

QI Work Plan 2014-2015 Evaluation Report

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Quality Improvement Program:

The Quality Improvement (QI) Program is accountable to the Mental Health Director. It is designed to assure to all payers and stakeholders that the processes for obtaining services are fair, efficient, cost-effective, and produce results consistent with the belief that people with mental illness may recover. In addition to attendance at the Quality Improvement Committee (QIC), beneficiaries and family members are encouraged to actively participate in the deliberations of the Mental Health Board, the outreach activities of the MHP, and in self-help education. All these efforts assist in the planning, design, and execution of the QI Program. The QI Program coordinates with performance monitoring activities throughout the organization, including but not limited to: beneficiary and system outcomes, utilization management, credentialing, monitoring and resolution of beneficiary grievances, fair hearings and provider appeals, assessment of beneficiary and provider satisfaction, and clinical records review.

The Quality Coordinator completes an annual Quality Improvement Evaluation and Work Plan. This is the annual evaluation of the overall effectiveness of the QI Program and Work Plan that examines QI activities and whether they have contributed to meaningful improvement in the clinical care and quality of service of those served by the MHP.

Program Description and Contract Adherence

Regarding Department of Healthcare Services (DHCS) Contract Requirements:

The MHP Quality Coordinator is a licensed Practitioner of the Healing Arts (Licensed Marriage and Family Therapist) who is primarily involved in Quality Improvement Program implementation, and who is ultimately accountable to the Mental Health Director. The Quality Coordinator coordinates performance monitoring activities throughout the Mental Health Division in collaboration with the Division's Utilization Review Coordinator, Provider Services Coordinator, Program Managers, Supervisors, and HHSA Quality Management Division staff members. The assessment of beneficiary and provider satisfaction and client and system outcomes is expected to remain a collaborative effort of all aforementioned parties. The MHP supports a Quality Improvement Committee (QIC) and a Utilization Review Steering Committee (URSC). The Napa County Health and Human Services Agency supports a Quality Excellence and Support Team (QuEST) which includes representation from the MH Division. The QIC is charged with recommending policy decisions, reviewing, and evaluating the results of Quality Improvement activities, instituting needed Quality Improvement actions and ensuring follow-up of such actions. The URSC develops, implements, evaluates, and improves utilization review processes, reviews reports of service utilization and makes recommendations

regarding under/over utilization patterns, and identifies service and resource gaps within the NCMHP continuum of care. The Quality Improvement and Utilization Review Committees collaborate to integrate current data into the Quality Improvement Committee's review process and formulation of recommendations. The QuEST Committee supports ongoing quality improvement projects.

QIC and URSC decisions and actions are memorialized by dated minutes which are signed by the Quality Coordinator or Utilization Review Coordinator, respectively and disseminated to the Mental Health Director and the Mental Health Division's Leadership team as well as to all members of each respective committee. URSC Dashboard reports are shared with the QIC members routinely, including during the past year. The activities of the QIC and the URSC continue to evolve as the MHP works to integrate Quality Improvement Committee and Utilization Review Steering Committee reviews and recommendations into the service delivery system.

The work of the QIC continues to revolve around review of those activities of the Mental Health Plan that relate to the items of the Quality Improvement Work Plan required by Federal and State regulation with consideration given to the local mental health service needs in Napa County. The Work Plan goals are structured within the six quality improvement domains and include Performance Improvement Projects (PIP) activities:

1. Monitoring Service Delivery Capacity
2. Monitoring Accessibility of Services
3. Monitoring Beneficiary Satisfaction
4. Monitoring Clinical Care
5. Monitoring Continuity of Care
6. Monitoring of Provider Appeals

Monitoring Service Delivery Capacity goals are designed to assess the implementation of mechanisms to assure the capacity of service delivery within the Napa County Mental Health Plan (NCMHP), including the description of the current number, types, and geographic distribution of mental health services within its delivery system. Cultural and Ethnic penetration rates are monitored annually on the Utilization Review Dashboard using the CA EQRO "Medi-Cal Approved Claims Data" as the data source. During FY 14/15, despite the penetration rate having dipped slightly from 2013 to 2014, the MHP maintained its revised EQRO Hispanic penetration rate goal of 5%. However, while the overall 'N' of those served increased along with increased overall Medi-Cal enrollment, as in the previous year, the

penetration rate by percentage dropped further to approximately 3.2%.¹ 0- 5 services and geographic distribution and service utilization patterns are also monitored on the Utilization Review Dashboard, along with measures related to hospitalizations and timeliness of aftercare appointments. In addition, the URSC analyzes data from Anasazi Unduplicated Client Services report and uses the County level Medi-Cal Eligibility data from the Self-Sufficiency to monitor ongoing penetration rates. Target goals and program intervention strategies are revised as necessary.

