INYO COUNTY BEHAVIORAL HEALTH

Annual Quality Improvement Work Plan

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I. INTRODUCTION AND PROGRAM CHARACTERISTICS

The goal of the Annual Work Plan for Quality Improvement activities of the Inyo County Behavioral Health (ICBH) is to provide the blueprint for the quality management functions designed to improve both client access and quality of care. This Plan is evaluated annually and updated as necessary. The QI program is accountable to Gail Zwier, Ph.D. Health and Human Services Deputy Director of Behavioral Health.

This Quality Improvement Plan ensures the opportunity for input and active involvement of consumers, family members, providers, and other interested stakeholders in the Quality Improvement Program. The QI members participate in the planning, design, and execution of the QI Program, including policy setting and program planning. The Plan activities also serve to fulfill the requirements set forth by the California Department of Health Care Services (DHCS) and the Specialty Mental Health Services Performance Contract requirements as related to the contract's Annual Quality Improvement Program description. As a Behavioral Health Division, the Plan will also address quality management issues as related to Substance Use Disorder services. The Plan addresses quality assurance/improvement factors as related to the delivery of culturally-sensitive behavioral health services. The planning and implementation of the Mental Health Services Act has provided an additional forum to identify areas for quality improvement as well as expansion of mental health services.

A. QUALITY IMPROVEMENT COMMITTEES (QIC)

Four committees comprise the QIC, the Business Analysis/Compliance Committee, QII Staff Trainings, Community Quality Improvement Committee (CQIC) and the Mental Health Advisory Board. These forums are responsible for the key functions of the ICBH Quality Improvement Program. These committees are involved in the following functions:

1. Business Analysis/Compliance Committee is responsible for addressing programs policy and procedural changes and compliance adherence. The committee includes the Behavioral Health Director, HHS Compliance Officer, Fiscal staff, Clinical and line staff. This committee meets at least quarterly and addresses:

- Fiscal coding and procedural needs.
- Eligibility clarification.
- Operations and workflow needs.
- Policy and Procedural changes
- Electronic Health Record (EHR) implementation.
- Monitoring and updating the Compliance Plan annually
- Use of outcome data to inform program planning decisions
- Capacity needs

Information from this meeting is documented and forwarded to the QII Staff Trainings to assure consistency and quality of services.

2. QII Staff Trainings is a quality assurance/improvement meeting conducted at least monthly. The QII provides an opportunity for program staff to review information from the Business Analysis/Compliance committee and items from the work plan. This forum reviews confidential, critical incident reports to ensure the quality of services for our consumers. Program staff attend this meeting and evaluate both consumer-focused issues (e.g. cultural diversity; clinical case review; clinical training issues, performance outcome measurement; clinical record audit results; consumer satisfaction results; denial of service; etc.) as well as system-focused (e.g. improvement of the QI format, employee suggestions/recommendations, partner concerns, clinic/site audit results, etc.) topics. QII's are identified for consumer participation (i.e.; Confidentiality Policies and Procedures). The function of the QII meeting also reviews and recommends action regarding issues such as:

- Specific case histories for high risk and high utilizing beneficiaries
- Clarification and feedback for Policies and Procedures
- Clinical quality improvement topics for integrated treatment of consumers
- Medication Monitoring issues specific to a consumer
- Legal and ethical issues such as potential boundary violations
- Denials of service
- Improved recovery focused treatment
- Treatment that is inappropriate or inadequate for an individual's needs
- Possible system level issues that relate to client care and access
- Review and identification of QI items/ and summary issues to be sent to CQIC

All proceedings and findings of the QII are documented and provided to the

CQIC in summary format to ensure that we maintain a client's confidentiality in this small, rural community.

3. The Community Quality Improvement Committee (CQIC) is charged with implementing the specific and detailed review and evaluation activities of the agency. On a quarterly basis, the CQIC:

- Collects, reviews, evaluates, analyzes information and implements actions that frequently involve the handling of information that is of a sensitive and confidential nature.
- Provides oversight to Quality Improvement (QI) activities, including the development and implementation of the Performance Improvement Projects.
- Recommends policy decisions, reviews and evaluates the results of QI activities, and monitors the progress of the Performance Improvement Projects.
- Institutes needed QI actions and ensures follow-up of QI processes.
- Documents all activities through dated and signed minutes to reflect all QI decisions and actions made by all four QIC meetings.

