# QUALITY WORK PLAN

## FY 2017-2018

The Quality Work Plan is a required element of the Quality Management Program, as specified by DHCS contract, Exhibit A Attachment 1 (relevant sections: 22-25), and by CCR Title 9, Chapter 11, § 1810.440.

Kings View Counseling Services for Kings County

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## A. Evidence of Monitoring Activities

1. **Beneficiary and Provider Problem Resolution**: grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, NOAs, and requests for change of provider are consumer and provider activities that are continuously monitored, analyzed for trends, and reported to the Quality Improvement Committee (QIC) on a quarterly basis. This is a permanent Quality Work Plan (QWP) monitoring activity item, as specified by DHCS contract, Exhibit A Attachment 1(22)(J)(1).

   Evidence of monitoring of these actions includes Compliance logs, Quality Management (QM) analysis spreadsheets/summaries, and QIC minutes. Logs and analysis documents are saved electronically to a secured QM network folder. QIC shall review monitoring outcomes and make recommendations relevant to improving performance and systemic outcomes.

QM ANALYSIS: MEDI-CAL/HIPAA VIOLATIONS:

**Medi-Cal Violations**:

| Medi-Cal Violations | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Total |
|---|---|---|---|---|---|
| Voids | 0 | 2 | 1 | 0 | 3 |
| Reversals | 0 | 6 | 97 | 103 | 206 |
| Totals | 0 | 8 | 98 | 103 | 209 |
| Amount | 0 | $2273.75 | $13374.90 | $16425.69 | $32074.34 |

**Update-Medi-Cal Violations**:

**HIPAA Violations**:

| HIPAA Violations | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Total |
|---|---|---|---|---|---|
| Standard | 0 | 8 | 98 | 0 | 106 |
| Breach | 0 | 0 | 0 | 0 | 0 |
| Totals | 0 | 0 | 98 | 0 | 106 |

**Update-HIPAA Violations:**

**Beneficiary Rights:**

| Beneficiary Rights | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Total |
|---|---|---|---|---|---|
| Grievances | 3 | 0 | 15 | 16 | 34 |
| Appeals | 0 | 0 | 0 | 0 | 0 |
| Expedited Appeals | 0 | 0 | 0 | 0 | 0 |
| Fair Hearings | 0 | 0 | 0 | 0 | 0 |
| Totals | 3 | 0 | 15 | 16 | 34 |

**Summary**:

In the 3rd quarter, Behavioral Health began assuming some of the duties previously managed by Kings View. This transfer of duties allowed Kings View time to do a more intensive review of client charts, resulting in an increase in voids/reversals for the 3rd and 4th quarters. Processes are being reviewed and improved as a result of the second half of the fiscal year.

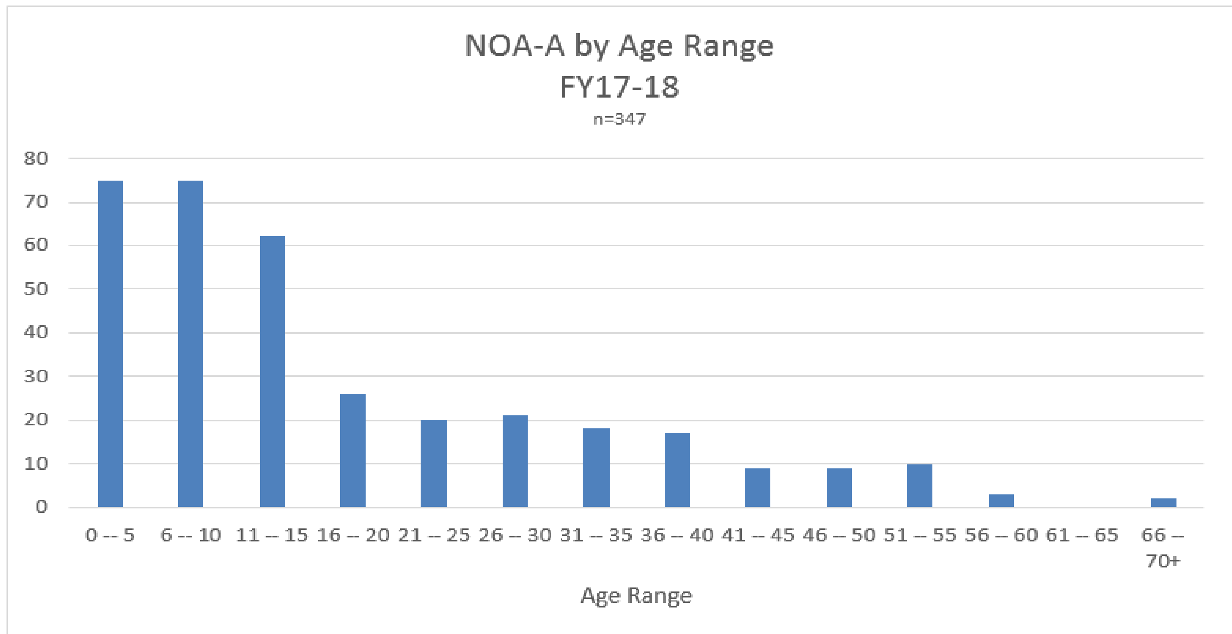
**Notice of Action:**

| Notice of Action | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Totals |
|---|---|---|---|---|---|
| NOA-A* | 67 | 89 | 76 | 115 | 347 |
| NOA-B | 0 | 0 | 0 | 0 | 0 |
| NOA-C | 3 | 3 | 0 | 0 | 6 |
| Totals | 70 | 89 | 76 | 115 | 353 |

(*) Includes any NOA-A issued pursuant to TBS Assessment.

