



ANNUAL QUALITY ASSURANCE REPORT

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Executive Director

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SUBJECT: Quality Assurance Activities Fiscal Year 2006

SUBMITTED: March 6, 2007

MAJOR UNUSUAL INCIDENTS

There were twenty-one major unusual incidents during fiscal year 2006, an increase from fourteen in fiscal year 2005. The MUI's continue to be reported to the Fairfield ADAMH Board in a timely manner. The number of MUI's are increasing, perhaps due to an increase in the total volume of services rendered and perhaps due to the type of clients being services. This trend will be monitored over time.

TRANSFERS FROM STATE HOSPITALS

There were six transfer to a state psychiatric hospital this year, a decrease from seven in fiscal year 2005. There were twenty-seven incidents of clients being hospitalized for psychiatric care in community hospitals, an increase from seventeen incidents in fiscal year 2005. This increase in the number of clients being referred for hospital care may be due to an increase in the number of clients being seen at the agency and higher proportions of severely mentally disabled client's.

Clients are still receiving scheduled appointments within the appropriate time frame following discharge from hospital care when the agency is notified of the clients discharge and they can be reached for follow-up care.

PLANT/PHYSICAL HEALTH AND SAFETY

During the month of September the local fire department conducted the annual review of the agency buildings. During this review, it was found that the portable fire extinguishers in the agency were due to be inspected. The inspection occurred on October 4th and the



fire inspector re-inspected on October 7th and noted the correction. The fire inspector noted no other findings.

A major cleaning was completed in the Lancaster office in March. Various chairs and furniture that were in disrepair were discarded and replaced. The computer storage area of the basement was completely cleaned out, new shelves were installed, and remaining equipment was re-organized.

Repairs were required for the heating/cooling unit in Franklin County, these were completed by the landlord for the building. In the Lancaster office, the agency's sign blew down and was damaged due to high winds, a new one will be ordered and the structure from which it hangs will be modified to increase stability. The agency refrigerators were also cleaned out.

RECORDS COMPLETENESS REVIEW

An average of eighty-nine percent of clinicians are meeting the 95% threshold for records completeness reviews in the past twelve months. This is up eleven percent from last fiscal year. The QA Committee continues to look at ways to revise the QA process to make record and peer review requirements clearer to clinicians.

PEER REVIEW

An average of ninety-one percent of clinicians are meeting the 90% threshold for peer review, which is up four percent over last fiscal year. Record consistency and maintaining up to date forms in the chart are the two main factors tracked in the peer review process.

UTILIZATION REVIEW

There were a total of 1024 new clients to the agency during the year. Sixty-three percent of the new clients were from Fairfield County.

There were a total of 19,615 units of service rendered in the agency for this fiscal year. The chart below shows a 5 year comparison of core services. This chart shows the trend of agency growth. The agency has seen increases in services in Franklin County, especially group services. The agency does not currently have an AOD program, clients who are dually diagnosed are seen individually.

Service Area	FY2002	FY2003	FY2004	FY2005	FY2006
Diagnostic Assessment	1393	1368	1720	2057	2122
Individual Counseling	4854	7085	9644	10718	11587
Group Counseling	2751	2327	1785	2483	2634
CSP	3164	5800	5749	3673	2702
Medication/Somatic	187	332	591	560	613
AOD Group	154	268	126	8	0
Total Units	12,503	17,180	19,615	19519	19686

AOD PROGRAM REVIEW

The agency does not currently have an active AOD program. The agency continues to see dually diagnosed clients on an individual basis.

INVOLUNTARY TERMINATIONS

There were no involuntary terminations during the year.

REVIEW OF WAITING LIST

MOPS does not maintain a waiting list, clients continue to be scheduled in the next available time slot as they request service. The chart below shows the annual breakdown for the average number of days that lapsed between a person's telephone intake and initial session and the average wait from intake to the first scheduled appointment.

	2005	2006
Average Mean Wait 1 st Session	31.16	34.90
Average Mean Wait 1 st Scheduled Appt.	25.00	28.36

GENERAL COMMENTS

The overall QA process continues to improve, the committee meets monthly to discuss issues related to QA including PSO and agency wide improvement activities, and strives to improve the overall QA process through monitoring of concerns, processes, and forms. The completion of the QA reports has fallen behind, but increased efforts are being made to improve the timeliness of the reports.

CLIENT RIGHTS AND GRIEVANCES

There was one client grievance filed with the agency. On 5/19/2006 client #01090405 filed a grievance with the client's rights officer regarding her psychiatric care. The client had concerns about medication side effects and past medical history. Dr. Hedges responded to the grievance on 5/23/2006. At the client's request psychiatric care was transferred to another agency. The client continues to see a therapist at this agency.

TREATMENT OUTCOMES REPORTING

The agency began completing "Outcome Reviews" during FY2006 as required by ODMH standards. The agency has looked at various areas of client satisfaction with services and quality of life using the ODMH data mart.

