

*Mendocino County Behavioral  
Health and Recovery Services*



County Annual Evaluation of  
Quality Improvement Work Plan  
Fiscal Year 2017 - 2018

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## Introduction and Overview

The Mendocino County Mental Health Plan (MHP) is unique in that Mendocino County Behavioral Health and Recovery Services (BHRS) contracts for the provision and arrangement of its mental health services to an Administrative Service Organization (ASO), Redwood Quality Management Company (RQMC), who in turn subcontracts out the adult and children's services to a network of community provider organizations. BHRS has retained outreach services and most substance use disorder treatment services.

The BHRS Quality Assurance / Quality Improvement Program (QA/QI) staff is responsible for monitoring the quality management of this business model. The QA/QI Program is accountable to the Behavioral Health Director, Behavioral Health Advisory Board, and Health and Human Services Agency Director.

The goal of the QA/QI Program is to improve access to and delivery of mental health and substance use disorders treatment services, while assuring that services are community based, beneficiary directed, age appropriate, culturally competent, and process and outcome focused. The QA/QI Program monitors, evaluates, and works to improve client access to services and the quality of services. The program collects and analyzes data about the performance monitoring activities conducted by Mental Health and Substance Use Disorders Treatment staff, including, but not limited to, timeliness and access, beneficiary and system outcomes, utilization management, clinical records review, monitoring of beneficiary and provider satisfaction, responsiveness of the 24-hour toll-free telephone line, and resolution of beneficiary and provider grievances and appeals.

This report evaluates the effectiveness and quality of the MHP QA/QI Program improvement activities conducted in FY 2017-18.

## Quality Improvement Work Plan

The MHP contract requires that MHPs establish and maintain a QA/QI Program and QM Work Plan, also referred to as a Quality Improvement (QI) Work Plan. The FY 2017-18 QI Work Plan supports the strategic initiatives and the goals and objectives of BHRS to provide quality services to beneficiaries in the most responsive and effective means possible. The goals and objectives are analyzed and evaluated to identify the effectiveness of programs and areas for improvement. BHRS leadership, MHP Providers, the Quality Improvement Committee and its subcommittees formulate these Goals and Objectives and evaluate their effectiveness.

The FY 2017-18 QI Work Plan has identified Strategic Initiatives and seven goals to work towards this past year. Within the seven goals are specific measurable objectives. These initiatives and goals support the mission, vision, and operating principles of Mendocino County Health and Human Services, as well as the strategic goals of BHRS.

## Quality Improvement Committee and Other Quality Management Committees

The QA/QI Program's principle workgroup is the Quality Improvement Committee (QIC). The QIC is comprised of MHP staff, providers, beneficiaries, family members, and other community stakeholders concerned about the quality of the behavioral health service delivery system. The QIC met six times at a variety of locations around the county to increase the number of community

members that can participate. Meetings in FY 17/18 were held in Ukiah, Covelo, Fort Bragg and Boonville.

In FY 17/18, the Quality Improvement Committee (QIC) merged with the Mental Health Services Act (MHSA) stakeholders committee meetings as there were several commonalities including the members, participants (clients, family members, providers, community stakeholders) and initiatives (public feedback and suggestions for the MHP and SUDT systems of care) that these committees were addressing. By combining these meetings, the goal was to have increased attendance by consolidating meetings. The merged committee developed a non-clinical Performance Improvement Project (PIP) with the goal of increasing client and family member attendance and participation. In addition to merging the meeting, interventions included holding meetings at Wellness Centers and other convenient locations. Skype was also used to connect the participants that could not attend in person. Adding Skype as an option increased the number of clients who were able to participate in the meetings. There were technical issues with the videoconferencing that didn't get worked out in the attempts to apply it. However, there is still hope that future meetings will include this option with the goal that anyone with an internet connection can participate in meeting. The total of number of participants was 96 over the six meetings with an average of 14 participants per meeting. Although the total number of participants decreased from FY 16-17, the total number of consumer participants increased by five over FY 16/17.

The presentation of data at the QIC was also improved with, in addition to handouts, PowerPoint presentations were created to present the data including trends, outliers, and improvements and support discussion and analysis.

