Shasta County Mental Health Plan
Quality Improvement Work Plan
Fiscal Year 2022-2023

Table of Contents

Quality Assessment and Performance Improvement Program Overview

A. Quality Assessment and Performance Improvement Program Characteristics

In accordance with the California Code of Regulations requirements in Title 9, Section 1810.440 and in accordance with the terms of the contract with the California Department of Health Care Services (DHCS), Shasta County Health and Human Services Agency (HHSA) through its Mental Health Plan (MHP) has established a Quality Assessment and Performance Improvement (QAPI) Program and develops an Annual Quality Improvement Work Plan (QIWP) that describes the quality improvement activities, goals, and objectives for the MHP.

The purpose of the QIWP is to provide up-to-date information that can be utilized by internal and external stakeholders as a resource and practical tool for informed decision making and planning. It includes performance improvement projects (PIPs), activities, and processes as required by the MHP contract with DHCS.

It is the goal of Shasta County HHSA to build a structure that ensures overall quality of services. This goal is accomplished by realistic and effective QI activities and data-driven decision making, collaboration amongst staff, including beneficiaries and family members, and utilization of technology for data and analysis. Through data collection and analysis, significant trends are identified, and policy and system-level changes are implemented, when appropriate.

Additionally, Shasta County HHSA strives to follow our Vision, Mission, and Values, as follows:

Our Vision:
Healthy people in thriving and safe communities.

Our Mission:
To engage individuals, families, and communities to protect and improve health and wellbeing.

Our Values:
Collaboration: Working together to achieve meaningful results
Adaptability: Embracing change
Respect: Honoring and serving others
Excellence: Providing high-quality service to our customers and community

B. Quality Assessment and Performance Improvement Program Components

The QI Coordinator or designee is responsible for facilitating Quality Improvement Committee (QIC) meetings and ensuring participants receive up-to-date information.

The QIC is responsible for monitoring the overall effectiveness of the MHP. This involves review and evaluation of Quality Management (QM) and QI activities; auditing, tracking, and monitoring; communication of findings; implementation of needed actions; ensuring follow-up for QM program processes; and recommending policy or procedural changes related to or because of these activities.

The QIC monitors:

- 24/7 Crisis Line Response
- Accessibility to Services
- Assessments of Beneficiary and Provider Satisfaction
- Clinical Documentation and Chart Review
- Credentialing Process/Monitoring
- Cultural Competency Activities
- Notices of Adverse Beneficiary Determinations
- Performance Improvement Projects
- Practice Guidelines
- Resolution of Grievances, Appeals, and Fair Hearings
- Resolution of Provider Appeals
- Training
- Utilization Management/Review

The QIC is comprised of representatives from Adult and Children's Services; Mental Health Services Act (MHSA) Advisory Committee; Compliance and Quality Improvement; Utilization Management and Quality Assurance; Fiscal; Business Office; Outcomes, Planning & Evaluation (OPE); Patients' Rights; and contracted providers as well as beneficiaries and their family members.

It is the goal of the QIC to build a structure that ensures the overall quality of services, including detecting both underutilization of services and overutilization of services. This is accomplished by realistic and effective quality improvement activities; data-driven decision making; collaboration amongst staff, including beneficiary participants and their family members; and utilization of technology for data analysis. Executive management and program leadership must be present to ensure that analytical findings are used to establish and maintain the overall quality of the service delivery system and organizational operations.

The QIC meets quarterly to monitor the status of the above items and make recommendations for improvement. Meeting reminders, information, and minutes are sent in advance and are also available on the HHSA share drive. These minutes reflect all activities, reports, and decisions made by the QIC. The QIC ensures that client confidentiality is protected during meetings, in meeting minutes, and in all other communications related to QIC activities.

Each participant is responsible for communicating QIC activities, decisions, policy, or procedural changes to their program areas, and reporting back to the QIC on action items, questions, and/or areas

of concern. To ensure that ongoing communication and progress is made to improve service quality, the QIC defines goals and objectives on an annual basis that may be directed toward improvement in any area of operation providing specialty mental health services.

