FY 17-18
Quality Management Plan

County of Siskiyou

Behavioral Health Division

I. Siskiyou County Health and Human Services, Behavioral Health Division

County of Siskiyou Behavioral Health Division (BHD) is an integrated mental health and substance abuse treatment department. BHD serves more than 1,200 clients each year across all ages.

The mission of the Behavioral Health Division is to promote the prevention of and recovery from mental illness and substance abuse of those we serve by providing accessible, caring and culturally competent services.

Our core values include:

- We believe that all individuals with their unique contributions are valued, should be treated with respect and encouraged to fulfill their potential. Specifically, we value the intrinsic worth of our clients as human beings who are to be treated with respect, courtesy, and care at all times.
- We value ourselves and one another, as employees, co-workers, and professionals. We will strive as one to promote: positive teamwork which focuses on the mission of the department, while supporting open, honest communication amongst its members; recognition and appreciation of individual staff contributions; quality and integrity of work and service delivery; and a work environment where creativity is encouraged and mistakes are seen as learning opportunities.

Our mental health services program is comprised of Children's Services (serving clients ages 3-18) and Adult Services (serving clients ages 18 and older). Services are delivered in the community, via contracted providers, family resource centers and at two clinics located in north and south Siskiyou County. Children's Services utilizes Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medi-Cal services to provide a variety of options for the treatment of children and adolescents such as: assessment; individual, group, and collateral therapies; rehabilitation; case management; mental health treatment for co-occurring disorders; and intensive care collaboration and intensive home-based services. In addition, therapeutic behavioral services are available through a contracted provider. In addition, BHD provides psychiatric evaluation and medication services. For urgent and acute problems, crisis services are available 24-hours per day, 7-days per week via phone, walk-in at our two clinic locations, two hospital emergency rooms and the jail. Adult clients are assessed, individual and group therapy, rehabilitation, and case management services are available. A mental health wellness program is available through a contracted service provider for clients and consumers in the community as part of the mental health plan's continuum of care. Mental Health Services Act funds provide supportive services for full-service partners.

II. Quality Management Program

Mission Statement: Under the direction of the BHD director, the quality management (QM) program shall monitor the service delivery system with the aim of improving services and meeting the needs of our beneficiaries. In order to provide system-wide quality care, every individual within our organization is responsible to ensure that the client’s mental health needs are met and are accountable for providing individualized services that are of high

quality, culturally relevant, language appropriate, cost efficient, and tailored to meet the unique needs of each client.

Goal: The goal of the QM program is the on-going development of a system that provides quality design, continuous improvement of services and efficient use of resources. This is accomplished by establishing mechanisms that effectively improve quality; assuring service delivery integration and interagency collaboration; examining the use of resources within the systems of care.

The functions of the QM program include:

- Establish and maintain a systematic process for monitoring and tracking key indicators for client care and administrative support functions;
- Support organizational decision-making; implement and evaluate on-going quality improvement activities across BHD;
- Develop communication strategies to share information with providers and other appropriate stakeholders; and
- Create quality improvement capability across programs and services.

The quality improvement annual work plan for FY 2016-17 identifies targeted goals within the following areas:

1. Performance improvement projects
2. Monitoring service delivery capacity
3. Monitoring accessibility of services
4. Monitoring the mental health plan service delivery system and clinical issues affecting beneficiaries
5. Monitoring continuity and coordination of care with physical health providers and other human service agencies
6. Monitoring provider appeals

In accordance with the Department of Health Care Services (DHCS) mental health plan (MHP) contract, the following areas of quality management may be reviewed and evaluated within the quality improvement committee (QIC) or through the quality assurance manager's and compliance analyst's keeping of logs and reviews:

- Access to and timeliness of services
- Consumer input
- Annual QI work plan goals and work plan evaluation findings
- BHD policies and procedures
- Performance improvement projects (PIP): clinical and non-clinical
- Routine data e.g., Anasazi data reports; inpatient utilization and crisis evaluation data; IMD utilization; board and care utilization
- Fiscal reports
- Compliance log data
- FSP/MHSA updates

