

*Mid-Del Youth and family Center, Inc.  
Policies and Procedures*

**600 General Program Standards**

	<u>Page</u>
<b>600 Introduction .....</b>	<b>5</b>
<b>601 Client’s Rights.....</b>	<b>6</b>
<b>602 Confidentiality/Privacy Policy .....</b>	<b>8</b>
General Provisions .....	8
General Procedures.....	9
Telephone Requests for Information.....	9
Client Request for Information .....	11
Release of Information to Third Parties .....	12
Disclosure of Information Without the Client’s Consent .....	14
Subpoenas.....	16
<b>603 Client Participation.....</b>	<b>18</b>
<b>604 Intake, Diagnosis, Assessment and Case Planning.....</b>	<b>18</b>
<b>605 Information and Referral .....</b>	<b>19</b>
Information Services .....	21
Receiving a Referral.....	22
<b>606 Case Consultation Services.....</b>	<b>23</b>
<b>607 Community Information, Consultation and Outreach Services.</b>	<b>23</b>
<b>608 Record Keeping .....</b>	<b>24</b>
Policy Statement.....	24
Safekeeping of Client Records .....	24
Maintenance and Disposal .....	25
Critical Incident Report.....	25
Records Content .....	25
Medical Information and Record of Medications (Shelter Only).....	29

*Mid-Del Youth and family Center, Inc.  
Policies and Procedures*

<b>609</b>	<b>Cooperative Service Agreements .....</b>	<b>30</b>
<b>610</b>	<b>Facility Visitation .....</b>	<b>31</b>
<b>611</b>	<b>Fee Schedule.....</b>	<b>31</b>
<b>612</b>	<b>Client Grievances and Abuse .....</b>	<b>31</b>
	Opinions and Recommendations.....	31
	Grievances and Complaints.....	32
	Procedures Regarding Allegations of Abuse and Neglect.....	34
	From Title 10:	
	A. General Definitions .....	34
	B. Procedure for reporting incidents of abuse, neglect or mistreatment .....	37
	C. Ensuring Client Safety .....	38
	D. Office of the Advocate Defender and Advocate General .....	40
<b>613</b>	<b>Environment .....</b>	<b>41</b>
<b>614</b>	<b>Unusual or Critical Incidents .....</b>	<b>41</b>
<b>615</b>	<b>Medical Emergencies .....</b>	<b>42</b>
<b>616</b>	<b>Evaluation of Services.....</b>	<b>43</b>
	Administrative Responsibilities .....	45
<b>617</b>	<b>Effective Quality Improvement Planning .....</b>	<b>46</b>
	Outpatient Behavioral Health Services .....	46
	Verification.....	46
	E.Q.I.P – Action Plan .....	47
	Goals and Objectives.....	47
	Program Organization .....	47
	Scope .....	48
	Program Oversight .....	48

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

Verification.....	48
E.Q.I.P Activities.....	48
Client Care Monitoring .....	48
Peer Review.....	49
Clinical Privileging .....	49
Review of Client Care Incidents .....	49
Monitoring of Client Care.....	50
Process Review .....	50
Client Satisfaction and Treatment Outcomes.....	50
Maintenance and Content of Client Records .....	50
Verification.....	50
QI - Monitoring and Evaluation.....	51
Assigned Responsibility.....	51
Scope of Care Covered by the QI M/E Program and Important Aspects of Care .....	51
Client Care Indicators and Evaluation Thresholds .....	52
Indicator .....	52
Thresholds .....	52
Data Collection and Evaluation .....	53
Corrective Action.....	53
Follow-Up on Previous Recommendations .....	53
Verification.....	54
Process Review.....	54
E.Q.I.P Process.....	55
Length of Stay Norms .....	55
Appropriateness and Clinical Necessity of Admissions .....	55
Indicator .....	56
Thresholds .....	56
Appropriateness and Clinical Necessity of Continued Treatment.....	56
Indicator .....	56
Thresholds .....	57
Appropriateness, Clinical Necessity and Timeliness of Support Services.....	57
Indicator .....	57
Thresholds .....	57
Utilization of Staff, Space and Other Resources .....	57
Indicator .....	57
Thresholds .....	58

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

Corrective Action .....	58
Follow-Up on Previous Recommendations .....	58
Verification.....	59

## **600 GENERAL PROGRAM STANDARDS**

### **600 Introduction (Approved 03/19/04)**

The policies contained in this section apply to all service programs and components provided by the organization.

Mid-Del Youth and Family Center, Inc. is a private, not for profit, community-based counseling and crisis intervention organization.

Mid-Del Youth and Family Center, Inc. operates several programs, each designed to meet particular needs of the community. Listed below are the programs Currently offered by the organization. For further information on each program, please refer to the program sections of the Policies and Procedures manual found with section 800 and 700.

- A. The Emergency Youth Shelter
- B. Outpatient Behavioral Health Services (to include Community At-Risk Services)
- C. Positive Directions (First Offender)
- D. School Based Services
- E. Project Safe Place
- F. Case Management/Service Coordination
- G. Youth Development Services
- H. Employee Assistance Programs
- I. Positive Power (adolescent anger management)
- J. E.N.D (End Nicotine Dependence)

K. Positive Directions (Second Step)

L. Prevention/Diversion Services (EOC Youth Coalition)

M. Family Based Services (STEP Parenting, PREP, Adult Compassion Workshop)

**601 Consumer/Client Rights (Approved 11/01/00)**

All persons receiving services from Mid-Del Youth and Family Center will enjoy all rights, benefits, and privileges guaranteed by laws and constitution of the State of Oklahoma and the United States of America, except those specially lost through due process of law. In addition to the above rights, all persons will have the right guaranteed (For the purposes of this section, outpatient services includes all services where the Consumers/Clients have the rights specified as follows.) (For the purposes of this section, outpatient services includes all services where the Consumer/Client does not reside in, or stay overnight in, the facility providing services to him/her.)

Each Consumer/Client served by Mid-Del Youth and Family Center can expect:

1. To be treated with respect and dignity. All agency personnel are expected to perform all services in a manner that protects, promotes, and respects individual human dignity.
2. The right to a safe, sanitary, and humane living environment or treatment environment.
3. The right to a humane psychological environment that protects him/her from harm, abuse, or neglect.
4. To be provided services in an environment, which provides reasonable privacy, promotes personal dignity, and provides opportunity for improved functioning.
5. Right to receive services or appropriate referral without discrimination as to race, age, color, gender, religion/spirituality, national origin, degree of disability, handicapping condition, legal status, and/or the ability to pay for the services.

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

6. To never be neglected and/or sexually, physically, verbally, or otherwise abused.
7. The right to be provided with prompt, competent, appropriate services and an individual treatment plan.
8. To be afforded the opportunity to participate in their treatment planning and consent, or refuse to consent to the proposed treatment unless these rights are abridged by a court on competent jurisdiction or in emergency situations as defined by law.
9. The right to permit family members or significant others to be involved in their treatment and treatment planning.
10. The right to have their records treated in a confidential manner.
11. Right to refuse to participate in any research project or medical experiment without specific informed consent as defined by law and that such refusal shall not affect the services available to the Consumer/Client.
12. The right to voluntarily participate in work therapy and to be paid reasonable compensation for such work.
13. The right to request the opinion of an outside medical or psychiatric consultant, at the expense of the Consumer/Client; and/or to request an internal facility consultation at no cost.
14. The right to have a full accounting of Consumer/Client's funds if they are held or monitored by the agency.
15. The right to assert grievances with respect to any alleged infringement of these stated rights or any other statutorily granted rights.
16. The right to never be retaliated against, or subject to any adverse conditions or treatment services solely or partially because of having asserted any of the Consumer/Client rights listed in this document.

Mid-Del Youth and Family Center policy is to train staff in these rights and to insist on their observance.

Mid-Del Youth and Family Center's policy is to ensure each Consumer/Client enjoys, and has explained to him/her, these rights. These rights are visibly posted in both Consumer/Client and public areas of the facility.

All persons receiving services from Mid-Del Youth and Family Center, Inc. shall enjoy all rights, benefits and privileges guaranteed by laws and the Constitution of the State of Oklahoma and the United States of America, except those specifically lost through due process of law. In addition to the above rights, all persons shall have the right guaranteed by the Substance Abuse Consumer/Client's Bill of Rights, unless an exception is specifically authorized by these standards or an order of a court of competent jurisdiction.

## **602 Confidentiality/Privacy Policy (Approved 03/19/04)**

It is the policy of the organization to protect the confidentiality/privacy and integrity of its Clients. It is the intent of the organization's confidentiality/privacy policy and procedures to assure full compliance with Federal Code 42 CFR and all other state and/or funding source requirements. Failure on the part of staff to abide by policy is grounds for disciplinary action, up to and including termination.

### **General Provisions**

The provisions of this policy and procedure apply to all forms of Client information, both written and verbal.

All case information will be treated confidentially, privately and will be protected against loss, theft, defacement, tampering or use by unauthorized persons and will only be released as required by law or by the Client's written consent.