The CQIC provides oversight and is involved in QI activities. The CQIC conducts an annual evaluation of the overall effectiveness of the QI program. This helps to demonstrate that QI activities, including Performance Improvement Projects, contribute to meaningful improvement in clinical care and consumer services.

The CQIC assures that QI activities are completed and utilizes a continuous feedback loop to evaluate ongoing quality improvement activities, including the Performance Improvement Projects. This feedback loop helps to monitor previously identified issues and provides an opportunity to track issues over time. The QIC continuously conducts planning and initiates new activities for sustaining improvement.

Each quarterly meeting of the QIC shall include a verbal summary of significant QIC meeting findings, decisions, actions, and recommendations. In addition, written information may also include data summaries, as available.

The composition has included the clinical managers, HHS Quality Improvement data analysts , an adult Native American consumer, an adult Hispanic consumer, a family member, Patient's Rights Advocate, community members affiliated with religious organizations, providers (including a contract provider), a social services employee, MHSA coordinator and Public Health Division representative. Invitations also have been made to include representation from Toiyabe Indian Family Services, Inyo County Superintendent of Schools, and the Rural Health Clinic.

Due to the diverse membership of the CQIC, information sharing will be provided in summary form only to ensure compliance with regulations pertinent to the limitations on the sharing of confidential information.

The CQIC presents information to the Mental Health Advisory Board to ensure that quality issues are discussed.

4. The Behavioral Health Advisory Board meets at least 10 times annually. The members of the Behavioral Health Advisory Board include appointed consumers, representative from the Inyo County Board of Supervisors, the Deputy Director of Behavioral Health and consumers. The Board receives information from the CQIC and provides feedback on access findings and policy change proposals. The comments from this forum are documented in the meeting minutes and reported back to the Business Analysis /Compliance Committee to finalize and policy changes.

B. SUBSTANCE ABUSE DOSORDER SERVICES INTEGRATION

The recognition of substance abuse as a factor in the treatment of persons with mental illness has gained increased attention through the above referenced Quality Improvement activities. The prevalence of persons with co-occurring disorders and the need for continued integrated service programs have been noted at all levels. This is fully integrated into the QIC meetings as well through other meetings with partners in Social Services, Law Enforcement and Probation, the Jail and hospitals.

C. ACCOUNTABILITY

The findings of the QIC meetings are accountable to the HHS Deputy Director of Behavioral Health. The QI program coordinates performance monitoring activities throughout the program and includes consumer and system level outcomes; implementation and review of the utilization review process; credentialing of licensed staff; monitoring and resolution of beneficiary grievances, fair hearings, and provider appeals; periodically assessing consumer, youth, and family satisfaction; and reviewing clinical records.

ICBH makes an effort to procure contracts with individual, group, and organizational providers, and for psychiatric inpatient care. As a component of the contract, these entities are required to cooperate with the QI program and allow access to relevant clinical records to the extent permitted by state and federal laws.

The QI plan is further integrated into the QI activities of the larger Inyo County Health and Human Services Department.

II. PROGRAM COMPONENTS

A. Evaluation of Overall Effectiveness

Evaluation of the overall effectiveness of the QI program shall be accomplished routinely, as well as annually, to demonstrate that:

- QI activities have contributed to improvement in clinical care;
- QI activities have contributed to improvement in services;
- QI activities have been completed or are in process; and
- QI activities have incorporated relevant cultural competence and linguistic standards to match consumer's cultural and linguistic needs with appropriate providers and services.

B. Specific QI Evaluation Activities

1. Quality Improvement

   - Review Access and Authorization Team logs to help identify trends in consumer care, in timeliness of service plan submission, and trends related to the utilization review and authorization functions;
   - Assess consumer and provider satisfaction surveys for assuring access, quality, and outcomes;
   - Review and evaluate results of QI activities, including progress on the development and implementation of the Performance Improvement Projects (one for clinical and one for non-clinical areas);
   - Review QI actions and follow-up on any plans for action;
   - Review charts to focus on appropriateness of care, appropriateness of reviewer comments, any plans of correction following initial review, and any significant trends of concern;
   - Review consumer- and system-level Performance Outcome Measures for adults and children to focus on any significant findings and trends;
   - Review medication monitoring processes to assure appropriateness of care, appropriateness of reviewer comments, any plans of correction following initial review, and any significant trends of concern;
   - Review new Notices of Action, focusing on their appropriateness and any significant trends;

- Review grievances or appeals submitted. The Quality Improvement Committees review the significant trends identified by the Behavioral Health Director that may influence policy- or program-level actions.

