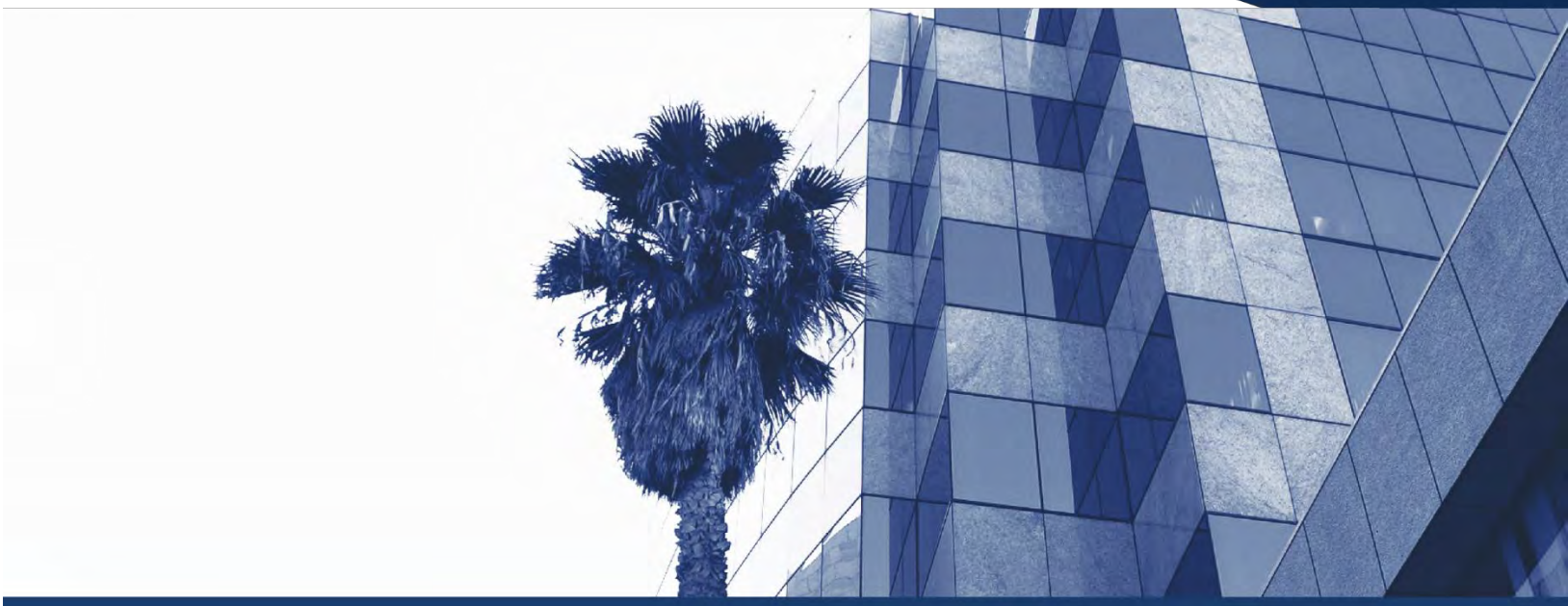


Quality Management Program Annual Report

Behavioral Health Services

Authority and Quality Improvement Services

405 W 5th Street
4th Floor
Santa Ana, CA 92701
(714) 834 3166

2016-2017

RICHARD SANCHEZ
DIRECTOR

MARY R. HALE
DEPUTY AGENCY DIRECTOR
BEHAVIORAL HEALTH SERVICES

DAVID HORNER
DIRECTOR
AUTHORITY & QUALITY IMPROVEMENT SERVICES

405 W. 5th STREET, 4TH FLOOR
SANTA ANA, CA 92701

(714) 834-5601
FAX: (714) 834-6575
dhorner@ochca.com

BEHAVIORAL HEALTH SERVICES
Authority and Quality Improvement Services

2016-2017 Quality Management Program Annual Report

Report Date: December 22, 2017
Report Period: July 1, 2016 – June 30, 2017

The Orange County Mental Health Plan has a robust set of procedures 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 during Fiscal Year (FY) 2016-17 include:

- Routine Medication Monitoring of 216 charts in adult services led to recommendations for specific cases (48% of charts). The most common comment categories were:
    - Suggested Testing Involving Labs, Body Mass Index (BMI), or Electrocardiograms (EKGs) (18%)
    - Medication Clarification or Suggestions (10%)
    - Missing Documentation or Consent Forms (10%)
    - Primary Care Physician (PCP) Follow Ups (6%)
    - Diagnosis Clarification or Suggestions (4%)

  The analysis of one particular medication record raised a number of concerns for the reviewer. Records showed the patient was staying on a high dose of benzodiazepines for a long period of time. The reviewer noted that it was likely that this patient was medically tolerant and addicted to the medication, and thus preferred to stay on benzodiazepines. Concerns were also raised in regard to the patient's age (older adult) and the effects of long term benzodiazepine use on the risk for cognitive and physical complications. The reviewer recommended this information be explained to the patient and suggested that the patient be gradually taken off of this medication. The reviewer also suggested coordination with the patient's primary care physician in order to ensure proper medication management and communication. This resulted in numerous discussions amongst various doctors who shared the same concerns and strategized an approach to take the patient off of

benzodiazepines in the safest manner. This patient's treatment is being closely monitored by the treating psychiatrist.

- Routine Medication Monitoring of 354 charts in children and youth services led to recommendations for specific cases (46% of charts). The most common comment categories were:
    - Suggested Testing Involving Labs, BMI, or EKGs (25%)
    - Medication Clarification or Suggestions (5%)
    - Missing Documentation or Consent Forms (9%)
    - Primary Care Physician Follow Ups (1%)
    - Diagnosis Clarification or Suggestions (6%)
- Sixteen percent of all medication monitoring reviews resulted in action taken by the treating psychiatrist in response to reviewer comments.

- The 2016-17 Quality Management Plan added an independent review of the Inpatient Treatment Authorization Requests (TAR) unit timeliness reporting. Discrepancies were found between the independent review and the annual reporting of timeliness by the Inpatient TAR unit. Work with the management of the Inpatient TAR unit clarified that in fact there were significantly more TARs processed in excess of the 14-day timeline than was originally believed. Forty three out of 4,734 TARs (0.9%) were processed outside of the timelines. Causative factors were identified and corrective actions implemented to improve the timeliness of response. This item will again be monitored in 2016-17.

- The Quality Improvement (QI) process resulted in a change which was implemented since the end of the 2016-17 year that provides an opportunity for improvement. 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. For the 2017-18 year, the grievance log has been expanded to identify the specific individual provider for which the grievance was logged. This will 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.

- Medication monitoring activities have contributed to an increase in the percent of charts for adults showing documentation of prescribing cultural and ethnic considerations.

- Medication monitoring activities have contributed to an increase in the percent of charts for children and youth showing documentation of consideration of non-psychiatric medical conditions in the choice of medications.

- Efforts to increase the percentage of valid statewide consumer preference surveys were not successful. Multiple steps were taken at the suggestion of the Community Quality Improvement Committee (CQIC), however the percentage of submitted surveys that were valid did not improve.