Monitoring Accessibility of Services goals are designed to assess timeliness of routine mental health appointments, timeliness of services for urgent conditions, access to after-hours care, and responsiveness of the MHP's 24 hour, toll free telephone number. The timeliness of routine mental health Access appointments for adults and children is analyzed monthly. In 2015, in response to CMS and DHCS agreeing on 1915b waiver Special Terms and Conditions that is setting required timeliness indicators, the previous timeliness indicator for Access to services was modified and moved from the Quality Management Plan (QM Plan) Dashboard to the Utilization review Dashboard to facilitate more frequent analysis. The data source remains the Request for Service Log, which was also revised and improved to better track time from request for services to first service.. Timeliness of access to medication services, including the timeliness from initial clinical assessment kept to first psychiatry appointment kept and the average number of days from inpatient hospital discharge to psychiatry appointment is reported monthly on the QM Plan Dashboard using the Central Access and Authorization Request for Services Log and the Inpatient Hospital Database maintained by Fiscal Department staff.

Goals for Monitoring Beneficiary Satisfaction address the degree to which mechanisms to ensure beneficiary or family satisfaction have been implemented. NCMHP assesses beneficiary and/or family satisfaction by administering and evaluating consumer satisfaction surveys, evaluating beneficiary grievances and fair hearings, and evaluating requests to change service providers on an annual basis.

NCMHP informs providers and other stakeholders of the results of beneficiary/family satisfaction activities and regularly shares results with QIC members through annual grievance reporting, notice of action, appeal, and requests for second opinions, and results of statewide Performance Outcome Quality Improvement surveys and Mental Health Service Act Full Service Partnership outcomes. In 2015, the Quality Coordinator and MH Staff Services Analyst took over the analysis of the POQI survey data from the QM Division and, in consultation with

¹ Penetration rates obtained from External Quality Review Organization (EQRO) statistics for Napa County for Calendar Year 2014. Exact numbers were not provided by BHC, thus this report is an approximate reading based on the bar graphs that were provided by EQRO.

the QIC, began a process of revising the presentation of this data in order to make it more meaningful and useful.

Monitoring Clinical Care- The scope and content of the QI Program reflect NCMHP's service delivery system and meaningful clinical issues that affect its beneficiaries. Annually NCMHP identifies clinical issues that are relevant to its beneficiaries for assessment and evaluation. For example, timeliness of Wellness and Recovery Plan completion is monitored monthly and reported on the QM Plan. The average number of hours of consumer use of the Emergency Response Team and all other Specialty Services Units, and the number of consumers served by the Crisis Residential program are also monitored and reported monthly and quarterly respectively, on the Utilization Review Dashboard. In addition, NCMHP implements appropriate interventions when individual occurrences of potential poor quality are identified through an electronic incident reporting, review, and response system. NCMHP adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. For example, the MHP critically reviews the year's grievances and change of provider requests annually. Providers, consumers, family members and quality management staff members of the QIC evaluate the analyzed data to identify barriers to improvement that are related to clinical practice and/or administrative aspects of the delivery system. NCMHP monitors the effectiveness and safety of medication practices. The MHP uses an electronic prescribing system that notifies providers when medications may be contraindicated. The Psychiatric Medical Director and medical staff monitor medication practice safety on a case by case basis.

Monitoring Continuity of Care- NCMHP is proactively working to ensure that services are coordinated and in many cases, integrated with physical health care and other agencies used by its beneficiaries. Whenever appropriate, NCMHP exchanges information in an effective and timely manner with other agencies used by its beneficiaries. For example, over the last five years, NCMHP and Napa County Alcohol and Drug Services have collaborated with Clinic Ole, an on-campus Federally Qualified Healthcare Center, in a physical and mental health care integration initiative, the CIC: Care Integration Collaborative. In addition, NCMHP monitors the effectiveness of its MOU with Physical Health Managed Care Plans (Partnership Health Plan of California

Monitoring Provider Appeals- NCMHP conducts monitoring activities that include provider appeals.

