Stanislaus County Behavioral Health and Recovery Services
Annual Quality Management Work Plan
FY 2016-2017

INTRODUCTION

The scope of this work plan is the overarching Quality Management aspects of the Stanislaus County Behavioral Health and Recovery Services (BHRS) for the fiscal year (FY) ***2016-2017***. The work plan outlined in this document involves a Department-wide focus on quality initiatives. In addition, each system of care and division will develop an action plan that is more specific to the functions of the respective systems. BHRS is committed to providing high quality care and services to all its customers.

Our Mental Health Services Act (MHSA) programs are fully implemented. We continue our efforts to integrate the essential elements of MHSA into every facet of our organization. These elements are community collaboration, cultural competence, client/family-driven systems and services, wellness for recovery and resilience, and an integrated services experience. We believe our Quality Management Work Plan supports the ongoing transformation of our department.

Consumer and family member involvement in quality management process continues to be very important to our organization. Consumers and family members have participated in the various Quality Improvement Committee (QIC) meetings held during the year. This is expected to continue in the current fiscal year. It is also expected that consumers and family members will continue to participate in work groups and stakeholder meetings in which consumers and family members provide valuable feedback and assistance to the department.

This work plan is formatted as follows. The first section presents some highlights of the work and accomplishments for ***FY 2015-2016***. The second section provides the outcomes for the Action Plans for ***FY 2016-2017***. The last section summarizes the Action Plans for ***FY 2017-2018***.

ACCOMPLISHMENTS FOR FY 2015-2016

Administrative and Fiscal Support Services Quality Improvement Council

This council has its focus on the fiscal and administrative support processes in the organization by managing and establishing process improvements for customer service, budget, position control, quality assurance and compliance, which includes the divisions of accounting and billing, purchasing, information systems and processes, contracts, human resources, quality services, medical records, utilization management, clerical/administrative staff and facilities.

- Customer Service Surveys within Fiscal and Administrative Services are conducted on a rotation basis via Survey Monkey. The surveys are designed to receive specific feedback in the area of customer satisfaction. Results are summarized and presented to the Admin QIC for recommendations based on what was learned and to identify process improvements. The department has standardized our survey process by establishing core questions that are asked in every survey for consistency and uniformity.

- For quality assurance, all staff has access to the presentation of what to do upon receipt of a subpoena, which includes who to directly contact and/or where to send for processing and the governmental mandates that are associated, including HIPAA regulations.

- The Release of Information training expanded to include an approach with the focus of technology being enhanced for the signature of this form, which included the purchase and disbursement of laptops (to key staff) with an electronic signature function for ease of access, customer service delivery, and timeliness for compliance. It also exposed the need for our contract providers to participate in trainings such as this for a more uniformed approach upon the completion of key processes.

- As a result of a survey conducted in February 2016, the Volunteer Services division provided a link to the County volunteer landing page for ease of access to those who are seeking to volunteer or utilize a volunteer. The landing page includes a list of all departments in the County, as well as contact information to the department's volunteer liaison, how the volunteer may be utilized within the department, and the application process. The BHRS Director of Volunteer Services identified strategies and processes in the areas of outreach via routine site visits, establishing program specific protocols, volunteer job descriptions, assignment agreements, time reporting, policy acknowledgements, and other related items, for efficiency and a shared understanding.

- The Probationary Review Committee continues to meet monthly to discuss employees who are on initial and now in addition, promotional probation. The committee invites Coordinators, Managers, and Sr. Leadership staff to the discussion. Strategies on how to accomplish successful employees are discussed, as well as re-direction needed in the area of corrective action, if necessary. It is a resource for the hiring authority to brainstorm with peers and have a clear understanding of the selection process for probationary personnel.

- The Hip Link Emergency Notification System was switched over to EverBridge. A monthly test of the notification process continues and has been initiated for actual emergencies. The Department has established a written protocol to include who should receive the information, training on how to respond to the information, and continued monitoring of the process.

