Mendocino County Behavioral Health and Recovery Services

County Annual Evaluation of
Quality Improvement Work Plan
Fiscal Year 2018 - 2019

Introduction and Overview

The Mendocino County Mental Health Plan (MHP) is unique in that Mendocino County Behavioral Health and Recovery Services (BHRS) contracts most 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 Assessment and Performance Improvement (QAPI) is responsible for monitoring the quality management of this business model. The QAPI Program is accountable to the Behavioral Health Director, Behavioral Health Advisory Board, and Health and Human Services Agency Director.

The goal of the QAPI 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 QAPI Program 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, 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/appeals.

The QAPI 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 committee has several subcommittees carrying out quality improvement and evaluation activities. These subcommittees include Quality Management/Quality Improvement, Utilization Management, a Clinical Performance Improvement Project, and a Non-Clinical Performance Improvement Project.

Additional quality management committees and workgroups include the Cultural Diversity Committee, Behavioral Health Leadership Team, Behavioral Health Executive Team, Compliance Committee and Administrative Service Organization Care Coordination. These entities inform and provide feedback to the QIC.

The MHP contract requires that the MHPs establish and maintain a QAPI program and QM Work Plan, also referred to as a Quality Improvement (QI) Work Plan. The QI Work Plan supports the strategic initiatives and the Goals and Objections of BHRS in providing the highest quality of 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. The BHRS leadership, MHP Providers, Quality Improvement Committee, and its subcommittees formulate these Goals and Objectives and evaluate their effectiveness.

The QI Work Plan has identified seven goals to work towards this past year. Within the seven goals are specific measurable objectives. These goals support the mission, vision, and operating principles of Mendocino County Health and Human Services, as well as the strategic goals of BHRS. The majority of this report is devoted to reviewing the achievement towards these goals.

Objectives, Scope, and Planned Activities Fiscal Year 19/20 Evaluation

Goal #1: Ensure mental health service capacity

Objective	*Activities/Strategies*	*Goal Status*	*Results*
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 (2,756), Mental Health Services (43,060), Targeted Case Management (7,422), Crisis Services (867), ICC (1,569), and IHBS (1,271). 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.	Met	Reported monthly to UM meeting and bi-monthly to QIC Types of services and services provided: Medication Management Support (3,225), Mental Health Services (28,450), Case Management (14,210), Crisis Services (2,607), ICC (4,653), IHBS (1,990), TBS (628). YTD Person by location: In County: 2,399 Out of County: 127 Ages: 0-11 (522), 12-17 (478), 18-21 (164), 22-24 (99), 25-40 (458), 41-64 (585), 65+ (93) Gender: male (1,240), female (1,158) Ethnicity: White (1,598), Hispanic (402), American Indian (205), Asian (25), African American (61), Other (34), Unknown (65) Primary Diagnosis: Adjustment (45), BIP (210), MDD (300), Schizophrenia (63), Schizoaffective (121), Anxiety (97), PTSD (420), ADD/ADHD (36), Conduct (102), Other Mood D/O (100), Psychosis (42), Other (738)
Objective B: Monitor service capacity	Staff productivity will be evaluated via productivity reports generated by the MHP Providers. Clinical Staff will bill an average of 60% per month. Supervisors and managers will receive reports to assess service capacity and cultural and linguistic service capacity.	Met	Year to date productivity was 61.25% which met our goal for this metric.

Goal #2: Ensure accessibility to mental health services

Objective	*Activities/Strategies*	*Goal Status*	*Results*
Objective A: Monitor timeliness from request for service to first clinical assessment	The goal is to provide a first assessment appointment within ten (10) business days from the date of first request for service. 95% will meet the timeline.	Met	Year to date result was 95% which met our goal for this metric.
Objective B: 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 10 business days. A minimum of 90% will meet the timeline.	Met	Year to date result was 90% which met our goal for this metric.
Objective C: Monitor timeliness of routine (initial) medication appointments / psychiatric appointments	The goal is to provide medical appointment / psychiatric appointments within fifteen (15) business days from the date of first request. A minimum of 90% will meet the timeline.	Not Met	Year to date result was 78% of psychiatric appointments were within 15 days of first request which did not met the goal. Attempts to improve this metric were conducted through exploring creative ways to increase available psychiatric appointment times. RQMC recruited for additional psychiatrists, worked with existing providers to increase availability, and restructured appointments to maximize time with the psychiatrist. In the QA/QI workgroup meetings we have decided to track both the attended appointment timeframe, and the offered appointment timeframe to help identify where to focus further improvement efforts.
Objective D: 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	Met	Year to date result was 100% which met our goal for this metric.