- Use of the CRAFFT in Children and Youth Behavioral Health Services (CYBH) continued into its second year. As a result, 100 mental health clients that were identified as also being at risk for substance abuse issues, were linked to and completed Seeking Safety as well as linked to substance use services. There was a substantial decrease in functional impairment and risk related to substance use.

ACCESS TO SERVICES

Behavioral Health Services (BHS) monitors the timeliness of routine and urgent initial requests for services. This information comes from the Mental Health Plan (MHP) 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**

  The goals of offering appointments within 24 hours of an urgent service request at least 90% of the time was met. The goal of offering an appointment within 5 days of a routine service request at least 85% of the time was met.

  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.

Below is the information for the 2016-17 fiscal year (Figure 1 and Figure 2).

Figure 1. Percent of offered appointments in time limits, FY 2016-17, by function area and urgency

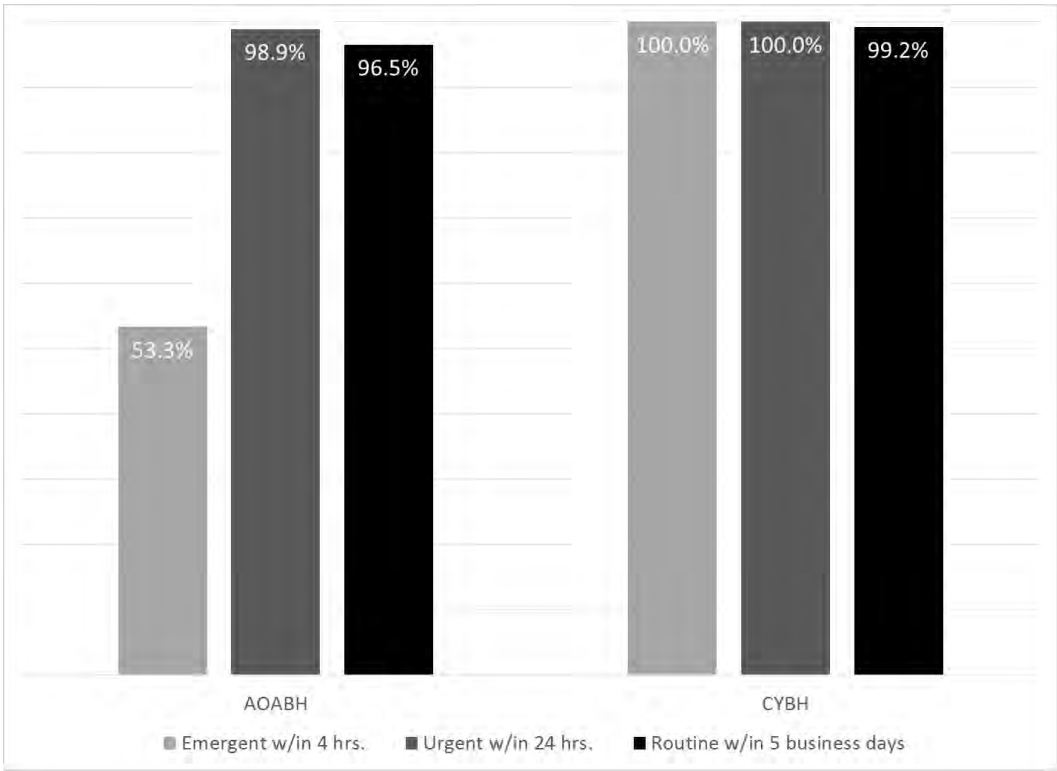
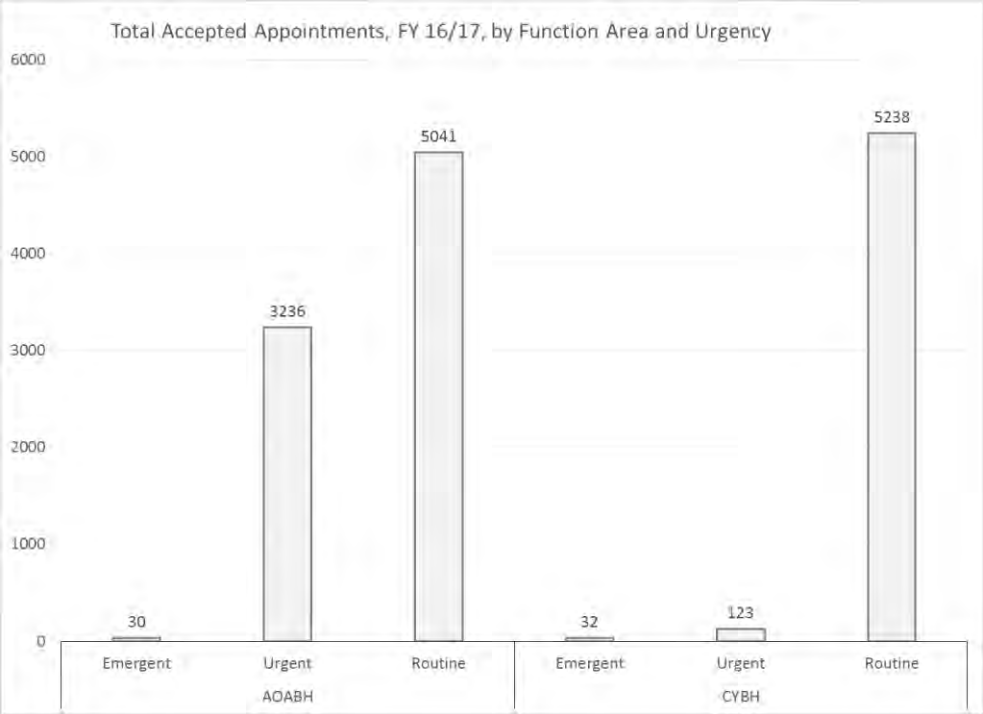


Figure 2. Percent of accepted appointments in time limits, FY 2016-17, by function area and urgency



BHS has met both the Implementation Plan standard and quality improvement goals established for routine and urgent calls for both Adult and Older Adult Behavioral Health (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.

The above goals have been met for all persons indicating a primary language of Spanish, Vietnamese, Farsi, and Korean. However, there continues to be some disparities based on primary language. In Adult and Older Adult Behavioral Health, those who were primarily Vietnamese speakers waited significantly longer (5.98 days) than English speakers (3.27 days) and Spanish speakers (3.47 days). In CYBH, those who were primarily Vietnamese speakers waited significantly less time (2.21 days) than English speakers (3.75 days) and Spanish speakers (3.99 days). There were no significant differences for urgent calls (
Table **1**).

