Kings View Counseling Services for Kings County

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.

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FY 2017-2018

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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 |  |  |  |  |  |
| Reversals |  |  |  |  |  |
| Totals |  |  |  |  |  |
| Amount |  |  |  |  |  |

**Update-Medi-Cal Violations**:

**HIPAA Violations**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| HIPAA Violations | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Total |
| Standard |  |  |  |  |  |
| Breach |  |  |  |  |  |
| Totals |  |  |  |  |  |

**Update-HIPAA Violations**:

**Beneficiary Rights**:

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

**Update-Beneficiary Rights**:

**Notice of Action**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Notice of Action | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Totals |
| NOA-A\* |  |  |  |  |  |
| NOA-B |  |  |  |  |  |
| NOA-C |  |  |  |  |  |
| Totals |  |  |  |  |  |

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

FY17-18 will need to be added.

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NOA-A Counts byAge 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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Quarter 2 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Quarter 3 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Quarter 4 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Totals |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Update-NOA-A by Age (MH Intakes Only)**: FY 2016-2017 data appears to reveal a significant concentration of NOA-As in ages 6-15. This age group makes up 40% of all the intake assessments for FY16-17 and 43% of all NOA-As. This trend will be further monitored in FY17-18.

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

Data from FY 2017-2018 will need to be added.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|   | 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 – Asian/Pacific Islander | Hispanic - Caucasian/White | Hispanic –Hispanic | Native American - Hispanic | Totals |
| Quarter 1 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Quarter 2 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Quarter 3 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Quarter 4 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Totals |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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

Data from FY 2017-2018 to be added.

**Update-Notice of Action-A**: NOA-A by Client ethnicity vs clinician ethinicity (MH Intakes Only): FY 2017-2018 will be the second year of review for this element. In FY 2016-2017 the largest ethnic group to receive a NOA-A was the Hispanic client. However, there was only a moderate difference in the frequency that a NOA-A was issued by a Caucasian clinician or an Hispanic clinician. More review on this item is necessary.

**Change of Provider Requests**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  Change of Provider | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Total |
|   | Requests | Approved | Requests | Approved | Requests | Approved | Requests | Approved | Requests | Approved |
| Adult beneficiaries |  |  |  |  |  |  |  |  |  |  |
| Child beneficiaries |  |  |  |  |  |  |  |  |  |  |
| Total |  |  |  |  |  |  |  |  |  |  |

Data from FY 2017-2018 will be added.

**Update-Change of Provider Requests**: The overall requests for change of providers has remained fairly constant over the last two fiscal years (FY 15-16 = 21 & FY 16-17 = 26). In FY16-17 92.3% of requests came from adults and 7.7% regarding children. In FY 16-17 72.7% of the requests came from female consumers verses 27.3% from male consumers. In addition, 50% of all requests came from Caucasian consumers followed by 23% for Hispanic consumers. This item will continue to be monitored.

**Provider Appeal Request**: Provider appeal may be received in response to managed care’s denial of a service authorization request or service claim. Provider appeals are continuously monitored as a function of managed care authorization and service review activities, but historically, have been so infrequent as to preclude trend analysis. This is a permanent QWP monitoring activity item, as specified by DHCS contract, Exhibit A Attachment 1(22)(J)(1).

Evidence of monitoring of this action has included Treatment Authorization Request (TAR; for acute inpatient services), MCO (provider claims), TBS (Therapeutic Behavior Services by Family Builders and JDT Consultants), and Katie A processing logs, all of which are maintained as part of managed care service authorization activities.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Provider Appeal | Acute Inpatient | Denial Reversed | TBS-FB | Denial Reversed | TBS-JDT | Denial Reversed | Katie A | Denial Reversed | MCO\* | Denial Reversed |
| Quarter 1 |  |  |  |  |  |  |  |  |  |  |
| Quarter 2 |  |  |  |  |  |  |  |  |  |  |
| Quarter 3 |  |  |  |  |  |  |  |  |  |  |
| Quarter 4 |  |  |  |  |  |  |  |  |  |  |
| Totals |  |  |  |  |  |  |  |  |  |  |

(\*)Formal appeals for MCO are presumed for MCO claims associated with TAR appeals that resulted in reversal of denial(s); such claims which were previously denied because an inpatient day was denied are automatically changed to approval of payment.

