Siskiyou Behavioral Health Division
Quality Improvement Work Plan 2015

GOALS	MONITORING MECHANISMS	PLANNED ACTIONS/INTERVENTIONS	BASELINE	TIMELINE	LEAD STAFF	RESULTS/EVALUATION
SECTION I PERFORMANCE IMPROVEMENT PROJECTS						
1.1 Non-Clinical Performance Improvement Project: Improving timely access from initial call to 1:1 appointment.	PIP Committee meetings, QI Committee meetings, Phone conferences with Nancy Callahan, IDEA Consulting; Technical assistance calls with Cyndi Eppler	See meeting minutes and PIP documentation for details.	PIP baseline data recorded in the Access Log and compiled by IDEA Consulting for PIP study. See meeting minutesfor details.	Implement interventions from 9/1-12/31/15.	Director, Quality Assurance Manager (QAM), PIP Committee, Behavioral Health Director	Interventions are being implemented on schedule.
1.2 Clinical Performance Improvement Project: To improve the effectiveness of services for clients with specific depressive diagnoses.	PIP Committee meetings, QI Committee meetings, Phone conferences with Nancy Callahan, IDEA Consulting; Technical assistance calls with Cyndi Eppler	See meeting minutes and PIP documentation for details.	PIP baseline data recorded in the Access Log and compiled by IDEA Consulting for PIP study. See meeting minutesfor details.	Data analysis of 311 Depressive Disorder NOS diagnosis by 12/31/15.	Director, Quality Assurance Manager (QAM), PIP Committee, Behavioral Health Director	Data collection and analysis deadline was adjusted to 12/31/15 to be able to perform additional research into individual clients with 311 Depressive NOS diagnoses and to provide reliable data.
SECTION II SERVICE DELIVERY CAPACITY: Monitoring the service delivery capacity of the MHP						
2.1 To track the availability of services and providers geographically, linguistically, culturally and by special populations served within Siskiyou County.	Review provider lists for accuracy.	Lists are available in English and Spanish for consumers to be provided by staff, reception desk and via postal mail. BHD participating in Blue Cross grant funded collaboration project to map current BH services throughout Siskiyou County.	Internal list last updated 1/4/16 and external list 12/30/15. Collaboration project data completed and published.	Quarterly revisions. Collaboration project data published.	Health Assistant main reception, Compliance Officer, QAM, Director participating in collaboration project.	Quarterly revisions of provider lists occuring on schedule. **Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
2.2 To increase the overall penetration rate by 2% to align more closely with the penetration rate of other small, rural counties.	Develop and implement clinical staff recruitment and retainment methods. EQRO data. Anasazi penetration data quarterly.	BHD to assign a clinician and case manager a minimum of one day per week to the outlying areas of the county (Happy Camp, Dorris/Tulelake and Scott Valley). Implement group curriculum in North County modeled on South County groups.	Penetration data from Anasazi and EQRO 2013.	Staff identified and assigned to outlying regions by 7/1/15. Staff identified and trained in group curriculum by 7/1/15. Groups implemented by 11/1/15. Annual evaluation of penetration rates.	Deputy Director of Clinical Services, Adult System of Care Site Supervisor	Clinical staff are assigned to outlying areas. Wellness Recover Action Plan model group started 10/15/15. Grief group was started on 10/20/15. OSHPD granted Siskiyou County designation as a Health Professional Shortage Area. Applied for and was accepted as a National Health Services Corps designated for both BHD offices. **Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
2.3 To increase clinical staff productivity by 5% by end of fiscal year.	QAM to monitor productivity through Anasazi reports annually. Clinical supervisors monitor productivity through monthly reports.	Train clinical staff and supervisors in Title 9 service descriptions and appropriate documentation of activities and time taken to provide service.	20401 hours of productive time in 2014 serving 1,216 clients	QA will generate Anasazi report yearly	Fiscal, IT, QAM	**1.35% increase in 2015. Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