- Review provider appeals. The Quality Improvement Committees review the significant trends identified by the Behavioral Health Director that may influence policy- or program-level actions.

- Review requests for State Fair Hearings, as well as review of any results of such hearings. The Quality Improvement Committees review the significant trends identified by the Behavioral Health Director that may influence policy- or program-level actions.

- Review other clinical- and system-level issues of concern that may affect the quality of service delivery. The information reviewed also allows the QIC to evaluate trends that may be related to culturally-sensitive issues and may require prescriptive action;

- Review potential need for or required changes in policy;

- Maintain an annual credentialing process to assure that all licensed staff are in compliance with their licensing requirements; and

- Monitor issues over time and make certain that recommended activities are implemented, completing the Quality Improvement feedback loop.

2. Monitoring of Previously Identified Issues and Tracking over Time
   Minutes of all QIC meetings shall include information regarding:

   - An identification of action items;
   - Follow-up on action items to monitor if they have been completed;
   - Assignments (by persons responsible);
   - Due date; and completion date.

   To assure a complete feedback loop, completed and incomplete action items shall be identified on the agenda for review at the next meeting. Chart reviews pending further action to implement plans of correction shall be identified for follow-up and reporting.

C. Inclusion of Cultural Competency Concerns in All QI Activities

On a regular basis, the QIC shall review collected information, data, and trends relevant to standards of cultural competence and linguistic preferences in service delivery and quality of care.

III. OBJECTIVES, SCOPE, AND PLANNED ACTIVITIES

Quality Improvement activities for FY 2017/2018 include the following objectives:

A. **Ensure ICBH Service Delivery Capacity**

The ICBH QI program shall monitor services in this county to assure service delivery capacity in the following areas:

1. **Utilization of Services** – Review and analyze reports from the Electronic Health Record (EHR) System and utilization of data from the DHCS Client Services Information system (CSI), as available.

2. **Service Capacity** – Staff productivity will be evaluated via productivity reports generated by the EHR System and fiscal staff. Fiscal and Program staff will meet monthly to review productivity reports and goal attainment.

These issues will also be evaluated to ensure that the cultural and linguistic needs of consumers are met.

B. **Monitor Accessibility of Services**

The ICBH QI program shall monitor accessibility of ICBH services in accordance with statewide standards and the following local goals:

1. **Timeliness of routine mental health appointments** – The goal for routine appointments is no more than 7 work days between the initial request and the intake appointment. This indicator will be measured by analyzing a random sample of new requests for services from the EHR.

2. **Timeliness of services for urgent or emergent conditions during regular clinic hours** – The goal for urgent or emergent conditions is no more than one (1) elapsed hour from the initial request until an actual staff response is provided. In the case of requests for authorization by a provider, an authorization decision is rendered within one (1) hour. This indicator will be measured by analyzing a random sample of urgent or emergent requests for services from the EHR.

3. **Access to after-hours services** – The goal for access to after-hours care for urgent or emergent conditions is no more than one (1) elapsed hour from the initial request until an actual staff response is provided. A protocol specific to suicide precautions in the Inyo County Jail or Juvenile Center mandates a face-to-face response within 24 hours and once per every 24 hours following for each person placed on this Suicide Watch. Inpatient hospitalizations do not require prior authorization for services. Requests for authorization for urgent specialty mental health services will receive an authorization decision within one (1) hour. Non-emergency

requests shall be referred for planned services during normal clinic hours. This indicator will be measured by analyzing a random sample of after hours requests for services from the EHR.

4. **Responsiveness of the 24-hour, toll-free telephone number** – During non-business hours, Progress House staff will answer the crisis line immediately and link urgent and/or emergent calls to the on-call mental health staff person. If required, an interpreter and/or the Universal Language Line will be utilized. This indicator will be measured by conducting random calls to the toll-free number. Three timed test calls will be made: two calls per year in English and one call per year in Spanish. Training of Progress House staff will occur annually.

