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2015-2016 Quality Management Program Annual Report

Report Date: September 29, 2016
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The Orange County Mental Health Plan has a robust set of processes in place to facilitate continuous improvement in processes and to identify specific examples of services needing improvement. Many, but not all, of the mechanisms for accomplishing these goals are defined in the Quality Management Program and the Quality Management Work Plan.

Some examples of how this array of processes and procedures have resulted in improvement in the quality of services include:

- Routine Medication Monitoring led to recommendations for specific cases, for example:
    - Monitoring through the pharmacy benefits manager identified a client receiving antidepressant at dosage exceeding FDA approved. Feedback was routed to the contract provider who subsequently lowered the dosage.
    - An overdue nursing assessment was noted and scheduled.
    - Medication consents could not be found and were subsequently completed with the client.
- Medication monitoring with attention to metabolic monitoring issues and inclusion of metabolic monitoring prompts in the electronic health record prescribing module have led to increases over the last three years in the percent of reviewed charts having the lab and metabolic data flow sheet updated.
- Division QIC meetings in CYBH led to recommendations for specific cases including recommendations to consider whether a particular medication was contributing to symptoms of anxiety.
- Division QIC meetings led to system changes as well. Following discussions in multiple forums including the quality improvement committee regarding limited resources for physical/mental health dual diagnoses, a contract with CHOC was developed this year for co-occurring issues which includes eating disorders. BHS outpatient clients can be referred to this program. In addition, a bottleneck was identified with housing support

that slowed movement of clients to a lower level of care, resulting in adjustments that decreased the wait time on the Shelter Plus Care wait list facilitating appropriate movement through the system.

- Monitoring and efforts to improve quality have led to increased percentages of calls to the 24/7 800 number that are answered within 30 seconds.
- Efforts to increase the percentage of valid statewide consumer preference surveys are expected to help the MHP have more useful feedback to help in evaluating the system of care.
- Improvement of the inpatient grievance management to better track dispositions.
- Use of the CRAFFT in CYBH was implemented. As a result, twenty-four mental health clients were identified as also being at risk for substance abuse issues, were linked to and completed Seeking Safety and were linked to substance use services. There was a substantial decrease in functional impairment and risk related to substance use.
- A client with over 100 emergency department and crisis service admissions within a two year period was able to avoid intensive long term mental health interventions by inducing physical problems that would move him out of mental health treatment, often inpatient, to physical health services. Inpatient psychiatric units weren't able to complete conservatorship issues because he wouldn't be present long enough. Intensive collaboration between CalOptima (the Managed Care Plan), the treating full service partnership, the inpatient team, and a local contracted psychiatric inpatient unit resulted in management of the psychiatric issues and the physical health issues in a way that allowed the psychiatric hospital to move forward and complete the T-con process. While this is more containment rather than treatment progress, it was an essential step in setting the groundwork for consistent mental health intervention.

ACCESS TO SERVICES

BHS monitors the timeliness of Routine and Urgent initial requests for services. This information comes from the Mental Health Plan Access Log. Only service requests from Medi-Cal beneficiaries are reported in these numbers. The determination of a Routine and Urgent need is based on the information conveyed by the caller and the clinical judgment of the individual taking the call.

- **Routine and Urgent Initial Service Requests – Medi-Cal only**

  For routine requests for service, BHS has historically set as its goal to offer an appointment within 14 calendar days of the request, as indicated in the State Approved Implementation Plan. In the coming year, County will request a modification of the Implementation Plan to move to a standard of 10 working days to bring greater consistency with the more common managed care standard.

  The standard process for both County operated and County contracted providers is for the first visit to be the initial assessment service. Therefore, in Orange County, the time from call to first offered appointment is equal to the time from call to first offered assessment service. Although our approved standard is 14 days, the Mental Health

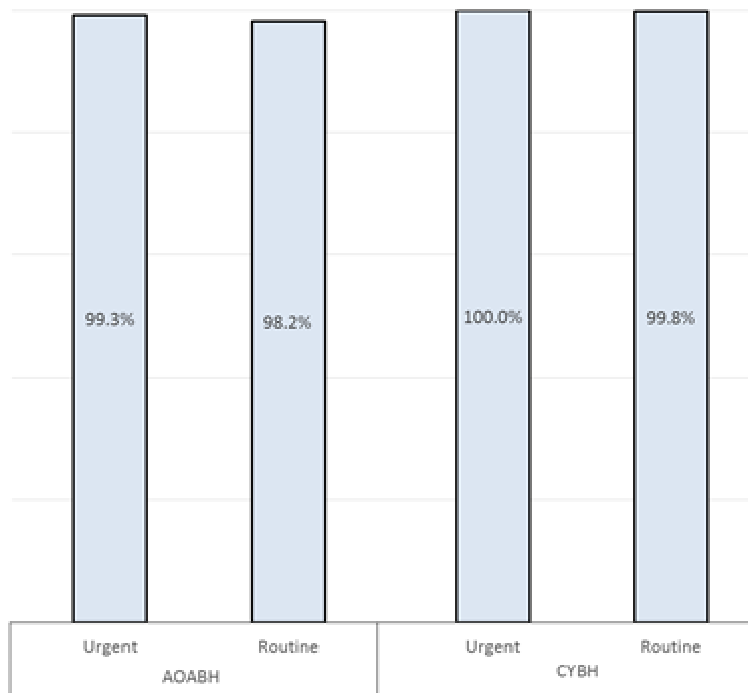
Plan has set a quality improvement goal target of offering 85% of all people requesting routine services an appointment for assessment within 5 working days of the initial call. In calculating the number of days to services, day 1 begins the day after the call is received.

For urgent calls, BHS' goal is to offer consumers an urgent appointment within 1 day of the initial call, as indicated in the State Approved Implementation Plan. The quality improvement goal is to reach this time frame in 90% of urgent calls.

Below is the information for the 2015-2016 fiscal year.

Figure 1

Percent of Offered Appointments within Time Limits, FY 15/16, by Function Area and Urgency (Urgent: 24 Hours, Routine: 5 Workdays)