I. Monitoring Service Delivery Capacity-Evaluation of Goals for FY 2014-2015

1) Continue to monitor the Cultural/Ethnic Penetration rates annually on the Utilization Review Dashboard.

a) **Goal #1:** Increase the Hispanic Penetration rate from 3.80% to 4.0% **Evaluation: Not met (goal to be re-evaluated in UR Steering Committee)**

b) **Goal #2:** Increase the 0-5 Age group population rate from 2.00% to 2.30%.

Evaluation: Unable to evaluate (data not available)

Penetration rates establish information on the number of individuals who receive (utilize) mental health related services relative to the general population. These rates of utilization can be compared to state, regional, and national figures. They allow a rough analysis of patterns of utilization across various key demographics.

It was the goal for FY 14/15 to have at least a 4.0% penetration rate for the Hispanic population and a 2.30% penetration rate for the 0-5 age group. In calendar year 2014, we achieved a penetration rate of approximately 3.20% for the Hispanic population.

Penetration rates for the 0-5 age group have not been provided by EQRO so evaluation cannot be done based on previous methodology. Although we did not meet our goal of 4.0 % penetration rate for the Hispanic population, the numbers served increased.

Data is taken from state published data of individuals who are Medi-Cal eligible, who enroll in treatment within the Napa Mental Health Plan (MHP) delivery system, and have at least one service divided by the total population (Medi-Cal eligible) in a Calendar Year. This “Medi-Cal Approved Claims Data for Napa County MHP” report is prepared by the California External Quality Review Organization’s (CAEQRO) for the Napa County MHP and the data can be evaluated in a number of ways (i.e., looking at Medicaid population eligibility, comparing against SMI/SED prevalence rates, cultural and ethnic populations, etc.).

II. Monitoring Accessibility of Services-Evaluation of Goals for FY 2014-2015

1) Timeliness of routine mental health appointments of adults and children will be analyzed monthly

Using data from the Adult and Children’s Central Access and Authorization Team (CAAT) Logs, the MHP monitored both of the following indicators monthly in its Quality Management Plan: Average number of days from first request for mental health service to the Access team to initial clinical assessment (adults and children) and the Average number of days from Access team’s initial clinical assessment to first case management (including FSP) or therapy routine service (for adults)

- a) **Goal # 1:** Continue to monitor wait times for routine mental health services to meet service delivery target of 14 days.
- b) **Goal #2:** Analyze data and continue implementing Access PIP.

Evaluation: Met

The MHP monitored and analyzed wait time data monthly for both the children's and adult units for the time between request for service and initial clinical assessment. The indicator was changed during the year to monitor the percentage of individuals requesting services who were seen within 10 business days. The 6 month average was 99.67% of individuals successfully meeting this target. The MHP also monitored and analyzed monthly the data for the average number of days from Access team's initial clinical assessment to first case management (including FSP) or routine therapy services for adults.

The MHP concluded a total of 11 PDSA cycles over the 2 FY period of the Access PIP. They covered sequential efforts to improve workflows and operations within the Access Unit with the overarching metric of reducing wait time for first appointment to less than the target 10 business days consistently. With the successful achievement of a steady and valid improvement in the target measure, the PIP status was shifted to "monitoring."

2) Timeliness of access to medication clinic services will be monitored. Wait times for psychiatric appointments to meet service delivery target of 14 days.

- a) **Goal #1:** Continue to monitor wait times for psychiatric appointments to meet service delivery target of 14 days. Using the Adult CAAT log and the Adult medication clinic authorization log, the MHP monitored the following indicator on the Quality Management Plan monthly: Average number of days from Access team's initial clinical assessment kept to first psychiatric appointment kept.

Evaluation: Not Met

Over Fiscal year 2014-2015 the target goal was only met 2 out of 12 months and the average wait times were well over 14 days. However, the MHP is re-assessing this indicator as it measures wait times only for individuals who are initially assessed in the Access unit and then referred to psychiatry. Over the past year, the MHP set up several triage processes to prioritize faster psychiatry services for individuals who were discharging from psychiatric care or referred directly by the FQHC. These processes bypass Access and result in much quicker assessments and appointments. However, they are not included in the data tracked for this indicator. Therefore it is doubtful that this indicator is providing accurate information regarding actual timeliness.

3) Timeliness of services for urgent conditions

- a) **Goal #1:** Develop MHP system criteria to define urgent care
- b) **Goal #2:** Develop a system for recording incidences of urgent services
- c) **Goal #3:** Set a timeliness standard and assess performance to the standard

Evaluation: Met

The MHP did define what constitutes an urgent care situation; develop a system for recording incidents, and set a timeliness standard.

