Quality Improvement Work Plan

2017 - 2018

Riverside University HEALTH SYSTEM Behavioral Health

Riverside University Health System – Behavioral Health
2085 Rustin Avenue, Suite 2002, Riverside, CA 92507

QUALITY IMPROVEMENT WORK PLAN
(2017-2018)

About Riverside County

Riverside County is one of 58 counties in the state of California, the fourth most populous county in the state. The United States Census reported the estimated population as of July 1, 2016 was at 2,387,741.

Covering more than 7,200 square miles, the county has 28 cities, large areas of unincorporated land, and several Native American tribal entities. It is bordered on the west by Orange County; the east by La Paz County, Arizona; the southwest by San Diego County; the southeast by Imperial County; and on the north by San Bernardino County.

Hispanic/Latino make up the largest race/ethnic group serviced for both mental health and substance abuse consumers. The second largest group served is Caucasian.

Riverside University Health System- Behavioral Health

During 2016-17 RUHS-BH significantly expanded services within the detention settings by adding over 60 new positons; added over 70 positions and 8 new contractors to meet service needs related to opting into the Drug Medi-Cal Waiver; opened a Crisis Campus that includes a Crisis Stabilization Unit with capacity for 12 and a Crisis Residential Treatment Center which has capacity for 16; and began work on expanding the Children's System of Care.

RUHS-BH also implemented a new Electronic Health Record in the detention settings to improve communication between correctional health and behavioral health staff; expanded tele-psychiatry services; and made significant progress with the goals outlined in the QI Work Plan for the 16/17 fiscal year. The department met 24 of its 31 goals, and partially met one more for a total of success rate of 77%.

Quality Improvement Work Plan

The QI Work Plan outlines what the department is doing in response to specific requirements within the MHP's contract with the state to provide Medi-Cal services to Riverside County Medi-Cal beneficiaries. The department utilizes a vast array of information and reports to review its performance, strengths, and challenges in these areas. Based on thoughtful analysis

and discussion amongst representatives from the executive team, management, multi-disciplinary department staff, contracted providers, and community stakeholders, the department identifies its priority goals, strategies to meet those goals, and how it will monitor progress through the development of the QI Work Plan.

The QI Work Plan includes Performance Improvement Projects (PIPs) for Mental Health and Substance Use services, feedback provided from the External Quality Improvement Organization (EQRO), areas identified in need of improvement as a result of the state's tri-annual systems review, as well as goals established by the department as internal data is collected and reviewed.

Quality Management

The purpose of a Quality Management program is to assist with the department's mission by monitoring the overall performance of the system through the collection, reporting, and analysis of data; developing goals and standards; and providing information to improve processes and overall efficiency/effectiveness of service delivery.

Quality Management in Riverside County is a compilation of several specific programs: Research, Evaluation, and Technology, Outpatient Quality Improvement, and Inpatient Quality Improvement. Collectively, these programs provide information and evaluation of current processes, identify areas for improvement, and ensure that the department complies with state and federal mandates related to behavioral health services.

Research: The Research Program is responsible for Quality Improvement types of reporting. 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, Medication Monitoring, Problem Resolution, and Chart Reviews among others. This includes designing methods to collect 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.

Evaluation: The Evaluation Program is responsible for the collection and analysis of outcome data. Working closely with the full range of the Department's Evidence Based Practices (EBP) to ensure fidelity to the EBP models and collect clinical outcomes resulting from these 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.

Technology (ELMR): The ELMR unit is responsible for working to maintain and improve the Department's Electronic Health Record (EHR) called ELMR (Electronic Management of Records). This includes developing forms, and creating reports for users to call on an as-needed basis. This unit also works 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. Other responsibilities include supporting contract providers in working with the Department to register their clients into ELMR.

Outpatient Quality Improvement: This program is responsible for the resolution and monitoring of beneficiary complaints, appeals, and grievances; provider complaints and appeals; state fair hearings; extensive clinical/medical records review for all the county and contracted Substance Abuse and Mental Health programs- including detention facilities and Cal Works; trainings on documentation and the department's electronic health record; processing Medication Declarations on dependent minors; and coordinating state/federal audits. This program works as the liaison with the information generated by Research and Evaluation, state and federal regulations, and staff working in the department.

Inpatient Quality Improvement: This program is responsible for 5150 designations, County and Fee-For-Service Hospitals, and the approval/denial of Acute and Administrative Bed Days related to mental health hospitalizations. This program works to improve on the quality of documentation related to inpatient services to facilitate improved client care.

