GLENN COUNTY
HHSA
HEALTH & HUMAN SERVICES AGENCY

Glenn County
Specialty Mental Health Plan

FY 2022/23

Quality Improvement
Work Plan
and FY 2021/22
Work Plan Evaluation

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM AND DESCRIPTION

The Glenn County Specialty Mental Health Plan (GCSMHP) has seven (7) county sites, of which two (2) 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. The QAPI Program will also include collection and submission of performance measurement data required by the Department of Health Care Services (DHCS). 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.*

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. Selection of charts may be random or targeted as necessary. 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.

Performance Improvement Projects

The GCSMHP will conduct a minimum of two Performance Improvement Projects (PIPs) each year, including any PIPs required by DHCS. One (1) PIP will focus on a clinical area

and one (1) on a non-clinical area. The GCSMHP will report the status and results of each performance improvement project to DHCS as requested, but not less than once per year.

Each PIP will:

1) *Be designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction;*
2) *Include measurement of performance using objective quality indicators;*
3) *Include implementation of interventions to achieve improvement in the access to and quality of care;*
4) *Include an evaluation of the effectiveness of the interventions based on the performance measures collected as part of the PIP; and*
5) *Include planning and initiation of activities for increasing or sustaining improvement.*

Practice Guidelines

The GCSMHP will adopt practice guidelines, and disseminate the guidelines to all affected providers and upon request, to clients and potential clients. The GCSMHP will take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other areas to which the guidelines apply will be consistent with the guidelines.

Such guidelines will meet the following requirements:

1) *They are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field;*
2) *They consider the needs of the beneficiaries;*
3) *They are adopted in consultation with contracting health care professionals, and*
4) *They are reviewed and updated periodically as appropriate.*

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 will meet quarterly, for a total of four (4) meetings annually.

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 annually 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. Medi-Cal 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 Diversity and Equity Committee

The Cultural Diversity and Equity Committee (CDEC) monitors the implementation of the GCSMHP Cultural and Linguistic Competence Plan (CLCP). The CDEC 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 CDEC annually. The CDEC will be involved in planning consumer and/or community events which focus on cultural awareness. The CDEC 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 CDEC 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 CDEC aims to meet monthly, but no less than six times per year.

Ethnic Services Committee

In coordination with the CDEC, the Ethnic Services Committee (ESC) provides assistance and consultation in the development of linguistically and culturally appropriate services delivered by bilingual/bicultural staff. The ESC intention is to provide better client care, staff care, training, and oversight on all components of the delivery of bilingual services. ESC 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 ESC also provides an opportunity for bilingual staff to come together and 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. ESC is also tasked with implementing actions identified and recommended by the Cultural Diversity and Equity Committee, as well as the External Quality Review Organization (EQRO) and the Department of Health Care Services (DHCS) reviews and audits. ESC focuses on meeting recommendation deadlines set forth by reviews. ESC also assists in providing the needed trainings identified by the CDEC with the use of its bilingual/bicultural staff members. ESC aims to meet on a monthly basis, but no less than six times per year. The ESC Mission statement is:

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 (HHSA). The GCSMHP will coordinate with other human services agencies and departments used by its clients. Referrals are made to these agencies and departments as necessary, to provide our clients with the highest quality of services available. We have an MOU with AMPLA Health Care, Inc., and we continue to make referrals. The goal of the program is to ensure that persons with mental illness have a medical home, and that physical health outcome indicators show improvement for consumers. The GCSMHP will assess its effectiveness annually.

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

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

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

- *Consumer Perception Surveys are administered at least annually, as required by the DHCS. Results are reviewed by staff in a number of meetings.*
- *QIC quarterly summaries are reviewed to discuss and evaluate 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 with staff in meetings, 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 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 mechanisms to assure authorization decision making standards are met.

The GCSMHP has and follows written policies and procedures for processing requests for initial and continuing authorizations of services.

- *See Authorization Process for Outpatient Mental Health Services P&P (MH-154).*
- *See Concurrent Review of Psychiatric Inpatient Hospital, Psychiatric Health Facility, Crisis Residential Treatment, and Adult Residential Treatment Services P&P (MH-160).*
- *See Coordination and Continuity of Medi-Cal Specialty Mental Health Services P&P (MH-156).*
- *See Single Case Agreements and Out of Network Access for Outpatient Services P&P (MH-142).*

The GCSMHP has mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and will consult with the requesting provider when appropriate.

