QI Workplan FY 17-18 Evaluation

Evaluation of QI Program Efficacy

Quality Improvement Committee

During FY 17-18, membership did not include a clinician or a case resource specialist. This is mostly due to the fact that we have been understaffed for the entire year. The Medical Support staff was represented by the Nursing Supervisor. The Mental Health Board chair represented both the Board and consumers. The QAM represented both the QAM and the Cultural Competency Committee.

Data Analysis

The QI Program gathers data to monitor access to care, timeliness of care, and quality of care. Multiple data points are monitored, tracked, and reported on to different groups, including the QIC. The purpose of this is to determine where improvement is needed and to determine what types of interventions should be implemented in order to create and sustain that improvement.

This past fiscal year, data analysis has been difficult due to the lack of an electronic health record (EHR) system. We worked diligently with our EHR vendor to implement the new system but, due to multiple difficulties with our vendor, our EHR is not yet implemented. This limits our ability to gather and track data, which therefore limits our ability to monitor compliance to our set standards, determine where improvement is needed, and if QI interventions are successful.

There also was not a QI Workplan in fiscal year 16-17, nor an evaluation of the Workplan from fiscal year 15-16, so there is not baseline data to compare information to.

Service Delivery Capacity/Network Adequacy

Accessibility of Services

Timeliness and Access to Services

We are currently unable to accurately track timeliness and access to services, as we are unable to track first request for services. We attempt to get insight into this issue by reviewing what the next available assessment appointment is. We run this weekly for both our Red Bluff and Corning offices for both English and Spanish-speaking clients. While these numbers are often higher than our standard, we offer walk-in assessments at our Red Bluff office twice daily to ensure clients have timely access to care. It is recommended that determining a way to track first request for services be a goal for the QI Program in fiscal year 18-19.

Tracking of Authorization Timeliness

We were able to pull data from fiscal years 16-17 and 17-18. Our system has clinicians turn in assessments, which are considered authorization requests, to chart room staff (Office Assistant II, or OA-II). Once processed, OA-IIs forward this to the Office Assistant III (OA-III) for further processing. OA-IIIs

prepare the documentation for review by a triaging clinician. The following data is reported in number of days between each step:

Fiscal Year 16-17	Assmt to OAII	OAII to OAIII	OAIII to Triage	Assmt to Triage
Averages:	4	8	17	29
Mode:	0	5	0	21

Fiscal Year 17-18				
Averages:	3	4	8	16
Mode:	0	1	1	14

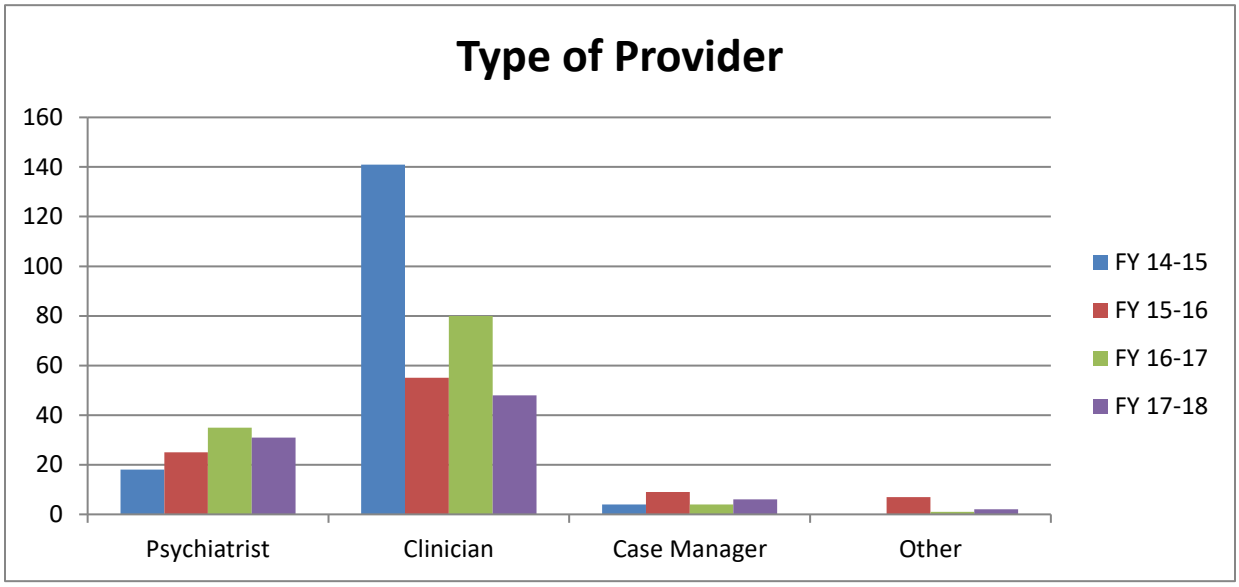
For fiscal year 16-17, it appears the lag in authorization was between OA-III receipt and the triage clinician reviewing the documentation for approval. Over the past year, we have been working to decrease this turnaround rate, even though we were not tracking the data formally. It appears that our efforts did improve this turnaround time, as we improved timeliness in all aspects of this process. It's recommended that continued improvement in authorization timeliness be a goal for the QI Program in fiscal year 18-19.