Clients shall be informed that their records may be subject to review by federal, state and local funding sources to verify and evaluate services delivered.

### **General Procedures**

A. The importance of maintaining the confidentiality/privacy of all

*Mid-Del Youth and family Center, Inc.  
Policies and Procedures*

information provided by persons served by Mid-Del Youth and Family Center, Inc. will be emphasized to all staff members as part of their orientation process.

- B. All information related to Clients is to be protected from unauthorized disclosure.
- C. All files containing Client information shall be locked and opened only as is necessary to perform normal work functions.
- D. Client records will be accessible to Mid-Del Youth and Family Center, Inc. staff members only to the extent required in the performance of their work.
- E. Any removal of a Client record from active or closed files shall be documented, indicating the date and to whom the record was released.
- F. Confidential/private information may be disclosed without a Release of Information Form both within the organization and with those outside agencies with who qualified service agreements exist, (i.e., Department of Human Services). In addition, the staff/visitor confidentiality/privacy form must be signed and dated.
- G. Any disclosure under these procedures, whether with or without the Client's consent shall be limited to the information necessary in light of the need or purpose of the disclosure.

**Telephone Requests for Information**

There is to be no acknowledgment that a person is a Client of Mid-Del Youth and Family Center, Inc., whether or not the caller is personally aware of the fact.

A caller is to be handled in such a way that a check of the Client's file can be made to ascertain if there is a Release of Information signed by the Client for the caller. If there is not an authorization in the file, a continued non-acknowledgment must be made.

*Mid-Del Youth and family Center, Inc.  
Policies and Procedures*

A. Procedures for Clerical/Receptionist Staff

1. No acknowledgment of a person's status as a Client of Mid-Del Youth and Family Center, Inc., is to be made.
2. The caller is to be informed that all Client information is protected by state and federal law and cannot be released without written authorization.
3. The caller is to be asked for his/her name, phone number and any additional message and informed that a member of the professional staff will return the call.
4. The message/request is to be given to the assigned counselor or supervisor.

B. Procedures for Residential Advisors

1. No acknowledgment of a person's status as a Client of Mid-Del Youth and Family Center, Inc., is to be made.
2. The caller is to be informed that all Client information is protected by state and federal law and cannot be released without written authorization.
3. The caller is to be asked for his/her name, phone number and any additional message and informed that the Shelter Director or another employee will return the call.
4. The message/request is to be given to shelter director, counselor responsible for treatment, or other designated person.

C. Procedures for Professional Staff

1. There is to be no acknowledgment that a person is a Client of Mid-Del Youth and Family Center, Inc. unless a written

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

authorization has been signed by the Client or a qualified service agreement exists.

2. A check of the Client's file for an authorization to release information to the caller is to be done prior to any acknowledgment of a Client's status.
3. If there is not an authorization for the release of information or a qualified service agreement, the caller is to be told that all Client information is protected by state and federal confidentiality/privacy laws and cannot be released without written authorization of the Client or his/her guardian or parent, if the Client is under the age of 18.

### **Client Request for Information**

In accordance with Federal law, Clients have access to their records only under certain conditions.

- A. An adult Client (18 years or older) may view his/her confidential case record within Mid-Del Youth and Family Center, Inc. offices only during normal office hours.
- B. A minor (under 18 years of age) may view his/her case record within the Mid-Del Youth and Family Center, Inc. offices with the consent of his/her parent or legal guardian during normal office hours.
- C. Client case records and files are the property of the organization. Clients are not allowed, under any circumstances, to copy or remove any file information or remove the case file from the premises.
- D. Materials obtained from other sources (e.g. hospital records, former therapists, family members) are not to be released; the Client must obtain that information directly from those sources.
- E. Records cannot be altered or destroyed before the Client sees them as there is potential legal liability.

F. Whenever possible, go over the record together with the Client.

### **Release of Information to Third Parties**

A. Any release of information to outside agencies or individuals must be preceded by a Consent to Release Information Form signed by the Client or by a person legally authorized to act in his/her behalf. Such release of information must be in writing, conform with appropriate state and federal regulations and contain the following:

1. The name of the program that is to make the disclosure, (e.g. Mid-Del Youth and Family Center, Inc.)
2. The name or title of the person or organization to which the disclosure is to be made.
3. The name of the Client.
4. The purpose or need for the disclosure.
5. The extent or nature of the information to be disclosed.
6. A specification of that date, event or condition upon which it will expire without expressed revocation.
7. The date on which the consent is signed.
8. The signature of the patient or the signature of a person legally authorized to sign under that section in lieu of the patient.
9. The signature of a witness.

B. Upon receipt of a properly executed request for confidential/**private** information, the authorized staff member is to do the following:

1. Make reasonable attempt(s) to contact the Client to explore the reason for the request.

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

2. Be certain Client understands potential implications of the data released.
3. Determine the extent of disclosure required.
4. Organize material to be released.
  - a. Whenever possible, communicate in writing, not on the phone.
  - b. Reveal minimum necessary data.
  - c. Stick to facts and first-hand knowledge.
  - d. Avoid psychodynamic material.
  - e. Write letter as if Client will read it - Clients often will.
5. Whenever possible, review letter with Client before it is sent.
6. Do not release material from other sources (e.g. hospital records, former therapists, etc.). This information must be obtained directly from those sources.
7. All information released must contain the notation:

"This information has been disclosed to you from records whose confidentiality/privacy is protected by state and federal law which prohibits further disclosures. A general authorization for the release of medical or other information is not sufficient for this purpose."

**Disclosure of Information Without the Client's Consent**

**A. Child Abuse:**

1. Any person having reason to believe that a child under the age of eighteen (18) years has had physical or mental injury or injuries inflicted upon him or her by other than accidental means where

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

the injury appears to have been caused as a result of abuse or neglect shall report the matter promptly to the county office of the Department of Human Services of the county wherein the suspected injury occurred.

2. "Abuse and neglect", as used herein, means harm or threatened harm to a child's health and welfare which can occur through: non-accidental physical or mental injury; sexual abuse, as defined by state law; or negligent treatment or maltreatment, including the failure to provide adequate food, clothing or shelter.

**B. Behavior Presenting a Danger to Self or Others:**

2. In the event that a person's behavior, either in and of itself or in conjunction with other information or history known to you is clinically judged to present a real and significant danger to self or others, the service provider shall notify the appropriate person(s) and/or organization and take any other reasonable measures to warn or otherwise provide for the safety of that person(s).
3. Such danger to self may include the threat of suicide and/or homicide, or the inability to care for self.
4. Knowledge of past incidents involving the Client by the service provider does not, in and of itself, constitute an exception to the confidentiality/privacy standard. However, when the evidence of a past incident raises the strong possibility of Future incidents that will endanger the Client or others, then such a situation, in and of itself, may be sufficient to justify the service provider's determination of a real and significant danger.

**C. Procedures to be Followed When the Client's Behavior Presents a Danger to Self or Others:**

1. It is important for the service provider to:
  - a. Document the data source(s), reliability, reasoning and rationale in developing a plan of intervention(s).

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

- b. Develop specific recommendations and record them together with the availability of resources.
  - c. Obtain consultations freely as needed to determine course of action.
2. Even though the service provider has decided to breach confidentiality/ privacy, as authorized above, the service provider should:
  - a. Alert the Client that information is to be released and discuss the basis for the decision and the impact on your working relationship.
  - b. Reveal the minimum data necessary to effect intervention.
  - c. Document in the Client's record, the extent of the disclosure, to whom and by whom the disclosure was made, and an explanation of the emergency that precipitated the disclosure.
3. Where a service provider undertakes services to a person whose past behavior makes it likely that an exception requiring disclosure may arise (e.g. a Client with a long history of violent or self-destructive acting out, or a Client experiencing emotional crisis), the Client is to be told at the initiation of services or when the difficulty arises in that situation. This procedure insures that if the Client's confidentiality/privacy must be violated at some point without their consent they have been consulted and have consented to participate in services with the understanding of such possible consequences.
4. Cases Involving Audits or Program Evaluation:

Information pertaining to any Client may be disclosed, without Client consent to authorized personnel for the purpose of conducting management audits, financial audits or program evaluation, but only to the extent required by the audit. Personnel

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

so authorized may not identify, either directly or indirectly, any individual Client in any report of such audit or such evaluation, or otherwise disclosed Client identities in any manner and must sign a staff/visitor confidentiality/privacy form prior to examining any Client files. A Visitor Confidentiality/Privacy Form is available from the receptionist.

5. Sharing Client information with supervisors relevant to the supervisory/case management process is authorized without the consent of the Client.

