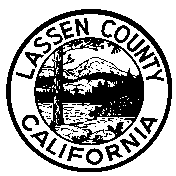
**Quality Improvement Program - Description**

**Behavioral Health Department**

**Health & Social Services Agency**

**County of Lassen**

**Fiscal Year 2015-2016**

The Quality Improvement Program of the Behavioral Health Department operates under the dual requirements of the California Department of Mental Health contract and the Health & Social Services Quality Oversight policy number HSS 09-05.

The Quality Improvement Committee of the Behavioral Health Department implements the Quality Improvement Work Plan. The committee evaluates the appropriateness, including over and under utilization of services, and the quality of services provided to beneficiaries.

The committee is accountable to the Director of the Behavioral Health Department. The committee is chaired by a licensed professional, who controls the clinical content of the committee meetings. The content includes the subject matter before the committee as shown in the agendas, the issues, problems, decisions, and resolutions. The committee is facilitated by the Quality Improvement Coordinator, who manages the process of the meetings. The process includes how the meeting is conducted, communications, procedures, and task management. The committee recommends policy decisions, including Performance Improvement Projects (PIP), institutes needed quality improvement actions, ensures follow up of quality improvement processes, and annually evaluates the quality improvement program.

The QI Work Plan allows the implementation of the Behavioral Health Quality Improvement Program, which includes some process/structural changes involved with Behavioral Health Integration. The Quality Improvement Committee was organized to allow for the Chairperson, Licensed Therapist, and Utilization Review Nurse, to provide clinical oversight and involvement in the QI process. This was not a change in role. The QI Coordinator was given the role of facilitating the QI meetings. The facilitator will be responsible for agenda/minutes and steering the meetings through the agenda items. Consultation between the chair and the facilitator prior to the CQI meetings ensures coverage of focused agenda items.

The committee is composed of the following members:

* HSS Behavioral Health Director
* Adult Services Supervisor \*
* Children & Family Services Supervisor \*
* Inpatient Utilization Review Nurse \*
* MHSA Coordinator
* Behavioral Health Fiscal Officer
* MHSA Fiscal Officer
* Patient Rights Advocate
* Consumer Representative
* IT Security & Software Specialist
* Quality Improvement Consultants

\* Licensed professionals.

The Quality Improvement Work Plan sets annual goals and objectives in six areas:

* 1. Service delivery capacity
  2. Accessibility of services
  3. Beneficiary satisfaction
  4. Electronic Health Record systems and clinical issues
  5. Continuity and coordination of care
  6. Provider appeals

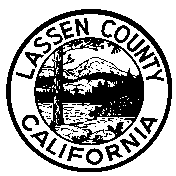
The goals and objectives are set out in the annual QI work plan, which details the action steps and calendar for completion.

For each goal/objective, the committee will go through a process to collect and analyze data, identify opportunities for improvement, design and implement interventions, measure the effectiveness of the interventions, and incorporate successful interventions. The committee completes the action steps within a continuous quality improvement process (CQI) modeled after the Quality Management Principles of the International Organization for Standardization (ISO 9000). The committee will corporate the process improvement toolkit from the Institute of Healthcare Improvement (PDSA Cycles).

The committee meets monthly. In between meetings, ad hoc continuous quality improvement (CQI) task subcommittees meet bi-weekly to complete the action steps for each of the goals/objectives. The QIC delegates work in the CQI task force. The CQI members are appointed by the Director and conduct their work under the auspices of the committee and the committee chairperson. The task force makes recommendations for service improvement to the committee, which in turn makes policy and procedure recommendations to the Director of the MHP. Multiple CQI task forces may operate concurrently on different goals / objectives.

The Quality Improvement Committee, through the Quality Improvement Chair, coordinates with others in the HSS agency management collecting the performance monitoring data. The committee collects monthly reports such as client numbers and demographics, outcomes, services and system performance, service utilization management, grievances, appeals and fair hearings, and clinical records review.

The committee completes an evaluation of the work plan at the end of each fiscal year in order to prepare the work plan for the coming fiscal year.

