FY 17/18

Quality Improvement Workplan

MONTEREY COUNTY BEHAVIORAL HEALTH

FISCAL YEAR 2017/2018

QUALITY IMPROVEMENT WORK PLAN (2017-2018)

About Monterey County

Monterey County is one of 58 counties in the state of California. The United States Census reported the 2010 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 (Marina, 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. During Fiscal Year 2016-2017 MCBH provided services to 11,960 consumers. The number of consumers served during Fiscal Year 2015-2016 was 10,482 (increase of 14%).

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. Through the use of data to inform decision, we are able to make the necessary changes to meet the needs of our community. Quality Management ensures to meet all state, federal, and local level regulatory requirements.

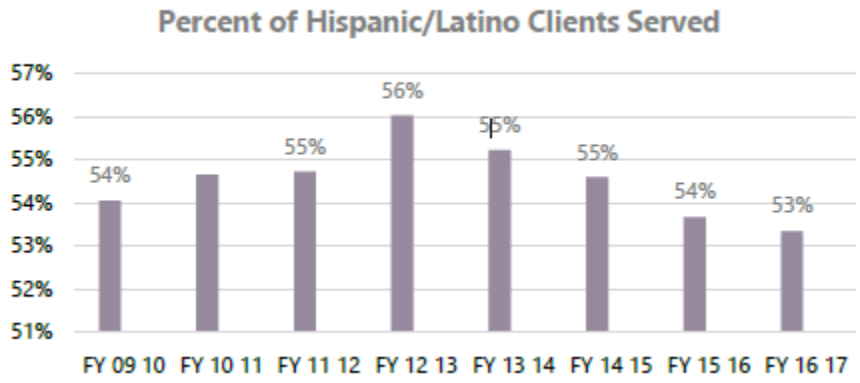
Quality Improvement Work Plan

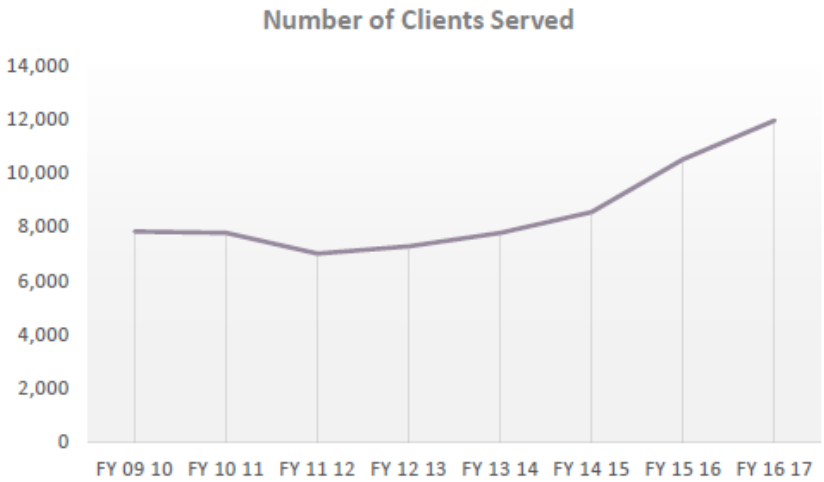
The goals identified in this work plan speak to our continuous quality improvement efforts to identify and meet the mental health and substance use disorder treatment needs of our community. The goals described here are not intended to be all encompassing, but are important to our overarching quality improvement efforts for Fiscal Year 2017-2018 (July 2017-June 30, 2018).

Evaluation of FY 16/17 QI Workplan

During FY16/17 we increased the overall number of individuals served by 14%. As the safety net provider, one significant area in which we strive to improve is to increase equitable distribution of services across all regions. A more equitable distribution of services would include, but not limited to, an increase in services provided to Hispanic/Latinos in our community. In FY 16/17, there was little change in the percentage of Hispanic/Latino clients served in our overall system of care but did see a 2% increase of services to Hispanic/Latinos in our South County region when compared to the prior fiscal year.

Behavioral Health Director, Amie Miller, along with stakeholders have established a goal increase equitable engagement of Latinos in mental health services by 7% in 3 years.





