Quality Improvement Plan

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APPENDIX A **Mental Health Centers Quality Assurance Plan**

APPENDIX B **Quality Improvement Tools**

This revised manual integrates the responsibilities of the SC Department of Mental Health Offices of Quality Management and Organizational Improvement. This manual supersedes and rescinds all previous policies, including the 1999 Medical Records Standards and the policy memorandum No. 90-01 entitled "Quality Assurance Manual for Community Mental Health Centers 90-01" and the "Quality Assurance Manual Policies and Procedures" August 2016 (previously revised October 2004, November 2006, May 2007, August 2007 May 2010 October 2012, July 2014, November 2014, July 2019).

1. Introduction: Mission, Priorities, Values, and Scope of Services

1.1. Introduction

The South Carolina Department of Mental Health (SCDMH) has been operating as an independent agency of state government since 1964. Today, with a network of 16 Mental Health Centers (MHCs) and their 44 satellite clinics covering 46 counties in SC; three licensed hospitals, including one for addiction treatment; two nursing homes; a Forensics program; and a Sexually Violent Predator Treatment Program, the SCDMH is one of the largest systems of care in SC.

1.2. Mission Statement

The mission of the Department is to "support the recovery of people with mental illnesses" through community-based services and the implementation of evidence-based and evidence-informed practices in the SCDMH system of care. As such, the Department is responsible for monitoring and guiding the overall integrity of its facilities on behalf of the citizens it serves.

1.3. Priorities

The SC Department of Mental Health gives priority to adults, children, and their families affected by serious mental illnesses and serious emotional disturbance. SCDMH is committed to eliminating stigma and promoting recovery, achieving our goals in collaboration with all stakeholders, and assuring the highest quality of culturally competent services.

1.4. Values

Respect for the Individual
Each person who receives SCDMH's services will be treated with respect and dignity and will be a partner in achieving recovery. SCDMH is committed to services that:

1.4.1. honor the rights, wishes, and needs of each individual;
1.4.2. promote each individual's quality of life;
1.4.3. focus on each individual's strengths in the context of the individual's culture;
1.4.4. foster independence and recovery;
1.4.5. demonstrate the value of family inclusion and the benefits of strong family support.

Support for Local Care
SCDMH believes that people are best served in or near their own homes or the community of their choice. SCDMH commits to the availability of a full and flexible array of coordinated services across the state, and to services that are provided in a healthy environment. SCDMH provides services that build upon critical local supports: family, friends, faith communities, healthcare providers, and other community services such as employment, learning, and leisure pursuits.

Commitment to Quality
SCDMH is committed to providing quality care for its patients by carefully identifying their needs and providing person-centered care. Therefore, SCDMH seeks to align the objectives of the organization with the needs of its patients. The Department will provide treatment environments that are safe and therapeutic, and work environments which inspire and promote innovation. SCDMH hires, trains, supports, and retains staff who are culturally competent, committed to the recovery philosophy, and value continuous learning. SCDMH provides services efficiently and effectively and strives to provide evidence-based and evidence-informed interventions.

Dedication to Improved Public Awareness and Knowledge
People with mental illnesses, trauma victims, and others who experience severe emotional distress are often misunderstood and stigmatized. Therefore, SCDMH has built formal partnerships with the state's educational institutions, including both K-12 and institutions of higher learning, to enhance curriculum content on mental health. SCDMH works with employers, sister state agencies, and public media to combat prejudice about mental illnesses.

1.5. Scope of Services

Each year, approximately 100,000 adults with severe and persistent mental illness and children with serious emotional disturbance receive services at Department facilities. Approximately 10,000 patients receive services from any of the inpatient facilities including treatment for addiction, general adult and forensic psychiatry, and children and adolescents, in addition to Long Term Nursing Care. Mental Health Centers serve approximately 90,000 patients through their clinics, detention centers, hospital emergency departments, primary care clinics, residential facilities, mobile clinics, and other sites in the community.

2. Leadership and Management

2.1. Agency Responsibilities

SCDMH is the designated State Mental Health Authority for purposes of administering federal and state funds under §44-9-70 of the 1976 South Carolina Code of Laws as amended. Additionally, the SCDMH is charged to "administer minimum standards and requirements for mental health clinics as conditions for participation in Federal-State grants-in-aid ..." §44-15 of this same law prescribes how community mental health programs are established in order to be eligible for federal and state funding.

