County of Santa Cruz Behavioral Health Services
QUALITY IMPROVEMENT WORKPLAN 2018-2019

Activity 1: Monitoring the service delivery capacity of the Mental Health & DMC-ODS Plans.

Goal	Measurement	Action	Data Sources	Resp. Party	Frequency	Status
1. Improve access for Latino populations of Santa Cruz County.	1.1 Penetration rate shall meet or exceed state average. 1.2 Maintain or exceed number of bi-lingual or bi-cultural staff.	Recruitments for Bi-lingual clinical staff will be put on continuous basis	Medi-Cal data EQRO data Personnel & CLAS Coordinator data	IT Staff CORE Personnel Analyst CLAS Coordinator	Penetration Rate/ Annually Staff ratios/ Quarterly	1. CY2017= 3.54% Statewide = 3.38% Medium Size Counties = 2.74%
2. Improve cultural & linguistic awareness in service delivery.	2.1 Increase number of staff attending CLAS trainings. 7 hours required annually. 2.2 Improve services to LGBTQ population.	2.1 Provide CLAS trainings throughout the year accessible to all staff & contractors. 2.2 Staff surveys & training. Supervisors insure to report gender, ethnicity & language on MHE 10 for employees.	CLAS reports from Staff Trainer. List of trainings. Survey results	CORE Staff Trainer	Annually Annually	2.1 CY 2017 7+ = 43 >7 = 89 0 = 103 TL = 235
3. Identify & improve areas lacking service capacity.	3.1 Monitor units of service by geographic area with goals set in annual budget & revisions of CLAS Plan. 3.2 Review of NACT data.	Meet with Providers monthly to identify barriers & share resources as possible Identify actions steps to increase capacity.	505 Reports, Avatar	CORE, Contractor Meetings	Quarterly	

Activity 2: Monitoring the accessibility of services.

Goal	Measurement	Action	Data Sources	Resp. Party	Frequency	Status
1. Insure callers receive linguistically appropriate responses.	1.1 Successful testing 100% of time.	Scheduled testing of 800 line will occur in English & Spanish	Access Logs/ Answering Service Logs	CORE Mgmt Access Team, QI, SUD	Monthly	FY17-18 July-Dec = 83% Jan-Jun = 100% FY 18-19 Jul-Sep = 83% Oct-Dec = 75%
2. Assure appropriate & timely access to routine, urgent and crisis services.	2.1 Appointments post-hospital for psychiatrists/NP will be no longer than 7 County business days. 2.2 Urgent Care will be authorized w/in 1 hour & provided within 96 hours	Recruitment of more psychiatry staff. Change to scheduling protocol allowing more intakes. Develop system for recording requests for urgent services.	Adult & Child Access log. Avatar service request log/Answering Service Log	CORE Mgmt, Access, QI CORE Mgmt	Quarterly	2.1 Compliance Rate FY 16-17 61% Youth 36% Adults FY17-18 56% Youth 34% Adults Staff training on use of Urgent button on SRDL
	2.3 Appointments for routine intake services will be no longer than 10 County business days. 2.4 Access to NTP services will occur within 3 days of request.	Develop reporting methodology to capture information.	Avatar service request log & scheduling calendar. Average length of time to initial appointment.	Access Teams for Adult, Gates for Youth, DMC-ODS providers.	Quarterly	2.3 Compliance Rate FY16-17 96% Adults 71% Youth FY17-18 98% Adults 93% Youth
3. Insure 24/7 response to calls on the 800 Toll-Free Access Line.	3.1 Calls from Answering Service will be reviewed daily during business hours to insure appropriate response.	Clinical staff including psychiatry will be available 24/7 to respond to calls on the 800 line.	Dispatch emails from Answering Service.	CORE Mgmt, Supervisors and QI	Daily during business hours.	On-going

Activity 2: Monitoring the accessibility of services.

Goal	Measurement	Action	Data Sources	Resp. Party	Frequency	Status
4. Insure 24/7 appropriate response to calls on the 800 Access Line for MHP & DMC-ODS.	4.1 Calls referred from Answering Service/County staff will be reviewed daily during business hours to insure appropriate response.	County staff will provide training to Answering Service/County Access staff to insure appropriate response and disposition. Scripts will be revised as needed to improve compliance.	Dispatch emails from Answering Service. Service Request & Disposition Log.	DMC-ODS & MHP mgrs. and QI	Daily during business hours.	Ongoing
5. Ensure beneficiaries who have ASAM Dimension 3 with a 2 or 3 score of severity get appt for MH assessment.	5.1 Number of referrals made with appt date.	Develop method to ensure appropriate referrals to MH. Referral form to be developed.	Avatar reports and referral form.	DMC-ODS providers, QI	Quarterly	Ongoing
6. Access to SUD Recovery Support Services to decrease admissions/re-admission to higher LOC.	6.1 Reports from claims & others indicating type of service.	Develop Program of Service, forms and provide training to DMC-ODS providers. Monthly monitoring of charts.	Avatar reports to be developed.	DMC-ODS Providers, QI, Admin	Monthly	Ongoing

