

# SAN DIEGO COUNTY BEHAVIORAL HEALTH QUALITY IMPROVEMENT PROGRAM AND WORK PLAN



## Quality Improvement Program and Work Plan

2015-2016

Fiscal Year July 1, 2015-June 30, 2016

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## INTRODUCTION

In accordance with California Department of Health Care Services (DHCS) requirements in Title 9, Section 1810.440, the County of San Diego Behavioral Health Services (SDCBHS) has a Quality Improvement (QI) Unit and an Annual Quality Improvement Work Plan (QIWP).

The goals of SDCBHS QI Unit are based on the healthcare quality improvement aims identified by the Institute of Medicine's (IOM) report: *"Crossing the Quality Chasm."* The targeted quality improvement aims for all healthcare services are to be *safe, client centered, effective, timely, efficient and equitable*. These IOM aims are interwoven throughout the QI Unit and QIWP. In addition, both are guided by SDCBHS' mission statement and guiding principles.

SDCBHS Guiding Principles:

- to foster continuous improvement to maximize efficiency and effectiveness of services
- to support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems
- to maintain fiscal integrity
- to ensure services are:
  - outcome-driven
  - culturally competent
  - recovery and client/family centered
  - innovative and creative
  - trauma-informed
- to assist County employees to reach their full potential

### **County of San Diego Behavioral Health Services**

#### **Mission Statement:**

To help ensure safe, mentally healthy, addiction-free communities. In partnership with our communities, work to make people's lives safe, healthy and self-sufficient by providing quality behavioral health services

## Quality Improvement Unit, FY 2015-16

### Quality Improvement Unit Purpose

The purpose of the SDCBHS QI Unit is to ensure that all clients and families receive the highest quality and most cost-effective mental health, substance use, and administrative services available.