The SCDMH is further instructed to "Promulgate rules and regulations governing the eligibility of community mental health programs to receive State grants, prescribing standards for qualification of personnel and quality of professional service and for in-service training and educational leave programs for personnel..." (§44-15-80 1976 South Carolina Code of Laws as amended). SCDMH fulfills these responsibilities, in part, through establishing standards of practice and monitoring the clinical and administrative integrity of the services and operations of its facilities, programs, and services.

SCDMH is subject to a complex mix of laws, policies, guidelines, regulations, and standards promulgated by federal and state funding, licensing bodies, third party payers' regulations and standards and national accreditation bodies. The psychiatric inpatient facilities are accredited by The Joint Commission (TJC). The two nursing homes are Centers for Medicare & Medicaid Services (CMS) certified. The addiction treatment center (inpatient facility) and the 16 Mental Health Centers are accredited by the Commission on the Accreditation of Rehabilitation Facilities (CARF).

SCDMH's quality improvement process identifies standards and utilizes protocols to promote compliance and monitor the quality of services according to the requirements of these diverse regulatory and accrediting bodies. SCDMH leadership is responsible for identifying quality measurements and ensuring that Quality Improvement Plans improve the effectiveness and efficiency of its operations and care. The methods used to assess and assure system integrity and the delivery of quality care include audits, site visits, periodic review of key operations, input from patients, training and education of providers as deemed necessary and appropriate.

2.2. Management Commitment

SCDMH has an internal organizational commitment to quality, program assessment, monitoring, and improvement. Therefore, each SCDMH facility designates a local Quality Improvement or Quality Assurance professional to operationalize this plan and is responsible for the following:

2.2.1. promoting evidence-based and evidence-informed clinical practices
2.2.2. assessing the quality of care rendered using key performance indicators
2.2.3. recommending specific quality improvement strategies based on identified needs
2.2.4. ensuring conformance with policies, procedures, and regulations of third-party payers; and
2.2.5. safeguarding against unnecessary or inappropriate utilization of care and services.

2.3. SCDMH - Organizational Structure

The SCDMH Offices of Organizational Improvement and Quality Management collaboratively coordinate statewide quality improvement activities under the direct supervision of the SCDMH Medical Director.

The Quality Management Advisory Committee (QMAC) was established by the SCDMH State Director in 2006 to address the challenges and opportunities for improving the efficiency and effectiveness of the Department's compliance program. Over time, QMAC began to broaden its focus and now routinely identifies opportunities for improvement in the delivery of services. QMAC is comprised of members of the highest level of management of the Department, including the State Director, Deputy of Community Mental Health Services, key leaders of inpatient facilities, Deputy Director of Administrative Services, Medical Director, Director of Organizational Improvement, Director of Quality Management and Compliance, Director of Information Technology, and select MHC Directors. This body advises the State Director and the Director of Organizational Improvement on issues and opportunities pertaining to the delivery of quality services and organizational improvement.

