

Fiscal Year 2015

Continuous Quality Improvement
Plan

Talbert House
Gateways Recovery

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VISION STATEMENT OF AFFILIATION CONTINUOUS QUALITY IMPROVEMENT PROGRAM

To ensure that Talbert House and Gateways Recovery provide the highest quality services in a uniform and consistent manner in compliance with evidence based best practice models.

PURPOSE OF CONTINUOUS QUALITY IMPROVEMENT

The purpose of the Continuous Quality Improvement (CQI) program is to act as a systematic and objective facilitator for the affiliation to achieve its organizational missions.

OBJECTIVES OF CONTINUOUS QUALITY IMPROVEMENT

1. To facilitate the mission of Talbert House and Gateways Recovery.
2. To focus on establishing and maintaining highest quality services through fidelity to Evidence-Based Practices (EBP).
3. To ensure the appropriateness of services provided.
4. To improve the efficiency (cost containment and time) of processes and services.
5. To improve the effectiveness of direct services to client needs.
6. To foster an agency-wide culture of continued process and outcome improvement.
7. To ensure compliance with funding and regulatory standards.
8. To resolve problems identified in the CQI process.
9. To identify and respond to gaps in service delivery.
10. To monitor and respond to issues of cultural diversity surrounding client care.

CONTINUOUS QUALITY IMPROVEMENT

Continuous Quality Improvement is a proactive approach to ensure that quality holds a central priority in all aspects of the affiliation's operations. CQI uses data to evaluate the effectiveness and efficiency of processes and to identify opportunities for improvement. CQI is non-punitive in its approach and is reliant upon the feedback of internal and external customers as well as the users of the CQI process itself. CQI does not focus on a single data point but looks at trends and variances in the data to focus efforts on improving the quality of services provided. All employees of the organization have an essential role to play in ensuring continuous quality improvement.

AUTHORITY TO ENSURE COMPLIANCE

The Executive CQI Committee ensures compliance with the CQI Plan. This committee functions under the supervision of the Program and Planning Committee of the Talbert House Board of Trustees. The administrative costs of CQI functions are designated in the budget as Central Services, which is allocated across the affiliation.

Each Service Line and Central Service department is responsible for developing quality indicators to monitor processes and outcomes regarding provision of services, and action plans to address deficiencies identified within this process. The Service Line and Department management is responsible for ensuring the implementation and measurement of these indicators and any subsequent action plans. Follow-up monitoring will be conducted by the Executive CQI Committee, and deficiencies not addressed or failing to show improvement through implemented action plans will receive intervention from the Executive CQI Committee.

Issues that are identified as system-wide will be referred to the affiliation Management Team for approval of action plans developed by the Executive CQI Committee. After approval of action plans, the Management Team will then be responsible to ensure the implementation of these action plans within the Service Areas.

COMPLIANCE DEFINITION AND PROCEDURES

Compliance with the CQI Plan will be monitored by the Executive CQI Committee. Compliance is defined as:

1. Turning in all required forms with complete information within established deadlines.
2. Recording of all CQI indicator data in the Quality Indicator Database and CQI Binders, ensuring that:
 - A. All deficiencies have action plans.
 - B. Action plans are measurable, concrete, feasible, and goal oriented.
 - C. Follow-up of action plans is documented.
 - D. Ineffective action plans are revised.

Each month, Service Areas and Departments will receive feedback as to their compliance rates via the CQI Documentation Report. Service Areas will be given one week upon notification to improve compliance rates through provision or correction of missing or incomplete items.

INDICATORS OF QUALITY

The CQI process involves having all levels of staff work with the Quality Improvement (QI) Administrator and the Executive CQI Committee to identify critical aspects of care and service for targeted improvement opportunities. The organization's scope of services and activities provide the basis for identifying the aspects of care and operations to be monitored. The scope of services and activities provided by the organization includes case management services, outpatient treatment, residential treatment, housing, assessment and diagnosis, prevention and education services. For Service Areas, emphasis will be placed on those aspects of care that have the greatest impact on quality of services. This includes aspects of care that are known to be problematic, that are offered to persons with multiple needs, or that are related to various minority groups. For Central Services Departments, emphasis will be placed on customer service, maximizing process efficiencies, minimizing risk to clients and to the agency, and helping Service Areas achieve optimal outcomes.

