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Quality Improvement 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 and 300 substance abusing 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. Commencing this fiscal year, the compliance work plan contains goals that were previously tracked on the QIWP. The compliance analyst and quality assurance manager attend both the QI and the compliance committees, 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 children/youth's timely access to treatment.
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), PIP team, CSOC supervisor, deputy director of clinical services, Praxis Consulting
Results/Evaluation: Quarterly review in QIC, and PIP team meetings

GOAL 1.2 CLINICAL PIP: The Behavioral Health Division (BHD) will increase the proportion of children/youth who are retained 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, PIP team, CSOC supervisor, deputy director of clinical services, Praxis Consulting
Results/Evaluation: Quarterly review in QIC, and PIP team meetings

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

GOAL 2.1 AVAILABILITY OF SERVICES: To track 100% of the available mental health services and providers geographically, culturally, linguistically, and by special population serving Siskiyou County.
Monitoring mechanisms: 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:

- The health assistant who updates the provider lists will log when updates occur.
- BHD participates in the Siskiyou Healthcare Collaborative Behavioral Health Task Group (BHTG) which maps through a 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 data on 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). Internal list updates every month. External list updates quarterly. 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.
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.
- The 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 and log activities.
- CSOC supervisor reviews medical necessity determinations and assessment data for clients being referred who are in the foster care system to BHD to assure that they are receiving level of care needed.
- Management and supervisors will monitor penetration data and develop strategies on how to increase rates.

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).
Timeline: Annual evaluation of penetration rates. Outreach log created by end of quarter three. Review of foster youth medical necessity forms as they are completed.
Lead Staff: QIC, BH director, deputy director of clinical services, CSOC supervisor

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 and clinical supervisors monitor productivity through monthly reports.
Interventions:

- Centralized scheduling
- Clearly identify which BHD clinical staff are exempt from the productivity standard.
- On-going training and testing of clinical staff and supervisors by QA in Title 9 service descriptions and allowable services.
- 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: 28% for clinicians, case managers and medical 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 4; documentation training for all new employee 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 offer an initial appointment (screening) for 100% of the adult 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.
- Update policies and procedures to align with the Medicaid managed care rules

Baseline: 5 days
Timeline: BHD publishes timeliness data annually for EQRO. Monitor access reports at quality improvement committee meetings quarterly and strategize solutions if screenings are not occurring timely.
Lead Staff: Intake coordinator, intake clinicians; clinical supervisors

Goal 3.2 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:

- To train staff to enter the appropriate code for urgent services in billable progress notes in order to track the amount of response time through electronic health record reports for the coming year. IT will work with Kings View to obtain the data reports.
- 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
- Fully staff Psychiatric Emergency Team (PET) to ensure timely response

Baseline: Average of 19 minutes, although this is not tracked reliably for urgent and emergent separately.
Timeline: Improved reporting by end of quarter 3. Annual review by QI committee
Lead Staff: Crisis workers, health assistants

SECTION 4 BENEFICIARY SATISFACTION: Monitoring beneficiary satisfaction activities.

GOAL 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 Advisory Board (BHAB), 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, increase membership of unrepresented groups on the agency committees.
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 by administering it to 100% of active clients at established time frames. To ensure compliance with the DHCS requirements for Children's System of Care outcome measurements by adapting the CANSA to accommodate required elements.
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. Run EHR reports of CANSAs administered and updates.
- Implement changes to the CANSA questionnaire in accordance with state mandates.

Baseline: Clinicians are administering the CANSA at the time of assessment and yearly (adults) and every six months (children/youth) .
Timeline: Live Praed Foundation training completed by the end of quarter 2. Full implementation of electronic forms in Anasazi by end of quarter 2. Reports of updates by the end of quarter 4. Training certifications of clinicians within 60 days of hire date. DHCS mandated changes in accordance with information notice time lines.
Lead Staff: Clinical supervisors
GOAL 5.2 UTILIZATION MANAGEMENT: To perform documentation reviews to monitor utilization of services and timely and appropriate documentation for 100% of new intakes, 100% of service authorization requests, 100% of treatment authorization requests, 100% of organizational and contractor

documentation (non-hospital), and 10% of active cases for utilization and peer reviews.
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. Targeted reviews occur when trends are found.
- 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.
    - Log inter-rater reliability reviews
- 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 and logs issues.
- Improvements will be recommended in crisis service documentation.

Baseline: 672 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 establish corrective action of 100% 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
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, corrective actions, training needs and recommendations documented will be logged.
- Institute a psychological autopsy process for suspicious deaths, suicides and homicides of client and client-related deaths.

- Staff trainings to identify and report quality concerns

Baseline: 4 issues were logged and resolved in FY 16-17
Timeline: Specific time frames will be issued with each quality of care plan of correction. Annual evaluation.
Lead Staff: QIC, compliance analyst

GOAL 5.4 MEDICATION MONITORING: To provide safe and effective medication practices through a review 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: 81 reviews per month in FY 16-17 or 22% 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 by providing two trainings in a fiscal year. Additional goals are established by the committee in the work plan.
Monitoring mechanisms: BHD cultural competence plan and work plan, training log, training agendas and sign-in sheets.
Interventions:

- The cultural competence plan will be revised per EQRO recommendations.
- The QI committee will receive updates from the cultural competence committee either in writing or via a presentation during a QI committee.

Baseline: Three cultural competence trainings in FY 16-17.
Timeline: Two trainings are planned in FY 17-18. Annual update of cultural competence plan due to DHCS by end of quarter 2. Establishment of cultural competence work plan goals by end of quarter 3. Regular reporting to the QI committee by the CCC chairperson.
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 improve coordination between Partnership Health/Beacon Network and the Behavioral Health Division through communication, tracking and continuity. To track 100% of referrals being made to Beacon in order to

improve continuous care.
Monitoring mechanisms: MOU; access reports; Children's System of Care– Beacon referral log; screening forms; policies and procedures.
Interventions:

- Invite a representative from Partnership Health/Beacon to a supervisor/manager's meeting
- Improve policies and procedures that relate to the MOU
- Change the Anasazi access form to include referrals from Beacon
- Develop Anasazi reports to monitor referrals

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. New policies by quarter 4.
Lead Staff: QIC, intake coordinator, CSOC health assistant, BHD director

GOAL 6.2 EXCHANGE OF INFORMATION: To provide consultation between physical health care providers, human service agencies, and BHD providers and respond to 100% of requests.
Monitoring mechanisms: Policy and procedure, chart reviews, consultation log
Interventions:

- Establish a procedure for psychiatric and clinical staff to follow when conducting consults with physicians.
- 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 unit health assistants will resume.
- Provide medication trainings to physician health care providers. Track trainings through the training log and sign-in sheets.

Baseline: Data not available for FY 16/17. The intake coordinator obtains authorizations for the release of information for children. 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 RELATIONS: Monitoring the provider appeal process and communications

GOAL 7 PROVIDER APPEALS: To improve the provider appeal process so that 100% of appeals are processed timely and 75% of non-hospital appeals are "informal" as defined in the provider manual.
Monitoring mechanisms: Inpatient census log; provider appeal log; denial letters

Interventions:

- Update provider log to reflect that NOAs were sent.
- Revise 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.
- Conduct regular meetings with non-hospital providers in order to improve communication and processes.

Baseline: 4 TARs denied and no appeals in FY 16-17; 56 contract and organizational provider services denied, 4 appealed
Timeline: Provider manual revision by quarter 4; policy and procedure completed by quarter 4; two meetings per year
Lead Staff: QIC, fiscal staff