Glenn County Specialty Mental Health Plan

QUALITY IMPROVEMENT WORK PLAN
FY 2015/16

QUALITY MANAGEMENT (QM) PROGRAM

The Glenn County Specialty Mental Health Plan (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.

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

The QM 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 grievances.

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

Staff, committees and task forces, report and provide feedback to the Quality Improvement Committee (QIC). The Behavioral Health Director is a regular member of the QIC. 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 management (QM) 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 QM Program.

The QIC will recommend policy changes, review and evaluate the results of QM activities including performance improvement projects, institute needed QM actions, and ensure follow up of QM 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 4 meetings annually.

System Improvement Committee

The System Improvement Committee (SIC) 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 management (QM) 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 QM activities including performance improvement projects, institute needed QM actions, and ensure follow up of QM processes. The SIC will meet twice per quarter for a total of 8 meetings annually.

Chart Review

Chart review activities may take place within the Quality Improvement Department, Quality Improvement Committee (QIC), Medication Monitoring, staff unit meetings, peer chart review, and as necessary.

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 that have attempted suicide, 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 fix. An ongoing feedback loop is used to track identified chart review issues and to document progress toward resolution over time.

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 unit 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, Drug and Alcohol 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 Compliance Committee 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 to 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 the monthly QIC/SIC meetings. The Compliance Committee aims to meet monthly, but no less than six 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 and service data (i.e. service codes used) 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 stay on top of HIPAA requirements impacting the GCSMHP. Service verification information is also reviewed.

Cultural Competence Task Force

The Cultural Competence Task Force (CCTF) strives to improve the Glenn County Specialty Mental Health Plan's (GCSMHP) awareness and practices with regard to all aspects of a diverse community. The CCTF is responsible for recognizing culturally competent efforts and activities and identifying those needing improvement. Additional responsibilities include reviewing goals and objectives which promote culturally competent services and team culture. 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 mission statement of the CCTF is: *Glenn County Health Services Agency is committed to promoting an individual's voice, creating a culture of balance and healing for all persons receiving services, integrating families and natural support systems into services when possible, individualizing services to meet the individual's needs, and supporting a safe learning environment for staff, to help them work as a team and understand the differences in culture impact on successful treatment.*

Organizational Providers

All providers are required by contract to meet standards established by the GCSMHP and State and Federal regulations. These standards are detailed in the GCMH Provider Handbook that they receive with their contract annually. Providers are also required to cooperate with the GCSMHP Quality Management (QM) Program and must allow the GCSMHP and other relevant parties' access to 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, DHCS consumer perception surveys, documentation, grievances/appeals/expedited appeals, incident reports, NOAs, provider appeals, and state fair hearings.

Staff Unit Meetings

Behavioral Health, Harmony House, TAY, and the Caseload Assignment Team, meet weekly. During the Behavioral Health meeting which includes Mental Health, Drug and Alcohol, Harmony House and TAY staff, clinical cases are reviewed. Discussions of treatment, culture, primary language, age, gender, and diagnostic issues, 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 GCSMHP to ensure continuity and coordination of care with physical health care providers, Drug and Alcohol Services, Probation, Juvenile Hall, Social Services, and other Human Services agencies. The GCSMHP will coordinate with other human services agencies used by its clients. Referrals are made to these agencies 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 and Anasazi for data, reports, and claims, to detect both underutilization and over utilization of services.

The GCSMHP has implemented the following mechanisms to assess client/family satisfaction:

- *At the direction of the Department of Health Care Services (DHCS), the GCSMHP administered the Consumer Perception Surveys in the Spring of 2015, per MHSUDS Information Notice 15-013. Copies of the results were reviewed at the 6/16/15 System Improvement Committee (SIC) meeting and by all staff at the 7/8/15 staff meeting.*
- *At each quarterly QIC meeting, the following items are discussed and evaluated: HIPAA Complaints, Client Grievances, Appeals and Expedited Appeals, State Fair Hearings, Notice of Actions (NOAs), Change of Provider requests, After Hours Crisis Line Testing, Trainings, Incident Reports, and Mortality and Morbidity. In addition, an Annual Client Grievance report is submitted to the DHCS each October which breaks down grievances by type, at which level, and whether they have been resolved or not, and if they are still pending. QM staff also review the Grievance Log at the end of each fiscal year to analyze the types of grievances, and to take an in*

depth look at the nature of the grievances to see if trends occur. These grievances are summarized, and this information is shared at the next QIC/SIC meeting.