**Quality Oversight Program**

**Lassen County Behavioral Health**

**Quality Improvement**

**Work Plan 2015-2016 – Cover page**

**Introduction**

**1. Criteria for Acceptable Plan**

a. Federal and state rules and regulations

* WIC
* CCR
* State contract
* Annual Review Protocol
* Cultural Competence – DMH Info Notice.

b. Phase II HSS Quality Oversight policy

* Quarterly trends analysis and recommendations
* Manage a process to improve services
* Ad hoc CQI project teams
* Client outcomes
* Culture change

**2. QIC Annual Evaluation of 2014-15 Work Plan**

a. Committee members agreed with the format of the Work Plan and wish to continue

b. Impacts seen in monitoring, reports, evaluations, and audits

d. From the overall evaluation 2013/2014 Priorities:

i. Management Reports

ii. Co-ordination w/PHP

iii. EQRO recommendations

iv. Denied Claims

**3. Evaluation of Contractual Areas FY14-15 QI Work Plan**

1. Service Delivery Capacity

i. Monitoring of access timelines, hospitalizations, grievance report and closed chart summary

ii. Small set of reports were identified for management decision making.

iii. Staffing needs and capacity identified for all MH Locations

1. Accessibility

i. On-call Services and Clinic telephone access monitoring and evaluation was conducted throughout the year resulting in the use of the language line for one Spanish speaking client, 1 call at 8:15am went to answer machine. 3 of the 4 calls (75%) were given a positive rate in satisfaction by the consumer caller.

1. Beneficiary Satisfaction

POQI survey conducted locally Goal was to increase overall satisfaction rate by 1% - resulted in an increase in satisfaction rate in all age categories except Older Adults which reduced. The small numbers of Older Adult surveys will significantly impact the results.

d. System & Clinical Issues

i. PIP on Coordinated Treatment Plans had partial success but not formalized and therefore was still in progress. PIP will be continued with modifications in FY 15/16

ii. ADMINISTRATIVE PIP was not attempted in 14/15 due to staff changes that included the director of Behavioral Health. EQRO goals were not met or partially met for compliance. In the EQRO Final Report.

iii. Dr. First electronic prescribing application was implemented during the FY13/14. Baseline is 0. Goals were met FY 14/15 and improvement recommendations provided for the FY15/16 QI Work Plan.

iv. Business Flow and Audit Review continue to progress and CQI meetings and recommendations produced some process changes. Policy & Procedures are being reviewed Front desk data collection and the revision of documentation policy, to include updates for EHR were completed.

v. Case Management goal was to standardize and measure services quality improvement and documentation standards of CM. This was partially achieved, the “Case Management for Mental Health Professionals Practice Guidelines” document written by NACM and SAMHSA identified levels of Case Management which is recommended for inclusion in the FY15/16 QI Work Plan.

e. Coordination – physical health & human services

i. Co-occurring disorder services goal was to increase the number of service to consumers with dual diagnosis of mental illness and substance abuse. The integration of services into MH has increased the number Integrated Recovery Group services has been established and clients with co-occurring diagnosis are attending 90 minute groups, weekly.

1. Provider Appeals

i. No provider appeals have been recorded.

**4. EQRO Observations from 2014/15 Plan**

1. Strengths:

i. The MHP overall, foster care, and TAY penetration rates for the past few years have consistently exceeded other small‐rural MHPs and statewide rates.

ii. The MHP has implemented a system to monitor COD screening, treatment and consumer progress

iii. The MHP is measuring progress towards achieving a functional EHR system.

iv. Consumer and family members report satisfaction with the wellness center

v. The MHP has established system to measure timeliness of key service points that provides the MHP regular information to evaluate and manage access.

**5. EQRO**

**6. Quality Oversight Program 2015-16 Priorities in Behavioral Health**

* 1. Continue to evaluate E H R functionality and capabilities for producing Reports
  2. Monitor and report on Integrated SUD Services within MH
     + Continue to administer and evaluate the findings of a consumer perception survey and expand understanding of the issues. Develop a broad assessment of tele-psychiatry services,

**Lassen County Behavioral Health**

**Quality Improvement Program**

**Annual Work Plan**

**FY2015-2016**

***The QI Program will have an annual QI Work Plan including the following:***

***1.* *An annual evaluation of the overall effectiveness of the QI Program, demonstrating that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service, and describing completed and in-process QI activities, including performance improvement projects:***

The annual evaluation of the overall effectiveness of the QI Work Plan will be conducted in July 2016.

