QI Work Plan: Tracking & Monitoring Tool

(as of 1/23/2013)

Outcomes*	Measurable Objectives	Change	Part of System to be Improved	Work Group Assignment	Objectives, Measures (Process & Outcome)	Progress Toward Goals & Current Activities
1. **Improve clients' wellness and recovery** 2. **Increase clients' independence from public mental health services** 3. **Increase contribution to a healthier community** 4. **Increase satisfaction and support of tax payers** *Mental Health System's role and contribution in achieving the Triple Aim in Santa Clara County: • Reducing the cost of care • Improving the patient experience • Boosting the overall health of the population you serve	1. Increase penetration 2. Increase flow of clients into and out of the system 3. Increase capacity 4. Increase access 5. Increase engagement & retention 6. Improve client satisfaction and experience with services 7. Improve efficiency 8. Decrease high acuity recidivism	**Transitional Care Planning**: redesign processes to assess, understand and plan; develop person-centered skills	**Core**: Assess, Understand, Plan **Support**: Staff Development & Supervision, Documentation, Auditing	TCP	1. 100% Staff skilled at delivering TCP practices 2. 100% Supervisors skilled at supporting staff in TCP practices 3. Ongoing supervision/coaching and support for TCP practices across the system 4. Increased MORS Scores for the Adult and Older Adult Division 5. Increased number of Strengths items and decreased number of Needs items on the CANS measurement tool for Family and Children's Division	
		Access and Capacity Management: improve flexibility of programs, contractual structure and referral processes (AB109, access points, LOCs) and customer services	**Core**: Access, Transition **Support**: Contracting, Reimbursement	Levels of Care (F&C)	1. Shorten the length of stay 2. Increase consistency of service array 3. Increase differentiation of services 4. Utilize financial resources with specific requirements and limitations 5. Create greater flexibility to move clients from one level of care/program to another 6. Link client-centered, family-driven services to 7. Improve understanding of each other's programs 8. To provide high quality care 9. Improve access to services by building in more consistent/predictable turn-over 10. To maintain open clear communication 11. Safety and well-being for each child and family 12. Define roles and expectations of providers and ensure appropriate training is provided	
				AB109 (Adult)		
				Rebekah's Pilot		
				Customer Service		
		Client Measurement: increase measurement of community and client needs, quality of life indicators and other outcome	**Core**: Assess, Understand Plan **Support**: Contracting	Peer Support Design	1. Develop supports for consumers in their person centered treatment plan. 2. Provide peer support for all consumers in the county at any stage in their recovery. 3. Provide meaningful consumer informed guidance for program development, program modification and program evaluation based on the information that will be acquired through surveys, focus groups and special studies. 4. Influence the PQIC with our lived experience.	

		measures: Client Outcomes , CANS (F&C, demand analysis)			5. Every consumer has the opportunity for peer support. 6. Promote a consumer culture that promotes recovery. 7. Contribute to the achievement of a system-wide consumer experience and consumer satisfaction that is respectful, dignified and welcoming. 8. Reduce stigma within the System. 9. Promote healthy living environments to encourage hope, recovery and reduce recidivism.	
				CANS		
				Performance Measures	1. Improved measurement of client and family outcomes 2. Managers are able to identify and act on opportunities for improvement as well as celebrate and reward success – at the system-level, program level (including with specific client cohorts) and individual client level 3. Contractors are appropriately evaluated, selected and contracted/recontracted per county requirements 4. There is sufficient transparency in reporting performance so that the MHB and other stakeholders are confident about knowledge of system and program-level performance 5. Improved cost effectiveness of services	
		Supervision: improve capacity to support staff in their work to advance client outcomes	**Core**: All **Support**: Supervision	Supervision		
		Streamline Documentation: streamline documentation requirements to reduce burden on staff, improve usefulness for clients	**Core**: All **Support**: Documentation & Reimbursement	Standards of Practice & Document.		
				Compliance		
		Clients Transitions: improve transitioning to/from FQHCs, IMDs, etc. – and into the community	**Core**: Access, Planning, Transition **Support**: External/Community Resources	Transitions		
				FQHC Referrals		

		Linkage to Services: reduce preventable readmissions to acute/ED services, improve linkage to 24 hour care, create drop-in services	**Core**: Inpatient Svs **Support**: External/Community Resources	NSN Collab		
				24 Hr Care		
				Grace Drop-In		
		EBPs: increase therapeutic skills and capabilities of staff (expand range of EBPs)	**Core**: Treat **Support**: Staff Devel & Superv	F&C LOC Sub-Work Groups		
				A/OA pending		
		Advancing Recovery: improve ability to treat clients at MORS 5, Older Adults	**Core**: Plan, Treat **Support**: Staff Devel & Sprv	MORS 5 Pilot		
				OA Task Force		