Board of Directors Meeting
Wednesday, June 22, 2022 11:00 a.m.
Virtual GoToMeeting

AGENDA

	Action Needed	Attachment
Roll Call		
CALL TO ORDER		
APPROVAL OF MINUTES	✓	✓
PRESIDENT'S REPORT		
Board Self-Assessment		*
DIRECTOR'S REPORT		
Stover properties update		
PROGRAM / QI COMMITTEE		
QI Plan and Goals	✓	✓
FINANCE		
Financials	✓	✓
Front Street vendor bids	✓	✓
16 W. Long Street vendor bids	✓	✓
Credit approval	✓	✓
HUMAN RESOURCES COMMITTEE		
Privileging Daniel Bloch, MD (addiction medicine)	✓	
Re privileging Maria Moreno, MD (psychiatrist)		

Good Things

Southeast has been selected as a subsite of The RISE Center VISTA Project through Columbus Metropolitan Housing Authority. We have been awarded 2 (two) VISTA members to serve from August 2022 – August 2023. One Vista will serve at Friends of the Homeless; the other will serve in the Community Catalyst Project and be located at Franklin Station. This project brings together United Healthcare, Columbus Metropolitan Housing Authority, PrimaryOne Health and Southeast with a focus on healthy metropolitan housing communities on the near-in west side of Columbus.

Ann Shelly, a volunteer with the Southeast Navigators Program (Navigators help people get access to good, affordable health insurance, Medicaid, and healthcare in general) was selected for a City of

Columbus CARE award. The CARE Coalition helps individuals, families and neighborhoods become healthy and strong again after something bad happens. They build up individuals and families in a crisis and help build up entire neighborhoods.

*denotes emailed

Board of Directors
Meeting Minutes
May 25, 2022 11:00 a.m.

Virtual via GoToMeeting

Members Present:
Tony Burns, Chair
Angela Fry, VP
Dave Lane, Immediate Past Chair
Eileen Goodman, Secretary
Kori Manus, Treasurer
Pat Halaiko
Kate Hamilton
Steve Sielschott
Don Strasser

Members Excused:
Kim Krone
Tim Wheat

Members Absent:

SE Staff:
Bill Lee, CEO
John Bell, CFO
Abul Hasan, Medical Director
Kim Cooksey, Clinical Director
Jenny O'Leary, Delaware Morrow Clinical Director
Melissa Miller, HR Director
Melissa Powers, Regional Clinical Director
Myken Pullins, Exec Assistant & PR Director
Nisaa Robinson, Adult and Family Clinical Director
Sandy Stephenson, Chief Healthcare Officer
Wendy Williams, Chief Operating Officer

Staff excused:

Call to Order: Rev. Tony Burns called the meeting to order at 11:00 am.

Steve Duraney, team leader for Ehits ACT team, ACT evidence based model gave a presentation on the program. Steve described a case study of a person with limited connections and was homeless and described his successful treatment outcome.

Approval of Board Minutes – Rev. Tony Burns moved to approve the board minutes from April 2022. Bill Lee asked for an amendment to minutes noting the Delaware ethics commission said it's not illegal but it's their decision not to have a staff person on a board. Dave moved to approve the amended minutes and Kori Manus seconded. All in favor.

President's Report – Rev. Tony Burns advised the board members that member Timothy Wheat recently had surgery for colon cancer and at The James Cancer Hospital in Columbus Ohio. We send him well wishes for a speedy recovery and the board would like to send a planter for comfort.

Executive Committee Minutes from April 13, 2022 and Ratification of Community Housing Network (CHN) application – Community Housing Network (CHN) provides permanent supportive housing (PSH) to individuals and families affected by disabilities and other special needs. For FY23, Southeast is applying for funding to continue providing resident engagement and supportive services at Briggsdale Apartments and Parsons Avenue apartments.

Motion - Dave Lane moved to ratify the submission of an application by the City of Columbus requesting $150,000 in funding for one year of programming in accordance with the application guidelines; FURTHER RESOLVED, the Board of Directors of Southeast Healthcare hereby authorizes the CEO to prepare, sign, and submit all documents required for inclusion in the proposal, and to execute all subsequent agreements necessary to receive funding. Kate Hamilton seconded the motion. All in favor.

Director's Report

Bill Lee reported the contracts submitted to Belmont, Harrison and Monroe Counties (BHM) Mental Health and Recovery Board and Delaware - Morrow County Mental Health and Recovery Board were received and approved for the full amount.

The Joint Commission surveyors visited Southeast Healthcare in person and completed the anticipated site visit. The board session was with Rev. Tony Burns, Steve Sielschott, Tim Wheat, Kori Manus and Angela Fry and it went well. Thank you for participating.

Jen Fraioli stated there was a lot of preparation go into the site visit and described the surveyors who attended were able to provide guidance.

PROGRAM / QI COMMITTEE

FY22 HRSA Accelerating Cancer Screening – Jen Fraioli presented the funding opportunity. RESOLVED, the Board of Directors of Southeast Healthcare hereby approves the submission of an application to HRSA requesting up to $500,000 in FY2022 Accelerating Cancer Screening Funding; FURTHER RESOLVED, the Board of Directors of Southeast Healthcare hereby authorizes the CEO to prepare, sign, and submit all documents required for inclusion in the proposal, and to execute all subsequent agreements necessary to receive funding. Don Strasser moved to approve, and Kori Manus seconded. All in favor.