Quality Improvement Committee: Overseeing the activities of the Quality Management activities is the Quality Improvement Committee (QIC). The QIC reviews these activities through the department's multiple reports, identifies opportunities for improvement, develops and recommends interventions to improve performance, and monitors/evaluates the effectiveness of the interventions. The QIC is chaired by the Research and Technology Program Manager and co-chaired by the Assistant Director of Programs. The committee includes a multi-disciplinary group of Behavioral Health employees from various regions/programs throughout the county, a minimum of at least one current consumer of services, a representative from a contracted agency, and a member of the Mental Health Board.

Outcome of 2016-17 Quality Improvement Work Plan Goals

Section 2: Service Capacity and Delivery of Services

Objective 2.1: *Review the current type, number, and geographic distribution of Mental Health Services within the Delivery System.*

Goal 2.1a: Continue review of current maps on the type, number, and location of all Behavioral Health services

Outcome: Goal met.

Some of the 18 maps created or updated during 2016-17 include:

- RUHS-BH Service Sites
- Population Density by Region
- MH Network by Miles/Drive Time
- MH Programs by Region
- Substance Abuse Network Coverage
- DUI Multiple Offenders by Region
- Substance Abuse Residential Consumers by Region

Goal 2.1b: Continue review of service data by:

a. Region/gender/race/ethnicity/diagnosis
b. Program/service type

Outcome: Goal met.

Quality Improvement Committee (QIC) reviewed data reports:

7/2016: Quality Improvement Indicators Hospitalizations (April 2016)

7/2016: Desert CSU and ETS Admission Data for Youth 0-17 (FY 14-15 and 15-16)

9/2016: Who We Serve Consumer Population Profile (2015-16)

9/2016: Initiation and Engagement of Alcohol and Other Drug Treatment (March 2016)

10/2016: REACH Annual Report (Dec. 2014-June 2016)

11/2016: CREST Annual Report (Dec. 2014-June 2016)

3/2017: Service Disparities: Unmet Need, Penetration, and Service Trends (12-2-16)

3/2017: Pathways to Wellness Annual Services Report (2015-16)

7/2017: Quality Improvement Indicators hospitalizations (May 2017)

Objective 2.2: *Establish goals for the number, types, and geographic distribution of Mental Health Services in the Delivery System.*

Goal 2.2a: Establish one CSU in the mid-county region by June 2018

Outcome: Goal met.

The mid-county CSU was opened in Perris on July 24, 2017 with capacity for 12.

In addition, a CSU was opened in Palm Springs in November 2016 with capacity for 12, and the Riverside CSU moved to a new location in June with capacity for 12.

Goal 2.2b: Opening of a new clinic in Perris by December 2018
Outcome: Goal on target. Estimates by the contractor indicate the site will be complete by November 2018.

Objective 2.2: *Establish goals for the number, types, and geographic distribution of Mental Health Services in the Delivery System.*
Goal 2.2c: Add one new county operated Substance Abuse program in each region by December 2017
Outcome: Goal met.
With the Implementation of the Drug Medi-Cal Waiver significant expansion of Substance Abuse services occurred in each region. The Desert Region added a START Team, a Coordinated Care Team, and Family Preservation Court Services at one clinic; Western Region added a Coordinated Care Team, Juvenile Drug Court, Family Preservation Court Services to one clinic, and the SU CARES team; Mid County added Family Preservation Court Services to three clinics, and a Coordinated Care Team.

Section 3: Timeliness to Services

Objective 3.1: *Monitor time to first appointment.*
Goal 3.1a: Obtain appointment for first offered routine request for mental health services within the county standards in 85% of requests for all regions of the county by 2017, and 95% by 2018.
Outcome: Goal not met.
The EQRO Timeliness Self-Assessment indicated time from the first request to first clinical assessment met the department standard 63.8% of the requests.
Additional data based on new procedures in obtaining data on offered (rather than attended) reports indicate an appointment for routine requests was: August 2016= 80.5%, September 2016= 81.5%, December 2016= 89.2%, June 2017 =75%. Given the previous goal of 95% by 2018, the goal for the 2017-18 Work Plan will be adjusted to reflect an achievable standard.

Objective 3.1: *Monitor time to first appointment.*
Goal 3.1b: Completion of the First Encounter Form to track time from initial contact through time to actual first service, including no shows and cancellations to be completed on an average of 75% across all programs
Outcome: Goal met
First Encounter Form data showed a continuing increase in completion of the form:

August 2016: 49.3%
Sept. 2016: 46.9%
Dec. 2016: 58.4%
June 2017: 76.5%
July 1, 2016-June 30, 2017: 84.6

Objective 3.1: *Monitor time to first appointment.*
Goal 3.1c: Develop system to measure request for psychiatric appointments
Outcome: Goal not met.
This goal is an ongoing discussion during the monthly ELMR Implementation meetings.
No workflow that will reliably capture the data, while being realistic for programs has yet been developed. This goal will be carried over to the 2017-18 Work Plan.