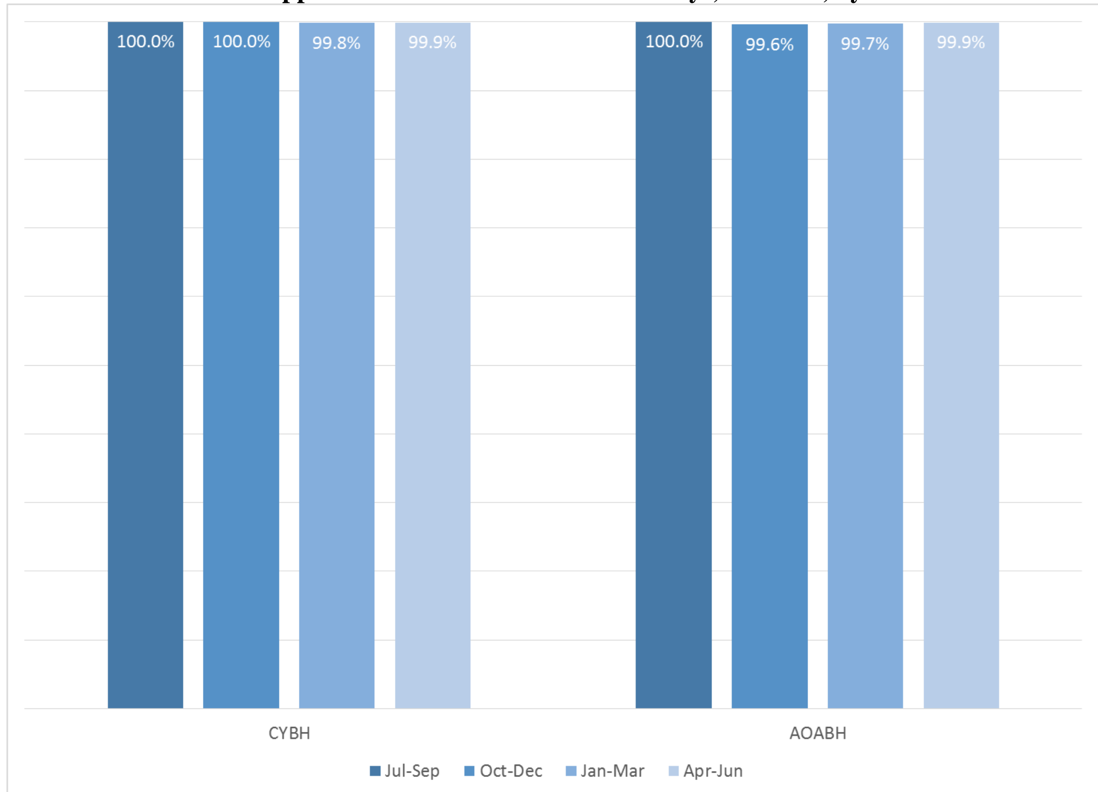


BHS has met both the Implementation Plan standard and the quality improvement goals established for Routine and Urgent calls for both AOABH and CYBH. This high level of meeting the established goals suggests that access to an initial assessment service is currently adequate to meet demands.

In 2015-16 BHS began reporting on disparities in time to initial offered appointment related to language spoken. Initial reporting was for CYBH. Reporting was for the 3rd and 4th quarters of 2015-16. During this time, English and Spanish made up 98.7% of the clients and 93.7% of the families. For both quarters the time to first offered appointment was less than the target of 5 days for both languages. There were differences that were statistically significant and were fairly small. For quarter three the average time to first offered appointment was 4.2 days for Spanish speaking clients

and 3.7 days for English speaking clients. For quarter four, the average time to first offered appointment was 3.5 days for Spanish speaking clients and 2.6 days for English speaking clients.

Figure 2. Percent of Offered Appointments within 14 Calendar Days, FY15/16, by Function Area



Fourteen calendar days is the requirement for routine appointments to be offered, as established in the state approved implementation plan. When an appointment is not offered within the required timeline the MHP is required to issue an NOA-E to the consumer. The Access log is carefully monitored to ensure that if the 14 day requirement is not met, an NOA-E is issued.

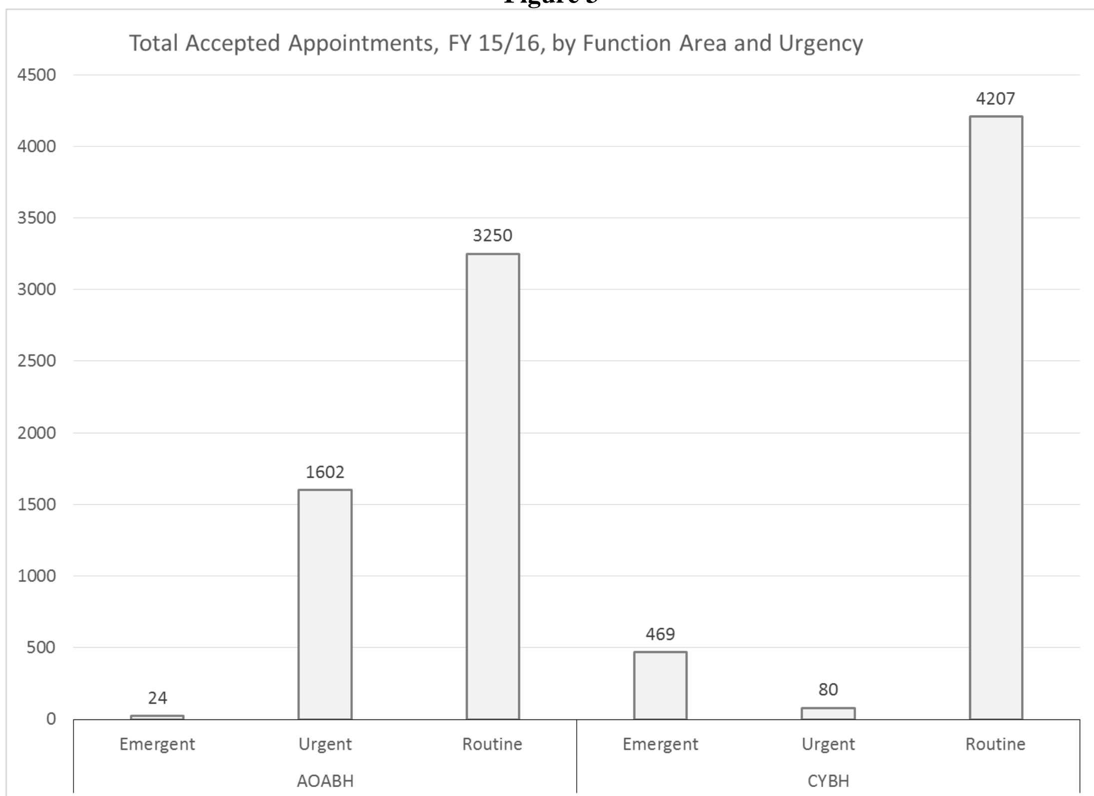
In 2015-16,

- Six logged requests were not offered appointments within timelines but were discovered to not be initial service requests. The provider has been re-trained on use of the Access Log.
- One service request was identified as not being offered an appointment within timelines but was found to be a duplicate of another request in the category below.
- Five services were requested that exceeded the timeline requiring an NOA-E. NOA-Es were not provided for any of these.
    - Three were not discovered until long after the request due to late logging so that the monitoring team was not aware the 14 day timeline was exceeded. The

provider has been re-trained on the use of the Access Log. All three were receiving services at the time of discovery so NOA-Es were not issued.

- Two requests for service were received for clients that were in facilities (one in jail, one in hospital) with anticipated discharge/release dates after the 14 days. Both were offered appointments on the anticipated date of discharge, technically requiring an NOA-E but practically the offered appointment was the earliest that could reasonably be offered and this was related to circumstances of the client, not late action by the MHP, so no NOA-E was provided.

