LAKE COUNTY BEHAVIORAL HEALTH DEPARTMENT

Quality Improvement Work Plan
2015-2016

Lake County Behavioral Health Department

Lucerne Office:
Physical: 6302 Thirteenth Ave.
Mailing: P.O. Box 1024
Lucerne, CA 95458
Phone: (707) 274-9101
Fax: (707) 274-9192

Clearlake Office:
7000-B South Center Dr.
Clearlake, CA 95422
Phone: (707) 994-7090
Fax: (707) 994-7092

Lake County Behavioral Health Department (LCBH) has adopted this QI Work Plan for FY 2015-2016 for the department and extended partners of LCBH. This plan was created to adherent to the QI Committee's 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, therefore may change to reflect new or revised projects throughout the FY 2015-2016 period.

Quality Improvement Coordinator and Committee

The QI Coordinator is responsible for organizing and facilitating the quarterly QI Committee (QIC) Meetings. QIC's core members and invited stakeholders are encouraged to actively participate and provide feedback of 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 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 Grievance, 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 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, revisions and updated as QIC/QM deems appropriate.

The Work Plan shall include:

- Evidence of the 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. And 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 2014-2015

The Quality Improvement Committee (QIC) coordinated with the Cultural Competency Committee and the Innovation Steering Committee to facilitate and co-facilitate monthly meetings, rotating each committee monthly so that each committee would meet quarterly. With a set monthly schedule, it allows for convenience for the shared community stakeholders. Each chair of the different meetings participated in Facilitation Training by RDA. The training's objectives were for facilitators to gain an understanding of the components and preparation necessary to conduct productive working meetings. RDA provided the committee chairs with tools that included a flash drive containing different templates, power point templates, sign-in sheets, meeting agendas, meeting schedules, flyers, and Learning Community CEU Certificates, when appropriate. The also provided facilitation boxes each committee uses to help provide better structure to the meetings.

By creating a team between the three committees we gain support that includes weekly scheduled check-in conference call to discuss pre, post, and support discussions. We utilize that time each week discussing how to improve the meetings, assigning tasks for the co-facilitators for upcoming meetings such as taking notes, assisting the flow of the meeting by asking questions to engage in participation, and bringing back conversations that may divert the direction of the meeting in a different direction than intended.

Due to this process each committee has gained a consistent group of stakeholders from other community services, consumer/family members, and still has the participation from ongoing staff members who may only be involved in our individual committees.

Objectives

- Acknowledge grievances, appeals, expedited appeals within 1 working day of when 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 to appropriate supervisory staff; seek consult by Compliance Manager and/or LCBH Director, if appropriate.
- Investigate and, if necessary, review the clinical records, and maintain ongoing status of outcome.
- Written follow-up to the member within 60 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 log as needed.

- Collect submissions of the suggestion boxes from each of the lobbies, report to quarterly to QIC.
- Update appropriate logs as needed
- Collect submissions of the suggestion boxes from each of the lobbies, report to quarterly QIC meetings

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 medical 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-hospitalizations 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 – Reviewing sample size of medication services by the psychiatrist and/or PA and maintain medications room safety environment and monitoring the medication

parameters. Results to be directly reviewed quarterly with the contract provider, psychiatrist, medication support staff, compliance and QI Coordinator. Report out to QIC.

Update - Reported at the November 4, 2015 Medication Monitoring Meeting a review of the Med Rooms in both 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.

1. Clinical PIP
   Data has shown that since 2010-11, there has been an increase in psychiatric emergencies at the county's two hospital emergency departments and subsequent psychiatric hospitalizations. In addition to the increased strain on the emergency departments, often these emergencies begin with law enforcement and require LCBH crisis team to intervene, requiring more of their staff with the increase. From the client's perspective, there's going through the wait, med screening process, and cost of an emergency room visit. Typically about 2/3rds of psychiatric emergencies can be resolved through crisis interventions by LCBH crisis staff, so may not have needed to go to the ER to begin with. Therefore, LCBH is researching appropriate location based on geographical/population and access to develop a crisis outreach center. This center can be another option in a more comfortable and private setting to try and resolve psychiatric emergencies and possibly prevent hospitalizations. Location researched to date in Kelseyville was chosen due to the location between both hospitals and due to lack of services for behavioral health in that area, it would give clients a behavioral health presence in that geographical area where currently there is none. However, we have been unable to obtain the approval of the local business association and continue to research in other, more welcomed areas. The goals are to reduce emergency room usage, reduce hospitalizations, and increase resolved crises.

   The PIP roadmap will be used and updated periodically as events happen and reviewed at the QIC.

   After our last EQRO we received feedback that will require us to update the roadmap and include more consumer/family member involvement.

