

NHS Human Services, Inc.
System Gap Analysis

Program:		Date of Analysis:	
System Element	Benchmarks to be assessed	Indicators of benchmarks	Current level of functioning
Accessibility	<ul style="list-style-type: none"> Ease of entry into services staffing sufficiency waiting period for services (urgent, emergent, routine) 		
Integration of Care	<ul style="list-style-type: none"> collaboration with other service providers family participation community member integration 		
Individualized	<ul style="list-style-type: none"> Cultural/multi-linguistic assessment Flexibility of services Consumer and family input obtained and utilized 		
Valued Outcomes	<ul style="list-style-type: none"> Continuity or return to vocational or educational placement Housing stability Stability in or increased functionality (GAF or ADL's) 		
Quality of Care Oversight	<ul style="list-style-type: none"> Level of care appropriateness Clinical supervision of staff Use of evidence based practices 		
System Performance Monitoring	<ul style="list-style-type: none"> Documentation monitoring Consumer satisfaction monitoring (callbacks etc) Incident management process 		

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The System Gap Analysis is designed to help facilitate the identification of areas in need of system improvement within programs. Following the identification of system gaps, as compared to program-specific benchmark indicators, programs can modify processes in order to address these areas of need more readily. The intent of this review is to provide programs with a holistic view of their service provision and areas that could benefit from additional analysis or support. When designing the indicators for the proposed benchmarks be mindful of program standards, local and federal regulations, national or state benchmarks for comparison, internal quality standards and expectations, and essentially the optimum level of functioning desired for a program. Services are expected to have system gaps because of the dynamic nature of behavioral healthcare. This results in constantly changing or emerging expectations. For this very reason, a system gap analysis to evaluate program efficacy is a necessity. This is a tool that should be used to maintain standards and keep pace with the changing expectations in healthcare, and to provide a mechanism to re-think, re-design, and re-imagine service provision.

Defining the System Gap Analysis

System Elements: These are broad categories of integral program functioning that encompass universal standards for behavioral healthcare and associated service delivery.

1. **Accessibility:** one's ability to enter into a continuum of care for treatment and service provision
 - a. **Ease of entry into services:** can an individual, family, friend, other provider identify the availability of service in the community and gain access to the appropriate individuals to enter into services via this program (also includes "no wrong door" entry to NHS services)?
 - *Example of indicator: Individuals reach a live person upon calling the program to inquire about services.*
 1. 24 hours per day/7 days per week
 2. During operating hours
 3. 50-75% of operating hours
 4. 25-49% of operating hours
 5. None, all inquiries are received via voice mail or some other means
- b. **Staffing sufficiency:** does the program have adequate staff to meet the community demand for this level of care?

• *Example of indicator: The program is staffed sufficiently to absorb all referrals and to maintain quality in the provision of services.*

1. 96-100% fully staffed compared to necessity (not budget)
2. 76-95% staffed to meet need
3. 50-75% staffed to meet need
4. 25-49% staffed to meet need
5. Non-operational due to lack of staff

c. Waiting period for services: are the waiting periods for urgent, emergent, and routine levels of need within regulation and NHS and payer expectations?

• *Example of Indicator: All individuals are able to receive services within regulatory requirements and internal expectations.*

1. All urgent, emergent, and routine requests for services are met within regulation
2. All urgent and emergent requests for services are met within regulation
3. All urgent requests for services are met within regulation
4. 50-75% of requests for services are met within regulation
5. 25-50% of requests for services are met within regulation

2. Integration of care: service coordination to include all appropriate bio-psychosocial spheres of an individual's life in services to facilitate recovery and independence

a. Collaboration with other services providers: Is physical health information obtained and incorporated into care, "regular" collaboration with internal and external behavioral health care providers (case managers, social workers, etc.), and participation with academic and vocational entities as appropriate?

