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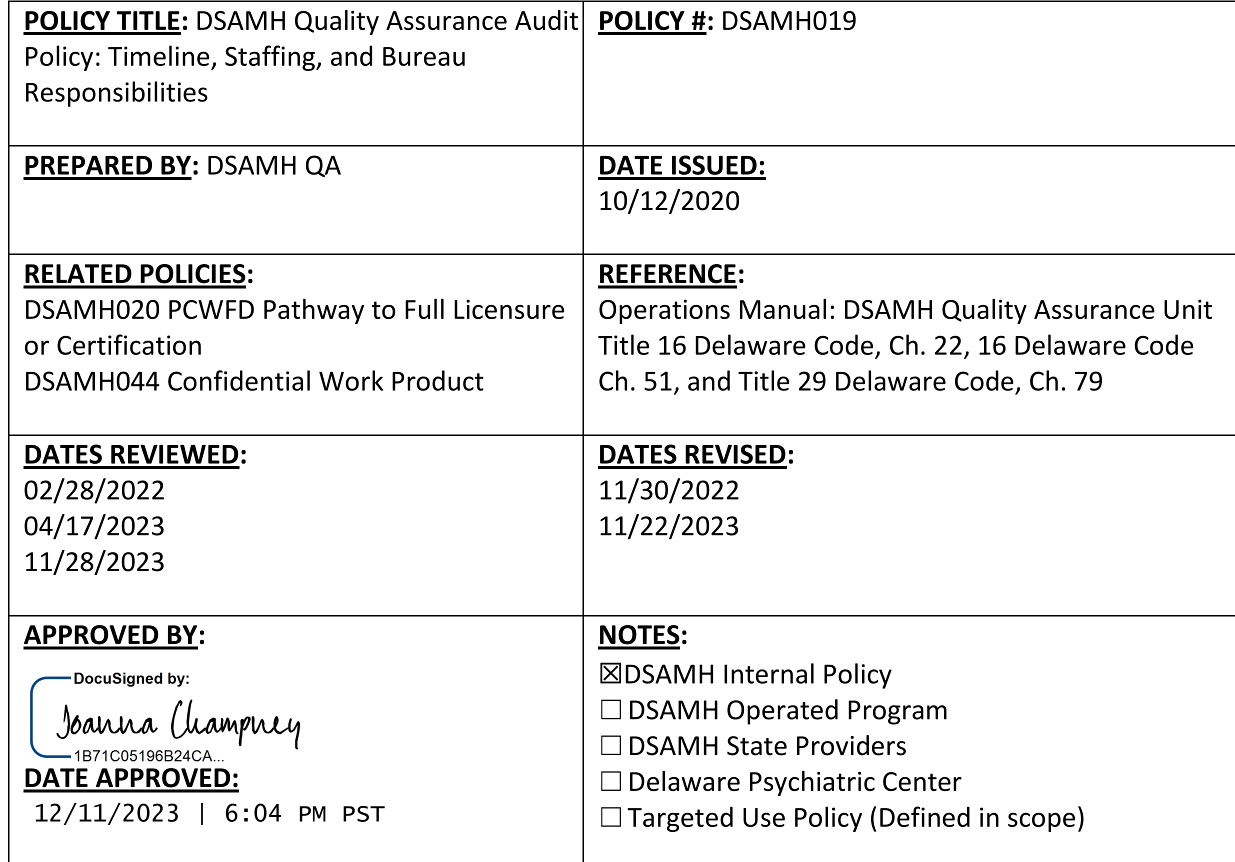
POLICY AND PROCEDURE