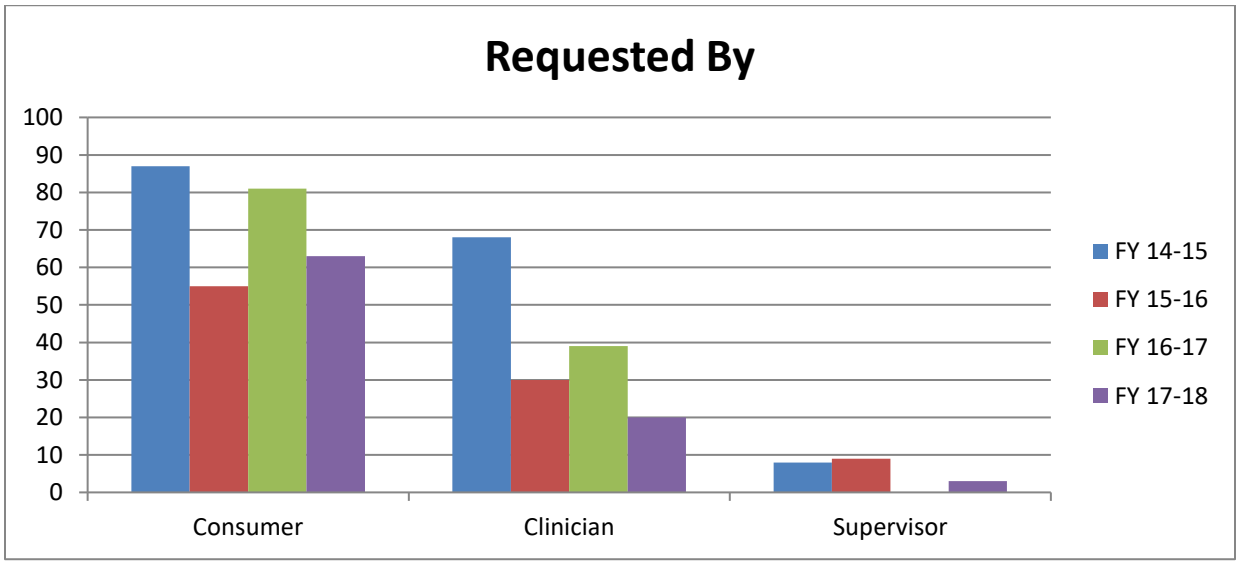
Beneficiary Satisfaction

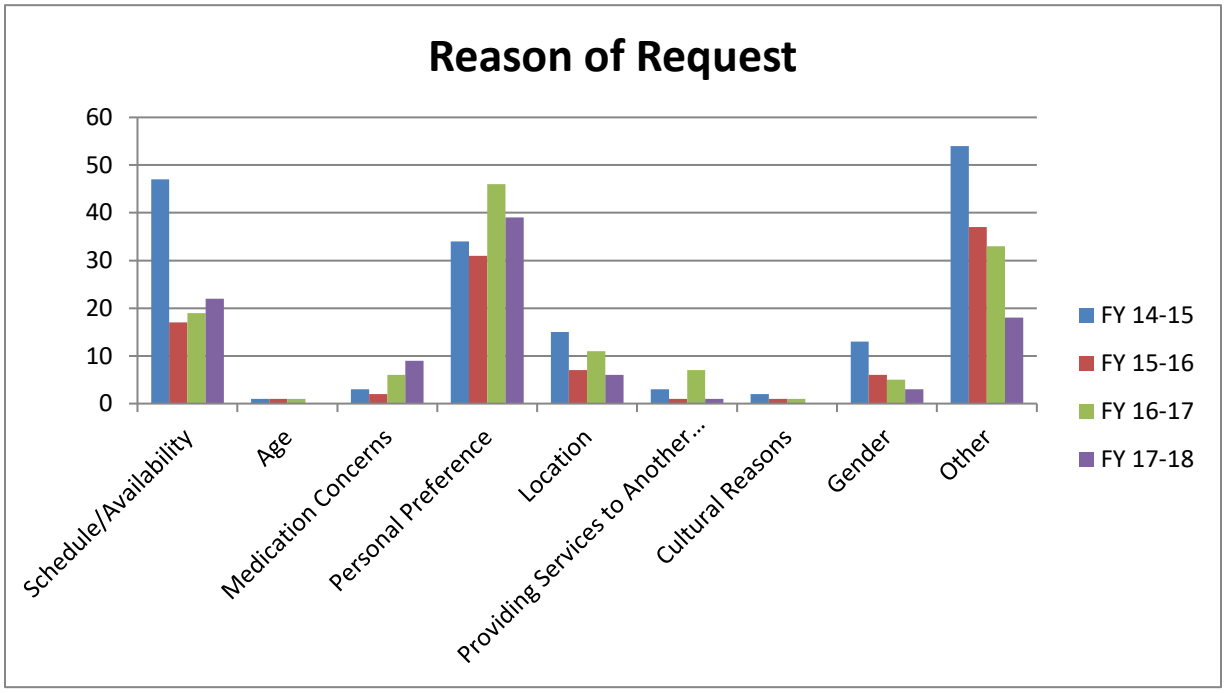
Change of Provider Requests

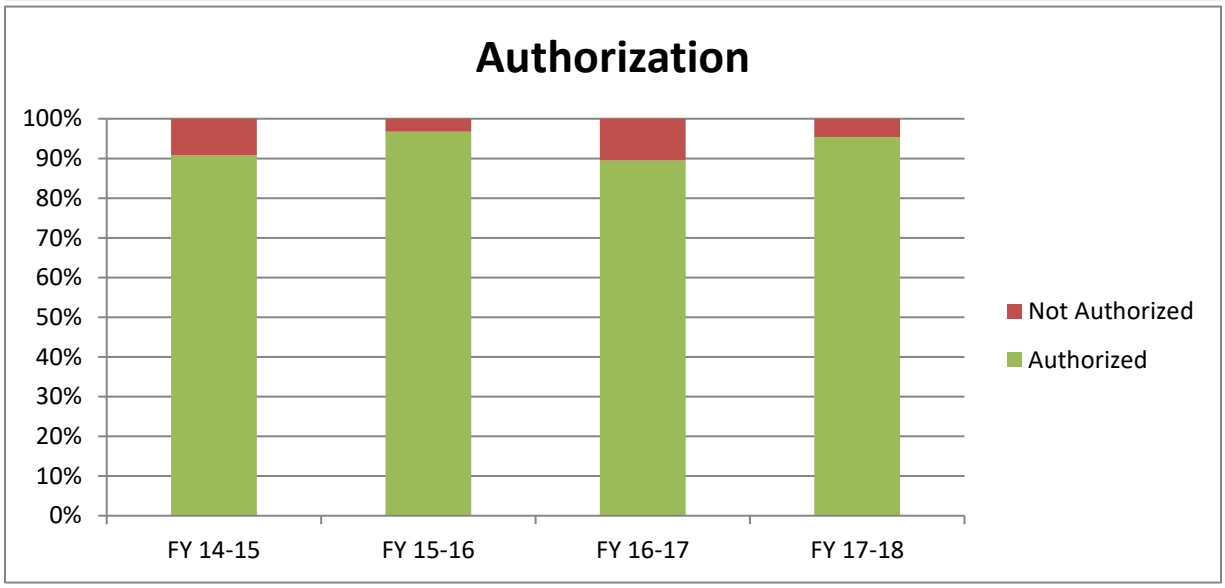
We were able to pull data from multiple fiscal years regarding requests to change providers. There is currently no particular goal in mind, as there has not been any clear trends regarding types of reason for change, type of provider to change, or authorization outcomes. We would expect, for example, that most of the types of provider requested to change would be clinician, as that