### **Subpoenas**

Any litigant can obtain a subpoena to compel the appearance of a witness and/or the production of relevant documents in court for the purpose of examination. The mere fact that a subpoena has been issued does not compel a service provider to testify, only to appear. Once in court, it is for the judge to decide whether the testimony or records in question are subject to a claim of privilege. After consideration of the privilege issue, if the judge orders a service provider to testify it is recommended that he/she does so. Receipt of a subpoena should be a stimulus for the service provider to perform the following procedures:

- A. Immediately upon receipt of a subpoena, the person to whom the subpoena is directed shall notify the Executive Director directly, or notify their program director that will, in turn, notify the Executive Director.
- B. All reasonable means shall be used to notify the Client or former Client of the subpoena.
- C. If the Client is known to be represented by an attorney, the attorney should be notified with consent of the Client.
- D. The Executive Director shall notify the organization's attorney, if appropriate.
- E. The person to whom the subpoena was issued shall respond in

accordance with the command of the subpoena.

- F. The disclosure of confidential/private information released pursuant to a subpoena shall be limited to only that information specified in the order pertaining to those persons expressly named in the order.
- G. A copy of the subpoena shall be placed in the Client's record.
- H. If the subpoena requires testimony by a service provider and such testimony is likely to occur, the following procedures are recommended:
  - 1. Attempt to prepare the Client, who is still receiving services, for the impact of disclosure by discussing confusing, technical or seemingly perjurious terms and by discussing the possible impact on the Client/counselor's ongoing relationship.
  - 2. Whenever possible, go over the record together with the Client.
  - 3. Do not release material obtained from other sources to the Client (e.g. hospital records, former therapists, family members). The Client must obtain that information directly from those sources.
  - 4. Do not alter or destroy records as this results in potential legal liability.

**603**

### **Client Participation (Approved 03/19/04)**

All Clients shall participate in treatment or service planning to the extent of his/her ability. When appropriate, family and/or significant other(s) shall be allowed to participate in treatment or service planning. Careful and complete explanation as to the nature of treatment shall be explained. When the Client or the family requests specific information about care, rehabilitation or treatment alternatives, information shall be given according to the organization's policy and procedure regarding the release of confidential/private information.

**604 Intake, Diagnosis, Assessment and Case Planning (Approved 03/19/04)**

The identification, diagnosis, assessment and case-planning component of service are provided to each and every Client seen in the organization.

This process provides the staff, the Client and the administration the information to determine which services best meet the Client's needs, whether the needs of the Client are being met and whether the staff member or program is providing services effectively. This process is separated into two components: the intake process and the case management process. The intake process takes place at the time of the first meeting with a potential Client, while the case management process takes place over the entire period of a person's involvement with the organization.

All portions of the identification, diagnosis, assessment and case planning service include some program specific procedures. The program specific procedures relate to one particular program and only that program while the major portion of the service is used in all programs of the organization. Individual program requirements are found in their respective standard operating procedures manuals. The staff of each program is to be fully familiar with the identification, diagnosis, assessment and case planning procedure for their particular program and for the organization, as a whole.

**Policy Statement:** To provide the best possible service to Clients, to evaluate the effectiveness of programs and to ensure consistency with Clients needs, it is the policy of Mid-Del Youth and Family Center, Inc. that:

- A. Each person referred to and appearing at Mid-Del Youth and Family Center, Inc. will receive the component of service known as Identification, Diagnosis, Assessment and Case Planning.
- B. This process will be separated into two components: the intake process, beginning with the **initial contact**, and the **case**

**management process**, which continues throughout a Client's involvement with the organization.

- C. This process will have a portion common to all of the programs of the organization and specific portions applying to specific programs within the organization.
- D. All clinical staff members of the organization will be familiar with the procedures of both the intake process and the case management process.

**605 Information and Referral (Approved 03/19/04)**

It is the policy of the organization to refer Clients to other resources who can best meet the Client's needs and when services are not available from the organization. It is the policy of the organization to make referrals for services or treatment only to licensed, certified or statutorily exempted facilities, entities or professionals. Additionally, it is the policy of the organization to provide information and referral services to non-Clients upon request.

The organization will provide information, referral and follow-up services to Clients, potential Clients, non-Clients, non-Clients or applicants who are found to be ineligible for organization services, as follows:

- A. Information will be obtained and transmitted to Clients about other alternatives for assistance with their problems if their needs cannot be met through the organization's service programs.
- B. Information explaining available services will be provided through the organization to Clients and potential Clients.
- C. If requested by the Client, the staff of the organization will provide referral services to another service provider who can better meet the needs of the Client. The referral will include: all necessary information including the service plan or needs of the Client, arranging for preliminary interviews, transmission of required

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

information to the other service provider and transportation, if required.

A formal referral to another provider shall contain the following information:

- A. A statement of the problem for which the specific service is requested;
- B. Background or other identifying information, which is related to the referral;
- C. A request for a follow-up report which contains information relative to the Client's examination, evaluation, rehabilitation and/or service processes and discharge status. Staffing of the case will be conducted to facilitate decisions regarding the referral of Clients, as appropriate.
- D. If a Client of this organization is accepted by another service provider, the staff member will implement a plan of follow-up to the other service provider, the Client, and/or the Client's family to insure that the Client is receiving the service needed and that the family is adjusting to the new service strategy.
- E. If the services are not meeting the needs of the Client, the staff member will intervene to adjust the services being provided or will actively seek another source of service.
- F. The staff member will document all contact with service providers, the Client or Client's families through the case management process and will obtain the necessary Consent to Release Confidential Information and **Privacy Authorization** documentation before information is released or provided to another service provider.
- G. The staff member will place in the Client's file copies of all forms submitted to other service providers.

The organization shall maintain updated resource directories of services for referrals to specific agencies or entities in an effort to provide

*Mid-Del Youth and family Center, Inc.  
Policies and Procedures*

services appropriate to the needs of individuals the organization is unable to service.

Mid-Del Youth and Family Center, Inc. shall maintain a directory of Currently available resources. The list of resources should minimally include for each listed resource:

- A. The name, location, phone number, hours or operation of the resource;
- B. The types of services provided by the resource;
- C. The name(s) of a contact person(s);
- D. The criteria for determining a Client's eligibility for services;
- E. Financial responsibility and/or cost to Client for services.

### **Information Services**

Providing information regarding the organization's services is an integral and ongoing function of the organization.

Information pertaining to services is to be provided to the general public and Clients when needed. Information to the general public may be through telephone conversations when the organization is contacted for information, through presentation to groups or through electronic and written media.

### **Receiving a Referral**

It is the policy of the organization to respond to all referrals received for services. The process for responding to both written and verbal referrals is as follows:

- A. Support staff will check the organization's records to see if the individual or family being referred has previously been a Client(s) of the organization.

- B. If the referred person(s) has not been a Client, the referral form will be filed for Future reference according to procedures established by the Executive Director.
- C. Prior to completing the initial intake on all new Clients, support staff will check the appropriate file for any referral(s) made to the organization. If a referral has been made, the information will be attached to the Initial Intake Form and given to the assigned counselor.
- D. Prior to completing the initial intake of all new Clients, support staff will check the appropriate file for any referral(s) made to the organization. If a referral has been made, the information will be attached to the Initial Intake Form and given to the assigned counselor.
- E. If the referral is for services for an active Client, the referral form will be routed to the assigned counselor immediately upon receipt.
- F. If the referral is made for a former Client whose services have been completed or terminated, the referral is to be routed to the counselor who last worked with the former Client for action and/or response, if any, prior to filing the referral in the closed case record.

**606 Case Consultation Services (Approved 03/19/04)**

It is the policy of the organization to utilize the case consultation process to provide Clients with the benefit of all the expertise available through organization staff or external consultants.

Case consultation is defined as a service that provides for the development and enhancement of the direct provision of residential and nonresidential services to youth and their family members.

Typically, staff provides case consultation services in three ways: informally on a one-to-one basis, formally via intra-organization consultation with a consultant and formally with other organization personnel, either individually or with a group of professionals with whom the organization has qualified service agreements.

**607 Community Information, Consultation and Outreach Services  
(Approved 03/19/04)**

Community information, consultation and outreach services are designed to reach each Mid-Del Youth and Family Center, Inc. organization purpose, program of service target populations, to promote available services and to give information on community identified problems and other related issues to the general public.

These services include presentations to human service agencies, community organizations, and individuals including the deaf and hearing impaired population (other than individuals in treatment and staff). Community information, consultation and outreach are in the form of lecture presentations, seminars, training and staff development, films or other visual displays and discussions in which factual information is disseminated. These presentations are made by staff members or trained volunteers. A speaker's bureau will be established and maintained to facilitate community based training and development according to organization purposes.

Written documentation on all community information and outreach activities shall be recorded on the appropriate organization form by the staff member who provides this service and shall include:

- A. The organization/person(s) receiving the services;
- B. Name of person(s) providing service;
- C. Number of persons attending;
- D. Date the service was delivered; and

E. Description of service.

**608 Record Keeping (Approved 03/19/04)**

**Policy Statement**

To assure the delivery of Quality services to its Clients, to form a base for program and personal evaluation and to serve as a source of data for research, training and education, Mid-Del Youth and Family Center, Inc. affirms the necessity of maintaining accurate, complete and timely records on all facets of its program in a secure, yet readily accessible, manner.

