SAN MATEO BEHAVIORAL HEALTH & RECOVERY QUALITY MANAGEMENT PROGRAM DESCRIPTION

I. QUALITY MANAGEMENT STRUCTURE AND PROCESSES

A. QUALITY MANAGEMENT PROGRAM

The purpose of the Quality Management Program of San Mateo County Behavioral Health and Recovery Services is to provide a framework within which the Mental Health Plan (MHP) and the Substance Use Disorder programs may:

- Define high standards of care for clients and their families;
- Enhance care to individuals and families through ongoing assessment of their needs and preferences, with focused attention on cultural, ethnic and language differences;
- Monitor the system-wide quality of clinical care, clinical services, and administrative or member services against objective standards;
- Promote fair, efficient, effective and appropriate use of behavioral health resources;
- Pursue opportunities to improve services, and
- Resolve identified problems.

The QM Program further defines:

- The scope and content of the Quality Improvement(QI) program;
- The authority, roles and responsibilities of individuals who are involved in the program;
- The role, structure, function and meeting frequencies of the QI Committee and its subcommittees, and
- The relationship of the QI program to other organizational components, including agency and individual contractors.

The QM Program is written in full compliance with Quality Improvement and Utilization Review Standards developed by DHCS, SUDS, OSD, and CMS. It affirms that San Mateo County will monitor changes in state and federal regulation or policy and will make every effort to assure consistent, full compliance with regulations. The QM Program further affirms that San Mateo County will make every effort to comply with all relevant legal mandates in its delivery of behavioral health services. These QM mandates are written into individual and agency contracts to assure their regulatory compliance in administrative and clinical practice.

B. SCOPE OF QM AUTHORITY

This QM Program is broad in scope and informs the structure and process of all behavioral health services provided by San Mateo County. These include:

- All community-based services directly provided by the County;
- All community-based services provided by contracted individual providers;
- All community-based services provided by contracted mental health and substance use disorder organizational providers;
- All psychiatric inpatient services for indigent and Medi-Cal clients provided by contracted private hospitals; and additionally
- All psychiatric inpatient services for indigent and Medi-Cal clients provided by the San Mateo Medical Center.

Unless otherwise noted, services to children and youth, adults, and older adults will follow general descriptions and definitions of service structure and expectations for service delivery. Special needs and exceptions will be clearly identified in appropriate sections of the plan.

C. QM PROGRAM STRUCTURE

Authority and Responsibility

- The Behavioral Health Director maintains overall authority for program direction and management.
- The Mental Health Medical Director is responsible for providing professional judgment regarding matters of quality of care, peer review, and clinical and medical procedures.
- The Quality Manager must be a licensed mental health practitioner. The Quality Manager is responsible for implementation of the QM Program.
- The QM program, through the QI Manager, is accountable to the Behavioral Health Director, the Assistant Director/Compliance Officer, and the Medical Director.

Quality Improvement Committee

The QI Committee is a standing Policy Committee within BHRS. It oversees QI activities and is actively involved in reviewing, analyzing and enhancing the QM Program. The QI Committee meets every other month. The QI Committee has a broad-based membership that is multidisciplinary and representative of BHRS groups and service programs. Membership includes lived experience peers and family members.

Contemporaneous, dated and signed minutes reflect all QI Committee decisions and activities. Minutes are distributed to QI Committee members.

The functions and duties of the San Mateo County Behavioral Health and Recovery Services (BHRS) Quality Improvement Committee (QIC) are specified in the Quality Improvement Committee: Policy 16-11.

Quality Management Program with the assistance of the Quality Improvement Committee will:

Regulatory requirements to assess youth and adult outcomes, youth system of care data collection mandates, federal requirements to monitor grievances, and managed care requirements to collect financial and clinical data are examples of ongoing QM processes.

1. Implement a monitoring process in San Mateo County utilizing at least the following array of activities and sources of information:

- Critical Incident Data Collection
- Psychological Autopsy Process
- Medication Monitoring Activities
- Utilization Management Data
- Case Review Boards and Committees
- Outcomes Assessment Data
- Satisfaction Surveys
- Grievances and Fair Hearing Logs
- Access Data and other Managed Care Data
- System of Care Data
- Results from planning, or approving and overseeing the progress of at least 2 quality improvement activities yearly (PIP).
    - At least two of these activities shall be conducted at the level of standards for Performance Improvement Projects (PIPs) as defined in DHCS protocol. One of these PIPs shall be in a clinical area and one in a non-clinical area.

