ALPINE COUNTY
BEHAVIORAL HEALTH SERVICES

Quality Improvement Work Plan

Fiscal Year 2018/2019

Final August 20, 2018

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I. QUALITY IMPROVEMENT PROGRAM OVERVIEW

A. Quality Improvement Program Characteristics

Alpine County Behavioral Health Services (ACBHS) has implemented a Quality Improvement (QI) program in accordance with state regulation for evaluating the appropriateness and quality of services, including overutilization and underutilization of services; timeliness standards; access; and effectiveness of clinical care.

It is the purpose of ACBHS to build a structure that ensures the overall quality of services. The QI program meets this objective through the following processes:

1) Identify goals and prioritized areas for improvement;

2) Collect and analyze data to measure against the identified goals or areas of improvement;

3) Based on data and identified trends, design and implement interventions to improve performance;

4) Measure the effectiveness of the interventions over time; and

5) Incorporate successful interventions across the system, as appropriate.

Executive management and program leadership is crucial to ensure that QI activities are used to establish and maintain the overall quality of the service delivery system and organizational operations. As a result, the QI program is directly accountable to the ACBHS Director.

B. Quality Improvement Committee

The Quality Improvement Committee (QIC) is responsible for the conducting key activities of the ACBHS Quality Improvement Program. QIC meetings are held at least bi-monthly.

1) QIC Responsibilities – The QIC is responsible for the following functions:

    a. Implement the specific and detailed review and evaluation activities of the agency.
        i. On a bimonthly basis, the QIC collects, reviews, evaluates, and analyzes data and implements actions that frequently involve handling sensitive and confidential information.
        ii. The QIC also provides oversight to QI activities, including the development and implementation of the Performance Improvement Projects (PIPs).

iii. The QIC reviews collected information, data, and trends relevant to standards of cultural and linguistic competency.

b. Recommend policy decisions; review and evaluate the results of QI activities; and monitor the progress of the PIPs.
    i. The QIC institutes needed actions and ensures follow-up of QI processes.

c. Assure that QI activities are completed and utilizes a continuous feedback loop to evaluate ongoing quality improvement activities.
    i. This feedback loop helps to monitor previously-identified issues and provides an opportunity to track issues over time.
    ii. The QIC continuously conducts planning and initiates new activities for sustaining improvement.

2) QIC Membership – The QIC is accountable to the ACBHS Director. Designated members of the QIC include the ACBHS Director; Clinical Coordinator; Behavioral Health Services Coordinator; Alcohol and Drug Program Specialist; designated clinical staff; designated administrative staff; and community members, including consumers and family members, as well as MHSA- and AOD-funded agencies. ACBHS contracts with several non-profit groups for outreach and engagement services. As a component of the contracts, these entities are required to attend the bi-monthly meetings of the QIC.

3) QIC Agenda – The QIC uses a standing meeting agenda to ensure that all required QI components are addressed at each QIC meeting, and which includes at least the following:

- Monitor QIC action items, recommended policy changes and system-level changes, and assignments from previous QIC meeting (To ensure a complete feedback loop, completed and incomplete action items shall be identified on the agenda for review at the next meeting.)
- Access Log Review
    - Review business days for first appointment
    - Assess response for urgent conditions (during regular hours and after-hours)
    - Review requests for cultural/linguistic services and assess results
- Review Inpatient / IMD / Residential programs: census, utilization, and length of stay
- Review processed Treatment Authorization Requests (TARs) for utilization and documentation compliance
- Review medication monitoring process to assure appropriateness of care
- Review NOABDs for appropriateness, documentation compliance, and trends
- Review URC decisions for quality, timeliness, and utilization management issues