Once important aspects of care and operations have been identified, Service Areas and Central Service Departments will select indicators to monitor the quality of these aspects of care and operations. CQI Indicators are measurable variables that are used to monitor the quality of either processes or outcomes of care and operations. Process indicators measure how services are provided, while outcome indicators measure the results of services received. Indicators will be chosen for each Service Area and Department through a collaborative process involving line staff as well as middle- and upper-management. This process will help align the focus of operations and outcomes across all levels of the organization.

Data collected through the tracking of indicators is used to drive quality improvement efforts. This is accomplished by comparing performance on an indicator to the indicator's established performance goal. This performance goal can be established in several ways. For example, it can be determined by establishing current performance baselines through benchmarking, comparing performance to standards established by funders or accrediting bodies, or comparing performance to state or national standards. Until the performance of an indicator meets the

performance goal, further action planning is required. The establishment of such indicators allows each Service Area and Department to systematically measure its performance in relation to achieving both the Service Area's and Department's mission and the agency's mission.

All indicators must be approved by the Executive CQI Committee and must meet the following criteria:

1. The indicator can measure the events it was intended to measure.
2. The indicator can be expressed numerically or contains a description of the population to which the indicator is applicable.
3. The indicator can detect changes in performance over time.
4. The indicator allows for comparisons over time within the Service Area/organization or between the Service Area/organization and other entities (allowing for risk adjustment when appropriate).
5. The data intended for collection is available.
6. Results can be reported in a way that is useful and meaningful to the organization and other stakeholders.

PEER REVIEW

PURPOSE

Peer Review is designed to foster high-quality direct service and to improve the effectiveness of the service provider staff.

The Purpose of Peer Review is to ensure that:

1. Pertinent, timely, appropriate and legible information is included in client records/service Documentation and is in compliance with all required standards.
2. High quality client care is provided with clinical pertinence and through appropriate service delivery as demonstrated by the organization's Best Practice standards and the Clinical Philosophy.
3. High quality client care is provided through the effective and efficient utilization of the program's resources and services

PROCEDURES

The Peer Review Committee of each service area will meet on a monthly basis. A simple majority (60%) constitutes a quorum and can transact business. The Chairperson will be selected by the Service Area Associate Director from the membership. The membership of the Peer Review-Committee will consist of direct service staff (peers) without supervisory presence, unless determined as needed. The membership of the Peer Review subcommittee will also be multi-disciplinary where possible.

1. Service Areas will review a minimum of 5% or five (5) charts/Prevention and Education Services (P&E) (whichever is greatest) quarterly. If reviewing 5% of charts/P&E Services poses a hardship to the Service area, a maximum number of charts/P&E Services tickets for monthly review will be set by the Service Area with approval by the Executive CQI Committee.
2. Charts/P&E Services will be randomly selected for Peer Review, but steps should be taken to ensure that all service providers are reviewed at least once per year.
3. Peer Review Committees will meet during the third week of each month.
4. Peer Review data is due to be turned in to the Service Areas CQI Committee on or before the first weekday of the following month.

Peer Review evaluation forms will be developed by each service team and used to guide the Peer Review process. Evaluation of Best Practices and the quality of client services will focus on:

1. Completeness of Record Review
2. Quality of Documentation Review
3. Utilization Management Review

The following service indicators should be included by all service teams as a part of their Peer Review:

1. Review of assessments to ensure appropriate relationship to treatment plans, including a review of the appropriateness of initial assessment of client's clinical and support needs.
2. Review to ensure that treatment goals are pertinent to assessed needs and are written in measurable, objective terms.
3. Review to ensure high quality client care is provided through the clinical pertinence and appropriateness of services delivered.
4. Review of adequacy of documentation in describing client status and service interventions.
5. Review to ascertain the appropriateness of continued treatment and/or receipt of the service areas services.
6. Review of service area admissions to ascertain the appropriateness of admission to the service area.
7. Review of sufficient quantity and quality of physician and other types of consultation according to recommendations within service plans and assessments.
8. Review of a sample of terminated records to assess continuity of care from assessment through treatment to discharge.

In addition, Peer Review Committees will be asked to work with their Service Area Associate Director in the review of quality indicators and in the generation of action plans when indicators are below their performance goal. This review is to ensure that communication of indicators is directed to staff, as well as to encourage successful implementation of action plans. Finally, the Peer Review Committee is charged with identifying problems in processes which may inhibit the delivery of quality service and could lead to less than optimal outcomes.

