San Luis Obispo County Mental Health
Quality Support Team Work Plan Fiscal Year 2015-2016

QST Work Plan:
The annual QST Work Plan identifies key areas that will be a focus of the MHP's quality improvement efforts for the year. The goal is data-driven, continuous quality improvement with measurable outcome benefits for plan members.

Goal # 1: Maintain a responsive toll free 24/7 Central Access line

Goal # 2: Monitor Service Delivery Capacity

Goal # 3: Increase system capacity to serve Latino beneficiaries

Goal # 4: Provide timely access to services

Goal # 5: Monitor attendance rates for key services

Goal # 6: Maximize consumer satisfaction responses

Goal # 7: Monitor and respond to beneficiary requests

Goal # 8: Monitor and respond to provider requests

Goal # 9: Implement interventions when better care was more appropriate

Goal # 10: Improve clinical documentation

Goal # 11: Conduct effective clinical records reviews

Goal # 12: Improve and update Policies & Procedures

Goal # 13: Develop improved Site Certification procedures

Goal # 14: Create a Data Dashboard to make performance data accessible and meaningful

San Luis Obispo County Mental Health
Quality Support Team Work Plan Fiscal Year 2015-2016

Goal # 1: Maintain a responsive toll free 24/7 Central Access line	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Monitor the performance of the toll free Central Access line during and after regular business hours <u>Measurable Objectives</u>: All calls will be logged as required (100% success rate) Staff who answer phones will utilize the scripted responses (90% success rate)	1. Implement scripted responses at all clinic locations and in Central Access (1st quarter) 2. Conduct monthly test calls (English and Spanish) to evaluate performance in the following areas: • Language capacity • Informing beneficiaries about how to access mental health services • Informing beneficiaries about how to access urgent services • Informing beneficiaries about how to access the problem resolution and fair hearing process • Log of calls that includes name of beneficiary, date of call, initial disposition 3. Complete quarterly reporting to DHCS (quarterly)	Managed Care Program Supervisor QST staff TMHA Hotline Coordinator

Goal # 2: Monitor Service Delivery Capacity	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Establish goals for the number, type, and geographic distribution of mental health services <u>Measurable Objective</u>: Maintain a network of providers (staff plus contractors) that is sufficient to provide adequate access to services within 14 days of referral or request	1. Continue to measure and track access and attendance at each clinic site as a measure of capacity (see Goals 3- 5 for detail) 2. Track wait time from acceptance of referral to initial appointment with Network Provider therapists 3. Track requests for service by beneficiary zip code; analyze for gaps (quarterly) 4. Conduct targeted Network Provider recruitment when delays or gaps (geographic area, language or clinical specialty) are identified	QST staff Managed Care staff and Program Supervisor

Goal # 3: Increase capacity to serve Latino beneficiaries	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person(s)**
Increase the number and percentage of clients served who are Latino <u>Measurable Objective</u>: 5% increase in utilization by Latino clients	1. Measure penetration rate (annually) 2. Measure number and percentage of clients served who are Latino (quarterly) 3. Track number of clients receiving three or more services by ethnicity to allow examination of our ability to retain consumers (quarterly) 4. Maintain bilingual staff capacity at all key points of contact, including at the toll free Central Access line	QST staff Latino Outreach and bilingual clinic staff BH Administration

Goal # 4: Provide timely access to services	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
A. Wait time for assessment (routine) <u>Measurable Objective</u>: Assessment offered within 14 days of request (80% success rate)	1. Monitor and report wait time for assessment for English and Spanish speaking consumers (monthly) 2. Evaluate the effect of the non-clinical PIP on reducing wait time (quarterly) 3. Allocate clinic and Managed Care staff so that sufficient intake appointments are available to meet the demand. 4. Recommend corrective action if a site is unable to meet the standard (monthly) 5. Make data-driven staffing recommendations to Behavioral Health Administrator	Managed Care Program Supervisor QST staff BH Administration Clinic Program Supervisors