**a. *Monitoring of previously identified issues, including tracking of issues over time.***

i. LCMH is to continue monitoring and tracking the timelines for intake assessments and reported monthly at the LCBH Leadership meeting.

ii. The MHP will monitor previously identified areas of concern, identified by the EQRO team. These areas include: Medi-Cal claims denial rates, Quality Improvement and Data Utilization

1. ***Planning and initiation of activities for sustaining improvement.***
   1. Tasks for the CQI teams have been identified from the EQRO report; and management discussions. These include: Improved Access timeliness, Electronic Records System evaluation, billing and staff training; Consumer & family satisfaction with quality and effectiveness of services provided,
   2. As areas of concern are identified, they are brought to the CQI Committee, whereupon, Continuous Quality Improvement “task force” teams will be formed to provide the data collection, input and analysis, and an ongoing feedback loop to the QIC with recommendations for policy changes and/or results of data collection pertaining to that identified area of concern.

iii. Planned CQI activities laid out in Attachment B indicate the time or period allocated for those areas identified and individuals responsible for each task.

**c. *Objectives, scope, and planned activities for the coming year, including QI activities in each of the following six areas;***

***2. Monitoring the service delivery capacity of the MHP:***

***a. The MHP implements mechanisms to assure the capacity of service delivery within the plan.***

***i. The MHP describes the current number, types and geographic distribution of mental health services within its delivery system.***

LCBH services for each area of the county are:

Susanville: Crisis Services, Evaluation and Assessment, Individual Therapy, Group Therapy, Dual Diagnosis Group, Socialization Group, Rehabilitation Services, Medication Support and Youth Services.

Westwood: Crisis Services, Evaluation and Assessment, Individual Therapy, Group Therapy, Dual Diagnosis Group, Rehabilitation Services, and Youth Services.

Beiber: Crisis Services, Evaluation and Assessment, Individual Therapy, Group Therapy, Dual Diagnosis Group, Rehabilitation Services, and Youth Services.

Fort Sage: Crisis Services, Evaluation and Assessment, Individual Therapy, Group Therapy, Dual Diagnosis Group, Rehabilitation Services, and Youth Services.

LCBH continually monitors the current number of clients through intake reports; services provided by age, ethnicity and gender are monitored and reported to the QIC annually. Service capacity with regards to ethnicity, are monitored using the tables produced by EQRO and ITWS. Currently, penetration rates for Medi-Cal beneficiaries by age group, and ethnicity are extremely high and Lassen County has been within the top 4 counties for the past few years.

Service Capacity will be identified for each of the One Stop locations as well as the Susanville Clinic. Once we understand the capacity available, we will be able to monitor and analyze productivity levels of staff and identify areas of improvement for services to consumers. Operational efficiency will also be a factor for analysis. Identification of more efficient ways to operate and provide services will be a priority in this fiscal year.

Composition of Lassen County Behavioral Health staff includes 4 Spanish-speaking direct service providers and 2 front office staff, **Goals:** Continue to collect and analyze data of services provided, conduct a staffing/capacity survey, and assess the quality of care for all consumers from diverse cultures through outcome measures, staff satisfaction, grievances and complaints.

***ii. The MHP sets goals for the number, type, and geographic distribution of behavioral health services.***

**Goal:** Because the LCBH penetration rate has been consistently high, any changes will be monitored with a LCMH goal for the FY15/16 to maintain or expand the current level of services within 95% of the previous FY levels.

**Goal:** LCBH will strive to employ staff with specific language skills and ethnic backgrounds in relation to the needs of the community. Staff will continue to be trained on cultural diversity in accordance with LCBH Cultural Competency Plan. LCBH will strive to maintain current level of 5 Spanish speaking staff.

***3. Monitoring the accessibility of services. In addition to meeting statewide standards, the MHP sets goals for:***

LCBH collects data in the four areas stated below. The data, which includes: access by age, service type, insurance type, timeline to intake, completed intakes and “no shows,” are reviewed at the MHP managers meetings on a monthly basis.