Documentation of this process will occur in the Peer Review minutes. This is to ensure communication of indicators to staff, as well as to encourage successful implementation of action plans.

REPORTING AND FEEDBACK

Completed record reviews with deficiencies will be distributed to Service Area Associate Director. Action plans are to be defined, signed off by the Supervisor and the CSP, and reported back to the Peer Review Committee no later than the next regularly scheduled Peer Review Meeting. Service Area Associate Directors may appeal findings to the Peer Review committee. If the appeal is not resolved at this level, an additional appeal may be made to the Service Areas CQI Committee.

Oversight of this process will be performed by the QI Administrator and the Executive CQI Committee.

Identified problems may trigger a focused review, which may be carried out by the Service Areas CQI Committee, the Peer Review committees, or by an ad-hoc committee appointed by the Executive CQI Committee.

CONFLICT OF INTEREST

No member of a Peer Review Committee, or the Service Areas CQI Committee will be directly involved in reviewing cases in which they are the primary care provider. Should problematic issues be discussed about a case in which a committee member is the primary service provider, the committee member may elect to be excused from the meeting during the discussion.

MAINTENANCE OF DOCUMENTATION

Permanent copies of Peer Review subcommittee review forms will be maintained at each Service Area site. Original Peer Review worksheets are to be kept at the service area site and filed separately from the client record. The QI Administrator will be responsible for maintaining documentation at the Executive Office. These records may be kept in electronic format.

CUSTOMER SATISFACTION SURVEYS

PURPOSE

The purpose of conducting customer satisfaction surveys is to ensure that processes within Talbert House and Gateways Health meet the needs and requirements of internal and external customers.

PROCEDURES

The function of customer satisfaction surveys are to:

1. Measure client satisfaction with each treatment service area.
2. Measure referral source satisfaction by each service area site.
3. Measure internal customer satisfaction with central services.

Client Satisfaction with services will be conducted on a minimum of a quarterly basis. Procedures for conducting client satisfaction surveys will be in compliance with the Agency client satisfaction survey policy. Additionally, the Executive CQI Committee will be responsible for approving service area procedures for conducting these surveys and variations to the standard client satisfaction survey form.

Referral Source Satisfaction will be conducted on an annual basis. Satisfaction will be captured from both internal and external referral sources and will include the following measures: (a) satisfaction with access (ease of referral), (b) satisfaction with service area information, (c) satisfaction with client information, and (d) overall satisfaction. Conducting and evaluating these surveys will be the responsibility of the QI Administrator.

Internal Customer Satisfaction with central services will be conducted on an annual basis. The data will be collected from appropriate customer groups using a format determined by central service directors. Conducting and evaluating these surveys will be the responsibility of the QI Administrator. Results of satisfaction evaluation will be shared with the Affiliation Management group with the intent to continuously improve Central Services' customer support of the service lines.

REPORTING AND FEEDBACK

Service Areas will receive quarterly reports outlining the Service Areas client satisfaction survey results. The format of these reports will be standardized across Service Areas, but specific information can be requested for analysis if not provided. It will be the responsibility of individual service areas to develop and submit action plans for identified deficiencies.

Service Areas will receive annual reports outlining the results of Referral Source Satisfaction surveys. It will be the responsibility of Service Areas Associate Directors and Service Areas CQI Committees to develop and implement action plans for identified deficiencies.

ANNUAL REVIEW OF MINORITY POPULATIONS

Annually, a focus review will occur relevant to minority populations. In this review, data from throughout the year will be analyzed with the intent to compare specific minority populations. The purpose of this review is to ensure quality services to all clients within the agencies.

ANNUAL EVALUATION OF CQI PROCESSES

All service areas and departments, in conjunction with their Service Areas CQI Committees, will annually evaluate CQI activity to determine:

- Whether CQI goals and objectives have been met for the year and whether revisions of quality indicators and performance goals are warranted.
- Whether professional standards of practice are achieved.
- Assess the efficiency of CQI activities and the adequacy of corrective actions.
- Assess the adequacy of the communication of CQI findings.
- Define improvements made within the Service Areas as a result of CQI activity.

This evaluation will be submitted in report format to the Executive CQI Committee. The Committee will then assess the adequacy of communicating CQI findings to staff, the Boards, funders and required regulatory bodies. The QI Administrator will be available to assist each Service Area with these annual reports.