The QIC oversees the strategic initiatives and the seven goals and accompanying objectives. The QIC, in turn, is supported by working subgroups and committees that carry out quality improvement and evaluation activities to address initiatives, goals and objectives.

The Quality Management/Quality Improvement (QM/QI) meetings and the Utilization Management (UM) meetings were held monthly with QA/QI/compliance staff from both BHRS and RQMC, as well as fiscal and administrative staff from both agencies. For the first half of 2017-18, these meetings were held jointly. In January of 2018, the committee meetings were separated to allow more time to discuss specific agenda items relative to each committee function.

Monthly monitoring of the seven goals of the QI Work Plan made up the majority of the agendas and provided opportunities to review data, monitor trends and assess outliers. From the data, the work teams formulated plans and activities to improve delivery capacity, access to care (timeliness and distance) and client satisfaction. Committee members also reviewed the results of chart audits, client grievances and appeals, no-show rates and psychiatric hospital readmission rates. Results of these monitoring activities are reported below.

Committees also reviewed the impact of expanded outreach and engagement efforts, updates on the clinical and non-clinical Performance Improvement Projects, upcoming training opportunities, and the SUDT goals of increasing Latino participants, meeting charting timeliness requirements and the results of customer surveys. Both QM/QI and UM make recommendations to the QIC Committee within the reporting process.

The Cultural Diversity Committee (CDC) meetings were held quarterly to review disparities, discuss cultural responsiveness strategies to overcome barriers, and review cultural responsiveness practices of BHRS and its contractors. CDC meetings are held in different locations throughout the County to support the attendance of stakeholders from as many areas of

the county as possible. CDC meetings are predominantly attended by service providers and community members. In FY 17/18 CDC meetings were held in Gualala, Laytonville, Hopland, and Fort Bragg.

CDC meetings include a training component that allows for focused discussion and review of disparities. In FY 17/18, the training topics included Hispanic/Latino culture, Native American culture, Marijuana culture, and Homeless culture. Topics are prioritized based on prior CDC stakeholder training priority surveys. Most of the meetings this year included discussions of the trauma and stigma and the resulting barriers to accessing services created by these conditions.

In addition to the educational discussions in CDC meetings, BHRS facilitated five cultural responsiveness trainings in FY 17/18. The trainings focused on suicide prevention, Native American cultural responsiveness, stigma reduction and mental health awareness, and Cultural and Linguistically Appropriate Service Standards. Over 130 individuals attended the trainings.

The Behavioral Health Executive Team (BHET), made up of the director, deputy director, and managers, and the Behavioral Health Leadership Team (BHLT), which added front line supervisors in addition to those in BHET, met monthly.

The BHET reviewed data from QM/QI, Mental Health Service Act (MHSA), CDC, and fiscal data to evaluate MHP and SUDT programs and make recommendations on policy changes and areas of improvement. This includes, but is not limited to, quality of care, service delivery, performance improvement projects, QIC and CDC findings, actions, and recommendations.

The BHLT also reviewed currently released MHSUDS Information Notices, new and updated policies and procedures, updated forms, trainings and events, and made recommendations for administrative improvements and efficiency.

The Mental Health Care Coordination meeting (previously the Mental Health Administrative Leadership meeting), is made up of the BHLT and the administrative leadership of the ASO, Redwood Quality Management Company. This meeting also reviews data, both program and fiscal, in order to coordinate and improve service delivery and expand capacity. Additional far-reaching issues such as creating housing for homeless mental health clients and the creation of psychiatric crisis facilities in the county are also discussed in this meeting.

The Compliance Committee meets quarterly and is made up of the Compliance Manager, the BHRS Director, BHRS Deputy Director, QA/QI Manager, the Fiscal Manager, Program Managers, the ASO CEO, the ASO QA/Compliance Officer, and the ASO Chief Operations Officer. The extended committee includes executive representation from subcontractor provider organizations and county line staff. County Counsel is in an advisory role.