Table 1. Number Mean calendar days from referral to first offered appointment, Medi-Cal clients, by primary language and urgency

	AOABH		CYBH	
	Routine	Urgent	Routine	Urgent
Other/Unk	3.58	0.00	3.18	--
English	3.27	0.04	3.75	0.69
Spanish	3.47	0.04	3.99	0.79
Vietnamese	5.98	0.09	2.21	0.00
Farsi	4.79	0.00	2.80	--
Korean	4.00	0.00	4.60	--
Total	3.34	0.04	3.79	0.70

Attempts have been made over the past year to develop data on the time from the initial request for an appointment with a psychiatrist to the time an appointment is offered. This attempt has not been successful. Efforts to pull data out of the Electronic Health Record (her) are significantly hampered by the structure of the data and the resources needed to extract data. While there are long term plans for a data warehouse that will address these issues, at the present time, data retrieval for this type of issue remains problematic.

In addition to the above, attempts to develop data on the time from a request for an appointment with a psychiatrist by an ongoing client to the time an appointment is offered has been met with a bit more success, but reports continue to be cumbersome in actual use.

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

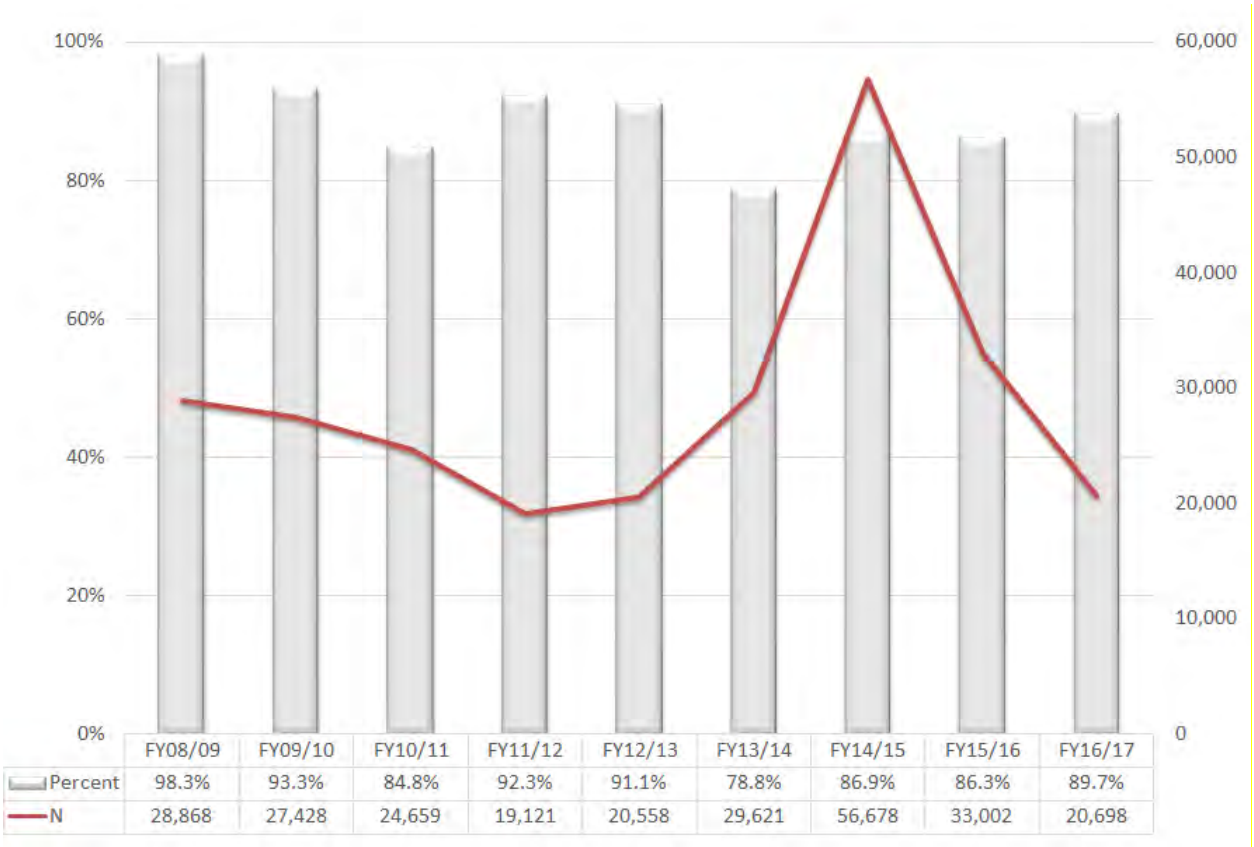
During FY 2015-16, the MHP contracted with CalOptima/Beacon to provide 24-hour, seven day a week access to the community. The Quality Management Work Plan goal is to answer 95% of calls within 30 seconds. A comparison figure for the community is that the physical health provider, CalOptima, sets its goal at 80% answered within 30 seconds. There has been discussion in the Community Quality Improvement Committee (CQIC) about bringing the goal of 95% more into alignment with other managed care plans, but no decision has yet been reached.

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 an Administrative Services Organization (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 and contributed to a decision, effective July 1, 2015, to return to splitting out the MHP calls from the MCP calls. 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. Ongoing monitoring indicates that the percentage of calls answered within 30 seconds has increased again this year, although still short of the 95% goal (Figure 3).

Figure 3. ASO telephone response within 30 seconds, by quarter, FY 2014-15 – FY2016-17



	FY08/09	FY09/10	FY10/11	FY11/12	FY12/13	FY13/14	FY14/15	FY15/16	FY16/17
Percent	98.3%	93.3%	84.8%	92.3%	91.1%	78.8%	86.9%	86.3%	89.7%
N	28,868	27,428	24,659	19,121	20,558	29,621	56,678	33,002	20,698

BENEFICIARY PROTECTION

- **Notices of Action (NOA)**

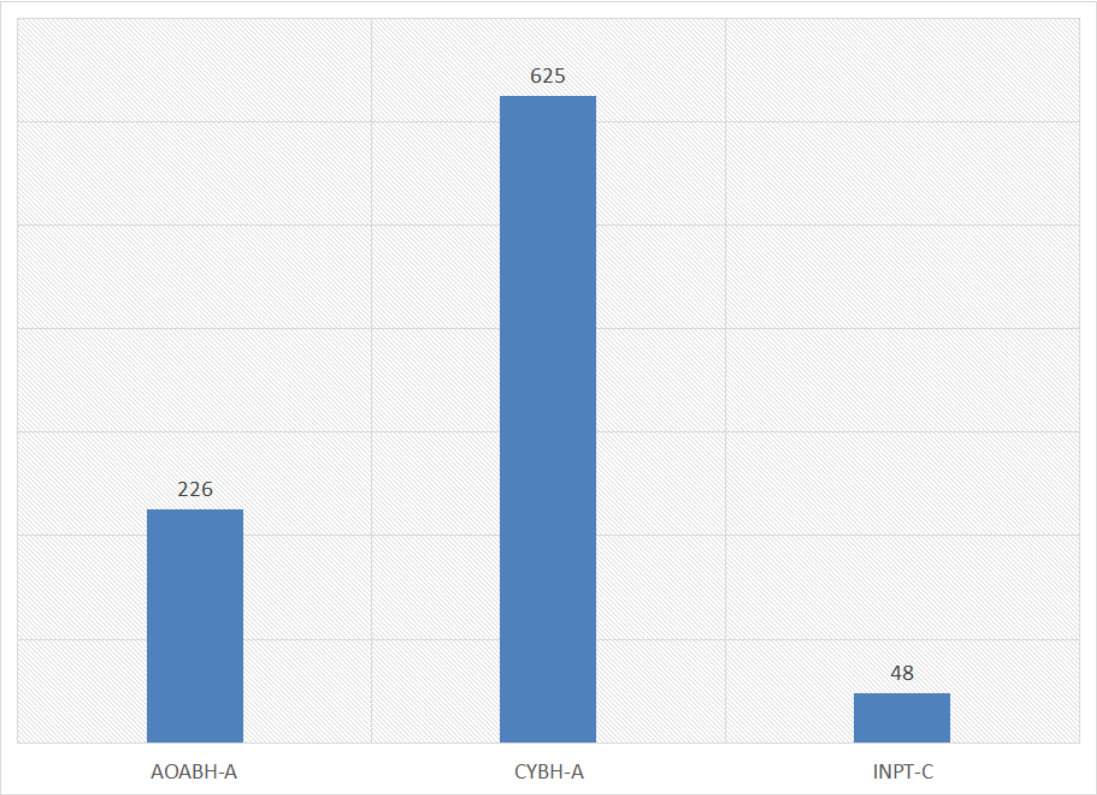
  NOAs are required when any of the following actions occur with a Medi-Cal beneficiary. During the current fiscal year only NOA-A's and NOA-C's were given.

