MONTEREY COUNTY
DEPARTMENT OF HEALTH Ray Bullick, Director

ANIMAL SERVICES
BEHAVIORAL HEALTH
CLINIC SERVICES
EMERGENCY MEDICAL SERVICES
ENVIRONMENTAL HEALTH
PUBLIC HEALTH
PUBLIC ADMINISTRATOR/PUBLIC GUARDIAN

Monterey County Behavioral Health (MCBH)
Quality Improvement (QI) Plan Fiscal Year 2014-2105 (FY14-15)

Area	Goal	Intervention	Measurement
EMR	Ensure the EMR system is well maintained and accessible.	QI staff will monitor system performance and quickly address problems to eliminate downtime.	99.9% online time for Avatar system.
EMR	Implement Meaningful Use Stage Two standards.	Attain compliance with Stage 2 Meaningful Use requirements.	Obtain ability to attest to meeting Meaningful Use Stage 2 standards in 2016.
EMR	Improve contract provider authorization process.	Develop an improved methodology for tracking case coordinator authorization of authorized services.	By 7/1/2015, implement a method for tracking authorizations and train staff on method.
EMR	Record all appointments in Avatar to develop uniform method of evaluating no-show appointments.	Develop policy requiring entry of all appointments into Avatar.	By 12/1/2014, all staff will be entering appointment data in Avatar.
EMR	Have all programs utilize the uniform waitlist option in Avatar.	Ensure that by 1/1/2015 all programs are using the waitlist.	By 2/1/15, develop waitlist review reports that will be evaluated on a monthly basis by executive management.
EMR	Work towards data sharing with safety net providers.	Participate in safety net integration project.	Develop implementation timeline and staff training on use of CCD documentation by the close of FYI 2014.
Communication	Immediately answer 90% of calls to the QI helpline.	Provide adequate staff coverage to respond to calls from County staff and contract providers.	Last fiscal year, the QI helpline responded to 8274 calls, answering 86% of calls immediately. Several technical glitches and staffing challenges created this response rate. During the next year QI staff will answer 90% of calls immediately.

Communication	Keep Staff informed of new QI initiatives.	Continue to produce monthly newsletter.	Monitor the number of staff that access content through the website.
Communication	Maintain an up-to-date Clinical Documentation Guide that acts as a consolidated resource for clinical staff.	Update/refine the Clinical Documentation Guide at least twice a year to ensure it is accurate and reflective of changing practices.	Clinical Documentation Guide will be updated at least twice in the next fiscal year.
Strategic Plan	Implement Strategic Plan.	Measure implementation of strategic plan implementation in monthly manager meetings.	Achieve goals as outlined in plan.
Policy/Procedure Improvement	Continue meetings with Beacon and Safety Net providers to establish improved referral methodologies.	Work towards contract with Beacon to fill gap in services in the South County region.	Currently, there are no mental health providers for the mild to moderate mental health clients in South County. Develop contract by 1/1/2015 to address this service gap.
Policy/Procedure Improvement	Facilitate collaborative case conferences in response to risks identified.	QI will collaborate with clinical staff to facilitate collaborative case conferences.	In FY 13/14, 9 collaborative case conferences were held. In the next FY increase this to a minimum of 10.
Policy/Procedure Improvement	Monthly QIC committee review of trends including grievances and change of clinician forms.	QI will review and track all grievances and change of clinician forms.	QI will report out trends relating to grievances and change of clinicians once a year.
Policy/Procedure Improvement	Improve coordination with primary care providers.	Develop policies and procedures regarding interface with primary care providers.	Create consultation liaison service and train staff on working with primary care providers.
Policy/Procedure Improvement	Develop a consumer welcoming project to improve the welcoming environment in the Salinas Regional Office.	Provide updated welcoming guide in all clinics.	Welcoming guide will be updated by 12/1/14.
Policy/Procedure Improvement	Update out-of-date policies.	Ensure polices are congruent with current business practices, statutes, and regulations.	Update 50 out of the 74 out of date policies.
Compliance	100% of staff will attest to reviewing compliance plan.	Compliance plan was developed on 7/1/2014.	All new staff and current staff with sign attestation indicating they have reviewed

