

# SAN BENITO COUNTY BEHAVIORAL HEALTH

## Annual Quality Improvement Work Plan



December 2015

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## I. INTRODUCTION AND PROGRAM CHARACTERISTICS

The Annual Work Plan for Quality Improvement activities of the San Benito County Behavioral Health (SBCBH) 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 Alan Yamamoto, L.C.S.W, Behavioral Health Director, who has substantial involvement in the implementation of the Quality Improvement Program and is a licensed mental health professional.

This Quality Improvement 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. 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 Department of Health Care Services, Mental Health Services Division, and Specialty Mental Health Services Contract requirements, as related to the contract's Annual Quality Improvement Program description. The SBCBH Plan addresses quality assurance/improvement factors as related to the delivery of culturally-competent specialty mental health services.

### A. Quality Management Committees

Two committees, the Quality Improvement Committee and the Quality Leadership Committee (QLC), are responsible for the key functions of the SBCBH Quality Improvement Program. These committees are involved in the following functions:

1. The Quality Improvement Committee (QIC) is charged with implementing the specific and detailed review and evaluation activities of the agency. On a quarterly 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. The QIC recommends policy decisions, reviews and evaluates the results of QI activities, and monitors the progress of the Performance Improvement Projects. The QIC institutes needed QI actions and ensures follow-up of QI processes. The QIC documents all activities through dated and signed minutes to reflect all QIC decisions and actions.

The QIC provides oversight and is involved in Quality Improvement activities. The QIC conducts an annual 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 assures that QI activities are completed and utilizes 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 of the QIC include the SBCBH Director, designated clinical staff, designated case management staff, and designated administrative staff.

In addition, management staff meet as a Subcommittee of the QIC Committee as time permits to discuss QI related topics on a more frequent basis than the quarterly meetings. This committee discusses topics such as Medi-Cal documentation, electronic health record implementation, preparing and responding to state and federal reviews, and other pertinent QI activities. A summary of these activities are shared with the QIC and Quality Leadership Committee members.

2. The Quality Leadership Committee (QLC) is integrated into the QIC Program through involvement in a general oversight and evaluation capacity. The QLC members review summaries of data and other critical information provided through the QIC functions. This information includes, but is not limited to, significant incidents and trends that will allow the QLC to evaluate the overall quality of care and service delivery of SBCBH mental health services.

The QLC also receives periodic updates on the progress of the Performance Improvement Projects. This information allows the QLC to have informed input on policy, system level changes, planning, and design of the mental health service delivery system. Members include clients, family members of clients, community representatives, external service providers of care, a psychiatrist, and representatives of other agencies.

Each quarterly meeting of the QLC shall include a verbal summary of significant QIC findings, decisions, actions, and recommendations, in accordance with Policy CLN: 27:00. In addition, written information may also include data summaries, as available.

Both the QIC and QLC are accountable to the SBCBH 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.

SBCBH procures contracts with individual, group, and organizational providers, and for psychiatric inpatient care. As a component of the contract, these entities are required to cooperate with the QI program and allow access to relevant clinical records to the extent permitted by State and Federal laws.

## II. 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 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; and
- QI activities have incorporated relevant cultural competence and linguistic standards to match clients' cultural and linguistic needs with appropriate providers and services.

### B. Specific QI Evaluation Activities

#### 1. **Quality Improvement Committee (QIC)**

The quarterly QIC meetings may include, but are not limited to, the following agenda items:

- Review reports to help identify trends in client care, in timeliness of treatment plan submissions, and trends related to the utilization review and authorization functions;
- Review client and provider satisfaction surveys, and client change of provider request to assure access, quality, and outcomes;
- Review the responsiveness of the 24-hour, toll-free telephone line;
- Review and evaluate results of QI activities, including progress on the development and implementation of the Performance Improvement Projects (PIP) (one for clinical and one for non-clinical areas);
- Review QI actions and follow-up on any plans for action;
- Review at least six (6) charts to focus on appropriateness of care, appropriateness of reviewer comments, any plans of correction following initial review, and any significant trends of concern;
- Review client- and system-level Performance Outcome Measures for adults and children to focus on any significant findings and trends;