Standard: QI Committee will assure at least two Performance Improvement Projects annually, one in a clinical and one in a non-clinical area. These quality improvement activities must reflect the MHP's delivery system and meaningful clinical issues that affect its beneficiaries.

2. Conduct an annual review (fiscal year) of the QM Plan and update the plan as necessary.

3. Develop an annual work plan (fiscal year) to include the following state mandated activities:

   - An evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities, including Performance Improvement Projects, have contributed to meaningful improvements in clinical care and client services, and describing completed and in-process QI activities, including PIPs.
   - Monitoring of previously identified issues, including tracking of issues over time;
   - Planning and initiation of activities for sustaining improvement, and
   - Establishing objectives, scope and planned activities for the coming year. Within this objective, there shall be QI activities in each of the following six areas:
     - Monitoring the service delivery capacity of the MHP.
     - Monitoring the accessibility of services
     - Monitoring client satisfaction
     - Monitoring the MHP's service delivery system and meaningful clinical issues that affect its clients.
     - Monitoring continuity and coordination of care with physical health care providers and other human service agencies.
     - Monitoring provider appeals.

Subcommittees

The QI Committee may name subcommittees to perform specific tasks. Subcommittees meet regularly or on an *ad hoc* basis and report findings and recommendations to the QI Committee. The Quality Manager or staff delegate may serve on any and all committees. Subcommittees include (see policy Quality Improvement Committee: Policy 16-11 for full list of subcommittees):

Research Subcommittee (Institutional Review Board [IRB])

- Meets the week before the QI Committee meets, as needed.
- Has the following membership: Quality Manager, QI Committee members with special expertise in research methodology and/or the subject matter in the proposed study, and the Medical Director.

- Reviews all research proposals for compliance with MH Policy 95-02, Research Policies and Procedures.
- Considers study design, burden or risk to client, ethical considerations, and other unique factors in study.

D. PRINCIPLES FOR QUALITY MANAGEMENT

All standards of care and administrative policies must be structured in a manner that ~~to~~ enables consistent monitoring. Wherever possible, the monitoring process and the assignment of responsibility for that monitoring (e.g., supervisor), or department (e.g., Management Information Systems [MIS], QI) will be identified.

QI monitoring and evaluation will be based on the following principles:

- Recruitment of front line participants, including clients and family members, in detecting and improving quality problems;
- Positive support, not criticism, for becoming aware of problems;
- Prevention of problems before they occur;
- Continuous effort at reducing the occurrence of significant problems;
- Focus on correcting inefficient/ineffective systems instead of blaming individuals or teams;
- Open display of findings.

E. MEDICATION MONITORING

Mental Health Policy 04-08, (Medication Monitoring) sets the standards for the Medication Monitoring process.

Purpose

The purpose of Medication Monitoring is to assure the quality of psychotropic medication treatment for mental health clients. The objectives are to:

- Increase the effectiveness of psychotropic medication use.
- Reduce inappropriate prescribing of psychotropic medication.
- Reduce the likelihood of the occurrence of adverse effects.
- Assure appropriate laboratory work is obtained at the onset and during the course of treatment.
- Increase the likelihood that related physical examinations occur and are documented.
- Improve the client and family's treatment compliance with respect to psychotropic medication use.
- Encourage client/family education about psychotropic medications in order to improve their participation in informed consent procedures and in treatment.

Standard: At least 5% of unduplicated clients shall be reviewed annually at each clinical site and at every contracted organizational provider where medication services are provided.

F. CRITICAL INCIDENT DATA COLLECTION

The Critical Incident Report is a CONFIDENTIAL reporting tool to document occurrences inconsistent with usual administrative, clinical, and facility practice (see MH Policy 93-11, Critical Incident Reporting). The reporting form indicates areas of significant risk, variability and concern that would trigger a report. This listing is not meant to be all-inclusive and the judgment of staff is relied upon to report all incidents that impact quality care or service. The critical incident report provides:

- A mechanism for immediate notification to Behavioral Health Administration of unusual events within our system, and
- A risk management/quality improvement tool that facilitates clinical and administrative procedure development, in-service education, facility improvement, and improvements in care models.
- The requirement to document, report and analyze critical incidents applies to all county mental health staff and also to staff of community mental health agencies.

G. PSYCHOLOGICAL AUTOPSY PROCESS

A psychological autopsy is a protected Peer Review process applied whenever there has been a client death by suicide, homicide, or suspicious circumstances (see MH Policy No. 94-1). The focus of this QI review is to identify system procedures or policies that could be improved.

