SECTION
ADMINISTRATIVE REQUIREMENTS

SUBJECT
Quality Assurance Process

DEFINITION

The Addictive and Mental Disorders Division, Mental Health Services Bureau of the Department conducts comprehensive evaluations of case management teams (CMTs) to meet the Bureau's quality assurance requirements. Department staff will perform announced quality assurance reviews. The purpose of the review is to insure that optimal services are being provided to individuals and that program rules and policies are being followed. Quality assurance results are utilized to improve the programs and services.

The quality assurance review is divided into two parts. Part one is the provider prepared standards. This is a documentation process where the CMT provides information to demonstrate compliance with specific standards. This is done prior to the onsite review at the request of the Program Manager or Community Program Officer (CPO). Part two is the onsite review of records.

Below are some helpful hints for review:

1. Make sure you know where all appropriate documentation is located.
2. Provide Department staff with private and ample workspace.
3. Review your own records (see CMT Chart Audits below).
4. Don't be afraid to ask questions.
5. Submit your provider prepared standards by the deadline requested.
6. Understand review dates can be tentative and may be moved due to staff conflicts and/or bad roads.
7. This is a learning experience for all of us.

CMT CHART AUDITS

Case management teams are also required to conduct chart audits at least quarterly on a sample of cases. No less than a ten percent (10%) random sample should be conducted when caseloads are at or near maximum. The sample size should be increased when caseloads are lower. The audit findings from case reviews are reported on the Report 1 of the quarterly reporting requirements (Refer to SDMI HCBS 899-2) or a CMT form that has been approved by the Program Manager and CPO.

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QUALITY ASSURANCE REVIEW FREQUENCY

Each case management team must receive a full review annually. 100% of all charts will be reviewed.

PERFORMANCE REVIEW STANDARDS

Performance standards consist of the standards outlined below:

1. Required documentation is readily available and principles of charting are followed. Refer to SDMI HCBS 804.

    A. All charts must contain the appropriate forms and be filled out completely, appropriately and correctly.
    B. Chart contains copies of the Level I (AMDD-145) and if applicable, the results of the Level II.
    C. Chart contains a copy of the Level of Care Determination and application.
    D. Chart contains a copy of the Screening Determination (AMDD-61).
    E. Chart contains an intake sheet. The admit date should equal the enrollment date and must be equal to or later than effective date on the AMDD-61 and equal to effective date on the DD/SLTC/AMDD-55.

2. The Person-Centered Recovery Plan (PCRP) is complete. Refer to SDMI HCBS 809-1, 809-2, 809-3, 809-5. The date of referral and referral source should match those on the intake sheet (AMDD-136). The services and units on the cost sheet should match the services and units in PCRP service delivery plan and should match the services and units in the prior authorization to Xerox.

3. Person-Centered Recovery Plan reevaluation occurs at least once every 90 days. Refer to SDMI HCBS 899-15. The chart should contain all the necessary reevaluations and amendment forms. These should be filled out appropriately.

4. Progress notes are complete. Progress notes should reflect the CMT involvement in the individual's life, the monitoring of quality of care and the review of the necessity of selected services. All entries must be signed and dated. Both team members must make reevaluation visits and both should have signed off on that entry.

5. Principles of charting. All entries must be legible and in ink.

6. Individuals on the waiting list are seen and selected according to SDMI HCBS manual policy. Refer to SDMI HCBS 406 and SDMI HCBS 899-20. Information on SDMI HCBS

services is sent to individuals on the waiting list. All individuals on the waiting list must be contacted within 5 days of receipt of the Level of Care referral and have received an in-person visit by the team within 45 days of the initial formal referral. All individuals selected for services must be in accordance with the waiting list criteria policy.

7. Agency staffing is sufficient to meet caseload needs. Refer to SDMI HCBS 802.

8. CMTs expenditures must match their authorized budgets. Refer to SDMI HCBS 805. The Department will track utilization and expenditures using the CMT monthly utilization reports to ensure that CMT provide services within authorized parameters.

9. Individual has free choice of providers. Review provider documentation to ensure that choice of providers was explained and offered to the individual.

10. Provider has good standing in their service area. CPO will conduct reference checks.

11. Individuals express satisfaction with their services and support. CPO will conduct interviews with individuals.

PROVIDER PREPARED STANDARDS

Provider prepared standards consists of the standards outlined below:

1. Provider reports and follows-up on all serious occurrences.

2. An annual survey is conducted and the results are utilized to improve services.

3. The provider employs licensed nurses. Refer to SDMI HCBS 802.

4. The provider completes the Report #1 and documents actions taken to resolve errors. Refer to SDMI HCBS 899-2.

5. CMT has sufficient computer capabilities to perform SDMI HCBS tasks.

AUDIT AND COMPLIANCE BUREAU

This Bureau will conduct financial audits upon request of the Mental Health Services Bureau.