Mariposa County Behavioral Health and Recovery Services

QUALITY IMPROVEMENT WORKPLAN

Fiscal Year 2020 - 2021

Mariposa County Behavioral Health and Recovery Services
5362 Lemee Lane

2020 – 2021 QIC Work Plan

Quality Assurance Program

Required Elements for the Quality Assurance Program

Mariposa County Behavioral Health and Recovery Services (MCBHRS) has developed a QA work plan to meet the criteria outlined in the Department of Health Care Services Contract. The QA Program's structure and elements are outlined in this document. The QA Program assigns responsibility to appropriate individuals, adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The QA Program shall be evaluated annually and updated as necessary per Title 9, CCR, Section 1810.440(a)(6) and Title 42, CFR, Section 438.240(e).

MCBHRS shall set standards and implement processes that will support understanding of, and compliance with, documentation standards set forth in the State Department of Health Care Services contract.

The QA Program shall:

- Conduct performance-monitoring activities throughout its operations.
- Activities shall include, but not be limited to;
    - Client and system outcomes,
    - Utilization management,
    - Utilization review,
    - Provider appeals,
    - Credentialing and monitoring, and
    - Resolution of beneficiary grievances.
- Ensure continuity and coordination of care with physical health care providers.
- Coordinate with other community services agencies used by its beneficiaries.
- Assess the effectiveness of any MOU with a physical health care plan or managed care.
- Have mechanisms to detect both underutilization of services and overutilization of services, as required by Title 42, CCR, Section 438.240(b)(3).
- Implement mechanisms to assess beneficiary/family satisfaction. The Mental Health Provider (MHP) shall assess beneficiary/family satisfaction by:
    - Surveying beneficiary/family satisfaction with the MHP's services at least annually;
    - Evaluating beneficiary grievances, appeals and fair hearings at least annually; and
    - Evaluating requests to change persons providing services at least annually.
    - Inform providers of the results of beneficiary/family satisfaction activities.
- Implement mechanisms to monitor the safety and effectiveness of medication practices.
    - The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs.

    - Monitoring shall occur for five percent of medication charts.
- Implement mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.
    - Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.
    - Take appropriate follow-up action when such an occurrence are identified.
    - Results of the intervention shall be evaluated by the MCBHRS annually.

Quality Assurance Unit (QA)

The QA unit is charged with conducting and overseeing the elements of the QA program. The QA unit will also provide guidance and support in the implementation of the QI work plan. MCBHRS will utilize the QI Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. The QI Work Plan supporting evidence shall include:

- Evidence of the monitoring activities including, but not limited to,
    - Review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Title 9, CCR, Section 1810.440(a)(5) and Title 42, CFR, section 438.416;
    - Evidence that QA activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;
- A description of completed and in-process QA activities, including performance improvement projects. The description shall include:
    - Monitoring efforts for previously identified issues, including tracking issues over time;
    - Objectives, scope, and planned QA activities for each year; and,
    - Targeted areas of improvement or change in service delivery or program design.
- A description of mechanisms MCBHRS has implemented to assess the accessibility of services within its service delivery area. This shall include;
    - Goals for responsiveness for the MCBHRS's 24-hour toll-free telephone number,
    - Timeliness for scheduling of routine appointments,
    - Timeliness of services for urgent conditions, and
    - Access to after-hours care.
- Evidence of compliance with the requirements for cultural competence and linguistic competence specified in Title 9, CCR, Section 1810.410.

Quality Improvement Committee (QIC)

The QIC shall be accountable to the Mental Health Director as described in Title 9 CCR, Section 1810.440(a) (1). Operation of the QIC shall include substantial involvement by a licensed mental health staff person, as described in Title 9 CCR, Section 1810.440(a)(4).

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The QIC shall include active participation by practitioners and providers, as well as consumers and family members in the planning, design and execution of the QI Work Plan, as described in Title 9 CCR, Section 1810.440(a)(2)(A-C).

There shall be a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in Title 42, CFR, Section 438.240(b)(1) and (d). Each performance improvement projects shall focus on a clinical area, as well as one non-clinical area.

QIC Activities

The QI Committee shall monitor the service delivery system with the aim of improving the processes of providing care and better meeting the needs of its clients. The QI Program Committee shall;

- Review the quality of specialty mental health services provided to beneficiaries.
- Recommend policy decisions;
- Review and evaluate the results of QI activities, including:
    - Performance improvement projects;
    - Institute needed QI actions;
    - Ensure follow-up of QI processes; and
    - Document QI Committee meeting minutes regarding decisions and actions taken.