- Review medication monitoring processes to assure appropriateness of care, appropriateness of reviewer comments, any plans of correction following initial review, and any significant trends of concern;
- Review new Notices of Action, focusing on their appropriateness and any significant trends;
- Review any grievances or appeals submitted. The QIC reviews the appropriateness of the SBCBH response and significant trends that may influence policy or program-level actions, including personnel actions;
- Review any provider appeals;
- Review any requests for State Fair Hearings, as well as review of any results of such hearings;
- Monitor the distribution of EPSDT brochures;
- Review other clinical and system level issues of concern that may affect the quality of service delivery. The information reviewed also allows the QIC to evaluate trends that may be related to culturally-sensitive issues and may require prescriptive action;
- Review potential or required changes in policy;
- Maintain an ongoing credentialing process to assure that all licensed staff are in compliance with their licensing requirements;
- Ensure that both the Office of Inspector General's Exclusion List and the Medi-Cal List of Suspended or Ineligible Providers lists are checked, prior to Medi-Cal certification of any individual or organizational provider and;
- Monitor issues over time and make certain that recommended activities are implemented, completing the Quality Improvement feedback loop.

## **2. Quality Leadership Committee (QLC)**

Each quarterly meeting of the QLC shall include a verbal summary of significant QIC findings, decision, actions, and recommendations. In addition, written information may also include data summaries, as available. Photocopies of the QIC meeting minutes are provided for QLC members for review and comment.

**3. Monitoring Previously Identified Issues and Tracking over Time**

Minutes of all QIC and QLC meetings shall include information regarding:

- An identification of action items;
- Follow-up on action items to monitor if they have been resolved;
- Assignments (by persons responsible); and
- Due date; and
- Completion date.

To assure a complete feedback loop, completed and incomplete action items shall be identified on the agenda for review at the next meeting. Chart reviews pending further action to implement plans of correction shall be identified for follow-up and reporting. SBCBH 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.

Due to the diverse membership of the QIC and QLC, information sharing with the QLC will not breach client confidentiality regulations; consequently, information of a confidential nature will be provided in summary form only. The QIC minutes are provided at the QLC meetings and assists to provide structure to the QLC meetings.

C. Inclusion of Cultural and Linguistic Competency Concerns in All QI Activities

On a regular basis, the QIC shall review collected information, data, and trends relevant to standards of cultural and linguistic competency.

### III. Objectives, Scope, and Planned Activities for the Coming Year

Quality Improvement activities for FY 2015/2016 include the following objectives:

A. Ensure SBCBH Service Delivery Capacity

The SBCBH QI program shall, on an annual basis, monitor services in this small county to assure service delivery capacity in the following areas:

- 1. Utilization of Services** – Review and analyze reports from the Kingsview Anasazi program. 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. Data will be analyzed by age, gender, ethnicity, primary language, and diagnosis; it will be compared to the goals set by the QIC for service utilization.
- 2. Service Capacity** – Staff productivity will be evaluated via productivity reports generated by the Kingsview Anasazi program.

Managers/Supervisors will receive periodic reports to assure service capacity.

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

B. Monitor Accessibility of Services

The SBCBH QI program shall monitor accessibility of services in accordance with statewide standards and the following local goals:

1. **Timeliness of routine mental health appointments** – The goal for routine appointments, including psychiatric services, is no more than sixty (60) working days between the initial request and the intake appointment. This indicator will be measured by analyzing a random sample of new requests for services from the Access Log. This data will be reviewed quarterly.
2. **Timeliness of services for urgent or emergent conditions during regular clinic hours** – The goal for urgent or emergent conditions is no more than one (1) elapsed hour from the initial request until an actual staff response is provided. In the case of requests for authorization by a provider, an authorization decision is rendered within one (1) hour. This indicator will be measured by analyzing a random sample of urgent or emergent requests for services from the Crisis Log. This data will be reviewed quarterly.
3. **Access to after-hours services** – The goal for access to after-hours care is no more than two (2) elapsed hours between the request for service and the actual face-to-face evaluation/intervention contact for emergency situations. Inpatient hospitalizations do not require authorization for services for the first 24 hours of admission for an emergency condition. Requests for authorization for urgent specialty mental health services will receive an authorization decision within one (1) hour. Non-emergency requests shall be referred for planned services during normal clinic hours. This indicator will be measured by analyzing a random sample of after hours requests for services from the Crisis Log and/or the Access Log, as well as the answering service's faxed reports of calls received. Data will be reviewed quarterly.
4. **Responsiveness of the 24-hour, toll-free telephone number** – During non-business hours, the answering service will answer the crisis line immediately and link urgent and/or emergent calls to the on-call mental health staff person. If required, an interpreter and/or the Language Line Solutions will be utilized. This indicator will be measured by conducting random calls to the toll-free number, both after hours and during business hours. At least one test call will be made per month: eight calls per year in English and four calls per year in Spanish. This data will be reviewed at

each quarterly QIC meeting after the test calls have been conducted.

- 5. Provision of culturally and linguistically appropriate services –** SBCBH strives to assure that the cultural and linguistic needs of clients are met in all of the above situations. This indicator will be 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 will be 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 will be reviewed quarterly.
- 6. Increasing client access –** SBCBH will endeavor to improve client access to mental health services through the following goals:
  - Increase FSP enrollment by 10 percent.
  - Increase the timeliness of initial mental health intake appointments to fourteen days or less from initial request for services.
  - Increase the timeliness for first mental health service following assignment to fourteen days or less.

C. Monitor Client Satisfaction

The QI program shall monitor beneficiary satisfaction via the following modes of review:

- 1. Client Survey –** Using the DHCS, POQI instruments in threshold languages, clients and family members will be surveyed annually or as required. This indicator will be 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 will be reviewed each fiscal year, after the results of the POQI surveys have been released by DHCS.
- 2. Youth and/or family satisfaction according to statewide standards –** 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 will be 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 will be reviewed after each survey administration.
- 3. Beneficiary grievances, appeals, and fair hearings –** All processed

beneficiary grievances, expedited appeals, standard appeals, and fair hearings will be reviewed at QIC meetings. Monitoring shall be accomplished by ongoing review of the Grievance Log for adherence to timelines for response. In addition, the nature of complaints and resolutions will be reviewed to determine if significant trends occur that may influence the need for policy changes or other system-level issues. This review will include an analysis of any trends in cultural issues addressed by our clients. This information will be reviewed quarterly, as available.

- 4. Requests to change practitioners/providers** – Quarterly, patterns of client requests to change practitioners/providers will be reviewed by the QIC. Measurement will be accomplished by review of QIC minutes summarizing activities of the Access Team and through annual review of the Change of Provider Request forms.
- 5. Informing providers of satisfaction survey results** – The results of client and family satisfaction surveys are routinely shared with providers. Monitoring will be accomplished by review of the results of the POQI surveys as related to clients who have received services from contract specialty mental health service providers. Survey results will be shared with staff, providers, consumers, family members, the Mental Health Board, and the Children’s System of Care Policy Committee. 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 will be reviewed annually.
- 6. Cultural and linguistic sensitivity** – In conducting review in the above areas, analysis will occur to determine if cultural or linguistic issues may have influenced results. Surveys will be provided in English and also in Spanish, San Benito County’s threshold language. The results of the POQI surveys will be analyzed to determine if at least seventy-five percent (75%) of Spanish speaking clients had access to written information in their primary language. This process will be reviewed annually.

