LAKE COUNTY BEHAVIORAL HEALTH DEPARTMENT

Quality Improvement Work Plan
2016-2017

Lake County Behavioral Health Department

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Lake County Behavioral Health Department (LCBH) has adopted this QI Work Plan for 2016-2017 for the department and extended partners of LCBH. This plan was created to adhere to the Quality Improvement Committee's (QIC) efforts in complying with the State Medi-Cal Contract. Once completed, the QI Work Plan is approved by Management and the QI Committee as a living document. As such, the QI Work Plan may change to reflect new or revised projects throughout the 2016-2017 period.

Quality Improvement Coordinator and Committee

The QI Coordinator is responsible for organizing and facilitating the quarterly QIC Meetings. QIC's core members and invited stakeholders are encouraged to actively participate in meetings and provide feedback on quality improvement activities that may or may not have been initiated by the QIC.

Each QIC meeting consists of reviewing data-driven decision making while creating collaboration among consumers and family members, clinical and supportive line staff, Managed Care staff, Compliance Staff, supervisors, management, Mental Health Board members, contracted providers, and other community service providers. These are key stakeholders to involve when reviewing up-to-date information, projects, and organizational processes. Some of the topics QI Committee reviews are:

- 24/7 Crisis/Access line response
- Accessibility to Services
- Beneficiary and Provider Satisfaction
- Clinician Documentation and Chart Reviews
- Notice of Action
- Operational Guidelines
- Performance Improvement Projects
- Resolution of Grievances, Appeals, Expedited Appeals, and State Fair Hearings
- Resolution of Provider Appeals
- Training

It is also the QI Coordinator's job to maintain good working collaboration with all of the stakeholders and to ensure the stakeholders remain informed by sending out agendas, minutes, meeting reminders, and other communications related to QIC activities.

It is essential that executive management and program leadership is present in order to ensure that the QIC's analytical data is used to meet the QIC's goals. The QIC's goals focus on the overall quality of service delivery, access, timeliness, under/over utilization of services and organizational operations.

QI Work Plan

Quality Management (QM) is required to have a Work Plan covering the current contract cycle and to conduct annual evaluations. The QI Work Plan is a live document, with revisions and updates as QIC/QM deems appropriate.

The Work Plan shall include:

- Evidence of monitoring activities including, but not limited to; review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Cal. Code Regs., Title 9, § 438.416;
- Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary services;
- A description of completed and in-process QM activities, including performance improvement projects. The description shall include:
    - Monitoring efforts for previously identified issues, including tracking issues over time;

    - Objectives, scope, and planned QM activities for each year; and,
    - Targeted areas of improvement or change in service delivery or program design.
- A description of mechanisms LCBH has implemented to assess the accessibility of service within its service delivery area. This shall include goals for responsiveness for the Contractor's 24-hour toll-free telephone number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, access to after-hours care; and
- Evidence of compliance with requirements for cultural competence and linguistic competence specified in Cal. Code Regs., Title 9, § 1810.410.

Significant Changes to QI during FY 2015-2016

FY 2015-2016 was filled with challenges that directly impacted QI throughout the year. The fires of 2015; the Rocky Fire, Jerusalem Fire, and the Valley "Firestorm", relentlessly hit the months of June through September, and brought hardships that Lake County has never seen. It also showed a lot of strength in the community's spirit with an impressive show of support throughout all of California and beyond. Where we lacked in the daily operations, we were able to provide and give to our community when it needed it most. Lake County Behavioral Health Department's Management Team worked countless hours in the Emergency Operations Center (EOC) and our staff assisted in manning over 900 hours in the various shelters set up around Lake County.

The beginning of the New Year brought even more challenges when we had a couple of key management members, as well as other staff members, depart LCBH; bringing the total to over 40 people who have moved on from LCBH for various reasons. This is in addition to a few staff members who have been required to be out on leave. In February, our Compliance Manager and our Behavioral Health Director both moved on to new ventures within one week and with very little advance warning. Other Management and staff members gained a large number of new responsibilities to cover for the sharp decrease in staff. In addition, 3 positions of our management team remain vacant.

