback.

Final reports are made available for all employees to review. Annual performance evaluations of all staff are conducted in **January** and July of each year prior to the **budget planning** process.

Safety and Risk Management
The Compliance/Safety will reviews all accident and incident data, facility safety, and transportation requirements and inspections, security of facility and information, and then recommends corrective action steps for prevention and/or improvement based on trends or compliance standards related to the areas of responsibility.
Reports of findings are submitted to the Leadership Team for their quarterly **PIP** review. The **PIP** Compliance Data Officer aggregates data related to serious incident reports, worker's compensation injuries, vehicle accidents, grievances, and other risk elements as outlined in **FOHFS** Risk Prevention Standards.
The data is analyzed to identify safety and risk trends and methods for improvement and prevention. Revisions in policies and procedures as well as corrective action steps involving training and supervision may be developed and distributed to the Leadership Team for

implementation throughout the agency.

Quarterly PIP and Risk Management reports, including aggregated data and corrective action steps for improvement and prevention, are submitted to the Executive Director, as well as the Leadership Team.

- **PROGRAM RESULTS/SERVICE DELIVERY QUALITY**

FOHFS chooses to measure the following dimensions of service quality on a quarterly basis. Following data collection and analysis by the PIP Compliance Data Officer, aggregated data is reviewed by the Leadership Team to identify patterns and trends.

- **Monitoring and evaluating steps occur with the following activities**:

- **Accuracy of case records** – Case records are reviewed randomly by Mental Health

Professional staff for self and peer audit activities to measure errors and compliance. Issues, trends, noted areas of needed improvement are discussed in monthly staff meetings facilitated by the Clinical Director staff.

- **Clinical Audit of case records** – Case records are reviewed on an ongoing basis by a

Clinical Auditor to measure errors and compliance. A case record review document is used to aggregate data and identify trends.

Assessment of services -- use of family conferences, family visitation, and parent groups are reviewed by **Clinical Director** staff and **MHPs** on a case-by-case basis; aggregated data is reviewed by **Clinical Director** Staff and Leadership Team to identify patterns and trends.

- **Client feedback** – Surveys are utilized to collect feedback from consumers regarding their

experiences with organizational programs and to solicit their ideas about areas needing improvement. Responses are aggregated by the **PIP** Compliance Data Officer, and reviewed by the Leadership Team.

- **Non-Client stakeholder feedback** -- Surveys are utilized to collect feedback from non-

Client stakeholders regarding their experiences with organizational programs and to solicit their ideas about areas needing improvement. Responses are aggregated by the **PIP** Compliance Data Officer, and reviewed by the Leadership Team.

- **CLIENT AND PROGRAM OUTCOMES**

FOHFS has well established outcome expectations within the agency to measure the effectiveness of services and the impact on consumers.
Staff members at all levels are involved in the development of outcomes and outputs using quarterly Performance Improvement Plans from each staffs as well as stakeholder feedback. Client and program outcomes tracked include but are not limited to:

- Evaluation of level and intensity of care - for provision of consistent, medically necessary services
- The health, welfare, and safety of our Clients
- Improving effectiveness of services through ongoing monitoring and improvement, community resources, and referral relationships
- Positive Stakeholder and community perception
- Financial Viability
- Personnel satisfaction and retention
- Compliance
- Safety and Risk Management

An analysis of outcome data is conducted by the PIP compliance/Safety Officer as well as by the Leadership Team and aggregated data is shared at staff meetings quarterly and with the Community Advisory Committee and State Regulatory agency on an annual basis. Corrective action plans are developed as needed based on the monitoring of these outcomes.

• COMPLIANCE: EXTERNAL REGULATORY REQUIREMENTS

FOHFS is a State Certified Provider of Medicaid reimbursable service in the outpatient behavioral health field in Oklahoma. The following regulatory agencies manage, monitor and provide oversight to the agency as a component of ongoing compliance requirements.

• PERFORMANCE IMPROVEMENT PLAN DATA MANAGEMENT PROCEDURES

FOHFS agency has assigned the responsibility of completing the data sources for compliance officer. The compliance officer analyzes and aggregates relevant data into a generated report for review by the Leadership Team. Follow up action, or corrective action is communicated Leadership Team.
Needed improvements, updates, additions or removal from the tracking tool list is at the discretion of the Leadership Team. The Leadership Team determines the rationale for data collection and use of information as a part of ongoing **PIP** efforts.
Recommendations and action plans are discussed and submitted to the Leadership Team.