BHRS Compliance Committee members are responsible for the development, implementation, on-going maintenance, and annual evaluation of the effectiveness of the BHRS Compliance Program. This past year, the compliance program description and policies were updated, including the Code of Ethics for BHRS staff. The committee monitored the completion of compliance training, internal monitoring and auditing activities, service verification, staff credentialing and verification, security risk analysis and incidents, compliance inquiries, and follow-up with State required corrective action plans.

The Awareness Activities Group is a work group made up of Mental Health and Substance Use Disorders Treatment staff that plan and develop community awareness activities throughout the

year to provide education, training, and de-stigmatization activities throughout the county. In FY 17-18, due to staffing changes, the group did not meet regularly. However, many of the activities assigned to this group were managed by other committees. These included 'May is Mental Health Month' and April as 'Alcohol Awareness Month' and the annual 'Suicide Prevention Week'.

### MCBHRS Strategic Initiatives FY 2017-2018

The Strategic Initiatives are population based and address the needs of Children, Transitional Aged Youth, Adults, Older Adults and the Community. Initiatives included:

- *Outcome measurements on CANS and ANSA:* A CANS or ANSA assessment is done with every client as a part of their initial assessment process. A follow up CANS or ANSA is also done every six months thereafter until the client concludes treatment. A closing CANS or ANSA is completed at the time of discharge from services. The initial assessment is compared to the most recent assessment to identify progress or regression in treatment. Changes in the client's sub-score as well as individual question scores indicates the progress of the client in treatment. CANS and ANSA results are also reviewed by clinicians every six months to evaluate a client's progress in treatment. Clinicians discuss these results with clients to help focus treatment interventions as well as plan for treatment transition and termination. RQMC also uses aggregate outcome scores to evaluate the effectiveness of services by sub-groups, programs and Organizational Provider Agencies.
- *Client Satisfaction:* In addition to annual Client Satisfaction Surveys (as described in Goal #3 below), the MHP also utilizes the Client Satisfaction Questionnaire (CSQ-4). The questionnaire is presented to clients every six months and at discharge. Results were generally positive about the providers' treatment. For FY 17/18, 469 responses indicate the following:
  - 92% reported that all or most of his or her needs were met by the program.
  - 97% reported that services helped or somewhat helped them deal more effectively with problems.
  - 96% reported that they would or most likely come back to the program if they needed help.
  - 94% reported very or mostly satisfied with the services they received.
- *Outreach and Engagement:* For FY 17/18, a third rehabilitation specialist was added to the Mobile Outreach and Prevention Services (MOPS), allowing for improved coverage of the three geographical areas of the county - North County, South Coast, and Anderson Valley/Ukiah area. The MOPS program received 50 referrals from all three of the geographical areas. Referrals were for those individuals who were in either pre or post psychiatric crisis with the goal to prevent a hospitalization or re-hospitalization and potentially engage in ongoing specialty mental health services. Of the individuals served by the MOPS team, 52% were female and 47% male. The ages of individuals referred or served were 8% - 18-25 years old, 40% - 26-59 years old, 26% - 60 years old or older, and 26% of unknown age. Those of unknown age were unwilling to engage to the point where we are able to obtain demographic information, but outreach and support services are offered.
- *Improve FSP access:* Our target goals for the MHSA Plan did not increase between FY 16/17 and FY 17/18 for FSPs. Goals for FY 17/18 were to serve the following number of clients at any given time: 5 children; 24 TAY; 40 Adults; 14 Older Adults; and 10 Behavioral Health Court clients. MHSA meeting minutes indicate Child FSPs were consistently lower

(1-2 at any given time) than the goal. TAY FSPs tended to be at or below the goal, but at one point there were 28 clients enrolled. Adults occasionally exceeded the goal of 40 (61 was the highest number at one point). Older Adults were typically at or below the goal of 14 (7-13 range). Behavioral Health Court remained consistently at or just below 10 clients being served.

- *Reduce hospital readmissions:* Over the course of FY 17-18, there were 645 admissions to psychiatric hospitals. Of those, following discharge, 69 clients (10.7%) were readmitted within 30 days. In comparison to FY 16-17 there were 551 admissions and 52 (10.6%) were readmitted within 30 days. Therefore, the readmission rate held steady at just above 10.5%.