EXECUTIVE CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

PURPOSE

The purpose of the Executive CQI Committee is to provide oversight and management of the CQI process. It is also responsible for communicating results of CQI findings throughout the agency and to the outside community upon request.

PROCEDURES

The Executive CQI Committee will be comprised of members who represent agency services. The committee will meet on a monthly basis during the last week of each month. A simple majority constitutes a quorum and can transact business.

1. Annual review and approval of the CQI Plan.
2. Monthly oversight of the Risk Management and Safety Subcommittees.
3. Quarterly evaluation and approval of site CQI data and action plans.
4. Developing uniform quality indicators system-wide, with a focus on Evidence-Based Practices.

5. Approval of individual Service Line and Service Team indicators (annually and as requested).
6. Ongoing evaluation of trends for identification of systemic problems.
7. Identification and oversight of CQI related training.
8. Development of standardized reporting for the Safety Subcommittee, the Risk Management Subcommittee, and Service Area CQI meeting minutes.
9. Oversight of the Consumer Satisfaction process, both internal and external.
10. Identification and oversight of systematic and agency trends of agency Morbidity and Mortality Conferences.
11. Provide regular (at least quarterly) feedback to the Boards of Trustees, Executive Director/President, Vice Presidents, Directors, Associate Directors, and Staff.

The QI Administrator will act as Chairperson for the Executive CQI Committee. The QI Administrator will also be responsible for providing committee members with a report each month, prior to the monthly meeting, which will serve as the basis for the meetings. This report will consist of:

1. Summarization of Service Line/Service Area data and reports under review.
2. Reports highlighting system-wide trends identified by the CQI process.
3. Additional material as requested by the Executive CQI Committee.

REPORTING AND FEEDBACK

The Executive CQI Committee will monitor the activities of the Service Area CQI Committees, Safety Committee and Risk Management Committee, as well as offer feedback as to the appropriateness of action plans. This committee will also review and approve the organizational CQI Plan, Service Line/Service Area quality indicators, client satisfaction surveys and peer review forms.

The Executive CQI Committee will report to the Institute for Training and Development (ITD) with recommendations of areas for trainings based on systemic issues identified in the CQI process. It will also communicate with Service Areas when issues that may be addressed through staff training have been identified.

Finally, the QI Administrator will present quarterly reports to the Program and Planning Committee of the Talbert House Board of Trustees. Other members may be asked to report as needed.

MAINTENANCE OF DOCUMENTATION

The QI Administrator will be responsible for maintaining permanent copies of Executive CQI Committee activity and reports.

SERVICE AREA CONTINUOUS QUALITY IMPROVEMENT COMMITTEE

PURPOSE

The purpose of the Service Areas CQI Committee is to ensure quality service delivery for each service area within the service line and to promote opportunities to improve service delivery.

PROCEDURES

The Central Service Departments and Service areas CQI Committee will meet monthly during the first week of each month. A simple majority (60%) constitutes a quorum and can transact business. The chairperson will be selected from and by the membership and will serve as chair for at least six (6) consecutive months if a rotation process is used. Associate Directors from

each service area represented in the Service Lines must sit on the committee. Members of Peer Review-Committees may be asked to attend Service Areas meetings as necessary. Minutes will be kept of these monthly meetings and a copy forwarded to the QI Administrator and to the Service Areas Executive CQI liaison.

The Service Areas CQI Committee is charged with monitoring the following on a monthly basis:

1. Peer Review: Monitor systemic issues and ensure follow-up on action plans.
2. Utilization Review --identification of problems/issues in Utilization Review, development of action plans to address problems/issues, and monitoring to ensure action plans are implemented; to include:
 - A. Staffing Issues: Issues involving ratio of actual staff to staff required for optimal client care.
 - B. Access Issues: Review of client waiting lists to assure that individuals on the list receive services or are referred to another service team for services according to regulatory and funding agency requirements.
 - C. Monitoring of the average monthly census in relation to capacity.
 - D. Any examples of high service utilization/high cost utilization.
 - E. Review of trends and patterns which may highlight gaps in service delivery.
 - F. Review of all cases of involuntary termination of clients. Involuntary termination will be defined according to paragraph (6) of the ODMH Rule 5122-27-07 of the Administrative Code.
 - G. Review of the trends and patterns of use of each service areas services.
 - H. Review of client satisfaction. Additionally, these reviews will include an annual assessment of the satisfaction service team referral sources. This review will be conducted annually with assistance from the QI Administrator and the Executive CQI Committee.
3. Environmental Review -- oversight of Service Areas Environmental Inspections. This includes developing action plans to address deficiencies identified in the inspections, as well as oversight to ensure follow-up on action plans.
4. Major Unusual Incidents/Complaints and Grievances - review of all Major Unusual Incidents and client complaints and grievances to ensure appropriate resolution and follow-up. This also includes a review of all incidents of restraint where applicable.
5. CQI Indicators and Fidelity Measures: review of Fidelity measures and CQI indicators, their appropriateness and the performance goals.
6. Reviewing and monitoring action plans for issues identified in Peer Review, CQI/Fidelity Measure indicators, Utilization Review, and Environmental inspections.

REPORTING AND FEEDBACK

Minutes and reports from the Service Areas CQI meetings will be forwarded to the QI Administrator on a monthly basis on or before the 15th day of each month. Identified problems and action plans will be monitored for implementation and resolution. Service Areas CQI minutes will be completed in the standardized minute format

MAINTENANCE OF DOCUMENTATION

Permanent copies of Service Areas CQI activity and reports will be maintained at Service Areas. The QI Administrator will be responsible for maintaining documentation at the Executive Office. These records may be maintained in electronic format.

RISK MANAGEMENT COMMITTEE

PURPOSE

The purpose of the Risk Management Committee is to review and monitor activity that places the system at risk.

PROCEDURES

The Risk Management Committee will be made up of representatives from Talbert House Departments and Service Areas. The committee will meet on a monthly basis. A simple majority (60%) constitutes a quorum and can transact business.

The Risk Management Committee is responsible for the following:

1. Monitoring and reviewing significant financial loss to a program as identified by the Finance Department.
2. Monitoring and reviewing significant issues that may place the affiliation at legal risk.
3. Monitoring actual and potential claims made to the affiliation's insurer(s).
4. Development of policy and procedures around issues identified as placing the agency at risk.
5. Oversight of training in risk management.
6. Monitoring trends of all Major Unusual Incidents (MUIs) and oversight of follow-up of MUIs.
7. Monitoring client grievances and complaints that may place the affiliation at legal risk.
8. Monthly reporting of activity to the Executive CQI Committee.
9. Providing feedback to Service Lines and Departments regarding pertinent issues identified in Risk Management.
10. Monitoring significant changes in the community that may have a significant impact upon the affiliation's ability to provide services.
11. Review and approval of quarterly CQI report of MUIs and incidents.

REPORTING AND FEEDBACK

The Risk Management Committee will meet monthly, during the fourth week of the month. The Risk Management Committee is responsible for providing feedback to Service Areas regarding pertinent issues identified in Risk Management. The committee will also be responsible for following-up on action plans recommended to assess that adequate action has been taken in addressing Risk Management issues.

The Risk Management Committee is also responsible for reporting minutes to the Executive CQI Committee on a monthly basis. Additionally, representatives of the Risk Management Committee are responsible for working with the QI Administrator in the preparation of the Risk Management Committee's contributions to the quarterly and annual CQI reports.

SAFETY COMMITTEE

PURPOSE

The purpose of the Safety Committee is to monitor and review information regarding safe working conditions for staff, clients, and visitors to each site.

PROCEDURES

The Safety Committee will be made up of representatives from Talbert House Service Areas. The committee will meet on a quarterly basis. A simple majority (60%) constitutes a quorum and can transact business.

The Safety Committee is responsible for the following:

1. Identify regulations and standards for programs by funder and regulatory agencies for safety and infection control requirements.
2. Identification and oversight of safety-related trainings. Including the presentation of Universal Precautions trainings.
3. Ensure all sites have a trained Safety Officer.
4. Identify and monitor trends and action plans identified in site Environmental Reviews.
5. Monitor all drills conducted by sites. This includes: fire, natural disaster, medical emergencies, utility failure, bomb, and violent or other threatening situation drills.
6. Monitor trends and deficiencies of agency drills that may require system-wide intervention and follow-up on action plans.
7. Provide a walk-through site inspection of each facility at least once per fiscal year.
8. Consult with the Facilities Management Department in the revision and creation of agency policy.

