Liberty Healthcare Corporation
The Freedom to Succeed™

Liberty QualityCare®

Quality Performance/Quality Improvement Resource Manual

Liberty Healthcare Corporation
401 East City Avenue
Suite 820
Bala Cynwyd, PA 19004

TABLE OF CONTENTS

The Main Course of Quality Performance/Quality Improvement (QPQI)

THE MAIN COURSE OF QUALITY PERFORMANCE/QUALITY IMPROVEMENT (QPQI)

Introduction: How to get started on a QPQI Journey

As administrative leaders, we have to guide and support our work groups to move from outcomes measurement to outcomes management in a way that will permeate the entire Liberty Healthcare organization. Of course this will require all of us in leadership positions to reassess how we organize and integrate all aspects of administration and the delivery of care systems that are based on data and results. As leaders of QPQI initiatives, we shall remain open-minded, data-driven, inquisitive, responsive, flexible, enthusiastic, focused, goal-oriented, and collaborative.

> Embody Liberty's overall mission: to be a trustworthy and outcomes-driven partner that empowers customers to achieve their goals with flexible and intelligent healthcare services.

The purpose of this QPQI Resource Manual is to assist you and members of your work group in your journey to improve outcome measurements and enhance a culture of performance. Chapter 1 includes sample reports, methodologies, and suggestions from Liberty Healthcare leadership for a variety of best practices that give expert suggestions for you and your work groups on how to keep this QPQI journey moving towards excellence. This resource manual provides detail for the KQI projects with samples of how some of our programs have creatively designed mechanisms to share this data with their work groups and customers. In chapter 2, we provide a taste of some significant outcome management tools and techniques that we hope might spark your creativity.

Except for our key quality indicator process, there is no prescriptive way to think about your outcomes management. Some of the examples we give are excellent for QPQI committee discussions. It is not about a QPQI report; it is about how we improve outcomes management and how we communicate the process improvements to all of our varied stakeholders. This is our new menu and we hope to add to both the QPQI entrées and the appetizers.

Initial Critical Decisions

What to think about before you select your QPQI entrée:

1. What critical decisions must be made initially?
2. What measurements will reflect expected program outcomes?
3. Who are all of the stakeholders?
4. Include all disciplines that affect outcome.

What to Measure

Initial critical decisions for the Liberty Healthcare work group to consider at the point of program/project implementation planning should relate to contract specific outcomes that are fiscal, professional, regulatory, or administrative. This program/project self-evaluation process begins as the implementation plan is being developed. The work group's commitment to data and results is nurtured by leadership as they plan to open the program/project.

This decision about what to measure is vital to avoid developing measurement indicators that are trivial, vague, impossible to measure, incompatible with the expectations of customers and other stakeholders, or inconsistent with Liberty Healthcare's mission. You'll want to take your time to outline the goals and functions of your program, project, and/or service early in its development. As you introduce the expectations, and even the perceptions of Liberty Healthcare for this QPQI initiative, it is a great time to think about the agencies, funding sources, and state requirements as you outline the delivery of care systems. Elicit input from all of your work group members, especially those involved in the implementation of the QPQI initiatives.

Key Quality Indicators (KQI)

Sample KQI Report

Key Quality Indicators

PROGRAM:					YEAR:									
Efficiency Indicators	**Benchmark**	MONTH	MONTH	MONTH	MONTH	MONTH	MONTH	MONTH	MONTH	MONTH	MONTH	MONTH	MONTH	YTD
														0
														0
														0
														0
														0
														0
Effectiveness Indicators														
														0
														0
														0
														0
														0
														0
														0
														0
Satisfaction Indicators														
														0
														0
														0
														0
														0
														0
														0
														0
Reduction of Risk Indicators														
Liberty Contract Compliance Audit Score														0
Number of Workers Compensation Claims Filed														0
Number of Sentinel Events/Significant Incidents Reported														0
Percentage of mandatory e-learning requirements completed														0
Number of referrals for reasonable suspicion drug screening														0
														0
														0
														0
Service Access Indicators														0
														0
														0
														0
														0
														0
														0
														0
														0

Key Quality Indicators (KQIs) are quantifiable measurements used by the Liberty Healthcare management work group to ensure that the company's operations are achieving its strategic, contractual, and customer service objectives. A common and consistent framework is utilized across all operations to foster excellence in business operations and service delivery.

> "Not everything that can be counted counts and not everything that counts can be counted."
>
> - Albert Einstein (1879-1955)

There are five (5) categories of data measurement that you and your work group will need to populate. The data elements you choose will be based on KQIs and on Liberty Healthcare's mission, contractual requirements, budget, quality performance/quality improvement data, and license/accreditation requirements for your specific program. The following definitions of these data measurement categories may help your work group select the data elements that would measure program performance in each category:

1. **Efficiency:** The relationship between the cost and resources needed to deliver the program and/or program components and the benefits achieved.

   Note: Improvement in efficiency is known to have a positive effect on the quality of the program.

2. **Effectiveness:** The degree to which the contracted services are provided in accordance with applicable program standard operating procedures to achieve the desired outcomes for the defined customer(s) by measuring change over time.

   Note: If the quality indicator is a primary program outcome, it should be categorized as "effectiveness".

