Quality Improvement Work Plan Evaluation

FY 2018 - 2019

OUTCOME OF QUALITY IMPROVEMENT WORK PLAN GOALS FOR FISCAL YEAR 2018-2019

Section I: Performance Improvement Projects (PIP)

Clinical Mental Health PIP

Title: Reaching Recovery

Goal: The goal of the PIP is to ensure that we have the right amount and intensity of services being provided to clients by clinicians, who are both stratified into five different levels of care based on MHC of Denver's model of Reaching Recovery. The intent is to be able to measure recovery outcomes per client and channel the appropriate level of intensity of service and duration of service in accordance with the Reaching Recovery model.

Intervention: To accurately measure the recovery process of each Adult client, we use 3 survey instruments- Recovery Needs Level (RNL), Recovery Marker Index (RMI), and CRM (Consumer Recovery Measure). The data will be collected through periodical submission of client recovery information through 3 survey instruments:
I. Recovery Needs Level: Completed by the primary clinician in electronic record at least once every 12 months in combination with their treatment plan. The baseline RNL was completed before 30 June 2018. Based on the baseline RNL scores, the clients were then stratified into 5 different levels of care.
II. Recovery Marker Inventory: Completed by provider quarterly in Avatar, the data provides clinicians with longitudinal perspectives of changes in a person's recovery process – from both an overall standpoint as well as more specific recovery dimensions. These observations can then be used to help guide clinical decisions for treatment focus
III. Consumer Recovery Measure: Completed by the Client quarterly either electronically in Avatar or on paper, the Consumer Recovery Measure is used to evaluate clients' perceptions of their own recovery.
Every area in the 3 instruments is measured by a single question with a different number of options. The different number of response options is intended to include all the significant measurable changes in the trait of interest. Starting from September 2018, irrespective of the admission date of the client, the RMI and CRMs will be completed every quarter for each client seen by the provider. The staff have already been trained on the perceptions and interpretation of each question in these instruments to main consistency and accuracy of the data collected over time.

Outcome: Reviewed in Steering Committee meetings throughout the FY 2018-2019

Non-Clinical Mental Health PIP

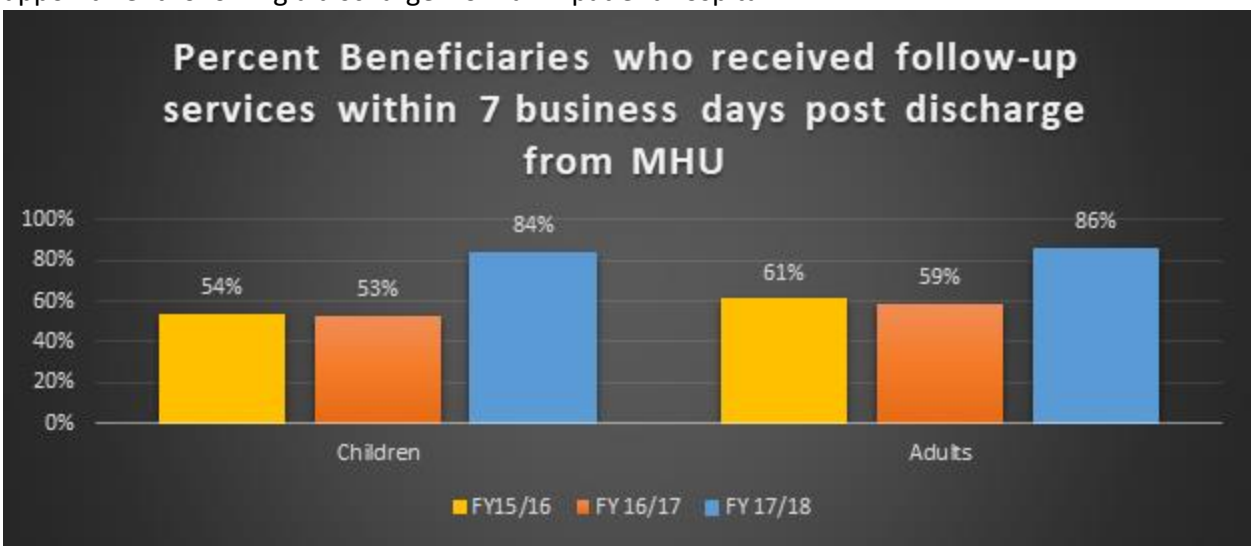
Title: Urgent Appointment

Goal: The goal of the PIP was to make available urgent appointment services to clients to reduce wait times, no-show rates and decrease psychiatric emergency room visits.