QI activities shall include:

- Collecting and analyzing data to measure against the goals stated in the QI annual work plan, which prioritized areas of improvement that have been identified;
- Identifying opportunities for improvement and deciding which opportunities to pursue;
- Identifying relevant committees internal or external to ensure appropriate exchange of information with the QI Committee;
- Obtaining input from providers, consumers and family members in identifying barriers to delivery of clinical care and administrative services;
- Designing and implementing interventions for improving performance;
- Measuring effectiveness of the interventions;
- Incorporating successful interventions into the MCBHRS operations as appropriate;
- Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Title 9, CCR Section 1810.440(a)(5).

QIC meeting agendas may include, but are not limited to, the following agenda items:

- Capacity and Service Delivery - Reviewing the utilization of services, assess the number of assessments monthly, identifying gaps in services in outlying areas or to underserved populations, and monitoring of penetration rates for Medi-Cal beneficiaries.
- Accessibility-Identify barriers to access of services, monitoring of afterhours access, 24/7 access components (see 24/7 Access P&P), and monitoring of threshold languages.

- Satisfaction- Identify areas for improvement by reviewing beneficiary surveys, reviewing reports on client "no shows", change of provider requests, and grievance/appeal summaries.
- Process Service Delivery**-** review, evaluate Policy and Procedures and compare current services with previous year's utilization.
- Continuity of Care**-** Design, implement and measure effectiveness of interventions for coordination of care with Primary Care Physicians and partner agencies.
- PIP Committee**-** Assign projects for evaluation of improving potential. Incorporate successful interventions into MCBHRS practices. Ensure completion of annual reports.
- Cultural Responsiveness Committee- Review implementation of Cultural Competence Plan to assure culturally competent practices and trainings are occurring.

The QIC meets at minimum quarterly and consists of the following individuals:

- MCBHRS Deputy Director
- Quality Improvement/Assurance Supervisor
- All Supervisors
- MHSA Coordinator
- QA staff
- Committee Chairs
- Beneficiaries
- Mental Health Board Members
- Community Service Providers
- Contract Providers
- Other MCBHRS leadership and direct provider staff

MCBHRS Communication of QI Activities:

The Division supports QI activities through the planned coordination and communication of the results of measurement of QI Goals. There are overall efforts to continually improve the quality of care provided. The planned communication may take place through the following methods:

- Recipients participating in the QI Committee report back to recipient groups
- Emails
- Presentations to the Mental Health Board
- Posters, brochures, notices and surveys displayed in common areas
- Sharing of the Department's annual QI Plan
- Distribution of meeting minutes

Other Division QI Activities/Committees

The Department has other standing committees where QI/UM activities occur. These include the Performance Improvement Project (PIP) committees, Compliance Committee, Cultural Competency Committee, and Primary Care Provider sub-committee (PCP). Other committees or work groups are created as necessary to resolve quality improvement issues.

Utilization Management (UM) Program

The Utilization Management Program shall:

- Be responsible for assuring that beneficiaries have appropriate access to specialty mental health services as required in Title 9, CCR, Section 1810.440(b)(1-3).
- Evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively or retrospectively.
- Implement mechanisms to assess the capacity of service delivery for its beneficiaries. This includes monitoring the number, type, and geographic distribution of mental health services within the Department's delivery system.
- Implement mechanisms to assess the accessibility of services within its service delivery area. This shall include the assessment of responsiveness of the MHP's 24 hour toll-free telephone number, timeliness of scheduling routine appointments, timeliness of services for urgent conditions, and access to after-hours care.
- Implement mechanisms to assure authorization decision standards are met. In instances when services are reduced, denied or terminated a Notice of Action (NOA) will be sent to client.

Evaluation

An evaluation is completed at the end of each fiscal year. The annual evaluation is conducted by the MHP and kept on file, along with the Quality Improvement Plan. These documents will be reviewed by the Leadership and others as appropriate.

The evaluation summarizes the following:

- The goals and objectives of the programs/service's Quality Improvement Plan;
- The quality improvement activities conducted during the past year;
- The performance indicators utilized;
- The findings of the measurement, data aggregation, assessment and analysis processes;
- The quality improvement initiatives taken in response to the findings;
- Recommendations: Based upon the evaluation, the actions deemed necessary to improve the effectiveness of the Department's/program services.