3. **Satisfaction:** The degree to which a customer or other stakeholder expresses, perceives, or demonstrates fulfillment or gratification of expectations, rights, needs, progress, preferences, and other desired outcomes.

   Note: The tool created to measure satisfaction should be flexible enough to measure overall feelings of satisfaction. Include both numerical and open-ended responses.

4. **Reduction of Risk:** The degree to which the program and/or its processes results in the avoidance or reduction of risk in negative outcomes for our customers and all stakeholders impacted by the program.

   Note: A reduction in risk may entail organized actions and processes that prevent, avoid, or decrease exposure to or the likelihood of negative clinical, medical, behavioral, environmental, and legal events and outcomes.

5. **Access to Care and Services:** Identification of barriers that compromise, hinder, or impede accessing program services or the delivery of care.

   Note: Those barriers to access can include, but are not limited to, building design, special needs, eligibility criteria, telecommunication, language formats, and transportation systems.

In order to develop an effective measurement system there are a number of ways to approach this task, such as: (1) leaders and providers can dialogue with other programs that have similar populations and comparable services. (2) The work group can examine well-established models.

Selection of Indicators

The selection of KQIs is a program group effort that, at a minimum, should include program management and the vice president of operations. Input from the work group, such as detailed intake information and health information from the population being treated, are all good sources of input. Typically, the establishment of a QPQI infrastructure takes from one (1) to four (4) years of focused effort.

Even though senior management initiates the QPQI infrastructure, the success of selecting quality indicators and ensuring outcome management depends on buy-in from the rank and file. The amount of time needed for this infrastructure development is dependent on program size, customer expectations, availability of resources, standards, and reporting requirements. The following are some key questions to ask before the indicators are selected:

- What difference do we hope to make through our QPQI program and how can it happen?
- What are the program's core values that underpin our work and are critical to our outcome success?
- What are the major goals of our program that will help Liberty Healthcare carry out its mission and reach its vision?
- What are the challenges and the opportunities facing our QPQI program?
- What key stakeholders should have input in determining the measures to be used in our QPQI program?
- Will the system of care data we collect inform all our major decisions?
- Do our processes and data instruments gather information on short-term, intermediate, and long-term outcomes?
- Will we use the results from our outcome evaluations to improve our systems of care?
- Are our QPQI activities integrated into all aspects of our systems of care?
- Do Liberty Healthcare employed and physician subcontracted staff within our systems of care have maximum access to data?

Annual Program Summary

Liberty Healthcare considers the annual program summary to be a product that reflects the real value of the program/project. It is intentionally presented as a two (2) page summary, as a common difficulty with outcome management systems is accumulation of data and detail that is too time consuming to read (Joint Commission). This QPQI initiative should be relatively easy to manage and analyze without expensive resources and time. Remember, it is not about the report, it is about sharing outcome measurements with key stakeholders so that the outcomes management process includes input from the entire work group and other key stakeholders.

Sample Template for Annual Program Summary

Liberty Healthcare Corporation
Annual Program Summary

[Program Name][Contract Year]

Program Overview
[Include a brief overview (1-2 short paragraphs) of the program. To the degree that they are relevant, consider the following: What did the customer contract with Liberty to do? What problem/challenge are we solving? What unmet need are we addressing?]

Program Objectives
[Identify our most important customer relevant program objectives.]

- [Program Objective]
- [Program Objective]
- [Program Objective]

Contract Year [Year] Achievements
The following are key program achievements for contract year [year]: This section of the document should be utilized to showcase/demonstrate the value and positive impact of the program. Examples may include exceeding established service level agreements, quantifiable cost savings, program recognition/awards, etc.]

- [Achievement]
- [Achievement]
- [Achievement]

Contract Year [Year] Operational Results
Following are key operational results for contract year [year]: [This section of the document should be utilized to present customer relevant outcomes data i.e. population served, resources provided, etc. The use of charts/graphs is encouraged to visually and comparatively represent data and/or trends.]

- [Operational Result]
- [Operational Result]
- [Operational Result]

For more information about Liberty Healthcare Corporation's [Insert Program Name] Program, please contact [Name], [Title], via phone at [Phone] or email at [Email Address].

Root Cause Analysis (RCA)

Root Cause Analysis (RCA) is a tool utilized by Liberty Healthcare leaders and managers as part of the ongoing QPQI process. RCA represents a structured approach to the investigation and analysis of significant adverse events or system deficiencies that require improvement.

When to Use RCA

Liberty Heathcare understands that a RCA is a demanding process that requires a commitment of time and energy, and therefore, that the integrity of the RCA process can only be maintained when there is an investment of time and resources. Since RCA is a very structured process that requires users to go through a series of step-by-step activities, the organization recommends selecting events for RCA if any one (1) of the following established criteria is met:

1. There is significant risk to Liberty Healthcare if a problem is not corrected.
2. The cause of a MAJOR system failure is not evident.
3. There are repeated failures that are ascribed to human error.
4. There is a sentinel event that results in death or serious injury.
5. There are a series of incidents that could result in death or serious injury.

