

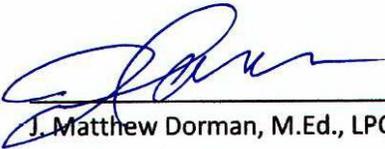
# Berkeley Community Mental Health Center Quality Improvement & Management Plan

July 2022—June 2025

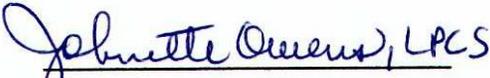


Approved by The Quality Improvement Team

May 2022

  
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J. Matthew Dorman, M.Ed., LPC  
Executive Director

4/21/2022  
Date

  
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Johnette Owens, LPCS  
Quality Improvement Director

4/21/2022  
Date

## Introduction

Berkeley Community Mental Health Center is responsible for promoting the development of a mental health system that maximizes the quality of life of each client. Furthermore, it is the policy of the Center to deliver services to clients in the least restrictive manner possible.

Berkeley Community Mental Health Center is committed to developing and maintaining the highest possible quality of care. It is the intent of the Board of Directors that this policy shall be implemented through careful adherence to appropriate standards, statutes, rules, regulations and ethics. Berkeley Community Mental Health Center is responsible for the operation of a Quality Improvement and Management Program that strives to monitor, protect, and enhance the quality of client care offered by the staff of the facility.

Berkeley Community Mental Health Center attempts to fulfill its mission to the clients, staff, and community. The organization's leaders, managers, clinical support staff, clinical staff, medical staff, nursing staff, and support staff are committed to plan, design, measure, assess, and improve performance and processes as part of the approach to fulfill the mission.

As part of this commitment, the Written Plan for Quality Improvement and Management at Berkeley Community Mental Health Center has been established and modified as determined by the annual review.

This plan is designed to provide a consistent process for improving the care provided, improve satisfaction of our clients, compare performance against benchmarks, reduce inefficiencies, effect change harmoniously, and conserve resources. Quality Improvement activity crosses all departments and services in order to respond to the needs of the client, staff, and community. Included in this system is the management of information which includes client specific, aggregate, and comparative data. In order to conserve resources, Quality Improvement and Management focuses on high risk, high volume, problem-prone, and regulatory required issues. Both outcomes and processes are included in the overall approach.

The continuous Quality Improvement process is a total facility approach. The program knows no boundaries. It crosses all functions, departments, employees, and it focuses on incremental improvements and long-term gains.

## Authority

The Quality Improvement Program is established by the Executive Staff of the Berkeley Community Mental Health Center. Quality Improvement initiatives are implemented by the Quality Improvement Team, a standing committee of professional and clinical support staff, headed by the Quality Improvement Director. The Quality Improvement Director is appointed by the Executive Director and is responsible for communication, coordination and dissemination of pertinent information to adjunct team members, chairs and other appropriate personnel.

## Purpose

Quality Improvement and Management activities at Berkeley Community Mental Health Center are developed to ensure that this Center meets its responsibilities to clients, staff, and the community. Activities are designed to meet the following objectives:

- To assure that services rendered are within acceptable standards of practice.
- To provide a means whereby client care meets the highest possible standards within a clean, safe, and therapeutic environment.
- To promote efficient and effective services.
- To assure that the clinical and clinical support staff objectively and systematically monitor and evaluate the quality and appropriateness of important aspects of care and services on an ongoing basis.
- To assure that as problems or opportunities to improve care and services are identified, appropriate action is taken and follow-up occurs, resulting in problem resolution and improved care and services.
- To provide mechanisms for assuring accountability of each clinical staff member for the care they provide.
- To provide ongoing review and revision of the Quality Improvement and Management program.
- To minimize risks within the Center through the development and implementation of risk management activities.
- To provide annual evaluation and revision as appropriate to the Quality Improvement and Management Program.

## Organization

The Quality Improvement and Management Program is composed of the following committees:

- Executive Council
- Quality Improvement Team
- Safety and Risk Management Committee
- Ad hoc Utilization Management Committee
- Physician Peer Review Team
- Cultural Diversity, Equity, and Inclusion Committee
- Corporate Compliance Committee
- Ad hoc Credentialing & Privileging Committee

The Quality Improvement Programs Director is responsible for the coordination and integration of the Quality Improvement activities within Berkeley Community Mental Health Center and serves as a liaison among programs and other committees/workgroups. Supervisors within the Center are responsible for implementing an ongoing system to monitor and evaluate the quality and appropriateness of client care and services. The system encompasses the scope of care and services provided within each program. The Quality Improvement Director shall recommend specific responses and time frames for action to its findings and shall assess the effectiveness and efficiency of such actions after their implementation.

