Quality Improvement Workplan FY 18/19

QUALITY IMPROVEMENT WORK PLAN (2018-2019)

About Monterey County

Monterey County is one of 58 counties in the state of California. The United States Census reported the 2010 Monterey county population to be estimated at 433,898. Covering 3,322 square miles, Monterey County is comprised of 12 incorporated cities, and is divided into the following regions: Monterey Peninsula (Monterey, Pacific Grove, Carmel-by-the-Sea, Carmel Valley, Seaside, Marina, Sand City, Del Rey Oaks and Pebble Beach); Big Sur; North County (Moss Landing, Prunedale and Castroville); and the Salinas Valley (Salinas, Soledad, Gonzales, Greenfield and King City). The economy is primarily based upon tourism and agriculture. The largest racial/ethnic group is Hispanic/Latino (57%) followed by White (31%). U.S. Census noted 20.3% of families with related children under 18 years of age lived in poverty (15.7% in 2010). The number of persons per household was 3.24 with a median household income of $58,582

Salinas is the largest city in the county. 40% of adults living in the city of Salinas do not have a high school diploma or General Education Diploma (GED); 30% of adults have less than 9th grade education (U.S. Census Bureau, 2009-2011).

Monterey County Behavioral Health

Monterey County Behavioral Health (MCBH) is organized into three geographic regions: Salinas Valley, Coastal Region, and South County. All regions provide services to children, adults, and older adults. While the growth in number of beneficiaries has increased tremendously in the last couple of years, engagement of Latino beneficiaries has been quite a challenge. With health equity vision in our mind, our main goal for the next 3 years is to increase the Latino beneficiaries by at least 7%. Also increasing are the number of services and programs offered to our clients. Hence, this fiscal year, our focus would be towards monitoring the program and evaluating their effectiveness, with a constant search for quality improvement projects.

Quality Management

Quality Management is a high priority in Monterey County. We value our community and the quality of service we provide. Quality Management is provided through a robust system comprised of multiple programs within our organization. Collectively, it is through these programs that we obtain information on quality of care, evaluation of current processes, and identification of areas for improvement. Using data to inform decision, we can make the necessary changes to meet the needs of our community. Quality Management ensures to meet all state, federal, and local level regulatory requirements.

Quality Improvement Work Plan

The goals identified in this work plan speak to our continuous quality improvement efforts to identify and meet the mental health and substance use disorder treatment needs of our

community. The goals described here are not intended to be all encompassing, but are important to our overarching quality improvement efforts for Fiscal Year 2018-2019 (July 2018-June 30, 2019). We have identified 8 Areas of focus, 14 Objectives, 29 Goals to address for this year with a health equity vision.

1. Area of Focus: Monitoring/Improving Access to Services

Objective 1.1: Monitor Distribution of Behavioral Health Services by type, number and geographic distribution

Goal 1.1: Quarterly review of all behavioral health program data by program value and health equity indicators such as Age, Gender, Race, Region, Diagnosis by Service Managers.
Intervention: Develop a process to automate the review process by QI staff through integration of data visualization tool with Avatar.
Measurement: Number of reviews completed in a year and trends detected, if any.
Baseline: Currently Access to Treatment program is reviewed monthly.

Goal 1.2: Quarterly review of current maps showing Behavioral Health services and Medi-Cal Eligible beneficiaries for all programs by QI
Intervention: (1) Collaborate with County GIS analyst to share advance ArcMap license
(2) Purchase required license for mapping drive-time analysis
Measurement: Number of Maps produced and trends detected if any.
Baseline: 12 Maps with drive-time analysis output were generated last quarter that included all behavioral health beneficiaries and service area of MCBH.

Objective 1.2: Implement DHCS Network Adequacy standards

Goal 1.3: Improve access to SUD services in the south county in accordance with Network Adequacy Policy by June 2019. Ensure all beneficiaries are located within Network Adequacy standards from their Mental Health Provider and SUD Providers
Intervention: Open one new SUD clinic for south county by December 2018
Measurement: Increase in number of SUD beneficiaries from south county
Baseline: All beneficiaries are located within 45 miles' radius from SMHS clinics within Monterey county. Lack of coverage area in the zip code 93451 for SUD services.

