Tehama County Mental Health Plan

Quality Assessment and Performance Improvement Plan

Fiscal Year 2019-2020

Quality Assessment and Performance Improvement Plan

The following document describes the quality improvement program structure of the Tehama County Mental Health Plan (MHP), an evaluation of quality improvement goals and activities in fiscal year 2018-2019, and goals and areas of focus for fiscal year 2019-2020.

It is the responsibility of the Tehama County MHP to ensure that all services authorized are delivered with the appropriate standard of care; ongoing quality improvement activities are undertaken with the goal of fulfilling that responsibility. The purpose of this plan is to provide up-to-date information about those ongoing quality improvement activities.

Quality Improvement Program Description

Overview

The Quality Improvement (QI) Program is designed to develop, implement, coordinate, monitor and evaluate performance activities throughout the Mental Health Plan (MHP). The primary concerns of the QI Program include, but are not limited to:

- Beneficiary access to services and authorization for services
- Program integrity and compliance
- Grievances and appeals
- Beneficiary and provider satisfaction
- Performance improvement
- Beneficiary and system outcomes
- Utilization management and clinical reviews

The QI program is comprised of the Quality Improvement Committee (QIC), Quality Assurance Manager (QAM), and service teams. The QI program is accountable to the Mental Health Director and will be evaluated and updated annually. The QI Program includes a QI Workplan which is evaluated annually for effectiveness. New QI goals are created annually based on this evaluation.

Quality Improvement Committee (QIC)

The purpose of the QIC is to improve the quality of mental health care and services provided by Tehama County Health Services Agency (TCHSA). It is the aim of TCHSA to provide accessible, timely, culturally competent, and cost-effective services to the community. The QIC monitors and evaluates quality and appropriateness of services at the beneficiary, provider and system levels. The QIC is responsible for recognizing inefficient processes, assessing barriers to quality of care, identifying solutions with measurable objectives and goals, taking actions to meet these objectives and goals, and evaluating the subsequent outcomes. Integral to the QIC's success in improving TCHSA services and quality of care is the continued integration of health services among agency centers and between agency centers and community health care providers, especially primary care providers. Collaboration among clinicians, supervisors, outside providers, consumers, patients' rights advocates, and community partners is essential to improve the integration of health care services.

QIC membership includes:

- Quality Assurance Manager (QAM) [CHAIR]
- Behavioral Health Director

- Behavioral Health Assistant Director
- Tehama County Mental Health Board Member(s)
- Contract Provider Representative(s)
- Business Operations Supervisor
- Licensed Clinical Supervisor(s)
- Cultural Competency Committee representative(s)
- Clinician(s)
- Medical Support staff
- Case Resource Specialist(s)
- Patients' Rights Advocate(s)
- Consumer(s)

The QIC functions include (but are not limited to):

- Review new or pending laws, regulations, or policies in mental health.
- Review issues, challenges, improvements, and successes related to quality of care.
- Review and evaluate the results of QI activities including Performance Improvement Projects.
- Initiate necessary QI actions and follow-up of QI processes.
- Review of grievances, appeals, expedited appeals, and state fair hearings to identify trends and areas for improvement as a system.
- Monitor and evaluate the quality and appropriateness of services at the beneficiary, provider and system levels and recommend solutions to identified issues.
- Review and evaluate the results of QI activities (internal and external) such as medication monitoring, audits of local outside providers, internal audits, annual reviews by an external quality review organization (EQRO) contracted by the State, and triennial review by the State.
- Review concerns of substandard care.
- Recommend policies, procedures and system changes to improve beneficiary care and outcomes as a result of QI activities or QIC actions.
- Review and evaluate data to identify strengths, common trends and areas for improvement.
- Document all activities through dated and signed minutes of committee meetings that reflect QIC decisions and actions.
- Standard report evaluations quarterly with an annual review.

Quality Assurance Manager (QAM)

The QAM is responsible for coordinating, managing and reporting on all aspects of the QI/Management processes of the MHP. The QAM chairs the QIC, prepares standard reports, coordinates annual consumer satisfaction surveys, manages all grievances and appeals, provides liaison services with the Department of Health Care Services personnel, verifies the credentials of licensed staff, audits contracted providers (both individual and organizational), oversees contracting with outside providers, performs site certification reviews for private and organizational providers, and develops Performance Improvement Projects in cooperation with systems of care.

Service Teams

The service teams consist of representatives from Adult Outpatient, Crisis, Medication Support, Case Management, Adult Drop-In Center, Transitional Age Youth, and Mental Health Services Act programs. The teams work on QI from a clinical perspective in conjunction with and at the direction of the QAM and the QIC.

