

BERKELEY COMMUNITY MENTAL HEALTH CENTER



QA/QI PLAN JULY 2007 - JUNE 2010

APPROVED BY BOARD OF DIRECTORS
April 12, 2007

Debbie Calcote

Debbie Calcote, MA
Executive Director

4-12-07

Date

Vicki J. Ellis

Vicki J. Ellis
Chairman, Board of Directors

April 12th, 2007

Date

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I. INTRODUCTION

Berkeley Community Mental Health Center is responsible for promoting the development of a mental health system that maximizes the quality of life of each client. Furthermore, it is the policy of the Center to deliver services to clients in the least restrictive manner possible.

Berkeley Community Mental Health Center is committed to developing and maintaining the highest possible quality of care. It is the intent of the Board of Directors that this policy shall be implemented through careful adherence to appropriate standards, statutes, rules, regulations and ethics. Berkeley Community Mental Health Center is responsible for the operation of a Quality Assurance and Quality Improvement Program that strives to monitor, protect, and enhance the quality of client care offered by the services of the facility.

Berkeley Community Mental Health Center attempts to fulfill its mission to the clients, staff, and community. The organization's leaders, managers, clinical support staff, clinical staff, medical staff, and nursing staff are committed to plan, design, measure, assess, and improve performance and processes as part of the approach to fulfill the mission.

As part of this commitment, the Quality Assurance and Quality Improvement Plan for Berkeley Community Mental Health Center has been established and modified as determined by the annual review.

This plan is designed to provide a consistent process for improving the care provided, improve satisfaction of our clients, compare performance against benchmarks, reduce inefficiencies, effect change harmoniously, and conserve resources. Quality Assurance and Improvement activity crosses all departments and services in order to respond to the needs of the client, staff, and community. Included in this system is the management of information which includes client specific, aggregate, and comparative data. In order to conserve resources, Quality Assurance and Quality Improvement focuses on high risk, high volume, problem prone, and regulatory required issues. Both outcomes and processes are included in the overall approach.

The continuous Quality Improvement process is a total facility approach. The program knows no boundaries. It crosses all functions, departments, employees, and focuses on incremental improvements and long term gains.

II. AUTHORITY

The Quality Assurance Program is established by the Executive Staff of the Berkeley Community Mental Health Center at the direction of the Board of Directors, who have ultimate responsibility for the quality of care and services provided.

Through Quality Assurance activities, the governing body is provided with information it needs in fulfilling the Center's mission and responsibility for the quality of client care. Quality Assurance initiatives are implemented by the Quality Improvement Team, a standing committee of professional and clinical support staff, headed by the Executive Director. There is a Quality Assurance Coordinator, appointed by the Executive Director, who is responsible for communication, coordination and dissemination of pertinent information to adjunct team members, chairs and other appropriate personnel. The Quality Assurance Coordinator reports to the Executive Director and serves on the Quality Improvement Team.

III. PURPOSE

Quality Assurance and Quality Improvement activities at Berkeley Community Mental Health Center are developed to ensure that this Center meets its responsibilities to clients, staff, and the community. Activities are designed to meet the following objectives:

- A. To assure that services rendered are within acceptable standards of practice.
- B. To provide a means whereby client care meets the highest possible standards within a clean, safe, and therapeutic environment.
- C. To promote efficient and effective services.
- D. To assure that the clinical and clinical support staff objectively and systematically monitor and evaluate the quality and appropriateness of important aspects of care and services on an ongoing basis.
- E. To assure that as problems or opportunities to improve care and services are identified, appropriate action is taken and follow-up occurs, resulting in problem resolution and improved care and services.
- F. To provide mechanisms for assuring accountability of each clinical staff member for the care they provide.
- G. To provide ongoing review and revision of the Quality Assurance and Quality Improvement program.
- H. To minimize risks within the Center through the development and implementation of risk management activities.
- I. To provide annual evaluation and revision as appropriate to the Quality Assessment and Improvement Program.

