Glenn County
Specialty Mental Health Plan

FY 2018/19
Quality Improvement Work Plan

and

FY 2017/18
Work Plan Evaluation

QUALITY IMPROVEMENT (QI) PROGRAM DESCRIPTION

The Glenn County Specialty Mental Health Plan (GCSMHP) is a part of Behavioral Health and one of the departments within the Health and Human Services Agency (HHSA). The GCSMHP is responsible for authorizing and providing inpatient and outpatient specialty mental health services to Glenn County Medi-Cal clients. Currently, the GCSMHP has five (5) county sites, two (2) of which are drop-in centers and one (1) satellite site.

The Quality Improvement (QI) Program will improve outcomes through structural and operational processes and activities that are consistent with current standards of practice and professional knowledge.

The QI Program will conduct performance monitoring activities through the GCSMHP, including but not limited to client and system outcomes; utilization management; utilization review; provider appeals; credentialing and monitoring; and resolution of client change of provider requests, grievances, appeals, and expedited appeals.

This QI Program description clearly defines the QI Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize areas for improvement. The QI Program will be evaluated annually and updated as necessary to assure that the goals of the GCSMHP are being met.

Staff, committees, meetings, and task forces, report and provide feedback to the Quality Improvement Committee (QIC). The Behavioral Health Director is a regular member of the QIC and if she is absent, she is kept informed by meeting minutes.

Quality Improvement Committee

The Quality Improvement Committee (QIC) is responsible for overseeing all quality improvement (QI) activities. The QIC provides a forum for the Glenn County Specialty Mental Health Plan's (GCSMHP) providers, staff, consultants, clients, family members, volunteers, Mental Health Advisory Board members, and community members to actively participate in the planning, design, and execution of the QI Program.

The QIC will recommend policy changes, review, and evaluate the results of QI activities including performance improvement projects (PIPs), institute needed QI actions, and ensure follow up of QI processes. The QIC will also monitor the utilization management (UM) process to ensure that the GCSMHP meets the established standards for authorization decision making or take action to improve performance if the timeframes are not met. The QIC will meet quarterly, for a total of four (4) meetings annually.

System Improvement Committee

The System Improvement Committee (SIC) also provides a forum for the Glenn County Specialty Mental Health Plan's (GCSMHP) providers, staff, consultants, clients, family members, volunteers, Mental Health Advisory Board members, and community members to review and analyze quality improvement (QI) and cultural competency data and information

in areas identified as needing improvement, in order to make informed program choices and system improvement. The SIC will recommend policy changes, review and evaluate the results of QI activities including performance improvement projects (PIPs), institute needed QI actions, and ensure follow up of QI processes. The SIC aims to meet twice per quarter, but no less than four (4) times per year.

Chart Review

Chart review activities may occur within the Quality Improvement (QI) Department, Quality Improvement Committee (QIC), Medication Monitoring, staff meetings, peer chart review, and as necessary. A formal chart review is conducted monthly that includes key QI staff and other staff members who are trained on the process.

Chart review will include a minimum annual sample of 10% of all open cases. Of this 10% sample, 50% will be randomly selected and 50% will be selected from the heaviest users, defined as those using crisis services more than two (2) times in a month or having more than two (2) hospitalizations in a year, and will include clients who have attempted suicide or homicide, or have presented as gravely disabled. Staff reviewing the charts will use a QIC-approved, Chart Review Checklist. Chart deficiencies/problems are noted at the bottom of the Chart Review Checklist and a copy is given to the appropriate staff to correct. An ongoing feedback loop between staff and supervisors is used to track identified chart review issues and to document progress toward resolution over time. QI staff also keeps a running log of pending corrections, reviews, and their respective due dates and dates of completion.

Utilization Review (UR) staff will monitor and approve out of county authorizations as well as inpatient treatment authorization requests. UR staff will also monitor specialty mental health services to ensure that consistent and cost-effective quality services are provided.

Staff meetings provide for a system-wide team approach involving multi-disciplinary staff to help develop appropriate goals based on a client's current medical, psychiatric, psychosocial, and substance use history. These meetings provide a coordinated system of care approach in order to avoid duplication of services regarding the planning, formulation, and development of comprehensive client treatment plans. Referrals are made to physical health care providers, Substance Use Disorders Services, Probation, Juvenile Hall, Social Services, and other agencies as indicated, to assure coordination and continuity of care and to provide our clients with the highest quality of services available.

Compliance Committee

In coordination with the Compliance Officer, the Compliance Committee (CC) performs vital functions to assure compliance with State and Federal regulations. The CC is responsible for the following compliance activities: Receiving reports on compliance violations and corrective actions from the Compliance Officer, advising the Compliance Officer on matters of compliance violations and corrective actions, advising the Director on compliance matters, advising staff on compliance matters, developing and maintaining the Compliance Plan and policies, ensuring that an appropriate record keeping system for compliance files is developed and maintained, ensuring that compliance training programs are developed and made available to employees and that such training is documented, ensuring that a

developmental review and audit system is developed and implemented to ensure the accuracy of claims documentation and submission process to all payers which include identifying compliance issues, recommending corrective action, and reviewing the implementation of corrective action. Compliance is also on the agenda and discussed at QIC/SIC meetings. The CC aims to meet monthly, but no less than six (6) times per year.

This committee will review, monitor, and work to ensure the following: Documentation is accurately coded and reflects the services provided, documentation is being completed correctly and in a timely manner, services provided meet medical necessity criteria, and incentives for unnecessary billing do not exist. Monthly data on staff productivity, service data (i.e. service codes used), and service verification information may be reviewed. Medi-Cal Denial Reports help to identify any potential compliance issues and the denials are reviewed and resolved on an ongoing basis as the EOB's are made available by DHCS on ITWS. Health Insurance Portability and Accountability Act (HIPAA) is a standard agenda item for this committee and we will continue to keep informed of HIPAA requirements impacting the GCSMHP.

Cultural Competence Task Force

The Cultural Competence Task Force (CCTF) monitors the implementation of the Glenn County Specialty Mental Health Plan's (GCSMHP) Cultural and Linguistic Competence Plan (CLCP). The CCTF is responsible for developing, implementing, and monitoring cultural competency throughout all levels of the agency. Additional responsibilities include reviewing goals and objectives which promote culturally competent services and agency culture as set forth by the CLCP annually. The CCTF will be involved in planning consumer and/or community events which focus on cultural awareness. The CCTF will also review data reports on access, retention, and client outcomes across age, race, ethnicity, gender, income, and town of residence. Recommendations will be made to outreach to disparate groups and to provide presentations to Executive Committee (EC), Mental Health Advisory Board, System Improvement Committee (SIC), and Quality Improvement Committee (QIC), as needed. The CCTF may also recommend policy changes to the appropriate committees, review and evaluate the results of the cultural competency activities, institute needed actions as specified by the QIC and SIC, ensure follow up of cultural competency processes, and provide training and awareness building for agency staff and the community. The CCTF aims to meet monthly, but no less than six times per year.

The vision/mission statement of the CCTF is:

We believe culturally and linguistically competent practices increase and improve quality of service, and create an atmosphere respective of cultural identity and self-awareness focusing on wellness for all.

