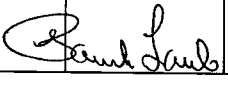


QUALITY

TEAM MENTAL HEALTH SERVICES		SIGNATURE	APPV.	REV.	REV.	REV.
	Administration			11/09		
Policy: CORRECTIVE ACTION PLANS						

Policy

It is the policy of Team Mental Health Services (TMHS) to have established protocols and procedures for the addressing and monitoring of corrective action plans that are required of various regulatory and auditing agencies. The purpose is to establish guidelines:

- To identify responsible parties to follow through and monitor
- To establish basic protocols for addressing plans of correction
- To improve the quality of processes and forms
- To assure timely compliance with regulatory standards.

Procedures

Team Mental Health will implement Plans of Correction that identify and address the following items:


- 1) What is the standard/indicator?
- 2) What is the identified deficiency?
- 3) What corrective action will be taken?
- 4) Who is responsible to take action?
- 5) When will this be done?
- 6) How will you monitor your corrective action?

The following are recommended steps in any plan of correction.

- 1) Upon receipt of a plan of correction the Quality Assurance Director (or designee) in consultation with the President will identify and assign who is the lead person responsible to take action for the identified plan of correction.
- 2) The lead person is responsible to identify who is responsible for what areas. This may require discussion and dialogue to identify if the issue overlaps departments/functions. The lead person can make assignments for specific areas that need addressed in the plan.
- 3) The lead person is responsible to set timelines necessary to address the deficiencies.
- 4) The lead staff is responsible to establish who is responsible to follow through including who is going to monitor and how it will be reported.

Whenever possible, TMHS will utilize as standard Plan of Correction template.

It will be the responsibility of the Quality Assurance Director, or designee, to maintain copies of the Plans of Correction.

TEAM MENTAL HEALTH SERVICES		SIGNATURE	APPV.	REV.	REV.	REV.
	Administration			11/09		
Policy: QUALITY MANAGEMENT						

Policy

It is the policy of Team Mental Health Services (TMHS) to provide Quality Management activities in order to:

- Ensure the provision of medically necessary, high quality treatment, supports and services;
- Meet recognized standards of care as delineated in the Mental Health Code and the CARF;
- Promote the provision of services that improve the individual's health status, increase independence, improve quality of life and support community integration and inclusion;
- Ensure contract compliance.
- Quality Management Staff have the authority to act on behalf of the Administration Team.

Procedures

Quality Management System

See the "Quality Management Plan" for the following:

- Description and scope of Quality Management Committee (QMC)
- Aggregate data on utilization and quality of services rendered
- Quality related activities
- Clinical service delivery areas to be monitored
- Performance indicators
- Methods and frequency of data collection
- Use of clinical care standards/practice guidelines, including:
- What standards are used and incorporated into QM activities
- Updating standards/guidelines
- Monitoring health and safety issues
 - Health and Safety issues are monitored by the Health & Safety Committee
 - The Safety Committee reports directly to the QMC any issues/concerns that must be addressed

Clinical indicators, clinical care standards/practice guidelines are developed by the QMC based on best practices and CARF guidelines (see "Quality Management Plan")

Chart Reviews (also see Utilization Management Plan) monitors compliance of all aspects of clinical documentation/treatment, including but not limited to the following:

- Coordination with Primary Care Physicians
- Person Centered Planning
- Inclusion

Monitoring of Sentinel Events

Monitoring of Sentinel Events is conducted through TMHS's contract with Managed Care Provider Networks (MCPN's)

Reports of the occurrence of Sentinel Events are also reviewed and analyzed by the QMC. (See "Sentinel Event" policy)

Quality indicators

Quality indicators are determined for each program dependent on contractual obligations, utilization management recommendations and CARF standards (see the "Quality Management Plan"). Remedial action plans, issued by the QMC, are required when:

- Inappropriate or substandard services are furnished
- A Recipient Rights complaint is substantiated