Figure 3



- **Time to Physician Appointment – Medi-Cal and non-Medi-Cal**

Mechanisms and processes were put into place in July 2016 to facilitate the reporting of an additional measure of access to care. In particular, the state has been interested in reporting on the wait time to providers. While this has not been completely defined at the state level, BHS has identified a method, implemented in AOABH and soon to be implemented in CYBH, for tracking the time from a requested appointment with an MD to the time the appointment is offered and to the time of the accepted appointment. BHS has identified two areas of interest; first is the time from an initial identification of need for MD services to the time of the offered and accepted appointments; second is the ongoing time from an identified need for an MD appointment to the time offered and accepted.

At the time of this annual report, reports on this indicator are just starting to be generated, analyzed and presented to management for planning purposes. The first report included information on both the initial time to offered appointment and accepted appointment and the ongoing time to offered appointment and accepted appointment.

AOABH appointment data ($n = 9195$) for the first six months of 2016 was analyzed in order to see the time from identification of a need for psychiatric services until an appointment with a psychiatrist was first offered and attended. On average, clients were offered appointments 17.7 days after the appointment was made, and attended 24.6 days after the appointment was made. This varied by program. This first report will be reviewed by managers to determine what if any actions might be initiated based on this information and to begin the process of fine tuning the reporting to be of the most possible utility for decision making.

- **24/7 Line Timely Call Access**

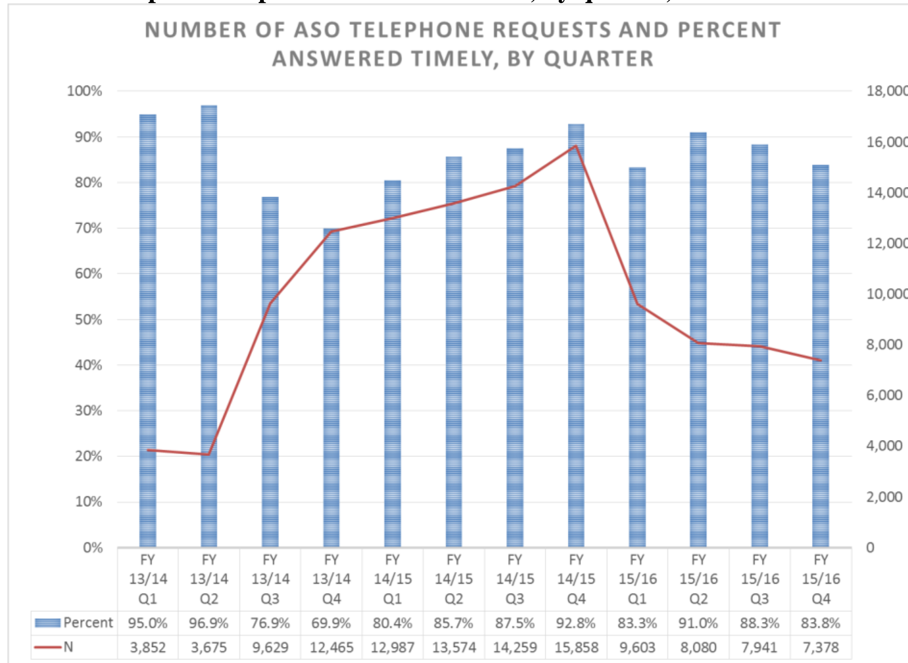
During FY15/16, the MHP contracted with Cal-Optima/Beacon to provide 24-hour, seven day a week access to the community. The Quality Management Work Plan goal is to answer 95% of calls within 30 seconds. A comparison figure for the community is that the physical health provider, CalOptima, sets its goal at 80% answered within 30 seconds.

In 2013-14, the last two quarters of routine monitoring of this access data indicated that in 2013-14 there was a dramatic increase in call volume for the third and fourth quarters, 190% above the first two quarters. This reflected expanded coverage under the Affordable Care Act and in addition contractual changes were made to facilitate beneficiary access with the ASO handling calls for both the Managed Care Plan (MCP) and Mental Health Plan (MHP). The calls reported include all calls that have come in for both the MCP and MHP as the ASO does not have an ability to screen out only MHP calls.

With this increased volume, there was a corresponding decrease in ability to handle calls in a timely manner. The MHP was able to use this data monitoring to identify the issue and work with the ASO to manage staffing. This helped increase the percentage of calls answered within the 30 second timeline, although the quality improvement goal of 95% is still not being reached.

Effective July 1, 2015 the MCP and MHP functions were again split out contractually to facilitate oversight and reporting for the MHP.

Figure 4. ASO telephone response within 30 seconds, by quarter, FY14/15 - FY15/16



	FY 13/14 Q1	FY 13/14 Q2	FY 13/14 Q3	FY 13/14 Q4	FY 14/15 Q1	FY 14/15 Q2	FY 14/15 Q3	FY 14/15 Q4	FY 15/16 Q1	FY 15/16 Q2	FY 15/16 Q3	FY 15/16 Q4
Percent	95.0%	96.9%	76.9%	69.9%	80.4%	85.7%	87.5%	92.8%	83.3%	91.0%	88.3%	83.8%
N	3,852	3,675	9,629	12,465	12,987	13,574	14,259	15,858	9,603	8,080	7,941	7,378