CMS Navigator Grant Non-Competing Continuation (due 5/31) – Jen Fraioli presented the funding opportunity. RESOLVED, The Board of Directors of Southeast Healthcare hereby approves the submission of an application to the Centers for Medicare and Medicaid Services for up to $333,563 to provide Medicaid and Marketplace outreach and enrollment, and other access to care services; FURTHER RESOLVED, the Board of Directors of Southeast Healthcare hereby authorizes the CEO to prepare, sign, and submit all documents required for inclusion in the proposal, and to execute all subsequent agreements necessary to receive funding. Pat Halaiko moved to approve, and Dave Lane seconded. All in favor.

2021 UDS report/UDS FQHC Data Performance Summary - Jen Fraioli presented the funding opportunity and noted Southeast submitted Uniform Data System (UDS) data in February 2022 for calendar year 2021. There was a total of 8,431 patients that qualified for the UDS, and 4,898 patients who had medical services. This is an increase over the past two years. Dave Lane

moved to approve the summary report as presented and Steve Sielschott seconded. All in favor.

FY22 HRSA American Rescue Plan/UDS+ Funding (FYI) - Jen presented the funding opportunity. Proposed Action: RESOLVED, the Board of Directors of Southeast Healthcare hereby approves the submission of an application to HRSA requesting up to $60,000 in Fiscal Year 2022 American Rescue Plan Uniform Data System Patient-Level Submission (ARP-UDS+) Supplemental Funding; FURTHER RESOLVED, the Board of Directors of Southeast Healthcare hereby authorizes the CEO to prepare, sign, and submit all documents required. Dave Lane moved approve and Kori Manus seconded. All in favor.

Patient Advisory Committee Input/Updates – Sandy Stephenson stated that we have reinstated a patient family advisory committee for Franklin County, Delaware & Morrow, Eastern Ohio including Belmont, Harrison, Monroe, Tuscarawas and Carroll. The committee is in the formation stages and we are in the process of choosing a chair. Committee functions are looking at data for the CCBHC grant and will provide input from the Program Committee.

Finance Committee

Kori Manus asked John Bell to report on the financials. John Bell commented on the investments and stated we had a major slide and thinks we are at the bottom or nearing the bottom of this. We did expect the pullback.

Motion - Kori Manus moved to approve the financials as presented. Dave Lane seconded. All in favor.

Kori Manus presented the procurement summary for replacement of heat pumps 2-1 and 2-2. Units were originally installed around 1985 and have reached the end of their life-cycle. Vendors (attach bids): Enervise Total Cost: $26,671.00 and Speer Mechanical Total Cost: $26,228.00

Vendor Recommended: Speer Mechanical

Motion - The Southeast Board selects Speer Mechanical to replace two heat pumps for 16 W. Long St. not to exceed $28,850. Kori Manus moved to approve. Dave Lane seconded the motion. All in favor.

HUMAN RESOURCES COMMITTEE (HR)

Pat Halaiko reported the HR committee reviewed privileging for the following staff positions.

Dr. John Garrity – Psychologist
Leann Greer – Prevention Specialist
Esther Conteh – Therapist
New Privileging – Brittany McCune, Pharmacist
Sally Hough, Nurse Practitioner
Jose Para, Nurse Practitioner
Monica Davis, Therapist
Eric Taube, Therapist

Motion - Pat Halaiko moved to approve the staff members for privileging and re privileging. Kori Manus seconded the motion and the motion passed.

Good Things -

For mental health awareness month Myken Pullins and Lauren Pond were interviewed by 10TV and production came out to the studio in Franklinton to interview them and the artists. A link will be sent to the board to watch the video.

ADAMH is sponsoring Southeast by showing a film documentary called Apart that follows three women incarcerated in Cleveland Ohio as they prepare to return home from prison and work to rebuild their lives after being separated from their children. The screening event will be held on Tuesday, July 26 5:00 at Capital University. More details to follow.

Adjournment – Dave Lane moved to adjourn the board meeting and Kori Manus seconded. All in favor.

Executive Session - Staff were excused from the Board meeting in order for the board to go into executive session

Board Minutes submitted by Myken Pullins, executive assistant for Eileen Goodman, secretary.

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Eileen Goodman, secretary

Board Motion

Program Quality Improvement Committee

Revised Quality Improvement/Quality Assurance Plan and Goals SFY 2023

June 2023

Background:

To meet HRSA and Joint Commission standards the Quality Improvement/Quality Assurance Plan and Goals must be reviewed and approved by the Southeast Board annually.

Changes to the QI plan on pages 5 and 9 are identified using track changes. There are no changes to the Radiation Plan.

The plans and goals have been reviewed by our lead dentist and Quality Council and both are recommended by the Quality Council.

Recommended Motion:

The Southeast Board has reviewed and approves the Southeast Healthcare SFY 2023 Revised Quality Improvement/Quality Assurance, Radiation Plan and Goals

Quality Improvement/Quality Assurance Plan
SFY 2023~~2~~

Southeast Healthcare
Quality Improvement & Quality Assurance Plan
SFY 2023~~2~~

CHALLENGE AND PHILOSOPHY

Southeast Healthcare strives to promote a culture of quality that includes an organization-wide management and staff philosophy of continuous Quality improvement (QI) and Quality Assurance (QA) in service delivery, operations and population health outcomes. The Quality Improvement Quality Assurance (QI/QA) Program provides a framework by which Southeast can assess, measure, and improve the quality of services.