Ethnic Services Coordinators Committee

In coordination with the Cultural Competence Task Force (CCTF), the Ethnic Services Coordinators' Committee provides assistance and consultation in the development of linguistically and culturally appropriate services delivered by bilingual/bicultural staff. The Ethnic Service Coordinators' intention is to provide better client care, staff care, training, and oversight on all components of the delivery of bilingual services. ESCC members meet regularly to coordinate the use of language services, such as identifying people who are

available to provide translation and interpretation on an ongoing basis. The ESSC also provides an opportunity for bilingual staff to come together, ask questions, discuss how others are translating complex mental health terms, and ensures consistency across all interpreters. This helps to improve the quality of care and standardize language for our clients, staff, and psychiatrists. ESCC is also tasked with implementing actions identified and recommended by the Cultural Competence Task Force as well as the External Quality Review (EQR), and Department of Health Care Services audits. ESCC focuses on meeting recommendation deadlines set forth by reviews. ESCC also assists in providing the needed trainings identified by the CCTF with the use of its bilingual/bicultural staff members. ESCC aims to meet on a monthly basis, but no less than six times per year. The ESC Mission statement is:

The ESCC vision/mission statement is:

To assist the agency with elimination of disparities within Behavioral Health for people of diverse backgrounds through training and support, as well as to ensure our Cultural and Linguistic Competence Plan remains effective and responsive to change.

Organizational Providers

All providers are required by contract to meet standards established by the Glenn County Specialty Mental Health Plan (GCSMHP) and State and Federal regulations. These standards are detailed in the Glenn County Mental Health (GCMH) Provider Handbook that providers receive with their contract annually. Providers are also required to cooperate with the GCSMHP Quality Improvement (QI) Program, and must allow the GCSMHP and other relevant parties to access relevant clinical records to the extent permitted by State and Federal laws. Prior authorization is required for all clients. Data that may potentially be studied includes: access and authorization process, billing, certifications and re-certifications, change of provider requests, chart review, contracts, credentialing, Department of Health Care Services' (DHCS) consumer perception surveys, documentation, grievances/appeals/expedited appeals, incident reports, NOABDs, provider appeals, and state fair hearings.

Staff Unit Meetings

Meetings occur at different frequencies depending on the staff and program, with most programs meeting at least monthly. These meetings include: All Behavioral Health, Substance Abuse Disorders Services (SUDS), Mental Health Services, Harmony House Adult Drop In Center, Transition Age Youth (TAY) Drop In Center, Child Abuse Treatment Team (CHAT), Katie A., System-wide Mental Health Assessment and Response Team (SMART), Crisis Team, Case Consultation, Group Supervision, Wellness Teams, Secondary Trauma, Behavioral Health Leadership Team, Program Managers, Case Assignments, Telepsychiatry, Support Staff, and Quality Improvement Team. Many of these meetings include discussions of treatment, culture, primary language, age, gender, and diagnostic issues, which allow both training and collaborative problem-solving to take place. Difficult cases are followed closely and frequently, and feedback is used to discuss issues and to assure that quality care is continuously delivered.

It is a value of the Glenn County Specialty Mental Health Plan (GCSMHP) to ensure continuity and coordination of care with physical health care providers, Substance Use Disorders Services, Probation, Juvenile Hall, and other departments within the Health and Human Services Agency (HHSA). The GCSMHP will coordinate with other human services agencies and departments used by its clients. Referrals are made to these agencies and departments as necessary, to provide our clients with the highest quality of services available. We have an MOU with AMPLA Health Care, Inc., and we continue to make referrals. The goal of the program is to ensure that persons with mental illness have a medical home, and that physical health outcome indicators show improvement for consumers. The GCSMHP will assess its effectiveness annually.

GCSMHP utilizes the Contact Log (a Microsoft Access database) and Anasazi (electronic health record) for data, reports, and claims, to detect both underutilization and over utilization of services.
The Glenn County Specialty Mental Health Plan (GCSMHP) has implemented the following mechanisms to assess client and family satisfaction:

- *The GCSMHP administers the Consumer Perception Surveys in May and November of each year, as required by the Department of Health Care Services (DHCS). Copies of the results are reviewed by staff in a number of staff meetings.*
- *Quality Improvement (QI) staff strive to provide responsive and timely actions to all change of provider requests, grievances, appeals, expedited appeals that are received, and provide this information to the Quality Improvement Committee (QIC).*
- *The GCSMHP reviews, discusses, and evaluates the following items in the QIC quarterly: HIPAA complaints, client grievances, appeals and expedited appeals, state fair hearings, Notice of Adverse Benefit Determinations (NOABDs), change of provider requests, 24/7 Crisis Line testing, trainings, incident reports, and reports of morbidity and mortality.*
- *Additionally, the GCSMHP submits the quarterly 24/7 test call update report forms, the Annual Beneficiary Grievance and Appeal Report, and any other reports to DHCS as requested.*

The Glenn County Specialty Mental Health Plan (GCSMHP) will inform providers of the results of client and family satisfaction activities in a number of ways.

- *Satisfaction survey results are distributed and discussed at staff meetings Quality Improvement Committee (QIC) and/or System Improvement Committee (SIC), and Leadership Team. The results of client grievances, appeals, expedited appeals, fair hearings and change of provider requests are discussed promptly with providers who are affected, if applicable and appropriate.*

The *Quality Improvement Committee (QIC)* will implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism will be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring will occur no less than annually.

- *Medication monitoring is performed using a Quality Improvement Committee (QIC)-approved Medication Monitoring Checklist. The Glenn County Specialty Mental Health Plan (GCSMHP) has a contract with a local pharmacist who reviews a minimum annual sample of 10% of all clients receiving medication services. Selection of charts may be*

random or targeted as necessary. The medication monitoring checklists are shared with medical staff to resolve any issues raised by the medication review and to make appropriate recommendations for responsive action in those cases where psychiatric medication prescribing practices or patterns vary from accepted clinical practices. Review criteria are based upon important aspects of care approved by the QIC and include: Appropriate medical monitoring, appropriateness of dosage level, indications for use of medication, evidence of positive responses to treatment, and chart documentation (evidence of adverse reactions and side effects, evidence of annual informed consent, evidence of appropriate laboratory work, evidence of client compliance, and evidence of client education). QI staff review the medication monitoring checklists at the end of each fiscal year to take an in depth look at issues noted and to see if trends occur. These medication monitoring checklists are summarized and this information is shared at the next QIC meeting.

The Glenn County Specialty Mental Health Plan (GCSMHP) will implement mechanisms to address meaningful clinical issues affecting clients system-wide.

- *Meaningful clinical issues will be identified through Chart Review, Performance Improvement Projects, Medication Monitoring activities, Utilization Review, and staff meetings.*

The Glenn County Specialty Mental Health Plan (GCSMHP) will implement mechanisms to monitor appropriate and timely intervention of individual occurrences that raise quality of care concerns. The GCSMHP will take appropriate follow up action when an individual occurrence is identified. The results of the intervention will be evaluated by the GCSMHP at least annually.