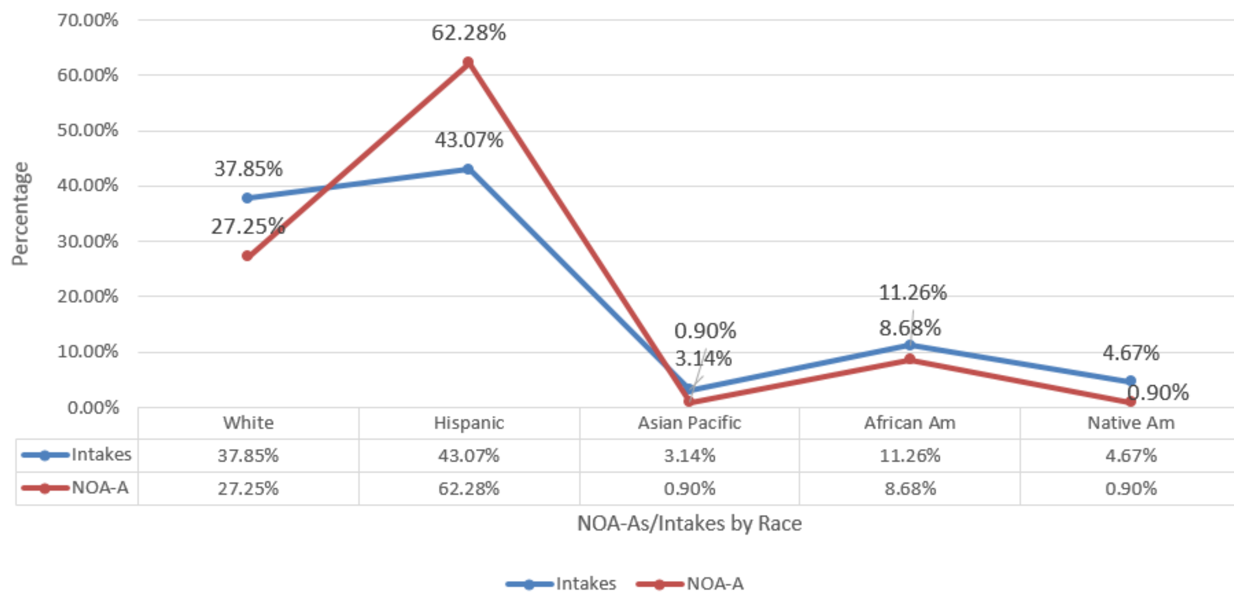
*NOA-A By Age (MH Intakes only):*

| NOA-A Counts by Age Range | 0 -- 5 | 6 -- 10 | 11 -- 15 | 16 -- 20 | 21 -- 25 | 26 -- 30 | 31 -- 35 | 36 -- 40 | 41 -- 45 | 46 -- 50 | 51 -- 55 | 56 -- 60 | 61 -- 65 | 66 – 70+ | Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter 1 | 10 | 20 | 13 | 7 | 3 | 3 | 1 | 3 | 1 | 1 | 3 | 2 | 0 | 0 | 67 |
| Quarter 2 | 21 | 18 | 20 | 6 | 2 | 4 | 7 | 4 | 1 | 4 | 0 | 1 | 0 | 1 | 89 |
| Quarter 3 | 26 | 12 | 9 | 4 | 8 | 6 | 3 | 3 | 2 | 1 | 2 | 0 | 0 | 0 | 76 |
| Quarter 4 | 18 | 25 | 20 | 9 | 7 | 8 | 7 | 7 | 5 | 3 | 5 | 0 | 0 | 1 | 115 |
| Totals | 75 | 75 | 62 | 26 | 20 | 21 | 18 | 17 | 9 | 9 | 10 | 3 | 0 | 2 | 347 |




**Update-NOA-A by Age (MH Intakes Only)**: FY 2017-2018 data appears to reveal a significant concentration of NOA-As in ages 0-10. This age group makes up 25% of all the intake assessments for FY17-18 and 43% of all NOA-As.

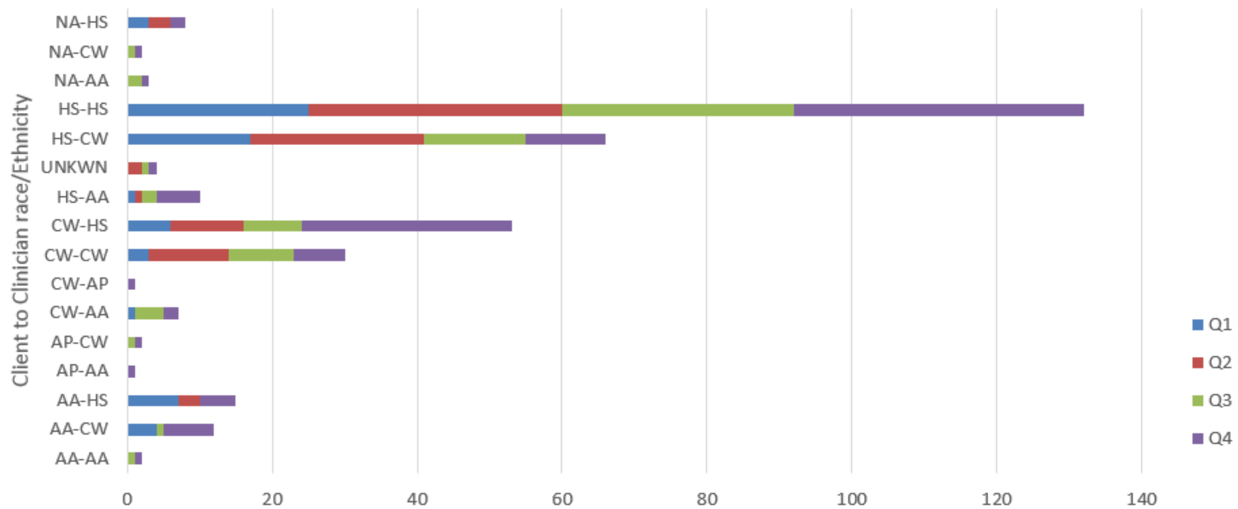
*NOA-A by Race/Ethnicity of Consumer (MH Intakes only)*




*NOA-A by Race/Ethnicity of Consumer to Clinician FY 2017-2018 (MH Intakes only)*

| | African American – African American | African American - Caucasian/White | African American - Hispanic | Asian/Pacific Islndr – Afridan American | Asian/Pacific Islndr – Caucasian/White | Caucasian/White - African-American | Caucasian/White – Asian/Pacific Islander | Caucasian/White-Caucasian/White | Caucasian/White - Hispanic | Hispanic - African-American | Hispanic – Hispanic | Hispanic - Caucasian/White | Native american | unknown | Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Quarter 1 | 0 | 4 | 7 | 0 | 0 | 1 | 0 | 3 | 6 | 1 | 25 | 17 | 3 | 0 | 67 |
| Quarter 2 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 11 | 10 | 1 | 35 | 24 | 3 | 2 | 89 |
| Quarter 3 | 1 | 1 | 0 | 0 | 1 | 4 | 0 | 9 | 8 | 2 | 32 | 14 | 3 | 1 | 76 |
| Quarter 4 | 1 | 7 | 5 | 1 | 1 | 2 | 1 | 7 | 29 | 6 | 40 | 11 | 4 | 1 | 115 |
| Totals | 2 | 12 | 15 | 1 | 2 | 7 | 1 | 30 | 53 | 10 | 132 | 66 | 13 | 4 | 347 |

NOA-A by Client to Clinician Race/Ethnicity
FY17-18 Quarters 1-4 Summary
n=347




| | AA-AA | AA-CW | AA-HS | AP-AA | AP-CW | CW-AA | CW-AP | CW-CW | CW-HS | HS-AA | UNKWN | HS-CW | HS-HS | NA-AA | NA-CW | NA-HS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Q1 | 0 | 4 | 7 | 0 | 0 | 1 | 0 | 3 | 6 | 1 | 0 | 17 | 25 | 0 | 0 | 3 |
| Q2 | 0 | 0 | 3 | 0 | 0 | 0 | 0 | 11 | 10 | 1 | 2 | 24 | 35 | 0 | 0 | 3 |
| Q3 | 1 | 1 | 0 | 0 | 1 | 4 | 0 | 9 | 8 | 2 | 1 | 14 | 32 | 2 | 1 | 0 |
| Q4 | 1 | 7 | 5 | 1 | 1 | 2 | 1 | 7 | 29 | 6 | 1 | 11 | 40 | 1 | 1 | 2 |

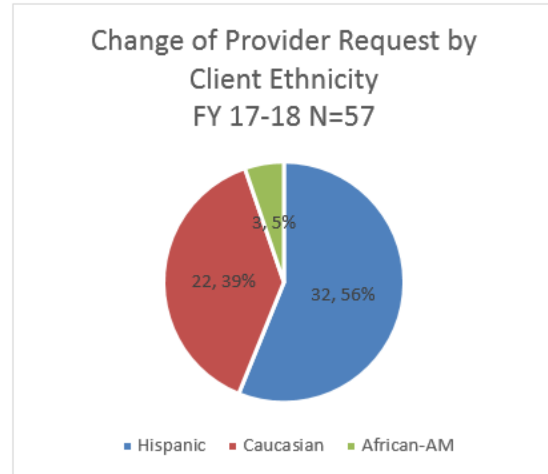
Events

**Update-Notice of Action-A**: NOA-A by Client ethnicity vs clinician ethinicity (MH Intakes Only): FY 2017-2018 was the second year of review for this element. The largest ethnic group to receive a NOA-A was the Hispanic client. In 63.46% of those events, the NOA-A was issued by an Hispanic clinician.