The QI/QA Program focus includes but is not limited to: clinical care, patient satisfaction, safety, operations, financial stability, management of resource utilization, risk management, and human resources development to ensure that services meet the needs and expectations of customers. The initiative is designed to assess and evaluate the quality and appropriateness of services and enterprise functions, to identify gaps/problems in service, and to promote opportunities to improve the various components of Southeast Healthcare operations.

SOUTHEAST MISSION

The Southeast Board of Directors developed the organization's mission statement to facilitate the following:
1) unify staff and Board members, 2) represent Southeast Healthcare to the community, and 3) be a policy tool for service planning purposes. Southeast Healthcare uses the Mission Statement to guide every aspect of our QI/QA Program. The mission statement is:

> *Southeast Healthcare is a comprehensive provider of mental health, chemical dependency, healthcare, and homeless services assisting diverse populations regardless of their economic status. With the belief that all people have the capacity to grow and change, we provide our services to people of all ages, cultures, races, religious preferences, genders, and sexual orientations in order to enhance wellness and recovery, thereby improving families, workplaces, and communities*

SOUTHEAST VALUES

1. An organizational and individual commitment to the value and legitimacy of people, including but not limited to race, gender, sexual orientation, veteran status, disability, religion, age, and socio-economic diversity of people and communities.

2. Patient-centered services that focus on what the patient needs and/or wants, the patient's culture, and that consider the patient's emotional, mental, physical, and spiritual well-being.

3. A "no eject, no reject" clinical policy and practice.

4. A primary focus on patient strengths, including families and communities, in assessment, treatment planning, and treatment provision processes.

5. Programs and services that are accessible, available, appropriate, and acceptable to persons served by Southeast.

6. Respect and advocacy for patient rights and dignity.

7. A customer service and satisfaction focus with the customer being broadly defined.

8. A commitment to quality improvement in our organizational and service environments for our staff and patients.

9. A commitment to operate with fiscal and operational efficiency and effectiveness.

10. A commitment to the support and development of all staff to reach their maximum potential.

PRINCIPLES OF THE SOUTHEAST QUALITY IMPROVEMENT PROGRAM

- **Leadership Involvement**. Strong leadership, direction and support of quality Improvement activities by the governing body and CEO are key to Quality improvement.

- **Customer Focus**. Meeting or exceeding needs and expectations of internal and external customers.

- **Recovery-oriented**. Services are characterized by a commitment to promoting and preserving wellness and expanding choice to meet individually defined goals and to support person-centered services.

- **Culture of Quality**. Involve people at all levels of the organization in improving quality and attaining desired outcomes. Quality is everyone's responsibility.

- **Data Informed Practice**. Using data to inform practice and measure results.

- **Prevention Over Correction**. Design good processes to achieve quality outcomes rather than fix processes after the fact. Appreciative Inquiry is one of the methods used to promote good process development.

- **Continuous Improvement**. Processes must be continually reviewed and improved. Small incremental changes do make an impact.

Responsibility, Authority, Structure

The Southeast Board

The QI/QA plan is reviewed and approved annually by the Southeast Healthcare Board of Directors. Through this process, the governing body gives authority for the implementation of this plan and all of its components. The Board's role is to monitor, evaluate and establish policy that supports improvements to care. Responsibility for managing the QI/QA Program is vested with the CEO, who holds responsibility for appointing a QI/QA Chair for the QI/QA program and Quality Council. The QI/QA Chair is responsible for the daily oversight of the program. The CEO informs the governing authority of the findings of QI/QA activities, monitors corrective actions identified by the Southeast Board, and reports progress back to the Board. QI/QA activity monitoring is documented in the Southeast Board's meeting minutes and is used for planning and improvement of enterprise functions.

The CEO:

- Designates the Chief Medical Officer to provide oversight for the QI/QA program and chair the Quality Council. The Director of Compliance works with the Chief Medical Officer to coordinate the design, implementation and evaluation of QI/QA functions.
- Ensures that the SE Board and Consumer Advisory Committees receive a written quarterly and annual QI/QA reports.
- Ensures that a summary of QI/QA findings is communicated to organization staff.

The Quality Council Chairperson holds authority and responsibility to:

- Implement the QI/QA Plan, directing the overall functioning, including performance improvement actions of the QI/QA Program and Quality Council.
- Chair Quality Council meetings.
- In consultation with the CEO, appoint Quality Council members as needed.
- Assign and delegate responsibilities not already provided for in the QI/QA Program.
- Assure evaluation findings are coordinated to identify areas that provide opportunities for improvement and/or may require further study.

In conjunction with the Quality Council Chair, the Director of Compliance is responsible for:

- Ensuring examination of findings of discrete activities are examined to detect trends that may indicate problems
- Ensuring annual evaluation of the Quality Improvement Program and revisions as needed.
- Preparation of monthly meeting agendas and distribution of materials for consideration prior to meeting.
- Assignment of staff/committees to effectively collect and evaluate data.
- Timely Quality Council review of Incident/Quality Improvement Reports and documentation of follow up.
- Recording, approval, and distribution of Quality Council meeting minutes
- Distribution of Quality Council findings to all appropriate persons and that the necessary follow-up occurs.
- Maintenance of complete, accurate records of all QI/QA functions and activities.
- Providing training on Quality Improvement for organization staff, including QI/QA orientation for new staff.
- Preparation and distribution of quarterly and annual reports for the Southeast Board, Patient Advisory Committees and other entities as required by contract or statute.

