



QA REPORT

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

FROM: Shawna Watts-Shumaker, MBA
Quality Assurance Coordinator

SUBJECT: Quality Assurance Activities Fourth Quarter Fiscal Year 2006
April, May, June

SUBMITTED: March 6, 2007

MAJOR UNUSUAL INCIDENTS

There were seven major unusual incidents during the fourth quarter of FY2006.

The first incident occurred on 4/06/2006. Client #04021901 was referred to emergency services at Fairfield Medical Center after expressing intent to commit suicide. The client was transported from the agency by private vehicle to Fairfield Medical Center, after assessment it was deemed that hospitalization was not necessary. The client was seen by Claire Robitaille on 4/13/2006.

The second incident occurred on 5/5/2006. Client #03112406 exhibited thoughts of suicide during a session. The client abruptly left the session without indicating where they were going. The Lancaster Police Department was contacted to help locate the client after several attempts were made to locate the client. Staff of the agency or the police department did not reach the client until the client showed up for a scheduled court session. The client was seen by Joe Dunson on 5/10/2006.

The third incident occurred on 5/23/2006. Client #06033103 had a seizure in the waiting room, paramedics were called and the client was transported to Fairfield Medical Center where the client was treated and released. The client was seen by Steve Ford on 6/7/2006.



The fourth incident occurred on 5/23/2006. Client #05102504 hit another vehicle parked in front of the agency. Lancaster Police Department was called to take an accident report. The incident was resolved between the parties involved.

The fifth incident occurred on 06/12/2006. While client #05080102 was in session, their vehicle was struck by a passing vehicle in front of the agency. Agency front office staff heard the noise of the impact. The driver of the other vehicle called the police to report the accident. No one was hurt during the incident. Chris Johnson saw the client on 06/19/2006.

The sixth incident occurred on 06/16/2006. The agency's staff psychiatrist was transported by squad to Fairfield Medical Center after experiencing spells of dizziness and loss of balance. The psychiatrist was treated and released from the emergency room for a minor illness. The psychiatrist returned to the agency on the next scheduled workday.

The seventh incident occurred on 06/19/2006. Client #05062302 foot was accidentally run over by an agency case manager in the parking lot of another agency. The case manager offered to take the client to the emergency room, however the client indicated that it was not necessary. The case manager reported the incident to the group home facilitator upon returning the client home. The client's foot was examined at that time by the group home facilitator, the client, and the case manager and, it showed some redness. However, the client continued to state that there was no pain and that a trip to the hospital was not necessary. AJ Bierly saw the client on 07/05/2006.

TRANSFERS FROM STATE HOSPITALS

There were two transfers from a state hospital during the fourth quarter of FY2006. There were four clients who were hospitalized for psychiatric care in community hospitals. The state and community hospitalizations remained stable compared to those made in the same time frame one year ago.

Clinicians are complying with requirements that clients be seen within fourteen days of discharge after hospitalization; in most cases clients are seen within seven days of discharge.

PLANT/PHYSICAL HEALTH AND SAFETY

There were no reportable issues with the plant/physical health and safety at the agency. Inspections continue to be conducted on a monthly basis.

RECORDS COMPLETENESS

An average of 93% of clinicians met the 95% threshold for record completeness.

Areas contributing to missed points included:

- Forty percent of the records reviewed were missing a copy of the current medical card.
- Twenty 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 13% of the clinicians.
- In 32% of the records reviewed there was at least one session recorded that did not match the billing record.
- Twenty-five percent of the records reviewed had an Individual Service Plan on the chart that needed to be updated.
- Six percent of the records reviewed did not have a reviewed health assessment.

There continues to be no reportable trends regarding the areas contributing to clinicians failing QA.

PEER REVIEW

An average of 95% of clinicians are meeting the 90% threshold for peer review. This was an increase of 15% from the fourth quarter of 2005. There seems to be no pattern for any one clinician failing peer review at this point. The largest area of trouble is that records are not being maintained consistently.

