



**Scioto Paint Valley Mental Health Center**

Quality  
Assurance  
Plan

**FY 2016**



## **SCIOTO PAINT VALLEY MENTAL HEALTH CENTER**

### **QUALITY ASSURANCE PLAN**

#### **OVERVIEW**

This document presents the comprehensive and systematic plan for the operation of the quality assurance program of Scioto Paint Valley Mental Health Center. The Quality Assurance Plan shall be the standard that guides business function and service delivery and applies to all programming and services at the Agency. Scioto Paint Valley Mental Health Center understands the need to strategically monitor and assess its performance as defined by the Agency's Performance Indicators. The Quality Assurance Plan will serve as the foundation for Performance Improvement. This comprehensive approach to Quality Assurance will define the Performance Indicators.

#### **PURPOSE**

To stay on target at both strategic and tactical levels, the Agency will continually monitor and evaluate its performance against a series of defined performance indicators and targets. By setting specific, measurable goals and tracking performance, the Agency can ascertain to what degree it is reaching its desired goals for service and business outcomes. Data will be collected from a variety of sources including clients, stakeholders and staff.

#### **MISSION**

It is the mission of Scioto Paint Valley Mental Health Center to provide leadership and services in the community wide effort, to foster positive optimal mental health and to prevent, reduce, and minimize effects of mental health problems.

In response to the mission statement, the Agency had developed the following goals to guide the overall mission:

- Meet the targeted mental health and substance abuse needs of our clients
- Obtain the funding necessary to provide services
- Provide a work environment which promotes quality, productivity and employee satisfaction

#### **SCOPE OF SERVICE**

The Agency is a comprehensive provider of mental health, substance abuse services to a five (5) county service area that includes Ross, Pike, Pickaway, Highland and Fayette. Services provided include: outpatient, day treatment, diagnostic assessment, pharmacological management, and forensic evaluation, crisis intervention services including pre-hospitalization services, consultation, prevention,

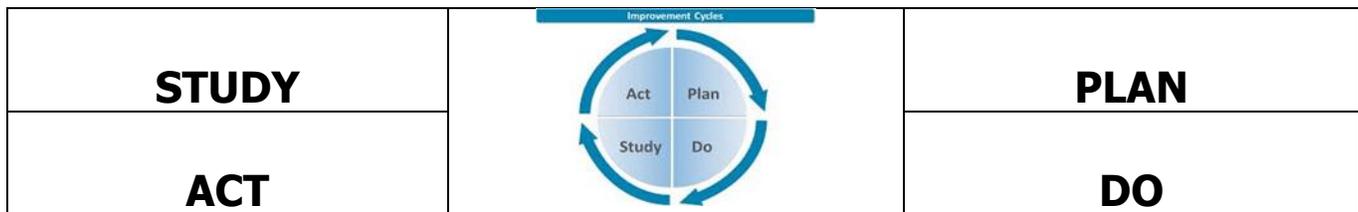
education, community psychiatric supportive treatment and residential care services. We also provide primary care services at one of our Ross County sites and in our Greenfield office.

The Agency’s structure is based on a decentralized model and operates clinics in each county of the service area. The satellite clinic in each of the five counties provides a full range of mental health and substance abuse services (excluding residential). Services that form the basis for identifying aspects of care (to be monitored/evaluated) have been chosen due to high volume, potential problems, and the wide range of needs that the service is required to meet.

**THE MODEL**

Quality Assurance is a systematic, ongoing process that is designed to assess and evaluate the quality and appropriateness of services, to resolve identified problems, to identify gaps in service, to promote opportunities to improve business practices and service delivery and overall organizational performance.

**THE QUALITY ASSURANCE MODEL**



1. **Study** the system or process where improvement is needed. Evaluate the available information and describe what the information is telling you. Are there particular problems and what are the causes?
2. **Act** and decide what change is needed. Will this be a large-scale or small-scale change?
3. **Plan** on how the data will be collected. When will the progress be reviewed? Who will do the work?
4. **Do** the work according to the plan that was created.
5. **Study** the gathered information and determine whether the desired outcome was achieved or not?
6. **Act** by deciding if any further action is needed to bring improvement to noted area.

