FY 16/17

Quality Improvement Workplan

MONTEREY COUNTY BEHAVIORAL HEALTH

FISCAL YEAR 2016/2017

QUALITY IMPROVEMENT WORK PLAN (2016-2017)

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 2015-2016 MCBH provided services to 10,482 consumers. The number of consumers served during Fiscal Year 2014-2015 was 8,558.

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 2016-2017 (July 2016-June 30, 2017).

Area of Focus: Monitoring/Improving Access to Services

Goal 1: Improve timely access to urgent appointments following an inpatient hospitalization and/or emergency department crisis evaluations (when warranted)

Interventions 1a: Develop a process to schedule and track urgent appointments
Measurement 1a: Obtain baseline for urgent appointments (within 5-calendar days of request)
Evaluation 1a: Appointments made available with 5-calendar days; review use of urgent appointments monthly
Baseline 1a: establish baseline

Intervention 1b: Use of telemedicine to improve timeliness to service
Measurement 1b: Decrease wait times to receive medication support services
Evaluation 1b: Telemedicine available in all service regions and wait times are decreased
Baseline 1ba: obtain baseline; develop tracking mechanism

Intervention 1c: Use of teletherapy to improve timeliness to service
Measurement 1c: Pilot use of teletherapy in south county region
Evaluation 1c: Evaluate effectiveness of teletherapy
Baseline 1c: Teletherapy available in south county program

Goal 2: Decrease wait times for follow up appointment following inpatient hospital (MHU) discharge

Interventions: Use of direct referral process for allocation of an outpatient appointment by providing client/family with outpatient appointment prior to discharge from MHU
Measurement: 10% increase from baseline (appointments within 7 days from discharge)
Evaluation: Review data quarterly with leadership via QIC; identify trends and interventions to address concerns, when warranted
Baseline: clients who received a follow up service 7 days following MHU discharge in FY 15/16

- Adults-45%
- Children-38%

Goal 3: Improve accessibility to care for determination of behavioral health needs.

Intervention 3a: Evaluate potential barriers to accessing care
Measurement 3a: Develop one (1) strategy to address the identified barrier(s)
Evaluation 3a: Increase number of individuals served
Baseline 3a: FY 15/16—10,482 individuals received a mental health service

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Intervention 3b: Test use of LOCUS-like tool for improved screening to more quickly get clients to appropriate levels of care
Measurement 3b: Assessment completed in shorter time frame; client was referred to appropriate level of care
Evaluation 3b: Evaluate the effectiveness of tool; evaluate time to completion of assessment
Baseline 3b: Obtain baseline

Goal 4: Increase number of clients served in Bienestar

Interventions: Continue to identify standards for transitions to appropriate level of care
Measurement: Increase number of clients referred to Bienestar and Integrated levels of care
Evaluation: Review data at least twice, yearly
Baseline: (FY 15/16) Bienestar: 591 served

Goal 5: Continue to work with Beacon and safety net providers to improve referral methodologies

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

Goal 6: Improve level of care with step down process

Interventions: Improve relationships with primary care to support step-down services and substance use disorder assessment and intervention. Develop policies/procedures regarding interface with primary care
Measurement: Improve coordination with primary care; step down clients from other levels of care
Evaluation: Strengthen relationships; development of policies to support work with primary care; continue integration of clinical staff in primary care clinics
Baseline: Psychiatrist, clinical supervisor, and clinical staff already placed in primary care; development of procedures

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Goal 7: Monitor 24/7 Call Line

Interventions: Train staff members on customer support and proper use of call-log system
Measurement: Improve customer service, information sharing, and logging calls received (daytime calls); 95% of the calls will follow protocol
Evaluation: Ongoing test calls conducted by QI; QIC to review call-log data, quarterly
Baseline: 1/2016 – 4/2016 test calls logged: 0 of 7

Goal 8: Identify method to track and follow-up on urgent behavioral health conditions with 90% accuracy

Interventions: Evaluate and identify a tracking methodology; make changes in Avatar to meet this need; educate staff on process/procedure
Measurement: Method for tracking and following up will be established; all ACCESS staff to be trained on process/procedure
Evaluation: QI to evaluate and identify a method to capture urgent conditions; establish protocols for follow up; QI team to evaluate monthly for first 3 months, quarterly thereafter, if no concerns arise
Baseline: establish baseline

