Contra Costa Behavioral Health Services

Quality Improvement Work Plan 2017

CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

The Quality Improvement Committee (QIC) monitors service delivery with the aim of improving the processes of providing care and better meeting the needs of beneficiaries. The QIC is a part of the Quality Assessment and Performance Improvement (QAPI) Program at Contra Costa Behavioral Health Services Division (BHSD) under the direction of the Quality Management Program Coordinator. The QAPI activities include collecting and analyzing data to measure against the goals or prioritized areas of improvement that have been identified; identifying opportunities for improvement and deciding which opportunities to pursue; identifying relevant committees to ensure appropriate exchange of information with the QAPI; obtaining input from providers, beneficiaries, and family members in identifying barriers to delivery of clinical care and administrative services; designing and implementing interventions for improving performance; measuring effectiveness of the interventions; incorporating successful interventions into the behavioral health services' operations; and reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review. The QAPI also reviews timeliness of services, consumer satisfaction, penetration and retention rates, service accessibility, and other service trends. In addition, the QAPI works in collaboration with the Ethnic Services and Behavioral Health Training manager to monitor and improve the quality of offered trainings and education for its workforce, inclusive of promoting greater cultural diversity, humility and competency. As a result of the monitoring activities described above, the QAPI recommends policy decisions, reviews and evaluates the results of quality improvement activities including performance improvement projects, institutes needed quality improvement actions, ensures follow-up of QI processes, and documents QAPI meeting minutes regarding decisions and actions taken. The QIC meets every month.

Guided by the above, the BHSD developed its 2017 Quality Improvement Work Plan. The contents of the Quality Improvement Work Plan were also informed by County efforts to better meet consumer needs and incorporate External Quality Review feedback and the BHSD's Strategic Plan. This Quality Improvement Work Plan provides a vehicle for BHSD management to: 1) meet quality improvement requirements specified in the Mental Health Plan contract with the State Department of Health Care Services (DHCS) for the expenditure of Medi-Cal (Medicaid) dollars; 2) address and solve issues raised during the implementation of the Drug Medi-Cal Organized Delivery System; and 3) address and solve issues raised in the tri-annual DHCS Audits and annual External Quality Reviews.[1] The QI Work Plan is evaluated on how activities were met and is revised on an annual basis. Activities are marked in brackets as being new, ongoing (continuing from the previous year), and/or completed in comparison to previous years.

The QI activities are divided into the following sections:

[1] Activities related to both Mental Health and Substance Use Disorder services are shaded gray.

Service Capacity

Behavioral Health DHCS Contractual Element: Assess the capacity of service delivery for beneficiaries, including monitoring the number, type, and geographic distribution of services within the delivery system.

Goal 1: Monitor service delivery capacity	
Objectives	**Actions**
1. Increase penetration rates by .05% for the following underserved populations: Latino, Asian/Pacific Islander, Birth to Six, and Older Adults.	1. Compare penetration rates for underserved populations to penetration rates from previous years. [ongoing]
2. Develop Prevention and Early Intervention (PEI) outcome indicators that determine outreach to underserved populations and linkage to mental health care.	1. Develop and report on demographic data, such as age group, race/ethnicity, primary language and sexual orientation to enable assessment of outreach and engagement efforts over time. [NEW]
	2. For PEI programs, develop and report on the number of people connected to care, and average duration of reported untreated mental illness to enable assessment of impact of programs connecting people from underserved populations to mental health care. [NEW]
3. Use geo-mapping to assess the relationship between consumer locations and resources available.	1. Use geo-mapping software to plot consumer and service locations. [NEW]
	2. Identify data, standards, and reporting requirements for Travel Time or Time to Service. [NEW and COMPLETED]
4. Review services designed for TAY and identify service needs.	3. Solicit interest among potential contractors to provide residential services to the TAY population. [NEW and COMPLETED]

Access to Care

Behavioral Health DHCS Contractual Elements: Assess the accessibility of services within service delivery area, including:

- *Timeliness of routine appointments;*
- *Timeliness of services for urgent conditions;*
- *Access to after-hours care; and*
- *Responsiveness of the 24 hour, toll free telephone number.*

Goal 2: Beneficiaries will have timely access to the services they need (*non-clinical performance improvement project)*	
Objectives	**Actions**
1. At least 90% of individuals, on average, requesting routine care mental health services will be offered an initial assessment appointment within 10 business days.	1. Report the percentage of new consumer appointment requests for which a routine clinician appointment is offered within 10 business days. [ongoing]
2. At least 80% of individuals, on average, requesting routine care mental health services will be offered psychiatry appointment within 15 business days.	1. Report the percentage of new consumer appointment requests for which a routine psychiatry appointment is offered within 15 business days. [ongoing]
3. 100% of urgent care mental health service requests are offered appointment within 2 business days for all consumers.	1. Report the percentage of urgent outpatient mental health appointments with clinicians that are offered within 2 business days of request. [ongoing]
4. At least 90% of hospital discharges are followed by an outpatient mental health visit within 7 calendar days.	1. Report the percentage of all hospital discharges for which the consumer receives an outpatient mental health appointment within 7 calendar days. [ongoing]
5. Reduce 30-day hospital readmission rate for mental health consumers to be below 10%.	1. Report annually 30-day hospital readmission rates for all consumers by system of care and countywide. [NEW]
6. Provide tele-psychiatry services in regions showing the greatest needs.	1. Pilot tele-psychiatry at the East Adult specialty mental health clinic. [NEW]
	2. Gather consumer input via focus groups. [NEW]

Goal 3: Reduce appointment no-show rates	
Objectives	**Actions**
1. Improve appointment data collection on mental health appointments.	1. Implement Cadence, the Epic appointment scheduling module. [ongoing and COMPLETED]
2. Implement Televox automated call reminder system across mental health clinic sites.	1. Explore text message option in the Televox automated call reminder system. [NEW and COMPLETED]
	2. Create reporting that integrates Televox and appointment adherence data. [NEW

Goal 3: Reduce appointment no-show rates	
Objectives	**Actions**
	and COMPLETED]

Goal 4: Improve the Behavioral Health Access Line triaging and referral processes into the behavioral health system of care	
Objectives	**Actions**
1. 75% of business hours Access Line calls are answered by a live staff within 3 minutes.	1. Compare the number of business hour calls that are answered within 3 minutes to the total number of business hour calls. [ongoing]
2. 75% of after-hours Access Line calls are answered by a live representative within 1 minute.	1. Compare the number of after-hour calls that are answered within 1 minute to the total number of after-hour calls. [ongoing and COMPLETED]
3. Increase regularity with which Access Line test calls are made for both daytime and after-hours.	1. On quarterly basis, conduct 10 tests calls, 6 (including 2 in Spanish) during business hours and 4 (including 2 in Spanish) after hours. [ongoing]
	2. Re-evaluate the Access Line test call protocol. [ongoing]

Beneficiary Satisfaction

Behavioral Health DHCS Contractual Elements: Assess beneficiary or family satisfaction at least annually by:

- *Surveying beneficiary/family satisfaction with services;*
- *Evaluating beneficiary grievances, appeals, and fair hearings;*
- *Evaluating requests to change persons providing services; and*
- *Informing providers of the results of beneficiary/family satisfaction activities.*

Goal 5: Evaluate consumer grievances, unusual occurrence notifications, and change of provider and appeal requests	
Objectives	**Actions**
1. Continue to review grievances, unusual occurrence notifications, and change of provider and appeal requests and identify system improvement issues.	1. Collect and analyze mental health service grievances, unusual occurrence notifications, change of provider, appeals, and fair hearing requests to examine patterns that may inform the need for changes in policy or programming. [ongoing]
	2. Present findings to the Quality Improvement Committee on a quarterly basis. [NEW]

