QI Workplan Goals FY 18-19

QI Program

QI Committee

Staff shortages continue to impact the QI program and the ability to have full QIC membership. Direct-care staff have not had time allotted to participate in QIC due to the need to provide direct-care services to clients, as many of our direct-care positions have been vacant. QIC members are also often representing multiple service teams and programs and fulfill multiple roles. For example, the Licensed Clinical Nursing Supervisor was present as both a supervisor and as a medication support staff member. The Mental Health Board Member was also a consumer and so represented both roles. We are hoping to improve QIC membership once staffing issues are addressed.

FY 18-19 Goal: Once staffing issues are resolved, engage direct-care staff in QIC.

QI Workplan and Evaluation

In fiscal year 16-17, there was no QI Workplan, which meant there was not an evaluation of that workplan completed. A QI Workplan was completed for fiscal year 17-18 and the evaluation for it comprises the previous section of this document. Because there was not an evaluation completed in the prior year, baseline data was difficult to find for this year’s evaluation. The hope is that next year’s evaluation will be more thorough and clear.

FY 18-19 Goal: Complete an evaluation of this QI Workplan by June 30, 2019.
Complete a new QI Workplan for the subsequent fiscal year by July 1, 2019.

Monitoring Service Delivery Capacity

Overview

Staff shortages continue to impact service delivery. Over this past fiscal year (17-18), the MHP has seen 2 supervisors and multiple clinicians leave. During this time, there were multiple new hires who also left employment. The MHP has ongoing recruitment occurring year-round for all levels of staff. The MHP initiated a specialized recruitment for new graduates of master’s programs in therapy and social work. Local schools were contacted directly, and recruitment gift-bags were handed out at local college job fairs. The MHP also worked to get approval to offer employment pending a graduate getting their BBS registration number in order to increase the applicant pool and improve hiring timelines. At the time of

this report, the MHP has 16 clinician positions, 6 of which are vacant, though there are multiple prospective hires.

FY 18-19 Goal: Increase the number of filled positions.

Network Adequacy

During this fiscal year, the California Department of Health Care Services (DHCS), initiated use of a Network Adequacy Certification Tool (NACT). This included mapping time and distance standards, listing all direct-care providers, and reporting on the number of services provided. The first submission was March 30, 2018, with plans for quarterly submissions afterward. Initial feedback from the first submission was that TCHSA "conditionally passed" the network certification requirements, with notes that the established standards were not met for adult and youth in both psychiatry provider capacity and outpatient specialty mental health services (SMHS) provider capacity. We also do not currently contract with an American Indian Health Facility (AIHF), which was also an established standard (see email from DHCS MHSD Final Rule dated 6/21/18).

Staffing has been an issue for the MHP for some time, especially with certain positions. TCHSA has had a continuous recruitment for psychiatrists through fiscal year 17-18 and years prior. This severely impacts how frequently and how quickly clients can be seen by providers. Recruitment efforts continue, and new efforts were made this past fiscal year to recruit directly from the universities in the area. TCHSA hopes to increase the number of filled positions, especially for direct-care positions.

FY 18-19 Goals: Increase the number of filled positions in order to meet network certification standards for provider capacity. Outreach to local AIHFs.

Penetration Rates for the Latino/Hispanic Population

The MHP continues to have a lower penetration rate for the county's threshold population (Latino/Hispanic) compared to other small counties. Penetration rates for the Latino/Hispanic population is provided annually by the EQRO. The most recent data is from calendar year (CY) 2016 (see figure 3B below).

In order to improve penetration rates for the Latino/Hispanic population, TCHSA planned to continue and expand Latino outreach by providing services in Corning, which has a large Latino population. Two clinicians and a health educator are budgeted for these services. However, over fiscal year 17-18, both of these clinicians ended up leaving, one in August and one in May. TCHSA, therefore, did not provide as many hours of services as planned in Corning, although outreach efforts continued. Recruiting attempts for these positions, which are reserved for bilingual staff, are ongoing. Services in Corning continue at a lower level, covered by bilingual clinicians who work primarily in other programs.

