Trinity County Behavioral Health
Annual Quality Management/Quality Improvement Work Plan FY 2019-20

A. Service Delivery Capacity

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Lead Person	Auditing Tool	Due Date/ Completion Date	Outcome Data / Trends	Possible Improvements and Results
Obtain bi-monthly reports to measure and ensure 100% of all Zip Codes in Trinity County have Medi-Cal access to TCBHS 1. Location of clients receiving services by zip code, age, and gender. 2. Types of services clients are receiving by zip code, age, and gender	**Generate reports for Evaluation** by QA Dept. and/or Leadership be presented to QIC on a bi-monthly basis.	DDQA or Designee	Reports and Dashboards utilizing data on Anasazi and monthly Penetration Reports.	Due: 06/30/20 Completed:	**8/2019 Report:**. Leadership noticed the high amount of Individual Therapy, Rehab, and Med. Mgmt. services results in a lower crisis services. **10/2019 Report:** **12/2019 Report:** **2/2020 Report:** **4/2020 Report:** **6/2020 Report:**	

B. Beneficiary/Family Satisfaction

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Lead Person	Auditing Tool	Due Date/ Completion Date	Outcome Data / Trends	Possible Improvements and Results
1. Develop new techniques to increase response rate to Client Satisfaction Survey to 50% of clients, for a semi-annual distribution	1. Distribute survey at both outpatient sites 2. Utilize new computers and/or paper version with peer support to administer the survey 3. Results will be shared with stakeholders, clients, staff, etc.	DDQA or Designee	1-2. Survey Monkey to key results 3. Meeting minutes, postings, etc.	1-2. Due Completed: 3. Due Completed:	**Date Survey Conducted:** **Date Results shared with:** Stakeholders: Clients: at individual appts. Staff: QIC:	
2. Obtain an 80% score on the annual Provider Satisfaction Survey.	Have internal and external providers complete the provider satisfaction surveys	DDQA or Designee	Survey Monkey (Provider satisfaction	Due: completed:	Date Survey Conducted: **Date Results shared with:** Staff: QIC:	

Monitor and measure trends.	annually and compile and share results with Staff and QIC.		survey forms)			
3. Obtain a 30% Client response rate to the post-discharge client quarterly telephone survey.	1. Have former clients: a) Complete surveys b) Answer Post Discharge Telephone Survey 2. Generate quarterly Discharge Reports for evaluation 3. Compile and communicate results	DDQA or Designee	Front Desk conduct Survey via telephone calls.	Due: 06/30/20 Completed:	**Discharge Data Reports and Phone Surveys conducted quarterly:** Leadership evaluated Discharge Data for FY 18-19 and detected a trend of 25% of all discharges show clients stopped coming without explanation. **1st Qtr. July-Sept., 2019:** **2nd Qtr. Oct. -Dec., 2019:** **3rd Qtr. Jan. -Mar., 2020:** . **4th Qtr. Apr. – June, 2020:**	A - Leadership will add a brief survey question section to the 30-day letter, asking why the client is no longer coming to TCBHS. A stamped return envelope will be included – to see if more information can be obtained. B – TCBHS Clinical Staff will receive refresher training for Discharge reasons to ensure uniformity. C- Med Records removed Crisis open/close Discharges out of data, resulting in a 28% of all discharges show clients stopped coming without explanation. **RESULTS:**
4. Ensure 100% Response to all Grievances. Review and monitor, together with Change of Provider requests. Ensure grievances, appeals and fair hearings, are input in Log within one working day. Standard Investigations to be completed, and beneficiaries notified of resolutions, within 30 calendar days. Appeals and Fair Hearings logged and processed in accordance with Final Rule time frames.	1. Maintain a Monitoring Log 2. Report to State annually and Review report with QIC bi-monthly.	DDQA or Designee	Grievance forms, appeal forms, change of provider requests, Monitoring Log /reports with trends.	Due: 10-1-21 to State **Completed:** 8-1-21	**8/2019 Report:** **10/2019 Report:** **12/2019 Report:** **2/2020 Report** **4/2020 Report:** **6/2020 Report:**	

