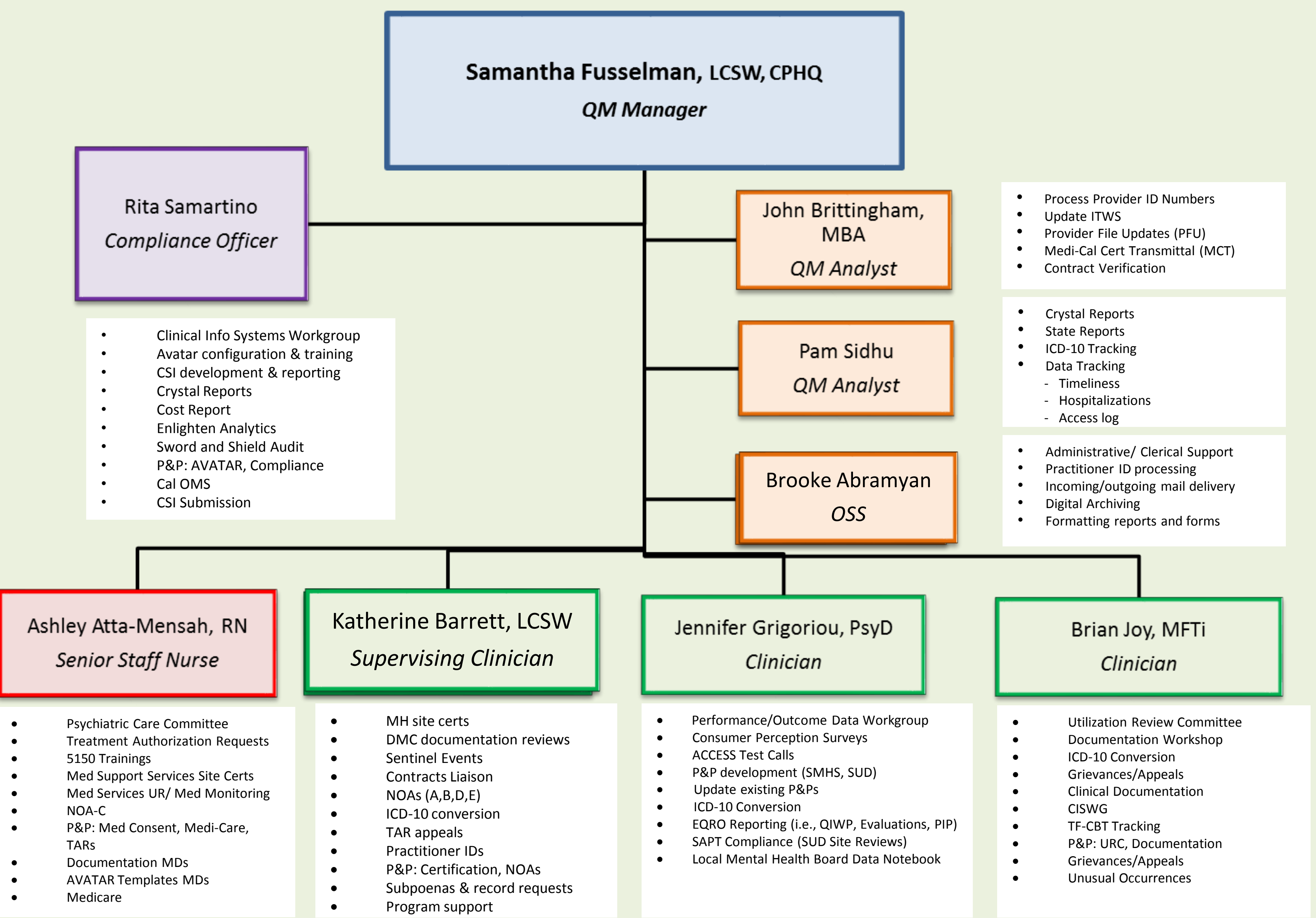
Quality Improvement Committee

January 13, 2016

Changes to Quality Management

- Created new committees and sub-committees/ work groups
- Changed QIC meeting schedule (quarterly on 2nd Wed's; April 6th)
- Provider participation at QIC (Brian)
- Implemented ICD-10 conversion
- QM webpage for consumers and providers
- SAPT/ Triennial Audits brought about changes in monitoring of compliance
- Addition of 2nd analyst = Fully staffed QM

QM Organizational Chart



New Committees/ Sub-committees

COMMITTEE	PURPOSE	EXAMPLES
Performance/ Outcome Data	Make meaningful use of programmatic data	CP Surveys, PIPs, measures
Utilization Review	Ensure documentation meets charting standards	HHSA and Contract Provider chart review submissions
Clinical Documentation	Increase competence, skill level, and accuracy in documentation	Progress notes, tx plans, diagnosis, assessments
Psychiatric Care Committee	Monitor the utilization of high utilizers in treatment	Inpatient stays, follow-up care plans
Medication Monitoring	Review/ monitor medication support services	Medication plans, charts, prescriptions
Clinical Information Systems	Streamline EHR & electronic reporting	AVATAR documentation, dx, billing, etc.
Provider Stakeholder	Collaborate on resources, maintain transparency, keep lines of communication open	Promote quality services & the appropriate/ efficient use of county resources
Drug Medi-Cal Organized Delivery System	Build capacity for SUD/AOD services; prepare for opting into DMC-ODS waiver	RFP's for more SUD/ AOD services; payment schedules for services; fund allocation

What are Provider Sites doing in these Areas?

