Quality Improvement Workplan

Evaluation

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 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, Outcome 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 for FY 16/17 Workplan Goals

As noted in the introduction of this document, in 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 no change in the percentage of Hispanic/Latino clients served in our system of care but there was a 2% increase of services to Hispanic/Latinos in our South County region when compared to the prior fiscal year.

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 outcomes (when warranted)

	Baseline FY 15/16	**Outcome** FY 16/17
Timely access post hospitalization	Development of standardized, automated process for real-time appointments	Testing phase; to be implemented 10/2017
Use of telemedicine in all regions to improve timeliness to care	Available in all regions	Available in all regions. Increase use in South County region
Teletherapy available in south county program	No baseline	42 individuals served

Goal 2: Decrease wait times for follow up appointment following inpatient hospital (MHU) discharge; medication support follow up service 7 days following MHU discharge

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

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

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

Baseline 3b: Obtain baseline for use of LOCUS-like tool
Outcome 3b: Identification of a different tool; Reaching Recovery with focus on recovery and identification of level of care; LOCUS-like tool was not utilized

Goal 4: Increase number of clients served in Bienestar

Baseline:	Outcome:
41*	26

* this number was previously reported as 591, which was incorrect. The correct number is 41 as shown above.

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

Baseline:	Outcome:
• Develop methodology	• 186 referrals made

Goal 6: Improve level of care with step down process
Outcome: Ongoing efforts to strengthen relationships

Goal 7: Monitor 24/7 Call Line

Baseline:	Outcome:
1/2016 – 4/2016 test calls logged: 0 of 7	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)

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

Baseline:	Outcome:
None	Ongoing efforts to identify standards for use of "urgent condition"

Goal 9: Improve behavioral health service delivery system with development of authorization process

Baseline:	Outcome:
Obtain baseline to develop a system-wide implementation of authorization program	Ongoing efforts ensue

Goal 10: Improve timeliness to service delivery post assessment

Baseline:	Outcome:
No current uniform process for using waitlist and referral exists	Ongoing efforts to standardize system-wide use of waitlist and referrals

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

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

	Baseline:	Outcome:
Use of evidence-based practices	27.28% of progress notes identified use of EBP	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
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%

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

	Baseline	Outcome
Protocols followed	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
No-show rates for medication support appointment	28%	21%

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

	Baseline:	Outcome:
CalOMS		89.0%
DATAR		68.7%
Overall Compliance	32.8%	78.8%

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

	Baseline: FY 15/16	Outcome: FY 16/17
Number of clients with ED Crisis Team visit	1,437	1,542
ED visit resulting in NMC inpatient admission	933 clients (64.9%)	552 clients (35.8%)
Mobile Crisis Team Services (all regions)	362 encounters	670 encounters
Received brief crisis interventions with significant support person	29 (8%)	95 (14%)
Resulted in involuntary hold	59 (16%)	104 (15%)
Received a crisis intervention with client AND a referral to community services	72 (20%)	179 (26%)

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

	Baseline:	Outcome:
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%) a as shown above.

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

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

	Baseline: FY 15/16	Outcome: FY 16/17
Number of clients received an ED crisis service	1,437	1,542
Number of clients who had 4+ ED crisis visits	285 (20%)	198 (13%)
Number of clients admitted to inpatient psychiatric hospital	933	914
Number of clients re-hospitalized	228 (24%)	221 (24%)

Area of Focus: Cultural and Linguistic Services

Goal 1: Improve cultural humility and sensitivity within service delivery
Outcome: Training titled "LGBTQ Cultural Competency and Data Collection Training" was conducted. Additionally, all staff training (provided by staff training academy) have a cultural relevance/humility component incorporated.

Goal 2: Continue to work with Beacon and safety net providers to improve referral methodologies in South County region
Baseline: D_3 FY 15/16: no mental health providers are available in this region
Outcome: An internet review resulted in no providers available in King City area

Goal 3: Improve health equity in for Latino population in South County region

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

Area of Focus: Beneficiary Satisfaction

Goal 1: Evaluate client/family satisfaction with services*

General satisfaction of services "I like the services that I received"	Baseline: Spring 2016	Outcome: 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 2: Continue to monitor and respond to grievances, appeals, expedited appeals, fair hearings, expedited fail hearing, provider appeals, and changes of clinician forms

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

Goal 3: Verification of services delivery by clients/family

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

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

Goal 1: Ensure EHR is well maintained and accessible to all users
Outcome: 99% online time

Goal 2: Implement Meaningful Use stage 2 requirements and/or continue use of best-practice standards of care
Outcome: Attestation for Stage 2 did not occur; however, multiple efforts were placed on best-practice methods for service delivery. For example, ongoing coordination efforts with community providers/partners and primary care; identification of tobacco use; risk assessment; patient education, etc.

Goal 3: HIPAA compliant data sharing across providers
Outcome: Efforts continue to ensure compliance with sharing of information in medical records as well as interoperability with partner electronic health records.

Area of Focus: Quality Improvement Committee (QIC)

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

	Baseline Calendar Year 2015	**Outcome** Calendar Year 2016
Quality Improvement Committee	7	9

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

Goal 3: Continue to educate on Compliance Plan and obtain attestations from all staff
Outcome: 50% compliance

Area of Focus: Utilization Management/Quality Improvement

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

Programs Reviewed	**Baseline** FY 15/16	**Outcome** FY 16/17
Mental Health	85%	22.6%
Substance Use Disorder (SUD)	100%	100%

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
Outcome: Supervisory utilization review tool was implemented January 2017. To date, there were a total of 204 completed chart reviews using this tool.

Goal 2: Continue to monitor medication practices
Baseline: FY15/16: 10% of every MD chart were reviewed
Outcome: FY16/17: 10% reviewed

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

	Baseline FY 15/16	**Outcome** FY 16/17
Charts reviewed by QI staff	8%	9 (4.4)
Charts reviewed by Supervisors	No baseline	204 (3.4%)

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

	Baseline FY 15/16	**Outcome** FY 16/17
Met timeliness standard	78.8%	77.2%

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

Baseline FY 15/16	**Outcome** FY 16/17
7	8

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

	Baseline FY 15/16	**Outcome** 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