- HIPAA breeches log data
- Beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals log data
- Notice of action form log data
- Change of provider request log data
- Test call log data
- Training log data
- Service verification log data
- Incident reports log data
- Medication monitoring log data
- Chart review log data
- Inpatient census log data
- Treatment authorization request data from the inpatient census log
- Service authorization review log data
- Presumptive transfer and waiver log data
- Provider appeals log data
- Cultural competence plan and minutes
- Compliance committee plan and minutes
- Quality of care concerns log data
- Behavioral health advisory board minutes and reports
- Agency recruitment and retention activities
- Katie A. statistics and procedures
- Client satisfaction survey data
- Staff satisfaction survey data
- Design and implement interventions to improve performance and measure the effectiveness of the interventions (PDSA).
- Recommend changes to and creation of policies and practices, as appropriate
- Documentation manual, and training log data
- Collect and analyze data to measure areas for improvement identified by the management team.
- Identify opportunities for improvement and decide which opportunities to pursue.
- Other processes within the service system

Siskiyou County does not delegate or contract quality management activities; the quality assurance manager is responsible for managing all related activities. All planned QM, QI and UM activities are in compliance with the MHP contract, Title 9 regulations, and 42 CFR. Compliance is achieved through continuous oversight, monitoring, tracking and training; a feedback loop that includes providers, managers, organizational providers and stakeholders; and ongoing communication.

III. **Quality Improvement Committee**

The quality improvement committee (QIC) meetings are held at least quarterly to review,

discuss, and make recommendations that impact the delivery of services, administrative processes, and performance improvement projects.

The quality improvement committee (QIC) is currently comprised of Behavioral Health Division (BHD) consumers, family member, director, quality improvement coordinator, case managers, community members, LPHAs, health assistants, intake coordinator, supervisor and representatives from the organizational provider network. The county is actively recruiting family members of consumers to participate on the QIC.

The activities of the QIC include, but are not limited to, the following:

- Recommending policy decisions
- Reviewing and evaluating the results of QM activities
- Performance improvement projects (PIPs)
- Instituting needed QI actions
- Ensuring follow-up of QI processes
- Documenting QI committee meeting minutes regarding decisions and the actions that are taken.

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Work Plan Fiscal Year 17-18

County of Siskiyou
Behavioral Health Division

The County of Siskiyou Behavioral Health Division (BHD) is an integrated mental health and substance abuse treatment department which served approximately 1,200 mentally ill clients last year. The quality improvement work plan (QIWP) and the quality improvement committee activities are key components of the BHD's quality management system as are the compliance work plan and the compliance committee. In addition, commencing this fiscal year, the compliance work plan contains goals that monitor the contract that were previously tracked on the QIWP. The compliance officer and quality assurance manager attend both committees, coordinate, and in conjunction with their respective committees monitor performance of the mental health plan's contract and make meaningful improvements to BHD's service system.

SECTION 1 PERFORMANCE IMPROVEMENT PROJECTS

GOAL 1.1 NON-CLINICAL PIP: The Behavioral Health Division (BHD) will improve timeliness from first request to first offered assessments for Children's System of Care (CSOC).
Monitoring mechanisms: PIP committee meetings, QI committee meetings, technical assistance calls with Behavioral Health Concepts
Planned actions: See meeting minutes and PIP documentation for details
Baseline: PIP baseline data recorded in the PIP documentation
Timeline: Continue until PIP is completed
Lead Staff: Quality improvement coordinator (QIC), QI/PIP Committee, CSOC supervisor, deputy director of clinical services
Results/Evaluation: Annual QI work plan evaluation 2018, quarterly review in QIC and PIP meetings

GOAL 1.2 CLINICAL PIP: The Behavioral Health Division (BHD) will increase the proportion of consumers who return after their first service.
Monitoring mechanisms: PIP committee meetings, QI committee meetings, technical assistance calls with Behavioral Health Concepts
Planned actions: See meeting minutes and PIP documentation for details
Baseline: PIP baseline data recorded in the PIP documentation
Timeline: Continue until PIP is completed
Lead Staff: QIC, QI/PIP Committee, CSOC supervisor, Adult System of Care supervisor, deputy director of clinical services
Results/Evaluation: Annual QI work plan evaluation 2018, quarterly review in QIC and PIP meetings

SECTION 2 SERVICE DELIVERY CAPACITY: Monitoring the service delivery capacity of the MHP

GOAL 2.1 AVAILABILITY OF SERVICES: To track the availability of mental health services and providers geographically, culturally, linguistically, and by special population serving Siskiyou County.
Monitoring mechanisms: QI committee meetings, Siskiyou County Health Care Collaborative Behavioral Health Task Group (BHTG) meeting agendas and data, review of provider list log, data provided by Partnership Health and Kings View regarding the number of MediCal eligibles in Siskiyou County.
Interventions:

- Internal and external provider lists are available in English and Spanish for consumers to be provided by staff, reception desk and sent via postal mail. The QIC will monitor the tracking logs which show when the provider lists are updated to ensure timely updates.