Goal 6: Monitor consumer/family satisfaction	
Objectives	**Actions**
1. Survey means (4.0 or higher) indicate consumers and/or their families are satisfied	1. Conduct a mental health consumer/family satisfaction survey twice per year to gather quantitative and qualitative data about satisfaction with services. [ongoing]

Goal 6: Monitor consumer/family satisfaction	
Objectives	**Actions**
with their care.	2. Report satisfaction survey findings to clinics and contracted providers. [NEW]
	3. Conduct mental health consumer/family member focus groups at the County clinics to gather qualitative data about satisfaction with services. [ongoing]
	4. Conduct in-depth program and fiscal review of MHSA funded programs, including site visits and consumer interviews and surveys. [ongoing]

Cultural and Linguistic Competence

Behavioral Health DHCS Contractual Elements: Comply with the requirements for cultural and linguistic competence.

Goal 7: Provide all consumers with welcoming, engaging, and culturally- and linguistically-appropriate consumer-centered care	
Objectives	**Actions**
1. Promote the delivery of services in a culturally competent manner.	1. Update the cultural competence plan, incorporating DHCS cultural competency plan requirements. [ongoing]
	2. Monitor accessibility of Access Line and services to non-English speakers. [NEW]
2. Train 100% of staff on cultural competence.	1. Track percentage of staff who complete cultural competency training. [ongoing]
3. Maintain the percent of mental health consumers/families reporting they agree staff are respectful and supportive of culture, values, beliefs, life ways and lifestyle at 80% or above.	1. Compare the number of consumers/family members who agree or strongly agree that staff are respectful and supportive to the total number of respondents. [ongoing]
4. Implement efforts to create a more Welcoming Environment for consumers and their families.	1. Distribute and evaluate Welcome Packet for new consumers. [NEW]
	2. Pilot the peer liaison role with SPIRIT interns who will interact with visitors, ensure required materials are available in the waiting room, etc. [NEW and COMPLETED]
	3. Identify programming for television monitors in waiting rooms. [NEW]
	4. Start development of a staff orientation that includes best practices in consumer- and family-centered care. [NEW]
5. Develop materials that are reflective of all individuals seeking care and convey inclusivity.	1. Convene Communications and Outreach Workgroup. [NEW]
	2. Develop style guide for communication materials. [NEW and COMPLETED]

Medication Practices

Behavioral Health DHCS Contractual Elements: Monitor safety and effectiveness of medication practices.

Goal 8: Promote safe and effective medication practices	
Objectives	**Actions**
1. Mental Health charts reviewed using the Medication Monitoring Tool will maintain an average compliance rate of at least 90%.	1. All (100%) of medical staff to have a sample of their charts reviewed once a year. [ongoing] 2. Conduct follow up with psychiatrists with the lowest compliance rates. [ongoing]
2. Implement and rollout e-Prescription at all County mental health clinics by 2017.	1. Provide training and technical assistance, so that 100% of clinic sites are e-prescribing. [ongoing]
3. Identify behavioral health consumers who are medication stable.	1. Develop reporting on consumers prescribed psychotropic medications. [NEW]
4. Medication lab monitoring protocols are adhered to.	1. Develop reporting on labs of consumers receiving injectable anti-psychotic medication. [NEW]

Service Delivery and Clinical Issues

Behavioral Health DHCS Contractual Elements:
a. Address meaningful clinical issues affecting beneficiaries system-wide.
b. Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.

