



New York State Office of Mental Health
Office of Quality Management
2005

Quality Improvement Plan
Name of Clinic
Date of the Current Plan

Section 1

Introduction

Introduction : Mission, Vision, Scope of Service (Describe briefly the clinic program that will be covered by this Plan, including the clinic's mission and vision, the types of services provided, its relative size, etc.)

The following Quality Improvement Plan serves as the foundation of the commitment of the this clinic to continuously improve the quality of the treatment and services it provides.

Quality. Quality services are services that are provided in a safe, effective, recipient-centered, timely, equitable, and recovery-oriented fashion.

(*Clinic name*) is committed to the ongoing improvement of the quality of care its consumers receive, as evidenced by the outcomes of that care. The organization continuously strives to ensure that:

- # The treatment provided incorporates evidence based, effective practices;
- # The treatment and services are appropriate to each consumer's needs, and available when needed;
- # Risk to consumers, providers and others is minimized, and errors in the delivery of services are prevented;
- # Consumers' individual needs and expectations are respected; consumers – or those whom they designate – have the opportunity to participate in decisions regarding their treatment; and 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.

Quality Improvement Principles. Quality improvement is a systematic approach to assessing services and improving them on a priority basis. The *(Name of Clinic)* approach to quality improvement is based on the following principles:

- Customer Focus.** High quality organizations focus on their internal and external 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 permit person-centered services.

- **Employee Empowerment.** Effective programs involve people at all levels of the organization in improving quality.
- **Leadership Involvement.** Strong leadership, direction and support of quality improvement activities by the governing body and CEO are key to performance improvement. This involvement of organizational leadership assures that quality improvement initiatives are consistent with provider mission and/or strategic plan.
- **Data Informed Practice.** Successful QI processes create feedback loops, using data to inform practice and measure results. 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. CQI 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 Over Correction.** Continuous Quality 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 providers can almost always find an opportunity to make things better.

Continuous Quality Improvement Activities. Quality improvement activities emerge from a systematic and organized framework for improvement. This framework, adopted by the hospital 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. Quality Improvement involves two primary activities:

- Measuring and assessing the performance of clinic services through the collection and analysis of data.
- Conducting quality improvement initiatives and taking action where indicated, including the
 - # design of new services, and/or
 - # improvement of existing services.

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

Leadership. The key to the success of the Continuous Quality Improvement process is leadership. The following describes how the leaders of the (Name of Clinic) clinic provide support to quality improvement activities.

The **Quality Improvement Committee** provides ongoing operational leadership of continuous quality improvement activities at the clinic. It meets at least monthly or not less than ten (10) times per year and consists of the following individuals: *(List titles of committee members. The membership should include a recipient/family member for adult settings and a family member for children settings. Indicate the Chairperson of the Committee.)*

The responsibilities of the Committee include:

- # Developing and approving the Quality Improvement Plan.
- # As part of the Plan, establishing measurable objectives based upon priorities identified through the use of established criteria for improving the quality and safety of clinic services.
- # Developing indicators of quality on a priority basis.
- # Periodically assessing information based on the indicators, taking action as evidenced through quality improvement initiatives to solve problems and pursue opportunities to improve quality.
- # Establishing and supporting specific quality improvement initiatives.
- # Reporting to the Board of Directors on quality improvement activities of the clinic on a regular basis.
- # Formally adopting a specific approach to Continuous Quality Improvement *(such as Plan-Do-Check-Act: PDCA)*.

The **Board of Directors** also provides leadership for the Quality Improvement process as follows:

- # Supporting and guiding implementation of quality improvement activities at the clinic.
 - # Reviewing, evaluating and approving the Quality Improvement Plan annually.
- (Describe how leadership will support clinic's QI Program.)*
-
-
-
-

The Leaders support QI activities through the planned coordination and communication of the results of measurement activities related to QI initiatives and overall efforts to continually improve the quality of care provided. This sharing of QI data and information is an important leadership function. Leaders, through a planned and shared communication approach, ensure the Board of Directors, staff, recipients and family members have knowledge of and input into ongoing QI initiatives as a means of continually improving performance.

This planned communication may take place through the following methods;

- *Story boards and/or posters displayed in common areas*
- *Recipients participating in QI Committee reporting back to recipient groups*
- *Sharing of the clinic's annual QI Plan evaluation*
- *Newsletters and or handouts*

Please describe your clinics method and/or mechanism for communication to recipients, staff and leadership. _____

Section 3

Goals and Objectives

The Quality Improvement Committee identifies and defines goals and specific objectives to be accomplished each year. These goals include training of clinical and administrative staff regarding both continuous quality improvement principles and specific quality improvement initiative(s). Progress in meeting these goals and objectives is an important part of the annual evaluation of quality improvement activities.