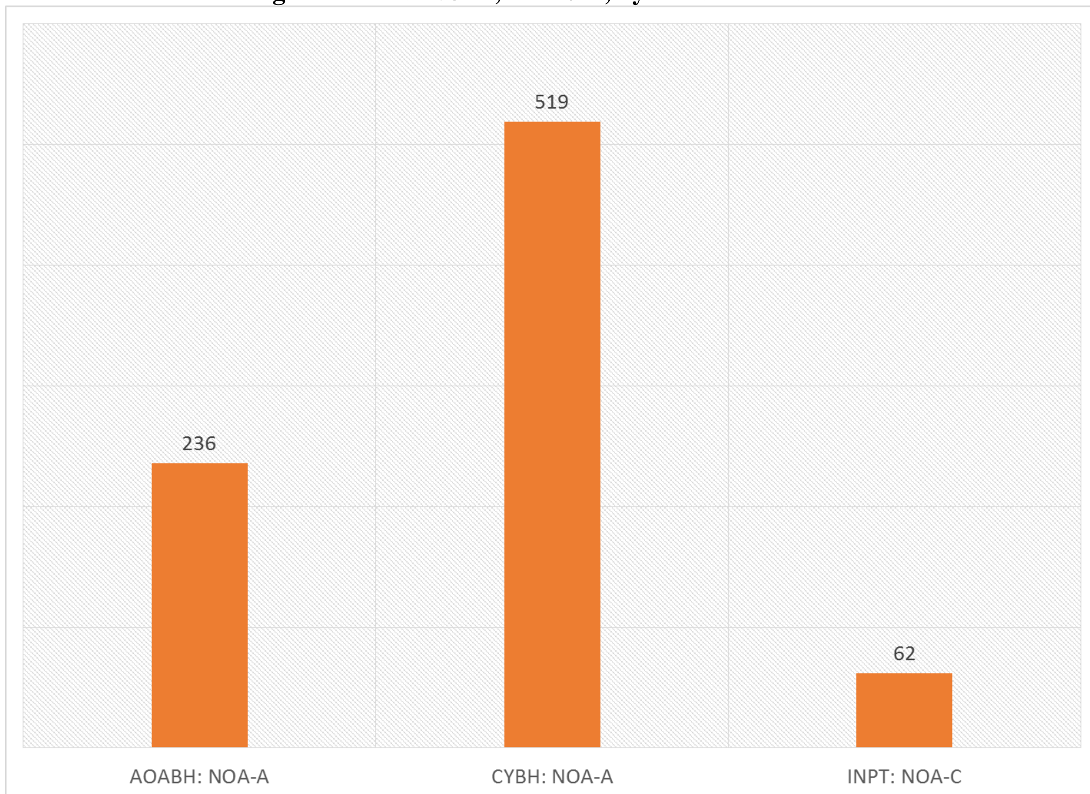
BENEFICIARY PROTECTION

- **Notices of Action**

  NOAs are required when any of the following actions occur with a Medi-Cal beneficiary. During the current fiscal year only NOA-A's and NOA-C's were given.

NOA-A: Denial of Services Following Assessment
NOA-B: Reduction of Services
NOA-C: Post Service Denial of Payment
NOA-D: Delay in Processing a Beneficiary Grievance or Appeal
NOA-E: Lack of Timely Services

Figure 5. Total NOAs, FY15/16, by Function Area



Outpatient services issue NOA-As whenever an initial assessment results in services being denied due to lack of medical necessity.

The majority of NOA-As are issued from CYBH. CYBH issued 519 NOA-A's this year, exactly the same number as were issued last fiscal year. The larger number of NOA-As from CYBH is a result of a specialized agreement with the Social Services Agency to assess all youth coming into Orangewood Children's Home, the County Social Services Agency children's home. While many of these youth understandably have some mental health issues, many do not meet the level of severity needed to meet medical necessity for EPSDT Medi-Cal. Past guidance from the State has indicated that these contacts do qualify as assessments rather than screenings and therefor if ongoing services are not offered by the MHP, an NOA-A is provided.

Adult Services issued 236 NOA-A's compared to last year when 71 were issued. This difference is being reviewed, but is thought to be related to a process change in which there is a single point of initial assessment for both mental health and substance use treatment services.

Inpatient Services Treatment Authorization Request (TAR) unit issues NOA-Cs whenever they deny payment for a hospital day or reduce a day to an administrative service day. In 2015-16 the TAR unit issued 62 NOA-C's compared to 204 in the

prior year. Historically the number of TARs and the number of NOA-Cs has varied widely. It is dependent on a variety of factors such as the number of days hospitals choose to put on one TAR and the fact that one poorly documented chart can lead to multiple NOA-Cs if the hospital has submitted the billing for that case on multiple TARs.

- **Provider Appeals and Inpatient Provider Treatment Authorization Request Appeals (FY 15/16)**

Table 1 reflects the number of inpatient days denied that were appealed by the provider**.** When a denial is appealed, the appeal is handled by physician staff not involved in the first level denial. Upon appeal, 28% of services were granted.

A second level of appeal is also available. These appeals go to the State. There have been almost no appeals since the State changed these second level appeals to a "loser pays" funding of the costs of the appeal. Once again this year, Orange County had no second level appeals.

Table 1
Inpatient Provider Appeals

Appeals to BHS (1st Level)				Appeals to DHCS (2nd Level)			
Appeal Requests	Days Appealed	Days Granted	Days Denied	Appeal Requests	Days Appealed	Days Granted	Days Denied
14	110	31	79	0	--	--	--

- **Medi-Cal Appeals**

There was one Medi-Cal appeal in FY15/16. It was during Q1 in CYBH and it was resolved within timelines. Historically the number of appeals has been very low.

There were no requests for expedited appeals.

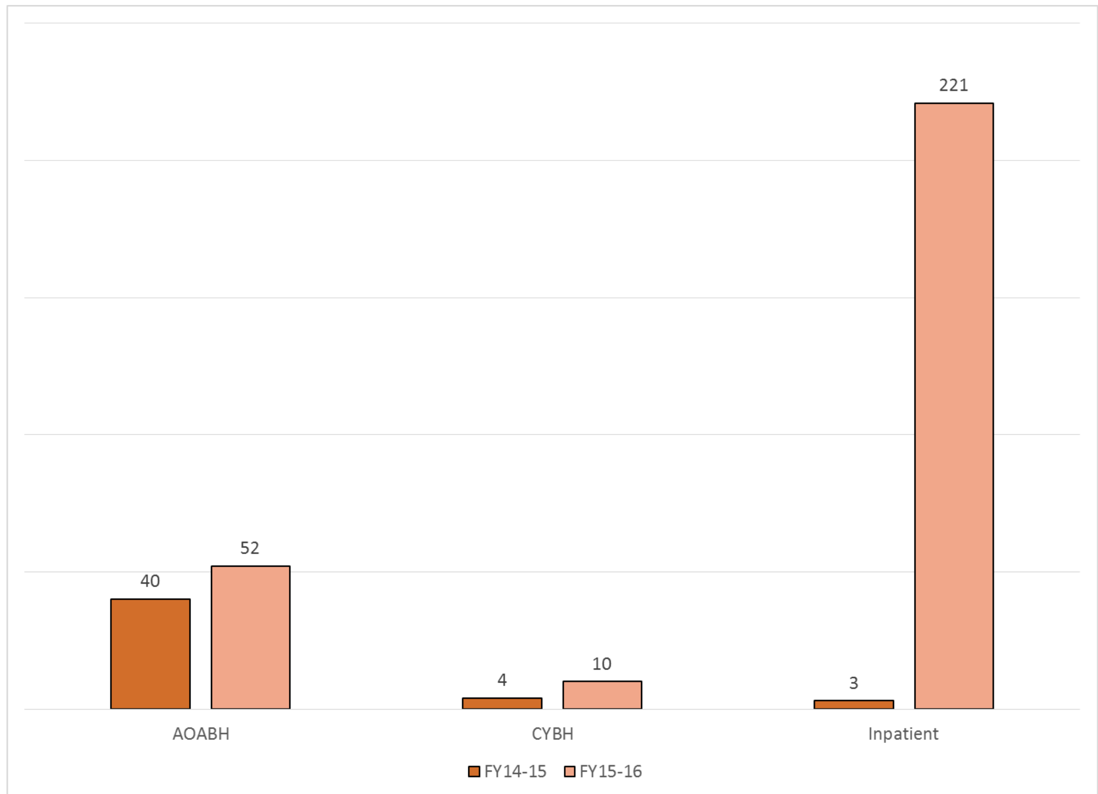
- **State Fair Hearings**

There were no fair hearings or expedited fair hearings this year in either AOABH or CYBH.