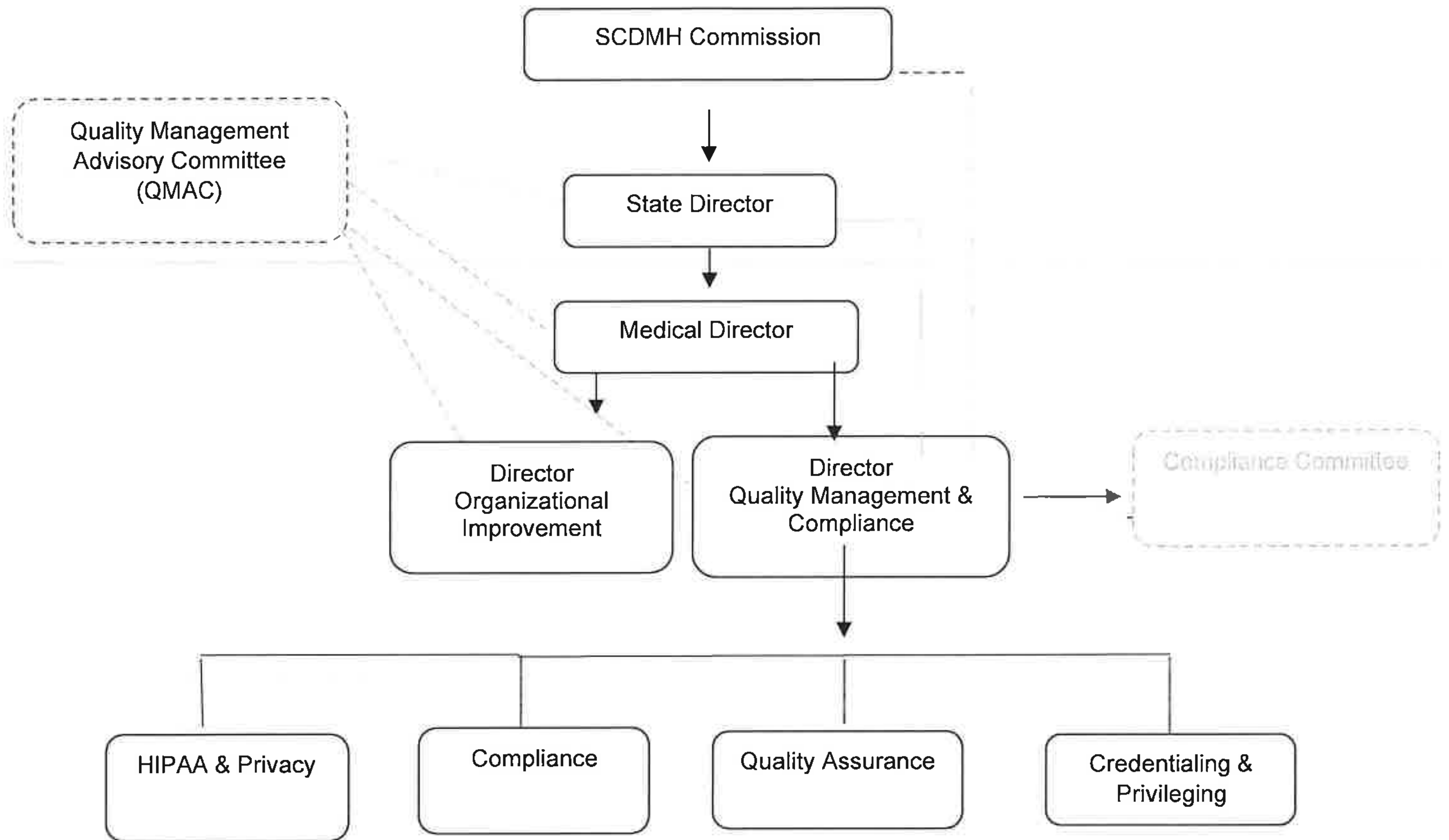
The Director of Organizational Improvement manages and coordinates agency wide efforts to assure that organizational improvement projects are managed as directed by SCDMH Senior Management and QMAC and assures that quality improvement initiatives are focused and aligned on improving operational, administrative, clinical efficiencies, and effectiveness.

The Director of Quality Management and Compliance reports to the State Director on matters of compliance and provides oversight to all quality assurance and compliance activities, including Quality Assurance Audits, Community Credentialing and Privileging, and HIPAA Privacy and Confidentiality.

The Director of the Office of Quality Assurance is responsible for coordinating and conducting audits of all facilities and provides consultation to the facilities regarding ways to improve documentation and compliance performance. The Director of the Office of Quality Assurance also serves as the liaison between the Department and the Commission on the Accreditation of Rehabilitation Facilities (CARF).

The Director of Credentialing and Privileging is responsible for coordinating all activities to ensure the accurate credentialing and privileging of all clinical staff of the Mental Health Centers, as well as programs such as Transitions and Clinical Care Coordination. This office is responsible for ensuring that all clinical staff employed by the SCDMH are appropriately credentialed to perform clinical activities at the Mental Health Centers and are appropriately trained and competent to deliver quality services. The credentialing and privileging of providers in the inpatient facilities is conducted within each facility. For example, Morris Village addiction treatment center credentials and privileges providers on an ongoing basis.