Quality Council

Quality Council is responsible for coordinating and integrating all Southeast Quality improvement efforts. The Quality Council structure is designed to encourage contributions from a variety of sources, facilitate accountability, and ensure follow through on improvement efforts. (See Southeast Healthcare Quality Council Organizational Chart below). QI/QA activities are integrated into Southeast's overall management process through posting and dissemination of QI/QA reports to staff and board members and through information sharing in staff meetings, treatment services supervision meetings, and patient advisory groups. Overall Quality Council functions include:

1. Determining areas of focus and performance goals for high -cost, high- risk, high -volume and problematic areas of operation using standardized indicators based upon the systematic, ongoing collection and analysis of valid and reliable data.
2. Comparing current and past performance to local, state and national benchmarks when available. Performance indicators are used to identify and measure the variation between desired and actual performance.
3. Requesting and analyzing report findings from committees involved in QI/QA activities to identify trends and patterns, and look for opportunities to improve the system.
4. Assigning responsibility for determining actions to be taken as a result of findings from reviews and for monitoring follow through. Determining where findings are to be channeled to reach the most appropriate user of the information.
5. Monitoring major review activities to ensure that assigned responsibilities are being fulfilled in accordance with the overall QI/QA Program.
6. Assuring that work is completed in a timely manner. Evaluating and updating the QI/QA Program and identifying recommendation to the CEO and Board.
7. Each Quality Council member attending at least 75% of the Quality Council meetings.

Composition/Membership of the Quality Council

Quality Council is a multi-disciplinary committee with representation from a variety of programs, positions, professional disciplines and geographic areas. Rotating clinical leadership members and the line staff appointments will serve for a term of one year. Term of membership for other members is indefinite.

The Members of the Quality Council include:

Chief Medical Officer, Chair	Chief HR and EEO Officer ~~Director~~
Chief Executive Officer, CEO	~~Line~~ Staff Appointments
Chief Operating Officer, COO	Chief Healthcare Officer
Regional Clinical Director	BHM Site Director
FQHC Practice Administrator	Operations Manager
Director of Vocational Services	Infection Prevention Control Officer
FOH Director	TC Site Director
Grants Manager	~~Assistant Medical Director,~~ Primary Care Provider
SMD Clinical Director	Adult and Family Clinical Director
Compliance Quality Improvement Director	Clients Rights Officer
Southeast Healthcare Board Member	

The Quality Council delegates responsibilities for identified review activities to subcommittees, PDSA Teams, review units, or individuals (who report directly to the Quality Council). The various areas of the subcommittees may intersect with other committee functions and are not mutually exclusive. Rotating committee chairpersons will serve a one year term. The Quality Council chair will designate the membership of each committee. However, for structural purposes, the following table identifies the various subcommittees of the QC and their responsibilities.

<table>
<tr><th colspan="3">Quality Council Chair: Medical Director</th></tr>
<tr><td colspan="3">Clinical Care
Chair: Chief Medical Officer</td></tr>
<tr><td>▪ Clinical Measures/Guidelines
Primary Care
Behavioral Healthcare
Dental
Pharmacy
▪ Clinical Measures/Health Indicators</td><td>▪ Patient Right’s
▪ Consumer Input
▪ Peer Review
▪ Human Subjects Review
▪ Access to Care</td><td>▪ Case Review
▪ Utilization Management
▪ Coordination and Integration of Care
▪ Medication Management Committee</td></tr>
<tr><td colspan="3">Unusual Incidents
Chair: Rotating Clinical Manager</td></tr>
<tr><td>▪ Sentinel Events
▪ Reportable Incidents</td><td>▪ Mortality and Morbidity</td><td>▪ Good Catch/Near Misses</td></tr>
<tr><td colspan="3">Operations
Chair: Executive Staff / Chief Executive Officer</td></tr>
<tr><td>▪ Fiscal Metrics/Dashboards
▪ NextGen Implementation</td><td>▪ Improvement Projects:
Timely note completion
Productivity</td><td>▪ Efficiency of Service Provision
▪ Community Partner Feedback</td></tr>
<tr><td colspan="3">Environment of Care
Chair: Operations Manager</td></tr>
<tr><td>▪ Infection Control
▪ Emergency Management/Disaster Mitigation
▪ Life Safety</td><td>▪ Facility Inspections
▪ Vehicle Management</td><td>▪ Medical Equipment
▪ Emergency Equipment
▪ Radiation Generating Equipment (RGE)</td></tr>
<tr><td colspan="3">HR
Chair: Director of Human Resources</td></tr>
<tr><td>▪ Privileging/Credentialing
Re-privileging
Additional Privileging Requests
▪ Affirmative Action</td><td>▪ Training
Mandatory
Focused</td><td>▪ Customer Service
▪ Performance Appraisal
▪ Employee Satisfaction</td></tr>
<tr><td colspan="3">Compliance/Risk Management
Chair: Compliance/Quality Improvement Director</td></tr>
<tr><td>▪ HIPAA
▪ Audits</td><td>▪ Claims Management
▪ EHR Review</td><td>▪ Deliverables Compliance Rates
▪ Accreditation, Certification, Licensure</td></tr>
</table>