- BHD participates in the Siskiyou Healthcare Collaborative Behavioral Health Task Group (BHTG) which maps through geographical information system (GIS) the behavioral health service providers throughout the county, tracks services and providers, developed a listserve of all known providers in Siskiyou County, and identifies service gaps.
- Partnership Health Plan (PHP) provides BHD with Medi-Cal eligible mental health clients and services in outlying areas.

Baseline: 18,025 Medi-Cal eligible in FY 16-17 (published by Kings View for FY 16-17). Internal list updates every month. External list updates at the end of each quarter. BHTG project data available as published.
Timeline: Revisions of provider lists per baseline timelines. Director attends the BHTG meetings for updates and to give input as meetings are scheduled throughout the fiscal year.
Lead Staff: Front desk health assistant, BHD director

GOAL 2.2 PENETRATION RATES: To increase the penetration rates among Hispanics and foster youth to be consistent with that of other small rural counties.
Monitoring mechanisms: EQRO data. Kings View penetration data.
Interventions:

- BHD assigns a clinician and case manager a minimum of one day per week to the outlying areas of the county depending on staffing resources to engage the Hispanic population in medically necessary services. Case manager will provide outreach at community health/resource fairs and serve on the BHTG multi-disciplinary team to provide outreach and engagement to the community, including Hispanics.
- Review medical necessity determinations for foster children being referred to BHD to assure that they are receiving level of care needed.
- Create an improved tracking system for outreach and engagement activities in outlying areas

Baseline: Overall penetration rate of 5.3% and 5.1% rate for Hispanics (published by Kings View for FY 16-17). 2.5% Hispanics compared to small-rural counties rate of 4.6%; 36.5% for foster youth compared to small-rural counties rate of 40.8% published by EQRO (data is from CY 2015). New goals have no baseline at present (2nd and 3rd bullet points)
Timeline: Annual evaluation of penetration rates. Tracking system created by end of quarter three. Utilization review of foster youth medical necessity forms annually.
Lead Staff: QIC, BH director, deputy director of clinical services

GOAL 2.3 CLINICAL PRODUCTIVITY: To increase current level of clinical staff productivity to an average of 60% for designated clinical staff.

Monitoring mechanisms: QIC to monitor productivity reports published monthly by BHD Fiscal Services. Clinical supervisors monitor productivity through monthly reports.
Interventions:

- Clearly identify which BHD clinical staff are exempt from the productivity standard.
- On-going training and testing of clinical staff and supervisors by QA and Medi-Cal consultant in Title 9 service descriptions and appropriate documentation of activities and time taken to provide service.
- Supervisor – manager strategy meetings
- Monthly reporting of staff productivity rates

- Revision of the quality assurance documentation manual and staff training to include Department of Health Care Services MHSUDS chart documentation IN 17-040

Baseline: 34% for clinicians and 23% for case management providers; yearly staff-wide documentation training; documentation training for all new employees; Info notice 17-040 training of supervisors and staff by end of quarter 2.
Timeline: Revision of the QA documentation manual is to be completed by quarter 2; documentation training for all new employees orientation by QA manager; Info notice 17-040 training of supervisors and staff by end of quarter 2.
Lead Staff: QIC, deputy director of clinical services, clinical supervisors

Section 3 SERVICE ACCESSIBILITY: Monitoring the accessibility of services throughout the MHP

Goal 3.1 INITIAL SCREENINGS: To provide an initial appointment (screening) for outpatient mental health services (non-urgent, non-psychiatric) within 10 business days from request.
Monitoring mechanisms: Access reports, screening documentation
Interventions:

- The quality improvement committee will monitor the access system for trends and performance. Conduct a non-clinical performance improvement project to improve timeliness for access to Children's System of Care (CSOC)
- Update policies and procedures to align with the Medicaid managed care rules

Baseline: 11 days for all services; 5 days for ASOC; 17 days for CSOC
Timeline: BHD publishes timeliness data annually for EQRO. Monitor access reports at quality improvement committee meetings quarterly. Non-clinical PIP will establish interventions timeline in order to improve access to CSOC.
Lead Staff: Intake coordinator, intake clinicians; clinical supervisors; PIP committee

Goal 3.3 RESPONSE TO URGENT AND EMERGENT CONDITIONS: To assure that clinical response to requests for urgent and emergent conditions will be made within 2 hours.
Monitoring mechanisms: QIC review of crisis data and yearly EQRO timeliness data submitted by BHD.
Intervention:

- Crisis workers enter the time of call and time of response on pertinent documents
- Implement electronic crisis assessment form to be able to collect accurate data
- Calculate response time to Mercy and Fairchild emergency rooms in relation to timeliness MOU agreements
- Fully staff Psychiatric Emergency Team (PET) to ensure timely response

Baseline: Average of 19 minutes
Timeline: Annual review by QI committee
Lead Staff: Crisis workers, health assistants

SECTION 4 BENEFICIARY SATISFACTION: Monitoring beneficiary satisfaction activities.