UTILIZATION REVIEW

There were a total of 250 new clients seen during the fourth quarter, which represents a twelve percent decrease from the third quarter of FY2006. Sixty-three percent of the new clients were from Fairfield County.

The table below shows the total number of units of services that were billed under each services area for FY2006 for all of Mid-Ohio Psychological Services Inc.

Service Area	1st Quarter FY2006	2nd Quarter FY2006	3rd Quarter FY2006	4th Quarter FY2006
Diagnostic Assessment	558.9	522.6	547.1	493.2
Individual Counseling	2683.8	2885	3148.3	2869.5
Group Counseling	604.7	578.8	691.3	759.2
CSP	655.6	578	796	671.9
Medication/Somatic	160.8	150.5	150.8	150.7
AOD Group	0	0	0	0

Increases in group services can be attributed to increases in service in the Franklin County office.

AOD UTILIZATION REVIEW

There are currently no AOD groups active within the agency. AOD clients continue to be seen on an individual basis. However, clients seen by the agency are dually diagnosed.

INVOLUNTARY TERMINATIONS

No involuntary terminations were conducted during the fourth quarter of FY2006.

REVIEW OF WAITING LIST

MOPS does not maintain a wait list. Clients continue to be scheduled in the next available time slot as they request services. The agency strives to schedule within 30 days.

Service Area	1st Quarter FY2006	2nd Quarter FY2006	3rd Quarter FY2006	4th Quarter FY2006
Days from Intake to First Session	45	35	32	35

GENERAL COMMENTS

A fire drill was conducted in the Lancaster office on 04/10/06 at 7:15am, with 3 participants, one from each agency building. The buildings were evacuated in 55 seconds.

A tornado drill was conducted in the Lancaster office on 04/07/06 at 7:30am, with 5 participants. The drill was conducted in 3 minutes.

The agency continues to refer people to other agencies for two primary reasons, payment coverage and people being in need of services we do not offer, such as treatment for young children. The agency has seen an increase in the number of existing clients that had to be referred to other agencies due to a change in the Medicaid status from Ohio Medicaid to an Ohio QMB card. The agency is not approved to accept the Ohio QMB card, so client services are no longer covered. The agency has facilitated transfer of these clients to various providers who are approved providers for Ohio QMB or who are funded to provide services based on client income. The changes from Ohio Medicaid to Ohio QMB started in January as a result of some changes at the state level.

The agency continues to refer people seeking services with private insurance to local private providers who are network providers. This allows the person seeking services to reduce their out of pocket expenses. In the event that they prefer to work with our agency, insurance companies are billed as a courtesy to the client. However payment for services are required in advance of the service being delivered, since the agency is out of network with all insurance companies.

The agency continues to refer people without insurance or other coverage to New Horizons for income based fees. However, since the Fairfield County ADAMH Board has passed a levy, the agency is hoping to be able to provide some sliding scale services in the near future.

The monthly summary sheet referral area was reviewed for referrals to other agencies made by clinicians during the past year, May 2005 – April 2006. Two clients were referred to the Fairfield County Board of MRDD for services after IQ testing revealed mental retardation. One client was referred to the Recovery Center for intensive AOD treatment. One client was referred to New Horizons for sliding scale services due to loss of Medicaid coverage.

The focused area of review for May was to review the agency's QA process.

Review QA Plan's Overall Goals And Objectives And Revise

The agency's current goals and objectives are listed below. No changes were made to the goals or objectives as they are still consistent with current QA activities.

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.

Comments: The agency continues to meet all state requirements for ODMH and ODADAS as well as maintaining the requirements of our national accreditation through CARF.

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.

Comments: The agency continues to improve in this area by developing E-trainings for staff and offering agency sponsored CEU trainings.

Goal: Clinical Accountability

Objectives: Quality Assurance staff will work with clinicians 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.

Comments: The committee continues to review charts for appropriate testing and diagnosis. Reviewers provide feedback to clinicians if goals are not supported by diagnosis. Reviews were conducted of high utilization clients and psychiatric clients to ensure that the agency is providing adequate care and that diagnosis supports the use of medication.

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.