- *The TAR, SAR, and Presumptive Transfer logs also serve as mechanisms to assure that authorization decision making standards are met. This log captures all pertinent information including CIN, client name, authorized service, and dates of authorization, and are periodically monitored by the QI Manager and the Youth and Family Program Manager.*

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 will be made by a health care professional who has appropriate clinical expertise in treating the client's condition or disease.

- *All authorizations of specialty mental health services decisions are made by licensed or waivered GCSMHP staff, using the statewide medical necessity criteria, the Mental Health Assessment and/or annual assessment update, the Treatment Plan, and any other relevant clinical information. The Assessment and/or annual update are used to document the client's medical necessity and symptomology and also document relevant information when the client does not meet medical necessity. A denial of services based upon medical necessity is clearly documented in the chart.*

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.

- *See Notices of Adverse Benefit Determination P&P (MH-104).*
- *As required by the State Department of Health Care Services (DHCS), the GCSMHP will send a Notice of Adverse Benefit determination when denying or limiting a service authorization. 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.*

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.*

- ***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 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.

The GCSMHP will act on an authorization request for treatment for urgent conditions within one hour of the request.

The GCSMHP will not require prior authorization for an emergency admission for psychiatric inpatient hospital services, whether the admission is voluntary or involuntary. The Contractor that is the MHP of the client being admitted on an emergency basis will approve a request for payment authorization if the client meets the criteria for medical necessity and the client, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing.

The GCSMHP may not require prior authorization for an emergency admission to a psychiatric health facility when the client has an emergency psychiatric condition.

The GCSMHP will authorize out of network services when a client with an emergency psychiatric condition is admitted on an emergency basis for psychiatric inpatient hospital services or psychiatric health facility services.

The GCSMHP will define service authorization request in a manner that at least includes a client's request for the provision of a service.

If the GCSMHP's provider network is unable to provide necessary services to a particular client, the GCSMHP will adequately and timely cover the services out of network, for as long as the GCSMHP's provider network is unable to provide them.

The GCSMHP will require that out-of-network providers coordinate authorization and payment with the GCSMHP. The GCSMHP must ensure that the cost to the client for services provided out of network pursuant to an authorization is no greater than it would be if the services were furnished within the GCSMHP's network.

The GCSMHP will permit Indian clients who are eligible to receive services from an Indian health care provider (IHCP) participating as a network provider, to choose that IHCP as his or her provider, as long as that provider has capacity to provide the services.

Provider Network

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 (a Microsoft Access database) and Anasazi (electronic health record) serve as the primary mechanisms for monitoring the capacity of the service delivery system. This log and Anasazi contain 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. Additionally, the GCSMHP now submits the Network Adequacy Certification Tool (NACT) and associated documents to the DHCS annually, which assess 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 staff who took the call, and the Quality Improvement and System Improvement Committees.*
- *The Contact Log (a Microsoft Access database) serves as the primary mechanism for monitoring the accessibility of urgent and emergent mental health and crisis services.*
    - *The Crisis Log within the Contact Log, captures all pertinent information including client #; client name; date of birth; gender; primary language; date of service; service code; contact location; time client contact requested; actual time of contact; end time; time billed to client; business hours; after hours; crisis disposition; crisis worker's name; and crisis comments.*
- *Anasazi (electronic health record (EHR)) serves as the primary mechanism for monitoring the accessibility of routine mental health services including medication services.*
    - *The CSI Assessment Record (assessment) within the EHR captures all pertinent information including client #; client name; date of first contact; referral source; assessment appointment 1st/2nd/3rd offer dates; assessment appointment accepted date; assessment start/end dates; medical necessity met (yes/no); treatment appointment 1st/2nd/3rd offer dates; treatment appointment accepted date; treatment appointment start date; close assessment process (successful process, or administrative close); if administrative close, reason, date, and referred to; and signature of staff entering information.*
    - *The Medication Services Referral (assessment) within the EHR captures all pertinent information including client #; client name; date of birth; age; caregiver or contact person name; primary phone number; financial eligibility; language; interpreter needed; is this a priority referral due to an inpatient hospitalization/discharge; information about prior psychiatric care; date of first contact; medication evaluation appointment 1st/2nd/3rd offer dates; medication evaluation appointment accepted date; name of assigned psychiatrist; appointment location; medication evaluation kept date; medication evaluation closed date; and referral processor scheduling comments.*
- *This information is periodically monitored by the clinical supervisors and managers, and is reviewed quarterly in the Quality Improvement and System Improvement Committees.*

The GCSMHP will maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services for all clients, including those with limited English proficiency or physical or mental disabilities. The GCSMHP will ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal clients with physical or mental disabilities, and ensure that all services are available and accessible to clients in a timely manner. The GCSMHP will adhere to, in all geographic areas within the county, the time and distance standards for adult and pediatric mental health providers developed by DHCS.