**Safekeeping of Client Records**

Information concerning Clients is to be safeguarded against loss, theft, defacement, tampering or use by unauthorized persons. Client case information is privileged and is to be released only as authorized by federal and state law, or by the Client's written consent. Confidentiality/privacy is to be stressed at all times.

Records are to be stored in locked files or cabinets, which are readily accessible to Mid-Del staff for prompt, efficient services to Clients. Confidentiality/privacy of Client records, verbal and written, inside and outside the organization is to be stressed in orientation and during intra-organization staff development programs and with all volunteers, regardless of their function. Records are available to staff and volunteers on a "need-to-know" job requirement basis only.

**Maintenance and Disposal**

Inactive case records will be stored in locked files or cabinets for a period of seven (7) years subsequent to discharge. In the case of a minor, the record shall be maintained until majority plus seven (7) years. Client records shall be destroyed either by shredding or incineration.

**Critical Incident Report**

Incident report forms shall be completed and signed by the counselor and Executive Director. Injury to a person, persons or property constitutes an unusual incident. See Section 614, "Unusual or Critical Incidents" and Health and Safety section.

### **Records Content**

- 1) Each record entry shall be legible, dated and signed by the staff member making the entry.
- 2) The Client intake form shall contain, but not be limited to, the following information:
  - a. Identification data to include, at a minimum: Client's name, home address, telephone number, significant others who are to be notified in case of an emergency and place of employment.
  - b. Referral source and reason for referral.
- a. A comprehensive assessment must be completed no later than five (5) visits following admission and shall contain, but not be limited to, the following:
  - 1) Presenting problem;
  - 2) History of presenting problem;
  - 3) Previous treatment;
  - 4) Health history including use of drugs and/or alcohol;
  - 5) Support systems (e.g. family significant others);
  - 6) Economic resources;
  - 7) Clients expectations in terms of services;

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

- 8) Present life situation;
  - 9) Vocational and educational information;
  - 10) Legal information when appropriate;
  - 11) Medications, if applicable.
- b. The clinical record shall contain a treatment/service plan which shall include, but not be limited to, the following information:
- 1) Goals for treatment/service are to be measurable, stated in behavioral terms and have time-framed objectives;
  - 2) Type and frequency of services to be provided;
  - 3) Primary staff person(s) responsible for providing services;
  - 4) Description of Client's involvement in, and response to, the treatment plan;
  - 5) Documentation of the Client's participation in the treatment plan, and the Client's signature; and
  - 6) Discharge criteria stated in terms of service goals and objectives.
- c. Treatment/Service plans shall be based on Client intake, assessment and evaluation data.
- d. Treatment/Service plans shall be dated and signed by all members of the treatment team who participate in the planning or in providing the services.
- e. The treatment/service plan shall be reviewed, and updated if necessary, every three (3) months, at a minimum. The

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

update shall document any of the following which apply:

- 1) Change in goals and objectives based upon Client's documented progress or identification of any new problems;
  - 2) Change in primary counselor assignment;
  - 3) Change in frequency and types of services provided;
  - 4) A statement documenting review and an explanation if no changes are made in the treatment plan.
- f. Specific requirements, time frames for treatment plans and treatment plan updates shall include:
- 3) An initial treatment plan, which is developed at intake.
  - 4) Prior to the fifth (5th) visit, a treatment plan shall be developed based on the comprehensive assessment of the Client's needs.
    - a. The Client record shall contain chronologically recorded notes which shall include the following information:
      - 1) Documentation of Client's progress toward service goals and objectives;
      - 2) Documentation of the implementation of the individualized treatment/service plan;
      - 3) Documentation of the Client's responses to treatment of services, changes in condition and outcome of treatment or services.
    - b. The Client record shall contain copies of all consultation reports concerning the Client.
    - c. When psychometric or psychological testing is done, the

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

Client record shall contain a copy of a written report describing the test results and implications and/or recommendations for treatment.

- d. The Client record shall contain progress notes for each visit or transaction, including missed visits and any additional information relating to the Client, which has been secured from sources outside the program.
- e. Documentation of case review for Clients who have not received any service(s) for ninety (90) days or more shall be documented, as well as all efforts to contact the Client.
- f. Clients who have not received any service(s) for ninety (90) days shall be terminated after it is determined that services are no longer needed or desired.
- g. A termination summary shall be written within fifteen (15) days after the Client's case has been closed. The termination summary shall contain the following:
  - 1) A statement of the presenting problem at intake;
  - 2) The initial condition and condition of the Client at the time the case was closed or services terminated;
  - 3) Services provided and outcome(s)/results;
  - 4) The final assessment; and
  - 5) Any recommendations and/or specific referrals for implementing aftercare services.
- h. Whenever possible, practical and/or applicable, each terminating Client needs to be involved in developing the aftercare plan.
- i. In the event of the death of a Client, a summary statement

including this information shall be documented in the case record.

### **Medical Information and Record of Medications (Shelter Only)**

The shelter's Client case record shall contain the following information on medications as appropriate:

- A. A record shall be kept of all medications which were administered by any organization employee;
- B. The record of medications administered shall include all of the following:
  - 1. Type of medication;
  - 2. Dosage;
  - 3. Frequency of administration to be entered at the time of each administration;
  - 4. Route of administration (oral, anal, injection);
  - 5. Signature of staff member who administered each dose.
- C. A record of pertinent information regarding adverse reactions to drugs, drug allergies or sensitivities shall be obtained on the Medical Information Form during intake. This information shall be kept in a highly visible location and given verbally to each residential advisor at the beginning of their next shift.

### **609 Cooperative Service Agreements (Approved 03/19/04)**

The organization shall establish cooperative service/referral agreements with those organizations or professionals necessary in the development of a continuum of care. These service/referral agreements shall include:

- A. The services to be provided;

- B. The duration of the agreement;
- C. The procedures to be followed in making referrals;
- D. Agreement that both parties shall abide by federal and state confidentiality/ privacy statutes, rules and regulations.

A cooperative service/referral agreement has been, and continues to be, defined as a "Qualified Service Agreement" by the organization. A Qualified Service Agreement is a written agreement between two individuals and/or two agencies that binds both parties to observing confidentiality/privacy of Client records as outlined in 42 CFR Part 2. This ensures that communications between the parties involved is for the purpose of performing program services and does not constitute disclosure, thereby precluding the need for a patient's/Client's signed release of information. (See CFR Part 2, sub part B, Qualified Service Organizations, Federal Register, Volume 40, Number 127, July 1, 1975.)

**610 Facility Visitation (Approved 03/19/04)**

Group visits to Mid-Del Youth and Family Center, Inc. are permitted only when the purpose of the visit is educational or professional. These require the prior approval of the Executive Director or designee.

Visits to group sessions are discouraged. Any such request must be referred to the group facilitator. Members of that particular group must also give permission for such a visit to occur.

**611 Fee Schedule (Approved 03/19/04)**

All Clients shall have access to written information about the program's fee schedule, the program's rules and Clients' rights. This information shall be available to individuals who are seeking service. Notice concerning these items shall be visibly posted.

- A. An individual can expect an explanation concerning the reason services were refused;
- B. A Client shall not be refused services based on inability to pay;
- C. A Client shall have the right to refuse services.

**612 Consumer/Client Grievances and Abuse (Revision Approved 03/19/04)**

It is the policy of the organization to maintain an open line of communication with Consumers/Clients and to afford each Consumer/Client adequate opportunity to express opinions, recommendations and complaints.

**Opinions and Recommendations**

Any Consumer/Client may at his/her discretion provide in writing any opinion or recommendation by sending it to the Executive Director Office. The Executive Director, at his/her discretion, may call a meeting of the staff to give the opinion or recommendation due consideration.

- A. If the Consumer/Client, for any reason, believes inadequate consideration was given to his/her opinion or recommendation, the Consumer/Client may, within 30 days, request, in writing, a written response from the organization.
- B. If the Consumer/Client is still dissatisfied, he/she may forward his/her recommendations to the Department of Human Services Office of the Advocate Defender.

**Grievances and Complaints – Client/Consumer (non-shelter)  
(Approved 11/01/00)**

- (1) Any Consumer/Client affiliated or not affiliated with Mid-Del Youth and Family Center may submit complaints. A complaint will be initiated by completing a Violation of Ethics Complaint Form. This form may be

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

obtained from the receptionist/secretary or office manager. Once completed, the Violation of Ethics Complaint form will be given to the Executive Director who will forward a copy to the Grievance/Ethics Violation Coordinator/Client Advocate. If the Executive Director is going to be on extended annual leave longer than three (3) working days, the complaint will be given to the person who is in charge while the Executive Director is gone. If the Grievance/Ethics Violation Coordinator/Client Advocate is on leave, the Executive Director will appoint a designee.