- The standardization of payroll procedures has expanded into the Electronic Time Card (ETC) process known as "punch time", which is paperless. 80% of staff has been trained on this process with the timecard keyed by the employee and electronically sent to the approver (supervisor or delegated authority). This effort has been ongoing through the subsequent fiscal years, each year adding another element.

- Recruitment resources continue to be a work in progress, as the Chief Executive Office has implemented changes due to NEOGOV (online application system) upgrades and the reorganization of key management staff within their department. The BHRS Intranet continues to be a key component in linking recruitment resources.

Adult, Older Adult and Forensics Systems of Care Quality Improvement Council

This QIC represents the Adult System of Care and Older Adult System of Care. The QIC strives to have consistent representation from all Adult/Older Adult County programs and contracted providers as well as consumer/community representatives.

- 63% of Adult and 68% of older adult English-speaking beneficiaries considered at "high risk" followed through on outpatient referrals with in fourteen (14) calendar days. The goal for both of these populations of 80% was not met. What became apparent was that it will be difficult to develop strategies to improve this objective without improving the data that is utilized to gather the information. The decision is to place primary emphasis on improving data collection and reporting. This will help ensure that the data collection is reflective of the target population, that the instances of DKAs are accounted for, and that there is accurate reflection of the data via 800 logs by all teams.
- Preliminary data for the Pilot Program showed that timely referrals (often within 1 day of exiting hospitals) were being given to clients and clients continued to n/s for assessment appointments. This encouraged the team to begin looking at barriers to follow up after hospitalization and improving processes which included multiple items for change in process. (See write up)
- The ASOC/OASOC/Forensics QIC began to look at the DKA process and obtained input from the various service teams regarding the status of the process surrounding DKAs. A subgroup was identified and began meeting to work on developing a specific protocol to follow up with DKAs. The strategies are as follows for the pilot program:

    - **Improve data collection to accurately track DKA and non-assessment actions.** – 1. DKA: if a client does not present for an assessment, the MHC will enter DKA into the electronic health record using the "One shot service Code 5" to stop the 14 day clock. 2. Non –Assessments Discharges. If the Discharge is a "non-assessment activity" the Transition Team will document this in their Tracking unit database.

    - **Notify referring party of DKAs.** 1. The mental health clinician will notify the referring party to inform them of the DKA. Referring party will try to re-contact and reschedule.

    - **Standardize process for DKAs follow up.** 1. Three phone calls – Program Staff will attempt to contact the client three times via phone call. 2. Letter – If the client is not reached with three phone calls, the program will send a standard DKA letter.

    - If successful, the next step in this process is the implementation of these 3 strategies to all BHRS ASOC, OASOC, and Forensics programs. Currently project is in process and will be implemented with target date in 16-17 fiscal year

- Reports will be requested to distinguish data between clients who are open to a BHRS program and those who are not.
- **LOCUS** -Teams to be trained in LOCUS via Deerfield. A workgroup to be formed to look and work towards LOCUS being included in EHR, all teams consistently completed and having useful outcomes from LOCUS that can aid staff in day to day work with clients and more accurate mental health documentation.
- **New psychiatric referral form** in process and teams being made aware of upcoming changes in the process to help accommodate. Process to continue into 16-17; form currently pending in BHRS Assessment Committee
- Psychiatrist and RNs to be trained in scheduler as well to help support the process re: looking at timelines and process improvement around client attendance to Psychiatric appointments. Dr and RNs trained in scheduler currently. In process – will continue into 16-17 year.
- **Chart Reviews –** Discussion in QIC re: beginning internal chart reviews for consistency and quality of mental health charting and chart standards. Only some teams are doing this currently. Chart review forms completed and policy in process. Teams are aware and preparing their own teams to begin process if currently not in place.
- ASOC/Older Adult QIC has consistent attendance and participations from all ASOC/Older Adult Programming and contractors with back up staff as needed to ensure consistency. Work in progress is attendance from consumer panel—which has been in consistent.