5. **Implement and Maintain Efficient Work Flow Standards** – Office workflow standards will be implemented and maintained to efficiently and consistently serve clients from first contact through discharge. Workflow processes will be documented in flowcharts and implemented through policies and procedures. Monitoring will be conducted through annual review of workflow processes and procedures.

6. **Assess Performance** – Quantitative measures will be identified to assess performance and identify areas for improvement. For example, Behavioral Health Director reviews authorization requests; productivity reports and late service plan reports. These areas will be measured through the quarterly review of the timeliness of assessments and service plans, completeness of charts, consumer surveys, and productivity reports. The results of these reviews will dictate areas to prioritize for improvement.

7. **Support Stakeholder Involvement –** Staff, providers, consumers, and family members review the evaluation data to help identify barriers to improvement. As members of the CQIC, providers, consumers, and family members help to evaluate summarized data. This ongoing analysis provides important information for identifying barriers and successes toward improving administrative and clinical services. In addition, the MHSA Steering Committee provides input on access and barriers to services. Measurement will be accomplished via review of Business Analysis/Compliance Committee, QII Staff Trainings, CQIC and Mental Health Advisory Board minutes. The CQIC will show findings quarterly and a summary annually.

C. **Monitor Client Satisfaction**

The QI program shall monitor client satisfaction via the following modes of review:

1. **Consumer Survey** – Using the DHCS Consumer Perception Survey (POQI) instruments in threshold languages, consumers and family members will be surveyed annually to determine their perception of services. This indicator will be measured by annual review and analysis of at least a two-week sample. Survey administration methodology will meet the requirements outlined by the DHCS Consumer satisfaction surveys generated by Inyo County Health and Human Services and by Behavioral Health will also contribute to quality improvement.

2. **Informing providers of satisfaction survey results** – The results of consumer and family satisfaction surveys are routinely shared with Staff and other providers. Monitoring will be accomplished by review of the results of the Consumer Perception Surveys. Survey results will be shared with staff, providers, and the Behavioral Health Advisory Board. This information is distributed on an annual basis and in the form of cumulative summaries to protect the confidentiality of consumers and their families.

3. **Beneficiary grievances, appeals, and fair hearings** – All processed beneficiary grievances, expedited appeals, standard appeals, and fair hearings will be reviewed by the HHS Deputy Director of Behavioral Health if appropriate and may include Inyo County Risk Management. Monitoring shall be accomplished by ongoing review of the complaint/grievance log for adherence to timelines for response. In addition, the nature of complaints and resolutions will be reviewed to determine if significant trends occur that may influence the need for policy changes or other system-level issues. This review will include an analysis of any trends in cultural issues or disparity in care addressed by our consumers. A summary of trends will be presented to the QIC meetings as appropriate for feedback on policy changes. A summary of these findings will be recorded in the CQIC meeting minutes.

4. **Requests to change practitioners/providers** – At least annually, patterns of consumer requests to change practitioners/providers will be reviewed by the QIC. Measurement will be accomplished by review of CQIC minutes summarizing activities of the Access Team and through annual review of the Change of Provider Request forms.

5. **Cultural sensitivity** – In conducting review in the above areas, analysis will occur to determine if cultural issues may have influenced results. Surveys will be provided in English and also in Spanish, Inyo County's threshold language. The results of the Consumer Perception Surveys will be analyzed to determine if Spanish speaking consumers had access to written information in their primary language.

D. **Monitor the Service Delivery System**

The QI program shall monitor the ICBH service delivery system to accomplish the following:

1. **Safety and Effectiveness of Medication Practices** – Annually, meaningful issues for assessment and evaluation, including safety and effectiveness of medication practices and other clinical issues are identified. Medication monitoring activities will be accomplished via review of cases involving prescribed medications. These reviews will be conducted between the ICBH Psychiatrist and another Psychiatrist. Review of cases receiving clinical and case management services will occur at staff meetings. An analysis of the peer review will occur to identify significant clinical issues and trends.

2. **Identify Meaningful Clinical Issues –** Quarterly, meaningful clinical issues will be identified and evaluated. Appropriate interventions will be implemented when a risk of poor quality care is identified. Monitoring will be accomplished via review of QIC minutes for satisfactory resolutions in the areas of grievances, medication monitoring, and peer chart review cases where plans of correction are requested. Re-occurring quality of care issues are discussed in staff meetings and at the QIC to address concerns.