Goal 9: Standardize processes and cross-regional referrals	
Objectives	**Actions**
1. Create a comprehensive, but simplified internal and external referral process across systems of care.	1. Build referral processes into electronic health records. [NEW] 2. Educate staff regarding available options (e.g., housing) for consumers. [NEW]

Goal 10: Increase use of evidence-based practices	
Objectives	**Actions**
1. Expand delivery of Dialectical Behavioral Therapy (DBT).	1. Re-engage staff in consultation trainings to maintain DBT fidelity and effectiveness and assure quality delivery of services. [ongoing] 2. Train staff, including conduct "Train the Trainer" for Team Leaders and Program Managers. [ongoing] 3. Revisit DBT referral process. [NEW]

Goal 10: Increase use of evidence-based practices	
Objectives	**Actions**
	4. Select an emotion regulation outcome measure. [NEW and COMPLETED]
	5. Develop outcomes educational materials for staff. [NEW and COMPLETED]
	6. Use centralized outcomes database. [NEW]
	7. Investigate the feasibility of expanding DBT to the adult system of care. [NEW]
2. Continued implementation of Trauma Focused Cognitive Behavioral Therapy (TF-CBT) in the Children's system of care.	1. Continue training opportunities and consultation on TF-CBT. [ongoing]
	2. Monitor certification of staff in TF-CBT in the move from state to national certification. [ongoing]
	3. Develop outcomes educational materials for staff. [NEW and COMPLETED]
	4. Use centralized outcomes database. [NEW]
3. Implement Family Based Therapy (FBT) for Eating Disorders in the Children's and Adult systems of care beginning in 2017.	1. Provide consultation to support FBT fidelity and effectiveness and assure quality delivery of services. [NEW]
	2. Monitor certification of staff in FBT. [NEW]
	3. Develop an outcomes plan, including tracking of referrals and participants. [NEW and COMPLETED]
4. Implement at least one evidence-based program across the adult system of care beginning in 2017.	1. Convene trainings on Cognitive Behavioral Social Skills Training (CBSST) and CBT for psychosis (CBTp). [NEW and COMPLETED]
	2. Develop certification plan for CBSST and CBTp. [NEW]
	3. Participate in consultation trainings. [NEW]
	4. Identify outcomes to measure program effectiveness. [NEW and COMPLETED]
5. Build internal capacity to provide trainings and supervision on evidence-based practices.	1. Revise and administer the Staff Development Survey that compiles a list of those trained and certified in various evidence-based practices. [ongoing]
	2. Assess capacity for staff to attend Train-the-Trainer trainings on evidence-based programs. [NEW]
6. Sustain and maintain ongoing implementation of evidence-based trauma-informed care.	1. Participate in the Trauma Transformed (T^2) collaborative, working together with Bay Area communities to change the way we understand, respond to, and heal trauma. [ongoing]
	2. Staff cohort receives train-the-trainer TIS training. [ongoing and COMPLETED]
	3. Convene a Trauma-Informed Collaborative to provide ongoing input and direction, including developing policies and procedures. [NEW]

Goal 11: Facilitate access to substance use disorder treatment that support sustained recovery	
Objectives	**Actions**
1. Infuse harm reduction strategies into the treatment of co-occurring disorders.	1. Develop literature that state individuals are not marginalized for substance use, displaying mental health symptoms, or having trouble following a treatment plan. [NEW]
	2. Recommend harm reduction strategies through peer support opportunities. [NEW]

Goal 12: Effectively collect data and communicate data findings to staff and the community	
Objectives	**Actions**
1. Develop electronic reporting capacity to regularly examine quality, access, and timeliness of services through the Behavioral Health Electronic Health Record.	1. Develop a communication plan that includes contract providers in the planning and implementation of electronic interoperability of EHR data between disparate systems. [NEW]
	2. Identify Champions and subject matter experts. [NEW]
	3. Hold validation sessions. [NEW]
	4. Conduct clinical content buildout. [NEW]
	5. Train all mental health staff. [NEW and COMPLETED]
	6. Launch Phase I of the electronic health record. [NEW and COMPLETED]
2. Develop capacity to regularly examine quality, access, and timeliness data.	1. Prioritize data and reporting needs with Business Intelligence, ensuring that the data system captures individual and program level data. [NEW]
3. Monitor program performance to improve BHSD capacity and service delivery.	1. Annually request COMPASS-EZ updates from BHSD managers. [NEW]
	2. Report out monthly at Program Managers meeting to provide updates and gauge progress toward BHSD goals and timelines. [NEW]
4. Identify levels of care and outcome measure(s) to assess consumer performance.	1. Analyze Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) instrument data. [ongoing]
5. Pilot utilization of the PHQ-9 and GAD-7.	1. Identify sites to host pilot. [NEW and COMPLETED]
	2. Convene pilot planning workgroup. [NEW]
	3. Establish workflows and provide staff training. [NEW and COMPLETED]
6. Use Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC-35) outcome measures for children and youth up to age 21.	1. Coordinate with Counties using the CANS to capture lessons learned and inform implementation planning. [NEW]
	2. Identify and train staff to become Train-the-Trainers. [NEW and COMPLETED]
	3. Form an Implementation Team to oversee infrastructure changes and training. [NEW]