Comments: The agency continues to monitor utilization of services by clients by monitoring clinical caseloads and high utilization reports. The case management team attempts to engage clients in external services when needed.

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.

Comments: Since last May, the agency has constructed a sidewalk between the 624 and 630 building due to stepping-stones becoming worn and raised and presenting a safety issue. A dehumidifier was added to the 632 building due to dampness and odor. Agency furniture was inspected and many chairs were disposed of and replaced due to age. The air conditioning unit for front half of 624 building was repaired. Carpet was replaced in the 624 building in the waiting room, front office, Executive Directors office and entry way. Carpet was also put down in the kitchen that was renovated into office space. Carpets were cleaned in the entire 632 building and in all of the common areas such as waiting room and hallways of the 630 building. A receptionist and the Administrative Coordinator cleaned and reorganized all of the shelving areas in the 624 front office. All of the agency supply closets were cleaned out and reorganized. The computer storage/basement storage area was cleaned out and new shelving was added to improve organization. The signage in front of the agency was replaced with a more secure version due to the old sign blowing down frequently. Ceiling tiles in the 632 building were repaired.

Review The Achievement Of Accepted Professional Standards Of Practice

The QA Coordinator continues to review /monitor training through Monthly Summary Reports as well as monitoring license expirations for all clinicians. The agency has implemented e training for the agency and is a certified CEU provider for State of Ohio Psychology Board and the State of Ohio Counselor, Social Worker, and Marriage and Family Therapist Board. The agency has offered 4 trainings since becoming certified and has another one planned for August.

Review The Resolution Of Identified Problems

The QA Committee continues to monitor corrective actions to reviewed charts and looking for ways to improve the efficiency of monitoring corrections including improving comments and suggestions on how to make corrections. The QA Coordinator communicates problems with the clinical supervisors and Executive Director. QA updates are shared with the Board of Directors at every meeting. The QA committee conducted an inter-rater reliability study and is currently editing the Records Review and Peer Review forms with clarifications, instructions for sections that had poor reliability, and an overall update.

Assess The Efficiency Of QA Activities

QA activities have fallen behind due to the inter rater reliability study and have remained behind due to the QA Coordinator not being able to devote adequate time to the reports and the QA reviewers being behind on reviews. Records Completeness and Peer reviews were suspended for the months of January and February in order to facilitate bringing QA reporting into a current time frame. The agency will still be in compliance with ODMH and ODADAS annual review requirements of ten percent of all cases by conducting approximately twenty-three reviews each month, the agency far exceeds the requirement on an annual basis.

Review The Adequacy Of Corrective Actions

Verifying that corrections have been made to charts continues to be a challenge for the QA Committee. The QA Coordinator continues to send out e-mail reminders if Correction Letters are not returned in a timely manner. However there has been some improvement in the number of clinicians who complete the corrections without being reminded.

Review Methods For Improving The Service Delivery System

Reminder calls continue to be made, and the agency continues to strive to get clients in within 30 days for services. Formal evaluations services and medication somatic services are being scheduled for the most part within 60 days. The case management and home based therapy programs continue to be improved through researching methodologies that

work best. The agency has applied for sliding scale funding for an Anger Management and expansion of the Sex Offender program from the ADAMH Board for FY2007.

Conduct A Bomb Threat Drill

A bomb threat drill was not conducted; it will be conducted in the near future.

A power failure drill was conducted on June 16, 2006 at 8:01am with 5 participants. The drill lasted 6 minutes and all agency procedures were followed.

AOD Services Review

The reporting of the AOD services review was delayed from June until now, the results of the review are reported as follows:

The agency does not currently have any AOD groups. A review was conducted of all 204 active clients who have an AOD diagnosis. Individual Service Plans were reviewed to assess if treatment goals are addressing these diagnoses. Releases of information and outside communication were reviewed on cases in which this agency is providing mental health services, and the AOD issues are being addressed by another agency.

