County of San Luis Obispo County Quality Support Team
DMC-ODS Work Plan Evaluation, Fiscal Year 2018-2019

QST Work Plan:

The annual QST Work Plan identifies key areas that were a focus of the County of San Luis Obispo's DMC-ODS quality improvement efforts for the year. The QST Work Plan draws upon the Department of Health Care Services (DHCS) Quality Strategy Report (6/29/2018), the Intergovernmental Agreement and feedback from EQRO to determine priorities. The Work Plan Evaluation details the results of our improvement efforts.

Goal # 1: Maintain a responsive toll free 24/7 Central Access Line

Measurable Objectives (shared with the MHP):

- All calls will be logged as required (100% success rate)
- Staff who answer phones will utilize the scripted responses

<table>
<tr><th>Planned Steps:</th><th>Results:</th></tr>
<tr><td>Refine and continue to test the effectiveness of scripted responses</td><td>Completed:
We revised scripts after feedback from DHCS (7/31/2019)</td></tr>
<tr><td>Track disposition details: number of referrals to MH and SUD services</td><td>Completed:
Of the 1311 calls requesting an initial service entered in Access Journal from 10/1/18 to 6/30/19, callers received the following number and types of referrals. The data below excludes follow up requests from CSU, PHF and inpatient facilities.

<table><tr><th>Referral Type</th><th>#</th><th>% of total</th></tr><tr><td>Drug & Alcohol Services</td><td>112</td><td>8.54%</td></tr><tr><td>Managed Care Plan</td><td>218</td><td>16.63%</td></tr><tr><td>Mental Health clinic or CBO</td><td>886</td><td>67.58%</td></tr><tr><td>Other</td><td>93</td><td>7.09%</td></tr><tr><td>Private Mental Health</td><td>2</td><td>0.15%</td></tr></table></td></tr>
<tr><td>Conduct at least two test calls per month (English and Spanish) to evaluate performance in key areas identified in the contract with Department of Health Care Services (DHCS)</td><td>Completed:
Managed Care staff completed test calls each quarter. Managed care Program Supervisor provided training to address call performance.

<table><tr><th rowspan="2">Quarter</th><th colspan="2">Result:</th></tr><tr><th>#</th><th>% In compliance</th></tr><tr><td>Q1</td><td>10</td><td>100%</td></tr><tr><td>Q2</td><td>8</td><td>100%</td></tr><tr><td>Q3</td><td>12</td><td>100%</td></tr><tr><td>Q4</td><td>9</td><td>88.89%</td></tr><tr><td>Total</td><td>39</td><td>97.43%</td></tr></table></td></tr>
</table>

Conduct training for Managed Care and TMHA SLO Hotline staff, particularly in documentation of requests	Completed: Managed Care Program Supervisor completed training with SLO Hotline volunteers and staff on 11/28/18 and is scheduled to train again on 8/28/19. She provided training for Managed Care staff on 1/30/19, 3/13/19, 3/2019, 4/17/19, 6/5/19, and 7/31/19.
Complete quarterly reporting of Central Access line performance to DHCS	Completed: Managed Care Program Supervisor submitted reporting form on time each quarter

Goal # 2: Monitor service delivery capacity

Measurable Objective:

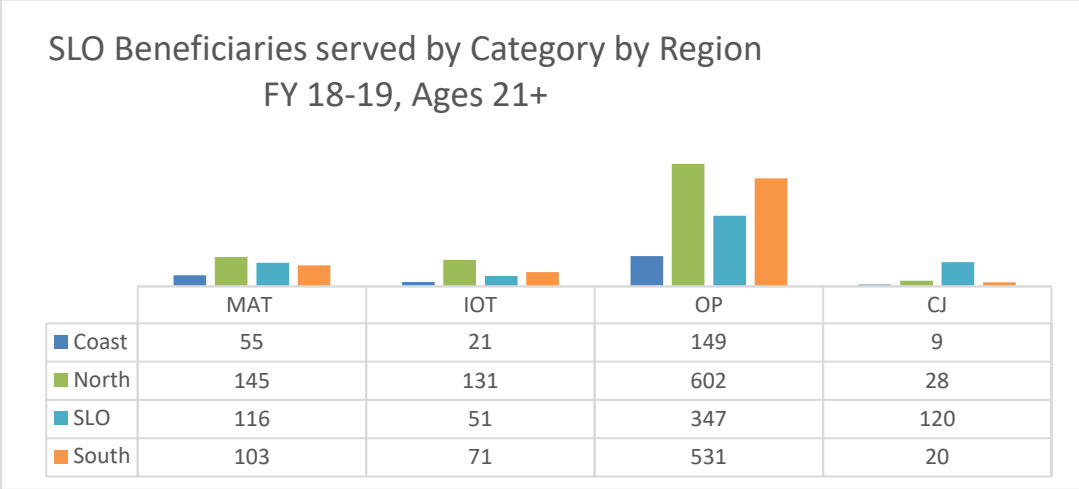
Maintain a network of providers (staff plus contractors) that is sufficient to include a full array of DMC-ODS services based on ASAM level.