POLICY TITLE: DSAMH Quality Assurance Audit Policy: Timeline, Staffing, and Bureau Responsibilities	**POLICY #:** DSAMH019
PREPARED BY: DSAMH QA	**DATE ISSUED:** 10/12/2020
RELATED POLICIES: DSAMH020 PCWFD Pathway to Full Licensure or Certification DSAMH044 Confidential Work Product	**REFERENCE:** Operations Manual: DSAMH Quality Assurance Unit Title 16 Delaware Code, Ch. 22, 16 Delaware Code Ch. 51, and Title 29 Delaware Code, Ch. 79
DATES REVIEWED: 02/28/2022 04/17/2023 11/28/2023	**DATES REVISED:** 11/30/2022 11/22/2023
APPROVED BY: DocuSigned by: Joanna Champney 1B71C05196B24CA... **DATE APPROVED:** 12/11/2023 | 6:04 PM PST	**NOTES:** ☒DSAMH Internal Policy ☐ DSAMH Operated Program ☐ DSAMH State Providers ☐ Delaware Psychiatric Center ☐ Targeted Use Policy (Defined in scope)

I. **PURPOSE:** In alignment with the Division of Substance Abuse and Mental Health's (DSAMH) Bureau of Policy, Compliance, and Workforce Development (PCWFD) mission, this policy identifies quality assurance oversight responsibilities and procedures related to performing audits for licensure, certification, or compliance with DSAMH contracts.

II. **POLICY STATEMENT**: DSAMH's Quality Assurance team will schedule and perform audits within the required licensure period for all programs requiring licensure or certification. Audits will be conducted professionally, objectively, and collaboratively, utilizing approved audit tools. Provider engagement will include provider education on intent to audit, explanation of the audit process and provider responsibilities, and expectations at the completion of the audit process. Every provider will be treated as a valued DSAMH partner and be provided real-time, transparent communication at all points during the audit process. Staff are cross trained to provide various PCWFD responsibilities. Programs to be audited are guided by Delaware State Code and/or as designated by DSAMH executive management.

III. **DEFINITIONS:**
"Audit" means a process utilized by DSAMH to inspect a program to ensure they are meeting the standards of care for the license or certification provided. The audit may also include a review of contractual obligations that may exceed the minimum required standards. The audit may be completed in person, virtually, or any combination of both. Audits will review the providers' compliance to their contract and the standards of care. Audits are structured into three (3) phases.

"Corrective Action Plan (CAP)" means a time-limited action plan that includes risk reduction strategies, responsible parties, measures of effectiveness, and actions the provider will take to address deficiencies. A CAP may be required from a provider to resolve audit deficiencies, respond to a community incident report, or mitigate other discoveries of program deficiencies.

“Deemed Status” means a licensure standing approved by DSAMH and bestowed upon programs that have been accredited by an accreditation body approved by DSAMH. Programs that have been granted Deemed Status will be inspected in accordance with §4.3.2 of the 6001 Facility Licensing Standards.

"For Cause Audit" means an audit triggered by a critical incident, community grievances, or other information obtained by DSAMH that initiates concern for the health and safety of clients being served by the program and/or serious concerns about adherence to standards of care and contractual obligations.

“Level I citation” means a finding that identifies significant health, life, and safety issues, including violations of client rights, confidentiality, safety, and staffing. Any Level I citation will result in the program being found in non-compliance.

“Level II citation” means a finding that does not identify significant health, life, and safety issues, including violations of client rights, confidentiality, safety, and staffing. Any Level II citation will result in the program completing a CAP and monitoring by DSAMH.

“Non-compliance” means the program or organization did not meet the license and/or certification standards or was not renewed by achieving program compliance at the end of a fixed period.

“Phase I” means the initial notification to the provider of intent to audit, explanation of audit process, and provider completion of attestation form and required documentation submission. Assistance is tailored to provider’s needs (telephonic support, video-conference support, or in person).

“Phase II” means the direct audit of program documentation with the provider: attestation form review, previous year Corrective Action Plan (CAP), policies, procedures, human resources documentation, staffing, chart reviews, interviews, and facility inspection as required by standards (in person or virtually).

“Phase III” means the time frame from the end of Phase II to the end of the licensure of the program. During Phase III, DSAMH may conduct a follow-up audit of the submitted provider attestation form or any concern areas noted during Phase I or Phase II. Visits may be scheduled or unannounced. In addition, QA may complete for cause audits in response to incidents, grievances, or other acute concerns identified by DSAMH.