is the type of provider we have the most of. We also seldom deny a request to change providers, but these have typically been due

to availability (e.g. no other provider is available).



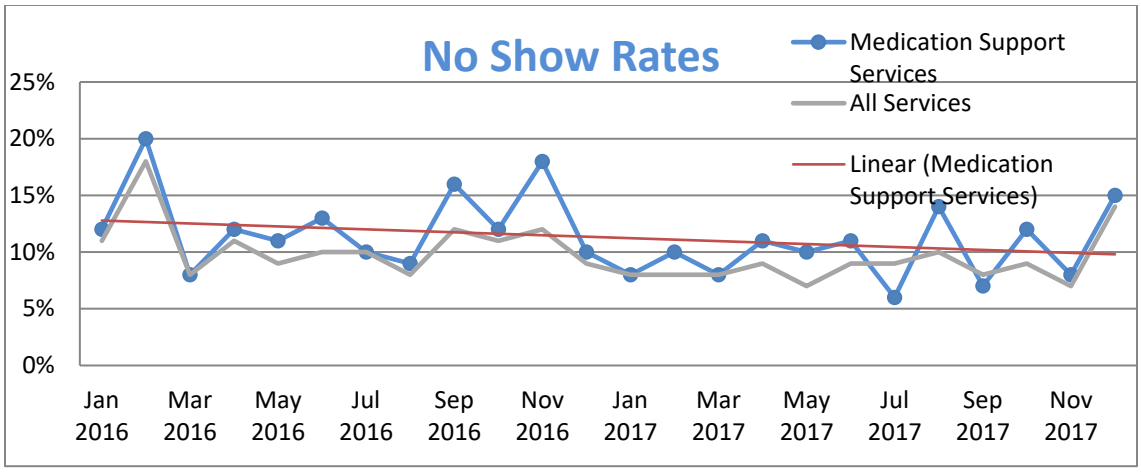






No Shows

Our standard for no-show rates is 10% for both clinical staff and psychiatrists. We implemented a PIP during calendar year 2017 to decrease medication support no-show rates, though our interventions did not appear to affect the no-show rates. The rates are somewhat erratic but appear to be decreasing overall.