## Change of Provider Requests FY 2017-2018:

| Change of Provider | Quarter 1 | | Quarter 2 | | Quarter 3 | | Quarter 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Requests | Approved | Requests | Approved | Requests | Approved | Requests | Approved | Requests | Approved |
| Adult beneficiaries | 9 | 9 | 12 | 9 | 10 | 8 | 7 | 7 | 38 | 33 |
| Child beneficiaries | 4 | 4 | 8 | 7 | 3 | 2 | 4 | 4 | 19 | 17 |
| Total | 13 | 13 | 20 | 16 | 13 | 10 | 11 | 11 | 57 | 50 |

**Update-Change of Provider Requests**: In FY 17-18 the requests for change of providers increased to 57 requests. This is twice the number form the last fiscal year. 74% of those requests were from femal clients, 97% from Engliosh speaking clients and 70% from adult clients.




**Second Opinion Requests**: Evidence of this monitoring activity is reported in the quarterly Problem Resolution Report, and assessments preceded by an NOA-A, reported from the EHR. This is a permanent QWP monitoring activity item.

Second Opinion Request FY 2017-2018 Children/Adults

| | Quarter 1 | | Quarter 2 | | Quarter 3 | | Quarter 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Requests | Reversals | Requests | Reversals | Requests | Reversals | Requests | Reversals | Requests | Reversals |
| Adults | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Children | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Totals | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

2. **Peer Utilization Review**: Utilization review of clinical records is a monitoring activity enacted monthly by members of the Utilization Review Committee. URC membership includes all clinical line staff and the Compliance Specialist. Three charts for each URC member are peer reviewed for completeness and for compliance with various CCR Title 9 documentation standards. One chart for each URC member is reviewed against the same criteria by the Compliance Specialist. This is a permanent QWP monitoring activity item, as specified by DHCS contract, Exhibit A Attachment 1(22)(J)(1).

   Evidence of monitoring is compiled by the QM Administrative Specialist; detailed review results for each chart are distributed to URC members and Management Team. The responsible providers (LPHA and/or medication provider) are required to take corrective actions and to notify the Compliance Specialist within 14 days that corrections were completed. The Compliance Specialist assigns sanctions and identifies services subject to void/reversal, as applicable, within one week of audit finalization. The rates of approved charts are reported by the Compliance Specialist

monthly to QIC in total and by program. A 90% approval rate is the goal set for all charts reviewed. Monitoring of the safety and effectiveness of medication monitoring practices by the Medications Monitoring Committee (MMC), supervised by a licensed pharmacist, is combined into this QWP item. Monitoring of SUD program compliance, coordinated by SUD UR coordinator, is also combined into this item.

*Annual Utilization Review Approval vs. Disapproval Rates:*

| FY17-18 | Charts | Disapproved | % | Approved | % |
|---|---|---|---|---|---|
| MH | 584 | 7 | 1.20 | 577 | 98.80 |
| SUD | 72 | 22 | 30.55 | 50 | 69.44 |
| Meds | 284 | 29 | 10.22 | 255 | 89.78 |
| Totals | 940 | 58 | 16.20 | 882 | 83.80 |

Quarter 1: **MH**: This quarter 132 charts were reviewed (47 CSOC & 85 ASOC). From this 131 charts were approved. This represents a 99.24% approval rate. **MEDS**: This quarter 65 charts were reviewed (10 CSOC & 55 ASOC). From this 59 charts were approved. This represents a 90.77% approval rate. **SUDS**: This quarter 18 charts were reviewed. From this, 5 charts were approved. This represents a 27.77.0% approval rate.

Quarter 2: **MH**: This quarter 146 charts were reviewed (63 CSOC & 83 ASOC). From this 145 charts were approved. This represents a 99.32% approval rate. **MEDS**: This quarter 83 charts were reviewed and from this 74 charts were approved. This represents a 89.15% approval rate. **SUDS**: This quarter 18 charts were reviewed. From this, 16 charts were approved. This represents a 88.88% approval rate.

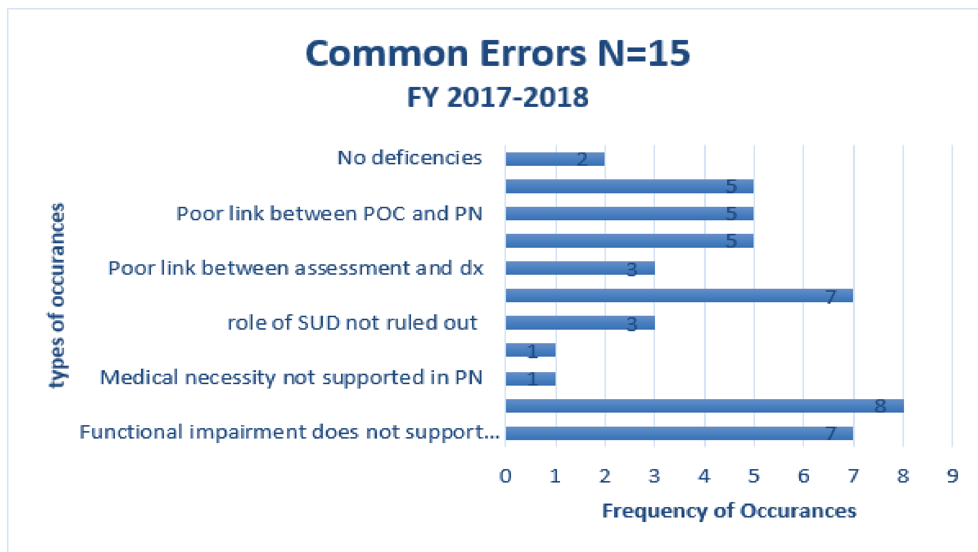
Quarter 3: **MH**: This quarter 160 charts were reviewed (81 CSOC & 79 ASOC). From this 156 charts were approved. This represents a 97.5% approval rate. **MEDS**: This quarter 95 charts were reviewed. From this 85 charts were approved. This represents a 89.73% approval rate. **SUDS**: This quarter 18 charts were reviewed. From this, 14 charts were approved. This represents a 77.77% approval rate.

Quarter 4: **MH**: This quarter 146 charts were reviewed (80 CSOC & 66 ASOC). From this 145 charts were approved. This represents a 99.32% approval rate. **MEDS**: This quarter 41 charts were reviewed and from this 37 charts were approved. This represents a 90.24% approval rate. **SUDS**: This quarter 18 charts were reviewed. From this, 15 charts were approved. This represents a 83.33% approval rate.

Annual Summary: **MH**: This year 581 charts were reviewed. From this 577 charts

were approved. This represents a 98.80% approval rate. **MEDS**: This year 284 charts were reviewed and from this 255 charts were approved. This represents a 89.78% approval rate. **SUDS**: This year 72 charts were reviewed. From this, 50 charts were approved. This represents a 69.44% approval rate.

