Mendocino County Behavioral Health and Recovery Services

Annual Quality Improvement Work Plan FY 2015/2016

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I. Quality Improvement Program

The Mendocino County Behavioral Health and Recovery Services (MCBHRS) Quality Improvement (QI) Program is responsible for providing support services to the Mental Health Plan (MHP), Substance Use Disorder Treatment (SUDT) program, consumers, and family members. The QI Program is accountable to the Mental Health Director, Mental Health Board, Health and Human Services Agency Director, and Board of Supervisors.

The goal of the QI Program is to improve access to and delivery of mental health and substance abuse treatment services, while assuring that services are community based, beneficiary directed age appropriate, culturally competent, and process and outcome focused. The QI Progam monitors, evaluates, and works to improves client's access to services and the quality of services. The program coordinates with performance monitoring activities throughout the MHP and SUDT, including, but not limited to, beneficiary and system outcomes, utilization management, clinical records review, monitoring of beneficiary and provider satisfaction, and resolution of beneficiary and provider grievances/appeals.

The Quality Improvement Program supports the strategic initiatives and the Goals and Objections of MCBHRS. The goals and objectives are analyzed and evaluated to identify the effectiveness of programs and areas for improvement. The MCBHRS leadership, MHP Providers, and quality improvement committee formulate these Goals and Objectives and evaluate their effectiveness.

This Quality Improvement Plan ensures the opportunity for input and active involvement of consumers, family members, MHP providers, Substance Use Disorder staff and other interested stakeholders in the Quality Improvement (QI) Program.

Ortner Management Group (OMG) provides specialty mental health services to adults 25 and over. Redwood Quality Management Company (RQMC) provides specialty mental health services to children ages 0-24. MCBHRS will provide substance use disorder treatment, AB109, Mobile Outreach and Prevention, CalWORKS and Katie A./WRAP services.

II. Quality Improvement Committees/Groups

MCBHRS has seven separate committees that are responsible for the key functions of the QI Program: Quality Management/Quality Improvement Work Group, Quality Improvement Committee, Cultural Competency Committee, the Behavioral Health Action Team (BHAT), Flash, Utilization Management (UM) Committee and Compliance Committee. Minutes from all

committee meetings are used to identify and monitor goals and objectives related to the QI program.

A. Quality Improvement Committee

The Quality Improvement Committee (QIC) recommends policy decisions, reviews and evaluates the results of QI activities, institutes needed QI actions, and ensures follow-up of QI processes. QIC also coordinates performance monitoring activities by reviewing reports from committees such as: Utilization Management, Quality Improvement/Quality Management, Cultural Diversity, and Compliance.

Standing members of the QIC are:
HHSA Assistant Director, Health Services
MCBHRS Deputy Director
Quality Assurance/Quality Improvement Manager/Supervisor
SUDT Manager/Supervisor
Ethnic Services Representative
BHRS Fiscal staff
Redwood Quality Management Company
Ortner Management Group
Clinical staff
Beneficiaries
Family members
Patients' Right Advocate
Community service providers
Ad Hoc Member: Medical Director

The QIC meetings are held bi-monthly at different locations throughout the county allowing the public and consumers to attend, ask questions, report on their experience receiving Specialty Mental Health Services and Substance Use Disorders Treatment, and provide recommendations for improvement.

All departmental personnel, MHP providers, and committee members may contribute to the agenda items. QIC meeting agendas may include, but are not limited to, the following agenda items:

- Grievances, appeals, state fair hearings
- Requests for change of provider
- Request for second opinions
- Notice of Actions
- Consumer Satisfaction Questionnaire Survey results

- Accessibility of Services
- Timely Access Reports
- Provider Appeals
- In-Patient Hospitalizations Reports
- Utilization of Specialty Mental Health
- Access Line Test Calls Report
- Service delivery capacity, trends, quality, and outcomes
- Cultural competency and linguistic services
- Policies and Procedures
- Performance Improvement Projects (PIP)
- Outcome Measures: Child and Adolescent Needs and Strengths (CANS) and Adult Needs Strengths Assessment (ANSA)
- Verification of Services

Data collected is reviewed bi-monthly, semi-annually and annually to determine the overall effectiveness of the QI program.

