



VENTURA COUNTY

BEHAVIORAL HEALTH

A Department of Ventura County Health Care Agency

**QUALITY ASSESSMENT AND PERFORMANCE
IMPROVEMENT PLAN
FISCAL YEAR 2018-19**

1911 Williams Drive • Oxnard, CA 93036

Ventura County Behavioral Health Quality Assessment and Performance Improvement Plan, 2018-19

BACKGROUND

The Ventura County Behavioral Health Department (VCBH) provides a system of coordinated services to meet the mental health and substance abuse treatment needs of Ventura County. The Department is committed to excellence through “best practices” and a consumer-driven and culturally competent approach to service delivery. The staff of the Ventura County Behavioral Health Department are dedicated to relieving suffering and enhancing recovery from mental illness, alcohol, and other drug problems. VCBH believes that real consumer and family member involvement is critical both to our commitment to excellence and for profound change in consumers lives, and is dedicated integrating consumers and family members throughout the Department’s organization and activities. The Behavioral Health Department Plan plays an important role as an integrated component of the Ventura County Health Care Agency System.

The Ventura County Behavioral Health Mission

To promote hope, resiliency and recovery for our clients and their families by providing the highest quality prevention, intervention, treatment, and support to persons with mental health and substance abuse issues.

The Ventura County Behavioral Health Quality Improvement Program is focused on the mission, goals and commitment of the Behavioral Health Department. The Quality Improvement Program is responsible for the coordination, planning, oversight, and communication of quality improvement principles, projects, analyses, and findings Department-wide to achieve the Department’s mission. The principles of wellness, recovery, resiliency, and cultural competency serve to direct all Quality Improvement activities and projects.

VENTURA COUNTY BEHAVIORAL HEALTH DEPARTMENT QUALITY IMPROVEMENT GOALS

- Promote a Department-wide commitment to quality of care and ongoing performance improvement by the active involvement involving beneficiaries, family members, providers, managers, and vendors in quality improvement processes;
- Continuously improve and enhance quality of care through ongoing, objective, and systematic monitoring of data that addresses behavioral health care;

- Proactively identify opportunities for improvement in both clinical and administrative aspects of VCBH operations;
- Implement change in a well-defined, systematic manner, and re-evaluate processes to ensure that improvement has occurred;
- Provide comprehensive oversight of delegated functions to ensure consumer care delivery is consistent with the values and standards of the VCBH;
- Provide an objective and systematic approach to continuous quality improvement that is in compliance with community standards of care and meets applicable regulatory and accrediting requirements and standards;
- Ensure VCBH programs, processes, and vendors are in alignment with VCBH regulatory, and accreditation standards;
- Ensure a system of timely communication of results to both stakeholders and staff regarding quality improvement activities.

Whenever possible, quality improvement (QI) efforts and projects will incorporate the following QI process that stresses the need for formalized assessment processes in the design, implementation, and evaluation of services:

- Collect and analyze data to measure against goals, standards, and/or prioritized areas of improvement that have been identified;
- Identify opportunities for improvement and decide which opportunities to pursue;
- Facilitate the design and implementation of interventions to improve performance;
- Measure the effectiveness of the interventions;
- Incorporate successful interventions in the Mental Health Plan (MHP) as appropriate.

The scope of VCBH QI includes, but is not limited to, all the following elements of consumer services:

- *Timeliness*: How quickly and easily do consumers obtain necessary services?
- *Appropriateness of Care*: Do members receive services appropriate to their individual needs and at the appropriate frequency?

- *Effective Care:* Are services effective and outcomes positive? Are there continuous initiatives to improve service effectiveness and clinical care outcomes?
- *Efficiency:* Are services being provided in a manner that best uses the available resources for consumers?
- *Coordination and Continuity of Care:* Is there coordination and continuity of care within the VCBH services and between the VCBH and community systems of care? Is the transition between the Ventura County Medical Center and VCBH seamless and well documented?
- *Wellness / Recovery:* Are services designed to engender hope and to promote choice, independence, and the development of functional competencies? Are consumers improving the quality of their physical, mental, and life circumstances?
- *Consumer Satisfaction:* Are consumers and family members satisfied with the quality of services they receive, the programs and providers that deliver them, and with their clinical outcomes?
- *Cultural Competency:* Are services provided in a manner that effectively meets the needs of county cultural and ethnic populations? Are healthcare service disparities being reduced?