C. Quality Improvement Committees and Sub Committees

The QI Work Plan is evaluated and updated annually by the QI Coordinator, QIC, and MHP management team. The QI Coordinator is responsible for finalization and submission of the QI Work Plan but will rely on the input and subject matter expertise of program and other work groups as needed to ensure an appropriate plan is written. In addition, QIC will collaborate with other stakeholders, work groups, and committees, including but not limited to:

- MHP Cultural Competency Committee (CCC)
- Compliance Committee
- Medical Staff Meetings
- Mental Health Alcohol and Drug Programs Board
- MHP Community Education Committee
- MHP & Public Guardian Placement Meetings
- MHP Clinical Care Meetings
- MHP Electronic Health Records (EHR)
- MHP Management Team
- MHSA Advisory Committee
- Organizational Provider Meetings
- Performance Improvement Process Committees
- Performance Improvement Project Workgroup
- Shasta County Continuum of Care
- Suicide Prevention Workgroup
- Utilization Review Committee

Quality Improvement Program Components

A. Evaluation of Overall Effectiveness

An evaluation of the overall effectiveness of the QI program is completed routinely as well as annually. QI activities have accomplished the following:

- Contributed to improving clinical care
- Contributed to timely access to services
- Contributed to improving client services
- Incorporated relevant cultural competence and linguistic standards to match clients' cultural and linguistic needs with appropriate providers and services

B. QIC Meetings

The QIC meetings may include, but are not limited to, the following agenda items:

- Review reports to help identify trends in client care, timeliness of access, timeliness of medication treatment plan submissions, services, and trends related to the utilization review and authorization functions
- Review and evaluate summary results of QI activities, including progress on the development and implementation of the two (2) Performance Improvement Projects (PIP)
- Review data from Access Logs showing responsiveness of the 24-hour access line
- Assess client satisfaction surveys results for assuring access, quality, and outcomes
- Review any issues related to grievances and/or appeals: the QIC reviews appropriateness of the Shasta County MHP response and significant trends that may influence policy- or program-level actions, including personnel actions
- Review any provider appeals, requests for State Fair Hearings, as well as review results of such hearings
- Review cultural competency issues or concerns
- Review HIPAA compliance issues or concerns
- Monitor issues over time and make certain recommended activities are implemented, completing the QI feedback loop

C. Performance Improvement Plan (PIP)

A PIP is defined by the Centers for Medicare and Medicaid Services (CMS) as "a project designed to assess and improve processes, and outcomes of care that is designed, conducted and reported in a methodologically sound manner." The CMS External Quality Review protocol mandates that the assigned External Quality Review Organization (EQRO) validate one clinical and one non-clinical PIP for each MHP.

Included in EQRO requirements and the California Code of Regulations, Title 42, the QIC is responsible for coordinating, organizing, and supporting PIPs from and throughout the organization. To be responsive and transformative, Shasta County MHP will continue its work on PIPs focused on:

1. Active Clinical PIP (Applied Behavioral Analysis)

Shasta County's clinical PIP is focused on reducing anxiety levels in children between the ages of 3 to 13. The Children's Services Branch has implemented Applied Behavioral Analysis (ABA) in youth diagnosed with depression and anxiety as an evidence-based clinical intervention designed to decrease risk behaviors and improve treatment efficacy by using positive reinforcement. This clinical PIP intervention is in the first remeasurement phase.

- **Monitoring mechanisms**: PIP committee meetings, QIC meetings, QIC Data meetings.
- **Planned actions**: See meeting minutes and PIP documentation for details.
- **Baseline**: PIP baseline data recorded in the PIP documentation.
- **Timeline:** January 2022 through July 2023.

2. Active Non-Clinical PIP (Reduce No-Show Rates)

Shasta County's non-clinical PIP is focused on reducing the beneficiary no-show rate by 5% (from 14% to 13.3%) for adult beneficiaries in the subunit 5151 BRES-Adult Service population through educational interventions and promoting the transportation options available through the MHP and Partnership HealthPlan.

- **Monitoring mechanisms**: PIP committee meetings, QIC meetings, QIC Data meetings.
- **Planned actions**: See meeting minutes and PIP documentation for details.
- **Baseline**: PIP baseline data recorded in the PIP documentation.
- **Timeline:** August 2021 through July 2023

D. Inclusion of Cultural and Linguistic Competency in QI Activities

The Shasta County MHP recognizes and incorporates the value of racial, ethnic, cultural, and linguistic diversity into the fabric of our planning and development of processes while maintaining an active MHP Cultural Competency Committee (CCC).