Goal 13: Improve consumer and community communication, collaboration, and education	
Objectives	**Actions**
1. Plan, coordinate, and oversee the Wellness Recovery Action Plan (WRAP) program for Contra Costa Health Services.	1. Monitor implementation of WRAP across the County. [ongoing]
	2. Hold WRAP facilitator training. [NEW]
	3. Identify data tool on program effectiveness. [NEW]
2. Educate peers and family members through Service Provider Individualized Recovery Intensive Training (SPIRIT) program, a college-accredited three college course series.	1. Implement coursework emphasizing recovery, including facilitation, coordination of speakers and activities, and assessment of students' readiness to graduate. [ongoing]
	2. Recruit consumers and family members of consumers. [ongoing]
	3. Consolidate and revise curriculum. [ongoing]
	4. Coordinate internship placements. [ongoing]
	5. Support students and alumni in obtaining and maintaining paid and unpaid employment. [ongoing]
3. Continue the Committee for Social Inclusion to foster a community alliance and provide public education.	1. Facilitate monthly meetings, including educational presentations. [ongoing]
	2. Update stigma brochures. [NEW]
4. Continue the Wellness and Recovery Education for Acceptance, Choice and Hope (WREACH) program.	1. Facilitate monthly sub-committee meetings. [ongoing]
	2. Educate on the "Tell Your Story" curriculum. [ongoing]
	3. Participate in Crisis Intervention Trainings (CIT). [ongoing]
5. Expand the PhotoVoice program to community-based organizations by 2017.	1. Provide facilitator training to community-based organization staff. [NEW]
	2. Coordinate implementation of PhotoVoice across the County, including with new populations (e.g., TAY). [ongoing]
	3. Begin holding PhotoVoice exhibitions in the community to reduce stigma. [NEW]
	4. Facilitate monthly sub-committee meetings. [NEW]
6. Provide Family Partnership training.	1. Hold trainings. [ongoing]
7. Hold Parent Cafes across the County by 2017.	1. Implement Family Partners in facilitating Parent Cafes. [ongoing]
8. Hold the Educate Equip Support (EES) program.	1. Hold at least two EES group with education parents/ caregivers, including Spanish language groups. [ongoing]
9. Provide Mental Health First Aid (MHFA) to the community.	1. Conduct MHFA train-the-trainer training for County and community based organization staff. [NEW and COMPLETED]
	2. Establish a strategic planning committee to plan implementation. [NEW]
	3. Provide community trainings. [NEW]
10. Assist consumers/family members develop	1. Hire peer Commute Navigation Specialists. [ongoing]

Goal 13: Improve consumer and community communication, collaboration, and education	
Objectives	**Actions**
increased skills and capacity for getting to and from mental health services via the Overcoming Transportation Barriers project.	2. Review relevant MHSA needs assessment recommendations. [NEW and COMPLETED]
	3. Compile and develop resources to share transportation information with staff and consumers and their families. [NEW]
	4. Review and revise as necessary transportation policy(ies) and standardize practices across clinics. [NEW]
	5. Liaise between County, service providers, and transit authorities, as well as act as the County representative in community forums related to transportation. [NEW]
	6. Create a Transportation Subcommittee. [NEW]