B. Cultural Diversity Committee

The Cultural Diversity Committee (CDC) provides oversight of cultural competency and linguistic services provided by the MHP providers and SUDT providers. They monitor, review, evaluate, and make policy recommendations to develop strategies to address disparities. The CDC notifies MHP providers, SUDT providers, and community partners of available trainings, workshops, and cultural events to increase knowledge and raise awareness about cultural diversity issues. Local tribal representatives and Latino providers are invited to attend CDC to report on cultural services and provide recommendations for improvement.

Members of the Cultural Diversity Committee include: HHSA Assistant Director, Health Services, MCBHRS Deputy Director, MCBHRS Quality Assurance/Quality Improvement Manager/Supervisor, MCBHRS SUDT Manager/Supervisor Ethnic Services Representative, Redwood Quality Management Company, Ortner Management Group, Clinical staff, Beneficiaries, Family members, Patients' Right Advocate, Community service providers, and Mental Health Advisory Board Liaison. Ad Hoc Member: Medical Director and BHRS Fiscal staff.

C. Behavioral Health Action Team

The Behavioral Health Action Team (BHAT) is integrated into the QIC Program through involvement in a general oversight and evaluation capacity. The BHAT reviews and evaluates MHP and SUDT programs and make recommendations on policy changes and areas of improvement. This includes, but is not limited to, trends, quality of care, service

delivery, performance improvement projects, QIC and CDC findings, actions, and recommendations.

Members of the BHAT include: HHSA Assistant Director, Health Services, MCBHRS Deputy Director, MCBHRS Medical Director, MCBHRS Quality Assurance/Quality Improvement Manager, MCBHRS Fiscal Manager, MCBHRS Program Managers, and designated agency staff.

D. Quality Management/Quality Improvement Work Group

The Quality Management/Quality Improvement Work Group (QM/QI Work Group) is a collaboration of MCBHRS and Administrative Service Organization (ASO) providers. QI/QM provides quality improvement and collaboration across the MHP. The QM/QI Work Group includes, but is not limited to, client satisfaction, access line test calls, reviewing reports, policies and procedures review and recommendations, and surveys outcomes.

Members of the Quality Management/Quality Improvement Work Group (QM/QI Work Group) include: MCBHRS Deputy Director, MCBHRS Quality Assurance/Quality Improvement Staff, MCBHRS fiscal staff, Redwood Quality Management Company, and Ortner Management Group.
Ad Hoc Member: HHSA Assistant Director, Health Services and Medical Director.

E. Flash Leadership

The Flash Leadership brings MCBHRS and ASO management together to strategize, plan, and collaborate on specialty mental health services being provided to Mendocino County beneficiaries.

Members of the Flash Leadership include: HHSA Assistant Director, Health Services, MCBHRS Deputy Director, MCBHRS Fiscal Manager, MCBHRS Compliance Officer, Redwood Quality Management Company, and Ortner Management Group.

F. Compliance Committee

The Compliance Committee is responsible for analyzing and understanding the regulatory environment and legal requirements, monitoring internal and external audits and investigations, and identifying risk areas. The committee develops, in conjunction with the Quality Improvement Committee, standards of conduct and policies and procedures that promote alliance to the Compliance Program. The committee also reviews and updates the Compliance Plan annually.

Members of the Compliance Committee include: MCBHRS Compliance Officer, HHSA Assistant Director, Health Services, MCBHRS Deputy Director, MCBHRS Fiscal

Manager, MCBHRS Quality Assurance/Quality Improvement Manager/Supervisor, Ethnic Services Manager, Redwood Quality Management Company Compliance Officer, and Ortner Management Group Compliance Officer. Ad Hoc Member: Medical Director and County Counsel.