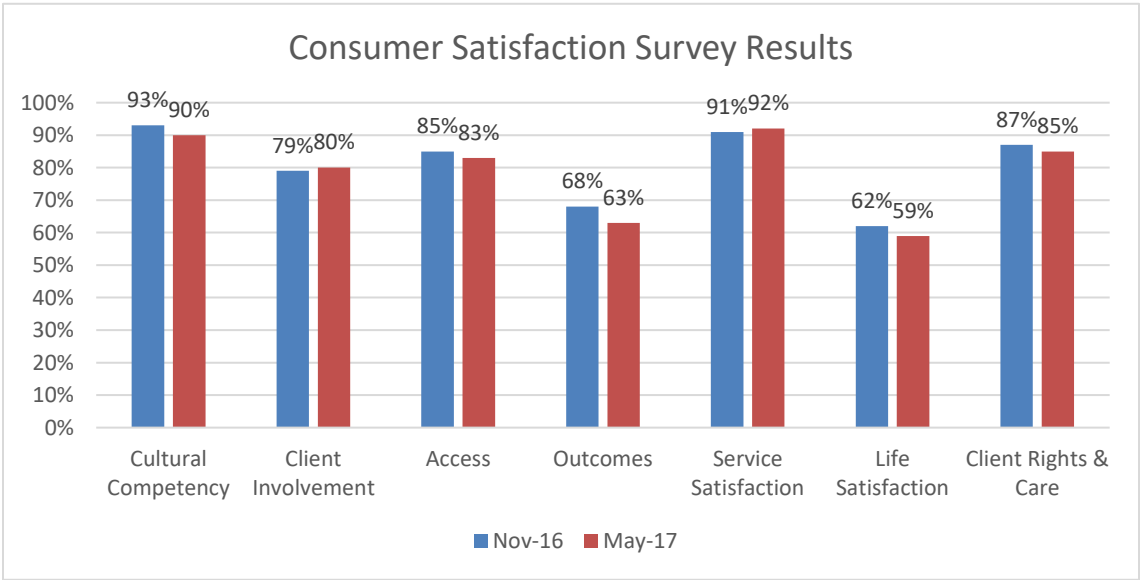
Grievances and Appeals

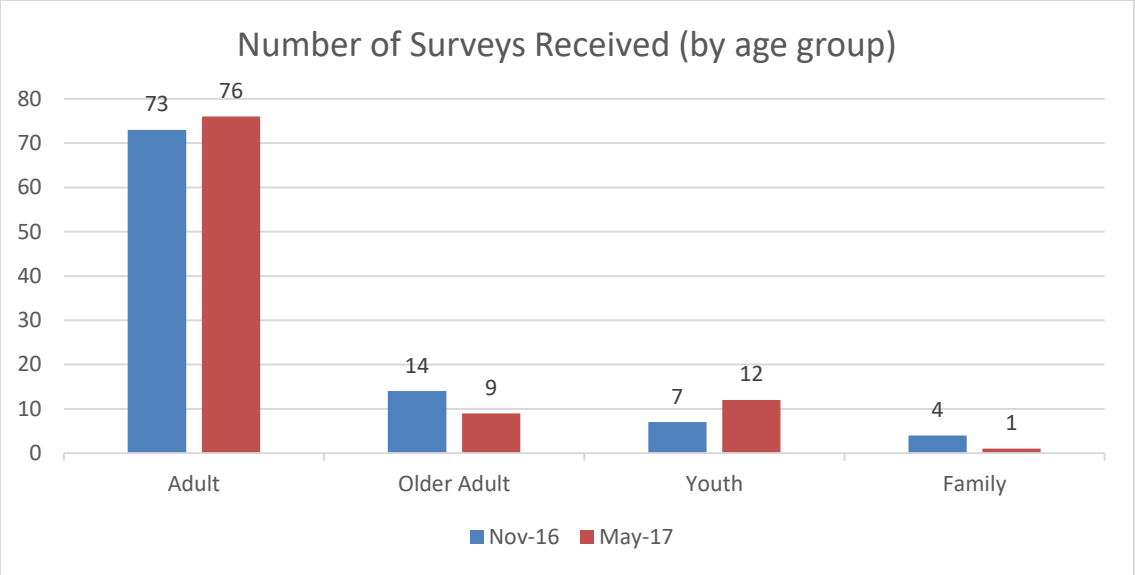
There were 0 appeals and 22 grievances during fiscal year 17-18. All 22 grievances were followed up on. 11 of the grievances did not have a letter sent, as the letter was not sent timely and was determined to be not beneficial to the client to send so late. 6 letters were sent timely and the remaining 5 were unable to be sent due to not having an address to send the letters to.

