

Organization/Facility Environmental Site Review (FESR)

Organization Name: _____ Contact Person: _____
 Address _____
 City _____ State _____ Zip _____ Phone Number _____
 Fax Number _____ Phoenix Number _____ MHS Number _____

Reason for Review (please check one) ----- Recredentialing Credentialing Quality Review Action Plan Follow-Up

Licensing Information: Currently state licensed/accredited DRG Exempt: _____

Accrediting Information CARF Accredited (Exp. Date _____) JCAHO Accredited (Exp. Date _____)
 COA Accredited (Exp. Date _____) AOA Accredited (Exp. Date _____)

Populations Served: Children (ages 11 and under) Adolescents (ages 12 –17) Adults (ages 18-64) Geriatric (65 & older)

Levels Of Care

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Inpatient Services | <input type="checkbox"/> 23 Hour Observation/Holding Bed Program | <input type="checkbox"/> Home Health | <input type="checkbox"/> Pathological Gambling Services |
| <input type="checkbox"/> Inpatient (Acute) Detoxification Program | <input type="checkbox"/> Ambulatory Detoxification | <input type="checkbox"/> Dual Diagnosis | |
| <input type="checkbox"/> Inpatient Substance Abuse Rehab Program | <input type="checkbox"/> Intensive Outpatient Program | <input type="checkbox"/> Respite Care | |
| <input type="checkbox"/> Residential Treatment Program/RTC | <input type="checkbox"/> Day Treatment | <input type="checkbox"/> Outpatient Mental Health and/or Substance Abuse Clinic | |
| <input type="checkbox"/> Partial Hospitalization | <input type="checkbox"/> Treatment Group Home | <input type="checkbox"/> EAP Services | |
| <input type="checkbox"/> (1/2) Half Day Partial Hospitalization | <input type="checkbox"/> Treatment/Therapeutic Foster Care Program | <input type="checkbox"/> Eating Disorders Program | |

Data Sources for Review

- | | | |
|---|---|--|
| <input type="checkbox"/> Policy and Procedures Manuals | <input type="checkbox"/> Treatment record reviews | <input type="checkbox"/> Review of emergency procedures |
| <input type="checkbox"/> Interviews with administrators | <input type="checkbox"/> Tour of facility/physical plant | <input type="checkbox"/> Review of safety procedures (physical, seclusion/restraint, sharps, etc.) |
| <input type="checkbox"/> Interviews with clinicians/practitioners | <input type="checkbox"/> Review of QM procedures/processes | <input type="checkbox"/> Attendance at staff, treatment planning or other meeting |
| <input type="checkbox"/> Interviews with staff | <input type="checkbox"/> Review of Treatment Protocols/Programs | |
- Other Sources: _____

Affected Account(s) _____

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Directions:

1. Answer each item by placing a check in the YES cell if the indicator is satisfied – if it is not satisfied place a check in the NO cell. If not applicable, place a check in the NA cell.
2. **NOTE: FOR CALIFORNIA PROVIDERS, THE ITEMS INDICATED WITH * AND THE RESPONSE IS “NO” MAY REQUIRE A CORRECTIVE ACTION PLAN FOR PROVIDERS WHETHER OR NOT THEY MEET THE 80% THRESHOLD.**