Historically the number of fair hearings has been very low.

- **Grievances**

Figure 6. Grievances by Fiscal Year and Function Area, FY14/15 - FY15/16



AOABH and CYBH experienced small increases in the numbers of grievances. A change in processes resulted in an artifact that makes it appear there was a substantial increase in Inpatient grievances.

In previous years, in order to facilitate a rapid response to persons filing grievances while they are in the hospital, hospital grievances were handed over to Patients' Rights Advocacy Services (PRAS) for processing. PRAS is in every hospital weekly to meet with patients and the longer allowed grievance processing time of 60 days did not make sense. However, the process was one in which persons submitting what initially could have been grievances were given the right to choose a quicker resolution through the Patients' Rights process. Most accepted this and these were referred to PRAS and were handled outside of the grievance process and so were not accurately reflected in the grievance logs.

In FY15/16, this process was changed and all inpatient grievances were logged, resulting in the large increase in inpatient Grievances over the prior year. However, PRAS upon arrival at the hospital would notify the client that the client could leave the process as a grievance in which case it might take a longer time, or the patient could withdraw it as a grievance and choose to use the PRAS advocacy route for getting the issue resolved. Not surprisingly, most patients chose to withdraw the grievance and have PRAS handle it through the advocacy route. The result is that

the resolution for all of these grievances in the FY15/16 grievance log simply indicates that the grievance was withdrawn. This process did not seem to be entirely within the spirit of the grievance process and also did not seem adequate for tracking, monitoring and assessment of quality improvement needs, so the process was again changed.

The high number of these inpatient grievances was determined to be best managed by assigning additional personnel resources to PRAS specifically to allow PRAS to handle the hospital grievances just as all other grievances are handled, and to do so in a timely manner to facilitate resolution while the patient is still in the hospital. In early 2016-17 BHS was able to identify and assign an additional position to meet this need. This change will be reflected in the next annual report. In addition, BHS is implementing the revised categories of grievances as established by DHCS and will report using those new categories in the next annual report.

Table 2. Medi-Cal Grievances, by Type and Function Area

		FY 15-16			
		Decision within timelines?		Disposition (resolved by Divisional QRT)?	
		Yes	No	Yes	No
ACCESS	AOABH	3		3	
	CYBH	1		1	
	INPATIENT	1		1	
CHANGE OF PROVIDER	AOABH	1		1	
	CYBH	2		2	
	INPATIENT	2		2	
QUALITY OF CARE	AOABH	38		38	
	CYBH	3		3	
	INPATIENT	131		131	
CONFIDENTIALITY	AOABH	2		2	
	CYBH	1		1	
	INPATIENT	1		1	
OTHER	AOABH	8		8	
	CYBH	3		3	
	INPATIENT	86		86	

All grievances were resolved within the 60-day timeframe. A total of 61 outpatient (County operated and contract clinics) grievances were filed in fiscal year 2015-16, which is an increase from 2014-15 of eleven for Adult and Older Adult Behavioral Health(AOABH) and of six for Children and Youth Behavioral Health (CYBH). Although there is no benchmark for

comparison, the number of grievances does not seem to be unusually high for an organization this size.

An annual evaluation of the grievances is challenging from multiple perspectives. Some grievances are written in a moment when the client is experiencing a high degree of frustration and by the time the investigative call is made the client feels less intensity about the experience. The written grievances can sometimes be difficult to understand as the client is experiencing serious symptomatology and may have an entirely different set of concerns when the investigative call is made.

The breakdown by categories or type of grievance are as follows for AOABH; **Access**- 2, **Change of Provider**- 1, **Quality of Care**- 39, **Confidentiality**- 1, and **Other**- 8.

The breakdown by categories or type of grievance are as follows for CYBH; **Access**- 1, **Change of Provider**- 2, **Quality of Care**- 4, **Confidentiality**- 1, and **Other**- 2.

The majority of grievances are best categorized as Quality of Care, particularly for AOBH programs. In review of this subgroup, 20 grievances were related to the client's perception of interactions with a specific provider including disrespect and or rudeness and 10 of these resulted in a change of provider.

The evaluation of grievances was made more time consuming by the fact that the grievance log does not include the name of the individual provider. Individual grievance folders had to be reviewed to provide some of the specific information. In addition, it is thought that waiting until the end of the year to determine if an individual provider is having multiple grievances is missing an opportunity for early intervention and improvement. Going into the coming year, a new process will be put in place. The current Grievance Log will be expanded to identify the specific individual provider for which the grievance was lodged. This would allow patterns to be identified, and when a provider has three or more grievances in a quarter, the supervisor will be notified and address this with the individual provider.

Quality of Care concerns included 10 interactions with medical professionals about medication recommendations. These resulted in 7 change of providers.

Only three grievances addressed access to treatment and timely appointments. Review of these grievances indicated that the clients had had earlier appointments but either missed or rescheduled them. Discussion of the possibility of appointment reminders for clients is ongoing.

Several grievances have resulted from a lack of understanding about the limitations and requirements of services. For example, completion of disability paperwork, payment assistance, access to records, missed appointments, urgent appointments, role of payee, and program rules. In this circumstance, it may be helpful for the provider to obtain permission to include a family member, support person or advocate from Patient's Rights.

It is not uncommon that homeless or transient clients may be impossible to reach to either follow up with the grievance or to provide the client with the results of the grievance. Sending the response letter to their service location care of the provider or the Service Chief to give to the client at the next visit is being considered.

Three grievances filed were solely related to confidentiality, one for CYBS and two for AOABH. The third grievance included issues of confidentiality but was categorized as "other" with a sub-category of "patient's rights." Any grievance for which initial review appears as if it might represent a breach of confidentiality is referred to the agency Office of Compliance for review and follow up.

BENEFICIARY SATISFACTION

Statewide Consumer Perception Survey

BHS last administered the Performance Outcome/Consumer Perception Survey between May 16-20, 2016 for Adults and Older Adults, Children and Youth, and the Family of Children and Youth. As of the date of this report, these survey forms have been submitted and are being scanned. The data from this survey period is not yet available from the California Institute for Behavioral Health Solutions (CIBHS). The most recent results available are from the surveys administered November 17, 2015 to November 21, 2015.

The Consumer Perception Survey includes the Mental Health Statistics Improvement Program (MHSIP), the Youth Services Survey (YSS) and the Youth Services Survey – Family (YSS-F). A scale of 1-5 was used with "1" representing "Strongly Disagree" and "5" representing "Strongly Agree." The mean ratings for the November 2015 administration are shown in Table 1. Please see the full reports for additional information.