"Provider" or “Organization” refers to agencies requiring certification or licensure.

"PCWFD" means DSAMH Bureau of Policy, Compliance and Workforce Development.

"QA" means Quality Assurance.

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IV. **SCOPE:** All staff employed in the PCWFD Bureau in the areas of Quality Assurance, Risk Management, and Provider Enrollment are required to follow this policy and related policies, State regulations, and Federal regulations. This scope extends to anyone participating in a program audit regardless of DSAMH title.

V. **PROCEDURES/RESPONSIBILITES:**

A. Programs have different or multiple source requirements that may apply to audits:
1. Delaware Code Title 16 6001 Substance Abuse Facility Licensing Standards,
2. Delaware Adult Behavioral Health DHSS Service Certification and Reimbursement Manual,
3. PROMISE Medicaid Certification Manual,
4. DSAMH published standards,
5. DSAMH contractual requirements,
6. Requirements from other regulating bodies such as DHCQ for group homes, and
7. SAMHSA requirements for programs providing Medication for Opioid Use Disorder (MOUD) services.

B. Audit tools shall be updated to reflect changes in federal, State, DMMA, or DSAMH standards. PCWFD will provide providers 60 days’ notice before implementing a new audit process, when possible.

C. DSAMH may provide additional support for any program that is a new provider or on provisional license status. Support may include:
1. Providing technical assistance to programs to meet the standard of care for the treatment modality and levels of care they provide.
2. Requiring Corrective Action Plans and monitoring of program CAP implementation.
3. Providing consultation with treatment programs throughout the State of Delaware to provide the best standard of care possible to Delaware residents.

D. The following describes the process for renewal of licensure or certification:
1. The Quality Assurance Administrator and/or Deputy Bureau Chief will prioritize the audit calendar to ensure all licenses and certifications can be provided per State regulations. Extensions, when necessary, must be approved by PCWFD Bureau Chief.
2. Provider Enrollment will notify the listed provider contacts from the Provider Directory 120 days before the expiration of the current license and/or certification. Providers must submit a new completed application 90 days prior to expiration of current license or certification.
3. Provider Enrollment shall notify the QA team upon submission of a completed application.
4. DSAMH has the option of issuing extensions, provisional licenses, or temporary licenses when a program cannot be provided full licensure before their current license expires. These options have limitations and require the approval of PCWFD Bureau Chief and may not exceed authority granted under Delaware regulations. Any situation that requires exceeding State code would require a DSAMH waiver signed by the DSAMH Director.
5. Policy and Compliance shall work cohesively and proactively to have licenses and/or certifications renewed prior to the expiration date.
6. Provider unresponsiveness must be elevated to the QA Administrator, Deputy Bureau Chief, and/or Bureau Chief for assistance in removing barriers.

E. Phase I Procedures:

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1. Provider Enrollment will review the completed application and any additional submitted documentation. They will file the completed application packet in the appropriate folder.
2. A designated member of the QA team shall send the "Notice of Intent to Audit" to the provider within a designated time frame prior to Phase II of the audit:
   a. SUD programs: 45 days prior to Phase II
   b. ACT, ICM, and GH: 60 days prior to Phase II
3. During Phase I of the audit, the designated team member will conduct a Phase I meeting with the provider within five (5) business days from the date that the "Notice of Intent to Audit" is sent to the provider, or at the provider's earliest availability. The provider may choose to decline the Phase I meeting and submit the completed documents.
4. During Phase I, the provider will be sent the following documents to complete and return to DSAMH:
   a. DSAMH Audit Guidance Form
   b. Program-Specific Attestation Form(s)
      i. Included in the Attestation are program-specific elements that are not verified during a clinical chart review.
      ii. The provider will be asked for the number of clients served during the review period and attest to the percentage of services provided on site or virtually.
   c. Program Staffing Survey
      i. The program staffing survey shall include any program staff that provided and documented services in the clinical record during the review period and all required staff per standards and contracts.
      ii. This shall include any PRN staff, as well as staff that are no longer employed by the program but worked during the review period.
5. Once a provider completes the Phase I meeting or declines the Phase I meeting, the provider has ten (10) business to complete and return the documentation requested during the Phase I meeting or via email if the meeting is declined.
6. The designated team member will upload the Phase I documentation in the appropriate file.