- *Individual occurrences of potential poor quality may be handled differently, depending on how the occurrence of potential poor quality was identified. Occurrences of potential poor quality may be identified in Chart Review, Performance Improvement Projects, Medication Monitoring activities, Utilization Review, staff meetings, monitoring and auditing activities, or by clients and staff. Based on the occurrence that was identified, interventions will be implemented as appropriate, and evaluated at least annually.*

QUALITY IMPROVEMENT WORK PLAN

The Glenn County Specialty Mental Health Plan (GCSMHP) will have a Quality Improvement (QI) Work Plan covering the current contract cycle, with documented annual evaluations and updates as needed. The QI Work Plan will include:

1) Evidence of the monitoring activities including, but not limited to, review of client grievances, appeals, expedited appeals, fair hearings, provider appeals, and clinical records review as required.
2) Evidence that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and client service.
3) A description of completed and in-process QI activities, including performance improvement projects. The description will include:
    a. *Monitoring previously identified issues, including tracking issues over time;*
    b. *Objectives, scope, and planned QI activities for each year; and*
    c. *Targeted areas of improvement or change in service delivery or program design.*

FY 2017/18 ANNUAL WORK PLAN EVALUATION

Service Delivery Capacity Goals
(Number, type, and geographic distribution of mental health services)

1) Increase the number of Individual Rehabilitation services provided to FSP clients at all locations to a total of 450 services over the next fiscal year. This will represent a 150% increase from the 300 Individual Rehabilitation services provided to FSP clients in FY 2016/17.
   * *(This goal is based upon the recognition that Individual Rehabilitation services is an important component of service delivery for FSP clients, but is an underrepresented service overall.)*
    - **Total (Individual Rehabilitation) services: 514**
        - **Overall Goal: 450**
        - **Goal Met**
        - Percentage of Goal Completed: 114.2%

2) Increase Group Therapy services provided in Willows to 24 services in the next fiscal year, representing an increase from 0 Group Therapy services provided in Willows in FY 2016/17.
   * *(This goal is based upon a threshold of providing at least one (1) six-week therapy group each quarter in FY 2017/18.)*
    - **Total (Group Therapy) services: 1**
        - **Overall Goal: 24**
        - **Goal Not Met**
        - Percentage of Goal Completed: 4.2%

3) Increase Group Therapy services provided in Orland to 48 services in the next fiscal year, representing an increase from 0 Group Therapy services provided in Orland in FY 2016/17. * *(This goal is based upon a threshold of providing at least two (2) 6-week therapy groups each quarter in FY 2017/18.)*
    - **Total (Group Therapy) services: 35**
        - **Overall Goal: 48**
        - **Goal Not Met**
        - Percentage of Goal Completed: 72.9%

4) Increase Intensive Home Based services (IHBS) services provided in Willows to a total of 120 services over FY 2017/18. Due to addressing a significant drop in this service type being provided in Willows during FY 2016/17, this increase will represent an approximate 757% increase from the 14 IHBS services provided in Willows over the next fiscal year.
    - **Total (IHBS) services: 59**
        - **Overall Goal: 120**
        - **Goal Not Met**
        - Percentage of Goal Completed: 49.2%

5) With training and support to staff, increase the number of plan development services provided to clients who received an Assessment or Reassessment by 10%. In FY 2016/17, only 465 clients out of 644 received a plan development service following their Assessment or Reassessment (72.2%).
    - **Total (assessment) services: 687**
    - **Total (plan development) services: 422**
        - **Overall Goal: 82.2%**
        - **Goal Not Met**
        - **Percentage of Goal Completed: 61.4%**

Accessibility of Services Goals

1) Responsiveness of the GCSMHP 24 hour toll-free telephone number.
    - *The GCSMHP 24 hour telephone service line will be tested, with a minimum of three test calls monthly. The GCSMHP's goal is that* ***80% of all test calls are successfully answered****. All test calls are recorded in the 24/7 Crisis Line Testing Log and scored on a 5 point scale. A point is given for each of the following criteria met: the call was answered, the crisis worker asked the caller if it was a crisis or an emergency, the caller was linked to interpretation services (if applicable), the test call was logged, and a crisis note was written. In order for a test call to be successful and pass, all five criteria must be met.*
        - **Total calls conducted: 37**
            - **Overall Goal: 29.6**
            - **Goal Not Met**
            - **Percentage of Goal Completed: 70.3%**

2) Timeliness of scheduling routine appointments.
   - *Clients requesting outpatient services will be seen for a face-to-face assessment within **ten (10) calendar days** of the initial request for services. The GCSMHP's goal is that **85% of all appointments are seen within 10 calendar days.***
     - **Average Days for All Clients: 9.2**
       - **Overall Goal: 85%**
       - **Goal Not Met**
       - **Percentage of Goal Completed: 67.4%**
     - **Average Days for Adults: 9.9**
       - **Overall Goal: 85%**
       - **Goal Not Met**
       - **Percentage of Goal Completed: 64.6%**
   - **Average Days for Children/Youth: 8.3**
     - **Overall Goal: 85%**
     - **Goal Not Met**
     - **Percentage of Goal Completed: 71.0%**
   - **Average Days for Foster Care: 8.8**
     - **Overall Goal:85%**
     - **Goal Not Met**
     - **Percentage of Goal Completed: 64.0%**

- *Clients requesting medication services will be seen for a face-to-face assessment within **fifteen (15) calendar days** of the initial request for services. The GCSMHP's goal is that **75% of all appointments are seen within 15 calendar days.***
  - **Average Days for All Clients: 26.5**
    - **Overall Goal: 75%**
    - **Goal Not Met**
    - **Percentage of Goal Completed: 18.6%**
  - **Average Days for Adults: 26.9**
    - **Overall Goal: 75%**
    - **Goal Not Met**
    - **Percentage of Goal Completed: 17.5%**
  - **Average Days for Children/Youth: 25.7**
    - **Overall Goal: 75%**
    - **Goal Not Met**
    - **Percentage of Goal Completed: 21.1%**
  - **Average Days for Foster Care: 29.0**
    - **Overall Goal:75%**
    - **Goal Not Met**
    - **Percentage of Goal Completed: 0.0%**

3) Timeliness of services for urgent conditions.
   - *Clients presenting during **business hours** with a crisis or an urgent condition will be **seen within one (1) hour**. The GCSMHP's goal is that **90% of clients are seen within one (1) hour**, but all efforts are made to see the client immediately.*
     - **Average Minutes for All Clients: 12**
       - **Overall Goal: 90%**
       - **Goal Not Met**
       - **Percentage of Goal Completed: 98.6%**
     - **Average Minutes for Adults: 12**
       - **Overall Goal: 90%**
       - **Goal Not Met**
       - **Percentage of Goal Completed:: 98.1%**
     - **Average Minutes for Children/Youth: 11**
       - **Overall Goal: 90%**
       - **Goal Not Met**
       - **Percentage of Goal Completed: 100.0%**
     - **Average Minutes for Foster Care: 10**
       - **Overall Goal: 90%**
       - **Goal Not Met**
       - **Percentage of Goal Completed: 100%**