Section 4: Access to Services

Objective 4.1: *Monitor access to after-hours care*

Goal 4.1: Review monthly reports on Crisis Team contacts after hours
Outcome: Goal met
REACH data indicated contacts:
2016: July 104, Aug. 118, Sep. 112, Oc.t 147, Nov. 97, Dec. 90
2017: Jan. 125, Feb. 125, Mar. 142, Apr. 152, May 137, June 12

Objective 4.2: *Monitor responsiveness of 24 hour toll free line in providing information on how to access appropriate services*
Goal 4.2a: Test call reporting on the 800# providing information about how to access specialty mental health services to be no less than 95% each quarter ***during*** business hours
Outcome: Goal met.
The July-Dec. 2016 Test Calls to Behavioral Health CARES Line report indicated enough information was provided in 92.3% of the calls. The Jan-June 2017 test calls indicated enough information was provided in 100% of the calls, for a FY average of 96%.

Objective 4.2: *Monitor responsiveness of 24 hour toll free line in providing information on how to access appropriate services*
Goal 4.2b: Test call reporting on the 800# providing information about how to access specialty mental health services to be no less than 80% each quarter ***after*** regular business hours

Outcome: Goal not met.
The July-Dec. 2016 Test Calls to Behavioral Health CARES Line report indicated enough information was provided in 36.4% of the calls. The Jan-June 2017 test calls indicated enough information was provided in 100% of the calls for a FY average of 68.2%. While improvement was demonstrated from FY15/16, this will continue to be an area of focus in the 2017-18 QI Work Plan.

Objective 4.2: *Monitor responsiveness of 24 hour toll free line in providing information on how to access appropriate services*
Goal 4.2c: Test call reporting on the 800# contact log to include the date, the name of the beneficiary, and the disposition to be no less than then 90% each quarter for calls ***during*** regular business hours
Outcome: Goal not met.
The July-Dec. 2016 Test Calls to Behavioral Health CARES Line report indicated test calls during business hours were recorded 61.5% of the time. The Jan-June 2017 test calls were recorded 44.4% of the time for a FY average of 53%. This will continue to be an area of focus in the 2017-18 QI Work Plan.

Objective 4.2: *Monitor responsiveness of 24 hour toll free line in providing information on how to access appropriate services*
Goal 4.2d: Test call reporting on the 800# contact log to include the date, the name of the beneficiary, and the disposition to be no less than then 90% each quarter for calls ***after*** regular business hours
Outcome: Goal not met
The July-Dec. 2016 Test Calls to Behavioral Health CARES Line report indicated the after-hours log to be unavailable. The Jan-June 2017 test calls indicated recorded information about the call was not entered in the log.

Section 5: Beneficiary Satisfaction

Objective 5.1: *Survey beneficiary/family satisfaction*
Goal 5.1a: Complete a direct interview with an a minimum of 400 beneficiary's contacted to complete a beneficiary satisfaction survey
Outcome: Goal not met
3,044 calls were attempted, but only 120 clients (3.9%) completed the survey. This goal will be carried over to the 2017-18 QI Work Plan.

Objective 5.1*: Survey beneficiary/family satisfaction*

Goal 5.1b: Complete the POQI bi-annually in all direct service programs

Outcome: Goal met.

RUHS-BH utilized several types of client satisfaction surveys over the course of the year including the Consumer Satisfaction Perception Surveys (Consumer (Adult), Youth, Youth Services for Families, and Older Adults); MHSIP Consumer Survey-Drug and Alcohol Programs; and the Client Service Phone Satisfaction Survey.

Objective 5.2: *Evaluate beneficiary grievances, appeals, and fair hearings*

Goal 5.2: Beneficiary grievances and fair hearings related to Quality of Service: Interaction/Conduct of Staff to be utilized as a category for a complaint in less than 30% of grievances filed.

Outcome: Goal met.

The Problem Resolution Report: Grievances, Appeals, and State Fair Hearings July-Dec. 2016 indicated grievances related to staff conduct was 29.5%, and doctor conduct was 10.3%. For the time frame of Jan.-June 2017 the percentages were 26.8% for staff conduct, and 22% for doctor conduct.

Objective 5.3: *Evaluate change of provider requests*

Goal 5.3a: Change of provider requests due to Dissatisfaction, without details of why the consumer was dissatisfied with the provider and/or service, to be less than 30% for both individual and organizational providers

Outcome: Goal not met.

The Change of Provider report (2016-17) indicated request due to Dissatisfaction (with the provider, facility, or support staff) was selected as an overall category in 13.6% of requests made. The 'General' reason for Dissatisfaction with vague or no detail was at 70% for individual providers and 62.8% for organizational providers for a combined average of 64.2%. An improvement from the 88% in FY15/16, this goal will continue to be focused on so that the specifics of dissatisfaction can be better analyzed and addressed.