- *All change of provider requests are reviewed by the Leadership Team. If the Leadership Team determines that a change of provider request is appropriate, the request is taken to the Caseload Assignment Team and reassigned. Upon reassignment, the Caseload Assignment Team informs QM staff of the disposition so it can be documented in the Change of Provider log. This log is reviewed and evaluated at each quarterly QIC meeting. QM staff also review the Change of Provider Log at the end of each fiscal year to analyze the change of provider requests and take an in depth look at the nature of the requests to see if trends occur. These change of provider requests are summarized and this information is shared at the next QIC meeting and at Leadership.*

The GCSMHP will inform providers of the results of client and family satisfaction activities in a number of ways. Satisfaction survey results are distributed at staff meetings as well as being discussed in Quality Improvement Committee and/or System Improvement Committee, and Leadership. The results of client grievances, appeals, fair hearings and change of provider requests are discussed promptly with providers that are affected, if applicable and appropriate.

The GCSMHP 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 QIC-approved Medication Monitoring Checklist. The 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 submitted to the QIC and the psychiatrist and/or R.N. to resolve any issues raised by the medication review, and to make appropriate recommendations for responsive action in those cases where psychotropic 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). QM 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 GCSMHP will implement mechanisms to address meaningful clinical issues affecting clients system-wide.

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

The 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 unit meetings, monitoring and auditing activities, or by staff and clients. Based on the occurrence that was identified, interventions will be implemented as appropriate, and evaluated at least annually.*

FY 2015/16 Quality Improvement Work Plan

The Glenn County Specialty Mental Health Plan (GCSMHP) will have a Quality Management (QM) Work Plan covering the current contract cycle, with documented annual evaluations and updates as needed. The QM 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 QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and client service.
3) A description of completed and in-process QM activities, including performance improvement projects. The description will include:
   a. *Monitoring previously identified issues, including tracking issues over time;*
   b. *Objectives, scope, and planned QM activities for each year; and*
   c. *Targeted areas of improvement or change in service delivery or program design.*

FY 2014/15 ANNUAL QM ACTIVITIES AND PROGRAM EVALUATION, INCLUDING PERFORMANCE IMPROVEMENT PROJECTS:

Evaluation of service delivery capacity goals for FY 2014/15

1) We will increase the number of Targeted Case Management services provided to our Transition Age Youth (TAY).
   - *There were 262 Targeted Case Management services provided to our TAY in FY 2013/14.*
   - *There were 543 Targeted Case Management services provided to our TAY in FY 2014/15.*
     - ***This is a 107.3% increase in Targeted Case Management services, and we were successful in achieving our goal.***
2) We will increase the number of Intensive Care Coordination (ICC) services and Intensive Home Base services (IHBS) provided to our Children and Transition Age Youth (TAY) enrolled in the Katie A. program.
   - *There were 103 Katie A. (ICC and IHBS) services provided to our children and TAY in FY 2013/14.*
   - *There were 916 Katie A. (ICC and IHBS) services provided to our children and TAY in FY 2014/15.*
     - ***This is a 789.3% increase in Katie A. services, and we were successful in achieving our goal.***

3) We will increase the number of clients receiving medication services, with the addition of tele-psychiatry.
   - *There were 196 clients receiving medication services in FY 2013/14. Of the 196 clients receiving medication services, 17 were receiving tele-psychiatry services.*
   - *There were 306 clients receiving medication services in FY 2014/15. Of the 306 clients receiving medication services, 179 clients were receiving tele-psychiatry services.*
     - ***This is a 56.1% increase in the number of clients receiving medication services.***
     - ***However, this is a 952.94% increase in the number of clients receiving tele-psychiatry services. We were successful in achieving our goal.***

Evaluation of accessibility of services goals for FY 2014/15

1) Responsiveness of the GCSMHP 24 hour toll-free telephone number.
   - *The GCSMHP 24 hour telephone service line will be tested monthly. The GCSMHP's goal is that all test calls are **answered by the fourth ring**. The Compliance and Quality Improvement Coordinator/Manager or designee will randomly call the 24 hour toll-free telephone number at least three (3) times per month and record the length of time it took to answer the call, as well as any other pertinent information, in the After Hours Crisis Line Testing Log.*
     - ❖ In FY 2014/15, there were **forty-five (45) test calls** to the 24 hour telephone service line. Of the 45 test calls, **43 calls** were answered within four (4) rings, or **95.6%** calls. There were two (2) test calls that were not answered. This information was shared with the Crisis Team supervisor for action.