Planned Steps:	Results:
Measure service delivery regionally Medi-Cal beneficiaries Served by Age, City, service type, and region, FY 18-19 *Clients in the tables and graph in this section are unduplicated within a service category, but may be represented in multiple service categories. For example, if a beneficiary is in IOT and MAT IOT, the beneficiary will be counted in both columns.*	Completed: **YOUTH 0-20**

Region	City	CM	OP	IOT	MAT	3.1+
Coast	CAMBRIA	1	4	0	0	1
Coast	CAYUCOS	0	2	0	0	0
Coast	LOS OSOS	1	8	3	1	0
Coast	MORRO BAY	0	6	1	0	0
Coast	SAN SIMEON	0	1	0	0	0
North	ATASCADERO	3	28	4	0	1
North	BRADLEY	0	2	0	0	0
North	CRESTON	0	3	0	0	0
North	PASO ROBLES	3	52	4	1	0
North	SAN MIGUEL	0	9	0	0	0
North	SANTA MARGARITA	0	3	0	0	0
North	TEMPLETON	0	7	0	0	0
SLO	SAN LUIS OBISPO	7	28	6	2	1
South	ARROYO GRANDE	11	26	1	1	0
South	GROVER BEACH	5	20	2	2	0
South	GUADALUPE	0	1	0	0	0
South	NIPOMO	7	31	2	0	1
South	OCEANO	5	17	1	0	0
South	PISMO BEACH	5	9	0	0	0
South	SANTA MARIA	0	4	0	0	0
ALL	**TOTAL**	**48**	**261**	**24**	**7**	**4**

ADULTS 21+

The graph below shows similar information for adults aged 21+



	MAT	IOT	OP	CJ
Coast	55	21	149	9
North	145	131	602	28
SLO	116	51	347	120
South	103	71	531	20

Services of all categories are available and utilized by clients in all geographic regions.

Track utilization of services (# of services by type and cost per beneficiary)

The tables to the right represent SLO Medi-Cal beneficiaries with kept services in FY 18-19.

Beneficiaries are unduplicated within each table, but may be repeated in different tables

Completed:

ASAM 1.0	**Youth (0-20)**	**Adult (21+)**
Number beneficiaries	153	1149
Number kept services	4017	44,500
Ave. Services per beneficiary	26.25	38.72
Total cost	$212,573.14	$1,706,600.32
Average cost/beneficiary	$1389.37	$1,485.29
Range of cost	$3.67 to $13,129.01	$5.64 to $13,945.21
Median cost	$892.90	$885.70
Standard Deviation	1587.37	1639.92

ASAM 2.1	**Youth (0-20)**	**Adult (21+)**
Number beneficiaries	16	269
Number kept services	894	22,411
Ave. Services per beneficiary	55.87	83.31
Total cost	$47,605.67	$942,688.58
Average cost/beneficiary	$2,975.35	$3504.42
Range of cost	$112.88 to $8368.08	$6.31 to $28,592.88
Median cost	$1953.38	$1974.70
Standard Deviation	2619.42	3904.37

MAT (RSS, 1.0 and 2.1)	**Youth (0-20)**	**Adult (21+)**
Number beneficiaries	8	352

	Number kept services	34	4,726
	Ave. Services per beneficiary	4.25	13.43
	Total cost	$2,433.07	$320,094.52
	Average cost/beneficiary	$304.13	$909.36
	Range of cost	$99.37 to $1029.70	$3.67 to $4735.85
	Median cost	$219.08	$623.18
	Standard Deviation	302.38	891.80
Complete annual Network Adequacy Certification Tool (NACT)	Completed: QST Division Manager submitted quarterly NACT and related documentation as required. DHCS notified the MHP in September that the submissions met adequacy standards for FY 18-19.		