2. Non-Clinical PIP
   LCBH does not currently have a process to close the referral loop for those people who were referred out. Without knowing if people are not accessing the referrals, they run a higher risk of their needs not getting met which could cause unnecessary and/or additional stress for the person that could potentially require higher levels of service. LCBH decided to create a PIP working with Beacon Partnership Healthplan to close the referral loop increase communication and decrease the amount of clients who do not follow through with their referrals.

   During FY 2014-2015 our process to refer Medi-Cal beneficiaries who call or come in requesting services but do not meet our SMI criteria was to give them Beacon's phone number and let the people initiate the contact. One of the interventions in our Non-Clinical PIP is to implement a collaborative referral process, assist the client with a referral and provide a follow-up letter re-iterating the referral resources that was provided to them. Other intervention will be completed as case-by-case situation evolve.

The PIP roadmap will be used and updated periodically as events happen and reviewed at the QIC.

Participate in Annual Program Review

Review all of our 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:

- 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, QIC and shared with our clients in means to be determined in order to improve quality of services.
b. Ensure that beneficiaries or family satisfaction surveys are available in their primary language
c. Provide the results of the beneficiary/family satisfaction activities
d. Monitor that at least 75% of the respondent will have access to written information in their primary language

f. Provide a "Suggestion Box" in each clinic lobby where anyone can anonymously make suggestions
g. Utilize other consumer satisfaction/opinion surveys as they become available.

Additional DHCS Contract and EQRO Items

a. Medication Quality – Maintain medication room environment, complete med room reviews and monitor the safety of the facility and storage/dispensing of medication in compliance with laws and regulations. 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, demographic forms of the LCBH populations that describe the current number, types and geographic distribution of mental health services within its delivery system. 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 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 not need to 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

Update: In 2015 LCBH Wet Coordinator researched online training materials to obtain 2 Cultural Competent training trainings per year for 100% of the staff and volunteers (as well as offering our contracted providers with this same opportunity). They came up with a series of staff trainings available online to assist meeting this requirement.

Currently, LCBH is looking at being more proactive from the time of first hire to ensure if an employee/volunteer starts that they receive two online trainings within the first 30 days and along with the rest of the staff members, 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

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

Responsible Party: MSRO	3 to 6 month measure	% met the goal	6 to 9 month measure	% met the goal	9 to 12 month Measure	% met the goal
Baseline: 14/15 FY 71% (5/7)	July – Dec 2015 4 MSRO report were taken all acknowledged within 1 day and resolved	100%	Jan – Mar 2016 6 MSRO reports were taken; all acknowledged within 1 day and resolved	100%	April – Jun 2016 6 MSRO Reports were taken; 5 out of 6 acknowledged within 1 day and resolved	83%
Goal: 90%						

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

Responsible Party: MSRO	3 to 6 month measure	% met the goal	6 to 9 month measure	% met the goal	9 to 12 month Measure	% met the goal
Baseline: 14/15 FY 0%						
Goal (if any expedited appeals are requested) 100%	No Expedited Appeals have been requested	N/A	No Expedited Appeals have been requested	N/A	No Expedited Appeals have been requested	N/A

Goals (cont.)

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

Responsible Party: MSRO	3 to 6 month measure	% met the goal	6 to 9 month measure	% met the goal	9 to 12 month Measure	% met the goal
Baseline: **14/15 FY 86% (6/7)** **Goal:** **100%**	July – Sept all MSRO responses were within the timeframe	N/A	Oct. – Dec all MSRO responses were within the timeframe	N/A	Jan – Jun 1/12 MSRO responses were not within the timeframe. NOA was provided	92%

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

Responsible Party: MSRO	3 to 6 month measure	% met the goal	6 to 9 month measure	% met the goal	9 to 12 month Measure	% met the goal
Baseline: **13/14 FY 100% (2/2)** **Goal:** **100%**	July – September 0 Requests for Transfers	N/A	October – December 0 Requests for Transfers	N/A	Jan – April 0 Requests for Transfers	N/A

e. Conduct quarterly Medication Monitoring Reviews/Meetings

Responsible Party: QI Coordinator	3 to 6 month measure	% met the goal	6 to 9 month measure	% met the goal	9 to 12 month Measure	% met the goal
Med Monitoring meetings **Baseline:** **14/15 FY 100% (4/4) Review & Meetings** **Goal:** **100%**	First Meeting July 16, 2015	100%	Second Meeting November 4, 2015 Next Meeting Scheduled for Jan. 28, 2016	100%	Third Quarter Jan. 28 meeting held. Fourth Quarter April 29 meeting held	100%

Goals (cont.)

