Butte County Department of Behavioral Health

Quality Assurance and Performance Improvement Work Plan

FY 2019-2020

Introduction

The goal of Butte County Department of Behavioral Health (BCDBH) Quality Improvement is to establish and maintain a planned and systematic process for monitoring key indicators associated with quality care, and to identify and implement quality improvement activities as needed.

The following document describes the quality improvement activities, goals and objectives of BCDBH for Fiscal Year 2018-19. This work plan consists of the following elements:

I. Quality Assurance and Performance Improvement Program Description
II. Quality Management Overview
III. Quality Improvement Work Plan
IV. Quality Improvement Committee
V. Annual Work Plan Summary/Evaluation for FY18-19
VI. New and Ongoing FY 19-20 Goals and Objectives by:
    - Accessibility of Services
    - Service Delivery Capacity
    - Monitoring of Beneficiary Satisfaction
    - Service Delivery System and Meaningful Clinical Initiatives

I. Quality Assurance and Performance Improvement Program Description

BCDBH is responsible for facilitating the Quality Assurance and Performance Improvement Program (QAPI) activities by utilizing qualitative measures to assess performance and identify and prioritize areas for improvement. This involves monitoring, assessing, and reviewing timely and relevant information in throughout the System of Care. BCDBH evaluates the impact and effectiveness of the care network through its QAPI Program. The QAPI Program includes:

a. Performance Measurement Data
    i. Collection and submission of performance measurement data required by BCDBH contract with DHCS.
    ii. Measure and annually report performance, using the standard measures identified by DHCS.
b. Monitoring Activities
    i. Conduct performance monitoring activities throughout BCDBH's operations.
    ii. These activities include, but are not limited to:

1. Beneficiary and system outcomes
2. Utilization management and review
3. Provider appeals
4. Credentialing and monitoring
5. Resolution of beneficiary grievances
6. Review of underutilization and overutilization of services
7. Performance Improvement Projects (PIPs)

c. Beneficiary Satisfaction
   i. The QAPI program assesses beneficiary/family satisfaction by:
      1. Surveying beneficiary/family satisfaction with BCDBH's services at least annually.
      2. Evaluating beneficiary grievances, appeals and fair hearings at least annually.
      3. Evaluating requests to change persons providing services at least annually.
      4. The QAPI program shall inform providers of the results of beneficiary/family satisfaction activities.

d. Medication Monitoring
   i. The QAPI program monitors for safety and assesses the effectiveness of medication practices.
   ii. Monitoring is conducted by a person licensed to prescribe or dispense prescription drugs.
   iii. Monitoring takes place at a minimum annually
   iv. Monitoring follows the procedures outlines in BCDBH Policy 214 – Quality Management Chart Review

e. Quality of Care Concerns
   i. In the event of a Quality of Care concern, the QAPI program, in conjunction with the QIC, will monitor appropriate and timely intervention of occurrences that raise quality of care concerns.
   ii. The QIC shall take appropriate follow-up action when such an occurrence is identified. This may include, but is not limited to Plans of Correction.

II. Quality and Performance Overview

The QAPI Program will improve BCDBH's established outcomes through structural and operational processes and activities that are consistent with current standards of practice. BCDBH is committed to evaluate, maintain and improve the quality and delivery of its services.

This includes performance monitoring, mechanisms to detect utilization and satisfaction of services, monitor medications practices, clinical issues, timely intervention and Performance Improvement Projects (PIPs).

The Quality Management and Compliance and SPRE Departments are responsible for the direct oversight of the QI process. In 2018, BCDBH combined the Quality Management with SPRE. Now this united department provides guidance and evaluation of current processes, identify areas for improvement, and ensures that BCDBH complies with state and federal mandates related to behavioral health services.