The CCC is co-chaired by the MHP's Ethnic Services Coordinator and QI Coordinator, allowing for an open line of communication between the CCC and the QIC. This communication flow allows for a broad representation of ideas and concerns throughout the MHP and promotes the adoption of the CCC's objectives into QI activities.

Data Collection

A. Data Collection Sources and Types

Shasta County utilizes data from various sources as part of the decision-making process including, but not limited to, the following data sources and types:

a. EHR reports
b. Treatment Authorization Requests (TAR) and Inpatient Logs
c. Client Grievance/Appeals Logs
d. Change of Provider Logs
e. Special reports/findings from DHCS or studies in response to contract requirements
f. EQRO Review results

g. Triennial Medi-Cal Audit results
h. Utilization of Services
i. Test Call Logs
j. Compliance Log
k. Urgent Care Data Database

Shasta County's MHP utilizes EHRs to obtain standardized reports including but not limited to Server Credentials Report, Client Roster Report, Client Services Listing, Assessment and Treatment Plans Listing, Assessment Measures Report, and the Scheduled Services Report. We use these standardized reports to analyze and track timeliness measures, i.e., Client Services Information (CSI) measures, quality of care measures, and outcome measures. These reports are reviewed with a workgroup within the QIC where any trends can be identified and brought to the QIC committee for discussion. Deficiencies are reviewed to determine new policy changes that may need to be adopted and implemented to improve timely access, MHP effectiveness, and outcomes.

Changes to data tracking policies are reviewed by the respected department heads and feedback is provided at QIC subcommittee meetings. Upon implementation, the efficacy and effectiveness of changes are discussed at the QIC meetings and reviewed as needed. Minutes and documentation of these activities are kept.

Quality Improvement Activities Goals and Data

The following goals and objectives are based upon the DHCS Managed Care contract requirements for QI Work Plans and Title 9 requirements in the areas outlined below.

A. Service Delivery – Capacity & Timeliness

Goal 1: *Maintain adequate capacity for delivery of medically necessary specialty mental health services based on geographic area, that are appropriate in number and type of service.*

Objective	Reporting Frequency	Responsible for Information
Objective 1.a: Monitor the number and type of service by geographic area and race/ethnicity, gender, and age and evaluate for appropriate level of service and penetration rates. Adjust service delivery when appropriate.	Annually	Data Analyst

Goal 2: *Maintain adequate capacity for timely delivery of routine and urgent specialty mental health services.*

Objective	Reporting Frequency	Responsible for Information
Objective 2.a: Track and monitor EQRO timeliness measures. Each measure has an individual goal. See Attachment A.	Quarterly	Data Analyst

Goal 3: *Evaluate crisis prevention and discharge planning activities for clients at risk of hospitalization or that have been hospitalized in the previous 12 months.*

Objective	Reporting Frequency	Responsible for Information
Objective 3.a: Increase percentage of **Adult** beneficiaries who receive a face-to-face follow-up mental health practitioner appointment within 7 days of discharge from a psychiatric inpatient facility from **64.1% to 67.3%** (a 5% increase over FY21-22). Data will not reflect those individuals who receive psychiatric care from providers other than	Quarterly	Data Analyst

Shasta County Mental Health. Day of discharge follow-up services are not eligible according to HEDIS criteria and will be tracked and reported on for internal purposes to move toward more consistent compliance.		
Objective 3.b: Increase percentage of **Youth** beneficiaries who receive a face-to-face follow-up mental health practitioner appointment within 7 days of discharge from a psychiatric inpatient facility from **84.8% to 89.0%** (a 5% increase over FY21-22). Data will not reflect those individuals who receive psychiatric care from providers other than Shasta County Mental Health. Day of discharge follow-up services are not eligible according to HEDIS criteria and will be tracked and reported on for internal purposes to move toward more consistent compliance.	Quarterly	Data Analyst
Objective 3.c: Maintain or increase percentage of **Foster Care** youth beneficiaries who receive a face-to-face follow-up mental health practitioner appointment within 7 days of discharge from a psychiatric inpatient facility at **75.0%**. Data will not reflect those individuals who receive psychiatric care from providers other than Shasta County Mental Health. Day of discharge follow-up services are not eligible according to HEDIS criteria and will be tracked and reported on for internal purposes to move toward more consistent compliance.	Quarterly	Data Analyst