  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 Service

The total number of NOAs given by function area in FY 2016-17 is shown in Figure 4.

Figure 4. Total NOAs, FY2016-17, by Function Area



Outpatient services issues 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 625 NOA-As this year, an increase over last fiscal year. The larger number of NOA-As from CYBH is primarily 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 Early and Periodic Screening, Diagnosis, & Treatment (EPSDT) Medi-Cal. Past guidance from the State has indicated that these contacts do qualify as assessments rather than screenings and therefore if ongoing services are not offered by the MHP, an NOA-A is provided.

Adult Services issued 226 NOA-As compared to last year when 236 were issued. This number jumped between the 2014-15 and 2015-16 fiscal years, it is thought due to a change in intake procedures. However, it appears to be stabilized at least for the past two years.

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.

For FY 2016-17, a new quality improvement item was added to the Work Plan that included an independent review of TAR processing timeliness by Authority and Quality Improvement Services (AQIS), which is external to the Inpatient TAR unit. This was to be a sampling review of the Inpatient TAR timeliness to validate accuracy of the annual reporting by the Inpatient TAR unit. This review determined that there were some discrepancies between the reported timeliness and the timeliness as reflected in the source database. Further exploration determined that there were a number of TARs processed in excess of the timeline that were not determined as such. The corrected information follows.

In FY 2016-17, 4,734 TARs were processed, representing an 8% increase from FY 2015-16 (4,364 TARs), a 15% increase from FY 2014-15 (4,121 TARS), and a 51% increase from FY 2013-14 (3,133 TARs). The results showed that 43 of the 4,734 TARs were processed beyond the 14-day timeline, which represents an error rate of 0.9%.

An analysis of the late TARs suggest that there were multiple contributing factors. In particular, the significant ongoing increase in the number of TARs while at the same time having short staffing due to position vacancies and training of newly hired staff, and delays in inputting and sending the TAR responses even when the reviews were completed within timelines.

A number of corrective actions have been implemented. Examples include procedures to ensure prioritization for review of any TARs approaching the timeline, procedures to ensure support staff log and mail TARs on the same day that they are completed by the Utilization Case Manager (UCM), and better coordination of coverage when UCMs have time off.

In addition to the above, in 2016-17 the TAR unit issued 48 NOA-Cs due to denial or reduction in payment, compared to 62 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 2015-16)**

Table 2 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, 4% 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 2. Provider Appeals and Inpatient Provider Treatment Authorization Requests FY 2016-17

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
46	585	26	540	0	--	--	--

In the coming year, the report of provider appeals will be incorporated with reporting of the initial review results to facilitate interpretation of the results of the appeals.

- **Medi-Cal Appeals**

There were two Medi-Cal appeals in FY 2016-17, compared to one in 2015-16. One appeal was in AOABH and another in CYBH. Both were 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, the same as in FY 2015-16. Historically the number of fair hearings has been very low.

- **Grievances**

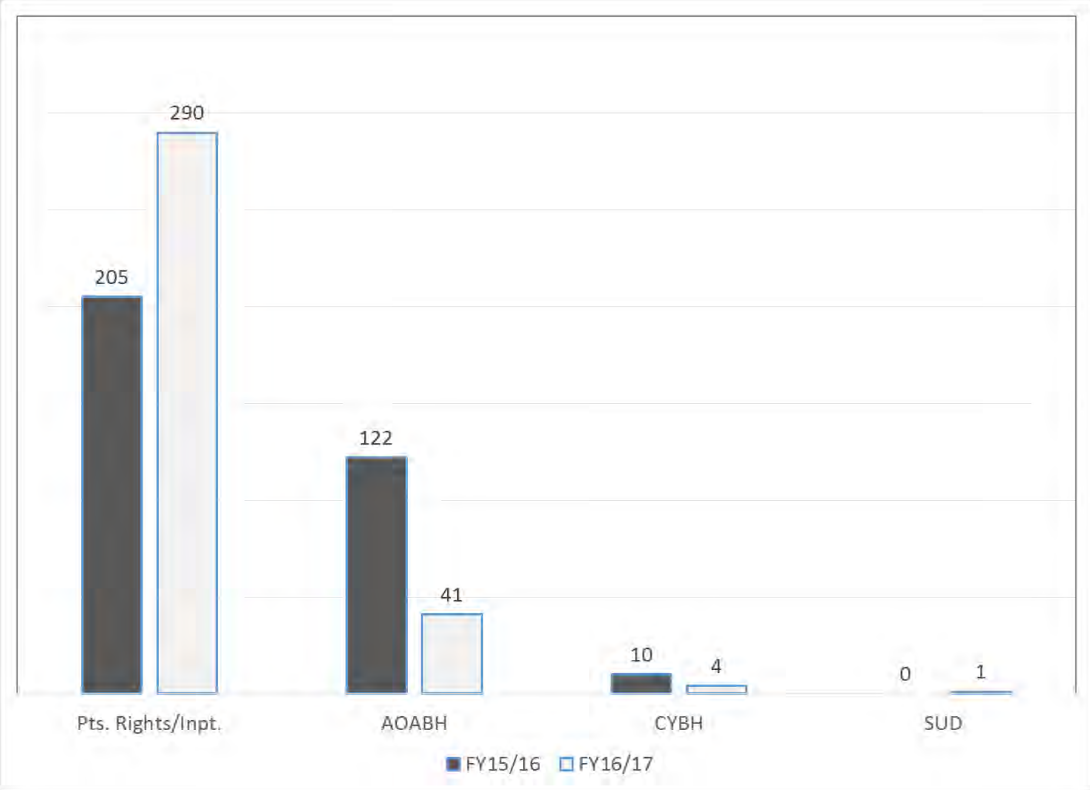
A total of 336 grievances were received during the 2016-17 fiscal year (Figure 5). The majority of these (290) were from patients in contracted mental health inpatient facilities. Of 46 outpatient services grievances, 44 were processed within the required timeframes. Two grievances that exceeded the timeline were clients who

could not be reached; one was a client receiving Substance Use Disorder (SUD) services, the other was a client in inpatient who had been discharged.