In an effort to ensure that ongoing communication and progress is made to improve service quality, the QAPI Program defines goals and objectives on an annual basis through a work plan that is directed toward improvement in any area of operation providing specialty mental health services. The QAPI Program relies on the input and subject matter expertise of program and other work groups as needed to ensure an appropriate plan is written. In addition, the QAPI Program will collaborate with stakeholders, work groups, and committees including, but not limited to:

- Cultural Competency Committee and all subcommittees
- Compliance Committee
- Children's System of Care
- Continuum of Care Reform Leadership Meetings and Workgroup
- Contractor Meetings
- Billing Department
- Medical Services Staff Meetings
- BCDBH & Public Guardian Placement Meetings
- Clinical Care Meetings
- Electronic Medical Records/Avatar
- BCDBH Executive and Leadership Team
- MHSA Advisory Committee
- Organizational Provider Meetings
- PIP Work Groups
- Utilization Review

Quality and Systems Performance Department is a team comprised of Research, Evaluation, Avatar, Quality Management, and Compliance. Collectively, these teams provide data and evaluation of current processes to identify areas for improvement.

Research: The Research Team is responsible for quality improvement reports. Examples of reports include state-mandated reports, client satisfaction reports (including the bi-annual administration of the State-required Performance Outcome Quality Improvement surveys), Change of Provider Reports, Clinical Document Checklist, No Show Reports, and Katie A checklists, among others. This includes designing methods to collect and analyze data on these topics and generating reports to communicate results of these efforts. Reports generated by this unit provide opportunities to analyze the quality of services being provided. A Dashboard was designed and developed by this team to better communicate quality efforts of our System of Care.

Evaluation: The Evaluation Team is responsible for the collection and analysis of outcome data and collect clinical outcomes resulting from programs. This unit is also responsible for the administration and reporting of outcomes relating to MHSA funded programs including Full-service Partnership programs, Prevention and Early Intervention programs, and Innovation programs, as well as for our Substance Use Division (SUD).

Avatar: This team is responsible for working to maintain and improve the Department's Electronic Health Record (Avatar). This includes developing forms (both clinical and administrative), and creating reports for users to call on an as-needed basis. This unit also works with our IT Department to create additional functionality in the system to auto-populate various fields to reduce redundancy, embed error checking routines, and promote interoperability with EHRs from other partner agencies. This Team also provides training on the department's electronic health record, as needed.

Quality Management: This team is the clinical authorization and regulatory arm of BCDBH's System of Care. This team is responsible for the resolution and monitoring of beneficiary complaints, appeals, and grievances; provider complaints and appeals; state fair hearings; trainings on documentation, compliance, patient's rights, and beneficiary notices; processing AB1299/Presumptive Transfer notification on out-of-county dependent minors; monitors contract providers, extensive clinical/medical records review for all the county and contracted Mental Health providers; clinical site certification, and coordinating state/federal audits. This program also provides and oversees information being disseminated by DHCS is being implemented in BCDBH's System of Care.

Compliance: This team is responsible for the training and dissemination of compliance guidelines as well as the clinical practice guidelines provided through BCDBH Policy and Procedures. This team includes the Patient's Rights Advocate. This team is responsible to assure that decisions for Utilization Management, beneficiary education and rights, coverage of services, and any other areas to which the guidelines apply are consistent with the guidelines adopted.

III. Quality Improvement Work Plan

The Quality Assurance Coordinator, in conjunction with the Quality Improvement Committee (QIC), and the Executive Team, evaluates and updates the QI Work Plan annually. It is an annual evaluation of the effectiveness of the QAPI Program activities and whether they have contributed to meaningful improvement in overall services provided by BCDBH System of Care. The QI Work Plan covers the current period of the DHCS contract and each area of the Work Plan is reported to the QIC.

This evaluation involves review of QI activities, auditing, tracking and monitoring, communication of findings, implementation of needed actions, ensuring follow-up for QAPI Program processes, and recommending policy or procedural changes related to these activities:

- 24/7 Access/Crisis Line Response
- Accessibility to Services
- Timeliness to Services
- Assessments of Beneficiary and Provider Satisfaction
- Practice Guidelines
- Satisfaction Surveys
- Credentialing Processes
- Cultural Competency Activities
- Notices of Adverse Beneficiary Determination (NOABD)
- Two Performance Improvement Projects—Clinical and Non-Clinical
- Resolution of Beneficiary Grievances, Appeals, and Fair Hearings
- Resolution of Provider Appeals
- Cultural, Linguistic Resources, and Documentation Training
- Utilization Management/Review
- Medication Practices
- Quality of Care Concerns

The QI Work Plan builds a structure that ensures the overall quality of services at BCDBH. This is accomplished by realistic and effective quality improvement activities and data-driven decision making; collaboration amongst staff, including beneficiary and family member staff, and the utilization of technology for data analysis.