- Timeliness
- Access
- Quality Improvement
- Penetration Rates
- Performance Outcome Measures

Audits & Reviews

FY 14-15

QI Work Plan Evaluation

DOMAIN	GOALS	MET GOALS?
Service Delivery Capacity	1. Track # beneficiaries served by age, gender, ethnicity, geographic distribution 2. Produce reports on penetration rates 3. Fidelity Assessment of Assertive Community Program 4. Increase training opportunities to staff (UR, documentation, productivity) 5. Improve employee morale, satisfaction, retention, delivery of services	1-2:Partially Met 3-5: Fully Met
Accessibility/ Utilization (of SMHS/ SUD services)	1. Track timeliness of 1st contact & Intake assessment — **42.85%:** w/in 14 days 2. 1st psychiatric service ($\bar{x}$**=53** days following request) — **30.69%:** w/in 30 days 3. Triage appt scheduled for timely 1st contact — **0 data:** in-op service codes 4. Develop ACCESS call log and procedures for logging calls 5. Conduct monthly chart reviews 6. Ensure provision of culturally and linguistically appropriate services	1-3: Partially Met 4-6: Fully Met
Beneficiary Satisfaction	1. Administer/ analyze/ utilize Consumer Perception Survey data 2. Monitor consumer grievances/ appeals- expedited appeals/ state fair hearings- expedited state fair hearings 3. Monitor/ track: NOAs, Change of Provider requests	1-3: Fully Met
Service Delivery	1. Update: Provider Guide, Clinical Survival Guide, materials, authorization requests 2. Streamline coding, billing, and tracking of EHR 3. Monitor EB treatment/ practices (ACT, TF-CBT, Functional Fx Therapy); 4. Conduct chart reviews 5. Targeted Case Management training 6. Develop Medication Monitoring Committee & corrective action process for disallowances 7. Assess performance and identify areas of improvement (i.e., QI on Tap; HHSA integration) 8. Develop strategic plan FY 14-15	1-5: Partially Met 6: Not Met 7-8: Fully Met
Continuity/Coordination of Care	1. Standardize protocol to identify referrals to healthcare providers 2. Increase the amount of collaboration between ADMH and outside healthcare organizations providing primary care	1: Not Met 2: Partially Met
Provider Appeals	1. Monitor provider appeals (No record of provider appeals for FY 14-15) 2. Review provider suggestions for improvement.	1: Not Met 2: Fully Met

FY 15-16

QI Work Plan

DOMAIN	GOALS	MET GOALS?
Service Delivery Capacity	• Increase Hispanic penetration rates • Reduce rate of inactive cases • Develop pop-specific care teams • Hire new Crisis Clinician	**IN PROGRESS**
Accessibility/ Timeliness (of services)	• Offer initial services w/in 14 days ; Urgent Requests: in 48 hours • Newly discharged inpatients have appt w/in 7 days • New Test Call procedure: 6 calls/mo. & 20% threshold language) • New ACCESS log procedure captures 95% beneficiary requests • Assessments: Parity in wait times for Non-English speakers	↓
Beneficiary Satisfaction	• Increase contract provider participation • Increase # of surveys collected (from FY 2014-2015) • Train providers in data collection procedures • Monitor/ track: NOAs, Change of Provider, Grievances/ Appeals	↓
Service Delivery/ Clinical Issues	• ICD-10 Conversion & billing • Update: Clinical Documentation Guide; Provider Guide: Authorization Request forms • Med Monitoring Committee • Track TF-CBT/ ANSA/ CANS/ LOCUS in AVATAR • Train staff on LOCUS • Weekly PCC	
Provider Relations	• Update Prac Enrollment Policy/ Procedures • 14-day turnaround from date of request • Update Cert/ Re-Cert policies & procedures	
Continuity/Coordination of Care	• Provider Stakeholder Work Group: Participation & Collaboration • Identify unmet clinical/ cultural/ linguistic needs or gaps in service	
PIPs	• Develop outcome/ performance measures for FSP/ CHIP • Utilize CP Survey results to improve or adapt services	
Improve Audit Results	• Reduce disallowances due to improper documentation • Continue Utilization Review • Establish baseline allowances: Treatment Plans, Progress Note Entries, Assessments	↓

Practitioner Enrollment Form

This form provides the information required to assign and add a new practitioner ID into the Health and Human Services Agency. A Practitioner ID enrollment form must be completed for all Mental Health and Substance Use Disorder practitioners who provide direct or indirect services to a client. This practitioner must be setup in the AVATAR system if direct or indirect services are to be authorized and/or billed in AVATAR.