Table 1. Consumer Perception Survey, Mean Scores for November 2015 Administration (1: Strongly Disagree to 5: Strongly Agree)

	Service Satisfaction				Treatment Outcomes			
	Access	Treatment Partici-pation	Cultural Sensitivity / Appro-priateness	General Satis-faction	Positive Outcomes	Function-ing	Social Connect-edness	N
YSS (age 13+)	4.2	4.1	4.4	4.3	3.9	3.9	4.2	483
YSS-F (parents/ guardians)	4.4	4.3	4.6	4.4	3.9	3.9	4.2	763
MHSIP (adults)	4.3	4.3	4.4	4.5	4	3.9	3.9	691

Overall, the results of these surveys are fairly positive. ***<u>It is important to note that while there are some significant differences between groups (see below), even those differences that are statistically significant are fairly minor.</u>*** These do not appear to reflect issues that require additional focus of attention in the coming year's Quality Management Plan. In addition, the differences are not consistent from one administration to the next so that there are minimal consistent patterns in the differences.

YSS

There were no significant differences related to ethnicity or gender. The scales measuring outcomes of services, functioning, social connectedness and satisfaction with services all improved significantly the longer the client was in services.

Trending the results over this administration and the two prior administrations, the only consistent findings are:

- Outcome of Services, Functioning and Social Connectedness consistently improve over length of time receiving services.

YSS-F

For family members of youth, ethnicity was significant with African Americans rating outcome of services and functioning lower, and Asian/Pacific Islanders rating those same two scales higher. Language in which the form was completed also yielded significant differences with those completing the forms in Spanish rating outcome of services and functioning higher than those completing the form in English. Outcome of services and functioning improved significantly the longer the client was in services across all ethnicities.

Trending the results over this administration and the two prior administrations, the only consistent findings are:

- Outcome of Services, Functioning and Social Connectedness consistently improve over length of time receiving services.
- Persons completing the forms in Spanish rate Outcome of Services and Functioning higher than others.

MHSIP

For adults completing the MHSIP there were no differences by race/ethnicity. Clients completing the forms in English rated outcomes and functioning lower than other clients. Women rated the quality of treatment and treatment plan participation higher than men.

As the results of the statewide consumer perception surveys were reviewed in the Community Quality Improvement Committee, it was noted that a fairly high number of surveys returned were not able to be included in the results. This resulted in a brief review of the factors involved and a plan to improve feedback by increasing the number of surveys

that could be included. This requires some procedural changes to improve the pre-survey notifications to the clinics, and some activities by QI staff to facilitate completeness of the forms before they are sent for scanning. This item was added to the work plan for 2016-17 and will be reviewed during the administrations during that year.

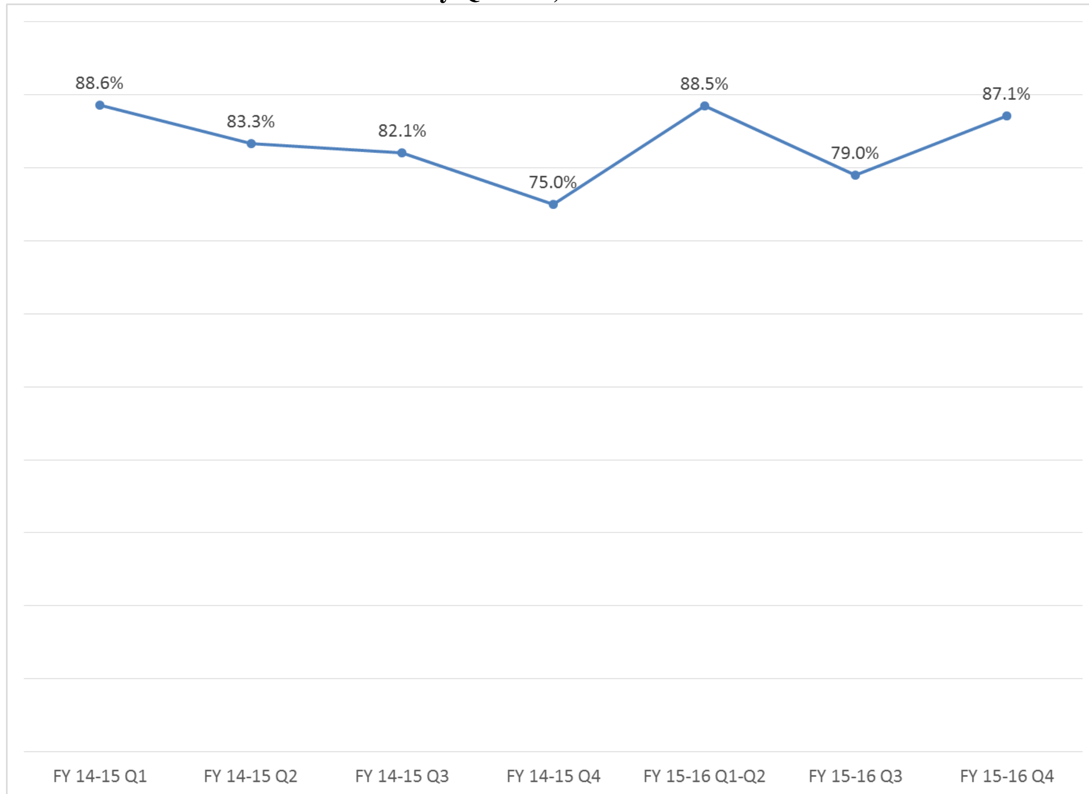
Trending the results over this administration and the two prior administrations, the only consistent findings are:

- There is no difference by race/ethnicity.
- Persons completing the survey on English forms tend to rate most scales lower than others.
- Women rated Quality of Care and Treatment Plan Participation slightly higher than men.

- **ASO Beneficiary Surveys – Medi-Cal and non-Medi-Cal**

The 24/7 800 number is expected to assess the satisfaction of beneficiaries calling the access line and to report this data and any findings and recommendations to BHS and providers. These surveys are conducted in the threshold languages, and assess whether beneficiaries had access to written materials in their primary language. There were 152 beneficiaries surveyed over FY15/16. There has been no consistent trends over time; over all quarters, at least 75% of beneficiaries have agreed that they are satisfied with the referral process.

Figure 7. Percent of ASO access line callers indicating that they “Agree” or “Strongly Agree” with the statement, “Overall, I am satisfied with the referral process when calling the 800-723-8641 Access Line.” by Quarter, FY 14/15-15/16



- **Change of Provider/2nd Opinion Requests – Medi-Cal and Non-Medi-Cal**

The most common reasons for change-of-provider requests in both Function Areas were “Care and Treatment” and “Personality.” “Care and Treatment” accounted for 24.7% of AOABH requests and 25.8% of CYBH requests. "Personality" accounted for 37.3% of AOABH Change-of-Provider requests and 21.9% of CYBH requests. Reports were not received from the following clinics: Q1: AOABH Anaheim, Q2: CYBH Touchstones, Q4: CYBH North.

For CYBH, the name of any provider who receives three or more requests to be changed in one quarter is referred to the program manager for further consideration if there is a larger issue present and in need of attention. The same process exists in AOABH however the criterion is four requests in one quarter. None reached criterion this year.