Quality Assessment and Improvement Plan

The QI Program monitors and tracks data for the following quality-related quantitative and qualitative reports:

- Service delivery capacity/network adequacy
    a. Network Adequacy Certification Tool (NACT)
    b. Medi-Cal penetration rates
- Accessibility of services
    a. Timeliness of access to services
    b. Timeliness of authorizations
- Beneficiary satisfaction of services provided
    a. Change of provider requests
    b. No-show rates
    c. Trends of beneficiary grievances, appeals, and fair hearings
    d. Results of bi-annual consumer satisfaction surveys, including comments
- Service delivery system, including meaningful clinical issues and safety/effectiveness of medication practices
    a. Results of internal peer chart reviews
    b. Results of medication compliance monitoring
    c. 24/7 Access/Crisis Line test call reports
- Continuity of care with physical health care and other providers
    a. Inpatient hospitalization follow-up appointments
    b. Re-hospitalization rates
- Provider appeals and satisfaction
    a. Timeliness of Treatment Authorization Requests (TARs)
    b. Trends of provider grievances and appeals

The QI Program may collect additional data in response to changes in regulation, ongoing QI projects, or as requested by management. Data is analyzed and evaluated at QIC meetings to identify quality issues, establish improvement initiatives, set goals, and document progress toward these quality improvement initiatives quarterly and annually.

Performance Improvement Projects

The MHP is committed to sustaining improvement gained through performance improvement projects (PIP). The QI Program will have at least one clinical PIP and one non-clinical PIP every year. A PIP may last more than one year, but once finished, a new PIP will be started. PIPs are determined by the QIC based on data collected by the QI Program.

Evaluation and Goal Setting

The QI Workplan will be evaluated annually, demonstrating that QI activities have contributed to meaningful improvement in clinical care and beneficiary service, and describing

completed and in process QI activities, including performance improvement projects. Upon completion of this evaluation, new goals for the QI Program will be set.

Review of Fiscal Year 2018-2019

Quality Improvement Committee

Staffing shortages continued to impact ability to have clinician or case resource specialists on the committee. The MHP was able to add an additional licensed clinical supervisor to the committee, which removed the need for the nurse supervisor to be functioning in dual membership roles as they had in previous years. The consumer representatives in this fiscal year were also mental health board members, so they continue to function in dual roles. Representation in other membership categories remained stable.

Quality Assurance Manager

The MHP was without a Quality Assurance Manager from May 2019 until September 2019, which created difficulties in completing the Quality Assessment and Improvement Plan within the goals established in the fiscal year 2018-2019 (FY 18-10) plan. A new Quality Assurance Manager was hired and began September 1, 2019.

Service Delivery Capacity/Network Adequacy

The MHP continues to be impacted by staff turnover, as multiple clinicians and the quality assurance manager left during this fiscal year, though multiple clinicians were also hired. Two new licensed clinical supervisors were hired during this fiscal year, and no clinical supervisors left, showing marked progress in that particular area of staffing. The MHP believes that stability in staffing and the supervisory level has a significant impact on stability at the direct-care staff level, which greatly impacts the MHP's ability to meet the needs of beneficiaries. The goal for FY 18-19 was to increase the number of filled positions. At the time of this review (October 2019), the MHP has 2 unfilled vacancies for licensed clinical supervisors and 5 unfilled vacancies for clinicians.

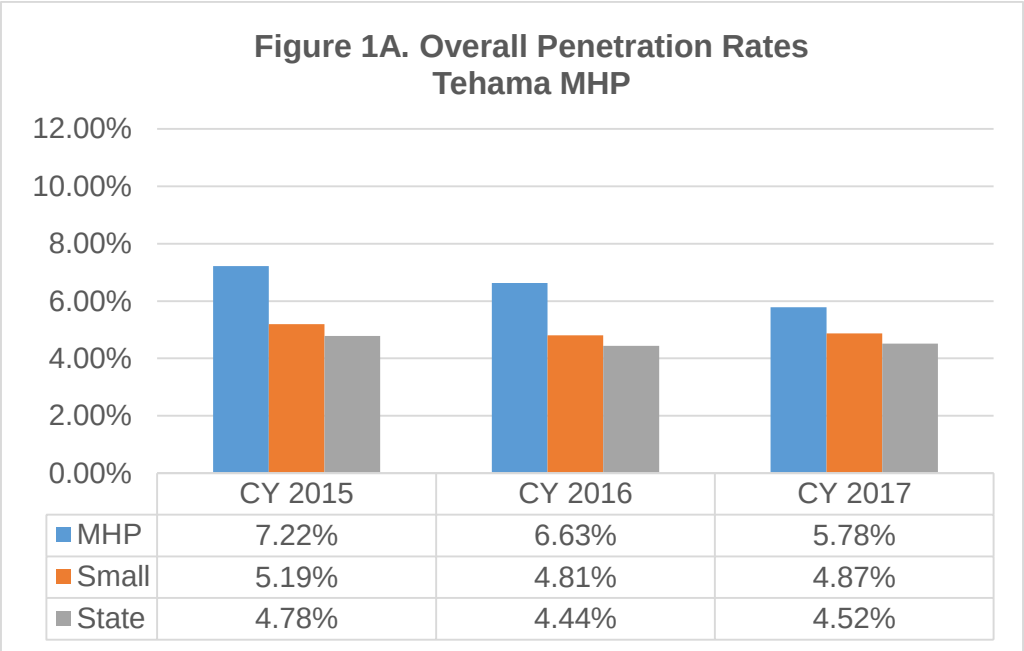
Network Adequacy Certification Tool.