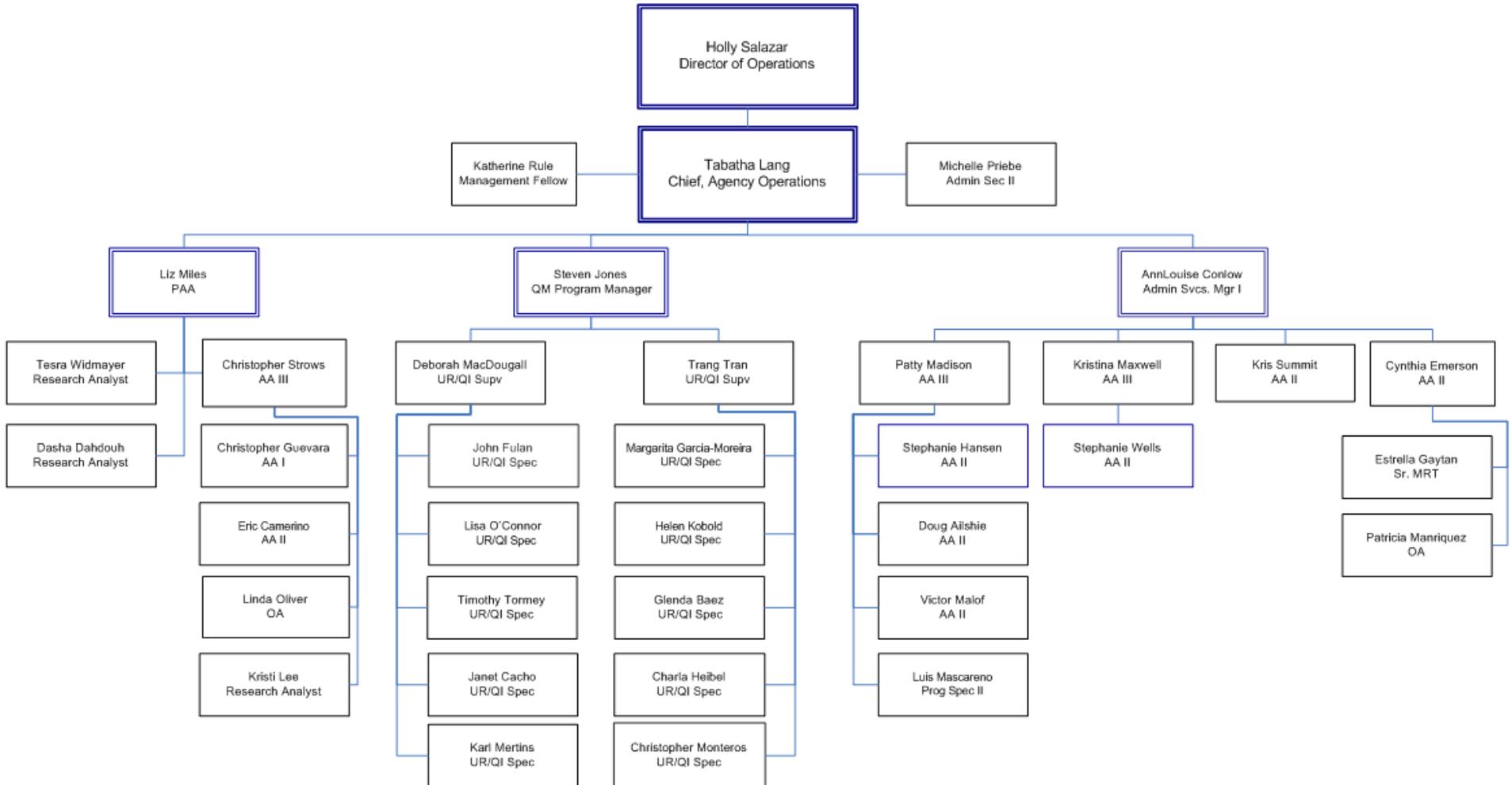
The QI Unit delineates the structures and processes that will be used to monitor and evaluate the quality of mental health and substance abuse services provided. The QI Unit encompasses the efforts of clients, family members, clinicians, mental health advocates, substance abuse treatment programs, quality improvement personnel, and other stakeholders.

The QI Unit and QIWP are based on the following values:

- Development of QI Unit and QIWP objectives is completed in collaboration with clients and stakeholders.
- Client feedback is incorporated into the QI Unit and QIWP objectives.
- QI Unit and QIWP are mindful of those whom data represent and, therefore, integrate client feedback to improve systems and services.

# Quality Improvement Unit Organizational Chart

## Behavioral Health Services Division Quality Performance and Improvement/MIS Research



## Quality Improvement Unit Structure

The following are components of the QI Unit structure:

- Executive Quality Improvement Team (EQIT)  
The EQIT is responsible for implementing the QI Unit, responding to recommendations from the Quality Review Council (QRC), and identifying and initiating quality improvement activities. The EQIT consists of BHS Director, BHS Clinical Director, Assistant Deputy Directors, and QI Chief. The EQIT reviews Serious Incidents and Grievances.
- Quality Improvement Performance Improvement Team (QI PIT)  
The QI Unit includes the SDCBHS QI PIT, which monitors targeted aspects of care on an on-going basis and produces reports monthly, quarterly, or annually. High-volume, high-frequency, and high-risk areas of client care are given priority. So opportunities for improvement can be identified, the QI PIT collects data which are analyzed over time and used to measure against goals and objectives. Reports in each of these areas are periodically brought to the EQIT and QRC for input.
- Quality Management (QM) Team  
The QM team is another component of the QI Unit and is comprised of Quality Improvement Specialists—licensed therapists and clinicians—who conduct a variety of reviews, audits, trainings, and other quality improvement functions for both County-operated and County-contracted programs.
- Management Information Services (MIS) Team  
The MIS team—another component of the QI Unit—provides data management and systems support to BHS client management system users, including but not limited to service providers, administrative and support staff, and BHS staff.
- Quality Review Council (QRC)  
The QI Unit includes the QRC, which is a standing body charged with the responsibility to provide recommendations regarding the quality improvement activities for mental health and the QIWP. The QRC meets at least quarterly, and the members are clients or family members, as well as stakeholders, from the behavioral health communities across all regions. The QRC provides advice and guidance to SDCBHS on developing the annual QIWP, including identification of additional methods for including clients in quality improvement activities; collection, review, interpretation, and evaluation of quality improvement activities; consideration of options for improvement based upon the report data; and recommendations for system improvement and policy changes.
  - Quality Improvement Committees (QICs)