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 2015 Apply Interventions to "Celebrate Consumer Perception Surveys" to obtain twice as many completed surveys. We received 31 Completed Surveys after intervention May 2016 Did not fully "celebrate" but did have staff focus on encouraging participants complete the survey. 36 surveys were completed	172% 116%

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

Responsible Party: QI Coordinator	3 to 6 month measure	% met the goal	6 to 9 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%**	July through December 3 Reviews completed	13%	January through March 2 Reviews were completed	33%	April through June 29, 2016 2 Reviews were completed	33%

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

Responsible Party: QI Coordinator	3 to 6 month measure	% met the goal	6 to 9 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%**	July through December 3 Reviews completed Average Score was 55.67	0%	January through March 2 Reviews completed Average Score was 41.5	0%	April through June 2 Reviews completed Average Score was 50	0%

Goals (cont.)

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

Responsible Party: QI Coordinator	3 to 6 month measure	% met the goal	6 to 9 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%**	July through September 11 Reviews completed	183%	October through December 26 Reviews completed (we will consider increasing our goal)	433%	January through June 65 Reviews completed (Goal to remain at 24/yr due to lack of staff availability; 0 were completed in June)	1083%

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: QI Coordinator	3 to 6 month measure	% met the goal	6 to 9 month measure	% met the goal	9 to 12 month Measure	% met the goal
Baseline: **Quality Review of overall charts 17%** **Goal:** **75%**	July through December 56 charts reviewed. The overall average of charts in compliance 55.17%	33 out of 56 met that goal 59%	January through March 42 charts reviewed. The overall average of charts in compliance 68.87%	31 out of 42 met that goal 74%	April through June 21 charts reviewed. The overall average of charts on compliance 81.01%	18 out of 21 met that goal 86%

Goals (cont.)

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

Responsible Party: QI Coordinator	3 to 6 month measure	% met the goal	6 to 9 month measure	% met the goal	9 to 12 month Measure	% met the goal
Monitoring Test Calls **<u>Baseline:</u>** **Test Calls FY 14-15** **6/24 = 25%**	July – September 3 test calls were completed (goal is 2/month)	Test Calls conduced 50%	October through December, 7 calls (process change to have Wellness Center Staff & Amador Co. conduct them)	Test calls conducted 117%	January through June 8 calls	Test Calls conducted 133%
<u>Goal:</u> **(24/24)** **Test calls and all recorded on the log** **100%**	None of the test calls were recorded on the logs	Test Calls Logged 0%	1 out of 2 required of the calls were logged	Test calls logged 50%	1 out of 4 required calls were logged	Test Calls Logged 25%

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	3 to 6 month measure	% met the goal	6 to 9 month measure	% met the goal	9 to 12 month Measure	% met the goal
<u>Baseline:</u> **Average of 39 after hours calls.**					January – April 218 calls total (54.5 Ave per month; 3 months out of 4 went over 50 calls)	
<u>Goal:</u> **50- Calls/ mo. CSS Contract number.** **Review for Quality & timeliness**	July – September 112 Calls total (37.33 Ave per month)	100%	October – December 83 Calls total (27.67 Ave per month)	100%		%25

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	3 to 6 month measure	6 to 9 month measure	9 to 12 month Measure
<u>Baseline:</u> **FY 2014-2015** **36% of all BIS** **<u>Goal:</u>** **Monitor Only**	July – Sept received 32 Intake Assessments of the 121 BIS that were completed = 26%	Oct – Dec received 24 Intake Assessments of the 79 BIS that were completed = 30%	Jan – Jun received 59 Intake Assessments of the 203 BIS that were completed= 29%

Goals (cont.)

n. Goal for the productivity of mental health staff

Responsible Party: QI Coordinator	3 to 6 month measure	6 to 9 month measure	9 to 12 month Measure
Baseline: **From Jun 2015** **50.43%** **Goal:** **Average 55% (intentions are to raise up to 70%).**	July 21– October 20 (3 mo. pay period) Overall productivity: 38.8%	October 21 – November 20 36.62% November 21 – December 20 45.87% December 21 – January 20 49.24% January 21 – February Staff was out; information was not obtained	February 21 – March 20 56% March 21 – April 20 63% April 21 – May 20 66% May 21 – is not available at this time and will be recorded on the 2016-2017 QI Work Plan

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

Responsible Party: QI Coordinator	3 to 6 month measure	% met the goal	6 to 9 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**	July 2015 (11/18) 61% August 2015 (8/15) 53% September 2015 (8/16) 50%	July 87% August 76% September 71%	October 2015 (5/14) 36% November 2015 (13/14) 93% December 2015 (6/11) 55%	October 2015 51% November 2015 133% December 2015 79%	January 2016 (9/14) 64% February 2016 (6/14) 43% March 2016 (5/15) 33% April 2016 Staff left, report incomplete at this time	January 2016 91% February 2016 61% March 2016 47% April 2016 N/A

*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).