PURPOSE

The purpose of the Quality Improvement Performance Plan (QIPP) is to provide a working document for the monitoring, implementation, and documentation of efforts to improve delivery of services to VCBH consumers. It is prepared on an annual basis and reviewed for appropriateness twice a year. Updates to the plan occur whenever there is a need to reflect the ongoing process of quality improvement.

Goals and objectives as described herein are intended to be embedded at the operational program level. Measurement of stated goals and objectives are based on data inputs and outputs provided by Quality Improvement, which are measured against established goals. The Implementation of the QIPP is through an operational infrastructure which includes the Quality Improvement Committee, Quality Improvement work groups, and relevant department teams and providers. The intent of such infrastructure is to provide a framework by which the QIPP, as well as related Performance Improvement Projects and research activities, can be implemented and facilitate accurate measurement of progress against benchmarks, standards of care, and/or applicable regulatory and accrediting requirements and standards.

REGULATORY, CONTRACTUAL AND POLICY REQUIREMENTS

The Ventura County Behavioral Health Department Quality Improvement program is designed to meet regulatory and CA Department of Health Care Services contractual requirements, as well as, Behavioral Health Department internal policies and procedures which require that our program:

1. Be conducted under the direction of the VCBH Director;
2. Be coordinated by a licensed mental health professional;
3. Report to the Board of Supervisors;
4. Document that the quality of care provided is being reviewed, through a variety of methods, including surveys, audits, focused reviews, data analysis, beneficiary grievance review, and other techniques designed to define quality care;
5. Identify quality of care problems;
6. Demonstrate a process which takes effective action to improve care where deficiencies are identified, and ensure through corrective action plan(s) and follow-up, that both specific as well as systemic quality of care issues are identified and are improved;
7. Address accessibility, availability, and continuity of care;
8. Monitor the provision and utilization of services to see that they meet professionally recognized standards of practice;
9. Regulations further require that VCBH's QI program be structured to ensure that:
 - a. A level of care which meets professionally recognized standards of practice is being delivered to all MHP consumers;
 - b. Quality of care problems are identified and corrected;
 - c. Appropriate care is not withheld or delayed for any reason;
 - d. That client rights are supported and that they are advised of their rights as delineated in the Welfare and Institutions Code , Code of Federal Regulations Title 42. and California Code of Regulations Title 9, Chapter 11;
 - e. The program is evaluated annually and updated as necessary.

ORGANIZATIONAL STRUCTURE AND RESPONSIBILITY

The Governing Body of the Mental Health Plan is the Board of Supervisors of Ventura County. While the Board is responsible for establishing, maintaining and supporting the Quality Improvement Program of the Mental Health Plan, the Board delegates the ongoing responsibility for the development and implementation of the Program to the VCBH.

Mental Health Director

The VCBH Director has ultimate responsibility for administration of the Mental Health Plan, oversight of the QI Program and for providing adequate resources and staffing for the program to function effectively.

Reporting to the Behavioral Health Advisory Board

The Advisory Board provides input to the administration of the Mental Health Plan and functions in an advisory capacity. The Advisory Board is involved in the Quality Improvement Committee by appointing an Advisory Board member to the QIC. In addition, there is a direct reporting link to each of the Advisory Board Subcommittees. QI reports generated through the oversight of the Quality Improvement Committee (QIC) are presented to the Advisory Board on a quarterly basis for their review and feedback. The annual Advisory Board report to the Board of Supervisors includes summaries and recommendations based on their review of the QI Program.

Committee Charters

Selected committee charters are attached at the end of this document.