Intervention: The main intervention was to offer urgent appointment to clients through provision of slots per week at MD clinics. Two new service codes were created for this purpose 361U and 331U. Staff were trained by the end of June 2017. The intervention began on July 2017.

Outcome:

i. Use of urgent appointment services has helped to increase the outpatient follow up appointment following a discharge from an inpatient hospital:



ii. There was steady decline in the length of time between initial appointment and the first therapeutic service

iii. Increase in the number of beneficiaries utilizing mental health services after adoption of 361U Urgent services.

Clinical SUD PIP

Title: Client engagement in continuum of care after discharge from residential treatment

Goal: The goal of the PIP is to improve and increase the continuity of care for SUD clients discharged from Residential treatment services to lower levels of care thereby increasing the period of sobriety, improving quality of care, and reducing relapse rate.

Intervention:

1. Case management service prior to discharge:

Case management is a service that assists a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination of SUD care, integration around primary care and interaction with the criminal justice system, if needed. Case management services includes (i) Periodic reassessment of individual needs to determine the need for continuation of case management services, (ii) Transition to a higher or lower level of SUD care, (iii) Development and periodic revision of a client plan that includes service activities, (iv) Communication, coordination, referral, and related activities, (v) Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services; and, (vi) Case management must be consistent with and shall not violate confidentiality of substance use disorder patients as set forth in 42 CFR Part 2, and California law.

2. Transition to lower level of care by completing an ASAM assessment and discharge plan 30-days prior to discharge: Completion of an ASAM assessment prior to discharge is an important component to determine client's level of care needs to support discharge planning and the development of a discharge plan further supports the individual's transition to another level of care, including their community.

Outcome: Established baseline and monitoring activities in progreess

Non-Clinical SUD PIP

Title: Improving Justification for Continuation of Stay for Residential Beneficiaries

Goal: This PIP is attempting to improve continuity of care by avoiding disruption in care for clients requiring residential treatment beyond 45 days. The goal is to decrease the time delay in authorizing continuity of care for residential treatment clients and to eliminate client's apprehension, if any, regarding the possibility of being declined services due to avoidable incomplete documentations provided to authorization team.

Intervention: By developing and implementing a tool to standardize expectations for submitting requests for continuation of stay, we hope to improve MCBH's Authorization Team process, and increase timeliness of the authorization procedure, and reduce delay in client's treatment and early discharges.

Outcome: Established baseline and monitoring activities in progress

Section II: 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 2018-2019 (July 2018-June 30, 2019). We have identified 8 Areas of focus, 14 Objectives, 29 Goals to address for this year with a health equity vision.

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

Objective 1.1: Monitor Distribution of Behavioral Health Services by type, number and geographic distribution

Goal 1.1: Quarterly review of all behavioral health program data by program value and health equity indicators such as Age, Gender, Race, Region, Diagnosis by Service Managers.
Intervention: Develop a process to automate the review process by QI staff through integration of data visualization tool with Avatar.
Measurement: Number of reviews completed in a year and trends detected, if any.
Baseline: Currently Access to Treatment program is reviewed monthly.
Evaluation: 1. Created Access dashboard (report 877) on Avatar for quarterly data monitoring

2. Created Monterey County Behavioral Health Bureau Health Equity Report Fiscal Year 2017-18 that provided a comprehensive analysis of Medi-Cal eligible clients and service disparity reports.
3. Provided quarterly reports on ASOC clients service utilization
4. In the process of completing Reaching Recovery dashboard that publishes information on clients served, health equity indicators and outcome measures of services.