In FY 18-19, the California Department of Healthcare Services (DHCS) initiated use of the 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. In review of our recent submission, DHCS found that the MPH "conditionally passed" in two areas and needed a corrective action plan to move into compliance with the standard. The two areas needing improvement were provider capacity for providing specialty mental health services (SMHS) to children and youth (the MHP was directed to increase its provider network in this category by 14.24 FTE) and timely access (first appointment within 10 days of request). At the time of this review, the MHP is working on a corrective action plan to address both of these categories.

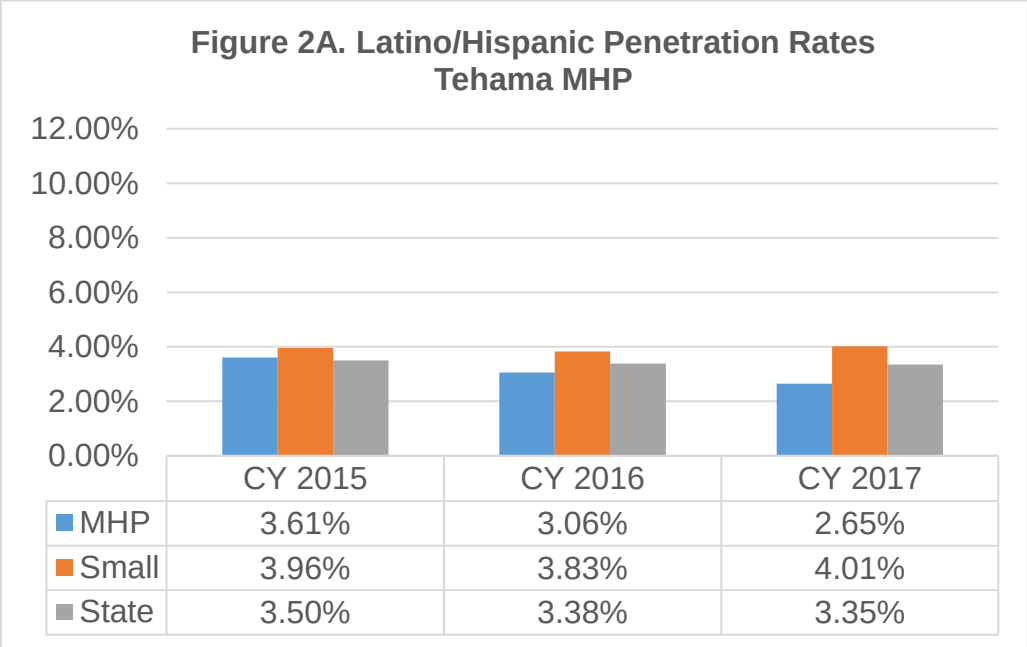
Medi-Cal Penetration Rates.

The goal for FY18-19 was to re-invigorate services in Corning in hopes of improving penetration rates for the Latino/Hispanic population. The bilingual clinician who was stationed in Corning left the MHP in December 2018 and that position remained vacant until April 2019.

Data reviewed at the annual EQRO in November 2018 showed that while the MHP has a higher penetration rate overall as compared to other small counties and the state, the penetration rate for Tehama County's threshold population (Latino/Hispanic) remains lower as compared to other small counties and the state, indicating a disparity in access.



	CY 2015	CY 2016	CY 2017
MHP	7.22%	6.63%	5.78%
Small	5.19%	4.81%	4.87%
State	4.78%	4.44%	4.52%



	CY 2015	CY 2016	CY 2017
MHP	3.61%	3.06%	2.65%
Small	3.96%	3.83%	4.01%
State	3.50%	3.38%	3.35%

Figures 1A. and 2A. taken form CalEQRO 2018 Report for Tehama County

Accessibility of Services

Timeliness of Access to Services.

The MHP made significant progress in its ability to track timeliness of access to services, which was the goal for FY 18-19. In spite of the difficulties in implementing electronic health records, and the limitations that come with functioning in a paper-based system, the MHP began tracking timeliness of services and can now track and report on data related to time between first request and first offered, accepted, and kept appointment and can also track that data by type of contact, referral source, and fund source. Table 1 shows a summary of timeliness to access data for FY 18-19, data represents May-June 2019.

Table 1.

	All Services	**Adult Services**	**Children's Services**	**Foster Care**
Average length of time from first request for service to first offered appointment (in business days)	8 Mean 0 Median 13 Std. Dev.	Mean Median Std. Dev.	Mean Median Std. Dev.	Mean Median Std. Dev.
State standard	10 business days			
Average length of time from first request for service to first kept appointment (in business days)	6.7 Mean 1.0 Median 14.0 Std. Dev.	6.4 Mean 1.0 Median 14.9 Std. Dev.	9.2 Mean 1.0 Median 14.9 Std. Dev.	4.5 Mean 1.0 Median 9.1 Std. Dev.
MHP standard or goal (in business days)	14 days	14 days	14 days	14 days
Average length of time from first request for service to first psychiatry appointment (in business days)	14.9 Mean 9.0 Median 13.8 Std. Dev.	13.3 Mean 8.5 Median 12.4 Std. Dev.	17.8 Mean 14.0 Median 16.2 Std. Dev.	19.5 Mean 23.0 Median 14.2 Std. Dev.
State standard	15 business days			

Timeliness of Authorizations.

