

MID-OHIO PSYCHOLOGICAL SERVICES, INC.

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Bradley A. Hedges, Ph.D.
Executive Director

QA REPORT

TO: Bradley A. Hedges, Ph.D.
Executive Director

FROM: Shawna Watts, MBA
Quality Assurance Coordinator

SUBJECT: Quality Assurance Activities for May 2003

SUBMITTED: August 6, 2003

I: MAJOR UNUSUAL INCIDENTS

There was one major unusual incident during the month of May. On 5-08-2003, client #02072501 had a seizure while receiving services. The front office staff called 911 and the client was treated by the Medics and then transported to Fairfield Medical Center for treatment. The client's clinician notified Dawn Coleman, of Fairfield County MRDD, the client's caseworker and then went to the Emergency Room at Fairfield Medical Center. The MUI report was faxed to the Fairfield County ADAMH Board.

II: TRANSFERS FROM STATE HOSPITALS

There were no transfers to state hospitals during the month of May. Client# 03010704 was transferred to Fairfield Medical Center on 5/16/2003 and released on 05/17/2003. This client was seen by Rick Gehlbach on 05/19/2003. Client# 03052904 was transferred to Fairfield Medical Center on 05/20/2003 and released on 05/23/2003. This client was seen by Scott Craft on 05/29/2003.

III: PLANT/PHYSICAL HEALTH AND SAFETY

No health or safety issues were identified by the building inspection in the month of May 2003.

IV: RECORDS COMPLETENESS REVIEW

| Clinicians | % Compliance With Standard | Chart Included AOD Services | Chart Included CSP Services |
|-------------------|----------------------------|-----------------------------|-----------------------------|
| Dr. Brad Hedges | 97 | NO | NO |
| Robin Rippith | 100 | NO | NO |
| Dr. Chris Ray | 98 | NO | NO |
| Tonya Kraner | 96 | NO | NO |
| Scott Craft | 92 | NO | NO |
| Dean Bachelor* | 90 | NO | NO |
| Stephanie Miller* | 94 | NO | NO |
| Claire Robitaille | 99 | NO | NO |
| Joni Grim* | 92 | NO | YES |
| Chris Johnson | 95 | NO | NO |
| Steve Ford | 95 | NO | YES |
| Amanda Moore* | 93 | NO | YES |
| Joe Dunson | 96 | NO | YES |
| Dr. David Mahl* | 90 | NO | NO |
| Mike Selegue | 98 | NO | NO |
| Tara Rice | 96 | NO | YES |
| Jodi Frazier | 97 | NO | YES |
| A.J. Bierly | 98 | NO | YES |
| Kelly Kleimeyer | 96 | NO | NO |
| Rick Gehlbach* | 91 | NO | NO |
| Dawn McCoy | 95 | NO | YES |
| Misty Coleman* | 90 | NO | NO |
| Bonnie Pearse | 99 | NO | NO |

*Denotes that the clinician did not meet the target threshold of 95% compliance with the standards. Thirty-five percent of the clinicians did not meet the 95% threshold for the record review. Reasons that clinicians did not meet the threshold and the percentage of records reviewed is as follows:

- Thirty-nine percent of the records reviewed were missing a copy of the current medical card.
- Twenty-two percent of the records reviewed were missing forms or had incomplete forms in the chart.
- Signatures were missing on some forms in the chart for 17% of the clinicians.
- In 13% of the records reviewed there was at least one session recorded that did not match the billing record.
- Twenty-two percent of the records reviewed had an Individual Service Plan on the

chart that needed to be updated.

- Sixty-one percent of the records reviewed did not have a reviewed health assessment.
- Sixty-one percent of clinicians were missing case notes for billed services.