IV. Quality Improvement Committee

It is the goal of the QIC to build a structure that ensures the overall quality of services, including detecting both underutilization and overutilization of services. This will be accomplished by realistic and effective quality improvement activities and data-driven decision making;

collaboration amongst staff, including beneficiary/family member staff; input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care, and utilization of technology for data analysis.

The QIC is comprised of representatives from BCDBH Executive Management, Adult and Children's Services, Access Team, Crisis Services, Medical Services, Mental Health Services Act (MHSA), Compliance, Fiscal, Business Office, Systems Performance, Contracted Providers, Patient Rights, Quality Management, as well as community and client/family members.

Persons participating in the QIC will not be discriminated against in any way on the basis and/or association with a person or group with one or more of these actual or perceived characteristics of age, ancestry, color, disability, ethnicity, gender, gender identity or expression, genetic information, marital status, medical condition, military or veteran status, national origin, political affiliation, pregnancy and related conditions, race, religion, sexual orientation, or any other basis prohibited by California state and federal nondiscrimination laws respectively.

The QIC meets monthly to monitor Timeliness of Consumer Access to services, State Fair Hearings, NOABDs, PIPs, Beneficiary Grievances and Appeals, Cultural Competence, Provider Information and Provider Grievances, Change of Provider Requests, Training, and Crisis Line response. QI Committee minutes are kept for a period of not less than three (3) years.

Each participant is responsible for communicating QIC activities, decisions, and policy or procedural changes in their program areas and reporting back to the QIC on action items, questions, and/or areas of concern. In an effort to ensure that ongoing communication and progress is made to improve service quality, the QIC defines goals and objectives on an annual basis that may be directed toward improvement in any area of operation providing specialty mental health services.

The QIC is also comprised of ongoing committees that report at least annually at meetings. These committees and teams include the following:

Quality Management Team—Chart/Utilization Review

Chart review activities occur monthly at Quality Management (QM) team meetings. The QM team reviews charts for appropriate clinical treatment and documentation of services being provided by BCDBH and contracted organizational providers. Areas reviewed are evidence of medical and service necessity, timeliness of required assessments and client plans, cultural competence issues, notices of beneficiary determination, compliance, appropriate authorization for services when required, coordination and verification of services, and evidence of improvement in client's quality of life.

A Medication Monitoring Checklist is utilized for chart review by the psychiatrist or pharmacist. The Checklist provides a means of peer review for medical staff in which medication and psychiatric issues for consideration are noted. A medical review is conducted at least annually.

Cultural Competency Advisory Team

The MHSA Coordinator/Ethnic Services Manager chairs the Cultural Competency Advisory Team (CCAT). Also included in the CCAT, is the new Language Access Coordinator—who will coordinate, standardize, and oversee all processes intended to improve & enhance the quality of translation (and interpretation) for BCDBH beneficiaries who have limited English proficiency (LEP). The CCAT conducts periodic formal cultural competence assessments to identify areas of strength and need. The CCAT makes recommendations to address priority needs. The CCAT updates the Cultural Competence Plan as needed to reflect emerging goals.

BCDBH Policy Review Committee

This committee oversees review of policy making activities to ensure compliance with regulatory requirements, ongoing professional development, industry standards, and the effective allocation of resources. This team is made up of BCDBH Leadership Team and direct service staff.

Peer Drop-in Centers

The QIC has representatives from Iversen Center, a peer drop-in center. These members provide the QIC with client input in order for better understanding and support of these services to clients. Iversen Center presents findings, at least bi-annually, from their call center, service delivery in conjunction with a contracted provider, and input from their clients.

V. 2018-2019 QI Work Plan Evaluation/Summary

The Quality Assurance Coordinator completes an annual QI Work Plan. There is an annual evaluation of the overall effectiveness of the QAPI Program activities and whether they have contributed to meaningful improvement in clinical services and in the quality of services provided by the MHP.

The 2018-2019 Quality Improvement Work Plan looked at these areas of service which were reported to the QIC:

1) **Accessibility of Services**
2) **Service Delivery Capability**
3) **Beneficiary Satisfaction**
4) **Service Delivery System and Meaningful Clinical Initiatives**

BCDBH combined the Quality Management Department with the System Performance, Research and Evaluations Team. Now this innovative clinical and data team provides guidance and evaluation of current processes, identify areas for improvement, and ensures that BCDBH complies with state and federal mandates related to behavioral health services.