Goal # 3: Provide timely access to services

Measurable Objective:

Track and maintain access to services to meet the timely access standards

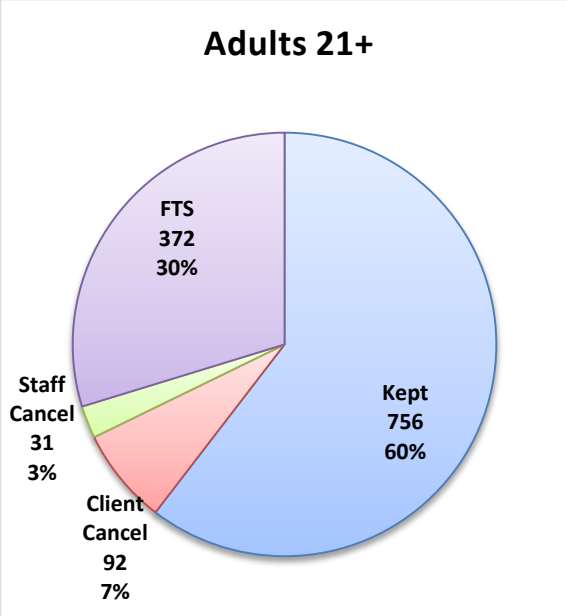
Planned Steps:	**Result: See** Attachment 2 Access Timeliness Metrics FY 18-19
Monitor and report wait time for assessment from call to offered assessment (10 business/14 calendar days)	Completed: 97 calls to the Central Access Line requesting a SUD services: Average Wait to offered appointment: 2.63 calendar days Median: 2 Mode: 1 SD: 2.50 Range: 0-13 Walk In (Same Day Service): 2593 (96.5% of referrals) Conclusions: Our clinics provide rapid access to services; walk in remains by far the most common way to access DMC-ODS services.
Monitor and track timeliness of follow up and ongoing care appointments (10 business/14 calendar days)	Not Completed: We were not able track this data point in Access Journal this year, but hope to have a solution that will allow us to track this next year.

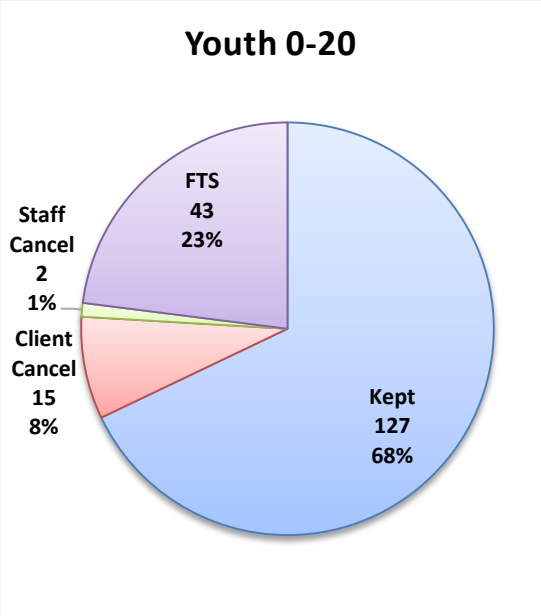
Goal # 4: Monitor attendance rates for and outcomes of intake assessments

Measurable Objective:

Planned Steps:	Result:
Track screening follow-up: # and % of clients with a kept assessment after a kept screening by site	Completed: **Screening to Assessment tracking by site**: The table below shows the number of kept Screenings and kept Assessments at each site in FY 18-19, followed by the percentage of clients with both a kept Screening and a kept Assessment during the FY. Clients may be duplicated between sites. **Assessment Attendance, all sites:** Clients may be duplicated within a site and between sites **Assessment Appointment Type (Attendance) by Site:** *Clients may be duplicated within a site and between sites*

Site	Kept Screening	Kept Assessment	% with both
Atascadero	277	166	59.93%
Paso Robles	141	111	78.72%
Grover Beach	401	192	47.88%
SLO	657	316	48.10%
South Street	119	98	82.35%
Total	**1595**	**883**	**55.36%**