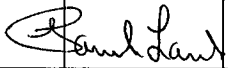
Utilization Management (see "Utilization Management" policy)

Consumer Satisfaction (see "Utilization Management" policy and the "Quality Management Plan")

Credentialing (see "Credentialing" policy)

Information Management

All information is obtained through the TMHS CTS system and/or the Quality Chart Review process. All information shall be regarded as confidential. Information obtained is available only to those responsible for evaluating and participating in the quality management and utilization management efforts and to those organizations responsible for monitoring treatment in order to assure the existence and effectiveness of the program for accreditation, licensing and reimbursement activities and in accordance with applicable laws and regulations.

TEAM MENTAL HEALTH SERVICES		SIGNATURE	APPV.	REV.	REV.	REV.
	Administration			11/09		
Policy: RESEARCH PROJECTS						

Policy

It is the policy of Team Mental Health Services (TMHS) that whenever any experimental research is proposed that involves TMHS consumers, a thorough review of the proposed research will take place. Such review will be undertaken to review the merits of each research project and the potential effects of the research procedures on the participants. No research will be undertaken by TMHS that could result in effective treatment being withheld from consumers.

Procedures

Prior to any research project being undertaken, the TMHS Quality Management Committee (QMC) shall conduct a thorough review. The review shall include the following:

- The adequacy of the research design;
- The qualifications of the individuals responsible for coordinating the project;
- The benefits of the research in general;
- The benefits and risks to the participants;
- The benefits to the organization;
- Any possible disruptive effects of the project on TMHS operations;
- Compliance of the research design with accepted ethical standards;
- The process to obtain informed consent from participants;
- The procedures for dealing with any potentially harmful effects that may occur in the course of the research activities.

The QMC shall attach a written summary report produced of the results of the review and shall submit the report to the TMHS President. The TMHS President has final approval on all research projects.

Informed Consent

All individuals asked to participate in the research project are given the following information:

- A description of the benefits to be expected for participating;
- A description of the potential discomforts and risks;
- A description of alternative services that might prove equally advantageous to them;
- A full explanation of the procedures to be followed, especially those that are experimental in nature.

A researcher not wishing to fully disclosed the purpose, nature and expected outcomes of the research to participants before it begins must clearly justify his/her methods. The researcher must justify to the QMC that such disclosure is inadvisable and that failure to

give full disclosure is not detrimental to the participants. Under such conditions disclosure may be deferred until a research project is completed.

All participants in proposed research projects shall sign a written informed consent prior to participating in the research. The informed consent shall address the participant's right to privacy and confidentiality. The consent document shall in no way include any language that releases the organization, its agents or those responsible for conducting the research from liability due to negligence. Participants are allowed to withdraw consent and discontinue participation in the research project at any time without affecting their status in TMHS programs.

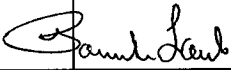
Minors

For youth to participate in research projects signed written consent from their parent or guardian is required. In addition to parent/guardian consent, youth between the ages of 12 and 18 years must also sign a written consent form prior to participation. In the case of children under 12 years of age and those participants who are legally or functionally incompetent to provide informed consent, participation will be allowed only when consent has been given by a person legally empowered to consent.

Upon completion of the research procedures, the principle investigator shall attempt to remove any confusion, misinformation, stress, physical discomfort or other harmful consequences that may have arisen with respect to the participants as a result of the procedures.

All research shall be conducted in a manner that adheres to professional standards concerning the conduct of research and are guided by regulations of the Department of Health and Human Services and any applicable law and regulation concerning the protection of human rights.

Upon completion, reports of all research projects are to be submitted to the President and the QMC.