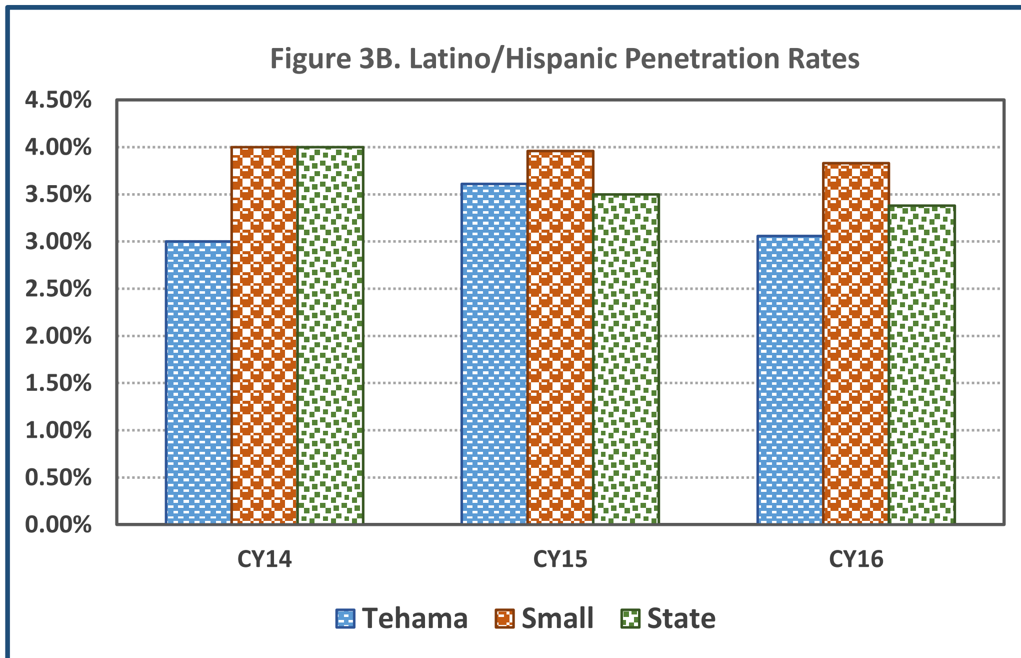

*Figure 3B from CalEQRO Report 2017

FY 18-19 Goal: Re-invigorate services in Corning by increasing hours of services provided after staffing issues are addressed. We hope this will improve penetration rates in following years.

Geographic Expansion

Over this fiscal year, we focused on retaining our Corning-based services with fewer staff members. We also provided Nurturing Parenting classes in Los Molinos, piloting services in this area. Also, in response to a shooting in Rancho Tehama, we provided groups and outreach in that area. During our MHSA community planning process, we conducted stakeholder feedback sessions in Red Bluff, Corning, and Los Molinos. During May, which is Mental Health Month in Tehama County, we had staff do outreach to multiple schools, including those in more rural areas.

FY 18-19 Goal: Re-invigorate services in Corning by increasing hours of services provided after staffing issues are addressed. Continue to provide outreach to other areas in Tehama County.

Monitoring the accessibility of services

Timeliness and access to services

This past fiscal year, we continued to provide walk-in appointment slots twice daily, once in the morning and once in the afternoon. While we recorded data regarding usage on these appointments, this data was not monitored or reported on in any particular way. Based on feedback from supervisors who prioritize walk-ins (when there is more than one) and clinicians who conduct walk-in assessments, we had regular use of walk-in slots but most often only had 0-1 walk-in per slot. It wasn't frequent that we had multiple walk-ins requiring supervisor triage, and if so, it was usually only 2 walk-ins, most of whom chose to do another walk-in slot.

We also measure length of time, in days, to available scheduled appointments weekly. This is done by front-desk staff finding the next available assessment slot (3-hour block of time) with any clinician. We currently do not have the ability to cross-reference these reports to determine how long from first contact until first actual appointment. We are working on a solution for measuring this, but it will likely require the implementation of our electronic health record. This report was reviewed in QIC in September.

We also utilized crisis slot appointments for psychiatrist evaluations for people with urgent conditions and those exiting from inpatient hospitals. Again, this data was not tracked or reported on in a formalized way, but feedback from supervisors was that these slots were being used but we also appeared to have enough openings to show that we were within capacity.

FY 18-19 Goals: Determine a way to measure timeliness to services. Determine methodology for monitoring and reporting on walk-ins and crisis slot usage.