			the compliance plan.
Compliance	Conduct phone based service verification calls to ensure all services that are billed for were provided.	QI staff conduct weekly service verification calls.	Work towards verifying 1% of total services.
Utilization Review	Conduct a review of 100% of Alcohol and Other Drug (AOD) providers.	QI staff will work in collaboration with AOD staff to conduct a timely review of all programs.	100% review of AOD programs in the next fiscal year.
Utilization Review	Conduct random utilization review of 10% of beneficiaries annually to ensure compliance with medical necessity standards utilizing new utilization review protocol.	Track supervisor/manager and contractor use of utilization review tool.	Supervisors will audit three charts a month for their subordinates. Managers will audit two charts per month. Each manager will have a substantive review of both County and contracted programs.
Performance Improvement	Develop a staff-based performance improvement project based on feedback from the staff advisory council, MCBEST.	Based on staff identified concerns, develop at least one performance improvement project for this fiscal year.	Last fiscal year the group addressed concerns regarding payeeship. This year staff will address a development of a mentoring system to help retain new staff.
Performance Improvement	Our 2013 satisfaction survey results indicated 44% of Adult System of Care clients felt partially or fully satisfied with their physical health status.	Continue regional implementation of the Bienestar primary care integration grant.	Increase number of consumer served from 118 in FY14 to 300 by the end of FY15. Evaluate changes in client satisfaction with physical health status.
Performance Improvement Metrics	Measure timely access to services.	Implement methodology of logging all appointments in Avatar to calculate time between request for services and actual provision of services.	By 12/1/14, have all staff using Avatar for initial intake appointments. By 1/1/15, capture baseline measurement of timeliness to urgent conditions: 1) Receive service within 10 days from contact for adults and children; 2) Receive service within 7 days from discharge from MHU.

Performance Improvement Metrics	Monitor 24/7 ACCESS line.	QI staff and ACCESS supervisors/manager(s) will conduct reviews of ACCESS Line responsiveness and work towards establishing a new afterhours call service.	95% of calls will follow appropriate protocol.
Performance Improvement Metrics	Monitory timely follow up after discharge from inpatient setting.	Increase the number of individuals who receive post discharge follow up	In 2013, 41% of individuals received a service within 7 days of discharge. Increase this to 45% by 2016.
Performance Improvement Metrics	Increase use of evidence based practices.	Support training on evidence based practices and promising practices. Develop fidelity monitoring plans for each evidence based practice.	By 2016 move from current baseline of 19% of services tied to evidence based practice to 30%.
Performance Improvement Metrics	Increase the engagement and equitable distribution of services to Spanish speaking clients.	Develop trainings for staff and contractors on engaging Spanish speaking clients. Ensure that contractors and staff are meeting linguistic accessibility standards.	System wide, Spanish speaking clients represent 21% of our population but receive 13% of services. We need to reduce this gap by 5% by 2016.
Performance Improvement Metrics	Measure the percentage of clients served in each region.	Increase the equitable distribution of services to clients in South County.	In 2013, South County clients are 18% of the MediCal population and 15% of our clients but receive 10% of total service value. We need to reduce the service value gap by 3% in 2015.
Performance Improvement Metrics	Measure the % of clients discharged from the Behavioral Health system with treatment goals met or partially met	Develop discharge planning training for staff to help consumers successfully exit from the Behavioral Health system.	Currently in 2014, 30% of Adult System of Care clients were discharged with treatment goals met or partially met. The goal is to increase this to 40% by 2016.
Performance Improvement Metrics	Measure the Natividad Medical Center (NMC) Inpatient Mental Health Unit (MHU) readmission rate.	Increase the number of clients served via the new GAP program. Engage clients in outpatient care to prevent readmission.	Currently, 17% of clients admitted to the NMC MHU are re-hospitalized within 30 days. The goal is to reduce this to 15% by 2015.

Performance Improvement Metrics	Increase the percentage of services documented within 72 business hours.	Supervisors and QI staff will monitor compliance with 72 hour documentation policy.	System wide in 2013, 84% of progress notes written by County staff were completed within 72 business hours. The goal is to increase this to 90% in 2015.
Performance Improvement Metrics	Maintain and increase the percentage of Behavioral Health clients who receive services after a hospital discharge within 7 days.	Monitor staff adherence to policy that all BH clients receive services within 72 hours after discharge.	In the last fiscal year, 89% hospitalizations had a follow up within 7 days.
Performance Improvement Project	Implement a collaborative pilot of Medication Assisted Treatment with Health Department Clinics	Develop a protocol and implement a medication assisted treatment program thorough the Bienestar clinic for both severely mentally ill clients and client referred from substance use providers.	Implement the clinic in early 2015; track the client outcomes for each of the groups using a standard AOD measurement.
Performance Improvement Project	Implement ACCESS screening tools to expedite the assessment process and improve the accuracy of the diagnosis	Continue testing and implementation of screening tools.	In 2013, the average ACCESS to Treatment assessment was 206 minutes with assessments in the coastal region being 122% longer than assessments in South County. Using screening tools and training, standardize the average assessment length and reduce the overall time.
Performance Improvement Project	Based on feedback from the Recovery Task Force (Adult Consumer Advisory Council), improve the welcoming experience for clients served in the Adult System of Care.	Work on rebranding the Adult System of Care offices to be more welcoming, especially to Spanish speaking clients.	A welcoming survey was conducted and the findings indicated 38% of clients did not feel welcomed in the clinics. Implement staff training and rebranding to reduce this number to 10%.
Performance Improvement Project	Test use of pallet of measures to track outcomes for the transition age youth system of care	Develop pallet of measures and assign clients to a panel so treat to target measures can be used.	By 1/1/15 begin testing of initial set of measures.