- (2) For purposes of determining time limits, a complaint shall be considered filed as soon as the Ethics Committee Chairperson has received a completed complaint form. The Ethics Committee Chairperson is the Executive Director and the remainder of the Ethics Committee is made up of various staff members whom the Executive Director appoints including the Grievance/Ethics Violation Coordinator.
- (3) Within three (3) working days of receiving the grievance/ethics violation complaint, the Ethics Committee Team will meet to review the complaint and conduct the necessary investigation.
- (4) Pertinent staff and/or Consumers/Clients will be interviewed over the next five (5) working days in order to resolve the complaint.
- (5) Within five (5) working days of the Ethics Committee meeting, the Ethics Violation form will be completed giving the investigative findings, recommended action(s), and the date the Ethics Violation form was forwarded to the Leadership Team.
- (6) The Leadership Team (Strategic Management Team) will meet within three (3) working days to review the Ethics Violation complaint and make their final review/decision in writing.
- (7) The final review/decision will be relayed, in writing, to the Consumer/Client by the Executive Director no later than five (5) working days after the Leadership Team has made its final decision. The Executive Director must contact the Consumer/Client before the five (5) days time begins so that if Consumer/Client will not be available during

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

the five (5) days time, a time can be scheduled immediately after the Consumer/Client is available for the reading of the final review/decision. It will be noted on the Ethics Violation form if the Consumer/Client wishes to appeal the final decision.

- (8) If the Consumer/Client does wish to appeal, the complaint will be forwarded to the Board of Directors.
- (9) The Board President will select three (3) members to serve on the Ad Hoc Appeals Committee. This committee will have ten (10) working days to convene a meeting. It will be provided with documentation of all previous activity to attempt to resolve the complaint. The committee will have the power to call witnesses. Both parties involved will be allowed an opportunity to present their case. After the Committee has had an ample opportunity to examine the testimony, they will have ten (10) working days to develop a report that will be given to the Consumer/Client in writing. Should the decision of the Ad Hoc Appeals Committee not be satisfactory to the Consumer/Client, the decision can be appealed in writing to the President of the Board to be considered at the next full board meeting. This appeal must be made in writing within ten (10) working days.
- (10) Membership of this Ad Hoc Appeals Committee shall be three (3) Board members with one being designated as Chairperson.
- (11) The Board of Directors will consider a request for an appeal of the Ad Hoc Appeals Committee decision at its next regularly scheduled full board meeting. This issue will be dealt within an executive session. The decision of the Board of Directors is final and exhausts the appeal avenues within the organization. This does not prohibit other avenues of appeal.

### **Procedures Regarding Allegations of Abuse and Neglect**

The State's legal basis and authority for the rules and procedures in this policy is found in Title 10, Sections 7302-3.2, 7302-6.3 and 7301, Oklahoma Statutes.

#### **A. General Definitions**

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

1. ABUSE – means harm or threatened harm to a child’s/resident’s health or welfare by a person responsible for the child’s/resident’s health or welfare, including but not limited to:
  - a. The intentional (non-accidental) use or offer of physical force by a person responsible for a child’s/resident’s health or welfare, aimed at hurting or injuring the child/resident; or
  - b. knowingly causing or permitting any person to intentionally injure a child/resident;
2. CHILD RESIDENT - means any person under the age of 18 and any person regardless of age or custody who resides in a DHS/OJA operated facility.
3. FACILITY - means a place, an institution, a building or part thereof, set of buildings, or an area whether or not enclosing a building or set of buildings which is used for the lawful custody and treatment of juveniles and children. This also includes any DHS/OJA operated or licensed residential care program.
4. HEAD OF FACILITY - means the Superintendent, Director or Supervisor of a DHS/OJA operated facility, or a private facility.
5. INJURY - means any hurt or harm, including appreciable physical pain.
  - a. SERIOUS PHYSICAL INJURY- means any physical injury determined to be serious by the physician, dentist or nurse who examines the child/resident, and includes but is not limited to the following: death, fracture, dislocation of any major joint, internal injury, concussion or second or third degree burn.
  - b. EMOTIONAL INJURY-means emotional damage evidenced by severe anxiety, depression or withdrawal, or untoward aggressive behavior toward self or others.
  - c. DEMONSTRABLE INJURY-means any injury in which there is clear evidence of physical injury (e.g., laceration, bruise,

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

burn, fracture), or an injury which is confirmed by the physician, dentist or nurse who examines the child/resident.

6. **MISTREATMENT/MALTREATMENT** - means harm or threatened harm to a child's/resident's health or welfare by a person responsible for the child's/resident's health or welfare which is caused by any violation of statutes, regulations written rules, procedures, directives, or accepted professional standards and practices, which is not found to be abuse or neglect, but which results in, or creates the risk of injury of a child/resident including but not limited to:
  - a. conduct which evidences a reckless disregard for the health or safety of child/resident;
  - b. acts or omissions which contribute to the delinquency of a child;
  - c. excessive or unauthorized use of force.
7. **NEGLECT**-means a willful act of omission which directly results in a child/resident suffering, or being exposed to a substantial risk of imminently suffering, physical injury or emotional injury, including but not limited to failure to furnish food, clothing, shelter or medical attention for the child/resident. Neglect also includes failure of staff to provide appropriate supervision when such failure results in consensual sexual activity between children.
8. **SEXUAL ABUSE** –means any sexual activity prohibited by State Law, including:
  - a. sexual exploitation, meaning:
    - 1) allowing, permitting or encouraging a child/resident to engage in prostitution; or
    - 2) allowing, permitting, encouraging or engaging in the lewd, obscene or pornographic photographing, filming or

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

depicting of a child/resident in those acts as defined by state law; or

3) the use of a child/resident in other sexual activity for personal gratification, by a person responsible for the child's/resident's welfare.

b. rape, incest and lewd or indecent acts or proposals as defined by state law, by a person responsible for the child's welfare.

9. CHILD/RESIDENT ABUSE, NEGLECT OR MISTREATMENT shall not include:

a. Not included as child abuse, neglect or mistreatment are:

1) the use of mechanical restraints as authorized by law and regulation;

2) the use of physical force authorized or permitted by law or organization policy. The use of unauthorized force shall be classified as abuse or mistreatment, as warranted by the facts and circumstances of the case.

b. When the use of physical force is authorized, the least force necessary under the circumstances shall be employed. In determining whether excessive force has been used, all of the circumstances surrounding the incident are to be taken into consideration, including:

1) the grounds for belief that force was necessary;

2) the age, sex and strength of the parties involved;

3) the kind of force employed;

4) the availability of alternative means of force or control; and

5) the extent of the harm inflicted.

B. Procedure for reporting incidents of abuse, neglect or mistreatment

1. REQUIREMENTS. State Law requires every person with reason to believe that a child is or has been abused or neglected to report the condition or incident to the appropriate DHS/OJA office for investigation. DHS/OJA rules extend that reporting requirement to include any suspected abuse, neglect or mistreatment of children/residents residing in DHS/OJA operated facilities or DHS/OJA custody or non-custody children in private facilities or programs. After filing a report, the reporting party is obligated to inform the parties involved about the disclosure , except when such information would be detrimental to any individual involved. A written explanation of why family was not informed is required documentation to be attached to the Critical Incident Report. Failure to report suspected abuse, neglect or mistreatment may result in criminal sanctions and/or employee disciplinary action. In addition to reporting conditions or incidents of suspected abuse, neglect or mistreatment within the

personal knowledge of a facility employee, a report shall be made in the manner prescribed by this Section under the following circumstances:

- a. an allegation of abuse, neglect or mistreatment is made by a child/ resident, parent, guardian or other person; or
- b. violent death of a child/resident occurs, whether apparently homicidal, suicidal or accidental; or
- c. death of a child/resident occurs under suspicious, unusual or unnatural circumstances; or
- d. injury to a child/resident occurs:
  - 1) as a result or in the course of the use of physical force by an employee; or
  - 2) as a result of an assault by a child/resident or other person; or
  - 3) under unexplained, suspicious or unusual circumstances; or

- 4) a child/resident is the apparent victim of or participates in rape, sodomy or other sexual activity prohibited by the State Law.
2. PROCEDURES. Any employee of a private or DHS/OJA public facility who has knowledge of a reportable incident shall make an immediate verbal report to the Office of Client Advocacy, law enforcement, State Office or county DHS, and/or for OJA custody youth, the OJA Office of Advocate General. Supervisory staff informed of alleged or possible mistreatment shall ensure compliance with the reporting requirements.

