

County of Orange
Behavioral Health Services
Mental Health Plan
Quality Management Program
Updated 7-10-15

The Behavioral Health Services (BHS) Quality Management (QM) Program consists of four parts: The Quality Management (QM) Plan, the Quality Assurance (QA) Plan, the Utilization Management (UM) Plan and Clinical Records Review, and the Quality Improvement (QI) Work Plan. Because the definitions of these types of activities vary between organizations and, to some degree, even between persons within an organization, these separate sections should be viewed as a whole.

The QM Program is organized to reflect the organization established in the contract between the Mental Health Plan and the Department of Health Care Services (DHCS). It is possible that a particular topic/heading may be addressed in multiple sections, since there is significant overlap in these sections as written in the contract.

Each year the QM Program is reviewed. The review includes a discussion of evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service.

Quality Management Work Plan

- A. Ensuring continuity and coordination of care with physical health care providers
The Memorandum of Understanding (MOU) with any physical health care plan shall be reviewed periodically to assess the effectiveness of that MOU. The MOU with CalOptima was revised in early 2015. BHS staff continue to participate on the CalOptima Quality Improvement Committee.
- B. Monitoring Medication Practices
In order to monitor the safety and effectiveness of medication practices, monitoring activities will be conducted and reported at least annually. The Associate Medical Director for Adult and Older Adult Behavioral Health Services, and the Associate Medical Director for Children, Youth and Prevention Behavioral Health Services shall be responsible for the oversight and management of the monitoring and reporting activities. Annual reports shall be completed by approximately three months after the end of the fiscal year and shall cover the prior fiscal year. As specified in the Quality Improvement Section of this plan, the results shall be reported to and discussed in the Community Quality Improvement Committee (CQIC).
- C. Monitoring of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals and clinical records review.
- 1) Beneficiary Grievance
Grievances will continue to be monitored quarterly. Data will be collected from Divisions by QIPC and will include at least the following items: 1) The number of grievances 2) The types of issues leading to grievances 3) Any grievances or fair hearings that may reflect systems issues. This data will be circulated to managers quarterly and will be presented to the Community Quality Improvement Committee twice a year for review, discussion and recommendations.
 - 2) Beneficiary Appeals and Expedited Appeals
Appeals will continue to be monitored quarterly. Data collected from Divisions by QIPC will include at least the following items: 1) The number of appeals, 2) The types of issues leading to appeals 3) Any appeals that may reflect systems issues. This data will be circulated to managers quarterly and will be presented to the Community Quality Improvement Committee twice a year for review, discussion and recommendations.
 - 3) Fair Hearings and Expedited Fair Hearings
Fair hearings will continue to be monitored quarterly. Data collected from Divisions by QIPC will include at least the following items: 1) The number of fair hearings, 2) The types of issues leading to fair hearings and 3) Any fair hearings that may reflect systems issues. This data will be circulated to managers quarterly and will be presented to the Community Quality Improvement Committee twice a year for review, discussion and recommendations.
 - 4) Provider Appeals
 - a) Inpatient acute psychiatric hospital providers submit Treatment Authorization Requests (TAR) for approval to the MHP to request

reimbursement for services provided to Medi-Cal beneficiaries. The MHP monitors the results of the TAR approval process as well as provider appeals of TAR denials. The Inpatient Managed Care Appeals Office will submit to the CQIC quarterly a summary report of: 1) The number of TAR denials appealed by providers, 2) The results of TAR 1st level appeals, 3) The results of TAR 2nd level appeals. This data will be presented to the Community Quality Improvement Committee at least twice a year for review, discussion and recommendations.

- b) A report of appeals from the Administrative Services Organization (ASO) which manages the network providers for BHS will be obtained quarterly. The provider appeal report will be reviewed and any unresolved or problematic cases will be reviewed and discussed in a quarterly joint management meeting with the ASO and BHS staff.
- 5) Clinical Records Review
- Clinical records reviews occur at several levels. For detailed plans, see Documentation Audits under the Quality Assurance Plan.