The FY 16/17 Workplan Evaluation can be found here: http://qi.mtyhd.org/wp-content/uploads/2014/09/QUALITY-IMPROVEMENT-WORKPLAN-Evaluation_FY-2016_2017.pdf

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

Goal: Improve timely access to care

Interventions 1.1: Develop a process to track requests for urgent appointments
Measurement 1.1: Develop and implement real-time appointment finder for urgent appointment requests (medication support and access to care evaluations)
Evaluation 1.1: Successful implementation of methodology (appointments available within 5 days of request)
Baseline 1.1: establish baseline

Intervention 1.2: Use of telemedicine to improve timeliness to mental health services
Measurement 1.2: Decrease wait times to receive medication support services
Evaluation 1.2: Telemedicine available in all service regions and wait times are decreased
Baseline 1.2:

Intervention 1.3: Continue to increase use of teletherapy to improve timeliness to mental health service
Measurement 1.3: Individuals served by this program
Evaluation 1.3: Increase number of individuals served
Baseline 1.3: 42 individuals served in all regions

Interventions 1.4: Appointments following discharge from mental health unit admission (when follow up care was warranted)
Measurement 1.4: 10% increase from baseline (appointments within 7 days from discharge)
Evaluation 1.4: Review data quarterly with leadership via QIC; identify trends and interventions to address concerns, when warranted

Baseline 1.4:	FY 15/16	FY 16/17
Adults	45%	42.5%
Children	38%	36.7%

Goal: Improve accessibility to care for determination of mental health and substance use disorder services

Intervention 1.5: Development and implementation of Call Center staffed by Social Workers (SW) to improve evaluation of need for services
Measurement 1.5: SW to answer 24/7 line and assess caller's needs
Evaluation 1.5: Successful implementation of use of Call Center

Baseline 1.5:	FY 15/16	FY 16/17
Number of clients opened to care	10,482	11,960 (14% increase)

Intervention 1.6: Identification and implementation of a level of care tool to determine the most appropriate level of care
Measurement 1.6: All individuals in Adult System of Care (ASOC) programs to receive evaluation based on the Reaching Recovery's Recovery Needs Level (RNL)
Evaluation 1.6: Evaluate RNL data to identify levels of care and work towards restructuring service delivery system to better meet the needs of individuals
Baseline 1.6: RNL's have been completed for all in individuals opened to an ASOC program

Interventions 1.7: Continue use of tracking referrals to/from Beacon; Work toward development of a contract with Beacon
Measurement 1.7: Increase number of clients referred and offered services through Beacon
Evaluation 1.7: Development of a contract and methodologies for referrals; Review of follow up care by Beacon

Baseline 1.7:	FY 15/16	FY16/17
	Develop methodology	186 referrals made

Intervention 1.8: Monitor 24/7 Call Line for mental health and substance use disorder services
Measure 1.8: 24/7 call line meets requirements for answering calls and referrals to appropriate interventions
Evaluation 1.8: QI Team to continue to conduct ongoing test call

Baseline 1.8:	FY 15/16	FY 16/17
	0 of 7 test calls logged	1/2017--6/2017 test calls logged: 0 of 33 (A "Call Center" is in the development phase. It was implemented on 8/28/17)

Interventions 1.9: Develop an improved methodology for authorization of services for mental health and substance use disorder services
Measurement 1.9: Evaluate effectiveness of authorization process; small-scale testing methodology
Evaluation 1.9: System-wide implementation of authorization program
Baseline 1.9: Obtain baseline

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

Goal Improving service delivery

Intervention 2.1: Evaluate outcomes data to examine if EBPs were used in treatment to support goal attainment for mental health and substance use disorder treatment services
Measurement 2.1: Clients with met or partially met treatment goals received services using EBPs when compared to those who did not attain goals.
Evaluation 2.1: Qualitative review of charts to examine data if clients with treatment goals met or partially met received EBPs as part of course of treatment when compared to those who did not meet treatment plan goals

Baseline 2.1:	FY15/16	FY 16/17
Partially/Fully Met Treatment Goals		
Overall System of Care	32%	32%
Access to Treatment	27%	24%
Adult System	13%	14%
Children's System	29%	27%
Substance Use Disorder	29%	30%

Interventions 2.2: Enhance use of follow-up protocol for no-show appointments for medication support
Measurement 2.2: System-wide use of follow-up protocols are followed
Evaluation 2.2: Consistent use of follow-up protocols for no-shows across the system

Baseline 2.2:	FY15/16	FY 16/17
	Inconsistent use of protocols	Continued efforts to obtain text-messaging consent to remind clients of upcoming medication support appointments; supporting staff received training on procedures to follow up

Measure 2.3: Monitor use of follow-up protocols
Evaluation 2.3: Decrease in no-show rates for medication support appointments

Baseline 2.3:	FY15/16	FY 16/17
	28%	21%

Interventions 2.4: Continue monthly monitoring of data submissions for substance use disorder treatment programs; provide CalOMS and DATAR training; offer technical assistance
Measurement 2.4: 5% overall non-compliance rate among SUD providers
Evaluation 2.4: QIC review of data, quarterly