4) Access to after-hours care

- a) **Goal #1:** Continue to provide 24/7 after hours access to care for emergent, urgent, or routine conditions

Evaluation: Met

Napa County Mental Health provides a 24/7 Access line. In the recently completed DHCS Triennial audit, the conduct of the test calls received a 100% compliant score- a significant improvement in performance over past audits. However, logistical problems still remain in accurately logging all calls.

5.) Responsiveness of the 24/7 toll-free number

- b) **Goal #1:** Conduct at least 2 test calls a quarter
- c) **Goal #2:** Record results of test calls

Evaluation: Met

Goal #1: More than 2 test calls per quarter were made and results improved consistently as feedback was provided to supervisors and staff. Later in the year, it became evident that test callers were becoming recognizable to the staff answering calls. Alternate strategies are being explored for staffing test calls, including using student trainees.

Goal #2: DHCS created a new Spreadsheet to log test call data and requires counties to submit the report quarterly.

5) Medication services are efficiently managed

Continue to monitor quarterly on QM Plan

The following indicators are monitored quarterly on the Quality Management Plan: % of individuals (children and adults) scheduled for Medication clinic intake evaluations who show up for their appointments and % of all scheduled Adult medication appointments kept.

- a) **Goal #1:** 90% of children and adult medication intake appointments scheduled are kept
- b) **Goal #2:** 88% of adult medication appointments scheduled are kept

Evaluation: Not Met

Goal #1: **Not Met.** The target of 90% was not met in any quarter. The annual average was ~80%.

Goal # 2: **Not Met.** The MHP did not meet the goal of 88% for FY 2014-2015. The annual average was ~ 82%

III. Monitoring Beneficiary Satisfaction Evaluation of Goals for FY 2014-2015

1) Beneficiary and family satisfaction surveys of the NCMHP continue to be conducted annually using the Performance Outcome Quality Improvement (POQI). POQI surveys are administered every 6 months on all NCMH teams. Results of all surveys are reviewed and analyzed by HHS Quality Management team, Program Managers, QIC, and Organizational Providers.

a) **Goal #1:** Beneficiary Satisfaction Survey target: 85 % of survey questions are ranked satisfied to very satisfied.

Evaluation: Partially Met

Due to staffing resources changes, the Quality Management Division was no longer able to provide analysis of the POQI. The MHP has taken this analysis on and is developing a new approach to analyzing the POQI data. Initial results were provided to the QIC, and revised goals will be included in the next QI Workplan.

2) **Beneficiary grievance, appeals, and fair hearings are tracked by the HHS Quality Management team and the Mental Health Quality Improvement Coordinator.**

A summary report is reviewed by the QIC annually and given to the Mental Health Program Manager and Mental Health Director.

a) **Goal #1:** Continue to monitor grievances, appeals, and fair hearings resolutions.

Evaluation: Met

The annual grievance report, Appeals and Requests to Change Providers Reports were reviewed at our Quality Improvement Committee (QIC) meeting on May 15, 2015. Napa County MHP tracks both the grievances and the appeals regularly via electronic logs. Appeals are monitored regularly by the Quality Coordinator, and the Mental Health Director is informed immediately if there is an appeal. There were no appeals in 14-15.

3) **Evaluate requests by beneficiaries to change providers.**

A request to change provider log is maintained by the MHP senior office assistant. Change of provider requests are monitored and evaluated by the Mental Health Quality Coordinator. QIC is provided with results annually.

a) **Goal #1:** Evaluate and successfully resolve over 95% of all requests.

Evaluation: Met

Change of provider requests are evaluated and responded to by the MH Director as per Napa County Mental Health policy. The change of provider requests were monitored by the Quality Coordinator in FY 2014-2015.

IV. Monitoring Mental Health Plan's Service Delivery System and Clinical Issues Affecting Beneficiaries FY 2014-2015

1) Medication Practices are reviewed for safety and effectiveness

- a) **Goal #1:** Once the Psychiatric Medical Director comes on board, set up a team meeting with new Psychiatric Medical Director to define the medication practices that will be evaluated for safety and effectiveness.
- b) **Goal #2:** Develop data measures and collection methodologies to monitor practices.

Evaluation: Not met

Although the MHP successfully recruited and hired a new Psychiatric Medical Director, due to staffing shortfalls in the adult med clinic, she was needed in the role of psychiatrist and the Medical Director functions have yet to be fully implemented. These goals will be carried over on the new Work Plan.

2) Interventions implemented when occurrences of poor care are identified.