***a. Timeliness for routine mental health appointments;***

LCBH initiates all routine intake appointments with no appointment walk in services. Within14 days of initial contact, and is monitored on a monthly basis. **Goal:** Keep the timeline within 14 days.

***b. Timeliness for services for urgent conditions;***

Clients in crisis or with urgent conditions are seen within 2 hours of initial contact. LCBH has Therapists and Case Management staff assigned to a crisis team. This procedure will continue and is monitored by team coordinator. Random QI checks of crisis timelines will be conducted by QI staff. **Goal:** Maintain the timeline to within 2 hours.

1. ***Access to after-hours care; and***

Access to after-hours care is covered through 24/7 call center, and an on-call contract with a local qualified provider. The call line makes a determination of status and needs the caller reports, and crisis are forwarded to the after hours provider who will have a face-to-face with the client at the hospital, E.R., Jail or Juvenile Hall. Or, if the caller is able to, follow up their interaction with LCBH the next morning. Monitoring of this system is through staff with the contact/crisis log. This continues to be monitored and reported to weekly the Leadership Team meeting. **Goal:** Follow up on 100% of crisis calls and walk ins.

1. ***Responsiveness of the MHP’s 24-hour telephone number. The MHP establishes mechanisms to monitor the accessibility of mental health services, services for urgent conditions and the 24-hour, toll free telephone number.***

Responsiveness of the 24 hour on-call service is monitored by the MH Quality Improvement CARE Coordinator. Test calls are made during work hours and after hours, using the same process as per the DMH Triennial Protocol. After hours language line access and utilization is available as needed. **Goal:** Monitor through contact log and test calls.

LCBH monitors the areas stated above through access/intake timeline reports, first contact log and test calls to the On-call contractor.

***4.*** ***Monitoring beneficiary satisfaction. The MHP implements mechanisms to ensure beneficiary or family satisfaction. The MHP assesses beneficiary or family satisfaction by:***

***a. Surveying beneficiary/family satisfaction with the MHP services at various intervals annually.***

LCBH complies with statewide standards for collecting beneficiary satisfaction surveys. LCBH conducts a satisfaction survey similar to the state POQI survey. Results will form new baseline data to be compared and analyzed. LCBH will conduct a survey with the clients in May annually. LCBH with CQI will look at other tools and decide on an accurate way of scoring the surveys.

“How are we doing?” surveys will continue to be collected from consumers at random intervals and on annual assessment. These surveys can also be dropped in the comments/ suggestions boxes within the LCBH clinic. All consumer perception surveys are reviewed at weekly Leadership Team meetings and provided to the CQI Committee for further review/recommendations.

**Goal**: Identify effective survey and scoring for broad analysis of baseline data, for future measurement.

***b. Evaluating Beneficiary grievances and fair hearings at least annually; and***

Beneficiary grievances and Fair Hearing requests are logged by the grievance Rehab Specialist and reviewed at management meetings and the QI Committee on a quarterly basis. Annual assessments of grievances, including inpatient surveys, to identify trends and recommend policy changes, by the QI Committee in July.

**Goal:** In order to provide open communication between staff and clients, LCBH encourages grievances and will respond to them within the timelines per LCBH policy and procedures.

***c. Evaluating requests to change practitioners and/or providers at least annually.***

Beneficiary requests to change providers are processed through the Access Team meetings and are logged in the Change of Provider log. The log is monitored bi-annually and reviewed annually by the QI Committee in June/July.

**Goal:** Analysis and evaluation of client requests to change providers will be completed annually in July.

***The MHP informs providers of the results of beneficiary/family satisfaction activities.***

LCBH receives Inpatient Surveys from consumers who have had a recent stay in hospital. These surveys are forwarded to the hospitals for their review. “How are we doing” surveys often produce good feedback to specific providers and the director acknowledges this with the providers mentioned; conversely, negative feedback regarding specific providers is also shared with the provider concerned. All surveys are anonymous.. The results from the surveys are presented to the all staff meeting.