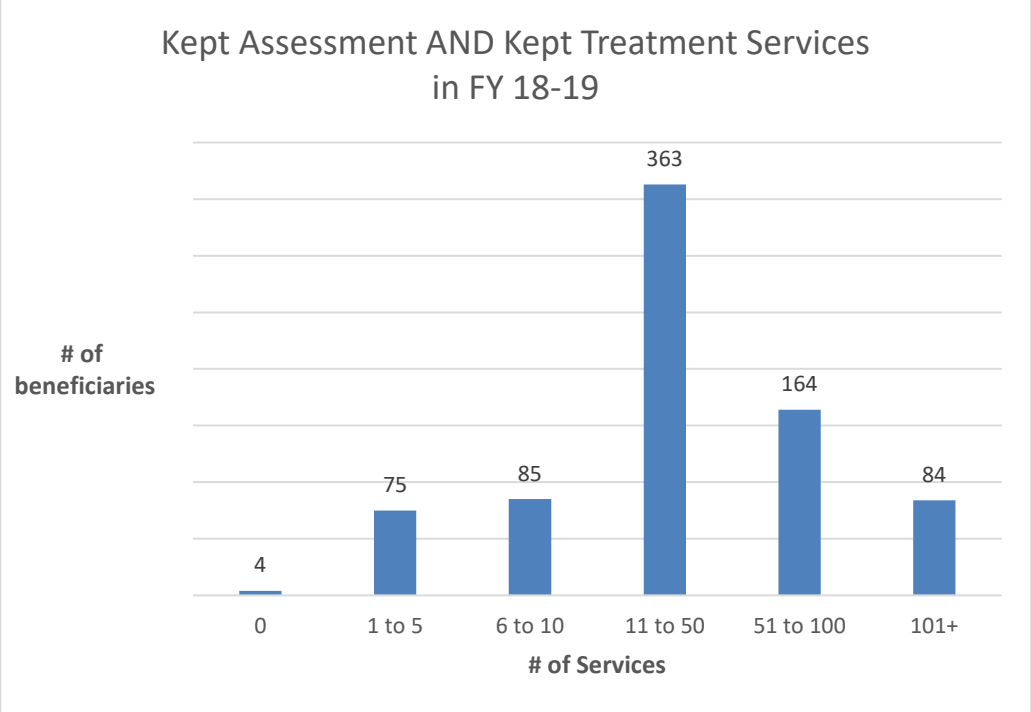


Site	# Assessment Services*	Kept (1,2)	FTS (5)	Staff Cancel (4)	Cancelled or Excused (3,7)	FTS %
Atascadero	297	166	100	2	29	33.67%
Paso Robles	164	111	42	4	7	25.45%
Grover Beach	269	192	62	1	15	22.79%
SLO	557	316	184	24	33	32.97%
South Street	141	98	27	2	14	19.15%
Total	**1428**	**883**	**415**	**33**	**97**	**29.06%**

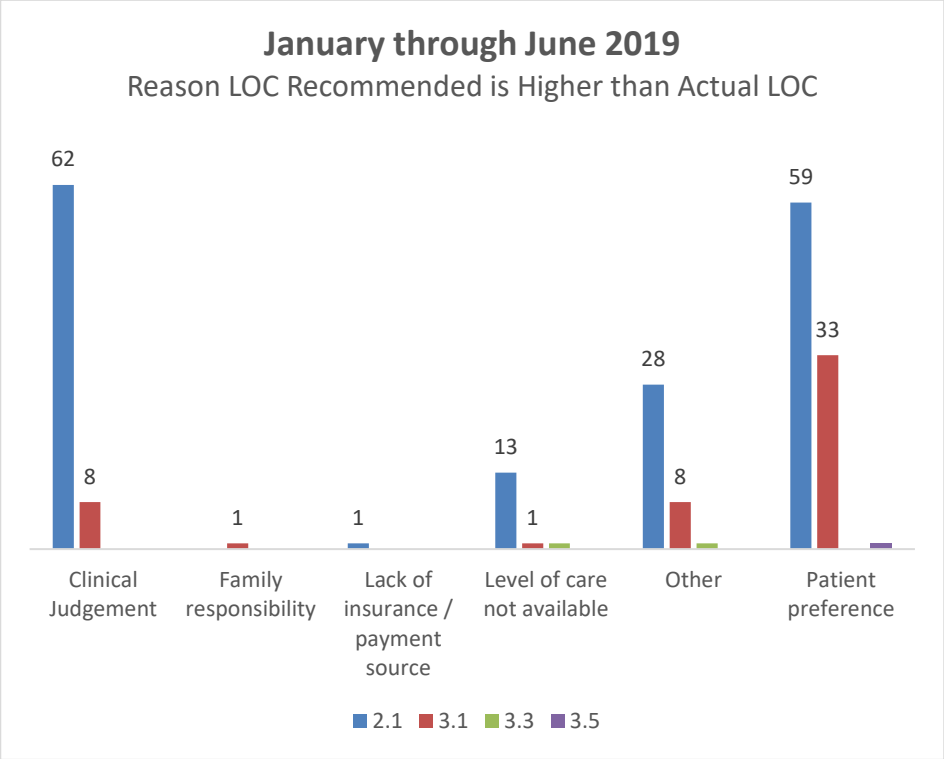
**Excludes Appointment Type 9 (unbillable) and 10 (cancelled due to crisis)*