Of the 204 charts reviewed for this review, 48 (24%) indicated that the client was seen for an evaluation only, and no treatment was provided. For these clients that received an evaluation only, 43 (90%) were provided with recommendations for structured substance abuse treatment, and 4 (8%) were provided with recommendations to engage in twelve-step meetings only. Only 1 client (2%) with an AOD diagnosis was not recommended for any treatment as the diagnosis included a specifier of sustained full remission, indicating that the client was working a program of sobriety with sustained success.

For the remaining 156 clients engaged in services at Mid-Ohio with an AOD diagnosis, 14 (9%) did not have any treatment goals related to substance abuse, with no reason given. A sampling of these clients' therapists indicated that these clients were in remission from their substance issues and did not require these services, or that the client declined substance treatment. Twenty-five clients (16%) had a treatment goal of maintaining sobriety only with no other specific interventions for maintaining sobriety being identified. Sixty-nine clients (44%) featured one treatment goal on their Individual Service Plan beyond simply monitoring sobriety, and 20 clients (13%) featured multiple goals related to their substance abuse but were not identified as using a structured AOD program. Sixteen clients (10%) were engaged in structured substance treatment through Mid-Ohio, utilizing twelve-step meetings, individual counseling, education regarding their drug of choice, and completion of specific homework assignments related to the twelve steps and relapse prevention.

Eleven (7%) of the 156 charts for clients who were to receive treatment beyond an evaluation only featured a Plan of Action, which is completed following a clients'

diagnostic intake. In half of these charts, the client did not return for additional sessions, and it is not clear why Individual Service Plans were not completed for the other charts.

The 204 charts for clients with substance-related diagnoses were examined to determine whether contact with historical or current AOD providers existed. Ninety-nine of these clients had not received substance treatment prior to or during treatment at Mid-Ohio, so no collateral information was needed. Of the remaining 105 clients, 26 (25%) had identified previous or current substance treatment to the therapist, but no releases of information were created to obtain records of this treatment and no data from the prior treatment was in the chart. Fifty-three (50%) clients had signed releases of information from other treatment providers, but that information was never received by this agency. Twenty-six (25%) clients' charts included information from past and current AOD providers. In addition to this information, each outside AOD provider was examined to assess the consistency that information was returned when requested by the agency. The breakdown of this information is as follows:

AOD Provider	No. of Times Information Was Requested	Information Returned	Information Not Returned	% of Successful Communication
Recovery Center	45	16	29	35.5%
The Counseling Center	19	4	15	21.0%
New Horizons	6	6	0	100%
Stepping Stones	6	0	6	0%
Rural Women's Recovery Program	5	3	2	60.0%
Health Recovery Services	4	1	3	25.0%
Marsh House	3	0	3	0%
Talbot Hall	3	2	1	66.6%
Maryhaven	2	0	2	0%
Pickaway Area Recovery Services	2	0	2	0%
Stanton Villa	2	2	0	100%
Recovery Concil	2	0	2	0%
Scioto Paint Valley	1	1	0	100%
Franklin County Health Department	1	0	1	0%
Behavioral Health Choices	1	1	0	100%
Twin Valley	1	1	0	100%
Shepherd Hill	1	1	0	100%
Spencer House	1	0	1	0%
Huntington Treatment Center	1	1	0	100%
FACTS	1	1	0	100%
Osterlin	1	0	1	0%
Buckeye Ranch	1	0	1	0%
Tri-County	1	1	0	100%
Total	110	41	69	48.2%

It should be noted that 10 of the cases reviewed are receiving concurrent services from an outside agency for AOD services. Of these cases, half had communication documented in the chart between MOPS and the other agency. The remaining half did not have adequately documented communication. Reasons that were cited included no release of information in the chart for the outside agency, or the release of information was expired with no documentation as to whether the client was still receiving services from the other agency.

These findings create areas for future reviews. Among the areas to be reviewed are whether on-going coordination of services with outside agencies is successful, and if the agencies were responsive when contacted. In the case where clients are not receiving treatment for their substance issues, the reasons for this decision need to be clearly documented. Finally, the quality of communication with outside sources throughout the treatment process needs to be analyzed.

The agency continues to forward quarterly reports to the Fairfield County ADAMH Board as they are completed.