2) Timelines of scheduling routine appointments.
   - *All routine clients requesting **outpatient services** will be seen for a face-to-face assessment within **fourteen (14) calendar days** of the initial request for services.*
     - ❖ In FY 2014/15, the average time from initial request to face-to-face assessment for **all clients** was **12 days**; this goal was met **69.3%** of the time.
       - *The average time from initial request to face-to-face assessment for **youth clients** (ages 0 – 17 years) was **12 days**; this goal was met **69.2%** of the time.*
       - *The average time from initial request to face-to-face assessment for **adult clients** was **12 days**; this goal was met **69.4%** of the time.*
   - *All routine clients requesting **medication services** will be seen for a face-to-face assessment within **twenty-one (21) calendar days** of the initial request for services.*
     - ❖ In FY 2014/15, the average time from initial request to face-to-face assessment with a psychiatrist for **all clients** seeing **all psychiatrists** is **30 days**; this goal was met **61.4%** of the time.
     - ❖ In FY 2014/15, the average time from initial request to face-to-face assessment with a psychiatrist for **all youth clients** (ages 0 – 17 years) seeing **all psychiatrists** is **15 days**; this goal was met **67.4%** of the time.
       - *The average time from initial request to face-to-face assessment with a psychiatrist for **youth clients** (ages 0 – 17 years) seeing **Dr. Zadra** was **42 days**; this goal was met **0.0%** of the time.*
       - *The average time from initial request to face-to-face assessment with a psychiatrist for **youth clients** (ages 0 – 17 years) seeing the **tele-psychiatrists** was **13 days**; this goal was met **72.5%** of the time.*
     - ❖ In FY 2014/15, the average time from initial request to face-to-face assessment for **all adult** clients seeing **all psychiatrists i**s **35 days**; this goal was met **59.4%** of the time.

- *The average time from initial request to face-to-face assessment with a psychiatrist for **adult clients** seeing **Dr. Zadra** was **45 days**; this goal was met **18.2%** of the time.*
- *The average time from initial request to face-to-face assessment with a psychiatrist for **adult clients** seeing the **tele-psychiatrists** was **34 days**; this goal was met **63.1%** of the time.*

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.*

   ❖ In FY 2014/15, the average minutes from time of request to time seen/spoken to for **all clients** was **12 minutes** during business hours; this goal was met **97.7%** of the time.
   - *The average minutes from time of request to time seen/spoken to for **youth clients** (ages 0 – 17years) was **20 minutes** during **business hours**; this goal was met **94.3%** of the time.*
   - *The average minutes from time of request to time seen/spoken to for **adult clients** was **10 minutes** during business hours; this goal was met **98.7%** of the time.*

4) Access to after-hours care.
   - *All clients requesting after-hours care 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.*

   ❖ In FY 2014/15, the average minutes from time of request to time seen/spoken to for **all clients** was **27 minutes** during business hours; this goal was met **96.9%** of the time.
   - *The average minutes from time of request to time seen/spoken to for **youth clients** (ages 0 – 17years) was **22 minutes, after hours**; this goal was met **91.2%** of the time.*
   - *The average minutes from time of request to time seen/spoken to for **adult clients** was **28 minutes** during business hours; this goal was met **98.9%** of the time.*

Evaluation of activities for sustaining improvement for FY 2014/15

1) Implement the System-wide Mental Health Assessment and Response Treatment (SMART) Team in collaboration with partners and partner agencies.
   - *The SMART (Student Mental Health Assessment and Response Team) started this school year and has been a tremendous success. We have great partnerships with all the Glenn County Schools, GCOE, law enforcement including both police departments, Sheriff's Department and CHP. We have served 21 kids in the first year. We are also working to encourage Child Welfare to be more active participants in SMART.*