• *Example of indicator: Documentation supports interaction with consumers' physical health provider and all other service providers as appropriate.*

1. 96-100% of individuals receiving services have physical health and ancillary provider interaction documented
2. 76-95% of individuals receiving services have physical health and ancillary provider interaction documented
3. 50-75% of individuals receiving services have physical health and ancillary provider interaction documented
4. 25-49% of individuals receiving services have physical health and ancillary provider interaction documented
5. Less than 25% of individuals receiving services have physical health and ancillary provider interaction documented

b. Family participation: If appropriate, are family members engaged in the individuals care (adults and children) and provided with modes of contacting treatment providers with questions, concerns or complaints?

• *Example of indicator: Fact sheets and contact information for treatment providers are provided to family members of individuals receiving services.*

1. 96-100% of the time upon engagement
2. 76-95% of the time upon engagement
3. 50-75% of the time upon engagement
4. 25-49% of the time upon engagement
5. Less than 25% of the time upon engagement

c. Community member integration: Are individuals linked with cultural, spiritual, recovery, religious, recreational and other community organizations as appropriate throughout care?

• *Example of indicator: Individuals are provided with referrals to ancillary services and activities as appropriate upon entry into service.*

1. Individuals and/or their family are provided with referrals in writing to ancillary services upon entry into services and staff facilitate connections directly to the services.
2. Individuals and their families are provided with written referrals and contact information for ancillary services.
3. Individuals and/or their family are given verbal referrals to ancillary services
4. Individuals are given referrals to ancillary services as the individual requests them from the service provider
5. No referrals or indication/documentation of referrals to ancillary services occur

3. Individualized: Service delivery is designed specifically for the individual and their family (e.g., no "cookie cutter" approaches) when making recommendations, designing treatment and service plans, and determining level and types of care.

a. Cultural/Multi-linguistic assessments: Are there means for assessing the role of an individual's culture in treatment upon entry into services and are there resources available for providing assessments and information to individuals for whom English is not a primary language?

• *Example of indicator: individuals are given a comprehensive bio-psychosocial assessment upon entry into services which includes cultural items of assessment in the individual's preferred language of communication.*

1. 96-100% of the time upon engagement
2. 76-95% of the time upon engagement
3. 50-75% of the time upon engagement

- 4. 25-49% of the time upon engagement
- 5. Less than 25% of the time upon engagement

b. Flexibility of services: can an individual select the care and services that they desire and meet their individual needs (e.g., menu selection approach)

• *Example of indicator: The program offers a variety of services and individuals have the right to select and reject the types of service received as appropriate in consultation with a staff person.*

- 1. 96-100% of the time upon engagement
- 2. 76-95% of the time upon engagement
- 3. 50-75% of the time upon engagement
- 4. 25-49% of the time upon engagement
- 5. Less than 25% of the time upon engagement

c. Consumer and family input utilized: the consumer and family (as appropriate) participate in all service-based care decisions including treatment and service planning, level of care determinations, etc.

• *Example of indicator: Consumer and family participation is documented in all service-based care decisions.*

- 1. 96-100% of the time
- 2. 76-95% of the time
- 3. 50-75% of the time
- 4. 25-49% of the time
- 5. Less than 25% of the time

4. Valued Outcomes: Service is designed specifically to help individuals achieve outcomes that are valuable to the consumer and/or their family and the community.

a. Continuity of or return to vocational or educational placement: As a result of services are individuals more likely to retain employment or educational placement or obtain employment/return to less restrictive educational setting?

• *Example of indicator: Individuals receiving care return to or obtain employment prior to discharge if appropriate.*

1. 96-100% of the time
2. 76-95% of the time
3. 50-75% of the time
4. 25-49% of the time
5. Less than 25% of the time

b. Housing stability: as a result of services, do individuals maintain housing stability or obtain housing stability (i.e., reduced out of home placements, incarceration, homelessness, etc.)