4) Access to after-hours crisis services.
   - *All clients requesting after-hours crisis services will call the GCSMHP 24 hour toll-free telephone number. The GCSMHP will have an on-call crisis worker handle the crisis. If the crisis is determined to be a 5150 or in need of a face-to-face evaluation, the client will be seen in person within one (1) hour. The GCSMHP's goal is that **90% of clients are seen within one (1) hour**, but all efforts are made to see the client immediately.*
     - **Average Minutes for All Clients: 19**
       - **Overall Goal: 90%**
       - **Goal Not Met**
       - **Percentage of Goal Completed: 94.1%**
     - **Average Minutes for Adults: 19**
       - **Overall Goal: 90%**
       - **Goal Not Met**
       - **Percentage of Goal Completed: 95.8%**
     - **Average Minutes for Children/Youth: 19**
       - **Overall Goal: 90%**
       - **Goal Not Met**
       - **Percentage of Goal Completed: 89.7%**

Activities for Sustaining Improvement

1) Revamp AB109 behavioral services for the re-entry population, and establish a mental health court to reduce recidivism and incarceration of persons who have a mental illness.
   - *We are in the process of implementing the Behavioral Health Treatment Court, which will the "Kickoff" event on August 15, 2018 in Willows.*

2) Restructuring of the Weekend Wellness program to increase afterhours support for clients.
   - *Although the Weekend Wellness program has not been able to increase afterhours support for clients, clients who attend the agency's "Consumer Voice" monthly meetings are in the process of forming a team to address afterhours phone support needs for clients.*

3) Increase services for persons who recently were discharged from psychiatric inpatient through use of a better exit interview process and access to interim care until fully connected with behavioral health services.
   - *After looking at last fiscal year's data for first follow up appointment after psychiatric inpatient discharge, there is still room for improvement. Only 34 of the 59 discharges (57.6%) received a follow up services within seven (7) days, and length of time to next service was not tracked, which may reveal level of engagement for these clients. Focus for additional study should include an investigation of why some clients did not get a follow up service (or were beyond seven (7) days, as well a calculation of length of time to second service.*

4) Establish wellness teams consisting of multi-disciplines to increase services and supports for FSP clients.
   - *Wellness teams have been established for FSP clients, with Wellness Team Meeting times on the fourth and fifth Wednesdays of each month, which allow for staff collaboration.*

5) Expand the use of case management to increase rehab and targeted case management services.
   - *Recruitment efforts have been successful in hiring many new case managers for both the adult and children's units, which has allowed for the expansion and availability of case management and rehabilitation services. Wellness team meetings have also provided consultation and training for case managers regarding their role and practice modalities with case management and rehab services.*

6) Increase intensive home-based services for foster youth, and increase use of TBS services to prevent group home placement.
   - *Both our Compliance and Quality Improvement Manager, and Children's Unit Program Manager have worked to clarify and optimize the TBS referral process, working closely with the contract agency that provides this service for the GCSMHP. IHBS services are part of an active clinical PIP that the GCSMHP has implemented. The first year of this PIP has shown a decrease in the percentage of IHBS service delivery to foster youth, but this is also coupled with an increase in the number of foster youth served this last fiscal*

year. Quality and access analysis shows that youth are being served but not always specifically with the IHBS modality. This will be a focus in the coming fiscal year.

7) Expand access to increased levels of care and additional treatment modalities for substance use disorders through contracting.
   - *The GCSMHP continues to integrate and establish parity in process with Glenn County Substance Use Disorder services. With a unified leadership and admin team, efforts have been made this last year to expand substance use disorder services. We have recently finished a contract with Aegis Treatment Centers to provide Narcotic Treatment Program (NTP) services to Glenn County beneficiaries. We have also started a contract with Progress House to provide Perinatal Residential substance abuse services for Glenn County beneficiaries as well.*

8) Implement use of action schedules in the EHR to increase compliance with documentation timelines.
   - *After a thorough review of what was necessary to implement the use of action schedules, it was determined not to be feasible because of the workload that would be required to implement and maintain them. The GCSMHP does an internal client list that is similar to action schedules but is more functional and user friendly.*

9) Continue implementation of Continuum of Care Reform.
   - *Efforts to implement the CCR continue with the county's multi-disciplinary team consisting of leadership from Child Welfare Services, Probation, Mental Health, and IDEA consulting. The group has attempted to meet each month to monitor progress and to move implementation action items forward. This group has also split into various sub-committees that work outside of the main meeting in order to accomplish specific tasks. The GCSMHP and its partners have made tremendous progress with implementation, but the work will continue as additional components of the CCR are rolled out.*

10) Prepare for implementation of CMS Managed Care Final Rules, and enhance network adequacy for timeliness of services requirements.
   - *Agency staff have prepared for and implemented CMS Managed Care Final Rules, and submitted network adequacy information as required. Preliminary findings from the March 2018 submission date indicated Glenn County did not meet the established standards for network adequacy regarding adult psychiatry provider capacity, children's psychiatry provider capacity, and mandatory providers – American Indian Health Facilities (AIHF). Once additional information is provided by the Department of Health Care Services, Glenn County will take action to ensure network adequacy standards are met.*

Performance Improvement Projects

1) **Non-Clinical PIP – Timely Access**
   - *Will implementing a triage assessment process help high-need clients with an urgent need access services within 5 days; ensure clients with a routine need for services access*

services within 10 days; and clients requesting psychiatric services receive services within 15 days?

- In an effort to develop a responsive access system, we designed a process for identifying the highest need clients to receive a first appointment as quickly as possible, initially setting goals to schedule requests for services within 7, 14, and 21 calendar days by prioritizing referrals for urgent, moderate, and routine clients.
- We analyzed the data after implementing our interventions, for January – March 2017, and found that 43.9% of the urgent need clients were seen within 7 days, 55.6% of the moderate need clients were seen within 14 days, and 85.7% of the routine need clients were seen within 21 days.
  - We plan to carry this PIP into next year using the new CMS Medicaid (Medi-Cal) Managed Care Final Rule timeframes, and will examine work flows and system issues to identify barriers and potential interventions to improve timely access.

2) **Clinical PIP – Intensive Home-Based Services**
   - *Will increasing the delivery of IHBS services to children, youth, and caregivers who have an open CWS case improve the family's resiliency, as indicated by the Risk and Resiliency Factors Inventory, and create an environment that supports permanency and/or a stable living situation?*
     - At baseline, 63.6% of IHBS clients improved their RRF scores. Unfortunately this decreased to 16.3% in FY 2017-18. This may be due to the fact that there were more CWS youth receiving IHBS services (from 28 youth in FY 2016-17 to 43 youth in FY 2017-18). Also, there has been staff vacancies that limited the number of staff available to deliver IHBS services.
       - A number of new people have recently been hired, and have been receiving intensive training on all components of service delivery, including IHBS services, RRF, and the full range of specialty mental health services.
       - Staff are being re-trained to complete the RRF and learn to use the information to help identify risk factors as well as improve resiliency.
       - We will continue to monitor these performance indicators to assess improvement in IHBS services and RRF scores for CWS youth over the next year.