Baseline 2.4:	FY15/16	FY 16/17
CalOMS		89.0%
DATAR		68.7%
Overall Compliance	32.8%	78.8%

3. Area of Focus: Crisis Intervention

Goal: Monitor and decrease inpatient hospital 7-day and 30-day readmissions rates for mental health services

Interventions 3.1: Develop and use of urgent appointment to secure outpatient follow up appointment following a discharge from an inpatient hospital
Measurement 3.1: Decrease number of re-hospitalization within 7 and 30 days of discharge
Evaluation 3.1: Review data, quarterly using Avatar report

Baseline 3.1:	FY 15/16	FY 16/167
Within 7-days from discharge	*81 (9%)	69 (7%)
Within 30-days from discharge	**229 (17.5%)	186 (14.6%)

* this number was previously reported as 437 (59%), which was incorrect. The correct number is 81 (9%) as shown above.
**this number was previously reported as 82 (11%), which was incorrect. The correct number is 229 (17.5%) as shown above.

4. Area of Focus: Cultural and Linguistic Services

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

Interventions 4.1: Identify trainings that incorporate cultural relevance and sensitivity to service delivery
Measurement 4.1: Identify one (1) trainings and encourage staff participation
Evaluation 4.1: All behavioral health staff to participate in cultural sensitivity/ humility training on a yearly basis
Baseline 4.1: obtain baseline

Goal: Improve health equity in for Latino population

Interventions 4.2: Prioritize regions when hiring new staff; use of telehealth and telemedicine; maintain full time psychiatrists;
Measurement 4.2: QIC to evaluate, quarterly
Evaluation 4.2: South County to see an increase in number of clients served by 1% using client served by region of residence data report in Avatar

Baseline 4.2:	FY 15/16	FY 16/17
Percentage of clients served by region	15%	17%
Percentage of Latinos served (overall service value)	49%	49%

5. Area of Focus: Beneficiary Satisfaction

Goal: Evaluate client/family satisfaction with services

Interventions 5.1: Identify a user-friendly consumer satisfaction survey
Measurement 5.1: Selection and implement satisfaction survey; use of data to inform decisions
Evaluation 5.1: Use survey; QIC to evaluate survey information, at least annually
Baseline 5.1:

General satisfaction of services "I like the services that I received"	Spring 2016	Spring 2017
Older Adults	88.9%	pending
Adults	95.7%	pending
Youth-- "Overall, I am satisfied with the services I received"	85.7%	pending
Youth Services for Families-- "Overall, I am satisfied with the services my child received"	83.5%	pending

* *Satisfaction Rates are calculated based on a percentage of clients who scored 3.5 or higher out of 5 for a given domain. The scoring system chooses to show only scores of 3.5 or higher because this means that the Satisfaction Rate is at least 70% (data calculated by CiHBS)*

Goal: 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 5.2: QI staff to address client concerns and adhere to problem resolution process;
Measurement 5.2: Respond to client concerns in accordance with problem resolution process, 100% of the time
Evaluation 5.2: Review trends in QIC, at least annually

Baseline 5.2:	FY 15/16	FY 16/17
Items logged and protocols followed	99%	100%

Goal: Verify of services delivery by clients/family

Interventions 5.3: Develop method for service verification and implement process
Measurement 5.3: Attempt to verify 1% of the face-to-face, outpatient (non-crisis intervention) services delivered during fiscal year
Evaluation 5.3: Take necessary actions, as indicated; Discuss trends in QIC, annually

Baseline 5.3:	FY 15/16	FY 16/17
Attempted Calls	277	95
Spoke with Client/Representative	11.5% (30)	28% (27)

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

Goal: Ensure EHR is well maintained and accessible to all users

Interventions 6.1: Monitor system performance, promptly address issue to eliminate downtime
Measurement 6.1: 99% online time for Avatar system
Evaluation 6.1: ongoing evaluation and monitoring
Baseline 6.1: 99% online time

Goal: Implement Meaning Use stage 2 requirements and/or continue use of best-practice standards of care

Interventions 6.2: Implement components for Meaningful Use and attest stage 3
Measurement 6.2: Obtain compliance with stage 3 via attestation and/or clear best-practice methodologies related to client care
Evaluation 6.2: Attestation of meaning use stage 3; identify components that support meaningful client care (Continuity of Care Document and My Health Point, client portals)
Baseline 6.2: use of best-practice model of care; did not attest for Stage 2 in FY 16/17

