SOUTHERN HIGHLANDS COMMUNITY MENTAL HEALTH CENTER

POLICY AND PROCEDURE MANUAL

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Policy 181 – Quality Assurance

I. POLICY

Southern Highlands Community Mental Health Center recognizes its responsibility to its consumers, its funding sources, and to the community to provide and ensure the best care possible given available resources. It is thus the responsibility of the administrative body of the Center to develop such procedures as may be necessary to execute that responsibility.

II. DISCUSSION

Title 64, Series 11, of the West Virginia Legislative Rules of the Department of Health mandates that all behavioral health centers shall have and implement a systems review of the appropriateness and effectiveness of consumer services. Southern Highlands further recognizes that quality assurance extends to compliance with other mandates relating to documentation of those services as well.

III. PROCEDURE

A. Administrative Review

Purpose: To ensure that the management body of the Center is apprised of the level of compliance with Center requirements regarding the physical integrity of the clinical record. (See Addendum)

1. All treatment plans will be checked to ensure all elements are completely filled out before the treatment plan is placed into the clinical record.

    a. After treatment plans are completed, the treatment plans will be checked by assigned staff in each county to ensure the treatment plan forms are completely filled out.

    b. If blanks are not completed, the treatment plan will be returned to the originator of the plan for completion.

    c. The assigned staff will have a system to keep track of the treatment plans they have returned to clinicians.

d. Clinicians will return all treatment plans to the assigned staff within two (2) working days.

e. Assigned staff will ensure all treatment plans are given to Medical Records' staff for filing in the clinical record within two (2) weeks of the date of service.

2. Each month a minimum of 10% of all active records will be reviewed for compliance with documentation requirements.

a. A report of the deficiencies found during that review will be given to the supervisor who will distribute it to the appropriate clinician. The clinician shall have five (5) working days in which to correct any instance of noncompliance noted or the supervisor will develop a corrective action plan.

b. If the clinician fails to respond with a corrective action plan, the supervisor may elect to issue a written warning and implement disciplinary action in accordance with Section 280 of this manual. If the corrective action plan has not been followed by the next review, a written warning will be issued by the supervisor.

c. If the discrepancy cannot be corrected, the supervisor will approve such and sign accordingly. Once the supervisor has signed the discrepancy, it will not be counted as a deficiency in future reviews.

The review will be filed in date order separate from the consumer record in the QA Specialist's office.

B. Clinical Review

Please refer to Policy 502 for uses and disclosures of Protected Health Information (PHI).

1. Outpatient

Purpose: The main objective of clinical review is to ensure that quality services are provided in all departments. It should be utilized by supervisors and staff as a learning experience.

a. Clinical supervisors will meet with their respective staff members to discuss services rendered as per Policy Section 251.III.

b. Documentation regarding the content of the supervision, the number of cases discussed and time spent will be maintained in the staff member's training file.

2. Residential Services Review

Purpose: To ensure that appropriate program plans of consumers residing in Center sponsored housing are current, appropriate, being followed, and activities are being documented.

a. Each month 10% of the charts of consumers living in Center sponsored housing will be reviewed by the Director of Community Support Services.

b. After each admission, the charts of consumers who were admitted to emergency respite or to the crisis residential unit will be reviewed by the Director of I/DD Services.

The review will be filed separately from the consumer record in the appropriate staff training file.

3. Day Program Services Review

Purpose: To ensure that day program treatment plans are current and are being implemented as developed.

a. Each month 10% of the charts of day programs will be reviewed by the Director of Community Support Services.

The review will be filed in alphabetical order separately from the consumer record in the appropriate staff training file.

4. CCSS Program Services Review

Purpose: To ensure that day program treatment plans are current and are being implemented as developed.

a. Each month 10% of the charts of day programs will be reviewed by the Clinic Administrator – Wyoming.

The review will be filed in alphabetical order separately from the consumer record in the appropriate staff training file.

C. Medicaid Services Review

Purpose: To ensure that services billed are documented in the progress notes or other appropriate document, that units of services are documented appropriately, that services are authorized by the Interdisciplinary Team, and that Clinic Services and Rehabilitation Services were provided and documented accurately.