Practitioner Enrollment Form Instructions:

All Practitioner ID enrollment request form submissions must be completed in full and signed and dated by both the **Practitioner** and by the **Authorized Provider Representative**. The packet should include search results in the form of screenshots from the following websites:

1. National Plan and Provider Enumeration System https://npiregistry.cms.hhs.gov/NPPESRegistry

2. Office of Inspector General List of Excluded Individuals/Entities Search
http://exclusions.oig.hhs.gov

3. System for Award Management-Search Records
https://www.sam.gov/portal/public/SAM

4. Medi-Cal Suspended and Ineligible Provider List (See link at bottom of web page→Medi-Cal Suspended and Ineligible Provider List)
http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp

Licensed and licensed/waivered practitioners *must include a screenshot of their licensure information in addition to items 1-4 above. Licensure information is available from the websites listed below:*

California Department of Consumer Affairs Breeze License Verification https://www.breeze.ca.gov

California Department of Consumer Affairs Vocational Nursing and Psychiatric Technicians
http://www.bvnpt.ca.gov/license_verification.shtml

California Association of Alcoholism and Drug Abuse Educators – CAADE http://caade.org/membership-search

California Association of DUI Treatment Programs – CADTP http://www.cadtp.org/counselors

California Consortium of Addiction Programs and Professionals- CCAPP https://www.ccapp.us/registry

Practitioner ID enrollment request forms for Mental **Health Rehabilitation Specialist** (MHRS) or **Mental Health Worker** (MHW) must include:

- A completed MHRS or MHW request form
- An image of the applicant's applicable degree (AA, college, Master's or PsyD/PhD)
- A copy of the applicant's resume
- MHW's should also submit a resume indicating that the full-time equivalent direct care experience in a mental health setting was met
- Graduate students need to submit documentation substantiating that they are currently enrolled in school.
- This documentation is in addition to that submitted for licensed/registered individuals.

This Practitioner ID Enrollment form must be completed for all Mental Health and Substance Use Disorder practitioners for direct and or indirect outpatient services provided to Yolo County Health and Human Services Agency HHSA clients.

New Request: ☐ **Update Credentialing/Change Request** ☐

Enclosure(s) check all that apply:

Updated to show all enclosures

1.NPPES ☐ **2.OIG** ☒ **3.SAM** ☐ **4.S&I List** ☐
Breeze License Verification ☐ **Vocational Nursing/Psy Tech** ☐ **CAADE/CADTP/CCAPP register** ☐
MHRS form ☐ **MHW form** ☐ **Master's/College/AA Degree** ☐ **Resume** ☐ **Transcripts** ☐

Date of Request:	**Requested ID Issue date**:	
Name of Agency/Organization:		
Street Address:		
City:	State:	Zip Code:
Telephone:	Email:	
Name of Authorized Representative Completing Form:		

New field

Practitioner Demographics

Name of Practitioner as it appears on NPI and/or license: (Last Name, First Name, MI)

Maiden Name (if applicable):

New field

Sex: ☐ Male ☐ Female Date of Birth Choose an item. Choose an item. YY:

New field

SS#/EIN# NPI Number: Primary Taxonomy Code:

Registration Date : Deactivation Date: Reason:

Practitioner Category : Choose an item. If Other, Please specify:

Area of Degree/Discipline Choose an item. If Other, Please specify

CA License information: ☐ Yes ☐ No License Number: Expiration Date:

New fields

DEA No: Expiration Date:

Billing Site Medi-Cal/Medicare Authorization:

Is office located in a Medi-Cal Authorized billing Site: ☐ Yes ☐ No
If office located in a Medicare Authorized billing site: ☐ Yes ☐ No

I certify that the information listed on this Practitioner ID Request form as submitted to Yolo County HHSA, is accurate and complete, under Title 42, California Code of Regulations, 455.436, 438.214(d) and 438.61.

New field

Practitioner Signature: ______________________ **Date:** ______________.

Provider Authorized Representative Signature: ______________________ **Date:** ______________.