For adults, the readmission rate was nearly the same over both years (FY16-17: 10.2%, FY 17-18: 10.1%). For youth, there appears to be a slight increase (FY 16-17: 7.9%, FY 17-18: 11.8%). Continuous efforts are made to provide services that reduce the likelihood of readmission, including follow up appointments upon discharge.

- *Meeting needs for clients that transitioned:* The MHP places a high priority on the supporting the transition of clients from acute settings to back to the community. Of those voluntarily accepting follow-up appointments, 399 appointments were provided with 99% of the follow-up appointment provided within seven days of discharge. The average was within one day of discharge.

For those in long-term care on LPS conservatorships, by the end of FY 17-18, we had an increased number of LPS clients recommended for locked and secure levels of care. Therefore, the utilization of higher level locked placements increased. Board and Care (B&C) utilization remained fairly stable which indicates we were able to transition clients to independent living. We were also able to transition some clients from Mental Health Rehabilitation Centers (MHRC) to B&C. The supportive living environment placement was heavily utilized to assist with transitioning, with the potential for several of the clients getting off conservatorship this year. We experienced an increase in referrals to LPS from individuals at the jail who were unable to be restored to competency, including an increase in requests for Murphy Conservatorships. That has contributed the need for higher level placements.

### Objectives, Scope, and Planned Activities Fiscal Year 17/18 Evaluation

Goals and objectives were determined by the QIC and supporting committees, based on meeting regulation and areas identified for improvement. The goals and objectives apply across Mendocino County's behavioral health system of care and are monitored regularly, often time monthly.

Each Goal/Objective has a method for measurement. Goals/Objectives that do not meet the set target by more than 5% are analyzed for the development of additional quality improvement initiatives.

Goal #1: Ensure mental health service capacity

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<b>Objective A:</b> Monitor utilization of services	Monitor the current number of clients served, types and geographic distribution of mental health services within the MHP delivery system.	Met	Data reported monthly to UM meeting and bi-monthly to QIC.
	Monitor the goals set for type of services, number of services, and geographical locations.	Not Met	Types of services/services provided: Med Mgmt. Support - 3,449 Mental Health Services - 38,464 Targeted Case Mgmt. - 11,607 Crisis Services - 3,246 ICC - 3,401 IHBS - 1,154
	Types of services/services provided goals: Medication Management Support - 2,756 Mental Health Services - 43,060 Targeted Case Management - 7,422 Crisis Services – 867 ICC - 1,569 IHBS - 1,271		
Locations: Inland, North County, North Coast, South Coast, Out of County	Met	Locations: Inland: 34,928 North County: 8,433 North Coast: 7,949 South Coast: 890 Out of County: 743	
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.		Ages: 0-11 (502), 12-17 (483), 18-21 (205), 22-24 (100), 25-40 (484), 41-64 (610), 65+ (125)  Gender: male (1,126), female (1,019)  Ethnicity: White (1,457), Hispanic (348), American Indian (168), Asian (27), African American (50), Other (46), Unknown (49)  Primary Diagnosis: Adjustment (63), BIP (231), MDD (324), Schizophrenia (73), Schizoffective (136), Anxiety (111), PTSD (472), ADD/ADHD (44), Conduct (123), Other Mood D/O (107), Psychosis (57), Other (404)	



Goal #1: *continued...*

Ensure mental health service capacity

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<p><b>Objective B:</b> Monitor service capacity</p>	<p>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.</p> <p>At minimum 50% of Clinical Staff will bill an average of 60% per month.</p>	Met	<p>Of the 50% MHP Clinical Staff measured, they had an average 64% productivity.</p> <p>Continued refinement of this goal is necessary to accurately gather service capacity and the provision of cultural and linguistic services.</p>

