



**Universal Mental Health Services, Inc.**  
**QUALITY IMPROVEMENT PLAN**  
**2010**

**1.0 PURPOSE:**

UMHS remains committed to adhering to a process of methods and procedures that result in the highest quality of services provided to clients in North Carolina. The following Quality Improvement Plan serves as the foundation of the commitment of UMHS to continuously improve the quality of the treatment and services provided. Furthermore, this Quality Improvement Plan will ensure UMHS's mission statement is achieved through the continuous quality improvement process.

Through this process, the organization will systemically:

- Assess and evaluate the timeliness of the implementation of services for consumers
- Assess and evaluate the effectiveness and appropriateness of the services provided for each consumer
- Improve the clinical and support processes that are most important to the health and safety of the clients we serve
- Correct any observed deficiencies identified through the quality improvement process
- Continue to expand the services we provide
- Continue to expand the areas in which services are provided

These objectives will be achieved through our policies and procedures, qualified staff and the continuation of client and personnel satisfaction.

## **2.0 QUALITY IMPROVEMENT PROCESS:**

- ***Responsibilities of the Quality Improvement Committee***
  1. Internal quarterly reviews for all current and closed consumer charts (25% quarterly resulting in 100% annually)
  2. Internal annual reviews for personnel training charts
  3. Review of critical incident and death reports
  4. Review of trends noted in incident reporting
  5. Providing oversight of qualification verification of professional staff
  6. Tracking outcomes data for consumers
  7. Providing oversight to problems and issues identified through quality improvement functions related to internal services
  8. Initiating quality improvement activities
  
- ***Composition of Quality Improvement Committee***
  1. Chair – VP/Operations
  2. Co-Chair – Quality Improvement Specialist
  3. VP Administration
  4. IT Director
  5. Regional Directors
  6. Medical Operations Manager
  7. Regional Office Manager
  8. Assistant Regional Office Manager
  
- ***Client/Stakeholder Participation***
  1. Client Satisfaction Survey
  2. Stakeholder Survey
  3. Comment/Suggestion Boxes

#### 4. Follow-Up For Discharged Clients

- ***Quality Improvement Sub-Committees***
  1. Client Right's Committee
  2. Safety Committee
  3. Medical Records Committee
  
- ***Responsibilities of Client Right's Committee***
  1. Provides review of incidents involving actual or alleged abuse, neglect, death, exploitation of any incident or concern involving the violation of a client's rights
  2. Provides review of all emergency use of restrictive interventions
  3. Review of investigations
  4. Review of trends
  5. Review and approval of behavior plans (for consumers)
  6. Meet quarterly for a total of four (4) times per year
  
- ***Responsibilities of Safety Committee***
  1. Monitors safety throughout the company
  2. Meets a minimum of quarterly for a total of four (4) times per year
  3. Members submit quarterly reports on all safety activities, concerns and probable solutions to any problems noted
  4. Review of worker's comp. claims/trends
  
- ***Responsibilities of Medical Records Committee***
  1. Reviews forms and reporting procedures to ensure compliance with rules of the Division in all area operated services
  2. Meets a minimum of quarterly for a total of four (4) times per year to review the records quantitatively

3. Reports findings of reviews to QI Committee

▪ ***Meeting Times and Minutes***

1. All sub-committees report directly to the QI Committee
2. Each sub-committee shall meet a minimum of quarterly
3. All meetings shall be recorded and minutes submitted to the Quality Improvement Committee
4. Activities of the sub-committees are monitored via monthly reports from each sub-committee chair to the QI chair
5. A report regarding QI activities of each sub-committee shall be included in the Quality Improvement Committee's annual report top the Senior Management Team

**3.0 QUALITY IMPROVEMENT ACTIVITIES:**

▪ ***Internal Utilization Record Review***

Internal utilization medical record review is performed as an ongoing process, carried out by a team of peers in each location. Each record is reviewed according to the standards set forth by the division requirements. Each new record is reviewed within 30 days of implementation to ensure that all requirements are present and met.