Other challenges that had a direct impact on the daily operations of LCBH, especially impacting QI, were that the California Department of Health Care Services (DHCS) conducted multiple program reviews within the last 6 month period. Reviews for DUI, DMC, and Licensing and Certification for both the Clearlake and Lucerne offices demanded the QI Coordinator to change focus to addressing issues due to lack of staff. This included collecting evidence, organizing necessary information, and reviewing/revising some policies and procedures to ensure they met the various prerequisites that took place to address the site review requirements. After the site reviews, each site review had Corrective Action Plans to prepare and submit within a strict timeframe, leaving little time to work on much of the Quality Improvement activities.

Objectives

- Continue to acknowledge grievances, appeals, and expedited appeals within 1 working day of when the Member Services Resolution Officer (MSRO) receives the item in writing.
- Monitor and review State Fair Hearings
- Log kept by MSRO to track trends (if any identified)
- Review and forward information to appropriate supervisory staff; seek consult by Compliance Manager and/or LCBH Interim Director, if appropriate.
- Investigate and, if necessary, review the clinical records, and maintain ongoing status of outcome.

- Written follow-up to the member within 45 days for grievances and appeals, and within 3 working days for expedited appeals (may be extended by up to 14 days in certain circumstances).
- For Medi-Cal beneficiaries, complete NOA if over the MHP's standard timeframe(s) for acknowledgement and/or response.
- Update MSRO log as needed.
- Collect submissions from the suggestion boxes from each of the lobbies and report quarterly to QIC.
- Update appropriate logs as needed

Other Activities Include

Evaluate request to change persons providing services at least annually (AKA Transfer Log)

To ensure each request is addressed to the best of the Department's ability to ensure transfer of clinicians/providers are available. Only having one doctor limits the amount of requests that are submitted. However, the need to ensure each request is addressed appropriately continues.

Timeliness and Access to Services

Research and implement easier, more systemic ways to track:

- Average length of time from first request (at Brief Intake Screening) to scheduled appointment; separating Adult and Children
- Average length of time from first (determinably medically necessary appropriate) service to first psychiatry appointment; separating Adult and Children
- Average length of time for urgent appointments (crisis services)
- Average length of time for follow-up appointment after hospital discharge
- Track and trend re-hospitalization data focusing on readmissions within 30 days
- Average No Show rates for Psychiatrist and Non-Psychiatrist appointments

QI/QM activities report and/or consult to

- Quarterly - Quality Improvement Committee
- Management/Compliance Manager
- Annually – EQRO
- Department of Health Care Services (DHCS)

Review Sub-Committees – through Quarterly reports to QIC

a. Cultural Competency Committee – identify cultural variations, satisfaction with/use of services across subcultures, identify culturally relevant issues surrounding the design and delivery of services, develop staff cultural competency, provide quarterly reports to QIC and BH Director, and develop and implement a Cultural Competency Plan, include and adhere to the CLAS Standards to be in compliance with requirements set by ADP.

b. Special Incident Sub-Committee – meets as needed to respond to request for review of special incidents. May initiate or conduct a peer-review process. Log for Unusual Occurrences maintained by QI Coordinator after submitted forms have been reviewed by Behavioral Health Director/designee

c. Medication Monitoring – Review a sample size of the medication services by the psychiatrist and/or PA and maintain the medication room safety environment and monitoring of the

medication parameters. Results are to be directly reviewed quarterly with the contracted provider, psychiatrist, medication support staff, and compliance and QI Coordinator. A report then needs to be sent out to QIC.

Last Med Monitoring Site Visit (to Med Rooms) – As reported at the November 4, 2015 Medication Monitoring Meeting, a review of the Med Rooms in both the Clearlake and Lucerne offices were discussed. Feedback and recommendations were made, and at the December Quality Improvement Meeting the findings were also reported and discussed. It was decided to obtain the information needed to address the recommendations and receive Management approval to pay for items suggested in the Med Rooms.