Structural Organizational Chart



2.4. Responsibilities of the SCDMH Quality Assurance Office

The Office of Quality Assurance is responsible for promoting MHC and facilities' compliance with the following QA requirements:

- 2.4.1 Establishes methods and procedures to ensure that services provided are of the highest quality.
- 2.4.1. Systematically monitors performance against established standards for practice and implements actions for improvements as needed to ensure that service delivery is appropriate and meets the needs of patients.
- 2.4.2. Audits DMH MHCs for compliance, primarily with billing rules and standards.
  - 2.4.2.1. The SCDMH QA Team conducts routine Quality Assurance and Utilization Review audits on an 18-month calendar cycle at minimum, as well as focused and desk audits to assure that facilities are in compliance with payers, accreditation, credentialing, and privileging, and SCDMH standards of Quality Assurance and Compliance.
- 2.4.3. Makes training available to staff regarding the delivery of high-quality mental health services.
- 2.4.4. Coordinates, supervises, provides necessary guidance, and facilitates the implementation, development, and monitoring of requirements contained in third-party payer's manuals as applicable to the operations of the particular facility.

2.4.5. The Quality Assurance (QA) Team is available to all facilities and programs for consultation about the development of programs, quality of care, and billing issues at their request. A QA liaison is assigned to each Center and Facility to act as their primary point of contact for compliance and quality related needs.

2.4.6. Training directly related to conformance with the SCDMH/SCDHHS contract and third-party payers is provided on a regular basis and as needed to assure the understanding of the staff and their conformance with service description and utilization. Training to enhance clinical skills is also offered as needs arise, based on audit findings, or at the request of the Centers and Facilities.

2.4.7. Approval of Forms - All clinical forms to be included in the medical record will be submitted to the Director of the SCDMH Quality Management or his/her designee for review and approval. Close collaboration may be necessary among the Director of this Division, the Director of Quality Assurance and the identified staff of the Division of Information Technology who manage the electronic medical records.

3. Quality Improvement Principles

The SCDMH encourages the implementation of a Quality Improvement Process to help promote the effectiveness and efficacy of clinical and administrative practices that affect patient care. SCDMH approach to quality improvement is based on the following principles:

3.1. Customer Focus. High quality organizations focus on their internal and external customers and on meeting or exceeding needs and expectations.

3.2. Recovery-oriented. Services are characterized by a commitment to promoting and preserving wellness and to expanding choice. This approach promotes maximum flexibility and choice to meet individually defined goals and supports person-centered services.

3.3. Employee Empowerment. Effective programs involve people at all levels of the organization in improving quality.

3.4. Leadership Involvement. Support of quality improvement activities by senior leadership is key to performance improvement. The involvement of organizational leadership ensures that quality improvement initiatives are consistent with the agency's mission and strategic plan.

3.5. Data Informed Practice. Successful Quality Improvement (QI) processes create feedback loops, using data to inform practice, benchmark progress, and measure results.

3.6. Statistical Tools. For continuous improvement of care, tools and methods are available that provide actionable, data-driven insights. Continuous Quality Improvement (QI) organizations use a defined set of analytic tools such as run charts, cause and effect diagrams, flowcharts, Pareto charts, histograms, and control charts to turn data into information. See Appendix B, Quality Improvement Tools.

3.7. Continuous Improvement. A process for creating an environment in which management and employees work together to constantly improve quality. Small incremental changes make an impact, and organizations can usually find opportunities to improve systems and practices.

4. Performance Measurement

Performance measurement is the process of regularly assessing the results produced by programs and services. It involves identifying processes, systems and outcomes that are integral to the performance of the service delivery system. Measurement includes selecting indicators of these processes, systems, and outcomes, and analyzing information related to these indicators on a regular basis. Continuous Quality Improvement involves utilizing data analysis and identifying specific opportunities for improvement.

SCDMH Senior Management and the Quality Management Advisory Committee (QMAC) identify goals and define key performance measurements for reporting. Progress reported in meeting these goals and related data analysis are important parts of the evaluation of quality improvement activities.