The MHP Leadership is alerted immediately when an incident report is filed via the Electronic Incident Reports system.

- a) **Goal #1:** MHP Director and members of MH leadership team continue to review incidents reported through electronic incident report system

Evaluation: Met

MH Leadership intervenes on a case by case basis, when incidents of poor care are identified. MH Leadership monitors incidents for patterns of occurrences.

3) Providers, beneficiaries, and family members evaluating data to identify barriers to improvement related to clinical practice and/or administrative aspects of the delivery system.

Continue to encourage and implement providers, beneficiaries, and family members feedback on data presented in QIC and UR Steering Committee monthly.

- a) **Goal #1:** Document provider, beneficiary, and family member feedback in QIC and URSC monthly meeting minutes
- b) **Goal #2:** Wherever appropriate, incorporate QIC member feedback based on reviews of mental health policies.

Evaluation: Met

Both the UR Steering Committee and the QIC continue to request feedback from providers, consumer committee members, and family members at each meeting on data analysis, Mental Health policies, and quality improvement efforts. QIC members are sent copies of MH policies that are in review and the MHP asks members for their feedback. When feedback is received, and it is appropriate, it is incorporated into the policy. In addition, QIC committee members have been active in developing flyers, Access information cards, and in the evaluation of the Quality Improvement Work Plan.

V. Monitoring Continuity and Coordination of Care with Physical Health Care Providers and other Health and Human Services Evaluation of Goals for FY 2014-2015

1) Coordination of mental health and physical health care is a primary focus of NCMHP and the on campus FQHC, Clinic Ole.

Over a 12 month period, Napa County's partnership of consumers, the Mental Health and Alcohol and Drug Services Divisions of the Health and Human Services Agency and Community Health Clinic Ole, working with Partnership Health Plan and Beacon Health care, our local public safety net health plan will:

- a) **Goal #1:** increase the number of people who participate in coordinated care
- b) **Goal #2:** monitor and make changes to improve consumer health outcomes.
- c) **Goal #3:** Continue working on objectives developed in Care Integration Collaborative (CIC) charter.

Evaluation: Partially Met

As a result of the successful launching of Clinic Ole on the campus of HHSA, and our key learning through the Care Integration Collaborative (CIC), HHSA expanded the County Campus staff through use of an Inter-Governmental Transfer (IGT) funding mechanism. IGTs are strategies by which Napa County could increase available funding for local health services to increase access and utilization through the Partnership Managed Medi-Cal Health Plan (MCP) as the fiscal intermediary. Although the IGT funds are vital in sustaining our current integration project, utilization of the tools learned through the CIC, (i.e. performing PDSAs or collecting data outcome measures) has not been actively pursued, as we have continued to spend much of our efforts over the course of FY 2014/2015 on policy initiatives, program planning, brainstorming evidence based practices as well as how to overcome data collection barriers due to interoperability challenges. Additionally, the team completed the project of creating integrated Release of Information Forms and Notices of Privacy Practices for the 3 partner agencies.

2) MOUs with Partnership Health Plan

- a) **Goal #1:** Continue MOUs and revise in collaboration with Partnership Health Plan, when needed.

Evaluation: Met – needs updating to reflect changes as a result of ACA implementation.

During Fiscal Year 2014-2015 there were significant changes to the relationship between the MHP and Partnership Health Plan as HHSa works with Beacon Healthcare, Partnership's chosen vendor for the delivery of Mental Health services in their Managed Care Plan. A pilot program was created that identified 20 ADS clients who met the mild to moderate criteria for MH services. These individuals were assessed and are being provided MH counseling under contract with Beacon Health Care.

VI. Monitoring of Provider Appeals Evaluation of Goals for FY 2014-2015

1) Monitor Provider appeal resolution

- a) **Goal #1:** Successfully resolve 95% of provider appeals.

Evaluation: Met

There were no provider appeals filed for Fiscal Year 2014/2015

2) Provider Satisfaction Surveys administered annually.

Continue to monitor annually on QM Plan: % of providers surveyed who respond positively (somewhat satisfied to very satisfied) to questions on satisfaction survey

- a) **Goal #1:** Provider Satisfaction Surveys: 80% respond somewhat satisfied to very satisfied.

Evaluation: Not Met

The pre-existing IPN Satisfaction Survey was critically examined by MH Leadership in consultation with the Compliance Officer. A determination was made that the existing format was not well designed and produced unhelpful results. The decision was reached to re-visit the approach to soliciting Provider feedback. This effort is ongoing.