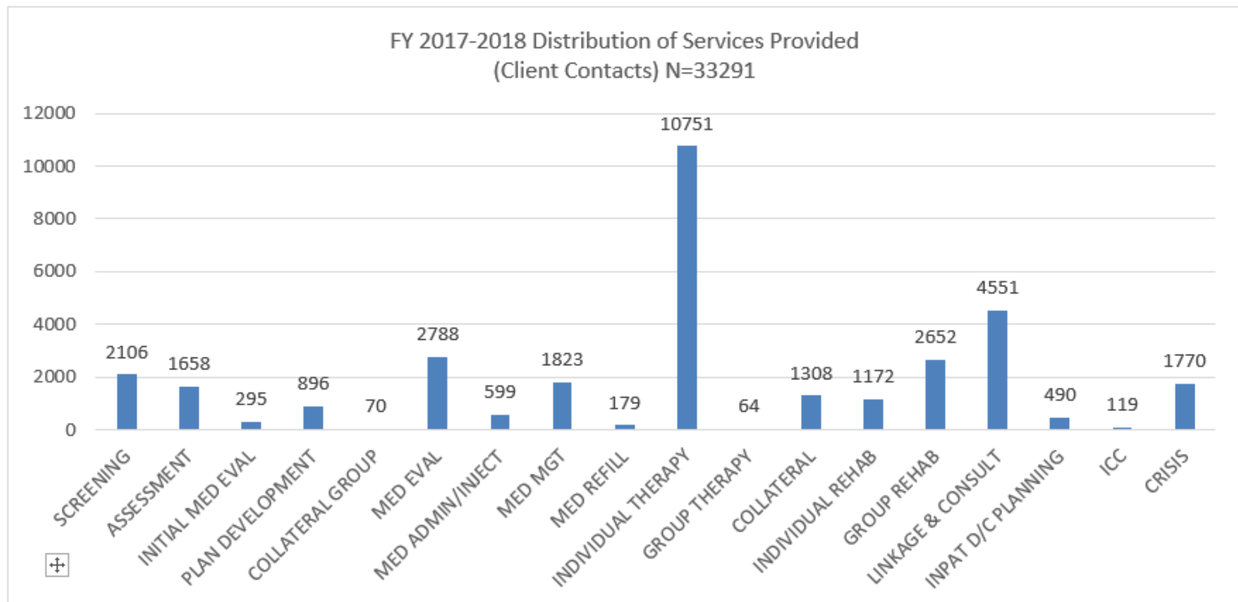
3. **Quality Review of Clinical Records**: Quality Review of clinical records is a monitoring and review activity enacted at least quarterly by clinical Managers and Supervisors; all reviewers are licensed clinicians with a minimum of two years of post-licensure status. Optimally, one chart per month is reviewed by each quality reviewer; the review is proctored by the Compliance Specialist. A Quality Review Worksheet is completed in order to ascertain the overall quality of clinical services provided, by review of chart areas as specified in the Annual Review Protocol for Consolidated Specialty Mental Health Services (medical necessity, assessment, client plan, progress notes, and other chart documentation). Results are tabulated and analyzed by the Clinical Director at least semi-annually. Review feedback is given back to providers by the Program Managers. This is a permanent QWP monitoring activity item, as specified by DHCS contract, Exhibit A Attachment 1(22)(J)(1).

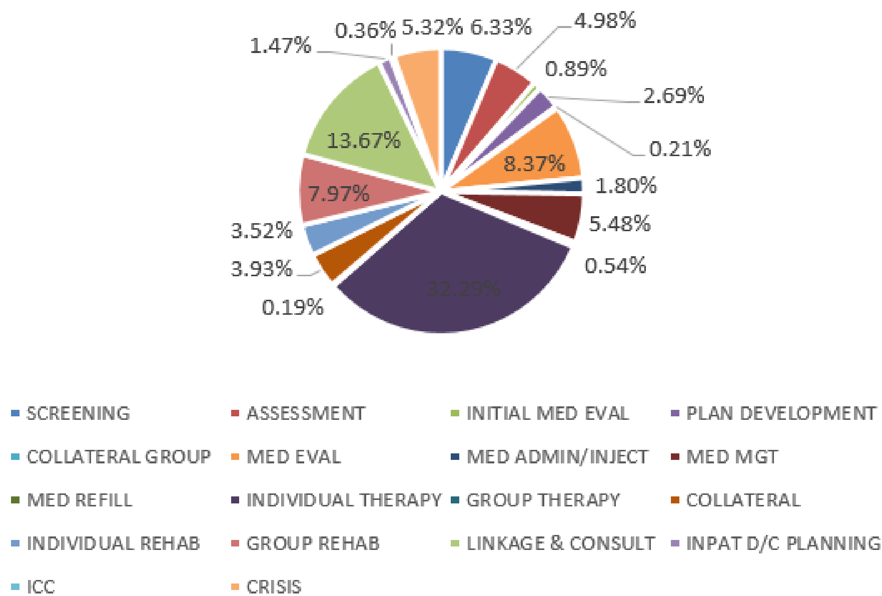


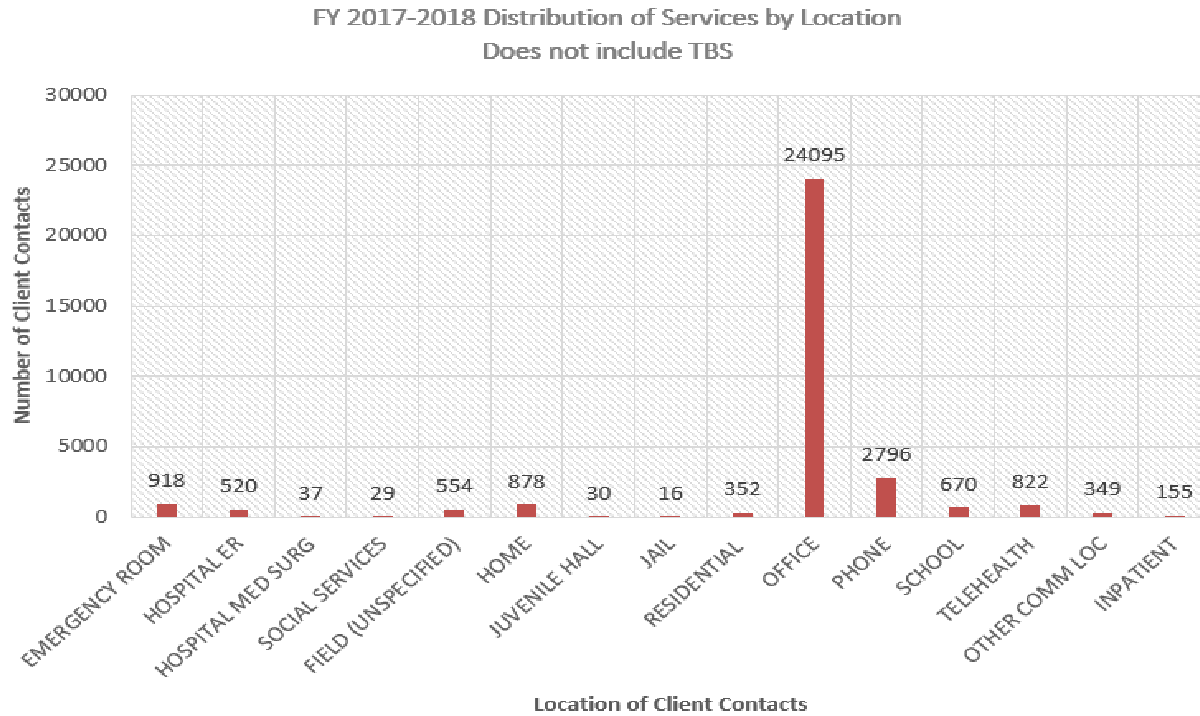

**SUMMARY**: Fifteen charts have undergone a thorough quality review of the clinincal record. Review of the trends seem to indicate that staff struggle with making a clear case for medical necessity, identifying functional impairment and reflecting medical necessity within the content of the presenting symptoms. Consequently, the diagnosis is at times not adequately supported by the assessment. The mental health assessment has been re-designed to divide the presenting problem into three distinct sections: 1) Description of Symptoms; 2) Description of functional Impairment; and 3) Description of current stressors. This will hopefully highlight for the clinician the need to consider the multiple elements of medical necessity.

4. **Service Capacity**: The number, types, and geographic distribution of mental health services being provided are to be monitored beginning with FY 2014-2015, to specifically assess quality improvement of service delivery capacity. The result of this monitoring will be to establish baseline statistics and annual goals for each variable. This is a permanent QWP monitoring activity item, as specified by the Annual Review Protocol for Consolidated Specialty Mental Health Services.

   Evidence of this monitoring activity is to be recorded quarterly in QIC minutes. QIC shall review monitoring outcomes and make recommendations relevant to improving performance and systemic outcomes.






