Monterey County Behavioral Health (MCBH)
Quality Improvement (QI) Plan--Fiscal Year 2015-2016 (FY15/16)

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	Transition EMR system to a hosted site "cloud-based"	QI staff will ensure seamless transition	Implementation by August 2015 with minor to no disruption to staff
EMR	Implement meaningful use stage two standards	Obtain compliance with stage 2 meaningful use requirements	Obtain ability to attest in 2015
EMR	Improve contract provider authorization process	Develop an improved methodology for tracking authorizations for all services by case coordinator; Continue exploration of EHR options	By 7/1/2016 implement a method of 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; use of call log system across system; train staff; make documentation available on QI website	By 12/1/2015 have all over 50% of staff entering appointment data in avatar.
EMR	Have all programs utilize a uniform waitlist/referral option in AVATAR	Ensure that by 1/1/16 all programs are using the waitlist	By 2/1/16, develop waitlist/referral review reports that will be evaluated on a monthly basis by executive management.

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EMR	Work towards data sharing with safety net providers	Participate in safety net integration project.	Continue work towards additional information sharing options; Develop implementation timeline and staff training on use of CCD documentation
EMR	Implement use of ICD-10 codes by 10/1/15 deadline;	QI staff will make transition seamless by use of easy usability of form, education of all staff, training using multiple modalities	100% of staff will complete transition process by deadline
Communication	Answer 90% of calls to the QI HelpLine; In FY 2014/2015, there was a total of 11,209 calls received, of which 9,593 (87.89%) of calls were answered. There was a 5% (563) abandonment rate (calls placed on hold where caller hung up); the average wait time of the caller prior to hanging up was 30 seconds.	Provide adequate staff coverage to respond the calls from county staff and contract providers	Answer 90% of calls to the QI HelpLine
Communication	Keep Staff informed of new QI initiatives	Continue to produce monthly newsletter; Monitor the number of staff that access content through QI website	Sustain communication with staff
Communication	Maintain an up to date Clinical Documentation guide that acts as a consolidated resource for clinical staff	Update/refine the documentation guide twice a year to ensure it is accurate and reflective of changing practices	Sustain communication with staff
Strategic Plan	Strategic Plan	Measure implementation of strategic plan implementation in monthly manager meetings	Goals as outlined in plan

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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; continue working with County council on development of contract	Currently, there are not mental health providers for the mild moderate in South County. Develop contract by 1/1/2015 to address this service gap
Policy/Procedure Improvement	Facilitate collaborative case conferences (CCC) in response to risks identified	QI will collaborate with clinical staff to facilitate collaborative case conferences.	Continue to make CCC available to staff; Facilitate at least 10 CCC during fiscal year 14/15
Policy/Procedure Improvement	Monthly QIC committee review of trends including; grievances, changes of clinician forms.	QI will review and track all grievances and changes of clinician forms; Continue to monitor, report trends, identify areas for improvement	QI will report out trends relating to grievances once a year
Policy/Procedure Improvement	Improve coordination with primary care	Develop policies and procedures regarding interface with primary care providers	Create consultation liaison service and train staff on working with primary care providers; work in conjunction with managed analyst to coordinate efforts
Policy/Procedure Improvement	Develop a consumer welcoming project to improve the welcoming environment in the Salinas Regional Office; Based on feedback from the Recovery Task Force (Adult Consumer Advisory Council)	Provide updated welcoming guide in all clinics; Inform and train staff; make available on QI website	Welcoming guides will be available in clinics by 12/1/15 (English and Spanish)
Policy/Procedure Improvement	Update out of date policies	ensure policies are congruent with current business practices	Update 20 out of the 50 out-of-date policies

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Compliance	100% of staff will attest to reviewing compliance plan.	Compliance plan was developed on 6/30/2016; work with Deputy Directors and implementation strategies	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 billed were provided; In FY13/14. a total of 1965 (1.38%) service verification calls were attempted. A response was noted for 478 (0.34%) of the calls. No contact with the client was noted for 1487 (1.05%) of the total service verification calls.	QI staff will conduct weekly service verification calls	Work towards verifying 1% of total services
Compliance	Achieve 5% error rate with submission of CalOMS data	1)Monthly monitoring of CalOMS Anomalies report to ensure report is functioning at capacity; 2)Update County's CalOMS user guide; 3)Re-train AOD staff on CalOMS data collection expectations	Decrease error rate from 32.8% to 5% by 6/30/2016
Utilization Review	Conduct a review of 100% of Alcohol and other drug providers (AOD)	QI staff will work in collaboration with AOD staff to conduct a timely review of all programs	Sustain review of 100% of AOD programs reviewed in the next fiscal year.