Quantitative Measures Adopted or Established to Assess Performance and to Identify and Prioritize Area(s) for Improvement

1) GCSMHP aims to ensure that all clients with complex needs are provided the appropriate intensity of service. As a method of tracking progress toward this goal, GCSMHP will aim to increase case management services and individual rehabilitation services overall by 150% in the next fiscal year. In FY 2016/17, there were 3,176 Targeted Case Management (TCM) services and 936 Individual Rehabilitation services provided.
   - **Total (TCM) services: 1,771**
     - **Overall Goal: 2657**
     - **Goal Not Met**
     - **Percentage of Goal Completed: 66.7%**

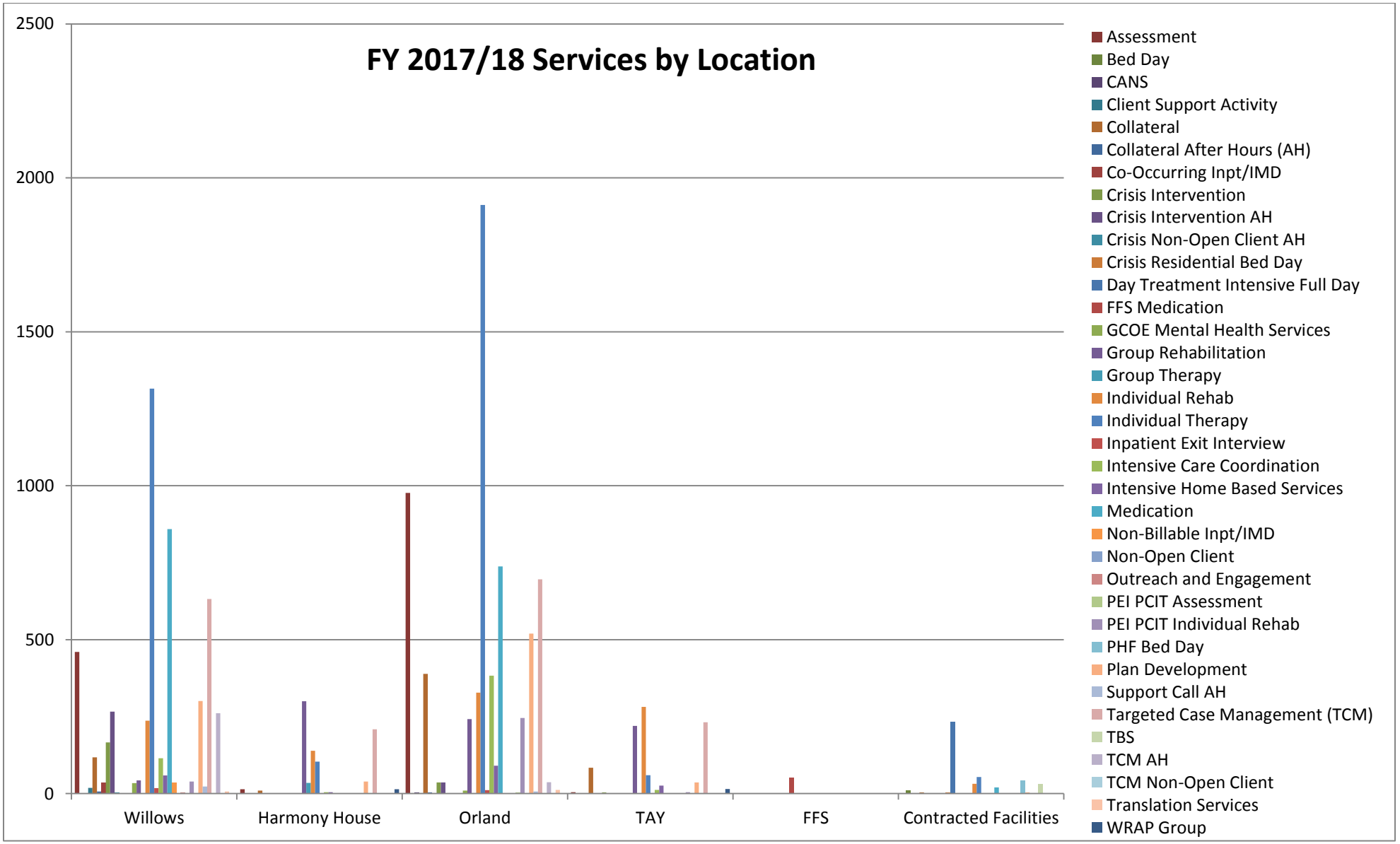
- **Total (Individual Rehabilitation) services: 1,018**
  - **Overall Goal: 1,404**
  - **Goal Not Met**
  - **Percentage of Goal Completed: 72.5%**

2) GCSMHP will improve follow-up services for clients who are recently discharged from inpatient hospitalization. We will continue to provide an exit interview for all clients who have discharged from in-patient psychiatric hospitalization. In order to increase access following discharge, we will work toward providing at least 80% of client with a follow-up appointment within 7 business days of their exit interview.
   - *Only 34 of the 59 discharges (57.6%) received a follow up services within seven (7) business days*
   - **Total follow-up appointments within 7 days: 34**
     - **Overall Goal: 47**
     - **Goal Not Met**
     - **Percentage of Goal Completed: 72.3%**

3) GCSMHP is in alignment with the values of the Continuum of Care Reform to keep children in permanent homes and in the lowest level of care. As a result GCSMHP will ensure that at least 60% of all children placed from the community into a group home were offered Therapeutic Behavior Services prior to placement.
   - *0 of the 2 clients (0%)placed in a group home that are served in-county were offered TBS prior to group home placement*
   - **Total In-County Clients Served with TBS Prior to Group Home Placement: 0**
     - **Overall Goal: 2**
     - **Goal Not Met**
     - **Percentage of Goal Completed: 0%**

4) GCSMHP values fidelity in service delivery models, and understands the importance of utilizing a treatment team approach for FSP clients. As a result GCSMHP will establish a goal of ensuring that 100% of FSP clients are assigned a case manager.
   - *143 out of 165 FSP clients in FY 17/18 were assigned a case manager.*
   - **Total FSPs assigned a Case Manager: 143**
     - **Overall Goal: 165**
     - **Goal Not Met**
     - **Percentage of Goal Completed: 86.7%**

GCSMHP current number, types and geographic distribution of mental health services within the service delivery system



FY 2017/18 Services by Location

Name of Service	Willows	Harmony House	Orland	TAY	FFS	Contracted Facilities	Sum of Services
Assessment	460	14	977	5		1	**1457**
Bed Day						10	**10**
CANS			3				**3**
Client Support Activity	19		2	1			**22**
Collateral	118	10	389	84		4	**605**
Collateral After Hours (AH)	7		4				**11**
Co-Occurring Inpt/IMD	37						**37**
Crisis Intervention	166		36	4			**206**
Crisis Intervention AH	266		36				**302**
Crisis Non-Open Client AH	3						**3**
Crisis Residential Bed Day						5	**5**
Day Treatment Intensive Full Day						233	**233**
FFS Medication					51		**51**
GCOE Mental Health Services	34		10				**44**
Group Rehabilitation	43	300	242	220			**805**
Group Therapy	1	35					**36**
Individual Rehab	237	139	328	282		32	**1018**
Individual Therapy	1315	104	1912	60		54	**3445**
Inpatient Exit Interview	18		11				**29**
Intensive Care Coordination	115	5	383	12			**515**
Intensive Home Based Services	59	5	91	26			**181**
Medication	859		738			20	**1617**
Non-Billable Inpt/IMD	36						**36**
Non-Open Client	1		1				**2**
Outreach and Engagement	3						**3**
PEI PCIT Assessment			5				**5**
PEI PCIT Individual Rehab	39		246	5			**290**
PHF Bed Day						44	**44**
Plan Development	301	39	520	36		4	**900**
Support Call AH	23		7				**30**
Targeted Case Management (TCM)	632	209	696	232		2	**1771**
TBS						32	**32**
TCM AH	261	1	37				**299**
TCM Non-Open Client	1						
Translation Services	7		12	1			**20**
WRAP Group		14		15			**29**
TOTAL MENTAL HEALTH SERVICES							**14096**

FY 2018/19 ANNUAL WORK PLAN GOALS

FY 2018/19 Service Delivery Capacity Goals
(for the number, type, and geographic distribution of mental health services)

1) Increase face to face service encounters up to 60% overall. In FY 17/18 approximately 46% of all encounters were face to face. A goal of 60% will represent a 14% increase overall.