Tracking of Authorization Timeliness

We require all services provided to have pre-authorization. This means that all assessments and service plans, both initial and updates, are reviewed by a licensed clinical supervisor OR a Clinician III, which is a licensed clinician working in a QA capacity. We call this process Triage and Review and Authorization, or Triage for short. Triage occurs daily with the expectation that all documents are reviewed within 14 calendar days from the date the document was received. For our outside service providers, this timeline is 5 business days. We did not report on authorization timeliness in QIC during this fiscal year but were able to pull the timeliness retroactively. We averaged 16 days from the date the assessment was completed to the date services were authorized.

FY 18-19 Goals: Track and report on timeliness regarding authorization procedures regularly. Improve timeliness of authorization to meet 14-day standard.

Monitoring beneficiary satisfaction

Change of Provider Requests

We continue to track Change of Provider requests and provide this data to DHCS annually via the Annual Beneficiary Grievance and Appeal Report (ABGAR). This report was reviewed in QIC in September, December, and May.

FY 18-19 Goal: Continue to track and report change of provider requests quarterly

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No Shows

We continue to track the percentages of no-shows. This report was reviewed in QIC in July, September, and December. Our standard for no-shows continues to be 10%.

FY 18-19 Goal: Continue to track and report no show rates quarterly.

Grievances and Appeals

The person handling grievances and appeals changed during this past fiscal year. It started with the Compliance Officer and was taken over by the Quality Assurance Manager (QAM) in April 2018. The Annual Beneficiary Grievance and Appeal Report (ABGAR) for FY 16-17 was reviewed in QIC in October. All grievances were logged in time to complete the ABGAR for FY 17-18 but not all grievances received letters.

FY 18-19 Goals: Improve compliance of timely logging grievances and sending necessary letters regarding grievances and appeals. Report on grievances and appeals in QIC regularly.

Consumer Satisfaction Surveys

Biannual consumer satisfaction surveys were completed in November 2017 and May 2018, per direction from the California Department of Health Care Services (DHCS). Comments from these survey periods were collected for analysis immediately after the survey period and presented to the QIC. Results from these surveys were available from California Institute for Behavioral Health Solutions (CIBHS), which collects these surveys for DHCS, months after the surveys were completed. Results from consumer satisfaction surveys were presented in QIC in October (reviewing Nov 2016) and January (comments from Nov 2017). While the information was disseminated in QIC, results were not posted in the public waiting areas, per last year’s goal.

FY 18-19 Goals: Continue to complete biannual consumer satisfaction surveys and continue to present results and comments. Begin trend analysis as more data comes in. Post results in public waiting areas. Attempt to track the number of consumers who decline to complete the survey, as well as the numbers of clients seen during the time the survey was being conducted, in order to compare to number of surveys received. Develop a process and tool for gathering consumer feedback in addition to the biannual consumer satisfaction surveys provided by DHCS.

Monitoring the service delivery system regarding clinical issues

Results of Internal Peer Chart Reviews (Peer Review)

The QAM took over Peer Review partway through the fiscal year. No data was reported on in QIC or clinical meeting. QAM gathered feedback from clinical staff regarding Peer Review. Feedback included that all time was spend reviewing assessments and service plans, which had already been reviewed through the Triage and Review and Monitoring process. Staff expressed feeling that they weren't sure what they should be reviewing for when reviewing progress notes, and that often the progress note review ended up being mostly administrative due to time constraints. Also, time for Peer Review was often shortened because of other circumstances, leaving even less time for progress note review.

Due to this feedback, QAM altered Peer Review to focus on the review of progress notes. This included a training on what to look for in progress notes (see Meeting Minutes for Clinical Meeting on 4/17/18) and having the review focus on only progress notes, including if services provided were in line with the assessment and service plan.

Other feedback from clinical staff was from Case Resource Specialists (CRSs) feeling it was out of their scope of practice to be reviewing therapy notes to determine if services were valid or not (e.g. appropriate for the diagnosis, if therapy was conducted appropriately, what interventions were used, etc.). This led to removing the CRSs from Peer Review, with plans to implement a CRS-specific Peer Review where they would only be reviewing those services that were within their scope of practice.

FY 18-19 Goals: Develop a UR process with QA clinicians. Revamp the Peer Review process, including tracking and data reporting, in order to provide appropriate feedback and training to clinicians. Initiate a CRS Peer Review.