2) Transition to a co-located Learning Center, to expand collaboration with partners and increase capacity.
   - *The Transitions Learning Center is fully operational and has created strong partnerships with GCOE charter school, Probation, and the Glenn County Jail. We are working on expanding this service to Alcohol and Drug clients and identify new mental health clients who could benefit from integrated health care services.*

3) Expand capacity to keep up with Health Care Reform and Medi-Cal expansion.
   - *In an effort to expand capacity and keep up with health care reform and Medi-Cal expansion, we have hired many new clinicians, case managers, and have increased our tele-psychiatry hours. We have fully implemented tele-psychiatry in the past year in both*

Willows and Orland location, and we are continuing to identify opportunities to expand and enhance our services.

4) Focus attention on suicide prevention and bullying in the schools.
    - *See it, Speak it, Change it – The Transition Age Youth Drop-In Center Peer Mentors along with Mental Health staff were able to present to Orland High School Freshman and Sophomore classes an anti-bullying program. The program focuses on teaching communication skills and giving information to create awareness. We are also partnering with superintendents across the county to support each school site with bullying prevention activities. As a component of this, we recently sent three staff to OLWEUS Training to become Train-the-Trainers. This is a program to prevent bullying in the schools.*

Evaluation of Performance Improvement Projects for FY 2014/15

1) **Non-Clinical PIP – 24/7 Toll-Free Crisis Line**
    - *The 24/7 Toll-Free Crisis Line PIP will focus on Improving access and quality of crisis services.*
    - *The GCSMHP identified a number of problems that were occurring with the 24/7 toll-free crisis line. Consequently, a PIP was formulated and instituted to monitor the 24/7 toll-free crisis line. As a result of being out of compliance for test calls on the last two Compliance Reviews, GCMH determined that a PIP addressing the 24/7 Toll Free Crisis Line was necessary to improve access and quality of services. The QI Department or designee is providing monthly test calls in English, Spanish, and other languages. A test call log is used to score all calls on the following criteria: 1) Was the call answered, 2) Did crisis staff ask caller if it was an emergency, 3) was the caller linked to an interpreter (if necessary), 4) was the call logged, and 5) was a crisis note written. The purpose of these test calls is to assess for the staff members ability to utilize the Language Line, or three-way calling to a Spanish speaking staff member. We meet monthly to review data and develop strategies to address the problems. Trainings have been provided throughout the year on the use of the Language Line. Additionally, all staff who answer the 24/7 toll-free crisis line have been provided with new cell phones through a different carrier that claim to provide better service in this rural area.*
    - *We are pleased with the results of our PIP this year. While there is still room for improvement, test call data shows that staff are improving on answering the call in a timely manner, asking if it is an emergency, and have a higher rate of linking clients to one of our bilingual staff or the language line, when needed.*
    - *We will continue this PIP for the next year to further refine and improve our Crisis Line and meet the needs of persons calling in crisis. We will also add test calls that ask about the client grievance and appeal process for 2015/16.*

2) **Clinical PIP – Mental Health Clients with Overdue Diagnoses**
    - *The Mental Health Clients with Overdue Diagnoses PIP focused on having more accurate and updated diagnosis forms in the client chart.*
    - *At the initiation of this PIP, we analyzed data provided by APS Health Care EQRO data. We found that Glenn County had an unusually high proportion of clients with an Anxiety diagnosis (32%), compared with the statewide average (11%). Based upon concerns regarding this initial data, we re-analyzed the data for all of our clients to determine if there were any other trends in the pattern of diagnostic categories common among our mental health clients. Primarily, we found that a high proportion of clients were given a "Deferred" or "Not Otherwise Specified" (NOS) diagnosis. However, when we examined to determine if the Deferred or NOS diagnosis was updated within sixty (60) days, we found*

that most had not been updated. As a result of this data, we selected four diagnostic categories to collect data on the timeliness of diagnostic updates from staff following the initial intake assessment. We analyzed data on the percentage of mental health clients who have a Deferred Diagnosis. We also analyzed data for each of the three identified diagnostic categories identified regarding the timeliness of diagnosis updates. A sixty (60) day goal was set, for staff to update the diagnosis for clients identified to have a Depressive Disorder NOS, Anxiety Disorder NOS, Mood disorder NOS, or Deferred Diagnosis, to ensure that clinicians were timely in updating these provisional diagnoses and providing treatment for the correct diagnosis.

