Department of Alcohol and Drug Addiction Services
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Columbus, Ohio 43215-2537

George V. Voinovich, Governor
Luceille Fleming, Director

OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION SERVICES
DIVISION OF QUALITY IMPROVEMENT

PROGRAM CERTIFICATION INSPECTION REPORT

PROGRAM OWNER: Tri-State Drug Rehabilitation and Counseling Program Inc.
6070 Branch Hill-Guinea Pike
Milford, Ohio 45150

PROGRAM SITE: **SEQ: 03234**
Kids Helping Kids
6070 Branch Hill-Guinea Pike
Milford, Ohio 45150

TYPE OF PROGRAM: Outpatient

Date of Survey: October 7 and November 5, 1997
Name of Surveyor: Janice C. Jones

SCOPE AND PURPOSE OF REVIEW
The purpose of this review was to compare the program's documentation and practices for compliance with the Ohio Department of Alcohol and Drug Addiction Services' (ODADAS) Standards for treatment program certification. The Standards are identified as follows: Rules 3793:2-1-01 through 3793:2-1-17 and Rules 3793:2-2-01 of the Ohio Administrative Code.

Tri-State Drug Rehabilitation and Counseling Program Inc. is a Kentucky, non-profit, corporation licensed to do business in Ohio.

On August 19, 1997, Kids Helping Kids submitted an "Application for Treatment Program Certification". The application was reviewed, determined to be complete, and a certification site visit was scheduled for October 7, 1997. The surveyor was unable to complete the survey on that date and scheduled to return to the agency on November 5, 1997.

The primary participants in the process were Penny Walker, Executive Director, and Michele Walton, Program Director.

Communications: (614) 466-3445 **TDD: (614) 644-9140** **FAX: (614) 752-8645**
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GOVERNING AUTHORITY

The owner of the program is Tri-State Drug Rehabilitation and Counseling Program Inc. The program has a governing authority known as the Board of Directors. The Chairperson of the governing authority is Eric Steinman.

The program has written policies, regulations, and/or by-laws for • selecting members, and identifying the officers, their responsibilities, length of terms and the number of successive terms • the number of members needed for a quorum • addressing conflicts of interest between the member and the program • orientation of new members.

The program's written policies, code of regulations or by-laws stating the responsibilities of the governing authority did not include the responsibilities of (a) ensuring that the hours of operation for alcohol and drug addiction services provided by the program accommodate the needs of persons served (b) ensuring that all alcohol and drug addiction services provided and employment practices are in accordance with non-discrimination provisions of all applicable federal and state laws and regulations.

Governing Authority minutes of 9/10/97 confirm the approval of the program's annual services plan and the review of the independent fiscal audit of the program. Minutes of 12/11/96 confirm the governing authority's approval of the program's annual budget. The program's Table of Organization illustrates the lines of authority for all positions within the program.

PROGRAM ADMINISTRATION

The program has policies and procedures for • planning • fiscal administration • personnel management • personnel qualifications • client abuse and staff neglect • management information • program evaluation • physical plant and safety • infection control • drug free workplace.

Planning:

The program has policies and/or procedures for governing the following planning issues:

- The purpose, goals and objectives of the program.
- A list of each alcohol and drug addiction service provided by the program and a brief description of each service.
- A schedule of the hours of operation of the services provided by the program.
- Estimated revenues by source and costs for each service provided by the program.
- Target populations for each of the services provided.

The planning policy requires an annual review and revision, as necessary.

Fiscal Policies and/or procedures:

The program has policies and/or procedures that include:

- A chart of Accounts.
- Procedures for preparing an annual revenue and expenditure operating budget for the program.
- A financial records disclosure policy.
- Policy that states the accounting method (accrual) used by the program.
- Policy requiring a monthly financial statement of the program that shows monthly expenditures and revenues received.
- Accounting procedures for receipts and disbursements.
- Billing procedures.

Personnel Policies and Procedures:

The program maintains written personnel policies and procedures that comply with relevant federal, state and local statutes. Personnel policies and/or procedures include:

- Provisions for providing cultural sensitivity training to staff.
- Employment recruitment and selection process.
- Provisions for promotion, discipline and termination of employment.
- Annual performance evaluation of each employee.
- Employee grievance procedure.
- Staff development, sick leave and vacation.
- Procedures for paying employees for time worked, and for overtime.
- Retirement plans and/or annuities.

The program has a policy ensuring that a copy of the program's personnel policies and procedures is available to each employee, and a procedure for notifying employees of changes in personnel policies and procedures.

