



**Volunteers
of America®**

GREATER OHIO

QUALITY IMPROVEMENT PLAN

Residential Reentry Programs Addendum

Revised: December 2014

Approved:

Table of Contents

I.	Overview of Program Services	3
II.	Facility Quality Improvement Responsibilities.....	4
III.	Administration Quality Improvement Responsibilities	5
IV.	Record Reviews	5
	A. Record Review	5
	B. Peer Review	6
	C. AoD Peer Review	7
V.	Observations	7
	A. Ohio Risk Assessment (ORAS) Assessor Observation	7
	B. Individual Session Observation	7
	C. Group Observation	8
VI.	Facility Reviews.....	8
	A. Staff Incident Reports.....	8
	B. Facility Reviews.....	8
	C. Facility Operations Log	9
VII.	Operational Standards Reviews	9
VIII.	Programmatic Standards Reviews	9
IX.	Complaints & Grievance Review	9
X.	Resident Advisory Committee	10
XI.	Client Satisfaction Surveys	10
XII.	Policy and Procedures Review	10
XIII.	Program Review	10
XIV.	Administration Review.....	Error! Bookmark not defined.
XV.	Utilization Review	11
XVI.	Risk Management Reviews.....	11
	A. Minor Unusual Incidents/ Non-Reported Incidents.....	11
	B. Major Unusual Incidents/ Critical Incidents/ Reportable Incidents.....	11
XVII.	QI Activities.....	12
XVIII.	Performance Measures.....	Error! Bookmark not defined.
XIX.	Reporting Quality Improvement Activities	Error! Bookmark not defined.

I. Overview of Program Services

The Residential Reentry Programs (RRP) provide evidence-based residential treatment in Cincinnati, Dayton, Mansfield, and Toledo for ex-offenders. In Cincinnati there is also an outpatient substance abuse treatment program. Our services include intensive case management, group and individual counseling, substance abuse treatment, sex offender treatment, job-readiness, cognitive skills, life skill development and referrals to community resources. The most significant program service is the maintenance of the cognitive-behavioral rich environment where our clients can identify risky behaviors that keep them involved in the criminal justice system and develop new skills to change their behaviors and reduce risk of recidivism. Additionally, the programs help ex-offenders acquire the skills necessary to strengthen family relationships, establish positive support networks and become productive members of their community.

All of the Quality Improvement (QI) activities outlined in this addendum shall be applied to any residential, non-residential or outpatient reentry services that are being provided at each respective facility at Volunteers of America of Greater Ohio.

Although VOAGO has developed an infrastructure with a Quality Improvement Manager, Program staff remain accountable for maintaining facility level obligations related to daily, weekly, monthly, semi-annual and annual monitoring of audit preparedness, standards compliance and case record completeness.

II. Facility Quality Improvement Responsibilities

Each facility is responsible for conducting ongoing QI functions. The details of these functions are outlined within this addendum. All monthly and weekly required Facility QI forms are to be sent to both the QI Manager (QIM) and Director of Program Operations (DPO) through email and posted in the designated folder on the server.

Task	Time Frame	Responsible Staff
Utilization Review	Quarterly	Intake Manager
Record Reviews		
<ul style="list-style-type: none"> • Record Review 	Weekly/monthly	PD, CS
<ul style="list-style-type: none"> • Peer Review 	Quarterly	PD, CMs, Clinical Staff
<ul style="list-style-type: none"> • AoD Peer Review 	Quarterly	PD, Clinical Staff
<ul style="list-style-type: none"> • Intake Review 	Monthly	PD, CS
Observations		
<ul style="list-style-type: none"> • ORAS Assessor Observation 	Monthly	PD, CS
<ul style="list-style-type: none"> • Individual Session Observation 	Monthly	PD, CS
<ul style="list-style-type: none"> • Group Observation 	Monthly	PD, CS
Facility Reviews		
<ul style="list-style-type: none"> • Staff Incident Reports 	Ongoing	PD
<ul style="list-style-type: none"> • Facility Review 	Weekly /monthly	PD, ROM
<ul style="list-style-type: none"> • Facility Operation Logs 	Daily	ROM
Operational Standards Review	Monthly	PD, ROM
Programmatic Standards Review	Monthly	PD, CS
Satisfaction Surveys		
<ul style="list-style-type: none"> • Participant Satisfaction 	Quarterly	PD
<ul style="list-style-type: none"> • Referral Source, Funder, and Collateral Stakeholder Satisfaction 	Quarterly	PD
Resident Advisory Committee	Monthly	PD
Policy and Procedure Review	Annually	All Staff