- *The analysis of this diagnostic data shows that this PIP improved the quality of our services and created a more timely and consistent method for conducting timely clinical assessments and identifying the correct diagnosis at the time of intake to services. The data analysis process occurred as planned. By generating and analyzing the data for timely diagnosis, and providing clinical training on specific diagnostic codes, clinical staff now diagnose clients in a timely manner. This data project also created a system level change, by eliminating the screening process and scheduling clients immediately for a clinical assessment. This also improved the timeliness in which clients received their assessment appointments.*
- ***This PIP was successfully implemented and was closed in 14/15.***

Status of FY 2014/15 Quantitative measures adopted or established to assess performance and to identify and prioritize area(s) for improvement

1) We will increase the number of clients served by the System-wide Mental Health Assessment Response Treatment (SMART) Team from 0 to 10.
    - *Our System-wide Mental Health Assessment Response Treatment (SMART) Team was implemented in January of 2015. Between January and June 30, 2015, we were able to serve 20 clients.*
        - ***We were successful in achieving our goal.***

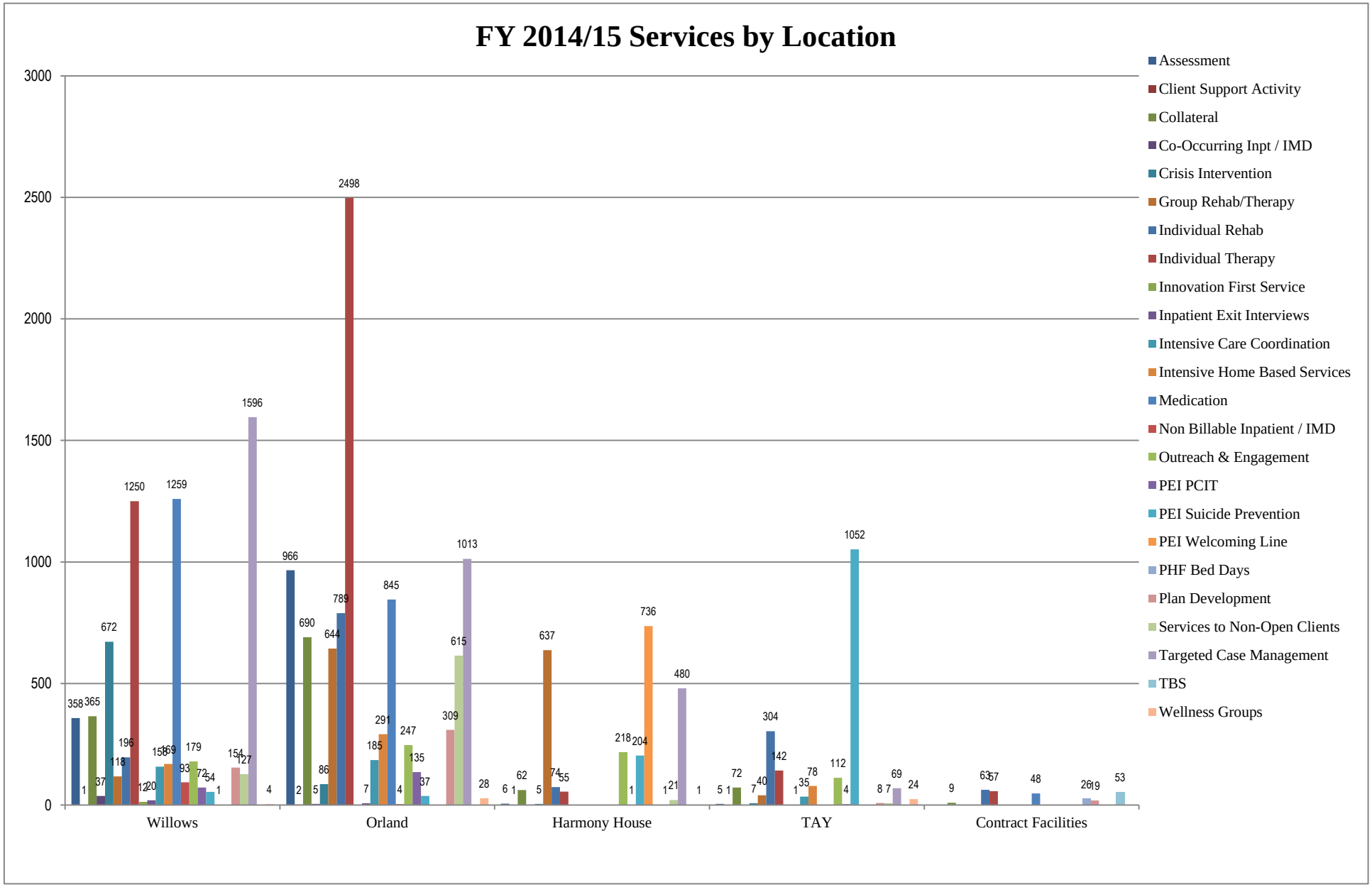
2) We will increase the number of open mental health clients served by AB 109 staff at the Transitions Learning Center from 0 to 15.
    - *In FY 2013/14, we served 2 mental health clients by AB 109 staff at the Transitions Learning Center.*
    - *In FY 2014/15, we served 7 mental health clients by AB 109 staff at the Transitions Learning Center.*
        - ***Although this is a 250% increase, we were not successful in achieving our goal of increasing the number of open mental health clients served by AB 109 staff at the Transitions Learning Center from 0 to 15.***

