

## QA

### Policy

1. The Board of Directors of Mid-Ohio Psychological Services, Inc. authorizes the Quality Assurance Committee to oversee the Quality Assurance procedures. The Quality Assurance Committee shall be comprised of a multi-disciplinary team including at minimum, the Clinical Director, the Quality Assurance Coordinator, and a representative of the support staff and will meet monthly.
2. The Quality Assurance Committee will be responsible for evaluating the Quality Assurance Plan. The quality assurance plan will be updated and approved annually by the Board of Directors during the October meeting. The Executive Director is responsible for integrating all Quality Assurance activities. The result of the Quality Assurance Review will be provided to the Board of Directors and the ADAMH Board on a quarterly basis. Monthly Quality Assurance meeting notes will be distributed to all staff members and an opportunity will be made for staff members to provide feedback concerning the activities of the Quality Assurance Committee and the provision of services.
3. The quality assurance plan is made up of five primary components: Client Records Review, Peer Review, Utilization Review, Professional Staff Organization, and the Safety and Infection Control. Each component reports their results to the Quality Assurance Committee monthly.
4. The Executive Director is responsible for reporting the results of the quality assurance review to the Board of Directors and the community mental health board at least annually.
5. Although Mid-Ohio Psychological Services, Inc. does not currently contract with other agencies, the Quality Assurance Committee and the Executive Director will ensure that every effort will be made to incorporate quality assurance standards within such contracts.
6. Efforts will be made to support a multi-disciplinary framework for all quality assurance reviews and activities. All disciplines currently working through Mid-Ohio Psychological Services, Inc. are represented in the Quality Assurance activities.
7. Confidentiality will be maintained during all quality assurance activities as ensured in the Client Rights Policy. To ensure confidentiality, only client ID numbers will be used in documenting issues germane to a particular client. All Quality Assurance minutes containing client specific information will be

kept in a locked area accessible only to the Quality Assurance Committee. Information, which must be shared with outside agencies, such as the ADAMH Board, will not have client names or other information, which may identify any individual client. The majority of the data will be in aggregate form.

8. When a conflict of interest occurs in the quality assurance procedures, every effort will be made within the organization to resolve the conflict. Usually this can be achieved by having the conflicting party simply remove themselves from the process and finding an appropriate replacement. If a conflict of interest cannot be resolved internally, the Board of Directors will develop a solution to the conflict. Service providers cannot review their own cases for Quality Assurance Activities.
9. All Client Rights complaints and Grievances will be reviewed by the Quality Assurance Committee at their regular meetings and will direct the Executive Director and/or Governing Board to take appropriate action. Additionally, the Quality Assurance Committee will include a description of Client Grievances and Complaints in their annual review report.
10. In conducting all quality assurance activities, special emphasis shall be placed on those aspects of care with the greatest impact on the quality of services, including those of high volume, those known to be problematic, those offered to persons with multiple service needs, and aspects of care related to ethnic and minority populations.
11. Each department/service shall have the opportunity to identify and review major aspects of care annually which may receive special emphasis. This review will be forwarded to the Quality Assurance Committee as part of the overall Quality Assurance Procedures. The results of this annual review will be forwarded to the Board of Directors and the ADAMH Board for appropriate action.
12. All Quality Assurance reports will be maintained for at least five years.
13. Core quality assurance activities (such as annual review of agency policies and procedures, client satisfaction survey, etc.) will be conducted on a scheduled basis as clarified on the *Quality Assurance Activity Schedule*.

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## **Procedure**

### **QUALITY ASSURANCE COMMITTEE**

The purpose of the Quality Assurance Committee is to oversee and carry out the Quality Assurance Plan. The Quality Assurance Committee shall review information from the Client Records Review/Peer Review/Utilization Review Professional Staff Organization/and the Safety and Infection Control. The Quality Assurance Committee reports to the Executive Director and the Board of Directors. The Quality Assurance Committee will be responsible for compiling the Annual Quality Assurance Review. The Quality Assurance Committee is responsible for ensuring that the overall quality assurance needs are met. If a trend and/or other clinical issue is identified, the Quality Assurance Committee will do a "focused review" and recommend corrective action to be carried out by the Executive Director if the issue is administrative in nature or the Clinical Director if the issue is clinical in nature.