The QICs are subcommittees of the QRC composed of QRC members and QI staff. Subcommittee minutes and activities are monitored by the QRC. The current QRC Subcommittees are:

- o QRC Membership Committee
- o Serious Incidents (ad hoc committee)

The following diagram depicts the committees and workgroups that make up the structure of the QI Unit:



## Quality Improvement Process

SDCBHS has adopted a continuous quality improvement model for producing improvement in key service and clinical areas. This model encompasses a systematic series of activities, organization-wide, which focus on improving the quality of identified key systems, service and administrative functions.

The overall objective of the quality improvement process is to ensure that quality is built, measure consistently, interpreted, and articulated into the performance of the SDCBHS functions. This objective is met through a commitment to quality from the administration, QI staff, clients, family members, and providers. The quality improvement process is incorporated internally into all service areas of SDCBHS. It is applied when examining the care and services delivered by the SDCBHS network of providers, programs, facilities, and the Administrative Service Organization.

### Client and Family Involvement in Quality Improvement

Consistent with our goals of involving clients and family members in the quality improvement process, many of the QI activities are based on input from clients and family members.

Clients, family members, providers and stakeholders are involved in the planning, operations, and monitoring of our quality improvement efforts. Their input comes from a broad variety of sources including the Mental Health Board, Alcohol and Drug Advisory Board, community coalitions, planning councils, client and family focus groups, client- and family-contracted liaisons, youth and Transitional Age Youth (TAY) representatives, Program Advisory Groups, client satisfaction surveys, client advocacy programs, complaints, grievances, and input from the County Behavioral Health website.

### Goals of Quality Improvement

The goals of the quality improvement process are to:

- 1) Identify important practices and processes where improvement is needed to achieve excellence and conformance to standards
- 2) Monitor these functions accurately
- 3) Draw meaningful conclusions from the data collected using valid and reliable methods
- 4) Implement useful changes to improve quality
- 5) Evaluate the effectiveness of changes
- 6) Communicate findings to the appropriate people
- 7) Document the outcomes

## Quality Review Council Focus

QRC has identified the following as quality concerns, and, therefore, as focus topics for FY 2015-16:

- *Client-centered services*: client grievances, client interaction with the Support Specialists, customer service, and monitoring of requests for Appeals and State Fair Hearings.
- *Safety*: reducing serious incidents, evaluating trauma-informed services, and maintain trauma-informed workforce.
- *Effective services*: continuity of care, reducing readmissions, and continued collaboration with stakeholders and hospital partners.
- *Efficient and accessible services*: focus on the AB 109 client population, timeliness of client and provider appeal processing, and establishing crisis residential and crisis stabilization services.
- *Equitable services*: client and family access to information on their preferred language, and continuity of care and connection to services for the jail population.
- *Timely services*: timely access to crisis and non-crisis Access and Crisis Line options, access time for mental health assessments, and access time between assessment and initial treatment.