▪ ***Medical Record Review***

Medical record review is performed as an ongoing process, completed by the members of the medical records sub-committee. Medical records are reviewed for completeness in regard to the presence of required components designated by the division. Each record is reviewed within thirty (30) days of admission to ensure that all required items are present in the medical record.

Records are reviewed for completeness prior to being filed. The medical records sub-committee shall perform a quantitative review of medical records quarterly. Any problems noted during these reviews shall be submitted to the appropriate program director for follow-up or further action as required.

▪ ***Personnel Training Chart Review***

Human Resources Personnel/Support Staff in each office will be responsible for ensuring that the initial review is completed within 30 days of hire. HR Staff will use the “Training File – Review/Check Sheet” in order to review the training file. HRC will help track the thirty days when a new hire is completed. HRC will also assist with tracking annual review updates to the Regional Office Manager by utilization of a spreadsheet on the 1<sup>st</sup> of each month. Any corrections needed will record these on the corrections needed page. If no corrections were needed, the Reviewer will sign-off on form and send the completed form to the QI Dept. If corrections are needed, Regional Office Manager or designee will make the necessary arrangements to ensure corrections are completed within a 2 week time frame and note the deadline on the form. The reviewer will review corrections and note that corrections have been completed by initialing and dating each corrected item on the original form. The Reviewer will then return the original form to the QI Dept. Personnel Charts will be reviewed at 25% quarterly with 100% completed annually.

▪ ***Review of Trends of Critical Incident Reports***

The Client Right’s Committee shall evaluate all incident reports, death reports, investigations and

grievances received for the quarter. Each incident shall be categorized and relevant data entered into a database created for tracking client incidents. The QI Dept. will submit a trending report to the Safety Committee quarterly. Concerns or questions regarding any incidents shall be reviewed at the Safety Committee meetings. Potential problems and adverse trends shall be studied and referred to the QI Committee for further analysis. The QI Committee shall refer recommendations to the appropriate program director or committee as necessary and shall monitor the progress of corrective action by requiring the responsible program or committee to submit written reports, as a minimum of quarterly, until corrective action is complete.

- ***Professional Staff Qualification Verification***  
The QI Director is responsible for qualification verification for all professional staff within UMHS. The Regional Director is responsible for ensuring that the individual's confirmation of education (transcript), the documentation of education and the documentation of experience are provided for the QI Dept. The QI Dept. will then verify that the education and experience are appropriate and adequate to qualify the candidate for the position desired. The QI Director will then sign the Qualification Verification form and will keep a copy for the QI Dept. and will send the original to be filed in the person's training chart and the Regional Director will be notified that the person is or is not qualified for the position.
  
- ***Tracking Outcomes Data***

Outcomes data will be retrieved from a variety of sources. Included in these sources are the GAF Scores, NC TOPPS, Client Satisfaction Surveys, Shareholder Surveys and Employee Surveys. The QI Director will review and relay the information received from this data onto the approved Outcomes form. This information will then be shared with the QI Committee and the committee will make educated recommendations from this data.

**4.0 COMMUNICATION OF THE QI PLAN:**

In an effort to achieve the exchange of ideas and information required for the continuous quality improvement of UMHS, communication and teamwork between all committees, sub-committees, and programs is expected. Each sub-committee chairperson shall provide a written quarterly report regarding assessments and activities to the QI Committee. Programs and/or committees responsible for quality improvements shall provide the QI Committee with quarterly written reports regarding progress toward meeting their identified goals. Communication of QI activities shall be carried out via distribution of the Quality Improvement Plan to all programs annually. An annual report of QI activities shall be submitted to the Agency Director and Senior Management Team annually.

Quality Improvement Specialist Signature:

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VP/Operations/Quality Improvement Director Signature:

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Clinical Director Signature:

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