



Glenn County Specialty Mental Health Plan

FY 2019/20

*Quality Assessment and
Performance Improvement Program*

*Last year's Work Plan Evaluation
and
Current QI Work Plan*

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM AND DESCRIPTION

The Glenn County Specialty Mental Health Plan (GCSMHP) has seven (7) county sites, two (2) of which are drop-in centers and one is a (1) satellite site. The GCSMHP is responsible for authorizing and providing inpatient and outpatient specialty mental health services to Glenn County Medi-Cal clients. The GCSMHP is also responsible for maintaining an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for the services it provides to its clients, and will improve outcomes through structural and operational processes and activities that are consistent with current standards of practice and professional knowledge.

The QAPI Program will conduct performance monitoring activities through the GCSMHP, including but not limited to client and system outcomes; utilization management; utilization review; service authorization; provider appeals; credentialing and monitoring; and resolution of client change of provider requests, grievances, appeals, and expedited appeals. This QAPI Program written description clearly defines the QAPI 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 QAPI Program will be evaluated annually and updated as necessary, to ensure the goals of the GCSMHP are being met, and includes the establishment of a Quality Improvement Committee (QIC).

Quality Improvement Committee

The Quality Improvement Committee (QIC) is responsible for reviewing and overseeing the quality of specialty mental health services provided to clients. The QIC provides a forum for the 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 QAPI Program by attending various meetings, committees, and staff meetings in which data is reviewed and evaluated. The Compliance and Quality Improvement Manager and the Compliance and Quality Improvement Coordinator share responsibility for the clinical oversight of the QAPI Program, and the Compliance and Quality Improvement Manager convenes the QIC meetings. The QAPI Program is accountable to the GCSMHP Director.

The QIC will recommend policy changes, review, and evaluate the results of QI activities including performance improvement projects (PIPs), institute needed QI actions, ensure follow up of QI processes, and document QIC meeting minutes reflective of its decisions and actions taken. The QIC will also monitor the utilization management (UM) and service authorization processes 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.

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.*

System Improvement Committee

The System Improvement Committee (SIC) also provides a forum for the GCSMHP providers, staff, consultants, clients, family members, volunteers, Mental Health Advisory Board members, and community members to review and analyze 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 (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 QI Department, QIC, Medication Monitoring, staff meetings, peer chart review, and as necessary. A formal chart review is conducted monthly that includes key QI staff and may include 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.

QI staff will monitor and approve out of county authorizations as well as inpatient treatment authorization requests. QI 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 includes 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. Medical Denial Reports help to identify any potential compliance issues and the denials are reviewed and resolved on an ongoing basis as the EOBs 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.

Mental Health Services Act Steering Committee

In coordination with the MHSA Coordinator, the Mental Health Services Act (MHSA) Steering Committee works diligently to monitor the requirements of the Full Service Partnership (FSP) program, which is a mandate of the California MHSA to provide integrated mental health and other support services to individuals whose needs are not met through other funding sources. The MHSA Steering Committee will review and monitor the provision of services to all mental health clients and will recommend clients to become a FSP, monitor the percentage of CSS funding used for the FSP program, maintain an accurate FSP client list, ensure mental health staff complete the required paperwork for their FSP clients, and review FSP flex fund and MHSA housing funds access requests for approval or

denial. In addition, the MHSA Steering Committee will also review and provide input on the MHSA annual plan and the MHSA 3-year plan as needed. Most members of the MHSA Steering Committee sit on other committees within the QAPI Program, which ensures a feedback loop among committees. The MHSA Steering Committee aims to meet monthly, but no less than ten times per year.

Cultural Competence Task Force

The Cultural Competence Task Force (CCTF) monitors the implementation of the 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, SIC, and 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 respectful of cultural identity and self-awareness focusing on wellness for all.

Ethnic Services Coordinators Committee

In coordination with the CCTF, the Ethnic Services Coordinators' Committee (ESCC) provides assistance and consultation in the development of linguistically and culturally appropriate services delivered by bilingual/bicultural staff. The ESCC 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 ESCC 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 Organization (EQRO) and the Department of Health Care Services (DHCS) reviews and 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 CLCP remains effective and responsive to change.