F. Phase II Procedures:
1. Prior to the audit the QA Team Lead, or designee, will:
   a. review the submitted Phase I documentation,
   b. review previous audits and CAPs,
   c. identify any Risk Management concerns to be reviewed during the audit, and
   d. identify other concerns or areas that may be reviewed during the audit.
2. The QA Team Lead will contact the provider to clarify any deficient information or request additional information.
3. The QA Administrator shall schedule the Phase II prior to the expiration of the license or certification.
4. In addition, the provider will be asked to provide the following to DSAMH:
   a. A list of all active clients during the review period.
   b. A list of all closed cases during the review period.
   c. A list of any clients that died during the review period.
5. Additional auditors will be assigned to support the Team Lead during the audit, depending on the number of support staff the provider has available or if the charts are navigated independently by DSAMH. A minimum of two (2) auditors shall be assigned to each audit for programs requiring four (4) record reviews. Compliance audits may be completed in person, virtually, or any combination as determined by DSAMH.

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6. The audit team will conduct the Phase II audit, including reviewing the Attestation Form, verifying prior-year CAP implementation, addressing any outstanding issues, and auditing program records.
7. The QA Team Lead will select charts to be reviewed. The minimum number of charts audited shall be four (4), including two (2) active and two (2) discharged charts. If no discharged charts are available, active charts will be substituted to ensure that a minimum of four (4) charts are reviewed. If no active charts are available, discharged charts will be substituted to ensure that a minimum of four (4) charts are reviewed. The team may request to review additional charts based on discovery. Certain programs, such as ACT, have higher minimum chart requirements.
8. Additional charts may be reviewed as needed. These charts may include clients who died or those who were involved in critical incidents during the audit period. Additional charts may be reviewed to further explore any trends identified during the audit.
9. The Phase II Audit will end with a summary identifying program strengths and any deficient standards of care that were identified during the audit. During the closing meeting, the provider has the opportunity to provide any information or feedback.
10. QA Team Lead will complete and send the audit report within ten (10) business days of the conclusion of Phase II.
11. Level I citations are for findings that involve threats to the health, safety, and welfare of clients. Determination of level I status is at the discretion of DSAMH, based on findings during the audit, and must be approved by the Deputy Bureau Chief or Bureau Chief. Any level I citation will result in the program being found in non-compliance.
12. Level II citations are any other findings that do not jeopardize health, life, and safety, but need to be corrected.
    a. DSAMH may escalate a repeated level II finding to a level I citation.
    b. Determination of the escalation to level I status is at the discretion of DSAMH, based on findings during the audit, and must be approved by the Deputy Bureau Chief or Bureau Chief.

G. Phase II Considerations:

1. The audit team has a standard process which informs the decision to provide the following licenses or certifications: Provisional or Full License or Certification. This is determined by the results of the audit and detailed in the Audit Survey Report. Providers will be informed of program status via the report as follows: Non-Compliance, Compliance, or Substantial Compliance. Programs that are noncompliant will receive a provisional license. Programs that are compliant will receive a full license. Programs that are in Substantial Compliance will receive a full license and are eligible to apply for deemed status, per the regulations set forth in Title 16, 6001: 4.3.2. and 17.0 et al.
2. The audit considers the following elements in reaching a decision on program status: Attestation Form, prior year Corrective Action Plans, incident reports, clinical audit, program visual inspections, and discovery of any practices that may impact the health, safety, and well-being of clients. The audit report will provide objective standards-based feedback, as well as qualitative feedback.
3. If the Phase II results in program noncompliance, the Team Lead shall consult with the audit team, the QA Administrator, Deputy Bureau Chief, and Bureau Chief of Policy and Compliance.
4. If the Phase II identifies a significant health, life, and safety issue during the audit, the issue will immediately be referred to the QA Administrator, Deputy Bureau Chief, and Bureau

Chief of Policy and Compliance. A meeting will be held to address the issues and identify next steps in the auditing process. Even if the provider's score appears to be in compliance, the audit team has discretion to find the program in noncompliance if documentation is missing or level I citations are found. The QA Administrator and/or Deputy Bureau Chief will schedule an emergency meeting with the PCWFD Bureau Chief and Associate Deputy Director if any program is in jeopardy of losing licensure status or if program practices are creating a safety risk for clients. Once findings causing a program to be in non-compliance are remediated, a program may be given full licensure at the discretion of the Bureau Chief.