Objective 3.d: Maintain psychiatric inpatient re-hospitalization within 30 days at **14.2%** or less for **Adult** beneficiaries.	Quarterly	Data Analyst
Objective 3.e: Maintain psychiatric inpatient re-hospitalization within 30 days at **9.5%** or less for **Youth** beneficiaries.	Quarterly	Data Analyst
Objective 3.f: Maintain psychiatric inpatient re-hospitalization within 30 days at **19.2%** or less for **Foster Care** youth beneficiaries.	Quarterly	Data Analyst
Objective 3.g: Maintain psychiatric inpatient re-hospitalization within 90 days at **21.0%** or less for **Adult** beneficiaries.	Quarterly	Data Analyst
Objective 3.h: Maintain psychiatric inpatient re-hospitalization within 90 days at **19.6%** or less for **Youth** beneficiaries.	Quarterly	Data Analyst
Objective 3.i: Maintain psychiatric inpatient re-hospitalization within 90 days at **15.4%** or less for **Foster Care** youth beneficiaries.	Quarterly	Data Analyst

Goal 4: *Ensure access to after-hours care and the effectiveness of the 24/7 toll free number.*

Objective	Reporting Frequency	Responsible for Information
Objective 4.a: Increase percentage of business-hours test calls from 77.42% to 81.29% (a 5% increase over FY21-22) that has all necessary elements logged in Access to Services Journal (ASJ).	Quarterly	Compliance and Quality Improvement
Objective 4.b: At least 90% of business-hours test calls requiring an interpreter will be completed successfully. Success is defined as: Correct language interpreter successfully engages with the caller.	Quarterly	Compliance and Quality Improvement
Objective 4.c: Increase percentage of after-hours test calls from 80.77% to 84.81% (a 5% increase over FY21-22) that has all necessary elements logged in Access to Services Journal (ASJ).	Quarterly	Compliance and Quality Improvement

Objective 4.d: At least 90% of after-hours test calls requiring an interpreter will be completed successfully. Success is defined as: Correct language interpreter successfully engages with the caller.	Quarterly	Compliance and Quality Improvement

B. Monitor Beneficiary Satisfaction

Goal 5: *Conduct activities to assess beneficiary/family satisfaction.*

Objective	Reporting Frequency	Responsible for Information
Objective 5.a: A three-question survey rating consumer satisfaction has been developed and implemented by the Shasta County Health and Human Services Agency as a whole. The surveys turned into Behavior Health and Social Services locations are collected and logged by QI staff to monitor for trends.	Semi-Annually	Compliance/ Quality Improvement

C. Safety and Effectiveness of Practices

Goal 6: *Ensure clinical practices are safe, effective, and support wellness and recovery.*

Objective	Reporting Frequency	Responsible for Information
Objective a: 100% of newly hired staff, in job specifications that require it, will continue to receive the clinical practice and documentation training within 90 days of hire (Children's, Adult, and Medication Support Staff).	Annually	Utilization Management and Quality Assurance
Objective b: Monitor medication consents for accuracy and to meet all required standards to set a baseline for improvement.	Quarterly	Utilization Management and Quality Assurance

D. Provider Appeals

Goal 7: *Evaluate beneficiary grievances, appeal, fair hearings, and change of provider requests for quality-of-care issues.*

Objective	Reporting Frequency	Responsible for Information
Grievance, appeal, expedited appeal, and change of provider Requests issues and resolutions will be reported	Quarterly	Compliance and Quality Improvement

to QIC quarterly and QIC will be evaluated to identify trends and discuss systemic issues as the arise.		