***** Note: The Forensic System of Care (FSOC) has started a QIC, separate from Adult and Older Adult as of mid-2016. The accomplishments from 2016-2017 will be added to this plan next year as appropriate. The following is a description of the FSOC QIC: *This QIC represents a variety of services from Substance Use to Mental Health to Public Guardian/Estate Management and range from in-custody or institutions to community/home based. This QIC is new and developing objectives while remaining open and flexible to modify them in meaningful ways. The focus of the objectives is to represent all teams and services and high light behavioral health integration.*

Children's System of Care (CSOC) Quality Improvement Council

The CSOC QIC enjoys broad representation from County programs and contracted providers as well as consumer/community representatives. The group selects projects for the year that have the potential to improve the quality of care and program effectiveness across the system.

- Assisted with a refresher 800 log training in support of the Non-Clinical PIP. Assisted in updating the training guides to meet current standards and provided two days of training in April, 2016- one for CSOC/contractors and the other for ASOC/OASOC/Forensics/contractors.
- Developed a report template in the Electronic Health Record to indicate which clients need a Teen-ASI (T-ASI) completed based upon the responses on the CRAFFT screening in the Comprehensive Assessment. Began utilizing this report for T-ASI reporting in QIC.
- 100% of Children's System of Care and contract agency programs completed a chart review for completion of the T-ASI tool for assessments in which a need was identified in the initial assessment. Continued to monitor the completion rates on the tool. Six staff (3 BHRS and 1 per contract agency) began providing training on the T-ASI tool. Training materials were developed, discussed, and planning of the training was managed by the Training Department. This year 55 staff was trained, with representation from all programs in the trainings. Trainers were placed on a rotation to continue the trainings on a quarterly basis.
- Co-Occurring training was placed on the calendar for August, 2016, with an outside trainer coming in. The QIC Committee discussed needs for the training and shared this information with the trainer, who agreed to incorporate requested materials and topics into the training.
- Finalized a standardized written protocol for CSOC internal chart reviews at the program level (monthly reviews). The protocol was distributed to all CSOC teams. Quality Services staff attended 5 of 6 teams to train staff on the peer review tool. The last team had been scheduled but had to reschedule to a date in the following fiscal year. Staff began following the new protocol as they were trained.

Managed Care Quality Improvement Council

The Managed Care QIC's major responsibility is quality of care and quality of service under the Medi-Cal Managed Care Plan. These responsibilities include, but are not limited to, access, complaint and grievance processes, utilization management, and compliance with clinical standards. Consumer involvement is a key quality process each year.

- Consumers/family members participated in 7 out of 8 meetings held during FY 15/16
- 84% of adult/older adult beneficiaries report overall satisfaction with services (MC KI 38.1)
- 82% of children/youth/parent report overall satisfaction with services (MC KI 38.2)
- 82% of monolingual Spanish speaking adult beneficiaries report overall satisfaction with services (MC KI 39.1)
- 89% of monolingual Spanish speaking children/youth/parent report overall satisfaction with services (MC KI 39.2)
- 100% of monolingual Spanish speaking older adult beneficiaries report overall satisfaction with services (MC KI 39.3)
- Family Member grievances resolved satisfactorily, 100% (MC KI 42)
- Consumer grievances resolved satisfactorily, 82% (MC KI 43)
- Peer review results – 95% of beneficiaries participated in outpatient treatment planning evidenced by signature on Client Care Plan (MC KI 28)
- Access – 95% of adult beneficiaries had a scheduled assessment within 14 business days of initial contact call (MC KI 1)
- Access – 55% of children/adolescent beneficiaries had a scheduled assessment within 14 business days of initial contact call (MC KI 6)
- Access – 92% of older adult beneficiaries had a scheduled assessment within 14 business days of initial contact call (MC KI 11)
- 100% of provider appeals were handled according to Medi-Cal regulations (MC KI 45)
- 100% of grievances and appeals were processed according to guidelines established by State DHCS (MC KI 25)
- Coordination of care with Managed Care Plans – Transitioned to Quarterly Meetings with Health Plan of San Joaquin and Health Net to monitor care coordination, individual case review, referral concerns, and other topics

Substance Use Disorders (SUD) Services Quality Improvement Council

This Quality Improvement Council (QIC) monitors the activities of the Stanislaus Recovery Center (SRC), Genesis Program and all outpatient SUD services. SRC is a full service adult treatment program, which includes detox, Outpatient Drug Free (ODF) and Intensive Outpatient Treatment (IOT) for SUD issues as well as a program component for clients with co-occurring SUD and mental health disorders. Genesis is the Department's methadone treatment program. A contracted program for perinatal women also participates in this QIC as do representatives from other adult programs providing outpatient SUD services.