Accessibility of Services

- Treatment Authorization Requests – Ongoing monitoring by the QIC of current practices and updates to Policy and Procedures ensuring timeliness requirements continue to be met as we transition to a concurrent review process for inpatient services.
- Metrics – The Metrics Dashboard has been revised based on QIC feedback, which included simplifying the graphs for Post-Psychiatric Hospitalization Timeliness and Access. Systems Performance has also integrated data collection of contractor timeliness to reflect the entire systems timeliness.
- Network Adequacy – The Network Adequacy Certification Tool (NACT) and supporting documentation was submitted timely each quarter. The annual submission was resubmitted in May 2019 to update information based on DHCS statewide clarification.
- Non-Clinical Performance Improvement Projects (Post-Hospitalization Follow-Up) – The PIP team standardized protocols and updated the Post-Hospitalization Discharge Planning Form in the EHR to reflect better outcomes. The PIP team will be running data to evaluate the changes.
- Quality Management has streamlined the contract provider authorization process and made the entire process paperless. This has removed the need for contract providers to courier packets of client information back and forth (some did this daily). The processing time for all documents processed by QM has reduced and QM is striving to meet our same day, next day goal for processing. Quality Management has worked closely with the youth clinics and contract providers to provide support as needed and has received feedback as to how we can continue to improve the process and become even more efficient. Quality Management staff continue to work with providers as we transition to a reduced need for initial authorizations for covered specialty mental health services.

Service Delivery Capacity

- Cultural Competency Activities – Annual update of Cultural Competency Plan, development and roll-out of **Language Access Coordinator** role in QM that includes development of Language Access Plan for BCDBH, increased Language Access training, development & implementation of Bilingual Certified staff Focus Groups, approval of all Language Access claims including Language Line Solutions and contracted translators, development of systems to improve tracking of Language Access needs for department

(i.e. Avatar reports to help track Language Access services being utilized by consumers & staff), working with department HR to update Bilingual Certification Examination and conduct all Spanish examinations for our department.

- A 4 hour In-Depth Avatar Training was implemented to train staff on how to complete required forms and provide opportunities for staff to practice using those forms on fake clients.
- Credentialing Processes – Quality Management continues to ensure staff credentials are verified upon employment and re-credential monthly.
- Utilization of Services – The High Utilization Client Report is provided monthly report provided to Leadership to evaluate high-utilization clients' trajectory through services in an attempt to mitigate barriers to continuity of care. The Metrics Dashboard is provided quarterly in an effort to monitor the timeliness to services, access to services, and quality of services. These metrics provide an opportunity for discussion around the efficient and effective utilization of services from an aggregate level.
- Contracted providers have a monthly meeting for monitoring and reports of increased oversite. Contractor documentation training is provided annually (and as needed) onsite. ICC/IHBS training is also provided for consistency and service provision.

Beneficiary Satisfaction

- Consumer Perception Surveys – Consumer Perception Surveys were distributed in November 2018 and May 2019. The Camp Fire occurred during survey week, which destroyed Paradise surveys and disrupted services county-wide effecting the number of surveys collected.
- Consumer Satisfaction Surveys – Surveys questions were updated this fiscal year. An electronic version was also added to the website. The bulletin boards at each site were updated to reflect current survey data.
- Resolution of Grievances, Appeals, and Fair Hearings – Ongoing monitoring of current practices and updates to Policy to ensure timeliness requirements are being met; Direct system changes in response to beneficiary grievances including updates to records request process/policy and increased staff training, development of special diagnoses referral process and list of out-of-network providers (i.e. Residential treatment for Eating Disorders).
- Patient's Rights/Beneficiary Protection – Joining of Patient Rights and the Beneficiary Protection roles in the QM Division to ensure quality client care, updates to and ongoing PRA/BPD NEO monthly trainings, updates to PRA BCDBH web page for efficient accessibility for both beneficiaries & staff. This has proven to be less complicated and has added clarity for our consumers.