B. Wait time for post hospital follow-up Measurable Objective: Follow up provided within 7 days of discharge (90% success rate)	1. Monitor and report wait time for post hospital follow-up (monthly) 2. Recommend corrective action if a site is unable to meet the standard (monthly) 3. Monitor and report the number and percentage of clients who are discharged from the PHF who were given an outpatient follow up appointment (monthly) 4. Monitor and report the number and percentage of clients who were given a post PHF follow up who kept at least one outpatient service at 7 and 30 days post discharge (quarterly)	Managed Care Program Supervisor QST staff BH Administration Clinic Program Supervisors
C. Wait time for urgent and crisis conditions Objective: Provide urgent/crisis appointments as quickly as beneficiaries' conditions require	1. Develop a process for timely scheduling of urgent services 2. When reporting capacity allows, monitor and report wait time for urgent and crisis appointments (monthly)	Managed Care Program Supervisor QST staff
D. Wait time for psychiatric assessment (routine) Measurable Objective: Psychiatric assessment provided within 30 days of request (90% success rate)	1. Monitor and report the amount of lapse time between request for medication support to date of MD assessment appointment at each clinic site (or, until data reporting capability allows, time to next available psychiatric assessment) (monthly) 2. Recommend corrective action if a site is unable to meet the standard	Medical Director QST staff

Goal # 5: Monitor attendance rates for key services	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
A. Medication evaluation appointments Objective: 85% attendance rate for all MD appointments	1. Monitor and report attendance rate at scheduled MD appointments by site and provider (monthly) 2. Recommend attendance improvement activities if attendance falls below the standard	QST staff Medical Director
B. Intake assessment appointments Measurable Objectives: 85% attendance rate (youth) 80% attendance rate (adults)	1. Monitor and report attendance rate at scheduled intake appointments by site (monthly) 2. Develop and implement a survey to determine reasons for missed intake appointments 3. Implement non-clinical PIP (Service Enhancement Program) at adult clinic sites (phased in, beginning in SLO)	QST staff BH Administration Clinic Program Supervisors Service Enhancement Staff

Goal # 6: Maximize consumer satisfaction	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Consumer Perception Survey Objective: 85% of responses on the Performance Outcome Quality Improvement (POQI) survey will be rated “Strongly Agree” or “Agree”	1. Encourage a representative sample of beneficiaries to complete the POQI survey (annually or twice yearly) 2. Recommend improvement activities if result falls below the standard 3. Report promptly to staff at all sites.	QST staff Clinic Support Staff

Goal # 7: Monitor and respond to beneficiary requests	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Resolve beneficiary requests at the lowest possible level <u>Measurable Objective</u>: Successfully resolve all beneficiary concerns within legal time frame (100% compliance)	1. Track all consumer requests (second opinion and change-of-provider requests, grievances, appeals/expedited appeals, fair hearings/ expedited fair hearings) 2. Monitor and report outcome and timeliness of resolution (quarterly)	Patient's Rights Advocate

Goal # 8: Monitor and respond to provider requests	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
A. Resolve provider appeals at the lowest possible level <u>Measurable Objective</u>: Successfully resolve provider appeals within legal time frame (100% compliance)	1. Track provider appeals and requests 2. Monitor and report outcome and timeliness of resolution (quarterly)	Managed Care Program Supervisor QST staff
B. Make timely authorization decisions <u>Measurable Objective</u>: Resolve TARs within 14 days of receipt (100% compliance)	1. Track and report the number and percentage of Treatment Authorization Requests (TARS) completed within 14 days. 2. Monitor and report outcome and timeliness of resolution (quarterly)	Managed Care Program Supervisor QST staff

Goal # 9: Implement interventions when better care was more appropriate	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Conduct regular review of Incident Reports <u>Measurable Objective</u>: Review and respond to Incident Reports within two weeks of report submission (within one day for suspected privacy incidents)	1. Review Incident Reports; monitor and report (monthly) 2. Refer Incident Report to Morbidity & Mortality Committee in event of death or serious injury 3. Make recommendations regarding follow-up when better care was more appropriate 4. Establish separate PHF and Outpatient Incident Report Review Committees to allow more detailed review of issues and concerns.	QST Staff Medical Director BH Administration Clinic Program Supervisor