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QI Goal # 1: Monitor and Ensure Service Delivery Capacity

Objective 1.A: Obtain on a monthly basis reports from EHR regarding the following; location of Clients' receiving services by zip code, demographics of Clients' receiving services, types of services Clients' are receiving and Clients' diagnoses.

Activities:

1. Monitor data collected on Medi-Cal beneficiaries in Mariposa County and beneficiaries in treatment with Mariposa County Behavioral Health and Recovery Services.
2. Monitor trending of the data on quarterly basis
3. Data will be analyzed by QIC and leadership to determine areas of deficiencies
4. Review and monitor NACT

Person(s) Responsible:

1. QA Staff Analyst
2. QA Supervisor
3. QIC
4. Leadership

Auditing Tool:

1. Electronic health record reports
    a. Client diagnosis reports
    b. Client assignment reports
2. NACT
3. GIS

Dates to be reported on:

1. Report monthly to QIC on client demographics.
2. Report semi-annually to QIC on diagnoses.
3. Report semi-annually to QIC on the types of services
4. Complete NACT annually and submit to DHCS
5. Report annually to QIC on NACT.

QI Goal # 1: Monitor and Ensure Service Delivery Capacity

Objective 1.B: Monitor Productivity, staff will have an overall productivity rate of 60%.

Activity:

1. Staff will enter all services into electronic health record.
2. Staff productivity will be evaluated by utilizing productivity reports based on client services reports.
3. Quality Assurance will monitor total productivity by staff member monthly.

Person(s) Responsible:

1. QA Supervisor
2. QA Staff Analyst
3. MCBHRS Leadership
4. MCBHRS staff

Auditing Tool:

1. Electronic health record reports
2. Productivity reports and spreadsheets

Dates to be reported on:

1. Report quarterly to QIC on productivity

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QI Goal # 1: Monitor and Ensure Service Delivery Capacity

Objective 1.C: Certify Satellite Sites

Activity:

1. Medi-cal certify the Coulterville site, and the Miwu Mati site
2. Locate new Coulterville site, enter into a lease for the new site
3. Get Board of Supervisors approval for both sites
4. QA will submit paperwork to Medi-Cal certify the new sites

Person(s) Responsible:

1. QA Supervisor
2. QA Staff Analyst
3. Deputy Director
4. Fiscal Analyst
5. IT Staff
6. HHSA Director

Auditing Tool:

Medi-Cal Certification Process
Medi-Cal Certification Tool

Dates to be reported on:

1. Report to QIC once, upon completion

QI Goal # 2: Ensure Accessibility to Services

Objective 2.A: Monitor timeliness of routine initial mental health assessments to ensure compliance with 10-business day standard.

Activity:

1. Track timeliness of assessments from date of request to first offered appointments
2. The NACT
3. Monitor timeliness by (Adults, Children, Foster Care)

Person(s) Responsible:

1. QA Staff Analyst
2. QA Supervisor
3. UM Committee

Auditing Tool:

1. Timeline to services spreadsheet
2. Electronic health record client services reports
3. The NACT

Dates to be reported on:

1. Report quarterly to QIC on assessment timeliness.

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QI Goal # 2: Ensure Accessibility to Services

Objective 2.B: Monitor Timeliness of routine initial medication appointments from the date of request to the first offered appointment within 15 business days.

Activity:

1. Track timeliness of medication evaluations from date of request to first offered appointments
2. The NACT
3. Monitor timeliness by (Adults, Children, Foster Care)

Person(s) Responsible:

1. QA Staff Analyst
2. QA Supervisor
3. UM Committee

Auditing Tool:

1. Dr. Tracking spreadsheet
2. Electronic health record client services reports

Dates to be reported on:

1. Report quarterly to QIC on initial medication appointment timeliness.

QI Goal # 2: Ensure Accessibility to Services

Objective 2.C: Track utilization of urgent appointments are being offered within 48 hours for assessments, and 96 hours for medication evaluations.

Activity:

1. Track utilization of urgent appointments on a quarterly basis. Ensure appointments are being offered within the following:
    a. Assessments will be scheduled no later than 48 hours after request
    b. Medical Evaluations will be offered within 96 hours.
2. Monitor timeliness by (Adults, Children, Foster Care)
3. Identify clients for increased outreach efforts.
4. Supervisors and UM to monitor.