We are often confident that our systems and processes are designed so well that errors are prevented, but the reality is that Liberty Healthcare is working toward perfecting our performance. When an error occurs, a thorough understanding of the fundamental reasons for and the interrelationship of the causes is essential to prevent repeating the error in the future. RCA attempts to identify the causes of errors. It is a systematic approach to uncovering the underlying reason for an error and can be applied to both sentinel events and close calls ("near misses").

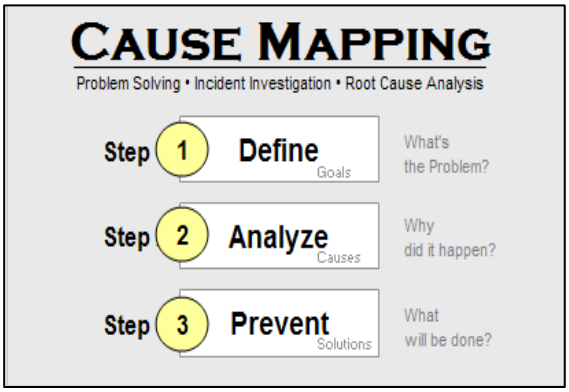
RCA focuses on causes rather than blaming the individual. Identifying and understanding the relationship between factors that allowed the error to occur is at the heart of the analysis - placing blame or assigning responsibility is not.

Steps for Conducting RCA

1. Clarify the Issue

a. A RCA should be conducted one incident or adverse event at a time. If there are multiple incidents of the same type, it is usually best to complete each RCA separately and then integrate the findings.

b. Make sure that there is a clear understanding of the facts surrounding the incident or adverse event.



c. Inquire with those that might have information and think outside the box but be aware of emotions that might alter perceptions of the incident or adverse event.

d. Gather documentation that may be relevant and take note of any personal observations that will contribute to understanding the incident or adverse event.

e. Set aside a time and place to talk with people privately to be clear about explaining the purpose of a RCA, what will happen during this process and what will be done with any information that is given.

2. ***Assemble the Review Work Group***: Membership should be formally appointed or assigned by a senior leader at Liberty and reflect individuals with knowledge of the incident/adverse event and any policy or practice requirements associated with the type of service or activity involved in the incident/adverse event – most work groups will include five (5) to seven (7) individuals.

   a. When possible, a QPQI or risk management staff will be assigned to the RCA.

   b. Additional members should include a management or supervisory representative responsible for the Liberty program or service in which the incident or adverse event occurred.

   c. The program or service investigator OR the person most familiar with any investigation that has been complete.

   d. A content expert with knowledge of best practices.

   e. One (1) or two (2) persons who were directly involved in the incident.

3. ***Assign Roles and Responsibilities***

   a. At a minimum, the roles of the work group leader and note taker need to be assigned.

   b. The above leadership group will be responsible for work between formal meetings and should be prepared to commit at least three (3) to five (5) hours beyond the time directly spent in meetings.

   c. The other RCA members can be assigned to assist with collection and organization of other data and information that will be utilized during the RCA.

4. ***Collect Information***

   a. The RCA work group leadership should identify important and relevant documents and information that will be needed by the RCA work group. This information will vary based upon the type of incident/adverse event under review and could include, but is not limited to: policies and procedures, autopsy reports, interviews, clinical records, etc.

      Listing the sequence of events in chronological order is important prior to the first RCA meeting and this information should be brought to the first meeting to facilitate the creation of a flowchart. Formal literature searches and reviews are very helpful to gain an increased awareness of the systems available across the country. In addition, you can call colleagues in other states to gather ideas that can be shared with the RCA work group members. Try www.qualitymall.org for some best practice ideas. All information should be shared with the full RCA work group. The work group can use this additional

information to think about approaches to solving the factors or clusters of factors that will be identified in the RCA.

5. Initiate RCA

a. Schedule and organize the RCA meetings – usually it will require two (2) to three (3) meetings – allow for adequate notice and select a location that has sufficient space without distractions. Include any visual representation equipment you will need, i.e. larger maker board, flip charts, PowerPoint for slides, etc.

b. Explain the process at the first full meeting of the work group – use PowerPoint slides or other visual handouts stressing the goal of prevention as a key focus of any RCA.

c. Review the incident/adverse event and include all of the collected information.

d. Create a flowchart of exactly what happened using the sequence analysis form as a guide. Make notes on the flowchart to identify any deviations from what standard or best practice suggests.

e. The designated work group leader initiates the brainstorming session following the established rules and the scribe records all of the factors identified by the individual work group members and records the findings on an Ishikawa (Fishbone) Diagram under the appropriate heading: people, documents, method, and equipment.

f. The work group members and the scribe will review the "Fishbone" Diagram and using the above mentioned categories, will cluster factors within each category in order to "drill down" common factors before the work group voting for causes begins.

g. The work group will now begin the voting process for the causes or the most fundamental reasons that led to the error. Each of the factors or cluster of factors are voted on by all of the work group members and work group members can vote multiple times on those factors they believe led to the error.

h. The work group scribe records the number of votes next to each factor or cluster of factors – i.e. (10).

i. The three (3) factors OR clusters of factors with the highest work group scores will be identified as the root causes on the Ishikawa (Fishbone) Diagram.

j. The work group will begin to create a Performance Improvement Plan (PIP) by identifying solutions to the root causes identified.

k. For each solution, the work group will discuss effectiveness, feasibility, estimated costs, and any special considerations that this solution could pose when implemented.