IV. ORGANIZATION

The Quality Assurance and Improvement Program is composed of the following standing committees:

- A. Program Managers Team
- B. Quality Improvement Team
- C. Safety and Risk Management Committee
- D. Utilization Management Committee
- E. Audit Team
- F. Physician Peer Review Team
- G. Staff Development Committee
- H. Cultural Competence Committee
- I. Corporate Compliance Committee
- J. Client's Rights Committee

The QA Coordinator is responsible for the coordination and integration of the Quality Assurance activities within Berkeley Community Mental Health Center and serves as a liaison among programs, services and other committees/teams. Supervisors within the Center are responsible for implementing an ongoing system to monitor and evaluate the quality and appropriateness of client care and services. The system encompasses the scope of care and services provided within each program. The QA Coordinator shall recommend specific responses and time frames for action to its findings and shall assess the effectiveness and efficiency of such actions after their implementation.

Program Managers Team

The Program Managers Team is composed of the Executive Director, Director of Administration, Director of Clinical Services and Nursing Services from the South Berkeley facility, Medical

Director, and the Program Directors of Adult Services, Child, Adolescent, and Family Services, and Crisis Intervention Services. The QA/QI Coordinator also serves on the team. Program Managers Team members are selected and assigned by the Executive Director. Program Managers Team meetings are held at least monthly. Additional Program Managers Team meetings with all supervisors are also held monthly. The Program Managers Team with all supervisors also functions as the Credentialing Committee.

Quality Improvement Team

The Quality Improvement Team is a standing committee composed of staff members who represent key elements of the Center. Team members are selected and assigned by the Executive Director and serve for at least one year. Selection is based on the needs of the Center, and strengths, knowledge, abilities, and skills, of individual staff members. All staff members have the opportunity to participate as a team member based on the needs of the QI Team and the Center. Other individuals may be asked to attend particular meetings based on the needs of the team. Standing membership includes: Program Managers Team, Quality Assurance Coordinator, and representatives from both locations, including, Access Center, Adult Services, CAF (Children, Adolescents, and Families), Clinical Support Services, and clients are represented by the Client Affairs Coordinator. Quality Improvement Team meetings are held at least monthly.

Safety and Risk Management Committee

The Safety and Risk Management Committee is a standing committee composed of, at a minimum, the Safety Coordinator, a Quality Assurance Coordinator, and nursing representative. A member from the Medical Staff may be appointed as an ad hoc member of the committee and will participate in committee deliberations as medical oversight and consultation is indicated. A client is asked to represent clients in the Center in all safety matters. Safety and Risk Management Committee members are selected and assigned by the Executive Director. Safety and Risk Management Committee meetings are held at least quarterly. The Quality Assurance Coordinator is responsible for directing the implementation, monitoring, and evaluation of all adverse incidents within the Center.

Utilization Management Committee

The Utilization Management Committee is an ad hoc committee composed of, at a minimum, Utilization Management Coordinator, nursing and clinical representation. A member from the Medical Staff may be appointed as a member of the committee and will participate in committee deliberations as medical oversight and consultation is indicated. Meetings are based on the needs of the Center, strengths, knowledge, abilities, and skills of the individual staff members. The Utilization Management Committee meets as needed for project reviews.

Audit Team

The Audit Team is a standing committee composed of QA staff and clinical staff members who represent various programs of the Center. Team members are selected and assigned by the Quality Assurance Coordinator and serve for two consecutive months. Selection is rotational and all staff members have the opportunity to participate as a team member. The Audit Team is responsible for auditing records from each service area and meets once per month.

Physician Peer Review Team

The Physician Peer Review Team is composed of the Medical Director, staff psychiatrists, staff nurse practitioner, and contract psychiatrists as needed. Physician Peer Review is scheduled monthly.

Staff Development Committee

The Staff Development Committee is composed of the designated Staff Development Coordinator and representatives from clinical and clinical support areas throughout the Center. Committee members are selected and assigned by the Executive Director and serve for at least one year. The Staff Development Committee meets as needed.

Cultural Competence Committee

The Cultural Competence Committee is composed of culturally diverse staff members among the clinical and clinical support areas throughout the Center. Committee members are selected and assigned by the Executive Director and serve for one year. The Cultural Competency Committee meets at least quarterly.

Corporate Compliance Committee

A Corporate Compliance Committee shall be appointed by the Executive Director and shall be chaired by the Corporate Compliance Officer (CCO). In addition to the CCO, committee membership, at a minimum, includes Executive Director, Director of South Berkeley office, Medical Director, Program Directors of Adult Services and CAF Services, and the QA Coordinator. Other knowledgeable persons who represent accounts receivable, utilization review, financial, clinical, human resources, etc, as determined by the Executive Director, may be included in the committee activities. The Committee shall meet no less than ten times a calendar year.