The MHP made a significant change to its triage and authorization process for assessments this fiscal year, in response to staff feedback. Previously all assessments were turned in and reviewed by a triage team made up of quality assurance staff and clinical supervisors. Clinical staff often gave feedback that they found this process to be confusing as they would sometimes get different direction depending on which staff was doing triage and also felt they were not able to staff the assessments appropriately with their supervisors. As a result, the MHP moved toward having supervisors review assessments for the individual clinicians they

supervise, which resulted in improved feedback from staff but also led to the unintended consequence of negatively impacting our timeliness of authorizations as some supervisors' schedules are more impacted than others. In FY 18-19, the MPH completed 1001 assessments and 41.5% of them were authorized within 14 days, with an average of 24 days to authorization.

Beneficiary Satisfaction of Services Provided.

Change of Provider Requests.

The MHP continues to track change of provider requests and report this data annually to DCHS via the Annual Beneficiary Grievance and Appeal Report (ABGAR). This data was also reported on and discussed in the QIC meetings in February and April, broken down by type of provider, person requesting the change, reason for request, and outcome (whether or not the request was authorized). Figures 3-6 provide summary data for the past 5 fiscal years.

Figure 3 Change of Provider Requests by Type of Provider.

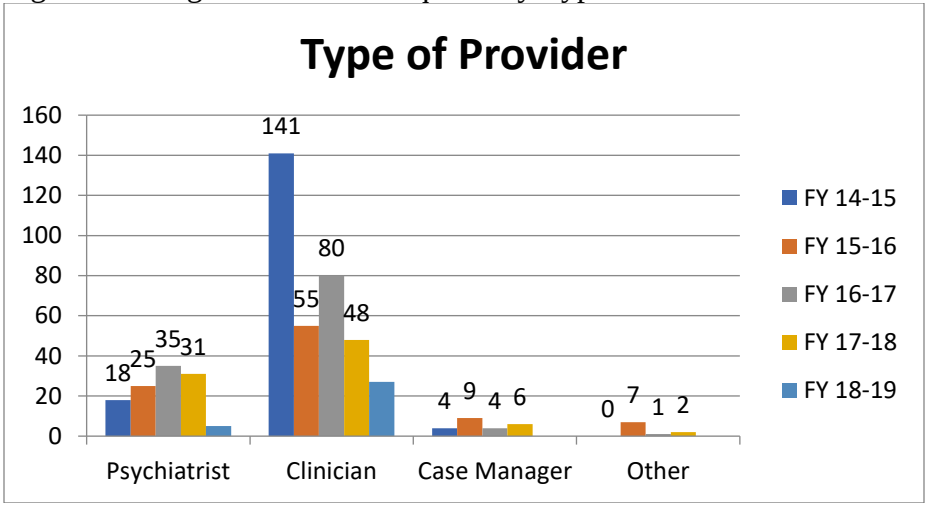


Figure 4 Change of Provider Requests by Who Requested Change.

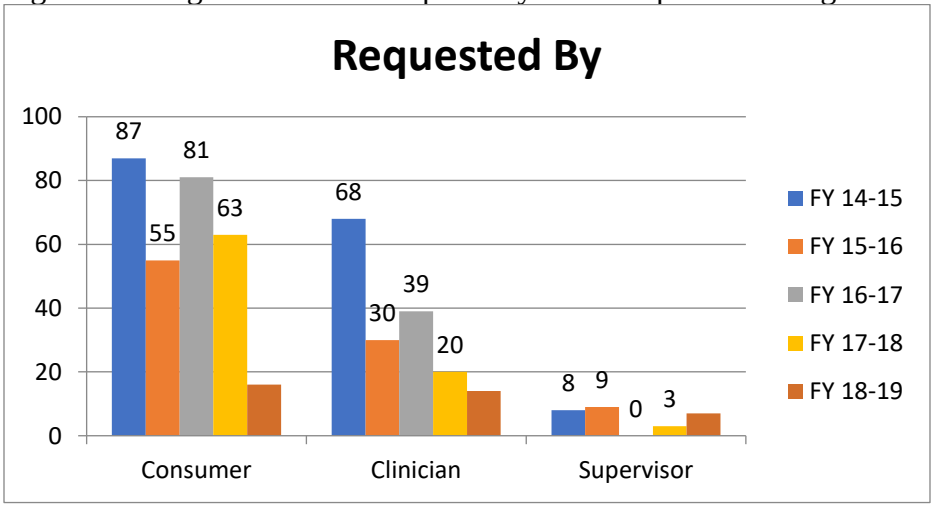


Figure 5 Change of Provider Requests by Reason of Request.