• DATA COLLECTION AND AGGREGATION

Case Record Review
Case records are reviewed randomly by **Mental Health Professional** staff for self and peer audit activities to measure Clinical appropriateness, technical errors, and regulatory compliance. Issues, trends, noted areas of needed improvement are discussed in monthly staff meetings facilitated by the Clinical Director staff.

A sample of **10%** of open cases are selected at randomly for quarterly review. A case record review report form is used for each record that incorporates specific review elements as deemed appropriate to that program.

• Case review items include but are not limited to:

- PCP Referral
- Appropriate Consents
- Appropriate Assessment tool Completion
- Master Treatment Plan
- Primary Diagnosis
- Progress Notes
- Incident Reports
- Treatment Plan Reviews (every 90 days)
- Length of time in care
- Aftercare plan
- Discharge Summary
- Clinical Audit of case records are completed on an ongoing basis by an appointed Clinical Auditor who has demonstrated no conflict of interest and is an objective reviewer of the case record. Clinical case audits measure technical errors, treatment components, intervention effectiveness, and service appropriateness as well as regulatory and professional compliance. A case record review document is used to aggregate data and identify trends.

The data collected from the Clinical audit report is aggregated to identify trends and implement necessary improvement plans. Summarized results and corrective action plans are documented on the quarterly Quality Assurance/ Performance Quality Improvement Report.

• Review of Risk Management Data

The Compliance/Safety Officer reviews all accident and incident data, facility safety, and transportation requirements and inspections, security of facility and information, and then recommends corrective action steps for prevention and/or improvement based on trends or compliance standards related to the areas of responsibility.

Reports of findings are submitted to the Leadership Team for their quarterly PIP review. The PIP Data compliance officer aggregates data related to serious incident reports, worker's compensation injuries, vehicle accidents, grievances, and other risk elements as outlined in **FOHFS** Risk Prevention Standards.

The data is analyzed to identify safety and risk trends and methods for improvement and risk prevention. Revisions in policies and procedures as well as corrective action steps involving training and supervision may be developed and distributed to the Leadership Team for implementation throughout the agency.
Quarterly **PIP** and Risk Management reports, including aggregated data and corrective action steps for improvement and prevention, are submitted to the **Executive Director**, as well as the Leadership Team.

- **Client Involvement/Satisfaction**

- Client Involvement/Satisfaction is evaluated quarterly by the Leadership Team. Client feedback questionnaires are part of the quarterly service plan review. Comprehensive Client satisfaction surveys are disseminated annually to all Clients, parents/guardians.

- **Client Outcomes Data**

Client Outcomes Data is collected, utilizing the outcomes measurement tool: Data is aggregated and reported on a quarterly basis by the **PIP Data** Compliance officer, and reviewed by the Leadership Team. This data is used to evaluate the health, safety and welfare of our Clients, behavioral changes, permanency of life situations, and changes in functional status.

- Data is analyzed by the PIP Data Compliance officer, and a report to the Leadership Team for PIP/QA review is provided quarterly. **Quarterly Review** meetings address areas of improvement, needs for improvement, program modification needs, areas of change, or trends.
- Follow up action to the findings in these reports and processes are assessed/implemented by members of the Leadership Team as appropriate.
- Summarized results and corresponding corrective action plans are documented on the quarterly departmental/program Performance Improvement Report.

- **DATA REVIEW AND ANALYSIS**

FOHFS recently appointed a dedicated **PIP** Data compliance officer to assist in PIP Coordination responsibilities and to compile all aggregation of reporting data from all **agency**. Data timelines are managed by the **PIP** Data compliance officer. All data is received, analyzed and aggregated on a monthly basis with quarterly, and annual reports (at a minimum) submitted to the Leadership Team for review.

- **The process for ensuring data integrity and reliability:**

- All data is given to the PIP Compliance Data Officer in raw forms, without any initial analysis that could influence future interpretations.

- All Client identifying information is redacted for confidentiality. If there is a need to refer to a specific chart or Client, only their Medicaid Number (MN) number is used.

