ALPINE COUNTY BEHAVIORAL HEALTH SERVICES
QUALITY IMPROVEMENT PROGRAM 2015-2016 WORK PLAN EVALUATION

INTRODUCTION AND PROGRAM OVERSIGHT

The Annual Work Plan for Quality Improvement (QI) activities of the Alpine County Behavioral Health (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 QI program is accountable to Alissa R. Nourse. M.Ed., Behavioral Health Services Director, who has substantial involvement in the implementation of the Quality Improvement Program.

This Quality Improvement Plan ensures the opportunity for input and active involvement of consumers, family members, providers, and other interested stakeholders in the Quality Improvement Program. The QI members participate in the planning, design, and execution of the QI Program, including policy setting and program planning. The Plan activities also serve to fulfill the requirements set forth by the California State Department of Health Care Services and County Specialty Mental Health Services Contract requirements, as related to the contract's Annual Quality Improvement Program description. The Plan addresses quality assurance/improvement factors as related to the delivery of culturally-competent specialty mental health services.

The QI Program will also conduct performance monitoring activities through the ACBHS, including but not limited to: client and system outcomes; utilization management; utilization review; provider appeals; credentialing and monitoring; and resolution of client grievances.

Quality Improvement Committee

The Quality Improvement Committee (QIC) is responsible for the key functions of the ACBHS Quality Improvement Program. This Committee is involved in the following functions:

1. The Behavioral Health Services Coordinator will facilitate the implementation of the QI Work Plan and the QI activities. Sufficient time to engage in quality improvement activities will be allocated (i.e. chart review, coordination of Program Improvement Plans (PIPs), facilitating committee activities, monitoring plan implementation).

2. Quality Improvement Committee (QIC) functions include implementing the specific and detailed review and evaluation activities of the agency. On a quarterly/bi-monthly basis, the QIC collects, reviews, evaluates, and analyzes information and implements actions that frequently involve the handling of information that is of a sensitive and confidential nature. The QIC also provides oversight to QI activities, including the development and implementation of the Performance Improvement Projects (PIPs) and the oversight of the Compliance Program. The QIC recommends policy decisions; reviews and evaluates the results of QI activities; and monitors the progress of the PIPs. The QIC institutes needed QI actions and follow-up of QI processes. The QIC documents all activities through dated and approved minutes to reflect all QIC decisions and actions.

- The QIC provides oversight and is involved in Quality Improvement activities. The QIC conducts an evaluation of the overall effectiveness of the QI program. This helps to demonstrate that QI activities, including Performance Improvement Projects, contribute to meaningful improvement in clinical care and consumer services.

- The QIC ensures that QI activities are completed and utilize a continuous feedback loop to evaluate ongoing quality improvement activities, including the Performance Improvement Projects. This feedback loop helps to monitor previously identified issues and provides an opportunity to track issues over time. The QIC continuously conducts planning and initiates new activities for sustaining improvement.

- Members 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.

- Each quarterly/bi-monthly meeting of the QIC shall include a verbal summary of significant QIC findings, decisions, actions, and recommendations. In addition, written information may also include data summaries, as available.

- The QIC is accountable to the ACBHS Director. The QI program coordinates performance monitoring activities throughout the program and includes client and system level outcomes, implementation and review of the utilization review process, credentialing of licensed staff, monitoring and resolution of beneficiary grievances, fair hearings, and provider appeals, periodically assessing consumer, youth, and family satisfaction, and reviewing clinical records for compliance with documentation standards. The QIC also provides oversight and monitors out of county authorizations as well as inpatient treatment authorization requests. This includes monitoring specialty mental health services to ensure that consistent and cost-effective quality services are provided.

- 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 quarterly/bi-monthly meetings of the QIC.

ACBHS contracts with Kings View for telepsychiatry services; independent contractors for outpatient services; and hospitals in the region and state for psychiatric inpatient services. As a component of the contracts, these entities are required to cooperate with the ACBHS QI program and allow access to relevant clinical records to the extent permitted by State and Federal laws.

PROGRAM COMPONENTS

A. Evaluation of Overall Effectiveness

Evaluation of the overall effectiveness of the QI program shall be accomplished routinely, as well as annually, to demonstrate that:

- QI activities access, timeliness, quality, and cost-effectiveness of services;
- QI activities have contributed to improvement in clinical care;
- QI activities have contributed to improvement in client services;
- QI activities have been completed or are in process;
- QI activities monitor compliance with state and federal regulations;
- QI activities regularly monitor client and family satisfaction with services;
- QI activities monitor the safety and effectiveness of medication practices; and
- QI activities have incorporated relevant cultural competence and linguistic standards to match clients' cultural and linguistic needs with appropriate providers and services.