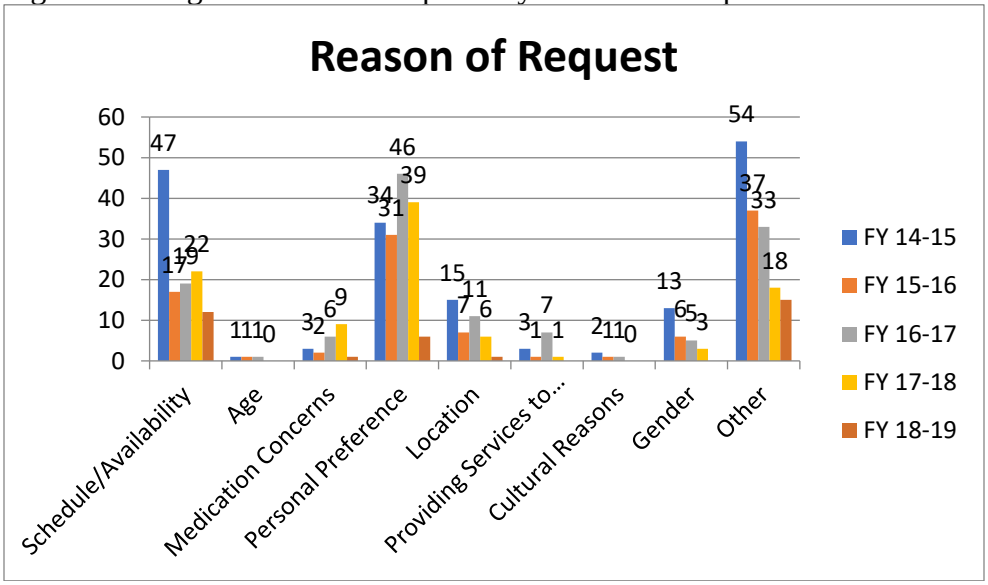
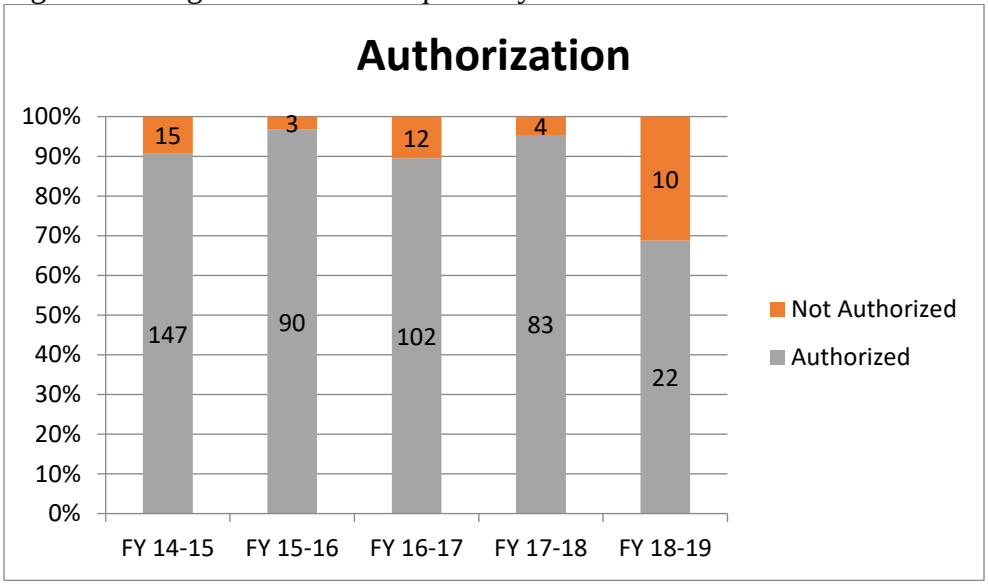


Figure 6 Change of Provider Requests by Outcome.



No-show rates.

Data regarding no-show rates continues to be tracked and the MHP's overall average remains under the 10% goal. No-show rates for January 2019 were reported in the April 2019 QIC quarterly report and showed an overall average of 7.25% for all services.

Trends of Grievances and Appeals.

The grievance and appeal log was updated this fiscal year in time for the ABGAR submission. All grievances and appeals were resolved within 90 days and appropriate letters were sent. While the MHP successfully tracked this data this fiscal year, it was not reported on or

discussed as a regular part of QIC meetings, which is where trends would be expected to be identified and analyzed in addition to the individual monitoring completed by the QAM.

Results of Bi-Annual Consumer Satisfaction Surveys.

Biannual consumer satisfaction surveys were completed in November 2018 and May 2019, per direction from DCHS. Results from both surveys were posted after the previous Quality Assurance Manager resigned and the position remained vacant for the remainder of the fiscal year, which led to no analysis of this data in FY 18-19.

Service Delivery System

Results of Internal Peer Chart Reviews.

Attempts were made in FY 18-19 to make improvements to the peer review process based on staff feedback in an attempt to make it more meaningful and helpful to staff from a training perspective. During this time the peer review process was put on hold. As a result, peer chart reviews did not happen consistently in FY 18-19, with the last being held in November 2018, and data from these reviews was not reported or discussed in QIC meetings. The MHP also did not meet its goal of developing a UR process with QA clinicians or a peer review for Case Resource Specialists (CRS).

Results of Medication Compliance Monitoring.

The MHP experienced a significant loss in FY 18-19 when the long-term contract physician who helped with on-call responsibilities for the crisis unit and completed medication compliance monitoring became ill and passed away. Medication compliance monitoring was therefore only completed for a portion of the fiscal year and the MHP was not able to find the staffing to continue this monitoring in the remainder of the fiscal year. Medication compliance monitoring results are available for July through October of 2018 and March of 2019 but were not reported on in QIC meetings.

24/7 Access/Crisis Line Test Call Reports.