Objective 5.3: *Evaluate change of provider requests*

Goal 5.3b: Change of provider requests due to Individual Providers not responding to the consumer to be less than 20%

Outcome: Goal met.

The Change of Provider report (FY 2016-17) indicated requests due to Individual Providers not responding to the consumer was at 17.2%. This is a significant decrease from the 37.7% recorded in FY16-17.

Section 6: Provider Appeals

Objective 6.1: *Monitor provider issues and appeals*
Goal 6.1a: Authorize TARS within 14 days
Outcome: Goal partially met
A tracking system was developed and implemented. CARES data for FY16/17 indicated TARS being authorized within the 14 day timeline at a rate of 73%. Services authorized in a timely manner reduce appeals at a later date when services are provided prior to the authorization being entered into the system. This goal will be continued in the 2017-18 Work Plan.

Goal 6.1b: Implement tri-annual meetings with contracted providers
Outcome: Goal met.
The first Managed Care Provider Meeting was held on 3/2/17, met during the next quarter on 6/1/17; and held a small workgroup on 6/28/17. An EPSDT Provider Meeting was held on 8/2/17. Substance Abuse Provider Meetings occur the second Thursday of each month.

Section 7: Clinical Care and Beneficiary Services

Objective 7.1: *Address meaningful clinical issues that affect beneficiaries*
Goal 7.1a: Develop and implement a single assessment to be used by Psychiatrists and Clinicians
Outcome: Goal met.
A single assessment was trained to during the entire months of February and March, and went live in April 2017. The single assessment is expected to reduce redundancies and barriers to treatment.

Objective 7.2: *Address meaningful clinical issues that affect beneficiaries*
Goal 7.2a: Analyze staff productivity and delivery of services
Outcome: Goal met.
A Best Practices committee was developed in 2016, and is scheduled to meet every 2 weeks. The purpose of the committee is to review data and workflow to identify the strengths of high

performing programs, and barriers to productivity. The committee made recommendations and piloted:

- Utilizing the EHR's scheduling calendar for all appointments rather than just doctors. The outcome was it works well for Substance Abuse programs, but was too complicated and interfered with workflow for mental health staff.
- Implementation of a new process of scheduling psychiatric appointments utilizing opportunities presented by No Shows. The outcome continues to be dependent on the physician.
- Development of a new 'Critical Caseload' report that consolidated previous reports identifying when specific forms are due for renewal (which was impacting billable services when assessments/care plans had expired). Initial feedback from programs was that the report saved them time.

Objective 7.3: *Review safety and effectiveness of medication practices*

Goal 7.3: Develop a new monitoring/tracking process for psychotropic medications prescribed to dependent minors

Outcome: Goal met.

A new committee was developed with representatives from Department of Social Services and RUHS-BH. The committee reviews data as well as general information to improve communication and workflow. Internally a new system was implemented that included a standardized communication form between the prescribing and reviewing physicians, and new reports that identify if the department is prescribing within state guidelines. The 2017 Monitoring of Adherence to State Guidelines for Foster Children on Psychotropic Medications report dated Jan. 1-Mar. 31 2017 indicated 84.8% of medication requests met state intra-class poly-pharmacy parameters. The Apr. 1-June 30 2017 report indicated that analyses on approved JV-220s across three time periods (baseline, 3rd Quarter and 4th Quarter), county physicians are requesting to administer psychotropic medications to foster children that meet state parameters 91.1% of the time in terms of dose, 85.8% of the time in terms of the number of medications requested, and 71.7% of the time in terms of intra-class poly-pharmacy

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Objective 7.4: *Quantitative measures are in place to assess performance and identify areas for improvement*

Goal 7.4a: Provide coordination of care to outpatient services following inpatient psychiatric hospitalization by implementing a Navigation Center by June 2017

Outcome: Goal met.

The Navigation Center began operating in June 2017 with the initial focus on the Arlington Hospital Campus (ITF) in the western region. The center is piloting participation in a daily round table meeting on clients that are new/being discharged.

Objective 7.4: *Quantitative measures are in place to assess performance and identify areas for improvement*

Goal 7.4b: Analyze rate of residential substance use clients receiving outpatient services following a residential stay

Outcome: Goal met.

Data from June-Dec. 2016 showed a baseline of 18.6%. With the implementation of the Waiver in February and the volume of requests, the Jan-June data showed a rate of 16.31%. This goal is included as a clinical PIP in the 2017-18 QI Work Plan.

Section 8: Monitor Clinical Documentation

Objective 8.1: *Interventions are implemented to address problem areas*

Goal 8.1a: Provide mandatory training for all program supervisors on chart documentation requirements per CCR, title 9, chapter 11.