HHSA Use Only – Approval (Clinician ☐ **or Non-Clinician** ☐ **)**

Quality Management Staff Signature **Date**:

Inpatient Utilization

Yolo County Medi-Cal Beneficiaries

Yolo County Medi-Cal Beneficiaries Inpatient Utilization Data

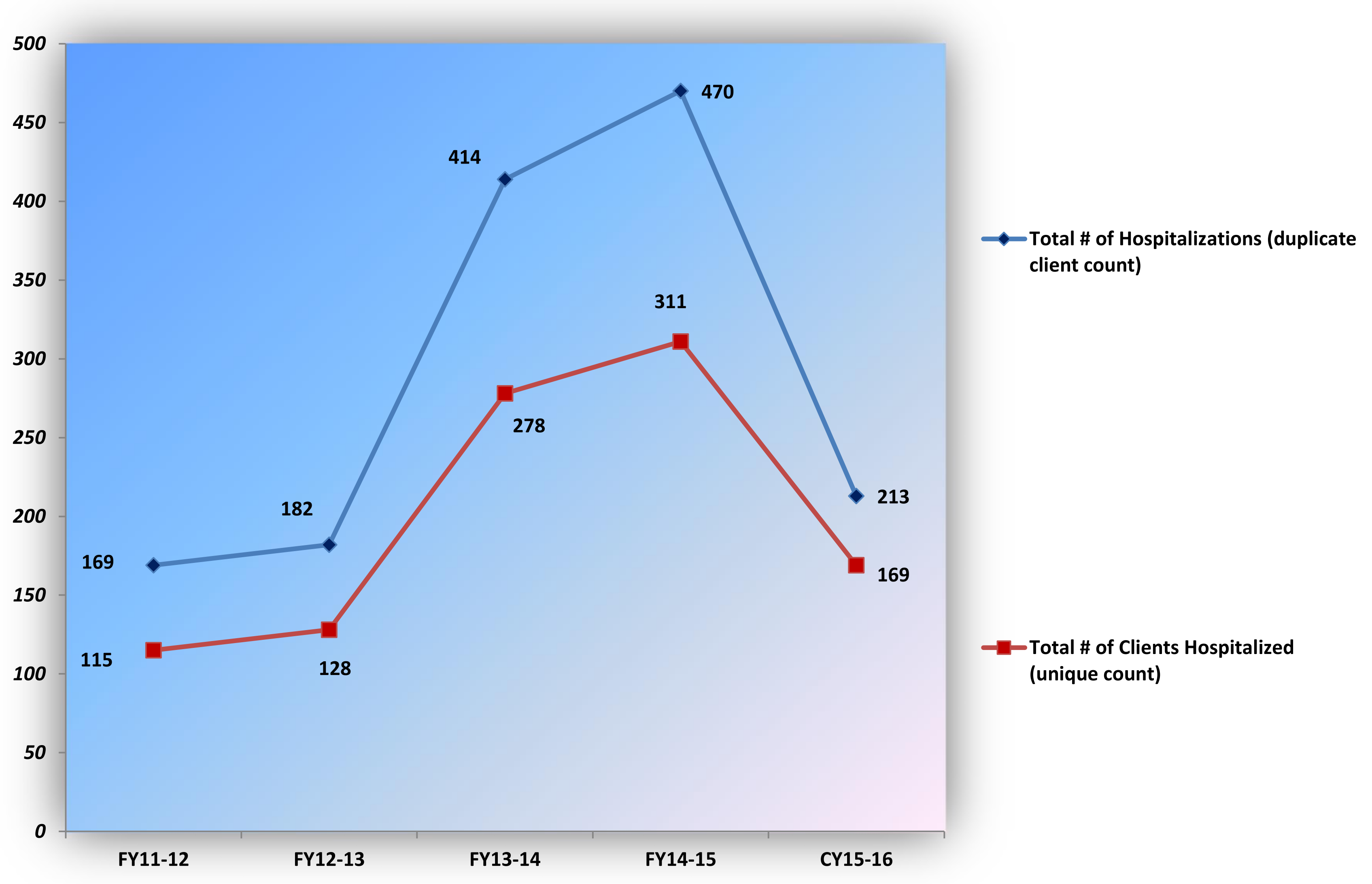
	FY11-12	FY12-13	FY13-14	FY14-15	CY15-16
Total # of hospitalizations (duplicate count)	169	182	414	470	213
Total # of clients hospitalized (unique count)	115	128	278	311	169
Total hospital days	1427	1449	3859	4401	2006
Average length of stay (# of days)	8	8	9	9	9
Total # of re-hospitalizations (w/in 30 days*)	27	28	74	93	34
Total # of re-hospitalizations (duplicate count*)	37	28	74	93	27
Total # of re-hospitalizations (unduplicated*)	20	19	45	53	34
Readmission rate (w/in 7 days**)	6%	5%	9%	7%	8%
Readmission rate (w/in 30 days***)	16%	15%	18%	20%	16%