Client's Rights Committee

The Client's Rights Committee is composed of the designated Client Advocate and representatives from clinical and clinical support areas throughout the Center. Committee members are selected and assigned by the Executive Director and serve as needed. The Client's Rights Committee meets as needed when efforts to process advocacy issues are not met to the client's satisfaction by the Client Advocate.

V. SCOPE

The scope of the Quality Assurance Program shall encompass all clinical services, clinical records review, utilization review, and review of safety/risk management data. The following teams and committees are established to routinely organize, manage, monitor, and report on aspects of care and critical areas of operation. Membership is designated by the Executive Director based on the strengths and abilities of individuals and what is in the overall best interest of the organization. Berkeley Community Mental Health Center's Quality Assurance program focuses on the quality of care areas concerning the delivery and outcome of treatment of direct and indirect clinical services. Admission and continued stay reviews are conducted according to admission and continued stay criteria established according to Center. The scope of Quality Assurance and Quality Improvement activities also includes:

A. Monitoring and Evaluation System

Quality Assurance and Quality Improvement monitoring activities include:

1. Medical Records Completeness Reviews
2. Medical Records Quality of Care Reviews
3. Medical Records Billing Audits
4. Corporate Compliance Audits
5. Utilization Review
6. Clinical Outcome Review - including development, implementation, and report of efficiency and effectiveness measures within each service area.

7. Consumer Satisfaction Review
8. Review of Service data and Reports

B. Scope of Committee/Teams

Program Managers Team

The responsibilities of Program Managers Team include:

1. Implementation of SCDMH Directives.
2. Approves and directs implementation of agency policies and operational procedures.
3. Approval of Credentialing and Clinical Privileging standards.
4. Ensures that client care and services meet all state, federal, regulatory and accreditation standards.
5. Review and approval of Credentialing and clinical privileging activity including:
 - a. Review all privileging applications and documentation.
 - b. Designation of privileging status of clinical staff members.
 - c. Ensure credentials folder of each clinician is updated at least annually and includes: Curriculum vitae, copy of diplomas, copy of licenses/certification, including current renewals, delineation of professional service privileged to render, and Quality Assurance data pertinent to the individual's pertinent practice.

Quality Improvement Team

The Quality Improvement Team is also involved in planning, prioritizing, strategy development, monitoring, educating, and promoting the acquisition and application of the knowledge necessary for improvement of quality. This includes recommendations for any special teams, committees or task forces chosen to address specific opportunity for improvement. Quality Improvement or project teams may be utilized to facilitate and assess progress towards goals and objectives specified in the Strategic Plan. This strategic plan is based on community and client needs of Berkeley County. These recommendations are provided to the Quality Improvement Team whose responsibilities include:

1. Organizational planning and performance improvement.
2. Review and evaluate program goals and objectives to ensure coordination with the overall philosophy and purpose of each program.
3. Initiate continuous Quality Improvement Teams by suggesting initial membership appointments, identifying mission and objectives, and to assure adequate resources to facilitate effective team functioning. Work groups will encourage participation of staff from all levels in the organization.
4. Review, monitor and evaluate short and long term outcomes within each program, as well as center-wide.
5. Review, monitor and evaluate aspects of care dealing with the rights of the person served and client satisfaction.
6. Review, monitor and evaluate aspects of staff development and overall satisfaction.
7. Initiate teams in the areas of:
 - a. Client satisfaction
 - b. Clinical Outcome/Effectiveness
 - c. Development of Clinical Practice Guidelines
 - d. Other projects or areas as determined appropriate
8. Identify and reduce structural barriers to the quality improvement process.
9. Facilitate smooth and consistent operation between teams, committees and programs to promote organizational quality in the delivery of services to persons served.

Safety and Risk Management Committee

The Safety and Risk Management Committee is responsible for investigating and reporting on specific functions and aspects of care dealing with risk management issues. Adverse Incidents are investigated, evaluated, and reported on a quarterly basis as a minimum, and monthly where feasible. This information will be utilized on a routine basis to improve accessibility, health, safety and other pertinent risk management issues that have a direct, or indirect, impact on the community, clients, staff, and the Center as a whole. These functions and responsibilities are systematic and ongoing to include appropriate and timely responses for addressing areas of concern or deficiency.