4.1. Ongoing and Long-Term Goals for SCDMH

The following are key ongoing and long-term goals for SCDMH:

4.1.1. Implement quantitative measurement to assess key processes and/or outcomes
4.1.2. Bring leadership, managers, and staff together to review quantitative data
4.1.3. Prioritize identified problems and set goals for their resolution
4.1.4. Achieve measurable improvement in the highest priority areas
4.1.5. Meet internal and external reporting requirements
4.1.6. Provide education and training to all employees
4.1.7. Develop or adopt necessary tools, such as practice guidelines, satisfaction surveys, and quality indicators.

4.2. Inpatient and Community Program Performance Measures

The following have been identified as key performance measures for both inpatient facilities and Mental Health Centers:

4.2.1. Number of Centers and Facilities that maintain uninterrupted DHEC licensure, CMS certification, Joint Commission accreditation or CARF accreditation, as applicable.
4.2.2. Percentage of credentialing files accurately completed
4.2.3. Percentage of patients and their families (youth) reporting satisfaction on a satisfaction survey (annually)
4.2.4. Reduction of wait time and waiting lists for Forensic services
4.2.5. Transition Services
4.2.5.1. Percentage of referrals to Transition Specialists screened within three days of referral
4.2.5.2. Average outpatient appointment date offered within three business days of inpatient discharge
4.2.5.3. Percentage of follow up within five days post inpatient discharge.

4.3. Mental Health Center Performance Measures

The following have been identified as key performance measures for Mental Health Centers:

4.3.1. Percentage of licensed clinicians, increase by 10% over prior fiscal year
4.3.2. Percentage of audited patient records that support patients' progress toward the achievement of treatment goals based on DLA-20 scores.
4.3.3. Percentage of patients assigned level of care within 60 days of admission
4.3.4. Primary Care Integration
4.3.4.1. Number of MHCs partnering with other agencies that provide primary care
4.3.4.2. Explore development of a data system for capturing primary care services provided to DMH patients
4.3.5. Treatment of Depression
4.3.5.1. Percentage of active patients with a depression-related diagnosis and a documented Patient Health Questionnaire (PHQ-9) score within the last 6 months.

4.4. Treatment of Psychotic Disorders Related to Schizophrenia
4.4.1.1. Percentage of active patients in treatment for Schizophrenia and related disorders with Long-Acting Injectable Medications (LAI).
4.4.1.2. Percentage of active patients in treatment of Schizophrenia and related disorders with Long-Acting Injectable medications (LAI) among

young adults (ages 18 – 21).

4.5. Mental Health Center HEDIS Performance Measures

The following measures are among the Healthcare Effectiveness Data and Information Set (HEDIS) tool that is used by more than 90% of America's health plans measuring performance on important dimensions of care. SCDMH uses the following behavioral health measures as quality initiatives:

- 4.5.1. Follow-Up Care for Children Prescribed ADHD Medications
- 4.5.2. Follow-Up After Hospitalization for Mental Illness
- 4.5.3. Antidepressant Medication Management
- 4.5.4. Metabolic Monitoring for Children/Adolescents on Antipsychotics
- 4.5.5. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

4.6. Inpatient Facility Performance Measures

The following have been identified as key performance measures for Inpatient Hospital programs:

- 4.6.1. Seclusion hours equal to or less than target range/value of psychiatric hospitals reporting core measures data to the National Research Institute (NRI), at (nri-inc.org) in accordance with The Joint Commission (TJC) and CMS performance measurement requirements.
- 4.6.2. Restraint hours equal to or less than target range/value of psychiatric hospitals reporting core measures data to NRI to meet TJC and CMS performance measurement requirements.
- 4.6.3. Percentage of patients assessed for psychological trauma; patient strengths; history of substance abuse is equal to or above the target range/value of psychiatric hospitals reporting core measures data to NRI to meet TJC and CMS performance measurement requirements.
- 4.6.4. Percentage of assessments compliant with timeliness, completeness, and support of medical necessity. (Per CMS Local Coverage Determination (LCD), the following assessments are monitored: History & Physical Exam; Physician Assessment; Nursing Assessment; Social Work Assessment; Activity Therapy Assessment; Psychology Assessment; Master Treatment Plan)

4.7. Long Term Care Key Performance Measures

The following have been identified as key performance measures for the Long Term Care programs:

- 4.7.1. Percentage of long stay residents with pressure ulcer/injury will be similar to or lower than the average percentage for the nation.
- 4.7.2. Percentage of Long Stay Residents experiencing one or more falls with major injury will be similar to or lower than the average percentage for the state.