The Quality Assurance Committee will review and annually assess the effectiveness of the Quality Assurance Plan. Specifically, this annual review will include a review of: 1) Achievement of plan's overall goals and objectives, 2) Achievement of accepted professional standards of practice, 3) Resolution of identified problems, 4) Assessment of the efficacy of Quality Assurance activities and the adequacy of corrective actions, 5) Improvement of service delivery systems, 6) Communication of the findings to the agency staff, the agency's governing body, and the local community mental health board.

This will be completed by reviewing the Quality Assurance Committee findings and reviewing the overall Quality Assurance process as it interfaces with the Board of Directors and the ADAMH Board.

The QA Committee meets monthly. The members are four clinical members, the QA Coordinator and the agency Clinical Director. The purpose of the committee and meetings is to encompass the entire QA process, as our agency size does not allow for separate committees to be developed for each area of QA.

During the monthly meeting, the current status of QA activities is given. This includes an update on what reports are being worked on and corrections being made from previous months. The committee addresses any areas of concern. All Client Rights complaints and grievances will be reviewed by the Quality Assurance Committee, and the committee will direct the Executive Director and/or Governing Board to take appropriate action. The focused area of review is addressed. Ideas are sought and action plans decided upon to meet QA calendar requirements. This may entail surveys, running statistical reports, or conducting chart reviews. Responses to the previous month's focus review are made based on the information collected during the review process.

Monthly summary reports are collected from clinical staff to track clinician CEU's for PSO purposes, community agency referrals, and referrals to and from hospital facilities.

Client Rights and Grievance issues are reviewed for the monthly QA report. Any needs for corrective action and re-education are facilitated through the agency's supervision process.

The committee also reviews Record Review, Peer Review, and Utilization Review.

## QA Goals and Objectives

**Goal:** Meet State requirements

**Objectives:** Clinicians, and other agency staff as applicable, must consistently complete documentation that is required by this agency, the State and the accrediting agencies that this agency is associated with.

**Goal:** Continuing Education

**Objectives:** Clinicians must continue to meet the standards of the State toward maintaining their licensure, developing competencies, and improving the quality of care for our clients.

**Goal:** Clinical Accountability

**Objectives:** Quality Assurance staff will work with clinician's to make sure that they are providing a thorough assessment, accurate diagnoses, and services that are consistent with the philosophies and standards of this agency and the state of Ohio.

**Goal:** Provide feedback about utilization of services

**Objectives:** QA staff will develop an understanding of what services are sought at this agency, how these services are accessed, if these services meet the needs of our clients, what other services are needed, are we attempting to meet the needs of our clients when we don't have the available service (if so how?), and what external services are we as an agency utilizing and what external services are our clients utilizing.

**Goal:** Ensure a safe environment free of hazards for staff and clients

**Objectives:** QA staff will conduct monthly physical plant inspections, quarterly fire drills, and monitor MUI's to provide re-education or preventative training to avoid future incidents.