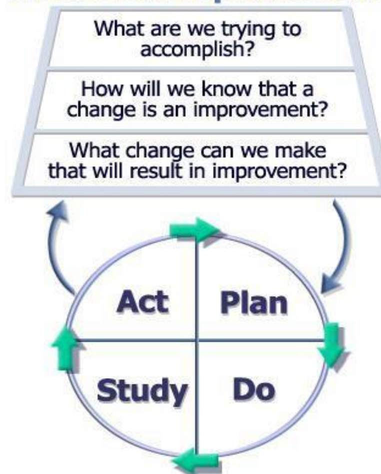
All **Southeast employees** are expected to participate in QI/QA activities through Quality Council, PDSA Teams that may be chartered as part of the six major QI categories when issues are identified and other activities to support the quality focus of the organization.

Quality Council Meetings

Quality Council meets monthly. Additional meetings may be called by QC Chair or the CEO. A simple majority of available Council members constitutes a quorum for the purpose of conducting business. Council minutes are taken and distributed for formal acceptance at the following meeting. After approval, minutes are distributed to all Council members, and/or other individuals, programs, or departments, as designated by the QC Chair. The committee will provide minutes to the Compliance/Quality Improvement Director for distribution. The Subcommittee chair is responsible for assuring the responsibilities of the committee are executed.

THE QUALITY IMPROVEMENT PROCESS

Southeast adopts the four step PDSA (plan, do, study, act) process for improving processes (goal-directed, interrelated series of actions, events, mechanisms, or steps). Quality Improvement (QI) is meant as the continuous study and adaptation of an organization's organization functions and processes to increase the probability of achieving desired outcomes and to better meet the needs of individuals and other users of services. Southeast will demonstrate quality improvement activities that are planned in a collaborative and interdisciplinary manner. Leaders use appropriate resources and involve those individuals, disciplines, and departments closest to the process, function, or service identified for improvement. Methodologies in the PDSA process are described below:



A. **PLAN:** Aim/Objective/Goal/outcome of the PDSA process. What do we hope to learn? What are we trying to improve (aim), by how much (goal) and by when. How will we know when we get to where we are going to meet our aims? How will we know that a change is an improvement? Will we use outcome or process measures?

1. These processes, functions or services include those identified as high cost, high volume, high risk, or problem prone, and are aligned with our mission, vision, and goals.

B. **DO:** How will we execute the plan section? Collect data. Also include observations, problems encountered

1. Data are collected for the purposes described above, in order to identify opportunities for improvement, identify changes that will lead to improvement, and sustain improvements.

C. **STUDY**: Summarize the results, analyze data (qualitative and quantitative). Did we get the intended outcome? If not, what changes need to occur?

1. Data shall be systematically analyzed on an ongoing basis using quality improvement techniques and display methods, as appropriate, which may include: 1) Run charts that display summary and comparative data, 2) Control charts that display variation and trends over time, 3) Histograms, 4) Pareto charts, 5) Cause-and-effect or fishbone diagrams, and other Quality improvement tools.

D. **ACT**: Summarize what was learned. Did we achieve the goal? Did we answer the questions we wanted to address?

1. Southeast will provide information to and gather feedback from staff, leaders, consumers and families about the redesigned processes and other changes.

E. Southeast will maintain documentation demonstrating utilization of the PDSA process.

SCOPE

The scope of the QI/QA Program encompasses all aspects of patient care and enterprise functions The QI/QA Program focuses on individual activities, review functions, and program structure. Its external focus looks toward enhancing relationships with community care providers, the overall community, and the system of care.

MEASURES

SEE ATTACHMENT A

CUSTOMER INVOLVEMENT

1. Patient Satisfaction surveys are conducted at least annually and the results are documented in QI/QA Reports; findings are shared with patients, staff, and funders.

2. Consumer focus groups are conducted at Southeast Healthcare Congregate Residential Programs at least quarterly. . Feedback from these focus groups is reported out to Quality Council quarterly.

~~3.~~ 3. Southeast's staff facilitate~~s~~ the Consumer Advisory Committee. Regional Consumer Advisory Committees meet monthly to focus on regional issues (One in Central Ohio and one in Eastern Ohio). Quarterly, the two groups come together to collaborate. The focus of their work

includes the following:, ~~and meets at least quarterly to:~~

a. Advise and inform the Quality Council on service needs and delivery of services
b. Review client/patient satisfaction and population data and make recommendation regarding service needs to the Quality Council
c. Assist with the recruitment of Committee members;
d. Make other recommendations regarding community issues and needs.

~~4.~~3. Patients and their family members are supported and encouraged to participate in the initial and ongoing treatment planning and review process.

REPORTING AND USE OF FINDINGS

Findings are used in the PDSA process to determine progress toward resolving problems and improving quality. Aggregate reports show program and organizational level findings while individual reports are generated for staff and teams. Quality Council analyzes data for patterns and trends, opportunities for improvement, and/or to minimize/mitigate risk.