2018-2019 VCBH Quality Assessment and Performance Improvement Plan Priorities

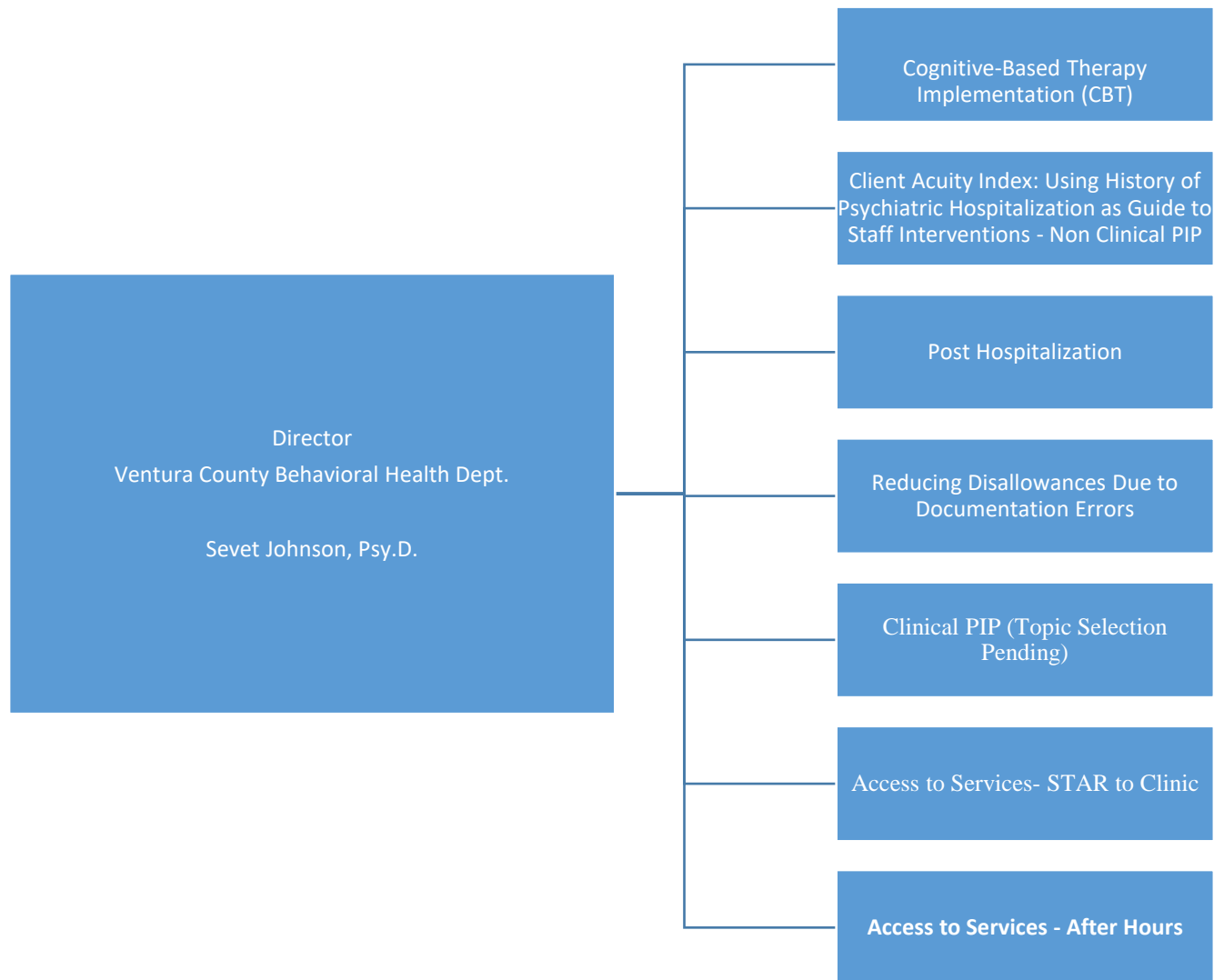
QAPI Priority Area 1: Identify most critical Key Performance Indicators for systematic review and evaluation (Access, Timeliness, Quality of Care, Health Equity and Acuity levels)	
<p>The following areas require expanded data review/ evaluation:</p> <ul style="list-style-type: none"> • Division Dashboard Performance Indicators (Youth and Family, Adults, SUTS) • MHSA Program Requirements • DMC-ODS EQRO Reporting Requirements • Contract Performance Indicators (Youth and Family) 	
Objective	<ol style="list-style-type: none"> 1. Identify data priorities across divisions to meet State mandates 2. Build additional dashboard features to meet agency need/ oversight 3. Identify ongoing evaluation framework and review cycle for programs/ divisions
Goals	Improve data oversight process, data integrity and evaluation
Responsible Partners	<ul style="list-style-type: none"> • Exec Team • EHR and QI Teams • Y&F Performance Indicator Workgroup (to be formed) • Adults Performance Indicator Workgroup (to be formed) • SUTS Performance Indicator Workgroup (to be formed) • MHSA Performance Indicator Workgroup (to be formed)
Evaluation Tools	<ul style="list-style-type: none"> • Access reports with evaluation, trends and gaps • Penetration reports with evaluation, trends and gaps • Timeliness reports with evaluation, trends and gaps • Quality of Care reports • Patient Acuity rates/ reports
Action Items	<ul style="list-style-type: none"> • Develop Workgroups (Identify KIPs and Gaps) • Build Dashboard features • Create Staff Training and Communication Plan
Results	

