# 805.0 Annual Quality Assurance Plan

## 805.1 Policy Approval Clearance Record

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| ☐ Mental Health Policy<br>☐ Developmental Services Policy<br>☒ Rural Services Policy | This policy supersedes: None | Number of pages in Policy: 5 |
| Review by Representative from the Office of the Attorney General: N/A | Date: n/a | Date Policy Effective:<br>9/7/11 |
| Rural Services Director Approval Signature:<br>*Barbara Legier* | Date:<br>9/7/11 | Policy Lead: Eric Skansgaard, CPM-II |

## 805.2 Statement of Purpose

**805.2.1** **Policy Statement:** As a Behavioral Healthcare Network, Rural Services endeavors to improve outcomes and monitors the quality of services and provides annual reports to the Nevada Division of Healthcare Financing and Policy

**805.2.2** **Purpose:** To a) ensure services are delivered in accordance with best practice standards and State and Federal requirements, b) ensure Rural Services systems are focused on continuous quality improvement while being client-centered, community-oriented, and strength-based, and c) to provide procedures and timelines facilitating review of service quality, data analysis, and a procedure for development, review, approval, and annual submission of a quality assurance report.

## 805.3 Authority

MSM 403.2(6)
NRS 433

## 805.4 Definitions

**805.4.1** **DHCFP:** State of Nevada Division of Healthcare Financing and Policy

## 805.5 Procedures: Quality Assurance Framework

### 805.5.1 Policy Development

Existing policy is examined to determine if it meets the needs of residents of rural Nevada and complies with State and Federal Regulations. Policy development begins with a charter outlining the key issues, desired outcomes, measurable goals, staff commitments to the work, and task timelines and responsible parties. Regulations are benchmarked and the policy team is convened. Policy team members are responsible for obtaining feedback from peers. Charters and policy drafts are submitted for clearance to the Leadership team. Such clearance may consist of review and comment or approval. Policies are approved upon signature by the Agency Director, but are not finalized until the completion of an implementation plan.

### 805.5.2 Training

Training is a key requirement for workforce development and a component of the policy development and compliance assessment process. The training process begins with a needs assessment based on performance, quality assurance compliance findings, staff interest, and industry best-practice standards. A training plan is developed that addresses these areas in order to meet the needs of staff and the agency. New policy is delivered through the training process which provides the mechanism to introduce new policy. Training requirements are defined in policy implementation plans, plans of correction, and agency and Division training policies.

### 805.5.3 Program Planning and Improvement

Performance improvement is a system composed of identified standards, measurable objectives, planned improvement and correction within a supervisory and administrative feedback loop. Performance indicators are established through legislative, regulatory, and program planning and evaluation activities. Measurable objectives (e.g., investigations, root cause analyses, surveys, audits, reviews, supervision) are completed by staff and lead to plans of correction specifying goals, key action, responsible parties, and timelines. Measurement results produce data for review by management and the Leadership Team, resulting in performance improvement plans expressed in a policy charter and for strategic planning purposes.

## 805.6 Procedures: Quality Assurance Activities

### 805.6.1 Staff Activities

Quality assurance is the responsibility of all staff. Staff of Rural Services will participate in quality assurance activities which identify: aspects of quality of care that supports person and family centered practice; identify clinical indicators to continually and systematically monitor quality of care; established markers which indicate problems or opportunities to improve care; identified action to correct problems and improve substandard care; tools to assess the effectiveness of the actions taken. Quality Assurance activities include, but are not limited to, the following:

A. **AVATAR and clinical chart data entry** is the responsibility of all staff as specified by documentation policy.

B. **Peer Reviews** address quality of practice and are completed by service delivery staff as outlined in RS Policy 307. These staff will complete two reviews per month on the electronic and physical chartwork of peers. CPM-I staff are responsible for ensuring the assignment, collection, review, and correction procedures occur monthly. CPM-Is will conduct a quarterly review of trends and corrective action and submit this report to CPP-I not later than the fifth day of each quarter.

C. **Consumer Surveys** are completed each spring by the Division of Mental Health and Developmental Disabilities. The report is completed by MHDS in the fall. Facilitation of the survey process is the responsibility of all staff.

D. **Environmental Reviews** are conducted by nursing, management and quality assurance staff as specified in RS 500, safety policy.

E. **Regulatory Chart Audits** address the regulatory aspects of practice as specified in state law, the Medicaid Service Manual, and Division and Agency Policy. Chart audits are conducted as specified in RS 307. Leadership recommendations and assignments will be documented in the G Drive, QA folder and subsequent action monitored and compiled at the time of the annual QA report.

F. **Supervision** of direct service staff shall occur not less than monthly and will be documented in supervision notes. Supervisors will review results of peer reviews and clinical chart audits as specified in RS 307, assign corrective action, and track completion. Feedback from other applicable quality assurance activities will be provided and documented. Themes and trends will be reported by CPM-I staff in the quarterly peer review.

G. **Administrative Reviews** consist of a review by the Clinical Program Manager II, Outpatient Servcies, of open clinical records/client files to evaluate compliance, quality and therapeutic outcome of the services

provided to the person served. Reviewer will review two clinical records from every center per year. The Clinical Program Manager II, Developmental Services, shall review open files to evaluate compliance, quality and efficacy of the services provided to the person served. Reviewer will review four files per office per year.

**H. Maintenance of Provider Standards** shall be conducted by the MAII and CPP-I as necessary. The MAII will monitor and disseminate billing and data cleansing reports monthly. Credentialing activities will occur annually or as necessary based on staffing patterns.