Goal #2: Ensure accessibility to mental health services

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<p><b>Objective A:</b> Monitor timeliness of routine (initial) mental health appointments from the date of first request to the date of first billable clinical assessment</p>	<p>Goal is to provide first billable clinical assessment (BPSA) within ten (10) business days.</p> <p>A minimum of 90% will meet the timeline.</p>	Not Met by 4%	<p>Result for FY 17-18 was 86%. This was for the <u>kept</u> appointment. Declining appointments offered within 10-days, rescheduling, and no-shows brought the overall number down.</p> <p>This goal was set in preparation for this year's timeliness requirement.</p>
<p><b>Objective B:</b> Monitor timeliness of routine (initial) medication appointments / psychiatric appointments</p>	<p>The goal is to provide medical appointment / psychiatric appointments within 15 business days from the date of first request.</p> <p>A minimum of 90% will meet the timeline.</p>	Not Met	<p>Result for FY 17-18 was 73%.</p> <p>For Adults, results improved as the year progressed, meeting the requirement from February onward. Children's results varied through the year, but never made the standard. Crisis initial psychiatric appointments were within the standard.</p> <p>This goal was set in preparation for this year's timeliness requirement.</p>

Goal #2: *continued...*

Ensure accessibility to mental health services

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<p><b>Objective C:</b> Monitor timeliness of services for urgent conditions during regular clinic hours</p>	<p>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.</p> <p>A minimum of 95% will meet the timeline.</p>	<p>Met</p>	<p>Result for FY 17-18 was 98% met the timeframe.</p> <p>This was consistent with the previous year's result.</p>
<p><b>Objective D:</b> Monitor access to after-hours care</p>	<p>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.</p> <p>A minimum of 95% will meet the timeline.</p>	<p>Met</p>	<p>Result for FY 17-18 was 99% met the timeline.</p> <p>This was consistent with the previous year's result.</p>
<p><b>Objective E:</b> Monitor responsiveness of the 24-hour, toll-free telephone number</p>	<p>County Mental Health will answer the 800 Access line immediately and provide information on how to access services, provide information on how 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.</p> <p>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.</p> <p>100% of all calls will be logged.</p>	<p>Not Met</p>	<p>The access line is measured by conducting monthly random test calls.</p> <p>This fiscal year 41 test calls were conducted: 36 in English and five (5) in non-English. Either the language line staff or a bi-lingual staff person was utilized for non-English speaking callers.</p> <p>93% of the test callers were provided with the information they needed regarding how to access specialty mental health services, information on urgent conditions, and information on beneficiary problem resolution and fair hearing process.</p> <p>14 out of 41 calls were not logged. (34%)</p> <p>Although information provided was a significant improvement from last year (67%), this objective will continue to be monitored for additional improvement.</p>

Goal #2: *continued...*

Ensure accessibility to MCBHRS services

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<p><b>Objective F:</b> Ensure provision of culturally and linguistically appropriate services</p>	<p>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.</p> <p>100% of progress notes in audited charts will indicate the language services were provided in (if applicable - who provided the interpretation).</p> <p>The focus of these reviews is to determine if a successful and appropriate response was provided which adequately addressed the beneficiaries cultural and linguistic needs.</p>	<p>Met</p>	<p>Reviewed access logs, crisis logs, and chart audits.</p> <p>100% of all progress notes audited included documentation of the language in which the service was provided.</p> <p>The following cultural trainings were offered: Native American, Cultural and Linguistically Appropriate Service Standards, and client culture/stigma reduction.</p>
<p><b>Objective G:</b> Monitor timeliness to authorization</p>	<p>Treatment Authorization Requests (TAR) will be reviewed for medical necessity and authorized or reauthorized as appropriate within 14 calendar days by RQMC POA and/or MC-POA.</p> <p>A minimum of 100% will meet the timeline.</p> <p>RQMC POA and MC POA will authorize expedited TARs as needed.</p>	<p>Met</p>	<p>Outpatient authorizations were transitioned this year to only those required authorizations for Day Treatment/Rebab, Adult/Crisis Residential, TBS and TFC. TBS was the only service requiring authorization in FY 17-18. 100% of the services were authorized within the correct time frame.</p> <p>100% of hospital TARs were authorized within 14 calendar days.</p> <p>Outpatient TARs were discontinued except for TBS services (only outpatient service provided by BHRS that requires prior authorization). There were no expedited TBS authorizations and all TBS authorizations were completed on time.</p>
<p><b>Objective H:</b> Monitor timeliness from request for service to first clinical assessment</p>	<p>The goal is to provide a first assessment appointment within ten (10) business days from the date of first request for service.</p> <p>100% will meet the timeline.</p>	<p>Not Met by 9%</p>	<p>The result for FY 17-18 was 91%, however, both the average and median were 6 days.</p> <p>This goal was set in preparation for this year's timeliness requirement.</p>