2) Increase IHBS services in the home to 50%. There were a total of 207 IHBS contacts in FY 17/18, and only 42 of those indicated they were provided in the home. This would be only approximately 20.3% of all IHBS services. Increasing this type of service provided in the home would represent a 29.7% increase overall.

3) Increase overall IHBS services up to 311 services in FY 18/19, representing a 50% increase from FY 17/18.

4) Increase group therapy services at the TAY up to 12 services in FY 18/19. 0 Group therapy services were provided in FY 17/18.

FY 2018/19 Accessibility of Services Goals

1) Responsiveness of the GCSMHP 24 hour toll-free telephone number.
   - *The GCSMHP 24 hour telephone service line will be tested, with a minimum of three test calls monthly. The GCSMHP's goal is that **80% of all test calls are successfully answered**. All test calls are recorded in the 24/7 Crisis Line Testing Log and scored on a 5 point scale. A point is given for each of the following criteria met: the call was answered, the crisis worker asked the caller if it was a crisis or an emergency, the caller was linked to interpretation services (if applicable), the test call was logged, and a crisis note was written. In order for a test call to be successful and pass, all five criteria must be met.*

2) Timeliness of scheduling routine appointments.
   - *All routine clients requesting outpatient services will be seen for a face-to-face assessment within **ten (10) calendar days** of the initial request for services.*
   - *All routine clients requesting medication services will be seen for a face-to-face assessment within **fifteen (15) calendar days** of the initial request for services.*

3) Timeliness of services for urgent conditions.
   - *All clients presenting during business hours with a crisis or an urgent condition will be **seen within one (1) hour**. All efforts are made to see the client immediately.*

4) Access to after-hours crisis services.

- *All clients requesting after-hours crisis services will call the GCSMHP 24 hour toll-free telephone number. The GCSMHP will have an on-call crisis worker handle the crisis. If the crisis is determined to be a 5150 or in need of a face-to-face evaluation, the client will be seen in person **within one (1) hour**. All efforts are made to see the client immediately.*

FY 2018/19 Planning and Initiation of Activities for Sustaining Improvement

1. Institute the Behavioral Health Treatment Court program designed to assist consumers who are incarcerated and prevent recidivism with wrap-around mental health services.

2. Create an Adult System of Care in the CRWC building in Orland, using person-centered care to improve care coordination for adults and older adults in the community.

3. Provide trainings to community partners and agencies on Safe Talk suicide prevention as part of our PEI plan.

4. Partner with Dos Rios Housing Committee, a regional group of service agencies and community partners, to help address homelessness in the region and to provide access to housing and shelter resources.

5. Develop and utilize improved onboarding processes for newly hired staff, including a comprehensive new hire binder that covers a wide array of agency, regulatory, and practice guidelines for the delivery of mental health services.

6. Conduct continuing agency-wide leadership development meetings based on the UC Davis curriculum.

7. Co-locate Children's Mental Health with Child Welfare to create a one-stop Children's System of Care.

FY 2018/19 Performance Improvement Projects

1) **Non-Clinical PIP – Timely Access**
   - *Will implementing a triage assessment process help high-need clients with an urgent need access services within 5 days; ensure clients with a routine need for services access services within 10 days; and clients requesting psychiatric services receive services within 15 days?*
     - In an effort to develop a responsive access system, we designed a process for identifying the highest need clients to receive a first appointment as quickly as possible. We initially set a goal to schedule a person with an urgent request within 7 days. We have reduced that goal to schedule a person with an urgent request within 5 days to help improve access to services.
     - Similarly, we initially set the goal to schedule an appointment within 14 days for clients with a routine request for services. We have reduced that goal to be within 10

days. For appointments with a psychiatrist, our initial goal was 21 days. It is now reduced to within 15 days. This modification of target goals was to continually improve timely access to services.

- Since we have implemented the levels of need for mental health services requests, we have seen an improvement in the percent of clients who are being seen within our 5 and 10 calendar day goals. Unfortunately, we continue to have difficulty accessing psychiatric services within our 15 calendar day goal.
- We plan to carry this PIP into next year and will examine work flows and system issues to identify barriers and potential interventions to improve timely access.

2) **Clinical PIP – Intensive Home-Based Services**
   - *Will increasing face to face support via Intensive Home-Based Services and other in-home service modalities increase permanency of placement for youth clients?*
     - It is the value of the Glenn County Health and Human Services Agency (HHS) to ensure that all clients and caregivers receive right amount of services at the appropriate level of intensity.
   - It is the value of GCSMHP to ensure that all of our youth clients are able to maintain stability in the community, and that all modalities of service delivery are exhausted before a change in and/or higher level of placement is planned. Through examining service data from FY 2016/17 we found that there was a low number of overall IHBS services delivered when compared with the total number of Katie A. subclass and other EPSDT beneficiaries identified as needing this level of care. We also found through examination of TBS services prior to group home placement that the service modality was underrepresented as well. Due to the number of children who continue to have multiple placements and instability in permanency, we have identified this as an important area to focus on.
   - This PIP will continue for FY 18/19 as the percentage of IHBS services provided actually dropped in FY 17/18. While it is apparent the target population of clients is being served, there are continued issues with staff using correct billing codes and service modalities. GCSMHP will continue to train to the Core Practice model and to ensure staff is providing IHBS services relevant to level of client need.

FY 2018/19 Quantitative Measures Adopted or Established to Assess Performance and to Identify and Prioritize Area(s) for Improvement

1) GCSMHP is instituting the Behavioral Health Treatment Court and will provide behavioral health services to clients who are incarcerated or at risk for returning to jail or prison. Within the next fiscal year, the GCSMHP will develop formal tracking and monitoring of these clients and aim to decrease recidivism rates by 40%.

2) GCSMHP is working to expand and improve suicide prevention activities in the community. Within the next fiscal year, the GCSMHP will provide at least 3 Safe Talk trainings to local community partners.

3) GCSMHP is working to ensure that beneficiaries are provided the appropriate level of care for services, as well as to improve compliance with documentation standards for specialty mental health services. In an effort to monitor levels of care in a standardized and consistent way, as well as to remain compliant with chart documentation timeliness, the GCSMHP will aim to increase timeliness of annual mental health assessments to 80% within the annual month of episode opening.

4) GCSMHP is evaluating the amount of face to face services beneficiaries are receiving, compared with staff productivity billing standards. GCSMHP will work toward improving the quality of care for beneficiaries as represented by 50% of all productive services being face to face with a client.