V: PEER REVIEW

| Clinicians | Percent Compliant With Standard | Chart Included AOD Services | Chart Included CSP Services |
|-------------------|---------------------------------|-----------------------------|-----------------------------|
| Dr. Brad Hedges | 91 | NO | NO |
| Stephanie Miller | 94 | NO | NO |
| Dr. Chris Ray | 92 | NO | NO |
| Dr. David Mahl | 95 | NO | NO |
| Robin Rippeth | 100 | NO | NO |
| Tonya Kraner | 99 | NO | NO |
| Steve Ford | 91 | NO | YES |
| Mike Selegue | 93 | NO | NO |
| Joni Grim | 92 | NO | YES |
| Scott Craft | 89 | NO | NO |
| Chris Johnson* | 76 | NO | NO |
| Claire Robitaille | 99 | NO | NO |
| Kelly Kleimeyer | 100 | NO | NO |
| Bonnie Pearse | 99 | NO | NO |
| Dawn McCoy | 99 | NO | YES |
| Dean Bachelor | 81 | NO | NO |
| Misty Coleman | 94 | NO | NO |
| Rick Gehlbach | 96 | NO | NO |
| Joe Dunson | 89 | NO | YES |
| Tara Rice | 96 | NO | YES |
| A.J. Bierly | 96 | NO | YES |
| Jodi Frazier | 96 | NO | YES |
| Amanda Moore | 97 | NO | YES |

*Denotes that the clinician did not meet the target threshold of 90% compliance with the standards.

- Thirteen percent of the clinicians did not meet the 90% threshold for peer review for the month of May.
- Sixty-nine percent of the records reviewed for peer review showed that the clinician did not complete the required forms, or make the necessary referrals.
- Seventy-four percent of the records were not maintained consistently in that case notes were not completed and not billed for. Also, the client,

clinician and the supervisor have not signed the progress note or other necessary documentation.

VI: UTILIZATION REVIEW

| Clinician | Number of Clients Assigned | Number of Clients Seen | Average Number of Contacts Per Client Seen |
|-------------------|----------------------------|------------------------|--|
| Dean Bachelor | 20 | 11 | 3.6 |
| Stephanie Miller | 50 | 10 | 1.2 |
| Brad Hedges | 54 | 13 | 1.4 |
| David Mahl | 22 | 2 | 1.5 |
| Chris Ray | 78 | 21 | 1.7 |
| Tonya Kraner | 52 | 24 | 1.5 |
| Robin Rippith | 41 | 25 | 1.5 |
| Dawn McCoy | 69 | 38 | 2.1 |
| Scott Craft | 119 | 31 | 2.1 |
| Steve Ford | 67 | 57 | 2.1 |
| Bonnie Pearse | 78 | 43 | 2.1 |
| Joni Grim | 87 | 29 | 2.1 |
| Chris Johnson | 132 | 23 | 2.0 |
| Claire Robitaille | 41 | 26 | 2.6 |
| Riek Gehlbach | 60 | 28 | 1.8 |
| Mike Seleque | 54 | 47 | 2.1 |
| Kelly Kleimeyer | 56 | 49 | 3.1 |
| Joe Dunson | 27 | 12 | 7.3 |
| Tara Rice | 36 | 23 | 1.9 |
| Misty Coleman | 43 | 26 | 7.0 |
| A.J. Bierly | 27 | 17 | 4.2 |
| Jodi Frazier | 26 | 12 | 4.9 |
| Amanda Moore | 28 | 16 | 5.6 |

The No Show rate for May was 16%. When considering both the no show rate and the cancellation rate, this figure is 33%.

| Service Area | Total Number of Units This Month (All of MOPS) | Monthly Allocated Medicaid Units for Fairfield County | Year to Date Total Units for MOPS | Year to Date Allocated Medicaid Units for Fairfield County |
|--------------------------------------|---|--|--|---|
| Diagnostic Assessment | 99.60 | 54.17 | 1258 | 595.87 |
| Individual Counseling | 732.40 | 189.17 | 6420.01 | 2080.87 |
| Group Counseling | 126.00 | 70.83 | 2188.2 | 779.13 |
| Medication/somatic Services | 46.70 | 21 | 303.3 | 231 |
| Community Support Program (CSP) | 404.30 | 433.33 | 5092.7 | 4766.63 |
| Alcohol and Other Drug (AOD) - Group | 10.0 | 65 | 246.6 | 715 |

The Medicaid units billed for the month of May 2003 for Fairfield County totals 1419. A total of 16521.25 Medicaid units were billed year to date for Fairfield County.