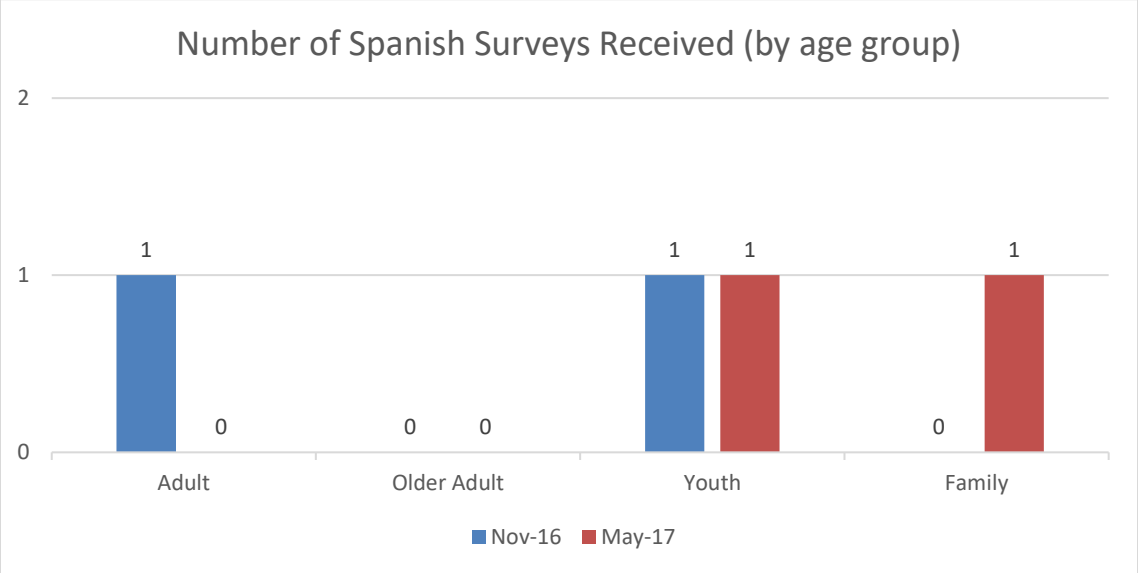
See Annual Beneficiary Grievance and Appeal Report (ABGAR) for details. It is recommended that an improvement in the timeliness of grievance resolution letters be a goal for the QI Program in fiscal year 18-19.

Consumer Satisfaction Survey Data

We collect the required DHCS consumer satisfaction survey data twice in fiscal year17-18. These results are not often available until 6 or more months from the date of the survey and therefore the survey data available at this time is from Nov 2016 and May 2017.







Service Delivery System/Clinical Issues/Medication Monitoring

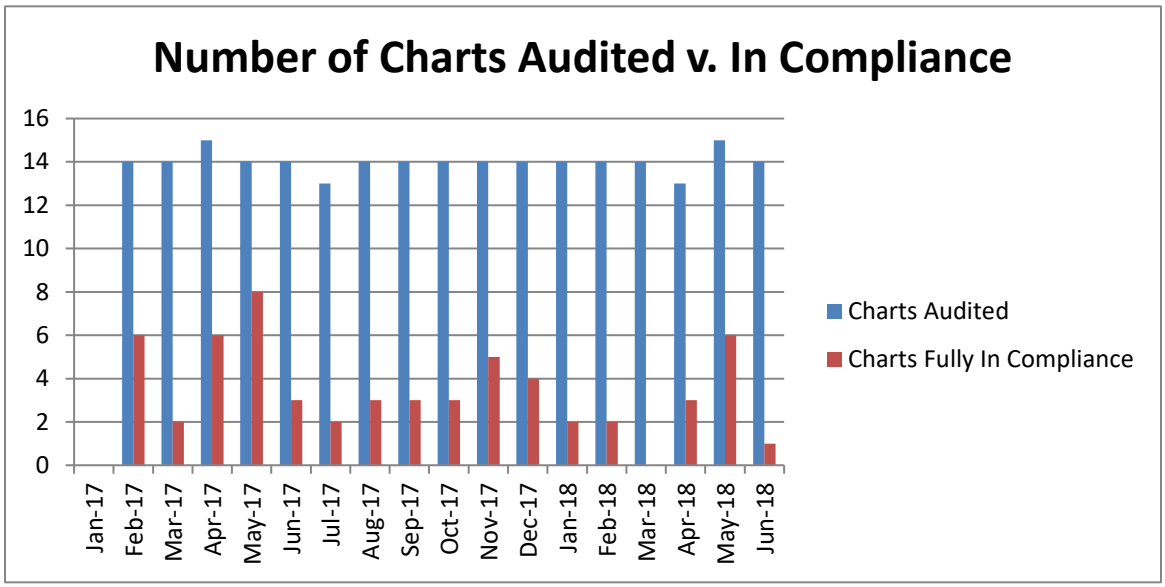
Results of Internal Peer Chart Reviews (Peer Review)