- Participated in "Latino access collaborative" in attempt to influence "penetration rates" within the historically underserved Latino populations of Stanislaus County
- Reviewed the process of linking clients to potential SUD services, developed a clearer understanding of the linkage process from CIP/CERT, the warm line and other "entry Portals" to SRC and potential SUD services. Was able to identify that 'Dropped linkages" were not due to information not being given.
- Identified areas for improvement in the peer review process, carried over project of modifying peer review tool to 16/17 SUD QIC
- Undertook review of SUD related docs and edited where needed to insure use of "SUD" specific language as opposed to AOD
- Reviewed and updated "SUD forms" overview document

OUTCOMES FOR FY 2016-2017

DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Customer Satisfaction	Customer Service	Adult, older adult, and children/youth/parent beneficiaries will be satisfied with the services they receive as evidenced by meeting or exceeding our customer satisfaction results for **FY 2015-2016** ***Medi-Cal key indicators: Beneficiary Satisfaction	We did not meet our goal of **90**% external beneficiary satisfaction in all categories. However, we did stay the same for Adult/Older Adults SOC and had an increase in satisfaction for the Children's SOC from last FY. There was a decrease in the number of responses from *3419* in **FY15-16** to *3021* in **FY 16-17**. **FY15/16** **FY16/17** Adult: 84% 84% = Older Adult: 84% 84% = Child/Family: 82% 83% +

DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Penetration	Easy Access to Services	Our overall penetration/prevalence rates will maintain or increase from **FY 2015-2016**. *Service Utilization Based on Prevalence Report	The methodology for calculating penetration is based on the expected prevalence (need) in our community of **5.75%** of population divided by the number of unduplicated clients served. The following are results: **FY15/16** **FY16/17** African-American: 69% 59% - SEA/PI: 13% 26% + Native American: 20% 18% - White American: 19% 19% = Other: 54% 48% - Hispanic Origin Hispanic: 30% 28% - Not Hispanic/Latino: 28% 29% + ***Overall there is a decrease in penetration/prevalence rate in most groups.** ***The main reason that the percentages by most race/ethnicity categories are so much lower in FY16-17 is that we used updated prevalence percentages and we changed the methodology to differentiate the percentages by race/ethnicity and Hispanic Origin in order to better reflect the differences in demographic prevalence.**

DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Geographic Access	Easy Access to Services	Services will be accessible to all county residents regardless of geographic location as evidenced by penetration rates. The Westside will increase by **1%** over **FY 2015-2016** results. ***Service Utilization Based on Prevalence Report	**FY15/16** **FY16/17** Ceres 27% 29% + Eastside 27% 27% = Modesto 40% 40% = Turlock 25% 28% + Westside 23% 23% = ***The Westside remained the same, while other locations remained the same or increased.**

<table>
<tr><th>DESCRIPTION</th><th>KEY PROCESS</th><th>ACTIVITIES</th><th>STATUS</th></tr>
<tr><td>Client Retention</td><td>Behavioral Health Promotion, Prevention, Treatment & Recovery</td><td>We will provide services in a culturally competent way as evidenced by such measures as the retention rate, which is the percentage, by ethnicity, of clients who receive three (3) or more visits within six (6) months after opening episode.

*Mental Health Client Retention by Ethnicity Report</td><td>Overall retention rates decreased from 76% in FY15-16 to 70% in FY 16-17.