G. Utilization Management Committee

The Utilization Management Committee (UM) reviews that authorization decisions standards are being meet and that there is consistency in the authorization process. The committee also assures that beneficiaries have appropriate access to services, evaluates the medical necessity, accessibility of services, appropriateness and efficiency of services, and assess the capacity of service delivery.

Members of the Utilization Management Committee include: MCBHRS Deputy Director, MCBHRS Quality Assurance/Quality Improvement Manager/Supervisor, MCBHRS SUDT Manager/Supervisor, MCBHRS Fiscal Staff, MCBHRS MHSA Program Manager, Redwood Quality Management Company, and Ortner Management Group. Ad Hoc Member: HHSA Assistant Director, Health Services and Medical Director.

III. MCBHRS Strategic Initiatives FY 2015-2016

Children and Families

- Shorten the time between assessment and treatment
- Measure client satisfaction at 6 month intervals and discharge
- Concurrent review of CANS score throughout treatment
- Examine clinical progress, CANS and GAF score to determine when clients are entering and exiting the system
- Target individualized services to allow appropriate level of care, as clinically indicated
- Monitor outreach and service engagement to increase linkage and reduce hospital readmissions

Transitional Age Youth (TAY)

- Concurrent review of ANSA score throughout treatment
- Examine clinical progress, ANSA and GAF score to determine when clients are entering and exiting the system
- Measure client satisfaction at 6 month intervals and discharge
- Linking clients to the Adult System of Care when they turn 25, initiate transition three months prior to 25th birthday
- Improve Full Service Partnership access, coordination of care, and psychiatric support

Adults

- Continued data collection on treatment outcomes
- Provide Full service Partnerships to clients within their communities
- Reduce hospitalization
- Continue transition of medication support services
- Expand medication services

Older Adults

- Increase the number of Full Service Partnerships
- Increase the number of older adults accessing Senior Peer Counseling

Community

- Continue building linkage with community's resources across lifespan
- Continue expand Mental Health Serviced in outlying communities
- Continue community outreach for suicide prevention and de-stigmatization
- Continue to provide consumer outreach events/forums for feedback and recommendation for improvement

IV. Objectives, Scope, and Planned Activities for the Coming Year

Quality Improvement Work Plan for FY 2015/2016 includes goals, objectives, and timelines. The MCBHRS QI and ASO QI will monitor services to assure service delivery capacity in the following areas:

Goal #1: Ensure MCBHRS service delivery capacity		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines – Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective A: Monitor utilization of services	Monitor the current number of clients served, types and geographic distribution of mental health services within the MHP delivery system. Monitor the goals set for the number of services, type of services, and geographical locations. Types of services and services provided goals: Medication Management Support (3,885), Mental Health Services (35,250), Targeted Case Management (6,956), Crisis Services (516), ICC (1,614) and IHBS (1,019). Locations: Coast, South Coast, Inland, and North County Review and analyze reports from the Electronic Medical Records (EMR) and utilization of data from Client Services Information system (CSI), as available. Data will be analyzed by age, gender, ethnicity, and diagnosis. 95% of Medi-Cal beneficiaries (initial cases) will have Periodic Updates and UMDAP completed and submitted to BHRS Fiscal Department.	Client Population Reports Reports provided by BHRS Fiscal and ASOs Data Analysis by QI/QM work group	Semi-annual Reports to QIC provided by BHRS Fiscal and ASOs Semi-annual Report to QIC provided by Utilization Management Committee Semi-annual Reports to QIC provided by MC Fiscal	July 2015 – June 2016
Objective B: Monitor service capacity	Staff productivity will be evaluated via productivity reports generated by the MHP Providers. Supervisors and managers will receive periodic reports to assure service capacity and appropriate cultural and linguistic services have been provided. At minimum 50% of Clinical Staff will bill an average of 60% per month.	Reports provided by BHRS Fiscal and ASOs Logs and Chart Audits	Semi-annual Report to QIC provided by MC Fiscal and ASOs	July 2015 – June 2016