**Update-Provider Appeal**: During FY16-17 there was only one provider appeal and that was in the 3rd quarter. The appeal was approved and the initial denial was reversed.

**Summary:**

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

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

**Update-Second Opinion Requests**: There was one request for second opinion during this fiscal year. The additional occurrences shown in the table above are reported as the result of the client having received NOA-A and presenting again within 6 months for an assessment, and/or being related to complaints received about a previous assessment. Four NOA-As were reversed and two were upheld. The one request received resulted in the client being no-show for the scheduled assessment.

3. 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.

Data from FY 2017-2018 to be added.

*Annual Utilization Review Approval vs. Disapproval Rates:*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| FY16-17 | Charts | Disapproved | % | Approved | % |
| MH |  |  |  |  |  |
| SUD |  |  |  |  |  |
| Meds |  |  |  |  |  |
| Totals |  |  |  |  |  |

Quarter 1: MH: MEDS: SUDS:

Quarter 2: MH: MEDS: SUDS:

Quarter 3: MH: MEDS: SUDS:

Quarter 4: MH: MEDS: SUDS:

Annual Summary:

4. 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).

Data from FY 2017-2018 to be added.

**Update:**

5. Program Capacity: Program Capacity by Consumer Descriptors and Under- and Over-Utilization of Services. As a step towards increasing our understanding of program capacity, the number of consumers being served, as cross-referenced to various consumer descriptors (e.g., gender, race, ethnicity, age, language, etc.), began to be monitored in FY 2013-2014. Results were reported quarterly. This monitoring activity was established pursuant to APS Healthcare’s EQRO review and QIC recommendation. In and of itself, this data was seen as having limited value at the close of FY 2013-2014, by being too general to relate to specific concerns and/or interventions. In FY 2014-2015, consumer descriptors were added to various other, more specific items tracked by the QWP, in an attempt to extract more meaningful use from this effort. This review topic was amended in FY 2015-2016 and 2016-2017 to include other specific QWP items that monitor aspects of under- and over-utilization of services, as required by 42 CFR § 438.240(b)(3), and as specified by DHCS contract, Exhibit A Attachment 1(22)(E).

6. 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.

Data from FY 2017-2018 to be added.

Data from FY 2017-2018 to be added.

Data from FY 2017-2018 to be added.

**Summary:**

7. 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 intak 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. The Quality Work Plan will now monitor the occurance of under-utilized intake assessment slots in the hopes of allocating resources where needed and only where needed.

**Summary:**

8. 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

**Summary**:

**Summary**:

9. 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.

 AMENDED FOR FY 2015-2016: The sample size was increased from 45 to 75 (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 |  |  |  |
| OCT-DEC |  |  |  |
| JAN-MAR |  |  |  |
| APR-JUN |  |  |  |

**Summary:**

10. Monitoring of provider network credentials, as an indicator of program integrity, is performed monthly by the QM Administrative Specialist and Administrative Support Staff, with second-level audit/oversight provided by the Compliance Specialist. The following data sources are checked: licensing/certifying association/governmental organization, NPPES, Medi-Cal’s suspended and ineligible providers list, Office of Inspector General’s excluded providers list, the Data Bank, and SAM-EPLS. This is a permanent QWP monitoring activity item, as specified by DHCS contract, Exhibit A Attachment 1(22)(C), and by the Annual Review Protocol for Consolidated Specialty Mental Health Services.

Evidence of monitoring is maintained in logs saved electronically to a secured QM network folder. Addition of this item is an amendment for FY 2014-2015. QIC shall review monitoring outcomes and make recommendations relevant to improving systemic outcomes.