## QUALITY ASSURANCE ACTIVITY SCHEDULE

### Issues to cover every month:

- Peer Review (5% sample – 90% passing)
- Record Completeness Review (5% sample-- 95% passing)
- Utilization Review (Time Utilization/Intake #'s/client utilization/units of service)
- Physical Plant
- MUI's
- Involuntary Terminations

- PSO activities (include peer review for maintaining clinical privileging)
- Review of waiting list (by payor source)
- Review services under contract
- Review Client Rights, complaints, and grievances

### **January**

- Review of trends and patterns of service, highlighting gaps of service
- Complete annual safety review summary and forward to the board of directors
- Fire Drill

### **February**

- Review accessibility, availability, and appropriateness of services for persons who speak a language other than English, or have a handicapping condition
- Conduct survey of utilization of services by minority groups, including handicapping conditions

### **March**

- Send quarterly report to the board

### **April**

- Review of referrals to other agencies
- Fire Drill

### **May**

- Review QA plan's overall goals and objectives and revise
- Review the achievement of accepted professional standards of practice
- Review the resolution of identified problems
- Assess the efficiency of QA activities
- Review the adequacy of corrective actions
- Review methods for improving the service delivery system

### **June**

- Send quarterly report to the board
- Review AOD services

### **July**

- Complete annual QA report and communicate findings to all agency staff, the board of directors, and the community mental health board
- Review of clinical pertinence and appropriateness of services rendered (Utilization Review)
- Fire Drill

### **August**

- Review client rights, complaints, and grievances as well as staff grievances and explore patterns. Forward report to the board of directors.

### **September**

- Send quarterly report to the board
- Review of service evaluation activities and identify services to be evaluated (pick one service area)

### **October**

- Review of continuity of services regarding the numbers and characteristics of persons who are discharged from a psychiatric inpatient hospital and who do not receive necessary services within two weeks of requesting such services
- Fire Drill

### **November**

- Invite members from consumer advocacy group for agency service review

### **December**

- Send quarterly report to the board
- Review Policy and Procedure Manual

## CLIENT RECORDS REVIEW

The purpose of Client Records Review is to insure the adequacy and completeness of the information contained in the case file. It is to ensure that pertinent, timely, appropriate, and legible information is contained in client records. Completeness shall refer to the specified uniformity in the record keeping.

### Process

The QA Coordinator will randomly choose client names from the active clients list and the QA termination query list for every clinician each month. The active clients must have been seen during the month of the review being conducted. The archive charts must have been seen in the last 12 months. Ten percent of all active records shall be selected and reviewed in a twelve-month period. This random selection of files shall represent at least one record from each clinician, one representation of each of the services provided including at least one AOD client, one youthful client record, one adult record, and one record representing an ethnic or racial minority group as available within the agency. AOD client records will be reviewed at least quarterly and the results will be reported to the Executive Director.

Each client case file within the outpatient framework shall be organized in a manner consistent with the outpatient policies and procedures and the model record on file at the agency. The general organization of the case file shall be the responsibility of the clerical staff.

The clinical members of the QA Committee will conduct the client records review, checking for completeness and for record adequacy. The selected charts will be reviewed for the current period, that is the month for which the QA review is being completed.

Checking completeness of outpatient client records entails the use of the *Patient Records Review Completeness Checklist*. These forms shall be utilized by the designated QA committee member who will indicate the presence or absence of case forms by checking the appropriate category. The team will check the various applicable categories. An item will be deemed applicable if the policies and procedures indicate a particular form is warranted within the time frame that the clinician has been involved with the case.

The *Patient Records Review Completeness Checklist* will be completed and *QA Review Correction Form* will be given to the clinician responsible for the case. The clinician will then make any corrections if necessary, sign and return the form to the QA Coordinator.

A QA Committee member will check for signatures and corrections, and notify the QA Coordinator of any problems experienced in the overall process. If corrections are necessary but are not made, the QA Coordinator shall bring this to the attention of the Clinical Director.

If the current period record reviews scores below ninety-five percent, then the entire chart will be reviewed. If the entire chart review receives a score of at least ninety-five percent, then the review is passed. If the entire chart review falls below a score of ninety-five percent, then a random sample of five additional records from the clinician will be reviewed for the current period. If the average score of the additional sampling is below ninety-five percent the results of this additional sampling will be reported to the Executive Director and the Clinical Director to ensure continued compliance. If a particular clinician is found to have consistent inadequacies in documenting clinical activities, reeducation and/or disciplinary action may be initiated through the supervision structure.