Performance Improvement Process will be conducted annually and it will be the goal of this process to:

- Identify areas in need of improvement
- Develop an improvement plan that clearly defines steps to take for corrective actions, reevaluate outcome measures if needed, revise performance indicators if needed
- Assign responsibilities to ensure completion of corrective action
- Develop summary report to be shared with clients, staff, and other stakeholders to ensure transparency, accountability and to garner valuable feedback to be used for continual quality improvement activities

## PROGRAMS SERVICES

\*All programs are accredited for both adults and children and adolescents unless stated

- Community Psychiatric Supportive Treatment (Mental Health & Substance Abuse)
- Crisis Intervention (Mental Health & Substance Abuse)
- Outpatient Treatment (Mental Health & Substance Abuse)
- Day Treatment (Mental Health and Adults Only)
- Community Services: Community Integration
- Employment Services: Employee Development Services
- Prevention Services (Substance Abuse)

\*Specific descriptions and objectives of the program can be found in Section Five of the Policy and Procedure Manual as well as the Agency Service Plan.

## DATA COLLECTION SYSTEM

Scioto Paint Valley Mental Health Center understands the need to strategically monitor and assess its performance as defined by the Agency's Performance Indicators identified in the Agency Quality Assurance Plan. This section of the Quality Assurance Plan describes the Agency process of obtaining the information that is used to meet Performance Indicators and how this information is disseminated to the Agency and other stakeholders for the purposes of Quality Assurance, Evaluation, Corrective Action, and Improvement.

It shall be the continual goal of Scioto Paint Valley Mental Health Center to demonstrate the effectiveness of the data collection system in place by addressing the following areas:

### 1. Reliability

- The Agency will take steps to ensure data is collected consistently across the board. For example, the intent is to guarantee that multiple data gatherers can replicate the information being reported.
- The Agency will have the following safeguards in place to ensure data is reliable:
  - Performance Indicators will be clearly identified and reviewed with all staff
  - Results will be collected and validated by Quality Assurance Committee
  - Staff shall receive training when asked to collect a particular data element

### 2. Validity

- The Agency will choose performance indicators and data elements to measure what it is both mandated to measure as well as what is agreed upon by the Quality Assurance Committee to measure.
- The Agency will have the following safeguards in place to ensure data is valid:
  - QA Plan will be reviewed by QA Committee, Agency Leadership, Board of Trustees and Paint Valley ADAMHS Board to ensure thoroughness and validity.
  - The Agency will ensure that input from clients, stakeholders and employees is garnered and that their input is incorporated in the performance indicators that are included in the Quality Assurance Plan.

### 3. Completeness

- The Agency will take steps to ensure that the data used for decision making is as complete as possible, no accredited programs are omitted from the information and performance improvement effort, no groups of persons served are omitted from the data gathering or analysis, no data elements or indicators are systematically missing, and any database is checked for completeness of records before final analyses are run and decisions made.
  - Staff members assigned for data collection will be trained on appropriate methods of data collection. Results will be shared with Quality Assurance Committee in a report. Recommendations and edits/additions will be included in the report.

### 4. Accuracy

- The Agency will take steps to ensure that data is recorded appropriately and that errors are caught and correction.
  - Staff members will be encouraged to re-run reports to ensure accuracy. Data will be reviewed with historical data to monitor variance/accuracy.

## DATA COLLECTION RATIONALE

Although quality service is a function of the relationship between service provider and the client who receives the service, quality is evidenced by complete and appropriate record keeping. Methods of review are therefore based on data that should routinely be found in any client record at any given time. The following is a modest overview of methods, sample sizes, frequency and reporting that will be used to verify quality and identify problems that are related to service provision.

## DATA COLLECTION METHODS

1. Individual Client Record Review
2. Annual Review of Performance Indicators
3. Clinician Peer Review
4. Clinical Safety Drill Reporting Form
5. Annual Review of Emergency Drills and Procedures
6. Annual Review of Grievances and Formal Complaints
7. Financial Audit by Independent Accounting Firm on Individual Client Records
8. Psychiatric Peer Review (Drug Utilization Evaluation)
9. Consumer Satisfaction Surveys
10. Stakeholder Satisfaction Surveys
11. External Website Survey
12. Internal Employee Satisfaction Surveys
13. Clinic Focus Reviews
14. Clinical Supervision
15. Annual Review of Critical Incidents
16. Anasazi Reports