Medication Compliance/Medication Monitoring

This report was reviewed in QIC in October and January. While the medication monitoring process was completed monthly, there didn't seem to be a change in the items commonly found to be out of compliance. There was also no clear improvement in charts found to be in total compliance (see QI Workplan Evaluation FY 17-18).

FY 18-19 Goal: Improve outcomes of medication monitoring process.

Access/Crisis line test calls

Over this past fiscal year, test calls have not been completed as regularly as planned. This is in part due to the CCRU Supervisor leaving in October, as this duty falls under this role. Due to some miscommunication, there were limited test calls made from November 2017 to March 2018. With the addition of a second Clinician III, the regularity of test calls improved. This report was reviewed in QIC in March and May and were reported to DHCS quarterly.

FY 18-19 Goals: Conduct at least 1 test call per month and at least 1 test call in a language other than English at least once per quarter. Improve test call results for logging compliance.

Continuity of Care with Physical Healthcare and Other Agencies

Inpatient Hospitalization Follow-Up and Re-Hospitalization Rates

We tracked multiple data points related to hospitalization, including 7-day follow-up appointments, 30-day re-hospitalization rates, and general number of clients hospitalized. This was reported on in QIC in June. However, as we recently discovered the flaws in our hospitalization data (see QI Workplan Evaluation FY 17-18), we will need to determine a more valid method of measuring this data. It is unclear if this will be available with the implementation of the electronic health record.

FY 18-19 Goal: Revise the data gathering process for post-hospitalization follow-up appointments and rehospitalization rates to ensure improved validity.

Continue Partner Agency Coordination

We currently partner with many agencies in the area, as well as with other centers within the Health Services Agency. Current partners include Department of Social Services (DSS), Law Enforcement (including Red Bluff Police Department (RBPD), Tehama County Sherriff's Department (TCSD), Probation, Tehama County Jail, Tehama County Juvenile Detention Facility (JDF), Saint Elizabeth's Hospital, and Restpadd Psychiatric Health Facility (PHF). We have numerous contracts and/or memorandums of understanding (MOUs), some of which are outlined below.

- MOU with DSS to provide Child and Family Team (CFT) Meeting Intensive Care Coordination (ICC) for youth who do not need mental health services
- Coordinate with DSS to provide services for Pathways to Wellbeing (aka Katie A) youth, including providing assessments at DSS and coordinating CFT meetings

- Provide services at the Day Reporting Center, Jail, and JDF
- Coordinate crisis services with law enforcement and Saint Elizabeth's Hospital
- Involved in the Tehama County 10-Year Plan to End Homelessness as a driving agency of this multi-agency project

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FY 18-19 Goal: Continue to partner with community agencies.

Integration with TCHSA Clinic

Medication Support Services for Specialty Mental Health Services (SMHS) will be moved to TCHSA's Rural Health Clinic (RHC), currently slated for 11/1/18. Eventually, all assessments, which will be combined mental health/substance use assessments, will be completed at the RHC for ease of consumer access and to decrease stigma by providing one point of entry for multiple services.

FY 18-19 Goal: Move Medication Support services to TCHSA shared site.

Provider Appeals and Satisfaction

Provider Appeals

No provider appeals were reported during fiscal year 17-18, but there were likely appeals for denied authorization, such as denied TARs. Provider appeals will be tracked and reviewed more regularly during fiscal year 18-19.

FY 18-19 Goal: Report at least annually in QIC on number of provider appeals.

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. This data was not presented on in QIC.

FY 18-19 Goals: Report at least annually in QIC on timeliness of TARs. As requirements change from TARs to concurrent review, adapt the process to continue to monitor timeliness and results of concurrent reviews.

Significant Changes and Current Initiatives

Triennial Audit

In December 2017, DHCS conducted an audit, which consisted of both a system review and chart review. We were 87% in compliance for systems and 91.9% in compliance for chart review. This demonstrated a large improvement since the previous audit where the chart review indicated 47% in compliance. We have since written a plan of correction (POC) for the pieces that were found to be out of compliance, with some actions already taken before June 2018.

FY 18-19 Goal: Complete Triennial Audit POC

Electronic Health Record (EHR), MyAvatar

We continue to work to implement MyAvatar, the EHR that we have purchased. This includes continued contact with our vendor, Netsmart, and workgroup meetings with TCHSA staff. Our current "go live" date is 1/28/19.