Data regarding test calls to the MHP's 24/7 access/crisis line was reported on at the March 2019 QIC meeting. That report showed an average of 1 call per month in the first 3 quarters of the fiscal year and indicated that all calls provided the information requested and positive resolution, and all but one call was properly recorded in the access log. The test call report submitted to DHCS for the fourth quarter of FY 18-19 showed 3 calls made during the fourth quarter, with all calls providing requested information and positive resolution and 2 out of the 3 calls recorded properly in the access log.

Continuity of Care

Inpatient Hospitalization and Follow-Up Appointments.

This data was reported on for the first 3 quarters of the fiscal year in the July 2019 QIC meeting. Data for the full fiscal year was reported to EQRO in the MHP Assessment of Timely Access (see Table 2).

Table 2.

(*NOTE: HEDIS measure goal is 7 days post-discharge*)	**All Services**	**Adult Services**	**Children's Services**	**Foster Care**
Total number of hospital admissions	115	94	18	3
Total number of hospital discharges	115	94	18	3
Number of follow-up appointments within 7 days	66	49	15	2
Average length of time for a follow-up appointment after hospital discharge	**5.6** days Mean 5.0 Median 1.8 Std. Dev.	**5.3** days Mean 5.0 Median 1.9 Std. Dev.	**5.0** days Mean 5.0 Median 0.0 Std. Dev.	**5.7** days Mean 6.0 Median 3.7 Std. Dev.
MHP standard or goal	7 days	7 days	7 days	7 days
Percent of appointment that meet this standard	84%	82%	94%	67%

In the workplan evaluation for FY 17-18, the MHP noted a flaw in its data gathering regarding follow-up appointments after inpatient hospitalization. Currently this data is tracked in an Access database that includes all hospitalizations initiated by Tehama County, regardless of fund source. If a client is not a beneficiary of the Tehama County MHP, they may have a hospitalization initiated by the MHP but would not have a follow up appointment scheduled with the MHP. Currently, there is not a way to isolate clients who are hospitalized and also beneficiaries of the MHP in order to more accurately track rates of follow-up appointments. As a result, the data we have indicates that of the follow-up appointments that are scheduled, over 80% of them (except in the foster care category) are scheduled within the 7 day standard but there is not an accurate way of determining how many of the total hospital admissions may have required a follow-up appointment but did not receive one.

Re-Hospitalization Rates.

The MHP continues to track and monitor data regarding psychiatric inpatient readmission rates within 30 days. This data was reported on for the first 3 quarters of the fiscal year at the July 2019 QIC meeting and for the full fiscal year in the MHP Assessment of Timely Access for CalEQRO (see Table 3).

Table 3.

	All Services	Adult Services	Children's Services	Foster Care
Total number of hospital admissions	115	94	18	3
Total number of hospital discharges	115	94	18	3
Total number with readmissions within 30 days	**7**	**5**	**2**	**0**
Readmission rate (30 days)	6%	4%	2%	0%

Provider Appeals and Satisfaction

Timeliness of Treatment Authorization Requests.

19 Treatment Authorization Requests (TAR) were received in FY 18-19. Of those TARs, 16 (84%) were processed within 14 days of receipt. This data was not reported on in QIC.

Provider Appeals.

There was no record of provider appeals, but it is likely some of those TARs may have been appeals but they are currently not tracked separately, a limitation that was also noted in QI goals for FY 18-19.

Significant Changes and Other Initiatives

Triennial Audit.

The goal of the MHP for FY 18-19 was to complete the plan of correction following the DHCS triennial audit in December 2017, at which time the system review showed the MHP was in 87% compliance and chart review showed 91.9% compliance. At the time of this review (October 2019), that plan of correction was still actively being worked on as it had been throughout the fiscal year.

Electronic Health Record.

During FY 18-19, the MHP continued to dedicate staff time and resources to working with vendor Netsmart on implementation of an electronic health record system. Multiple unexpected difficulties arose throughout the year in getting the platform to work in the way the MHP needed it to in order to ensure beneficiary privacy and confidentiality, proper data reporting, and correct billing functions. At the time of this review (October 2019), these efforts were still underway with a target of going live during the 2019-2020 fiscal year.

Outcome Measures.

The MHP expected to go live with electronic health records and created a goal for FY 18-19 around utilizing outcome measures within that platform. While electronic health records did not go live in this fiscal year, the MHP did implement use of the Child and Adolescent Needs and Strengths (CANS-50) and the Pediatric Symptom Checklist (PSC-35). The CANS-50 is used with clients ages 6-20 and the PSC-35 is used with clients ages 3-18, both are administered every 6 months (at annual assessment and semi-annual treatment plan appointments). The Prodromal Questionnaire-16 (PQ16) has also been introduced for use with individuals ages 15-30 at intake assessment and yearly at annual assessment appointments. While these tools have been implemented, the MHP does not currently have a way of monitoring and tracking this outcome data.

Cognitive Processing Therapy.

The MHP initiated use of Cognitive Processing Therapy (CPT) as an evidence-based treatment for PTSD in November of 2017. Since that time, the MHP has hosted two trainings conducted by Kathleen Chard, PhD, co-creator of CPT, followed by consultative phone calls with clinicians as they became certified in the modality. Of the current MHP clinical staff, 3 have been certified in CPT and 4 are currently working toward certification.