## PERFORMANCE INDICATORS

CARF International defines a performance indicator as, "A quantitative expression that can be used to evaluate key performance in relation to objectives. It is often expressed as a percent, rate, or ratio" (CARF 2013 Standards Manual, p. 410). And as stated above, the Center shall gather feedback and establish performance indicators for the following areas:

- Effectiveness
- Efficiency
- Access
- Satisfaction
- Organizational/Business

## DATA COLLECTION METHODS OVERVIEW

**1. Individual Client Record Review:** Each Clinic Director, along with the Corporate Compliance Officer will review five (5) records per month to ensure accurate documentation, ISP compliance, chart completeness, etc. This will result in a yearly goal of reviewing of 480 charts. Record Review audits charts from an administrative perspective to ensure thoroughness of the record. The Agency Board of Trustees offered some guidance on this process as well by establishing the need for our Center to define critical areas to look at when reviewing individual client records. Individual Client Record Review occurs on a monthly basis with each Clinic Director along with the Corporate Compliance Officer reviewing five charts at other clinic sites and then submitting these findings to the Corporate Compliance Officer who is responsible for processing this data and reporting on the findings in the Quality Assurance Meetings held each month.

1. Does the ICR have a current and signed Individualized Service Plan (ISP)?
2. Does the ICR have a current Health Assessment for the client?
3. Are there progress notes for every rendered service?
4. Does the ICR have up-to-date Authorization of Release Forms?
5. Does ICR have up-to-date Comprehensive Assessment?

**2. Peer Review:** The purpose of the Peer Review Committee is to conduct a thorough review of client cases and the clinician's actions on these cases to ensure appropriate levels of care. During this time, progress notes are reviewed along with the overall completeness of Individual Client Record. This review looks to see if services provided coincide with listed services on the client Individualized Service Plan. The Peer Review Committee audits records from a clinical perspective to ensure Individualized Service Plan adherence, and overall goal progress. Clinical Peer Review occurs on a quarterly basis and involves clinicians at each clinic site. Clinicians are asked to pull charts of "challenging" cases.

- 3. Financial Audit by Independent Accounting Firm on Individual Client Records:** This individual client record review is conducted by an independent accounting firm that ensures that services billed coincide with client's Individualized Service Plan; and billing information is accurate and meets state billing requirements. A Financial Audit by an Independent Accounting Firm occurs each year and is conducted by an independent firm that samples a random number of charts. Findings are reported to the board.
- 4. Psychiatric Peer Review (Drug Utilization Evaluation):** The Psychiatric Peer Review examines the appropriateness of prescribed medication per client diagnosis, overall effectiveness of prescribed medication and overall satisfaction of client with medication prescribed. Psychiatric Peer Reviews occurs on a monthly basis and sample size varies but methodology and frequency remain constant. Findings are reported to the Associate Director of Intensive Services as well as the Corporate Compliance Officer who shares this information at the monthly Quality Assurance Meeting.
- 5. Consumer Satisfaction Surveys:** Each year, the Agency participates in a survey process with our client served population. The intent of this survey process is to examine all provided services to clients and their effectiveness in an attempt to improve overall service delivery and ensure that services are efficient, effective and high-quality. Consumer Satisfaction Surveys along with Stakeholder Surveys occur each year and will focus on all services provided by the Agency. The Stakeholder Surveys will focus on various groups in the community that hold a stake or interest in the services we provide. Consumer Satisfaction Surveys along with Stakeholder Surveys will be monitored by the Quality Assurance Committee.
- 6. Stakeholder Satisfaction Surveys:** The Agency values the opinions of the community and it is understood that community opinion regarding mental health services can greatly influence overall public opinion of services. The opinions regarding services, client outcomes, and access to services that are gathered from stakeholder satisfaction surveys is incorporated into the Agency's effort to improve service delivery and client outcomes.
- 7. Clinical Focus Reviews:** A clinical focus review will take place when a program receives a rating below 85% based on the results of the consumer satisfaction survey. The focus reviews looks at trends, feedback received, noted problems and areas for improvement, future goals, and implementation of action plan. Focus Reviews occur when a service program receives a rating of below 85% from the Consumer Satisfaction Survey. Focus reviews occur at the location where the service did not reach the 85% threshold.
- 8. Clinical Supervision:** The underlying purpose of clinical supervision is to oversee the delivery of clinical services within context: ensure safety, facilitate learning, promote reflection and understanding, support staff, and enhance competence and resilience, problem solve, and improve client outcomes. Clinic Supervision is an ongoing review of clinical work that takes place weekly at each clinic location. Supervision works to address

concerns/questions that clinicians have regarding services, clients, the Agency, etc. Supervision is the first-line defense in ensuring that Quality Assurance is top priority.