D. Monitoring efforts for previously identified issues

- 1) Linkage to Physical Health Care
 - a) The CQIC identified as an area for improvement the linkage of seriously and persistently mentally ill (SPMI) adults receiving services to physical health care providers. This grew out of a review of charts indicating that evidence of linkage was only infrequently documented. Over several successive years processes were put in place that resulted in a significant improvement in this area. Monitoring and improvement efforts in this area continue. Ongoing review of performance in this area will continue. See the QI Work Plan sections on Linkage to Physical Healthcare and Performance Improvement Projects for details.
 - b) Several years ago the CQIC identified the need to improve the welcoming atmosphere in clinics. A Policy and Procedure (P&P) was developed to encourage improvement in this area. This continues to be an area for follow up. See the QI Work Plan section on Welcoming Drop-In Visits for details.

Quality Assurance Plan

In order to support understanding of and compliance with established documentation standards, a number of QA activities will be conducted. These include activities to inform providers of the standards and activities to monitor performance of providers in regards to these standards. Standards will include those required to support claims for specialty mental health services as well as other providers. Standards include those detailed in the contract with the Department of Health Care Services for provision of specialty mental health services.

A. Documentation Manual

A documentation manual will be maintained by Quality Improvement and Program Compliance (QIPC). This manual will address specific documentation requirements, including content as well as timelines. Behavioral Health Services has a wide array of programs and some programs may have specific variances from the standard requirements. The manual will be updated as needed.

B. Annual Provider Training

Service providers are required to take an annual training that includes multiple topics. One of these topics is appropriate documentation of services. It includes examples of acceptable and unacceptable documentation; issues that have been identified by audit/review staff or others as needing improvement during the prior year; reminder of the ways in which staff may obtain guidance for their documentation questions; and other general documentation issues. There are several versions of this training, so that each provider may take the one that most closely matches his/her work assignment.

C. New Provider Training

County service providers receive a variety of trainings within a short time after starting employment. For staff starting with Adult and Older Adult Behavioral Health Services, one of these trainings is a two-part training referred to as the New Provider Training. The first part is the Initial Clinician Coding and Documentation Training. This is a 6-8 hour training reviewing documentation standards and expectations as well as the coding of services that insures proper billing. The second part is a 4-hour training on the development of treatment plans. This includes training on proper documentation and on development of recovery oriented plans. The second part is available not only to new providers, but is also available as a refresher for staff who express interest or who are requested by their supervisor to attend. For staff starting with Children and Youth Behavioral Health, a four-hour on line training is required. This training is updated annually and includes documentation training as well as issues related to billing and compliance of the services documented. It includes multiple examples of acceptable and unacceptable documentation.

D. Documentation Audits

Periodic review of documentation will be conducted by QIPC for services provided by both County-operated clinics and those operated by contracted organizations. These reviews will include features of QI, QA and UR. Services will be reviewed for

compliance with documentation standards, for issues of quality of care, and for both over-utilization and under-utilization of services. See the section Utilization Management Program and Clinical Records Review, below, for details. When documentation at a County-operated clinic is not sufficient to support claims submitted and paid the provider(s) will be required to correct where possible and if not possible they will be required to credit back the service to the payor. When documentation at a contract-operated clinic is not sufficient to support claims submitted and paid it will be recommended to the provider(s) to correct where possible and if not possible they will be required to credit back the service to the payor.

E. Audit Team Inter-rater Consistency Training

Those staff participating in documentation audits/reviews will attend regularly scheduled meetings which include review and discussion of examples of both acceptable and unacceptable documentation.

In addition, at least annually, a formal exercise will be held in which the explicit focus is reviewing of records and developing of concurrence among the audit/review staff regarding the interpretation of standards to be applied during audits/reviews. A write up of this activity will be maintained and included in the annual review of the quality management program.