Individual and Aggregate Reporting

Results of employee reviews through the peer and case review process will be shared with clinicians, teams and supervisors in accordance with peer and case review policies and procedures.

QI/QA reports incorporate the following elements:

- Description of the purpose of the review.
- Frequency of the review.
- Methodology of the review.
- Results of the review.
- Conclusions and analysis of the review.
- Recommendations for improvement (as appropriate).
- Communication of the review results.

Aggregate findings and results are compiled and reported through the QI/QA Committee structures. Reporting methods are discussed below.

- Quarterly and annual QI/QA Program reports are prepared by the QI/QA Compliance/Quality Improvement Director. These reports are distributed to and discussed with Southeast Board's Program Committee for presentation to the full Board.

- Summary reports are available to staff and patients. Reports are tailored to meet the needs of their intended audiences while respecting individual confidentiality.

Conflict of Interest Requirements

No Southeast staff member may participate in a Quality Improvement peer review activity in which he/she has direct service or case management responsibility. That is to say, no persons are permitted to review their own cases. All questions concerning possible conflicts of interest will be discussed with the QI/QA Committee Chairperson immediately.

Confidentiality Requirements

ORC 2305.251 protects the confidentiality of Quality Assurance (Improvement) documents and findings from unauthorized disclosure. Southeast staff members will respect the confidentiality of organization customers and sign a Confidentiality Statement upon employment with the organization (this statement is maintained in their personnel files). All patient information is considered confidential and may only be released to organizations or persons outside Southeast when appropriately authorized or so ordered by a court. QI/QA source data documents will never be subject to release and meeting minutes are maintained in a manner in which assures their confidentiality.

Staff involved in QI/QA activities are authorized to access clinical records based on the "need to know" principle; that is, staff may access only those clinical records which are assigned to them to review. In the course of any quality Improvement review activities, no staff member may breach any policy regarding patient confidentiality. Individuals who breach confidentiality will be subject to Southeast disciplinary procedures.

Data reported in the course of Quality Improvement review activities identifies patient cases and/or staff by number rather than name. In the case of patients, only case numbers may be used at meetings, in minutes and in reports. For staff members, code numbers will be used as a means of reporting individual and aggregate data.

INFECTION PREVENTION PROGRAM

The purpose of the Infection Prevention Program is to provide an environment that is safe for persons receiving care, treatment and services, as well as for employees and visitors. The overarching goal of the infection prevention and control program is to reduce risks of acquiring and transmitting infections by proactively preventing, identifying, reporting infections and evaluating the infection plan. The Infection Prevention and Control (ICP) Plan is included in Attachment B.

RADIATION SAFETY PROGRAM

The purpose of the Radiation Safety Program is to communicate administrative policy, operational procedures and standards of conduct regarding the use of radiation generating equipment (RGE) at Southeast Healthcare Services Dental Clinic. Policies and procedures and protocols regarding the Southeast RGE are addressed in Attachment E.

**QUALITY IMPROVEMENT/QUALITY ASSURANCE PLAN ATTACHMENT E-
RADIATION SAFETY PROGRAM**

The purpose of the Radiation Safety Program is to communicate administrative policy, operational procedures and standards of conduct regarding the use of radiation generating equipment (RGE) at Southeast Healthcare Services Dental Clinics.

The Radiation Safety Program of Southeast Inc. is designed to:

1. Protect patients, workforce, and the general public and environment from unnecessary exposure to radiation

2. Provide training and instruction to workers includes:
    a. The ALARA program and personnel radiation monitoring
    b. Safely and securely operating the X-ray equipment onsite
    c. Workers knowledge of emergency procedures and radiation detection equipment
    d. Inventory and disposal recordkeeping
    e. Self-reporting, corrections and enforcement of the program
    f. Annual Audits and inspections

Every Southeast Inc. employee that uses RGE shall be familiar with and comply with the provisions of the manual.

The Annual Audit

The RSO (Radiation Safety Officer) – Manager of the Radiation Safety Program, along with senior management, will annually conduct an audit of the Radiation Safety Program, as well as checking, reviewing and correcting any deficiencies. All copies of audits will be retained.

Organization & Scope of Program

The RSO will ensure that the original conditions and information on the license stays current, or when needed, file for timely amendments including address changes, new ownership (in advance), bankruptcies, and notice of a new and properly trained RSO.

The RSO will check to make sure that manufacturer operation & maintenance manuals are on hand for each type of RGE.

The RSO will make sure the gauges are used the way they are intended.

Radiography

Southeast, Inc. adheres to the American Dental Association's (ADA) guidelines for radiography. The policy will apply to all patients, regardless of age.

General Procedures

1. All dental radiographs will be taken using appropriate lead aprons.
2. Staff taking radiographs will have documentation of appropriate Radiology training as required by the State of Ohio.

Type and Frequency of Radiographs

The following radiograph recommendations are consistent with the American Dental Association (ADA) 2004 guidelines for dental radiographic examinations.

Radiographs will be performed at dentist's discretion. Dentist may delegate this discretion to staff members who have proper training.

See http://www.ada.org/sections/professionalResources/pdfs/topics_radiography_examinations.pdf for the full ADA Guidelines for Prescribing Dental Radiographs document. The recommendations are subject to clinical judgment and may not apply to every patient.