Goal 9: Improve behavioral health service delivery system

Interventions: Develop an improved methodology for authorization of services; small-scale testing methodology
Measurement: Evaluate effectiveness of authorization process
Evaluation: System-wide implementation of authorization program
Baseline: Obtain baseline

Goal 10: Improve timeliness to service delivery post assessment

Interventions: Evaluate current process; identify areas for enhancement; standardize referral process across the organization; train staff on standard process
Measurement: All programs will utilize standardized process for use of waitlist and referral
Evaluation: QI team to conduct utilization review, quarterly; bring forth concerns of wait list to leadership
Baseline: No current uniform process for using waitlist and referral exists

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

Goal 1 Improve client's goal attainment to move to lower levels of care

Interventions 1a: Identify current use of EBP and evaluate training needs to support fidelity to the models; develop a method for measuring effectiveness of EBP
Measurement 1a: Focus on two (2) EBPs; train staff on EBP; support fidelity to EBP model
Evaluation 1a: Clinical staff receive training and support for EBP; evaluate number of clients who moved to a lower level of care and received services using EBPs
Baseline 1a: FY 15/16: 27.28% of progress notes identified use of EBP (239,151 service totals)

Intervention 1b: Evaluate outcomes data to examine if EBPs were used in treatment to support goal attainment
Measurement 1b: Clients with met or partially met treatment goals received services using EBPs when compared to those who did not attain goals.
Evaluation 1b: 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 1b: FY 15/16 data

- Overall System of Care- 32%
- Access to Treatment- 27%
- Adult's System- 13%
- Children's System- 29%
- Substance Use Disorders- 29%

Goal 2: Increase understanding data for no-show rates for appointments for medication support in order to improve client engagement in treatment.

Interventions 2a: Enhance use of follow-up protocol for no-show appointments for medication support
Measurement 2a: System-wide use of follow-up protocols are followed
Evaluation 2a: Consistent use of follow-up protocols for no-shows across the system
Baseline 2a: Inconsistent use of follow-up protocols

Measure 2b: Monitor use of follow-up protocols
Evaluation 2b: Decrease in no-show rates for psychiatrists
Baseline 2b: CY 15 data—28% no-show rates for appointments with psychiatrists

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Goal 3: Monitor compliance with CalOMS and DATAR submissions for substance use disorder (SUD) services delivery capacity

Interventions: Continue monthly monitoring of data submissions; provide CalOMS training; offer technical assistance
Measurement: 5% overall compliance rate among SUD providers
Evaluation: QIC review of data, quarterly
Baseline: FY15/16 DHCS data: overall SUD providers in our system had a 32.8% compliance rate

Area of Focus: Crisis Intervention

Goal 1: Decrease number of unnecessary emergency department (ED) Crisis Team visits (at Natividad Medical Center, NMC); increase number of clients who receive mobile crisis

Interventions: use of mobile crisis services to manage crisis event in community setting
Measurement: decrease number of unnecessary emergency department visits; increase mobile crisis services
Evaluation: QIC data evaluation, quarterly via mobile crisis report via Avatar
Baseline: FY 15/16

Number of clients with ED Crisis Team visit	1,437
ED visit resulting in NMC inpatient admission	933 clients (64.9%)
Mobile Crisis Team Services (all regions)	362 encounters

- 59 (16%) resulted in involuntary holds
- 72 (20%) received a crisis intervention with client AND a referral to community services
- 29 (8%) received brief crisis intervention with significant support person

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Goal 2: Monitor and decrease inpatient hospital 7-day and 30-day readmissions rates

Interventions: Develop and use of urgent appointment to secure outpatient follow up appointment following a discharge from an inpatient hospital
Measurement: Decrease number of re-hospitalization within 7 and 30 days of discharge
Evaluation: Review data, quarterly using Avatar report
Baseline: FY 15/16

Within 7-days from discharge	437 (59%)
Within 30-days from discharge	82 (11%)

Goal 3: Increase understanding of crisis utilization service (MHU, ED Crisis, etc.) and identify strategies to address concerns