REPORTING AND FEEDBACK

The Safety Committee will meet on a quarterly basis. The Safety Committee is responsible for monitoring and providing feedback to Service Areas on an ongoing basis. Each month the committee must ensure that action plans adequately address Safety issues identified in the CQI process. Additionally, the committee must follow-up on action plans to ensure that they have been carried out and monitor changes following implementation of the action plans.

The Safety Committee is also responsible for reporting minutes to the Executive CQI Committee on a quarterly basis. Additionally, representatives of the Safety Committee are responsible for working with the QI Administrator in the preparation of the Safety Committee's contribution to the annual CQI report.

MORBIDITY AND MORTALITY CONFERENCES

In order to reduce risk and to improve the quality of care for consumers, each Service Line/Area within the affiliation is required to conduct a Morbidity and Mortality (M and M) Conference for specified adverse events. These conferences are to occur within 30 calendar days of the adverse event. These events include, but are not limited to:

1. Death of a client (other than natural causes).
2. Serious injury to a client.
3. Client causes serious and imminent risk of harm/death to others.

The agency conducts a Morbidity and Mortality Conference as part of the CQI process to determine if there is an opportunity for improvement. The goal of the conference is to perform a retrospective review of a major incident in order to prevent or decrease the seriousness of such incidents in the future. There are numerous benefits to conducting such reviews. These include:

1. Supporting sound clinical practice
2. Examining appropriateness of treatment/interventions
3. Identifying patterns of practice that need further study
4. Identifying systems issues that contribute to adverse events
5. Identifying gaps in clinical training and/or supervision

CONFERENCE PROCEDURES AND FORMAT

The Chief Medical Officer determines if the event requires an M and M conference based on information that is shared by the QI Administrator and other relevant staff. Typically, the primary

service provider presents the case and other relevant staff is invited to participate. These staff includes the QI Administrator, supervisors, physicians, and other clinical staff involved in the client's care, as well as a representative of the local Mental Health Recovery Services Board where appropriate. If the primary service provider is unavailable to present the case, the supervisor is responsible for presenting the case. The Medical Director (or designee) chairs the conference, and the Clinical Director (or designee) is responsible for reviewing the chart.

The format for the presentation should include the following elements:

1. *Reason for visit* – this describes why the client was originally referred to the Service Line and the chief complaint/problem.
2. *History of Present Illness* - describes the severity and duration of the symptoms, any treatments that have made the symptoms improve or worsen, and difficulties with functioning related to these symptoms.
3. *Past Psychiatric/Chemical Dependency/Criminal Justice History* - includes prior hospitalizations and/or incarcerations and client's subsequent response.
4. *Family History* - includes information on family members who have mental illness, chemical dependency, and criminal justice involvement.
5. *Medical History* - includes information about severe illnesses or chronic problems for which a client has received or is receiving treatment. This also includes a list of current medication and information on the client's compliance with the medication.
6. *Chemical Dependency History* - specifies drugs used/abused and frequency and nature of use.
7. *Mental Status Exam* –includes appearance and behavior, mood, affect, thought processing, thought content, perceptions, suicidal or homicidal ideation (including present or past threats/attempts), and cognitive function.
8. *Diagnosis* - use the current Diagnostic and Statistical Manual for client's diagnosis.
9. *Treatment/Service* - lists the type of treatment or service the client was receiving at the agency and elsewhere. This also includes how the client was doing with the service or treatment and his/her attitude toward the service or treatment.
10. *Nature of Events Leading to the Incident* - focuses on contacts service provider(s) had with client prior to the incident and frequency of contacts leading up to the incident.

After the primary service provider completes the presentation, there is time for discussion. If the participants determine that there is a deficiency that needs to be addressed, an action plan will be created with oversight service line leadership. All discussion and action plans will be documented in the M and M Conference Minutes using the CQI minutes format. A copy of the presentation and minutes will be forwarded to the QI Administrator. A copy of this material should also be filed with the MUI Report (separate from the ICR). Identification and oversight of systematic and agency trends will be presented to ECQI Committee as needed.