QAPI Priority Area 2: Improve Staff Data Entry and Data Fidelity	
<ul style="list-style-type: none"> • Identify data priorities and reporting needs • Update VCOS • Staff Training required to ensure reporting accuracy • Staff Oversight 	
Objective	<ol style="list-style-type: none"> 1. Identify staff entry data priorities across clinics 2. Build additional performance management reports for CAs/ Medical Directors

Goals	Improve data integrity of critical data and staff oversight process
Responsible Partners	<ul style="list-style-type: none"> • Exec Team • Clinic Administrators • Medical Directors • EHR
Evaluation Tools	<ul style="list-style-type: none"> • Productivity reports • Clinic performance management reports
Action Items	
Result	

QAPI Priority Area 3: Agency Communication & Stakeholder Input	
<ul style="list-style-type: none"> • QIC • Annual Reporting Structure • Staff/ Stakeholder Surveys and Engagement 	
Objective	<ol style="list-style-type: none"> 1. Create effective structure to review BH current state and needed quality improvement priorities/ activities 2. Educate staff/ stakeholders of BH achievements and gaps to share in QI activities
Goals	Increase Internal and External knowledge and engagement in quality improvement
Responsible Partners	<ul style="list-style-type: none"> • Executive Team • BH Communications Workgroup • QIC Executive Steering Committee • Quality Improvement Committee • BHAB
Evaluation Tools	<ul style="list-style-type: none"> • BH Dashboards • Surveys • Annual reports
Action Items	
Results	

COMMITTEE AND WORKGROUP STRUCTURES



Quality Improvement Committee Organizational Charter

Purpose

The Quality Improvement Committee (QIC) is responsible for the oversight of Quality Improvement activities as presented in the Quality Improvement Work Plan. The QIC identifies key quality issues and provides feedback to the progress and results of the Quality Improvement Work Plan objectives and projects. The Quality Improvement Committee meets monthly and is comprised of community leaders, consumers and family members, Mental Health Board members, and VBCH staff. The QIC provides oversight of quality improvement project activities and data management.

Responsibilities

- Review, track and monitor the resolution of beneficiary grievances, state fair hearings, and provider appeals.
- Oversee and participate in the review of QI activities, including performance improvement projects.
- Recommend and review policy decisions, and ensure follow-up of QI process.
- Identify quality of care projects and issues and refer to the Director and BH Administration.
- Review QI Workgroup reports and recommend implementation and follow-up activities.
- Identify barriers to clinical practice and administrative aspects of the delivery system.

Membership

- Director
- Medical Director(s)
- Quality Assurance Manager
- Division Managers
- Behavioral Health Managers
- Clinic and Program Administrators
- Mental Health Board Appointees
- Ethnic Services Manager
- Adult Consumers
- TAY Consumers
- Family Members
- Provider Representatives
- Clinicians



Project Title: Cognitive-Behavioral Therapy as Primary Intervention Modality in VCBH for Youth & Family

Project Description:

Ventura County Behavioral Health is the state contracted government entity dedicated to provide quality behavioral health services to the community members who meet medical service necessity for Specialty Mental Health Services.