Performance Improvement Projects:

We understand the value of these projects and look forward to working together with our stakeholders to research meaningful items for our PIPs.

1. Clinical PIP
   At this time, there is no clinical PIP to evaluate. This will be updated throughout the year as projects are identified.

2. Non-Clinical PIP
   At this time, there is no non-clinical PIP to evaluate. This will be updated throughout the year as projects are identified.

Participate in Annual Program Review

Review the entire system from a QI standpoint. Work with EQRO to review areas of improvements in clinical care and beneficiary services. Seven performance measures include:

- Total Beneficiaries Served by LCBH
- Total Costs per Beneficiaries Served
- Penetration Rates
- Count of Therapeutic Behavioral Services (TBS) Beneficiaries Served (compared to the four percent (4%) Emily Q Benchmark)
- Total Psychiatric Inpatient Hospital Episodes, Costs, and Average Length of Stay
- Psychiatric Inpatient Hospital 7-Day and 30-Day Recidivism Rates
- Post-Psychiatric Inpatient Hospital 7-Day and 30-Day Specialty Mental Health Services (SMHS) Follow-Up Service Rates

Within the Annual Review these elements are focused on:

- Prior Year Review Findings
- Performance Measurements
- Performance Improvement Project Validation
- Consumer and Family Focus Group(s)
- Information Systems Review
- Site Review Process Barriers
- Conclusion of the review (including Strengths and Opportunities of Access to Care, Timeliness of Services. Quality of Care, Consumer Outcomes, and EQRO's recommendations)

The QI Coordinator and the internal stakeholders work to organize, research, and provide appropriate data to the EQRO Reviewer prior, during, and post EQRO's site visit. The findings, recommendations, and final report are shared with the QIC.

Monitor Consumer Satisfaction

a. Participate in the DHCS bi-annual Consumer Surveys as directed, submit the results and review the outcomes as they are made available to the Department
    - Baseline set in May 2015; LCBH feels the amount of surveys completed are not a substantial amount of information to review. Once the Consumer Survey outcomes from the November 2015 collection are available this information will be reviewed by Management and QIC and shared with our clients in means to be determined in order to improve quality of services.
    - Currently, we have been unable to review this information but look forward to seeing how the increased amounts of surveys that we focused collecting from clients will impact this information.
b. Ensure that beneficiaries or family satisfaction surveys are available in their primary language
c. Provide the results of the beneficiary/family satisfaction surveys
d. Monitor that at least 75% of the respondents will have access to written information in their primary language
e. Provide a "Suggestion Box" in each clinic lobby where anyone can anonymously make suggestions

Utilize other consumer satisfaction/opinion surveys as they become available.

Additional DHCS Contract and EQRO Items

a. Medication Quality – Maintain medication room environments, complete med room reviews and monitor the safety of the facility and storage/dispensing of medication in compliance with laws and regulations, and support correct prescribing.
b. Provider Quality – Monitor the accessibility of services. Monitor Recent Discharge High Triage (RDHT) slots for timeliness, appointments kept/not kept and the impact on hospitalizations. Ensure crisis/urgent care is available 24/7 and monitor the response time to maintain within 1 hour timeframe
c. MHP to adopt or establish quantitative outcome measures to assess performance to identify and prioritize area(s) for meaningful improvements in clinical care and beneficiary services
d. Ensure Compliance Team monitors and addresses provider appeals
e. Ensure services are accessible through clinic-based services and the 24-hour toll-free telephone number; monitor and log 800# to assure response to hospital calls are within the 1-hour response timeframe; conduct test calls (equal to 2/month)
f. Monitor the completions of Utilization Reviews on staff who provide services (example, to ensure the code meets progress note contents) which are used to provide feedback to the supervisors and monitor compliance of the charts
g. Monitor the completions of Utilization Reviews on charts (reviewing for Medical necessity, assessments, TX plans updated) which are used to provide feedback to the supervisors and monitor compliance of charts.
h. Monitor the service delivery capacity; gather data collected from CSI, utilize demographic forms of the LCBH populations that describe the current number, types and geographic distribution of mental health services within its delivery system. This is to ensure the information is available to management in order to make changes in operations if deemed necessary.

