FY 19-20

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 Health and Human Services-Behavioral Health (ICHHS-BH) 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 ICHHS-BH 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

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
- Cultural Competency Training
- 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 QIC in summary format to ensure that we maintain a client's confidentiality in this small, rural community.

3. The Quality Improvement Committee (QIC) 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 QIC provides oversight and is involved in QI activities. The QIC 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 QIC 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 in the past has included 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 have been made to include representation from Toiyabe Indian Family Services, Inyo County Superintendent of Schools, and the Rural Health Clinic. In FY 17/18 and 18/19 we experienced a decline in community involvement in our QIC meetings compared to prior years.

In FY 19/20 we focused on increasing community involvement in our committees by hosting a series of stakeholder engagement events. These events were structured in a way that participants wanted to attend; we provided food, delivered information, starting with the basics of our programs and defined our various meeting structures. In 2020 we started a survey of the month question for both internal stakeholders and consumers. Our clients will have the opportunity to engage their peers in answering our survey and receive a gift card for their engagement efforts. These efforts will increase the consumer voice in our decision making.

Due to the diverse membership of the QIC, 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 QIC presents information to the Behavioral 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 QIC 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.

ICHHS-BH makes an effort to procure contracts with individual, group, and organizational providers, as well as 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 program conducts annual sit visits with our contracted providers to ensure program integrity.

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 data 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.
Our QIC meeting also includes our Cultural Competence Committee, which helps drive our strategies.

III. OBJECTIVES, SCOPE, AND PLANNED ACTIVITIES

Quality Improvement activities for FY 2019/2020 include the following objectives:

A. **Ensure ICHHS- BH Service Delivery Capacity**

The ICHHS-BH 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 QA staff. QA 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 ICHHS-BH QI program shall monitor accessibility of ICHHS-BH 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 10 business 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 Access Line** – 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. Four test calls will be made per quarter: two calls per quarter in English and two calls per quarter in Spanish. Training of all staff utilizing Access Line 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 QIC, 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, QIC and Behavioral Health Advisory Board minutes. The QIC will show findings quarterly and provide an annual summary.

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 ICHHS-BH 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 ICHHS-BH 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 Behavioral Health Advisory Board and to the other QIC meetings.
6. **Conduct Frequent Peer Reviews** – ICHHS-BH 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 ICHHS-BH for psychiatric consultation or continuity of care.

2. ICHHS-BH 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

ICHHS-BH 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. Network Adequacy Reports
3. Medication Monitoring Forms and Logs
4. Chart Review Forms and Logs
5. Consumer Complaint Log

6. Provider Complaint Log
7. Special Reports from DHCS or studies in response to contract requirements
8. 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 QIC meeting minutes.

VI. DELEGATED ACTIVITIES

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

OBJECTIVE	ACTIVITY	PERSON(S) RESPONSIBLE OR PROGRAM	AUDITING TOOL	TIMELINES/ COMPLETION DATE
Goal #1: Monitor and Ensure Service Delivery Capacity				
Objective A: Location of clients receiving services by zip code Demographics of clients receiving services (Adult, Children, Foster) Types of services clients are receiving Client diagnoses	Monitor data collected on Medi-Cal beneficiaries Data to be analyzed by QIC and Leadership to determine areas of deficiencies	QA Staff Analyst QA Supervisor QIC Leadership	Client roster report Client diagnosis report Client services report NACT	Quarterly
Objective B: Monitor Productivity in accordance with predetermined staff-specific productivity measures	Staff will enter all services into Kingsview Staff productivity will be evaluated by utilizing productivity reports based on the client services report Supervisors will monitor reports	QA Analyst Leadership Staff	Anasazi Reports Productivity spreadsheet	Monthly
Objective C: Track previously identified QI activities over time	Analyst Team will track QI activities over time to include objectives, scope, and planned activities with targeted areas of improvement	QA Analyst Leadership QIC	QI Work Plan QIC Agendas QIC Minutes	Ongoing tracking system Report quality of care concerns quarterly at QIC
Goal #2: Ensure Accessibility to Services				
Objective A: Monitor timeliness of routine initial mental health assessment to ensure compliance with the 10 business day standard	Assign to PIP to explore options Provide training to staff on the CFR 42 requirements for time and distance	QA Analyst QA Supervisor	NACT Assessment Measures Report CANS	Quarterly