Outcome: Goal met.

Supervisor specific trainings were held on 2/7/2017 and 3/6/2017. Supervisors, senior clinicians, supervising office assistants, staff development officers, and senior peers were trained. Supervisors unable to attend these trainings were also offered the trainings specific for CT's, and/or the trainings provided to all direct service staff to ensure they received, at a minimum, the same information their staff received.

Objective 8.1: *Interventions are implemented to address problem areas*

Goal 8.1b: Provide mandatory training for all program clinical therapists on chart documentation requirements per CCR, title 9, chapter 11.

Outcome: Goal met.

Clinicians were required to attend training specific to assessments, and were mandated along with all direct service staff to attend training on care plans, progress notes, and overall documentation requirements. Trainings were held daily throughout the entire months of February and March for a total of 62 trainings provided for at least 1,622 staff with the expectation that the trainings would provide staff with the latest information on what/how to document.

Section 9: Cultural Competence

Objective 9.1: *Cultural Competency and Linguistic Standards*
Goal Develop service based trainings specific to Asian, Native American, African American, and Latino communities
Outcome: Goal met.
Trainings and activities continue to be provided by the cultural competency program including:
Hmong Stories of Hope (Outreach Event with Behavioral Health presentations) (10/19/16)
Celebrating Recovery Across Cultures (multi-cultural event with Behavioral Health presentations) (12/14/16)
Trans Youth Care Symposium (formal training with CE's offered) (5/6-7/17)
HOPE Event (Healthy Options for Positive Engagement), cultural event with panel representing Filipino, Cambodian, Chinese, Taiwanese and Lao cultures) (5/31/17)
Working with American Indians: A Beginning (formal training with CE's offered) (6/15/17)
Working with American Indians: Storytelling as a Healing Modality in Trauma Informed Care (formal training with CE's offered) (8/31/17)

Section 10: Continuity and Coordination with Physical Health Care

Objective 10.1: *Coordinate mental health services with physical health care*
Goal 10.1: Continue with integrated services through IEHP
Outcome: Goal met.
Interdisciplinary Care Team meetings are held during the first week each monthly with IEHP, as well as with Molina, Kaiser, and Landmark.

Objective 10.2: *Exchange information in an effective and timely manner with other agencies*
Goal 10.2: Implement ability to receive and provide Continuity of Care document with Tech Care (EHR in the detention system)
Outcome: Goal met.
The department receives CCDs from Detention every day at midnight. The CCD currently includes the client's: Name, DOB, Height, Weight, BMI, Blood pressure, Heart rate, Body temp., and smoking status.

Objective 10.3: *MOU's to guide effective practices with physical health care plans/agencies*
Goal 10.3: Continue with MOU's with IEHP and Molina
Outcome: Goal met.
MOU's remain in place.

2017-18 Quality Improvement Work Plan Goals

Section 1: Performance Improvement Projects

Objective 1.1 *Clinical Mental Health PIP*
Goal: Unengaged consumers who have a Psychiatric Hospitalization should receive an Outpatient service within 7 days
Study Population: Consumers with an inpatient admission at the county Inpatient Treatment Facility (ITF) who are not open to the Mental Health outpatient system and reside in the county.
Study Question: Will the implementation of navigation strategies with peer supports result in an increase in percentage of unengaged consumers that access follow-up outpatient services post-hospital discharge?

Objective 1.2 *Non-Clinical Mental Health PIP*
Goal: Improve retention for children beyond 5 services.
Study Population: Children less than 18 years of age served in the county children's clinics and system of care children served by contracted providers
Study Question: Will expansion of children's services with new Mental Health contracts increase access and improve retention rates?

Objective 1.3 *Clinical Substance Abuse PIP*
Goal: Increase continuity of care for adults in substance abuse treatment
Study Population: Consumers transitioning from residential and detoxification services
Study Question: Will managing the transition between treatment modalities increase engagement into the full continuum of care?

Objective 1.4 *Non-Clinical Substance Abuse PIP*
Goal: Increase the penetration rate for adolescents served in substance abuse programs
Study Population: Youth under 18 years old who need substance use treatment services
Study Question: Will contracting with a new provider and expanding services in outpatient settings increase the number of adolescents served?

Section 2: Service Capacity and Delivery of Services

Objective 2.1: *Review the current type, number, and geographic distribution of Mental Health Services within the Delivery System.*

Goal 2.1a: Continue review of current maps/reports on the type, number, and location of all Behavioral Health services

Responsibility: Research, Managers/Administrators/Executive Team

Evaluation Tool(s): Maps, Who We Serve Report, Fiscal service detail reports

Plan: Review in QIC, Managers, and Directors meetings

Baseline: Specific maps continue to be developed/reviewed as needed for program analysis. In FY 16/17, 18 new maps were developed to capture information needed for a program and/or region.