REGULATION REVIEW	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
1. Annual Quality Improvement Program Review:		
A. Conduct Quality Improvement Committee meetings every two months to monitor and evaluate Work Plan, including the following QI components: 1. PIP Projects 2. Monitoring access and quality of services (Inpatient, IMD, Board & Care, and other out-of-home placement utilization; timeliness of services) 3. Katie A implementation and outcomes 4. FSP utilization and outcomes 5. MHSA implementation and outcomes; including PEI activities 6. AOD services 7. Cultural and Linguistic Competence 8. Compliance Program	A. Every 2 months	A. Completed. The QI Committee began meeting every other month in August 2015 1. PIP Projects were not submitted in FY 15/16 or 16/17. Two (2) active PIPs are scheduled for submission for the FY 17/18 EQR. 2. ACBHS monitors the access and quality of services for the two (2) inpatient clients who are under public guardianship. This activity is conducted monthly by the Clinical Coordinator. 3. ACBHS has no current Katie A clients. 4. ACBHS has three (3) FSP clients and our Clinical Coordinator measures the outcomes. 5. The MHSA Program Coordinator monitors the implementation and outcomes, including PEI activities. 6. ACBHS has an AOD Program Specialist who has engaged in many outreach activities in the community and participates in Talking Circle and the Dual Diagnosis Group. 7. ACBHS has a Native Wellness Advocate on staff who has established a number of wellness activities around the Washoe Tribal culture. MHSA staff has several senior programs, have begun some Veteran's information programs, works closely with the school district regarding youth activities. In April 2016, our Cultural and Linguistic Competence Plan was updated. 8. Our Compliance Plan was completed in April 2016. ACBHS staff reviews policies and procedures regularly at staff meetings, which are held at least three (3) times per month.

REGULATION REVIEW	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
9. Monitoring Strategic Initiatives 10. Consumer Input 11. Other a) Drug Medi-Cal b) Fiscal Information c) HIPAA d) Anasazi Implementation Progress e) QM Documentation Standards		9. Not applicable at this time. 10. Completed in our annual MHSA Update through the stakeholder process. 11. In FY 15/16, there were no identified issues regarding the following program components: DMC, fiscal, HIPAA, Anasazi/EHR. The Triennial Medi-Cal review in FY 15/16 highlighted a few documentation issues that have been addressed through the Plan of Correction.
B. The minutes of all QIC meetings shall include the following information: 1. Identification of action items; 2. Follow-up on action items to monitor if they have been completed; 3. Assignments (by persons responsible); 4. Due dates; and 5. Completion dates.	B. Jan. 2016	B. Completed. The QIC minutes reflect the following as of October 2015: 1. Action items are identified 2. Action items are monitored and followed up on. 3. Staff members are assigned. 4. Due dates are reflected in the minutes 5. Completion dates are reflected in the minutes. *To foster a feedback loop, completed and incomplete action items shall be identified on the agenda for review at the next meeting. Chart reviews pending plans of correction shall be identified for follow-up and reporting. ACBHS has developed a "meeting minutes" template to ensure that all relevant and required components are addressed in each set of minutes. Meeting minutes will also be utilized to track action items and completion dates.*
C. Review and evaluate progress of Work Plan	C. Annual	C. Completed. The QIC evaluates the progress of the work plan annually.

REGULATION REVIEW	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
D. Inclusion of Cultural and Linguistic Competence concerns in all QI Activities. The QIC and CLC Committees are combined for efficiency and effectiveness in this small, rural county.	D. Annual	D. Completed. The QIC acts as the Cultural Competence Committee (CCC) on the alternating months of QIC meetings.

REGULATION REVIEW	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
2. Utilization Management Program:		
A. Review and analyze reports from the Anasazi program and utilization of data from the CA DHCS Client Services Information system (CSI), as available. The data will include the current number of clients served each fiscal year and the types and geographic distribution of mental health services delivered within the delivery system. Penetration rates will be examined at least annually. Data will be analyzed by age, gender, ethnicity, and diagnosis; it will be compared to the goals set by the QIC for service utilization.	A. Every 2 months /Quarterly	A. Completed. The ACBHS Clinical Coordinator does this every two months.
B. Track all Notices of Action (CCR 1820.205)	B. Monthly	B. No NOAs in FY 15/16.