Goal: HIPAA compliant data sharing across providers

Interventions 6.3: Continue exploration of methods for data sharing across providers; Participation in data sharing workgroups/committees to identify an electronic master patient index solution (eMPI)
Measurement/Evaluation 6.3: Identification of eMPI process
Baseline 6.3: Multiple barriers: Restrictions related to confidentiality laws and lack of interoperability among different systems

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

Goal: Ensure policies are congruent with business practices for mental health and substance use disorder services

Interventions 7.1: Facilitate monthly QIC meetings; update policies/ recommend policy decisions/ update policies to meet needs of client population and congruency with business practices
Measurement 7.1: Ten (10) monthly meetings per calendar year; QIC comprised of staff, community partners, clients, and advocates; policies are congruent with client care and business practices
Evaluation 7.1: Minutes place on QI website and reflect policy changes/updates
Baseline 7.1: CY 2016: Total of 9 QIC meetings held

Goal: Continue to educate county and contracted provider staff on Compliance Plan and obtain attestations from all staff

Intervention 7.2: Incorporate Compliance Plan attestation and confidentiality agreements during onboarding process for new-hires through the training academy; Review compliance by existing staff members
Measurement 7.2: 100% of incoming staff who submit claims to DHCS will sign attestation; utilize report available in Avatar
Evaluation 7.2: Monitor attestation by new and existing staff members
Baseline: Obtain baseline; many were signed on paper and will need to be collected for tracking purposes.

8. Area of Focus: Utilization Management/Quality Improvement

Goal: Continue ongoing evaluation for medical necessity/appropriateness for level of care/efficiencies

Interventions 8.1: Review 85%-100% of mental health and 100% of substance use disorder services (SUD) programs
Measurement 8.1: Programs reviewed at least annually
Evaluation 8.1: QI team review mental health and SUD programs using clinical utilization review tool; finding, recommendations, and plan of corrections will be directly discussed with program managers/supervisors
Baseline 8.1: FY16/17

Mental Health Programs reviewed	22.6%
SUD Programs reviewed	100%

Interventions 8.2: Continue to support use of clinical supervision to support medical necessity criteria is met.
Measurement 8.2: Revamp UR tool to more accurately reflect clinical need and assessment of medical necessity criteria to be used by Supervisors/Mangers
Evaluation 8.2: QI team will review "clinical UR tool" monthly for first 3 month of implementation; QI to review quarterly, thereafter, using report in Avatar. Mangers to review quarterly via report in Avatar
Baseline 8.2: 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 8.3: 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 8.3: Practices meet prescribing standards
Evaluation 8.3: review 10% sample of each MD charts on a yearly basis
Baseline 8.3: FY16/17: 10% of every MD chart continued to be reviewed

Goal: Increase compliance with 72-hour documentation of services standard to support ongoing communication with other staff regarding client's treatment

Interventions 8.4: Training development under training academy to support staff in identification of ways to meet requirement
Measurement 8.4: 85% of progress notes will meet timeliness requirement
Evaluation 8.4: Training through training academy; QI to continue monitoring via UR process to support increase of compliance

Baseline 8.4:	FY 15/16	FY 16/17
Met timeliness standard	78.8%	77.2%

Goal: Support client care when treatment team determines need for collaborative process to address client concerns, including high-risk situations

Interventions 8.5: Facilitate Collaborative Case Conferences (CCC) to meet client needs
Measurement 8.5: QI to continue to make CCC available to all staff and providers and facilitate process
Evaluation 8.5: QI to report back to leadership, as appropriate, and make recommendations for system changes, when applicable

Baseline 8.5:	**Baseline** FY 15/16	**Outcome** FY 16/17
CCC held	7	8

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

Interventions 8.6: Update/refine Clinical Documentation Guide at least annually
Measurement 8.6: Updated Clinical Documentation Guide will accurately reflect changing business practices

Interventions 8.7: Continue communication via QI monthly newsletter
Measurement 8.7: Sustain communication with staff

Interventions 8.8: Continue to update QI website content to ensure most up-to-date information is available
Measurement 8.8: Ongoing evaluation and updating of content

Interventions 8.9: Continue to improve communication between QI team and staff/ contracted partners to incorporate staff input in projects and system changes
Measurement 8.9: 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 8.6 – 8.9:	FY 15/16	FY 16/17
Updates to Clinical Documentation Guide	2	3
Monthly QI Newsletter Distribution	10	8
Maintain QI Website up-to date	Ongoing	Ongoing
QI participation on team/program meetings with direct staff	Ongoing	Ongoing