**D. Monitor the Service Delivery System**

The QI program shall monitor the SBCBH service delivery system to accomplish the following:

- 1. Safety and Effectiveness of Medication Practices** – Annually, meaningful issues for assessment and evaluation, including safety and effectiveness of medication practices and other clinical issues are identified. Medication monitoring activities will be accomplished via review of at least ten (10) percent of cases involving prescribed medications. These reviews will be conducted by a person licensed to

prescribe or dispense medications. In addition, peer review of cases receiving clinical and case management services will occur at QIC meetings. An analysis of the peer reviews will occur to identify significant clinical issues and trends.

- 2. Identify Meaningful Clinical Issues** – Quarterly, meaningful clinical issues will be identified and evaluated. Appropriate interventions will be implemented when a risk of poor quality care is identified. Monitoring will be accomplished via review of QIC minutes for satisfactory resolutions in the areas of grievances, medication monitoring, and peer chart review 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.
- 3. Documentation & Medical Records System** – Client documentation and medical records system fulfills the requirements set forth by the California Department of Health Care Services, Mental Health Division and San Benito County Specialty Mental Health Services Contract requirements. Monitoring of medical records will include; client’s signature (or electronic equivalent) receiving services, or the client’s legal representative’s signature. 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 shall include a written explanation of the refusal or unavailability. Signatures of the individual providing service or the team/representative providing services will be recorded.
- 4. Implement and Maintain Efficient Work Flow Standards** – Office work flow standards will be implemented and maintained to efficiently and consistently serve clients from first contact through discharge. Work flow processes will be documented in flowcharts and implemented through policies and procedures. Monitoring will be conducted through annual review of work flow processes and procedures.
- 5. Assess Performance** – Quantitative measures will be identified to assess performance and identify areas for improvement, including the Performance Improvement Projects and other QI activities. SBCBH will monitor both under-utilization of services and over-utilization of services. The BH Director reviews data on review loss reports; productivity reports; and late treatment plan reports. These areas will be 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 will dictate areas to prioritize for improvement.
- 6. Support Stakeholder Involvement** – 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 QLC, providers, clients, and family members help to evaluate summarized data. Members of the QIC and QLC shall not be subject to discrimination or any other penalty in participating in the QIC/QLC role. This ongoing analysis provides important information for identifying barriers and successes toward improving administrative and clinical services. In addition, the MHSA Steering Committee provides input on access and barriers to services. Measurement will be accomplished via review of QIC and QLC minutes, and will occur annually.

7. **Conduct Frequent Peer Reviews** – SBCBH will evaluate the quality of the service delivery by conducting six (6) peer reviews every quarter. Reviews will be conducted by staff. Clinical Supervisors will review charts annually. Issues and trends found during these reviews will be addressed quarterly at the QIC meetings.

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**

1. 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. In addition, the Access Log includes tracking requests for psychiatric consults with physical healthcare providers. Appropriateness of exchange of information is measured during peer chart review by assuring the presence of a signed consent form. This information will be reviewed annually.
2. SBCBH will ensure continuity and coordination of care with other human service agencies used by clients.
3. A Memorandum of Understanding (MOU) is developed with a physical health care plan, Anthem Blue Cross, to coordinate care.

F. **Monitor Provider Appeals**

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 shall be recorded in the QIC meeting minutes. The QIC will review the provider appeals and complaints annually for any trends and addresses these issues.

## IV. Steps in the Review Process

SBCBH 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 and implement interventions to improve performance.
5. Measure the effectiveness of the interventions.
6. Ensure follow-up of QI processes through the QI feedback loop to incorporate successful interventions in the mental health service system.

## V. Data Collection

### A. Data Collection

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

1. Utilization of services by type of service, age, gender, ethnicity, and primary language via CSI and the Anasazi Program
2. Access Log (Initial Contact Log)
3. Anasazi Electronic Health Record Reports
4. Crisis Log
5. Medication Monitoring Forms and Logs
6. Peer Chart Review Forms and Logs
7. Client Grievance Log
8. Special Reports from DHCS or studies in response to contract requirements
9. Change of Provider request forms from beneficiaries

### B. Data Analysis and Interventions

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

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.

## VI. Delegated Activities

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