3. **Implement and Maintain Efficient Work Flow Standards** – Office workflow standards will be implemented and maintained to efficiently and consistently serve consumers from first contact through discharge. Workflow processes will be documented in flowcharts and implemented through policies and procedures. Monitoring will be conducted through review of workflow processes and procedures.

4. **Assess Performance** – Quantitative measures will be identified to assess performance and identify areas for improvement, including the Performance Improvement Projects and other QI activities. For example, Behavioral Health Director reviews data on review loss reports; productivity reports; and late service plan reports. These areas will be measured through the quarterly review of the timeliness of assessments and service plans, completeness of charts, consumer surveys, and productivity reports. The results of these reviews will dictate areas to prioritize for improvement.

5. **Support Stakeholder Involvement –** Staff, providers, consumers, and family members review the evaluation data to help identify barriers to improvement. This ongoing analysis provides important information for identifying barriers and successes toward improving administrative and clinical services. In addition, the MHSA Steering Committee provides input on access and barriers to services. This is reported to the Mental Health Advisory Board and to the other QIC meetings.
6. **Conduct Frequent Peer Reviews** – ICBH will evaluate the quality of the service delivery by conducting chart audit peer reviews on a regular basis, at least quarterly. Reviews will be conducted by staff during staff meetings and at QII Staff Training. Issues and trends found during these reviews will be addressed at the QIC meetings to review need for policy or procedural changes.

The activities and processes outlined above will maintain sensitivity to the identification of cultural and linguistic issues.

E. **Monitor Continuity and Coordination of Care with Physical Health Care Providers**

When appropriate, information will be exchanged in an effective and timely manner with health care providers used by consumers.

1. Review of data collection through the Coordinated Care Collaborative (CCC) for interaction between primary care physicians and ICBH for psychiatric consultation or continuity of care.

2. ICBH will meet with the Rural Health Clinic or Northern Inyo Hospital Staff at least annually and to identify continuity of care process issues.

3. Measurement will also be accomplished during ongoing review of the clinical treatment plans. These reviews will identify referrals to alternative resources for treatment or other services whenever requested, or when it has been determined that an individual may benefit from referral to other health care providers. Appropriateness of exchange of information is measured during peer chart review by assuring the presence of a signed consent form.

F. **Monitor Provider Appeals**

Provider appeals will be recorded in a Provider Complaint Log and will be reviewed by the appropriate entity (e.g., the Business Analysis/Compliance Committee) and a recommendation for resolution will be made to the Mental Health Director. The resolution and date of response shall be recorded in the Log. The QIC reviews the Log for any trends and addresses these issues.

IV. STEPS IN THE REVIEW PROCESS

ICBH shall incorporate the following steps for each of the above QI activities:

1. Identify goals and objectives.
2. Collect and analyze data to measure against the goals, or prioritized areas of improvement, that have been identified.
3. Identify opportunities for improvement and decide which opportunities to pursue.
4. Design and implement interventions to improve performance.
5. Measure the effectiveness of the interventions.
6. Ensure follow-up of QI processes through the QI feedback loop to incorporate successful interventions in the mental health service system.

V. DATA COLLECTION

A. Data collection

Data collection sources and types shall include but not be limited to:

1. Utilization and Accessibility of services by type of service, age, gender, ethnicity, and primary language via CSI and the EHR System
2. Medication Monitoring Forms and Logs
3. Chart Review Forms and Logs
4. Consumer Complaint Log
5. Provider Complaint Log
6. Special Reports from DHCS or studies in response to contract requirements
7. Change of provider request forms from beneficiaries

B. Data Analysis and Interventions

1. Administrative staff shall perform preliminary analysis of data. If the subject matter is appropriate, clinical staff shall be asked to perform an analysis. Subsequent review shall be performed by the QIC.

2. The design of interventions shall receive input from individual staff, from committee meetings (including representatives of external agencies and consumers), and from management.

3. Interventions shall have the approval of the Behavioral Health Director prior to implementation.

4. Effectiveness of interventions will be evaluated by the QIC. Input from the committees will be documented in the minutes and a summary in the CQIC meeting minutes.