CLIENT RIGHTS AND GRIEVANCES

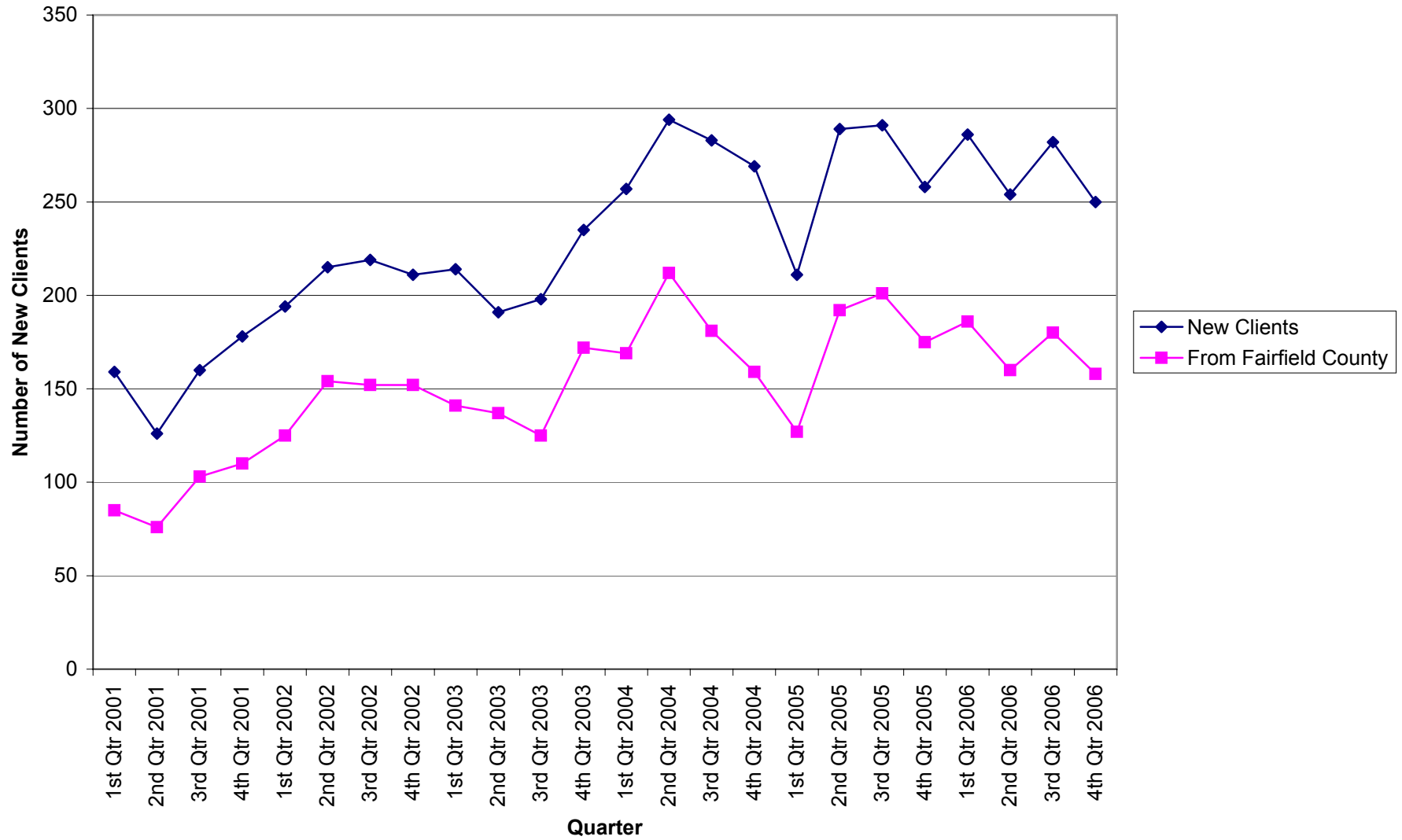
There was one client grievance filed with the agency during the fourth quarter. On 5/19/2006 client #01090405 filed a grievance with the client's rights officer regarding her psychiatric care. The client had concerns about medication side effects and past medical history. Dr. Hedges responded to the 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