Goal 2.1b: Continue review of service data by:
Region/gender/race/ethnicity/diagnosis/program/service type

Responsibility: Research, Managers/Administrators/Executive Team

Evaluation Tool(s): Maps, Who We Serve Report, Fiscal service detail reports

Plan: Review in QIC, Managers, and Directors meetings

Baseline: Who We Serve Report; Service Disparities: Unmet Need, Penetration, and Service Trends Report; Pathways to Wellness Annual Services Report; Full Service Partnership Outcomes Reports continue to be utilized for service data review.

Objective 2.2: *Establish goals for the current type, number, and geographic distribution of Mental Health Services within the Delivery System.*

Goal 2.2: Opening of a gender specific MOMs Intensive Outpatient program in Temecula Substance Abuse clinic

Responsibility: SA Administrator, Deputy Director, Program Supervisor

Evaluation Tool(s): Opening of the program serving female consumers that are actively parenting, or trying to reunify with, children under the age of 18

Plan: Configure existing space with program materials including cribs, toys, and nutritional supplies, hire staff

Baseline: Current program is for outpatient services.

Section 3: Timeliness to Services

Objective 3.1: *Monitor time to first appointment.*

Goal 3.1a: Obtain appointment for first offered routine request for mental health services within the county standards in 85% of requests for all regions of the county by 2017, and 95% by 2018.

Responsibility: Administrators, Clinic Supervisors, QI, Research

Evaluation Tool(s): Timeliness to Services report

Plan: The Best Practices Committee will continue to review feedback from programs and implement pilot projects on differing approaches to improving timeliness.

Baseline: This goal was over a 3 year period. The 2016 goal of 75% was met. The 2017 goal of 85% was not met. The goal for 2018 was 95% but is being revised to a more representative percentage of 85%.

Goal 3.1b: Continue monitoring completion of the First Encounter Form to track time from initial contact through time to actual first service, including no shows and cancellations. Completion to be on an average of 85% across all programs

Responsibility: Administrators, Clinic Supervisors, QI, Research

Evaluation Tool(s): First Encounter Form Report

Plan: Review completion reports in QIC, Managers/Administrators to review with their programs to keep importance of completing the form in the daily workflow

Baseline: The latest data (June 2017) showed the First Encounter Form was at a completion rate of 76.5%.

Goal 3.1c: Develop system to measure request for psychiatric appointments

Responsibility: ELMR, Research, Associate Medical Directors, QI

Evaluation Tool(s): Measuring tool

Plan: Work with administrators and supervisors on workflow

Baseline: No current system in place to measure time from request to psychiatric appointment

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Goal 3.1d: Develop system to measure first offered appointment requests for mental health services for Managed Care Contract Providers

Responsibility: Managed Care Program Manager, Research

Evaluation Tool(s): Timeliness to Services report for Managed Care Providers

Plan: Develop contracted provider workgroup to develop a system(s) for tracking timeliness to services, develop infrastructure to record the data, train providers on the system, develop report to include the new data

Baseline: System is in place to obtain data on first offered appointment within the county's EHR, but no system currently exist to gather this information from contractors

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Section 4: Access to Services

Objective 4.1: *Monitor access to after-hours care*
Goal 4.1: Develop and implement tracking form and reporting process for after-hours calls to Full Service Partnership (FSP) programs across all regions
Responsibility: Research, QI, FSP monitors
Evaluation Tool(s): Test Call Reports
Plan: Meet with FSP committee to develop system
Baseline: TAY programs are new to the department with no test calls yet conducted.

Objective 4.2: *Monitor responsiveness of 24 hour toll free line in providing information on how to access appropriate services*
Goal 4.2a: Continue test calls to the CARES 24 hour toll free line, and expand test calls to include the SU CARES toll free line
Responsibility: Research
Evaluation Tool(s): Test Calls Report
Plan: Develop test call scripts for the Substance Use CARES line, assign staff to make test calls to both Mental Health and Substance Abuse programs
Baseline: Test calls currently are only made to Mental Health programs

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Goal 4.2b: Test call reporting on the 800# providing information about how to access specialty mental health services to be no less than 80% each quarter ***after*** regular business hours
Responsibility: Research, CARES
Evaluation Tool(s): Test Calls Reports
Plan: Training of contracted agency, obtain/review bi-weekly contact logs
Baseline: The 2016-17 FY average of test calls indicated information on how to access specialty mental health services was provided in 68.2% of test calls made.