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Utilization Review	Conduct random utilization review of 10% of beneficiaries annually to ensure compliance with medical necessity standards utilizing new utilization review protocol.	Work with Deputy Director on implementation; Track supervisor/manager and contractor use of utilization review tool	Supervisors will audit three charts a month for their direct staff. Managers will audit two charts per month for their direct staff (supervisors). Each manager will have a Supervisor review of both county and contracted programs.
Utilization Review	Conduct utilization review of 100% of programs to ensure compliance with medical necessity standards	1)QI staff will review 100% of programs utilizing utilization review monitoring tool; 2)Discuss findings with managers/ supervisors regarding identified trends; 3) track trends/ outcome recommendations and participation in Staff Academy Trainings	Track changes to identified documentation issues; Track participation in Staff Academy Trainings
Performance Improvement	Development of mentorship program to support incoming staff; improve retention of new staff; improve staff morale;	Continue work with staff advisory council MCBEST (Monterey County Bringing Everyone's Strengths Together	Development of mentorship program
Performance Improvement	Increase number of consumer served from 380 to 450 consumer served; 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; Evaluate changes in client satisfaction with health status.	Increase consumers served to 450

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Performance Improvement Metrics	Measure timely access to services	Implement methodology of logging all appointments in Avatar so the calculation between request for services; Improved flow of discharges from MHU (June 2015) to improve client engagement and decrease wait times; Implemented use of call log across system	By 1/1/16 capture baseline measurement of Timeliness to urgent conditions. 1) Receive service within 10 days from contact for adults and children;
Performance Improvement Metrics	Monitor 24/7 access line; new contracted began 1/2015--all test calls passed	QI staff and access supervisors/manager(s) will conduct reviews of access line responsiveness. Work towards establishing a new after-hours call service.	95% of calls will follow appropriate protocol.
Performance Improvement Metrics	Monitor timely follow up after discharge from inpatient setting	Increase the number of individuals who receive post discharge follow up	In 2014, 45% of individuals received services within 7 days of discharge. Continue to Increase services 55% by 2016
Performance Improvement Metrics	Increase use of evidence based practices (EBP)	Supporting training on evidenced-based practices and promising practices. Develop fidelity monitoring plans for each evidence-based practice; monitor use of QI time for specific EBP	By 6/30/2016, move from current baseline of 21% of services tied to evidence-based practice to 30%
Performance Improvement Metrics	Increase the engagement of equitable distribution of services to Spanish-speaking clients	Develop training 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. In 2014, 20% of clients preferred Spanish but their received 15% of services

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Performance Improvement Metrics	Measure the percentage of clients served in each region	Continue increase the equitable distribution of services to client in South County	In 2014, South County clients are 17% of the Medi-Cal population. 15% of those clients received 14% of our (2013 reported 10% of total service value).
Performance Improvement Metrics	Measure the % of clients discharged from the Behavioral Health System with treatment goals met or partially met or partially met	Develop discharge planning trainings for staff to help consumers successfully exit from the Behavioral Health system	In FY 14/15, 18% of the clients were discharged with treatment goals met (decreased from 30% of Adult-System-of-Care clients for FY13/14;tThe goal is to increase this to 40% by 2016
Performance Improvement Metrics	Measure the Natividad Medical Center (NMC) inpatient Mental Health Unit (MHU) re-admission rate	Increase the number of clients served through Gap services program. Engage client 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	The percentage of services documented within 72 business hours	Supervisors and QI staff will monitor compliance with 72-hour documentation policy; Continue to work on improving documentation timeliness via training of direct staff, supervisors, and through use of data reports	The goal is to increase this to 90% in 2015 (there was a decrease in timeliness system-wide from 84% to 78%
Performance Improvement Metrics	Increase client access to treatment	Increase the number of days the outpatient clinics are opened for Walk-In services to community members; Development of pilot program in Salinas region	Increase the number of clients who receive a timely contact to determine mental health needs

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Performance Improvement Project	Implement ACCESS screening tools to expedite the assessment process and improve the accuracy of 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, we aim to standardize the average assessment length, and reduce the overall assessment time
Performance Improvement Project	Each Deputy Director of Services will identify and work on a performance improvement project (PIP). Each PIP will target client care, accessibility, or client satisfaction	Educate all Deputy Directors on PIPs, including Plan Do Study Act (PDSA) to support PIP	Each PIP will use measureable outcomes and reviewed quarterly