III. Administration Quality Improvement Responsibilities

Each QIM is responsible for conducting ongoing QI functions within each facility. The details of these functions are outlined within this addendum.

Task	Time Frame
Direct Tasks	
• Record Review	Monthly
• Group Observation	Monthly
• Individual Session Observation	Monthly
• ORAS Assessor Observation	Monthly
• Facility Review	Monthly
• Complaint and Grievance Review	Quarterly
• Program Review	Annually
Oversight, Data Management, & Reporting	
• Operational Standards Review	Monthly
• Programmatic Standards Review	Monthly
• Administration Review	Monthly
• Utilization Review	Monthly
• Client Satisfaction Surveys	Quarterly
• Risk Management Review	Quarterly

IV. Record Reviews

A review of a sample of case files to ensure they are complete, timely and in compliance with all regulatory bodies. As part of Record Review, documentation strengths and areas of potential improvement are identified. For deficiencies noted, recommendations are made and action plans are developed to ensure performance improvement.

A. Record Review

<p>Frequency – Monthly</p> <p>Person Responsible for Completing & Reporting –Program Director and Clinical Supervisor monthly; QI Manager monthly and for internal audit.</p> <p>Minimum Number of Records Reviewed – A number equal to 10% of all open cases for both residential and any non-residential or outpatient programs provided by each RRP.</p> <p>100% of all files of new clients are reviewed within 14 days of program admittance. This review is conducted by the Program Director.</p> <p>100% of all closed cases of clients discharged within the last 30 days are reviewed monthly. This review is conducted by the Program Director and Clinical Supervisor.</p> <p>When applicable, files reviewed should include a participant from each of the following programs: sex offender, substance abuse, transitional control, electronic monitoring, and outpatient. Files for participants that fall into more than one category may be chosen.</p> <p>Selection Method – Files should be selected at random by the individual completing the review. Records from each staff member’s caseload are to be included in each audit.</p>

The VOAGO Residential Reentry Program has implemented protocol to establish guidelines for the completion of activities that ensures that case file documentation is complete, timely and in compliance with all regulatory bodies. To ensure case files meet documentation standards and are reviewed in a consistent and uniform manner, a Record Review Form has been developed and used at each RRP by the Program Directors. Residential Reentry Program Policy # 1400:02 Quality Record Review Compliance details the steps that are taken to assure case files are monitored for compliance and action plans implemented to address any deficiencies.

The QI Manager will create a formal report on the results of the reviews completed and submit it to the Program Director for review and action each month. Record Review Forms are saved to the Corrections folder on the U: drive of the VOAGO server each month along with resulting reports and action plans. The Program Director will review results with direct service staff to provide feedback and implement Performance Improvement Action Plans when indicated. The Program Director will ensure staff training is completed to assist staff in the improvement of documentation practices. Any corrections in client files must be completed in compliance with VOAGO policy standards as documented in Policy # 600:02.

Note: The QI Manager reserves the right to re-audit corrected charts, as necessary and appropriate.

B. Peer Review

The Peer Review process assesses the appropriateness, accuracy, and quality of records and services provided. This process also helps to ensure that the programs are compliant with all contractual and regulatory bodies.

- **Frequency** – Quarterly (minimum)
- **Person Responsible for Completing** – All Facility Case Managers and Clinical Staff
- **Person Responsible for Reporting** –Program Director
- **Minimum Number of Records Reviewed** – A number equal to 10% of all open cases for both residential and any non-residential or outpatient programs provided by each RRP.
- **Selection Method** – Files should be selected at random by the Program Director or Clinical Supervisor.