Table 3. Breakdown of Change of Provider/2nd Opinion, FY2015/2016

Lang-uage	Care/Tx	Person-ality	Tx Approach	Gender	Medi-cation	Sched-ules	Loca-tion	2nd Opin.	Other	No Rsn
AOABH										
9	37	56	10	16	5	12	0	4	3	2

CYBH										
8	30	1	2	23	0	10	0	0	13	23
AOABH & CYBH Totals										
17	**67**	**57**	**12**	**39**	**5**	**22**	**0**	**4**	**16**	**25**

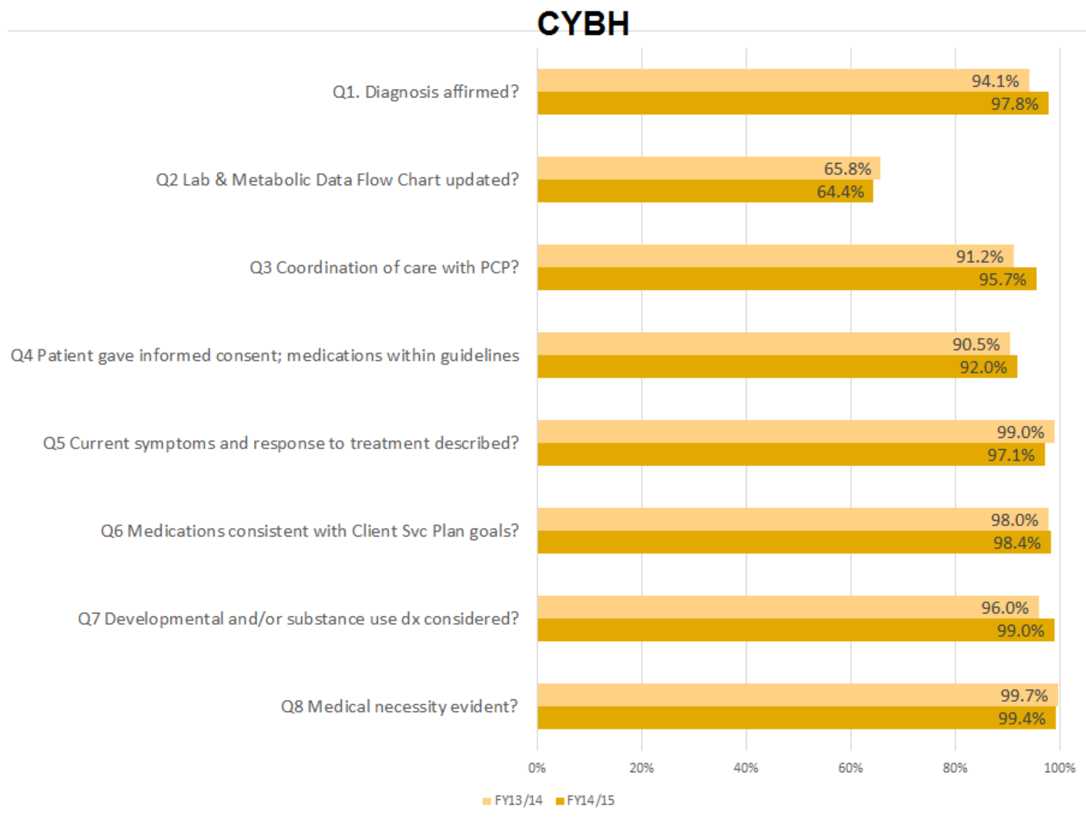
MEDICATION MONITORING

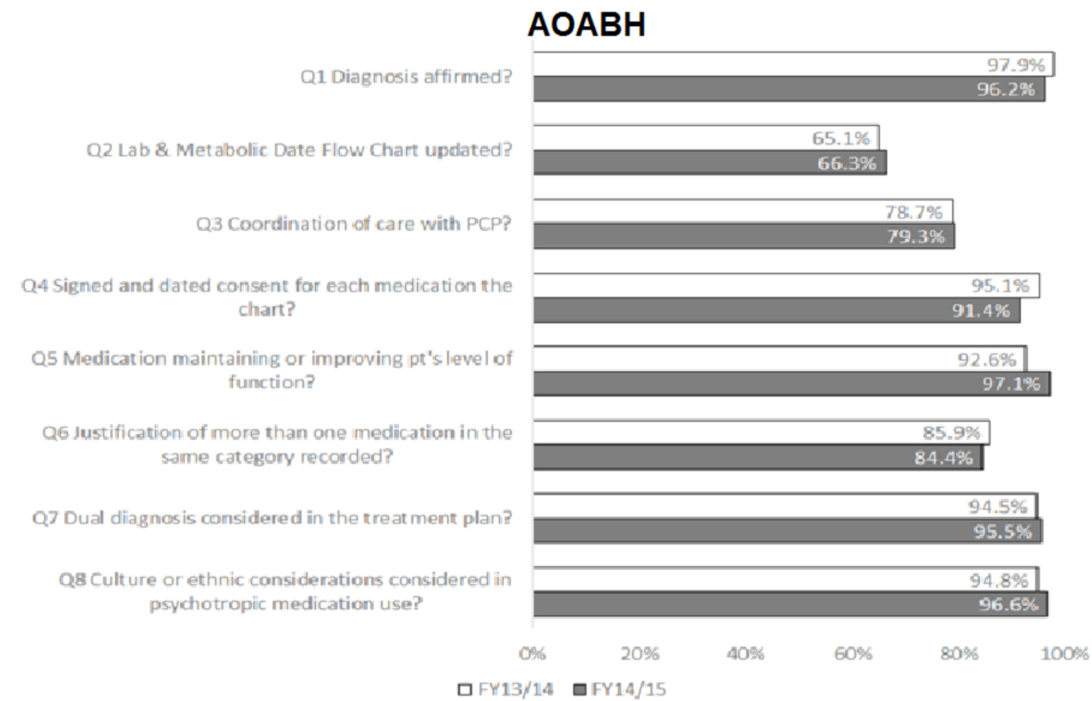
- **Medication Monitoring Review**

  The BHS Medical Director and Associate Medical Directors oversee a medication monitoring system that includes a peer-review of medication use and prescribing. Results of this monitoring have been presented to the Community Quality Improvement Committee.

  Psychiatrist annual chart reviews look at medication management on eight items, including diagnosis review, linkage with primary care, update of lab information, whether the prescribed medication is showing evidence of effectiveness, justification when polypharmacy is used, medication consent form signed and dated, and consideration of dual diagnosis and cultural/racial factors. Figure 9 shows medical monitoring outcomes for both CYBH and AOABH, FY13/14 vs FY14/15. Data for FY15/16 is currently being analyzed and final reports for this fiscal year will be available by November 2016.

Figure 8. Medical Monitoring, FY13/14 vs FY14/15, by Function Area





- **Monitoring Continuity and Coordination of Care with Physical Health Providers and Other Human Services Agencies**

  Improving coordination of care with physical health providers has been a BHS initiative reflected in the Quality Management Work Plan for more than a decade. The ongoing implementation of the EHR provides an opportunity to continue this effort.