1. Each month a random sample of at least 10% of the cases for whom Medicaid services were provided the preceding month will be chosen for review.

2. Each case will be reviewed to ensure compliance with existing Medicaid standards.

3. A copy of the findings of each case will be given to the appropriate program director and then shared with the appropriate clinician for his/her comments. The report will then be filed in date order in the Medicaid QA Specialist's office.

4. A summary report of this audit will be given to the management team each month with recommendations for further action.

5. If corrective action is required to billings already submitted, the Controller will be informed and will initiate proper follow up.

ADMINISTRATIVE REVIEWS

ADDENDUM

STANDARDS FOR COMPLETING ADMINISTRATIVE REVIEWS

1. **ECONOMIC ASSESSMENT** – The economic assessment (fee) is completed by the fee clerk at the clinic where the consumer is seen. If the consumer does not come into the clinic, the case manager will complete the fee at the consumer's location. Fees are due at the initial contact and annually thereafter. OBHS is not considered a third party payor. ResCare is a third party payor. The record will be counted as deficient if the fee is out of date. If the fee has since been done, it will not be counted as deficient. The record will be counted deficient if the Agreement to Pay is not in the record. **TO CORRECT THE DEFICIENCY,** a new fee must be completed. **PERSON RESPONSIBLE** is who ever routinely completes the fee for the individual.

2. **CARE CONNECTION FORM** – A Care Connection form is required annually for all consumers. If the diagnosis changes, a form must be completed as a result of the change. The reviewer will look at Client Care Connection Diagnosis Form in AVATAR to determine the diagnosis. If either is not in agreement with other parts of the record, the record will be counted as deficient. **TO CORRECT THE DEFICIENCY,** the Client Care Connection Diagnosis Form must be completed. **PERSON RESPONBIBLE** is the case manager, service coordinator, and community engagement staff.

3. **RELEASE OF INFORMATION** – A release of information must be completed before any information is provided to any family member, guardian, advocate, or individual outside of the agency. The reviewer will look for a signed release for information sent to other agencies. **TO CORRECT THE DEFICIENCY,** a release must be signed or information cannot be provided as requested. **PERSON RESPONSIBLE** is the staff releasing the information, case manager, service coordinator and community engagement staff. All releases of information are handled and documented by Medical Records staff at the appropriate site.

4. **CONSENT TO TREAT** – Every consumer including crisis and walk-ins must have a consent to treat. The only exception is consumers who are in the involuntary commitment process. If, at any point, the consumer decides to change the involuntary process to a voluntary process, a consent must be signed. **TO CORRECT THE DEFICIENCY,** a consent to treat must be signed prior to additional services provided. **PERSON RESPONSIBLE**, the deficiency will be counted for the person who completed the intake or had the crisis contact but the case manager must make the correction.

5. **TREATMENT PLANS** – Treatment plans will be completed for all consumers who meet criteria for high end services. The initial treatment plan is completed within seven days of

the intake. A master treatment plan is developed within 30 calendar days of the intake and rewritten annually. Master treatment plan composed of 1) Signature page, 2) Problem/Need list, 3) problem/Goal Objective page, and treatment plan review note. Treatment plans must be reviewed at least every 90 calendar days. The reviewer will go to the last annual treatment plan and determine that the plan was reviewed every 90 calendar days. Each review date will be documented on the review form. All blanks will be completed on the treatment plan. The DSM-5 diagnosis must include the numerical code and written description. The record will be counted as deficient if services have been provided after the treatment plan has expired, there are blanks on the form, signatures are missing, or the diagnosis is not current and updated when the diagnosis changes. If the consumer is receiving services from another facility (state hospital, ResCare, etc.), there must be evidence that the treatment plan has been requested. Case managers should request the complete plan; but we will accept what is sent. The original treatment plan must be scanned into the record. The reviewer will look in the medical record room for treatment plans that have not been scanned. If it is not there, the record will be counted as deficient. **TO CORRECT THE DEFICIENCY,** the treatment plan must be completed if out of date, signatures must be obtained, blanks completed, or the diagnosis corrected. **PERSON RESPONSIBLE** is the case manager or in the case of an initial treatment plan, the intake staff.