**Summary**:

# 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/discharges and the average number of hospital days per admission. IRC thusly reports that data back to the QIC.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| FY16-17 | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | ANNUAL |
| DISCHARGES |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DAYS |  |  |  |  |  |  |  |  |  |  |  |  |  |
| AVERAGE STAY |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| TREND/COMPARISON | FY 2016-2017 | FY 20170 |
| D/C’S | DAYS | AVERAGE | D/C’S | DAYS | AVERAGE |
| QUARTER 1 | 46 | 296 | 6.43 |  |  |  |
| QUARTER 2 | 49 | 460 | 9.39 |  |  |  |
| QUARTER 3 | 56 | 383 | 6.84 |  |  |  |
| QUARTER 4 | 58 | 426 | 7.34 |  |  |  |
| ANNUAL | 209 | 1565 | 7.49 |  |  |  |

**Summary**:

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.

|  |  |  |  |
| --- | --- | --- | --- |
|   | Unduplicated Crisis Episodes | Hospital Admissions Initiated by MHP | Hospitalization Rate |
| Quarter 1 |  |  |  |
| Quarter 2 |  |  |  |
| Quarter 3 |  |  |  |
| Quarter 4 |  |  |  |
| Total |  |  |  |

**Update**:

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).

 The current QIC membership includes licensed and unlicensed clinicians and providers, administrative (non-clinical) staff members, representative(s) of Kings County Behavioral Health, a consumer family member, adult consumer member (not employed by Kings View or Behavioral Health), and a TAY consumer member (not employed by Kings View or Behavioral Health).

 Evidence of active participation and expression of varied perspectives by QIC members is documented in QIC meeting minutes.

**Update:**

The following are committees that are represented and routinely report to QIC:

* Safety Committee
* Inpatient Utilization Review Committee
* Clinical Practices Committee (no clinical supervisors or managers)
* IMD Committee
* Cultural Competency Taskforce/CCC
* Utilization Review Committee

|  |  |  |
| --- | --- | --- |
|  | QIC Membership & Attendance for FY 2017-2018 |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |
| X= Attended E= Excused Absence A= Unexcused Absence CX=Meeting Canceled NA=Not applicable | July 2017 | August 2017 | Sept 2017 | October 2017 | Nov 2017 | Dec 2017 | Jan 2018 | Feb 2018 | March 2018 | April 2018 | May 2018 | June 2018 |
| Cris Hernandez |  |  |  |  |  |  |  |  |  |  |  |  |
| Delia Velho |  |  |  |  |  |  |  |  |  |  |  |  |
| Eric Douglass |  |  |  |  |  |  |  |  |  |  |  |  |
| George Gomez |  |  |  |  |  |  |  |  |  |  |  |  |
| Rich Smith |  |  |  |  |  |  |  |  |  |  |  |  |
| Juan Orozco |  |  |  |  |  |  |  |  |  |  |  |  |
| Kerri Freeman |  |  |  |  |  |  |  |  |  |  |  |  |
| Unchong Parry |  |  |  |  |  |  |  |  |  |  |  |  |
| Linda Swaffar |  |  |  |  |  |  |  |  |  |  |  |  |
| Lupe Wong |  |  |  |  |  |  |  |  |  |  |  |  |
| Marissa Valero |  |  |  |  |  |  |  |  |  |  |  |  |
| Nora Lynn |  |  |  |  |  |  |  |  |  |  |  |  |
| Darrell Hamilton |  |  |  |  |  |  |  |  |  |  |  |  |
| Yolanda Estrada |  |  |  |  |  |  |  |  |  |  |  |  |
| Alex Rocha |  |  |  |  |  |  |  |  |  |  |  |  |
| Darrel Hamilton |  |  |  |  |  |  |  |  |  |  |  |  |
| TAY Consumer Member |  |  |  |  |  |  |  |  |  |  |  |  |
| Adult Consumer Member |  |  |  |  |  |  |  |  |  |  |  |  |
| Consumer Family Member |  |  |  |  |  |  |  |  |  |  |  |  |

4. EVALUATION OF THE QUALITY MANAGEMENT PROGRAM: The QM Program shall be evaluated annually and updated as necessary per CCR Title 9, § 1810.440(a)(6) and 42 CFR § 438.240(e).