C. Service Delivery System/Clinical Issues

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Lead Person	Auditing Tool	Due Date/ Completion Date	Outcome Data / Trends	Possible Improvements and Results
1. Annual Clinical Documentation training for all MHP provider staff	Update annual clinical documentation training and provide to all MHP staff	DDQA or designee AND Triage/ UR Manager in consultation with Clinical Director	1. Training handouts 2. Staff sign-in sheets 3. QA/ QIC Minutes	Due: 6/30/20 Completed:		
2. 100% of Hospital charts will be reviewed to determine appropriateness of admission, length of stay, and recommendations, to ensure the validity of hospitalizations. a. Monitor to ensure Re-Hospitalization Rate of all hospitalizations are within 30 days. b. Increase rate of Post Discharge Follow-Up to 80% within 7 days	1. Charts will be reviewed concurrently within 1 Business Day of admission. 2. Leadership will analyze for Cost/Benefit Savings use of Cedar Home to determine any decrease in Hospitalizations.	Clinical Director, Medical Director	1. TARS, Concurrent Reviews, Hospitali-zation Rpt, including Re-Hospitali-zations, and Post Discharge Follow-Up rates. 2. Cedar Home Report to QIC.	Due: bi-monthly	**8/2019 Report:** **10/2019 Report:** **12/2019 Report**: **2/2020 Report:** **4/2020 Report:** **6/2020 Report:**	
3. 20% of Clinical Charts to be reviewed annually. Evaluate services and documentation. Error	Medical Records to assign charts to be reviewed, then monitored by UR Team at	Triage/ UR Manager or	Client review chart tool	**Ongoing activity** Due: 6/30/20	**8/2019 Report:** **10/2019 Report:**	

rates will meet state expectations of 3%	monthly meetings, and logged in UR Binder.	designee, Clinical Supervisors, staff	Chart Review tracking Log.	Completed:	**12/2019 Report:** **S/2020 Report:** **4/2020 Report:** **6/2020 Report:**	

D. <u>Monitor Safety and Effectiveness of Medication Practices</u>

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Lead Person	Auditing Tool	Due Date/ Completion Date	Outcome Data / Trends	Possible Improvements and Results
1. Promote safe medication prescribing practices 2. 100% Evaluation of all Charts for effectiveness of prescribing practices	1. Monthly medication monitoring of clients receiving medication services by the staff nurses 2. Review prescribing practices and provide feedback to Medication Mgmt. Committee. 3. Use of practice guidelines approved by the Medication Mgmt. Committee will be found in 95% of charts reviewed by nurses. 4. Random charts and charts requested for review monthly. Not less than 2 charts will be reviewed weekly 5. Results will be discussed at the bi-monthly QIC meeting	Medical director Nurses	1-2. Bi-monthly report to QIC committee 3. Nurses will evaluate MD prescription practices according to guidelines approved by the Medication Monitoring Committee and established practices. 4. QIC Minutes	**Ongoing activity** Due: 6/30/20 Completed:	**8/2019 Report:** **10/2019 Report:** **12/2019 Report:** **2/2020 Report:** **4/2020 Report:** **6/2020 Report:**	

E. Continuity and Coordination of Care with Physical Health Providers

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Lead Person	Auditing Tool	Due Date/ Completion Date	Outcome Data / Trends	Possible Improvements and Results
1. Coordination of physical health care services for clients a. Generate or Renew Emergency Room MOU with Mountain Communities Health Care District (MCHCD). b. Client Vitals uniformly measured and provided, upon Psychiatrist request, prior to all psychiatry and telepsychiatry appointments.	1. Meet monthly with local collaboration to improve needs of community 2. Attend state meetings to stay informed and bring updates to local level 3. Work to improve the communication between the psychiatrist and primary care physician regarding clients who need close monitoring of medical condition and medications	Agency Dir. Clinical Dir. Medical Dir.	QIC Minutes	Due: 6/30/20 Completed:		

F. Meaningful Clinical Issues/ Other System Issues

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Lead Person	Auditing Tool	Due Date/ Completion Date	Outcome Data / Trends	Possible Improvements and Results
1. Scan charts into EHR, continue the process of converting to paperless	1. Scanning documents into the electronic health record	DDQA or Designee	Monitoring/ Tracking for scanned docs and Anasazi document mgmt. program	Due: 6/30/20 Completed:	**8/2019 Report:** **10/2019 Report:** **12/2019 Report:** **2/2020 Report:** **4/2020 Report:** **6/2020 Report:**	