Objective 1.3: Timeliness of services

Goal 1.4: Obtain appointment for first offered routine request for BH service within county standards in 90% of requests for all regions of the county by Dec 2018, 95% by June 2019
Intervention: Implement and train Access to Treatment staff to complete first encounter form to track time from initial contact to first offered appointment and first accepted appointment, including no shows and cancellations.
Measurement: Number of first encounter forms completed every month.
Baseline: Currently, there is no system in place to track first offered and first accepted appointments

Goal 1.5: All beneficiaries to receive 7-day follow-up appointments after discharge from Mental Health Unit by June 2019
Intervention: Quarterly review of appointments following discharge from mental health unit data to identify trends, and address concerns if any.
Measurement: Percentage of Medi-Cal Beneficiaries and non-MediCal Beneficiaries receiving 7-day follow up appointment post-discharge from Mental Health Unit.
Baseline: 84% of Children Beneficiaries and 86% of Adult Beneficiaries received 7-day follow-up services post-discharge from MHU including TARs in FY 17/18.

Goal 1.6: Implement timeliness standards for each program by June 2019
Intervention: Develop a process in place to track timeliness standards quarterly, and identify trends in the data to inform QIC.
Measurement: Number of timeliness standards tracked by behavioral health
Baseline: Some of the Timeliness measures tracked currently:

1. Average time from admission to first assessment among beneficiaries: 4.8 days
2. Percentage of clients receiving first therapeutic services within 10 days of admission: 97.3%
3. No-show rates for psychiatric appointments: 21% in FY 17/18

Objective 1.4: Monitor access to after-hours care

Goal 1.7: Continue utilization review of real-time appointment finder for urgent appointment requests (361U) and evaluate its successful implementation.
Intervention: Review Monthly reports to track urgent services utilized in accordance with timeliness standard
Measurement: Number of clients who receive urgent services within 5 days from open episode where applicable in all four access to treatment clinics
Baseline: Percentage of clients receiving urgent appointments within 5 business days: 74% in FY17/18

Goal 1.8: To study the health equity predictors of new clients through mobile crisis intervention
Intervention: Review Monthly reports to track Crisis Interventions utilized in accordance with timeliness standard
Measurement: No. of clients who receive Crisis intervention services within 5 days from open episode where applicable in all four access to treatment clinics
Baseline: In FY16/17, there were 374 NMC MHU Clients who did not engage in out-patient services of which 8% were new clients. Their mean age was 38 years, 42% Female, 48% Hispanic/Latino vs 32% White. Almost half of the clients were from Salinas Valley region.

Goal 1.9: Test call reporting to provide information about how to access specialty mental health services to be no less than 80% during and after regular working hours by June 2019.
Intervention: Monitor responsiveness of 24-hour toll free line in providing information on how to access appropriate services
Baseline: 0 of 33 calls logged in 2017.

2. Area of Focus: Monitoring/Improving Delivery of Services and Capacity

Objective 2.1: Improve Penetration Rate by 7% in 3 years among Hispanic/Latino clients

Goal 2.10: Continue use of teletherapy and telemedicine services in the county to increase the number of clients served by 5% by the end of Dec 2019 and 10% by the end of June 2019.
Intervention: Continue to promote and review use of teletherapy and telemedicine services
Measurement: Percentage increase in number of individuals served in these programs
Baseline: Currently there are 50 clients in telemedicine program of which 44% belong to south county.

Goal 2.11: Encourage staff to use electronic health record to its full potential to improve service delivery and quality of services provided.
Intervention: Continue to inform staff regarding Avatar updates periodically and use of scheduling calendars to track appointments.
Measurement: Number of reports sent to staff regarding new forms/service codes or changes made in Avatar
Baseline: This will be tracked going forward

Objective 2.2: Improve service delivery

Goal 2.12: 30% increase in the number of text-messaging consents obtained to remind clients of upcoming medication support appointments.
Intervention: Continued efforts to obtain text-messaging consent to remind clients of upcoming medication support appointments
Measurement: 1. Number of text-messaging consent obtained by gender and race/ethnicity
2. Number of clients who received and responded to text messages

Baseline: In FY 17/18, 634 consents collected to remind clients of upcoming medication support appointments

Goal 2.13: Decrease no-show rate for medication support appointments to 15% by the end of Dec 2019 among TAY clients.
Intervention: Continue to implement Avanza-TAY PIP by providing incentives to youth who attend MD appointments
Measurement: Decrease in no show rate percentage to psychiatry appointment among TAY.
Baseline: Current no-show rates remain at 40% for TAY.