**Goal:** continue with the current process of informing individual providers of the results of beneficiary grievances. LCBH is to inform staff annually, at the “all staff” meeting on Oct 19, 2016, of the results of the satisfaction survey for May 2016.

***5. Monitoring the MHP’s service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of Medication practices. The scope and content of the CQI Program reflects the MHP’s delivery system and meaningful clinical issues that affect its beneficiaries. Annually the MHP identifies meaningful clinical issues that are relevant to its beneficiaries for assessment and evaluation.***

***a. These clinical issues shall include a review of the safety and effectiveness of medication practices. The review shall be under the supervision of a person licensed to prescribe or dispense prescription drugs.***

***b. In addition to medication practices, other clinical issue(s) will be identified by the MHP.***

Aspects of the MHP service delivery system and meaningful clinical issues will be monitored throughout the year in accordance with the CQI Work Plan activities calendar as at Attachment B.

Although chart reviews are conducted according to LCBH Compliance Plan (average 5 charts per month), clinical and non-clinical chart reviews are conducted by the UR nurse and Clinical Supervisors at the weekly team meetings. Any QI issues that arise from these rmeetings are brought to the CQI Committee where recommendations for improvement are made by a CQI team.

One of the tasks for a CQI team is to review the training requirements of staff, starting with the new hires. Management and line staff, across the department, are involved in this CQI task with the aim of improving the process and levels of training throughout the department.

1. Medication monitoring is conducted using the Dr First software application within our EHR. This application was implemented in April 2013. The psychiatrists and medication support staff are trained on its use and continue to enter data.
2. **Goal:** to establish a number of reports that can be made available through this application.

b. Other issues identified for this QI Work Plan are to establish use of the blueprint for successful PIPs, and Documentation for levels of case management as outlined in Attachment B.

***6. The MHP will implement appropriate interventions when individual occurrences of potential poor quality are identified.***

The MHP will act quickly to address all issues that reveal a potential for poor quality in services including services provided by LCBH network providers. Areas of concern may be identified from the Access Log, Grievance Log, Provider complaints, chart audits and Consumer surveys, and will be addressed at the weekly interdisciplinary team meetings. If a specific issue is identified as an area of concern, the issue will be brought to the QI Committee. The QI Committee will identify participants and make assignments for CQI activities. The Quality Improvement Coordinator will then conduct CQI activities that will address the issue and report recommendations for improvement back to the QI Committee.

***7. At a minimum, the MHP adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement.***

Although a monthly productivity report is currently used, it is only one of a number of quantitative measures that could be analyzed to measure performance. This QI Work Plan includes a CQI activity to establish further quantitative measures e.g. DrFirst reports to assess performance that could be analyzed at the weekly manager’s meetings. The CQI team will report their recommendations to the QI Committee who will prioritize areas for improvement.

***8. Providers, consumers and family members evaluate the analyzed data to identify barriers to improvement that are related to clinical practice and/or administrative aspects of the delivery system.***

Data that tracks and monitors the quality of care is shared with the QI Committee to assure thatPractitioners, providers, consumers and family members have an opportunity to evaluate the data and assist in identifying any barriers or potential barriers to the improvement of the clinical practices.

Administrative issues are shared with the QI Committee to provide informed “consumer perspective” when recommending or making system changes.

***9. Monitoring continuity and coordination of care with physical health care providers and other human services agencies. The MHP works to ensure that services are coordinated with physical health care and other agencies used by its beneficiaries.***

* 1. ***When appropriate, the MHP shall exchange information in an effective and timely manner with other agencies used by its beneficiaries.***

***b. The MHP shall monitor the effectiveness of its MOU with Physical Health Care Plans.***

The MHP has integrated staff from Integrated Substance Use Disorder Services(SUD) in order to provide trained specialty assistance at the intake/assessment stage and to co-facilitate services for consumers with co-occurring disorders, as required. All consumers are provided substance use screening to identify any level of need for those services. The MHP uses an interagency authorization to release and share information, to provide continuity of care with other primary care, specialty services or consumer referrals to Health and Social Services as allowed in law.

The MHP Policy & Procedure (MH 09-07 Primary Care Provider Consultation and Referrals) addresses the current process for coordination of care with physical health care providers. The referral and coordination of care log is kept by the LCBH psychiatrist and referrals and requests for consultations are monitored annually by the QI Committee.