RELATIONSHIPS WITH OTHER COMMITTEES

HUMAN SUBJECTS COMMITTEE/INSTITUTIONAL REVIEW BOARD

The Human Subjects Committee is a subcommittee of the Executive CQI Committee. It is comprised of at least five members. It must have at least one member whose primary concerns are scientific and one member whose primary concerns are non-scientific. Standing members of the committee include the Chief Research Officer, the Clinical Director, the Medical Director and the QI Administrator. The remaining members are appointed by the Executive CQI Committee. In addition, the committee may request the presence of an ad hoc client representative, as

needed, to provide input to the committee's review of an application for research. The Human Subjects Committee reviews and approves applications and protocols for studies within the Affiliation in accordance with the Human Subjects Policy. The Committee also tracks all studies being conducted within the Affiliation.

DIVERSITY COMMITTEE

The Diversity Committee functions as a collaborative entity with the Executive CQI committee. While there is no direct line of authority between the committees, the Diversity Committee is responsible for working with the Executive CQI Committee around areas of Quality Improvement relating to diversity issues.

The Diversity Committee will be called on to review deficiencies regarding areas of diversity which are identified in the CQI process. This includes, but is not limited to, the annual minority client review. The Diversity Committee will collaborate with Executive CQI in creating action plans to address these deficiencies.

TRAINING IN THE CQI PROCESS

PURPOSE

The basic purpose of providing training to all staff is to ensure an understanding of the CQI process. Furthermore, this training will provide a mechanism to enhance the culture surrounding CQI by increasing awareness that CQI is a process that is useful, logical, non-punitive and non-burdensome.

INITIAL TRAINING FOR ALL STAFF

CQI is a component of mandatory training as part of the required new employee orientation process. The purpose of this training is to ensure that new employees get accurate and timely instruction in the CQI process.

Orientation for all staff will address the following:

1. What is Continuous Quality Improvement?
2. What CQI means for staff and for the organization.
3. A general overview of the CQI plan including:
 - a) Peer Review
 - b) Structure of the CQI process
 - c) Risk Management and Safety
 - d) Client Satisfaction procedures
 - e) Accountability in the CQI process
 - f) Fidelity to Best Practices
 - g) Confidentiality

CONFIDENTIALITY

All Continuous Quality Improvement materials are considered confidential in nature. CQI minutes and documents that are not maintained in appropriate files or forwarded to the Executive CQI Committee should be shredded.

All documentation produced by the Peer Review Committees (including review sheets, minutes, and reports) and the Service Area CQI Committees (including indicator review sheets, minutes, and reports) will be considered sensitive in nature and, when printed, stamped:

*This is a Confidential Quality Assurance Document of Talbert House, Cincinnati, Ohio
It is prohibited from disclosure by Ohio Revised Code 2305.24, 2305.25, and 2305.251.*

*This is a confidential Quality Assurance Document of Gateways Recovery, Cincinnati, Ohio
It is prohibited from disclosure by Ohio Revised Code 2305.24, 2305.25, 2305.251.*

The client record and information within is confidential. Staff involved in CQI activities has access to selected client records as long as such access is reasonable.

Committee recommendations and findings are to be maintained in confidence within the CQI Committees or subcommittees, and, where applicable, communicated only to the specific staff person and his/her immediate supervisor. Should unethical, illegal, exploitative practices and/or circumstances putting the agency at risk of liability be identified, staff confidentiality will be waived, and such findings will be immediately reported to the President. All CQI Committees and subcommittee worksheets, meeting minutes, and reports to the agency's Board of Trustees and will be considered sensitive in nature and stamped as a Confidential CQI document. While written information may be distributed to the Board, such information will not be introduced into Board minutes (recommendations from CQI may be placed in Board minutes).

PARTICIPATION OF CLIENTS SERVED

Consumers may participate in CQI activities by:

1. Clients completing consumer satisfaction surveys.
2. Clients and families volunteering to be part of research interviews and focus groups.
3. Clients and families participating in gathering of outcome data.

Consumers will also have access to the QI Administrator and appropriate CQI summary reports. This access will be communicated to clients through fliers which will be posted at each office location along with client rights.

DISSEMINATION OF CQI INFORMATION

Contractually mandated CQI measures will be communicated to the appropriate county boards as required. Quarterly reports will also be communicated to the Governing Board of the agency through the agency Program and Planning Committee. Appropriate monthly and quarterly reports will also be distributed to each Service Line and department. Service Line leadership will then distribute CQI data and reports to applicable supervisors and staff.

Results of CQI activity will be communicated to clients and their families through agency communications, newsletters, and upon request.