• *Example of indicator: Children receiving care maintain or return to housing in their home and avoid out of home placements.*

1. 96-100% of the time
2. 76-95% of the time
3. 50-75% of the time
4. 25-49% of the time
5. Less than 25% of the time

c. Increased functionality: Do individuals level of functioning as indicated by a Global Assessment of Functioning score or Activities of Daily Living/Instrumental Activities of Daily Living scores increase as a result of services?

• *Example of indicator: Upon discharge individuals GAF as assessed by a clinician is higher than it was upon entry into services and indicates a higher level of functionality.*

1. 96-100% of the time
2. 76-95% of the time
3. 50-75% of the time
4. 25-49% of the time
5. Less than 25% of the time

5. Quality of Care Oversight: Processes exist to monitor, track, and ensure quality of care standards are met.

a. Level of care appropriateness: Upon entry into a service, is level of care evaluated in a systematic, qualitative, and quantifiable way?

• *Example of indicator: Level of care is determined through a comprehensive assessment and psychiatric evaluation upon entry into services and is documented in a standardized and quantifiable way.*

1. All individuals receive a written level of care evaluation that is quantifiable via a matrix or other standardized measurement.
2. Individuals receive a comprehensive clinical assessment by a credentialed clinician which includes level of care recommendations.
3. Individuals receive a psychiatric evaluation which is written and documents level of care recommendations.

4. Individuals receive an assessment by a non-licensed, non-clinical staff person which determines level of care placement.

5. All individuals receive the same level of care that enter into the service.

b. Clinical supervision of staff: Is appropriate on-going clinical supervision provided to and accessible to all individuals providing services to individuals with behavioral health diagnoses by a clinically credentialed supervisor?

• *Example of indicator: Clinical supervision is provided to all staff who provide clinical services.*

1. Weekly by a credentialed clinician

2. Monthly by a credentialed clinician

3. As needed/PRN by a credentialed clinician

4. By a non-credentialed clinician

5. None

c. Use of Evidence-Based Practices: Do programs utilize Evidence-Based Practices in service provision?

• *Example of indicator: Trauma-focus cognitive behavioral therapy is provided when evidence of trauma is present in treatment.*

1. 96-100% of the time

2. 76-95% of the time

3. 50-75% of the time

4. 25-49% of the time

5. Less than 25% of the time

6. System Performance Monitoring: Monitoring processes for fundamental processes linked with Federal, State, payer, and NHS regulations.

a. Documentation Monitoring: Is there a system in place to ensure the proper, timely, and appropriate completion of all documentation required for billing, licensure, etc?

• *Example of indicator: Progress notes are reviewed to ensure they are complete, accurate and legible.*

1. All progress notes
2. 50-75% of progress notes
3. A random sample of progress notes are reviewed weekly
4. A random sample of progress notes are reviewed monthly
5. Progress notes are not reviewed on a consistent basis

b. Consumer satisfaction monitoring: Is there a process for monitoring consumer satisfaction with services and for "regular" monitoring of quality of service provision as viewed by the consumer (i.e., quality callbacks, Consumer Satisfaction Survey Device, etc.)

• *Example of indicator: Consumer satisfaction and concerns are monitored regularly through a standardized process of quality call-backs.*

1. Via a random sample of service recipients weekly
2. Via a non-random sample (e.g. all of staff person "X's" consumers) of service recipients
3. Monthly during GMP
4. Annually
5. Never

c. Incident management process: Is there a process for identifying, tracking, reporting, debriefing and assessing incidents as they occur during the course of operation?

• *Example of indicator: A process for tracking all incidents and monitoring follow up to incidents and corrective actions exists and is updated regularly.*

1. A written incident management process exists for the service and is followed and monitored weekly
2. An incident management process exists but is not written but is tracked and monitored
3. An incident management process exists but is not tracked or monitored
4. Incident reports are completed but not reviewed or followed up on
5. No incident management procedure exists