Goal # 10: Improve clinical documentation	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Provide regular training to improve documentation <u>Measurable Objective</u>: 100% of MHP staff will attend documentation training at least annually	1. Revise and distribute Documentation Guideline update (twice yearly; more often if needed) 2. Establish training schedule to include all MHP and contractor sites; provide regular training at sites and new employee orientation 3. Publish a bimonthly documentation tips newsletter 4. Track attendance at face-to-face and completion of E Learning documentation training (annually)	QST staff

Goal # 11: Conduct effective clinical records reviews	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Establish a consistent audit protocol and schedule as part of Utilization Management Program <u>Objective</u>: Identify areas of strength and deficiency in documentation to help guide training and to ensure appropriate access and billing for services	1. Establish a monthly audit schedule to include all MHP and contractor sites with a focus on high utilizers of services or areas of specific need 2. Review NOA – A denial decisions by Site Authorization Teams to ensure that beneficiaries have appropriate access to Specialty Mental Health Services (quarterly) 3. Analyze and report results (monthly)	QST staff Health Information Technology (HIT) staff Compliance Officer

Goal # 12: Improve and update Policies & Procedures	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Review, revise, approve and post Policies & Procedures in a manner that provides up-to-date and accessible guidance for staff <u>Objectives</u>: • Review and reformat 100% of MHP policies in 1st quarter • If significant updates are needed, prioritize and complete revisions by end of the FY	1. Prioritize the most urgent revisions 2. Work with Compliance Steering Committee to create an accessible intranet structure for Policy & Procedures 3. Develop a review and approval process that ensures that, upon revision, policies are accurate, applicable and consistent with current laws and regulations	QST staff Compliance Steering Committee QST Committee BH Administration

Goal # 13: Develop improved Site Certification procedures	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Identify DHCS site certification standards and incorporate into MHP procedures <u>Objective</u>: Create a standardized set of procedures for certification and tracking of all county operated, contract provider, and out of county provider sites	1. Develop a review and monitoring process that ensures that each site requiring certification remains in compliance with standards 2. Develop a common tool and strategy for identifying out of county providers that need to be certified in order to serve SLO beneficiaries 3. Report progress (quarterly)	QST staff Program Supervisors Contract providers