<u>FY15/16</u> <u>FY16/17</u>
African American 74% 68% -
Southeast Asian/PI 75% 73% -
Hispanic 75% 72% -
Native American 77% 65% -
White American 77% 72% -
Other 68% 48% -

*The lower percentages for FY16/17 are due to a change in methodology, including the use of “visits” (one service counted per day) rather than “services” (there can be multiple services in one day). We are also working on a change for fiscal year percentages based on using any opening in the fiscal year that meets the three-visit criteria.</td></tr>
<tr><td>Quality Care</td><td>Behavioral Health Promotion, Prevention, Treatment & Recovery</td><td>The LOCUS software has been implemented for all Adult System of Care programs.

We will continue to analyze how reports are being utilized to assist with treatment decisions.</td><td>The LOCUS committee continues to meet and address training issues, report utilization, and the use of the LOCUS in treatment planning and decisions in the adult system of care.</td></tr>
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DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Recovery Principles	Behavioral Health Promotion, Prevention, Treatment & Recovery	To promote recovery and resiliency concepts in the Children's System of Care (CSOC), the Child and Adolescent Needs and Strengths (CANS) has been selected for use throughout the SOC.	The CANS committee continues to meet and discuss staff recertification in using the tool, training, report utilization, and the use of the CANS in treatment planning and decisions in the Children's System of Care.

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<tr><th>DESCRIPTION</th><th>KEY PROCESS</th><th>ACTIVITIES</th><th>STATUS</th></tr>
<tr>
<td>Cultural & Ethnic Diversity</td>
<td>Human Resource Development</td>
<td>We will maintain the current measure of cultural and ethnic diversity of our staff as related to our threshold language, which is Spanish.

This will be evidenced by measures that identify the rate to which our staff reflect the general Hispanic population and the rate to which our staff reflect our Spanish-speaking population.

FY 2016-2017 we had 617 total staff.

*Ethnicity and Language Report</td>
<td>Overall staffing of 617 decreased from the previous year of 635.

The diversity of our work force seems to have stabilized and continues to be generally reflective of our community.

The percentage of Hispanic staff and Spanish-speaking staff are shown below by work function.

<table>
<tr><th></th><th><u>FY15/16</u></th><th><u>FY16/17</u></th></tr>
<tr><td>Overall Hispanic Staff by</td><td></td><td></td></tr>
<tr><td>Function:</td><td>29.1%</td><td>31.6% +</td></tr>
<tr><td>Admin/Managers:</td><td>23.6%</td><td>29.6% +</td></tr>
<tr><td>Direct Services:</td><td>28.7%</td><td>30.4% +</td></tr>
<tr><td>Support Services:</td><td>33.3%</td><td>36.3% +</td></tr>
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<table>
<tr><th></th><th><u>FY15/16</u></th><th><u>FY16/17</u></th></tr>
<tr><td>Overall Spanish</td><td></td><td></td></tr>
<tr><td>Speaking Staff:</td><td>21.3%</td><td>22.2% +</td></tr>
<tr><td>Admin/Manager:</td><td>14%</td><td>16.1% +</td></tr>
<tr><td>Direct Services:</td><td>21.3%</td><td>21.8% +</td></tr>
<tr><td>Support Services:</td><td>24.5%</td><td>25.5 +</td></tr>
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DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Cultural & Ethnic Diversity	Human Resource Development	To improve BHRS staff awareness of individual bias and beliefs, sensitivity to behavioral health clients and other diverse populations including LGBTQ and Southeast Asian culture, and the impact of social economic status, the department provided multiple cultural competency training this fiscal year: 1) California Brief Multicultural Training for Clinical Staff. This is a requirement for all BHRS staff and is 15 hour module training. 2) Principles of Interpreting (12 hr training) 3) LGBTQ 101 Training (3 hr training) 4) Southeast Asian Culture, Immigration & Trauma Info (6 hr training) *BHRS Courses Report	Attendance: **BHRS Staff** **Partner Staff** **1)** 23 7 **2)** 33 10 **3)** 42 5 **4)** 26 0

DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Staff Satisfaction	Human Resource Development	Senior Leadership will convene all-staff meetings at least twice a year to provide information and support to staff.	We will have an all-staff meeting in October 2017. A new Behavioral Health Director started in September 2016 and therefore will facilitate his first all-staff meeting in October. He routinely updates staff by using email messages, monthly Leadership meetings and semi-annual all staff meetings.
Compliance	Ethical Behavior and Regulatory Compliance	The Mental Health Plan will have satisfactory outcomes on State audit processes as evidenced by chart audit results below the **5%** disallowance threshold.	We participated in the Triennial review in January 2017. Our Systems Review overall percentage of compliance is **95%**. Our Chart Review overall percentage (prior to our appeal, which was accepted) is **96.4%**. We have met our goal.

QMT WORK PLAN - FY 2017-2018

DESCRIPTION	KEY PROCESS	ACTIVITIES	TARGET DATE
Customer Satisfaction	Customer Service	Our internal and external customers will be satisfied with the services they receive as evidenced by meeting or exceeding our customer satisfaction results for **FY 2016-2017**.	**6/30/18**
Customer/Family Member Involvement	Customer Driven Services	Consumers and family members will participate in workgroups and stakeholder meetings throughout the fiscal year. They will also participate in standing committees of the department, e.g., Cultural Competence Oversight Committee.	**6/30/18**
Penetration	Easy Access to Services	We will continue to calculate penetration rates and analyze quarterly reports to establish our baseline and penetration targets.	**6/30/18**
Client Retention	Behavioral Health Promotion, Prevention, Treatment & Recovery	We will provide services in a culturally competent way as evidenced by such measures as the retention rate, which is the percentage, by ethnicity, of clients who receive three (3) or more visits within six (6) months after opening episode. We will continue to monitor for improvement of the overall retention rate for Medi-Cal beneficiaries, while maintaining equal distribution among client groups by ethnicity.	**6/30/18**

DESCRIPTION	KEY PROCESS	ACTIVITIES	TARGET DATE
Quality Care	Behavioral Health Promotion, Prevention, Treatment & Recovery	The LOCUS software has been implemented for all Adult System of Care programs. The LOCUS committee will review reports and establish goals for consistent use among all adult programs. They will ensure that consistent training is conducted for new staff.	**6/30/18**
Recovery Principles	Behavioral Health Promotion, Prevention, Treatment & Recovery	To promote recovery and resiliency concepts in the Children's System of Care, the Child and Adolescent Needs and Strengths (CANS) has been selected for use throughout the SOC. We will analyze quarterly reports to determine that the CANS is being completed and utilized during the course of treatment to assist in treatment planning needs.	**6/30/18**
Cultural & Ethnic Diversity	Human Resource Development	We will maintain the current measure of cultural and ethnic diversity of our staff as it relates to our threshold language, which is Spanish. This will be evidenced by measures that identify the rate to which our staff reflect the general Hispanic population and the rate to which our staff reflect our Spanish-speaking population.	**6/30/18**

DESCRIPTION	KEY PROCESS	ACTIVITIES	TARGET DATE
Cultural & Ethnic Diversity	Human Resource Development	To improve BHRS staff awareness of individual bias and beliefs, sensitivity to behavioral health clients and other diverse populations including older adults, LGBTQ, and the impact of social economic status, we will continue to utilize the California Brief Multicultural Competence Scale (CBMCS) training curriculum. This is required for all BHRS staff. The CCESJC committee will continue to monitor the Cultural and Linguistically Appropriate Services (CLAS) standards within the Department. The department will continue to also provide other culturally competent training to BHRS and Partner staff as appropriate.	**6/30/18**
Cultural & Ethnic Diversity	Community Capacity Building	Continue to develop the community's capacity to support the individuals living in those communities to enhance their emotional well-being.	**6/30/18**
Staff Satisfaction	Human Resource Development	Senior Leadership will convene all-staff meetings at least twice a year to provide information and support to staff.	**6/30/18**
Compliance	Ethical Behavior and Regulatory Compliance	Staff will be in compliance with required law and ethics training.	**6/30/18**