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 Glenn County Mental Health (GCMH) Provider Handbook that providers receive with their contract annually. Providers are also required to cooperate with the GCSMHP QAPI 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, DHCS consumer perception surveys, documentation, grievances/appeals/expedited appeals, incident reports, notices of adverse benefit determinations (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 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, Substance Use Disorders Services, Probation, Juvenile Hall, and other departments within the Health and Human Services Agency (HHS). 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.

The GCSMHP utilizes the Contact Log (a Microsoft Access database) and Anasazi (electronic health record) for data, reports, and claims, and to detect both underutilization and over utilization of services.

- *Additionally, the GCSMHP submits the Network Adequacy Certification Tool (NACT) and associated documents to the DHCS quarterly.*

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

- *Consumer Perception Surveys are administered in May and November of each year, as required by the DHCS. Results are reviewed by staff in a number of meetings.*
- *Quarterly QIC reviews, discusses, and evaluates the following items: HIPAA complaints, client grievances, appeals, and expedited appeals, state fair hearings, NOABDs, change of provider requests, 24/7 Crisis Line testing, trainings, incident reports, and reports of morbidity and mortality. Results are shared by staff by phone, email, and as needed.*
- *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. Results are shared with staff as appropriate.*

The GCSMHP has implemented a mechanism to monitor the safety and effectiveness of medication practices, under the supervision of a person licensed to prescribe or dispense prescription drugs, and 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 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. 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 GCSMHP has implemented mechanisms to address meaningful clinical issues affecting clients system-wide, including:

- *Chart Review, Performance Improvement Projects, Medication Monitoring activities, Utilization Review, and staff meetings.*

The GCSMHP continues to monitor for 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 raised by clients and staff. Based on the occurrence that was identified, interventions will be implemented as appropriate, and evaluated at least annually.*

UTILIZATION MANAGEMENT (UM) PROGRAM

The Glenn County Specialty Mental Health Plan (GCSMHP) operates a Utilization Management (UM) Program to assure clients have appropriate access to specialty mental health services as required.

The Compliance and Quality Improvement Manager and the Compliance and Quality Improvement Coordinator are responsible for all UM activities, and evaluate medical 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 for UM by the QIC or 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 has implemented 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 GCSMHP has implemented mechanisms to assess the accessibility of services within its service delivery area. This includes 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 GCSMHP has structured UM activities in accordance to Title 42, CFR, Section 438.210(e), which states that 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 may place appropriate limits on a service based on criteria applied under the State Plan, such as medical necessity and for the purpose of utilization control, provided that the services furnished are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

SERVICE AUTHORIZATION

The Glenn County Specialty Mental Health Plan (GCSMHP) has implemented the following mechanisms to assure authorization decision making standards are met.

- *See Authorization Process for Outpatient Mental Health Services 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 made by the GCSMHP 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) *GCSMHP will notify the requesting provider, and give the client written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.*

- *All authorizations of specialty mental health services decisions are made by licensed or waived 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.*

For standard authorization decisions, the GCSMHP will provide notice as expeditiously as the client's condition requires not to exceed fourteen (14) calendar days following the receipt of the request for the service, with a possible extension of up to fourteen (14) additional calendar days when:

- *The client, or the provider, requests extension, or*
- *The GCSMHP justifies (to the department upon request) a need for additional information and how the extension is in the client's interest.*

For cases in which a provider indicates, or the GCSMHP determines, that following the standard timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum function, the GCSMHP will make an expedited authorization decision and provide notice as expeditiously as the client's health condition requires and no later than 72 hours after the receipt of the request for service. The GCSMHP may extend the 72 hour time period by up to fourteen (14) calendar days if the client requests an extension, or if the GCSMHP justifies (to the department upon request) a need for additional information and how the extension is in the client's interest.

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.*
- 4) A description of mechanisms to assess the accessibility of services within the service delivery area, including the responsiveness of the 24 hour toll-free number, timeliness for scheduling routine appointments, timeliness of services for urgent condition, and access to after-hours care.
- 5) Evidence of compliance with the requirements for cultural competence and linguistic competence.

FY 2018/19 WORK PLAN EVALUATION

Grievances, Appeals, Expedited Appeals, Change of Provider Requests, Fair Hearings, Provider Appeals, and Clinical Records Review

Monitoring of these activities occurred monthly and the results were reviewed in quarterly Quality Improvement Committee (QIC) meetings.