Attachment 1 – Policies for Revision during FY14-15

POLICY NUMBER	POLICY CATEGORY	POLICY TITLE
100	ADMINISTRATION	Division Policies and Procedures
103	ADMINISTRATION	Program Audits By Outside Agencies
106	ADMINISTRATION	Employee/Volunteer/Equipment
109	ADMINISTRATION	Contract Monitoring
110	ADMINISTRATION	Use of Medical Transport
118	ADMINISTRATION	Emergency Management Teams
119	ADMINISTRATION	Beneficiary Satisfaction Survey
120	ADMINISTRATION	Notice of Action
125	ADMINISTRATION	MediCal Site Certification
126	ADMINISTRATION	Posting of Grievance Procedure
132	ADMINISTRATION	Credentialing and Re-Credentialing
140	ADMINISTRATION	Stipends Policy
145	ADMINISTRATION	Expected Levels of Achievement
201	PERSONNEL	Staff Training
202	PERSONNEL	Safety Practices for Field Visits
205	PERSONNEL	Employment of Spouse or Relatives
207	PERSONNEL	Educational Leave
300	LEGAL	Reporting of Child Abuse
300B	LEGAL	Reporting of Elder and Dependent Adult Abuse
301	LEGAL	Filming of Clinical Activity
305	LEGAL	Patients' Rights
308	LEGAL	Modification of Application for 72 Hr Detention by Crisis Team
310	LEGAL	Contact with the News Media
312	LEGAL	Firearms Possession
313	LEGAL	Release of Information
400	PROGRAM	Hours of Clinic Operation
402	PROGRAM	Dangerous Consumers & Those In Possession of Weapons
406	PROGRAM	BHAS Short-Doyle MediCal Admin Days
407	PROGRAM	Cancellation/No Show
410	PROGRAM	Committee and Staff Meetings
416	PROGRAM	Medical Records Requirements for Crisis Unit
417	PROGRAM	Change of Clinician
418	PROGRAM	Medical Share of Cost
423	PROGRAM	Medical Records Purging
426	PROGRAM	Completion of Axis III
431	PROGRAM	License Waiver Application

432	PROGRAM	AS CM Rep. Payee Services
433	PROGRAM	AS CM Rep. Payee Services Eligibility
434	PROGRAM	AS CM Rep. Payee Services Intake Procedure
435	PROGRAM	Representative Payee Case Action
436	PROGRAM	Representative Payee Reporting Responsibilities
437	PROGRAM	Deceased Client Accounts
438	PROGRAM	Medical Waste Management
441	PROGRAM	Medication Refills
442	PROGRAM	Family Participation in Service Delivery
443	PROGRAM	Scope of Practice
444	PROGRAM	Physician Availability
447	PROGRAM	Reassessment of Clinical Service Needs
448	PROGRAM	Transfer of Clients from Provider to SOC
449	PROGRAM	Transfer from SOC to MCP
451	PROGRAM	Use of Translators and Interpreters
452	PROGRAM	Distribution of Translated Materials
455	PROGRAM	Interface With Physical Health Care
467	PROGRAM	Medical Record Review Annual Review
467A	PROGRAM	Supervisor E.H.R. Review and Annual Updates
471	PROGRAM	Advance Health Care Directive
477	PROGRAM	Therapy Dogs
489	PROGRAM	Referrals from Clinic Services
490	PROGRAM	Urgent Collaborative Case Conferences (URCC)
492	PROGRAM	CAR--update name
500	PATIENT CARE	Consent for Psychotropic Medication
501	PATIENT CARE	Psychotropic Medication Monitoring Plan
502	PATIENT CARE	Lithium Treatment Monitoring
503	PATIENT CARE	Medical Diagnostic Procedures
504	PATIENT CARE	Tardive Dyskinesia (TD): Recognition and Management
505	PATIENT CARE	Response to calls from individuals with Suicidal Ideation
508	PATIENT CARE	Contaminated Waste Needles and Supplies Disposal
509	PATIENT CARE	Minor Inpatient Treatment
510	PATIENT CARE	Transfer of Psychiatric IP to NMC
511	PATIENT CARE	Electro Convulsive Treatment
513	PATIENT CARE	ECT Referrals
514	PATIENT CARE	Handling of Physician Samples
515	PATIENT CARE	Use of Clozaril