**Note:** the Policy & Procedure is currently under review for change includes the Dr’s First application.

* 1. ***Monitoring Provider Appeals***

LCBH tracks all provider appeals through the Tracking Log. The UR Nurse periodically examines the problems and will bring these to the attention of the LCBH Director. Any system issues will be brought to the attention of the QI Committee, who will assure quality of care is delivered and problems are resolved at the earliest possible time. The QI Committee will analyze the tracking log annually to identify trends.

***11. The following process shall be followed for each of the QI work plan activities identified in items 1 through 10 above that are not conducted as performance improvement projects, to ensure the MHP monitoring the implementation of the QI Program. The MHP shall follow the steps below for each of the QI activities:***

***a. Collect and analyze data to measure against the goals, or prioritized areas of improvement that have been identified.***

***b. Identify opportunities for improvement and decide which opportunities to pursue.***

***c. Design and implement interventions to improve its performance.***

***d. Measure the effectiveness of the interventions.***

***e. Incorporate successful interventions in the MHP as appropriate.***

LCBH incorporates the PDSA Rapid Cycle model for its Continued Quality Improvement process as described in the cover sheet, QI Program Description.

***If the MHP delegates any QI activities, there will be evidence of oversight of the delegated activity by the MHP.***

LCMH does not contract or delegate any QI activities.

**Attachment A**

**Health and Social Services**

**Quality Oversight Program**

**Mental Health Quality Improvement**

**2015-16 Work Plan Summary Table**

The annual work plan shall include an evaluation demonstrating meaningful improvements in clinical care and beneficiary satisfaction, monitor previously identified issues, sustain improvements, and (set) goals and objectives in the following six areas:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **i. Service delivery capacity** | **ii. Accessibility of services** | **iii. Beneficiary satisfaction** | **iv. Service delivery system & clinical issues** | **v. Coordination with physical care provider & human services** | **vi. Provider appeals** |
| Monitor data collection reports | 24 hour telephone | Consumer perception survey (May and July) | PIP | Co-occurring disorder services, DD Group | Monitor & analyze |
| Performance measures (B) |  | How are we doing?  Survey | PIP |  |  |
| Identify Staffing/service capacity |  | Grievances & appeals | Medication mgmt – Doctors First |  |  |
|  |  | Change of Providers | Denied Claims (C) |  |  |
|  |  |  | Levels of CM |  |  |
|  |  |  | Training CQI |  |  |

**Previously Identified Issues:**

1. 24/7 telephone line (Triennial audit)
2. Performance Measures (EQRO)
3. Denied Claims (EQRO)
4. Monitor integrated services (Integration Team)