1. To monitor the service delivery capacity of the MHP, QI is monitoring how many people are accessing the 800# (clients, family/friends, and community members) for services.

   August 2015 there was a change in the 800#; public callers such as clients/family members will remain using our usual 800#. However, Crisis Support Services of Alameda will answer those calls. The services that Crisis Support Services provides includes after-hours telephone crisis intervention, prevention and education, disaster mental health, trauma informed care and stress counseling.

   Calls from hospitals, placements, law enforcement, and other calls that do meet the same requirements as our access line have been given a different 800# that will continue to be answered by our current answering service.

   Both 800#s have access to our after-hours crisis staff.

i. Monitor the MHP's service delivery system and meaningful clinical issues affecting beneficiaries and ensure the data is available to compliance and supervisory staff. This information may be utilized for training purposes.
j. Update/modify the department's Cultural Competency Work Plan annually and adhere to the objectives set in order to meet the goals listed in the plan.
   - Work with WET Coordinator and Cultural Competency Committee/liaison to set up training, monitor sign in sheets and review staff's participation
   - Monitor Department's focus for evidence of CLAS

Currently, LCBH is looking at being more proactive from the time of first hire to ensure that when an employee/volunteer starts that they receive two online trainings within the first 30 days, and then annually thereafter. As all staff will be attending training annually. We are also in the process of developing a system to ensure we capture all the trainings in order to track that everyone is doing them.

Goals

FY 2016-2017 we will continue to utilize the Baselines set in 2014-2015, considering the challenges during FY 2015-2016 we had on QI Work Plan

a. Acknowledge grievances, appeals, expedited appeals within 1 working day of when MSRO received them

Responsible Party: MSRO	1 to 4 month measure	% met the goal	5 to 8 month measure	% met the goal	9 to 12 month measure	% met the goal
Baseline: 14/15 FY 71% (5/7)						
Goal: 90%	3/3	100%	N/A	N/A	1/1	100%

b. Complete the review and submit response within 45 days, 3 working days for expedited appeals

Responsible Party: MSRO	1 to 4 month measure	% met the goal	5 to 8 month measure	% met the goal	9 to 12 month measure	% met the goal
<u>Baseline:</u> 14/15 FY 0% **<u>Goal</u> (if any expedited appeals are requested) 100%**	0	NA	0	N/A	0	N/A

c. Complete NOA if over the MHP's standard timeframe(s) (Medi-Cal beneficiaries only)

Responsible Party: MSRO	1 to 4 month measure	% met the goal	5 to 8 month measure	% met the goal	9 to 12 month measure	% met the goal
<u>Baseline:</u> 14/15 FY 86% (6/7) **<u>Goal:</u> 100%**	0	NA	0	N/A	0	N/A

d. Evaluate request to change persons providing services at least annually (AKA: Transfer Log)

Responsible Party: MSRO	1 to 4 month measure	% met the goal	5 to 8 month measure	% met the goal	9 to 12 month measure	% met the goal
<u>Baseline:</u> 13/14 FY 100% (2/2) **<u>Goal:</u> 100%**	0	NA	0	N/A	0	N/A

e. Conduct quarterly Medication Monitoring Reviews/Meetings

Responsible Party: QI Coordinator	1 to 3 month measure	4 to 6 month measure	7 to 9 month measure	10 to 12 month measure	% met the goal for the yr
Med Monitoring meetings <u>Baseline:</u> 14/15 FY 100% (4/4) Review & Meetings **<u>Goal:</u> 100%**	1	1	1	1	100%

f. Increase participation in the DHCS Bi-Annual Consumer Surveys

Responsible Party: QI Coordinator	Survey	% met the goal
Baseline: **May 2015 = 9 Surveys** **Goal:** **November 2015** **18 Surveys** **May 2016** **31 Surveys**	 November 2016 = 23 Surveys May 2017 = TBD	 100% TBD

g. Clinician Service Documentation Review conducted in order to review all clinical staff within a year.