9. **Annual Trend Analysis of Critical Incidents:** An important aspect of ongoing quality assurance is to learn from things that have occurred and use this data to prevent those events from occurring in the future. Trend analysis looks at patterns of events and processes the findings to implement procedures/plans to prevent those occurrences from happening again or to minimize the possibility. Review of Critical Incidents consists of reviewing all incident reports received within a given year and determining trends/patterns. The process evaluates how the Agency can improve on areas and performance improvement is directly connected to this annual review process.
10. **Annual Review of Performance Indicators:** A Performance Improvement Plan will occur each year to determine whether or not the Agency met stated indicators. This review will either prompt the Agency to take corrective action and address deficiencies or will show Agency compliance to Performance Indicators. This review will be conducted by members of the Leadership Team. Review of Performance Indicators will occur from within Leadership and Management each year. The purpose of this review will be to evaluate current indicators being monitored and to determine whether or not these indicators are resulting in better outcomes or if the indicators need to change.
11. **Anasazi Reports:** Our electronic health record, Anasazi, has tremendous capabilities to run reports that enable the Agency to ensure compliance on numerous indicators contained in this plan. Anasazi will be a critical element in ensuring that Agency expectations are met.

#### **THE DATA COLLECTED BY THE AGENCY SHALL INCLUDE:**

- Financial information
- Accessibility status reports
- Resource allocation
- Surveys
- Risk Management
- Human Resources
- Technology
- Health and safety reports
- Field trends
- Service delivery

#### **THE DATA COLLECTED BY THE AGENCY SHALL ADDRESS:**

- The needs of persons served
- The needs of personnel
- The needs of other stakeholders
- The business needs of the Agency

**PERFORMANCE INDICATOR GRID**

<b>Domain</b>	<b>Objective</b>	<b>Indicator</b>	<b>Who Applied To</b>	<b>Time of Measure</b>	<b>Data Source</b>	<b>Obtained By</b>	<b>Performance Goal</b>
<b><i>Effectiveness</i></b>							
	Clients will have a reduction of their symptoms as a result of receiving services as well as reporting that they deal more effectively with daily problems.	Clients self-reporting on client satisfaction survey that their symptoms have decreased as a result of services and a greater ability to deal effectively with daily problems.	All clients who are active at time of survey.	At randomized intervals throughout the client's time in the program.	Client Satisfaction Survey Instrument Question 8.1 and 8.2	Clinical Teams and Clerical Teams will assist in this effort.	85% of the clients surveyed will report at a level of 80% or greater that their symptoms have decreased as a direct result of receiving service and that they deal more effectively with daily problems.
	Clients will report that receiving treatment has helped them find more purpose in life.	Clients self-reporting on client satisfaction survey that they feel they have more purpose as a direct result of the treatment they have received.	All clients who are active at time of survey.	At randomized intervals throughout the client's time in the program.	Client Satisfaction Survey Instrument Question 8.7	Clinical Teams and Clerical Teams will assist in this effort.	85% of the clients surveyed will report at a level of 80% or greater that treatment has helped them find more purpose in life.
<b><i>Efficiency</i></b>							
	Stakeholders and/or clients will report that their treatment provider and/or	Clients self-reporting on client satisfaction survey that their	All clients who are active at time of survey.	At randomized intervals throughout the client's time in the program.	Client Satisfaction Survey Instrument Question 6	Clinical Teams and Clerical Teams will assist in this effort.	85% of the clients surveyed will report that their treatment provider and/or

