**I. 2014-2015 Goals and Objectives**

The following goals and objectives are based upon the four DHCS Managed Care contract requirements for quality improvement work plans:

1. **Accessibility of Services**

The MHP is responsible for monitoring accessibility of services. In addition to meeting statewide standards, the MHP will set goals for timeliness of routine mental health appointments and urgent care conditions; access to afterhours care; and 24-hour responsiveness.

1. **Service Delivery Capacity**

The MHP is responsible for the monitoring of service delivery capacity. The MHP will evaluate the distribution of mental health services by type of service and geography of client within its delivery system.

The MHP currently contracts with three youth organizational providers for Medi-Cal outpatient specialty mental health services. The providers serve a specific catchment area to ensure all geographic areas of the County are provided service.

The MHP currently contracts with two providers for wellness center services (Round Mountain and Redding) to provide supportive assistance to individuals with mental health challenges.

The MHP contacts with all Federally Qualified Health Centers (FQHC’s) in Shasta County for services provided in Redding, Shasta Lake City, Anderson, Shingletown, Round Mountain, Burney and Fall River Mills. For those clients that do not meet the MHP target population, the FQHC’s provide primary and mental health care.

1. **Beneficiary Satisfaction**

The MHP in partnership with the Managed Care program and QIC are responsible for monitoring beneficiary satisfaction and ensuring that beneficiaries are informed of their rights and the problem resolution process. The Managed Care program reports annually to DHCS on all grievances and appeals and their outcomes. The findings are reported to the QIC for review and implementation of new or revised policies and procedures.

1. **Service Delivery System and Meaningful Clinical Issues**

The MHP, in partnership with the Managed Care Program and QIC will monitor the service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices. The MHP shall annually identify meaningful clinical issues that are relevant to its beneficiaries for assessment and evaluation.

**Accessibility of Services**

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| **Goal 1: Foster new and sustain existing collaborations with HHSA staff and other partners to create a community-based spectrum of mental health treatment services.** | **Processes to Evaluate** |
| **Objectives:**1. Evaluate current system for processing initial service requests to determine if resources can be reallocated, improved, or created for continued support of client wellness and recovery.

**Measurement:**1. Increase the percentage of clients who receive first clinical assessment within 20 days from the first request for services from 86% to 90%.

**Target was met for all ages and quarters except for Q3 for youth.**1. Increase the percentage of clients who receive first psychiatrist appointment within 30 days of first request for services from 64% to 68%.
2. All random test calls requesting crisis services will comply with 24/7 crisis response protocols.
3. Decrease average length of time between medical clearance and client disposition determination by 10% from FY12/13 baseline.
 | 1. Dates for request for service and 1st assessment will be generated from Anasazi billing system.
2. Dates for request for service and initial medication evaluation will be generated from Anasazi billing system.
3. Random test call logs will be gathered on a quarterly basis to determine percentage of calls that follow the 24/7 crisis response protocols.
4. Urgent care database will be used to calculate average length of time between medical clearance and client disposition determination.
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| 1. Assess accessibility of services for underrepresented cultures including, but not limited to, Hispanic, Mien, Black, Native American, Indian, and Lesbian/Gay/Bisexual/Transgender/Questioning (LGBTQ).

**Measurement:**1. 85% of random test calls requesting mental health services will demonstrate staff proficiency with language line transfers, accessibility of interpreted materials and interpreters.
2. Increase participation of MHP and organizational provider staff in cultural competency training activities from 50% to 75%.
3. The MHP Cultural Competency Committee will meet a minimum of quarterly and will:

1. Develop a FY14/15 Cultural Competency Plan; and2. Develop a FY15/16 QM Workplan Goal. | 1. Random test calls logs will be reviewed to determine percentage of calls that staff demonstrated proficiency with language line transfers, accessibility of interpreted materials and interpreters.
2. Sign in sheets will be gathered at each Cultural Competency Training to determine the percentage of attendees.

c. The Cultural Competency Committee will submit a FY1415 Plan to DHCS and submit a recommended QM Workplan Goal to the QI Coordinator |
| 1. Improve penetration rates of underserved populations.

**Measurement:**1. Increase Medi-Cal penetration rates among underserved populations identified in the 2011 External Quality Review Organization (EQRO) report by 10% based on the most recent available data.
 | 1. The Monthly Medi-Cal Eligibility File will be used to measure quarterly penetration rates by gender, age group, and race/ethnicity.
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**Service Delivery Capacity**

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| **Goal 2: Ensure that MHP services and resources are appropriately allocated to address mental health treatment needs.** | **Processes to Evaluate** |
| **Objectives:**1. Maintain an ongoing evaluation of clients by geographic area to assess population needs and allocation of treatment resources in areas of most need:

**Measurement:**1. Resources for the provision of services will be allocated throughout Shasta County based on needs identified by ongoing data collection and reporting.
 | 1. Client zip code and service type will be gathered from Anasazi billing system.
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| 1. Evaluate crisis prevention and discharge planning activities for clients at risk of hospitalization or have been hospitalized in the previous 12 months. Identify options for training, reallocation of resources, or other supports to assist staff with workload:

**Measurement:**1. Decrease psychiatric inpatient rehospitalization within 30 days by 10% from FY09/10 percentage of rehospitalizations.
 | 1. Client discharge date will be gathered from Urgent Care database and matched with prior hospitalizations in previous 30 days
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| 1. Ensure all clients experiencing inpatient hospitalization receive appropriate follow up discharge contact.