Goal #2: *continued...*

Ensure accessibility to MCBHRS services

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<b>Objective I:</b> Monitor timeliness for a follow-up appointment after a psychiatric hospital discharge	The goal is to provide a follow-up appointment within seven (7) days from the date of discharge from a psychiatric hospital.  100% will meet the timeline.	Not Met by 1%	The result for FY 17-18 was 99% of the appointments met this standard.  This represents an increase by 2% above the FY 16-17 result (97%).

Goal #3: Monitor Client satisfaction

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<b>Objective A:</b> 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 completed surveys received by 5%.	Met	Increase from May 2017 to November 2018 - 3% more surveys completed.  Increase from November 2017 to May 2018 - 17% more surveys completed.
<b>Objective B:</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 by 5% and overall satisfaction.	Met	Increase in the number of surveys received from March 2017 - 38 surveys to March 2018 - 245 surveys, representing an increase of 545%.  Overall client satisfaction - agree and strongly agree - in March 2017: 88%.  Overall client satisfaction - agree and strongly agree - in 2017-18: 88%.
<b>Objective C:</b> 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.  The information is distributed on an annual basis & in a format to protect the confidentiality of beneficiaries.	Met	Presented to MHP, posted on website, and QIC meeting

Goal #3: *continued...*

Monitor Client satisfaction

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<p><b>Objective D:</b> Review beneficiary grievances, appeals, expedited appeals, fair hearings, and expedited fair hearings</p>	<p>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.</p> <p>100% will meet the timeline.</p> <p>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.</p>	<p>Met</p>	<p>All beneficiary grievances, appeals, and expedited appeals were logged, processed and evaluated.</p> <p>Mendocino County did not have any beneficiary appeals or expedited appeals in FY 17-18.</p> <p>Mendocino County did not have any State Fair Hearing requests in FY 17-18.</p> <p>21 grievances filed by 14 clients. Timeliness: 100% met the timeline all 31 grievances were responded to within 60 calendar days.</p> <p>Nature of Complaint/Resolution                      5 – Grievances about staff members. One staff member received more than one complaint which was managed as a personnel issue.                      3 – Clients stated they were not receiving the services they wanted. There were no commonalities or trends; each complaint was resolved in the clients’ favor.                      1 – Services not timely                      3 – Grievances about procedure that were barriers for clients                      4 - Grievances about other clients                      2 – Regarding perceived safety issues.                      3 – Complaints about housing.</p>

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<p><b>Objective A:</b> Monitor safety and effectiveness of medication practices</p>	<p>Providing safe and effective medication practices.</p> <p>Medication monitoring activities will be accomplished via review of at least five (5) percent of cases involving prescribed medications.</p> <p>These reviews will be conducted by a person licensed to prescribe or dispense medications.</p>	<p>Met</p>	<p>Two medication audits were conducted (40 adult, 10 children charts) by an independent psychiatrist. Results identified the need to improve and consistently document AIMS, labs and physical exams.</p> <p>As a result, the medical director developed a guideline addressing medication management practices to improve the provision of services and consistent documentation.</p>
<p><b>Objective B:</b> Identify meaningful clinical issues</p>	<p>Meaningful issues for assessment and evaluation, including safety and effectiveness of medication practices, will be identified and evaluated.</p> <p>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.</p>	<p>Met</p>	<p>From the results of the first medication audit, the reviewing psychiatrist made recommendations and those recommendations were implemented by RQMC in the medication management program. For the second audit, the same psychiatrist noted “huge improvement” in progress notes and had some additional recommendations for quality improvement.</p> <p>Previous survey results indicated that some of the responding providers did not feel confident diagnosing and treating co-occurring clients. Therefore, as part of the clinical PIP which was designed to address better treatment for co-occurring clients, clinical staff had training on co-occurring diagnosing and treatment.</p> <p>Provider staff also indicated they are working with many clients who have experienced trauma. Therefore, additional training on trauma was provided.</p>