5. **System Monitoring of Unutilized Intake Assessment Slots**. The monitoring of no-show rates at intake assessments was an area of review since FY 2013-2014. As a result of QWP data for FY 2013/2014 through FY 2016/2017, Kings View adopted the "Open Access" Model. In this model, intake assessment appointments are not scheduled in advanced but rather occure as consumers walk into the clinic. A specific number of intake staff are standing by, prepared to provide the assessment as need. As a result of this model change, no shows for intake assessments no longer exsists. However, what we have seen is the emergence of available intake appointment slots that are underutilized. Whether as a result a "no show" or as a result of a prepared assessment slot not being utilized, the end result is still a wasted resource. For FY 2017-2018 the Quality Work Plan will monitor the occurance of under-utilized intake assessment slots in the hopes of allocating resources where needed and only where needed.

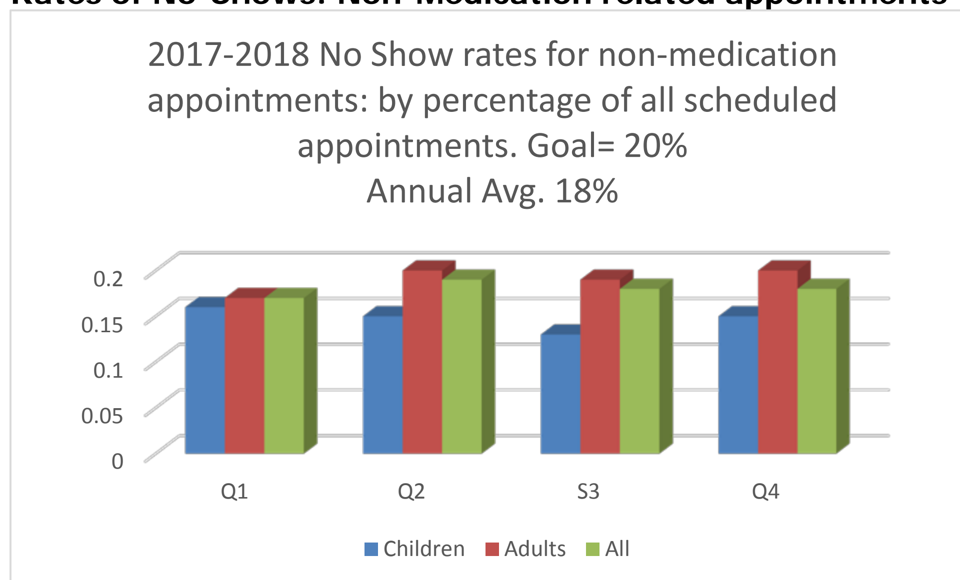
Unused Open Access Assessment Slots by Day: FY 2017-2018

| | Mon | Wed | Thurs | Fri | Total | Daily Avg. |
|---|---|---|---|---|---|---|
| Q1 | 21 | 29 | 17 | 18 | 85 | 1.33 |
| Q2 | 19 | 29 | 12 | 18 | 75 | 1.53 |
| Q3 | 11 | 10 | 4 | 6 | 31 | .60 |
| Q4 | 25 | 28 | 11 | 16 | 80 | 1.56 |
| FY 17-18 | 76 | 96 | 44 | 55 | 271 | 1.37 |

**Summary:** The key to the most effective use of the Open Access Model is to correctly staff the day, based on an accurate anticipation of the fdemand flow. Wednesday tends to be the busiest day and is consequently dtaffed the heaviest. However, it also has the largest average of unused assessment slots. It may be that we are placing our staff at the wrong time of the day or it may be that we have simply staffed too heavily on Wednesday. While the data is helpful, it requires additional clarification.

6. **No-Shows for Clinicians and Psychiatry**. Subsequent to direction from QIC, Kings View has included in its Quality Work Plan a formal review and monitoring of no-shows. No-shows have a direct impact on timeliness of services as well as impact quality of care. Specific areas being monitored regarding no-show include the following:
   - Average No-Shows for Clinicians/Non-Psychiatrists
   - Average No-Shows for Psychiatrists
   - MHP standard or goal
   - All, Adult, Children

**Rates of No-Shows: Non-Medication related appointments**




**Quarter 1:** In the first quarter of the fiscal year there were 9670 non medication related appointments scheduled. Of these, the no show rate was 12.75% (13.85% for children & 12.45% for adults).

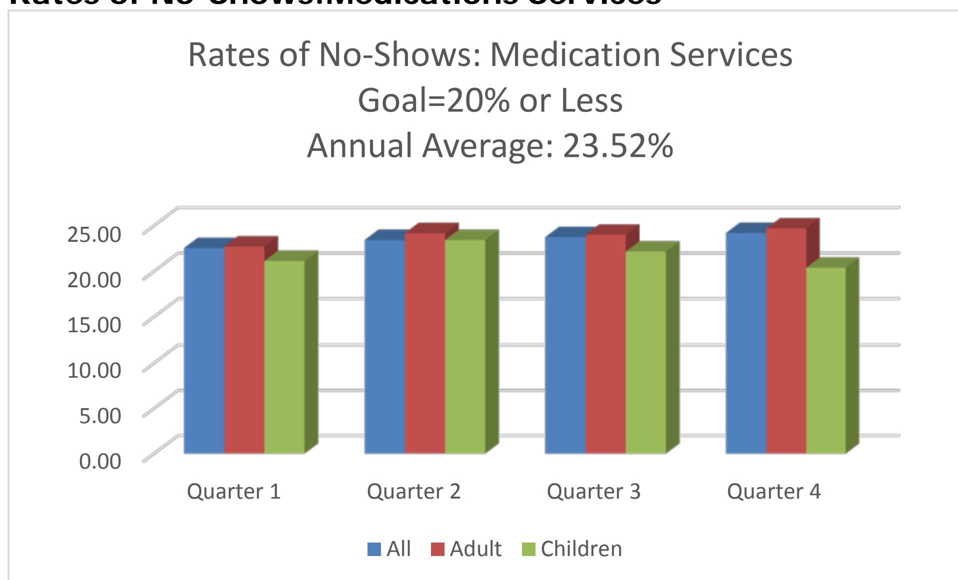
**Quarter 2**: In the second quarter of the fiscal year there were 9504 non medication related appointments scheduled. Of these, the no show rate was 19% (20% for children & 15% for adults).

**Quarter 3**: In the third quarter of the fiscal year there were 10435 non medication related appointments scheduled. Of these, the no show rate was 18% (13% for children & 19% for adults).

Quarter 4: In the fourth quarter of the fiscal year there were 10657 non medication related appointments scheduled. Of these, the no show rate was 18% (15% for children & 20% for adults).

Annual: For Fiscal year 2017-2018 there were 40266 non medication related appointments scheduled. Of these the no show rate was 18% (15% for children & 19% for adults).

**Rates of No-Shows:Medications Services**




**Quarter 1:** In the first quarter of the fiscal year there were 1109 medication appointments (169 children & 940 adults). Of those, the no show rate was 22.54% (21.13% for children & 22.76% for adults).

**Quarter 2**: In the second quarter of the year there were 1272 medication appointments (226 children & 1046 adults). Of those, the no show rate was 23.43% (23.42% for children & 24.18% for adults).

**Quarter 3**: In the third quarter of the year there were 1360 medication appointments (194 children & 1166 adults). Of those, the no show rate was 23.75% (22.16% for children & 24.01% for adults).

**Quarter 4**: In the fourth quarter of the year there were 1302 medication appointments (152 children & 1150 adults). Of those, the no show rate was 24.19% (20.39% for children & 24.69% for adults).

**Annual:** For fiscal year 2017-2018 there were 5043 medication appointments (741 children & 4302 adults). Of those, the no show rate was 23.52% (20.91% for children & 23.96% for adults).