## Performance Improvement Projects

To be responsive and transformative, the QI Unit will continue its work on two Performance Improvement Projects (PIPs) that began in FY 2014-15, focused on:

- 1) Impact of Peer and Family Support Specialists on Client Recovery, Engagement, and Advancement
- 2) Continuity of Care: Suicide Prevention after Discharge from Behavioral Health Services

## Targeted Aspects of Care Monitored by QI Unit

### Appropriateness of Services

- Utilization Management
- Assessment
- Level of Care
- Treatment Plans
- Discharge Planning
- Education Outcomes
- Employment Outcomes

### Access to Routine, Urgent and Emergency Services

- Call Volume for the Access and Crisis Line (ACL)
- Access Times for Assessments
- Access to Crisis Residential Services
- Access to Inpatient Hospital Beds
- Access to Residential Treatment Services

### Utilization of Services

- Average Length of Stay (ALOS) for Hospitals
- Readmission Rate
- Patterns of Utilization
- Retention Rate
- Completion Rate

### Client Satisfaction

- Grievance
- Provider Transfer Requests
- Satisfaction Surveys

### Cultural Competence

- Trauma-Informed
- Analysis of Gaps in Services
- Penetration Rate of Populations
- Provider Language Capacity
- Use of (Verbal and Non-Verbal) Language Interpreters Services
- Training Provided and Evaluated for Feedback
- Staff Cultural Competence Awareness

### Client Rights

- Quarterly Client Rights Reports
- Conservatorship Trend Reports
- Patient Advocate Findings
- LPS Facility Reviews

### Effectiveness of Managed Care Practices

- Provider satisfaction
- Provider Denials and Appeals
- Credentialing Committee Actions
- Client Appeals and State Fair Hearings

### Coordination with Physical Health and Other Community Services

- Integration with Physical Health Providers
- Outcomes Resulting from Improved Integration
- MOUs with Healthy San Diego

### Safety of Services

- Medication Monitoring
- On-Site Review of Safety

## Quality Improvement Work Plan, FY 2015-16

### **Developing the Quality Improvement Work Plan**

The purpose of the SDCBHS QIWP is to establish the framework for evaluating how the QI Unit contributed to meaningful improvement in trauma-informed care and administrative services. The QIWP defines the specific areas of quality of services, both clinical and administrative, that SDCBHS will evaluate for FY 2015-16.

The QIWP defines the 1) objectives, 2) goals, 3) indicators and/or measures, 4) planned interventions, 5) data collection and interpretation, and 6) planned reports. The QIWP includes plans for monitoring previously identified issues, sustaining improvement from previous years, and tracking of issues over time.

The QIWP will be monitored and revised throughout the year, as needed. The QIWP is reviewed by the QRC and approved by the EQIT. A formal evaluation will be completed annually.

### **Annual Evaluation of the Quality Improvement Work Plan**

SDCBHS shall evaluate the QIWP annually in order to ensure that it is effective and remains current with overall goals and objectives. This evaluation will be the Annual QIWP Evaluation. The assessment will include a summary of completed and in-process quality improvement activities, the impact of these processes, and the identified need for any process revisions and modifications.

### **Target Objectives for the Quality Improvement Work Plan**

The targeted objectives of the QIWP are based on the IOM aims and address QRC recommendations. It ensures high-quality trauma-informed systems and services are being engaged by clients and family members in San Diego County.

### **Quality Improvement Work Plan Goals**

The QIWP Goals define targeted measures by which Behavioral Health Services can objectively evaluate the quality of services, both clinical and administrative, provided to clients and families. Some of the goals are process goals while others are measurable objectives. The target areas for improvement have been identified in the following ways:

- 1) Client and family feedback about areas that need improvement
- 2) Systemwide enhancement identified through data and analysis