GOAL 4.4 CONSUMER/FAMILY MEMBER INVOLVEMENT: To increase consumer and family member involvement in the quality improvement process through QI events, the QI committee, cultural competence committee (CCC), BH mental health board (BHB), and through peer-employee positions.
Monitoring mechanisms: Committee and event sign-in sheets
Interventions:

- Family member meet and greet event to inform families about BHD services and committees
- Incentives to be offered to consumer and family members for participation on the committees
- Hire two part-time peer employees for the Behavioral Health Division

Baseline: 2 consumer members in FY 16-17
Timeline: Family event to be held by the end of quarter 2; hiring of peer employees by the end of quarter 3.
Lead Staff: QIC

SECTION 5 CLINICAL ISSUES: Monitoring clinical performance.

GOAL 5.1 PERFORMANCE OUTCOMES: To fully implement the CANSA as an outcome measurement system-wide. To ensure compliance with the DHCS requirements for Children's System of Care outcome measurements.
Monitoring mechanisms: Anasazi data, training completion certificates
Interventions:

- Formal live training for clinicians in the use of the CANSA by the Praed Foundation. On-going Praed Foundation web based training for new employees.
- Fully implement outcome measurements into clinical practice and the electronic health record.

Baseline: The clinicians will utilize the CANS and ANSA electronic forms until the CANSA is implemented in Anasazi.
Timeline: In house Praed Foundation training completed by the end of quarter 2. Full implementation of electronic forms in Anasazi by end of quarter 2. Training certifications of clinicians within 60 days of hire date.
Lead Staff: Clinical supervisors

GOAL 5.2 UTILIZATION MANAGEMENT: To perform documentation reviews to monitor utilization of services and timely and appropriate documentation.
Monitoring mechanisms: Inpatient census/TAR log and TARs; HID chart review log; completed utilization and peer review forms; and provider denials and appeals.
Interventions:

- Provide training to all clinical providers and supervisors in order to increase quality care, compliance, accurate billing and timely completion of documentation.
- Utilization review: Cases are selected at random by the quality department and forwarded to consultant.
- Peer review: Cases are selected at random by the quality department and forwarded to clinical staff.
- Treatment Authorization Requests are reviewed by the quality assurance manager and recorded on the inpatient census log, and TAR forms.
    - Train all psychiatrists on CLIN 14-00 Inpatient Treatment Authorization Requests policy and procedure and Title 9 medical necessity criteria for acute care as part of their new hire orientation including telepsychiatrists.
    - Incorporate inter-rater reliability to the TAR process
- Utilization review of all documentation submitted in support of invoices by contracted or organizational providers is done by the quality assurance manager. Appeals follow the process in the provider manual.
- HID staff review charts for documentation timeliness 60 days after client admission and reviews the caseloads of clinician's when they tender their resignations.
- Quality assurance manager tracks, trends and identifies issues for training, and in order to develop guidelines and policies.
- QIC promptly intervenes when quality of care concerns are identified

Baseline: 848 reviews were completed in FY 16-17
Timeline: Utilization and peer review: outcomes presented annually to the quality improvement committee; Quality of care concerns are communicated to management team and supervisors within 24 hours of discovery; TARs: completed within 14 days of receipt; HID reviews within 60 days of assessment and when clinicians resign. Inter-rater reviews by end of quarter 2 and quarter 4. Training provided as trends are identified and at least yearly.
Lead Staff: QIC, HID, clinical supervisors

GOAL 5.3 QUALITY CARE: To monitor appropriate and timely intervention of occurrences that raise quality of care concerns and are identified through the quality improvement process.
Monitoring mechanisms: Incident reports, after hours call log, access reports, compliance hotline calls, beneficiary log, chart reviews, medication monitoring worksheets, quality of care log
Interventions:

- Compliance analyst and QIC will take timely appropriate follow-up action and document action taken. Documentation will include, memorandums, correspondence to clients and legal representatives/guardians, and incident reports. Quality of care issues will be logged by the QIC and corrective actions, training needs and recommendations documented.
- Complete a sequester policy and procedure
- Institute a psychological autopsy process for suspicious deaths, suicides and homicides of client and client-related deaths.