* The QM Director or designee shall appear before the MH Advisory Board to describe QM activities, priorities, and QI projects (as described in the QWP) at least annually.
* The QWP shall be revised as needed and annually, so as to show how QI activities have contributed to improvement in clinical care and beneficiary service.
* QIC shall be shown to be involved in recommending policy decisions, reviewing and evaluating the results of QI activities, instituting needed QI actions, ensuring follow-up of QI processes, and documenting QI committee meeting minutes.
* Appropriate follow-up activities will evidence that timely interventions are implemented when quality of care concerns are identified. Such items shall be listed below when not addressed by standing items.

Quarter 1 Summary:

Quarter 2 Summary:

Quarter 3 Summary:

Quarter 4 Summary:

# C. Completed and In-Process QM Activities

1. Impact of Prevention and Early Intervention Contacts on Reducing Rate of Re-hospitalization: The focus of this item was to consider the impact of timely post-hospitalization contacts of consumers on the rate of re-hospitalization within 30 days of discharge. Re-hospitalization rates have fallen from a high of 28% to a low of 14%. We have reached our internal goal of **15% or less** only one year (FY 2014-2015). The re-hospitalization rate for FY 2016-2017 was 18.72%.

| GOAL: 15% OR LESS | All | Adults | Children |
| --- | --- | --- | --- |
| Quarter 1 | Admissions |  |  |  |
|  | Readmitted <30 days |  |  |  |
|  | Re-hospitalization Rate | % | % | % |
| Quarter 2 | Admissions |  |  |  |
|  | Readmitted <30 days |  |  |  |
|  | Re-hospitalization Rate | % | % | % |
| Quarter 3 | Admissions |  |  |  |
|  | Readmitted <30 days |  |  |  |
|  | Re-hospitalization Rate | % | % | % |
| Quarter 4 | Admissions |  |  |  |
|  | Readmitted <30 days |  |  |  |
|  | Re-hospitalization Rate | % | % | % |
| Totals | Admissions |  |  |  |
|  | Readmitted <30 days |  |  |  |
|  | Re-hospitalization Rate | % | % | % |

**Summary**:

2. 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 to QIC 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 | *P-VALUE* | AVERAGE SCALE SCORE AT COMPLETION |
| QUARTER 1 |  |  |  |  |  |  |  |
| QUARTER 2 |  |  |  |  |  |  |  |
| QUARTER 3 |  |  |  |  |  |  |  |
| QUARTER 4 |  |  |  |  |  |  |  |

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 | *P-VALUE* | AVERAGE SCALE SCORE AT COMPLETION |
| QUARTER 1 |  |  |  |  |  |  |  |
| QUARTER 2 |  |  |  |  |  |  |  |
| QUARTER 3 |  |  |  |  |  |  |  |
| QUARTER 4 |  |  |  |  |  |  |  |

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.

Quarter 1 Summary:

Quarter 2 Summary:

Quarter 3 Summary:

Quarter 4 Summary:

Annual Summary:

3. 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 to QIC by the Kings View Corporate Director of Quality Improvement.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| DIFFICULTY WITH EMOTIONAL RESPONSE SCALE (DERS) | PAIRED SETS | CONVERSLY SCORED CHANGE FROM PRE TO POST- AVG | REVERSED SCORED FROM PRE TO POST- AVG | COMBINED CHANGE FROM PRE TO POST – AVG  | % CHANGE | *P-VALUE* | NOTE |
| QUARTER 1 |  |  |  |  |  |  |  |
| QUARTER 2 |  |  |  |  |  |  |  |
| QUARTER 3 |  |  |  |  |  |  |  |
| QUARTER 4 |  |  |  |  |  |  |  |
| TOTAL |  |  |  |  |  |  |  |

COMBINED SCORES ARE REPORTED.