| # | CATEGORY | QUESTION | YES | NO | NA | COMMENTS |
|------|-------------------------------|--|-----|----|----|----------|
| 1 * | Availability | * Are emergency services available on-site or by referral 24 hours a day, 7 days a week, 365 days a year? | | | | |
| 2 * | | * Are routine appointments available within 7 days? | | | | |
| 3 * | | * Are urgent appointments available within 24 hours? | | | | |
| 4 * | | * Are appointments for life-threatening emergencies available immediately? | | | | |
| 5 * | | * Are appointments for non-life threatening emergencies seen within 6 hours? | | | | |
| 6 * | | * Is the facility in compliance with the Americans with Disabilities Act (ADA), or is working toward compliance where practicable? | | | | |
| 7 * | | * Does the facility have the ability to assess the waiting time for an evaluation once the member arrives? | | | | |
| 8 | Credentialing/ Privileging | Does the facility have policies and procedures for credentialing or privileging, recredentialing/reappointment? | | | | |
| 9 | | Does the facility document staff education, training, licensure and experience? | | | | |
| 10 | | Does the facility retain a copy of license and documentation of experience for each employee? | | | | |
| 11 | | Does the facility have a primary source verification process in place to verify licenses of staff members? | | | | |
| 12 | | Does the facility have a process in place to review Medicare/Medicaid sanctions of staff members? | | | | |
| 13 * | | * Does the facility have a process in place to review any state regulated sanction of staff members? | | | | |
| 14 | | Does the facility have a process in place to review any disciplinary actions against staff members? | | | | |

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| # | CATEGORY | QUESTION | YES | NO | NA | COMMENTS |
|----|-------------------------------|--|-----|----|----|----------|
| 15 | Quality Assurance/ Management | Does the facility have a quality assurance committee (QAC) that meets on a regular basis? | | | | |
| 16 | | Does the facility have representation of key disciplines/departments on quality assurance committee (QAC)? | | | | |
| 17 | | Do formal procedures exist for diagnosis of problems, tracking resolution and monitoring for improvement? | | | | |
| 18 | | Is patient satisfaction evaluated and reported on an ongoing basis? | | | | |
| 19 | | Does the facility have a policy and procedure for evaluating patient complaints? | | | | |
| 20 | Clinical Operations | Are there policies and procedures for clinical standards of care developed and implemented by the facility? | | | | |
| 21 | | Are there regular meetings with clinical staff and administration to review administrative and clinical policies, procedures and other issues? | | | | |
| 22 | | Are there program specific criteria in place for admissions, continuing stay and discharge? | | | | |
| 23 | | Do programs have defined treatment philosophies and orientations? | | | | |
| 24 | | Does the staffing ratio follow the facility's policies and procedures and jurisdictional statutes, if any? | | | | |
| 25 | Treatment Records | Does a multidisciplinary team provide treatment?' | | | | |
| 26 | | Are admission and continued stay criteria consistent with level of care and have a treatment focus? | | | | |
| 27 | | Is a comprehensive treatment plan completed within appropriate time frame for level of care? | | | | |
| 28 | | Does practitioner have opportunity to address clinical modalities specific to clinical needs of individual patients? | | | | |
| 29 | | Is there evidence of active participation by patients in treatment planning when possible? | | | | |

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| # | CATEGORY | QUESTION | YES | NO | NA | COMMENTS |
|----|----------|--|-----|----|----|----------|
| 30 | | Is there evidence in treatment records that discharge or long-term care planning starts from day of admission? | | | | |
| 31 | | Does a formal system exist to assure patient follow-through on aftercare arrangements or assertive action taken if patient/guardian fails to follow-up? | | | | |
| 32 | | Does the organization demonstrate the incorporation of relevant cultural issues into its treatment program? | | | | |
| 33 | Safety | Does each program inform members of rights and responsibilities and organizational grievance procedures? | | | | |
| 34 | | Does the organization have policy and procedure for emergency coverage? | | | | |
| 35 | | Are areas where members are seen free from physical furnishings or equipment that represent a risk/safety hazard? | | | | |
| 36 | | Does the facility have a contraband policy and procedure, especially how discoveries of illicit drugs and/or weapons are handled? | | | | |
| 37 | | Do suicide prevention/precaution protocols exist? | | | | |
| 38 | | Does the Psychiatric Residential Treatment Facility (PRTF) treating patients under the age of 21 comply with the CMS (HCFA) guidelines regarding restraint and seclusion? Review attestation letter. | | | | |
| 39 | | Are there clear policies and procedures for the use of seclusion and/or restraint, if utilized? | | | | |
| 40 | | Does staff receive initial and ongoing training in the use of seclusion and restraints, if utilized? | | | | |
| 41 | | Facility/program has policy and procedure addressing unrestricted access by patients to other areas without supervision. | | | | |
| 42 | | If applicable, facility/program has designated smoking area and facility restricts smoking privileges to certain hours or patients will be supervised during this time. (If non-smoking facility, indicate N/A). | | | | |