Outcome: Goal Met

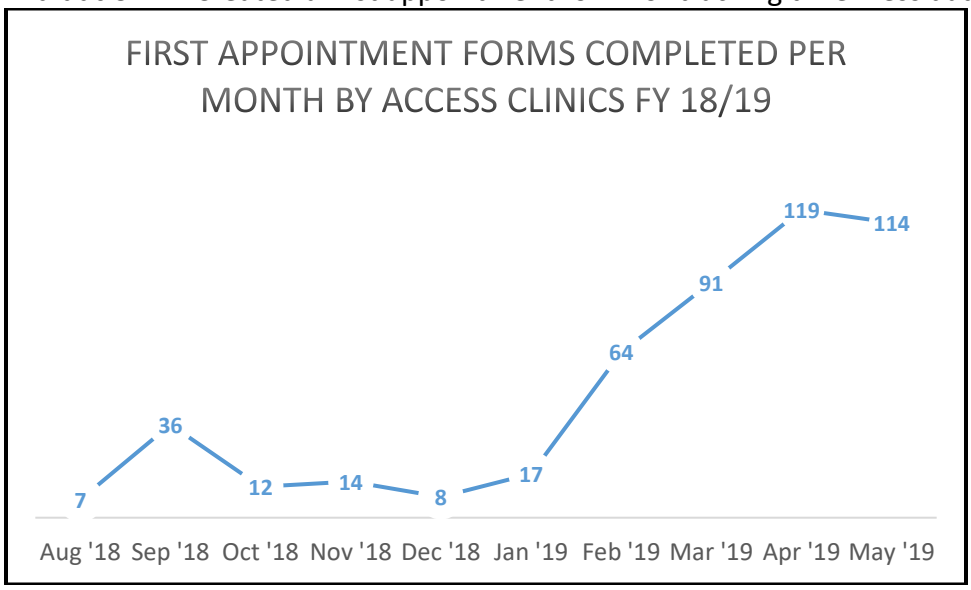
Goal 1.2: Quarterly review of current maps showing Behavioral Health services and Medi-Cal Eligible beneficiaries for all programs by QI
Intervention: (1) Collaborate with County GIS analyst to share advance ArcMap license
(2) Purchase required license for mapping drive-time analysis
Measurement: Number of Maps produced and trends detected if any.
Baseline: 12 Maps with drive-time analysis output were generated last quarter that included all behavioral health beneficiaries and service area of MCBH.
Evaluation: 1. Transitioned to ArcGIS Pro software and updated the Arc Map software to most current 10.6 version.
2. Created new SUD services maps after DMC-ODS waiver implementation
3. Provided 12 Maps with drive-time analysis output quarterly and submitted to state for evaluation.
Outcome: Goal Met

Objective 1.2: Implement DHCS Network Adequacy standards

Goal 1.3: Improve access to SUD services in the south county in accordance with Network Adequacy Policy by June 2019. Ensure all beneficiaries are located within Network Adequacy standards from their Mental Health Provider and SUD Providers
Intervention: Open one new SUD clinic for south county by December 2018
Measurement: Increase in number of SUD beneficiaries from south county
Baseline: All beneficiaries are located within 45 miles' radius from SMHS clinics within Monterey county. Lack of coverage area in the zipcode 93451 for SUD services.
Evaluation: 1. Sun Street Centers expanded its drug and alcohol treatment services to South County, by opening a new facility in King City
Outcome: Goal Met

Objective 1.3: Timeliness of services

Goal 1.4: Obtain appointment for first offered routine request for BH service within county standards in 90% of requests for all regions of the county by Dec 2018, 95% by June 2019
Intervention: Implement and train access to treatment staff to complete first encounter form to track time from initial contact to first offered appointment and first accepted appointment, including no shows and cancellations.
Measurement: Number of first encounter forms completed every month.
Baseline: Currently, there is no system in place to track first offered and first accepted appointments
Evaluation: 1. Created a first appointment form for tracking timeliness data of new clients



Outcome: Goal Met

Goal 1.5: All Medi-Cal eligible beneficiaries to receive 7day follow-up appointments after discharge from Mental Health Unit by June 2019

Intervention: Quarterly review of appointments following discharge from mental health unit data to identify trends, and address concerns if any.
Measurement: Percentage of Medi-Cal Beneficiaries receiving 7-day follow up appointment post-discharge from Mental Health Unit.
Baseline: 84% of Children Beneficiaries and 86% of Adult Beneficiaries received 7-day follow-up services post-discharge from MHU including TARs in FY 17/18.
Evaluation: 86% of Children Beneficiaries and 65% of Adult Beneficiaries received 7-day follow-up services post-discharge from MHU including TARs in FY 18/19. Additionally, 6% Children beneficiaries and 12% Adult beneficiaries did not receive any service post discharge from MHU including TARs in FY 18/19.
Outcome: Goal Partially Met

Goal 1.6: Implement EQRO timeliness standards for each program under BH services by June 2019
Intervention: Develop a process in place to track timeliness standards quarterly, and identify trends in the data to inform QIC.
Measurement: Number of EQRO timeliness standards tracked by MCBH
Baseline: Some of the Timeliness measures tracked currently:

1. Average time from admission to first assessment among beneficiaries: 4.8days
2. Percentage of clients receiving first therapeutic services within 10 days of admission: 97.3%
3. No-show rates for psychiatric appointments: 21% in FY 17/18