7. **Program Integrity**. Program integrity, to ensure that services reimbursed by Medi-Cal were received by the beneficiary, is monitored each quarter during "Service Verification Week." Each clinician obtains a client's written signature at the close of each service, verifying the date, type, and duration of the service provided. The Compliance Specialist or designee randomly selects a representative sample, and then looks for a matching verification form or group sign-in sheet. The goal is to achieve no less than 100% verification of the sample. Refer to P&P MCC:13. Outcomes are reported to providers. QIC shall review outcomes and make recommendations relevant to improving performance and systemic outcomes.

   Monitoring of program integrity was first implemented in November 2013, and has continued since then on a quarterly basis. This is a permanent QWP monitoring activity item, as specified by the Annual Review Protocol for Consolidated Specialty Mental Health Services.

   In FY 2015-2016 the sample size was increased from 45 samples to 75 samples (approximately 15% of services, randomly sampled). The increased sample size was shown to reflect more similarity to the dataset.

| Quarter | Outcome | Immediate Response | Follow-Up/Intervention |
|---|---|---|---|
| JUL-SEP | Pass-100% | Result distributed. | None. |
| OCT-DEC | Pass-100% | Results distributed | None |
| JAN-MAR | Pass-100% | Results distributed | None |
| APR-JUN | Pass-100% | Results distributed | None |

**Summary:** In each quarter for FY 2017-2018 we achieved our compliance rate.

## B. Evidence of Meaningful Improvement

1. **REDUCTIONS IN PSYCHIATRIC HOSPITAL DAYS/EPISODE RATE AND NUMBER OF CONSUMERS HOSPITALIZED**: A function of the monthly Inpatient Review Committee (IRC) is to monitor trends associated with the number of hospital admissions and the average number of hospital days per admission. IRC thusly reports that data back to the QIC.

| FY 17-18 | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | ANNUAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HOSPITALIZED | 20 | 20 | 15 | 25 | 19 | 17 | 17 | 26 | 27 | 22 | 24 | 15 | |
| DAYS | 159 | 153 | 102 | 141 | 93 | 54 | 147 | 184 | 175 | 104 | 128 | 100 | |
| AVERAGE STAY | 7.95 | 7.65 | 6.8 | 5.6 | 5.8 | 3.2 | 8.6 | 7.1 | 6.5 | 4.7 | 5.3 | 6.6 | |

| TREND/ COMPARISON | FY 2016-2017 | | | FY 2017-2018 | | |
|---|---|---|---|---|---|---|
| | ADMITS | DAYS | AVERAGE | ADMITS | DAYS | AVERAGE |
| QUARTER 1 | 46 | 296 | 6.43 | 55 | 414 | 7.52 |
| QUARTER 2 | 49 | 460 | 9.39 | 61 | 288 | 4.72 |
| QUARTER 3 | 56 | 383 | 6.84 | 70 | 506 | 7.23 |
| QUARTER 4 | 58 | 426 | 7.34 | 61 | 332 | 5.44 |
| ANNUAL | 209 | 1565 | 7.49 | 247 | 1540 | 6.23 |

**Summary**:
In fiscal year 2017-2018 there were 247 unduplicated hospital admissions for a total of 1540 days. The average stay was 6.23 day. This is a 16.8% decrease from fiscal year 2016-2017.

2. **RATE OF PSYCHIATRIC HOSPITALIZATION PURSUANT TO CRISIS ASSESSMENT & INTERVENTION** <20%:
   - In order to stretch our abilities, QIC has reduced our current internal goal of Kings View crisis assessments that lead to hospitalizations from no more than **20%** to no more than **15%.** In order to meet that goal we will strive to improve our PEI responses as well as by improving our capacity to appropriately link at-risk consumers to lower levels of care, which has frequently included facilitating expedited access to our outpatient services.
   - PEI Case Manager, PEI Peer Support Specialist, and PEI Clinician will continue to provide operational support of risk interventions, timely access to community resources, and expedited access to non-acute treatment services.

FY 2017-2018 Data comparing crisis episodes and hospitalizations by Kings View

| | Unduplicated Crisis Episodes | Hospital Admissions Initiated by MHP | Hospitalization Rate |
|---|---|---|---|
| Quarter 1 | 476 | 52 | 10.9% |
| Quarter 2 | 439 | 40 | 9.11% |
| Quarter 3 | 492 | 42 | 8.53% |
| Quarter 4 | 524 | 44 | 8.39% |
| Total | 1931 | 178 | 9.22% |

**Summary**:
Durring fiscal year 2017-2018 Kings View conducted 1931 independent 5150 assessments. Of those, 178 resulted in decisions to hospitalize. Over the course of the year, 9.22% of Kings View 5150 assessments resulted in decisions to hospitalize. Kings View met and exceeded their standard of 20%.

3. **QUALITY IMPROVEMENT COMMITTEE**: The QIC shall include active participation by practitioners and providers, as well as beneficiaries and family members in the planning, design, and execution of the QI program. This is a permanent QWP quality improvement item, as specified by DHCS contract, Exhibit A Attachment 1(23)(E).

   All functions related to the Quality Improvement Committee were assumed by Kings County Behavioral Health in FY 17-18.

4. **PRE-/POST-TEST OUTCOME MEASURES FOR DEPRESSION AND ANXIETY**: During FY 2013-2014, procedures for collecting and reporting on clinic-wide outcome data were formalized and continued in the FY 2016-2017 QWP.
   - Burns scales for Depression and Anxiety have continued to be used as evidence-based outcome measures for adults.
   - The CANS was implemented February 2015 for pre-/post-test outcome measures for children, replacing the Burns scales. It has been available as an assessment in the EHR since the 3rd quarter of FY15-16.
   - Outcomes will continue to be reported quarterly by the Kings View Corporate Director of Quality Improvement.

| BURNS SURVEY: DEPRESSION | PAIRED SETS | AVG INITIAL SCORE | AVG INTER-MEDIATE SCORE | AVG FINAL SCORE | AVG % CHANGE IN SCORE | AVERAGE SCALE SCORE AT COMPLETION |
|---|---|---|---|---|---|---|
| QUARTER 1 | 10 | 37.9 | N/A | 19.9 | 47.49% | MILD |
| QUARTER 2 | 26 | 45.73 | N/A | 29.65 | 35.16% | MODERATE |
| QUARTER 3 | 22 | 57.09 | N/A | 36.63 | 35.83% | MODERATE |
| QUARTER 4 | 19 | 38.00 | N/A | 24.26 | 35.61% | MILD |

SCORING: 0-5 NO DEPRESSION; 6-10 NORMAL BUT UNHAPPY; 11-25 MILD DEPRESSION; 26-50 MODERATE DEPRESSION 51-75 SEVERE DEPRESSION; 76-100 EXTREME DEPRESSION.

| BURNS SURVEY: ANXIETY | PAIRED SETS | INITIAL | INTER-MEDIATE | FINAL | % CHANGE | AVERAGE SCALE SCORE AT COMPLETION |
|---|---|---|---|---|---|---|
| QUARTER 1 | 10 | 36.5 | N/A | 17.7 | 51.50% | MILD |
| QUARTER 2 | 23 | 41.08 | N/A | 24.39 | 40.63% | MILD |
| QUARTER 3 | 22 | 49.72 | N/A | 27.63 | 44.97% | MODERATE |
| QUARTER 4 | 22 | 38.40 | N/A | 18.77 | 52.63% | MILD |

SCORING: 0-5 NO ANXIETY; 6-10 NORMAL BUT NERVOUS; 11-25 MILD ANXIETY; 26-50 MODERATE ANXIETY; 51-75 SEVERE ANXIETY; 76-100 EXTREME ANXIETY.