l. In addition to the RCA leader, each solution must have an identified owner that is recorded by name with a specific month, day, and year that this solution will be implemented.

m. The RCA work group must then identify specific strategies that will measure the effectiveness of each identified solution with identified owners recorded by name to measure effectiveness and with specific month, day, and year of data analysis.

n. The RCA work group leader and work group scribe will prepare a draft PIP and

distribute this plan to all work group members with a specific deadline for additional comments. Be prepared to provide rationale for the work group findings and for any objections or issues with Liberty Healthcare chain of command when they review the plan.

o. Report findings and the PIP to Liberty's appropriate vice president of operations and the vice president quality performance/quality improvement/compliance officer.

p. The work group leader will make the necessary revisions and work with the scribe to prepare a final PIP.

q. The RCA work group leader will sign the approved PIP, record the date and send a copy to the appropriate vice president of operations and the vice president quality performance/quality improvement/corporate compliance officer.

Sentinel Event Reporting and Investigation

The leaders, supervisors, and managers of all programs/contracts of Liberty Healthcare are expected to accurately identify possible sentinel events, respond in an appropriate and timely fashion, comply with proper reporting procedures, and apply corrective actions or improvements as applicable. A sentinel event is defined by The Joint Commission as "any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness." The term "clients" shall be used in Liberty Healthcare's standard operating procedure to apply to any patient, client, consumer, offender, or resident of a program in which Liberty provides services. Liberty leadership and supervisory staff will exercise their best judgment in identifying any given adverse incident as a "sentinel event".

A Corporate Compliance Reportable Event is defined as any event, including a potential sentinel event, that is reported through the channels for corporate compliance reporting (i.e., the Employee Help Line or direct communication through chain of command, human resources, or the corporate compliance officer). Any such event is investigated by the corporate compliance officer in accordance with LHC-CP SOP #6 – Procedures for Reporting, Investigating & Responding to Compliance Issues.

Contract Compliance Audit

At all times, Liberty Healthcare will be in full compliance with all contractual requirements and deliverables. Vice presidents of operations shall monitor the quality and adequacy of services for each contract. They shall monitor and require that operations are conducted in compliance with all contractual requirements and deliverables, applicable federal and state rules and regulations, and applicable policies and procedures.

Fulfilling the obligations contained in contracts signed by Liberty Healthcare is a core responsibility of the VPO, in order to facilitate customer retention and minimize risk to the company.

For each Liberty contract, a contract compliance audit tool will be developed and filed in the contract's QPQI folder within the shared operations files. The master audit tool will be developed at the commencement of a new contract and updated/revised every time there is an amendment. The tool is populated with a numbered list of verbatim text of the requirements and deliverables identified in the contract (long sections of text may be paraphrased). The VPO is responsible to compile the list of contract requirements and deliverables, and the list will be double checked by the program director or another corporate office staff person.

Compliance will be monitored through periodic audits. The VPO determines the frequency of the audits, but all contracts will be audited a minimum of annually and the completed audit tool placed in the shared file by the end of December of each year. More frequent reviews may be required of all or part of a contract requirement/deliverable list based on the significance of the item, stage of the program (e.g., in early stages audits may be more frequent), and general performance. The audits will generally be performed during an on-site visit to the respective contract location. The reviews may be conducted by the VPO and program director, directors of other similar programs run by Liberty, or other corporate office leaders as determined and arranged by the VPO.

Customer Satisfaction

It is important to understand that what matters to Liberty depends on what matters to our contracted customers as our contract renewals and payments come from this customer source. Having to serve disparate customer 'masters' can be difficult and takes time and focus. Some customer expectations are not outlined contractually and require superb listening skills to discover what quality means to a specific customer group.

Knowing the payor sources' expectations is vital to the program's survival. The customer's demands may need separate attention from the client demands and balancing time and energy for both is important. A key customer may be an agency referral source and their expectations may also require detailed attention. Each customer requires different initiatives and therefore each QPQI initiative must be poignant and relatively straight forward to reach each of these very vital masters. Step back and look at the big picture before you start your QPQI initiatives so that your outcomes evaluation system is manageable and meets the expectations of all the various customers.

Client Satisfaction

Liberty Healthcare initiated a client satisfaction program in 2006 to determine clients' perceptions of their treatment program. This annual internal survey assesses clients' satisfaction in several dimensions. The resulting data is analyzed and compared over years.

There is much to commend the use of client satisfaction surveys as a form of evaluation. It can be implemented relatively inexpensively and is easy to interpret. This form of evaluation may indicate to clients that their experiences and observations are important – a further indication that someone cares about them. Liberty Healthcare makes the assumption that these client satisfaction surveys provide the most valuable indication on how our programs are impacting our clients' lives. The survey is anonymous to reduce any fear that clients may have about losing the benefits of treatment services.