- Notices of Adverse Beneficiary Determination (NOABDs) – The following NOABDs were implemented: Delivery System, Modification Notice, Payment Denial Notice, NOABD Grievance and Appeal Timely Resolution Notice, Timely Access Notice, Financial Liability Notice, Denial Notice, Authorization Delay Notice, Notice of Grievance Resolution.

Service Delivery System and Meaningful Clinical Initiatives

- 24/7 Crisis Line Response & Grievances & Appeals – Ongoing test call monitoring & training (see test call categories tested), updates to policy & SOP's, mandatory Language Access training to assist crisis line staff in accessing Language Access resources, continued monitoring, updating, and use of Avatar "Grievance and Clients' Rights Education Report" where staff can pull instructions on how to refer client to PRA/BPD.
- Clinical Performance Improvement Projects (Outcome Measures) – The Clinical PIP focusing utilizing consumer outcome measures (MORS and CANS) to better inform treatment decisions and service delivery to improve the beneficiary's level of care was closed this fiscal year. The study demonstrated review of chart information along with diagnosis, treatment plans, and outcome measure helped informed the department on the efficiency of interventions.
- Clinical Performance Improvement Projects (Trauma Informed/PTSD) – The new clinical PIP will be implementing Trauma Informed assessment and intervention techniques in an effort to ensure appropriate diagnosis of PTSD, especially after the traumatic events (Camp Fire, Oroville Dam Spillway Incident, etc.) over that last several years. This PIP is in the beginning stages.
- Practice Guidelines and Data Monitoring – Chart Review monitors documentation to ensure adherence with Medi-Cal requirements. The FY18/19 Non Clinical PIP offered the opportunity to review data collection methods for post-inpatient follow up appointments. Utilizing program staff and analyst feedback, the data collection form has been updated to increase data integrity. Metrics track national and state benchmarks for monitoring consistency in data evaluation.
- Clinical Documentation, Training and Chart Reviews – QM has increased the amount of audits for better monitoring the appropriateness of services provided (QM, PHF, CSU, contract providers) with increased participation of clinical program managers. Quality Management has also initiated quarterly meetings with each BCDBH clinic program manager for review of reports and audit results. Contractor audit results will be available on a quarterly basis as well.

- The Quality Management Department has launched a new documentation manual that is user friendly and capable of frequent updates as DHCS Final Rule and Parity is implemented. It is online and a hard copy is given to each participant at the New

Employee Orientation Training. The QA Coordinator has also increased annual documentation training by going to site staff meetings for a more in-depth and clinic targeted training. Manual updates are distributed agency wide for continuity and continued education.

- Quality Management has partnered with clinical Program Managers on a quarterly basis to review chart audit results, documentation concerns, performance and productivity, and elicits feedback for improved monitoring.

Other Significant System Changes in FY18-19 that are monitored by QIC

- A new Medical Director will be welcomed in the fall of 2019.
- Trauma Informed System: BCDBH has begun implementation of a trauma-informed delivery system by training every BCDBH employee for the awareness and impact of trauma related stress. All BCDBH employees completed a trauma-informed survey to establish a baseline for change. BCDBH has partnered with our county Child Protective Services to bring awareness and a more complete trauma-informed intra-system to our county. *A trauma-informed system is one in which all parties involved recognize and respond to the impact of traumatic stress and in collaboration use the best available science to maximize physical and psychological safety and facilitate the recovery of the child and family, and support their ability to thrive (NCTSN/SAMHSA).* BCDBH plans to continue with trauma-informed training and is developing a PIP around a trauma-informed delivery system.
- Mobile Crisis Team (MCT) partners with law enforcement to provide crisis related outreach and engagement as well as respond to 911 requests regarding possible psychiatric or emotional crises in the community. Butte County BH has had a partnership with Chico Police department for over one year and has expanded its Mobile Crisis Team to provide partnership with BCSO in South County. MCT operates with the goal of reducing the use of involuntary psychiatric hospitalization when appropriate by providing consultation, crisis assessment and engagement of the individual in need, seeking alternative treatment resources, including referrals to voluntary psychiatric services as available.
- Newly revamped New Employee Orientation (NEO) with different tracks based on employment position.
- In April 2019, BCDBH obtained approval from the Mental Health Services Oversight and Accountability Commission for the use of MHSA Innovation funds for the CARE (Collective Action for Resiliency & Education) Project. The CARE Project builds upon the research-based Infant Early Childhood Mental Health Consultation Model (IECMHC) to bring

specialized mental health support to young children in natural learning and play environments. The IECMHC model is a best practice approach for early childhood to address trauma. This model promotes positive mental health outcomes, allows for prevention and management of early childhood trauma, and utilizes intervention strategies that are effective in supporting young children. The CARE Project is a multi-faceted, intensive-intervention, and research-based project which builds mental health professional capacity and service access at target locations that are most accessible to children, families, and professionals in need.