- Twenty-two (22) Grievances
- Zero (0) Appeals
- Zero (0) Expedited Appeals
- Forty-seven (47) Change of Provider Requests
- Zero (0) Fair Hearings
- Zero (0) Provider Appeals
- Clinical records review occurs monthly and the results are documented in the QIC minutes

Service Delivery Goals

- 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.
 - **Total services: 13305**
 - **Total face to face services: 11453**
 - **Goal met - 86%**

Note: this data differed upon re-reporting of both the baseline and end of the most recent fiscal year. Please see Targeted Areas of Improvement, Change in Service Delivery, or Program Design section, goal number 9 for a detailed description of data discrepancies. At baseline, the face to face services were 77.05%, but still improved to 82.6% 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.
 - **Total IHBS services: 432**
 - **Total IHBS services in the home: 72**
 - **Goal not met - 17%**
- 3) Increase overall IHBS services up to 311 services in FY 18/19, representing a 50% increase from FY 17/18.
 - **Total IHBS services: 432**
 - **Goal met - 139%**
- 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.
 - **Total TAY Group Therapy services: 0**
 - **Goal not met - 0%**

Accessibility of Services Goals

1) Responsiveness of the 24/7 toll-free Access Line.

*The 24/7 toll-free Access Line will be tested with a minimum of three test calls monthly, with **80% of all test calls answered successfully**. All test calls are recorded in the 24/7 Testing Call Log and scored on 5 criteria. In order for a test call to pass, all five criteria must be met.*

- **Total Calls Conducted: 36**
 - **Goal met - 80.6%**

2) Timeliness of routine mental health outpatient appointments.

*100% of all clients requesting routine mental health outpatient services will be offered a face-to-face assessment within **ten (10) business days** of the initial request for services.*

- **Average Business Days (All Clients): 6.4**
 - **Goal not met - 88.7%**
- **Average Business Days (Adults): 6.4**
 - **Goal not met - 88.4%**
- **Average Business Days (Children/Youth): 6.5**
 - **Goal not met - 89.2%**
- **Average Business Days (Foster Care): 6.5**
 - **Goal not met - 90.2%**

*85% of all clients requesting routine mental health outpatient services will be seen for a face-to-face assessment within **ten (10) business days** of the initial request for services.*

- **Average Business Days (All Clients): 10.2**
 - **Goal not met - 69.2%**
- **Average Business Days (Adults): 10.4**
 - **Goal not met - 69.2%**
- **Average Business Days (Children/Youth): 9.9**
 - **Goal not met - 66.5%**
- **Average Business Days (Foster Care): 8.4**
 - **Goal not met - 69.2%**

*85% of all clients requesting routine medication services will be seen for a face-to-face assessment within **fifteen (15) business days** of the initial request for services.*

- **Average Business Days (All Clients): 14.3**
 - **Goal not met - 60.4%**
- **Average Business Days (Adults): 14.3**
 - **Goal not met - 60.7%**
- **Average Business Days (Children/Youth): 14.1**
 - **Goal not met - 59.1%**
- **Average Business Days (Foster Care): 21.4**
 - **Goal not met - 0%**

3) Timeliness of services for crisis and urgent conditions.

85% of all clients presenting during business hours in crisis or with an urgent condition will be **seen within one (1) hour**, although all efforts are made to see the client immediately. All clients requesting after-hours crisis and urgent 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**.

- **Average Minutes (All Clients): 7.2**
 - **County Goal met - 99%**
 - **State Standard for Urgent Services: 48 hours**
 - Overall Goal: 100%
 - **Goal met**
- **Average Minutes (Adults): 6**
 - **County Goal met - 99.2%**
 - **State Standard for Urgent Services: 48 hours**
 - Overall Goal: 100%
 - **Goal met**
- **Average Minutes (Children/Youth): 12**
 - **County Goal met - 98.1%**
 - **State Standard for Urgent Services: 48 hours**
 - Overall Goal: 100%
 - **Goal met**
- **Average Minutes (Foster Care): 22.2**
 - **County Goal met - 93.5%**
 - **State Standard for Urgent Services: 48 hours**
 - Overall Goal: 100%
 - **Goal met**

Targeted Areas of Improvement, Change in Service Delivery, or Program Design
(Strategic Initiatives)