In 2016-17, the grievance process was expanded to include SUD services, in preparation for eventual contracting with the State to provide Drug Medi-Cal Organized Delivery System (DMC-ODS) services. It is anticipated that the number of SUD grievances will increase substantially when that contract is implemented and there is a wider distribution of information on the availability of this process for persons receiving SUD services.

There is an opportunity for improvement in the process for tracking and utilization of grievance information. 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 for further analysis and early intervention for improvement. The Grievance Log has now been 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.

Figure 5. Grievances by Fiscal Year and Function Area, FY2015-16 – FY2016-17



Grievances in FY 2016-17 fit into five broad categories: access, change of provider, confidentiality, quality, and other. The breakdown of grievances by type and function area are shown in Table 3.

Table 3. Medi-Cal Grievances, by Type and Function Area

	AOABH	CYBH	PRAS	SUD	Total
Access	1	1	1	0	3
Change of Provider	4	1	3	0	8
Confidentiality	0	0	1	0	1
Quality	28	2	123	0	153
Other	8	0	162	1	171
Total	41	4	290	1	336

Inpatient Facilities

Grievances filed by patients at County-contracted hospitals are similar across facilities. The average number of grievances filed per 100 admissions is 4.74.

BENEFICIARY SATISFACTION

Statewide Consumer Perception Survey

BHS last administered the Performance Outcome/Consumer Perception Survey between May 15-19, 2017 for Adults and Older Adults, Children and Youth, and the Families of Children and Youth. Survey forms are currently being scanned and the data from this survey period are not yet available from the California Institute for Behavioral Health Solutions (CIBHS).

The most recent results are from surveys administered November 17, 2016 to November 21, 2016.

The Consumer Perception Survey includes the Mental Health Statistics Improvement Program (MHSIP), the Youth Services Survey (YSS) and 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 2016 administration are shown in Table 4. Please see full reports for additional information.

Table 4. Consumer Perception Survey, Mean Scores for November 2016 Administration (1: Strongly Disagree to 5: Strongly Agree)

	Satisfaction				Functioning			
	Access	Participation	Culture	General	Outcomes	Functioning	Social	n
YSS May 2016	4.2	4.2	4.4	4.3	3.9	3.9	4.1	463
YSS-F May 2016	4.4	4.2	4.5	4.3	3.9	3.9	4.2	462
MHSIP May 2016	4.3	4.4	4.4	4.4	4.0	4.0	4.0	689
YSS Nov 2016	4.2	4.1	4.5	4.3	3.9	3.9	4.1	626
YSS-F Nov 2016	4.4	4.3	4.6	4.4	3.9	3.9	4.2	888
MHSIP Nov 2016	4.4	4.4	4.5	4.5	4.1	4.1	4.1	659

Overall, the results of these surveys are fairly positive. ***It is important to note, that while there are some differences between groups (see below), those differences that are statistically significant are fairly minor.*** 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.
- The scales measuring, participation, cultural sensitivity, satisfaction, outcomes, and functioning all improved significantly the longer the client was in services.
- The Cultural Sensitivity scale showed an extremely mild but statistically significant gender difference. Females rated their experience very slightly higher (4.5) than did males (4.4). No trend is noted as the prior administration showed no statistically significant differences.

YSS-F

- There was one significant difference related to ethnicity. Latinos reported slightly better outcomes (3.9) than Caucasians (3.6). This is consistent with prior year findings. Prior years have shown the ratings of functioning as being higher for those completing the form in Spanish, but there was no significant difference on that scale for this administration.
- There were no significant differences between genders.

- Consistent with prior years, the longer a client was in services, the higher the client rated on the functioning scale.

- There was no relationship found between length of time in services and overall outcomes of treatment this year, whereas last year there was a relationship.

Mental Health Statistic Improvement Program (MHSIP)

For adults completing the consumer perception survey for November 2016, responses to service satisfaction items averaged between "agree" (4) and "strongly agree" (5). The responses to personal functioning items are lower at the "agree" (4) level. All intergroup differences were mild. The only differences that are consistent across multiple administrations of the surveys are that females and those responding on Spanish language forms report very slightly higher ratings.

- For adults completing the MHSIP, there were no differences by race/ethnicity.

- Consumers in the Prevention and Intervention programs and the CalWorks program gave the highest satisfaction ratings.

- There was no difference by age.

- Consumers responding on the Spanish language survey reported slightly higher scores on rating access then did those responding on the English and Vietnamese language surveys.

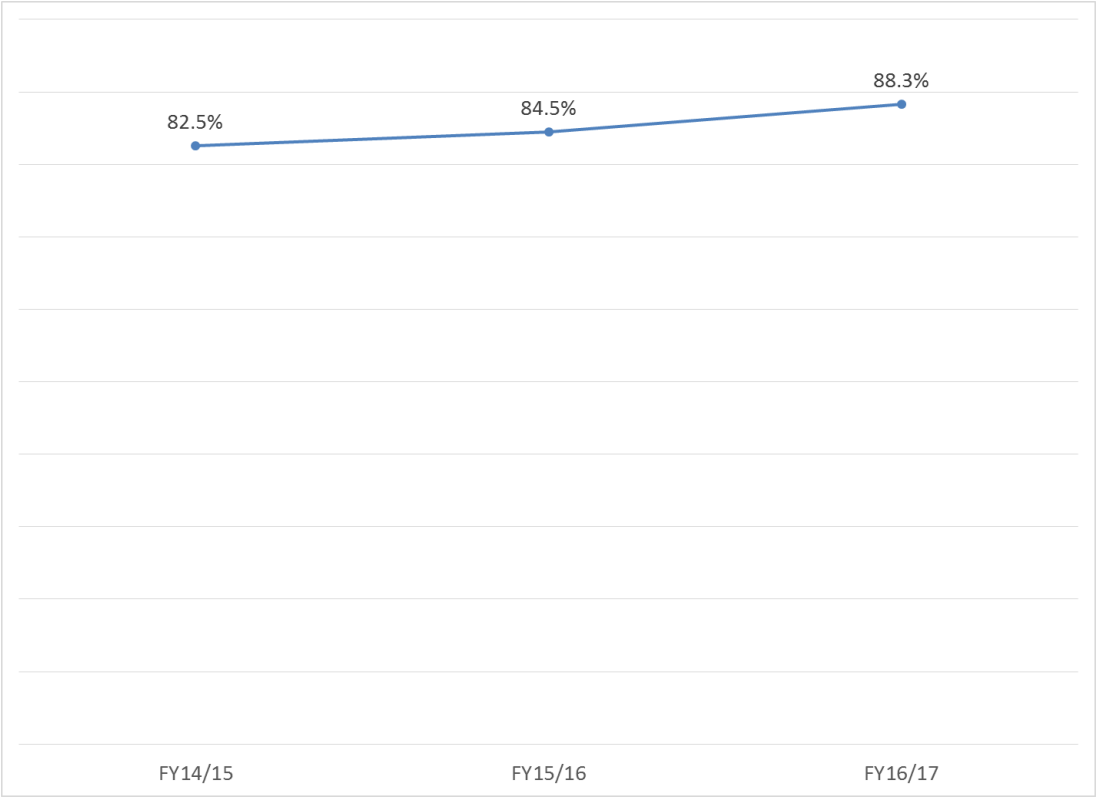
- Females scored very slightly higher on all scales then did males.