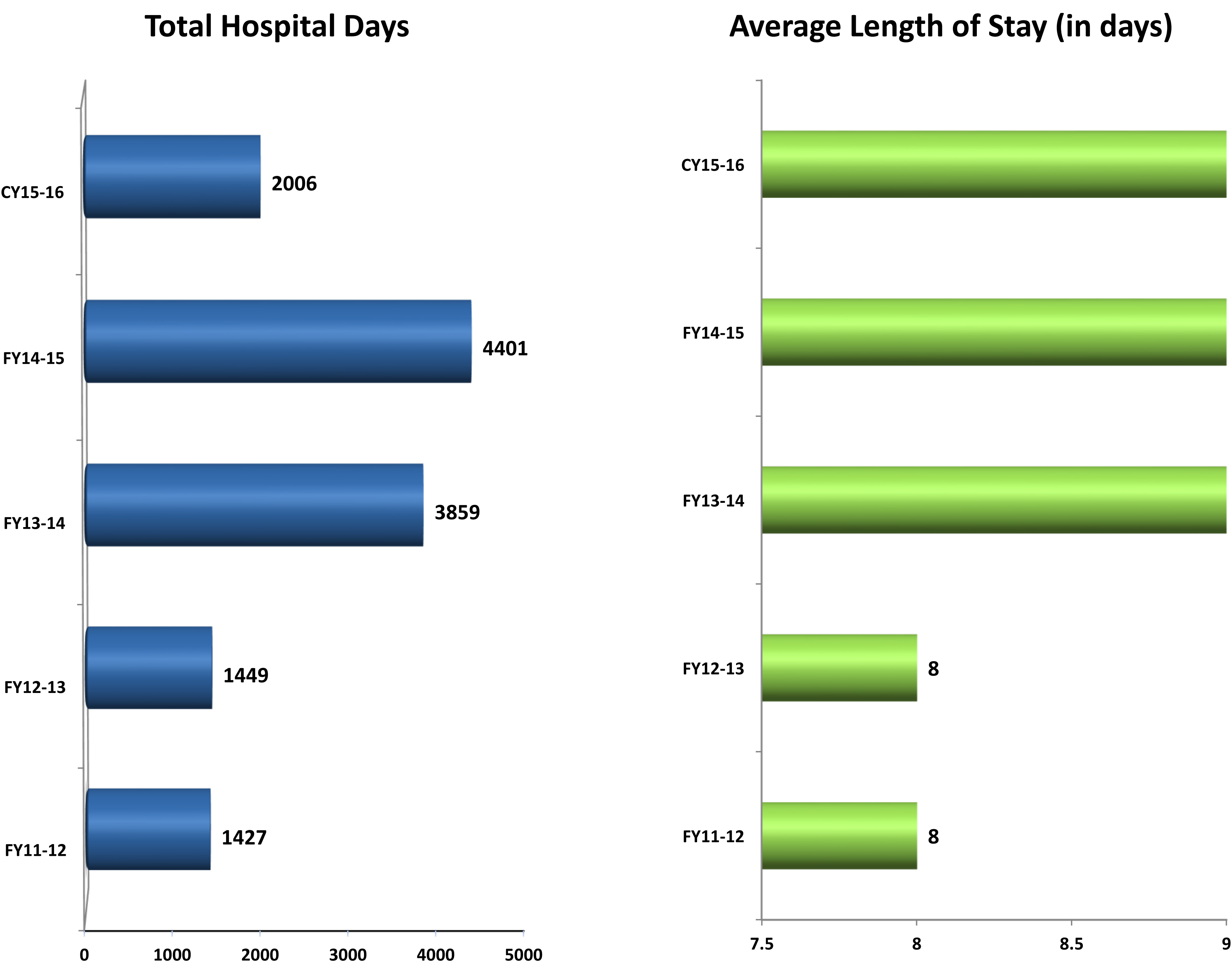
* Re-hospitalizations within 30 days

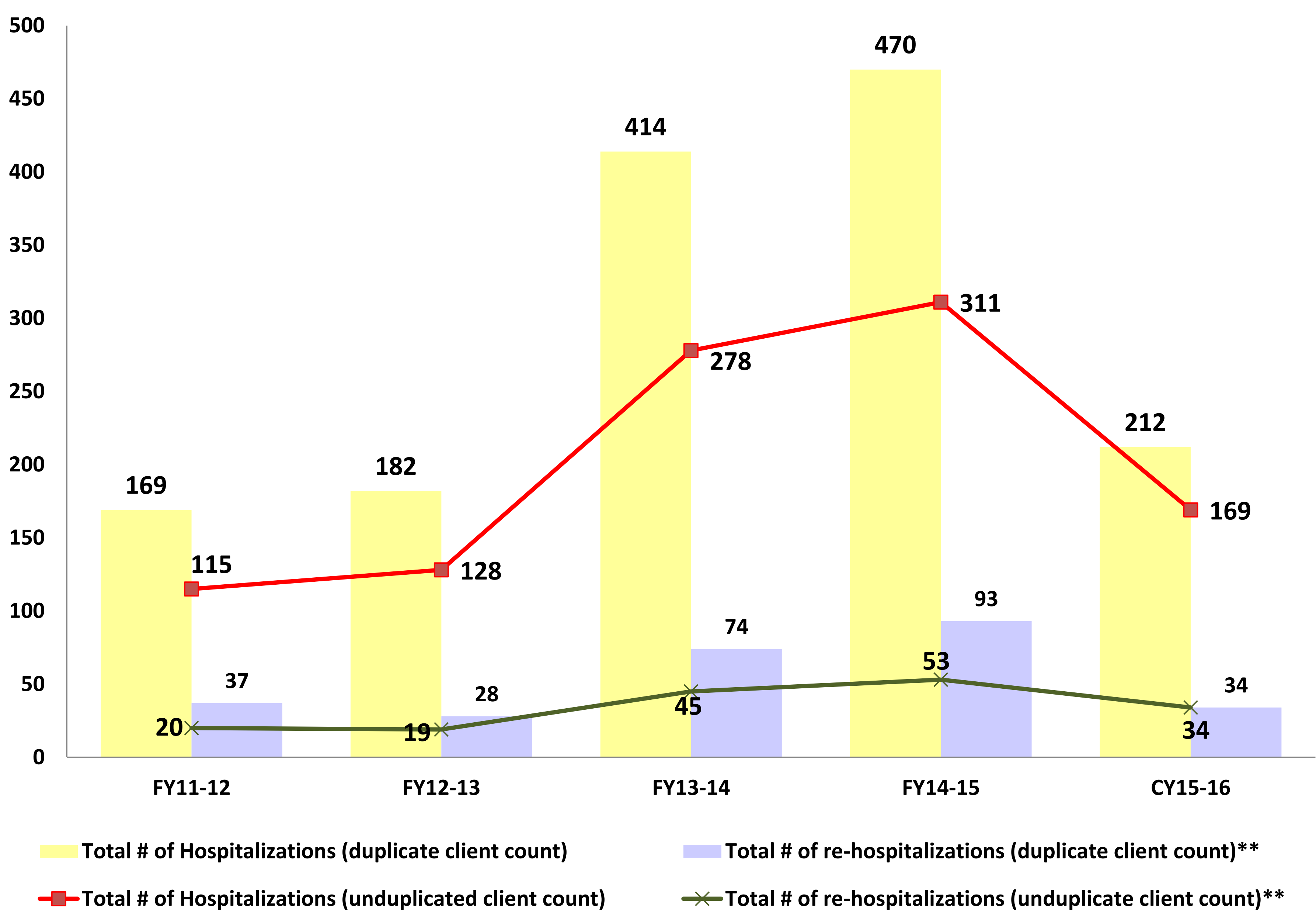
** Statewide readmission