A reportable incident is defined as any unusual occurrence outside of the normal activities of the facility. Incidents are reported whether they occur within the facility, the parking lot, or other areas of the community. Examples of reportable incidents include, but are not limited to:

1. Injuries or accidents of clients, visitors, or staff.
2. Any medical emergency involving a client, visitor, or staff which requires first aid or medical assistance.
3. Any evidence of burglary/theft from the Center, its clients, staff, or visitors.
4. Accidents which do or do not result in an injury, i.e., slipping on a walkway, falling, etc.
5. Potential safety or health hazards observed.
6. Threats of any nature, i.e. telephone, verbal, directed towards clients, staff or visitors.
7. Any incident which gives cause for concern for the welfare of clients, staff or visitors.
8. Instances of abuse or neglect, including reports to Department of Social Services.

In addition to investigating critical incidents for tracking as defined above, certain major incidents of a more urgent nature may be referred for a Quality of Care Review Board (QCRB) in accordance with the Berkeley Community Mental Health Center Policy and Procedures for Quality of Care Review Boards (S057). The Executive Director may appoint a QCRB to respond to incidents such as:

1. Homicide involving a client, staff or visitor.
2. Suicide of an active client or staff member.
3. Major injuries to clients, visitors or staff.
4. Any other major occurrence or tragic event at the discretion of the Executive Director.

The goals of the Safety and Risk Management Committee include:

1. To assure implementation of a Center wide safety program which includes development of policy and procedures and subsequent staff training relating to fire safety, disaster preparedness, hazard reporting, etc.
2. To assure tracking and documentation system for all incidents, including follow up and implementation of any corrective action until follow up is no longer indicated.
3. To review safety and incident related data and to identify trends and patterns associated with risks or to identify problem areas.
4. To conduct root cause analysis on incidents as appropriate.
5. To provide thorough investigation on all sentinel events.
6. To promote quality improvement activity through identifying opportunities towards maximizing safety of physical and therapeutic environment and reducing Center, staff and client risks.

Utilization Management Committee

The responsibilities of the Utilization Management Committee include directing the implementation, monitoring, and evaluation of trends and patterns pertaining to Utilization Management within the Center. The Utilization Management process uses various ongoing and systematic techniques related to specific aspects of care delineated in the DMH Audit and Utilization Review Tool. This committee meets as needed and at the direction of the Executive Director.

Audit Team

The responsibilities of the Audit Team include ongoing monitoring and professional review of a representative sample of opened and closed medical records of persons served across all programs. Clinicians utilize the DMH audit and utilization review tool to review medical records for Corporate Compliance, Quality Assurance and accuracy. Each clinician serves a two month term for this team which meets monthly.

Physician Peer Review Team

The responsibilities of the Medical Staff Committee include:

1. Physician Peer Review
2. Approval and implementation of medical management related procedures
3. Review/management of physician utilization

Staff Development Committee

The Staff Development Committee meets as needed to plan for assessment of staff training needs and assure that the mechanisms are in place to maximize compliance with minimum training requirements and the provision of training opportunities to meet priority needs identified by staff. Specific responsibilities of the Staff Development Committee include:

1. Identification of training needs of clinical and clinical support staff.
2. Promote staff awareness of internal and external training opportunities.
3. Identify opportunities and strategies for enhancement of staff development activities.
4. Plan required training opportunities through in-house training.

Cultural Competence Committee

The purpose of the Cultural Competence Committee is to:

1. Heighten staff awareness of the importance of a person's culture in the treatment process.
2. Make staff aware of their own biases and beliefs, to challenge thought processes and to raise awareness of other cultures/belief systems.
3. Examine existing cultures/belief systems in our catchment area and educate staff about these cultures and how we can better serve/understand these cultures in the role of counseling and treatment.
4. Plan required training opportunities through in-house training.

Corporate Compliance Committee

The purpose of the Corporate Compliance Committee is to:

1. Advise regarding and implement all aspects of corporate compliance.
2. Examine existing standards and procedures, assess alternative courses of action, determine a course of action and implement the necessary policies and procedures.
3. Design and implement a monitoring program consistent with Corporate Compliance Plan utilizing the DMH Audit Tool.

Client's Rights Committee

The purpose of the Client's Rights Committee is:

1. To ensure effective resolution of client concerns and/or possible rights violations that the Client Advocate cannot address to the client's satisfaction.
2. To advocate for the rights of the persons served.