FY 18-19 Goal: Fully implement MyAvatar

Outcome Measures

We have been planning on implementing an outcome measure with the implementation of our EHR. We have elected to use Feedback Informed Treatment (FIT) and plan to implement this 90 days after our EHR has been fully implemented. We also plan on including program or treatment-specific outcome measures in our EHR as much as possible. We will also be implementing the Children and Adolescent Needs and Strengths tool (CANS-50) and the Pediatric Symptom Checklist (PSC-35).

FY 18-19 Goals: Implement FIT 90 days after EHR implementation. Implement CANS-50 and PSC-35.

Cognitive Processing Therapy

The American Psychological Association's website describes Cognitive Processing Therapy as "a specific type of cognitive behavioral therapy that has been effective in reducing symptoms of PTSD that have developed after experiencing a variety of traumatic events." "CPT is generally delivered over 12 sessions and helps patients learn how to challenge and modify unhelpful beliefs related to the trauma.

In so doing, the patient creates a new understanding and conceptualization of the traumatic event so that it reduces its ongoing negative effects on current life."[1]

In November 2017 all clinicians and licensed clinical supervisors attended a 3-day training on Cognitive Processing Therapy (CPT), a trauma-focused Cognitive Behavioral Therapy for adults. The training was conducted by Kate Chard, a co-creator of this treatment, and included interventions for both individual and group modalities. Since this training, we have had regular supervisory phone calls with Kate Chard to certify as many clinicians as possible. Of our current clinicians, XX are certified, with XX still working toward certification. We plan on conducting another training in February 2019 for all newly hired clinicians, as well as an advanced training for those already certified.

CPT includes the use of 2 outcome measures, the Patient Health Questionnaire (PHQ-9) and the PTSD Checklist for DSM-5 (PCL-5). While we are working to implement a method of collecting this data on a large scale, each clinician is tracking this data for each client receiving CPT. We've seen positive outcomes from CPT per clinician report and have received positive feedback from clinicians regarding the treatment itself.

FY 18-19 Goals: Conduct a second CPT training for newly hired staff. Conduct a refresher and advanced training for staff already trained in CPT. Implement a method of gathering and reporting PHQ-9 and PCL-5 data, including outcomes.

Child and Family Team (CFT) Meetings

Over the past year, we have continued to regularly meet with the Tehama County Department of Social Services (DSS) to facilitate smooth implementation of Continuum of Care Reform (CCR). This has led to increased collaboration between agencies and better services for clients, including conducting initial behavioral health assessments at DSS's site. As a result of these meetings, it became apparent that we needed a central agency to organize and conduct CFT meetings for all CCR clients. This led to the decision of TCHSA engaging in a contract with DSS to provide all CFT facilitation for all foster youth, regardless of whether they require mental health services or not. With the onset of presumptive transfer, this process gains complexity and so while we recently implemented this contract and we continue to meet with DSS and make changes as needed to finalize and streamline the process of CFT coordination.

FY 18-19 Goals: Continue to refine the process for working with foster youth and DSS, including CFT meeting coordination, Katie A services, and presumptive transfer.

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[1] www.apa.org/ptsd-guideline/treatments/cognitive-processing-therapy.aspx.Accessed 5/17/2018

Mental Health Services Act (MHSA)

TCHSA's MHSA coordinator position was vacant for more than one year. In December of 2017, the position was filled. At the time of hire, the MHSA *Three-Year Plan* and *Annual Update* were six months overdue. Rather than issuing a *Plan* with insufficient stakeholder input, TCHSA focused on a robust community program planning (CPP) process that would result in community outreach and feedback of a level sufficient to clearly drive program design and goals. To help design and support the CPP process, TCHSA-BH reinstated a MHSA Stakeholder committee representative of diverse community groups. In February 2018, the MSHA Stakeholder Committee shaped and approved the CPP document, recommending adoption by the County's Mental Health Board. TCHSA-BH conducted three large community meetings in Red Bluff, Corning (bi-lingual Spanish support) and Los Molinos (bi-lingual Spanish support). TCHSA-BH also conducted four focus groups including transition-age youth clients, adult and older adult clients, the LGBTQ+ community and members of the incarceration re-entry team. TCHSA-BH also conducted outreach at several standing meetings, including the Public Health Board, and via "email blasts" to over 300 recipients. Outreach was successful, and the MHSA CPP survey received 275 responses. Between the survey and stakeholder meetings, TCHSA-BH received 595 comments, either in writing via the survey or received in meetings. TCHSA-BH used this large bedrock of survey responses and comments to identify key trends and shape goals within TCHSA's *Three-Year Plan* and *Annual Update*.