2.4 To review active BHD cases to determine appropriate level of care.	Case Reviews held at 6 month intervals to evaluate medical necessity, risk factors, progress and current service level.	Case review and discharge guidelines for determining appropriate level of care (i.e. severe vs. mild/moderate) created and clinical staff have been trained.	New process	On-going reviews	Deputy Director of Clinical Services, Site Supervisors, clinical staff	**Interventions completed by Quality Manager. Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
SECTION III SERVICE ACCESSIBILITY: Monitoring the accessibility of services throughout the MHP						
3.1 To provide an initial screening for services within 14 business days from request.	Review of Access Log, Screening documentation and NOA-Es	Completion of Beacon's screening tool by licensed, registered or waivered professionals.	Met goal for January - Mid-March 2015.	Continue current process and report to QIC quarterly. Review goal annually.	Director, QAM, Health Assistants	**Screening process suspended in May 2015 due to lack of staff to conduct staffings but restarted in October 2015. Meeting 14-day timeline. Goal has been evaluated for 2015, see QI work plan**

3.2 To monitor and make improvements to the 24-hour crisis line responses. To ensure that calls are being conducted in caller's preferred language.	Review request for services in the Access Log. Compliance Officer will use test call log as a reference to determine that the Language Line was used to conduct the caller to their preferred language.	24-hour crisis telephone services will be evaluated for quality by conducting at least 2 test calls per month and a minimum of six Spanish language test calls annually. Results of the test calls will be recorded in the test call log, communicated to relevant staff or crisis line contractor; and concerns addressed. Results will be reviewed in the QIC and recommendations made to Management Team as indicated.	2 test calls per month. 6 Spanish language in 2015.	QAM will monitor quarterly and review findings with QIC.	Compliance Office, QAM	**Compliance Officer reporting to DHCS quarterly. Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
3.3 To assure that clinical response to requests for urgent and emergent conditions will be made within 2 hours.	Review of Crisis Log and Anasazi reports	Continue with current processes.	:27 minutes average in 2014	Develop improved tracking system	QAM, Adult System of Care staff	**Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
SECTION IV BENEFICIARY SATISFACTION: Monitoring beneficiary satisfaction						
4.1 To conduct beneficiary satisfaction activities with a goal of increasing responses to satisfaction surveys to no less than 100 aggregate surveys provided in English and Spanish language. To inform providers of the results of the benficiary satisfaction activities per administration of survey. To conduct MHSA focus groups in no less than four geographic locations.	Review of satisfaction survey data by QAM. Sign in sheet and agenda review of focus groups.	Compliance Officer oversees the survey process. California Institute of Mental Health tool is used. Survey results submitted to DHCS, published on the BHD web site, distributed to the Behavioral Health Board, Organizational providers, QIC and BHD staff. MHSA will conduct focus groups annually in four geographic locations.	39 Adults; 4 Older Adults; 22 Youths; 10 Family of children surveyed in Spring 2015. Total of 115 responses in Fall 2015.	Surveys are being conducted biannually. Focus groups annually.	QAM, Compliance Officer, MHSA	**115 completed in Fall 2015. Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
4.2 After a report of the results of the Beneficiary Satisfaction Survey are received from IDEAS Consulting, at least one area for improvement will be identified and remedial interventions will be implemented.	Review of satisfaction survey in QIC.	Review the spring 2015 survey when the report is available.	To Be Determined	Survey data was not available until October 2015. Results of surveys were presented and discussed at QIC meeting.	QAM, IDEAS Consulting, QIC	**The members expressed that they would be interested in developing more specific surveys or other tools to measure satisfaction than to set a goal based on the BSS. Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