Interventions: Use of Harbage consultation for in-depth review and understanding of crisis utilization services
Measurement: Increased understanding of utilization and identification of strategies to address issues
Evaluation: determine based on report from Harbage Consultation
Baseline: FY 15/16

Number of clients received an ED crisis service	1,437
Number of clients who had 4+ ED crisis visits	285 (20%)
Number of clients admitted to inpatient psychiatric hospital	933
Number of clients re-hospitalized	228 (24%)

Area of Focus: Cultural and Linguistic Services

Goal 1: Improve cultural humility and sensitivity within service delivery

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

Goal 2: Continue to work with Beacon and safety net providers to improve referral methodologies in South County region

Interventions: Work toward development of a contract with Beacon to meet community needs
Measurement: Contract obtained with Beacon
Evaluation: Development of a contract and methodologies for referrals
Baseline: D_3 FY 15/16: no mental health providers are available in this region

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Goal 3: Improve health equity in for Latino population

Interventions: Prioritize regions when hiring new staff; use of telehealth and telemedicine; maintain full time psychiatrists;
Measurement: QIC to evaluate, quarterly
Evaluation 3a: 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 3a: D_3 FY 15/16: Percent of clients served in this region was 15% (13% in FY 14/15)

Evaluation 3b: Review equity of service value using Breakdown of clients served by ethnicity
Baseline 3b: D_3 FY 15/16—53% of Latinos received 49% of the overall service value

Area of Focus: Beneficiary Satisfaction

Goal 1: Evaluate client/family satisfaction with services

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

Goal 2: Continue to monitor and respond to grievances, appeals, expedited appeals, fair hearings, expedited fail hearing, provider appeals, and changes of clinician forms

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
Evaluation: Review trends in QIC, at least annually
Baseline: 99% all calls are logged and all processes are followed

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Goal 3: Verify of services delivery by clients/family

Interventions: Develop method for service verification and implement process
Measurement: Attempt to verify 1% of the face-to-face, outpatient (non-crisis intervention) services delivered during fiscal year
Evaluation: Take necessary actions, as indicated; Discuss trends in QIC, annually
Baseline: Prior method of collection yielded 11.5% of the 277 calls attempted

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

Goal 1: Ensure EHR is well maintained and accessible to all users

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

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

Interventions: Implement components for Meaningful Use and attest stage 2
Measurement: Obtain compliance with stage 2 via attestation and/or clear best-practice methodologies related to client care
Evaluation: Attestation of meaning use stage 2; identify components that support meaningful client care (Continuity of Care Document and My Health Point, client portals)
Baseline: use of best-practice model of care

Goal 3: HIPAA compliant data sharing across providers

Interventions: 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: Identification of eMPI process
Baseline: Multiple barriers: Restrictions related to confidentiality laws and lack of interoperability among different systems

Area of Focus: Quality Improvement Committee (QIC)

Goal 1: Ensure policies are congruent with business practices for mental health and substance use disorder services

Interventions: Facilitate monthly QIC meetings; update policies/ recommend policy decisions/ update policies to meet needs of client population and congruency with business practices
Measurement: 10-12 monthly meetings per calendar year; QIC comprised of staff, community partners, clients, and advocates; policies are congruent with client care and business practices
Evaluation: Minutes place on QI website and reflect policy changes/updates
Baseline: CY15: Total of 7 QIC meeting held

Goal 2: Incorporate QI activities related to substance use disorder (SUD) 1115 Drug MediCal special terms and conditions.

Interventions: Develop and review policies for implementation of SUD service delivery; review of other QI activities in accordance with 1115 Waiver implementation, including, but not limited to reviewing information on problem resolution
Measurement: Present and approve policies related to SUD services; Review of data related to, but not limited to, timely access of services, initial contact, frequency of follow-up, and problem resolution process.
Evaluation: QIC to review and provide feedback on ongoing basis (QIC to facilitate 10-12 monthly meetings)
Baseline: none. To me incorporated (implementation plan approved by DHCS in 11/2016)

Goal 3: Continue to educate on Compliance Plan and obtain attestations from all staff

Intervention: Incorporate Compliance Plan attestation in onboarding process for new-hires through the training academy; Review compliance by existing staff members
Measurement: 100% of staff who submit claims to DHCS will sign attestation; utilize report available in Avatar
Evaluation: 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.