TEAM MENTAL HEALTH SERVICES		SIGNATURE	APPV.	REV.	REV.	REV.
	Administration			11/09		
Policy: SATISFACTION SURVEYS						

Policy

It is the policy of Team Mental Health Services (TMHS) to conduct a periodic Satisfaction Survey of a representative number of consumers and other stakeholders. Consumer Satisfaction Surveys are completed on an annual basis or otherwise specified in a Quality Plan, and other stakeholder surveys are conducted annually.

Procedures

Methodology

Questionnaires will be made available to 100% of the consumers in each program for two to three weeks. A neutral third party distributes the questionnaires (e.g., receptionist). Programs may have color-coded forms to distinguish the number of completed surveys for that program.

Each consumer should be given:

- A questionnaire
- An envelope to seal their response if the consumer wishes

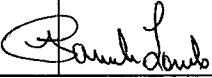
TMHS staff will:

- Allow time during the visit to complete the survey
- Keep track of the number of surveys handed out
- Keep track of the *number* of consumers who refuse to complete the survey

A minimum of 10% of the current census should be completed by each program.

All surveys are due to the President (or designee) within one (1) week of initial distribution. The President (or designee) will compile the results of the consumer survey and provide the data to each program for public posting for both consumers and staff.

The President (or his/her designee) shall compile an analysis comparing quarterly results and distribute to the Leadership Team.

TEAM MENTAL HEALTH SERVICES		SIGNATURE	APPV.	REV.	REV.	REV.
	Administration			11/09		
Policy: UTILIZATION MANAGEMENT						

Policy

The policy of Team Mental Health Services (TMHS) provides utilization management to ensure the following:

- That the care provided is consistent in quality;
- That services provided are clinically/medically necessary
- That services provided are clinically/medically appropriate
- That services provided are the appropriate length of treatment;
- That services provided are effective and that the utilization of ancillary services are efficient
- That services provided are reviewed at the appropriate frequency;
- That services provided are delivered at the identified amount, scope, intensity & duration.
- That services provided are the proper utilization of clinic resources (right time, right service, and right cost)

Procedure

Utilization Management Activities

Utilization Review

- Each month, clinical members of the URC review consumer records identified by the TMHS Quality Assurance.
- Specific discipline peers may only review those records completed by a peer in the same discipline.
- Upon completion of the reviews the President (or his/her designee) also reviews the Utilization Review forms and returns them for correction or review to those clinicians that have not received an acceptable review score.
- Clinicians have 10 business days to make the necessary corrections and return documentation of those corrections to the QA Department (or designee).
- If corrections are not received within 10 business days, the clinician's Program Director is notified for follow up.
- The President (or his/her designee) provides a synopsis of the data of the completed Utilization Review forms and gives that synopsis to the Quality Management Committee (QMC) for review.

Chart Review

Clinical Chart Reviewers conduct regular chart audits of consumer records using the Chart Audit Review Form. Qualitative indicators must be reviewed by a trained staff. Chart Reviews are based on the following criteria:

- Chart audit priorities will include staff in first three months of employment and clinicians discontinuing employment.
- All completed Chart Audit Review forms are sent to the clinician for review/corrections by the date identified on the form and are returned to the Program Director.
- If necessary corrections are not completed within the identified timeline, a reminder is sent to the clinician and their immediate supervisor.
- Trends in Chart Audit forms are analyzed by the President (or his/her designee) and referred to the QMC.
- The URC is responsible for the following:
 - Assuring the PCP is reviewed at least annually
 - Review of Outcome Measurements;
 - Review of Consumer Satisfaction Surveys (see "Consumer Satisfaction Survey" policy and the Quality Management Plan).
 - Utilization Studies (retrospective and concurrent review); Unit/program specific monitoring;
 - Defining admission, continued stay and discharge criteria
 - Defining length of stay norms

Clinical Practice

Each area of practice within TMHS will be sampled throughout the year for monitoring and evaluation. Reports on these reviews will be presented to the QMC and Leadership Team.