REGULATION REVIEW	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
C. Approve/deny all Treatment Authorization Requests (CCR 1810.365, 1820.225, 1830.215 – 220)	C. 14 days	C. No TARs in FY 15/16.
D. Maintain access log, crisis log, training log, and test calls log to ensure that clients calling the crisis line receive timely and responsive services in their preferred language	D. Every 2 months /Quarterly	D. Completed. The ACBHS Admin Assistant maintains the access log, crisis log, training log and test calls log monthly.
E. Ensure inpatient services meet Title 9 Medical Necessity Criteria; conduct authorization and payment in a timely manner (CFR 438.206 and CCR 1830.220)	E. Quarterly/ Semi-Quarterly	E. Completed. The ACBHS Clinical Coordinator maintains the Medical Necessity criteria quarterly.
F. Authorize services for out of county children, TBS, and Day Treatment services (CCR 1810.215)	F. 14 days	F. No authorizations of this type in FY 15/16.

REGULATION REVIEW	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
G. Implement quality review of charts on a monthly / quarterly basis (to be determined by Clinical Coordinator) to ensure compliance with state and federal regulations.	G. Monthly/ Quarterly	G. Completed. The Clinical Coordinator reviews charts monthly.

ACCESS TO SERVICES	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
1. Monitor and report quarterly progress to established goals:		
A. Measure length of time from initial contact to first appointment (CCR 1810.345, 1810.405, CFR 438.210)	A. 14 days	A. Completed. Since April 2015, the access log for ACBHS has evolved many times to meet the criteria of the state standards. For FY 16/17, the length of time from initial contact to first appointment is 3.419 days.
B. Track and trend access data for timely appointments for urgent conditions. (CCR 1810.253)	B. Same day	B. Completed. ACBHS has been able to see clients the same day for urgent conditions.
C. Track and trend access data to ensure timely access to follow-up appointments after hospitalization	C. 7 days	C. Completed. ACBHS had one client in July 2016 who had a hospitalization. The clinician transported the client home from the hospital and continued follow up care.
D. Monitor length of time from referral to psychiatric appointments	D. 21 days	D. Completed. ACBHS has monitored the length of time from referral to psychiatric appointments through our access log and it has been determined that the average length of time is 13.333 days (FY 16/17).

E. Responsiveness of the 24-hour toll free telephone line by at least 6 test calls per year to ensure information is provided on how to access specialty mental health services, what services are available to treat urgent conditions, and how to use the problem resolution process	E. 100%	E. Based on the first 3 quarters of the FY 16/17 and the 24/7 test call quarterly reporting to the state, ACBHS has met the requirements 83.3289% of the time.
F. Review informing materials; update as necessary	F. Annually	F. Completed. ACBHS updates the informing materials monthly in our 4 office locations.
G. Review policies and procedures related to the Katie A. subclass; update as necessary	G. Annually	G. Completed.

BENEFICIARY SATISFACTION	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
1. Assess beneficiary and/or family member satisfaction with services:		
A. Annual evaluation of grievances, appeals, and fair hearings. Goal is to resolve 99% of grievances and appeals within regulatory standards.	A. 90%	A. ACBHS has had no grievances, appeals, or fair hearings filed since FY 14/15.
B. Annually review change of provider requests and second opinion requests (CCR 1830.225 and 1810.405)	B. Annually	B. One (1) change of provider request was made. It was reviewed by the Director and the Clinical Coordinator and the request was granted. No second opinion requests were filed.
C. Youth and/or family satisfaction according to statewide standards – Utilization of the DHCS Youth Services Survey (YSS) and Youth Services Survey for Families (YSS-F) measurement instruments. The YSS will be collected from youth ages 12 and older and the YSS-F will survey children's families. This data will be reviewed each fiscal year.	C. Semi-Annually	C. Completed. Youth and/or family satisfaction surveys were sent out to youth and their families. We have the results available through our Penetration Reports that are done semi-annually.