**Annual Summary**:
Target/ Goals Met. The Goals/ Targets set for both Burns Anxiety and Drepression was to see a minimum of 25% decrease in scores from treatment initiation to treatment conclusion. Kings View Outcome Measures Report consist of QI indicators that have been selected by the Management and Quality Improvement Team to be monitored throughout the 2017-2018 Fiscal Year. The QI Indicators have been identified for specialized monitoring to track Kings View program intervention effectiveness as it pertains to anticipated outcomes with achieving project goals and delivering high quality services.

5. **DBT (Dialectical Behavior Therapy) TREATMENT OUTCOME MEASURES**: Since FY 2012-2013, we have administered the Difficulties in Emotional Regulation Scale (DERS) to quantify progress for consumers receiving DBT services. The DERS is administered at the beginning of treatment and every six months. The goal is to measure a 25% change (in difference between dysregulation and skillfulness) from pre- to post-test. Outcomes will continue to be reported quarterly by the Kings View Corporate Director of Quality Improvement.

| DIFFICULTY WITH EMOTIONAL RESPONSE SCALE (DERS) | PAIRED SETS | COMBINED CHANGE FROM PRE TO POST – AVG | % CHANGE | NOTE |
|---|---|---|---|---|
| QUARTER 1 | 7 | 26.86 | 51.93% | Target/ Goal Met |
| QUARTER 2 | 7 | 22.00 | 43.38% | Target/ Goal Met |
| QUARTER 3 | 6 | 25.83 | 40.95% | Target/ Goal Met |
| QUARTER 4 | 5 | 26.80 | 51.73% | Target/ Goal Met |

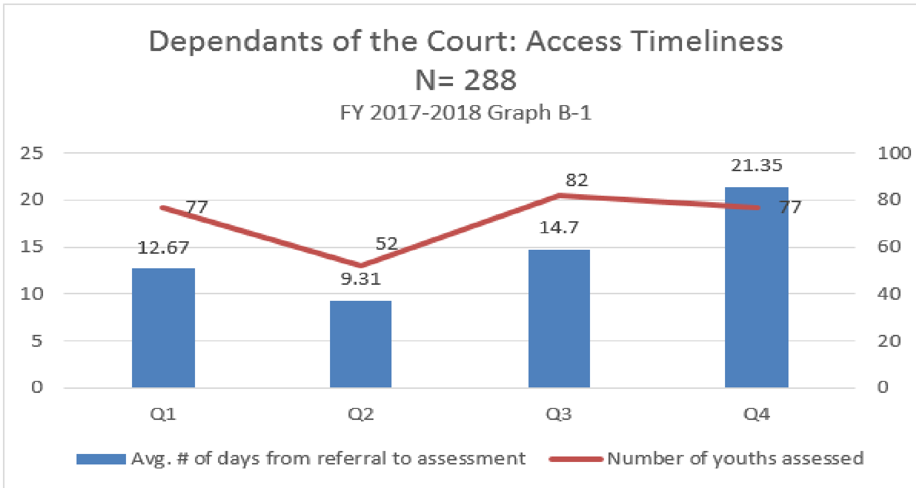
COMBINED SCORES ARE REPORTED.

**Annual Summary**:
Target/ Goals Met. Kings View Outcome Measures Report consist of QI indicators that have been selected by the Management and Quality Improvement Team to be monitored throughout the 2017-2018 Fiscal Year. The QI Indicators have been identified for specialized monitoring to track Kings View program intervention effectiveness as it pertains to anticipated outcomes with achieving project goals and delivering high quality services.

## C. Mechanisms to Assess the Accessibility of Services

1. Due to the implamenttion of the Open Access Model, timeliness of scheduling of routine appointments is measured from when the client walks into the clinic requesting services to the time they begin their initial mental health assessment. Our goal is for 80% of our consumers, positiviely screened for a mental health assessment, to have that assessment begin within 7 bussiness days. Our pilot program from April 2017 to June 2017, indicated that the average wait time from screening to assessment significantly dropped to 8 days. Our pilot data will serve as our baseline data for this coming year. See data field A-1 & A-2

2. In order to respond to the unique needs of Dependant of the Court children, Kings View has developed an independent review for this population. Kings View will monitor timeliness of access to an initial mental health assessment from the day in which a referral is provided by Child Welfare Services. In addition to monitoring the average number of day from receipt of referral to initial mental health assessment, data will be collected on the total number of referrals for that quarter. We anticipate a possible link between timeliness an d capacity. See graph B-1




3. Kings View will also continue to monitor that timeliness of access to services for psychiatric services. In FY16-17 the average time from referral to initial psychiatric evaluation was 45 day. The goal for FY 2017-2018 will be an average of 21 day. We will also be collecting data on no shows for initial medication evaluations. We expect to see possible links between no shows and wait times. See data field C-1

A-1 Data from FY 2017-2018: Excludes DOC children opened through Children Services

| OUTPATIENT MH: 80% within 7 days | | All | Adults | Children |
|---|---|---|---|---|
| Quarter 1 | Average | 1.65 | 1.59 | 1.77 |
| | Percent % met | 98.31% | 98.73% | 97.47% |
| | RANGE | 1-18 | 1-15 | 1-18 |
| | COUNT | 237 | 158 | 79 |
| Quarter 2 | Average | 1.48 | 1.45 | 1.54 |
| | Percent % met | 98.70% | 97.87% | 100% |
| | RANGE | 1-9 | 1-9 | 1-5 |
| | COUNT | 231 | 141 | 90 |
| Quarter 3 | Average | 1.84 | 1.99 | 1.55 |
| | Percent % met | 98.55% | 98.33% | 98.96% |
| | RANGE | 1-50 | 1-50 | 1-19 |
| | COUNT | 276 | 180 | 96 |
| Quarter 4 | Average | 1.36 | 1.33 | 1.48 |
| | Percent % met | 99.10% | 98.80% | 100% |
| | RANGE | 1-12 | 1-12 | 1-6 |
| | COUNT | 222 | 166 | 56 |
| FY17-18 | Average | 1.6 | 1.6 | 1.59 |
| | Percent % met | 98.65% | 98.45% | 99.07% |
| | RANGE | 1-50 | 1-50 | 1-19 |
| | COUNT | 966 | 645 | 321 |

A-2 Data from FY 2017-2018: Excludes DOC children opened through Children Services

| OUTPATIENT MH: 80% within 3 days | | All | Adults | Children |
|---|---|---|---|---|
| Quarter 1 | Average | 1.65 | 1.59 | 1.77 |
| | Percent % met | 91.14% | 90.51% | 92.41% |
| | RANGE | 1-18 | 1-15 | 1-18 |
| | COUNT | 237 | 158 | 79 |
| Quarter 2 | Average | 1.48 | 1.45 | 1.54 |
| | Percent % met | 90.91% | 92.20% | 88.89% |
| | RANGE | 1-9 | 1-9 | 1-5 |
| | COUNT | 231 | 141 | 90 |
| Quarter 3 | Average | 1.84 | 1.99 | 1.55 |
| | Percent % met | 88.41% | 86.67% | 91.67% |
| | RANGE | 1-50 | 1-50 | 1-19 |
| | COUNT | 276 | 180 | 96 |
| Quarter 4 | Average | 1.36 | 1.33 | 1.48 |
| | Percent % met | 95.05% | 95.78% | 92.86% |
| | RANGE | 1-12 | 1-12 | 1-6 |
| | COUNT | 222 | 166 | 56 |
| FY17-18 | Average | 1.60 | 1.60 | 1.59 |
| | Percent % met | 91.20% | 91.16% | 91.28% |
| | RANGE | 1-50 | 1-50 | 1-19 |
| | COUNT | 966 | 645 | 321 |

**Summary:** At the beginning of FY 2017-2018, Kings View was continuing it's role of the managed care plan. The QWP at that time set a 7 day standard of timeliness for outpatient mental health services. The 7 day standard was clearly met at a rate of 98.65% of the time, primarily as a result of the Open Access model. By mid year, Behavioral Health had taken over managed care oversite and had formalized an updated QWP. The new QWP set a 3 day turnaround standard. That standard was also met using the Open Access model, at a rate of 91.20% of the time.