Sample Client Satisfaction Survey (Program/Project)

CLIENT SATISFACTION (Program/Project)

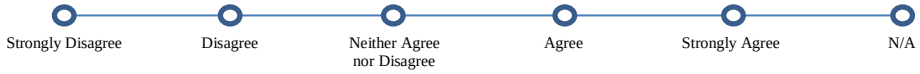
Your opinion is important to us. There are eleven (11) statements below. For each statement, check **ONLY ONE (1)** of the boxes that **best matches** how you feel : "Strongly Disagree ","Disagree ", "Neither Agree nor Disagree ","Agree", **OR** "Strongly Agree". **Your Responses are confidential** and will be used to inform the (Program Name) leadership and work group of how you responded to these questions so that your input is considered in improvements to your program. Please indicate below if you have responded in previous years since we compare results year to year. It should take you about 10 to 15 minutes to complete this questionnaire. We thank you in advance for your time and effort.

Have you participated in the _____ client satisfaction survey before?

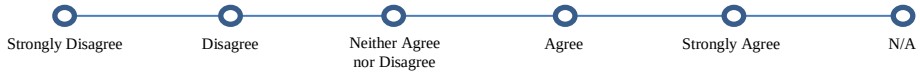
_____YES _____NO

Measurement Indicators: Strongly Disagree, Disagree, Neither Agree nor Disagree, Agree, Strongly Agree, NA

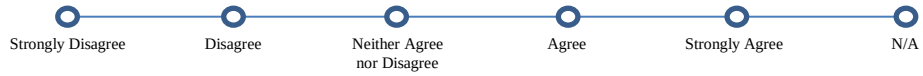
1. I believe the program is addressing my needs.



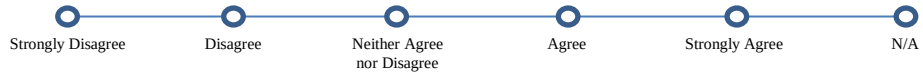
2. I understand my program goals.



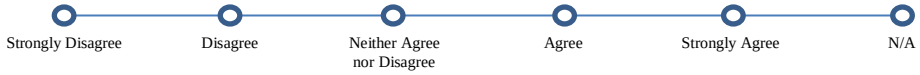
3. I feel the program is helping me with my treatment goals.



4. I get respect from the staff.

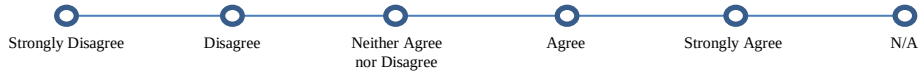


5. If I have a concern or a problem, I know what to do and who to talk to.

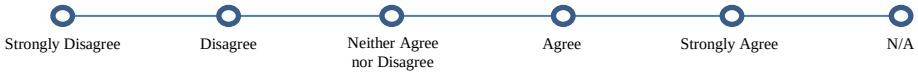


6. I am able to access program services.

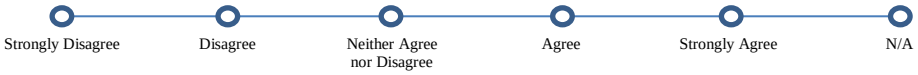
7. I feel safe.



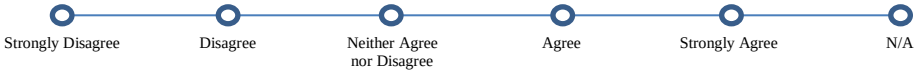
8. If I don't feel safe, I know what to do.



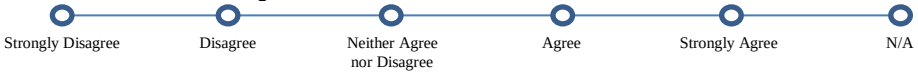
9. I have places for privacy where I live.



10. The place where I live meets my needs.



11. I am able to keep active.



Open Questions/Comments – (Program Project)

1. What do you find beneficial about the _____ program?
2. What changes would you make to the _____ program?
3. What questions should be asked in the next client satisfaction survey?
4. What other comments do you have for the _____leadership work group?

Questions that the client recommends to be added should be reviewed carefully and added to the following year's client satisfaction survey. These questions often get to the heart of a client's concern and support the importance of client input into the development of surveys about their satisfaction.

Medical Staff Peer Review

1. Liberty Healthcare has established a second level peer review that includes board certified physicians, nurse practitioners, operations executives, and quality performance/quality improvement expertise.

Without clinical and administrative guidance, peer to peer feedback, and formal performance review, the quality of services cannot be assessed.

2. Upon customer request, Liberty Healthcare has established this comprehensive system of second level clinical evaluation to review the delivery of services to include both the appropriateness of the services of care, the timeliness of this care, documentation of the care services, and systems of care.
3. Results of the second level peer review are recorded and signed by the medical chairperson.

Liberty QualityCare® News

1. Liberty Healthcare is constantly looking for ways to keep our employed and physician subcontracted staff updated on the latest and greatest medical, QPQI, and Six Sigma methodology as part of our efforts to provide safe, high-quality care to our clients and patients.
2. Liberty Healthcare distributes a quarterly newsletter in the spring, summer, fall, and winter to briefly update our employed and physician subcontracted staff on new medical research.
3. These quarterly newsletters include information on current quality performance/quality improvement initiatives that foster caregivers to provide safe, quality-driven systems of care.
4. Liberty Healthcare encourages employed and physician subcontracted staff to report concerns in good faith about the delivery of care systems without fear of retaliation.

The Appetizers of QPQI

THE APPETIZERS OF QPQI

QPQI Strategic Planning

"Our plans miscarry because they have no aim. When a person does not know what harbor they are looking for, no wind is the right wind."