Goal #2: *continued…*
Ensure accessibility to MCBHRS services

Objective	***Activities/Strategies***	***Goal Status***	***Results***
Objective E: 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.	Met	Year to date result was 98% which met our goal for this metric.
Objective F: 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. 95% will meet the timeline	Met	Year to date result was 98% which met our goal for this metric.
Objective G: Monitor inpatient readmission rates within thirty (30) days	BHRS QA/QI 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.	Not Met	Year to date result was 14% which did not met our goal for this metric. Our Adult services had a rate of 14% and our Children's services had a rate of 15%.

Goal #2: *continued…*
Ensure accessibility to MCBHRS services

Objective	***Activities/Strategies***	***Goal Status***	***Results***
Objective H: Monitor client no-show rates for scheduled psychiatrist and clinician appointments	BHRS QA/QI 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 3% Met	Year to date result was 13% for psychiatrist appointments. Year to date result was 6% for clinician (other than psychiatrists) appointments. Though we missed the overall goal by 3% for psychiatrist appointments, we met the goal for clinician appointments. We have continued to discuss the no-show rates in the QAQI work group meetings and continue to look for ways to reduce the rate for psychiatry appointments.
Objective I: Monitor responsiveness of the 24-hour, toll-free telephone number	BHRS QA/QI or contractor 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. 95% 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.	Not Met	The access line is measured by conducting random test calls to the line monthly. This fiscal year 39 test calls were conducted: 33 in English and 6 in non-English. Either the language line or a bi-lingual staff person was utilized for non-English speaking callers. 67% of the 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. 82% of calls were logged. 18%calls were not logged. Efforts to improve this metric in fiscal year 18-19 have included updating the Access Log Instruction Manual, Training Access Line staff in the manual, and working with our after-hours call center to ensure they are trained in the policy and manual instructions. Additional efforts in fiscal year 19-20 are to increase the number of individuals answering the Access Line.

Goal #2: *continued…*
Ensure accessibility to MCBHRS services

Objective J: 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. 95% of progress notes 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 beneficiaries 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.	Met	100% of all progress notes audited indicated the language in which the service was provided.
Objective K: 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 RQMC POA and/or MC-POA. A minimum of 100% will meet the timeline RQMC POA and MC POA will authorize expedited TARs as needed.	Not Met	Year to date result was 99.6% of TAR's met the standard. Only 2 TAR's were outside of the range, they were 16 days and 17 days respectively.

Goal #3: Monitor Client satisfaction

Objective	***Activities/Strategies***	***Goal Status***	***Results***
Objective A: Conduct State Consumer Perception Survey	Using the DHCS Consumer Perception Survey instruments, in threshold languages, clients and family members will be surveyed to determine their perception of services twice a year. Goal is to increase the participation of the number of surveys received. Survey administration methodology will meet the requirements outlined by the CA DHCS.	Not Met	Decrease from May 2018 to November 2019 was 57% fewer surveys completed. It is believed that the decrease in responses was due to major fires that affected our county. During the survey week hazardous air quality warnings related to the fires were issued keeping more people at home. Change from November 2018 to May 2019 was undeterminable as this data was not available on ITWS at the time of writing.

Goal #3: *continued…*
Monitor Client satisfaction

Objective B: Conduct beneficiary and/or family satisfaction survey	Utilization of BHRS 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.	Met	Increase from March 2018 (245 surveys) to March 2019 (308 surveys) was 26% Overall client satisfaction (agree and strongly agree) in March 2019: 87%
Objective C: Measure self-perception and service satisfaction.	Results from Consumer Perception and Beneficiary Satisfaction Surveys will demonstrate a majority of beneficiaries believe that have improved in their functioning and are satisfied with services.	Met	Results presented to MHP, posted on website, and QIC meeting.
Objective D: 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 beneficiaries and their families.	Met	Results presented to MHP, posted on website, and QIC meeting.
Objective E: Review beneficiary grievances, appeals, expedited appeals, fair hearings, and expedited fair hearings	BHRS QA/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.	Met	All beneficiary grievances, appeals, and expedited appeals were logged, processed and evaluated. There were 26 grievances this fiscal year. Timeliness: 26 grievances were responded to within 60 calendar days. This is 9 less grievances than fiscal year 17-18. Mendocino County did not have any Beneficiary Appeals in fiscal year 18-19. Mendocino County did not have any State Fair Hearings in fiscal year 18-19.

Goal #3: *continued…*
Monitor Client satisfaction

Objective F: Review beneficiary Change of Provider Requests and Second Opinion Requests	BHRSQA/QI will log, process and evaluate beneficiary Change of Provider Requests and Second Opinion Requests, ensuring they are processed timely and accurately. 100% will meet the MHP standard of being processed within 10 business days. The nature of the requests will be reviewed to determine if significant trends occur that may influence the need for policy changes or other system-level issues.	Met	All beneficiary Change of Provider Requests and Second Opinion Requests were logged, processed and evaluated. There were 24 Change of Provider Requests this fiscal year. Timeliness: All 24 Change of Provider Requests were responded to within 10 calendar days. Mendocino County had 2 Second Opinion Requests this fiscal year. They were all responded to within 10 days.