### C. Ensuring Client Safety

1. PROTECTION/MEDICAL TREATMENT. In the event of alleged abuse, neglect or mistreatment in a facility, it is the responsibility of the head of the facility or his/her designee to assure protection and/or medical attention for the child/resident.
2. PRELIMINARY INVESTIGATION. When a situation arises which may be reportable, each staff member who was present shall immediately prepare and submit to the head of the facility a written incident report describing what he/she saw or heard. It is the responsibility of the head of facility to make a preliminary investigation to determine which staff were present when a reportable incident occurred, and ensure that they submit the required written report. In addition, the head of facility is responsible for obtaining any related medical record or report, or any other report which pertains to the incident. All reports prepared pursuant to the preliminary investigation are to be submitted to the head of facility or his/her designee within 24 hours of the report of the incident. No further investigation by facility staff shall occur pending investigation by the Office of Advocate Defender.
3. EMPLOYEE REMOVAL. Employee removal or discharge may result as described in the following:
  - a. if the results of the preliminary investigation, written reports and/or the initial investigation of the Office of Advocate Defender, indicates reasonable cause to believe abuse, neglect or serious misconduct has occurred and/or removal of an

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

employee from the work station is necessary to ensure the child's/resident's safety, the head of the facility will follow DHS/OJA organization policy relating to immediate removal from duty.

- b. if written reports and the initial oral report of the investigator indicates reasonable cause to believe that an act has been committed by an employee which would subject an employee to discharge, the head of facility may initiate action to discharge the employee. The applicable corrective disciplinary action would include the following procedures:
  - 1) letter of notice of proposed adverse action;
  - 2) response time to notice letter; and
  - 3) letter of final adverse action.
4. FAILURE TO REPORT. Any employee who fails to report abuse, neglect or mistreatment as required by OAC 340:2-3-6 shall be deemed guilty of misconduct and subject to disciplinary action.
5. INTERFERENCE PROHIBITION. Any employee who interferes with an abuse, neglect or mistreatment investigation, or who attempts to intimidate a witness, victim or employee accused of alleged abuse, neglect or mistreatment through force or fear by threatening physical or mental harm to a witness, victim or others, shall be deemed guilty of misconduct and subject to disciplinary action. Any contractor shall be subject to immediate termination of his/her/its contract with DHS/OJA for:
  - a. interfering with an abuse, neglect or mistreatment investigation;
  - b. allowing his/her/its employees to interfere or retaliating against any employee for reporting or cooperating in such investigation; or
  - c. denying the assigned investigator immediate and direct access

to contractor employees, facilities, Clients, places and records of any type.

6. **STAFF TRAINING.** In order to assure that staff are aware of their responsibilities under the rules in this section, the head of the facility will ensure that each facility staff member receives initial training on the rules in this section within 30 days of his/her employment at the facility, and that all facility staff receive supplemental training at least once bi-annually. The head of facility is responsible to maintain a system to document compliance with the training requirement.

**D. Office of the Advocate Defender and Advocate General**

1. **AUTHORITY.** The Office of Advocate Defender is by statute and DHS rules responsible for all abuse, neglect or mistreatment investigations involving children in DHS operated facilities, and children in the custody of DHS who are placed in private or public facilities. By administrative action, the Office of the Advocate Defender is also assigned responsibility for investigating alleged abuse, neglect or mistreatment involving non-custody children residing in a facility. The OJA Office of Advocate General is the chief advocate for the rights of juveniles in the custody of OJA. The Advocate General, administrative head of the Office of Advocate Defender, is authorized to obtain assistance from DHS/OJA staff in carrying out his/her investigative responsibilities.
2. **MISTREATMENT GRIEVANCE ASSIGNMENTS.** If OAC deems the incident as a mistreatment grievance, it is processed as set forth in the OAC 340: 2-3-6 through 2-3-8 for DHS custody youth. For juveniles in the custody of OJA, the mistreatment grievance shall be processed as set forth in the OJA Office of Advocate General rules, 377: 3-1-25 through 3-1-26.

**613 Environment (Approved 03/19/04)**

Mid-Del Youth and Family Center, Inc. shall maintain, at a minimum, all accreditation, inspection, safety and building code regulations required by local, state and federal authorities and laws relative to the types of

services provided by the organization.

## **614 Unusual or Critical Incidents**

All staff is required to report unusual or critical incidents.

An unusual or critical incident is defined as any act or situation that might, or does, result in injury to persons or property.

“Sentinel event” is a type of critical incident that is an unexpected occurrence involving the death or serious physical or psychological injury to a consumer, or risk thereof. Serious injury specifically includes loss of limb or function. The phrase “or risk thereof” includes a variation in approved processes, which could carry a significant chance of a serious adverse outcome to a consumer. These events signal the need for immediate investigation and response. Sentinel events include, but are not limited to: suicide, homicide, criminal activity, assault and other forms of violence, including domestic violence or sexual assault, and adverse drug events resulting in serious injury or death.

Specific examples which are to be reported include, but are not limited to, allegations of child abuse; fire; electrical failure; bomb threat; sewer backup; AIDS contact; flood; gas or water leakage; staff illness or injury on duty; Client injury; irate parent or Client; media inquiries; nuisance phone calls; property damage; prowler; suicide threat or attempt; theft; tornado; vandalism; vehicle accident; staff misconduct; medication error; criminal activity; use of physical restraint on Client; Client self-abuse; sexual assault and sexual activity between shelter residents.

After taking appropriate action, the staff member involved or initially made aware of the situation is required to complete the organization's Critical Incident Report Form within one (1) working day and submit it to the Executive Director.

Any extreme or unusual behavior(s), which in a staff person's opinion, needs to be known by supervisory or administrative staff is to be reported using this form. Critical incident reporting data will be utilized by the E.Q.I.P team and Strategic Management Team for trend analysis,

incident prevention, and quality improvement initiatives. All data will be monitored and reported quarterly.

**615 Medical Emergencies (Approved 03/19/04)**

Emergency Medical Care: In the event a Client or staff member requires emergency medical care:

- A. Staff on-duty will immediately be notified of the location of the injury or illness with as much detail as possible.
- B. Staff shall administer First Aid if needed.
- C. If it is the opinion of a staff member that a Client needs to go to the emergency room, a discussion will take place with the co-worker and either parent/legal guardian or, if necessary, on-call staff will be contacted to transport the youth to Children's Hospital. Staff will take a copy of the signed Parent/Guardian Agreement form from the case file. **Do not take the original file documents to the hospital.**
- D. If it is the opinion of a staff member that the juvenile or other staff member needs emergency treatment, and cannot or should not be moved, the receptionist will make a request for ambulance service by calling 911.
- E. Any staff member may authorize a call to 911; however, an attempt should be made to notify the Executive Director or his/her designee and follow his/her direction.
- F. Parent or legal guardian should be contacted and informed of the nature of the injury/illness and requested to meet the Client at the hospital.
- G. In the event a staff member is transported, the Executive Director shall be notified.
- H. In all instances cited above, a Critical Incident Report shall be written.

**616 Evaluation of Services (Approved 03/19/04)**

It shall be the policy of the Board of Directors of Mid-Del Youth and

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

Family Center, Inc. to annually review each program of service provided by the organization. Pertinent statistical and demographic data shall be reviewed quarterly. See Organizational Leadership and Management, Section 300.

The annual review of service programs by the Board of Directors will occur as follows:

At a regular meeting of the board, under the direction of a member of the committee of the board responsible for evaluating services, the staff member(s) responsible for a program of service or designee will present a summary of the program that includes the following information in a written and oral format:

- A. A brief historical sketch that includes a synopsis of the service, its philosophical base, program goals, community needs to which it responds, how the service fulfills the mission of the organization, significant changes, if any, in the program that have occurred and the principal funding source(s).
- B. An explanation of who is served, who refers Clients, how Clients are served through specific services or activities, what limitations, if any, exist to eligibility, how and when other organization services are made available and how referrals are made to other service agencies.
- C. Relevant statistical and demographic data that includes the total number people served, the number of units of service provided and any other such data pertinent to the program. Audiovisual materials are encouraged.
- D. Future plans and/or suggestions on how to improve service, the identification of existing barriers to program effectiveness and possible strategies, as how to best remove those barriers should complete the presentation.

The quarterly review of Client data and demographic information given to the board should contain the following:

*Mid-Del Youth and family Center, Inc.  
Policies and Procedures*

- A. Total number of individuals receiving service, by program;
- B. Who made the referrals;
- C. Rationale for referrals;
- D. What services and/or activities were provided and/or performed; and
- E. Information as to age, sex and place of residence.
- F. Budgetary figures based on expenditures and funds received for providing such services.
- G. Performance measures and outcomes for quarter being reviewed.
- H. Specific Operational Action Plan Progress
- I. Reporting of QA activities and QI initiatives specific to program or service.

**Administrative Responsibilities**

- A. Services will be monitored monthly in regard to program goal achievement. This review will be referred to as a “**process analysis**” (TQM & Six Sigma Tools) and will be reported and recorded in the form of a monthly report to administration. See Organizational Leadership and Management, section 300.
- B. A quarterly review will be conducted with staff and administration to identify quality assurance problems (DMAIC) and make necessary changes in program direction. See Organizational Leadership and Management, section 300.
- C. Opportunities for program innovation and quality improvement initiatives (DMAIC) will be reviewed quarterly with staff and administration. See Organizational Leadership and Management, section 300.

D. An annual review and evaluation report will be made to administration. The evaluation will be the basis of the following year's operational action plan.