- *Seneca (4 B.C. – 65 A.D.)*

Define:

Create a streamlined method for annual data reporting that ensures that employed and physician subcontracted staff ultimately provide safe and efficient quality of care to patients, individuals, clients, residents, and releasees**.**

Measure:

Monitor services and systems delivery of care through performance measurement data collection that addresses Liberty Healthcare's structure for coordinating and integrating services, care delivery functions, or activities across our operations.

Analyze:

Focus on the customer's satisfaction with delivery of care and services.

Improve:

Evaluate the systems and processes to evaluate the outcome in services and delivery of care systems.

Control:

Strengthen Liberty Healthcare systems of care delivery and services through Six Sigma methodology with a focus on Lean Six Sigma to control errors and costs.

In summary, set realistic goals with your program work group, goals that can be achieved. It is equally important that the program work group demonstrate to the customer organization the value of your program through outcome evaluation and customer feedback.

Best Practices "A Little Help From our Friends"

"I get by with a little help from my friends"

– The Beatles

"For the things we have to learn before we can do them, we learn by doing them."

– Aristotle <u>The Nicomachean Ethics</u>

Become Data Driven

Initiate a needs assessment using objective outcome data to anticipate barriers to compliance with this program wide QPQI initiative. In this era of competition and organizational survival, Liberty Healthcare establishes flexible QPQI programs that depend on senior program management to drive its evolution. This data is often tucked away and must be found as needed and used to improve care and services. Consequently, to be the best you need to do more than the Key Quality Indicator summary reports, annual QPQI reports, and client/customer satisfaction surveys. More and more we are being ask for quantitative data to ensure that we are the best and consequently, outcome evaluation must be part of your program's tools, meeting/committee structures, and internal reporting processes.

Listen to Input

Balancing the dual goals of reducing variability in the clinical operations and improving quality requires ongoing input from key stakeholders in determining the QPQI measures to be used in the program. It is important to elicit leadership support and commitment to the QPQI initiatives. Family and client input are also vital to program development. Early dialogue about the resources available for the QPQI initiatives will help frame the KQI indicators. Discussion of the standardized tools that will be used to quantify care is also essential.

Quarterly Outcome Management in Formal QPQI Committees

TIPS for ongoing review of QPQI outcomes:

Confidentiality Statements – QI Acts of 1986 and 2005 – A statement would be recorded at the beginning of your QPQI Report/Plan/Agenda/Minutes:

Sample Confidentiality Statement

This Continuous Quality Improvement/Risk Management/Utilization Review Plan is the property of Liberty Healthcare Corporation and Liberty of _____.

The document and contents therein contain confidential information which is legally privileged and protected by the National Healthcare Quality Improvement Act of 1986 and the Quality Improvement/Patient Safety Act of 2005. This Continuous Quality Improvement/Risk Management/Utilization Review Plan and its contents are intended only for use in improving performance and patient safety and may be viewed only by authorized personnel. The authorized recipient of this information is prohibited from disclosing this information except for the purpose of quality performance improvement and will retain the information as a confidential, peer protected document.

The disclosure of this document or the contents therein to any person without the consent of Liberty Healthcare or Liberty _____ is a violation of the Quality Improvement Act of 1986. Any person who violates this Act is subject to a civil money penalty of $10,000 for each violation.

If you are not the intended recipient of this document, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of this document is strictly prohibited. If you have received this document in error, please notify _____ at (phone number) immediately to arrange for the return of this document.

Sample QPQI Quarterly Meeting/Committee Review of Outcomes Reporting

Executive Summary Ideas:

- Program-Based Outcome Evaluation
- Community-Based Outcome Evaluation
- QA/QP/QI Research
- Program Training and Research

Continuous Quality Improvement Initiatives - Program Overviews That Are Reviewed In Quarterly Meetings

- Mission of Program
- Purpose of Program
- The Long-Term Goals of Program
- Governing Body

Outcome Evaluation Data - September, 2014 – December, 2014

- Review Procedure
- Committee Members Participation
- Data Analysis
- Thresholds of Evaluation and Goals

Effectiveness: Sample

1. Standard of Care: Provide continuous active treatment, which includes aggressive, consistent implementation of a program of specialized and generic treatment, and related programmatic services.
2. Standard of Care: Psychoactive medications are prescribed to treat symptoms of a diagnosed psychiatric disorder or condition.
3. Standard of Care: Treatment work groups demonstrate readiness for placement and discharge planning.
4. Standard of Care: Recidivism or re-admission rates are reviewed to expand efforts to measure reductions in recidivism or re-admissions.

Efficiency: Sample

1. Standard of Care: Placement or discharge criteria are identified early in the treatment planning.
2. Standard of Care: Contacting referral sources is timely and intermittent.
3. Standard of Care: Response to referral sources is timely and efficient.
4. Standard of Care: Personnel practices select and retain desirable employed and physician subcontracted staff.