Goal 4.2c: Test call reporting on the 800# contact log to include the date, the name of the beneficiary, and the disposition to be no less than then 90% each quarter for calls ***during*** regular business hours
Responsibility: Research, CARES

Evaluation Tool(s): Test Calls Reports
Plan: Staff training, review reports, monthly audits
Baseline: The 2016-17 FY average was calls were recorded in the contact log with all the required information in 53% of the test calls made.

Goal 4.2d: Test call reporting on the 800# contact log to include the date, the name of the beneficiary, and the disposition to be no less than then 90% each quarter for calls ***after*** regular business hours
Responsibility: Research, CARES
Evaluation Tool(s): Test Calls Reports
Plan: Training of contracted agency, obtain/review bi-weekly contact logs
Baseline: The 2016-17 test calls indicated calls were not being recorded after hours.

Section 5: Beneficiary Satisfaction

Objective 5.1*: Survey beneficiary/family satisfaction*
Goal 5.1a: Complete the POQI bi-annually in all direct service mental health programs
Responsibility: Evaluation, Program Administrators, Program Supervisors
Evaluation Tool: POQI Survey results
Plan: Run reports of active programs and number of consumers, distribute copies of POQI's to each program for completion
Baseline: POQI's are being completed bi-annually in Mental Health programs

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Objective 5.1*: Survey beneficiary/family satisfaction*
Goal 5.1b: Complete the Treatment Perception Survey (TPS) quarterly in all direct service substance abuse programs
Responsibility: Evaluation, Program Administrators, Program Supervisors
Evaluation Tool: Treatment Perception Survey (TPS) results
Plan: Run reports of active programs and number of consumers, distribute copies of TPS's to each program for completion.
Baseline: The TPS is a new survey being implemented for SA programs

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Objective 5.1*: Survey beneficiary/family satisfaction*
Goal 5.1c: Complete a direct interview with an a minimum of 400 mental health and/or substance abuse beneficiary's contacted to complete a beneficiary satisfaction survey

Responsibility: Research, Sr. Peer Support Specialist
Evaluation Tool: Client Service Phone Satisfaction Survey
Plan: Recruit additional volunteers to conduct phone surveys
Baseline: Out of the 3,044 attempted calls made to request a survey in FY 2016-17, 120 (3.9%) clients completed the survey

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Objective 5.2: *Evaluate beneficiary grievances, appeals, and fair hearings*
Goal 5.2: Interaction/Conduct of Staff to be utilized as a category for a complaint in less than 25% of staff grievances filed, and 15% of doctor grievances.
Responsibility: Research, QI, Program Managers/Administrators, Program Supervisors
Evaluation Tool(s): Problem Resolution Report
Plan: Share report with managers, administrators, and program supervisors to increase awareness of complaints related to perceptions of staff behaviors.
Baseline: The 2016-17 FY average indicated grievances related to staff conduct was 28.15% for staff, and 16.15% for doctors

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Objective 5.3: *Evaluate change of provider requests*
Goal 5.3a: Change of provider requests due to Dissatisfaction, with vague or without details of why the consumer was dissatisfied with the provider and/or service, to be less than 30% for both individual and organizational providers
Responsibility: CARES, ACT, QI
Plan: Modify system to create a hard stop where information is required
Baseline: The 2016-17 FY average of a change in providers due to dissatisfaction with vague or no details was at 64.2%.

Goal 5.3b: Modify Electronic Health Record to collect narrative information on client request for a change of provider due to being dissatisfied.
Responsibility: ELMR team, QI
Evaluation Tool(s): Change of Provider Request Report
Plan: Modify system to capture the data, run a report quarterly to begin obtaining information on issues that may be occurring in the clinics
Baseline: The Change of Provider Request Report for FY 16/17 indicated the primary reason for the request in county clinics was 'Dissatisfied' in 43% of the requests. The system does not currently have the ability to collect additional information on the details of the dissatisfaction.

Section 6: Provider Appeals

Objective 6.1: *Monitor provider issues and appeals*
Goal 6.1a: 85% of Treatment Authorization Requests (TARs) to be authorized within 14 days
Responsibility: CARES
Evaluation Tool(s): TAR authorization tracking sheet
Plan: Review monthly for compliance to avoid delays in authorizations that result in provider appeals; identify and problem solve issues related to TARs listed as "pending"
Baseline: TARS are being authorized at a rate of 73%

Section 7: Clinical Care and Beneficiary Services

Objective 7.1: *Address meaningful clinical issues that affect beneficiaries*
Goal 7.1a: Implement Child Assessment of Needs and Strengths (CANS) in children's service programs
Responsibility: Children's Deputy Director, Administrators, Supervisors, QI, and Research
Evaluation Tool(s): Completion of CANS
Plan: Introduce concept of CANS, determine levels of service based on CANS results, train on completion of the CANS, monitor completion of the CANS at pre-determined points of completion.
Baseline: CANS has been discussed and modeled but not yet implemented.