4.3 To evaluate beneficiary grievances, appeals and fair hearings quarterly for timeliness, care concerns and trends.	Compliance officer oversees the grievances, appeals and fair hearings and informs QAM and Director of any immediate quality of care concerns.	Evaluate trends and beneficiaries' concerns leading to requests. Recommendations by the QIC will be made to management.	Recorded on log same day as receipt, client within required time frames. Reviewed by QAM annually.	Trends and recommendations made to Management Team when indicated and at least annually.	HA front desk receptionist, QAM, Compliance Officer, QIC	**Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
4.4 To evaluate requests to change persons providing services quarterly for timeliness, quality of care concerns and trends.	Compliance officer informs QAM and Director of any immediate quality of care concerns.	Evaluate trends and beneficiaries' concerns leading to requests. Recommendations by the QIC will be made to management.	Recorded on log same day as receipt, change made and client notified within 10 days. Reviewed by QAM annually.	Trends and recommendations made to Management Team when indicated and at least annually.	HA front desk receptionist, QAM, Compliance Officer, QIC	**Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
4.5 To maintain a level of consumer and family member involvement in the quality improvement process through membership on the Quality Improvement Committee.	Attendance at meetings, QIC minutes	Recruit at least one family member to join QIC through networking with staff, BH Board members and posting information in lobby areas.	No family members at start of 2015. Two consumer members at start of 2015.	Recruit one family member by 7/1/15.	QAM, Director	**New strategies for recruitment of family members were discussed at the meeting on 11-19-15. Three consumers members on the QIC as of July 2015.**
4.6 To identify and implement a performance outcome measurement tool for Children's and Adult Services.	Supervisor's meeting agenda	Adult services supervisor has chosen the Adult Needs and Strengths Assessment (ANSA) as an outcome measure. Children's services has been utilizing the Children and Adolescent Needs and Strengths Assessment during 2015.	No outcome tools being utilized by Adult services.	Train staff and develop form in Anasazi by 12/31/15.	Deputy Director, Adult Services Supervisor	**Form completed in Anasazi. Goal has been evaluated for 2015, see QI work plan evaluation document for details.**

SECTION V CLINICAL ISSUES: Monitoring Clinical Issues						
5.1 To monitor the quality of service delivery through clinician peer reviews of 5% of active cases.	Peer Review Log; Quality of Care Log	HID assigns reviews and maintains the Peer Review Log. QAM publishes data outcomes of reviews for Management Team and QIC. QAM intervenes when quality of care concerns arise promptly notifying Director, Deputy Director of Clinical Services and Site Supervisors as appropriate and records issues on Quality of Care Log.	6% of active cases reviewed in 2014	Outcomes presented annually to the QIC. Quality of Care concerns are communicated to Management Team and Site Supervisors by Peer Review Checklist or face-to-face contact within 24 hours of discovery.	QAM, Site Supervisors	**Conversion to electronic based reviews by 2016. Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
5.2 To monitor appropriate access and level of services to beneficiaries through utilization reviews of 10% of active cases.	TAR Log and TARs; SAR Log and SARS; Utilization Review Log, Case Review Log	Utilization review cases are selected at random by the Health Information Department and forwarded to Consultant. Treatment Authorization Requests are reviewed by QAM and recorded on the Inpatient Census Log, TAR worksheets and the original TAR forms. Children's Supervisor reviews Service Authorization Requests and maintains SAR Log. Tracking trends and identifying issues for training, the development of guidelines and protocols will be established through the UR process to promote consistent clinical decisions. QAM publishes data outcomes of reviews for Management Team and QIC.	66 Service Authorization Requests 2014; 29 Treatment Authorization Requests 2014	Data of outcomes presented annually to the QIC and Management Team. Quality of care concerns are communicated to either Director, Deputy Director of Clinical Services and Site Supervisors by Utilization Review Checklist or face-to-face contact within 24 hours of discovery.	QAM, Director, Children's Supervisor	**Conversion to electronic based reviews in 2016. Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