VI. DELEGATED ACTIVITIES

At the present time, ICBH does not delegate any review activities. Should delegation take place in the future, this Plan will be amended accordingly.

DESCRIPTION	GOAL Mental Health and Substance Use Disorders program	METHOD
ACCESS- QI committee emphasizes the access to services. Community outreach efforts to inform Hispanic and Native American populations of services to increase admissions of these underserved populations. Mental Health and SUD Services	**Goal: 5% increase in Hispanic and Native American outreach.**	Quarterly: Examine and graph new admissions and case load indicate AGE, RACE, GENDER, LANGUAGE, AIDE CODE/PAYOR and LOCATION of residence. Track outreach efforts
TRACK FOSTER CHILDREN SERVICES	**Goal: All children will be screened for service need.**	Quarterly: QA will determine with CPS the new FC children for that quarter and verify that they have been screened.
Timeliness of routine mental health appointments- The goal for routine appointments is no more than (7) work days (Defined by Bishop Clinic days of operation) between the initial request and the intake appointment. Mental Health and SUD services	**Goal: 75% goal of routine appointments conducted within 7 work days.** **Identify: gender, age, race (Hispanic/Native American) and language (Spanish) of those impacted greater than 20 days.**	Monthly: Compare the date of admission to first contact EHR progress note date. A cancellation/no show are accepted as a good faith contact. Calculate average response days % that met standard Range in Days **"Orientation Group" data for impact on access.** **1. Questionnaire for those who did not continue in services.**
Timeliness of Psychiatry Appointments- The goal is a psychiatry appointment with in 30 work days.	**Goal: 75% of routine Psychiatry appointments conducted within (10) work days.**	Quarterly: Days from authorization date on auth form to EHR Progress note by psychiatrist. Cancellation/ No show are accepted as a good faith contact. % appointment that met standard Range in days
Timeliness of Emergency Psychiatry appointments- Within 10 work days.	**Goal: 75% to meet standard.**	Monthly: Compare EHR crisis note date to Psychiatry appointment date.
No Show for Psychiatrist	**Goal set for :** **Cancel=5%**	Monthly : Run report on Cancel and No show and compare to schedule.

	No Show= 10%	
Timeliness of Follow-up to Hospitalization- The goal is to have contact with in 2 work days following discharge from a Psychiatric Hospitalization.	**Goal: 75% of cases follow up with in 2 work days**	Quarterly: Date of discharge from Hospital on LOG compared to EHR progress note date. Average length of time for follow-up appointment and % of appointments that met standard.
Review of re-admissions to Hospitalizations No more than 10% re-admission with in 30days	**Goal 10%**	Quarterly: Examine Hospital admissions for re-admission within 30 days.
Timeliness of services for Urgent or Emergent conditions <u>during regular clinic hours</u>- Clinic hours are defined as 8:00-12:00 and 1:00-4:00 Monday through Friday excluding holidays. Both Urgent and Emergent have the same response timeframes. **Urgent** is defined (9CCR 1810.253*) "Urgent condition means a situation experienced by a beneficiary that without timely intervention, is highly likely to result in an immediate emergency psychiatric condition."* **Emergent** is defined (9CCR 1810.216) *"Emergency Psychiatric Condition" means a condition that meets the criteria in section 1820.205 when the beneficiary with the condition, due to a mental disorder, is a current danger to self or others, or immediately unable to provide food or utilize, food shelter or clothing, and requires psychiatric inpatient or psychiatric health facility services."*	**Goal of 75% of responses within 1 hour.** **1 Hour phone contact to discuss plan of response.**	Monthly: Compare date/time on EHR call log to date/time response of On-Call worker noted in either call log or Progress note. Calculate Average response time
Timeliness of response to afterhours Urgent/Emergent requests-<u>After hours</u> response is defined all other time outside the above clinic hours. Both Urgent and	**Goal is 75% of responses to be within the time frame.**	Monthly: Compare EHR Call Log date/time to On-Call provider date/time on either the call logging or progress note.