Evaluation: Created timeliness measures dashboards for MH and SUD in Avatar. Some of the measures for FY 18/19 are:

1. Average time from admission to first assessment among beneficiaries: 1 days
2. Percentage of clients receiving first therapeutic services within 10 days of admission: 71%
3. No-show rates for psychiatric appointments: 30% in FY 1819

Outcome: Goal Met

Objective 1.4: Monitor access to after-hours care

Goal 1.7: Continue utilization review of real-time appointment finder for urgent appointment requests (361U) and evaluate its successful implementation.
Intervention: Review Monthly reports to track urgent services utilized in accordance with timeliness standard
Measurement: No. of clients who receive urgent services within 5 days from open episode where applicable in all four access to treatment clinics
Baseline: Percentage of clients receiving urgent appointments within 5 business days: 74% in FY17/18
Evaluation: 270 clients received urgent appointment services in FY 1819 from all four access clinics and about 275 received services within 5 business days of request.
Outcome: Goal Met

Goal 1.8: To study the health equity predictors of new clients through mobile crisis intervention
Intervention: Review Monthly reports to track Crisis Interventions utilized in accordance with timeliness standard
Measurement: No. of clients who receive Crisis intervention services within 5 days from open episode where applicable in all four access to treatment clinics
Baseline: In FY16/17, there were 374 NMC MHU Clients who did not engage in out-patient services of which 8% were new clients. Their mean age was 38 years, 42% Female, 48% Hispanic/Latino vs 32% White. Almost half of the clients were from Salinas Valley region.
Evaluation: There were 90 new clients who received crisis intervention services in FY 1819. Of these 49% received therapeutic services within 5 days of request.
Outcome: Goal Partially Met

Goal 1.9: Test call reporting to provide information about how to access specialty mental health services to be no less than 80% during and after regular working hours by June 2019.
Intervention: Monitor responsiveness of 24-hour toll free line in providing information on how to access appropriate services
Baseline: 0 of 33 calls logged in 2017.
Evaluation: 14 of 49 test calls logged in FY 1819
Outcome: Goal Not Met

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

Objective 2.1: Improve Penetration Rate by 7% in 3 years among Hispanic/Latino clients

Goal 2.10: Continue use of teletherapy and telemedicine services in the county to increase the number of clients served by 5% by the end of Dec 2019 and 10% by the end of June 2019.
Intervention: Continue to promote and review use of teletherapy and tele-medicine services
Measurement: Percentage increase in number of individuals served in these programs
Baseline: Currently there are 50 clients in telemedicine program of which 44% belong to south county.
Evaluation: This FY we saw 2 times increase in teletherapy service utilization. Currently there are 230 clients in telemedicine program of which 27% belong to south county, 29% coastal region, 6% North county region and 37% Salinas Valley region. 50% of the Teletherapy service users are Hispanic/Latino population, 28% are White and 23% belong to other race categories.
Outcome: Goal Met

Goal 2.11: Encourage staff to use electronic health record to its full potential in order to improve service delivery and quality of services provided.
Intervention: Continue to inform staff regarding Avatar updates periodically and use of scheduling calendars to track appointments.
Measurement: Number of reports sent to staff regarding new forms/service codes or changes made in Avatar

Baseline: This will be tracked going forward
Evaluation: 9 reports sent in MH.
Outcome: Goal Met

Objective 2.2: Improve service delivery

Goal 2.12: 30% increase in the number of text-messaging consents obtained to remind clients of upcoming medication support appointments.
Intervention: Continued efforts to obtain text-messaging consent to remind clients of upcoming medication support appointments
Measurement: 1. Number of text-messaging consent obtained by gender and race/ethnicity
2. Number of clients who received and responded to text messages
Baseline: In FY 17/18, 634 consents collected to remind clients of upcoming medication support appointments
Evaluation: In FY 18/19, 979 text-messaging consents (54% increase from last FY) collected to remind clients of upcoming medication support appointments. 57% of those who signed up were Hispanic/Latino clients, and 25% were Whites
Outcome: Goal Met

Goal 2.13: Decrease no-show rate for medication support appointments to 15% by the end of Dec 2019 among TAY clients.
Intervention: Continue to implement Avanza-TAY PIP by providing incentives to youth who attend MD appointments
Measurement: Decrease in no show rate percentage to psychiatry appointment among TAY.
Baseline: Current no-show rates remain at 40% for TAY.
Evaluation: We conducted a Randomized cohort study on 54 participants where half of the participants received positive behavioral re-enforcements in the form of gifts for attending MD appointments and the rest did not. Preliminary results show that the attendance for those who received the incentives improved from baseline of 45% to 84% by the end of 6 months. The no-show rate has decreased from 40% to 15% among our intervention group and from 40% to 27% among no intervention group.
Outcome: Goal Met