Types of data analysis being used:

- Analysis/measures of central tendency
- Graphical representation of numbers
- Analysis of variance, if applicable

- **Report formats:**

- Reports are formatted with Tables of raw numbers, Figures giving graphical representations of the raw data, then narratives summarizing the data, noting trends, and making recommendations for the Leadership Team's consideration.
- The narrative takes the form of a heavily modified **CRAF** Reporting format

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• Timeframes for dissemination and review:

- Full PIP Reports, covering all track able data, are compiled each quarter for review by the Leadership Team, with review done within **15** days of the end of the quarter
- The four Quarterly Reports are then aggregated into an Annual Report
- Timeframes for implementation of proposed changes and follow-up reporting are set by the Leadership Team during the report review.
- Any pressing ad hoc issue confronting the PIP staff results in a report generated for discussion during the next weekly scheduled Leadership Team meeting, where the issue will be reviewed, and alterations to practice proposed, and the timeline for follow up reporting set. This process is followed when pressing issues are discovered, necessitating timely review and response prior to the Quarter Report process.

- **Review procedures including detailed procedures for stakeholder review:**

- The PIP staff prepares a condensed version of the Quarterly and Annual Reports, designed to be brief and easily reviewed by all stakeholders.
- These reports are given to Clinical staff during staffing meetings, to representatives of the Oklahoma, provided to the **Executive Director** to disseminate to the Community Advisory Committee, and other community support/referral sources. This information is also posted on

the agency website for review by current or potential Clients, or other providers within the community.

- Each format of the PIP report includes simple instructions for providing feedback to the agency, whether by phone or by email, including who to address the comments to, as well as the option to be included in follows up contact when improvements and changes are implemented.

• Analysis of stakeholder feedback:

- Comments from all stakeholders who reviewed and responded to the PIP report are collected by the individual identified as the point of contact on the report.
- That individual redacts any Client identifying information, and comments if necessary, and forward them on to the PIP Compliance data officer.
- The Compliance data officer will code all of the subjective responses given, and perform all appropriate factor analyses to look for patterns and trends in the data
- All the data gathered from feedback is compiled into a report, following the format of the above documents, to be disseminated to the Leadership for discussion and planning in practice/policy improvements, or changes.

• IMPLEMENTING IMPROVEMENT AND ASSESSMENT OF THE EFFECTIVENESS OF THE PIP PROCESS

An evaluation of the PIP Process is completed each year at the annual PIP Planning Meeting. Recommendations for improvement are made from stakeholder feedback, Clinical and administrative staff, the Community Advisory Committee, and the Audit and Finance Committee, to the PIP Coordinator, and Leadership Team based on the annual agency PIP report. Assessment of the PIP structure, responsibilities, and procedures are also completed by the Leadership Team at this time.
Each departmental leader reports all PIP tracking tools, indicators, reason for measurement, frequency of use, and data sources for review on an annual basis. Needed improvements, updates, additions or removal from the tracking tool list will be at the discretion of the Leadership Team. Rationale for data collection and its use is a part of the ongoing PIP effort. Recommendations regarding data repots are discussed and submitted for vote by all members of the Leadership Team.
Changes made to the existing Performance and Quality Improvement Plan, structure, policy and process are based on these recommendations. Any changes made, are communicated to the appropriate staff or stakeholders.

• Planning ahead

The Leadership Team is responsible for ensuring that corrective action plans are implemented and that timeframes are maintained. The Leadership Team and departmental leaders are responsible for monitoring the results of the implementation of corrective action plans, and setting reasonable timelines for completion and review of corrective action results.
The impacts of the corrective action plans are monitored through measurement of improvement of stakeholder satisfaction, personnel retention rates, incident reports, reductions in non-compliance items reviewed during case record reviews and risk management reviews, and enhanced achievement of Client outcomes.
Review of all holdover issues from prior reports or inclusion of goals and activities to the updated report are voted on by all members of the Leadership Team.
Each departmental leader completes an annual short term and long term goal report. The departmental goals are reviewed by the Leadership Team for implementation in the agency's Strategic Plan on an annual basis.
Development of the agency's annual strategic plan
Development of the agency's annual strategic plan is completed in three stages:

- Stakeholder feedback and involvement
- Agency short and long term goals
- Leadership Team review, discussion and implementation

Administrative revisions in policies and procedures as well as corrective action steps involving training and supervision may be developed and distributed to the Leadership Team for implementation throughout the agency.
Improvements that occur as a result of **PIP** corrective action plans and any plans that are in the implementation stages, including the agency strategic plan, are communicated through an annual Performance and Quality Improvement Narrative Report which is provided to all staff and is included in stakeholder information packets and/or on the agency website.