Goal #4: Monitor the service delivery system

Objective	***Activities/Strategies***	***Goal Status***	***Results***
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 50 cases (40 adult, 10 youth) involving prescribed medications. These reviews will be conducted by a person licensed to prescribe or dispense medications.	Not Met	Only one medication audit with 20 charts were conducted by an independent licensed pharmacist who made recommendations. BHRS had a change in our chart auditor, which impacted our ability to complete the targeted number of reviews. In fiscal year 19-20 we have contracted with a licensed pharmacist to complete audits on 80 charts, at 20 per quarter.
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.	Met	During one of the medication reviews the licensed pharmacist made recommendations and suggested areas of improvement. The ASO received a corrective action plan from BHRS and plans to incorporate the recommendations in their medication management program.

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

Objective C: Review request for change of provider	BHRS QA/QI will log, process, and evaluate all change of provider request. 95% will meet the timeline. All requests will be evaluated to determine if there are trends or areas needing quality improvement.	Met	Request for change of provider forms are made available at the reception area of all outpatient mental health service sites. Request for Change of Provider are recorded in a log and reported monthly to the QIC committee. There were 24 Requests for a Change of Provider submitted this fiscal year. This is 3 fewer requests than fiscal year 17-18. Timeliness: All were responded to within 10 business days.
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.	Met	Timeliness data was presented monthly and demonstrated trends across the year. 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. Areas identified for improvement: • Timely access to psychiatry • No Show rates • Medication Chart Auditing Trends demonstrated continuous improvement in all other areas of timeliness and no-show rates. Geographical reports also demonstrate accessibility of services.
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.	Met	Feedback from stakeholders indicated that the best location for meetings is at the wellness centers. Successful consumer turnout was also found in joining QIC-MHSA meetings. Further refinement of 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. Focus for coming year is to increase consumer interaction at meetings. Feedback from stakeholders regarding the best time of the meeting (different times work for different groups of stakeholders) has resulted in the fiscal year 19-20 schedule having varied meeting times.

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

Objective F: Monitor clinical records and chart audits	BHRS QA/QI will evaluate the quality of the service delivery by conducting chart audits. 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.	Met	BHRS QA/QI conducted a 6% audit of all MHP charts this past year. RQMC conducted a 2% review of progress notes and 100% review of primary documents for charts. An additional 6% review of the co-occurring client's charts occurred this year. 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.
Objective G: Monitor authorized services to verify claimed/billed services were actually provided	BHRS Fiscal will send verification of services letters to a random 5% of beneficiaries receiving services at least three (3) times per year.	Met	Last Year: MHP completed four verification of service mailings over the last fiscal year 08/06/18 78 Letters sent out 11/19/18 78 letters sent out 02/04/19 69 letters sent out 05/15/19 71 Letters sent out Total: 296 letters This represents 12% of beneficiaries

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

Objective	*Activities/Strategies*	*Goal Status*	*Results*
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. 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 69 charts. 100% had ROIs that included a Primary Care Physician. This equaled 3% of clients.

Goal #6: Monitor provider appeals

Objective	*Activities/Strategies*	*Goal Status*	*Results*
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.	Met	All provider appeals are recorded in a Provider Complaint Log and reviewed at QIC. There was only one provider appeal filed with the Mental Health Plan. The Provider Appeal was from an Inpatient Psychiatric Facility regarding a payment denial. The appeals were reviewed by and responded to in writing within 60 days.
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.	Met	All provider suggestions are discussed and reviewed monthly in the QA/QI work group meetings with BHRS and ASO staff.

Goal #7: Monitor SUDT Services

Objective	*Activities/Strategies*	*Goal Status*	*Results*
Objective A: Monitor clinical records and chart audits	BHRS QA/QI will evaluate the quality of the service delivery by conducting chart audits. 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.	Met	BHRS QA/QI conducted a 6% audit of all SUDT charts this past year. 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.
Objective B: Monitor timeliness of service delivery	Timeliness of the following will be monitored: • Treatment Plans (Goal: 30 days and 90 days thereafter) • Stay Reviews (Goal: every 6 months) • Completion of progress notes (Goal: 5 days) A minimum of 90% will meet the timeline Review and analyze data from WITS.	Met Not Met Not Met	Year to date result was 95% of SUDT Treatment Plans met the 30/90 day goal, with only 16 Treatment Plans outside of the range out of 342 total. Stay Reviews are done outside of WITS and not tracked in FY18-19 Of 8,345 progress notes entered, 1.452 were entered more than 5 days from the service date.
Objective C: Substance Use Disorder Treatment clients will complete 2 customer surveys a year.	Review consumer surveys and present the results.	Not Met	While SUDT completed the consumer surveys, the results were not presented.