Goal 2.14: 90% Compliance rate among SUD providers by June 2019
Intervention: Continue monthly monitoring of data submissions for substance use disorder treatment programs; provide CalOMS and DATAR training; offer technical assistance
Measurement 2.4: Overall compliance rate among SUD providers
Baseline: In FY17/18, the overall compliance rate among SUD Providers was 80%- 75% for DATAR and 85% for CALOMS.
Evaluation: The overall compliance rate among SUD Providers was 85% for DATAR and 100% for CALOMS.
Outcome: Goal Partially Met

Objective 2.3: Improve service delivery capacity for LGBTQ Beneficiaries with Mental illness

Goal 2.15: Improve service delivery capacity for LGBTQ Beneficiaries with mental illness and/or substance use disorder through providing trainings to staff to improve skills for assessment and treatment of this population.
Intervention: Identification of training module and implementing annual training made mandatory to all staff.
Measurement: Percentage of clinical staff attending the training.
Baseline: Yet to implement the intervention
Evaluation: Yet to implement the intervention
Outcome: Goal Not Met

Objective 2.4: Reduce Hospital readmission rates
Goal 2.16: Reduce the number of clients receiving inpatient hospital services who are readmitted within 30 days to 10%
Intervention: Use of Urgent appointment to secure out-patient follow up appointment following a discharge from in-patient hospital
Measurement: Percentage of clients readmitted within 30-days.
Baseline: In FY 17/18, the hospital re-admission rate was 15% within 30 days from discharge.
Evaluation: In FY 18/19, the 30-day post-discharge hospital re-admission rate was 12%
Outcome: Goal Partially Met

3. Area of Focus: Crisis Intervention

Objective 3.1: Reduce the response time of 24-hour toll free Access Crisis

Goal 3.17: To reduce the response time of the Access line via the 24-hour toll free number by at least 10 percent by June 2019
Intervention: Measure the responsiveness of the 24-hour toll free number through call log and test calls. Training for access staff on issues identified by a process improvement process.
Measurement: Average **r**esponse time to crisis calls
Baseline: Yet to be implemented
Evaluation: In progress
Outcome: Goal Met

Objective 3.2: Beneficiary wellness and Recovery progress

Goal 3.18: To reduce the number of Emergency, crisis, and in-patient services, including psychiatric hospital bed days. Continue to Monitor responsiveness to crisis intervention and Mobile crisis calls
Intervention: Develop a system to carefully track service outcomes associated with Mobile Crisis/ER Crisis Intervention Beneficiaries
Measurement: 1. Reduction in expensive health care services such as emergency room and in-patient services
2. Increased Client engagement and self-care resulting in reduced emergency and hospital admissions especially for ASOC program
Baseline: Total expenditure in FY 16/17 for ER Crisis, and in-patient services was $7,622,025.
Evaluation: Yet to be implemented
Outcome: Goal Not Met

4. Area of Focus: Cultural and Linguistic Services

Objective 4.1: Improve cultural humility and sensitivity within delivery system for mental health and substance use disorder services

Goal 4.19: All behavioral health staff to participate in cultural sensitivity/ humility training on a yearly basis
Intervention: 6hour long Mathew Mock Cultural Competency training would be made available to all staff multiple times a year
Measurement: Number of staff who participated and feedback received
Baseline: Yet to be implemented
Evaluation: 325 staff members have completed the training
Outcome: Goal Met

Goal 4.20: Increase the number of Latino clients served in all regions by at least 5% by June'19
Intervention: Prioritize regions when hiring new staff; use of telehealth and telemedicine; maintain full time psychiatrists
Measurement: QIC to evaluate, quarterly
Baseline: Currently 76.46% of Beneficiaries from south county belong to Hispanic/Latino population compared to 49% in FY16/17.
Evaluation: Ongoing process. South county is fully staffed with 93% bilingual employees.
Outcome: Goal Met