Quarter 1 Summary:

Quarter 2 Summary:

Quarter 3 Summary:

Quarter 4 Summary:

Annual Summary:

4. CLINICAL PIP – COLLABORATIVE DOCUMENTATION: Collaborative Documentation is a process for clinicians and clients to collaborate in the documentation of new and updated assessments, new service plans and reviews, and progress notes—office based or in community—with individuals, families and groups. The mental health plan recognizes that clinicians spend a great deal of time documenting and often are challenged with meeting productivity for actual time spent with clients. A concurrent issue may be that clients are not as engaged, nor are they given enough opportunity to provide their input and perspective on services and progress. From the consumer perspective, there is evidence to suggest that the practice of collaborative documentation is effective in promoting consumer involvement, improved treatment outcomes, and more positive treatment experiences. From the provider perspective, there is evidence of improved understanding and cooperation between the therapist and consumer, improved treatment outcomes and improved workplace satisfaction. The study question for this PIP is this: Will the implementation of Collaborative Documentation improve the level of Client Engagement and Involvement for our consumers when compared to past experiences?

*Intervention: Collaborative Documentation*

* Kings View will facilitate the training of identified staff in the process of Collaborative Documentation.
* Participating Kings View providers will identify 20% of their clients in which Collaborative Documentation can be used.
* Providers will administer to consumers the “Client Response to Collaborative Documentation Program.”
* Participating staff will complete the “Staff Response to Collaborative Documentation Program.”

*Data Collection:*

* Quality Improvement staff will collect data from the “Client Response to Collaborative Documentation Program” form. This is a four question survey. Questions include:
	+ “How helpful was it to have your provider review your note with you at the end of the session?”
	+ “How involved did you feel in your care?”
	+ “How well did the provider do in introducing you to the new system of documentation?”
	+ “Do you want your provider to continue to include you in the documentation process?”
* Quality Improvement staff will collect data from the “Staff Response to Collaborative Documentation Program” form. This is a six question survey that includes the following:
	+ “How long have you been doing collaborative documentation?”
	+ “How easy was it to learn collaborative documentation?”
	+ “How helpful was collaborative documentation?”
	+ “How involved were your clients in collaborative documentation?”
	+ “How helpful was collaborative documentation on your paperwork proficiency?”
	+ “Has collaborative documentation impacted your workplace satisfaction?”
* Quality Improvement staff will also collect data on consumer responses to the consumer satisfaction survey question 19, “Staff helped me to obtain the information I needed so that I could take charge of managing my illness.

*Performance Indicators:*

* Consumer response to question number 2 on the “Client Response to Collaborative Documentation Program” (i.e., “How involved did you feel in your care?”) will rank as “involved” or “very involved” 97% of the time.

**Update:** While early data (May to June 2017) has indicated that Collaborative Documentation is successful in improving client perception of involvement in the therapy process. Consumer response to question 1 “*Did you find Collaborative Documentation to be helpful?*” reached 85.9% helpful or very helpful in the preliminary data. Question 2 “*Did Collaborative Documentation help you feel more involved in the treatment process?”* had a positive response in 87.19% cases. Question 4 “*Do you want your provider to continue with Collaborative Documentation?*” had a positive response in 97.4% of the cases. We anticipate completion of data collection by the end of December 2017 and the conclusion of data analysis by February of 2018.

5. NON-CLINICAL PIP – TIMELY ACCESS TO MENTAL HEALTH ASSESSMENT

 AS A RESULT OF THE OPEN ACCESS MODEL: Due to the complex nature of psychological disorders, successful treatment requires timely access treatment services. With increased demand for mental health services, organizations must improve operational efficiencies to offer appointments when needed and to also avoid long wait times. To overcome and improve these barriers pertinent to accessibility of services, specifically a mental health assessment, the Mental Health plan collects and monitors various metrics that align with these efforts to better understand where we have gaps and opportunities to improve. The mental health plan collects data on the length of time from initial contact to first assessment with a standard goal of 14 days for 75% of all appointments. Interventions such as increasing the number of assessment appointments slots and using an alternative strategy for scheduling of appointments appear to have had positive impact on the rate of adult and children gaining access to services; however, despite significant improvement from prior years, the Mental Health Plan had noted the set targets were not being met. In the FY15-16 data collected, only 29.06% of all services met the standard (compared to FY14-15, 22.11%). This included 34.56% for adults and 23.23% for children.