The results of the client records review will be reported in the monthly QA report by recording individual compliance with the standards in a records completeness review table. The table also reports whether or not the chart that was reviewed included AOD and CSP services. In addition to the table, an overall agency percentage will be calculated to record the percentage of clinicians who did not meet the threshold. Percentages will also be calculated to record the reasons why charts did not pass the records review process; this information is also recorded in the Selected Record Review Issues graphs.

## PEER REVIEW

Peer Review is the process of evaluating the quality and therapeutic outcome of the services provided to the client. Peer Review assesses the relationship of the diagnosis to the treatment plan, how the treatment is implemented, how the therapeutic process develops, and reviews the counselor's therapeutic responsibilities for the quality of care given the client. The purpose of Peer Review is to ensure high quality client care is provided that is clinically pertinent and appropriate.

Peer Review shall occur on a monthly basis, using the same random sampling of charts that was used for the Client Records Review. The QA Committee shall review records chosen at random (5% of all active records) for Peer Review. At least ten percent of the Peer Review shall be drawn from clients terminated from service within the last year. During this process, the clinical staff member responsible for any case under review is excluded from the Peer Review of his/her client's case record.

The Peer Review utilizes the *Peer Review Check Sheet*, which addresses the appropriateness of the therapeutic intervention, the diagnosis, treatment plan, that services were related to the treatment plan goals and objectives, and documentation accurately reflects the services were provided. The review will include ensuring that AOD client's admission, continued stay, and discharge are appropriate based on the ODADAS protocols for level of care (youth and adult) for publicly funded clients including a minimum of methodology, frequency, and content of activities. The QA Committee shall find, upon completion of their review, the case to be adequately managed and implemented therapeutically or not adequate. If it is found to be deficient, the reviewer shall note the deficiencies on the QA Review Correction forms used during the Client Records Review and it will be given to the clinician responsible for the case.

It is then the clinician's responsibility to take appropriate action to either bring the case into compliance with accepted standards or offer a written explanation which addresses the noted deficiency by means of clarifying and explaining the nature of the deficiency.

In this case, the reviewer may then find the explanation adequate or may find the explanation to be inadequate, which is noted and the deficiencies forwarded once again to the clinician who will then take action to correct them. If the clinician chooses to appeal the findings of the reviewer, he/she may do so by filing a written appeal to the QA Coordinator or Clinical Director of the agency whose responsibility it is to then accept the clinician's explanation or enforce the findings of the reviewer within five working days of the receipt of the appeal.

The indicators for Quality Assurance can be found on the *Peer Review Checklist*. The threshold for compliance is identified as ninety percent compliance per client

and ninety percent compliance for each therapist. The agency threshold will be ninety percent compliance.

The results of the peer review will be reported in the monthly QA report in the following areas: the individual compliance with the standards will be reported in a peer review table, this table records if the case reviewed included AOD and CSP services. In addition to the table an overall agency percentage will be calculated to record the percentage of clinicians who did not meet the threshold. Percentages will also be calculated to record the reasons why clinicians did not pass the peer review process, this information is also recorded in the Compliance Review graph.

## UTILIZATION REVIEW

The purpose of the Utilization Review is to assess the efficiency of the services delivery system and appropriate utilization of agency resources. It is to ensure high quality client care is provided through the effective and efficient utilization of the program's resources and services. This entails review of clinical time utilization, scheduling, space allocation, hours of operation, service modalities, and budgeting. The Utilization Review determines if and what agency resources are under utilized or over utilized, and if these resources are being inefficiently scheduled. It further makes recommendations to the governing body to address any of its findings. The Utilization Review examines length of stay, discharge, and continuation of care criteria, as well as if and when referrals to other resources are appropriate.