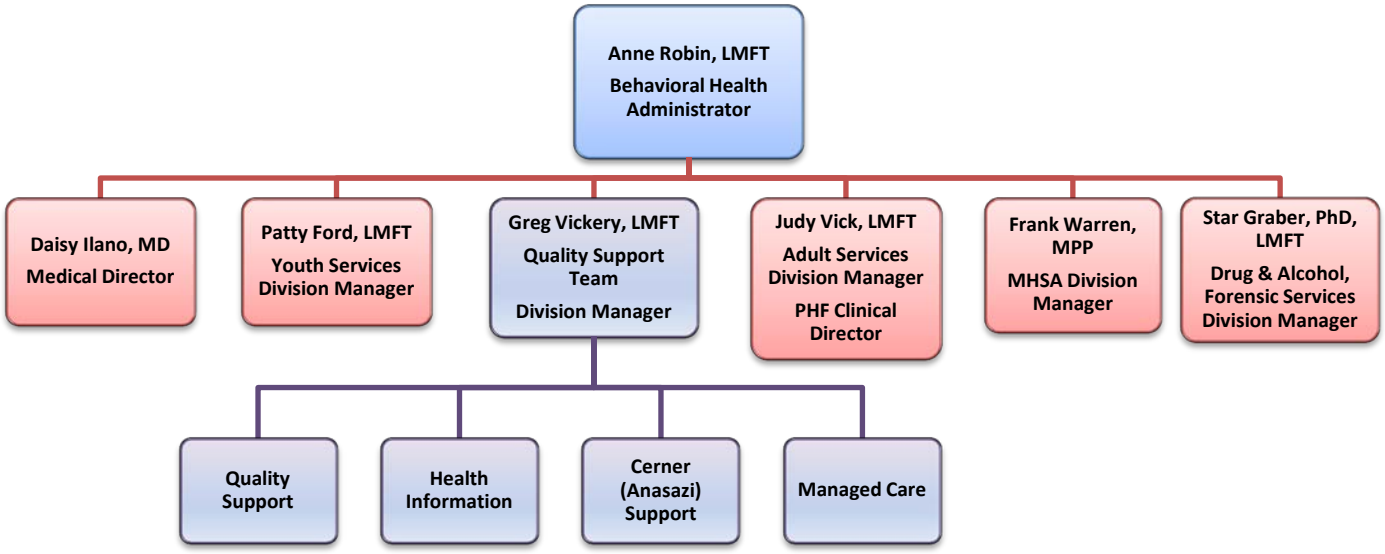
Goal # 14: Create a usable 'Data Dashboard'	**Planned Steps/Activities to Reach the Goal (Reporting Frequency)**	**Responsible Person/Group**
Improve the reporting capabilities of QST to make performance data accessible and meaningful <u>Objective</u>: Identify and define key performance indicators and create a user-friendly tool for presenting the indicators to staff and consumers	1. Identify key performance indicators (outcome and quality measures) based on final decisions made by DHCS based on Metrics Work Group input 2. Develop a Data Dashboard for presenting the material in an accessible manner 3. Report this information to DHCS and MHP stakeholders 4. Recommend system and process changes based on performance data	QST staff IT & Fiscal staff "Data Dynamos" team DHCS staff/ Metrics Work Group

Quality Support Team Program Structure and Description
Fiscal Year 2015-2016

Purpose:

- To define the Quality Support Team (QST) program's structure and elements
- To assign responsibility for QST activities to team members
- To provide a framework for understanding the Quality Support Team Work Plan, which establishes quantitative measures to assess performance and identifies and prioritizes areas for improvement
- To clarify processes for identifying and implementing improvements to better meet the needs of the MHP's beneficiaries

Organizational Overview:
The chart below shows a very simplified view of the MHP's Management Team and where QST fits in the structure. The QST Division Manager, Greg Vickery, LMFT, reports directly to the Behavioral Health Administrator and participates on the Behavioral Health Management Team.



Notes: The chart omits participation on the Management Team by the Health Agency Fiscal Manager because reporting lines are different. Additionally, the Health Agency Compliance Officer is not represented, even though there is a high level of collaboration between the Compliance Officer and the Quality Support Team Division Manager and the two programs share similar responsibilities and goals.

The chart above also serves to highlight lines of reporting through the QST Division Manager that are important for the overall quality of the services provided by the MHP.

- Health Information staff report to Kathy McGuire, who is a Registered Health Information Technician (RHIT). Health Information staff play a key role in managing the paper and electronic medical record and for ensuring quality of documentation.

- Cerner (Anasazi) Support staff are responsible for the ongoing implementation and maintenance of the electronic health record and for training staff to efficiently operate the system. The MHP made a deliberate organizational decision with this line of reporting to ensure that the tools developed within the EHR comply with documentation requirements.

- Managed Care staff report to Amanda Getten, LMFT. The advantage of the MHP's reporting structure is apparent in the description of duties below. Managed Care staff perform core access, authorization and quality of care duties, including:

- Central Access:
  - Operate the MHP's toll-free 24/7 Central Access Line during business hours. Provide information to beneficiaries about:
    - How to access specialty mental health services including assessment
    - How to access services to treat urgent conditions
    - How to access the beneficiary protection processes
    - How to access other services in the community including substance abuse treatment and non-specialty mental health/physical healthcare services through CenCal Health
  - Provide training and oversight for the afterhours contractor (Transitions Mental Health Association's SLO Hotline)
  - Provide access to services in the beneficiaries' language of preference
  - Monitor the effectiveness of the Central Access Line