The Program Director ensures that no staff member reviews a chart where s/he has current or previous involvement in the participant's care. In the situation where a staff member is reviewing a record where s/he has had partial involvement (i.e. completed the ORAS), s/he reviews all areas of the chart except for the area where s/he was involved. In this instance, another worker reviews the portion that the worker cannot.

At no point may a staff person complete a peer review for his/her own documentation.

Additionally, staff reviewing the chart must be eligible to provide the service being reviewed in the participant's chart. (For example, if a diagnostic assessment was used, then it may only be reviewed by an individual who is licensed or certified to complete such an assessment.) A checklist is used during the Peer Review to determine the compliance with various benchmarks that were established for the purpose of meeting agency, local, state and federal guidelines. If there are concerns with a chart, the staff member writes this information on the form to inform the primary worker of improvements that are needed.

The primary case manager is required to correct the chart, if needed, sign the form, and forward it to the Program Director for review. The Program Director (or designee) will ensure the corrections were completed in the chart, and provide written feedback when applicable, sign the form and forward it to the QI Manager. The QI Manager determines the final compliance score and creates a report of the results.

The Program Director or designee is responsible for responding to the report, including plans for correcting/improving areas of deficiency. Any corrections in case files must be completed in compliance with VOAGO policy standards as documented in Policy # 600:02.

C. AoD Peer Review

A review of a sample of case files by VOAGO staff members qualified to provide the service(s) they are reviewing is conducted to ensure services are appropriate (based on assessed need) and documentation is accurate and complete. The procedure for this task is the same as listed above for Peer Reviews except that only AoD sections of the case file are reviewed. As part of AoD Peer Review, documentation strengths and areas of potential improvement are identified. For deficiencies noted, recommendations are made and action plans developed to ensure performance improvement.

A separate review form has been developed for AoD Peer Review to ensure that treatment services are appropriate and accurate. AoD Peer review includes, but is not limited to, a review of assessments, diagnostic information, treatment plans, progress notes, and discharge summary. The purpose of the AoD Peer Review is to ensure the appropriateness of the participant's admission, continued stay, and discharge from the program and to examine the quality of services provided.

V. Observations

A. Ohio Risk Assessment (ORAS) Assessor Observation

The program will observe, coach and monitor staff members who are conducting ORAS assessments to assist them in effectively completing the assessment according to State guidelines.

The Program Director or designee conducts regular monitoring and observation of staff in completion of ORAS assessments. Each staff member certified to conduct the ORAS assessment will be observed and rated monthly. The evaluator will use the ORAS Direct Observation Tool to document observation results and provide feedback and coaching to staff members for continued improvement in assessment skills.

The completed ORAS Direct Observation Tools will be forwarded to the QI Manager for analysis.

B. Individual Session Observation

The program will observe, coach and monitor staff members who are conducting case management or individual sessions with participants to assist them in effectively completing the sessions according to best practices.

The Program Director or designee conducts regular monitoring and observation of staff during case management or individual session. Each case manager will be observed and rated monthly. The evaluator will use the Individual Session Observation Tool to document observations and provide feedback to the staff member for continued improvement in best practices.

The completed Individual Session Observation Tool will be forwarded to the QI Manager for analysis.

C. Group Observation

The program will observe, coach and monitor staff members who are facilitating treatment groups to monitor for fidelity to the curriculum and uses best practices in group facilitation.

The Program Director or designee conducts regular monitoring and observation of staff facilitating group sessions. New facilitators will be observed more frequently to monitor and coach them as they develop and enhance group facilitation skills.

Observations will occur at minimum monthly for all new facilitators and/or any facilitator who has an overall rating score of (1.9) or below. Those with an overall rating score of two (2) or above will be observed a minimum of quarterly.

The evaluator will use the Group Observation Tool to document observation results and provide feedback and coaching to staff members for continued improvement in assessment skills.

The completed Group Observation Tools will be forwarded to the QI Manager for analysis.

VI. Facility Reviews

To ensure the health and safety of both clients and staff, all staff incidents are reported and facilities are regularly reviewed during Facility Reviews. Results may be shared with the Risk Management and Safety Committees.