### Executive Council

#### *Membership:*

Executive Director  
Medical Director  
Director of Administrative Services  
Director of Accounts Payable & Receivable  
Director of Quality Improvement

Director of Clinical Services  
Human Resources Coordinator  
Manager of Emergency & Forensics services  
Manager of Special Operations  
Manager of School-Based Services

Executive Council members are selected and assigned by the Executive Director. Executive Council meetings are held at least monthly.

*Scope:*

- Implementation of SCDMH Directives.
- Approves and directs implementation of agency policies and operational procedures.
- Ensures that client care and services meet all state, federal, regulatory and accreditation standards.
- Identify staff development needs.

Quality Improvement Team

*Membership:*

QI Director  
Customer Service Supervisor  
Cultural Diversity Chair  
Peer Support Specialist  
Adult Services Representative  
Access/Mobile Crisis Representative  
Nursing Representative

Clinical Support Representative  
School Based Representative  
Outreach Representative  
Care Coordinator  
CAF Representative  
Care Coordination Representative  
Member At-Large

The Quality Improvement Team is a standing committee composed of staff members who represent key elements of the Center. Team members are selected and assigned by the Executive Director and serve for at least two years. Selection is based on the needs of the Center, and strengths, knowledge, abilities, and skills of individual staff members. All staff members have the opportunity to participate as a team member based on the needs of the QI Team and the Center. Other individuals may be asked to attend particular meetings based on the needs of the team. Clients are represented through standing agenda item of "Client Suggestions" as well as the Peer Support Specialist being a member of the Peer Advisory Board. Quality Improvement Team meetings are held at least monthly.

*Scope:*

- Planning, prioritizing, strategy development, monitoring, educating, and promoting the acquisition and application of the knowledge necessary for improvement of Quality
- Initiate and make recommendations to performance improvement workgroups chosen to address specific opportunities for improvement and ensure adequate resources to facilitate effective workgroups
- Areas for which workgroups may be initiated:

- Client satisfaction
- Clinical Outcome/Effectiveness
- Development of Clinical Practice Guidelines
- Other projects or areas as determined appropriate
- To identify and reduce structural barriers to the quality improvement process
- Facilitate smooth and consistent operation among center functions. Work groups will encourage participation of staff from all levels in the organization.
- Quality Improvement or project teams may be utilized to facilitate and assess progress towards goals and objectives, specified in the Agency Strategic Plan
- Review and evaluate program goals and objectives to ensure coordination with the overall philosophy and purpose of each program
- Review, monitor and evaluate short- and long-term outcomes within each program, as well as center-wide
- Review, monitor and evaluate aspects of care dealing with the rights of the person served and client satisfaction
- Review, monitor and evaluate aspects of staff development and overall satisfaction

## Safety and Risk Management Committee

### *Membership:*

Safety Coordinator  
 Quality Improvement Director  
 Adverse Incident Report Coordinator  
 Facilities Manager  
 Peer Support Specialist  
 Nursing representative

A member from the Medical Staff may be appointed as an ad hoc member of the committee and will participate in committee deliberations as medical oversight and consultation is indicated. Client input about safety matters is provided via the Peer Support Specialist and his/her participation in the Client Advisory Board activities. Safety and Risk Management Committee meetings are held at least quarterly. The Quality Improvement Director is responsible for directing the implementation, monitoring, and evaluation of all adverse incidents within the Center.

### *Scope:*

The Safety and Risk Management Committee is responsible for investigating and reporting Risk Management issues. Adverse Incidents are investigated, evaluated, and reported on at least quarterly. Information garnered from Safety and Risk Management activities will be utilized to improve the accessibility, health, and safety of the community, clients, staff, and the Center as a whole. These functions and responsibilities are systematic and ongoing to include appropriate and timely responses for addressing areas of concern or deficiency.