Reduction in Risk: Sample

1. Standard of Care: Care systems are offered in an environment free from maltreatment.
2. Standard of Care: Care systems promote the general health and well-being of the population.
3. Standard of Care: Restrictive procedures (e.g., personal physical restraint, access to personal property, increased supervision) are not used when less restrictive procedures are clinically appropriate.
4. Standard of Care: Medications are provided appropriately, safely, and effectively.
5. Standard of Care: The population is provided care in an environment free of health and safety hazards.
6. Standard Of Care: High risk delivery of care systems are identified early.

Customer Satisfaction: Sample

1. Standard of Care: Processes are offered for the expression of satisfaction with the care, treatment, and/or services being provided.

Access to Care and Services: Sample

1. Standard of Care: Access to care /services shall be delivered in a timely manner.

Sample QPQI Review of Data Measurements (Staffing Contract)

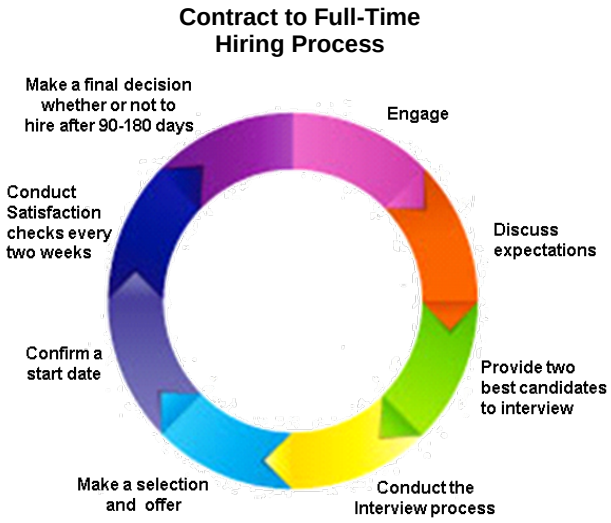
A staffing outcome system requires the support and commitment of the highest levels of both Liberty Healthcare and the customer organization. Our vice presidents of operations must convey a clear, concise endorsement of staffing outcomes that are reviewed in an organized fashion to successfully promote the customer organization buy-in. In addition to providing data to support financial initiatives, this staffing data review must demonstrate a hands-on commitment to the recruitment of qualified staff that will provide safe, quality care and delivery systems to our customer organization.

Our administrative customers may lose interest if a brief summary review cannot show staffing outcomes that will foster customer organizational growth and stability. By creating staffing review processes that are to the point, combine staffing and recruitment plans, and are quick and easy to understand and peruse, Liberty Healthcare can facilitate collaborative and open administrative dialogues with our customers that will elicit interest and begin the formation of a committed partnership. In the header and/or footer offer strict assurances of confidentiality (see sample above).

Executive Summary:

In 3 or 4 lines - this summary is reviewed monthly with the customer and program work group:

1. Illustrate ways that the staffing and recruitment delivery of services will assist the customer in the improvement of the overall effectiveness of our customers' programs.
2. Provide an overview of activities and significant events.
3. Describe the staffing pipeline



Current staffing during the reporting month and year: Illustrate these findings in a graphic format in order to make the staffing report concise:

Measurement Data	Number (Indicate decimal) – 1 decimal
Initial Resource Count	2.6
Requests Filled	3.0
Terminations	0.0
Promotion / Transfer	1 Promotion

Measurement Data	Number (Indicate decimal) – 1 decimal
Position No Longer Required	1.0
Total Vacancies	2.0
Final Resource Count	2.6

Resource Hours Worked: Illustrate these findings in a graphic format:

Name	Hire Date	Annual Limit	Month Worked	Hours Worked	YTD Accrued	YTD Worked	Over/ Under	Hours Remain
J. Doe	10/10/14	999.00	Oct	96.50	726.00	761.00	35.00	229
W. Doe	10/12/14	1760.00	Oct	144.00	576.00	576.00	-0.89	1184

Current Vacancies: Illustrate in graphic format:

Position Title	Program	State
Primary Care Physician	Physician Services	South Carolina
Inpatient Psychiatrist	Riverview Psychiatry	Maine

Detailed activity related to the vacancies above:

- Primary Care Physician: Dr. John Doe is currently in the credential work group process.
- Inpatient Psychiatrist: Dr. Jane Doe is in the process of onsite interviews and we expect to forward the competency file to the credential group by the end of the week.

Summary: This would be concluded with 1 or 2 paragraphs:

- Present your staffing findings as it relates to the customer expectation.
- Outline strategies that will help secure the customer participation in the outcome evaluation process.
- Explain this month's purpose of the staffing outcome evaluation and provide any changes that are expected for next month.
- State success for the customer clearly.
- Redefine the scope of this staffing outcome evaluation to ensure that the customer agrees with the current scope.

Best Practice Summary

"A candle loses nothing by lighting another candle." In other words, be willing to help others and share your knowledge and insights with others who may benefit."

- Frances Hesselbein, Leadership by example

In order to become a data driven organization, Liberty Healthcare programs must develop QPQI strategic plans that provide an opportunity for self-assessment, organizational growth and refinement, and strategic goal attainment. This transformation to becoming data-driven takes time and effort in order to reflect both Liberty Healthcare and the program's core values. This task must be very efficient since measuring tangential, irrelevant, or inconsequential aspects of the delivery of care will result in our Liberty employed and physician subcontracted staff losing interest in this outcome evaluation process. Liberty Healthcare supports each program in verifying the effectiveness of its clinical practice in order for the program to survive and advance.