Monitor the service delivery system

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<p><b>Objective C:</b> Review request for change of provider</p>	<p>MCBHRS QI will log, process, and evaluate all change of provider request.</p> <p>100% will meet the timeline.</p> <p>All requests will be evaluated to determine if there are trends or areas needing quality improvement.</p>	<p>Met</p>	<p>Request for change of provider forms are available at reception areas of all outpatient mental health service sites. Request for Change of Provider are recorded in a log and reported monthly to the QIC committee.</p> <p>There were 25 Requests for a Change of Provider submitted this fiscal year. Timeliness: All were responded to within the 10 business days standard.</p> <p>Analysis of requests:            3 - In person rather than telepsych            8- Didn't like provider or wants better fit            8 - Change of organizational provider:            2 - Closer provider            2 - Gender specific            2 – Canceled request</p> <p>All requests were accommodated. Based on analysis of the requests, we identified several requests to change organization providers were because clients believed they had to switch providers to attend a group provided by another provider.</p>
<p><b>Objective D:</b> Assess performance and identify areas for improvement</p>	<p>Quantitative measures will be identified to assess performance and identify areas for improvement, including the Performance Improvement Projects and other QI activities.</p> <p>These areas will be measured through the review of the timeliness of assessments and service plans, completeness of charts, consumer surveys, and productivity reports.</p> <p>The results of these reviews will dictate areas to prioritize for improvement. Trainings will be provided as necessary.</p>	<p>Met</p>	<p>Timeliness data was presented monthly and demonstrated trends across the year.</p> <p>Geographical, population, and service reports were also presented monthly. The data was reviewed for trends and network adequacy. Outreach data was also reviewed to look at access, trends, and network adequacy.</p> <p>Areas identified for improvement:</p> <ul style="list-style-type: none"> <li>• Timely access to psychiatry</li> <li>• Timely access to first appointment</li> <li>• No Show rates</li> <li>• Co-occurring diagnosis and treatment</li> </ul> <p>Trends demonstrated continuous improvement in all areas of timeliness and no-show rates. Geographical reports also demonstrate accessibility of services.</p>

Goal #4: *continued...*  
Monitor the service delivery system

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<p><b>Objective E:</b> Monitor stakeholder involvement</p>	<p>Staff, providers, consumers, and family members review the evaluation data to help identify barriers to improvement.</p> <p>This ongoing analysis provides important information for identifying barriers and successes toward improving administrative and clinical services.</p> <p>This will be measured by the number of consumers attending and participating in the QIC meeting.</p> <p>QIC meetings will be held in different locations throughout the county to provide more option for stakeholder involvement.</p>	Met	<p>Performance Improvement Project created to increase consumer and family member involvement in QIC meetings. It was found that the best location was at the wellness centers. Success was also found in joining QIC-MHSA meetings. Further refinement of the meeting process was addressed that included PowerPoints to display required data sharing. Continued efforts to increase meeting attendance were made with the addition of videoconferencing equipment and software.</p>
<p><b>Objective F:</b> Monitor clinical records and chart audits</p>	<p>MHP QI will evaluate the quality of the service delivery by conducting chart audits.</p> <p>A total of 5% of clients charted will be audited per year. The charts selected will be clients who have received services during the period being audited.</p>	Met	<p>BHRS conducted a 3% audit of all MHP charts this past year.</p> <p>RQMC conducted a 2% review of progress notes and 100% review of primary documents for charts. Also, RQMC conducted a review of 5% of the charts of clients with co-occurring client's conditions.</p> <p>The audit and review findings and recommendations are reported to providers in person and in writing. The charts were audited to insure they met medical necessity, as well as, clinical and state documentation standards.</p>
<p><b>Objective G:</b> Monitor authorized services to verify claimed/billed services were actually provided</p>	<p>MHP Fiscal will send verification of services letters to a random 5% of beneficiaries receiving services at least three (3) times per year.</p>	Met	<p>MHP completed four verification of service mailings in FY 17-18.</p> <p>08/15/17 - 31 Letters sent out 11/09/17 - 61 letters sent out 01/29/18 - 72 letters sent out 04/23/18 - 74 Letters sent out Total: 238 letters</p> <p>There was one (1) call back from a client that did not understand the letter. Client confirmed receipt of services.</p>