Goal 14: Maintain effective and consistent utilization review practices	
Objectives	**Actions**
1. Improve communication with those who interface with or are part of the UR Team.	1. Hold regularly scheduled UR meetings on authorization, Level 1, and centralized reviews. [ongoing]
	2. Conduct documentation training monthly and by request at County operated clinics and community-based organizations. [ongoing]
	3. Attend County and community-based organization meetings to announce and communicate UR regulatory changes. [ongoing]
	4. Send mass mailers and emails to all providers, and County owned and operated clinics on UR changes. [ongoing]
2. Train 100% of staff on HIPAA.	1. Track percentage of staff who complete HIPAA training. [NEW]

Continuity and Coordination of Care

Behavioral Health DHCS Contractual Elements: Work to ensure continuity and coordination of care with physical health care providers. Coordinate with other human services agencies used by beneficiaries.

Goal 15: Promote prevention and early intervention	
Objectives	**Actions**
1. Better integrate PEI programs with mental health treatment programs.	1. Develop and disseminate PEI reports that highlight outreach to underserved populations and linkage to mental health care. [NEW]
	2. Facilitate PEI staff capacity to increase access to mental health care. [NEW]

Goal 15: Promote prevention and early intervention	
Objectives	**Actions**
2. Strengthen and integrate suicide prevention efforts.	1. Conduct monthly multi-agency Suicide Prevention Committee meetings. [ongoing]
	2. Develop Suicide Prevention Pilot program into a county-wide program. [NEW]
	3. Develop linkage and use of statewide suicide prevention resources, such as Each Mind Matters and Know the Signs. [NEW]

Goal 16: Integrate behavioral health services with other County systems	
Objectives	**Actions**
1. Serve 10-20 adult mental health consumers with chronic health conditions caseload per region through the Coaching to Wellness program (clinical performance improvement project).	1. Screen, enroll, and provide individual, group, and community linkages services to participants on an ongoing basis. [ongoing]
	2. Evaluate the program on consumer perceptions of their own wellness and wellbeing, changes in consumer behaviors and symptoms, and cross-service collaboration. [ongoing]
	3. Rollout program to West County. [NEW and COMPLETED]
	4. Hire additional project staff. [ongoing]
2. Provide with high fidelity Functional Family Therapy as part of the Mentally Ill Offender Crime Reduction Grant under the Contra Costa County Probation Department.	1. Collect data on treatment adherence. [ongoing]
	2. Administer the Youth Outcomes Questionnaire Therapeutic Alliance (YOQ TA) and YOQ-Self-Report (SR) TA to measure therapeutic alliance and youth symptoms and social behavior difficulties. [ongoing]
3. Coordinate Drug Medi-Cal Waiver services with primary care and mental health services.	1. Conduct outreach and training to primary care on referrals and coordination of care. [NEW]
	2. Designate staff at Access Line to address calls from primary care. [NEW]
	3. Update substance use disorder services forms to include primary care information. [NEW]
	4. Screen mental health consumers on substance use and make appropriate referrals. [NEW]
	5. Start Drug Medi-Cal certification process at specialty mental health clinics. [NEW]
	6. For dual-diagnosed consumers not engaged in treatment, hold voluntary groups when they come in for financial support. [NEW]
	7. Educate judges on appropriate referrals and level of cares. [NEW and COMPLETED]
	8. Access Line to begin accepting calls from jails from individuals needing substance use disorder services. [NEW and COMPLETED]

Goal 17: Improve services to youth in foster care	
Objectives	**Actions**
1. Monitor the use of ICC and IHBS services.	1. Staff complete Child and Family Team Meeting Action Plan and Progress Summary. [NEW]
	2. Draft fidelity tool. [NEW]
2. Identify outcome measure(s) to assess consumer performance.	1. Review the Child and Adolescent Needs and Strengths as an outcomes tool. [NEW]