Two outcome measures involved in CPT, the Patient Health Questionnaire (PHQ-9) and the PTSD Checklist for DSM-5 (PCL-5) continue to be used to determine changes in symptomology in clients receiving CPT.

Child and Family Team Meetings.

The MHP continued to work with DSS over the last year to refine the Child and Family Team meeting process and coordinate Katie A services and presumptive transfer. Child Family Team Meetings (CFT) were facilitated by the MHP during this fiscal year, which required extensive coordination and involved CFT meetings for all foster youth, regardless of participation in specialty mental health services.

Mental Health Services Act.

The MHP set goals for FY 18-19 to complete the MHSA 3-year plan, begin implementation of the innovation plan and re-start the use of TeenScreen through Stanford University's pilot program. The MHSA 3-year plan was completed in this fiscal year and the MHP actively worked throughout the fiscal year on a collaborative effort with CalMHSA and thirteen other counties to implement a tech suite that will provide an app-based resource for peer-to-peer counseling. The MHP also made progress toward re-starting the use of TeenScreen but was not able to complete that goal in FY 18-19.

May is Mental Health Month.

The MHP continued its outreach and stigma-reduction activities this fiscal year in celebration of May as Mental Health Month. Highlights in FY 18-19 included multiple suicide prevention and intervention trainings, Mental Health First Aid trainings in English and Spanish, and stigma reduction activities such as a screening of the film "Suicide: The Ripple Effect" followed by a panel discussion.

10-year Plan to End Homelessness.

The MHP did not meet its goal of transitioning out of the Vista Way building, but significant progress was made in FY 18-19 toward the goal of having a one-stop shelter and homeless services center in Tehama County. At the time of this writing (October 2019), Tehama County Health Services Agency, which oversees the MHP, had been awarded block grant funding to support this project and was actively moving forward with plans.

On-Call Clinicians.

The MHP goal for FY 18-19 was to increase the number of clinicians participating in the on-call clinician program and provide weekend and holiday coverage. The MHP added 3 new clinicians to the on-call program in FY 18-19, but also saw 2 on-call clinicians leave, weekend and holiday coverage by on-call clinicians was maintained throughout FY 18-19.

Performance Improvement Projects

Interventions for the clinical PIP related to reduction of benzodiazepine use initiated in January 2018 were continued during FY 18-19 but no data was gathered along with the interventions, which required retrospectively establishing this data via chart review. At the time of this review (October 2019), the MHP was working to review charts of clients identified by PIP baseline data to determine outcomes related to interventions delivered in FY 18-19 and doing additional data gathering to determine rates of benzodiazepine use amongst current medication support clients. The MHP plans to analyze this data, evaluate interventions and initiate new interventions as needed, with the goal of closing the PIP in September of 2020.

The MHP made several efforts to initiate a non-clinical PIP in FY 18-19 but no new PIP was implemented in this fiscal year.

Goals for Fiscal Year 2019-2020

Quality Improvement Committee

While staffing shortages continue to make line staff representation on the committee difficult, staffing has improved for the MHP and QIC meetings are now held quarterly instead of monthly. This should help minimize the challenges with getting line staff representation due to impacted schedules. In FY 19-20, the MHP will work to get clinician and case resource specialist representation on the committee, in addition to seeking representation from a consumer who is not also a mental health board member.

Service Delivery Capacity/Network Adequacy

The MHP will continue to work actively to fill all vacant positions during FY 19-20 in hopes of improving abilities to adequately meet the needs of beneficiaries. The MHP is also increasing contracts with contract providers and with staffing agencies in order to increase timely access and accessibility for beneficiaries to services.

Network Adequacy Certification Tool.

In an effort to improve timely access as part of the corrective action plan resulting from the MHPs June 2019 NACT submission, the MHP is working to implement a new programmatic structure in which clients can begin treatment in a group modality immediately upon determination of medical necessity, while a therapist is assigned and a treatment plan

established. The MHP is also working to expand current contracts and explore new ones in order to help meet the provider to beneficiary ratio needs outlined in the NACT. The goal for FY 19-20 is to come into full compliance with the requirements outlined in the NACT by expanding our available providers and adding additional groups to improve timeliness.

Medi-Cal Penetration Rates.

Efforts were made early in FY 18-19 to reinvigorate services in Corning and outreach to other areas to improve penetration rates amongst the Latino/Hispanic population but these efforts were limited when the bilingual clinician assigned to corning left in December 2018 and the position remained vacant until April 2019. The MHP relied on our contract provider to continue providing services to the monolingual Spanish speaking population in Corning. That position has now been filled. The goal for FY 19-20 is to improve penetration rates by establishing a regular bilingual clinician presence in Corning and establishing regular meetings for the cultural competency committee, to include bilingual staff representation, with the goal of increasing outreach and access to services amongst the Latino/Hispanic population.

Accessibility of Services

Timeliness of Access to Services.

The MHP was able to establish tracking systems in FY 18-19 to monitor time between first requested and first offered, accepted, and kept appointment for outpatient specialty mental health services. The goal for FY 19-20 is to establish systems for tracking that data further by age and foster care categories, as well as to track timeliness to first request and first appointment for psychiatry services. An additional goal for FY 19-20 is to report on this data at quarterly QIC meetings and use the data to generate discussion about how to improve outcomes.