    - Conduct random chart review for quality and appropriateness of client care; timeliness of services; and compliance with documentation standards (assessments, service plans, etc.)
    - Monitor UR Return for Review and Correction process through summary format
    - Review clinical peer reviews and plans of correction for approval or further action
    - EHR Process for quality assurance
- Assess client and family satisfaction surveys for access and cultural competence issues
- Review grievances or appeals (client or provider) for appropriateness of response and trends
- Review requests for or results of State Fair Hearings
- Discuss Patient's Rights issues
- Monitor Change of Provider Requests
- Review provider satisfaction surveys (annually)
- Review data for client- and system-level performance outcome measures and projects (PIPs)
- Review Clinical Team Meeting Assessments (CANS, PSC, etc)
- Review Compliance Program issues
- Review Access Line Test Calls (quarterly report)
- Review Contracted Org Providers Cert/Recert Status
- Annual Reviews
    - Triennial Review Spring/Summer 2019
    - Final Rule
    - SUD Monitor
    - EQR
- Review new regulations and CA Department of Health Care Services (DHCS) Information Notices / All Plan Letters
- Verification of services provided
- Discuss timely interventions to mitigate issues, including quality of care and clinical concerns
- Other items for discussion

4) QIC Sign-In Sheet – A Sign-In Sheet is collected at the beginning of each QIC meeting.
    - A Confidentiality Statement is integrated into the QIC sign-in sheet and ensures the privacy of protected health information.

5) QIC Meeting Minutes – The QIC uses a meeting minute template to ensure that all relevant and required components are addressed in each set of minutes.
    - Meeting minutes are utilized to track action items and completion dates.
    - Minutes are maintained by the Behavioral Health Services Coordinator or designee, and are available for required annual audits and triennial reviews.

C. Annual Quality Improvement Work Plan

The Annual Work Plan for Quality Improvement activities of ACBHS provides the blueprint for the quality management functions designed to improve both client access and quality of care. This Plan is evaluated annually and updated as necessary.

The ACBHS annual QI Work Plan includes at least the following components:

1. An annual evaluation of the overall effectiveness of the QI Program, utilizing data to demonstrate that QI activities have contributed to meaningful improvement in clinical care and client services;

2. Objectives and goals for the coming year;

3. Previously identified issues, including tracking issues over time; and

4. Activities for sustaining improvement.

The ACBHS Behavioral Health Services Coordinator facilitates the implementation of the QI Work Plan and the QI activities. Sufficient time to engage in QI activities will be allocated to this position (e.g., conducting chart reviews, coordinating Performance Improvement Projects, facilitating the committee, monitoring activities).

The QI Work Plan ensures the opportunity for input and active involvement of clients, family members, licensed and paraprofessional staff, providers, and other interested stakeholders in the Quality Improvement program. QIC members participate in the planning, design, and implementation of the QI program, including policy setting and program planning.

The ACBHS QI Work Plan addresses quality assurance/improvement factors as related to the delivery of timely, effective, and culturally-competent specialty mental health and substance use disorder services.

The QI Work Plan is posted on the ACBHS website, and is also available upon request. It is provided to the External Quality Review Organization (EQRO) during its annual review of the ACBHS system. The QI Work Plan is also available to auditors during the triennial Medi-Cal review.

II. DATA COLLECTION – SOURCES AND ANALYSIS

A. Data Collection Sources and Types

Data sources and types may include, but not are limited to, the following (as available):

- Client and service utilization data by type of service, age, gender, race, ethnicity, primary language, veterans, and LGBTQ
- Electronic Health Record Reports
- Access Log (initial contact log)
- Crisis Log
- Test call logs
- Client satisfaction surveys
- Client Grievance/Appeal Logs; State Fair Hearing Logs
- Change of Provider forms and logs
- Medication Monitoring forms and logs
- Staff training logs
- Notice of Adverse Benefit Determination (NOABD) forms and logs
- Second Opinion requests and outcomes
- Treatment Authorization Requests (TAR) and Inpatient logs
- Staff productivity reports
- Clinical Review QI Checklists (and plans of correction)
- Peer Chart Review Checklists (and plans of correction)
- Compliance logs
- Policies and procedures
- Meeting minutes
- EQR and Medi-Cal Audit results
- Special Reports from DHCS or other required studies

B. Data Analysis and Interventions

1. The Behavioral Health Services Coordinator performs preliminary analysis of data to review for accuracy and completion.
    a. If there are areas of concern, the QIC discusses the information. Clinical staff may be asked to implement plans of correction, as needed.
    b. Policy changes may also be implemented, if required.
    c. Subsequent review is performed by the QIC.