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed QI Intervention or previous next steps:
<b>QIWP Target Area: Services Are Client Centered</b>					
1	State Required  Ongoing	Decrease the number of grievances within identified target areas by 5%.	Number of grievances related to customer service/staff interactions.	Quarterly Grievances and Appeals report.  Annual Quality Review Committee (QRC) report.	Update the Grievances and Appeals tracking log with the new categories that are tracked by the Department of Health Care Services (DHCS).  Advocacy contractors to report on trends of incomplete grievances.
2	Systemwide Enhancement  3 <sup>rd</sup> year	Develop a baseline on the percentage of clients seen by Peer and Family Support Specialists.	Number of contacts by quarter.	Quarterly analysis report.  Data on the Support Specialist contacts from the Administrative Services Organization's (ASO) client management system.	Continue the Performance Improvement Project (PIP) on the impact of the Support Specialists on client recovery.  Evaluate the contacts between the Support Specialists and clients in CCBH.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed QI Intervention or previous next steps:
<b>QIWP Target Area: Services Are Safe</b>					
3	Systemwide Enhancement  Ongoing	Reduce the number of the following serious incidents by 5% from last Fiscal Year: 1) death related incidents 2) Suicidal attempts and homicide related incidents	Number of serious incidents.  San Diego county suicide rates.  Trend across all available years.	Monthly/Quarterly Serious Incident Summary report.  Results from the PIP on the correlation between the use of the HRA within the BHA and post-discharge suicide.  Report on the use of the HRA within the BHA.	Continue the PIP started in FY 2014-15 that focuses on strategies to prevent or at least reduce post-discharge suicides by expanding efforts to provide effective follow-up care after discharge of at-risk clients and adopting policies and procedures that best match at-risk clients to post-discharge follow-up services.  Begin tracking trends on the use of the HRA within the BHA to determine its correlation to client outcomes.  Continue to conduct quarterly webinars to train all clinical staff on the use of the HRA to assess for risk.
4	Systemwide Enhancement  Ongoing	Evaluate changes via a Trauma Informed Assessment from 2012 in the following three areas among the BHS system workforce: 1) What is Trauma Informed Systems? 2) How to apply and integrate Trauma Informed Systems? and 3) How to ask about trauma and know how to respond if disclosure is made?	Results from the Trauma Informed Assessment.	Re-issue the Trauma Informed Assessment developed by the Trauma Informed Systems Integration (TISI) team.	Implement the Behavioral Health Services Scan.  Work with the consultant to further develop the Trauma-Informed Systems Initiative (TISI) in BHS.  Work with the trauma-informed systems consultant to assess and analyze survey results, and put into action plan.  Leverage the results of the Trauma Informed Assessment and the Scan in collaboration with the CYF System of Care Outcomes Committee.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed QI Intervention or previous next steps:
<b>QIWP Target Area: Services Are Effective</b>					
5	Systemwide Enhancement  3 <sup>rd</sup> Year	Increase the number of clients discharged from a psychiatric hospital who connect to outpatient services within 7 and within 30 days after discharge by 5% from last Fiscal Year to provide effective continuity of care.	Connection to services within 7 and within 30 days after discharge.	ASO report and dashboard on client services after psychiatric hospital discharge.	Continue to track the number of clients who connect to outpatient services within 7 and 30 days following discharge.  Continuity of Care: Examine types of services used after discharge for patterns of care.
6	Systemwide Enhancement  EQR  Ongoing	Reduce the number of hospital readmissions among CYF and A/OA within 30 days by 5% from last Fiscal Year.	Number of hospital readmissions within 30 days.  Trend of hospital readmissions within 30 days.	ASO report and dashboard.	Continue to monitor and report on readmissions within the CYF and A/OA Systems of Care.  Continue collaboration between Hospital Partners and outpatient programs to identify methods to reduce readmissions.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed QI Intervention or previous next steps:
<b>QIWP Target Area: Services Are Efficient and Accessible</b>					
7	State Required  Ongoing	Provide specialty mental health services to 2% (65,269 clients) of county population.	Number specialty mental health clients in ratio to number of San Diego County residents.  Percent of county population served.	Quarterly reports and Databook.  Annual System of Care reports.	Continue to review penetration data annually.