**I. Staff Training** shall occur at hire and annually as specified by training policy. Training resulting from investigation, peer or regulatory review, or plan of correction shall be documented by sign off sheet and in the supervision notes kept by each supervisor.

**J. Policy and Procedure Development and Implementation** is the responsibility of all staff. Assignment to a policy team in the charter of any policy constitutes a non-negotiable task assignment for the duration of the charter.

**K. Accounting and Billing Review / Data Cleansing** is conducted by the MAII and is monitored monthly in conjunction with the AA staff of each center.

**L. Development / Monitoring of Budgetary and Regulatory Performance Indicators** is the responsibility of the CPP-II in conjunction with the leadership team and will be conducted as specified in RS 306.

**M. Review of Managerial Reports / Clinical Practice** is the responsibility of supervisors and CPM-I staff as specified in QA component of Work Performance Standards. The Administrative Program and Nursing AAII will generate managerial reports every other week and distribute these to all centers. The CPM-II conducts review of the CPM-I non-negotiable reports at each supervision but not less once per quarter. Findings and action planning will be documented in supervision notes.

**N. Oversight of Serious Incident Reports**, including Root Cause Analyses are the responsibility of the CPP-II and CPP-I and will be conducted according to MHDS policy. Subject to availability from MHDS, The CPP-II will ensure data and trending status on incident reports are provided to the leadership team monthly. Data from Root Cause Analyses will be reported to the leadership team for inclusion in performance improvement plans each quarter.

**O. Coordination of Fact-Finding and Investigative activities** occurs under the direction of the Agency Director. Assignment to any investigation or fact-finding makes this activity a top priority for assigned staff. Findings and corrective action are shared with managers and the leadership team at the discretion of the Agency Director.

**P. Collaborative development of Corrective Action Plans** is the responsibility of all staff. Supervisors and CPM-I staff will implement and monitor progress on CAPs within the timelines specified.

**Q. Institutional Coordination and Oversight** is conducted by the CPP-II who will coordinate referrals from inpatient to outpatient statewide. PASRR oversight is conducted by the CPP-I who will report not less than quarterly to the leadership team.

**R.** **Oversight of Contract Service Provision** occurs in collaboration with the Director of Nursing, CPM-II, CPM-I, and DS QA staff. The Administrative Program and Nursing AA will maintain monthly contract provider spreadsheets and crystal reports. The Director of Nursing will report contract provider utilization and corrective action plans monthly.

**S.** **Quality Assurance Data Analysis and Trending** are the responsibility of CPP-II and CPP-I staff. Predefined monthly status reports are provided to the leadership team.

**805.6.2 Data Review, Corrective Action, and Policy**

The Rural Services Leadership Team is composed of the following:

**A.** Agency Director

**B.** Director of Community Services

**C.** Director of Outpatient Services

**D.** Director of Nursing

**E.** Clinical Program Planner II/QA Supervisor

**F.** Quality Assurance/Clinical Program Planner

**G.** Psychologist

**H.** Business Manager

**I.** Ad Hoc supervisors / subject matter experts

The Rural Services Leadership Team holds weekly Meetings of the Administrators of Rural Services (MARS). Weeks one and three of each month emphasize policy development and implementation. Week four constitutes data review with Standing Report Items from the following Departments:

**A.** Mental Health / Community Services

**B.** Mental Health / Quality Assurance

**C.** Mental Health / Psychological Services

**D.** Mental Health / Nursing Services

Department heads present pre-defined data, including performance data and clinical and regulatory audit findings. Data and findings are measured against established markers / performance indicators, including budget performance indicators, regulatory requirements, policy and procedure indicators, and BHCN regulatory requirements. MARS team members discuss and develop a) plans of correction and b) policy suggestions. This process embodies the feedback loop between staff QA activities, systematic review, corrective action, and policy development.

**428.5.3 Data Analysis and Report Preparation**

**A.** On a quarterly basis, Rural Services Quality Assurance Staff will report to MARS:

**1.** Peer Review Synopsis

**2.** Regulatory Review Synopsis

**3.** Budget Performance Indicator Synopsis

**4.** Investigations / Incident Reports / Root Cause Analyses Synopsis

5. Environmental Review Synopsis

**B.** At the end of each fiscal year, Rural Services Quality Assurance staff will compile annual quality assurance data and generate a report for DHCFP. This report will address:

1. Identified aspects of qualify of care which supports person and
2. family-centered practice;
3. Indicators and clinical criteria to continually and systematically
4. monitor these aspects of quality care;
5. Established markers, which indicate problems or opportunities to
6. improve care;
7. Identified action to correct problems and improve substandard care;
8. Tools to assess the effectiveness of the actions taken
9. Recommendations for future action

**C.** Quality assurance staff will provide a draft of the Quality Assurance Report to the Agency Director for Review and comment. The Agency Director will ensure the final report is completed not later than August 30th of each year.

**D.** A final report will be forwarded to DHCFP not later than August 31st of each year.

## 805.6 Policy Cross Reference

**805.6.1 RS 306 Budget Performance Indicator Monitoring**

**805.6.2 RS 517 Serious Incidents Process**

**805.6.3 RS 304 Compliments Suggestions and Complaints**

**805.6.4 RS 1003 Person Centered Planning**

**805.6.5 RS 520 Med Error, Incident Reporting, and ADRs**

**805.6.5 RS 307 Peer and Supervisory Administrative File Reviews**

**805.6.5 RS 700 Policy Development Process**

**805.6.5 RS 205 Rural Services Training Development and Approval Process**