The program has a policy and procedure for permitting each employee the right to review his/her own personnel file.

A personnel file is maintained on each employee. Personnel files of four (4) service providers were reviewed. Personnel files of three (3) paraprofessionals who serve as service providers (junior/senior staff) did not contain resumes. The files of one paraprofessional (BR) did not contain copies of credentials. Position descriptions for Paraprofessional staff include the requirement that the person be registered with the Ohio Credentialing Board (OCB) as candidates for CCDC. The files of three (3) paraprofessionals were reviewed. All of the files contained applications for registered candidate status, but no documentation of registered candidate status. On 11/12/97, the Executive Director faxed documentation that two of the three paraprofessionals had attained registered candidate status, as verified by OCB.

Job descriptions of service providers(junior staff, senior staff, trainees) do not reflect that the clinical supervision is being provided by individuals credentialed and/or licensed to provide clinical supervision. The roster provided to the surveyor lists three (3) paraprofessional trainees. The job description for Trainees states that the responsibilities include (a) writing observaions on client progress (b) doing one-on-ones with permission, and (c) to co-lead raps. This makes it appear as though Trainees are providing chemical dependency services. If Trainees are providing chemical dependency services, as indicated by their job descriptions, the trainees need to obtain the proper credentials that would allow them to provide these services.

Affirmative Action Plan:
The program has an Affirmative Action Plan that has stated goals for hiring of a culturally diverse staff at all levels of the program and for attempting to have staff who reflect, as nearly as possible, the racial composition of its service area.

Client Abuse and Staff Neglect:
The program has a written policy and procedures for handling cases of client abuse and staff neglect. The policy includes procedures for notifying appropriate regulatory boards, when applicable.

Physical Plant and Safety:
The program has on file a copy of an initial Building Permit issued by the Clermont County Building Inspections Department (Permit # 93-2647). The program has on file a copy of a fire inspection report (3/97). The program has a fire evacuation plan. Fire evacuation routes are posted at the program site. Fire drills are conducted quarterly at the program site and a written record is kept of each fire drill. The program has documentation to reflect that employees and volunteers have been trained in the fire evacuation procedures. The program services are handicap accessible. The program has written policies and/or procedures for infection control.

QUALITY ASSURANCE
The program has a written plan for conducting quality assurance activities that is in essential compliance with the requirements of the Standards.

The quality assurance plan, policies, and procedures do not require that the Utilization review

include an examination of service usage patterns and trends.

The program maintains monthly documentation of Utilization review, Peer review and Completeness-of-records reviews.

CLINICAL MANAGEMENT
The program has written policies and procedures that include:

- Admission criteria
- Procedures to follow when an individual has been determined to be inappropriate for admission to the program.
- Procedures for making referrals to other organizations.
- Procedures for terminating client services, and for terminating services against the advice of the program.
- Releasing of client information to other organizations.

The program has an affiliation agreement with Bethesda Hospital for the provision of emergency medical services.

The program has a policy/procedure for client education on HIV infection, AIDS related complex and AIDS.

The program does not have a policy for providing communications assistance to clients, family members/significant others, at no additional cost, who speak a language other than English, or who have a communications disorder such as deafness or hearing impairment.

The program has a policy that states that individuals credentialed by professional regulatory boards in Ohio shall not practice outside of their scope of practice as defined by their regulatory board(s).

CLIENT RECORDS
The program has written policies and/or procedures for maintaining a uniform client records system that includes • Confidentiality of client records • Releasing client information • A system for locating client records removed from the central filing area • Access to client records by staff, clients and others • Storage and destruction of client records • Components of client records.

Client records are maintained in a secure room in locked filing cabinets as required by 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.

Three (3) client records were reviewed. The assessment instrument being used gathers the needed information from which alcohol and drug treatment is based. The following exception was noted: Assessments did not include a recommended course of treatment. Documentation is present within reviewed files which indicates that the client is aware of the applicable laws regarding confidentiality of client records, the Client Rights policy and the Grievance procedure. Initial treatment plans are being written on the day of admission to the program. The initial treatment plans do not contain the problems to be addressed in treatment or the service(s) to be provided. Individualized treatment plans were being written within the required time frame.

CLIENT RIGHTS AND GRIEVANCES

The program's Client Rights policy and Grievance procedure are in place, and they are in essential compliance with the requirements of the Standards. A copy of the Client Rights policy and the Client Grievance procedure are posted at the program site in a place accessible to clients. Documentation exists within client files that reflects that clients have received copies of the policies/procedures. Documentation exists within the personnel files which indicates that the program staff is familiar with the policies/procedures, as required by the Standards.