The integration of Evidence Based Practices (EBPs) in community behavioral health is expected by the **state** and is vital in ensuring that consumers have access to the highest level of services, which integrate clinical expertise with external scientific evidence, and the perspective, values, needs, choice, and voice of those we serve. Cognitive Behavioral Therapy (CBT) is valued in the behavioral health field to be highly effective and culturally sound evidence based treatment.

The purpose of this project is the implementation of Cognitive-Behavior Therapy as the primary modality of individual, family and group therapy in VCBH and the establishment of a system by which outcome measures are used to report client outcomes associated with receiving CBT to established fidelity.

Opportunity Statement:

Within and between each service sites, there exists a significant variance in the skill level of the Behavioral Health Clinicians and the quality in treatment each client receives. To date, there has not been a standardized treatment for county consumers and staff have not been asked to demonstrate competence to a measurable level of skill.

It is imperative that county mental health providers serve their community with quality care and meet the state standard of utilizing EBPs in treatment and that a measurable level of care standard is set.

The intention of this project is Evidence Based Practices (EBP) Training to all VCBH clinical staff in Youth and Family Division, specifically CBT. CBT adherence is measured through the use of the Cognitive Therapy Rating Scale (CTRS) used to rate recorded sessions. A peer mentoring model has been incorporated to support implementation, as recorded sessions are listened to in team meetings and fidelity to CBT is measured by the CTRS. Outcome and fidelity measures will be utilized to measure effectiveness.

	All Diagnosis	Depression /Anxiety	Frequency
Clinical Measures	VCOS	VCOS PhQ9 GAD7	Annually (ages 13+) Every Individual/group session
Functioning	VCOS	VCOS PhQ9	Y & F: annually (ages 13+) Every Individual/group session
Client Satisfaction	VCOS	VCOS	Y & F: annually
Fidelity	CTRS	CTRS	1 x during duration of treatment
Further, client's length of stay in treatment is expected to lessen as more effective services are provided.			

Scope:

- Identification of EBP and accredited trainer – The Academy of Cognitive Therapy
- Training of all (Youth and Family) clinical staff in basic CBT
- Training of peer mentors (CBT coaches) in Advanced CBT
- Use of audio-taping sessions and rating with CTRS fidelity scale
- Program based on-going supervision/oversight of recorded sessions and use of CTRS fidelity scale
- Training on the use of identified Outcome measures to measure effectiveness
- Development of data entry systems to track fidelity and outcome measures

Additional planned scope:

- Training of identified Community Based Organizations in basic CBT
- Identification of CBO's plan to provide on-going oversight adherence to CBT

Out of scope: Certification of their CBT coaches for CBOs and the on-going oversight of CBT at those agencies

Team Members: Permanent

Name	Department	Name	Department
Angela Riddle	VCBH Y &F	Patricia Gonzales	QI (Outcome Measures)
Faizal Ummer	QI		

Team Members: Ad Hoc

Name	Department	Name	Department
Academy of Cognitive Therapy Troy Thompson Dr. Leslie Sokol	CBT trainer	CBT coaches	Virna Merino, PhD Kimberly Prendergast, MFT Brandy Manzano, MFT Peter Schriener, LCSW Lorna Hawley, LCSW Heather L Johnson, LCSW
Dave Roman and Pete Pringle	AVATAR/Technology	CA's & Managers	All Y&F clinics
Consumers	Y&F	Pete Owen	Contracts Department
Carla Cross	Training Department	Martha Serrano	Training Department

Goals/Expected Benefits:

- Increased adherence to evidence based treatment – scientific based, culturally relevant treatment which respects the voice of the consumer
- Measurable competency standard and level of care standard Improved outcomes & satisfaction for clients
- Structure implementated to in-put and measure fidelity and outcome measures
- Reduced length of stay



Project Title: Client Acuity Index: Using History of Psychiatric Hospitalization as Guide to Staff Interventions - Non Clinical PIP

Project Description:

To use client acuity as a guide in determining the extent of services for enrolled clients. Acuity to be determined by; frequency of past psychiatric hospitalizations, time since last hospital admission and lengths of stays.