F. Contract QA Training

Contracted providers develop their own mechanisms for documentation review and training of their providers. To facilitate this process, QIPC has developed a formal “certification” program for those staff whom the contracted provider assigns responsibility for oversight of their documentation. This includes attendance at several trainings and a review by QIPC of a packet of items that the “applicant” submits as acceptable. For children’s services, the AQIS CYS QRT manager conducts a monthly meeting with each contract provider organization. During this meeting documentation issues are one of the routine topics. In addition, the AQIS CYS QRT manager meets monthly with all contract consultants who monitor the contract provider organizations to discuss documentation and other issues to insure consistency. Also, a CYBH manager meets quarterly with a group of all contract provider organizations and this meeting is attended by the AQIS CYBH QRT manager to address any questions that might come up around documentation or other compliance related issues.

In addition, the contract staff meet regularly in a group with the County contract monitors (also called contract liaisons). Part of this meeting is discussion and review of documentation issues. This is to develop consistency and to provide a forum for questions related to documentation.

Utilization Management Program and Clinical Records Review

- 1) The Utilization Management (UM) Program shall evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries. Clinical Records Review - CYS
 - a) All County clinics are also subject to internal sampling reviews by the QIPC - CYS QRT Audit Team at a minimum once a quarter. At least 80 paid claims are selected and reviewed by the Audit Team to ensure appropriate billing and to ensure the documentation meets County, State and Federal documentation standards. The selection of claims is based on the following criteria: high cost paid claims (of 200 dollars or more) and paid claims which appear to be duplicates. The Audit Team is composed of licensed mental health professionals. Feedback is provided to the Supervisor of the unit reviewed and follow up is conducted to insure that the services have been appropriately repaid.
 - b) All Contract Clinics are subject to internal reviews by Contract Consultants on a quarterly basis if their prior reviews had an error rate of greater than 5%. Contract Consultants may be from QIPC – CYS QRT or directly from CYS. These groups are coordinated through QIPC – CYS QRT to insure consistency of the process. At least 10 paid claims per clinic are selected to insure appropriate billing and to insure the documentation meets County, State and Federal documentation standards. The selection of claims is based on the following criteria: high cost paid claims (of 200 dollars or more) and paid claims which appear to be duplicates. The Contract Consultants are licensed mental health professionals. This review follows the same protocol as the review in a) ii, above. Feedback is provided to the Supervisor of the unit reviewed and follow up is conducted to insure that the services have been appropriately repaid.
- 2) Clinical Records Review – Adult services
 - a) All County and contracted clinics providing treatment services are subject to internal sampling reviews by the QIPC at least twice annually. There will be some variations in procedures to adapt to varying program designs and needs, but in general, the procedure will be as follows. At least 40 paid claims are selected and reviewed by the Audit Team to ensure appropriate billing and to ensure the documentation meets County, State and Federal documentation standards. In addition, the supervisors/managers may request that additional items be included in the review for a variety of management and quality reasons. A paid claims report is run for a designated audit period, usually about 6 months prior to the review. Ten charts are randomly selected and for those ten clients all paid claims within the designated audit month are reviewed. Occasionally there will be a business need for the review to look at services more recent than 6

months past. In these cases the review will be of charges entered into the billing system as billable, regardless of whether or not they have yet been paid. Formal reports of each audit will be prepared by QIPC. For contracted clinics, the report will go to the supervisor/manager providing oversight to that contractor, who will arrange to discuss the findings with the contract administration and QI staff. For County operated clinics the reports will go to the Program Manager, Division Manager and the Behavioral Health Director. The Audit Team is composed of licensed mental health professionals and trained mental health specialists. Feedback is provided to the supervisors/managers/contract monitors of the unit reviewed for follow up.