2. The changes to programs and/or interventions are discussed with individual staff, QIC members (including consumers and family members), Behavioral Health Advisory Board members, and management.

3. Program changes have the approval of the Behavioral Health Director or the Clinical Coordinator prior to implementation.

4. Effectiveness of program changes are evaluated by the QIC.
    a. Input from committee is documented in the minutes. These minutes document the activity, person responsible, and timeframe for completion. Each activity and the status for follow-up are discussed at the beginning of each meeting.

III. Quality Improvement Activities, Goals, and Data

The Quality Improvement program for Fiscal Year 2016-2017 includes the following activities, goals, and baseline FY 2015-2016 data.

A. Ensure ACBHS Service Delivery Capacity – Annually, the ACBHS QI program monitors services to assure service delivery capacity in the following areas:

1. Utilization of Services

- Activity: Review and analyze reports from the Kings View Cerner program. The data includes the current number of clients served each fiscal year and the types of mental health and substance use disorder services delivered. Data is analyzed by age, gender, ethnicity, primary language, LGBTQ, veterans, and diagnosis; it is compared to the goals set by the QIC for service utilization.
- Goal: Increase the number of mental health services received by Transition Age Youth (TAY) in FY 2017-2018.
- FY 2016-2017 Baseline Data: There were an average of 8 mental health services received by TAY clients in FY 2016-2017.
- FY 2017-2018 Data: There were an average of 4 mental health services received by TAY clients in FY 2017-2018. We will review this data annually to assess improvement in the measure.

2. Service Delivery Capacity

- Activity: Data around telepsychiatry services, which are provided by Kings View, is reviewed periodically to ensure service capacity.
- Goal: Maintain the number of clients served by Telepsychiatry in FY 2017-2018.
- FY 2016-2017 Baseline Data: Twenty (20) clients received Telepsychiatry services in FY 2016-2017.
- FY 2017-2018 Data: Twenty-two (22) clients received Telepsychiatry services in FY 2017-2018.

These issues are also evaluated to ensure that the cultural and linguistic needs of clients are met.

B. Monitor Accessibility of Services – The ACBHS QI program monitors accessibility of services in accordance with statewide standards and the following local goals:

1. **Timeliness of routine mental health appointments**
   - Activity: This indicator is measured by analyzing a random sample of new requests for services from the Access Log. This data is reviewed quarterly.
   - Goal: Maintain the number of clients referred for mental health services who receive an initial intake assessment appointment within ten (10) calendar days after the request for services.
   - FY 2016-2017 Baseline Data: 317 of the 351 (90.3%) clients referred for mental health services in July – December 2016 received an initial intake assessment appointment within fourteen (14) calendar days after the request for services. *Note*: *This data reflects the previous ACBHS standard of fourteen (14) calendar days to initial intake; the data will be updated to reflect the new 10-day standard in the next QI Work Plan update.*
   - FY 2017-2018 Data: 53 of the 55 (96.4 %) clients referred for mental health services in FY 2017-2018 received an initial intake assessment appointment within ten (10) calendar days after the request for services.

2. **Timeliness of services for urgent or emergent conditions during regular clinic hours**
   - Activity: This indicator is measured by analyzing a random sample of urgent or emergent requests for services from the Crisis Log. This data is reviewed quarterly.
   - Goal: Maintain the percentage of business-hours crisis requests with a response time of one (1) hour or less.
   - Baseline FY 2017-2018 Data: In FY 2017-2018, there were 7 business-hours crisis calls, with 100% responded to within one (1) hour.

3. **Access to after-hours Emergency services**
   - Activity: ACBHS is working with local law enforcement to improve response, coordination, and communication regarding after-hours crisis calls.
   - Goal: Develop a protocol for after-hours crisis response that meets the needs of the community.
   - Baseline FY 2017-2018 Data: In FY 2017-2018, there were 13 after-hours crisis calls, with 100% responded to within one (1) hour.

4. **Responsiveness of the 24-hour, toll-free telephone number**
   - Activity: During non-business hours, the answering service answers the crisis line immediately, and links urgent and/or emergent calls to the on-call mental health staff person. If required, an interpreter and/or the Language Line Solutions is utilized. This indicator is measured by

conducting random calls to the toll-free number, both after hours and during business hours. At least five (5) test calls are made per month; split between English and Spanish. This data is reviewed at each quarterly QIC meeting.