- 1) Institute the Behavioral Health Treatment Court program to 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%.
 - *Glenn County Adult Behavioral Health Treatment Court Program has been implemented and began providing services in August 2018 to address the needs of individuals with identified mental health symptoms and diagnoses, substance use disorders, or both. The mission of this specialized court is to integrate mental health and substance abuse treatment with judicial supervision for the promotion of public safety, individual responsibility, and reduction of recidivism. This collaborative court model ensures the unique treatment needs of each participant are met with the appropriate resources and level of care.*
 - *We have multiple data points that are being collected and sent to a consultant, and recidivism data is located on the progress reports that are sent to the court. The program has referral, screening, assessment, and risk assessments that are done prior to a participant entering the program. Once the participant has entered the program, an entrance survey and progress report is done monthly for the court. When a participant has discharged, an exit survey is done.*
 - *To date, the program has served 9 total participants, with 1 successful completion, 1 discharge for medical reasons, 1 discharge for non-compliance, and 1 who was re-arrested.*

- 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.
 - *Initially, the vision of the GCSMHP was to move all adult treatment providers, both mental health and substance use disorders, into the Orland CRWC building. However in the Fall of 2018, the Parkside building (adjacent to the adult drop-in center Harmony House) became available and all adult treatment providers either relocated fully or have weekly space in this building. All of our adult unit-specific providers have office space at Parkside. However, there are some providers who serve all-ages that are not stationed at Parkside. Regardless, the adult unit is continually working on providing person-centered services, partnering with other agency providers, and has begun to hold Wellness Team meetings for Full Service Partners (FSP) clients to ensure the provision of person-centered care. The adult unit management has also reestablished attendance at regular integrated Glenn Health and Human Services Agency (HHS) Adult System of Care meetings that are multi-discipline and focus upon whole-person care.*

- 3) Expand and improve suicide prevention activities by providing trainings to community partners and agencies on safeTALK suicide prevention as part of our PEI plan. Within the next fiscal year, the GCSMHP will provide at least 3 safeTALK trainings to local community partners.
 - *Two more HHSA staff attended the safeTALK Train the Trainer training in 2018-19. A safeTALK training committee has been formed to receive requests from the community and to conduct training.*
 - *Safe Talk trainings have been provided on 4/26/19 for staff and mental health advisory board members, 5/23/19 for community and schools, and again on 7/25/19 for probation officers, HHSA staff, and the general public. We will also provide safeTALK training as part of the in-service days for Orland Unified School District teachers and staff on 8/7/19. The overall response for this training has been extremely positive.*

- 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.
 - *We have several key behavioral health staff on this committee, including our MHSA Coordinator, who represent Glenn County Behavioral Health and provide input. Recently members of this committee have drafted a 10 year plan to end homelessness in Glenn County, which includes some behavioral health specific components, and a plan to make use of the MHSA No Place Like Home funds. Furthermore, we have made efforts to better track and provide outreach and engagement with persons experiencing homelessness through our adult drop-in center, Harmony House.*

- 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.
 - *A process has been created to onboard new staff, including a binder of reference information for all new hires. This binder contains a wide spectrum of GCSMHP and HHSA agency-wide policies, practice guidelines, program information, documentation, and other valuable training. New staff are always welcomed by their new supervisor their first day to begin the onboarding process. Early on in the onboarding process staff also meet with the behavioral health director and are taken on a tour of the behavioral health offices to familiarize themselves with both the locations and programs located within them.*

- 6) Conduct continuing agency-wide leadership development meetings based on the UC Davis curriculum.
 - *Ongoing follow up trainings have been scheduled, however the initial curriculum that was presented to agency leaders in 2017 has not returned. HHSA as a whole continues integration efforts with establishment of a Management Strategic Plan, and specialized trainings that include cross-department attendance.*

- 7) Co-locate Children's Mental Health with Child Welfare to create a one-stop Children's System of Care.
 - *This is still in process and plans are being made to move to a new location in the Fall of 2019. All children's services, including mental health, substance use disorders, and child welfare, will be located in HHSA's Walker Street Location in Orland. This location will also include adjunctive services such as eligibility and probation as well.*