Objective 7.2: *Address meaningful clinical issues that affect beneficiaries*
Goal 7.2a: Implement standardized induction training for new staff
Responsibility: Workforce Education and Development, QI
Evaluation Tool(s): Implementation of training series
Plan: For direct service staff, include education on how to complete a thorough assessment, what and how services are provided to consumers
Baseline: Currently staff are responsible for signing up for trainings that are provided on varying days each quarter. Each program provides the hands-on training for their staff resulting in significant differences in consistency and quality of training.

Objective 7.3: *Review safety and effectiveness of medication practices*
Goal 7.3: Develop monitoring tool for Medication Assisted Treatment services
Responsibility: QI, SA Psychiatrist
Evaluation Tool(s): MAT monitoring tool

Plan: Research best practices for MAT, obtain protocols developed by providers, review and include newly developed departmental protocols
Baseline: MAT is a new service, no previous monitoring tool in existence

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Objective 7.4: *Quantitative measures are in place to assess performance and identify areas for improvement*
Goal 7.4a: Develop new contract monitoring process to ensure providers are being reviewed in accordance with their specified scope of services
Responsibility: QI, Children's Deputy Director, Central Children's Program Administrator, Managed Care Program Manager, Fiscal, MRU Support
Evaluation Tool(s): Development of new monitoring tools
Plan: Design new plan for oversight responsibility, develop and/or update service specific monitoring tools, coordinate review schedule and regular meetings, develop new tracking tools/process, and streamline contacts for providers
Baseline: Current process has had difficulty maintaining pace with changing scopes of services, coordinating the various point persons, and streamlining reports to ensure quality of services

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Section 8: Monitor Clinical Documentation

Objective 8.1: *Interventions are implemented to address problem areas*
Goal 8.1a: Implement standardized induction training for all new Behavioral Health staff to ensure understanding and competency in documentation requirements
Responsibility: Workforce Education and Development, QI
Evaluation Tool(s): Implementation of training series
Plan: Coordinate the start dates and provide new staff with 1-2 weeks of training prior to starting in a program. For direct service staff, include education on what and how services are provided to consumers, along with training on the department's electronic health record and how to document in the chart.
Baseline: Currently staff are responsible for signing up for trainings that are provided on varying days each quarter. Each program provides the hands-on training for their staff resulting in significant differences in consistency and quality of training.

Objective 8.1: *Interventions are implemented to address problem areas*
Goal 8.1b: Provide trainings on ASAM Criteria for determining Level of Care for Substance Abuse treatment to ensure indicated level of care is consistent with actual level of care received
Responsibility: Workforce Education and Development, QI, SA Admin.

Evaluation Tool(s): ASAM Referrals report
Plan: Develop curriculum, coordinate and schedule trainings, coordinate registration process

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Section 9: Cultural Competence

Objective 9.1: *Cultural Competency and Linguistic Standards*
Goal 9.1: Goal: Develop 3 workforce training workshops for mental health and substance abuse providers that will address Cultural Competency and Diversity in 3 underserved communities in Riverside County.
Responsibility: Cultural Competency Program Manager
Evaluation Tool(s): Implementation of the workshops
Plan: Develop workgroups to develop training materials on the LGBTQ, African American, Asian American, Native American, and Latino Communities
Baseline: Previous training on cultural competency was limited in scope, and the week-long length of the training made it difficult for staff to attend

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Section 10: Continuity and Coordination with Physical Health Care

Objective 10.1: *Coordinate mental health services with physical health*
Goal 10.1: Continue with integrated services through IEHP
Responsibility: IEHP, CARES manager
Evaluation Tool(s): PHQ9 and SDQ monthly reports
Plan: County to continue to provide monthly Physical Health Questionnaire and Strengths and Difficulties
Questionnaire data to IEHP monthly on consumers enrolled in the Behavioral Health Integration/Complex Care Integration (BHI/CCI) program
Baseline: MOU with IEHP for the BHI/CCI program initially implemented in 2015

Objective 10.2: *Exchange information in an effective and timely manner with other agencies*
Goal 10.2: Expand capacity behavioral health staff to access physical health care information out of the hospital and ambulatory care clinics electronic health record (Epic).
Responsibility: IT, Research
Evaluation Tool(s): CCD document with both physical and behavioral health information
Plan: Utilize data warehouse to receive/export data
Baseline: Current CCD includes only the client's physical health information

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Objective 10.3: *MOU's to guide effective practices with physical health care plans/agencies*
Goal 10.3: Continue with MOU's with IEHP and Molina
Responsibility: Administration
Evaluation Tool(s): Memorandums of Understanding
Plan: Continue to meet quarterly
Baseline: Meetings occurring quarterly