C. Records, Reports, and Dissemination

1. All teams and committees integrated into QA activities shall submit written data summaries relative to their respective areas on a quarterly basis. These summaries shall include all findings, recommendations, actions taken, results of action taken and any other relevant information as deemed appropriate. These summaries will be formally reviewed by the QI Team and Board of Directors.
2. The Quality Assurance Coordinator is responsible for communication, coordination, and dissemination of pertinent information to all team members, committee chairs, supervisors, and other appropriate personnel.
3. A written report of all pertinent QA activities is prepared by the QA Coordinator and submitted to the Executive Director on a quarterly basis. The report is then submitted to SCDMH, Quality Assurance Division.
4. Committee chairpersons and/or project team leaders will participate in presentation of summaries to the Board of Directors through written reports and participation in Board meetings when required.

VI. OBJECTIVES OF PERFORMANCE IMPROVEMENT ACTIVITIES

Berkeley Community Mental Health Center is making the transition from QA to QI, towards expanding traditional Quality Assurance activity to include organization performance improvement. The Center is in the process of developing the essential components of a continuous quality improvement program. The facility has determined that a strong Quality Improvement program with supplementation by improvement/design teams is the most effective use of current resources. The main emphasis is to improve the quality of the organization in fulfilling its mission and vision addressing efficacy, appropriateness, availability, timeliness, effectiveness, continuity, safety efficiency, respect and caring. These components include, but are not limited to:

- A. Enhancement of the performance improvement program from past experience.
- B. Focus on efficiency of the processes and desired outcomes (benchmarking).
- C. Collaboration of activities.
- D. Education/training on identified issues.
- E. Use of improvement teams for complex issues

Performance improvement activities are part of the everyday duties of the staff throughout the facility. Berkeley Community Mental Health Center attempts to provide interdisciplinary improvement collaboration for the purpose of improving continuity of care and efficiency. When an individual's performance is questioned, evaluation and recommendation for action will be done through peer review, according to protocol and standards within appropriate clinical management procedures and Human Resources guidelines.

VII. CONTINUOUS QUALITY IMPROVEMENT MODEL

The Program Managers Team and Quality Improvement Team provide direction for planning, strategy development, monitoring, educating and promoting the acquisition and application of the knowledge necessary for improvement of quality. This includes guidance to any special teams or

task forces chosen to address specific opportunity for improvement through the use of Total Quality Management and Continuous Quality Improvement philosophies and strategies.

Berkeley Community Mental Health Center employs a systematic approach for improving the organization's performance by improving existing processes. The departments/committees involved in the review of performance activity will make decisions on what improvement needs to be made. In cases where priorities need to be set, assistance may be obtained from committee, team or organization leaders.

A. Measurement

Performance measurement will be continuously and consistently monitored. Monitoring will focus on client care processes and outcomes. The focus will include components of the process which will look at performance (including individual), coordination, integration, outcomes and improvement.

A variety of analytical tools may be utilized to evaluate the total care provided. Data sources include, but are not limited to:

1. Medical Records
2. Special studies
3. External Reference Databases
4. Incident Reports
5. Statistics and historical patterns of performance
6. Peer Review
7. Monitoring results
8. Consumer Satisfaction Questionnaire
9. Safety Statistics
10. Infection Control Data
11. Referral sources
12. Cost Analysis

Repeated measurement over time allows a focus on the process' stability or a particular outcome's predictability. All departments and committees will be responsible for gathering data on their performance which addresses the needs, expectations, and reaction of clients and staff. Each service area gathers data on identified high risk, high volume, problem prone, and regulatory required items as the major focus of their QI program.

B. Improvement Cycle

The following performance improvement cycle will be utilized in the development of project and departmental quality improvement activities:

1. **Planning** - Identification of goals related to improving performance.
2. **Design** - Identification of processes, functions and service consistent with the organization's mission, vision, and plan.
3. **Measurement:**
 - a. Defining responsibility and scope of services.
 - b. Defining and prioritizing internal and external customers.
 - c. Defining critical aspects of performance and improvement (availability, efficiency, effectiveness, satisfaction, safety, respect and caring).
 - d. Defining indicators - goals or benchmarks.
4. **Assessment** - Collection of data essential to facilitate improvement.
5. **Improvement** - Establishing priorities for improvements and innovations.