Equipment Monitoring and Evaluation

General Equipment Maintenance and Product Recalls

All dental equipment will be tracked within an inventory data base. Each piece of equipment will be monitored and checked per manufactures instructions. All new equipment will be logged and all warranties will be adhered to.

If the need for maintenance occurs, a licensed professional will be contacted. Once the equipment is repaired, the information will be tracked within the inventory database.

When the dental department receives notice that a product is subject to a recall the Lead Dentist will check lot numbers, serial numbers or other product designators, gather all affected products, and comply with manufacturer's instructions regarding the recall.

Radiologic Protection

Appropriate lead aprons will be placed over the patient for all radiographs. Lead aprons will be stored hanging; they will not be folded or creased when not in use, as this will increase the risk of holes or tears in the lead shield. Every year all lead aprons used for x-ray protection will be visually evaluated.
If there are kinks or irregularities upon inspections, a radiograph will be taken of the suspect areas. The image will be processed and examined for breaks in the lead lining. If irregularities are confirmed, a replacement lead apron will be ordered and the faulty one will be discarded. If no irregularities are confirmed by way of radiograph, the lead apron will be put back into normal use. Records of testing will be maintained by the operations department.

Staff members will visually check the surrounding area before beginning to take any radiograph to ensure there is a clear path of the radiation beam. The operator will also inform patients who are moving to and from the operatories to stand clear of the path of the x ray beam.

All RGE will be calibrated every three (3) years by Benco Dental and any findings will be corrected immediately. All calibration reports will be kept by the RSO.

Competency- The dental assistants shall yearly be evaluated by the Lead Dentist and Practice Administrator on their clinical radiographs and radiological safety according to the IHS radiological criteria for quality care.

A copy of the X-Ray Machine Certification is located in the dental binder at the front desk of the dental clinic. The master copy is located in the operations department.

Annually, Southeast sets targets to evaluate programs across the organization and as part of the organizational quality improvement plan. The purpose of the evaluation component measures is to monitor outcomes important to Southeast and set goals to improve. Some measures are created internally, and some are drawn from external reporting requirements. The evaluation areas and targets are set by Quality Council in consultation with the managers of each program and are approved by the Board of Directors each fiscal year.

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Primary Care

Name	Evaluation Area	Target
Childhood immunization status	Patients turning two during the measurement year will have completed identified immunizations.	50%
Tobacco use: screening and cessation	Patients 18 and older will be screened for tobacco use and, if identified as a user, will receive a cessation intervention.	90%
Tobacco use: screening and cessation	Homeless patients who use tobacco will receive a cessation intervention.	80%
Colorectal cancer screening	Patients aged 50-75 will complete a colorectal cancer screen.	32%
Cervical cancer screening	Women aged 21-64 will be screened for cervical cancer.	43%
Hypertension controlling high blood pressure	Patients aged 18-85 with hypertension will have a blood pressure reading ≤ 140/90mmHg.	69%
Diabetes A1c> 9 or untested	Patients aged 18-75 with diabetes will have a hemoglobin A1c score > 9% or missing.	32% (or lower)
BMI screening and follow-up 18+ years	Patients aged 18+ will have evidence of BMI percentile documentation and a documented follow-up plan when outside normal parameters.	71%
Child weight screening/BMI	Patients aged 3-17 will have evidence of BMI percentile documentation AND documentation of counseling for nutrition AND documentation of counseling for physical activity.	80%
IVD Aspirin use	Patients 18 years and older with an active diagnosis of IVD will have documentation of the use of aspirin or another anti-platelet.	85%
Statin therapy	Patients considered at risk of cardiovascular events will be prescribed statin therapy.	80%
HIV screening	Patients aged 15-65 will be tested for HIV.	65%
HIV linkage	Newly diagnosed HIV patients will be seen for a follow-up treatment within 30 days of HIV diagnosis.	90%
Breast cancer screening	Women between 50-74 years of age who had a mammogram within the 27 months prior to the end of the measurement period.	30%
Screening for depression and follow-up plan	Patients over 12 years of age will be screened for depression, and if positive, will have follow up plan documented in the chart on the day of the screen.	75%
Depression remission	Patients aged 12 years and older with major depression or dysthymia reached remission 12 months after the index event as evidenced by a PHQ-9 score equal or less than 5.	20%

Dental

Name	Evaluation Area	Target
Dental sealants	Children ages 6-9 years at moderate to high risk for caries will receive a sealant on a first permanent molar tooth.	40%

Behavioral Health

Name	Evaluation Area	Target
BH prescriber show rates - Ongoing	Increase BH prescriber appointment show rates.	70%
BH prescriber show rates - Eval	Increase BH prescriber evaluation appointment show rates.	58%
PHQ-9 reduction	Patients with a PHQ-9 score ≥15 with a minimum of 2 PHQ-9 screens in EMR will experience an improvement as evidenced by a reduction in their PHQ-9 score.	60%
PHQ-9 second screen	Patients with a PHQ-9 score ≥15 will have a second PHQ-9 screen completed with 30 days.	80%
CCBHC 3.3: Suicide rate	Decrease suicide rate per 1,000 patients.	30% decrease
Use of first-line psychosocial care for children and adolescents	Children and adolescents will have a minimum of 2 visits with the agency before prescribing antipsychotic medication.	50%
Use of Multiple Concurrent Antipsychotics in children and adolescents	Children and adolescents on multiple concurrent antipsychotics.	Less than 3%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Patients with an AOD diagnosis will begin treatment within 14 days of diagnosis (includes BOR and MAT patients).	51%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Patients who begin substance use treatment will have two or more additional services with 34 days of the initial visit (includes BOR and MAT patients).	23%
Metabolic Syndrome	Complete a PDSA and determine a goal.	9/1/22
7-Day Follow-Up After Hospitalization for Mental Illness	Patients will have a follow-up visit with a mental health practitioner within 7 days after discharge.	59%
30 Day Follow up after Hospitalization for Mental Illness	Patients will have a follow-up visit with a mental health practitioner within 30 days after discharge.	86%
Utilization Review: Frequency of Services	Average number of days between services.	By team/program