averages range between 8 - 9% at 7-days

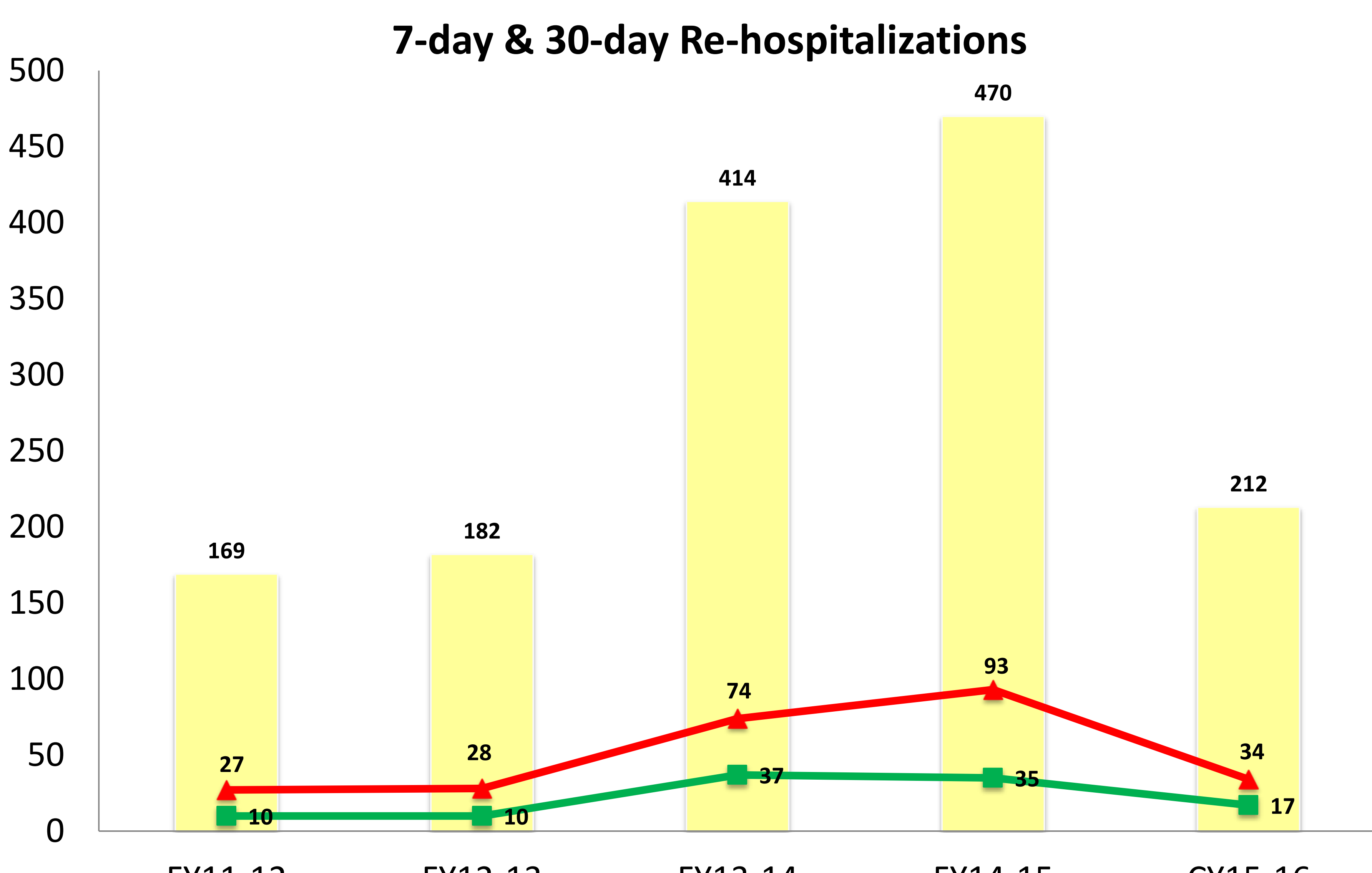
*** Statewide readmission averages range between 18 - 19% at 30-days