Timeliness of Authorizations.

Data for timeliness of authorizations for assessments was tracked during this fiscal year but not reported on or discussed in QIC meetings. Part of the MHP's triage and authorization process changed in FY 18-19 in that clinicians began having their assessments reviewed and authorized by their individual supervisors instead of the triage team. As a result of this process, timeliness of authorization data was often reviewed in supervisors meeting to address concerns and discuss as a change in the process was implemented. The goal for FY 19-20 is to continue monitoring this data with supervisors but also begin reporting and discussing on this data in QIC and using it to propel discussions about improving timeliness, to track data separately by MHP and contract provider, and to bring timeliness of authorizations to within 5 days.

Beneficiary Satisfaction of Services Provided

Change of Provider Requests.

The MHP continued to monitor and track this data in FY 18-19 but did not report on it regularly in QIC meetings, the goal for FY 19-20 is to regularly report this data at QIC meetings and use the data to generate discussion about system improvements.

No-Show Rates.

Rates continue to remain low for the MHP but this data was only reported on once at QIC during FY 18-19, the goal for FY 19-20 is to report on this data regularly at QIC and use the data to generate meaningful discussion about system improvements.

Trends of Grievances and Appeals.

A new grievance and appeal log was established in FY 18-19 to track and monitor this data more effectively but with staffing changes it was not consistently used or reported on. The goal for FY 19-20 is to keep this log actively updated and report on the results regularly in QIC, using the data to analyze trends and initiate meaningful discussions about improvements related to grievances and appeals.

Results from Bi-Annual Consumer Satisfaction Surveys.

The bi-annual survey provided by DHCS was given twice in FY 18-19 but results were not analyzed or discussed in QIC. The goal for FY 19-20 is to incorporate reporting of these results in QIC after each administration, using the data to discuss needed system improvements to address client feedback, and noting trends over time.

Service Delivery System

Results of Internal Peer Chart Reviews.

The peer review process was changed significantly and then put on hold in FY 18-19, the goal for FY 19-20 is to re-start monthly peer reviews with clinicians, use the data from those peer reviews to guide documentation training with clinical staff, and report on that data regularly in QIC and use it to generate meaningful discussion about system improvements. Other goals for FY 19-20 in this category are to initiate a peer review process for case resource specialist staff, as well as a regular utilization review by QA staff.

Results of Medication Compliance Monitoring.

The physician who had long been doing medication compliance monitoring for the MHP passed away in FY 18-19 and a replacement has not yet been found. The goal for FY 19-20 is to find another individual to complete medication compliance monitoring on a monthly basis, and report on that data regularly in QIC and use it to generate meaningful discussion about system improvements.

24/7 Access/Crisis Line Test Call Reports.

Data from last fiscal year shows that the MHP met the goal of 1 test call per month but struggles with consistently logging those calls remain and the data was only reported on once at QIC. The goal for FY 19-20 is to continue to make one test call per month, have all calls recorded properly in the access log, and report on this data regularly at QIC and use it to generate meaningful discussion about system change.

Continuity of Care

Inpatient Hospitalization Follow-Up Appointments.

The MHP continues to monitor, track and report on this data regularly at QIC but has not yet resolved the data collection flaw identified in the review of FY 17-18. Currently, the MHP

tracks all hospitalizations, regardless of fund source, but would only be expected to arrange follow-up appointments if the client is a beneficiary of the MHP. In cases of out-of-county or private insurance clients, the MHP would not arrange a follow up appointment but the data tracking tool being used does not allow for the filtering out of those clients. So, the MHP can determine the percentage of appointments made that fall within 7 days but does not currently have a way of telling which of the clients that did not receive a follow up appointment should have had one scheduled. The goal for FY 19-20 is to resolve this issue in order to have more accurate data to report regularly at QIC and then use that data to generate meaningful discussion about system improvements.

Re-Hospitalization Rates.

This data was tracked during FY 18-19 and reported on once during QIC, rates remain low. The goal for FY 19-20 is to report the data more regularly at QIC and generate meaningful discussion about system improvements based on trends noted in the data.

Provider Appeals and Satisfaction

The MHP processed 19 TARs during FY 18-19 and 3 of them were not processed within 14 days. The goal for FY 19-20 is to approve all TARs within 14 days and develop a system for tracking provider appeals separately so they can be monitored and reported on. Another goal for FY 19-20 is to report on all TARs and provider appeals regularly at QIC.

Significant Changes and Other Initiatives

Outcome Measures.

The MHP has implemented use of the CANS-50 for clients age 6-20, the PSC for clients ages 3-18 and PQ16 for clients ages 15-30, and the PHQ-9 and PCL-5 for clients receiving CPT as their primary mode of treatment. The goal for FY 19-20 is to design and implement a data collection system for monitoring and tracking of client outcomes.

Performance Improvement Projects

As of the time of this writing (October 2019), the MHP is actively working on a clinical PIP focused on reduction of benzodiazepine usage and connection with alternative treatments to improve client outcomes, as well as a nonclinical PIP focused on improving beneficiary satisfaction when transitioning from specialty mental health services to continued treatment with the managed care plan. The goal for FY 19-20 is to continue interventions and data gathering related to these two PIPs and report on progress at quarterly QIC meetings.