ACT

Name	Evaluation Area	Target
Item H1	Consumer to staff ratio for ACT Team will be at or below 10:1	Each team (EHITS, SHINE, Forensic, Delaware/Morrow) will achieve a score of 4 on the Annual Fidelity Review.
Item S5	Frequency of contact with patient (average of 3 contacts per week).	Each team (EHITS, SHINE, Forensic, Delaware/Morrow) will achieve a score of 4 (4=3-3.9 contacts per week) on the Annual Fidelity Review.
Item S7	Individualized Substance Use Treatment (Note: To achieve a 3, a Substance Use Specialist must be identified on each team and provide services to patients with an SUD diagnosis)	Each team (EHITS, SHINE, Forensic, Delaware/Morrow) will achieve a score of 3 on the Annual Fidelity Review.

First Episode Psychosis (Delaware/Morrow)

Name	Evaluation area	Target
Staffing capacity	Consumer to staff ratio for FEP Team will be at or below target of 25:1 to ensure adequate intensity and individualization of services.	20:1
Response to referrals	Individuals referred will be contacted within 3 business days.	100%
Service access	Individuals will have their first appointment within 10 days of intake.	100%
Pharmacology: Metabolic side effects	FEP patients receiving Psychiatry services from Southeast will have Height, Weight, Blood Pressure, HgA1c, and Lipids assessed at enrollment.	100%
Pharmacology: Metabolic side effects	FEP patients receiving Psychiatry services from Southeast will have Height, Weight, Blood Pressure, HgA1c, and Lipids assessment repeated 3 months after enrollment.	100%

My RecoveryWorks (Franklin County)*

Evaluation Area	Target
Unduplicated number of individuals seen	500
Number of new registrants on web site	175
Number of presentations to community partners and clients	240

*Not currently evaluating this program, pending ongoing support from ADAMH.

Recovery Works North (Delaware/Morrow)

Evaluation Area	Target
Unduplicated individuals being seen annually	96
Number of new registrants on web site	60
Number of presentations to community partners and clients	120

Vocational: Project Work

Evaluation Area	Target
Total number of participants	330
Number of new participants	250
Total number of job starts	83
Number of clients exceeding 90 days of continuous employment	25
Average hourly income	$10.50
Average hours worked per week	20

Vocational: Rebel/IPS

Evaluation Area	Target
Total number of participants	100
Number of new participants	10
Total number of job starts	20% of total participants (20)
Number of clients exceeding 90 days of continuous employment	20% of clients placed (40)
Average hourly income	$10.50
Average hours worked per week	20
Average caseload	20

Vocational: Career Development (Franklin County, includes PW)

Evaluation Area	Target
Total number of participants	400
Number of new participants	55
Total number of job starts	25% of total participants
Number of clients exceeding 90 days of continuous employment	30% of total job starts
Average hourly income	$10.50
Average hours worked per week	20
Transitional work opportunities: percent of participants not working in janitorial or fast food (excludes PW)	60%

Vocational: Adult Employment (Delaware/Morrow)

Evaluation Area	Target
Total number of participants	220
Total number of job starts	60%
Percent of clients exceeding 90 days of continuous employment	75%
Average hourly income	$9.55
Average hours worked per week	25
Average caseload	40

Vocational: Supported Employment (BHM)

Evaluation Area	Target
Clients offered benefit analysis to assess impact on current benefits	100%
Job-ready participants who become employed within a year	50%
Number of clients exceeding 90 days of continuous employment	50%
Average hourly income	$9.50
Rapid job search within 30 days	100%
Face-to-face employer contacts per employment specialists per week	6

Transitional Youth Programs

Name	Evaluation Area	Target
Life and Job skills program	A minimum of one (1) identified goal on the Individual Case Plan will be achieved by the end of services for all participants engaged in services	85%
renew	Number of enrollees working	15
renew	Average hours per week	18
renew	Average rate of pay	$12.00
Bridges program	Participants residing in a stable living situation, as defined by Participants not having more than two episodes of either unpaid or emergency housing types within a 12-month period	90%
Bridges program	Charts audited by Program Managers and Clinical Director will meet 80% compliance	90%

Friends of the Homeless

Evaluation Area	Target
Number served	1,300
Average length of stay (days)	45
Occupancy rate %	100%

PATH

Evaluation Area	Target
Number contacted/served (outreach)	482
Number enrolled	361
Number connected to Community Mental Health Services	271

Bridge to Success

Evaluation Area	Target
Number served	95
Average length of stay (days)	180
Percent successfully discharged to housing	90%