- 3) A service verification process shall be in place to ensure that services claimed to Medi-Cal did occur.
 - a) For services, a sampling of claimable services will be selected each month. A mailer will be sent to the consumer/parent/guardian offering an opportunity for the consumer/parent/guardian to contact BHS if the service did not occur and to provide some satisfaction information if the service did occur.
- 4) The Utilization Management Program shall be responsible for assuring that beneficiaries have appropriate access to specialty mental health services. This shall include assessment of responsiveness of the 24/7 toll free telephone number, timeliness of scheduling routine appointments, timeliness of services for urgent conditions and access to after hour care.
 - a) Responsiveness of the 24/7 toll free telephone number
BHS utilizes an Administrative Services Organization (ASO) to maintain its 24/7 access line. The target for responsiveness of this line is that the ASO will answer at least 95% of telephone calls within 30-seconds. In addition, test calls will be made to the ASO quarterly. The percentage of calls appropriately connected to a live person speaking the caller's language will be captured and reported for discussion and suggestions for improvement at the QI meeting with the ASO.
 - b) Timeliness of scheduling routine appointments
Access is monitored by use of an access log at all points of access. This log captures the date of the initial request for specialty mental health services by MediCal members, as well as the date of the offered appointment. The BHS access standard is for the date of the offered appointment for routine requests to be two weeks or less from the date of the request. However, BHS strives to offer appointments for routine requests even sooner. Within each Division the target is for at least 85% of clients requiring a routine mental health appointment to be offered an appointment within five (5) days of the initial request.
 - c) Timeliness of services for urgent conditions
Access is monitored by use of an access log at all points of access. This log captures the date of the initial request for specialty mental health services by MediCal members, as well as the date/time of the offered appointment. The

BHS access standard for urgent conditions is for the offered appointment to be within 24 hours of the request. Within each Division the target is that at least 90% of clients requiring services for an urgent condition will be offered an appointment within 24 hours of contact.

d) Access to After-Hours Care

Access to after-hours care through the ASO is monitored during joint ASO-County management meetings. After hours care is also available through ETS and the CAT teams.

5) Implementing mechanisms to assure that authorization decision standards are met.

Access to specialty mental health services requires authorization only for access to the Network providers (pre-authorization of both initial and follow up requests) and for inpatient payment (retrospective review and authorization). For access to outpatient services, the prospective treatment team assesses and makes a decision about whether or not ongoing service will be provided.

a) Written policies and procedures (P&Ps) for processing requests for initial and continuing authorizations of services.

i. The Inpatient unit provides concurrent consultation but only retrospective reviews for payment. Pre-authorization and continuing authorization is not required.

ii. The ASO maintains P&Ps regarding initial and continuing authorizations of services.

b) Mechanisms to ensure consistent application of review criteria for authorization decisions

i. At least annually, the inpatient authorization unit shall conduct a formal exercise to increase the consistency of review criteria for inpatient payment authorizations. This report shall be reviewed in the Community Quality Improvement Committee.

ii. At the ASO an Inter-Rater Reliability assessment is conducted annually, to monitor reliability and validity between clinicians and with the standard. The tool is administered to all utilization review clinicians.

c) Decisions to deny service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition or disease.

i. Responsibility for insuring that staff on the inpatient unit have the appropriate training to make these decisions rests with the inpatient Program Manager. The Program Manager reviews the staffing list and has involvement in hiring decisions for that unit.

ii. The ASO conducts an Inter-Rater Reliability assessment annually, to monitor reliability and validity between clinicians

and with the standard. The tool is administered to all utilization review clinicians.

- d) Decisions are made within the required timelines and notices of action related to these decisions must be provided within the required timeframes.
 - i. The ASO maintains policies and procedures that address timelines for authorization decisions and notices of action. Timeline compliance is also monitored and reported quarterly.
- 6) Mechanisms for assessing the capacity of service delivery for beneficiaries, including the number, type, and geographic distribution of mental health services within the BHS mental health delivery system.
 - a) The CYS regional clinics:
 - i. Spreadsheets are maintained that monitor case assignments and type of health plan in order to distribute cases effectively to ensure compliance with mandate to serve specific populations.
 - ii. Health plan type and billing are input into IRIS and reports used to monitor services and expenditures to different mandated populations.
 - iii. Conduct supervisory review to monitor effectiveness of services provided and to monitor need for changes when service capacity may be over-extended.
 - iv. Monthly DSH reports are reviewed. These reports facilitate analysis of distribution of workload and allow meaningful assignment of cases to clinical staff.
 - v. Monthly meetings are held with contract providers to monitor the utilization of clinical staff and distribution of services to mandated populations.
 - vi. Monthly meetings are held with CYS Service Chiefs to review workflow issues and clinic capacity to serve more clients.
 - b) The CYS Central Programs:
 - i. Referrals are generated by the agencies with which the client is already linked, primarily Probation and SSA. There are periodic meetings with CYS referral sources and any service delivery problems are addressed at that time. Each agency has a policy for referral and an expectation of CYS response time. Each service delivery site differs due to the nature of the client and the work that the service delivery site does. Agencies are required to let CYS know when service delivery expectations are not met. CYS addresses service delivery problems in a timely fashion, be they stemming from a one-time glitch to a need to redistribute existing resources to meet the changing needs of the referral agencies.