- Network Provider panel:
  - Recruit, credential and re-credential a panel of individual Network Providers that is sufficient to meet the needs of beneficiaries. Considerations include:
    - Timely access
    - Size
    - Mix of services and specialties
    - Geographic distribution
    - Accessibility
  - Authorize Network Provider services
  - Monitor the quality and effectiveness of services provided by the panel

- Authorize and monitor services for youth in out-of-county adoptive, foster and KinGAP placements

- Authorize and monitor services for SLO beneficiaries provided by out-of-county inpatient facilities (TAR and Short-Doyle)

- Review provider appeals

- Assessments:
  - Complete comprehensive assessments to determine whether medical necessity criteria are met for specialty mental health services in a variety of clinic locations
  - Monitor timeliness of initial services and recommend improvement actions when needed

❖ QST staff report directly to the QST Division Manager. QST staff execute key QM, QI and UM duties including:

- Janet Lorenzo, ASO II
  - QST Committee:
    - Collects, reports and presents access, appeal and other data elements tracked by the QST Committee
  - QST subcommittees:
    - Organizes, monitors and tracks QST subcommittees
    - Maintains minutes, agendas and records
  - Consumer Perception Survey
    - Organizes, ensures administration of twice yearly survey
    - Collects and reports results to QST and providers
    - Reports outcome data to DHCS
  - Site Certification

        - Conducts site reviews
        - Coordinates with DHCS site reviewers
        - Monitors, tracks and maintains certification records
        - Maintains ITWS files
    - Medical Care Evaluation Study
        - Assist with reporting and data analysis
    - Quality of Care concerns
        - Tracks and records Incident Reports
        - Coordinates follow up requests
    - Policy & Procedure
        - Reviews, drafts, coordinates input and approval
    - Committee membership: QST Committee (MHP and PHF), PHF Leadership

- Jackie Miller, LMFT
    - Outpatient utilization management
        - Reviews medical records to ensure:
            - Consistent application of medical necessity criteria by Site Authorization Teams per policy 3.20 *Authorization of Services and Medical Necessity*
            - Adherence to contract and MHP documentation requirements
            - Proper coding and claiming of specialty mental health services
            - Identification of over or under utilization of services
        - Provides staff training to improve documentation and coding
    - Clinical PIP coordinator
    - Committee membership: QST Committee (MHP), Morbidity & Mortality, Incident Report Review (MHP)

- Angela Atwell, RN
    - Inpatient utilization review
        - Reviews medical records to ensure
            - Consistent documentation of medical necessity criteria for admission
            - Consistent documentation of medical necessity criteria for continued stay
            - Adherence to documentation requirements in contract and regulation
        - Authorization decisions (see Utilization Review Plan)
        - Provides staff training to improve documentation
    - Committee membership: QST Committee (PHF), PHF Leadership, Incident Report Review (PHF), Pharmacy and Therapeutics, Peer Review

QST Committee Structure

The MHP's outpatient QST Committee and subcommittee structure is illustrated at the right. The MHP has separate outpatient and PHF QST committees; several key subcommittees are shared.

QST Committee (Outpatient) Membership:

- QST Division Manager (chair)
- BH Administrator
- Medical Director
- Youth & Adult Services Division Managers
- QST staff

- □ Managed Care Program Supervisor
- □ Behavioral Health Advisory Board member
- □ SLO BH Patient's Rights Advocate
- □ SLO BH Ethnic Services Manager
- □ Compliance Officer
- □ Contractor/Provider staff
    - o Family Care Network Director of Clinical Services
    - o Transitions Mental Health Association (TMHA)
        - ▪ Division Director
        - ▪ QA Specialist
    - o Latino Outreach Clinical Supervisor
- □ Peer/Advocate members:
    - o TMHA Peer Advocacy Program Manager
    - o Family Advocate
    - o Health Navigator
    - o Peer representative