A. Staff Incident Reports

Staff must report incidents to the Program Director immediately after any staff safety incident. Incident Report Forms are completed by the staff person reporting the incident and reviewed by the Program Director. Safety Incident Reports should be completed and forwarded to appropriate VOAGO administrative staff by the close of the next business day following the occurrence.

Incidents must be reported in accordance with VOAGO Policy 300:22.

All Staff Incidents are reviewed by the Director of Human Resources (or designee). Reported staff incidents are monitored for trends and patterns. When areas of potential improvement are noted, the Safety Officer will share these results with the Safety Committee to review and develop corrective action strategies. The results of reviews, recommendations made and performance improvement strategies implemented are shared at quarterly Risk Management and QI Committee Meetings.

B. Facility Reviews

To ensure the health and safety of clients, facility reviews at all program locations are conducted. The Shift Supervisor conducts daily shift reports, completing the Shift Report form at the end of each shift and forwarding it to the Resident Operations Manager for review.

The Resident Operations Manager at each facility conducts a weekly Facility Review utilizing the Weekly Facility Review form and forwarding it to the Program Director, Director of Program Operations, and QI Manager.

The Program Director (or designee) conducts a monthly Facility Review utilizing the Monthly Facility Review form and forwarding it to the Resident Operations Manager, Director of Program Operations and QI Manager.

After reviews are completed, the QI Manager conducts an analysis of the information, generating a facility compliance score and noting any trends/patterns. Results of the analysis of Facility Reviews are shared with the Program Director and Director of Operations.

C. Facility Operations Log

The Resident Operations Manager under the direction of the Program Director is responsible for maintaining an operations log in compliance with ACA and DRC requirements. These logs may be reviewed by the QI Manager at a minimum annually during the Internal Audit.

A log shall be kept for:

- Chemical Control
 - Key Control
 - Vehicle maintenance and mileage
 - Kitchen logs
 - Inventory Log
 - Emergency Drills
 - Facility Inspections
 - Tools
 - Visitor Log
 - Weapon Log
 - Search Log
 - Contraband Log
 - Urine Drug Screen Log
 - Breathalyzer
- Log

VII. Operational Standards Reviews

To ensure compliance with referral source and accreditation standards, an electronic log has been created for tracking of various outcomes. Examples of operational standards includes reviews of head counts, medication logs, searches, meal audits, and facility reviews. Program Directors should work with ROMs to ensure timely completion of the entries on a monthly basis.

VIII. Programmatic Standards Reviews

To ensure compliance with referral source and accreditation standards, an electronic log has been created for tracking of various outcomes. Examples of programmatic standards includes reviews of groups, assessments, risk level at admittance, CCIS completions, and discharge reviews. Program Directors should work with Clinical Supervisors to ensure timely completion of the entries on a monthly basis.

IX. Complaints & Grievance Review

To ensure participant rights are not being violated, all participant complaints and grievances are reviewed and monitored. Additionally, grievances are reviewed and monitored to ensure noted issues were addressed and resolved within the timeline set forth in the VOAGO Client Grievance Policy and Procedures.

The QIM serves as the agency's Client Rights Officer and is responsible for tracking and analyzing all complaints and grievances documentation. Program Directors are required to submit copies of client complaints and grievances to the QIM by the 5th day of every new month. The QIM will provide quarterly reports to the Program Directors and Director of Program Operations on a quarterly basis.

X. Resident Advisory Committee

Each Program Director shall lead a small group of select residents in a resident advisory committee. The purpose of this committee is to provide an ongoing forum for residents to provide input into the program and give feedback on services. Selection of residents is completed by program staff and should include residents in various phases of the program. The Resident Advisory Committee should meet no less frequent than one time per month and minutes should be kept and stored on the U:drive.

XI. Satisfaction Surveys

Quarterly, designated program staff will facilitate the distribution of client satisfaction surveys. As part of this process, all active participants will be asked to complete a satisfaction survey (to ensure surveys are collected at different points in treatment). Separate surveys will be given to residents, outpatient clients, and referral sources. Surveys will be submitted to the QI Manager for analysis. The QI Manager shall produce quarterly reports.