Standard: 100 percent of cases where a client death is by suicide, homicide, or suspicious circumstances has occurred will be reviewed in a Psychological Autopsy.

The Medical Director has the responsibility to assure that Psychological Autopsies occur in a timely manner, and to report findings to the QI Committee.

H. PEER REVIEW

Peer Review is a valued QI process, intended to improve care for clients, not to function as a supervisory tool for managers. Peer Review is a legally protected activity, and is not

subject to discovery; Peer Review may not be described as a case conference and is not reported in the client chart.

Peer Review is mandated by MH Policy 94-03, Peer Review, and is inclusive of all county mental health clinical staff and clinical staff of community mental health agencies. The policy applies to full and part-time staff, but is optional for trainees.

Standard: Any staff member who has direct clinical involvement with clients will present one client's case to a group of clinician's peers at least once annually.

Monitoring by QI assures that Peer Review occurs, but does not include review of the checklists written for individual clinicians.

I. CREDENTIALING PROCESS

The MHP will assure that its healthcare practitioners have the training and experience to provide quality care. Choosing practitioners who will work well in the care delivery system is part of this responsibility. The credentialing process will operate in a timely manner to allow for early detection of potential problems that could have an impact on the care provided to clients.

Credentialing policies apply to all licensed, waivered and registered mental health practitioners. This includes psychiatrists, psychologists, clinical social workers, marriage and family therapists, registered nurses, and nurse practitioners.

Credentialing policies shall be applied across the entire MHP, to assure high quality care wherever services are offered.

County Operated Clinics

The MHP relies on San Mateo County Employee and Public Services (EPS) policies to assure the competency and appropriateness of new applicants for employment as clinical practitioners. However, while the initial screening and selection process is a valuable and important component in a credentialing process, it does not perform all the critical reviews necessary to fully assess the practitioner's ability to deliver care.

MH Policies 98-16 and 99-04 establish objective credentialing and re-credentialing criteria for licensed, waivered, or registered professional staff employed or contracted with County Mental Health Services.

Standard: All licensed, waivered, or registered candidates for employment or under consideration for contract will be subject to credentialing review as defined in current policy.

All professional employees as described above will be re-credentialed at the time of license or certification renewal.

Any negative findings from an initial or subsequent credentialing review will be reported to appropriate supervisors or managers for their review and action.

Contracted Community Agencies

The function of assuring the competency of their clinical staff is delegated to community mental health agencies through the clinic certification process. The MHP shall verify the integrity of this process during site certification visits and more often as appropriate and necessary to assure compliance.

Standard: Agencies shall follow MHP criteria for internal credentialing of licensed staff.

Agencies shall document their procedures to assure the competency of other clinical and administrative staff to provide quality mental health care and to process claims for services

Contracted Individual Providers

The MHP recognizes its responsibility to develop and implement a credentialing and re-credentialing process to select and evaluate the practitioners who participate in service delivery for its clients. The following policies refer to that process:

- MH Policy 98-05 - Managed Care - Credentialing Process
- MH Policy 98-07 - Provider Selection and Performance Criteria
- MH Policy 98-08 - Credentialing Committee
- MH Policy 98-10 - Concerns/Complaints about MHP Providers

Delegation of Credentialing

The MHP is responsible for assuring its clients that the same standards for provider participation are adhered to across the entire organization. There are circumstances where delegation of credentialing is appropriate, as long as policies are developed that specify at least the same credentialing criteria as are used by the MHP. In addition to community mental health agencies, other organizations to which credentialing may be delegated include professional group practices, hospital-based clinics, Independent Practice Associations (IPAs), and Administrative Services Organizations (ASO). See MH Policy 98-09, Delegation of Credentialing, Re-credentialing, Re-certification or Reappointment of Providers.

Other Oversight Functions

Certification of Organizational (agency) Provider Sites - Effective with statewide consolidation of outpatient Medi-Cal services and the assumption of greater county risk in providing those services, the responsibility for site certification was given to counties. (See MH Policy 98-12, Provider Certification.)

DMH has retained the responsibility for certifying/recertifying county owned and operated sites.

Inpatient chart reviews are conducted by QI staff on charts from all private hospitals, contract or noncontract, serving MHP clients. This utilization review function consists of retrospective review of charts, and currently includes close to 100% of episodes claimed to Medi-Cal for MHP clients in private hospitals.