Domain	Objective	Indicator	Who Applied To	Time of Measure	Data Source	Obtained By	Performance Goal
	Agency representative was on time for their scheduled appointment or was provided a reason why their treatment provider and/or Agency representative was running behind schedule.	treatment provider and/or agency representative was on time for their scheduled appt.					Agency representative was on time for their scheduled appointment or the client was provided a reason why the individual was running behind schedule.
<b>Efficiency</b>							
	Staff with a productivity standard will achieve their required productivity by the end of Fiscal Year 2016.	Staff will achieve their productivity standard within the required timeframe.	Clinical staff having a productivity standard.	Quarterly report that is compiled by Lynn Albright	Quarterly Productivity report	Clinical Team	85% of staff with a productivity standard will achieve a 90% productivity standard by the end of Fiscal Year 16.
<b>Access</b>							
	New clients scheduled for a diagnostic assessment will be seen within two weeks of initial contact.	Clients will be seen for their diagnostic assessment within two weeks of being scheduled.	New clients that are being scheduled for a diagnostic assessment.	The report will be generated on a quarterly basis.	Quarterly Quality Assurance Report	Clinical Team/CCO	85% of clients that are new and that are scheduled for a diagnostic assessment will be seen within two weeks of initial contact.

Domain	Objective	Indicator	Who Applied To	Time of Measure	Data Source	Obtained By	Performance Goal
	New clients scheduled for an initial pharmacological management service with a prescriber will be seen within four weeks from the time they were referred.	Clients will be seen by a psychiatrist within four weeks of being referred.	New clients that are being scheduled for psych. services.	The report will be generated on a quarterly basis.	Quarterly Quality Assurance Report	Clinical Team/CCO	85% of clients that are new and that are scheduled for an initial pharmacological services with a prescriber will be seen within four weeks from the time they were referred.
	To ensure that clients are seen in a timely fashion, the Center is striving to see an overall reduction of "staff cancels" for client appointments in Fiscal Year 2016.	The Center will see a 40% overall reduction in "staff cancels"	All Clinicians	This report will be generated on a quarterly basis.	Quarterly Quality Assurance Report	Compliance Officer	The Center will see an overall 40% reduction in "staff cancels" when compared with the percentage of "staff cancels" that occurred in Fiscal Year 2015.
<b>Satisfaction</b>							
	Ensure that clients are satisfied with the services they are receiving to the point that they recommend services to their family and friends if	95% of clients surveyed will report that they will recommend services to a family member or friend.	All clients who are active at time of survey.	At randomized intervals throughout the client's time in the program.	Client Satisfaction Survey Instrument Question 12	Clinical Teams and Clerical Teams will assist in this effort.	95% of the clients surveyed will recommend our services to family and friends.

Domain	Objective	Indicator	Who Applied To	Time of Measure	Data Source	Obtained By	Performance Goal
	needed.						
	Ensure that clients not only find the services to be effective but that they enjoy the services here.	95% of clients surveyed will report that they like the services here.	All clients who are active at time of survey.	At randomized intervals throughout the client's time in the program.	Client Satisfaction Survey Instrument Question 13	Clinical Teams and Clerical Teams will assist in this effort.	95% of the clients surveyed will report that they like the services that were offered at the Center.
	Increase overall client satisfaction in services.	90% of services that are surveyed will see a 5% or greater improvement in overall client satisfaction.	All clients who are active at time of survey.	At randomized intervals throughout the client's time in the program.	Client Satisfaction Survey Instrument Question 14	Clinical Teams and Clerical Teams will assist in this effort.	Center will see a 5% improvement of overall satisfaction with services as compared to overall satisfaction percentage with services in FY 14.
	Ensure that the Center is capturing information regarding each accredited program.	10% expected client survey return from each accredited program and services.	All CARF accredited programs	Utilize client satisfaction form and tally up results throughout the year.	Utilize client satisfaction form and tally up results throughout the year.	Compliance Officer and Clerical Teams	Center will receive 10% client survey return from each CARF accredited program to meet this goal.