FY 2021/22 WORK PLAN EVALUATION

FY 2021-22 Review of Grievances, Appeals, Expedited Appeals, Change of Provider Requests, Notices of Adverse Benefit Determinations (NOABDs), 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.

- **17 Grievances**
  - *4 Access: Timeliness of services*
  - *4 Quality of Care: Treatment Issues or Concerns*
  - *4 Quality of Care: Staff Behavioral Concerns*
  - *5 Other: Operational*
  -
- **Zero (0) Appeals**
- **Zero (0) Expedited Appeals**
- **21 Change of Provider Requests**
  - *1 Personal Preference*
  - *0 Second Opinion*
  - *6 Gender Preference*
  - *9 Little/no Connection*
  - *0 Scheduling Difficulty*
  - *5 Staff/Client Conflict*
- **98 NOABDs: 2021**
- **Zero (0) Fair Hearings**
- **Zero (0) Provider Appeals**
- **Clinical Records Review** occurs monthly, and the results are documented in the monthly chart review summaries and reviewed in quarterly QIC.

FY 2021/22 Service Delivery Goals

1) Increase collateral services for Innovation clients from a baseline of 1.7% of overall services in FY 2020/21, up to 10% of overall services in FY 2021/22.
   a. The final YTD measure for this goal was not met at 2.1% of overall Innovation services being collateral.
2) Increase Individual Rehabilitation services for FSP adults from a baseline of 21.3% of overall services in FY 2020/21, up to 30% of overall services in FY 2021/22.
   a. The final YTD measure for this goal stayed at baseline of 21.3%.
3) Increase IHBS services for FSP youth from a baseline of 10% of overall services in FY 2020/21, up to 20% of overall services in FY 2021/22.
   a. This goal was not met with the final YTD measure increasing to 14.3%.
4) Ensure FSPs receive a Wellness Team Meeting or CFT within 90 days of opening to the program. Current tracking methods were unable to establish a baseline. Part of this goal will to adapt better tracking methods. We hope to be able to have at least 60% of FSPs meet this goal.

a. This goal was not met. Tracking this data continues to be a barrier to monitoring this service delivery goal.

5) Provide an assessment service for clients participating in the School Wellness Grant program. There is no baseline as this is a new program, but we hope to provide an assessment for at least 60% of clients who participate in these services.
    a. This goal was met with 70% of client's participating in the School-Based Wellness grant receiving assessment.

FY 2021/22 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.*

      83% were successful test calls.

2) Timeliness of routine mental health outpatient appointments.
    - *80% of clients requesting routine mental health outpatient services will be offered a face-to-face or telehealth assessment within **ten (10) business days** of the initial request for services.*
        - *87.44% met this goal.*
    - *70% of 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.*
        - *80% met this goal.*
    - *70% of clients requesting medication services will be seen for a face-to-face assessment within **fifteen (15) business days** of the initial request for services.*
        - *60% of client requesting medication services were seen for assessment within fifteen business days, GCBH did not meet this goal.*

3) Timeliness of services for urgent conditions and access to afterhours care.
    - *90% of 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**.*
        - *99% met this goal.*

FY 2021/22 Targeted Areas of Improvement, Change in Service Delivery, or Program Design *(Strategic Initiatives)*

1) Establish an online referral process to increase access. Completed

2) Establish a co-occurring subcommittee to look at more ways to improve care coordination and service for beneficiaries in this population. Completed

3) Creation of an entirely school-based mental health program utilizing the Wellness School Grant. We are currently working to fill a supervisor, four clinical, and two case management positions for this program. Completed

4) Implementation of concurrent review. *In progress*

5) Reviewing EHR products to begin implementation of a new system by the end of this fiscal year. *In progress.*

6) Starting with a new telepsychiatry provider that will offer more hours and the capability for providers to work onsite once per month. Completed

7) Develop policies and procedures regarding information sharing and collaboration for families who are accessing the FURS 24/7 access line. Completed

8) Have Children's System of Care leadership participate in ACTS Project (Advancing California's Trauma-informed System) to address secondary trauma, psychosocial safety and outcomes with families participating in child welfare and behavioral health services. Completed

FY 2021/22 Performance Improvement Projects

1) **Client Engagement** (Non-Clinical PIP)
This PIP will aim to improve and simplify our intake process to create better client engagement and retention as evidenced by improved timeliness from the request for service to the start of treatment, an increased percentage of requests for service that result in access to treatment, and a reduction in the number of new admissions who do not go on to start treatment.
The conclusion of the client engagement PIP finds that while providing convenient reminders, and maintaining the same assessor and treating clinician is a best practice, it does not appear to significantly increase the overall client engagement.