In an effort to improve timely access to a mental health assessment, Kings View implemented the “Open Access” model. The anticipated result of this model is to meet and exceed our standard or 14 days from 1st contact to mental health assessment.

*Intervention: Open Access Model*

* Kings View began utilizing the Open Access Model as the instrument for how consumers enter our system.
* Consumers can walk into the mental health clinic anytime between 8:00am and 2:00pm and request mental health services.
* The consumer will then receive a full screening by the “Daily Screener” (a licensed or registered MFT or licensed SW or ASW clinician). The screening will be initiated within 30 minutes of when the consumer requested services.
* If the consumer is deemed to be eligible for specialty mental health services they will receive a mental health assessment by the next available clinician. The time between screening and assessment should be no more than 2 hours.
* The entire process should be completed in a single day.
* Data and progress report to be provided to QIC on a quarterly basis.

*Data Collection:* The Access Department and Quality Management staff will collect data on a daily basis. This data will include:

* Number of screenings, number of consumers moved on to assessments, and the number of completed assessments each day,
* Number of consumers who were unable to fully complete the intake process and the reason why,
* The utilization of staff necessary to accommodate Open Access,
* The time it takes from walk in to screening, from screening completion to finished assessment, and the amount of time from walk-in to completed assessment.
* The PIP also reviews the consumer satisfaction survey questions 7 and 9.

*Performance Indicators:*

* The time from initial contact to 1st service will be 7 days or less—Goal is 90%.
* Consumers will answer question 7 of the consumer satisfaction survey (Services were available at times that were good for me.) with “agree” or “strongly agree,” 100% of the time.
* Consumers will answer question 9 of the consumer satisfaction survey (Services were available at times that were convenient for me.) with “agree” or “strongly agree,” 100% of the time.

**Update**: Preliminary data collection began in mid April 2017 with early, very positive results. Our ability to meet our timeliness goal for the 4th quarter of last fiscal year increased to near 89%. This is compared to an average quarterly compliance rate of 27.7%. The average wait time increased from a quarterly average of 26 days, down to a quarterly average of 8 days. Data collection for this PIP will be completed in December 2017 and the data analysis soulod be compelted in February 2018.

# D. 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 walk 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.

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.

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.

|  |  |  |  |
| --- | --- | --- | --- |
| OUTPATIENT MH: 80% within 7 days | All | Adults | Children |
| Quarter 1 | Average |  |  |  |
|  | Percent % met |  |  |  |
|  | RANGE |  |  |  |
|  | COUNT |  |  |  |
| Quarter 2 | Average |  |  |  |
|  | Percent % met |  |  |  |
|  | RANGE |  |  |  |
|  | COUNT |  |  |  |
| Quarter 3 | Average |  |  |  |
|  | Percent % met  |  |  |  |
|  | RANGE |  |  |  |
|  | COUNT |  |  |  |
| Quarter 4 | Average |  |  |  |
|  | Percent % met  |  |  |  |
|  | RANGE |  |  |  |
|  | COUNT |  |  |  |
| FY16-17 | Average |  |  |  |
|  | Percent % met |  |  |  |
|  | RANGE |  |  |  |
|  | COUNT |  |  |  |