8	State Required  Ongoing	Ensure that 95% of Client and Provider Appeals of Managed Care decisions are addressed within timelines (60 days for Level I decisions and 21 days for Level II documentation requests from the State).	Number of levels I and II appeals.  Turnaround times for addressing all levels I and II appeals.	ASO levels I and II appeals report.	Continue to monitor levels I and II appeals to ensure that they are addressed within timelines.
9	Systemwide Enhancement  1 <sup>st</sup> Year	Establish a crisis residential facility in the North Inland region of San Diego county.	Utilization of crisis residential services in north county among adult and older adult clients.  The use of inpatient services in north inland county among adults and older adults.	ASO reports.  Additional ASO reports and extracts on facility data.	Open a crisis residential facility in the North Inland region of San Diego county.  Track utilization of crisis residential services in north county.  Track utilization of inpatient services in north county.
10	Systemwide Enhancement  1 <sup>st</sup> Year	Establish an adult crisis stabilization facility in north county.	Utilization of crisis stabilization services in north county among adult and older adult clients.  The use of inpatient services in north inland county among adults and older adults.	ASO reports.  Additional Cerner reports and extracts on facility data.	Open a crisis stabilization facility in north county.  Track utilization of crisis stabilization services in north county.  Track utilization of inpatient services in north county.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed QI Intervention or previous next steps:
<b>QIWP Target Area: Services Are Equitable</b>					
11	State Required  Ongoing	75% of clients and families indicating that they had access to written info in their primary language and/or received services in the language they prefer.	Mental Health Statistics Improvement Program (MHSIP) and Youth Services Survey (YSS) responses to items focused on the availability of materials and services in the clients' preferred language.  Impact of race/ethnicity and language in Request for Services Logs.	Semi-annual client satisfaction survey, including threshold languages from MHSIP and YSS.  Monthly Request for Services Logs.	Continue to provide all beneficiary packet materials in all threshold languages.  Continue to regularly evaluate and update translated documents.  Begin the analysis on the impact of race/ethnicity and language in Request for Services Logs.  Administer the YSS and MHSIP surveys.
12	Systemwide Enhancement  1st Year	Increase connection to after-jail outpatient services within 30 days after release from jail among the juvenile and adult/older adult populations by 5% from last Fiscal Year.	Crisis response data among juvenile and adult/older adult populations.  Connection to outpatient services after release from jail by race/ethnicity among the juvenile and adult/older adult populations.	Jail Services/Juvenile Forensic Services Report with emphasis on data for clients discharged from jail and connected to outpatient services.	Evaluate connection to outpatient services within 30 days after release from jail among the juvenile and adult/older adult populations.  Break down the post-jail juvenile and adult/older adult populations by race/ethnicity.

#	Based on:	Goal:	Indicator/Measure:	Method for Data Collection:	Proposed QI Intervention or previous next steps:
<b>QIWP Target Area: Services Are Timely</b>					
13	State Required  Ongoing	<ul style="list-style-type: none"> <li>o 95% of calls answered by the Access and Crisis Line (ACL) crisis queue are within 45 seconds.</li> <li>o Average speed to answer all other (non-crisis) calls is within 60 seconds.</li> <li>o A minimum of 83% of CYF programs meet the mental health assessment timeliness standard (5 days).</li> <li>o A minimum of 90% of A/OA programs meet the mental health assessment timeliness standard (8 days).</li> </ul>	<p>Number of crisis and non-crisis ACL calls received.</p> <p>Response rates for crisis and non-crisis ACL calls.</p> <p>Percent of CYF and A/OA providers who meet the mental health assessment timeliness standard.</p>	<p>Report on ACL access times and types of calls received.</p> <p>Quarterly ACL Performance Standards Report.</p> <p>Request for Services Logs.</p>	<p>ACL Contract Standard reports.</p> <p>Access time reports on routine and urgent mental health services submitted by programs.</p> <p>Investigate the Cerner system capabilities to develop a report that is able to document access times from assessment to initial treatment service.</p>