- Ratings for Functioning and for Perception of Outcomes increased the longer a person had been in treatment.

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

The ASO 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. In FY 2014-15, FY2015-16, and FY2016-17 there were 126, 152, and 150 participants, respectively. While there appears to be a slight improvement over time, the trend falls short of statistical significance (Figure 6).

Figure 6. 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 fiscal year, FY 2014-15 to 2016-17



- **Inpatient Satisfaction Survey**

  Summary: 79 inpatient satisfaction surveys were collected from patients at four hospitals. The sample was 64% male, 95% English-speaking, and 53% White. The lowest-rated satisfaction items reflected possible problems with hospital cleanliness and comfort, being kept informed regarding care, and overall satisfaction with treatment. This finding mirrors the lowest-rated satisfaction items from the 2016 survey. Patient reports reflected 100% compliance with handbook distribution requirements at two out of four facilities. Compared to 2016, patient reported receipt of handbooks increased (to 100%) at two facilities and decreased slightly at two facilities. Since 2015, the survey reflected a trend toward improved confidentiality practices but a mild decrease in overall satisfaction.

  One facility received ratings that were markedly lower than other facilities. The facility's rating in 2017 decreased compared to the rating received in 2016. This result was unexpected, as the facility had received favorable results from separate, internally conducted surveys. The survey results were discussed with the facility.

Overall results showed that in 2017 compared to 2016, patients were less likely to indicate that they would recommend the hospital to friends and family needing similar help (71.4% in 2017 vs. 89.6% in 2016). However, this difference is almost entirely due to the lower ratings given by patients at the abovementioned facility.

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

The breakdown of Change of Provier/2nd Opinion Requests for FY 2016-17 is shown in Table 5. The number of Change of Provider/2nd Opinion Requests was significantly less in 2016-17 (171) than in 2015-16 (264). The categories of reasons for clients seeking a change of provider or second opinion are fairly broad. This year, as in most recent years, the most common reasons for change-of-provider requests in both Function Areas were "Care and Treatment" and "Personality." "Care and Treatment" accounted for 13.4% of AOABH requests and 25.3% of CYBH requests. "Personality" accounted for 50.9% of AOABH Change-of-Provider requests and 16.0% of CYBH requests.

For both CYBH and AOABH, 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. No single provider reached this criterion this year.

Table 5. Breakdown of Change of Provider/2nd Opinion, FY2016-17

Lang-uage	Care/Tx	Person-ality	Tx Approach	Gender	Medi-cation	Sche-dules	Loca-tion	2nd Opin.	Other	No Rsn
AOABH										
4	15	57	5	8	4	8	0	3	8	0
CYBH										
1	19	12	11	8	4	1	0	0	11	8
AOABH & CYBH Totals										
5	**34**	**69**	**16**	**16**	**8**	**9**	**0**	**3**	**19**	**8**

MEDICATION MONITORING

- **Medication Monitoring Review**

The BHS Medical Director and Associate Medical Directors for AOABH and for CYBH services 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.

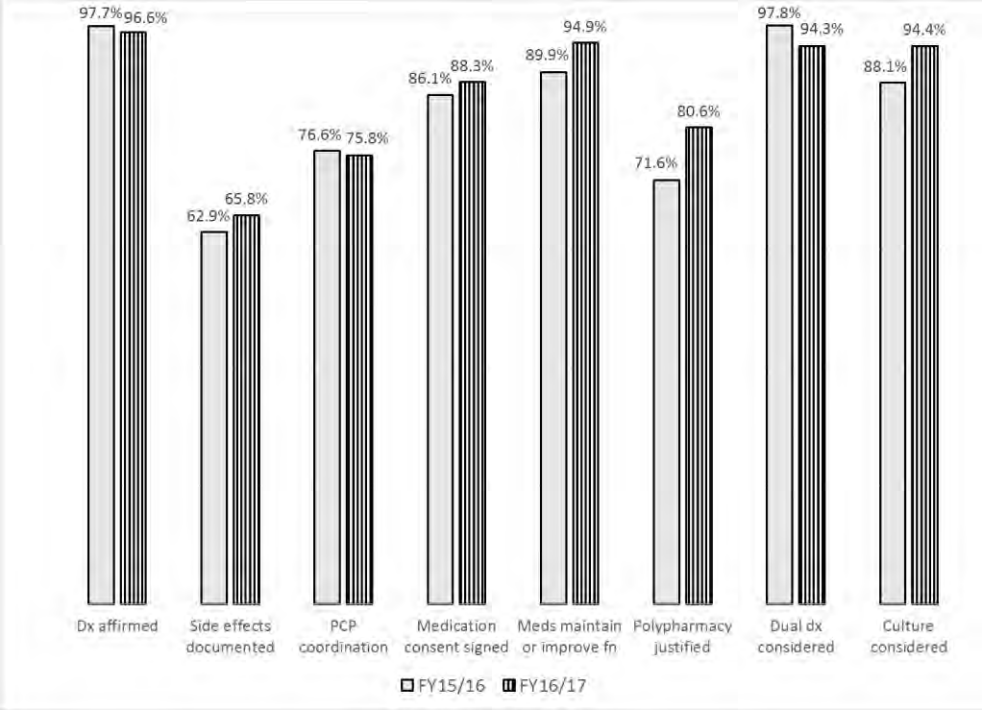
Adult Services

Psychiatrist annual chart reviews look at medication management on eight items.

- Diagnosis review,
- Side effects are addressed,
- 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.

As compared to last year, the only statistically significant change was an increase in the percent of charts showing documentation of prescribing cultural and ethnic considerations (Figure 7).