Goal #2: Ensure accessibility to MCBHRS services		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines - Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective A: Monitor timeliness of routine (initial) mental health appointments from the date of first request to the date of first billable clinical assessment	Goal is to provide first billable clinical assessment (BPSA) within 14 days. A minimum of 85 % will meet the timeline.	Timeliness of Access report	Reports to QIC 6 x yr. provided by ASOs	July 2015 – June 2016
Objective B: Monitor timeliness of routine (initial) medication appointments / psychiatric appointments	The goal is to provide medical appointment / psychiatric appointments within thirty (30) calendar days from the date of first request. A minimum of 85% will meet the timeline.	Timeliness of Routine Medication Appointment Report	Reports to QIC 6 x yr. provided by ASOs	July 2015 – June 2016
Objective C: Monitor timeliness of services for urgent conditions during regular clinic hours	The goal for urgent or emergent conditions is no more than one (1) elapsed hour from the request for service and face-to-face evaluation. A minimum of 95% will meet the timeline	Review of RQM/OMG Crisis Logs. Review age groups 0-24 & 25 up	Reports to QIC 6 x yr. provided by ASOs	July 2015 – June 2016
Objective D: Monitor access to after-hours care	The goal for access to after-hours care is no more than two (2) elapsed hours between the request for service and the face-to-face evaluation/intervention contact for emergency situations. A minimum of 95% will meet the timeline.	Review of RQM/OMG Crisis Log. Review age groups 0-24 & 25 up	Reports to QIC 6 x yr. provided by ASOs	July 2015 – June 2016

Goal #2: ***continued…*** **Ensure accessibility to MCBHRS services**		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines – Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective E: Monitor responsiveness of the 24-hour, toll-free telephone number	Integrated Care Management Solutions will answer the 800 Access line immediately and provide information on how to access services, provide information on to process a problem resolution or state fair hearing and link urgent and/or emergent calls. If required, an interpreter and/or Language Line will be utilized. 100% of all access line calls will provide beneficiaries with the information they need regarding how to access specialty mental health services, information on urgent conditions, and information on beneficiary problem resolution and fair hearing process. 100% of all calls will be logged. .	At least two (6) test calls will be made each month in English and in one other language. Results of these monthly test calls will be reviewed at QI/QM.	Semi-Annual Reports to QIC provided by OMG	July 2015 – June 2016
Objective F: Ensure provision of culturally and linguistically appropriate services	This indicator will be measured by audits of the Access Log, Crisis Log and/or chart audits, as well as the results of test calls. 100% of progress notes in audited charts will indicate the language services were provided in (if applicable - who provided the interpretation). The focus of these reviews is to determine if a successful and appropriate response was provided which adequately addressed the consumer's cultural and linguistic needs. In addition, requests for the need for interpreters will be analyzed to assure that client's received services in their preferred language.	Documentation in Progress Notes Documented on Access or Crisis Log All forms provided to clients are to be in threshold language.	Semi-Annual Reports to QIC provided by MCBHRS QI and ASOs	July 2015 – June 2016