Assessment and Treatment Service relationship:

The frequency array below shows the number of treatment services that each of the 775 unique beneficiaries who kept an Assessment in FY 18-19 received, in addition to the Assessment. Some services may have occurred in a previous treatment episode during the year and some were prior to assessment, so it is not strictly speaking a representation of retention. It demonstrates that 99.48% of clients who attend an Assessment also received at least one more service, and most received many more services.



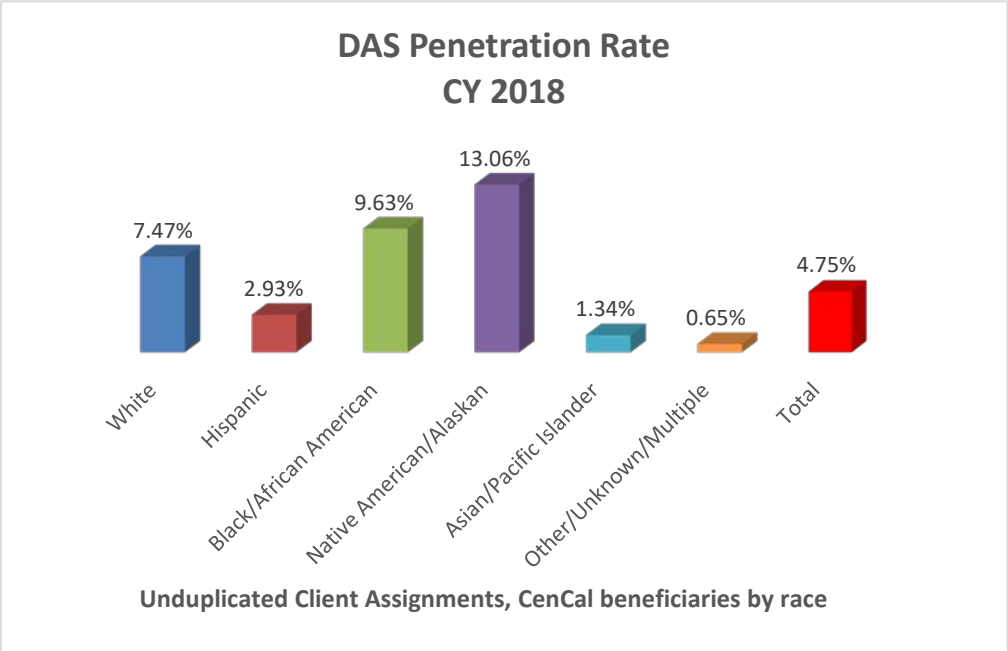
Analyze ASAM level of care recommendations	• Total # ASAM LOC submitted to state: 1549 • Concordance: Recommended LOC exactly matches Actual LOC o 69% (Initial Assessment) o 82% (Follow-up) • Most common difference: Recommended = 2.1; Received = 1.0



Goal # 5: Increase capacity to serve minority beneficiaries

Measurable Objective:

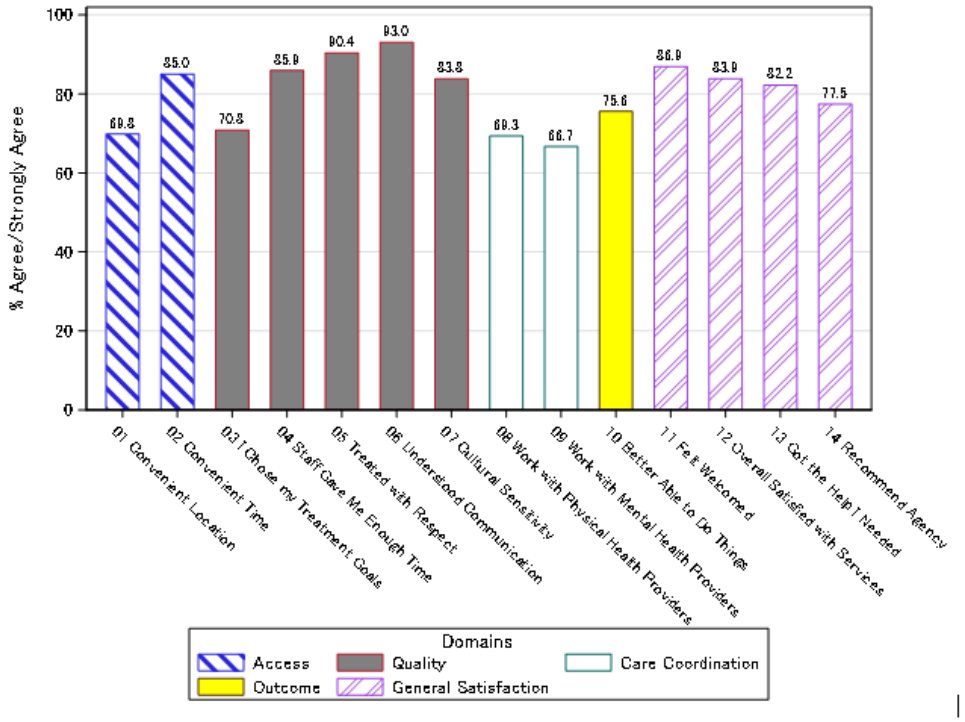
Increase the percentage of Latino clients served by 5% after establishing baseline