3) In order to expand capacity to keep up with Medi-Cal expansion, we will increase group services provided to our Medi-Cal clients by 20%.
    - *In FY 2013/14, there were 905 group services provided.*
    - *In FY 2014/15, there were 1439 group services provided.*
        - ***This is a 59% increase in group services that were provided. We were successful in achieving our goal.***

4) We will increase the number of suicide and bully prevention activities in the schools from 0 to 5.

- *The Transition Age Youth Drop-In Center Peer Mentors and Mental Health staff were able to present an anti-bullying program to Orland High School freshman and sophomore classes: See it, Speak it, Change it –The program focuses on teaching communication skills and giving information to create awareness.*
  - *August 4, 2014, one (1) presentation was made to the Orland High School Freshman.*
  - *April 29, 2015, two (2) presentations were made to Orland High School Freshman and Sophomores.*
- *The following additional presentations were made:*
  - *September 2014, one (1) presentation was made to the Glenn County Office of Education school board.*
  - *June 12, 2015, one (1) presentation was made to the Mental Health Advisory Board.*
  - ***Although we were not successful in reaching our goal of five (5) presentations in the schools, there were three (3) presentations were made at Orland High School, and efforts were made to improve collaboration with all schools.***
    - *Staff had plans to present to the Willows High School freshman orientation, but new administration made it difficult to confirm. Additional efforts were made to present at this school, however at least five (5) appointments were cancelled and the presentation never occurred.*
    - *After each presentation at Orland High School, staff continued collaboration with the school by tabling at lunch time. Staff used outreach items and question wheel to continue relationships with the youth and staff.*
    - *Staff attempted phone and email contact with Willows junior high school, Willows Intermediate School, however phone calls and email were never returned. School administration relayed to Mental Health administration that they liked their own bullying program and were not interested.*
    - *Staff worked toward improving collaborative efforts with Orland's junior high school, CK Price. A few informal presentations were made to the school staff which led to discussing continued collaboration. As a result, staff will be tabling at CK Price's open house on August 20, 2015, and hopes to be able to present to the school this next year.*