The following are the ongoing long term goals for the (Name of Clinic) QI Program and the specific objectives for accomplishing these goals for the year _____. *(Indicate the current year.)*

- To implement quantitative measurement to assess key processes or outcomes; **(An example of an objective** involving quantitative measurement: The average number of “no shows” will be reduced overall by 30% from its current average of _____ within the next 12 months.)
- To bring managers, clinicians, and 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;

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

Selection of a Performance Indicator. A ***performance indicator*** is a quantitative tool that provides information about the performance of a clinic'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
- Clinical importance - whether it addresses a clinically important process that is:
 - # high volume
 - # problem prone or
 - # high risk

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 quality improvement efforts.

(Describe the factors which you will consider in selecting a measure of quality.)

The Performance Indicator Selected for the (Name of Clinic) Quality Improvement Plan. For purposes of this plan, an indicator(s) comprises five key elements: name, definition, data to be collected, the frequency of analysis or assessment, and preliminary ideas for improvement. The following Table presents each performance indicator currently in use by the clinic, along with the corresponding descriptors.

| Measure of Service Quality <i>(Complete this table for each indicator which is selected. Note that only one indicator is required during the first year of the agreement.)</i> | |
|---|---|
| Name | Name. Usually a brief two or three word title. |
| Definition | <i>Definition. With detail, explain the name by including the data elements and the type of numerical value to be used to express the indicator (percentage, rate, number of occurrences etc.).</i> |
| Data Collection | <i>Describe how the data will be collected as well as the method and frequency of collection, and who will collect the data.</i> |
| Assessment Frequency | <i>State how often the Quality Improvement Committee will assess information associated with the indicator.</i> |

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

- Self over time.
- Pre-established standards, goals or expected levels of performance.
- Information concerning evidence based practices.
- Other clinics or similar service providers.

(List here the assessment strategies you will use. See APPENDIX A, attached, for examples of performance improvement tools.)

Section 5

Quality Improvement Initiative

Once the performance of a selected process has been measured, assessed and analyzed, the information gathered by the above performance indicator(s) is used to identify a continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon clinic priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones. The model utilized at Name of Clinic is called Plan-Do-Check-Act (PDCA). *(Modify the following as appropriate for your program. If you choose a model other than PDCA, describe the model here.)*

- # **Plan** - The first step involves identifying preliminary opportunities for improvement. At this point the focus is to analyze data to identify concerns and to determine anticipated outcomes. Ideas for improving processes are identified. This step requires the most time and effort. Affected staff or people served are identified, data compiled, and solutions proposed. (For tools used during the planning stage, see sections “a” thru “k” in APPENDIX: A.)
- # **Do** - This step involves using the proposed solution, and if it proves successful, as determined through measuring and assessing, implementing the solution usually on a trial basis as a new part of the process.
- # **Check** - At this stage, data is again collected to compare the results of the new process with those of the previous one.
- # **Act** - This stage involves making the changes a routine part of the targeted activity. It also means “Acting” to involve others (other staff, program components or consumers) - those who will be affected by the changes, those whose cooperation is needed to implement the changes on a larger scale, and those who may benefit from what has been learned. Finally, it means documenting and reporting findings and follow up.

An evaluation is completed at the end of each calendar year. The annual evaluation is conducted by the clinic and kept on file in the clinic, along with the Quality Improvement Plan. These documents will be reviewed by the Office of Mental Health as part of the clinic certification process.

The evaluation summarizes the goals and objectives of the clinic's Quality Improvement Plan, the quality 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 quality improvement initiatives taken in response to the findings.