Emergent have the same response timeframes. (*see definitions above)*	**1 Hour phone contact to discuss plan of response.**	
Jail Response 24 hours to respond and evaluate ISO cell needs.	**Goal 75%**	Monthly: Compare EHR Call Log date/time to On-Call provider date/time on either the call logging or progress note .
#800 review- Test the response of the 800#. **Annual test calls.**	**Suggestion:** **1.Calls to be answered in 4 rings 90% of the time.** **2. Quality of response Indicators: identified agency/self. Appropriate resource and safety concerns addressed 100% of the time.** **3.800# call tests conducted quarterly.**	QI team conducts 800# test and reports results to QIC. 1. Sample calls to include- access to services and language access. 2. DHCS has a quarterly report to be completed and submitted.
Performance expectations- Initial assessment/Diagnosis Within 30 calendar days of Admission Admission Diagnosis date to be the first date of a service within the admission.	**Goal 90%**	Quarterly: EHR date of admission compared to date of assessment.
Performance expectations- Treatment plan Within 60 calendar days of Initial assessment. Time frame to start at date of 1st service in admission.	**Goal 90%**	Quarterly: EHR date of admission compared to date of treatment plan signed by consumer.

SUD Treatment Plan Therapist and consumer to sign within 30 calendar days of admission. Psychiatrist to review within 15 calendar days of the therapist or consumer signing.	**Goal 90%**	Quarterly: EHR date of admission compared to date of treatment plan signed
Performance expectations-Initial Authorization Outpatient services within 14 work days	**Goal: 100% to be reviewed through authorization/staffing notes.**	Quarterly: Authorization sheet/staffing notes Reviewed # Not Reviewed# Crisis Only#
Performance expectations- Annual review In general the annual treatment plan and assessment update is to be the month of the Admission.	**Goal: 100% to be reviewed in the Month they are due or by next service date.**	Annual Due log compared to authorization (sheet) /staffing notes.
SUD Update of treatment plan Therapist and consumer to sign update with 90 calendar days of the signing of the initial treatment plan. Psychiatrist to review within 15 calendar days of the therapist or consumer signing.	**Goal 90%**	EHR date of admission compared to date of last treatment plan signed.
Performance expectations-Timeliness of progress notes.	**Goal 100% for completion in 7 days of service. *Additional 7 days for co-signature**	Monthly review of date of service and date note signed
SUD Timeliness of Progress Notes	**Goal 100% for completion in 7 days of service. *Additional 7 days for co-signature**	Monthly review of date of service and date note signed
Beneficiary Protection- Complaints and grievances. Change in Provider Requests	**Goal: Maintain 0**	Quarterly: Examine LOG-Trends reported per MH director.

Beneficiary Protection- Notices of action	**Goal: Maintain 0**	Quarterly: Examine LOG-Trends reported per MH director.
Provider Complaints/grievances	**Goal: Maintain 0**	Quarterly: Examine LOG-Trends reported per MH director.
Organizational providers are certified and recertified in compliance with title 9	**Goal: Maintain 0**	Quarterly: Examine log-DHCS Report
Capacity Capacity might be thought of as related to productivity. Productivity is calculated as 60% of the available hours (available hours subtracts out staffing and other meetings as well as benefit time) and gives credit for all direct services, not just billed ones. As a clinic we have never really gotten close to meeting productivity standards as we have set them. Exceeding them or having a waiting list would suggest the need to add staff, all other things being equal. We tend to add staff as we add new programs or expand existing ones. Gail Zwier PhD ,Mental Health Director	**Goal: Productivity of staff 60% goal for billable services. Increase by 5% in fiscal year.** **Goal: Increase services to SMI Diagnosis population by 5% in fiscal year.** **Goal: Review location of services and increase underserved populations by 5% in fiscal year.**	Quarterly: Review staff productivity logs Quarterly: Review case load Diagnosis for SMI population. **Consideration to exclude age 0-17** Quarterly: Review case load and Medi-Cal Eligibles.
Diagnosis Trends	**QIC review Goal to monitor if service array appropriate to diagnosis of consumers.**	Annual: Diagnosis report at the end of the quarter to see trends in diagnosis and if array of services and group content fits clinical needs. This will be done by clinical staff
Program Integrity 1. Are services actually provided to consumers? 2. Services without progress notes 3. Assessments billed actually completed	1. **Goal: 90% accuracy** 2. **Goal: Maintain 0** 3. **Goal: Maintain 0**	Consumer Verification Activity Fiscal sends service without progress notes report to staff. Corrections and disallowances examined. EHR report on Assessment billed compared to

		assessments completed in EHR.