Hospitalizations

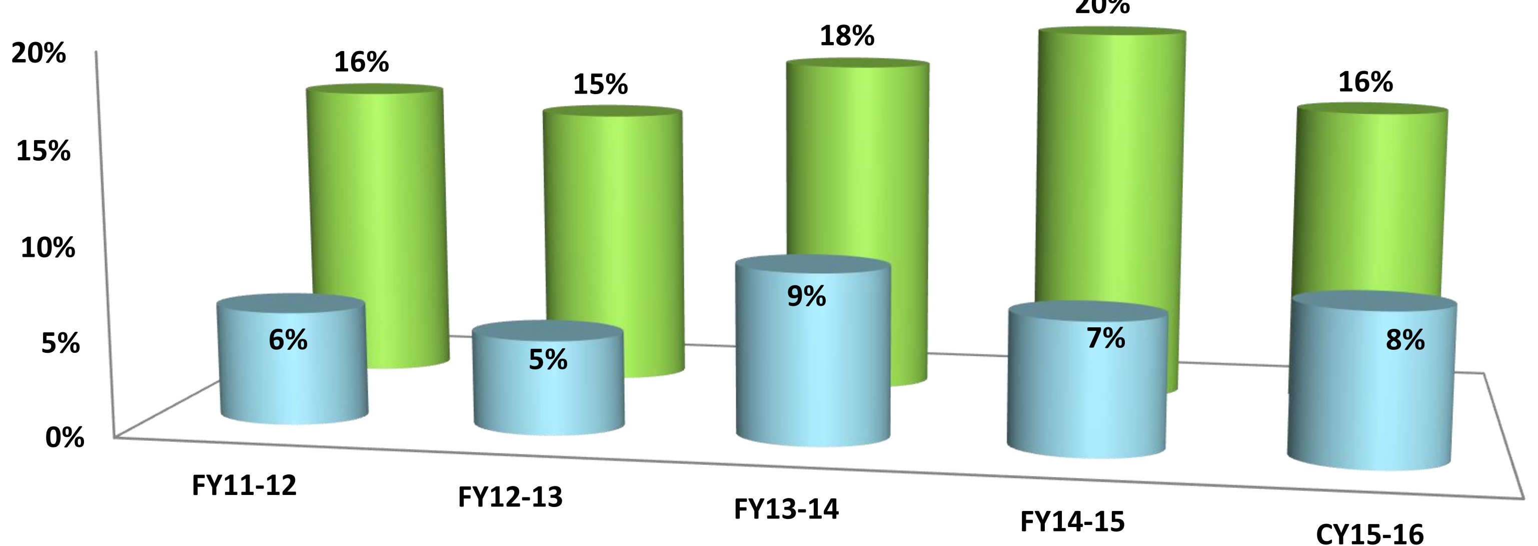



Total Hospital Days
CY15-16
2006
FY14-15
4401
FY13-14
3859
FY12-13
1449
FY11-12
1427
0
1000
2000
3000
4000
5000
Average Length of Stay (in days)
CY15-16
9
FY14-15
9
FY13-14
9
FY12-13
8
FY11-12
8
7.5
8
8.5
9