**Summary:**

**Additional Summary**:

| OUTPATIENT PSYCHIATRY: 75% WITHIN 21 DAYSReferral to Initial Medications Evaluation | All Clients | Adults | Children |
| --- | --- | --- | --- |
| Quarter 1 | Referral to Initial Med Eval (Avg Days) |  |  |  |
|  | Percentage that met standard |  |  |  |
|  | Number of Referrals |  |  |  |
|  | Number of No Shows |  |  |  |
| Quarter 2 | Referral to Initial Med Eval (Avg Days) |  |  |  |
|  | Percentage that met standard |  |  |  |
|  | Number of Referrals |  |  |  |
|  | Number of No Shows |  |  |  |
| Quarter 3 | Referral to Initial Med Eval (Avg Days) |  |  |  |
|  | Percentage that met standard |  |  |  |
|  | Number of Referrals |  |  |  |
|  | Number of No Shows |  |  |  |
| Quarter 4 | Referral to Initial Med Eval (Avg Days) |  |  |  |
|  | Percentage that met standard |  |  |  |
|  | Number of Referrals |  |  |  |
|  | Number of No Shows |  |  |  |
| FY 16-17 | Average Days |  |  |  |
|  | Percentage that met standard |  |  |  |
|  | Number of Referrals |  |  |  |
|  | Number of No Shows |  |  |  |

**Summary:**

2. 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

| URGENT MH\* APPOINTMENT: 1 DAY | All | Adults | Children |
| --- | --- | --- | --- |
| Quarter 1 | Intake to therapist contact  |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals |  |  |  |
| Quarter 2 | Intake to therapist contact  |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals |  |  |  |
| Quarter 3 | Intake to therapist contact  |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals |  |  |  |
| Quarter 4 | Intake to therapist contact  |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals |  |  |  |
| Total | Intake to therapist contact  |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals |  |  |  |

(\*) NON-PSYCHIATRIC SERVICE

**Summary**: In Fiscal year 2016-2017 there were no Urgent referrals made for outpatient mental health services. The lack of urgent referrals may be worthy of future review.

| URGENT MED APPOINTMENT: 2 DAYS | All | Adults | Children |
| --- | --- | --- | --- |
| Quarter 1 | Referral to appointment |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals |  |  |  |
| Quarter 2 | Referral to appointment |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals |  |  |  |
| Quarter 3 | Referral to appointment |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals |  |  |  |
| Quarter 4 | Referral to appointment |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals |  |  |  |
| Total | Referral to appointment |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals |  |  |  |

| EXPEDIENT MED APPOINTMENT: 14 DAYS | All | Adults | Children |
| --- | --- | --- | --- |
| Quarter 1 | Referral to appointment |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals\* |  |  |  |
| Quarter 2 | Referral to appointment |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals\* |  |  |  |
| Quarter 3 | Referral to appointment |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals\* |  |  |  |
| Quarter 4 | Referral to appointment |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals\* |  |  |  |
| Total | Referral to appointment |  |  |  |
|  | Percent that met standard |  |  |  |
|  | Number of referrals\* |  |  |  |

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

**Summary:**

3. 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 |  |  |  |  |  |  |  |  |  |  |  |  |  |
| COMPLIANT RESPONSES  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Summary:**

4. Responsiveness of the 24/7 toll-free access telephone line is measured against criteria for call content and by logging of the call with an immediate disposition. Front-line staff and the after-hours contractor (Central Valley Suicide Prevention Hotline) were provided with scripts to ensure that required content elements (i.e., how to access beneficiary services, how to file a grievance, and how to access urgent services) were responded to adequately.

* 4 test calls by a combination of English and non-English speakers are conducted monthly.
* These results are reported to the state quarterly. The test caller worksheet and reporting were updated to conform to the state form.

Quarter 1:

Quarter 2:

Quarter 3:

Quarter 4:

**Summary:**

*Logging:*

*Language:*

# E. 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.

Quarter 1:

Quarter 2:

Quarter 3:

Quarter 4:

**Summary**:

# Appendix I: New and Amended P&P/AD

# Appendix II: Attachments

## 1. 2016-2017 Triennial Systems Review Plan of Correction

## 2. 2016-2017 External Quality Review Response Plan