Responsible Party: QA Team Leader	1 to 4 month measure	% met the goal	5 to 8 month measure	% met the goal	9 to 12 month Measure	% met the goal
Baseline: **Quality Review of clinicians services 2/month** **Goal:** **(24/24) Reviews 80%**	 TBD					

h. Clinician Overall Score of Services in Compliance with Title 9 regulations

Responsible Party: QA Team Leader	1 to 4 month measure	% met the goal	5 to 8 month measure	% met the goal	9 to 12 month Measure	% met the goal
Baseline: **Quality Review of clinicians services averaging an overall score of 60% in compliance** **Goal:** **Quality Review of clinicians services averaging 75%**	 TBD					

i. Quality Review of Overall Charts (minus services) conducted to review 10% of all mental health charts throughout the year.

Responsible Party: QA Team Leader	1 to 4 month measure	% met the goal	5 to 8 month measure	% met the goal	9 to 12 month Measure	% met the goal

Baseline: **Quality Review of overall charts 2/month** **Goal:** **(24/24)** **URs** **100%**	TBD					

j. Quality Review Score of Overall Charts in Compliance. Last DHCS chart review LCBH was 17% in compliance. Per "Chart Review Database (CR DMH Reqd. Total Score, Column I)

Responsible Party: QA Team Leader	1 to 4 month measure	% met the goal	5 to 8 month measure	% met the goal	9 to 12 month Measure	% met the goal
Baseline: **Quality Review of overall charts 17%** **Goal:** **75%**	TBD					

k. Monitor test calls during and after business hours and if they were logged appropriately.

Responsible Party: QI Coordinator	1 to 3 month measure	% met the goal	4 to 6 month measure	% met the goal	7 to 9 month measure	% met the goal	10 to 12 month measure	% met the goal
Monitoring Test Calls **Baseline:** **Test Calls FY 14-15 6/24 = 25%** **Goal:** **(24/24)** **Test calls and all recorded on the log** **100%**	3/5	60%	0/10	0%	0/5	0%	0/2	0%

l. Track the amount of calls for appropriate use of after-hour 24/7 crisis/access line to monitor the contracted amount of 50 calls after hours from consumer crisis/access line after facilities and law enforcement receive their own separate number. All calls are also monitored for quality review and follow-up interventions.

Responsible Party: QI Coordinator	1 to 4 month measure	% met the goal	5 to 8 month measure	% met the goal	9 to 12 month Measure	% met the goal
Baseline: **Average of 39 after hours calls.**	43.5	87%	28.5	57%	*Projected 31*	*Projected 62%*

Goal: **50- Calls/ mo. CSS Contract number. Review for Quality & timeliness**						

m. Monitor number of clients who received a Brief Intake Screening (BIS) and attend an initial Assessment (BIS to Initial Assessment) use information for tracking timeliness and quality.

Responsible Party: QI Coordinator	1 to 4 month measure	5 to 8 month measure	9 to 12 month Measure
Baseline: **FY 2014-2015** **36% of all BIS** **Goal:** **Monitor Only**	TBD		

n. Goal for the productivity of mental health staff

Responsible Party: QI Coordinator	1 to 4 month measure	5 to 8 month measure	9 to 12 month Measure
Baseline: **From Jun 2015** **50.43%** **Goal:** **Average 55% (intentions are to raise up to 70%).**	57.5%	62% (Feb only)	60.33% (3 mo. average)

o. Service Delivery: Clients who received follow-up services after hospital discharge

Responsible Party: QI Coordinator	1 to 4 month measure	% met the goal	5 to 8 month measure	% met the goal of 70%	9 to 12 month Measure	% met the goal
Baseline: **2014** **338 client, 156 did not have follow up services*** **54% did have follow up services (Follow-up Rate)** **Goal:** **70% Follow up Rate**	TBD					

*LCBH tracks reasons for follow up services. This number includes clients who declined services, are seeing another provider, or did not show for their scheduled appointment as we were unable to contact them (AWOL).