**Measurement:**a. Establish a baseline of Adult clients that receive follow up psychiatrist contact within 7 days of discharge, and increase by 10% over baseline.b. Establish a baseline of Youth clients that receive follow up psychiatrist contact within 14 days of discharge, and increase by 10% over baseline. | a. & b. Client discharge date, discharge plan and appointment date will be gathered from Urgent Care Database to determine length of time for follow up discharge contact. |

**Beneficiary Satisfaction**

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| **Goal 3: Provide a meaningful experience for individuals who receive mental health services in Shasta County.** | **Processes to Evaluate** |
| **Objectives:** 1. Conduct client satisfaction surveys (POQI) annually as required by DHCS.

**Measurement:*** 1. Evaluate POQI 2012 survey results and improve client satisfaction by 10% of the difference between 2012 baseline and the goal of 95% that Agree or Strongly Agree in:

Adult1. “I like the services that I received here”.2. “I was able to get all the services I thought I needed”.Youth1. “Overall, I am satisfied with the services I received”.2. “I got as much help as I needed.”Youth Caregiver1. “My family got as much help as we needed for my child”b. Client participation and response rate to annual POQI surveys will increase by 10% for each subsequent year from August 2012 survey results.  | a. Distribution of responses to selected questions from annual POQI surveys will be compared to 2012 baseline.b. Count of participants in annual POQI surveys will be compared to 2012 baseline**.** |
| 1. Conduct client satisfaction surveys on a regularly scheduled basis and include the adult, youth and organizational provider clients.

**Measurement:*** 1. Client participation and response rate to ongoing Mental Health Services Act (MHSA) and Crisis Residential and Recovery Center (CRRC) surveys will increase by 10% from FY12/13 response rate.
 | a. Count of participants in ongoing MHSA and CRRC surveys will be compared to FY12/13 baseline**.** |
| 1. Timely resolution of all client grievances.

**Measurement*** 1. Ensure 100% of client grievances are appropriately resolved within 60 days, or within the 14 day extension if applicable.
	2. Maintain FY11/12 level of zero NOA-E’s issued.
 | 1. Review grievance log to count the percent of grievances appropriately resolved within 60 days, or within the approved 14 day extension
2. Review NOA log to monitor the number of NOA-E’s issued.
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| 1. Consumers and family members are employed and/or volunteer in key roles throughout the MHP.

**Measurement*** 1. Maintain consumer and family member participation in MHP committees, by attendance of a minimum of once per quarter, including the Mental Health Alcohol and Drug Advisory Board (MHADAB), Quality Improvement Committee (QIC), Advancing Recovery Performance Improvement Project (ARC), Triple P Performance Improvement Project, and Cultural Competency Committee (CCC).
 | a. Facilitator of each group will be surveyed on a quarterly basis to determine committee participation in the last 3 months. |
| 1. Implement MORS throughout Adult Services as a recovery measurement tool.

**Measurement:**a. Upon implementation of MORS, 90% of adult clients participating in the Advancing Recovery (ARC) Performance Improvement Project will receive a MORS assessment at least quarterly. | a. Client information will be reviewed to measure percentage that received quarterly MORS assessment. |

**Service Delivery System and Meaningful Clinical Issues**

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| **Goal 4: Develop an infrastructure of continuous quality improvement that supports wellness and recovery in Shasta County.** | **Processes to Evaluate** |
| **Objectives:**1. Ensure that clinical practices are safe, effective and support wellness and recovery in Shasta County.**Measurement:**1. All newly hired staff, in job specifications that require it, will receive Core Skills training.
2. Increase the percentage of Medi-Cal beneficiaries with a physical activity (4.1%) and/or contact with nature (1.1%) related objective included in their Treatment Plan by 10% from FY1213.
 | a. Review HR database and attendance sheets to determine staff that received Core Skills training.b. Treatment plan review checklist will be used to determine percentage of treatment plans with a physical activity/nature related objective. |
| 2. Utilize the two Performance Improvement Projects (PIPs) to improve wellness and recovery.**Measurement:**1. Ensure clients participating in the Advancing Recovery PIP demonstrate the following objectives:
2. At least 50% will be able to identify one family or community support
3. At least 30% will report participation in meaningful relationships and/or activities when surveyed
4. At least 50% will identify a short-term recovery goal linked to usable strengths
5. At least 80% have a designated PCP
6. At least 50% have at least one PCP visit in the last 12 months
7. Less than 10% are homeless
8. Set wellness and recovery measurements for youth PIP, including process to evaluate.
 | * 1. Client data in Recovery Tracker will be reviewed to monitor percentage of clients meeting each goal.
	2. Youth PIP committee will determine measurements.
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| 3. Review medication practices for safety and effectiveness.**Measurement**:1. Define the medication practices that will be evaluated for safety and effectiveness.

b. Develop data measures and collection methodologies to monitor medication practices. | TBD |
| 4. Monitor provider appeals for timeliness of resolution.**Measurement:**a. 100% of provider appeals will be resolved within the state mandated timeframe. | a. Review provider appeal logs to count percentage of appeals appropriately resolved within state mandated timeframe. |