Goal 2.14: 90% Compliance rate among SUD providers by June 2019
Intervention: Continue monthly monitoring of data submissions for substance use disorder treatment programs; provide CalOMS and DATAR training; offer technical assistance
Measurement 2.4: Overall compliance rate among SUD providers
Baseline: In FY17/18, the overall compliance rate among SUD Providers was 80%- 75% for DATAR and 85% for CALOMS.

Objective 2.3: Improve service delivery capacity for LGBTQ Beneficiaries with Mental illness

Goal 2.15: Improve service delivery capacity for LGBTQ Beneficiaries with mental illness and/or substance use disorder through providing trainings to staff to improve skills for assessment and treatment of this population.
Intervention: Identification of training module and implementing annual training made mandatory to all staff.
Measurement: Percentage of clinical staff attending the training.
Baseline: Yet to implement the intervention

Objective 2.4: Reduce Hospital readmission rates

Goal 2.16: Reduce the number of clients receiving inpatient hospital services who are readmitted within 30 days to 10%
Intervention: Use of Urgent appointment to secure out-patient follow up appointment following a discharge from in-patient hospital
Measurement: Percentage of clients readmitted within 30-days.
Baseline: In FY 17/18, the hospital re-admission rates was 15% within 30 days from discharge.

3. Area of Focus: Crisis Intervention

Objective 3.1: Reduce the response time of 24-hour toll free Access Crisis

Goal 3.17: To reduce the response time of the Access line via the 24-hour toll free number by at least 10 percent by June 2019
Intervention: Measure the responsiveness of the 24-hour toll free number through call log and test calls. Training for access staff on issues identified by a process improvement process.
Measurement: Average response time to crisis calls
Baseline: Yet to be implemented

Objective 3.2: Beneficiary Wellness and Recovery progress

Goal 3.18: To reduce the number of Emergency, crisis, and in-patient services, including psychiatric hospital bed days. Continue to Monitor responsiveness to crisis intervention and Mobile crisis calls
Intervention: Develop a system to carefully track service outcomes associated with Mobile Crisis/ER Crisis Intervention Beneficiaries
Measurement: 1. Reduction in expensive health care services such as emergency room and in-patient services
2. Increased Client engagement and self-care resulting in reduced emergency and hospital admissions especially for ASOC program
Baseline: Total expenditure in FY 16/17 for ER Crisis, and in-patient services was $7,622,025.

4. Area of Focus: Cultural and Linguistic Services

Objective 4.1: Improve cultural humility and sensitivity within delivery system for mental health and substance use disorder services

Goal 4.19: All behavioral health staff to participate in cultural sensitivity/ humility training on a yearly basis
Intervention: 6-hour long Cultural Competency training would be made available to all staff multiple times a year
Measurement: Number of staff who participated and feedback received
Baseline: Yet to be implemented

Goal 4.20: Increase the number of Latino clients served in all regions by at least 5% by June'19
Intervention: Prioritize regions when hiring new staff; use of telehealth and telemedicine; maintain full time psychiatrists
Measurement: QIC to evaluate, quarterly
Baseline: Currently 76.46% of Beneficiaries from south county belong to Hispanic/Latino population compared to 49% in FY16/17.

5. Area of Focus: Beneficiary Satisfaction

Objective 5.1: Survey Beneficiary satisfaction

Goal 5.21: Complete a direct interview with a minimum of 200 Beneficiaries' contacted to complete a beneficiary satisfaction survey
Intervention: Direct face to face Verification of at least 1% of non-crisis intervention services delivered to clients/family by QI staff during the Fiscal year
Measurement: Number of calls attempted and number of Beneficiaries completing the survey
Baseline: Out of 96 calls attempted in FY 17/18, the response rate among beneficiaries was 27%

Objective 5.2: Evaluate Beneficiary grievances, appeals, and fair hearings

Goal 5.22: Continue to monitor and respond to grievances, appeals, expedited appeals, fair hearings, expedited fail hearing, provider appeals, and changes of clinician forms for mental health and substance use disorder services
Interventions: QI staff to address client concerns and adhere to problem resolution process;
Measurement: Respond to client concerns in accordance with problem resolution process, 100% of the time
Baseline: Items logged and protocol followed 100% of the time in FY 17/18.