2) **Improving FSP Services** (Clinical PIP)
This PIP will aim to improve outcomes for our FSP consumers by creating a more structured program utilizing evidence-based case management and rehab mental health service modalities.
The clinical PIP appears to have confounding results. Significant variation between quarter measurements indicated data gathering methods threatened the validity of the

outcome measures. It is known that the FSP model is an EBP, and as such, GCBH intends to continue striving to adhere to FSP service model.

FY 2021/22 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 assistances 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.

FY 2022/23 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.

OBJECTIVES, SCOPE, AND PLANNED QI ACTIVITIES FOR FY 2022/23

FY 2022/23 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.

FY 2022/23 Service Delivery Goals

1) Increase provision of therapy and rehabilitation outpatient groups to adults and youth. One adult rehab group was offered 4x a year in FY 21/22, GCBH aims to increase this to one adult therapy group offered 2x a year, and 2 rehab groups offered 4x a year. For youth, two therapy groups were offered, and 3 ongoing rehab groups in FY 21/22. GCBH aims to increase this to 3 therapy groups and 4 rehab groups for youth.

2) Receive infrastructure grant which will allow service expansion of capacity to serve youth and families by average of 12% per year.
3) Increase the provision of IHBS to the number of youths who qualify for Pathways to Wellness EPSDT services from a baseline of 42% of all qualifying youth in FY 21/22 receiving at least one IHBS service to 60% of all qualifying youth I FY 22/23.

FY 2022/23 Accessibility of Services Goals

- 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.
   - *80% of 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.*
   - *70% of 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.*
   - *70% of 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.
   - *90% of 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**.*

FY 2022/23 Targeted Areas of Improvement, Change in Service Delivery, or Program Design *(Strategic Initiatives)*

1) Transition to the CalMHSA Semi-Statewide EHR, with a Go Live target date of January 2023.
2) Finalize and execute a contract for our afterhours crisis services with Sierra Mental Wellness Group.
3) Continuing to develop CalAIM deliverables, in partnership with CalMHSA, and implementing new policies and procedures related to CalAIM.
4) Finalizing a needs assessment from our Behavioral Health Continuum Infrastructure Project (BHCIP) Planning Grant, and preparing to apply for the next round of funding targeting youth and family program infrastructure.
5) Starting initial planning with Partnership Health as they will become the new Managed Care Medi-Cal plan in Glenn County.
6) Exploring DMC-ODS options for our county and how this will be affected by the change to Partnership Health by 2024.

7) Purchase use of Mobile Crisis Vehicles, large enough to conduct direct services from, through use of the Crisis Care Mobile Units grant.
8) Beginning initial planning with our county Public Guardian and County Counsel offices to update LPS processes, plan for in-county restore to competency for misdemeanors, Murphy Conservatorship, and begin Care Court planning.
9) Improve data collection and plan for service delivery next school year with our MHSSA program.
10) Assist the Glenn County Office of Education with utilization of Student Behavioral Health Incentive Program (SBHIP) funds to further enhance school-based services in Glenn County.

FY 2022/23 Performance Improvement Projects

- **Improving FSP Services** (Clinical PIP)

This PIP will aim to improve outcomes for our FSP consumers by creating a more structured program utilizing evidence-based case management and rehab mental health service modalities.

2) **CalAIM BHQIP** (Non-Clinical PIP)

This PIP will monitor progress toward implementing the Behavioral Health Quality Improvement Program as part of CalAIM initiative. Through the 22/23 fiscal year, the BHQIP will take steps to implement CalAIM reform, including goals of payment reform, BH policy changes, and data exchange.

FY 2022/23 Cultural and Linguistic Standards

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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.

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2) Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in Glenn County.

3) Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

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2) Inform all clients of the availability of language assistances services clearly and in their preferred language, verbally and in writing.
3) Ensure the competence of staff providing language assistance service, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
4) 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:

1) Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the GCSMHP's planning and operation.
2) Conduct ongoing assessments of the GCSMHP's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
3) 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.
4) 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.
5) Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
6) Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
7) Communicate GCMHP's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.