Area of Focus: Utilization Management/Quality Improvement

Goal 1: Continue ongoing evaluation for medical necessity/appropriateness for level of care/efficiencies

Interventions 1a: Review 100% of mental health and substance use disorder services (SUD) programs
Measurement 1a: All programs reviewed at least annually
Evaluation 1a: 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 1a: FY15/16

Mental Health Programs reviewed	85%
SUD Programs reviewed	100%

Interventions 1b: Develop process for clinical supervision to support medical necessity criteria is met
Measurement 1b: Revamp UR tool to more accurately reflect clinical need and assessment of medical necessity criteria to be used by Supervisors/Mangers
Evaluation 1b: 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 1b: Obtain baseline pending development of tool; QI team to review clinical UR completed by Supervisors/Managers, quarterly via Avatar report and report back

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Goal 2: Continue to monitor medication practices

Interventions: 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
Evaluation: review 10% sample of each MD charts on a yearly basis
Baseline: FY15/16: 10% of every MD chart were reviewed

Goal 3: Continue monitoring and evaluation for documentation of medical necessity, appropriateness of services, and quality of care on an ongoing basis

Intervention 3a: Boost utilization review process to include more comprehensive understanding and targeted feedback, including informing training needs to training program
Measurement 3a: Continue evaluation and monitoring of services by QI
Evaluation 3a: 10% review of charts, annually
Baseline 3a: FY 15/16: 8% charts were reviewed

Intervention 3b: Enhance clinical review tool to support clinical supervision and ensure medical necessity is met
Measurement 3b: Develop and implement use of clinical UR tool; Improved quality of service delivery; continue to ensure charts meet medical necessity; increase the number of charts/progress notes that meet compliance for claiming
Evaluation 3b: Each supervisor will utilize enhanced clinical review tool with supervisee to review charts weekly; QI team will review effectiveness of tool and report back, monthly for 3 months, quarterly, thereafter.
Baseline 3b: obtain baseline

Goal 4: Increase compliance with 72-hour documentation of services standard to support ongoing communication with other staff regarding client's treatment

Interventions: Monthly compliance review by supervisors via EHR report; QI will continue to review compliance and provide staff/supervisor feedback, as necessary
Measurement: 85% of progress notes will meet timeliness requirement
Evaluation: QI to continue monitoring via UR process to support increase of compliance
Baseline: FY 15/16: 78.82% of all progress notes met timeliness requirement

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Goal 5: Support client care when treatment team determines need for collaborative process to address client concerns, including high-risk situations

Interventions: Facilitate Collaborative Case Conferences (CCC) to meet client needs
Measurement: QI to continue to make CCC available to all staff and providers and facilitate process
Evaluation: QI to report back to leadership, as appropriate, and make recommendations for system changes, when applicable
Baseline: FY 14/15: total of 10; FY 15/16: total of 7

Goal 6: QI to continue ongoing communication, support, and provide resources for staff and contracted partners

Interventions 6a: Update/refine Clinical Documentation Guide at least annually
Measurement 6a: Updated Clinical Documentation Guide will accurately reflect changing business practices
Evaluation 6a: Updated documentation guide posted to QI website
Baseline 6a: Update at least annually

Interventions 6b: Continue communication via QI monthly newsletter
Measurement 6b: Sustain communication with staff
Evaluation 6b: Monthly newsletter is electronically sent to all staff and providers and made available on the QI website, monthly
Baseline 6b: FY 15/16—11 monthly newsletters were developed and distributed

Interventions 6c: Continue to update QI website content to ensure most up-to-date information is available
Measurement 6c: Ongoing evaluation and updating of content
Evaluation 6c: Sustain communication with staff; content is accurate and up-to-date
Baseline 6c: updated content as necessary

Interventions 6d: Improve communication between QI team and staff/ contracted partners to incorporate staff input in projects and system changes
Measurement 6d: Increase QI participation staff meetings; provide information of upcoming changes and performance improvement efforts; receive and evaluate feedback; incorporate feedback into change process, when appropriate
Evaluation 6d: regular participation in supervisor/manager meetings and participate in program team meetings as requested
Baseline 6d: QI currently participates in program team meetings and supervisor/manager meetings when requested