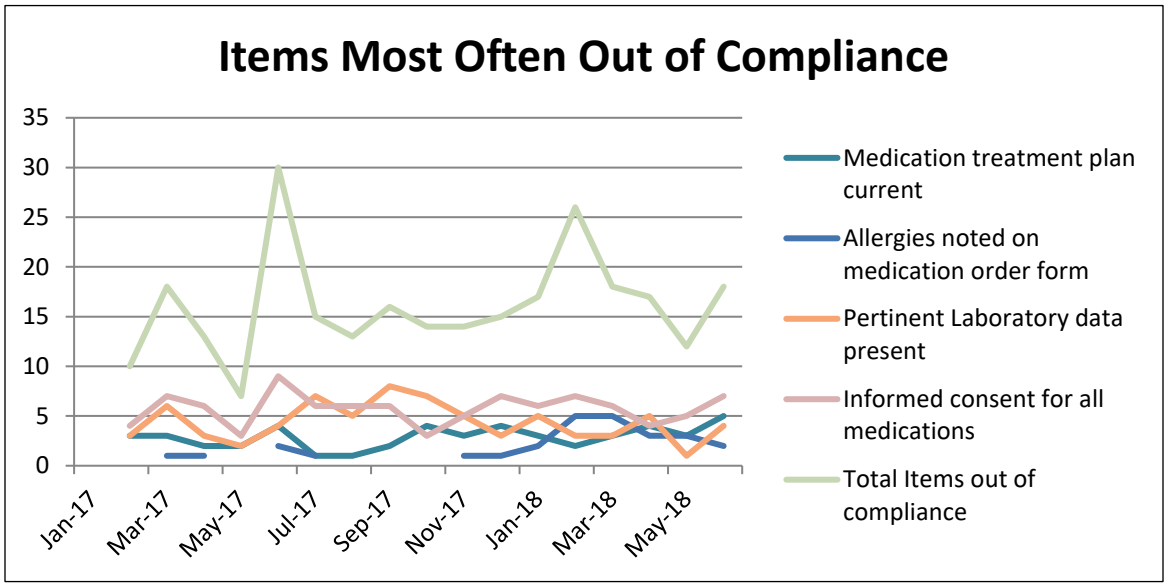
No data was available for this section.

Medication Compliance/Medication Monitoring

We conducted medication compliance/medication monitoring reviews monthly during calendar years 2017 and 2018, with the exception of January 2017, when our reviewer was unavailable. Compliance results did not appear to either improve or worsen between February 2017 and July 2018, as demonstrated in the figures below. The items that were most often out of compliance also did not

change. It's recommended that an improvement in the number of items in compliance be a goal for the QI Program in fiscal year 18-19.





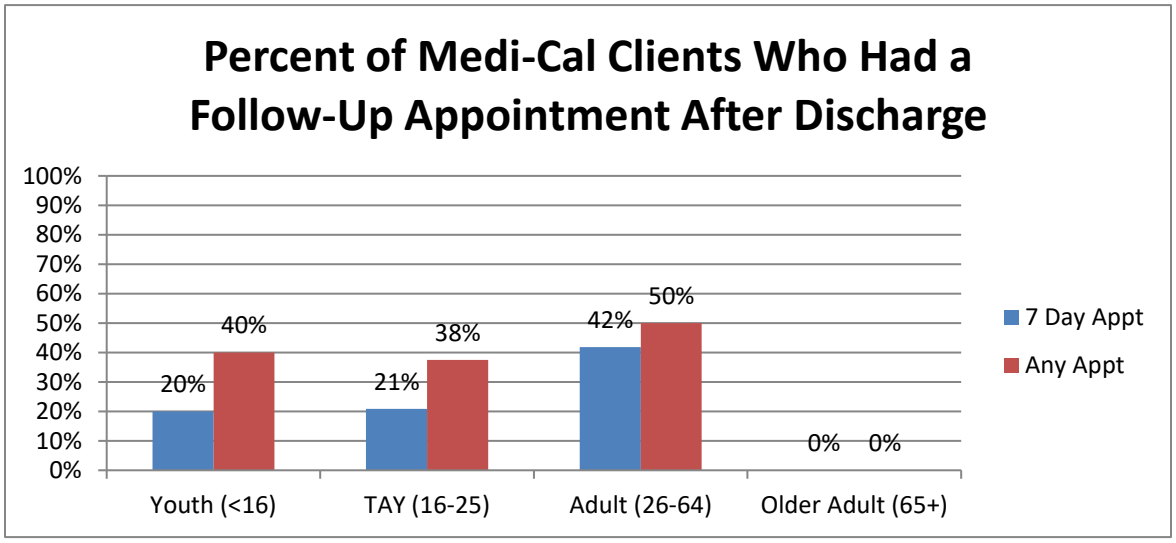
Access/Crisis Line Test Calls

During fiscal year 17-18, there were a total of 10 test calls made. 6 of these were during business hours and 4 were after business hours, which includes weekends and holidays. 0 non-English test calls were made during this fiscal year. The majority of calls met the requirements (addressed the concerns of the caller): access questions 71%, urgent questions 100%, problem resolution 0%. However, the majority of calls were not logged appropriately (42%). It's recommended that training on access questions and the problem-resolution process be given to all Access/Crisis line staff, as well as re-training on logging calls appropriately. It's also recommended that an improvement in the responses and logging be a goal for the QI Program in fiscal year 18-19.