Domain	Objective	Indicator	Who Applied To	Time of Measure	Data Source	Obtained By	Performance Goal
<b>Organizational/Business</b>							
	The Center will be attractive and well-maintained.	95% stakeholders surveyed will report that the Center was well-maintained and attractive.	All Clinics	Utilize client and stakeholder satisfaction form and tally up results throughout the year.	Utilize client and stakeholder satisfaction form and tally up results throughout the year.	Compliance Officer and Clerical Teams	Center will see 95% of stakeholders that are surveyed report that the clinic they encountered was well-maintained and attractive.
	To ensure that the Center remains productive and produces sufficient revenue for ongoing operations.	The Center will have a 20% or less overall "No Show" rate by the end of FY 15.	All Clinicians	This information will be gathered on a quarterly basis.	Anasazi report that captures "No Show" Information	Compliance Officer/IT	The Center will successfully meet this goal if we have a 20% or less "no show" rate when compared to FY 15 "no show" rate.
	To provide continual access to clients in need, the Center understands the importance of filling critical vacancies in a	Vacancies are filled in a timely manner.	Human Resources	Throughout the year information will be gathered by job posting, hire date and orientation.	Communication with HR/Dates	Compliance Officer/HR	The Center will meet this goal if we do not average more than 5% staff vacancies for a period averaging thirty days or

Domain	Objective	Indicator	Who Applied To	Time of Measure	Data Source	Obtained By	Performance Goal
	timely manner.						more during FY 16
	The Center desires that individual client records we accurate, thorough and complete.	Records will be in compliance to meet regulatory environmental standards.	Clinician/Clinic Director/Assoc. Directors/Clerical	Each Clinic Director and the Compliance Officer will review 5 records each month that consist of 1 newly admitted client, 1 recently terminated, and 3 ongoing cases. Auditing team will utilize the Agency Record Review Form for this process.	Compliance Officer will gather all the record review forms each month and will present this information to each Clinic Director so that clinicians can fix the records. This information is reported to the Board quarterly as well.	Compliance Officer and Clinic Directors	85% of records reviewed will achieve at least 85% compliance in the specified areas being reviewed.
	Each clinic will operate in a safe fashion to ensure the safety of client, staff and stakeholders at all times.	Clinics will conduct their required quarterly and annual drills and inspections.	Facility Coordinator/ Clinic Directors/Clinic Safety Committee	Quarterly and annually	Agency specified inspection and drill form located in Agency Procedures 06-01-04 and 06-01-07	Clinic Directors/Clinic Safety Committee and Facility Coordinator	100% of clinics will conduct all quarterly drills and inspections as specified by Agency Policy and Procedure in FY 16.
*This is the Program Service Expense/Total Expense Ratio*	The Center will spend at least 60% of its funds to provide services	Independent audit report will demonstrate this objective	Agency-wide	Fiscal Year	Independent Annual Audit - December of next FY is when report is finished	CFO/Auditors/ CCO	At least 60% of funds will go for the provision of services.

## **IMPORTANT ORGANIZATIONAL FUNCTIONS AND DIMENSIONS OF QUALITY ASSURANCE:**

The framework and process of the Quality Assurance Plan complies with applicable standards of CARF, the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services. Quality Assurance Activities focus on improvements in functions and processes in the areas of direct client care, governance, management operations and support functions.

## **AGENCY DELEGATION OF QUALITY ASSURANCE RESPONSIBILITIES:**

Quality Assurance monitoring and evaluating activities are performed and controlled through the use of a committee structure in the organization. Committee membership is designed to assure appropriate representation of all functional areas of the Agency.

**1. Board of Directors:** The Board of Directors maintains ultimate responsibility for the Quality Assurance Plan. The Executive Director and Quality Assurance Committee, assume quality assurance responsibilities for the Agency.

**2. Quality Assurance Committee:** This committee is chaired by the Corporate Compliance Officer and convenes on a monthly basis to meet with Clinic Directors as well as the Associate Directors. The QA Committee is responsible for implementing, revising, and monitoring adherence to Agency Quality Assurance Indicators and Performance Goals and delineating these findings to the Board of Directors and the Agency leadership and staff.

The Quality Assurance Committee shall be constituted of the following: Executive Director, Associate Director of Clinical Services, and Associate Director of Intensive Service, Corporate Compliance Officer, and Clinic Directors.

**3. Management:** The Management Staff play a vital role in ensuring that their staff works toward the stated performance goals in this Quality Assurance Plan. This is accomplished through guidance, supervision, relaying information in meetings, and upholding Agency standards for Quality Assurance on a daily basis.

**4. Agency Staff:** Quality Assurance is the collective responsibility of every employee. Quality Assurance is guided by the Quality Assurance Plan as well as the Agency Policy and Procedure Manual, and is maintained by adherence to this plan and by ensuring that all work is done in an ethical and proper manner.