Figure 7. Adult - Medication monitoring review, percent "yes," FY 2016-17 vs. prior fiscal year



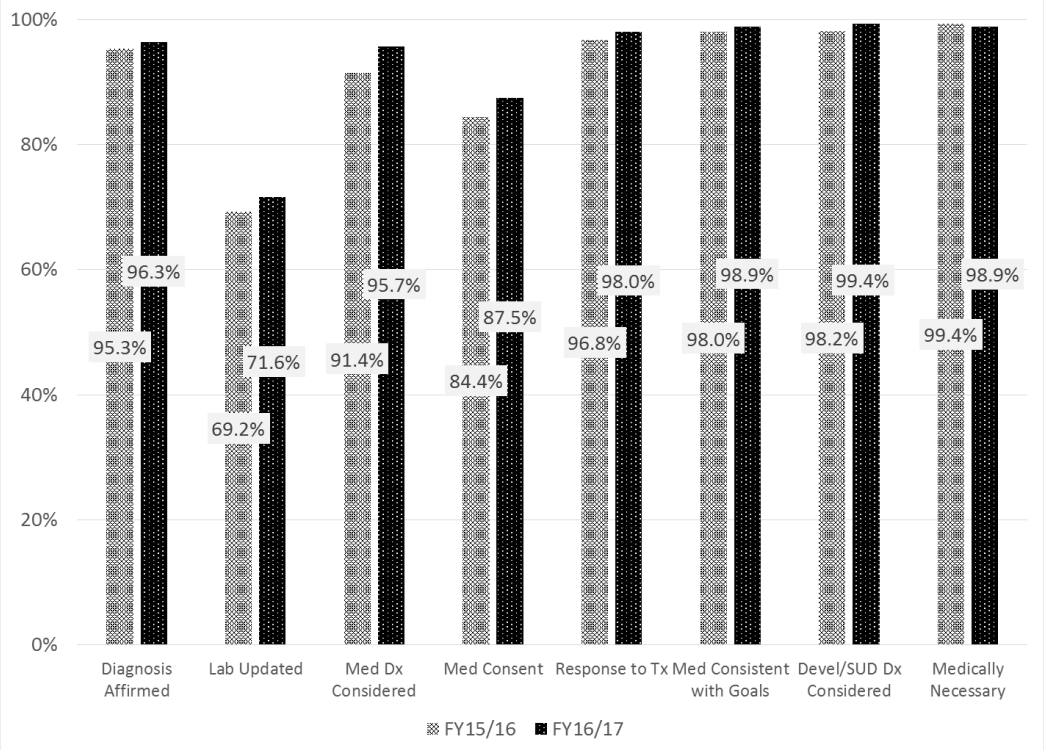
Children and Youth Services

Psychiatrist annual chart reviews look at medication management on eight items.

- Diagnosis review,
- Update of lab information,
- Whether non-psychiatric medical conditions were considered in evaluating medication choices,
- Medication consent form signed and dated,
- Evidence of level of response to treatment,
- Medications consistent with care plan goals,
- Developmental and/or substance abuse diagnoses considered in treatment,
- Medical necessity for treatment clearly documented.

As compared to last year, the only statistically significant change was an increase in the percent of charts showing documentation of consideration of non-psychiatric medical conditions in the choice of medications (Figure 8).

Figure 8. Children/Youth - Medication monitoring review, percent "yes," FY 2016/-7 vs. prior fiscal year



- **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 Electronic Health Record (EHR) provides an opportunity to continue this effort.

During the 2015-16 year, preparations were made for implementation of data sharing via a secure coordination of care document (CCD), 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 was completed and was implemented in 2017.

Also in 2015-16, a number of changes to the EHR were discussed and have received approval from the BHS Medical Director and BHS Associate Medical Directors. Most of these have been implemented during the 2016-17 year. 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 and the status of implementation are listed below.

- Prompt providers and document interventions to obtain benefits for clients without healthcare coverage. Implemented June 2017.
- Prompt providers and document interventions to link clients with primary healthcare provider/PCP. Implemented June 2017.
- Efficient charting of General Medical Conditions that also allows for specific data reporting. Implemented June 2017.
- Track labs and medical records received from PCPs, medical clinics and other relevant medical specialists. These documents continue to be scanned into a specified EHR folder.
- Allow HCA to distinguish labs obtained through BHS versus outside organizations. Implemented process to specify and sort into specified EHR folders labs that were ordered by BHS, those that came from emergency departments or hospitals and those that came from other sources.
- Facilitate communication of essential BHS-focused medical information to outside general medical providers in the case of transfer. Implemented the use of the CCD.
- Track coordination of care (information sent) to PCP or other relevant outside medical specialists. Implemented the use and standardized EHR location for this communication form.

The medication monitoring process gathers information on the percentage of charts reflecting documentation of coordination of care with the PCP. In AOABH, the percentage of charts reflecting this coordination has stayed fairly consistent at about 76%. In CYBH, this item is included in the item regarding whether or not there is evidence of consideration of physical health issues in the care planning,so is not gathered separately.

The State Consumer Perception Surveys gather some information on mental health clients' interactions with physical health providers. In the November 2016 administration, Youth Satisfaction Survey results indicated that 68.5% of youth have had an office/clinic visit with a physician or nurse for health check-up when sick within the last year. This is up from 2015, when results were 65%.

For 2016-17, one planned activity was geared to the importance of linkage between BHS and the clients' primary care provider. The specific goal was:

> This year, AQIS will conduct a focused review of PCP linkage in the FSPs and PACT programs. The initial step for this review will be to establish a baseline.

This goal was not met. Due to workload issues, the stated project was not implemented.

PERFORMANCE IMPROVEMENT PROJECTS

- **CRAFFT**

Use of the CRAFFT in CYBH continued into its second year. As of October 2, 2017, 100 mental health clients age 12 and older, have been identified as also being at risk for substance abuse issues. Clients completed at least one Seeking Safety module and were linked to substance use services. There was a substantial decrease in functional impairment and risk related to substance use. As measured by the Substance Abuse Choices Scale (SACS), 20% demonstrated small improvement (at least 0.2 standard deviations), 10% showed medium improvement (at least 0.5 standard deviations) and 24% showed large improvement (at least 0.8 standard deviations). The initial mean score of 5.2 on the SACS was in the clinically significant to serious range. The mean was reduced to 3.7, slightly below the clinical cutoff of 4, which is considered reflective of a "clinically significant problem with a need for intervention."

- **Triage Grant Project**

The Triage Grant Program is the OC Health Care Agency's (HCA) implementation of a state grant meant to better serve individuals in the community experiencing a behavioral health crisis. The Triage Grant Program's primary goals are to: 1) provide timely assessment, crisis intervention, and treatment, 2) improve the individual's experience by providing alternatives to inpatient hospitalization utilizing the most dignified and least restrictive referral options whenever possible and appropriate, 3) support individual recovery and wellness, and 4) reduce costs. To meet these goals, HCA partnered with the Hospital Association of Southern California (HASC) to place 12 Licensed Triage Staff (LTS) in 6 local Emergency Departments (EDs) throughout the County to provide assessment, crisis intervention, education, counseling, referral, gathering of collateral information, and follow-up services for adults and youth experiencing behavioral health crises. In addition to Licensed Triage Staff (LCSWs, NPs, RNs, and Psychologist), Peer Mentors have been utilized at the County Crisis Stabilization Unit (CSU) and participating EDs to provide reassurance, encouragement, advocacy, share their story of hope and recovery with individuals who meet criteria for Severe and Persistent Mental Illness (SPMI) and assist with linkage to outpatient County Clinics upon discharge. The participating hospitals are: CHOC, Fountain Valley Regional Hospital, Los Alamitos Medical Center, Saddleback Memorial Medical Center, St. Joseph Hospital, and UCI Medical Center; the Triage Grant Program plans to expand to 3 additional hospitals by the end of 2017.