Goal #2: *continued…* Ensure accessibility to MCBHRS services		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines - Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective G: Monitor timeliness of routine (initial) mental health appointments from the date of first request to the date of first billable clinical assessment for Latino beneficiaries	Goal is to provide first billable clinical assessment (BPSA) within 14 days. A minimum of 85 % will meet the timeline.	Timeliness of Access report	Reports to QIC 6 x yr. provided by ASOs	July 2015 – June 2016
Objective H: Monitor timeliness of routine (initial) medication appointments for Latino beneficiaries	The goal is to provide medical appointment within thirty (30) calendar days from the date of first request. A minimum of 85% will meet the timeline.	Timeliness of Routine Medication Appointment Report	Reports to QIC 6 x yr. provided by ASOs	July 2015 – June 2016
Objective I: Monitor timeliness to authorization	Treatment Authorization Requests (TAR) will be reviewed for medical necessity and authorized or reauthorized as appropriate within 14 calendar days by OMG POA/RQMC POA and/or MC-POA. A minimum of 100% will meet the timeline OMG/RQMC POA and MC POA will authorize expedited TARs as needed.	Authorization Log and Authorization Audits	Reports to QIC 6 x yr. provided by MCBHRS QI and ASOs	June 2015 – July 2016

Goal #3: Monitor Client satisfaction		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines – Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective A: Conduct a Client Survey	Using the DHCS Consumer Perception Survey instruments, in threshold languages, clients and family members will be surveyed to determine their perception of services. Goal is to increase the participation of the numbers of surveys received Survey administration methodology will meet the requirements outlined by the CA DHCS.	5% increase in the number of surveys completed	Semi-annual reports to QIC provided by MCBHRS- QI	Survey implemented dates to be determined by DHCS July 2015 – June 2016
Objective B: Assess beneficiary and/or family satisfaction	Utilization of MC-Beneficiary Satisfaction Surveys at least annually to measure overall satisfaction, access to services, treatment plan development, informing materials/rights, grievance. Goal is to increase the participation of the number of surveys received and overall satisfaction.	5% increase in the number of surveys completed	Annual Reports to QIC provided by MCBHRS QI and ASOs	July 2015 – June 2016
Objective C: Informing providers of the results of the beneficiary and/or family satisfaction activities	The results of client and family satisfaction surveys are shared with providers. Survey results will be shared with staff, providers, local Mental Health Board and QIC. This information is distributed on an annual basis and in the form of cumulative summaries to protect the confidentiality of consumers and their families.	Survey Results	Report to QIC Annually and post to county Website ASOs and MCBHRS QI	July 2015 – June 2016

Goal #3: ***continued…..*** **Monitor Client satisfaction**		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines – Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective D: Review beneficiary grievances, appeals, expedited appeals, fair hearings, and expedited fair hearings	MC QI will log, process and evaluate beneficiary grievances, appeals, expedited appeals, state fair hearings, and expedited state fair hearings within the State required timeframe. 100 % will meet the timeline. The nature of complaints and resolutions will be reviewed to determine if significant trends occur that may influence the need for policy changes or other system-level issues.	Grievance and Appeal logs	Reports to QIC 6 x yr. provided by MCBHRS- QI	July 2015 – June 2016

Goal #4: Monitor the service delivery system		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines – Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective A: Monitor safety and effectiveness of medication practices	Providing safe and effective medication practices. Medication monitoring activities will be accomplished via review of at least ten (10) percent of cases involving prescribed medications. These reviews will be conducted by a person licensed to prescribe or dispense medications.	Policy and Procedures Chart Audits	Annual Report to QIC provided by ASOs	July 2015 – June 2016

Goal #4: *continued…* Monitor the service delivery system		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines – Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective B: Identify meaningful clinical issues	Meaningful issues for assessment and evaluation, including safety and effectiveness of medication practices, will be identified and evaluated. An analysis of the clinical reviews will occur to identify significant clinical issues and trends. Appropriate interventions will be implemented when a risk of poor quality care is identified.	Policy and Procedures Chart Audits	Annual Report to QIC by ASOs	July 2015 – June 2016
Objective C: Review request for change of provider	MCBHRS QI will log, process and evaluate all change of provider request. 100 % will meet the timeline. All request will be evaluated to determine if there are trends or areas needing quality improvement.	Change of Provider Log	Reports to QIC 6 x yr. provided by MCBHRS- QI	July 2015 – June 2016
Objective D: Assess performance and identify areas for improvement	Quantitative measures will be identified to assess performance and identify areas for improvement, including the Performance Improvement Projects and other QI activities. These areas will be measured through the review of the timeliness of assessments and service plans, completeness of charts, consumer surveys, and productivity reports. The results of these reviews will dictate areas to prioritize for improvement. Trainings will be provided as necessary.	Review of 5% of consumer charts. Training calendar provided by ASO QI and MCBHRS QI Review of trends and processes PIP Reports	Semi-annual chart audit results to QIC reported by MCBHRS QI and ASOs	July 2015 – June 2016