Opportunity Statement:

Ability to provide staff with clinically minded structure based on need for services by clients' clinical history and acuity with reference to caseload coverage.

Team Members:

Name	Department	Name	Department
John Schipper	VCBH Adult Division Chief		

Goals/Expected Benefits:

Project goal is to develop a method to categorize clients by acuity given information available in the electronic health record in order to implement methodical approach to client services in reference to clinical need, increase caseload coverage, develop balanced caseloads and provide structure to staff serving a high rate of consumers.



Project Title: Post Hospitalization

Project Description:

Clients who are discharged from an inpatient psychiatric hospital require timely follow-up in order to address the issues that led to hospitalization so that future inpatient stays are not necessary. The federal government has instituted a standard that all post-inpatient clients should be seen face-to-face within 7 seven post-discharge for follow up care. DCHS follows the federal standard except that they allow face-to-face, phone and field contacts to count. VCBH has adopted a similar standard that all post inpatient clients should be offered a face-to-face appointment within 7 days post discharge. This acknowledges that clients often refuse the first available appointments or choose not to attend follow-up appointments.

Currently, STAR tracks first-offered post-Inpatient Psychiatric Unit (IPU) appointments for unenrolled clients. It's the protocol at STAR to abide by the VCBH standard 100% of the time. Currently, there is no mechanism in place to track the first-offered for enrolled clients who are known to be receiving inpatient care. Also, many enrolled and unenrolled clients are placed in IPUs without the direct knowledge of VCBH.

The plan is to introduce three processes to increase and monitor compliance with the VCBH standard:

1. VCBH RISE staff based at A&R will review Hillmont Psychiatric Center census data to identify enrolled and unenrolled clients who need follow-up care. They will then alert IPU discharge workers (for unenrolled) and VCBH clinics (for enrolled) of the need to offer a follow-up appointment within 7 days.
2. VCBH will develop an electronic healthcare record mechanism to track appointments offered for enrolled clients.
3. VCBH QA department will alert STAR (for unenrolled) and the VCBH clinics (for enrolled) whenever they receive an authorization request from non-HPC hospitals so that follow-up can be coordinated with these hospitals by the date of discharge.

Opportunity Statement

The current project offers the opportunity to identify more clients who are in inpatient care and offer them timely follow-up appointments with the end goal of reducing recidivism in inpatient care.

Scope:

The project will involve both the Adult, and Youth and Family Divisions including STAR and RISE. The Youth and Family process will be measurably assisted by the opening of the planned Crisis Stabilization Unit in the spring of 2016. At that time, VCBH will have more direct knowledge of youth inpatient stays no matter the location. The project will also require the resources of the QI department to develop a tracking mechanism for enrolled clients as well as QA to assist in the notification of authorization requests.

Goals/Expected Benefits:

The project intends to result in 100% compliance to the VCBH standard of offering a follow-up appointment within seven days of inpatient hospitalization to every qualified client known by VCBH to require follow-up care. The ultimate outcome is a reduction in inpatient recidivism and the accompanying costs and emotional hardships that come with it.

Team Members:

Name	Department	Name	Department
Felicia Skaggs	RISE/STAR	Keiko Fukue	RISE
Faizal Ummer	QI		



Project Title: Reducing Disallowances Due to Documentation Errors

Project Description:

This project addresses clinical documentation errors, as identified by monthly VCBH Utilization Review audits and tri-annual DHCS audits. It is costing tens of thousands of dollars in lost revenue for the Behavioral Health Department. This project will seek to identify the primary sources of documentation errors and develop training protocols to address them.

Opportunity Statement:

The opportunity exists to address clinical documentation deficiencies that would not only generate additional revenue, but would also promote documentation standards that are central to good clinical practice.

Although documentation deficiencies have been identified by UR for the past several years, the department has been unable to propose a structured plan to address this problem. Availability of necessary resources to adequately address this problem is an ongoing concern.

Current conditions are as follows:

- Current disallowances due to documentation deficiencies averages 20,000 minutes per month
- Eighteen percent (24% Adult / 5% YF) of all charts reviewed indicate out-of-date Client Plans – the single largest cause of disallowances.