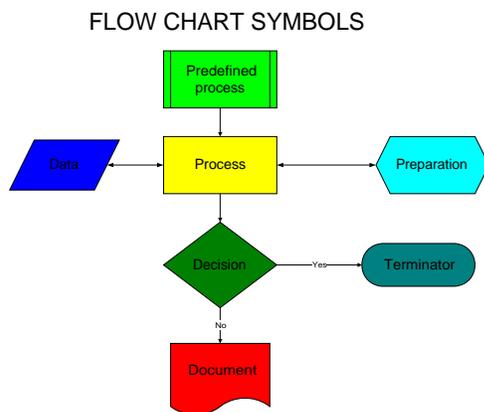
- # Summarize the progress towards meeting the Annual Goals/Objectives.
- # For each of the goals, include a brief summary of progress including progress in relation to training goal(s).
- # Provide a brief summary of the findings for each of the indicators you used during the year. These summaries should include both the outcomes of the measurement process and the conclusions and actions taken in response to these outcomes. Summarize your progress in relation to your Quality Initiative(s). For each initiative, provide a brief description of what activities took place including the results on your indicator. What are the next steps? How will you "hold the gains." Describe any implications of the quality improvement process for actions to be taken regarding outcomes, systems or outcomes at your program in the coming year.)
- # Recommendations: Based upon the evaluation, state the actions you see as necessary to improve the effectiveness of the QI Plan.

APPENDIX A. Quality Improvement Tools

Following are some of the tools available to assist in the Quality 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 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 judgement” 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:

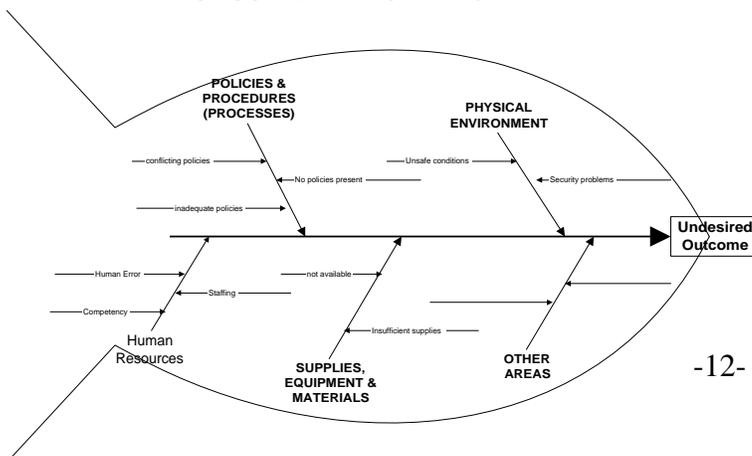
- 1) Sift through large volumes of data.
- 2) Encourage new patterns of thinking.

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 Ishikawa 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 quality 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 & EFFECT DIAGRAM



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) To 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.

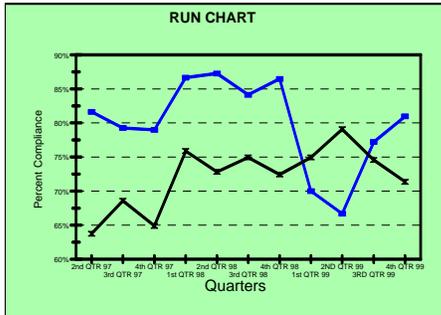


The “Pareto Principle” says 20% of the source causes 80% of the problem. Pareto charts allow the team to graphically focus on the areas and issues where the greatest opportunities to improve performance exist.

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:

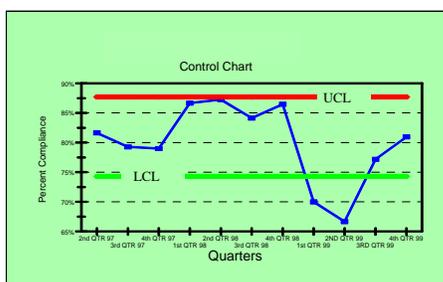
- 1) Understanding variation in process performance
- 2) Monitoring process performance over time to detect signals of change
- 3) Depicting how a process performed over time, including variation.



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

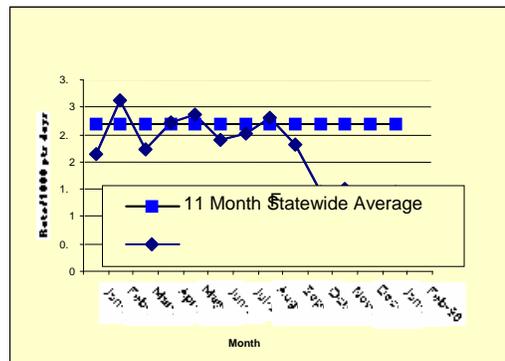
- i. **Control Chart:** A control chart is a statistical tool used to distinguish between variation in a process resulting from common causes and variation resulting from special causes. It is noted that there is variation in every process, some the result of causes not normally present in the process (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) Assess 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.