Goal #4: *continued...*  
Monitor the service delivery system



<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<b>Objective H:</b> Monitor inpatient readmission rates within thirty (30) days	MHP will monitor the number of psychiatric hospital readmissions within date of discharge from last psychiatric hospitalization.  The goal is that no more than 10% of clients discharged from the hospital will be readmitted within 30 days.	Met	Out of 645 total hospital admissions for FY 17-18 10.7% of those patients were Mendocino County Medi-Cal beneficiaries that were readmitted within 30 days from discharge.  As described above, this is comparable to last year's readmission rate.
<b>Objective I:</b> Monitor client no-show rates for scheduled psychiatrist and clinician appointments.	MHP will monitor the rate of client no shows for scheduled psychiatrist and clinician appointments.  The no-show rate goal for psychiatrist appointments is no higher than 10%. The no-show rate goal for clinician (other than psychiatrists) appointments is no higher than 10%.	Not Met by 6%  Met	For FY 17-18, the no-show rate for psychiatrists: 16% Previous year, the no-show rate was 13.9%.  For FY 17-18, the no-show rate for clinicians other than psychiatrists: 9%. Previous year, the no-show rate was 10.9%

**Goal #5: Monitor continuity and coordination of care with non-psychiatric medical providers**

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<b>Objective A:</b> 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.  90% of charts will have a signed release of information for the beneficiary's health care provider(s).	Met	ROIs: We reviewed Releases of Information in 189 charts (15% of Adult clients). 100% had ROIs that included a Primary Care Physician. This result was consistent with FY 16-17 findings.

**Goal #6: Monitor provider appeals**

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<p><b>Objective A:</b> Monitor provider appeals</p>	<p>Provider appeals will be recorded in a Provider Appeal Log and will be reviewed by UM and reported to QIC.</p> <p>100% of appeals will be followed up within state recommended timeframe.</p> <p>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.</p>	Met	<p>All provider appeals are recorded in a Provider Complaint Log and reviewed at QIC. There were two provider appeals filed with the Mental Health Plan. One of the Provider Appeals was from an Inpatient Psychiatric Facility regarding a payment denial. One was from an outpatient provider regarding a Treatment Authorization audit. The appeals were reviewed by and responded to in writing within 60 days.</p>

Goal #7: Monitor SUDT Services

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<p><b>Objective A:</b> Increase the number of Latino participants</p>	<p>Increase the number of Latino participants by 10% or more.</p> <p>Review and analyze data from WITS.</p>	Not Met	<p>New client admissions for the last six months of FY 16-17 showed 14.2% were Latino. This past fiscal year, only 11.7% of new clients were Latino.</p> <p>Continue review and analyze data to develop outreach and other activities to increase Latino participation.</p>
<p><b>Objective B:</b> Monitor timeliness to complete progress note</p>	<p>Goal is to complete progress notes within 7 days.</p> <p>A minimum of 90% will meet the timeline.</p> <p>Review and analyze data from WITS.</p>	Met	<p>97% of the 9,508 progress notes written in FY 17-18 met the goal of completion within 7 days of the date of service.</p>

Goal #7: *continued...*  
Monitor SUDT Services

<b>Objective</b>	<b>Activities/Strategies</b>	<b>Goal Status</b>	<b>Results</b>
<p><b>Objective C:</b> Substance Use Disorder Treatment clients will complete two (2) customer surveys a year.</p>	<p>Review consumer surveys and present the results.</p>	<p>Met</p>	<p>Surveys were completed quarterly. There were 51 responses.</p> <p>The survey includes 13 questions that address location and availability of services; participation; respectful, understandable staff; welcoming, likable service environment; and whether the respondent would recommend the agency to others. Responses were positive for every question for each quarter. On a scale of 1 – 5, with 5 being the most positive, the average score for all responses was 4.5.</p>