### Process

The QA Coordinator will conduct utilization review. The QA Coordinator reviews the *Utilization Report*, *Active Client Lists*, and the *Staff Productivity by Service Report* to create the Utilization Review table that records the number of clients assigned to each clinician, the number of clients the clinician saw in that month, and then the average number of contacts is calculated. In addition, the percentage of agency dollars billed per clinician and the proficiency of scheduling and production by agency staff is calculated for the monthly QA report. The reports are also used to calculate the utilization of AOD services within the agency. In the event that there is a client wait list, it will be reviewed. Payer source information will be evaluated using the *Services for a Specific Payer Report* and an agency service budget will be created using this information for the monthly QA report. The month being reviewed is the preceding the month, all findings will be reported in the monthly QA report and any areas of concern will be discussed in the QA Committee Meeting.

### Client Record

The Utilization Review will be conducted as part of the *Peer Review Checklist*.

The QA Committee will concern itself with reviewing the general nature of the services delivery system provided to the client. Utilization review will ascertain that service providers are providing only authorized services. The committee assumes the task of assuring that the service is most appropriate to the needs of the client, and that the length of involvement is appropriate to those needs. Additionally, all clients involuntarily terminated will be reviewed.

The committee will review client records to assure coordination of assessment, treatment and termination of services. This committee will assure sufficient availability of consultation. Finally, the committee will monitor and review

continuity of services to those discharged from psychiatric inpatient hospitals through monthly summary forms completed by clinicians. The monthly summary forms are reviewed, the hospital discharge date is recorded along with the date the client was seen following discharge. These dates are reviewed to make sure the client received a follow-up session with their clinician within 14 days of discharge.

### **Scheduling and Monthly Reports**

The QA Committee reviews the content of the monthly *MOPS Client Summary Report* pertaining to service delivery. The committee compares the reports to trends in the agency's historical information and is to identify services that are being under-utilized, over-utilized, or inefficiently scheduled. Corrective action will be directed through the Clinical Director toward specific issues related to direct clinical care and will be forwarded to the Board of Directors for issues which much be addressed at a more global level.

### **Client Involvement**

All clients/families of clients will be given the opportunity to complete an anonymous *Quality of Service Survey*, which will be made available to them annually. All surveys will be collected when completed. Clients will be surveyed in the following areas:

- Accessibility (Timeliness of appointments)
- Appropriateness (Responsiveness to client needs)
- Cultural Competency (of staff providing services)
- Recommendation of services to others
- Overall satisfaction

Additionally, the local mental health board will share the results of the community wide mental health service survey and this data will be integrated into the Utilization Review to determine areas of service to be developed. Finally, persons served, and their families or significant others will be invited to participate in the planning, implementing and evaluating all mental health education services through the Community Service Plan.

### **Referral Source Surveys**

The ADAMH Board will conduct a referral source survey annually. Referral sources will be surveyed in the following areas:

- Access (ease of referral)
- Program Information (general information about program)
- Client information (feedback about client)
- Overall satisfaction

All surveys will be collected when completed, and the information will be compiled and reported in the QA report. The results of the survey will be incorporated into Utilization Review to determine areas of service to be developed.

### **Correction of Problems**

It is the responsibility of the Executive Director to ensure the correction of all deficiencies identified by the QA Committee within a time frame agreed upon by the Governing Board

### **Indices and Thresholds**

Each therapist is expected to maintain at least a fifty percent contact ratio. Waiting lists shall not exceed fifteen clients with a maximum estimated time until service of three months. The length of stay threshold shall be established based on community norms as provided by the ADAMH Board consistent with diagnostic category.

### **Wait list Management**

Mid-Ohio Psychological Services does not use a wait list for clients. Clients are served on a first come, first serve basis and are schedule with the appropriate clinician at the first available appointment time.