QST Committee activities: (See monthly meeting minutes, PowerPoint slides and agenda for additional detail)

- □ Develop, approve, and monitor the goals and objectives of the QST Work Plan (see Work Plan for detail)

- □ Monitor key quality indicators (monthly), including:
    - o Wait time for assessment and acute care follow up (English and Spanish)
    - o Wait time for psychiatric appointment
    - o Attendance at key appointments

- □ Monitor key quality indicators (quarterly), including:
    - o Notices of Action
    - o Grievances, Appeals (beneficiary and/or provider), Fair Hearing requests
    - o Change of Provider and Second Opinion requests
    - o Peer Review Results (medical services provided by prescribers and nursing staff)

- □ Periodic monitoring of beneficiary satisfaction (twice yearly Consumer Perception Survey)

- □ Review and evaluate results of other quality improvement activities, including the clinical and nonclinical PIPs

- □ Receive reports from subcommittees and recommend necessary actions, including corrective actions when opportunities for more appropriate care are identified.
    - o Morbidity & Mortality Committee is chaired by the Medical Director. This subcommittee meets monthly to review instances of death or serious injury. See Policy 15.02 *Morbidity & Mortality Committee* for additional detail.

    - o Peer Review Committee is chaired by the Medical Director. This subcommittee meets monthly to review the clinical documentation of medical staff to ensure the safety and effectiveness of prescribing practices. See Policy 11.03 *Peer Review Committee* for additional detail.

    - o Incident Review Committee is chaired by the QST Division Manager. Outpatient Incident Reports from Behavioral Health staff and contractors are reviewed to ensure improved care and appropriate follow up. See Policy 15.04 *Outpatient Incident Reports* for additional detail.

- □ Receive reports from Cultural Competence committee

- Review and recommend policy changes and additions

- Other quality improvement activities as identified, including making recommendations for training and program development that improve beneficiary care. Examples include recommending that the successful nonclinical PIP, which concluded in FY 2014-2015, be implemented system-wide to improve access for clients following an inpatient psychiatric admission.

QST Committee (PHF)

Membership:

- QST Division Manager (chair)
- BH Administrator
- Medical Director
- Adult Services Division Manager (PHF Clinical Director)
- QST staff
- PHF Care Program Supervisors
- PHF Nursing Supervisor
- PHF Nursing Line staff
- Behavioral Health Advisory Board member
- SLO BH Patient's Rights Advocate

QST Committee activities: (See monthly meeting minutes, PowerPoint slides and agenda for additional detail)

- Monitor key quality indicators (monthly), including:
  - Incidents: Injuries, elopement, medication errors, Unusual Occurrences, seclusion and restraint episodes
  - Utilization Review Statistics, including documentation concerns and denial
  - Admission data, including number of admits, readmits, average daily census, and LOS

- Monitor key quality indicators (quarterly), including:
  - Patient satisfaction, infection control, other aspects of care including seclusion and restraint documentation.
  - Peer review results

- Receive reports from subcommittees and recommend necessary actions, including corrective actions when opportunities for more appropriate care are identified.

  - PHF Leadership Committee is chaired by the Medical Director. This subcommittee meets monthly to oversee operations and ensure quality of care. See PHF Policy 13.00 *PHF Leadership Committee* for additional detail.

  - Utilization Review Committee is chaired by the Medical Director. This subcommittee meets monthly to review the clinical documentation and to make authorization decisions. See PHF Policy 13.01 *Utilization Review* and the current UR Plan for additional detail.

  - Incident Review Committee (PHF) is chaired by the QST Division Manager. PHF Incident Reports are reviewed to ensure improved care and appropriate follow up. Unusual Occurrences are also discussed and corrections are implemented in this subcommittee.

  - Pharmacy & Therapeutics Committee is chaired by the Medical Director. This subcommittee meets every other month to review and monitor medication prescribing practices and to ensure safety and efficacy. See PHF Policy 13.12 *Pharmacy & Therapeutics Committee* for additional detail.