- The department has established a Peer Workforce Workgroup, composed of current peer advocates, counselors who began their career as peers, and a peer volunteer. This group is discussing ways to enhance the job specifications, analyzing peer certification implications, salary, and career ladder considerations. This group will provide a formal recommendation to BCDBH leadership in the late fall on ways to strengthen peer providers in our workforce.
- Expanded Tele-med psychiatric services; Crisis services has access to psychiatrist, which has helped with avoiding hospitalization by providing psychiatric/medication consultation at Crisis or on the Crisis Stabilization Unit. Clients have access to medication evaluation, changing and/or starting medications, and stabilization in the continuum of care at crisis services.
- The combining and restructure of the Quality Management and System Performance (data analysis) with a new Assistant Director position to manage the Quality and Performance Teams.

VI. 2019-2020 Goals and Objectives

The following goals and objectives are based upon the four DHCS Managed Care contract requirements for quality improvement work plans. Each objective includes a baseline for ongoing improvement.

1. **Accessibility of Services**
   BCDBH is responsible for monitoring accessibility of services. In addition to meeting statewide standards, the MHP will set goals for timeliness of routine mental health appointments and urgent care conditions; access to afterhours care; and 24-hour responsiveness.
2. **Service Delivery Capacity**
   BCDBH is responsible for the monitoring of service delivery capacity. BCDBH will evaluate the distribution of mental health services by type of service and geography of client within

its delivery system, as well as the cultural competency of the direct service staff.

3. **Beneficiary Satisfaction**

   BCDBH is responsible for ensuring that beneficiaries are informed of their rights and the problem resolution process and for monitoring beneficiary satisfaction. The MHP reports annually to DHCS on all grievances and appeals and their outcomes. The findings are reported to the QIC for review and implementation of new or revised policies and procedures.

4. **Service Delivery System and Meaningful Clinical Initiatives**

   BCDBH, in partnership with QIC, is responsible for monitoring the service delivery system and to make meaningful improvements in clinical care and beneficiary services. BCDBH will annually identify meaningful clinical issues that are relevant to its beneficiaries for assessment and evaluation.

Accessibility of Services

Address Metrics as Identified by Department of Health Care Services *Lead: Quality Management Team (QM)* Strategic Plan Core Issue: *Access, Utilization and Integration; Standardization and Compliance* Value: Beneficiary outcomes are better with timely access to services.					
Goal: Beneficiaries will have timely access to the services they need.					
Objective	**Measurement**	**Responsible Entity**	**Planned Steps and Activities**	**Monitored Data**	**Met/ Ongoing**
1. Outpatient Appointment Wait Times (non-urgent): First offered appointment scheduled within 10 business days of initial request (youth and adult) BCDBH **GOAL**: 100%	Metrics Dashboard	QM/ Systems Performance (SPRE) Clerical Supervisors	• QM will capture data and report progress by sites at both the QIC and administrative meetings. • Clerical Supervisors will provide training and monitoring of utilization forms that capture data.	FY1718 (15 bus days) Adults: 100% ↑ Children: 98% ↓ FY1819 (10 bus. days) Adults: 99.93% ↓ Children: 92.69% ↓	Ongoing
2. Psychiatry Appointment Wait Times: First offered appointment scheduled within 15 business days of initial request (youth and adult) BCDBH **GOAL**: 100%	Metrics Dashboard	QM/SPRE Clerical Supervisors	• QM will capture data and report progress by sites at both the QIC and administrative meetings. • Clerical Supervisors will provide training and monitoring of utilization forms that capture data.	FY1819: Baseline Adult: 53% Children: 61.75%	Ongoing
3. Psychiatric Hospitalization Readmissions: Percentage of psychiatric discharges followed by a psychiatric readmission within 30 days. BCDBH **GOAL**: 13.4% (at or below)	Metrics Dashboard	Non-Clinical PIP Committee QM/SPRE Clerical Supervisors Post-Hospitalization case management teams	• QM standardize method of capturing data. • Revise and train staff on Inpatient Discharge Follow-up Form to track post-hospitalized beneficiaries. • QM will capture data and report the progress at both the QIC and administrative meetings.	FY1718 All: 12.9%↓ FY1819 All: 12.74% ↓	Met, but still monitored