G. Performance Improvement Projects (work in progress, will change)

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Lead Person	Auditing Tool	Due Date/ Completion Date	Outcome Data / Trends	Possible Improvements and Results
1. Continue Clinical Performance Improvement Project (PIP) to decrease or better manage Anxiety symptoms of client population, ensure accurate data collection and analysis for improvement of clients' mental health.	1.Determine a needed improvement and find proof of need. 2.Use interventions to attempt improvement in area of needed change. 3.Use measurement tools to analyze effects of intervention. 4.Report to QIC and EQRO	PIP committee	1. PIP Meeting minutes 2. Quarterly Adult Needs and Strengths Assessment (ANSA) Reports 3. EQRO Roadmap	Due: 4/1/2020 – QIC report Completed:	**8/2019 Report:** **10/2018 Report:** **12/2019 Report:** **2/2020 Report:** **4/2020 Report:** **6/2020 Report:**	
2. Complete Non-Clinical Performance Improvement Project (PIP) which will improve Timeliness in Access to the Agency.	1.Determine a needed improvement and find proof of need. 2.Use interventions to attempt improvement in area of needed change. 3.Use measurement tools to analyze effects of intervention. 4.Report to QIC and EQRO	PIP committee	1. PIP Meeting minutes 2. Monthly Access to Services Assessment (ASA) Reports 3. EQRO Roadmap	Due: 4/1/2020 Completed:	**8/2019 Report:** **10/2019 Report:** **12/2019 Report:** **2/2020 Report:**. **4/2020 Report:** **6/2020 Report:**	

H. Accessibility of Services

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Lead Person	*Auditing Tool*	*Due Date/ Completion Date*	Outcome Data / Trends	Possible Improvements and Results
1. Conduct 2 Test Calls per month for 100% responsiveness of the 24/7	Test 800 and local number during and/or after regular business hours for 24/7 responsiveness in English or other languages.	DDQA or designee	Test Call form and overnight log of calls from contractor	Due: bi-monthly and 6/30/209 Completed:	**8/2019 Report:** 2 Test Calls in July, 1 for Access, and 1 for Crisis = both PASSED**.** **10/2019 Report:**	

access to services telephone line (toll free and local lines).					**12/2019 Report**: **2/2020 Report:** **4/2020 Report:** **6/2020 Report:**	
2. 100% success rate of length of time from initial request/referral to first appointment. Adult Services—10 days Youth Services—10 days	Monitor average length of time from first request for service to first clinical assessment. Report to QIC Bi-Monthly	DDQA, Clinical Director, or designee, and QIC	Anasazi data Crisis / Access Log	Due: 6/30/20 Completed:	Percentage of requests that were offered scheduled Assessment Appts. within policy time frames. **8/2019 Report:** **10/2019 Report:** **12/2019 Report:** **2/2020 Report:** **4/2020 Report:** **6/2020 Report:**	
3. 100% response to client access of after-hours care. Track response time, by on call crisis worker to hospital (within one hour), once the medical clearance of consumer has been announced.	Maintain and monitor Crisis treatment availability outside of regular business hours.	Triage / UR Manager and Clinical director	Crisis Nightline Service data Anasazi data After-hours electronic log	Due bi-monthly reporting and 6/30/20	**8/2019 Report** **10/2019 Report:** **12/2019 Report:** **2/2020 Report:** **4/2020 Report:** **6/2020 Report:**	
Overall Goal/Objective	**Planned Steps and Activities to Reach Goal/Objective**	**Lead Person**	**Auditing Tool**	**Due Date/ Completion Date**	**Outcome Data / Trends**	**Possible Improvements and Results**