The documentation issue has been longstanding. Following a compliance directive in 1999, documentation trainings were mandatory for a period of 5 years. Unfortunately, after the mandate expired, so too did the trainings. Sporadic trainings have been offered when requested by specific programs, but there has been little progress in developing a department wide training protocol. Site-specific efforts have been made to address documentation timeliness with varied results.

The benefit of completing this project is that documentation meets clinical practice standards and increased revenue. Those benefiting are all staff providing clinical services, consumers related to improved documentation, admin, Billing and Fiscal.

Scope:

- Data analysis (Utilization Review reports, DHCS audit reports, etc)
- Development of training protocols based on analysis
- Formation of a training development team
- Development of training materials
- Training implementation
- Ongoing chart reviews to assess impact and make adjustments as needed in training protocols

Goals/Expected Benefits:

- Identify leading causes of documentation disallowances
- Develop a Division-wide practice standard to address the identified issues
- Resolution if the identified issues should result in substantial revenue recovery.

Team Members:

Name	Department	Name	Department
Pete Pringle	BH Adult		
Carla Cross	BH Training		
Jennifer Dougherty	BH Y&F		
Angela Riddle	BH Y&F		



Project Title: Access to Services

Project Description:

The data below indicates how long it takes on average from RFS to the first visit with psychiatrist.

For N=464, RFS Date to First Psychiatrist Appointment, Adults only, FY 15/16, Routine Cases, the following descriptive statistics were calculated in days.

Mean: 95

Mode: 70

Median: 87

Standard Deviation: 47

Minimum: 3

Maximum: 294

Range: 291.00

For N=129, RFS Date to First Psychiatrist Appointment, Youth only, FY 15/16, Routine Cases, the following descriptive statistics were calculated in days.

Mean: 119

Mode(s): 35, 84, 90

Median: 106

Standard Deviation: 56

Minimum: 28

Maximum: 315

Range: 287

The data above is only preliminary and shows that access to services needs to be streamlined and evaluated for improvement opportunities. More detailed cycle time data will be collected during the MEASURE Phase of this project. The data will be specified and described in a Data Collection Plan, and used to analyze the process in more detail. Furthermore, the data collection results will help in guiding team to problem areas.

Another issue that may be introducing inefficiency into the STAR process of accessing treatment is the accuracy of the decision-making at screening and assessment with respect to diagnostic criteria and markers of functional impairment. If the STAR process is indeed too lax and clients are being admitted without adequate basis (i.e., so called “false positives”), they are undeniably consuming resources inappropriately and slowing down the process.

There is also concern that the speed and arduousness of the STAR process may be causing some appropriate referrals to “drop-out” before being assessed or receiving services/treatment. In order to evaluate the protocols, this project will also gather data that examines both admissions that “drop-out” or minimally engaged in available service (treatment) in the first 18 months of enrollment and referrals that “drop out” prior to admission into treatment. Preliminary data reflecting the “drop-out” rate is shown in the next paragraph for FY 15/16.

From 1836 instances of RFS, 1752 instances make it to 1st available appointment in STAR, 903 instances make it from RFS to an assessment, 628 instances make it from RFS to the first appointment at their assigned clinic and 464 instances make it from RFS to a first psychiatric appointment at their assigned clinic (adults only).

For 771 instances of RFS for youth, 762 make it to 1st available appointment in STAR, 411 instances make it from RFS to an assessment, 304 instances make it from RFS to the first appointment at their assigned clinic and 129 instances make it from RFS to a first psychiatric appointment at their assigned clinic

Opportunity Statement:

Smoking related illness is the #1 cause of death in people with mental or substance use d/o's. While the overall rate of smoking in the general population has declined, this has not been the case for the population we serve.