Best Practice Through a High Performance Culture

- Our Liberty Healthcare culture is the collection of our shared values, attitudes, and standards.
- Liberty's leaders are committed to maintaining a high performance culture.
- A high performance culture will result in:
  - Excellent program outcomes.
  - Highly satisfying work environments for those who share the company's values and goals.
  - Satisfied customers.
  - More business and increased revenues.

QPQI Initiatives for a High Performance Culture

Liberty Healthcare is in the process of developing the "Liberty QualityCare" package. Liberty QualityCare will be a process-oriented and outcomes driven template for quality assurance and improvement that will include risk management methodology, innovative training techniques specifically geared toward health care professionals, performance measures and benchmarking for specialized health care entities, and consultative services to engage front-line staff in performance improvement.

Six Sigma Techniques for Process Improvement

Six Sigma simply means a measure of quality that strives for near perfection. Six Sigma is a disciplined, data-driven approach and methodology for eliminating defects (driving toward six standard deviations between the mean and the nearest specification limit) in any process – from product to service.

The statistical representation of Six Sigma describes quantitatively how a process is performing. To achieve Six Sigma, a process must not produce more than 3.4 defects per million opportunities. A Six Sigma defect is defined as anything outside of customer specifications. A Six Sigma opportunity is then the total quantity of chances for a defect.

The fundamental objective of the Six Sigma methodology is the implementation of a measurement-based strategy that focuses on process improvement and variation reduction through the application of Six Sigma improvement projects. This is accomplished through the use of two Six Sigma sub-methodologies: DMAIC and DMADV. The Six Sigma DMAIC processes (define, measure, analyze, improve, control) is an improvement system for existing processes falling below specification and looking for incremental improvement. The Six Sigma DMADV process (define, measure, analyze, design, verify) is an improvement system used to develop new processes or products at Six Sigma quality levels. It can also be employed if a current process requires more than just incremental improvement. Both Six Sigma processes are executed by Six Sigma Green Belts and Six Sigma Black Belts, and are overseen by Six Sigma Master Black Belts.

Quotes About Outcome Evaluation and Excellence

"***Remember the 'baby sitter' analogy….we are here to take care of the program, to nurture it and help it thrive and grow, but in the end we do not own it…it ultimately belongs to the customer. As long as we take great care of the 'baby' we will be asked to continue to 'babysit' it and take care of it."***

"We are what we repeatedly do. Excellence, then, is not an act, but a habit"
- Aristotle

– Dr. Adam Deming, Executive Director, Indiana Sex Offender Management and Monitoring –

"What you look at, you improve."

– Dr. Hugh Sage, Executive Director, Robert M. Greer Center

"Review of KQI's regularly with staff can identify and improve individual performance issues."

– Dr. Shan Jumper, Executive Director, Illinois Treatment and Detention Facility

"A detailed monthly staffing report and well defined KQI indicators developed early in program implementation will keep the stakeholders well informed and will highlight progressive performance improvement."

– Alexis Small, Program Manager. South Carolina Physician Services

"Process mapping will transform (your program) by changing how (you) solve problems and manage work".

– Richard Maurice, Director of IT/QA, North Carolina Independent Assessments

"Quality is an attitude of always doing our best"

– Barbara J. Stachowiak, Nurse Practitioner, Project Director, Quality Reviews, District of Columbia

"Detailed cost data is a path to succeed"

- Steven Bryant, Executive Director, Illinois Conditional Release Program

"With staffing contracts it is imperative to have benchmarks in place to measure performance against. These include number of days a position is open, days to fill a position and days until a candidate starts are all important. Lastly, keeping the customer up to date on the recruitment status is extremely important, either with weekly meetings or email updates."

– Dr. Charles ("Charlie") Sproule, Vice President of Operations, Liberty Healthcare Corporation

"Maintaining 'status quo' is only an illusion. Change is inevitable. Quality Improvement is assuring that change is directed toward excellence."

– Gretchen A. Gibbs, RN, FNP, MSN, Director of Clinical Support Services, Liberty Healthcare Corporation

"I consider each of my customer's individually. Each requires its own initiatives, and each initiative needs to be poignant and relatively straight forward."

– Aaron Harmon, RN, BA, Program Manager, Fulton County Health Center, Ohio

"To excel in QPQI, you must keep evolving; make it a campaign for your work group so that everyone knows what we have done and what we still must do to be the best."

- Kevin Rice, LCSW, Executive Director, California Restoration of Competency

References

Deming, Adam, Psy.D. Executive Director, Indiana Sex Offender Management and Monitoring (INSOMM) Annual Outcome Report, 2014

Joint Commission Health Care Staffing Services Certification Manual, 2014.

Royse, David and Bruce A. Thyer, Program Evaluation, 1996.

Sage, Hugh, Ph.D., Executive Director, Robert M Greer Center, Continuous Quality Improvement/Risk Management/Utilization Review Plan, 2014

Sproule, Charlie, Ph.D., Vice President of Operations, South Carolina Physician Staffing Monthly Report, 2014

Savin, Howard A. and Susan Soliveria Kieslng, Accountable Systems of Behavioral Health Care, 2000.

Villanova University, Six Sigma Certification, 2014