Continuity of Care

Seven Day Inpatient Hospitalization Follow-Up

When reviewing the data from fiscal year 17-18, it was made apparent that there was some validity issues with regards to the collection of this data. This data is currently being gathered from an Access database that includes all hospitalizations initiated by Tehama County, regardless of fund source. While we attempted to isolate hospitalizations for Medi-Cal beneficiaries, we determined that we were unable to determine what county these Medi-Cal beneficiaries were residents of. This impacts our ability to accurately report on the 7-day post-hospitalization follow up appointments, as we would only be initiating these follow-up appointments for clients who would be returning to Tehama County. Client who are residents of other counties are released to their county of residence, who is responsible for their follow-up care. We would therefore not be initiating a follow-up appointment for these clients, even though we initiated the hospitalization. It is recommended that determining a method for improved tracking of hospitalization follow-up be a goal for the QI Program in fiscal year 18-19.
The following data is pulled from our fiscal year 17-18 method of tracking:



Medi-Cal Clients Who Had a Follow-Up Appointment Within 7 days of Discharge

# stay	Youth (<16)		TAY (16-25)		Adult (26-64)		Older Adult (65+)		Total	
	%	n	%	n	%	n	%	n	%	n
1	13%	1	19%	4	37%	23	0%	0	30%	28
2	0%	0	50%	1	50%	3	N/A		44%	4
3	100%	1	0%	0	75%	3	N/A		67%	4
4	N/A		N/A		100%	2	N/A		100%	2
Total	**20%**	**2**	**21%**	**5**	**42%**	**31**	**0%**	**0**	**34%**	**38**

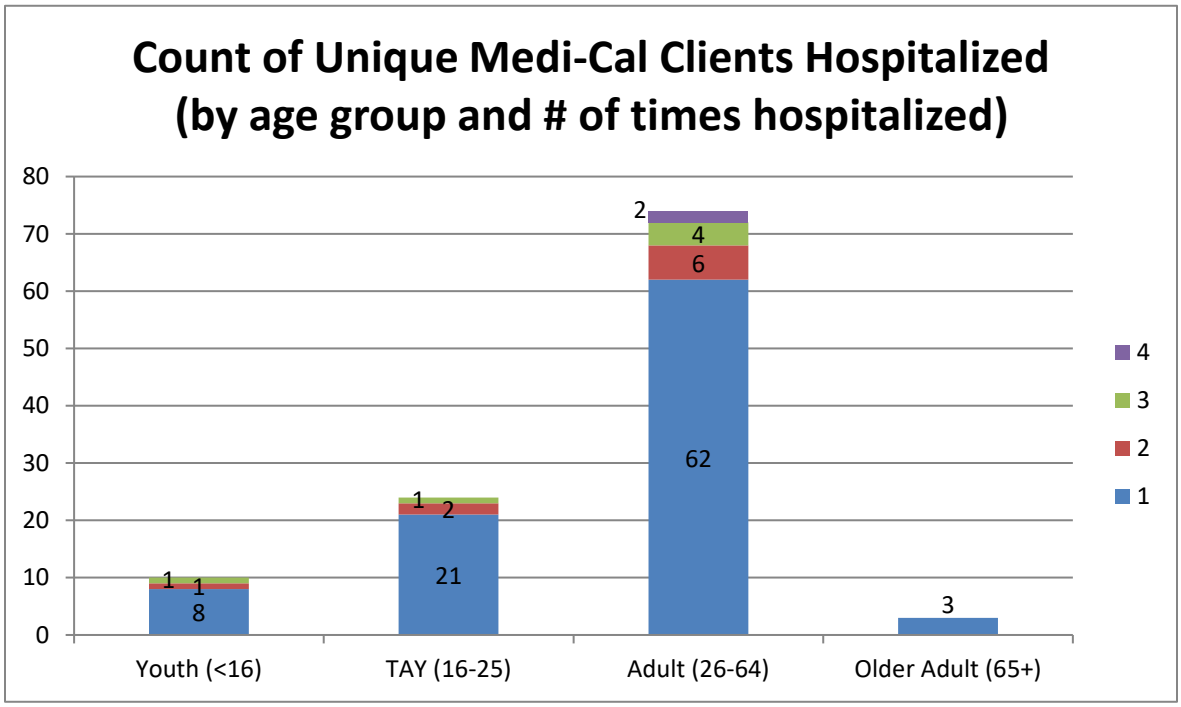
Medi-Cal Clients Who Had a Follow-Up Appointment After Discharge