Scope:

In Scope:

Request For Service (RFS) through beginning of treatment (first appointment at assigned clinic or with psychiatrist, if required)

Adults

Youth

Routine

Self-Referral
 New Clients
 Returning Consumers (Over 1 year)
 Referred-Out
 Expedite
 Decision-Making Criteria Mechanism/Process (Screening, Assessment and Treatment Protocol)
Out of Scope:
 Ventura County residents coming from out of County
 Urgent
 Additional staff

Goals/Expected Benefits:

The goals for this project support and guide the improvement of the VCBH client-access experience by streamlining and improving the accuracy of the process. Specifically, increase process efficiency and improve quality by:

- 1) Creating a process whereby 100% of those that request mental health services are referred to an appropriate treatment provider (e.g., those in the mild to moderate range of severity going to managed care and community-based providers, and the moderate to severe going to VCBH);
- 2) Optimizing client throughput;
- 3) Reducing cycle time (i.e., lessen the time from RFS to first appointment offered in STAR, to actual assessment, to first appointment at assigned clinic, and to the first appointment with a psychiatrist (goals are still to be determined upon more availability of data).
- 4) Ensuring the accuracy of those referred out, decreasing “drop-outs” of those remaining in VCBH, improving the accuracy of screening and assessing.

The above will utilize examination of redundancies, rework and non-value-added steps, while ensuring the accuracy and reliability of decision-making throughout the process.

Team Members:

Name	Department	Name	Department
John Schipper	Chief/Adult Division	Pete Pringle	Chief/Youth Division
Julie Glantz	BHM/Adult Division	Clara Barron	BH/MHSA
Lourdes Solorzano	BOS District 5 Office	Patricia Gonzalez	QI
		Shanna Zanolini	QI



Project Title: Access to Services -- After Hours

Project Description:

Mechanisms to address the accessibility of after-hours care.

Opportunity Statement:

VCBH provides access to request for services, crisis intervention, and information 24/7 through our Access Line. This project will assess the mechanisms of after hours care.

Scope:

The Access Line provides services for consumers who may be experiencing a Mental Health Crisis through a toll free number 1-866-998-2243. The Crisis Team is staffed 24/7. Experienced and trained mental health staff will provide assistance and support on the phone and, if indicated, will respond in person, generally within one hour.

For consumers wanting to access Mental Health services, the same line provide access to a qualified mental health specialist who will conduct a screening interview to discuss what services might best the consumers' needs.

If VCBH services appear to be the best possible option, he/she will be scheduled for a comprehensive assessment with a mental health clinician. If VCBH services appear not to be the best option, consumer will be provided with alternative resources in their community.

Call Log:

Currently, the Access Line receives between 2,000 and 2,500 calls per month. All these calls are logged into a Call Log and categorized into three types: request for services (RFS), information, and clinical (crisis, support, or follow up). Client provides name, age, city where client is, and telephone number. Staff checks whether consumer is currently enrolled in Mental Health services, whether language assistance is needed, time call began and ended, and brief narrative of type and outcome of call—that is, finding consumer the appropriate level of care (the right provider). A monthly Call Log is printed for review.

24/7 Test Call Quarterly Update Report, Mystery Shopper:

VCBH assesses the Access Line using the 24/7 Test Call Quarterly Update Report Form through “mystery shoppers.” The mystery shopper reports capture number of calls made after hours, non-English test calls, and information about how to access specialty mental health services. The form contains seven questions, and compares both business hours and after-hours.

Goals/Expected Benefits:

The goals for this project support and guide the improvement of the VCBH consumer after-hours access experience by analyzing call volume, nature of call, and outcome of call. Specifically improve quality by:

- 1) Ensuring 100% of calls are logged
- 2) Maintain a 90% or above score on the 24/7 Test Call Quarterly Update Report Form on initial disposition of request (e.g., caller provided with clinic hours/location, beneficiary scheduled for assessment with Provider at Date/time, warm hand off to 24-hour Crisis Clinician)
- 3) Maintain a 95% or above score on the 24/7 Test Call Quarterly Update Report Form on language capability in all languages (non-English) spoken by beneficiaries of the County.

Team Members:

Name	Department
Julie Glantz	BHM/Adult Division
Shanna Zanolini	Sr Psychologist/QI
Dave Roman	PA/Electronic Health Record
Eric Elhard	Clinic Administrator/Crisis
Robin Boscarelli	Clinic Administrator/Crisis