XII. Policy and Procedures Review

The policies and procedures for the corrections line of service for VOAGO should be reviewed and revised if necessary on an annual basis. While the Director of Program operations is the primary reviewer, program staff at all levels will be given portions to review and revise. Final changes will be submitted by the DPO to the Regional and Executive Vice Presidents for approval.

XIII. Program Review

The Quality Improvement Manager will conduct annual internal audits of each RRP in accordance with the Affiliate Quality Improvement Plan. This will include a comprehensive review of DRC standards, ACA standards, ODMHAS standards. The QI Manager compiles a Program Review Report to ensure noted program performance challenge(s) or issue(s) are being addressed and performance improvement strategies that were implemented are having the desired affect. The internal audit includes the following:

- Record review (10 closed and 10 open files)
- Operations review
- Programming review
- Staff interviews (all management staff, 75% program staff, 15% security staff)
- Participant interviews (minimum of 2)
- SecurManage[®] review for accuracy and appropriate usage levels
- Mandatory ACA standards review

XIV. Utilization Review

Periodic utilization review activities will be performed to monitor accessibility, appropriateness and effectiveness of services. Utilization Review may include, but is not limited to:

- **Termination Review** – To assess the appropriateness and effectiveness of services. To monitor for potential gaps in services. To determine areas where services might be enhanced to strengthen program success.
- **Admission/Intake Review** – To monitor accessibility and ensure services were appropriate and efficient.
- **Length of Stay Review** (as needed) – To monitor the appropriateness and effectiveness of services.
- **Demographic Characteristic Review** (as needed) – To ensure services meet the cultural needs of residents and ensure one demographic group does not disproportionately represent program successes or failures.

XV. Risk Management Reviews

Conducted to ensure the health and safety of clients; appropriateness of services; accessibility of services; to identify potential risk management concerns; and to monitor for potential service gaps or under-met client needs.

A. Minor Unusual Incidents/ Non-Reported Incidents

These are generally considered less severe unusual incidents that may impact service delivery but are not required to be reported to appropriate funding and regulatory bodies (i.e., ODMHAS, APA, ODRC, ODMH, CSB, VA, etc.). The QIM is responsible for tracking these incidents and reporting trends and observations on a quarterly basis.

B. Major Unusual Incidents/ Critical Incidents/ Reportable Incidents

These are generally serious unusual incidents that may pose an immediate liability risk to VOAGO. Major Unusual Incidents are those incidents that are required to be reported to appropriate funding and regulatory bodies (i.e., ODMHAS, APA, ODRC, BCS, VA, etc.). Examples of Major Unusual Incidents include, but are not limited to:

- Deaths
- Major Medical Incidents
- Violence or Aggression
- Possession or Use of Weapons on Facility Property
- Client Abuse or Neglect
- Alleged Criminal Acts
- Life Threatening Situations
- Abuse or Neglect of Minor Child or Elderly
- Major Violations of Program Rules that may Result in Eviction or Immediate Removal from Program

Staff members are required to submit Unusual Incidents Reports to the Program Director immediately upon discovery. The Program Director reviews reported incidents and meets with the staff person who reported

the incident to debrief and to assess for other potential risk (as necessary and appropriate). The QIM is responsible for tracking these incidents and reporting trends and observations on a quarterly basis.

All Unusual and Major Unusual Incidents MUST be reported to the following VOAGO administrative staff by the close of the next business day following the occurrence or discovery:

- QI Manager
- Director of Program Operations
- Vice President of Program Operations
- Executive Vice President of Program Operations
- CEO/President

The Program Director must also report Major Unusual Incidents to appropriate regulatory bodies within specified time frames.

XVI. QI Activities

Outlined below are the quality improvement activities that will be measured to monitor the VOAGO RRP. Unless otherwise noted, the following scoring process is utilized:

- Fully Compliant: 90%+ aggregate compliance.
- Mostly Compliant: 76%-89% aggregate compliance.
- Partially Compliant: 70%-75% aggregate compliance.
- Minimally Compliant: 0%-69% aggregate compliant

Review Areas and Performance Measures are detailed in the agency-wide QI Plan.