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| # | CATEGORY | QUESTION | YES | NO | N/A | COMMENTS |
|------|------------------------------|---|-----|----|-----|----------|
| 43 | Appearance | Are facility and programmatic offices neat, clean and professional? | | | | |
| 44 | | Does the environment or office site (i.e., magazines, pictures, children, adult, ethnic, etc.) reflect the culture of the members served? | | | | |
| 45 | Record Keeping | Are files containing any member information maintained in a locked and safe setting? | | | | |
| 46 | | Are member records kept in individual folder by name or identification number? | | | | |
| 47 | | Records are available, as appropriate, to other practitioners or staff at the site. | | | | |
| 48 | Treatment Record Practices | Are forms and treatment record methods maintained in a consistent manner with the model treatment record? | | | | |
| 49 | | * Does the facility record meet professional standards for documentation? | | | | |
| 50 * | Confidentiality | * Does the facility/program have a policy addressing confidentiality issues? | | | | |
| 51 | | Confidential and verbal communication is not audible to unauthorized persons. | | | | |
| 52 | | Computer screens with patient information are removed from view. N/A if no computer. | | | | |
| 53 | | Fax forms with patient information are removed from view. N/A if no fax. | | | | |
| 54 | | Mail with patient identifiable information is not visible by unauthorized persons. | | | | |
| 55 | | Other documents with patient identifiable information are not visible by unauthorized persons. | | | | |
| 56 | Utilization Review | Are there policies and procedures for a UR/UM program? | | | | |
| 57 | | Is continued treatment review done on a calendar or diagnosis basis? | | | | |
| 58 | Organization/ Administration | Does the organization have a clearly defined written organizational plan identifying the roles and responsibilities of leadership and the governing body? | | | | |

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|----|---|---|-----|----|-----|----------|
| 59 | Staffing | Does the organization have a written staffing plan including number and types of disciplines employed? | | | | |
| 60 | | Does the organization document staff training and education? | | | | |
| 61 | Psychiatric Residency Training Programs | Are the Accreditation Council on Graduate Medical Education (ACGME) supervisory guidelines (V.B.3) followed by the program? | | | | |
| 62 | | If ACGME has identified supervisory concerns, is there a corrective action plan in place? | | | | |
| 63 | | Are patients informed of their psychiatrists' status as trainees? | | | | |
| 64 | Medication Safety | All medications, including samples, are stored in a safe location that is not accessible to patients | | | | |
| 65 | | Does the organization/facility maintain a record of medication samples kept and distributed? | | | | |

Not Scored:

66 Do you submit electronic claims to any insurer? [Yes/No] To ValueOptions? [Yes/No]

67 Number of ValueOptions members treated at this location within the past year _____

68 Have you visited the ValueOptions web site? [Yes/No]

69 Have you used the ValueOptions web site to check for member eligibility and claims status? [Yes/No]

70 [If they have filed electronically] What was the experience like?



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General Comments:

| | |
|--|------------------------------|
| Reviewer's Signature _____ | |
| Reviewer's Name _____ | Reviewer's Credentials _____ |
| (Please Print) | |
| Reviewer's Phone Number _____ | |
| Service Center _____ | Date of Review _____ |
| Vendor _____ | |
| *Note: The information in this box is mandatory. If incomplete, the review will not be scored. | |

Please return tool to Fran Pike 1701 Will O Wisp Dr. Virginia Beach, VA 23454.