5.3 Goal: To monitor appropriate and timely intervention of occurences that raise quality of care concerns and are identified through the quality improvement process.	Incident Reports, Compliance Hotline Calls, Beneficiary Log, Peer Reviews, Utilization Reviews, Medication Monitoring Worksheets, Quality of Care Log	QAM and Compliance Officer will take timely appropriate follow-up action and document action taken. Documentation will include, memorandums, Beneficiary Log, correspondence to clients and legal representatives/guardians, Peer Review Log, Utilization Review Log, Medication Monitoring Worksheets, Compliance Hotline Call Log, and Incident Reports. Quality of Care issues will be logged by QAM.	Review processes are in place.	QAM will monitor logs regulaly and review findings with QIC and Management Team.	QAM, Compliance Officer, Director, Deputy Director of Clinical Services, Quality Improvement Committee (QIC)	**Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
5.4 To monitor safety and effectiveness of medication practices of 10% of active medical clients.	Medication Monitoring Worksheets	Pharmacist reviews nine charts monthly and completes the Medication Monitoring Worksheet. Worksheets are routed to Deputy Director and assigned Psychiatrist for review. After Psychiatric review and response, worksheets are routed back to Deputy Director then to Compliance Officer. Deputy Director and Psychiatrist address quality of care concerns. Compliance Officer logs worksheets, secures them and provides data to QIC biannually. Quality of care concerns logged.	7.3% monitored in 2014	Reviews conducted monthly. Data presented to QIC annually.	Compliance Officer, Deputy Director	**23% of medical cases reviewed in 2015. Goal has been evaluated for 2015, see QI work plan evaluation document for details.**

5.5 To increase cultural competence of clinical staff.	Training Log, training agendas and sign-in sheets	Compliance Officer and Cultural Competency Committee will identify trainings to improve clinical competence in serving Hispanic consumers their families and performing community outreach. In addition, training will be identified and offered to increase clinical staff's understanding of the Recovery model approach.	Two cultural competence trainings yearly.	Trainings will be provided by 12/31/15. Annual review by QAM.	Compliance Officer, Cultural Competence Committee Co-Chairs	**One training occurred in 2015. Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
SECTION VI PHYSICAL HEALTH CARE & OTHER AGENCIES						
6.1 To monitor coordination between Partnership Health/Beacon and the Behavioral Health Division.	Review MOU; Review Access Log; Review screenings and referrals.	Referrals process in place to Beacon based on level of care indicated at assessment. Orientation group to assist client in determining appropriate level of care and provider.	The number of clients who are referred to Beacon annually due to low to moderate medical necessity determined annually.	Monitoring data provided to QIC annually by QAM.	Management Team, QAM, Health Assistants	**Orientation group began October 2015.**
6.2 To monitor appropriate exchange of information between physical health care and human service agencies.	Policy and procedures; Peer Reviews	Peer reviews will determine presence of signed authorizations to release information and appropriate exchange of information.	Review 8% of active cases	QAM publishes data outcomes of reviews for Management Team and QIC annually.	QAM	**Goal has been evaluated for 2015, see QI work plan evaluation document for details.**
SECTION VII PROVIDER APPEALS						
7.1 To monitor provider appeals.	Inpatient Census Log, Provider Appeals Log	Provider appeals will be recorded in Inpatient Census Log for TAR appeals and the Provider Appeals Log for contracted providers. Letters will be sent to contractors with the reasons for the denials of services. Organizational providers will be invited to trainings to assist their staff in understanding regulatory and BHD requirements. Organizational Provider Manual will be updated annually. A system will be put into place to inform organizational and contracted providers when Policy and Procedural changes occur. QAM will train the CSOC Site Supervisor to provide UR for organizational providers and contractors.	No data from 2014	Logging of appeals will occur as indicated. Training will be held annually. QAM training and assistance to CSOC supervisor will be on-going.	QAM	**Goal has been evaluated for 2015, see QI work plan evaluation document for details.**