- Goal: The ACBHS after-hours 24-hour telephone service answers the call within one (1) minute. The line is tested monthly.
- FY 2016-2017 Baseline Data: Sixty-two (62) test calls were conducted in FY 2016-2017, with 56 (90.3%) being answered by staff within one (1) minute.
- FY 2017-2018 Data: Sixty (60) test calls were conducted in FY 2017-2018, with 58 (96.7 %) being answered by staff within one (1) minute.

5. Provision of culturally and linguistically appropriate services

- Activity: This indicator is measured by random review of the Access Log and/or the Crisis Log, as well as the results of test calls. The focus of these reviews is to determine if a successful and appropriate response was provided which adequately addressed the client's cultural and linguistic needs. In addition, requests for the need for interpreters are reviewed (via the Access Log) to assure that staff are aware of the need for an interpreter and that clients received services in their preferred language, whenever feasible. This information is reviewed quarterly.
- Goal: Maintain or increase the percentage of successful test calls to the toll-free hotline in FY 2017-2018 at the same capacity as in FY 2016-2017.
- FY 2016-2017 Baseline Data: Sixty-two (62) test calls were conducted in FY 2016-2017, with 45 (72.6%) that were overall successful.
- FY 2017-2018 Data: Sixty (60) test calls were conducted in FY 2017-2018, with 51 (85 %) that were overall successful.

6. Increasing client access

- Activity: ACBHS endeavors to improve client access to mental health services, targeting high-need populations. This indicator is measured through an analysis of clients who received FSP services in the fiscal year. This information is reviewed annually.
- Goal: Increase FSP enrollment by 20% in FY 2017-2018.
- FY 2016-2017 Baseline Data: Five (5) clients received FSP services in FY 2016-2017.
- FY 2017-2018 Data: Five (5) clients received FSP services in FY 2017-2018.

C. Monitor Client Satisfaction – The QI program monitors client satisfaction via the following modes of review:

1. Monitor Client Satisfaction

- Activity: Using the DHCS POQI instruments in threshold languages, clients and family members are surveyed twice each year, or as required.

This indicator is measured by annual review and analysis of at least a one-week sample. Survey administration methodology will meet the requirements outlined by the CA DHCS. This data is reviewed twice each fiscal year, after the surveys have been analyzed.

- Goal: Increase the number of POQI survey respondents by 25%.
- FY 2016-2017 Baseline Data: A total of 4 clients responded to the DHCS POQI instrument in FY 2016-2017.
- FY 2017-2018 Data: This data will be added one the Fall 2018 surveys have been collected.

2. Monitor Youth and/or Family Satisfaction

- Activity: Utilization of the DHCS, POQI YSS and YSS-F measurement instruments assures the use of instruments that are accepted statewide as the basis for satisfaction surveys. The YSS and YSS-F are collected from youth ages 12 and older and the children's families. Survey administration methodology will meet the requirements outlined by the CA DHCS. This data is reviewed after each survey administration.
- Goal: Increase the number of YSS and YSS-F survey respondents.
- FY 2016-2017 Baseline Data: In FY 2016-2017, there were no YSS or YSS-F surveys completed.
- FY 2017-2018 Data: This data will be added one the Fall 2018 surveys have been collected.

3. Monitor Beneficiary Grievances, Appeals, and State Fair Hearings

- Activity: All processed beneficiary grievances, expedited appeals, standard appeals, and fair hearings are reviewed at QIC meetings. Monitoring is accomplished by ongoing review of the Grievance Log for adherence to timelines for response. In addition, the nature of complaints and resolutions is reviewed to determine if significant trends occur that may influence the need for policy changes or other system-level issues. This review includes an analysis of any trends in cultural issues addressed by our clients. This information is reviewed quarterly, as available.
- Goal: The MHP will respond in writing to 100% of all grievances within 60 calendar days.
- FY 2016-2017 Baseline Data: There was one (1) grievance in FY 2016-2017, with 100% responded to within 60 calendar days from the date of receipt.
- FY 2017-2018 Data: There were 0 grievances in FY 2017-2018.