Cultural and Linguistic Standards

1) The GCSMHP will ensure that clients will receive effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2) The GCSMHP will recruit, retain and promote at all levels of the GCSMHP a diverse staff and leadership that are representative of the demographic characteristics of Glenn County.
3) The GCSMHP will offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each client with Limited English Proficiency (LEP) at all sites, in a timely manner during all hours of operation.
4) The GCSMHP will provide all clients in their preferred language, both verbal offers and written notices informing them of their right to receive language assistance services.
5) The GCSMHP has the expectation that family and friends should not be used to provide interpretation services, except on request by the client.
6) The GCSMHP will make available easily understood client related materials and post signage in threshold languages.
7) The GCSMHP will ensure that data on clients' race, ethnicity, and spoken and written language are collected in the health record and updated annually.

QUALITY IMPROVEMENT (QI) PROGRAM

The Glenn County Specialty Mental Health's (GCSMHP) Quality Improvement (QI) program will monitor the service delivery system with the aim of improving the processes of providing care and better meeting the needs of its clients.

The Quality Improvement Committee (QIC) will review the quality of specialty mental health services provided to clients. The QIC will recommend policy decisions; review and evaluate QI activities results, including performance improvement projects; institute needed QI actions; ensure follow-up of QI processes, and document QIC meeting minutes reflective of its decisions and actions taken. Dated and signed minutes are kept for a minimum of three (3) years.

The Compliance and Quality Improvement Manager and Behavioral Health Director share responsibility for the clinical oversight of the QI Program, and the Compliance and Quality Improvement Manager convenes the QIC meetings. The QI Program is accountable to the GCSMHP Director. Providers, clients, family members, coaches and peer mentors actively participate in the planning, design and execution of the QI Program by attend various meetings, committees and staff meetings in which data is reviewed and evaluated: *Quality Improvement Committee (QIC), System Improvement Committee (SIC), Mental Health Advisory Board, Consumer Voice Forum, the MH Staff meetings, TAY Staff meetings and the Harmony House staff meetings.*

The GCSMHP will maintain a minimum of two active performance improvement projects (PIPs). The performance improvement projects will focus on a clinical area and one in a non-clinical area.

The Quality Improvement Committee (QIC) is responsible for overseeing all Quality Improvement (QI) activities. QI activities will include:

1) Collecting and analyzing data to measure against the goals, or prioritized areas of improvement that have been identified;
2) Identifying opportunities for improvement and deciding which opportunities to pursue;
3) Identifying relevant committees internal or external to the GCSMHP to ensure appropriate exchange of information with the QIC;
4) Obtaining input from providers, clients and family members in identifying barriers to delivery of clinical care and administrative services;
5) Designing and implementing interventions for improving performance;
6) Measuring effectiveness of the interventions;
7) Incorporating successful interventions into the GCSMHP operations as appropriate;
8) Reviewing client grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required.

QUALITY ASSURANCE (QA)

The Glenn County Specialty Mental Health Plan (GCSMHP) has set standards and implemented processes that will support understanding and compliance with the standards set in this section and any standards set by the GCSMHP. Quality Assurance (QA) activities may include monitoring performance so that the documentation of care provided will satisfy stated requirements. The documentation standards for client care are minimum standards to support claims for the delivery of services. All standards will be addressed in the client record; however, there is no requirement that the records have a specific document or section addressing these topics.

A. <u>Assessments</u>:

1) The following areas will be included as appropriate as a part of a comprehensive client record when an assessment has been performed *(Note: for children or certain other clients unable to give a history, this information may be obtained collaterally from parents/care-givers, etc.)*:

   a) Presenting Problem: client chief complaint, history of the presenting problem(s), including current level of functioning, relevant family history and current family information.
   b) Relevant conditions and psychosocial factors affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma.
   c) Mental Health History: Previous treatment, including providers, therapeutic modality (e.g. medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports.
   d) Medical History: Relevant physical health conditions reported by the client or a significant support person. Include the name and address of current source of medical treatment. For children and adolescents: Include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports.
   e) Medications: Information about medications the client has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment will include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications.
   f) Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications), over-the-counter, and illicit drugs.
   g) Client Strengths: Documentation of client strengths in achieving client plan goals.
   h) Risks: Situations that present a risk to the client and/or others, including past or current trauma.
   i) A mental status exam.
   j) A complete five axis diagnosis from the most current DSM, or a diagnosis from the most current ICD-code will be documented, consistent with the presenting problems, history, mental status examination and/or other clinical data, and
   k) Additional clarifying formulation information, as needed.

2) Timeliness/Frequency Standard for Assessment:
   - *Assessments will be completed within 60 days of opening, and*
   - *Updated annually.*

B. Client Plans:

1) Client Plans shall:
   a) Have specific observable and/or specific quantifiable goals/treatment objectives;
   b) Identify the proposed type(s) of intervention/modality;
   c) Have a proposed frequency and duration of intervention(s);

d) Have interventions that focus and address the identified functional impairments as a result of the mental disorder;
e) Have interventions that are consistent with the client plan goal;
f) Be consistent with the qualifying diagnoses;
g) Be signed (or electronic equivalent) by:
    i. *The person providing the service(s), or*
    ii. *A person representing a team or program providing services, or*
    iii. *A person representing the GCSMHP providing services;*
    iv. *By one of the following as a co-signer, if the client plan is used to establish that services are provided under the direction of an approved category of staff, and if the signing staff is not of the approved category:*
        A. A physician,
        B. A licensed/waivered psychologist,
        C. A licensed/registered/waivered social worker,
        D. A licensed/registered/waivered marriage and family therapist,
        E. A registered nurse;
h) Include documentation of the client's participation in and agreement with the client plan.
    i. *Examples of acceptable documentation include, but are not limited to, reference to the client's participation and agreement in the body of the plan, client's signature on the plan, or a description of the client's participation and agreement in the client record;*
    ii. *The client plan provides that the client will be receiving more than one type of specialty mental health service;*
    iii. *When the client's signature of the signature of the client's legal representative is required on the client plan and the client refuses or is unavailable for signature, the client plan will include a written explanation of the refusal or unavailability.*

2) The GCSMHP will offer a copy of the client plan to the client, and whether a client has received or declined a copy will be documented on the client plan.

3) Timeliness/Frequency of Client Plan:
    - *Client Plans will be completed within 60 days of opening,*
    - *Updated when there are significant changes in the client's condition, and*
    - *Updated at least annually*

C. Progress Notes:

1) Progress notes will describe how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning, as outlined in the client plan. Items that will be contained in the client record related to the client's progress in treatment include:

    a) Timely documentation of relevant aspects of client care, including the documentation of medical necessity;

b) Documentation of client encounters, including relevant clinical decisions, when decisions are made, alternative approaches for future interventions;
c) Interventions applied, client's response to interventions and the location of the interventions;
d) The date the services were provided;
e) Referrals to community resources and other agencies, when appropriate;
f) Documentation of follow-up care, or as appropriate, a discharge summary; and
g) The amount of time taken to provide services;
h) The signature of the person providing the service (or electronic equivalent); the person's type of professional degree; licensure or job title; and the relevant identification number; if applicable

2) Timeliness/Frequency of Progress Notes. Progress notes will be documented at the frequency by type of service indicated below:
   - *Progress Notes will be documented by the end of the next business day.*
   - *With supervisor approval, Progress Notes may be completed up to a maximum of three business days from the date of service.*
   - *With written Director approval, Progress Notes may be completed beyond these timeframes.*

a) **Every Service Contact:**
   i. Mental Health Services;
   ii. Medication Support Services;
   iii. Crisis Intervention;
   iv. Targeted Case Management;

b) **Daily:**
   i. Crisis Residential;
   ii. Crisis Stabilization (1x/23hr);
   iii. Day Treatment Intensive; and

c) **Weekly:**
   i. Day Treatment Intensive: a clinical summary reviewed and signed by a physician, a licensed/waivered psychologist, clinical social worker, or marriage and family therapist; or a registered nurse who is either staff to the day treatment intensive program or the person directing the service;
   ii. Day Rehabilitation;
   iii. Adult Residential.