A reportable incident is defined as any unusual occurrence outside of the normal activities of the facility. Incidents are reported whether they occur within the facility or on its grounds, or in other locations where the Center conducts its business. Examples of reportable incidents include, but are not limited to:

- Medication errors
- Use of seclusion or restraints
- Incidents involving injury or any medical emergency
- Communicable disease
- Infection Control
- Violence or aggression
- Use or possession of weapons
- Elopement and/or wandering
- Vehicular accidents
- Biohazardous accidents
- Unauthorized use or possession of licit or illicit substances
- Abuse and neglect
- Suicide or attempted suicide
- Other sentinel events

In addition to investigating critical incidents for tracking as defined above, certain major incidents of a more urgent nature may be referred for a Quality of Care Review Board (QCRB) in accordance with the Berkeley Community Mental Health Center Policy and Procedures for Quality of Care Review Boards (BCMHC Policy S057). The Executive Director may appoint a QCRB to respond to incidents such as:

- Homicide involving a client, staff or visitor
- Suicide of an active client or staff member
- Major injuries to clients, visitors or staff
- Any other significant event at the discretion of the Executive Director

The goals of the Safety and Risk Management Committee include:

- To assure implementation of a center-wide safety program which includes development of policy and procedures and subsequent staff training relating to fire safety, disaster preparedness, hazard reporting, etc.
- To assure tracking and documentation system for all incidents, including follow up and implementation of any corrective action until follow up is no longer indicated
- To review safety and incident related data and to identify trends and patterns associated with risks or to identify problem areas
- To conduct root cause analysis on incidents as appropriate
- To provide thorough investigation on all sentinel events
- To promote quality improvement through identifying opportunities for maximizing the safety of the physical and therapeutic environments of the Center and reducing Center, staff, and client risks

Utilization Management Committee (ad hoc)

*Membership:*

Quality Improvement Director  
Utilization Management Coordinator

Nursing representative  
Clinical representative

A member from the Medical Staff may be appointed as a member of the committee and will participate in committee deliberations as medical oversight and consultation as indicated. Meetings are based on the needs of the Center, and the strengths, knowledge, abilities, and skills of individual staff members. The Utilization Management Committee is an ad hoc committee that meets as needed for project reviews at the direction of the Executive Director.

*Scope:*

- Directs the implementation, monitoring, and evaluation of trends and patterns pertaining to Utilization Management within the Center.
- Employs various ongoing and systematic techniques related to specific aspects of care identified in the DMH Audit and Utilization Review Tool.

### Physician Peer Review Team

*Membership:*

Medical Director

Physicians of the Center

Nurse Practitioners of the Center

Nurses of the Center

Quality Improvement Director

Additional participants may be appointed as appropriate. Physician Peer Review Team is scheduled at least quarterly.

*Scope:*

- Physician Peer Review
- Approval and implementation of medical management related procedures
- Review/management of physician utilization

### Diversity, Equity & Inclusion Committee

*Membership:*

The Diversity, Equity & Inclusion Committee is composed of culturally diverse staff members among the clinical and clinical support areas throughout the Center. Committee members are selected and assigned by the Executive Director and serve for at least one year. The Cultural Diversity, Equity, and Inclusion Committee meets at least quarterly.

*Scope:*

- Evaluating, enhancing, and monitoring sensitivity to and competence in cultural diversity, equity and inclusion of staff and Center operations and procedures.
- Orientation of new Center employees to cultural sensitivity and competence.

- The activities of the Cultural Diversity, Equity, and Inclusion Committee include but are not limited to:
  - Evaluation of recruitment efforts
  - Staff training
  - Evaluation of written communications
  - Evaluation of physical environment

#### Corporate Compliance Committee

##### *Membership:*

Corporate Compliance Officer  
 Executive Director  
 Medical Director

A Corporate Compliance Committee shall be appointed by the Executive Director and shall be chaired by the Corporate Compliance Officer (CCO). Other knowledgeable persons who represent medical services, accounts receivable, financial, clinical, human resources, etc., as determined by the Executive Director may be included in the committee activities. The Committee shall meet no less than quarterly.

##### *Scope:*

- Advise center staff on and implement all aspects of Corporate Compliance Plan
- Examine existing standards and procedures, assess and determine alternative courses of action, and implement the necessary policies and procedures
- Quarterly reporting to DMH Corporate Compliance Office
- Design and implement a monitoring program consistent with Corporate Compliance Plan utilizing the DMH Audit Tool

#### ad Hoc Credentialing and Privileging Committee

##### *Membership:*

Staff of DMH Office of Credentialing & Privileging

##### *Ad hoc BCMHC Committee Membership:*

Executive Director  
 Medical Director  
 Clinic Director  
 Director of Human Resources  
 Quality Improvement Director

##### *Scope of DMH OCP:*

- Manages, organizes, communicates all credentialing and privileging activities for clinical and medical employees of DMH