4. Monitor Requests to Change Providers

- Activity: Quarterly, patterns of client requests to change practitioners/providers are reviewed by the QIC. Measurement is accomplished by review of QIC minutes summarizing activities of the Access Team and through annual review of the Change of Provider Request forms.

- Goal: Monitor beneficiary Requests for Change of Provider including reasons given by consumers for their Change of Provider requests.
- Data: Review patterns of beneficiary Requests for Change of Provider at each QIC meeting to identify trends.

5. Inform Providers of Survey Results

- Activity: The results of client and family satisfaction surveys are routinely shared with ACBHS staff providers. Monitoring is accomplished by review of the results of the POQI surveys as related to clients who have received services from ACBHS. Survey results are shared with staff, consumers, family members, QIC, and the Behavioral Health Board. This information is distributed on an annual basis and in the form of cumulative summaries to protect the confidentiality of clients and their families. This process is reviewed annually.
- Goal: Survey results are to be shared with identified stakeholders.
- FY 2016-2017 Baseline Data: Survey results were shared with staff, consumers, family members, QIC, and the Behavioral Health Board in FY 2016-2017, through face-to-face meetings.
- FY 2017-2018 Data: Survey results were shared with staff, consumers, family members, QIC, and the Behavioral Health Board in FY 2017-2018, through face-to-face meetings.

6. Monitor Cultural and Linguistic Sensitivity

- Activity: In conducting reviews in the above areas, analysis occurs to determine if cultural or linguistic issues may have influenced results. Surveys will be provided in English and in Spanish. Surveys and activities will take into account Native American culture. This process is reviewed annually.
- Goal: Maintain or increase the percentage of consumers/families reporting that staff were sensitive to their cultural/ethnic background in FY 2017-2018 at the same capacity as in FY 2016-2017.
- FY 2016-2017 Baseline Data: Sixty-seven percent (66.7%) of consumers/families reported that staff was sensitive to their cultural/ethnic background in FY 2016-2017.
- FY 2017-2018 Data: This data will be added one the Fall 2018 surveys have been collected.

D. Monitor the Service Delivery System – The QI program monitors the ACBHS service delivery system to accomplish the following:

1. Review Safety and Effectiveness of Medication Practices

- Activity: Annually, meaningful issues for assessment and evaluation, including safety and effectiveness of medication practices and other clinical issues are identified. Medication monitoring activities are accomplished via review of at least 10% of cases involving prescribed

medications. These reviews are conducted by a person licensed to prescribe or dispense medications.

- Goal: Continue to annually conduct medication monitoring activities on at least 10% of medication charts.
- FY 2016-2017 Baseline Data: 36% (9) of the medication charts were reviewed in FY 2016-2017.
- FY 2017-2018 Data: 4.2% (1) of the medication charts was reviewed in FY 2017-2018.

2. Identify Meaningful Clinical Issues

- Activity: Quarterly, meaningful clinical issues are identified and evaluated. Appropriate interventions are implemented when a risk of poor quality care is identified. Monitoring is accomplished via review of QIC minutes for satisfactory resolutions in the areas of grievances, medication monitoring, and cases where plans of correction are requested. Re-occurring quality of care issues are discussed in staff meetings and at the QIC to address concerns in a timely manner.
- Goal: Clinical staff participate in at least 12 clinical trainings each year.
- FY 2016-2017 Baseline Data: In FY 2016-2017, each clinical staff member participated in an average of 14 clinical trainings.
- FY 2017-2018 Data: In FY 2017-2018, each clinical staff member participated in an average of 12 clinical trainings.

3. Review Documentation and Medical Records System

- Activity: Client documentation and medical records system fulfills the requirements set forth by the DHCS and Alpine County MHP contract requirements. Documentation of the client's participation in and agreement with their client treatment plan will be included. When the client is unavailable for signature or refuses signature, the client treatment plan includes a written explanation of the refusal or unavailability. Signatures of the individual providing service or the team/representative providing services are recorded.
- Goal: Maintain the percentage of completed and signed Treatment Plans in FY 2017-2018 at the same capacity as in FY 2016-2017.
- FY 2016-2017 Baseline Data: All of the Mental Health Treatment Plans (100%) due in FY 2016-2017 where completed and signed.
- FY 2017-2018 Data: Forty-eight (48) of the Mental Health Treatment Plans (98.0%) due in FY 2017-2018 where completed and signed.