Planned Steps:	Result:
Measure Penetration Rate (PR) annually	Completed: We calculated PR using the same method we've used since CY 2014 for the MHP – by dividing unduplicated client assignments by race by the comparison group per CenCal Health Demographics report for the calendar year. This formula is slightly different than the one used by DHCS and the one used by EQRO. As noted in the graph below, there continue to be disparities between racial groups. PR for Latino beneficiaries is less than half the rate as White beneficiaries. Additionally, by our calculations, the number and % of beneficiaries who identified as Latino decreased. CenCal Health also reports a significant decrease in Latino beneficiaries.  We are unsure of all the reasons for this decrease, but it makes sense in the larger national political climate that affects the Latino population. We anticipate that anxiety related to "Public Charge" policies will further decrease participation by Latino beneficiaries in treatment. We will continue to monitor and will work with our Cultural Competence Committee to determine best practice approaches to increasing access for Latino beneficiaries despite the political climate on a Federal level.

Maintain bilingual staff capacity at all key points of contact, including at the Central Access Line	Completed: We continued to maintain bilingual capacity at the Central Access Line and at regional clinics.
Continue to support bilingual preferred hiring and expansion of the Promotores project to all areas of the county to expand capacity to serve Latino consumers	Completed: SLOBHD expanded our contract with Center for Family Strengthening to provide interpretation services for Spanish-speaking clients.

Goal # 5: Maximize consumer satisfaction

Measurable Objective:
Ensure consumer satisfaction as evidenced by responses to the Treatment Perception Survey (TPS). Satisfaction questions will be rated "Strongly Agree" or "Agree" by at least 85% of respondents.

Planned Steps:	Results:
Implement TPS Evaluate responses and analyze for trends and improvement opportunities Continue training efforts to strengthen staff recovery orientation competencies Consider client access and satisfaction when looking at service hours and location	Completed: Figure 1. Percent of survey participants in agreement by survey questions and five domains 

Goal # 6: Monitor and respond to beneficiary requests

Measurable Objective:
Successfully resolve all beneficiary concerns at the lowest possible level within the required timelines.

<table>
<tr><th>Planned Steps:</th><th>Results:</th></tr>
<tr><td>Track all consumer requests and report quarterly</td><td>Completed:
<table>
<tr><th>Role</th><th>Entity</th><th>Change of Provider</th><th>Grievance</th><th>Other</th><th>Quality of Care</th><th>Second Opinion</th></tr>
<tr><td>Clinic</td><td>DAS (unknown site)</td><td></td><td>1</td><td>1</td><td></td><td></td></tr>
<tr><td>Clinic</td><td>DAS Drug Court</td><td></td><td></td><td></td><td></td><td>1</td></tr>
<tr><td>Clinic</td><td>GB DAS</td><td></td><td>3</td><td>6</td><td>2</td><td>1</td></tr>
<tr><td>Clinic</td><td>MAT</td><td></td><td>1</td><td></td><td></td><td>1</td></tr>
<tr><td>Clinic</td><td>PR DAS</td><td></td><td>1</td><td></td><td>1</td><td></td></tr>
<tr><td>Clinic</td><td>SLO DAS</td><td>1</td><td>7</td><td>5</td><td>4</td><td>4</td></tr>
<tr><td>NTP</td><td>Aegis</td><td></td><td>1</td><td>3</td><td>4</td><td></td></tr>
<tr><td>SLE</td><td>Casa Solana</td><td></td><td>5</td><td></td><td>5</td><td></td></tr>
<tr><td>SLE</td><td>Restoration House</td><td></td><td>1</td><td>3</td><td></td><td></td></tr>
<tr><td>SLE</td><td>Restorative Partners</td><td></td><td>1</td><td></td><td></td><td></td></tr>
</table>