D. Inform providers of the results of the satisfaction surveys. The results of client and family satisfaction surveys are routinely shared with staff, providers, the Behavioral Health Advisory Board, and other interested stakeholders. This cumulative information is distributed on an annual basis. This process will be reviewed annually. Areas for improvement will be identified.	D. Annually	D. Completed. Providers are given the results of the satisfaction surveys through both the QIC meeting process and the Clinical Team Meetings (CTM).
E. Analyze data from grievances and appeals for any type of cultural impact or trends. Review data and identify areas for improvement.	E. Annually	E. No complaints or grievances were made in the FY 15/16.

SERVICE DELIVERY SYSTEM	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
1. Identify and make recommendations regarding clinical areas that need improvement:		
A. Collect and analyze relevant clinical issues, review data, and identify areas for improvement.	A. Annually	A. Clinical issues are discussed weekly and tracked via clinical team meeting agendas and minutes.
B. Collect and analyze Mental Health Services Act FSP Outcomes in four key domains including Emergency, Residential, Legal and Discharge Values, review data and identify areas for improvement.	B. Quarterly	B. MHSA FSP outcomes are tracked by the Clinical Coordinator.
C. Collect and analyze satisfaction surveys regarding client and family satisfaction and well-being, review data, and identify areas for improvement.	C. Quarterly	C. Completed. Satisfaction surveys were sent out to clients. We have the results available through our Penetration Reports that are done semi-annually.
D. Report to consumers, family members and other stakeholders the updates and outcomes of QI	D. Annually	D. Completed. Reports are made to the public at the QIC meetings, in the MHSA stakeholder process, and through the Substance Abuse Prevention planning process.

SERVICE DELIVERY SYSTEM	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
measures in order to obtain feedback and that providers, beneficiaries, and family members evaluate data to identify barriers to improvement		
E. Collect and analyze progress of the Performance Improvement Projects, review data, and identify areas for improvement.	E. Annually	E. PIP Projects were not submitted in FY 15/16 or 16/17. Two (2) active PIPs are scheduled for submission for the FY 17/18 EQR.
F. Implement outcome measures to assess effectiveness of services	F. July 2016	F. Completed. The clinical staff measures outcomes of clients through a number of outcome measure tools such as ANSA, CANS, PHQ-9, GAD-7, PCL and MORS.
G. Monitor safety and effectiveness of medication practices. Annually, meaningful issues for assessment and evaluation, including safety and effectiveness of medication practices, are identified. Medication monitoring activities will be accomplished via review of at least 10% of cases involving prescribed medications; these reviews will be conducted by a	G. Annually	G. Medications are prescribed only by the Psychiatrist during Telepsychiatry sessions. ACBHS is working closely with Kingsview and the Psychiatrist by using a medication monitoring protocol.

SERVICE DELIVERY SYSTEM	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
person licensed to prescribe or dispense medications. In addition, peer review of cases receiving clinical and case management services will occur during utilization review. An analysis of the peer review results will occur to identify significant clinical issues and trends. **2. Continuous implementation of clinical and other training for staff on an annual basis:** A. Cultural Competence B. Billing and Documentation C. Law and Ethics D. Confidentiality and Compliance		A. Training logs are available upon request. B. Training logs are available upon request. C. Training logs are available upon request. D. Training logs are available upon request.

CONTINUITY & COORDINATION OF CARE	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
1. Coordinate with physical health care to share information and decrease duplication of services (CFR 45 Parts 160 and 164):		
A. Exchange information. When appropriate, information will be exchanged in an effective and timely manner with health care providers used by clients. Measurement will be accomplished during ongoing review of the clinical assessments and discharge summaries. These reviews will 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. Appropriateness of exchange of information is measured	A. Annually	A. ACBHS staff began discussions integrated health care through a Leadership meeting process in October 2016. The Leadership team consisted of the ACBHS Director, Clinical Coordinator, and the BHS Coordinator. In November 2016, an Integrated Health Care Committee began and included Clinical staff and Public Health staff. Currently, this group meets monthly.

during peer chart review by assuring the presence of a signed release of information form. This information will be reviewed annually. When Memoranda of Understanding (MOUs) are developed with a physical health care plan/provider, a method will be identified to support coordination of care, including medication reconciliation, whenever possible.		
B. Develop a methodology for collecting information for each client regarding whether the client has a primary care provider, by name and date of the most recent appointment. Collect and analyze number of clients with an established primary care provider; review data and identify areas for improvement.	B. June 2016	B. This activity is being completed by our Administrative Assistant I who is the primary client contact in the clinical office.
C. Develop and utilize a ROI to obtain permission from the	C. June 2016	C. This activity is being completed by our Administrative Assistant I who is the primary client contact in the clinical office.

client to exchange health information. Collect and analyze the number of clients with a signed authorization in order to exchange information with primary care providers by first establishing baseline data. Review data and identify areas for improvement. D. Collect and analyze number of linkage and warm handoffs to primary care providers to assess, treat, and monitor physical health issues by first establishing baseline data. Review data and identify areas for improvement.	D. June 2016	D. This activity is being completed by the clinician.