Person(s) Responsible:

1. QA Staff Analyst
2. QA Supervisor
3. UM Committee

Auditing Tool:

1. Timeline to services spreadsheet
2. Electronic health record reports

Dates to be reported on:

1. Report quarterly to QIC on urgent appointment timeliness.

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QI Goal # 2: Ensure Accessibility to Services
Objective 2.D: Monitor Post Hospitalization follow up appointments. Ensure they are within 7 calendar days of discharge.

Activity:

1. Follow up appointments will be tracked according to discharge date
2. Identify clients for increased outreach efforts
3. Supervisors and UM to monitor

Person(s) Responsible:

1. Hospital Liaison
2. QA Staff Analyst
3. UM Committee
4. Leadership

Auditing Tool:

1. Post hospitalization follow up sheets
2. Timelines to services spreadsheet
3. Electronic health records report
4. Hospitalization 20/21 spreadsheet

Dates to be reported on:

1. Report monthly to QIC on hospitalization appointment timeliness.

QI Goal # 2: Ensure Accessibility to Services
Objective 2.E: Monitor psychiatric inpatient readmission rates

Activity:

1. Follow up appointments will be tracked according to discharge date and admission date.
2. Identify clients that have been readmitted within 30 days of prior discharge.
3. Supervisors and UM to monitor

Person(s) Responsible:

1. Hospital Liaison
2. QA Staff Analyst
3. UM Committee
4. Leadership

Auditing Tool:

1. Post hospitalization follow up sheets
2. Timelines to services spreadsheet
3. Electronic health records report
4. Hospitalization 20/21 spreadsheet

Dates to be reported on:

1. Report Quarterly to QIC on hospitalization re-admissions.
    a. by (Adults, Children, Foster Care)

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QI Goal # 2: Ensure Accessibility to Services

Objective 2.F: Monitor the 24/7 access line with an overall passing rate of 95%

Activity:

1. Test calls will be conducted at a rate of no less than two per month.
2. Calls will be evaluated on the following information:
    a. How to access specialty mental health services,
    b. Information for urgent conditions,
    c. How to use the beneficiary problem resolution and fair hearing process.
3. 24/7 Access training (including interpreter access) will be offered to all staff annually.
4. Test call reports will be submitted to DHCS quarterly.

Person(s) Responsible:

1. QA Supervisor
2. QA Staff Analyst
3. UM Committee
4. Leadership

Auditing Tool:

1. Test call worksheets
2. Test call logs
3. Interpreter services invoices
4. 24/7 Access report

Dates to be reported on:

1. Report quarterly to QIC
2. Test call will be submitted to DHCS quarterly

QI Goal # 2: Ensure Accessibility to Services

Objective 2.G: Ensure provision of culturally and linguistically appropriate services

Activity:

1. Culturally relevant trainings will be planned annually in accordance with the Cultural Competence Plan.
2. Linguistic access training will be offered to staff.
3. Update CRC Plan annually.
4. Update CRC Training Plan annually.
5. Provide an annual update summary

Person(s) Responsible:

1. CRC Committee
2. QIC
3. QA Supervisor

Auditing Tool:

1. Sign in sheets
2. Training flyers
3. Pre-post tests
4. Cultural Responsiveness Plan

Dates to be reported on:

1. Report to QIC semi-annually on updates.
2. Report annually to QIC on CRC plan and training plan.
3. Report annually on the previous year's CRC plan and training plan.

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QI Goal # 2: Ensure Accessibility to Services

Objective 2.H: Treatment authorization requests (TAR) will be reviewed for medical necessity and authorized or re-authorized as appropriate within 14 calendar days. Continue to utilize concurrent TARs to authorize services as appropriate.

Activity:

1. TARs will be reviewed and decisions will be documented within 14 days of receipt.
2. UM Committee will monitor timeliness of TARs monthly to ensure 100% meet the 14 day timeline.
3. Continue to utilize the concurrent TAR process to authorize services.

Person(s) Responsible:

1. QA Supervisor
2. Medical Director
3. Deputy Director
4. Medical Records Staff
5. UM Committee
6. QA Team

Auditing Tool:

1. TAR log
2. Authorization audits
3. Authorization protocol

Dates to be reported on:

1. Report to QIC quarterly on TAR timeliness.

QI Goal # 3: Beneficiary Satisfaction

Objective 3.A: Assess Beneficiary and/or family member satisfaction with the services through MCBHRS by utilizing consumer perception surveys twice annually. Goal is to increase the number of completed surveys and increase overall satisfaction by 3%. Communicate the results of surveys to staff, providers and stakeholders.