Objective 5.3: Evaluate Change of Provider requests

Goal 5.23: Change of provider requests due to Dissatisfaction, without details of why the consumer was dissatisfied with the provider and/or service, to be less than 30% for both individual and organizational providers
Goal 5.24: Change of provider requests due to Individual Providers not responding to the consumer to be less than 20%
Intervention: Monitor and Evaluate change of provider request forms periodically, address concerns during QIC meeting.
Measurement: (1) Percentage of Beneficiaries who requested change of provider because of dissatisfaction in the service provided
(2) Percentage of Beneficiaries who requested change of provider because of inadequate/no response from providers
Baseline: Yet to be implemented

6. Area of Focus: Electronic Health Record (EHR)-Avatar

Goal 6.25: Ensure EHR is well maintained and accessible to all users
Intervention: Monitor system performance, promptly address issue to eliminate downtime
Measurement: 99% online time for Avatar system
Baseline: 99% online time

7. Area of Focus: Quality Improvement Committee (QIC)

Goal 7.26: Ensure policies are congruent with business practices for mental health and substance use disorder services
Intervention: Facilitate QIC meetings; update policies/ recommend policy decisions/ update policies to meet needs of client population and congruency with business practices
Measurement: 10- Monthly or 4 quarterly meetings per calendar year; QIC comprised of staff, community partners, clients, and advocates; policies are congruent with client care and business practices
Baseline: Total of 9 QIC meetings held in FY 17/18

8. Area of Focus: Utilization Management/Quality Improvement

Goal 8.27: Continue ongoing evaluation for medical necessity/appropriateness for level of care/efficiencies
Intervention: Review 85%-100% of mental health and 100% of substance use disorder services (SUD) program
Measurement: Programs reviewed at least annually
Baseline: In FY17/18, 59.4% of Mental Health Program and 100% of SUD Program were reviewed.

Intervention: Continue to support use of clinical supervision to support medical necessity criteria is met.
Measurement: Revamp UR tool to more accurately reflect clinical need and assessment of medical necessity criteria to be used by Supervisors/Mangers
Baseline: Implementation of use of Clinical Supervisory tool was started 1/19/17. From Jan to June 2017, there have been a total of 141 charts reviewed by Clinical Supervisors within MCBH.

Interventions: Continued monitoring of medication practices; MD consultant to review documentation and report back to QI and Medical Directors; MD and QI to provide training as necessary
Measurement: Practices meet prescribing standards
Baseline: FY16/17: 10% of every MD chart continued to be reviewed

Goal 8.28: Increase compliance with 72-hour documentation of services standard to support ongoing communication with other staff regarding client's treatment
Interventions: Training development under training academy to support staff in identification of ways to meet requirement
Measurement: 85% of progress notes will meet timeliness requirement
Baseline: Training through training academy in progress; QI to continue monitoring via UR process to support increase of compliance
Baseline: In FY 17/18, 77% of progress notes met timelines requirement.

Goal 8.29: QI to continue ongoing communication, support, and provide resources for staff and contracted partners

Interventions: Update/refine Clinical Documentation Guide at least annually
Measurement: Updated Clinical Documentation Guide will accurately reflect changing business practices

Intervention: Continue communication via QI monthly newsletter
Measurement: Sustain communication with staff

Interventions: Continue to update QI website content to ensure most up-to-date information is available
Measurement: Ongoing evaluation and updating of content

Interventions: Continue to improve communication between QI team and staff/ contracted partners to incorporate staff input in projects and system changes
Measurement: Continue QI participation staff meetings; provide information of upcoming changes and performance improvement efforts; receive and evaluate feedback; incorporate feedback into change process, when appropriate

Baseline Goal 8.29:	FY 17/18
Updates to Clinical Documentation Guide	1
Monthly QI Newsletter Distribution	8
Maintain QI Website up-to date	Ongoing
QI participation on team/program meetings with direct staff	Ongoing