D. Other.
1) All entries to the client record shall be legible.
2) All entries in the client record shall include:
   i. The date of service:
   ii. The signature of the person providing the service (or electronic equivalent); the person's type of professional degree, licensure or job title, and the relevant identification number, if applicable.

The date the documentation was entered in the client record.

UTILIZATION MANAGEMENT (UM) PROGRAM

The Utilization Review (UR) Team is responsible for all Utilization Management (UM) activities. UR Team meets weekly to evaluate necessity, appropriateness and efficiency of services provided to Medi-Cal clients prospectively and retrospectively. Any problems or issues identified by this team will be reviewed in Quality Improvement Committee (QIC). Charts can also be referred to the UR Team by the QIC and any other staff when there are concerns about the quality of care, specifically the authorization, provision, or documentation of specialty mental health services to a particular client.

The Glenn County Specialty Mental Health Plan (GCSMHP) will implement mechanisms to assess the capacity of service delivery for its clients. This includes monitoring the number, types, and geographic distribution of mental health services within the GCSMHP delivery system.

- *The Contact Log serves as the primary mechanism for monitoring the capacity of the service delivery system. This log contains data on all requests for services including requests for mental health services, psychiatric services, and urgent and emergent services (crisis), and allows for Quality Improvement (QI) staff to monitor timeliness of services and the capacity of the service delivery system.*
- *Penetration rate and service data is reviewed in Quality Improvement Committee (QIC), which shows the number of Medi-Cal beneficiaries in our county and the number we have served. This data also includes the numbers and types of services that are provided.*
- *Weekly case assignments meetings also help to ensure that the GCSMHP is monitoring the service delivery capacity and making changes as necessary.*

The Glenn County Specialty Mental Health Plan (GCSMHP) will implement mechanisms to assess the accessibility of services within its service delivery area. This will include an assessment of responsiveness of the GCSMHP 24 hour toll-free telephone number, timeliness of scheduling routine appointments, timeliness of services for urgent conditions, and access to after-hours care.

- *The Crisis Line Testing Log serves as the primary mechanism for monitoring the accessibility of the responsiveness of the GCSMHP's 24 hour toll-free telephone number. The GCSMHP utilizes IDEA Consulting to randomly call the 24 hour toll-free telephone number at least three (3) times per month and record the following information: Test call date, time, caller, name given, person answering the call, reason for the call, if the staff member asked if it was a crisis or an emergency, if the caller was linked to interpreter services (if applicable), comments, if the test call was logged, if a crisis note was written, and if the test call passed or failed and if not, the reason why.*
    - *The results of these calls are shared with the Crisis Team supervisor, the Performance Improvement Project Team, and the Quality Improvement and System Improvement Committees. Feedback is also given to the crisis workers.*
- *The Contact Log serves as the primary mechanism for monitoring the accessibility of mental health services, including urgent and emergent / crisis services. This log captures all pertinent information including the following information: client #, client name, date*

of birth, language spoken at home, date of request, time of request and time seen (for crisis calls), mode of entry (ex., phone, walk-in, written), contact reason, referred by, date of completed referral packet received, screening appointment date, assessment appointment date, disposition, date referral closed, reason referral closed and comments.

- *This information is periodically monitored by the clinical supervisors and is reviewed quarterly in the Quality Improvement and System Improvement Committees.*
- *The Contact Log is also used to obtain the timeliness of service data for routine services, psychiatry services, and crisis services.*

The Glenn County Specialty Mental Health Plan (GCSMHP) will implement mechanisms to assure authorization decision making standards are met.

- *See Outpatient Services Intake and Approval Process P&P.*
  1) *GCSMHP and its subcontractors will have in place and follow, written policies and procedures for processing requests for initial and continuing authorizations of services.*
  2) *GCSMHP will have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, and will consult with the requesting provider when appropriate.*
  3) *Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the client's condition or disease.*
  4) *Decisions must be made with the timeframes outlined for service authorizations, and notice of action related to such decisions much be provided within the timeframes set forth.*
- *All authorizations of specialty mental health services decisions are made by licensed or waivered GCSMHP staff, using the statewide medical necessity criteria, the Mental Health Assessment and/or annual assessment update, the Treatment Plan, and any other relevant clinical information. The Assessment and/or annual update are used to document the client's medical necessity and symptomology and also document relevant information when the client does not meet medical necessity. A denial of services based upon medical necessity is clearly documented in the chart.*
- *The Contact Log also serves as a mechanism to assure that authorization decision making standards are met. This log captures all pertinent information including: client #, client name, date of birth, language spoken at home, date of request, time of request and time seen (for crisis calls), mode of entry (ex., phone, walk-in, written), contact reason, referred by, date referral received, assessment appointment date, disposition, date referral closed, reason referral closed and comments, and is periodically monitored by the clinical supervisors as well as quarterly in QIC.*
- *As required by the State Department of Health Care Services (DHCS), the GCSMHP will send a Notice of Adverse Benefit determination due to a lack of timely service, to clients when the GCSMHP has not provided services according to the GCSMHP and statewide timeliness standards. Information about the Client Problem Resolution Process, which includes grievances, appeals, expedited appeals, and state fair hearings,*

will also be included with any written notice of adverse benefit determination for lack of timely service.

- ***The following are the GCSMHP and statewide timeliness standards:***
  - *Clients requesting non-hospital specialty mental health services will be seen within ten (10) business days of request for services, and authorized within sixty (60) days. Clients requesting medication services will be seen within fifteen (15) business days of request for services. Clients requesting urgent or emergent services will be seen and authorized within one (1) hour.*
  - *Authorizations for services for adopted KINGAP or AAP children or youth placed outside of his/her county will be made within three (3) business days following the date of request for service and will notify the host county and the requesting provider of the authorization decision. If the GCSMHP documents the need for additional information to evaluate the client's need for the service, an extension may be granted up to three (3) business days from the date the additional information is received, or fourteen (14) calendar days from the receipt of the original Treatment Authorization Request, whichever is less. The GCSMHP must arrange reimbursement for the services provided to the child or youth within thirty (30) calendar days of the date of authorization of service.*
  - *Day Treatment and Day Rehabilitation services must be preauthorized and will be authorized upon receipt and review of the Request for Utilization Review Authorization of Services packet.*

Compensation for Utilization Management Activities: Pursuant to Title 42, CFR, Section 438.210(e), compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any client. The Glenn County Specialty Mental Health Plan (GCSMHP) has structured Utilization Management Activities in a way so as to not provide incentives for any individual or entity to do so.