4.8. Data Collection Strategy, Analysis, and Dissemination

The performance of SCDMH facilities may be measured using available data regarding structural, process, and outcome indicators. Quality Improvement tools (See Appendix B) may be used in the gathering and presentation of data. Data will be reported at least on an annual basis unless otherwise specified.

Data will be analyzed and aggregated to reflect trends, strengths, and opportunities for improvement. Each Facility will establish a system for regular reporting and review as defined by local Quality Improvement Plans or Procedures which may include reporting to:

- 4.8.1. SCDMH Mental Health Commission
- 4.8.2. SCDMH Quality Management Advisory Committee (QMAC)
- 4.8.3. Mental Health Center and Inpatient Facility Directors

4.8.4. Board of Directors, Mental Health Centers
4.8.5. Inpatient Governing Body
4.8.6. Facility Quality Improvement Committees
4.8.7. Facility Safety or Risk Management Committees

4.9. Quality Improvement Methodologies

Once the performance of a selected process has been measured, assessed, and analyzed, the information gathered on the above performance indicator(s) is used to identify a continuous quality improvement initiative to be undertaken. The purpose of an initiative is to improve the performance of existing services or to design new ones. Various quality improvement models may be applied such as:

4.9.1. PDCA (Plan Do Check Act)
4.9.2. PDSA (Plan Do Study Act)

PDCA (Plan Do Check Act), used by the American Association of Quality, is encouraged as a model strategy for improvement applying the following steps:

Plan - The first step involves identifying preliminary opportunities for improvement. The focus is to analyze data to identify concerns and to determine anticipated outcomes. Ideas for improving processes are identified. Affected staff or people served are identified, data compiled, and solutions proposed.

Do - This step involves using the proposed solution, and if it proves successful, as determined through measuring and assessing, implementing the solution usually on a trial basis as a new part of the process.

Check - At this stage, data is again collected to compare the results of the new process with those of the previous one.

Act - This stage involves making the changes a routine part of the targeted activity. It also means "Acting" to involve others (other staff, program components or consumers) - those who will be affected by the changes, those whose cooperation is needed to implement the changes on a larger scale, and those who may benefit from what has been learned. Finally, it means documenting, reporting findings and following up.

4.10. Organizational Improvement Project Teams

Organizational Improvement Project teams are encouraged and may be charged with carrying out quality improvement efforts. To be effective, the team should include individuals representing the areas that will be affected by the proposed improvement. The teams may use a variety of quality improvement approaches and tools, identify areas in need of improvement, review performance data, develop improvement plans, and monitor improvement efforts. (See Appendix B)

5. Quality Assurance Auditing Activities

5.1. SCDMH QA Audits – Scope

Each SCDMH facility will designate a local Quality Assurance Coordinator to direct Quality Assurance reviews. Audits may be designed to meet accreditation or payor requirements. See Appendix A, Mental Health Centers Quality Assurance Plan, designed based on South Carolina Department of Health and Human Services requirements and for additional audit procedures.

Mental Health Centers will participate in Quality Assurance audits to determine appropriate utilization and compliance with standards of care.

The Quality Assurance process will include reviews of:

5.1.1. medical records
5.1.2. utilization management and review systems
5.1.3. privacy and protection of confidentiality
5.1.4. performance and outcome measures, as applicable and in accordance with standards and requirements
5.1.5. staff credentials

An expectation of ≥90% accuracy and timeliness of medical documentation has been determined for all facilities.

5.2. SCDMH Quality Assurance Team

The SCDMH QA Team has experience with third party payers, Compliance, HIPAA, outcomes, and accreditation standards and can provide the necessary consultation to the Centers. The Director of Quality Assurance and staff will have experience providing clinical services or should meet all the requirements to be credentialed to provide clinical services.