SERVICE CAPACITY	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
1. Track the current number, types and geographic distribution of mental health services and number of providers (CFR 438.207):		
A. Collect and analyze the number of unduplicated clients served, including the number of clients for each fiscal year who are new to the system, by first establishing baseline data to determine a target/goal. Review data and identify areas for improvement.	A. June 2016	A. This item is being completed and data can be provided upon request.
B. Collect and analyze the number of County wide Medi-Cal beneficiaries compared to Medi-Cal beneficiaries currently in treatment, including potential and actual Katie A. Subclass clients; review data and identify areas for improvement. Provide a penetration rate across all clients, as well as subclass members.	B. Annually	B. Results indicate that 11% of the county's Medi-Cal beneficiaries are ACBHS clients. ACBHS tracks this information through the Penetration Report which can be provided upon request. ACBHS has no subclass members at this time.

C. Collect and analyze geographic distribution of services by first establishing baseline data. Review data and identify areas for improvement.	C. Annually	C. Results indicate that 34% of clients were from the Markleeville area, 49% of clients were from the Woodfords and/or the Hung-A-Lel-Ti Community, 7% of clients were from the Kirkwood area, 7% of clients were from the Bear Valley area and 3% identified themselves as homeless. This data can be provided upon request from our Anasazi/Cerner reporting system.
D. Collect and analyze no-show data by first establishing baseline data. Review data and identify areas for improvement.	D. June 2016	D. During the 15/16 Fiscal Year, there were 162 no shows for clinical staff and 17 no shows for the psychiatrist. This data can be provided upon request from our Anasazi/Cerner reporting system.
E. Collect and analyze discharge data to evaluate reasons for clients' discharge.	E. June 2016	E. This data can be provided upon request from our Anasazi/Cerner reporting system.

PROVIDER APPEALS	TARGET/GOAL	EVALUATION ACTIVITIES & EVIDENCE
1. Monitor provider appeals		
A. Complete provider satisfaction surveys at least every two years	A. Every 2 years	A. In June 2016, 20 Provider Satisfaction Surveys were mailed to all the providers that ACBHS has listed. ACBHS received seven (7) completed surveys indicating their satisfaction. Survey results are available upon request.

Steps in the Review Process

ACBHS shall incorporate the following steps for each of the above QI activities:

1. Identify goals and objectives.
2. Collect and analyze data to measure against the goals, or prioritized areas of improvement, that have been identified.
3. Identify opportunities for improvement and decide which opportunities to pursue.
4. Design, implement, and evaluate effectiveness of interventions to improve performance.
5. Follow-up the processes through the QI feedback loop to incorporate successful interventions in the mental health service system.

Data Collection

A. Data Collection

Data collection sources and types shall include, but are not be limited to:

1. Utilization of services by type of service, age, gender, ethnicity, and primary language via CSI, CalOMS, and the Anasazi program.
2. Access and timeliness of services by Access log data
3. Utilization Review
4. Crisis Log
5. Medication Monitoring Forms and Logs
6. Peer Chart Review Forms and Logs
7. Inpatient Census Log
8. Client Complaint and Grievance Log
9. Compliance log
10. Special Reports from DHCS or studies in response to contract requirements
11. Change of Provider request forms from beneficiary's log

B. Data Analysis and Interventions

1. Behavioral Health Services Coordinator shall perform preliminary analysis of data. If the subject matter is appropriate, clinical staff shall be asked to implement plans of correction. Policy changes may also be implemented, if required. Subsequent review shall be performed by the QIC.

2. The design of interventions shall receive input from individual staff, from committee meetings (including representatives of external agencies and consumers), the BHAB meetings, and from management.
3. Interventions shall have the approval of the Behavioral Health Services Director or Clinical Coordinator prior to implementation.
4. Effectiveness of interventions will be evaluated by the QIC. Input from the committees will be 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.