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



FY 2014/15 Services by Location

Name of Service	Willows	Orland	Harmony House	TAY	Contract Facilities	Sum of all Services
Assessment	358	966	6	5	0	***1335***
Client Support Activity	1	2	1	1	0	***5***
Collateral	365	690	62	72	9	***1198***
Co-Occurring Inpt / IMD	37	5	0	0	0	***42***
Crisis Intervention	672	86	5	7	0	***770***
Group Rehab/Therapy	118	644	637	40	0	***1439***
Individual Rehab	196	789	74	304	63	***1426***
Individual Therapy	1250	2498	55	142	57	***4002***
Innovation First Service	12	0	0	0	0	***12***
Inpatient Exit Interviews	20	7	0	1	0	***28***
Intensive Care Coordination	158	185	0	35	0	***378***
Intensive Home Based Services	169	291	0	78	0	***538***
Medication	1259	845	0	0	48	***2152***
Non Billable Inpatient / IMD	93	4	0	0	0	***97***
Outreach & Engagement	179	247	218	112	0	***756***
PEI PCIT	72	135	1	4	0	***212***
PEI Suicide Prevention	54	37	204	1052	0	***1347***
PEI Welcoming Line	1	0	736	0	0	***737***
PHF Bed Days	0	0	0	0	26	***26***
Plan Development	154	309	1	8	19	***491***
Services to Non-Open Clients	127	615	21	7	0	***770***
Targeted Case Management	1596	1013	480	69	0	***3158***
TBS	0	0	0	0	53	***53***
Wellness Groups	4	28	1	24	0	***57***
TOTALS	**6895**	**9396**	**2502**	**1961**	**275**	***21029***

GCSMHP service delivery capacity goals (for the number, type, and geographic distribution of mental health services) for FY 2015/16

1) To increase the number of Targeted Case Management services provided to our clients.

2) To increase the number of Plan Development services provided to our clients to support client participation in treatment planning.

3) To increase the number of Intensive Care Coordination and Intensive Home Based Services to children enrolled in the Katie A. program.

GCSMHP accessibility of services goals for FY 2015/16

1) Responsiveness of the GCSMHP 24 hour toll-free telephone number.
    - *The GCSMHP 24 hour telephone service line will be tested monthly. The GCSMHP's aim is that all test calls will be answered by the fourth ring. The Compliance and Quality Improvement Manager/Coordinator or designee will randomly call the 24 hour toll-free telephone number at least three (3) times per month and record the length of time it took to answer the call, as well as any other pertinent information, in the After Hours Crisis Line Testing Log.*

2) Timeliness of scheduling routine appointments.
    - *All routine clients requesting outpatient services will be seen for a face-to-face assessment within fourteen (14) calendar days of the initial request for services.*
    - *All routine clients requesting medication services will be seen for a face-to-face assessment within twenty one (21) 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.*

Planning and initiation of activities for sustaining improvement for FY 2015/16

1. Create a comprehensive Quality Improvement and Compliance program for our Alcohol and Drug program that is a component of our Behavioral Health program.

2. Expand training for staff on Secondary Trauma. Initial training was very well received by staff, and we will hire a trainer to provide additional training to staff to support them in delivering exemplary services.

3. Continue developing creative solutions to provide Psychiatry and Tele-psychiatry to our clients. Our longstanding psychiatrist retired last year, and we will identify different options for providing this important service to our clients.

4. Continue expanding our collaborative relationships with Child Welfare services to enhance our Katie A. services, Foster Youth services, and SMART program.

Performance Improvement Projects for FY 2015/16

1) Non-Clinical PIP – *24/7 Toll-Free Crisis Line*

- *The 24/7 Toll-Free Crisis Line PIP will focus on Improving access and quality of crisis services.*
- *We first analyzed the test calls data in February – March 2014. We continued to conduct test calls each month, and have analyzed the data again for April 2014 – July 2015. The percent of the test calls that were considered successful increased from 14.3% to 42.1%. The percent of callers who were asked if it was an emergency increased from 14.3% to 60.7%. The percent of callers who were successfully linked to an interpreter on the Language Line, or bilingual staff (if necessary) increased from 0.0% to 57.1%. The percent of test calls that were logged increased from 42.9% to 69.1%, and the percent of crisis notes written increased from 33.3% to 71.2%.*
- *We are very pleased with our results thus far. We will continue this PIP for the next year to further refine and improve our Crisis line and meet the needs of persons calling in crisis. We will also add test calls that ask about the client grievance and appeal process for 2015/16.*

2) Clinical PIP – *Enhance Recovery and Wellness by ensuring client involvement in Treatment Planning, as signified by a client signature on the Treatment Plan.*