The program evaluation will be conducted according to the following schedule:

- A. Tenth (10th) Month                      Staff review of planned progress.
- B. Eleventh (11th) Month                Administrative review of planned progress.
- C. Twelfth (12th) Month                Final evaluation report.

**617                      Effective Quality Improvement Planning (Approved 03/19/04)**

**Integrated Alcohol and other Drug/Mental Health Services**

Ongoing Quality Assurance and Improvement activities will be conducted to objectively and systematically to monitor and evaluate the Quality of Client care and to correct identified problems and look for opportunities for innovation and quality improvement.

At the direction of the Board of Directors, the Executive Director or designee is assigned the responsibility to ensure that a comprehensive system designed to accomplish these tasks is developed, implemented and maintained. This may be accomplished either through the direct supervision by the Executive Director, or the Director of Programs and Services, through the assignment of their designee. See Organizational Leadership and Management, section 300.

Clinical and administrative staff will monitor and evaluate the results of all Quality Assurance and Improvement activities to ensure the Quality of Client care and clinical performance and correct identified deficiencies and actively seek opportunities for program innovation and quality improvement. Results of E.Q.I.P committee team activities will be reported via the Executive Director, or Director of Programs and Services, or designee, to the Board of Directors. These activities will be accomplished according to directives and time frames established in the written Quality Assurance plan.

Methods of Quality Assurance and Quality Improvement, monitoring

and evaluation activities, as detailed in the Effective Quality Improvement Planning (E.Q.I.P) Action Plan, will be based on the particular needs and characteristics of the various populations served by the Integrated Alcohol and other Drug/Mental Health Services.

### **Verification**

- A. E.Q.I.P Committee Meeting Minutes\*
- B. E.Q.I.P Committee Minutes For Yearly Review\*
- C. Board Minutes reflecting reporting of E.Q.I.P activities\*

### **Effective Quality Improvement Planning-Action Plan**

#### **Goals and Objectives**

The goals of the Effective Quality Improvement Planning System are to a) ensure that the services provided through the Integrated Alcohol and other Drug/Mental Health Services, and the documentation of these services, are meeting the needs of the Clients served, and to b) routinely evaluate services to correct deficiencies and make necessary improvements to ensure services are client-driven, responsive, cost-effective, and continually improving.

#### **Program Organization**

In order to meet the established goals and objectives of the program, the E.Q.I.P (Effective Quality Improvement Planning) Team schedules routine audits of case records and provides ongoing training to supervisors who are working with outpatient behavioral health and Prevention and Education staff. The E.Q.I.P team Committee that meets quarterly for the purpose of planning and implementing improvements to organization programs and services.

The E.Q.I.P team is responsible for the ongoing examination of the practices and documentation of the staff. This service is provided through regular and unannounced audits of records and programs. Reports resulting from these audits are submitted to the E.Q.I.P committee for use in their regular meetings. The E.Q.I.P Team then has the responsibility to work with those supervisors and staff to remedy any practices identified as in need of attention and to promote ongoing training concerning issues identified by the process. Based on the

findings determined during quarterly meetings, the team also makes recommendations regarding needed policy changes concerning staff development, credentialing processes, and opportunities for innovation and quality improvement initiatives. Annually, the team will review all program and service policies and procedures, making recommendations concerning necessary changes to the Executive Director, or designee.

## **Scope**

The E.Q.I.P process encompasses all aspects of the Integrated Alcohol and other Drug/Mental Health Services and those other components of the organization that directly affect its operation. See Organizational Leadership and Management, section 300.

## **Program Oversight**

The operation and effectiveness of the E.Q.I.P program is the direct responsibility of the Executive Director; the Director of Programs and Services serves as the chairman of the team. Responsibility and oversight of the program falls within the duties of the Executive Director, or designee, who is responsible to coordinate the information with the organization's Board of Directors.

## **Verification**

- A. E.Q.I.P Committee Meeting Minutes\*
- B. E.Q.I.P Committee Minutes For Yearly Review\*
- C. Board Minutes Reflecting Reporting of E.Q.I.P Activities\*

## **Effective Quality Improvement Planning Activities**

The E.Q.I.P team conducts the reviews of Client care and record keeping unless a member of the committee has a direct responsibility in the area concerned. The process will insure objectivity by disallowing any members to survey their own areas. When necessary, the chairperson of the team will assign additional members to avoid any conflict regarding this issue. The duties of the team and the E.Q.I.P program include the following activities:

## **Client Care Monitoring**

The monitoring coordinator is assigned the task of monitoring Client care as described in the Monitoring and Evaluation section of this policy.

## **Peer Review**

The peer review process and subsequent findings are within the purview of the Executive Director, or designee, who coordinates the sessions and chairs the meetings. The E.Q.I.P committee will meet quarterly for the purpose of conducting peer review activities. The committee will select three (3) charts from each clinician and review for their compliance with program and policy requirements as measured by the Individual Case File Audit/Review form. Follow-up responses recommended by the team are forwarded, in writing, to the Executive Director, or designee for assignment of appropriate action.

## **Clinical Privileging**

Clinical Privileging of all outpatient behavioral health and prevention and education staff is completed by the Director of Programs and Services. The Executive Director will provide guidance and oversight in conjunction with the Clinical Director over all clinical privileging of staff providing direct services to clients. The Clinical Privileging Packet is completed on each prospective clinician, prior to the provision of any outpatient behavioral health service, to ensure that all minimum requirements are met for the services they will be providing. Persons applying to provide services must demonstrate that their training and experience meet the requirements for the services they wish to perform. The process examines licensure, certifications, and relevant experience, circumstances from the past that may impose restrictions on their service, education and requires references, a resume and a transcript, and appropriate state licensing board documentation. Other considerations in the process include their acceptance of the employee code of conduct, the confidentiality/privacy statement and exceptions, the drug free workplace policy and the Clients' rights policy. Based on the findings determined during quarterly meetings, the E.Q.I.P team also makes recommendations regarding needed policy changes concerning the credentialing process.

## **Review of Critical Incident Reports**

Incident reports are reviewed by the Executive Director, or Director of Programs and Services, or designee. Reports are to be made on the appropriate form and submitted immediately to the office of the Executive Director, or Director of Programs and Services, or designee.

## **Monitoring of Client Care**

The Executive Director, or Director of Programs and Services, or designee, functions as the Monitoring and Evaluation Coordinator and may assign the task of monitoring Client care as described in the Monitoring and Evaluation section of this policy.

## **Process Review**

The Executive Director, or Director of Programs and Services, or designee, is responsible for conducting all Process Review activities as described in the Process Review section of this policy. See also section 300, Organizational Leadership and Management.

## **Client Satisfaction and Treatment Outcomes**

Client satisfaction and treatment outcomes are monitored according to the methods described in the Quality Improvement Monitoring and Evaluation section of this policy.

## **Maintenance and Content of Client Records**

All outpatient behavioral health charts are audited at inception, during treatment and upon case closure utilizing the Individual Case Audit form by persons assigned by the Executive Director, or designee. In addition, periodic review of charts will be conducted as described in the peer review section of this policy.

The standards detailing the content and Quality of outpatient behavioral health records are found in the Case Documentation Guidelines, which are provided to each staff person upon being credentialed to provide services.

## **Verification**

- A. Critical Incident Report Forms
- B. Case Audit Form
- C. Case Documentation Guidelines
- D. E.Q.I.P Committee Meeting Minutes\*
- E. E.Q.I.P Committee Minutes - Peer Review results\*
- F. Completed Incident Reports With Verification of Review\*
- G. Sample Completed Case Audit Forms\*
- H. Completed Credentialing Packets\*
- I. Results of Initial, Ongoing and Final Case Audits\*

### **Quality Improvement - Monitoring and Evaluation**

#### **Assigned Responsibility**

The coordination of all Quality Improvement Monitoring and Evaluation (M/E) activities are the direct responsibility of the Director of Programs and Services and are conducted with guidance and oversight by the Executive Director, and input from the Clinical Director and program staff. Through these M/E activities, issues concerning Client care are systematically evaluated and recommendations are made directed at improving the quality of overall care.

#### **Scope of Care Covered By the M/E Program and Important Aspects of Care**

All aspects of Client care related to services provided through the outpatient behavioral health program are pertinent to the M/E process.

The most important aspects of care include, but are not limited to:

- A. Client involvement

- B. Positive Client satisfaction
- C. Positive outcome/s and performance measures
- D. Length of care as compared to established norms, and
- E. The absence of valid Client complaints.

The examination of pertinent administrative reports, incident reports, record reviews and Client contacts will be considered in the process. The Executive Director and Director of Programs and Services, or a person designated by them for this purpose, will examine all components of the program services with specific emphasis on those having direct impact upon Client care.