Of the 58 Grievances that required a response, 49 were completed on time (84.5%)
At clinic sites, perceived negative interactions with staff (12) and disagreement about LOC (10) were the most common grievances
</td></tr>
<tr><td>Complete quarterly DHCS report</td><td>Completed:
The Patients' Rights Advocate completed reporting in a timely manner</td></tr>
<tr><td>Track # and % of NOABDs by type</td><td>Completed:
The BH Patient's Rights Advocate trained staff to complete each type of Notice of Adverse Benefit Determination (NOABD) as required. We tracked the number and percentage of NOABDs by type. The number of appeals (2) is rather low for the number of NOABD Payment Denials and Termination notices we issued.
<table>
<tr><th>NOABD Type</th><th>Purpose</th><th>#</th><th>%</th></tr>
<tr><td>Denial</td><td>Reduction of service, but still some service</td><td>11</td><td>9.73%</td></tr>
<tr><td>Grievance/Appeal Delay</td><td>Processing/resolution delay</td><td>4</td><td>3.54%</td></tr>
<tr><td>Other Level of Care</td><td>Referral to Holman Group for MH care</td><td>26</td><td>23.01%</td></tr>
<tr><td>Payment Denial</td><td>Documentation doesn't support claim</td><td>53</td><td>46.90%</td></tr>
<tr><td>Termination</td><td>Notice to client that all services will end</td><td>19</td><td>16.81%</td></tr>
<tr><td>Grand Total</td><td></td><td>113</td><td>100.00%</td></tr>
</table>
Our Grievance, Appeal and NOABD numbers are lower than expected. Our PRA will increase staff and consumer educational efforts.</td></tr>
</table>

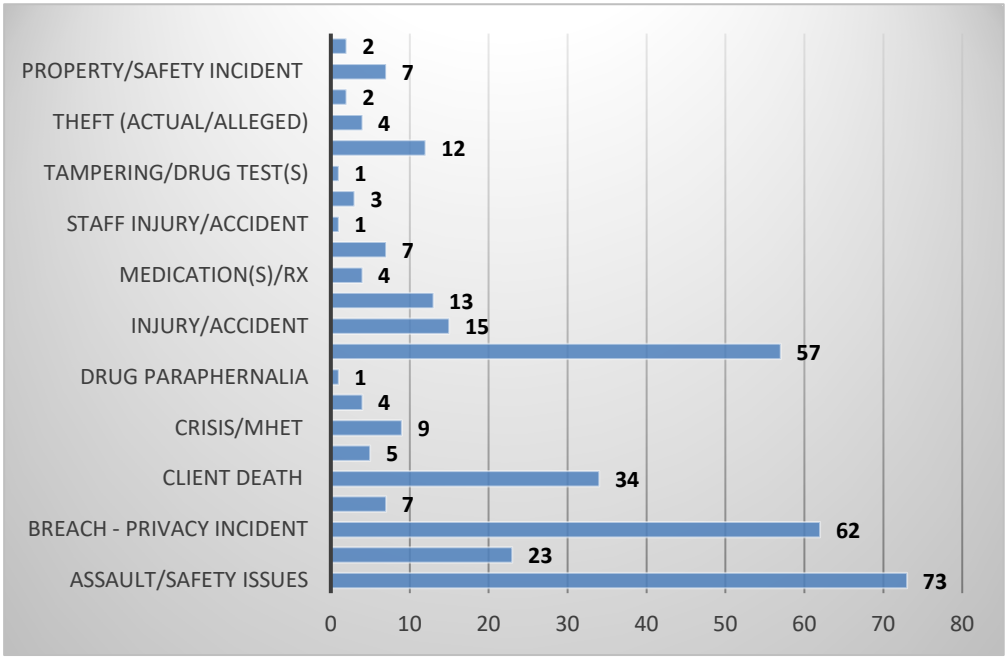
Goal # 7: Monitor and respond to provider requests and appeals

Measurable Objectives:
Successfully resolve all provider appeals at the lowest possible level within the required timelines.