- *The Treatment Planning and Client Involvement PIP will focus on improving client outcomes as evidenced by clients that are involved in their treatment planning.*
- *It is the value of Glenn County Mental Health to ensure that clients are leaders in their treatment planning. When clients participate in the development of their treatment goals and objectives, they are more likely to embrace the identified actions and achieve positive outcomes. We also want to support client leadership in developing goals and having an active voice in their treatment. This strategy promotes wellness and recovery, while helping the client manage symptoms and outcomes.*
- *As an indicator of client participation, clients are required to sign their Treatment Plan. To determine if there was a problem with obtaining client signatures on Treatment Plans, a random review of client Treatment Plans found that staff have difficulty consistently obtaining client signatures on Treatment Plans. Of the 396 treatment plans reviewed from January 2014 – February 2015, 78.8% of them were signed by the client and 21.2% were not signed at all. Of the Treatment Plans that were signed, only 37.6% were signed within 7 days of the development of the plan. This data identifies two significant issues: a) A high number of treatment plans are not signed; and b) There is a delay in obtaining clients signatures on Treatment Plans, which may indicate that the client was not actively involved in developing the treatment goals and providing leadership to the treatment planning process.*
- *These issues place Glenn County Behavioral Health at risk for being out of compliance with state regulations and may have an impact on clients achieving positive outcomes. As a result of this baseline data, we have identified this issue as an important area for improvement to ensure participation and positive outcomes for our clients.*
- *We will review client Treatment Plans to see if staff are obtaining client signatures. This information will be continually recorded by administrative staff in an electronic log so we can analyze our improvement over time. We will also administer a survey at least quarterly to a random sample of clients who participated in their treatment planning in the prior 3*

months. The surveys will be collected in a confidential manner, and will be given to our contracted Evaluator for entry and analysis. Results will be shared with staff to discuss if any additional interventions need to be developed to ensure client participation and satisfaction with Treatment Plans.

FY 2015/16 Quantitative measures adopted or established to assess performance and to identify and prioritize area(s) for improvement

1) With the creation of a comprehensive Quality Improvement and Compliance program for our Alcohol and Drug program, we will increase the number of hours of training that staff receive on program requirements from 1 to 4 monthly.

2) In partnering with Chico State to provide training, we will increase the number of trainings on Secondary Trauma for staff and leadership from 0 to 5.

3) With the addition of tele-psychiatry services in Orland, we will increase the number of psychiatric services provided in Orland to be consistent with the number of services provided in Willows.

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 GCMHP 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) 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, Advocacy, Support, Knowledge (ASK), Consumer Voice Forum, Children's Interagency Coordinating Council (CICC), 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 (PIP). The performance improvement projects will focus on a clinical area and one in a non-clinical area.

The QIC is responsible for overseeing all 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. Assessments:

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:
   - *The GCSMHP has established that Assessments will be completed within 60 days of opening.*
   - *Reassessments will be completed 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. Whether a client has received or declined a copy will be documented on the client plan.

3) Timeliness/Frequency of Client Plan:
   - *The GCSMHP has established that Client Plans will be completed within 60 days of opening. The client plan will be updated at least annually, or when there are significant changes in the client's condition.*

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:
   - *The GCSMHP has established that 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.*

   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:
   ii. The date of service:
   iii. 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.
   iv. 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 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 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 of completed referral packet received, screening appointment date, 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.*
- *Penetration rate data is utilized in QIC which gives up the number of Medi-Cal beneficiaries in our county and the number we have served. This quarterly data also includes the numbers and types of services that we are providing.*
- *Weekly staff meetings also assure that the GCSMHP is monitoring the service delivery capacity and is making changes as necessary, so that its clients' needs are met.*

The 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 Compliance and Quality Improvement Coordinator/Manager or designee will 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, Quality Improvement, and the System Improvement Committees. Feedback is 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 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 Reassessment, the Treatment Plan, and any other relevant clinical information. The Assessment and Reassessment 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 Action (NOA-E) 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 action 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 fourteen (14) calendar days of request for services, and authorized within sixty (60) days.*
        - *Clients requesting urgent or emergent services will be seen and authorized within one (1) hour.*
        - *Authorizations for services for foster children or youth placed outside of his/her county will be made within three (3) working 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) working 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 GCSMHP has structured Utilization Management Activities in a way so as to not provide incentives for any individual or entity to do so.