6. **INDIVIDUAL PROGRAM PLAN COMPONENTS** – Individual program plans for day treatment, residential, etc., are separate activities but are components of the Master Treatment Plan. The Day Treatment Method Card will be included for all CCSS Day Treatment Plan meetings. These plans will be developed by each individual program providing these services. The case manager is responsible for scheduling the IDT to approve these plans. If the primary case manager cannot attend the IDT, a qualified staff member may convene the meeting in the absence of the primary case manager. There is to be one meeting for all members of the team, including the consumer. Each program will not do their plan in isolation. The individual plans are not accepted unless the full plan is completed. Likewise, the Master Treatment Plan will not be accepted unless the program components are completed. If any member of the team cannot be present and a substitute staff cannot represent a program, the plan must be presented to the other members of the team or a full meeting must be held at a later time. **TO CORRECT THE DEFICIENCY**, the individual components of the treatment plan must be completed, signed, and in the record with the other parts of the plan. The date must be the same as the IDT meeting and all members must sign the plan. **PERSON RESPONSIBLE** is the staff who writes the individual program plan.

7. **PSYCHIATRIC EVALUATION** – The completed, typed psychiatric evaluation must be in the record within two weeks from the date of the evaluation. **TO CORRECT THE DEFICIENCY,** the evaluation must be placed in the record. **PERSON RESPONSIBLE** is the psychiatrist.

8. **PSYCHOLOGICAL EVALUATION** – The completed, typed psychological evaluation must be in the record within two weeks from the date of the evaluation. **TO CORRECT THE DEFICIENCY,** the evaluation must be placed in the record. **PERSON RESPONSIBLE** is the psychologist.

9. **PROGRESS NOTES** – All progress notes must be completed in AVATAR and show the objective from the treatment plan that the service is tied to. **TO CORRECT THE DEFICIENCY,** the progress note must be corrected. **PERSON RESPONSIBLE** is the person who wrote the progress note.

10. **THERAPY NOTE** – All therapy notes must be completed in AVATAR and show objective from the treatment plan or treatment strategy that the service is tied to. Therapy notes must have the approved template embedded in each note. **TO CORRECT THE DEFICIENCY**, the therapy note must be corrected. **PERSON RESPONSIBLE** is the person who wrote the therapy note.

11. **PHYSICAL EXAM** – There must be evidence in the record that every consumer who receives services for longer than one year has either received, refused, or been referred for a physical exam annually. The referral must include the physician's name, consumer signature, staff signature, dates, etc. Lab work and x-rays are not considered physicals. Hospital admission or discharge summaries will be accepted as a physical as long as they are signed by a physician and must have consumer's vital signs on them. The record will be counted as deficient if there is no evidence that the consumer has refused a physical or been referred for a physical. **TO CORRECT THE DEFICIENCY,** a consumer signed referral or refusal must be in the record. It is not a deficiency if the referral was sent but the information has not been received. **PERSON RESPONSIBLE** is the case manager.

12. **ASSESSMENTS** – Any assessment that has been completed must be filed in the record. All required assessment for Medicaid and BHHF must be completed as required. If services have not been delivered, the record will not be counted as deficient; but consideration should be given to making the case inactive especially if the consumer has a pattern of missed appointments. **TO CORRECT THE DEFICIENCY,** the assessment must be filed in the record. **PERSON RESPONSIBLE** is the staff who administers the assessments – in most cases the case manager, service coordinator, therapist or community engagement specialist.

16. **DAY HABILITATION**– Any consumer attending day treatment programs will have the following requirements:

    MONTHLY PROGRESS NOTE – A monthly note must be filed in the record which includes the billable units and times, and the transportation provided.

    WAGE EVALUATION – Any consumer who works in the sheltered workshop or mobile work crew must have a wage evaluation completed semi-annually.

    TO CORRECT THE DEFICIENCY, the appropriate information/note/form must be placed in the file. **PERSON RESPONSIBLE** is the day treatment staff.