The following procedures would be followed if a wait list became necessary for AOD clients:

A. An intake would be made

Intake usually begins when a client calls with a presenting problem. Support staff is to complete an Initial Telephone Contact form and assign the client to a clinician for intake according to established guidelines provided by the AOD Treatment Program Director. During the initial phone intake, every effort will be made to determine the existence of any special needs including assistance with language, physical challenges or the potential impediments to the provision of treatment and every effort will be made to address these concerns at no cost to the client.

B. The client would then be categorized into one of the following groups based on the intake information

1. Pregnant women

2. Intravenous drug user
  3. Clients with medical and/or psychiatric emergencies
  4. Non-emergency status clients
- C. The support staff member taking the intake will then notify the referral source by telephone that the client has been put on a wait list and given the expected length of wait time and then ask the referral source to contact the office weekly if they need an updated wait list status.
- D. The client will be contacted on a weekly basis to notify them of any changes in their wait list status and to verify that there has not been a change in the clients needs.
- E. Clients will be removed from the wait list when a clinician becomes available, by order of importance with clients with medical and/or psychiatric emergencies and pregnant women being removed first, then intravenous drug users, and lastly non-emergency status clients.
- F. The Quality Assurance Committee will verify with the Administrative Coordinator each quarter whether there is or has been a wait list in effect, and if there is they will check to make sure that clients are being managed according to this policy.

## **PROFESSIONAL STAFF ORGANIZATION**

### **Purpose**

The QA Committee will conduct the activities of the Professional Staff Organization (PSO) for Mid-Ohio Psychological Services, Inc. to assure the highest degree of professionalism, ethics, and conduct within the scope of the resources available to the agency. The QA Coordinator will be responsible for the verification and maintenance of staff members credentialing and licensing. The committee will be responsible for the quality of all clinical care, verifying that staff are practicing within the scope of practice, and clinical privileges. The committee will also review the professional disclosure statements of the clinical staff. The committee will ensure that all mental health personnel are qualified by training or continuing education to serve persons of culturally diverse backgrounds. These qualifications should include: the effects on ethnic minority persons of psychiatric interventions, including psychotropic medications; issues related to differential diagnosis of ethnic minority persons; and vernacular language patterns of ethnic minority persons.

### **Authority**

The members of the QA Committee will conduct all PSO activities. Information regarding clinician's CEU requirements will be collected from the Monthly Summary Report completed by clinicians. Any professional needs within the agency, professional status concerns, and listings of professional staff persons will be reported to the committee for review and action. The Clinical Supervisors are responsible for all diagnoses and treatment of clients whose therapy is not performed by an independently licensed practitioner.

## **SAFETY AND INFECTION CONTROL**

The QA Committee will conduct the safety and infection control activities. The Executive Director is responsible for seeing that the agency is in compliance with all Federal, State, and local requirement for health, safety, and accessibility. All findings will be reported to the Quality Assurance Committee and the Executive Director who will take corrective action.

### **Purpose**

S&IC activities include monitoring, assessing, identifying, resolving, and evaluating potentially dangerous situations to clients, staff, and the general community within the agency and its satellite. Areas of concern include, but are not limited to: Physical Plant, Disaster Evacuation, Hazardous Waste, Electrical Cords, Fire safety, Handicapped Access, Incident Reporting and Infection Control.

Please see the agency's risk management policies and procedures for detailed information.

### **Process**

Each month a member of the QA Committee will complete a *Quality Assurance Safety and Infection Control Form*. Any issues discovered will be brought to the attention of the committee and reported in the QA report. The other areas of concern to the S&IC are address in the agency's Risk Management and Incident Reporting policies and procedures.

## **MAJOR AND UNUSUAL INCIDENT REPORTING**

All major, unusual incidents will be reviewed monthly by the Executive Director and brought to the attention of the Quality Assurance Committee and the Board of Directors. Specific attention to patterns, trends, and risks that may be identified will be reported on in the QA report. The agency's policies and procedures for reporting MUI's is listed under Incident Reporting.

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