TREATMENT SERVICES

The program provides Assessment Services, Individual and Group Counseling Services, Crisis Intervention Services, and Intensive Outpatient Treatment Services.

Assessment Services:

The program provides alcohol and drug dependency Assessment services. Service providers are appropriately credentialed and/or licensed to provide assessment services. The Assessment service providers, and the service component are supervised by Michele Walton, CCDC III.

Individual and Group Counseling Services:

The program provides Individual and Group Counseling services. One of the paraprofessional service providers (B R) does not have documentation in file of registered candidate status.

Crisis Intervention Services:

The program provides Crisis Intervention Services. The program has an affiliation agreement with a hospital (Bethesda) for necessary emergency medical care. All Crisis Intervention service providers have current training and/or certification in First Aid, CPR techniques and De-escalation of Disruptive and Aggressive Acts. The service component is supervised by Michele Walton, CCDC III.

Intensive Outpatient Services:

The program provides Intensive Outpatient Services. Intensive Outpatient services are provided at least three (3) days per week, three (3) hours per day. Services include assessments, individual and group counseling, crisis intervention and alcohol/drug addiction education. The Intensive Outpatient services staff to client ration is 1:10 or less. The program does not have a policy that includes the description of the staffing patterns for maintaining the required staff to client ratio. Michele Walton, CCDC III, provides supervision for the service providers and

for the service component.

DEFICIENCIES:

1. The program's written policies, code of regulations and/or by-laws stating the responsibilities of the governing authority do not include (a) ensuring that the hours of operation for alcohol and drug addiction services provided by the program accommodate the needs of persons served, or (b) ensuring that all alcohol and drug addiction services provided and employment practices are in accordance with non-discrimination provisions of all applicable federal and state laws and regulations, as required by OAC 3793:2-1-02 (I)(9()(10).

   Corrective Action: The Executive Director said that the policy will be revised to meet the requirements of the Standards.

2. All personnel are not qualified by education, experience and/or credentials to function in their assigned tasks as defined in their job descriptions, as required by OAC 3793:2-1-03 (N)(4).

   Corrective Action: The Executive Director said that all personnel will obtain the required credentials to function in their assigned tasks as defined in their job descriptions.

3. All service providers of Individual and Group Counseling were not qualified by credentials and/or licensed to provide this service, as required by OAC 3793:2-1-11 (H).

   Corrective Action: The Executive Director said that all of the service providers will obtain the proper credentials and/or licenses to provide this service. **Resolution:** On 11/12/97, the Executive Director faxed confirmation of the service providers' credentials. One service provider has no documentation of credentials. Documentation to be provided to ODADAS.

4. The program does not have a written policy and/or procedure for providing communication assistance to clients, their family members and/or significant others, at no additional cost to the person served, who speak a language other than Standard English as a primary means of communication, or who have a communication disorder such as deafness or hearing impairment, as required by OAC 3793:2-1-05 (D)(15).

   Corrective Action: The Executive Director said that a policy will be written to meet the requirements of the Standards.

5. Assessments did not include a recommended course of treatment, as required by OAC 3793:2-1-08 (L)(14)

   Resolution: The Executive Director said that the assessment currently being used has

Resolution: The Executive Director said that the assessment currently being used has been revised to include the required information.

6. The Initial Treatment Plans do not contain the duration, frequency and type of service(s) to be provided, as required by OAC 3793:2-1-06(J)(4).

   Corrective Action: The Executive Director said that the Initial Treatment Plan will be revised to include the required information.

7. The program's written policies and/or procedures for Intensive Outpatient Services did not include a description of the staffing pattern and provisions for maintaining required staff to client ratio due to staff planned and unplanned leaves of absence, as required by OAC 3793:2-1-17 (K)(3).
   Corrective Action: The Executive Director said that a contingency policy will be written to meet the requirements of the Standards.

8. The program's procedures for conducting Utilization review do not include a review of the client waiting lists or an examination of service-usage patterns and trends, as required by OAC 3793:2-1-04 (G)(3)(4).
   Corrective Action: The Executive Director said that the appropriate indicators/monitors will be added to the quality assurance monthly review forms.

9. Job descriptions do not indicate that clinical supervision is being provided by individuals who are qualified to provide supervision, as required by OAC 3793:2-1-11 (I)(1-7), or 3793:2-1-08 (J) (1-7).

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