5. Area of Focus: Beneficiary Satisfaction

Objective 5.1: Survey Beneficiary satisfaction

Goal 5.21: Complete a direct interview with a minimum of 200 Beneficiaries' contacted to complete a beneficiary satisfaction survey
Intervention: Direct face to face Verification of at least 1% of non-crisis intervention services delivered to clients/family by QI staff during the Fiscal year
Measurement: Number of calls attempted and number of Beneficiaries completing the survey
Baseline: Out of 96 calls attempted in FY 17/18, the response rate among beneficiaries was 27%
Evaluation: Out of 21 calls attempted, the response rate among beneficiaries was 33%
Outcome: Goal Not Met

Objective 5.2: Evaluate Beneficiary grievances, appeals, and fair hearings

Goal 5.22: 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: 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
Baseline: Items logged and protocol followed 100% of the time in FY 17/18.
Evaluation: Items logged and protocol followed 100% of the time
Outcome: Goal Met

Objective 5.3: Evaluate Change of Provider requests

Goal 5.23: Change of provider requests due to Dissatisfaction, without details of why the consumer was dissatisfied with the provider and/or service, to be less than 30% for both individual and organizational providers
Goal 5.24: Change of provider requests due to Individual Providers not responding to the consumer to be less than 20%
Intervention: Monitor and Evaluate change of provider request forms periodically, address concerns during QIC meeting.

Measurement: (1) Percentage of Beneficiaries who requested change of provider because of dissatisfaction in the service provided

(2) Percentage of Beneficiaries who requested change of provider because of inadequate/no response from providers

Baseline: Yet to be implemented

Evaluation:

1. 16% of Beneficiaries (n=7) requested change of provider without details of why the consumer was dissatisfied with the provider and/or service
2. 3% of Beneficiaries(n=3) requested change of provider because of inadequate/no response from providers

Outcome: Goal Met

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

Goal 6.25: Ensure EHR is well maintained and accessible to all users

Intervention: Monitor system performance, promptly address issue to eliminate downtime

Measurement: 99% online time for Avatar system

Baseline: 99% online time

Evaluation: 99% online time

Outcome: Goal Met

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

Goal 7.26: Ensure policies are congruent with business practices for mental health and substance use disorder services

Intervention: Facilitate monthly QIC meetings; update policies/ recommend policy decisions/ update policies to meet needs of client population and congruency with business practices

Measurement: Quarterly QIC meeting; QIC comprised of staff, community partners, clients, and advocates; policies are congruent with client care and business practices

Baseline: Total of 9 QIC meetings held in FY 17/18

Evaluation: Changed to quarterly meeting- 4 meetings held in FY 18/19

Outcome: Goal Met

8. Area of Focus: Utilization Management/Quality Improvement

Goal 8.27: Continue ongoing evaluation for medical necessity/appropriateness for level of care/efficiencies

Intervention: Review 85%-100% of mental health and 100% of substance use disorder services (SUD) program

Measurement: Programs reviewed at least annually
Baseline: In FY17/18, 59.4% of Mental Health Program and 100% of SUD Program were reviewed.
Evaluation: 1. 69% of MH and 100% of SUD programs reviewed
Outcome: Goal Met

Intervention: Continue to support use of clinical supervision to support medical necessity criteria is met.
Measurement: Revamp UR tool to more accurately reflect clinical need and assessment of medical necessity criteria to be used by Supervisors/Mangers
Baseline: 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.
Evaluation: Continued usage of clinical supervisory tool.
Outcome: Goal Met

Interventions: 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: Practices meet prescribing standards
Baseline: FY16/17, 10% of every MD chart continued to be reviewed
Evaluation: MD chart review process in progress
Outcome: Goal Met

Goal 8.28: Increase compliance with 72-hour documentation of services standard to support ongoing communication with other staff regarding client's treatment
Interventions: Training development under training academy to support staff in identification of ways to meet requirement
Measurement: 85% of progress notes will meet timeliness requirement
Baseline: Training through training academy in progress; QI to continue monitoring via UR process to support increase of compliance. In FY 17/18, 77% of progress notes met timelines requirement.
Evaluation: In FY 18/19, 82% of progress notes met timelines requirement.
Outcome: Goal Met

Goal 8.29: QI to continue ongoing communication, support, and provide resources for staff and contracted partners

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

Intervention: Continue communication via QI monthly newsletter
Measurement: Sustain communication with staff

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

Interventions: Continue to improve communication between QI team and staff/ contracted partners to incorporate staff input in projects and system changes
Measurement: 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

Goal 8.29:	FY 17/18	FY 18/19
Updates to Clinical Documentation Guide	1	1
Monthly QI Newsletter Distribution	8	9
Maintain QI Website up-to date	Ongoing	Ongoing
QI participation on team/program meetings with direct staff	Ongoing	Ongoing