Goal 8: *Monitor Appeals for Timely Resolution*

Objective	Reporting Frequency	Responsible for Information
100% of appeals will be resolved within the timeframes specified by state and federal regulating agencies.	Quarterly	Compliance and Quality Improvement

E. QIC Activities

Goal 9: *Strengthen the infrastructure and improve the practices and effectiveness of the Quality Improvement Program.*

Objective	Reporting Frequency	Responsible for Information
Objective a: The QI Committee will increase stakeholder involvement in the QI Committee activities, decisions, and oversight.	Semi-Annually	QIC Members
Objective b: The QI Committee will assure participation of direct care staff in quality improvement (QI) activities, by having Program and Organizational Provider leads and Ethnic Services Coordinator report to the QI Committee with QI activities their staff/agencies are currently engaged in, and what programs and efforts are having a positive impact.	Quarterly	QIC Members

Attachment A – EQRO Timeliness Measures

First Offered Appointment **Maintain percentage of first offered appointment (including assessment) within 10 business days from the initial request for services:**
1): For **all** clients: 95% or higher for FY22-23. FY21-22 was 96.3%.
2): For **adult** clients: 95% or higher for FY22-23. FY21-22 was 100%.
3): For **youth** clients: 95% or higher for FY22-23. FY21-22 was 92.6%.
4): For **Foster Care youth** clients: 95% or higher for FY22-23**.** FY21-22 baseline was 96.9%.

First Accepted Appointment **Maintain percentage of first accepted appointment within 10 business days from the initial request for services:**
5): For **all** clients: 95% or higher for FY22-23. FY21-22 was 92.0%.
6): For **adult** clients: 95% or higher for FY22-23. FY21-22 was 99.2%.
7): For **youth** clients: 95% or higher for FY22-23. FY21-22 was 84.8%.
8): For **Foster Care youth**: 95% or higher for FY22-23. FY21-22 was 96.9%.

First Kept Appointment **Maintain percent of kept assessment appointment within 10 business days from the initial request for services:**
9): For **all** clients: 95% or higher for FY22-23. FY21-22 was 92.9%.
10): For **adult** clients: 95% or higher for FY22-23. FY21-22 was 99.2%.
11): For **youth** clients: 95% or higher for FY22-23. FY21-22 was 84.8%.
12): For **Foster Care youth** clients: 95% or higher for FY22-23. FY21-22 was 88.7%.

Initial Request for Services **Track and monitor the average, median, standard deviation, and range in business days from the initial request for services to the first kept clinical appointment:**
13): For **all** clients.
14): For **adult** clients.
15): For **youth** clients.
16): For **Foster Care youth** clients.

Second Request for Services **Track and monitor the average, median, standard deviation, and range in business days from the first kept clinical appointment to the second kept clinical appointment:**
17): For **all** clients.
18): For **adult** clients.
19): For **youth** clients.
20): For **Foster Care youth** clients.

First Offered Psychiatric Appointment **Maintain or increase the percentage of all clients with a first offered psychiatric appointment within 15 days of first request for service:**
21): For **all** clients: 88.9% or better for FY22-23. FY21-22 was 88.9%.
22): For **adult** clients: 87.3% or better for FY22-23. FY21-22 was 87.3%.
23): For **youth** clients: 92.5% or better for FY22-23. FY21-22 was 92.5%.
24): For **Foster Care youth**: Maintain 100% for FY22-23. FY21-22 was 100%.

First Offered Psychiatric Appointment **Track and monitor the average, median, standard deviation, and range in business days from the day the appointment was entered in the EHR to the first offered psychiatric appointment:**
25): For **all** clients.
26): For **adult** clients.
27): For **youth** clients.
28): For **Foster Care youth** clients.

First Kept Psychiatric Appointment **Track and monitor the average, median, standard deviation, and range in business days from the day the appointment was entered to the first kept psychiatric appointment:**
29): For **all** clients.
30): For **adult** clients.
31): For **youth** clients.
32): For **Foster Care youth** clients.

Urgent Condition **Maintain 100% of all clients presenting with an urgent condition, as defined in Title 9, Subsection 1810.253, will be seen within two days or less. (Standard is 48 hours for clients with prior authorization; 96 hours without prior authorization).** **a) Date from evaluation capable date/time to face-to-face evaluation start date/time** **b) Date from assignment start date to first appointment or service with a practitioner.**
33): All clients: a) FY21-22 99.2% b) FY21-22 100.0%
34): All **adult**: a) FY21-22 99.1% b) FY21-22 100.0%
35): All **youth** clients: a) FY21-22 99.4% b) FY21-22 100.0%

36): All **Foster Care youth** clients:

a) FY21-22 100.0%
b) FY21-22 100.0%