4. Post-Psychiatric Hospitalization: Percentage of discharges that receive follow-up or step down appointment within 7 calendar days of discharge. BCDBH **GOAL**: 60% (at or above)	Metrics Dashboard	QM/SPRE Clerical Supervisors Post-Hospitalization case management teams	• QM standardize method of capturing data. • Revise and train staff on Inpatient Discharge Follow-up Form to track post-hospitalized beneficiaries. • QM will capture data and report the progress at both the QIC and administrative meetings.	FY1718 All: 52.6%↑ FY1819 All: 74% ↑	Met, but still monitored
5. Post-Psychiatric Hospitalization: Percentage of discharges that receive a follow-up or step down appointment within 30 calendar days of discharge BCDBH **GOAL**: 70% (at or above)	Metrics Dashboard	QM/SPRE Clerical Supervisors Post-Hospitalization case management teams	• QM standardize method of capturing data. • Revise and train staff on Inpatient Discharge Follow-up Form to track post-hospitalized beneficiaries. • QM will capture data and report the progress at both the QIC and administrative meetings.	FY1718 All: 68.4% ↑ FY1819 All:	Met, but still monitored
6. Define "Urgent Condition" and incorporate into Metrics collection data "Client/Caller identified as needing an appointment within 72 hours" Proposed Metric: The length of time from service request for urgent appointment to actual encounter	Incorporate data in Metrics Dashboard	QM/SPRE Clerical Supervisors Leadership Team	• QM will define and standardize method of capturing data. • Develop a more accurate tracking system to identify an Urgent Condition in EHR.	TBD	New

Service Delivery Capacity

Cultural Competency and Service Delivery *Lead: Cultural Competency Coordinator* Strategic Plan Core Issue: *Access, Utilization and Integration; Standardization and Compliance* Value: To provide all beneficiaries will appropriate and culturally relevant services.					
Goal: Ensure that MHP services and resources are appropriately allocated to address mental health treatment needs					
Objective	Measurement	Responsible Entity	Planned Steps and Activities	Monitored Data	Met/ Ongoing
1. Assess population needs using the Organization Assessment by increasing survey penetration rates to inform Cultural Competency strategies and initiatives. a. BCDBH **GOAL**: Increase consumer survey participation by 100% (132 surveys) b. BCDBH **GOAL**: Increase staff survey participation by 25% (233 surveys)	Number of survey participants Survey responses	SPRE, Cultural Competency Coordinator Cultural Competency Committee	• Strengthening the 2015 Organizational Assessment process to gather consumer and staff input. • Utilizing the results of the Assessment to inform and update strategies specified in the Cultural Competency Plan: Criterion 3. • Sharing results of the Assessment with the Cultural Competency Committee to solicit recommendations on initiatives and strategies for Criterion 3.	a. Baseline FY1516: 66 consumer participants FY1819: 322 consumer participants ↑ b. Baseline FY1516: 186 staff participants FY1819: 219 staff participants ↑	Met, but still monitored Met, but still monitored

2. Calculate staff to consumer demographic ratios and language capabilities to ensure the populations are congruent.
 	
BCDBH **GOAL**: Obtain 100% of full staff demographics
	Ratios of staff demographics to consumer demographics
	
	Ratios of bilingual staff to monolingual consumers
		SPRE
		
		Cultural Competency Coordinator,
		
		QMAC
			• Collect full staff demographics.
			  ○ Race/ethnicity demographics to match client demographics located in the Avatar admissions screen.
			  ○ Fluent languages spoken
			• Compare demographic ratios to identify any discrepancies
				Baseline: (to be determined in FY1920)	Ongoing

Beneficiary Satisfaction

Provide a Meaningful Experience for Individuals Who Receive Mental Health Services in Butte County