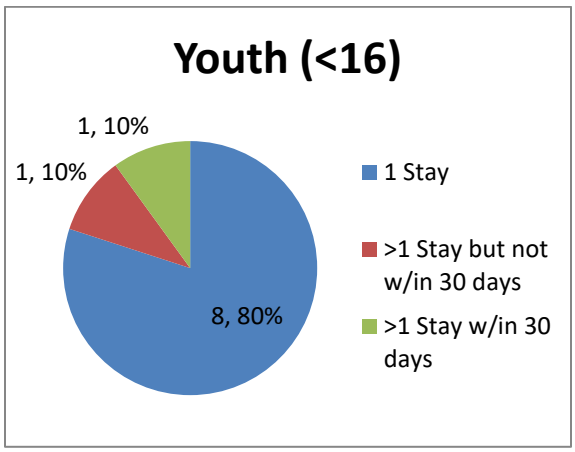
# stay	Youth (<16)		TAY (16-25)		Adult (26-64)		Older Adult (65+)		Total	
	%	n	%	n	%	n	%	n	%	n
1	38%	3	38%	8	47%	29	0%	0	43%	40

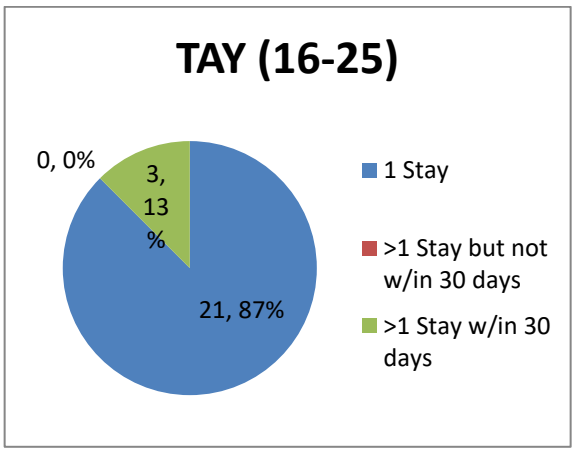
2	0%	0	50%	1	50%	3	N/A	**44%**	**4**	
3	100%	1	0%	0	75%	3	N/A	**67%**	**4**	
4	N/A	N/A	100%	2	N/A	**100%**	**2**			
Total	**20%**	**2**	**21%**	**5**	**42%**	**31**	**0%**	**0**	**45%**	**50**

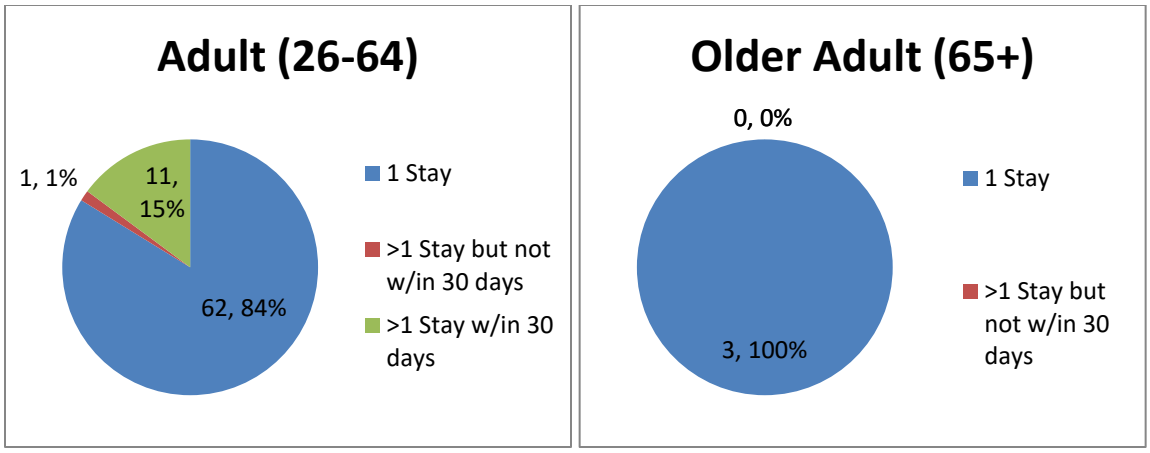
Re-hospitalization Rates

We have also been monitoring re-hospitalization rates, though not clearly indicated in the previous QI Workplan. We currently measure 4 age groups: Youth (younger than 16), Transitional Age Youth (ages 16-25), Adult (ages 26-64), and Older Adult (65 years or older). The following data is from fiscal year 17-18.









Provider Appeals and Satisfaction

Treatment Authorization Requests (TARs)

23 TARs were received last fiscal year. All of them were processed within 14 days of receipt, meaning we were 100% compliant with our standards.

Provider Appeals

There were no provider appeals in FY 17-18 that were reported on.

Performance Improvement Projects

The External Quality Review by the EQR Organization (EQRO) occurred in November 2017, during which we had a non-clinical PIP focused on no-show rates for medication support services. Interventions included additional reminder calls, fit-in procedures, and considering public transportation when making appointments. The outcome of the PIP was that there was no significant decrease in the rate of no-shows for medication support services. This PIP was ongoing during the EQR and ended December 2017. PIP discussion occurred in QIC in December and as part of the no-show report in July and September.

The QI Program did not have an ongoing clinical PIP during FY 17-18 but had a concept-only PIP related to benzodiazepine reduction. Plans for data collection and interventions are ongoing at this time.

It's recommended that having 2 active PIPs be a goal for the QI Program in fiscal year 18-19.