Activity:

1. Develop services survey and train office support in requesting surveys
2. Utilize Peer Support for client assistance
3. Survey beneficiaries and/or family member for satisfaction with MCBHRS services and service providers
4. Request pilot to utilize iPad submission

Person(s) Responsible:

1. FSC/ Medical Records
2. QA Supervisor
3. QIC
4. QA Analyst
5. Leadership

Auditing Tool:

1. POQI semi-annually
2. Meeting minutes
3. Survey forms
4. Survey results

Dates to be reported on:

1. Survey administration in the Fall and Spring.
2. Results presented to QIC after each survey period.
3. Results presented to Unit and BH all staff meetings to identify improvement.

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QI Goal # 3: Beneficiary Satisfaction
Objective 3.B: Assess engagement and service delivery. Decrease overall no show rate to 10%. Decrease psychiatric no shows to 10%.

Activity:

1. Monitor no show rates with a goal of 90% of appointments being kept and an overall 10% no show rate.

Person(s) Responsible:

1. QA Staff Analyst
2. PIP Committee
3. Leadership

Auditing Tool:

1. EHR reports

Dates to be reported on:

1. Report to QIC quarterly on current no show rates.
    a. For Psychiatrist and Clinicians
        i. by (Adults, Children, Foster Care)

QI Goal # 4: Monitor Safety and Effectiveness of Medication Practices
Objective 4.A: Monitor safety and effectiveness of medication practices.

Activity:

1. Conduct chart audits on 5% of active charts
2. Medical director will audit charts for tele-psych clients and Nurse Practitioner
3. Run reports on the types of medications prescribed for the UM Committee
4. Contract with another county to conduct medication chart review for Mariposa charts, and Mariposa will conduct medication chart reviews for other county.
    a. Send 2 charts a month to other county to review.

Person(s) Responsible:

1. Medical Director
2. UM Committee
3. QA Supervisor
4. QIC

Auditing Tool:

1. Medication Chart Review Tool

Dates to be reported on:

1. Report to QIC on a semi-annual basis.

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QI Goal # 4: Monitor Safety and Effectiveness of Medication Practices
Objective 4.B: Draft and create medication policies and procedures on standards of practice.

Activity:

1. Create medication practice policies and procedures
2. Have medical director sign off on policies and procedures

Person(s) Responsible:

1. Medical Director
2. QA Supervisor
3. QIC
4. QA Staff Analyst

Auditing Tool:

1. Medication Chart Review Tool

Dates to be reported on:

1. Report to QIC once upon completion.

QI Goal # 4: Monitor Safety and Effectiveness of Medication Practices
Objective 4.C: Monitor, track and trend medication usage.

Activity:

1. Monitor the use of psychotropic medication in children
    a. Track and trend the rate of use of psychotropic meds in children
    b. Track and trend to ensure lab work is being completed
2. Monitor the use of antipsychotic medication in children
    a. Track and trend the rate of use of antipsychotic meds in children
    b. Track and trend to ensure lab work is being completed

Person(s) Responsible:

1. Medical Director
2. QA Analyst
3. QA Supervisor

Auditing Tool:

1. Electronic Health Record reports

Dates to be reported on:

1. Report to QIC quarterly on data

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QI Goal # 5: Coordination and Quality of Care

Objective 5.A: Coordinate services with Primary Care Providers (PCP) and other agencies utilized by MCBHRS Beneficiaries.

Activity:

1. Provide staff trainings on coordination with PCPs
2. Continue participation in the 'Living Free Initiative'
3. Continue quarterly meetings with managed care partners
4. Continue collaboration the MACT

Person(s) Responsible:

1. QA Supervisors and Staff
2. UM Committee
3. Medical Director
4. Contract Providers
5. Intense Outpatient TX
6. Case Managers
7. Living Free Initiative
8. Anthem Blue Cross
9. CA Health and Wellness

Auditing Tool:

1. SMI screening tool
2. Timeliness report
3. NOABD review
4. Referral form
5. Training records
6. Sign in sheets
7. Agendas
8. Minutes

Dates to be reported on:

1. Report to QIC semi-annually on efforts to coordinate services with PCPs and managed cares.

QI Goal # 5: Coordination and Quality of Care

Objective 5.B: Monitor Medi-cal billing and documentation compliance.