Lead: QA Coordinator/QM/SPRE

Strategic Plan Core Issue: *Access, Utilization and Integration; Standardization and Compliance*

Value: To ensure that beneficiaries are treated in accordance to Butte County Behavioral Health's core values

Goal: To increase beneficiary satisfaction

Objective	Measurement	Responsible Entity	Planned Steps and Activities	Monitored Data	Met/ Ongoing
1. Administer the Consumer Perception Survey bi-annually as required by DHCS and work towards increasing beneficiary participation. BCDBH **GOAL**: Increase and/or maintain survey numbers and participation compliance percentages.	Metrics Dashboard Total number of completed surveys Participation compliance %: number of completed surveys / total number of face-to-face services billed in an office during the week of the survey	Each Clinical Site bi-annually QM/SPRE	• Compare previous participation compliance percentages • Provide survey comments/ feedback directly to clinics within a practical amount of time. • Report to QIC quarterly	May 2017: 1,739/77% November 2017: 1,282/76% ↓ May 2018: 1,748/83% ↑ November 2018*: 1,226/80% ↓ *Camp Fire effected	Ongoing
2. Give clients an opportunity to provide feedback through a Consumer Satisfaction Survey. BCDBH GOALS: a. 10 locations (minimum) b. Collect 100 surveys c. Make survey available in a minimum of 2 threshold languages.	BCDBH will post satisfaction surveys in the lobbies of all clinics in threshold languages.	Each Clinical Site bi-annually QM/SPRE	• MHP and clinic results will be posted at each site. • Report to QIC	FY1718 a. 18 locations ↑ b. 102 surveys ↑ c. English, Hmong, Spanish ↑	Met, but still monitored

3. Timely resolution of all client grievances. BCDBH **GOAL**: Timely resolution of 100% of grievances	• Timely resolution of all client grievances	Patient's Rights: designated QMD staff	• Review grievance log to count the percent of grievances appropriately resolved within 90 days, or within the approved 14 day extension • Report to QIC quarterly	Baseline FY14-15: 100% FY1617: 100% FY1718: 100% FY1819: 100%	Met, but still monitored

Service Delivery System and Meaningful Clinical Initiatives

Lead: QA Coordinator

Ensure BCDBH Provides Adequate Accessibility to After hours and 24/7 Care as Needed

Strategic Plan Core Issue: *Access, Utilization and Integration; Standardization and Compliance*
Value: To meet the needs of our beneficiaries 24/7 to ensure quality and continuity of care

Goal: Monitor the accessibility of 24/7 and urgent services to beneficiaries CSU and our PHF

Objectives	Measurement	Responsible Entity	Planned Steps and Activities	Monitored Data	Met/ Ongoing
1. Improve the 24/7 access line and language availability to meet DHCS standards. BCDBH **GOAL**: 100% pass rate on Crisis/Access Line Test Calls	Test Call Log Quarterly Test Call Log to DHCS	QM/Crisis Services Patients' Rights Advocate	• Track the crisis call log to identify language line utilization and quality of calls. • Training with Crisis/Access Line team to review Policy and Procedure #264: Access to 24 hour crisis and urgent care services. • Crisis Supervisor will discuss results of test calls in staff meeting and provide re-training as needed. • QM to administer test calls and report to QI quarterly.	FY1718: 89% ↓ FY1819: 89.6% ↓	Ongoing
2. Monthly CSU chart audits with 90% Compliance BCDBH **GOAL**: 12 Audits	QM/CSU outpatient Chart Audit tool/DHCS CSU site audit protocol QIC Minutes		• QM will meet with CSU staff monthly for chart audit. • Crisis Supervisor will discuss results of audit findings in staff meeting and provide training as needed.	Baseline FY1415: 0 FY1617: 3 FY1718: 12 with 73% compliance FY1819: 8 with 90.5% compliance	Ongoing

3. Monitor consumer concerns/complaints and grievances specific to access of these 24/7 services. BCDBH **GOAL**: 0	Grievance Log QIC Minutes		• Review grievance log to count the percent of grievances appropriately resolved within 90 days, or within the approved 14 day extension	Baseline FY14-15: 0 FY1617: 0 FY1718: 7 FY1819: 0	Met, but still monitored