4. Implement and Maintain Efficient Workflow Standards

- Activity: Office and billing workflow standards are implemented and maintained to efficiently and consistently serve clients from first contact through discharge, and bill correctly and consistently. Workflow processes are documented and implemented through policies and procedures. Monitoring is conducted through annual review of related policies and procedures; and updated as necessary.

- Goal: Develop and implement billing and workflow policies and procedures.
- Data: Evidenced by the number of policies and procedures written and implemented in FY 2017-2018.

5. Assess Performance

- Activity: Quantitative measures are identified to assess performance and identify areas for improvement, including the PIPs and other QI activities. ACBHS monitors both under-utilization of services and over-utilization of services. The BH Director reviews data on the percentage of billable services (productivity reports). These areas are measured through the quarterly review of the timeliness of assessments and treatment plans; completeness of charts; client surveys; and productivity reports. The results of these reviews dictate areas to prioritize for improvement.
- Goal: Maintain the percentage of billable services delivered by staff in FY 2017-2018.
- FY 2016-2017 Baseline Data: Eighty-six percent (86.3%) of services delivered by staff were billable services in FY 2016-2017.
- FY 2017-2018 Data: Thirty-three percent (37.1%) of services delivered by staff were billable services in FY 2017-2018.

6. Support Stakeholder Involvement

- Activity: Staff, including licensed mental health professionals, paraprofessionals, providers, clients, and family members review the evaluation data to help identify barriers to improvement. As members of the QIC, providers, clients, and family members help to evaluate summarized data. This ongoing analysis provides important information for identifying barriers and successes toward improving administrative and clinical services. In addition, the Behavioral Health Advisory Board provides input on access and barriers to services. Measurement is accomplished via review of QIC minutes and rosters, and occurs annually.
- Goal: Increase attendance at QIC to fill at least one (1) consumer slot at each meeting in FY 2017-2018.
- This goal is new for FY 2017-2018. Baseline data will be added in the next update of the QI Work Plan.
- FY 2017-2018 Baseline Data: There were 0 consumers in attendance at QIC in FY 2017-2018.

7. Conduct Frequent Peer Reviews

- Note: ACBHS does not currently have the capacity to conduct peer chart reviews. The feasibility of this activity will be periodically reviewed and implemented when possible.

The activities and processes outlined above will maintain sensitivity to the identification of cultural and linguistic issues.

E. Monitor Continuity and Coordination of Care with Physical Health Care Providers – When appropriate, information is exchanged in an effective and timely manner with other health care providers used by clients.

1. Monitor Coordination of Care

- Activity: Monthly Integrated Health Care Committee meetings are held to discuss care coordination, and identify referrals to alternative resources for treatment or other services whenever requested, or when it has been determined that an individual may benefit from referral to other health care providers.
- Goal: Maintain regular Integrated Health Care Committee meetings, as evidenced by meeting minutes and tracking of action items.
- Data: Integrated Health Care Committee meetings have been held monthly since November 2016; meeting minutes are maintained by designated staff.

F. Monitor Provider Appeals

1. Monitor Provider Appeals

- Activity: Provider appeals and complaints are reviewed as received by the QIC. A recommendation for resolution will be made to the Behavioral Health Director. The resolution and date of response are recorded in the QIC meeting minutes. The QIC reviews the provider appeals and complaints annually for any trends and addresses these issues.
- Goal: Monitor the number of TAR appeals in FY 2017-2018.
- FY 2016-2017 Baseline Data: There were 0 TAR appeals in FY 2016-2017.
- FY 2017-2018 Baseline Data: There were 0 TAR appeals in FY 2017-2018.

IV. DELEGATED ACTIVITIES STATEMENT

ACBHS does not delegate any review activities. Should delegation take place in the future, this Plan will be amended accordingly.