OBJECTIVE	ACTIVITY	PERSON(S) RESPONSIBLE OR PROGRAM	AUDITING TOOL	TIMELINES/ COMPLETION DATE
Monitor timeliness of psychiatry appointments to ensure compliance with the 15 business day standard	Timeliness of assessments will be tracked from date of request to first offered appointment Staff will further delineate the data into Adult, Children's, and foster children			
Objective B: Monitor timeliness of response to urgent and emergent calls during clinic hours to ensure 75% are made within one hour Monitor timeliness of response to urgent and emergent calls after hours to ensure 75% are made within one hour	Staff will utilize the on-call logs Data to be analyzed by QIC and Leadership to determine areas of deficiencies	QA Analyst Leadership Staff	On-Call logs	Quarterly
Objective C: Track utilization of urgent appointment provision within 7 days	Urgent conditions will be included in quarterly timeliness report	QA Analyst Supervisors	Call Logs	Quarterly
Objective D: Monitor post hospitalization follow up appointments being offered within 7 days. Develop a P&P	Follow up appointments will be tracked according to discharge date Identify clients for increased outreach efforts	Hospital Liaison (?) Assistant to the Deputy Director, BH	Post hospitalization follow up sheets Hospitalizations Spreadsheet	Quarterly
Objective E: Monitor the responsiveness of the 24 hour, toll-free telephone number with all calls being	Test Calls will be conducted at a rate of no less than four per quarter • 2 calls will be in English	QA Staff QIC	Test Call Worksheet Test Call scripts	Quarterly

OBJECTIVE	ACTIVITY	PERSON(S) RESPONSIBLE OR PROGRAM	AUDITING TOOL	TIMELINES/ COMPLETION DATE
provided appropriate information and logged Monitor no show rates and cancellation rates for Psychiatry	• 2 calls will be in Spanish Calls will be evaluated on the following information: • How to access specialty mental health services • Information for urgent conditions • How to use the beneficiary problem resolution and fair hearing process • 24/7 Access training (including interpreter access) will be offered to all staff bi-annually		Test call data will be reported quarterly to DHCS and reviewed at QIC Language Line dashboard	
Objective F: Ensure the provision of culturally and linguistically appropriate services by developing a mental health-focused interpreter training curriculum	Culturally relevant trainings will be planned annually in accordance with the Cultural Competency Plan Linguistic access training will be offered to staff	QIC CRC	Sign in sheets Training flyers Pre/Post tests	Projected Completion: Dec 2019 Annual Training Reassessed every October QIC for the CCP in Dec.
Objective G: Monitor no show rates and cancellation rates for clinicians	Monitor no show and cancellation rates with a goal of 90% of appointments being kept	QA Staff Analyst Leadership	Survey results reported to staff Survey Results	Quarterly

OBJECTIVE	ACTIVITY	PERSON(S) RESPONSIBLE OR PROGRAM	AUDITING TOOL	TIMELINES/ COMPLETION DATE
	Tracked quarterly and sorted by Adult, children, and foster care services and further delineated by MHP initiated, and client initiated cancellations		Report to QIC Email	
Objective H: Treatment Authorization Requests (TAR) will be reviewed for medical necessity and authorized or reauthorized as appropriate within 14 calendar days	TARs will be reviewed and decisions will be documented within 14 days of receipt Monitor this indicator monthly 100% will meet this timeline	QA Supervisor Medical Director Deputy Director	TAR Log Authorization Audits reported semi-annually to QIC	Semi-Annually
Objective I: Fully implement CANS (ages 6-20) and PSC-35 (ages 3-18) for all new clients by March 2020 Timing and administration – CANS and PSC-35 are due: 1. At initial intake (within 60 days) 2. Ongoing every 6 months while case is open 3. At discharge.	Children's Team will work with Child Welfare to develop policies and procedures related to implementation, to include roles and responsibilities (DHCS Notice 17-052, DHCS Notice 18-007, DHCS Notice 18-029) Develop a P&P for training new employees who are responsible for administering the assessments	Children's Program Chief Children's Team Child Welfare Services CPS Supervisor QA Staff Case Reviewers	Kingsview Report CFSR Case Reviews	Quarterly Reporting
GOAL # 3: Beneficiary Satisfaction				
Objective A: Assess beneficiary and/or family member satisfaction Goal is to increase number of	Develop services survey Train office staff in requesting surveys	Staff QIC	QIC POQI annually Meeting Minutes	Quarterly After each State Survey and Satisfaction