- Concurrent Admission Reviews
 - Admission reviews will be done on a 5% random sample of all admissions to each unit/program.
 - Continued Stay and Discharge Planning Reviews
 - Identified cases will be reviewed for the appropriateness of a continued stay when the case has been open at least 90 days.
 - Appropriateness of Discharge Planning
 - A review of 1% of all cases closed within the past 90 days will be conducted to determine the appropriateness of discharge planning and discharge.
 - Identifying utilization-related problems, based on their review of utilization review data, both individual and aggregate

Scope of Utilization Management program

The Utilization Management program will monitor, evaluate and problem-solve as needed in the following areas:

- Appropriateness of admission to TMHS and to it's units/programs;
- Appropriateness of continued stay;
- Appropriateness of extended stay beyond expected length of stay;

- Appropriateness of timely initiation of discharge planning;
- Appropriateness of discharge;
- Appropriate use of support and/or contract services;
- Appropriate use of consultants;
- Individual and aggregate data review of clinical practice;
- Results of any consumer care evaluation studies, consumer profile, analysis, etc...
- Monthly management information system data;
- Appropriate fiscal management information to identify other utilization issues;
- Under- or over-utilization of TMHS by consumers with various demographic characteristics;
- Review of personnel utilization data;
- Review of fiscal management information related to monitoring or resource allocation and related challenges.

Utilization Review Committee (see "Utilization Review Committee" policy)

Confidentiality of Review Data

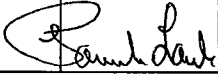
Findings and recommendations of the Utilization Management program shall be regarded as confidential. Such information is available only to those responsible for evaluating and participating in the quality management and utilization management efforts and to those organizations responsible for monitoring treatment in order to assure the existence and effectiveness of the program for accreditation, licensing and reimbursement activities and in accordance with applicable laws and regulations.

In order to maintain confidentiality and assure Evidence Based practice and best practices, consumers shall be identified by numbers only.

Conflict of interest

No person directly responsible for the care of a person under review may participate in the review activities associated with that person's care.

No person likely to receive financial benefit from the decisions regarding any case under review will serve in the Utilization Management program.

TEAM MENTAL HEALTH SERVICES		SIGNATURE	APPV.	REV.	REV.	REV.
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Policy: UTILIZATION REVIEW COMMITTEE						

Policy

It is the policy of Team Mental Health Services (TMHS) to conduct Utilization Management activities through the establishment of the Utilization Review Committee (URC).

Procedures

The URC meets a minimum of quarterly and is comprised of the following members:

- o TMHS Quality Assurance Director (or his/her designee)
- o TMHS Vice-President
- o TMHS Program Directors
- o TMHS Quality Reviewer(s)
- o Assigned representatives from clinical programs/departments

The URC performs and/or coordinates utilization review activities in an effort to ensure the following:

- o Maintenance of quality care;
- o That services provided are clinically necessary and that clinically necessary services are provided;
- o Appropriate length of treatment;
- o Effective and efficient utilization of ancillary services;
- o Proper utilization of clinic resources.

The URC meets monthly to conduct one or more of the following activities:

- o Conduct Utilization Reviews
- o Review of Outcome Measurements;
- o Review of Data Collection;
- o Review of Consumer Satisfaction Surveys (retrospective and concurrent);
- o Review of Chart Audit forms and respective analysis;
- o Utilization Studies (retrospective and concurrent review);
- o Unit/program specific monitoring;
- o Defining admission, continued stay and discharge criteria;
- o Defining length of stay norms;
- o Defining other criteria sets as required for specific utilization-related retrospective or concurrent studies;
- o Identifying utilization-related problems, based on their review of utilization review data, both individual and aggregate;
- o Recommending correction action, as appropriate, and assuring the implementation of appropriate corrective actions and following up to see if those actions were effective.

Results of URC activities and applicable findings/recommendations are sent to the Quality Management Committee for review and possible Plans of Correction (if applicable) a minimum of quarterly.

Minutes from URC meetings are distributed to committee members and the TMHS President.