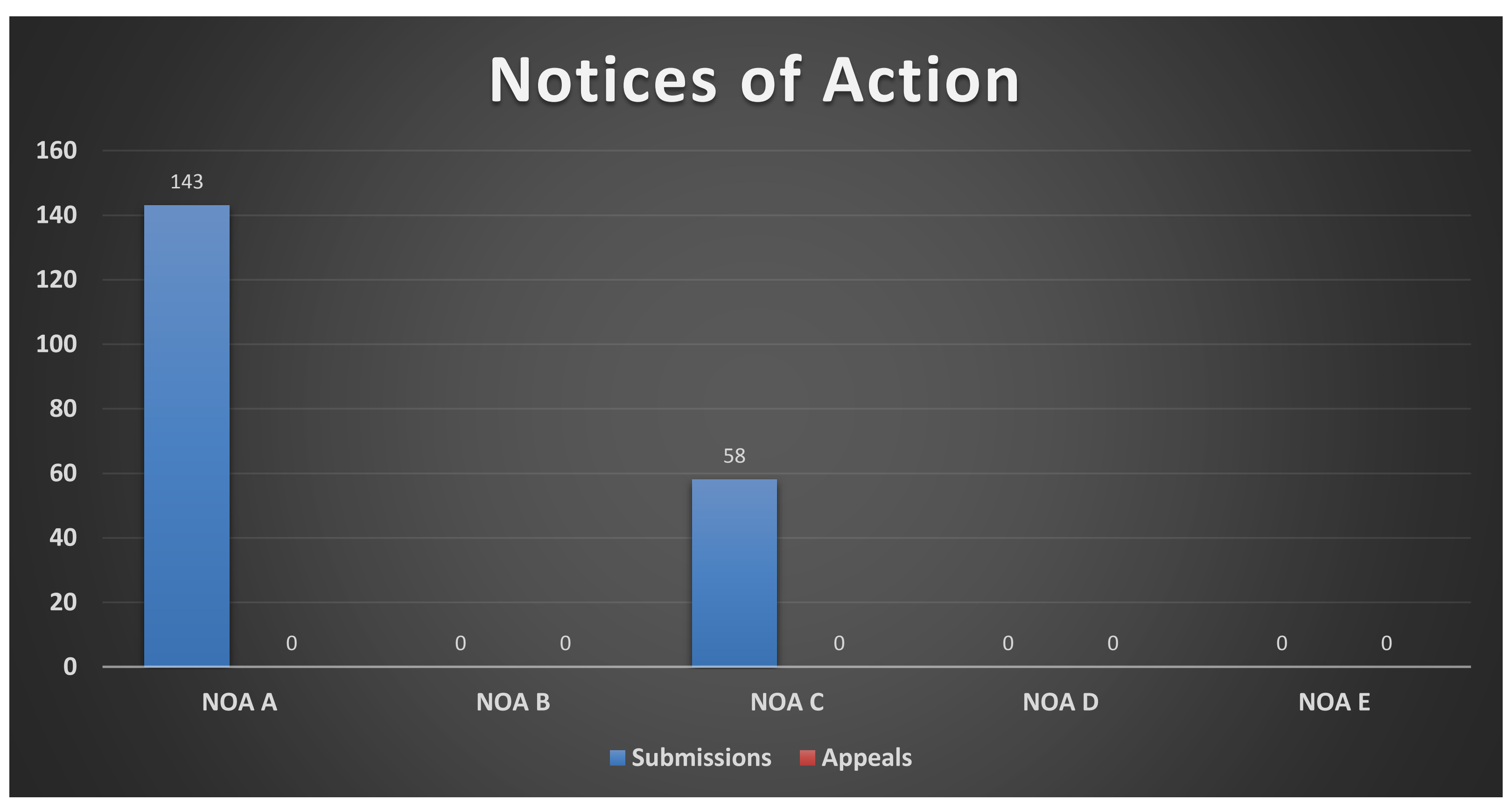

Hospitalizations – Re-hospitalizations
500
450
400
350
300
250
200
150
100
50
0
169
182
414
470
212
115
128
278
311
169
37
28
74
93
34
20
19
45
53
34
FY11-12
FY12-13
FY13-14
FY14-15
CY15-16
Total # of Hospitalizations (duplicate client count)
Total # of re-hospitalizations (duplicate client count)**
Total # of Hospitalizations (unduplicated client count)
Total # of re-hospitalizations (unduplicate client count)**


7-day & 30-day Re-hospitalizations
500
450
400
350
300
250
200
150
100
50
0
169
182
414
470
212
27
28
74
93
34
10
10
37
35
17
FY11-12
FY12-13
FY13-14
FY14-15
CY15-16
Total # of hospitalizations
Total # of re-hospitalized admissions within 30 days
Total # of re-hospitalized admissions within 7 days

Readmission Rates



Readmission Rate within 7 days* Readmission Rate within 30 days**



NOA A:	Assessment indicates that the client does not meet medical necessity criteria
NOA B:	Denial or modification to a request for payment (for a service that has not been provided)
NOA C:	Denial or modification to a request for payment (for a service that was already provided)
NOA D:	Delay in coming to a decision regarding a grievance, standard appeal, or expedited appeal
NOA E:	Failure in providing timely services