OBJECTIVE	ACTIVITY	PERSON(S) RESPONSIBLE OR PROGRAM	AUDITING TOOL	TIMELINES/ COMPLETION DATE
completed surveys Goal is to increase overall satisfaction by 3%. Assess knowledge and requests for services	Utilize peer support for client assistance Survey beneficiary and/or family member for satisfaction		Consumer Satisfaction Survey Consumer Question of the Month	Survey
Objective B: Communicate the results of surveys to all stakeholders	Discuss the results at the community QIC meeting following results	QA Staff Leadership	Survey results Meeting minutes Sign-in sheet	Quarterly, as applicable
GOAL #4: Monitor Safety and Effectiveness of Medication Practices				
Objective A: Monitor safety and effectiveness of medication practices Identify Quality of Care Concerns regarding Psychotropic Medication	Conduct chart reviews Update medication consents to adhere to state regulations Medication monitoring Run reports on the types of medications prescribed Develop a P&P regarding actions to address these concerns Report to QIC	Nurse supervisor QA Staff QIC	Medication Chart Reviews QIC Agenda/Minutes	Monthly Quarterly
GOAL #5: Coordination and Quality of Care				
Objective A: Coordinate services with Primary Care Provider (PCP) and other agencies	Evaluate coordination with Primary Care Providers Meet with managed care	QA Staff Contract Providers	Screening tool Timeliness Reports	

OBJECTIVE	ACTIVITY	PERSON(S) RESPONSIBLE OR PROGRAM	AUDITING TOOL	TIMELINES/ COMPLETION DATE
	partners Outreach to PCP and offer case management support for continuity of care Formalize a referral system between agencies	Staff PCP's	NOABD Review Referral form Policy and procedure Training	
Objective B: Monitor Medi-Cal billing and documentation compliance	Conduct Chart reviews Provide training if necessary Track billing errors to determine if further training is necessary Review compliance log	QA Staff Compliance Officer Leadership	Compliance Log Chart Audits	Quarterly
Objective C: Monitor Drug Medi-Cal billing and documentation compliance in accordance with Title 22 regulations	Develop a SUD chart audit tool with Title 22 compliance Conduct chart audits at a rate of 5% per year	SUD supervisor SUD staff QA analyst Compliance officer	SUD chart tool Chart audit log	Quarterly
Objective D: Monitor Beneficiary grievances, change of providers, and appeals Grievances will be resolved within regulatory standards of 90 calendar days	Monitor change of provider requests, including the reason given by consumers and Notice of Adverse Benefit Determination (NOABDs) Monitor Grievance/Appeal log	QA Staff Compliance Officer Leadership	Grievance submissions Grievance reports Report to QIC quarterly NOABD log	On-going

OBJECTIVE	ACTIVITY	PERSON(S) RESPONSIBLE OR PROGRAM	AUDITING TOOL	TIMELINES/ COMPLETION DATE
Standard Appeals will be resolved according to regulatory standards of 30 calendar days Expedited appeals will be processed within 72 hours	Educate staff in the CFR 42 requirements		Change of Provider Requests Change of Provider Reports Report to QIC quarterly	
Objective E: Develop and provide a training on identifying and coding of co-occurring disorders Develop a reporting mechanism Performance Improvement Project	Provider trainings will be held or invitations will be made for in house training	QA Staff SUD Team Clinical Staff Leadership	Referral Form-(in development) Co-occurring disorder report	Pre-work-July/August 2019 Implementation-August/September 2019 Evaluation : March 2020 & ongoing
Objective F: Performance Improvement Project Non Clinical PIP: Timeliness-all appts. scheduled by front office and block	Train front office staff to make appointments Pilot with adult clinicians, followed by SUD, and children's clinicians	QIC/ PIP committee QA Staff Clinical Staff Supervisors	Timeliness Reports NACT Stakeholder Feedback	Pre work July – September 2019 Phased implementation from July-October Evaluation: Starting in October 2019 and Ongoing Quarterly