It is the intent of Berkeley Community Mental Health Center to be proactive in improving care and processes. Improvements to care and efficiency are the expected outcome of the QI program. The process and all activities are to support that intent. The process is to make good things happen in a constructive way and not just to engage in the activities.

C. Assessing the Process

Berkeley Community Mental Health Center has a systematic process for assessing the collected data (measurement) in order to achieve quality care delivery that is available, timely, effective, continuous, safe, efficient, and caring. These measurements will look at the performance of the process over time and make comparisons to internal and/or external data sources as available and appropriate.

The following mechanisms are utilized for reviewing and assessing client care:

1. Peer Review Reports
2. Risk Management Reports
3. Quality Improvement Reports such as Consumer Satisfaction and Clinical Outcome Reports
4. Recommendations of Committees or Project Teams
5. Medical Records Audits and Completeness Reports as indicated

Evidence of assessment may be found in records of meetings, reports of assessment, conclusion and strategies, medical records documentation, as well as education and training records.

VIII. METHODS

Each team member, coordinator, or supervisor has the responsibility to monitor, evaluate, and report on activities within their respective areas of responsibility. The method for conducting these QA measures is a planned, systematic and ongoing process to thoroughly and consistently maintain and improve the overall quality of care and service provided, as well as to improve the organizational quality.

A. Monitoring

The monitoring process is designed to identify patterns and/or trends in effectiveness and efficiency of care and service delivery, significant clinical events, risk management issues, utilization management issues, and outcomes of care and services.

B. Evaluation Process

The evaluation process is designed to determine the presence or absence of an opportunity to improve on an aspect of care, a problem in the quality and appropriateness of care, and to determine how to interpret, address, and resolve problem areas.

C. Aspects of Care

Aspects of care are routinely identified, implemented, and measured based on critical areas of importance, both internal and external to the Center. They are further defined by their effect or impact on clients, staff, and community, their frequency of occurrence, and risk areas to all those involved with the Center.

D. Indicators

Indicators are routinely established to monitor specific criteria with each aspect of care. These are objectively measurable and based on current baseline data. These should reflect processes of care and services and/or outcomes of care and services.

E. Thresholds

Thresholds should be established for each indicator to utilize for cutoffs to measurements and levels of acceptability.

F. **Data Collection**

Data is collected and assimilated for each indicator at a minimum of quarterly, and monthly where feasible. Formal reports of the data and findings are compiled and formally presented quarterly.

G. **Action Taken**

Results of data collection and recommendation for actions to take are routinely incorporated into the decision making process of programs and governing authorities.

IX. CONFIDENTIALITY

The deliberations and findings of the Quality Assessment and Improvement related committees or project teams are confidential in nature. Client related information and staff related findings follow the guidelines within the SCDMH Confidentiality Policy. Relevant staff related from Quality Assessment and Improvement activities are considered in renewal/revision of individual clinical privilege and appraisal of non-clinically privileged staff members.

X. ANNUAL EVALUATION

The Quality Assessment and Improvement Program is to be evaluated annually by the Quality Improvement Team and the Executive Team, or at any time such action is indicated. The annual evaluation data will be incorporated in the Center's Annual Management Report, which is prepared at the end of the year. The Management Report is sent to the Board of Directors via the Executive Director. As a result of the review, the Quality Assurance and Improvement Plan is revised each fiscal year based on activities as documented in the Annual Management Report.

APPENDIX A - SERVICE REPORTS AND DISSEMINATION

Monthly:

1. Caseload Report
2. Utilization Review Report (date of last service, last assessment, last PMA)
3. Financial Review Due Date Report
4. Plan of Care, Outcomes, GAF Report (given one month before due date)
5. No Show Reports
6. Court Ordered/Probation and Parole Lists for review and update
7. Productivity Reports for previous month
8. CIS update report
9. Incident Report Summary/Risk Management
10. Financial/Risk Management Report
11. Special Committees Reports
12. Personnel Update

Quarterly:

1. QA Audit Report for previous quarter
2. Committee Reports (see QA/QI plan)
3. Review of Ineligibles
4. Self Pay Process
5. IPS Update
6. Technology Report
7. Resource Plus Committee Update
8. Community Education and Prevention

Bi-annual:

1. Centerwide Outcomes Report
2. Update for Strategic Plan Objectives

Annual:

1. Risk Management
2. Annual Management Report including Outcome Reports
3. Accessibility Plan Update
4. After Hours Review