Activity:

1. Conduct chart audits on no less than 10 % of open clients
    a. UM will look for trends – Identify training needs
2. Annual documentation review
3. Provide training of the documentation manual twice annually
4. Track billing errors to determine if further training is necessary
5. Review compliance log

Person(s) Responsible:

1. QA Supervisor
2. QA Staff Analyst
3. Super User Team
4. Compliance Officer
5. MCBHRS Leadership
6. Fiscal

Auditing Tool:

1. Compliance log
2. Chart audit tool
3. Chart audit log
4. Super user log
5. CSI, suspense and other errors report

Dates to be reported on:

1. Report quarterly to QIC
2. Report annually to UM

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QI Goal # 5: Coordination and Quality of Care

Objective 5.C: Monitor Drug Medi-cal billing and documentation compliance with title 22 regulations.

Activity:

1. Utilize SUD chart audit tool with title 22 compliance monthly
2. Conduct chart audits at a rate of 10% per year

Person(s) Responsible:

1. QA Supervisor
2. QA Staff Analyst
3. SUD Supervisor
4. SUD Staff
5. Compliance Officer

Auditing Tool:

1. SUD chart audit tool
2. Chart audit log

Dates to be reported on:

1. Report Quarterly to QIC
2. Report Annually in UM

QI Goal # 5: Coordination and Quality of Care

Objective 5.D: Monitor Beneficiary grievances, change of providers, and appeals. Grievances will be resolved within 90 days. Standard appeals will be resolved according to the 30-calendar day standard. Expedited appeals will be processed within 72 hours.

Activity:

1. Monitor change of provider requests, including the reason given by consumers
2. Provide NOABD's when needed
3. Monitor grievance/appeal log

Person(s) Responsible:

1. UM Committee
2. QA Supervisor
3. QI Staff
4. QA Analyst
5. Compliance Officer
6. Leadership

Auditing Tool:

1. Grievance submissions
2. Grievance reports
3. NOABD log
4. Change of provider requests
5. Change of provider reports

Dates to be reported on:

1. Report to QIC Quarterly on timeliness of processing
2. Report to DHCS Annually via ABGAR

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QI Goal # 5: Coordination and Quality of Care

Objective 5.E: Enhance Contract Provider Relations

Activity:

1. Provider meetings will continue to occur quarterly to assist in open communications
2. STRTP meetings will transition to provider meetings as contracts are entered into
3. Provider trainings will be held or invitations will be made for in house trainings
4. Provider appeal process will be monitored

Person(s) Responsible:

1. QA Supervisor
2. QA Staff Analyst
3. Compliance Officer

Auditing Tool:

1. Provider meeting sign in sheets
2. Provider meeting minutes
3. Training sign in sheets
4. Provider appeals

Dates to be reported on:

1. Report to QIC Quarterly on efforts to enhance relations with contract providers.

QI Goal # 5: Coordination and Quality of Care

Objective 5.F: Performance Improvement Projects

Clinical PIP = Utilization of the Feedback Informed Treatment (FIT) model to improve engagement.

Non-Clinical PIP = Utilize the new EHR, automated phone reminders to reduce no show rates.

Activity:

1. Utilize the FIT model to improve engagement of clients
2. Utilize InSync automated call reminders to reduce the no show rates (overall, clinical, and psychiatric)

Person(s) Responsible:

1. PIP Committee
2. Clinical Staff
3. Supervisors
4. QA Analyst
5. QIC

Auditing Tool:

1. EHR no show reports
2. EHR treatment session reports
3. FIT Model

Dates to be reported on:

1. Clinical PIP: report to QIC monthly progress
2. Non-Clinical PIP: report to QIC monthly progress

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QI Goal # 6: Outcomes
Objective 6.A: Monitor and utilize outcomes data for CANS and PSC.

Activity:

1. Monitor compliance in collecting CANS and PSC data.
2. Capture and track outcomes data for CANS and PSC.
3. Utilize outcomes data for CANS and PSC.

Person(s) Responsible:

1. Childrens Supervisor
2. QA Analyst
3. QA Supervisor

Auditing Tool:

1. CANS-50
2. PSC-35
3. CANS/PSC tracking sheet
4. Electronic Health Record reports

Dates to be reported on:

1. Report to QIC quarterly on CANS and PSC outcomes data.