Activity 3: Monitoring beneficiary satisfaction

Goal	Measurement	Action	Data Sources	Resp. Party	Frequency	Status
1. Improve beneficiary satisfaction across all ethnic, cultural, linguistic, age and gender groups.	1.1 Number of beneficiary grievances related to quality of client care will be reduced from prior year.	QI quarterly analysis of complaints reported to QIC thematized & assigned to mgr of work area.	Grievance & Change of Staff Log	QI, CORE Mgmt, DMC-ODS Oct 2018	Quarterly	1.1 FY17-18 = 16 FY16-17 = 17
	1.2 Response of consumers & families during focus groups & stakeholder meetings.	Focus groups & stakeholder meetings will be held at least twice a year.	Attendance records of meetings.	Adult/Child/ SUD Service Directors MHSA Sr. Mgr	Bi-annually	Strategic Planning Mtg Minutes on website, MHSA Town Hall Mtgs, Focus Groups

Activity 4: Monitoring the MHP's service delivery system and meaningful clinical issues affecting beneficiaries, including safety and effectiveness of medication practices.

Goal	Measurement	Action	Data Sources	Resp. Party	Frequency	Status
1. Monitor appropriate & effective service delivery for adults & children matching needs with level of services.	1.1 Adult & youth consumers with CANS & ANSA evaluations. 1.2 Reporting system to retrieve info by individual & aggregate.	1.1Team Supervisors & staff ensure completion of CANS/ANSA. 1.2 CANS/ANSA used to develop treatment plans and monitor progress. 1.3 Developed methodology for county/contract staff to monitor change over time.	Avatar	Adult & Child Mgrs, IT staff	6 mos or as needed	Reports available individually & aggregate, run by clinicians & supervisors.
2. Increase consumer and family involvement in policy and decision-making through participation in QI processes.	2.1 Consumer & Family Member participation in forums, "town meetings" etc.	2.1 Outreach to NAMI, consumer groups, LMHB to educate on function of QIC.	List of meetings & numbers/types of attendees.	CORE Mgmt and QIC	Quarterly	2.1 FY 16-17 9 Consumers & Family Members participated in 2 focus groups. FY 17-18 15 Consumer & Family Members participated in 2 focus groups.

Activity 4: Monitoring the MHP's service delivery system and meaningful clinical issues affecting beneficiaries, including medication management issues

Goal	Measurement	Action	Data Sources	Resp. Party	Frequency	Status
3. DMC authorizations for residential treatment will be made within 24 hours.	3.1 Number, percent & time period for DMC prior authorization requests approved or denied. 3.2 Brief ASAM vs ALOC alignment LOC	Develop baseline. Develop mechanism such as pre-admit to eliminate use of Brief ASAM where possible.	Database	SUD Mgmt	Quarterly	Q1 = 98%
4. Track & trend occurrences of poor care/other Sentinel Events for MHP & DMC-ODS.	4.1 Identify any barriers to improvement: clinical or administrative.	Develop electronic Sentinel Event database. Increase education on form used by county & contract staff.	Reports/Reviews currently paper folder kept with QI. Sentinel Event Reporting Forms	QI/CORE QIC	Quarterly	
5. Consistent use of appropriate medication consents by psychiatry staff.	5.1 UR peer record review.	Develop new peer review process.	UR Chart Review minutes.	Chief of Psychiatry & QI	Training as needed, review monthly	

Activity 5: Monitoring continuity and coordination of care with physical health care providers and other human service agencies.

Goal	Measurement	Action	Data Sources	Resp. Party	Frequency	Status
1. Improve coordination of care between behavioral health and primary care.	1.1 Inclusion of BMI, weight, medical condition(s), name of PCP & med list in medical record.	Hiring of MA's to insure they include vitals in medical record & share with PCP.	Avatar	FQHC Services, QI	Monthly & aggregate quarterly.	
	1.2 MOU with CCAH will be updated as needed.	Quarterly meetings with CCAH to monitor MOU activities. Monthly coordination meetings with Beacon (CCAH BH intermediary).	CCAH MOU	BH Director, Adult/Child Services Directors, Chief of Psychiatry	Quarterly with CCAH Monthly with Beacon	MOU Updated 1-2018
	1.3 DMC-ODS Providers will ensure each beneficiary has a physical exam within 30 business days of admission.	QI staff to monitor medical records and train providers. Collaboration with CCAH as needed.	Exam in EMR	DMC-ODS Providers & QI	Monthly	Pending
2. Implement CCR	2. Katie A services; ICC, IHBS services. STRTP MHP approval.	Child Mgmt meetings with contractors & providers. QI training, review of STRTP's.	Meeting & training dates	Child Mgmt/QI	Provider meetings monthly	STRTP MHP Approval Pending 1 out of 3, 2 to cease operation.

Activity 6: Monitoring provider appeals

Goal	Measurement	Action	Data Source	Resp. Party	Frequency	Status
1. Reduce number of provider appeals and complaints to zero.	1.1 Number of provider complaints and appeals per year compared to prior year.	The number and types of provider complaints/appeals will be compared by quarter.	Provider appeal letters. Primary correspondence files.	QI, MHP/DMC - ODS Providers	On-going	1.1 All inpatient services: FY 17-18 TL = 23 PHF = 1 3 approved 20 denials upheld . 1.2 DMC Provider Appeals: FY18-19 1 upheld