4. 100% Success rate for length of time from initial request/referral to first psychiatry appointment Adult/Older Adult—15 Business days Child/Youth—15 Business days	Monitor average length of time from first request for psychiatric appointment/assessment and report bi-monthly to QIC.	DDQA or designee, Medical Director	Anasazi data	Due: 6/30/20 Completed:	**8/2019 Report:** **10/2019 Report:** **12/2019 Report:** **2/2020 Report:** **4/2020 Report:** **6/2020 Report:**	
5. Respond to 100% of requests for appointments for urgent conditions within 1 hour	Monitor and look for trends of average length of time for response to an urgent condition- Report Bi-monthly to QIC	DDQA or designee	Anasazi data Crisis / Access Log	Due: 6/30/20 Completed:	**8/2019 Report:** **10/2019 Report:** **12/2019 Report:** **2/2020 Report:** **4/2020 Report:** **6/2020 Report:**	
6. 100% of Offered follow-up services after hospitalization provided with 7 days.	Track average length of time for an offered follow-up appt. to clients returning to Trinity County, after hospital discharge.	DDQA or designee	Anasazi data	Due: 6/30/20 Completed:	1. **Total number of hospital admissions:** July: Aug: Sept.: Oct.: Nov: Dec.-thru May: June: 2. **Total number of follow-up contacts:** July: Aug: Sept: Oct: Nov: Dec. - May:	

					June:	
7. Monitor hospitalizations per month.		DDQA or designee, Triage Manager	Anasazi data Hospitalization monitoring Log	Due: 6/30/20 Completed:	1. **Total number of hospital admissions:** July – Aug. – Sept. - Oct. – Nov – Dec. – Jan. – Feb. - Mar – Apr – May - June - **Total number with readmission within 30 days:**	
8. Ensure less than 30% NO Shows/ Cancellations rate	Tract percentage of appointments that met standards (set during FY 15-16).	DDQA or designee	Anasazi data	Due: 6/30/20 Completed:	1. **Average no shows/Canc for clinicians/non-psychiatrists:** **1st Qtr.:** Weaverville - Hayfork - **2nd Qtr.:** Weaverville - Hayfork – **3rd Qtr.:** Weaverville – Hayfork – **4th Qtr.:** Weaverville – Hayfork – 2. **Average no-shows for psychiatrists:** **1st Qtr.:** Weaverville - Hayfork - **2nd Qtr.:**	

					Weaverville – Hayfork – **3rd Qtr.:** - Weaverville – Hayfork – **4th Qtr.** – Weaverville - Hayfork -	
9. Respond to 100% of calls from the jail within 1 Business Day.	Track percentage of crisis calls that met standards	Triage Manager, or designee	Jail Log - Data submitted by crisis staff	Due: 6/30/20 Completed:	**8/2019 Report:** **10/2019 Report:** **12/2019 Report:** **2/2020 Report:** **4/2020 Report:** **6/2020 Report:**	

I. Compliance with Requirement for Cultural Competence and Linguistic Competence

Overall Goal/Objective	Planned Steps and Activities to Reach Goal/Objective	Lead Person	Auditing Tool	Due Date/ Completion Date	Outcome Data / Trends	Possible Improvements and Results
1. Begin penetration of isolated Elderly population.	1. Implement suggestions/ recommendations of Golden Age Center / Roderick Center in Hayfork.	Cultural Competency Committee, Itinerant Case Manager / Peer Specialist	1. Anasazi reports 2. EQRO Reports on penetration rates	Due: 6/30/20 Completed:		
2. 2 bi-annual Client/ Family member sensitivity trainings - 1 Consumer Perspective 1 Organization Presentation	Provide annual trainings for staff regarding client/ family member perspectives and cultures	Cultural Competency Committee	Training sign-in sheets, Client/ family member satisfaction survey, fliers	Due: 6/30/20 Completed:		
3. Provide 1 Itinerant Case Manager / Peer	Cultural Competency Committee (CCC) will	CCC	1. CCC Meeting minutes.	Due: 6/30/20		

Specialist, annually, to conduct groups and activities within other Agencies an outreach attempt.	assess Itinerant Case Manager / Peer Specialist activities for improvement, or outreach direction, and give recommendations to Leadership.	Itinerant Case Manager / Peer Specialist	2. QIC Meeting minutes. 3. Photos, videos, client satisfaction survey results	Completed:		
4. All policies, forms, and procedures, to be sensitive to race, culture, gender, and sexual identity.	CCC Chair will consult with Latino, Native American and LGBTQ to examine policies/procedures/forms, building sites, etc.	Cultural Competency Committee	Review of forms by consultants	Due: 6/30/20 Completed:	Every new, revised, or updated Policy is reviewed for Gender, sexual identity, and cultural/race issues for neutrality on an ongoing basis.	