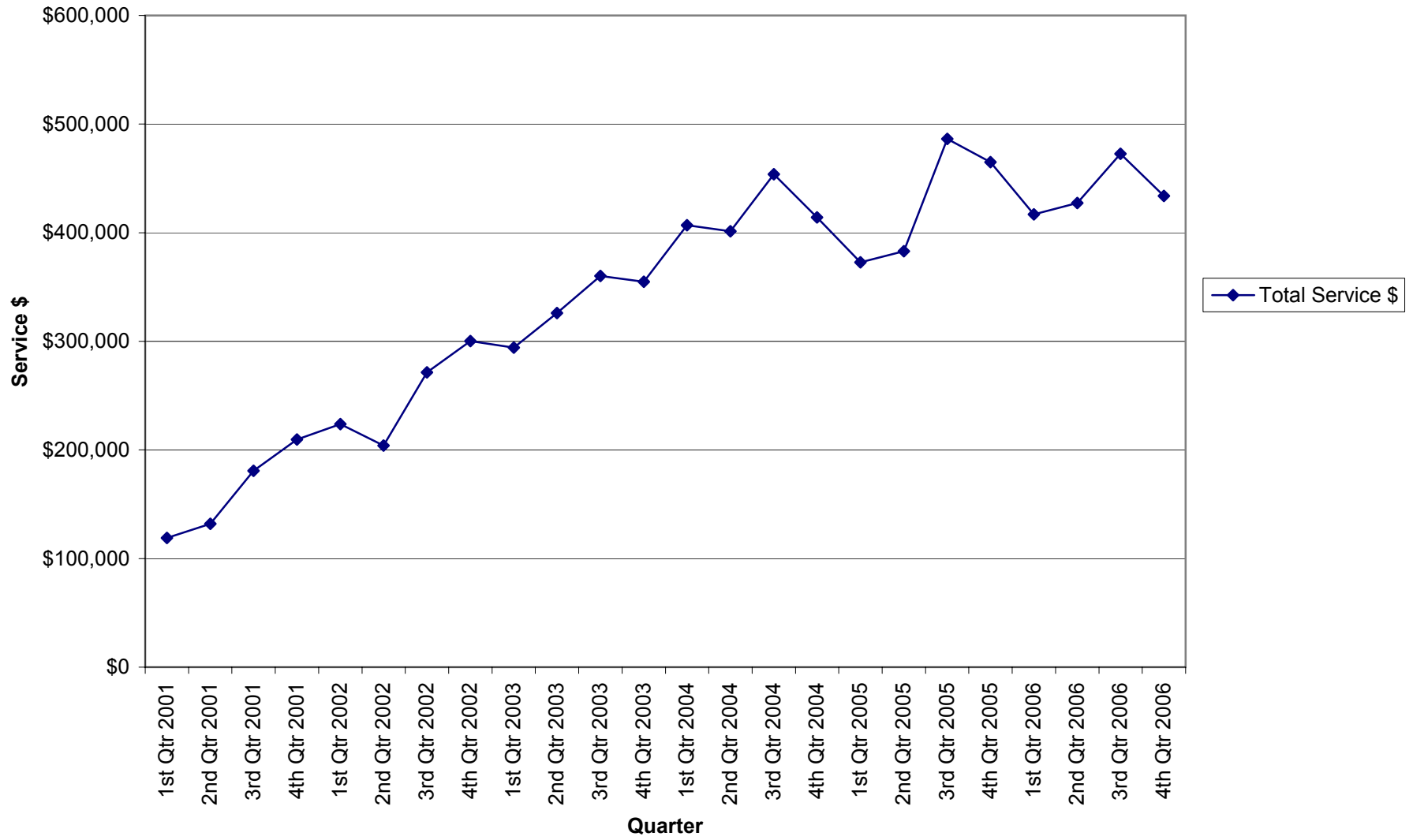
The agency continues to complete "Outcome Reviews" as required by ODMH standards. The agency has looked at various areas of client satisfaction with services and quality of life using the ODMH data mart.