**Attachment B**

**Behavioral Health QI Work Plan – Activities**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Activity – Action Step** | **Responsible Party**  **QI Coord CQI** | | **Source of Data** | **Sep**  **2015** | **Oct 2015** | **Nov 2015** | **Dec 2015** | **Jan 2016** | | **Feb 2016** | | | **Mar 2016** | | **Apr**  **2016** | **May**  **2016** | | **Jun**  **20116** | |
| **Annual Evaluation of Work Plan** |  |  | All Reports |  |  |  |  | |  | |  |  | |  | | |  | | \* | |
| **i. Service Delivery Capacity** |  |  |  |  |  |  |  | |  | |  |  | |  | | |  | |  | |
| a. Monitor Data Collection Reports |  | \* | All sources |  |  |  |  | |  | |  |  | |  | | |  | |  | |
|  |  |  | Collect & Analyze Data |  |  | \* | \* | | \* | | \* | \* | | \* | | | \* | |  | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | |  |  | |  | | | \* | | \* | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  |  | |  | | |  | | \* | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  |  | |  | | |  | |  | |
| b. Baseline data & performance measures |  | \* | All sources |  |  |  |  | |  | |  |  | |  | | |  | |  | |
|  |  |  | Collect & Analyze Data | \* | \* | \* | \* | | \* | | \* | \* | | \* | | | \* | |  | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | |  |  | |  | | |  | | \* | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  |  | |  | | |  | | \* | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  |  | |  | | |  | | \* | |
| c. Identify Staffing/Service Capacity |  | \* | ECHO services reports |  |  |  |  | |  | |  |  | |  | | |  | |  | |
| **Goal:** ID IS needs |  |  | Collect & Analyze Data |  |  |  |  | |  | | \* | \* | | \* | | | \* | | \* | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | |  |  | |  | | |  | | \* | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  |  | |  | | |  | |  | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  |  | |  | | |  | | \* | |
|  |  |  |  |  |  |  |  | |  | |  |  | |  | | |  | |  | |
| **Activity – Action Step** | **Responsible Party**  **QI Coord CQI** | | **Source of Data** | **Sep**  **2015** | **Oct 2015** | **Nov 2015** | **Dec 2015** | **Jan 2016** | | **Feb 2016** | | | **Mar 2016** | | **Apr**  **2016** | **May**  **2016** | | **Jun**  **2016** | |
| **ii. Accessibility** |  |  |  |  |  |  |  | |  | |  |  | |  | | |  | |  | |
| a. After hours, On call services |  | \* | Test calls, First contact/crisis log. |  |  |  |  | |  | |  |  | |  | | |  | |  | |
| **Goal:** to answer 100% of calls, |  |  | Collect & Analyze Data | \* | \* | \* | \* | | \* | |  |  | | \* | | | \* | | \* | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | | \* |  | |  | | |  | |  | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  | \* | |  | | |  | |  | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  |  | |  | | |  | | \* | |
| **iii. Beneficiary Satisfaction** |  |  |  |  |  |  |  | |  | |  |  | |  | | |  | |  | |
| a. Consumer Satisfaction Survey |  | \* | POQI Survey, “how are we doing?” survey, Grievance Log |  |  |  |  | |  | |  |  | |  | | |  | |  | |
| **Goal:** ID accurate scoring measure and collect baseline data |  |  | Collect & Analyze Data |  |  |  |  | |  | |  |  | |  | | | \* | |  | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | |  |  | |  | | |  | | \* | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  |  | |  | | |  | |  | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  |  | |  | | |  | |  | |
| b. How are we doing? |  | \* | Comment box |  |  |  |  | |  | |  |  | |  | | |  | |  | |
| **Goal:** monitor & analyze electronic data services and reports |  |  | Collect & analyze data |  |  |  |  | | \* | |  |  | |  | | |  | | \* | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | |  |  | |  | | |  | | \* | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  |  | |  | | |  | | \* | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  |  | |  | | |  | |  | |
|  |  |  |  |  |  |  |  | |  | |  |  | |  | | |  | |  | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Activity – Action Step** | **Responsible Party**  **BH Director CQI** | | **Source of Data** | **Sep**  **2015** | **Oct 2015** | **Nov 2015** | **Dec 2015** | **Jan 2016** | | **Feb 2016** | | | | **Mar 2016** | | **Apr**  **2016** | **May**  **2016** | | | **Jun**  **2016** |
| c. Grievance and Appeals |  |  | As reported by Kimberly |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| **Goal:** respond within P&P timelines |  | \* | Collect & Analyze Data |  |  |  |  | | \* | |  | |  | |  | | |  | \* | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | |  | |  | |  | | |  | \* | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | | \* | |  | |  | | |  | \* | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  | |  | |  | | |  | \* | |
| d. Access timeliness |  | \* | Log |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| **Goal:** |  |  | Collect & Analyze Data |  |  |  |  | | \* | |  | |  | |  | | |  | \* | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | | \* | | \* | | \* | | |  | \* | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  | |  | | \* | | | \* | \* | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  | |  | |  | | |  | \* | |