- 8) 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.
 - *The GCSMHP standard for assessments is that they may be completed annually, but not less than every two (2) years, and should be updated as needed. Through monthly chart review and a review of client lists, QI staff noticed a decline in assessments being completed annually, with the percentage of clients who needed a reassessment in June 2018 at only 55%. This information was disseminated to all GCSMHP staff through regular and monthly retraining on documentation standards, supervision, and chart review activities. Monitoring activities have continued since then, and although the monthly percentage of clients needing reassessments has varied, the overall average for FY 2018/19 has increased to 77.4%. The GCSMHP will continue its efforts to increase the timeliness of annual assessments.*

- 9) 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.
 - *The GCSMHP has focused on the productivity of direct services staff for many years. Recent scrutiny of reports has led supervisors to more closely monitor the provision of face to face services, as a means of improving the quality of client care. However, upon review of the initial base-line data that stated 46% of services were face to face, it was discovered there were discrepancies in the data. QI staff discovered additional indicators denoting a face to face service, which may have been excluded from prior reports, such as telepsychiatry and interpreter present services. There was also a limitation of the EHR reporting capabilities discovered by QI, as it was found staff could only choose face to face or interpreter present capabilities, not both. Despite this, there was still improvement noted in the amount of face to face services overall provided in the last fiscal year of this plan. In FY 2017/18, there were 77.05% of services provided that were face to face (defined as face to face, telepsychiatry, and interpreter present and excluding admin, phone, and staff only). In FY 2018/19, 82.6% of services provided were face to face. This is a 5.55% overall improvement.*

Performance Improvement Projects

1) Timely Access (Non-Clinical PIP)

- *Will implementing a triage assessment process help high-need clients with an urgent need access services within 5 business days; ensure clients with a routine need for services access services within 10 business days; and clients requesting psychiatric services receive services within 15 calendar days?*
 - Since we have implemented the levels of need for mental health services requests, we have seen a 263.1% increase for high-need clients with an urgent need access services within 5 business days; a 161.2% increase for clients with a routine need access services within 10 business days; and a 127% increase for clients access to psychiatric services within 15 business days, and we aim to continue making progress on this goal despite the shortage of psychiatrists in rural California.

2) Intensive Home-Based Services (Clinical PIP)

- *Will increasing the delivery of Intensive Home-Based Services (IHBS) to children, youth, and caregivers who have an open CWS case improve the family's resiliency and increase the number of children who are reunified with their family, as indicated by an improvement in the Life Domain Functioning section of the California CANS-50?*
 - Overall, the PIP did not meet many of the targeted percentages for improvement. There were staffing shortages in the first year of the PIP and many changes in the second year, and so it has been difficult to maintain a set vision and training on coding. We will continue to implement system changes and staff training associated with this PIP, and work to continually improve our intensive services for foster youth in the future.

Cultural and Linguistic Standards

Monitoring of the cultural and linguistic standards and activities occurred in monthly Cultural Competence Task Force (CCTF) and Ethnic Services Committee (ESC) meetings and the results were shared in quarterly Quality Improvement Committee (QIC) meetings.

The GCSMHP has complied with all provisions of the Cultural Competence Plan submitted on 11/28/18 and approved by the Department of Health Care Services (DHCS).

The GCSMHP continues to follow the national standards for culturally and linguistically appropriate services (CLAS) to advance health equity, improve quality, and help eliminate health care disparities.

OBJECTIVES, SCOPE, AND PLANNED QI ACTIVITIES FOR FY 2019/20

Grievances, Appeals, and Expedited Appeals, Fair Hearings, Provider Appeals, and Clinical Records Review

Monitoring of these activities will occur monthly and the results will be reviewed in quarterly Quality Improvement Committee (QIC) meetings.

Service Delivery Goals

- 1) Increase services to youth up to age 20 with a family member or collateral present from a base line of 28.1% last fiscal year, up to 32% of overall services.
- 2) Provide at least one group service series in Willows (therapy or rehab); we had 0 in this last fiscal year.
- 3) Provide at least one therapy group in either Willows or Orland; we had 0 group therapy services in 2018/19 (so far only rehab group).
- 4) At least 50% of all FSPs will have a plan development session with their case manager. Last fiscal year, 9 out of 168 (5.4%) FSPs served had a plan development session with their case manager.
- 5) Increase all services provided by a case manager to FSPs. Last fiscal year, Case Managers provided only 30.8% of total services to FSPs, with other provider types providing the remaining 69.2% of overall services. As the primary modality of FSP work is rehabilitation and case management, we would like to see an increase of 10% to at least 40% of overall services provided to FSPs being delivered by a case manager.
- 6) Provide at least one group service series in Grind Stone Rancheria; we had 0 last fiscal year.