### **Client Care Indicators and Evaluation Thresholds**

The following represents the indicators by which the M/E process will evaluate performance concerning the important aspects of care and the thresholds at which further evaluation is deemed necessary:

#### **Indicator**

- A. Increase or reduction of census/admissions.
- B. Client Satisfaction Survey results.
- C. Reduction of Global Assessment of Functioning (G.A.F.) scores
- D. Pre and Post CAR Scores
- E. Discharge and 90 day follow-up survey that measures:
  - a. Relevance (extent to which a service corresponds to the client's perception of his or her problem and needs;
  - b. Impact (the extent to which services reduce the problem;
  - c. Gratification (the extent to which services enhance the client's self-esteem and contribute to a sense of empowerment and integrity)

- F. Average length of care.
- G. Client grievances and/or formal complaints.

### **Thresholds**

- A. Increase or reduction of census/admissions of 25% in any quarter.
- B. Less than 99.9% of Clients report average or above in overall results on Client Satisfaction Survey.
- C. Less than 90% of discharged Clients do not experience a marked reduction in G.A.F. score compared to score upon admission.
- D. Less than 90% of discharged Clients do not experience a marked reduction in CAR score compared to score upon admission.
- E. Average length of care for Clients discharged in any quarter is 25% less than or greater than established norm
- F. Number of Client grievances exceeds 3% of average client census during quarter.
- G. There is any substantiated complaint concerning Client care or violation of any Client's rights during previous quarter.

### **Data Collection and Evaluation**

Information will be collected concerning each of the Client care indicators for comparison to the established threshold by the Director of Programs and Services, or designee. This comparison will occur as a routine activity of the E.Q.I.P Committee during the regularly scheduled quarterly meeting. E.Q.I.P meeting minutes will reflect the results of this comparison.

### **Corrective Action**

In any instance where the comparison of collected data indicates performance outside the established thresholds, the committee will assess

the information to determine if the results appear to be indicative of any specific or general Client care issues. Based on this assessment, recommendations concerning appropriate corrective actions may be developed by the committee. Upon the approval of the Executive Director, or designee, their recommendation(s) will be implemented in an effort to remedy the identified Client care issue. If, at that time, no action is deemed necessary by the committee, the issue will be placed on the agenda of the next M/E meeting for further review and evaluation. See DMAIC, in Organizational Leadership and Management, section 300.

### **Follow-Up on Previous Recommendations**

As a routine part of the M/E activities conducted during the quarterly meetings of the E.Q.I.P Committee, corrective plans implemented during each of the previous four (4) quarters will be evaluated to assess their effectiveness and determine if the identified Client care issue has been adequately addressed.

The results of all M/E activities will be communicated to relevant supervisory personnel concerning issued raised pertinent to their area of responsibility. All relevant findings, reports and actions taken will be shared with those staff effected by recommended changes. Actions may include referrals for training or other staff development activities. Based on the findings determined during quarterly meetings the E.Q.I.P team also makes recommendations regarding needed policy changes concerning staff development. The Director of Programs and Services, or designee, will serve as a contact person for staff who wishes to forward information to be considered or shared with the E.Q.I.P Committee. Additionally, the results of all M/E activities will be reported, in writing, to the office of the Executive Director, and Director of Programs and Services.

### **Verification**

- A. E.Q.I.P Committee Meeting Minutes Concerning M/E Activities
- B. E.Q.I.P Committee Minutes – M/E Threshold Evaluation Results
- C. E.Q.I.P Committee Minutes – M/E Corrective Action Plans
- D. E.Q.I.P Committee Minutes – M/E Corrective Action Plan Evaluation

## Results

### E. M/E Reports to the Executive Director and Director of Programs and Services

## **PROCESS REVIEW**

Process Review will be conducted through the implementation of an ongoing, comprehensive process directed at identifying under-utilization, over-utilization and/or inefficient use of resources available to the organizations programs and services. The E.Q.I.P team utilizes the Six Sigma methodology, a disciplined extension of Total Quality Management. This method utilize the DMAIC (Define, Measure, Analyze, Improve, and Control). More information can be found in section 300, Organizational Leadership and Management.

Reviewing performance as it relates to the use of organization resources will be the responsibility of the Executive Director, or designee, or their designee. The process includes both an ongoing review and retrospective look at how the BHOP program is operating, focusing specifically on the admission process, treatment appropriateness, supportive services and the utilization of facility resources.

## **E.Q.I.P Process**

The E.Q.I.P committee, chaired by the Director of Programs and Services, or designee, or their designee, will meet at minimum quarterly for the purpose of examining those areas described above. In preparation for these meetings, data relating to the agenda will be collected by a person assigned by the Director of Programs and Services, or designee, for examination during the meeting.

## **Length of Stay Norms**

On an annual basis, the E.Q.I.P Committee will establish length of stay norms for the facility based on an average of the length of care for all Clients discharged the previous twelve (12) months. Other similar agencies will be contacted to provide a greater basis for benchmark comparison.

## **Appropriateness and Clinical Necessity of Admissions**

The appropriateness and clinical necessity of admissions to the outpatient behavioral health program will be examined as they relate to individual Clients and to the overall program. This evaluation will be based on the following indicators:

### **Indicator**

- A. Percent of successful prior authorizations by OFMQ on Medicaid Clients.
- B. Results of E.Q.I.P activities during case audits, staffings, and quality improvement initiatives.

### **Thresholds**

- A. Greater than 5% denial rate on prior authorizations through OFMQ during any quarter.
- B. Findings of inappropriate or questionable admissions during the E.Q.I.P process.

## **Appropriateness and Clinical Necessity of Continued Treatment**

The appropriateness and clinical necessity of continued treatment in the outpatient behavioral health programs will be examined as they relate to individual Clients and to the overall program. This evaluation will be based on the following indicators:

### **Indicator**

- A. Percent of successful prior authorization extensions by OFMQ on Medicaid Clients.
- B. Results of E.Q.I.P case audits, staffings, and quality improvement initiatives.

### **Thresholds**

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

- A. Greater than 5% denial rate on prior authorization extensions through OFMQ during any quarter.
- B. Findings from E.Q.I.P activities indicating questions or a need for concern.

**Appropriateness, Clinical Necessity and Timeliness of Support Services**

The appropriateness, clinical necessity and timeliness of support services in the programs and services are examined as they relate to individual Clients and to the overall program service delivery. This evaluation will be based on the following indicators:

**Indicator**

- A. Results of Client satisfaction surveys and staff feedback.

**Thresholds**

- B. Grievances filed from Clients or staff.
- C. Written or oral complaints.

**Utilization of Staff, Space and Other Resources**

The appropriateness of the use of staff, space and other resources in the programs and services will be examined as they relate to individual Clients and to the overall program service delivery. See the C.A.R.E Committee Team in Organizational Leadership and Management, in section 300. This evaluation will be based on the following indicators:

**Indicator**

- A. Ease of operation.
- B. Professional appearance.
- C. Results of Client satisfaction surveys.
- D. Staff feedback.

## **Thresholds**

- A. Grievances from Clients or staff.
- B. Obvious inefficiencies or cluttered appearance.
- C. Written or oral complaints from Clients, staff or outside contacts.

## **Corrective Action**

In any instance where the comparison of collected data indicates performance outside the established thresholds, the committee will assess the information to determine if the results appear to be indicative of any specific or general resource issues. Based on this assessment, recommendations concerning appropriate corrective actions may be developed by the committee. Upon the approval of the Executive Director, or designee, their recommendation(s) will be implemented in an effort to remedy the identified facility resource issues. If, at that time, the committee deems no action necessary, the issue will be placed on the agenda of the next E.Q.I.P Committee meeting for further review and evaluation. Findings and recommendations will be resolved in conjunction with the organizations C.A.R.E (Communication, Acceptance, Relationships, Empowerment) Committee Team.

## **Follow-Up On Previous Recommendations**

As a routine part of the activities conducted during the quarterly meetings of the E.Q.I.P Committee, corrective plans implemented during each of the previous four (4) quarters will be evaluated to assess their effectiveness and determine if the identified resource issue(s) has been adequately addressed.

The results of E.Q.I.P activities will be communicated to relevant supervisory personnel concerning issued raised pertinent to their area of responsibility and to the C.A.R.E Committee Team. All relevant findings, reports and actions taken will be shared with those staff effected by the recommendations. Actions may include referrals for training or other staff development activities. The E.Q.I.P Committee chairperson serves as the contact for staff wishing to forward information to be considered by the Committee. Additionally, results of activities will be reported, in writing, to the Executive Director, or designee of the organization.

*Mid-Del Youth and family Center, Inc.*  
*Policies and Procedures*

**Verification**

- A. E.Q.I.P Committee Meeting Minutes Concerning QI Activities
- B. E.Q.I.P Committee Minutes - QI Threshold Evaluation Results
- C. E.Q.I.P Committee Minutes -QI Corrective Action Plans
- D. E.Q.I.P Committee Minutes - QI Corrective Action Plan Evaluation Results
- E. E.Q.I.P Reports to the Executive Director, or designee
- F. C.A.R.E Committee Team Minutes – Related Action Plans