C-1 Data from FY 2017-2018: Includes all referrals for initial Medication evaluations

| OUTPATIENT PSYCHIATRY: 75% WITHIN 21 DAYS Referral to Initial Medications Evaluation | | All Clients | Adults | Children |
|---|---|---|---|---|
| Quarter 1 | Referral to Initial Med Eval (Avg Days) | 33.20 | 33.65 | 30.77 |
| | Percentage that met standard | 26.51% | 24.28% | 38.46% |
| | Number of Referrals | 83 | 70 | 13 |
| | Number of No Shows | 17 | 14 | 3 |
| Quarter 2 | Referral to Initial Med Eval (Avg Days) | 28.49 | 27.61 | 32 |

| OUTPATIENT PSYCHIATRY: 75% WITHIN 21 DAYS<br>Referral to Initial Medications Evaluation | | All Clients | Adults | Children |
|---|---|---|---|---|
| | Percentage that met standard | 41% | 45% | 25% |
| | Number of Referrals | 100 | 80 | 20 |
| | Number of No Shows | 24 | 22 | 2 |
| Quarter 3 | Referral to Initial Med Eval (Avg Days) | 26.63 | 26.22 | 29.88 |
| | Percentage that met standard | 49.38% | 48.61% | 55.55% |
| | Number of Referrals | 81 | 72 | 9 |
| | Number of No Shows | 22 | 21 | 1 |
| Quarter 4 | Referral to Initial Med Eval (Avg Days) | 29.45 | 29.56 | 28.72 |
| | Percentage that met standard | 38.63% | 40.26% | 27.27% |
| | Number of Referrals | 88 | 77 | 11 |
| | Number of No Shows | 17 | 15 | 2 |
| FY 17-18 | Average Days | 29.16 | 29.19 | 30.66 |
| | Percentage that met standard | 38.92% | 39.8% | 34% |
| | Number of Referrals | 355 | 299 | 56 |
| | Number of No Shows | 80 | 72 | 8 |

**Summary:** The average wait time in fy 2018-2019 was 29 days from the date the medication referral was received. While this continues to fall short of our internal goal of 21 days, it is a significant improvement from the 45 day average of fy 2016-2017. The wait time for children is greater and this is partially due to the necessity of the initial medication evaluation being performed by a psychiatrist and not a Family Nurse Practictioner.

4. **Timeliness of service for urgent conditions** is measured from the day the request for urgent service is made, to the day of the consumer's appointment with a provider/clinician; our goal is 2 business days for psychiatry and 1 business day for counseling/case management. We define an "urgent" condition as being when the threat of decompensation is imminent and will probably lead to acute hospitalization without treatment. We also measure accessibility for "expedient" conditions (for psychiatry only), which we define as special requests from clinicians for timely medical appointments for their consumers, or for medication appointments after recent hospital discharges.
   - Average length of time for urgent appointment
   - MHP standard or goal
   - Percent of appointments that meet this standard
   - All, Adult, Children

**Summary**: In Fiscal year 2017-2018 there was only one urgent referral for non-medical out-patient services. This was preceided by no urgent referrals for non-medical

out-patient services in fy 2016-2017. It is recommended that this monitoring item be discontinued.

| URGENT MED APPOINTMENT: 2 DAYS | | All | Adults | Children |
|---|---|---|---|---|
| Quarter 1 | Referral to appointment | N/A | N/A | N/A |
| | Percent that met standard | N/A | N/A | N/A |
| | Number of referrals | 0 | 0 | 0 |
| Quarter 2 | Referral to appointment | 1 | 1 | N/A |
| | Percent that met standard | 100% | 100% | N/A |
| | Number of referrals | 1 | 1 | 0 |
| Quarter 3 | Referral to appointment | N/A | N/A | N/A |
| | Percent that met standard | N/A | N/A | N/A |
| | Number of referrals | 0 | 0 | 0 |
| Quarter 4 | Referral to appointment | N/A | N/A | N/A |
| | Percent that met standard | N/A | N/A | N/A |
| | Number of referrals | 0 | 0 | 0 |
| Total | Referral to appointment | 1 | 1 | 0 |
| | Percent that met standard | 100% | 100% | N/A |
| | Number of referrals | 1 | 1 | 0 |
| EXPEDIENT MED APPOINTMENT: 14 DAYS | | All | Adults | Children |
| Quarter 1 | Referral to appointment (Avg.) | 16 | 22 | 10 |
| | Percent that met standard | 50% | 0% | 100% |
| | Number of referrals* | 2 | 1 | 1 |
| Quarter 2 | Referral to appointment (Avg.) | 8.25 | 8.25 | N/A |
| | Percent that met standard | 100% | 100% | N/A |
| | Number of referrals* | 4 | 4 | 0 |
| Quarter 3 | Referral to appointment | 7.71 | 6.66 | 14 |
| | Percent that met standard | 100% | 100% | 100% |
| | Number of referrals* | 7 | 6 | 1 |
| Quarter 4 | Referral to appointment | 20 | 20.66 | 16 |
| | Percent that met standard | 50% | 42.8% | 0% |
| | Number of referrals* | 8 | 7 | 1 |
| Total | Referral to appointment | 11.85 | 11.61 | 13.33 |
| | Percent that met standard | 71.14% | 72.22% | 66.66% |
| | Number of referrals* | 21 | 18 | 3 |

*Corrected to count only referrals for which the client followed through with an appointment.

**Summary:** In FY 2017-2018 the average wait time for an expedited medication referral was 11.85 days. This meets our internal goal of 14 days.

5. **Timeliness of access to after-hours care** is measured from the time our crisis clinician receives a call requesting a 5150/5585 assessment to the time s/he arrives at the ER. Our goal is that 90% of the calls will be responded to within 60 minutes at the Hanford ER (Adventist Health).
   - Due to concerns beginning with FY15-16 about the reliance on self-report for this data, an audit mechanism was implemented. We have continued to cross-reference self-report with the system-logged time from the after-hours call response report, and have combined it into one report.

| CALCULATED ON CRISIS WORKER SELF-REPORT, CROSS-REFERENCED TO SYSTEM RESPONSE TIME | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | TOTAL |
| NUMBER OF CRISIS CALLS | 98 | 88 | 72 | 98 | 70 | 82 | 82 | 94 | 108 | 119 | 99 | 90 | 1100 |
| COMPLIANT RESPONSES | 93 | 84 | 67 | 93 | 68 | 77 | 76 | 82 | 98 | 107 | 79 | 77 | 1001 |
| | 95% | 95% | 93% | 95% | 97% | 94% | 94% | 87% | 91% | 90% | 80% | 85% | 91% |

**Summary:** Kings View responded to requests for crisis evaluations, within one hour, 91% of the time. One pattern that emerged was that the more requests that come in the greater our response time. Looking at how shifts are staffed, especially in the evenings and weekends, is becomes evident.

## D. Evidence of Compliance with Cultural & Linguistic Competence

1. **Cultural Competency training**. Kings View has standardized its cultural competency training for its administrative, management, and clinical staff. This includes: 1) a policy identifying minimum standards for staff training; 2) an identified training coordinator; 3) provision or facilitation of at least four CLAS training opportunities for staff during the year; and 4) monitoring of staff conformance to cultural competency training policies.
   - Evidence of implementation of cultural competency training programs shall be reported quarterly to QIC.
   - Refer to Administrative Directive AO #38.

   **Summary**: Durring the fiscal year of 2017-2018, 34 out of 68 staff (50%) achieved their 4 hours of cultural humility training. Another 14 staff achieved 3 hours of cultural competency training.