Planned Steps:	Results:
Track provider appeals	Completed: We processed two appeals by a Residential Treatment provider.
Monitor and report outcome and timeliness of resolution	Completed: We had significant difficulty with the documentation and claiming of Residential Treatment providers. We extended timelines multiple times in order to get the documentation we needed to render an authorization decision. In all, we issued 53 NOABD Payment Denials to alert contracted providers that we would not pay or claim to Medi-Cal for services rendered.

Goal # 8: Implement interventions when better care was more appropriate

Measurable Objective (combined with MHP):
Review and respond to Incident Reports within one month of report submission.

Planned Steps:	Result:
Review Incident Reports; monitor and report. Make recommendations regarding follow-up when better care was more appropriate	Completed: We tracked the following types and frequency of Incident Reports 

<table>
<tr>
<td>Refer Incident Report to Morbidity & Mortality Committee in event of death or serious injury</td>
<td>Completed:
M&M Committee, chaired by the BH Medical Director, changed processes to allow more in-depth review of records, followed by case discussion, with good success. The committee meets monthly.

<table>
<tr><th>Cause of Death, DAS records reviewed in FY 18-19</th><th>#</th></tr>
<tr><td>Natural Causes</td><td>1</td></tr>
<tr><td>Overdose (Not ruled suicide by coroner)</td><td>3</td></tr>
<tr><td>Suicide (includes OD if ruled intentional by coroner)</td><td>4</td></tr>
<tr><td>Unknown</td><td>2</td></tr>
<tr><td>Total</td><td>10</td></tr>
</table>
</td>
</tr>
</table>

Goal # 9: Improve clinical documentation

Measurable Objective:

- All DMC-ODS staff will attend documentation training annually
- Establish Practice Guidelines for Youth Mental Health Assessment

<table>
<tr><th>Planned Steps:</th><th>Results:</th></tr>
<tr><td>Complete and distribute Documentation Guideline update (annually and as needed)</td><td rowspan="4">Completed:
The results and trends from auditing inform the QST Clinician of necessary documentation training. Training in conducted in several forms: 1:1 training in person or via written correspondence, quarterly DMC-ODS documentation refresher trainings (at 5 DAS clinic sites), week-long DMC-ODS documentation training for new DAS employees, 1 annual training refresher for CBO, and weekly/monthly documentation tips. The training schedule for FY 18-19 contains detailed information.</td></tr>
<tr><td>Establish training schedule to include all County operated and contractor sites; provide regular training at sites and at new employee orientation</td></tr>
<tr><td>Publish a bimonthly documentation tips newsletter</td></tr>
<tr><td>Track attendance at face-to-face and completion of E Learning documentation training (annually)</td></tr>
</table>

Goal # 10: Conduct effective clinical records reviews

Objectives:

Establish and implement a monthly audit schedule as part of Utilization Management Program.

Identify areas of strength and deficiency in documentation for each monthly audit to help guide training and to ensure appropriate billing for services.

Planned Steps:	Results:
Develop and implement a monthly audit schedule to include all sites	Completed: QST Clinician conducts a monthly targeted audit of SUD services. Some examples of targeted audits from FY 18-19 are: progress note timeliness, progress note required DMC-ODS content, documentation/travel time, perinatal services, ASAM LOC and service hours provided, and review of charts during seven different site reviews. The Monitoring Plan documents FY 18-19 audits completed.
Conduct comprehensive audits quarterly	
Examine utilization trends and consistency in authorization decisions	
Conduct more targeted review of cases as documentation concerns or other issues emerge	

Goal # 11: Develop improved Site Certification and monitoring procedures

Measurable Objective:
Create a standardized set of tools and procedures for certification and tracking of all county operated and contract provider sites.

Planned Steps:	Results:
Conduct annual site monitoring visits	Completed: QST staff revised the monitoring tools and completed program monitoring visits at all sites
Revise monitoring tools as needed	
Promptly follow up with completing and reporting of CAPs	
Ensure that each site maintains current DMC certification	Deferred: DHCS is transitioning providers to PAVE
Obtain SUD Treatment certification for all clinic sites	In process

Goal # 12: Monitor the safety and efficacy of medication practices

Measurable Objective (shared with MHP):
Create a standardized set of tools and practice guidelines for prescribers

Monitor prescribing practices during regular peer review

Planned Steps:	**Results:**
Develop a monitoring process that ensures that each site certification remains current. Medical peer review (monthly)	Completed, Ongoing: • The MHP's Medical Director expanded Peer Medication Review Committee, which meets monthly • Medical Director created additional policy guidance to help practitioners who prescribe controlled substances.