Baseline: 8 quality of care concerns were logged and resolved in FY 16-27
Timeline: Specific timeframes will be issued with each quality of care plan of correction. Annual evaluation.
Lead Staff: QIC, compliance analyst

GOAL 5.4 MEDICATION MONITORING: To monitor safety and effectiveness of medication practices of 10% of active medical clients.
Monitoring mechanisms: Medication monitoring log and review sheets
Interventions:

- Continue with monitoring process as described in HID 13-27 policy and procedure
- All psychiatric providers are required to read the policies for medication monitoring and medication consents. Create a template for a cover page and signature page template.
- Monitor timeliness of med department in processing reviews.

Baseline: 9 (108) reviews per month in FY 16-17 or 24% of active medical clients.
Timeline: QIC review annually.
Lead Staff: HID, medical services supervisor, compliance analyst, medication monitoring consultant

GOAL 5.5 CULTURAL AND LINGUISTIC COMPETENCE: To increase the cultural and linguistic competence of staff.
Monitoring mechanisms: BHD cultural competence plan, training log, training agendas and sign-in sheets.
Interventions:

- Revise the cultural competence work plan per EQRO recommendations and monitor goals annually
- The QI committee will receive updates from the cultural competence committee either in writing or via a presentation during a QI committee.

Baseline: Two cultural competence trainings in FY 16-17.
Timeline: Two trainings are planned in FY 17-18. Annual update of cultural competence work plan due to DHCS by end of quarter 2.
Lead Staff: Cultural competence committee chairperson, QIC

SECTION 6 PHYSICAL HEALTH CARE: Monitoring coordination with physical health and other agencies

GOAL 6.1 COORDINATION BETWEEN MANAGED CARE PLAN AND BEHAVIORAL HEALTH: To monitor coordination between Partnership Health/Beacon Network and the Behavioral Health Division.
Monitoring mechanisms: MOU; access reports; Children's System of Care– Beacon referral log; screening forms; policies and procedures.
Interventions:

- Invite Partnership Health/Beacon to a supervisor/manager's meeting
- Change the Anasazi access form to include referrals from Beacon
- Develop Anasazi reports to monitor referrals
- Report to QIC annually regarding referrals to and from Beacon and trends.

Baseline: 1st quarter FY 17-18 data: 19 adults, 4 children referred to Beacon; 2 adults referred by Beacon.
Timeline: New report will be developed by quarter 4.
Lead Staff: QIC, intake coordinator, CSOC health assistant, BHD director

GOAL 6.2 EXCHANGE OF INFORMATION: To monitor appropriate exchange of information and consultations between physical health care providers, human service agencies, and BHD providers.
Monitoring mechanisms: Policy and procedure, chart reviews, consultation log
Interventions:

- The intake coordinator and adult services screeners will offer an authorization for the release of PHI to clients for appropriate exchange of clinical information with physical health care providers and human service agencies.
- Tracking of psychiatric to physician consultations through entry on the consultation log and sign-in sheets to be completed by the Medical Services staff.
- Provide medication trainings to physician health care providers. Track trainings through the training log and sign-in sheets.

Baseline: Medical services began logging data in calendar year 2017 and recorded that there have been 8 consultations between psychiatric providers and physicians. The intake coordinator obtains authorizations for the release of information for children and the adult screeners get releases for adult clients. No medication trainings occurred during FY 16-17. CPS social workers sign authorizations for foster children.
Timeline: Annual quality improvement committee review
Lead Staff: Medical services staff, intake coordinator, ASOC screeners

SECTION 7 PROVIDER APPEALS: Monitoring provider appeal process.

GOAL 7.1 PROVIDER APPEALS: To monitor and improve the provider appeal process.
Monitoring mechanisms: Inpatient census log; provider appeal log; denial letters
Interventions:

- Revise the provider manual by quarter 3.
- Streamline the provider appeals process by following the provider manual.
- Provider appeals are done in accordance with the division's guidelines for timeliness and the levels of appeal as described in the provider manual.

Baseline: 5 TARs denied and 2 TAR appeals in FY 16-17; (TBD) ___ contract and organizational provider services denied, ___ appealed
Timeline: Provider manual revision by quarter 3; policy and procedure completed by quarter 4
Lead Staff: QIC, fiscal staff