- ii. Monthly DSH reports are reviewed. These facilitate analysis of distribution of workload and allow meaningful assignment of cases to clinical staff.
- iii. Monthly meetings are held with contract providers to monitor the utilization of clinical staff and distribution of services to mandated populations.
- iv. Monthly meetings are held with CYS Service Chiefs to review workflow issues and clinic capacity to serve more clients.

Quality Improvement Work Plan

The goal of the quality improvement work plan is to monitor the service delivery system with the aim of improving the processes of providing care and better meeting the needs of its clients.

The Community Quality Improvement Committee (CQIC) consists of senior managers from across the Mental Health Plan, consumer and family members, community provider/contract organization provider, Mental Health Board Member. This committee recommends policy decisions; reviews and evaluates the results of QI activities, including performance improvement projects; institutes needed QI actions; ensures follow-up of QI processes; and documents QI Committee meeting minutes regarding decisions and actions taken.

The Community Quality Improvement Committee Advisory Group (CQIC-AG) is a working and study group of consumer and family members. This group is an opportunity to engage consumers and family members in more depth than occurs at the CQIC. It was developed at the recommendation of the consumer/family members on the CQIC several years ago. It allows for extended time for questions from members, special presentations to keep them informed, time to propose, consider and discuss recommendations for QI actions that the CQIC then takes under advisement for decisions.

QI Activities

- A. Reviewing of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals and clinical records review. The monitoring activities related to these issues are described in the QM Work Plan. The results from that monitoring are presented to the Community Quality Improvement Committee at least twice a year for review, discussion and recommendations.
- B. Performance Improvement Projects (PIPs) -
 - 1. CRAFFT Project: Substance use screening and intervention will be implemented in CYBH. New clients will be screened for substance use with the CRAFFT. Those who screen positive will be assessed for substance abuse severity with the SACS; clients assigned to a trained clinician will receive a module from the Seeking Safety program. Clients assigned to a trained therapist will be reassessed with the SACS after completion of Seeking Safety; clients assigned to other therapists will be reassessed with the SACS after 6 weeks.
 - 2. Triage Grant Project: This project will expand the number of mental health personnel available to provide crisis support services that include crisis triage, targeted case management and linkage to services for individuals with mental health illness who require a crisis intervention. Triage personnel will be located at various points of access throughout the community, such as hospital emergency rooms, jails, homeless shelters and clinics. The project consists of

four components: the Mental Health Triage Personnel, the Peer Mentor staff, the Psychiatric Services, and the Evaluator. Outcome measurements will include 1) reduction in inpatient utilization, 2) reduction in wait times, 3) client satisfaction, 4) increased linkages, 5) increased client self-sufficiency, 6) decreased recidivism and 7) decreased cost.

- C. Welcoming Drop In Visits - Members of the CQIC and CQIC-AG visit various clinics on a drop in basis. They fill out a short questionnaire on the facilities and whether they experienced a welcoming environment. This information is then reported to the CQIC and managers are asked to discuss and respond for QI opportunities. The results are also reviewed and discussed in the CQIC.
- D. Linkage to physical health care - The MHP will continue to review the chart documentation of clients in Adult Mental Health Services to see if there is evidence of linkage to physical health care. The MHP will engage in Interdisciplinary Care Team (ICT) meetings with the Managed Care Plan – Cal Optima (MCP). MHP staff will participate in coordination meetings with the MCP and on the MCP Quality Improvement Committee.