All auditors are expected to uphold the highest standards of ethical behavior. Auditors will assure confidentiality of the records, documents, and findings and not share these with other Mental Health Centers or Facilities, unless it is information related to best practices that will enhance the practices of other Mental Health Centers and Facilities. Specialized staff may be added to the team by the SCDMH Director of QA when there is a question or issue requiring examination that can best be addressed by specialists from the areas in question.

6. Credentialing and Privileging of Service Providers

6.1 Provider Qualifications

The SCDMH Office of Credentialing and Privileging is responsible for credentialing all staff providing direct or billable services in the Mental Health Centers and other outpatient programs such as the Office of Transition Services. The SCDMH centralized credentialing and privileging process follows the standards and criteria established by the National Committee for Quality Assurance (NCQA). These processes are equally applicable to both licensed and non-licensed staff employed by or contracted by SCDMH working at the different MHCs. SCDMH partners with an outside vendor to assist the Office of Credentialing and Privileging with management of the credentialing process. However, the SCDMH Medical Director and the SCDMH Credentialing Committee provide oversight and have decision making authority over outpatient credentialing practices. The committee meets monthly to review newly hired personnel and recredentialing files.

The SCDMH Office of Credentialing and Privileging is responsible for ensuring that only appropriately credentialed clinicians provide services in the MHCs. This Office works closely with the office of Human Resources since employment with the Department is contingent upon the individual being granted privileges based on training and competency. All clinicians are expected to deliver services within their scope of practice and in areas where privileges have been approved.

Credentials are reviewed every two years, and privileges are granted based on areas of competency and performance. For detailed information on the process of Credentialing and Privileging, refer to the SCDMH Credentialing and Privileging Policy.

Credentialing and privileging of SCDMH clinical staff working at the Inpatient Facilities will be privileged by each facility in accordance with their accreditation requirements. Credentialed staff are expected to

deliver services within their scope of practice and in areas where privileges have been approved in accordance with accreditation and regulatory requirements.

6.2 Medical Staff

The SCDMH MHCs and Inpatient Facilities will have adequate, qualified medical staff committed to the principle that the provision of high-quality services should be the overarching goal in the delivery of care and treatment to all patients diagnosed with mental, emotional, and/or addictive disorders. The SCDMH Office of Credentialing and Privileging is responsible for credentialing all medical staff in the Mental Health Centers. Credentialing and privileging of medical staff working at the Inpatient Facilities will be privileged by each facility in accordance with their respective accreditation requirements.

6.3 SCDMH QA Audits of Credentialing & Privileging- Process and Methodology

6.3.1 Each quarter the QA auditors will perform a random review of the Credentialing files of clinical staff.
6.3.2 Auditors will access the files through the secured shared drive or vendor portal and will complete the audit tool for each of the files reviewed.
6.3.3 At the end of the audit, the auditor will share the findings with the Director of the Office of Credentialing and Privileging.
6.3.4 When a recurring deficiency is identified, the Director of the Office of Credentialing and Privileging will issue a Quality Improvement Plan to ensure process improvement.
6.3.5 Reports on audit findings will be communicated with the staff of the Office of Credentialing and Privileging and the SCDMH Credentialing Committee at their monthly meeting.

7. Training and Education

7.1. SCDMH encourages its clinical staff to seek the necessary training to maintain competency in their areas of practice. The training programs must be designed to provide continuous knowledge of evidence-based practices.

7.2. In addition, the SCDMH Office of Quality Assurance is responsible for providing training to the Department's clinical staff on third party payers' standards of care and requirements for service delivery.

8. Safety and Risk Management

SCDMH Office of Risk Management also uses the quality improvement process outlined in this plan. Quality improvement tools such as root cause analysis may be applied in responding to critical incidents, complaints, and grievances. Incident reporting and patient advocacy are managed through the Office of General Counsel. A designated representative from the Office of Quality Management and Compliance participates in the DMH Risk Management Review Committee.

9. Scheduled Evaluation

This plan is reviewed and updated as needed, whenever significant changes occur, at least every three years. The evaluation summarizes the goals, objectives, and the quality improvement activities conducted during the most recent review period. This evaluation may include the targeted processes, systems, outcomes, performance indicators, and associated findings. Evaluation information is used in reviewing and redefining SCDMH strategic initiatives and priorities for improvement.