  During the 2015-16 year, preparations have been made for implementation of data sharing via a secure coordination of care document (part of the national meaningful use criteria). This document electronically pulls together a summary of items necessary for coordination with physical health and other providers, facilitating the communication process. The document functionality has been completed and is expected to be in use by the end of the 2016 calendar year.

  Also in 2015-16 a number of changes to the EHR were discussed and have received preliminary approval from the BHS Medical Director and the BHS Associate Medical Directors. Although these efforts are not yet implemented, they are moving forward for discussion with the EHR core management team. They include new prompts and fields in some of the Powerforms that focus on PCP linkage, general medical conditions, health plan status, and labs/records obtained from outside providers. The goals of these changes are listed below.

    - Prompt providers and document interventions to obtain benefits for clients without healthcare coverage
    - Prompt providers and document interventions to link clients with primary healthcare provider/PCP.
    - Efficient charting of General Medical Conditions that also allows for specific data reporting.
    - Track labs and medical records received from PCPs, medical clinics and other relevant medical specialists.
    - Allow HCA to distinguish labs obtained through BHS versus outside organizations.
    - Facilitate communication of essential BHS-focused medical information to outside general medical providers in the case of transfer.
    - Track coordination of care (information sent) to PCP or other relevant outside medical specialists.

  The medication monitoring process gathers information on the percentage of charts reflecting documentation of coordination of care with the PCP. In CYBH, the percentage increased from 91.2% in 2013-2014 to 95.7% in 2014-2015. In AOABH the percentage increased from 78.7% in 2013-14 to 79.3% in 2014-15.

  The State Consumer Perception Surveys gather some information on mental health clients' interactions with physical health providers. In 2015, the Youth Satisfaction Survey results indicate that 65% of youth have had an office/clinic visit with a physician or nurse for a health check-up when sick within the last year. The Youth Satisfaction Survey – Family version suggests that 73% of the youth clients have had an office/clinic visit with a physician or nurse for a health check-up when sick in the past year.

In July 2003, BHS Quality Improvement and Program Compliance (QIPC, now AQIS) conducted a study to look at the degree of communication and linkage between behavioral health providers and primary care physicians. At that time, 232 charts were reviewed only five of these charts contained records received from primary care physicians (PCPs).

Since this initial study, it has been an administrative goal to improve coordination with physical healthcare providers. Chart reviews have been conducted every few years since the July 2003 study. The most recent review was in the summer of 2013 and is due for re-review in the 2016-17 year.

PERFORMANCE IMPROVEMENT PROJECTS

- **Seeking Safety Project**

In 2015-16 this project has been implemented in Children & Youth Behavioral Health (CYBH). The goal of the project is to identify youth receiving mental health treatment services who are substance abusers and at risk for substance abuse, and to provide a brief, targeted intervention. Youth identified as at risk for substance abuse are being provided with modules from Seeking Safety, an empirically supported intervention for trauma and substance abuse. All new clients, age 12 or older, are screened with the CRAFFT screening test, a short clinical assessment tool designed to screen for substance-related risks and problems in adolescents. A total score of two or higher on the CRAFFT identifies "high risk" for a substance use disorder. Clients who met this threshold received one or more modules of Seeking Safety, selected by the clinician. The Substances and Choices Scale (SACS), a brief measure of substance abuse symptomology and seriousness, was administered before and after participation in Seeking Safety.

As of 08/22/2016, 81 clients had been entered into the program and 24 had completed at least one Seeking Safety module and the pre/post SACS. SACS scoring is as follows:

- Scores 2 and above indicate the need for further enquiry and/or more formal assessment.
- Scores 4 and above will, in most cases, signify problems that are clinically significant and indicate the need for intervention.
- Scores 6 and above are indicative of serious problems likely requiring a specialist substance use service.

The 24 clients who received the Seeking Safety intervention obtained a mean initial SACS score of 5.8 and a follow-up mean of 2.9. This is a statistically significant and meaningful decrease in risk for these youth.

In the 2016-17 year it is anticipated that the project will be expanded to include contract clinics and screening of clients will take place at annual review in addition to intake.

- **Triage Grant Project**

This is the Orange County BHS implementation of a California grant to better meet the needs of individuals experiencing mental health crises by providing funds for triage staff at key points of contact. The Orange County implementation makes use of Peer Mentors, Licensed Triage Staff,

Psychiatrists, and an Evaluator. Parts of this grant were rolled out in January 2016 and the remainder will be rolled out in 2016-17. The Peer Mentors have been serving clients at the Crisis Stabilization Unit who meet criteria for SPMI and a County clinic referral since January 2016. Peer Mentor services will begin to be implemented in the eight participating hospitals emergency departments in a coordinated roll out starting in approximately September 2016. Licensed Triage Staff services began at several of the hospitals in August 2016 and will be implemented at all of the hospitals by the end of 2016.

Criterion measures are:

- Reduced inpatient utilization
- Improved linkage to services
- Improved consumer/family satisfaction
- Improved consumer self-sufficiency
- Reduced consumer wait times
- Reduced costs associated with inpatient utilization

A review of the data available through the first quarter of 2016 was conducted. At that time, 63 individuals discharged from the CSU have been served by the Peer Mentor program. The average enrollment in the program was for 9.5 days (ranging from less than one day up to 63 days). There was an average of three peer mentor contacts per consumer. Sixty-two percent of consumers were linked with Open Access, a mental health clinic, or both. Data regarding consumer outcomes and satisfaction is not yet available but is anticipated to begin within the next 1-2 months.

CLINICAL RECORDS REVIEW

Clinical records reviews occur continuously throughout the year. To facilitate reporting schedules the annual report on records reviews is compiled based on calendar year while most other reporting is compiled on the fiscal year. The most recent annual clinical records summary was for the 2015 calendar year. In that year a total of twelve thousand six hundred twenty five billed services were reviewed.

When services are found to not be compliant with requirements, some may be correctible and some will not be correctible. Clinics are given the opportunity to correct those that are correctible, however the services are still counted as part of the error rate. This provides managers with data on what might be expected in the system as a whole without additional activities.

Of the 12,625 services reviewed approximately 14% were not passed. Those clinics with a high not passing rate were re-reviewed. Performance rates are reported to management and to the Agency Compliance Office. Corrective actions include continuous ongoing training and the feedback to the clinics. Any service that should not have been billed, is recouped through the void/replace process for reporting to DHCS.

One of the main reasons for recoupment of services was that there was no progress note found. This is often found to be data entry error when the date of service entered into the billing system does not match the date on the paper progress note. It is anticipated that this number in the County operated clinics will drop significantly in 2016 since by the end of that year the majority of the County operated clinics billing Medi-Cal will be entering progress notes directly into the documentation module of the electronic health record, making it impossible for the billing date to not be equal to the date of service documented.