Accessibility of Services Goals

- 1) Responsiveness of the 24/7 toll-free Access Line.
 - *The 24/7 toll-free Access Line will be tested with a minimum of three test calls monthly, with **80% of all test calls answered successfully**. All test calls are recorded in the 24/7 Testing Call Log and scored on 5 criteria. In order for a test call to pass, all five criteria must be met.*
- 2) Timeliness of routine mental health outpatient appointments.
 - *Clients requesting routine mental health outpatient services will be offered a face-to-face assessment within **ten (10) business days** of the initial request for services.*
 - *Clients requesting routine outpatient services will be seen for a face-to-face assessment within **ten (10) business days** of the initial request for services.*
 - *Clients requesting medication services will be seen for a face-to-face assessment within **fifteen (15) business days** of the initial request for services.*

- 3) Timeliness of services for urgent conditions and access to afterhours care.
 - *All clients presenting during business hours in crisis or with an urgent condition will be **seen within one (1) hour**, although all efforts are made to see the client immediately. All clients requesting after-hours crisis and urgent 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**.*

Targeted Areas of Improvement, Change in Service Delivery, or Program Design
(Strategic Initiatives)

- 1) Increase outreach and engagement for clients experiencing homelessness, and improve access to mental health services for all persons utilizing Harmony House.
- 2) Utilize the wellness team meeting model to coordinate care for adults with intensive needs.
- 3) Provide a group specifically for our LGBTQ+ population.
- 4) Develop a process to track referrals to other services and/or agencies.
- 5) Refine the process for tracking foster care youth and referrals to the appropriate level of care, as well as screening and referral for all EPSDT eligible youth in need of ICC or IHBS services.
- 6) Co-location of Children's mental health, child welfare services, substance use disorder services, probation, and eligibility.
- 7) Implement system-wide use of the scheduling process in order to fulfill new CSI requirements.
- 8) Update the contact log in order to meet new CSI requirements, and to track more meaningful data.
- 9) Reorganize Day Crisis services to utilize a smaller crisis team that will be able to provide more consistent follow-up and engagement.
- 10) Contract out afterhours crisis services.
- 11) Develop a new medical necessity tool that will more accurately indicate which level of care a client should be referred to.
- 12) Begin viewing demos and piloting Cerner's new EHR product, Millennium and plan for implementation.
- 13) Develop a dual diagnosis treatment component by increasing services for the dually diagnosed population, providing some dual diagnosis focus at our drop-in centers, and potentially hire coaches with lived SUD experience as well.

Performance Improvement Projects

1) Access at Harmony House (Non-Clinical PIP)

- *Will improving outreach, engagement, and referral to specialty mental health services for persons attending Harmony House (adult drop-in center) improve access to mental health services as evidenced by at least 60% of persons attending Harmony House being open to mental health services?*

2) Family Functioning (Clinical PIP)

- *Will increasing family engagement, evidenced by at least 32% of overall services for children and youth up to age 20 including a family member or significant support person present, improve outcomes for youth and their families as evidenced by at least a 10% overall improvement in Family Function scores on the CANS-50?*

Cultural and Linguistic Standards

The GCSMHP will promote the delivery of services in a culturally competent manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

The GCSMHP will comply with all provisions of the Cultural Competence Plan submitted and approved by the Department of Health Care Services (DHCS).

The GCSMHP will follow the national standards (below) for culturally and linguistically appropriate services (CLAS) to advance health equity, improve quality, and help eliminate health care disparities.

Principal Standard:

- 1) Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

- 2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
- 3) Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in Glenn County.
- 4) Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

- 5) Offer language assistance to clients who have limited English proficiency (LEP) and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- 6) Inform all clients of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- 7) Ensure the competence of staff providing language assistance service, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- 8) Provide easy to understand print and multimedia materials and signage in the languages commonly used by the populations in Glenn County.

Engagement, Continuous Improvement, and Accountability:

- 9) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the GCSMHP's planning and operation.
- 10) Conduct ongoing assessments of the GCSMHP's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
- 11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- 12) Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- 13) Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- 14) Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
- 15) Communicate GCMHP's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.