| **iv. System & Clinical Issues** |  |  |  |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| a. SCERP PIP |  | \* | Collect & Analyze Data | \* | \* | \* | \* | | \* | | \* | | \* | | \* | | | \* | \* | |
| **Goal: Per PIP** |  |  | ID opportunity to improve |  |  |  |  | |  | |  | |  | |  | | |  |  | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  | |  | |  | | |  |  | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  | |  | |  | | |  |  | |
|  |  |  |  |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| b. Clinical PIP |  | \* | Integration Care Plans |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| **Goal: Per PIP** |  |  | Collect & Analyze Data |  |  |  | \* | |  | |  | |  | |  | | |  | \* | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | |  | |  | |  | | |  |  | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  | |  | |  | | |  |  | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| **Activity – Action Step** | **Responsible Party**  **QI Coord CQI** | | **Source of Data** | **Sep**  **2015** | **Oct 2015** | **Nov 2015** | **Dec 2015** | **Jan 2016** | | **Feb 2016** | | | | **Mar 2016** | | **Apr**  **2016** | **May**  **2016** | | | **Jun**  **2016** |
| c. Medication management – Dr’s 1st |  | \* | Reports |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| **Goal:** ID Reports |  |  | Collect & Analyze Data |  | \* | \* | \* | | \* | |  | |  | |  | | |  |  | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | |  | |  | |  | | |  |  | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  | |  | |  | | |  |  | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | | \* | |  | |  | | |  |  | |
| d. Denied Claims |  | \* | ShareCare reports |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| **Goal:** identify changes in claims |  |  | Collect & Analyze Data |  | \* | \* | \* | | \* | |  | |  | |  | | | \* | \* | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | | \* | |  | |  | | |  |  | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  | | \* | |  | | |  |  | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  | |  | | \* | | |  |  | |
| e. Level of CM |  | \* | MH Case Management Practice Guideline |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| **Goal:**  Identify levels of CM and documentation protocol |  |  | Collect & Analyze Data |  |  |  |  | |  | |  | | \* | | \* | | | \* |  | |
|  |  |  | ID opportunity to improve |  |  | \* |  | |  | |  | |  | |  | | |  |  | |
|  |  |  | Design & Implement intervention |  |  |  | \* | | \* | | \* | |  | |  | | |  |  | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  | |  | |  | | |  | \* | |
| f. Training CQI |  | \* | Reports |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| **Goal:** ID staff training schedules and syllabus |  |  | Collect & Analyze Data |  | \* | \* |  | |  | |  | | \* | | \* | | | \* | \* | |
|  |  |  | ID opportunity to improve |  |  |  | \* | |  | |  | |  | |  | | |  |  | |
|  |  |  | Design & Implement intervention |  |  |  |  | | \* | |  | |  | |  | | |  |  | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | | \* | |  | |  | | |  |  | |
| **Activity – Action Step** | **Responsible Party**  **QI Coord CQI** | | **Source of Data** | **Sep**  **2015** | **Oct 2015** | **Nov 2015** | **Dec 2015** | **Jan 2016** | | **Feb 2016** | | **Mar 2016** | | | | **Apr**  **2016** | **May**  **2016** | | | **Jun**  **2016** |
| **v. Coord w/PCP’s and other HSS agencies** |  | \* |  |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| a. Co-Occurring Integrated Services |  | \* | ShareCare reports, SASSI & MISS-SA reports |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| **Goal:** increase the # of enrollees by 10% |  | \* | Collect & Analyze Data | \* | \* | \* | \* | | \* | | \* | | \* | | \* | | | \* |  | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | |  | |  | |  | | |  | \* | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  | |  | |  | | |  |  | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  | |  | |  | | |  |  | |
|  |  |  |  |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| **vi. Provider Appeals** |  |  |  |  |  |  |  | |  | |  | |  | |  | | |  |  | |
| a. Monitor and analyze |  |  | By UR report |  |  |  |  | |  | |  | |  | |  | | |  |  | |
|  |  |  | Collect & Analyze Data |  |  |  | \* | |  | |  | |  | |  | | |  | \* | |
|  |  |  | ID opportunity to improve |  |  |  |  | |  | |  | |  | |  | | |  |  | |
|  |  |  | Design & Implement intervention |  |  |  |  | |  | |  | |  | |  | | |  |  | |
|  |  |  | Measure effectiveness |  |  |  |  | |  | |  | |  | |  | | |  |  | |

This QI Work Plan for FY 15/16 was produced by the Behavioral Health CQI Committee with assistance from ZIA Parners; K. Minkoff and C. Cline and Director of Behavioral Health, Licensed Clinical staff, Non- licensed MH staff.