- Reviews each employee's credentialing documentation and determines the services for which employees will be privileged
- Biennial re-credentialing of all staff

*Scope of BCMHC:*

- Assists the DMH OCP staff by ensuring new hire credentialing documentation is complete and accurate and submits to DMH OCP
- Meets as needed to review credentialing and privileging related issues and communicates findings to DMH OCP

## Scope of QI Plan

The scope of the Quality Improvement Program shall encompass all clinical services, clinical records review, utilization review, and review of safety/risk management data. Berkeley Community Mental Health Center's Quality Improvement Program focuses on the quality of care areas concerning the delivery and outcome direct and indirect clinical services. Admission and continued stay reviews are conducted according to admission and continued stay criteria established by the Center. The scope of Quality Improvement and Management activities also includes:

*Monitoring and Evaluation System*

- Medical Records Completeness Reviews
- Medical Records Quality of Care Reviews
- Medical Records Billing Audits
- Corporate Compliance Audits
- Utilization Review
- Clinical Outcome Review: including development, implementation, and report of efficiency and effectiveness measures within each service area
- Client Satisfaction Review
- Review of Service Data and Reports

*Records, Reports, and Dissemination*

All teams and committees integrated into Quality Improvement activities shall submit written data summaries relative to their respective areas on a quarterly basis. These summaries shall include all findings, recommendations, actions taken, results of action taken and any other relevant information as deemed appropriate. These summaries will be formally reviewed by Quality Improvement Team.

The Quality Improvement Director is responsible for communication, coordination, and dissemination of pertinent information to all team members, committee chairs, supervisors, and other appropriate personnel.

A written report of all pertinent Quality Improvement activities is prepared by the Quality Improvement Director and submitted to the Executive Director on a quarterly basis. The report is then submitted to SCDMH, Quality Assurance Division.

Committee chairpersons and/or project workgroup leaders will participate in presentation of summaries to the Board of Directors through written reports and participation in Board meetings when required.

## Objectives of Performance Improvement Activities

The Center has determined that a strong Quality Improvement Program with supplementation by performance improvement workgroups is the most effective use of current resources. The main emphasis is to improve the quality of the organization in fulfilling its mission and vision through addressing efficacy, appropriateness, availability, timeliness, continuity, safety, efficiency, respect and caring. These components include, but are not limited to:

- Enhancement of the performance improvement program from past experience
- Focus on efficiency of the processes and desired outcomes (benchmarking)
- Collaboration of activities
- Education/training on identified issues
- Use of improvement workgroups for complex issues

Performance improvement activities are part of the everyday duties of the Center staff. Berkeley Community Mental Health Center attempts to provide interdisciplinary improvement collaboration for the purpose of improving continuity of care and efficiency. When an individual's performance is questioned, evaluation and recommendation for action will be done through peer review, according to protocol and standards within appropriate clinical management procedures and Human Resources guidelines.

## Continuous Quality Improvement Model

The Executive Council and Quality Improvement Team provide direction for planning, strategy development, monitoring, educating and promoting the acquisition and application of the knowledge necessary for improvement of quality. This includes guidance to any special workgroups or task forces chosen to address specific opportunity for improvement.

Berkeley Community Mental Health Center employs a systematic approach for improving the organization's performance by improving existing processes. The departments/committees involved in the review of performance activity will make decisions on what improvement needs to be made.

### *Measurement*

Performance measurement will be continuously and consistently monitored. Monitoring will focus on client care processes and outcomes. The focus will include components of the process which will look at

performance coordination, integration, outcomes and improvement. A variety of analytical tools may be utilized to evaluate the total care provided. Data sources include but are not limited to:

- Medical Records
- Special studies
- External Reference Databases
- Incident Reports
- Statistics and historical patterns of performance
- Peer Review
- Monitoring results
- Client Satisfaction Questionnaire
- Safety Statistics
- Infection Control Data
- Referral sources
- Cost Analysis

Repeated measurement over time allows a focus on the process's stability or a particular outcome's predictability. All departments and committees will be responsible for gathering data on their performance which addresses the needs, expectations, and reaction of client and staff. Each service area gathers data on identified high risk, high volume, problem prone, and regulatory-required items as the major focus of their QI program.