- Performance Outcome Targets include: 90% of individuals will be seen within 1 hour of ED admit
- 60% of individuals will be diverted to the least restrictive, recovery oriented treatment option in lieu of hospitalization
- 75% of individuals will be linked to outpatient services within 5 days of ED discharge.

A review of the data available from FY 2016-17 was conducted. From the start of program implementation in August 2016 through June 2017, there were 2,621 individuals served by the Triage Grant Program. Of these individuals:

- 51% of individuals were seen within 1 hour of ED admit
- 62% of individuals were diverted to the least restrictive, recovery oriented treatment option in lieu of hospitalization
- 46% of individuals were linked to outpatient services within 5 days of ED discharge

For this same FY 2016-17 period, a review of data was conducted for Peer Mentoring Services outcomes. Findings showed:

- Approximately 546 individuals were enrolled with Peer Mentoring Services upon discharge from CSU or participating EDs
- There were an average of 4 service contacts per individual served.
- 49% of enrolled individuals were able to link to services. Of these individuals:
    - 18% linked to Open Access Services
    - 15% linked to PACT
    - 65% linked to AOABH outpatient Clinic Services

The third part of the grant is contracted with Resource Development Associates (RDA) to provide an outside evaluator (a requirement of the grant) to analyze outcomes and program performance based on the use of multiple data elements and targeted analysis. In November 2016, RDA conducted on-site focus groups with LTS and ED staff at 3 hospitals, as well as Peer Mentors, CSU staff, HASC, and HCA to gather information and identify successes and challenges. A formal evaluation based on these focus groups and data analysis was provided to HCA in February 2017.

- **SUD Risk Factors**

A proposed SUD Medi-Cal quality improvement project is in its early stages. The goal is to provide intensive treatment to clients at highest risk for treatment failure. Data for FY 2014-15 and FY 2015-16 was reviewed. Data analysis determined variables available at intake that could distinguish between clients successfully completing vs. those dropping out or failing treatment. The following factors were found to be associated with treatment failure:

1. Needle user: Used needles in the last 30 days
2. Under 21 years old
3. Still using: Used primary drug in 2 out of last 30 days

4. Homeless
5. No social support: No days of social support (AA, counseling, etc.) in last 30 days
6. Homeless or dependent living (group home, institution, incarcerated, etc.)
7. Unemployed
8. Non-oral use: Primary drug route is other than oral

- **Trauma Informed Care**

Over several years, the HCA BHS has seen a significant increase in clients with multiple issues indicating a trauma history. We have seen an increase in homelessness, substance use, and clients with mental illness/co-occurring issues who have contact with the criminal justice system. We are seeking to improve the outpatient behavior health services system of care (as measured by consumer satisfaction and clinical improvement) by addressing deficiencies in our ability to deliver trauma-informed care. To this end, BHS has targeted training our various program staff and developed trauma informed programming throughout our system. In early 2018, a survey will distributed to BHS clinical, support and administrative staff to assess the degree to which we are currently a trauma-responsive system, to establish a baseline, and to assist with planning for trauma-informed training and program implementation.

- **Performance Outcome Measurement System Development**

In 2016-2017, BHS began to strengthen its data analytics capabilities by hiring three Research Analysts IVs and two Senior Research Analysts. These data analysts were hired into Adult Older Adult Behavioral Health, Children and Youth Behavioral Health, Prevention and Early Intervention, and Authority and Quality Improvement Services. One of the early tasks set out by BHS administration for these data analysts working with managers and existing data resources was set out in the Quality Management Plan for 2016-17:

> BHS will implement a cross-function-area work group to organize the many different performance measurement indicators currently in use and to develop a core set of measures to use across BHS. This should include some standardized functional assessments to included items such as level of housing; work status; days incarcerated; etc. Measures shall be developed that provide age appropriate options, depending on the population served.

Some early tasks were identified and set out as specific goals in the 2016-17 Quality Management Plan. These included:

> 1) A standardized set of demographics will be implemented. 2) A core set of measures will be selected as the preferred outcome tool for each of the types of programs. 3) A small scale implementation of one of the preferred outcome tools will be implemented.

The task might seem to be fairly simple, however BHS is a large system and already had many measures, assessments and outcome goals in place based on a variety of oversight and regulatory needs and requirements. Most of these were not comparable, used different definitions, and tended to be siloed by factors such as program and client population.

Before individual goals could be addressed, it was necessary to do a thorough inventory and organization of the measures in use and develop a schema for categorizing the types of programs that could then be used to develop consistency in measures and definitions used.

Goal 1, a standardized set of demographics, was partially completed. Many of the oversight bodies and regulatory requirements established inconsistent categories of almost every demographic. For some demographics a set was developed that captured all the various elements across all requirements and allowed the data for any given program to be pulled so as to meet its specific reporting requirements or to group for comparison across programs, depending on need. For others, the work continues.

Goal 2, the selection of a core set of measures to be used as the preferred outcome tools for each type of programs was completed. A schema matching type of program to the preferred outcome tools was established and implemented. A client outcome suite of measures, the Outcome Questionnaire (OQ), was selected to be used across the system. Different elements of the OQ suite are more or less appropriate depending on factors from age of clients served to expected length of the program.

Goal 3, a small scale implementation of the OQ was completed in Children and Youth Behavioral Health.

- **OQ Implementation**

  Implementation of the OQ has occurred throughout programs on a rolling basis. The measure has been started to be used in all of the Children and Youth Behavioral Health clinics and all of the specialized Children and Youth Behavioral Health programs. It has also been implemented in nine Prevention and Intervention programs, as well as one Adult and Older Adult Behavioral Health program. Reports are not yet available for all programs that have implemented the OQ, but are becoming available in staggered timeframes, and an increasing number will become available as implementation continues. A total of 12 programs (two in Children and Youth Behavioral Health, nine in Prevention and Intervention, and one in Adult and Older Adult Behavioral Health) have begun to provide reports. The reports include OQ assessments from a total of 1,618 individuals (579 in Children and Youth Behavioral Health programs, 605 in Prevention and Intervention programs, and 434 in Adult and Older Adult Behavioral Health programs).

In addition to these three goals, an additional standardization has been completed, although not yet implemented in the EHR. In particular, a standardized set of discharge categories has been finalized and a standardized set of referral and linkage categories has been finalized.

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 2016 calendar year. In that year, a total of 13,292 services were reviewed, up from 12,625 billed services during the prior year.

When services are found to not be compliant with requirements, some may be correctible while some may not. 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 12% were not passed, down from the prior year when14% 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 was anticipated that this number in the County operated clinics would drop significantly in 2016 since by the end of that year the majority of the County operated clinics billing Medi-Cal would 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. This analysis was not conducted due to resource constraints, but will be conducted during the current year and will be incorporated into the 2017 report as well.

ochealth
CARE AGENCY

Behavioral Health Services

405 W 5th Street
4th Floor
Santa Ana, CA 92701
(714) 834 3166