Goal #4: ***continued…*** **Monitor the service delivery system**		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines – Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective E: Monitor stakeholder involvement	Staff, providers, consumers, and family members review the evaluation data to help identify barriers to improvement. This ongoing analysis provides important information for identifying barriers and successes toward improving administrative and clinical services. This will be measured by the number of consumers attending and participating in the QIC meeting. QIC meetings will be held in different locations throughout the county to provide more option for stakeholder involvement.	QIC Meeting Sign-in sheets QIC Meeting Minutes	Reported by MCBHRS-QI	July 2015 – June 2016
Objective F: Monitor clinical records and chart audits	MHP QI will evaluate the quality of the service delivery by conducting chart audits. 10 % clinical review and chart audit per year.	Chart Audits Improvement in services and documentation	Semi-annual reports to QIC by MCBHRS QI and ASOs Implementation of trainings that address trends	July 2015 – June 2016

Goal #5: Monitor continuity and coordination of care with non-psychiatric medical providers		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines – Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective A: Monitor continuity and coordination of care with medical providers	When appropriate, information will be exchanged in an effective and timely manner with health care providers used by clients. Measurement will be accomplished during ongoing review, as well as Referral to Physical Health Care forms. 85 % of charts will have a signed release of information for the beneficiary's health care provider(s).	Release of Information to be reviewed during chart audit	Semi-annual report to QIC Provided by ASOs	July 2015 – June 2016

Goal #6: Monitor provider appeals		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines – Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective A: Monitor provider appeals	Provider appeals will be recorded in a Provider Appeal Log and will be reviewed by UM and reported to QIC. 100 % of appeals will be followed up within state recommended timeframe. A recommendation for resolution will be made to the Mental Health Director. The resolution and date of response shall be recorded in the Log, which is reviewed by UM for any trends. Any trend will be reported to QIC.	Provider Appeal Log	Semi-annual reports to QIC by BHRS- QI	July 2015 – June 2016

Goal #6: *continued…* Monitor provider appeals		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines – Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective B: Review provider suggestions for improvement	Provider suggestions for improvement will be considered and implemented, when appropriate. 100% of provider suggestions will be reviewed monthly at QI/QM work group and responded to as needed. Review will be conducted on a monthly basis, if suggestions are received.	QI/QM meeting minutes	Ongoing As reported by BHRS QI and ASOs	July 2015 – June 2016

Goal #7: Monitor SUDT Services		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines – Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective A: Increase the percentage of consumers who complete Family Dependence Drug Court.	Review and analyze data from WITS.	SUDT Reports form WITS	Reports to QIC 6 x per yr. by MCBHRS-QI	July 2015 – June 2016
Objective B: Reduce the number of no shows	Reduce the number of no shows to 10% or less. Review and analyze data from WITS.	SUDT Reports from WITS	Reports to QIC 6 x per yr. by MCBHRS QI	July 2015 – July 2016

Goal #7: *Continued…* Monitor SUDT Services		**Date Completed:**		
Objective	***Activities/Strategies***	***As Evidenced By***	***Reporting Timelines – Staff Responsible***	***Date Completed Anticipated Completion dates***
Objective C: Substance Use Disorder Treatment clients will complete 3 customer surveys a year.	Review consumer surveys and present the results.	SUDT Survey Reports	Annual reports to QIC by BHRS-QI	July 2015 – June 2016