#### *Improvement Cycle*

The following performance improvement cycle will be utilized in the development of project and departmental quality improvement activities:

- Planning: Identification of goals related to improving performance
- Design: Identification of processes, functions and service consistent with the organization's mission, vision, and plan
- Measurement:
  - Defining responsibility and scope of services
  - Defining and prioritizing internal and external customers
  - Defining critical aspects of performance and improvement (availability, efficiency, effectiveness, satisfaction, safety, respect and caring)
  - Defining indicators, goals or benchmarks
- Assessment: Collection of data essential to facilitate improvement
- Improvement: Establishing priorities for improvements and innovations

It is the intent of Berkeley Community Mental Health Center to be proactive in improving care and processes. Improvements to care and efficiency are the expected outcome of the QI program. The process and all activities are to support that intent.

#### *Assessing the Process*

Berkeley Community Mental Health Center has a systematic process for assessing the collected data in order to achieve quality care delivery that is available, timely, effective, continuous, safe, efficient, and caring. These measurements will look at the performance of the process over time and make comparisons to internal and/or external data sources as available and appropriate.

The following mechanisms are utilized for reviewing and assessing client care:

- Risk Management Reports
- Quality Improvement Reports such as Client Satisfaction and Clinical Outcome Reports.

- Recommendations of Committees or Project Teams
- Medical Records Audits as indicated

Evidence of assessment may be found in records of meetings, reports of assessment, conclusion and strategies, medical records documentation, as well as, education and training records.

## Methods

Each team member, coordinator, or supervisor has the responsibility to monitor, evaluate, and report on activities within their respective areas of responsibility. The method for conducting these Quality Improvement measures is a planned, systematic and ongoing process to thoroughly and consistently maintain and improve the overall quality of care and service provided, as well as to improve the organizational quality.

### *Monitoring*

The monitoring process is designed to identify patterns and/or trends in effectiveness and efficiency of care and service delivery, significant clinical events, Risk Management issues, Utilization Management issues, and outcomes of care and services.

### *Evaluation Process*

The evaluation process is designed to determine the presence or absence of an opportunity to improve an aspect of care, a problem in the quality and appropriateness of care, and to determine how to interpret, address, and resolve problem areas.

### *Aspects of Care*

Aspects of care are routinely identified, implemented, and measured based on critical areas of importance, both internal and external to the Center. They are further defined by their effect or impact on client, staff, and community, their frequency of occurrence, and risk areas to all those involved with the Center.

### *Indicators*

Indicators are routinely established to monitor specific criteria with each aspect of care. These are objectively measurable and based on current baseline data. These should reflect processes of care and services and/or outcomes of care and services.

### *Thresholds*

Thresholds should be established for each indicator to utilize for cutoffs to measurements and levels of acceptability.

### *Data Collection*

Data is collected and assimilated for each indicator at a minimum of quarterly, and monthly when feasible. Formal reports of the data and findings are compiled and formally presented quarterly.

### *Action Taken*

Results of data collection and recommendation for actions are routinely incorporated into the decision-making process of programs and governing authorities.

## Confidentiality

The deliberations and findings of the Quality Improvement and Management related committees or project teams are confidential in nature. Client-related information and staff-related findings follow the guidelines within the SCDMH Confidentiality Policy. Relevant staff-related information from Quality Improvement and Management activities are considered in renewal/revision of individual clinical privileges and the appraisal of non-clinically privileged staff members.

## Evaluation

The Quality Improvement Program is evaluated on an ongoing basis and overseen by the Leadership Council and QIT. All evaluation data will be incorporated in the Center's Annual Management Report which is prepared at the end of the year. The Management Report is sent to the Board of Directors via the Executive Director. The Quality Improvement and Management Plan is revised as needed based on activities as documented in the Annual Management Report.

## Appendix: Service Reports and Dissemination

### *Monthly:*

- Caseload Report
- Utilization Review Report of Caseloads
- No Show Reports
- Court Ordered/Probation and Parole Lists for review and update
- Productivity Reports for previous month
- Housing and Employment
- Incident Report Summary/Risk Management
- Financial/Risk Management Report
- Special Committees Reports as needed
- Personnel Update

### *Quarterly:*

- QA Audit Report for previous quarter
- Committee Reports (see QA/QI plan)
- Update for Strategic Plan Objectives
- Review of Ineligibles
- IPS Update
- Communication Mechanisms Review/Update
- Technology Report

### *Bi-annual:*

- Center-Wide Outcomes Report

### *Annual:*

- Risk Management
- Annual Management Report including Outcome Reports
- Update for Accessibility Plan
- After Hours Review
- Review of Program Plans

### *3 Years:*

- Accessibility Plan
- QA/QI Plan
- Strategic Plan