5. The QA Administrator or Deputy Bureau Chief will authorize the report to be sent to the provider. DSAMH may provide a license or certification without waiting for an approved CAP. The QA Administrator will approve the QA Checklist, authorizing the Administrative Assistant to send the signed license or certification to the provider.
   a. The following levels of care are NOT eligible for a 2-year license or certification:
      i. ACT
      ii. ICM
      iii. Group Homes
      iv. Any program coming off of provisional licensure, including new provisional licensure
6. The QA Team Lead or designee will send the provider a summary report. The provider shall return the signed Provider Acknowledgement Receipt of Survey Report and signed CAP Acceptance Form. If needed, a CAP shall be returned within ten (10) business days, or thirty (30) days as required by program regulation.
   a. For SUD Programs, within ten (10) business days
   b. For ACT, ICM, and Group Homes, within thirty (30) calendar days
7. The QA team lead will assist the provider in developing an acceptable CAP. Once the CAP is approved by the QA team lead, the team lead will forward the CAP to the QA Administrator and Deputy Bureau Chief.
8. Once the CAP has been accepted, the QA Administrator will sign the CAP acceptance form and a copy of the license and/or certification shall be emailed to the provider. A physical copy of the license and/or certification shall be mailed to the provider only upon request.
9. The QA Administrator and/or Deputy Bureau Chief and QA team lead will determine the frequency and length of CAP follow-up based on the acuity of the items identified in the CAP. The QA team lead will conduct follow-ups with the provider. The QA team lead will document progress on the DSAMH CAP compliance tracker located on the DSAMHQA shared drive.

H. Phase III Procedures:

1. The QA Administrator and/or Deputy Bureau Chief will select programs requiring a Phase III audit. The Phase III audit is an abbreviated on-site or virtual audit that may include checking items from the Attestation Form, physical site inspection, any areas noted on the most recent CAP, HR files, and chart reviews. If a program is found to be in noncompliance during a Phase II audit, or level I citation is identified, a Phase III follow up may be immediately initiated.
2. A Phase III audit can be scheduled at the discretion of DSAMH QA at any point during the certification/licensing period.
3. Audits may include on site, unannounced site visits, follow up review of charts and documentation, or other activities as needed.
4. As appropriate, PCWFD may involve other Bureaus depending on nature and severity of programs status.

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I. Additional Audit procedures:
   1. For cause audits may be completed in response to incidents, grievances, or other acute concerns identified by DSAMH. Timelines for these audits will be defined by the DSAMH Policy and Compliance leadership.
   2. If at any point during the process, a provider is not responding to e-mail and phone inquiry, the Team Lead will elevate the issue to the QA Administrator, Deputy Bureau Chief, and Bureau Chief noting outreach efforts taken to date.
   3. All Quality Assurance activities and findings are driven by relevant standards of care, required for program modality, and level of care. Concerns not associated with a specific standard of care must be brought to the QA Administrator, Deputy Bureau Chief, and Bureau Chief for review.
   4. All Quality Assurance activities and findings are considered private, privileged, and confidential (see DSAMH044).
   5. If a new provider is challenged with recruiting new clients, the QA Administrator will refer them to other DSAMH resources for assistance.
   6. Lack of client enrollment or other operational delays may require a provider to consider moving program to inactive status or seeking an extension to the 180-day limit for new provisional licenses (see DSAMH020).

VI. **POLICY LIFESPAN:** This policy will be reviewed annually.

VII. **RESOURCES**: N/A