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

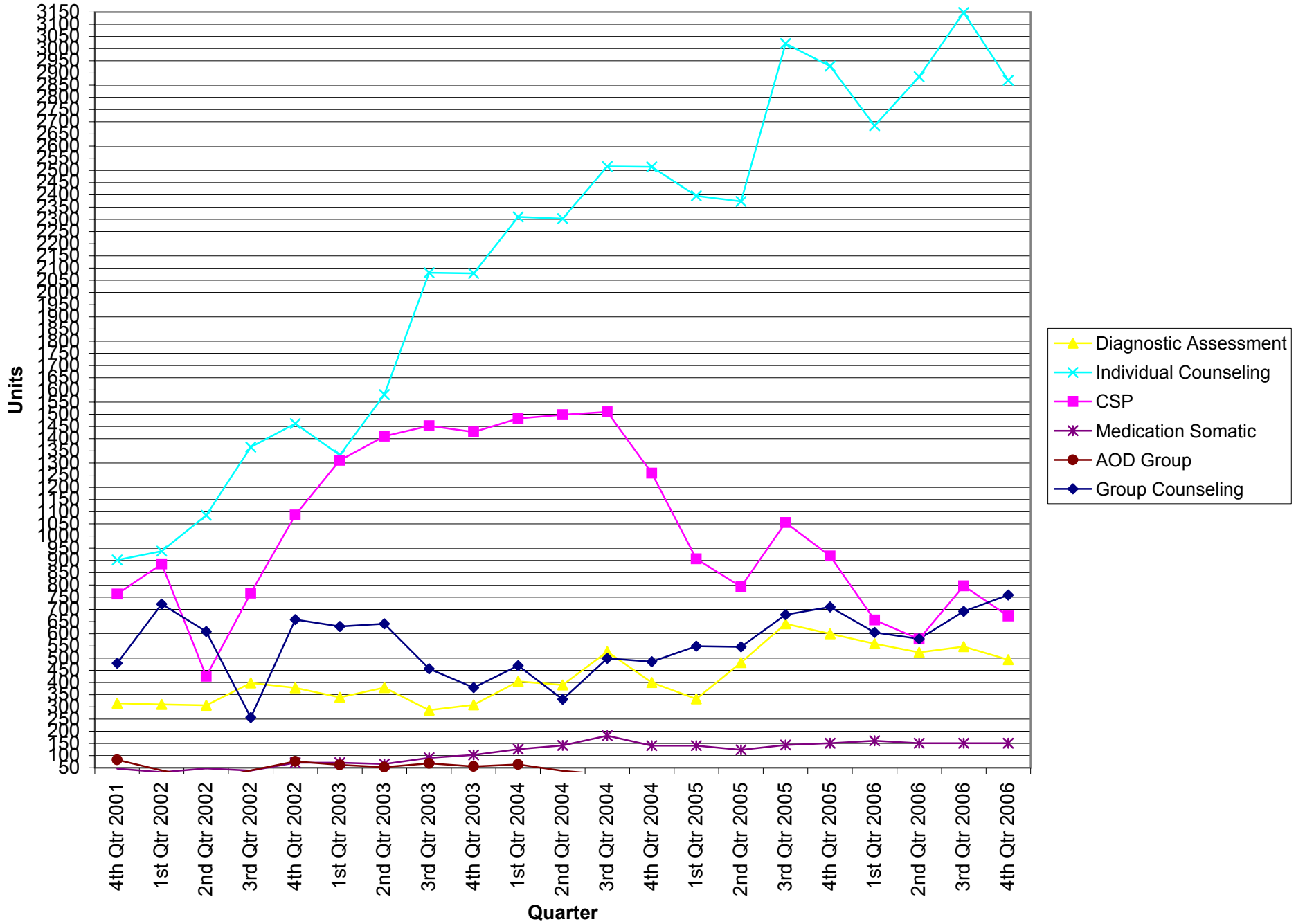
New Clients



Total Quarterly \$'s of Service



Quarterly Units of Service



Quarterly Compliance Review