Also, during winter and spring of 2018, TCHSA-BH also wrote and gained approval for a new MHSA innovation plan that will facilitate the use of technology for mental health services, the hope being that this application will improve the quality of and access to services. Related to this innovation plan, TCHSA joined the California Mental Health Services Authority (CalMHSA). TCHSA-BH was selected as one of five pilot sites for a restructuring of a key MHSA program, TeenScreen, through Stanford University's Department of Child and Adolescent Psychiatry.

FY 18-19 Goals: Complete the MHSA 3-Year Plan. Begin implementation of the innovation plan. Re-start the use of TeenScreen through Stanford University's pilot program.

May is Mental Health Month

TCHSA has partnered with Tehama County Board of Supervisors to declare May Mental Health Month. This has been occurring for many years. During this month, we attempt to promote awareness, decrease stigma, and outreach to residents.

FY 18-19 Goal: Provide continued outreach and stigma-reduction activities during the month of May.

10-Year Plan to End Homelessness

TCHSA is one of the lead agencies in the Tehama County Homeless Stakeholder Collaborative. There are 4 main goals of the 10-Year Plan:

1) One Stop Concept: a central location or locations that can offer a wide range of services that are needed by the homeless population in a welcoming environment;
2) Temporary Housing: short-term housing that can immediately be made available to homeless individuals, with support services that help them prepare to move into permanent housing;
3) Sustainable Housing: permanent and affordable housing that will help homeless individuals stabilize and build self-sufficiency; and
4) An Awareness Campaign: that raises public awareness of the need to address homelessness, and proven strategies to address it.

As part of this plan, our Vista Way site has been identified as the best option for a One-Stop Center that will also act as a year-round homeless shelter. Services currently being provided at Vista Way will be relocated to the Walnut Street campus, including peer-led services. Once the One-Stop/Shelter is completed, TCHSA plans to provide services and conduct outreach at this location.

FY 18-19 Goal: Transition out of Vista Way site and move services to Walnut Street to begin One-Stop/Shelter renovations.

On-Call Clinicians

TCHSA has recently implemented an on-call clinician program, based on a request from community partners that TCHSA have after-hour clinicians that can go to the hospital to do crisis assessments. The goal is to provide 24/7 coverage in order to improve and expedite the crisis assessment process, which currently occurs at the Community Crisis Response Unit (CCRU), a 23-hour Crisis Stabilization Unit (CSU). By doing crisis assessments at the local hospital, the program also alleviates the issue of getting medical clearance and having to transport clients between the CCRU and the hospital. It should also mean that clients who are determined to need inpatient services can be transferred directly from the hospital to a psychiatric health facility (PHF) rather than transferring to the CCRU and then to the PHF.

FY 18-19 Goal: Increase the number of clinicians participating in the On-Call Clinician Program and provide weekend and holiday coverage.

Additional Guidance from DHCS

DHCS continues to provide additional guidance via information notices (INs). During the last few months of fiscal year 17-18, there were numerous INs that require systemic changes in TCHSA processes and policies, as well as updates to forms and additional training for staff. While steps have been taken to address these changes, the process for change can be cumbersome and slow-moving.

FY 18-19 Goal: Make necessary systemic changes to adopt new guidance from all INs produced by DHCS.

Performance Improvement Projects (PIPs)

During fiscal year 17-18 we finished our non-clinical PIP regarding no-show rates for medication support appointments. Our interventions did not appear to be impactful in the way we were hoping but we plan to continue to monitor no-show rates and may gather additional data in the future to determine alternative interventions that may have more of an impact.

We have begun working on a new clinical PIP focused on benzodiazepine reduction. While the PIP is currently in the conception phase, we have gathered some data, have planned interventions, and are working on implement of said interventions.

We have also begun working on a new non-clinical PIP regarding clients who are only receiving medication support services. We are looking to decrease these number by successfully transitioning stable clients to a lower level of medication support services via their primary care provider and successfully engaging non-stable clients in other mental health services.

FY 18-19 Goals: Implement interventions for the clinical PIP. Gather data and begin implementing interventions for the non-clinical PIP.