VII: AOD UTILIZATION REVIEW

AOD Group Therapy sessions in the month of May 2003 showed that the average attendance at each session was 70%. Overall, 5 women utilized AOD Group services during the month of May, and attended an average of 1.4 of 2 sessions.

| Sessions Offered | 05/05/2003 | 05/12/2003 | 05/19/2003 | 05/26/2003 |
|------------------|------------|------------|------------|------------|
| 5 Females | 4 | 3 | 0* | 0* |

* Group was canceled.

VIII: INVOLUNTARY TERMINATIONS

No involuntary terminations were conducted during the month of May 2003.

IX: PROFESSIONAL STAFF ORGANIZATION

The clinical staff maintains current licensure requirements. The following clinicians attended workshops during the month of May.

| Clinician | Workshop Name | Dates Attended | # of CEU's |
|-------------|---|----------------------|------------|
| Brad Hedges | Best Practices in Sex Offender Management | 05/28/2003-5/30/2003 | 0 |
| Joe Dunson | ODADAS Cross-Training-Recovery Center | 05/01/2003 | 0 |

X: REVIEW OF WAITING LIST

There were a total of 64 new clients seen this month. Fifty of the new clients were from Fairfield County. Seventy-eight percent of the new clients were from Fairfield County. The total number of clients seen in the month of May 2003 was 719.

XI: REVIEW OF SERVICES UNDER CONTRACT

No changes are noted regarding the services under contract.

XII: FOCUSED REVIEW AREA

The focused area of review for the month of May was to review and revise the overall goals and objectives of the QA plan, review the achievement of accepted professional standards of practice, review the resolution of identified problems, assess the efficiency of the QA activities, review the adequacy of corrective actions, and review methods for improving the service delivery system.

QA Plan goals and objectives- A few of the objectives and goals of the QA plan have not been completed due to a lack of time for committee members. The QA Coordinator will be coordinating the return of these activities. First monthly meeting will begin occurring again, and have been scheduled for September, October, November and December in advance. Quarterly reports will begin to be completed again with the completion of the fourth quarter of 2003. This report will be sent to the Mid-Ohio Board and ADAMH Board upon completion.

Review the achievement of accepted professional standards of practice- Peer review processes address this area. In addition, the agency tracks license expiration dates to ensure that all clinicians licenses are valid. CEU's are recorded on the Monthly Summary Forms, and malpractice insurance coverage is provided.

Review resolution of identified problems- Agency reports used for QA have been under review to correct calculation problems identified. The reports have been modified to correct these errors.

Assess the efficiency of QA activities- QA activities have been behind for an extended period of time. To correct this problem, the Administrative Coordinator was assigned as QA Coordinator. This will allow for the three clinicians to work on chart reviews and checking corrective actions.

Review the adequacy of corrective actions- Follow-up on corrective actions by clinicians has not been done consistently, so it was decided that clinicians will be reminded to make corrections by email if corrections are not received by the due date. If corrections are still not received, the clinician's supervisor will be notified. To follow-up on the corrective actions, 25% of files will be reviewed to insure corrective actions were completed appropriately.

Review methods for improving the service delivery system- Feedback for improving services is addressed during staff meetings and the Friday Clinical Supervisors Meetings. In addition there will be a monthly Supervisory Staff Meeting that includes Clinical and Support Staff Supervisors.

XIII: RESPONSE TO LAST MONTHS FOCUS REVIEW

In response to last month's review of referrals to other agencies the problem identified with the inconsistency with the types of referrals reported by staff was addressed by providing a letter with the forms when they were distributed, asking that all referrals be reported and examples were given of the types of referrals that could be reported. The examples given included referrals made to other agencies includes referrals made to community agencies such as Community Action, Job and Family Services, Children Services or any other place that may be referred to for assistance. In addition, to increase the response rate of staff, the letter requested that the form be turned in even if there was nothing to report, and that the report would be given on the first business day of the month, so that form could be filled out as the referral occurred.

XIV: CLIENT RIGHTS AND GRIEVANCES

No client grievances were made during the month of May.

cc: Fairfield County Mental Health and Recovery Services Board
MOPS Board of Directors
MOPS Staff
QA Minutes Logbook