NEVADA COUNTY
BEHAVIORAL HEALTH

Quality Improvement Work Plan

Mental Health and Substance Use Disorder Services

Fiscal Year 2018-2019

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I. Quality Improvement Program Overview

A. Program Characteristics

The function of the Nevada County Behavioral Health (NCBH) Quality Improvement (QI) Mental Health (MH) and Substance Use Disorder (SUD) Work Plan (referred to as the "NCBH QI Work Plan" throughout this document) is to plan and monitor compliance with the program goals regarding access to services, improvements to service delivery, and enhancements to quality of care. This purpose is accomplished by following a planned and systematic process of collecting data, setting objectives, and monitoring progress.

Monitoring quality improvement, compliance activities, and consumer rights issues occurs through regular management oversight, as well as through Quality Improvement Committee (QIC) and Compliance Program Committee reviews. Feedback is also obtained through the following:

- Consumer, youth, and family surveys
- Utilization review activities
- Chart audits
- Medical peer review
- Regular QIC and Compliance Program Committee meetings
- Management meetings
- Mental Health Board (MHB) review
- Review of consumer and provider complaints
- Review of special incidents
- Periodic clinical training

The NCBH QI Work Plan includes activities required by the Mental Health Plan (MHP) contract with the California Department of Health Care Services (DHCS) for the provision of Medi-Cal Specialty Mental Health Services; and the Intergovernmental Agreement between NCBH and DHCS for the provision of Drug Medi-Cal substance use treatment services. QI projects, whenever possible, incorporate the processes outlined in the agreements between NCBH and DHCS. These processes include:

- Collecting and analyzing data to measure access, quality, and outcomes, against goals or identified prioritized areas of improvement,
- Identifying opportunities for improvement and determine which opportunities to pursue,
- Designing and implementing interventions to improve its performance,
- Measuring the effectiveness of interventions, and
- Integrating successful interventions in the service delivery system, as appropriate.

It is the goal of NCBH to build a structure that ensures the overall quality of services. This goal is accomplished by realistic and effective quality improvement activities and data-driven decision making; collaboration amongst staff, including consumers and family members; and utilization of technology for data analysis. Through data collection and analysis, significant trends are identified; and policy and system-level changes are implemented, when appropriate.

B. Quality Management Committees

Essential to the performance of the QI program is a complete information feedback loop wherein information flows across clinical, programmatic, and administrative channels. NCBH has established two committees, the Quality Improvement Committee and the Compliance/Utilization Management Committee, that include representation from the MHP (licensed MH and licensed and or certified Substance Use Disorder (SUD) clinicians, management, etc.), organizational providers, consumers, family members, and stakeholders, to ensure the effective implementation of the QI Work Plan. These committees are involved in the following functions:

1. The Quality Improvement Committee (QIC) is charged with implementing the quality improvement activities of the agency. Monthly, the QIC collects, reviews, evaluates, and analyzes data and implements actions that frequently involve handling information that is sensitive and confidential. The QIC also provides oversight to QI activities, including the development and implementation of the Performance Improvement Projects (PIPs). The QIC recommends policy decisions; reviews and evaluates the results of QI activities; and monitors the progress of the PIPs. The QIC documents all activities through dated and signed minutes to reflect all QIC decisions and actions.

   The QIC assures that QI activities are completed and utilizes a continuous feedback loop to evaluate ongoing quality improvement activities, including the PIPs. This feedback loop helps to monitor previously identified issues and provides an opportunity to track issues over time. The QIC continuously conducts planning and initiates new activities for sustaining improvement. Specific responsibilities of the QIC include, but are not limited to, the following:
   - Review quality of care concerns
   - Collect and analyze consumer survey responses
   - Be a resource to individual programs
   - Report data collection and outcome monitoring activities to Behavioral Health to improve system performance
   - Formulate corrective action plans as necessary to improve consumer-driven care
   - Plan, develop, and implement PIPs
   - Review and update the Implementation Plans for Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS)
   - Initiate corrective action plans adopted by the QIC to improve consumer access to services and quality of care
   - Review and recommend action regarding issues involving:
     - High-risk and individuals with high utilization of services
     - Unresolved clinical issues
     - Unresolved complaints
     - Evidence of treatment that is not within professional or ethical standards
     - Denials of service
     - Treatment that appears to be inadequate or ineffective
     - Utilization of inpatient and IMD services
   - Identify and address systems issues

- Monitor grievances and appeals
- Promote consumer and family voice to improve wellness and recovery
- Develop strategies to integrate health and behavioral health care throughout Nevada County
- Review Katie A./CCR service activities and assess outcomes

Designated members of the QIC include the Quality Assurance Manager; clinical staff; case management staff; administrative staff; clients; family members; and other stakeholders. Members sign a Confidentiality Statement to insure the privacy of protected health information. This confidentiality statement is integrated into the QIC sign-in sheet, which is collected at the beginning of each meeting.

NCBH procures contracts with individual, group, and organizational providers, SUD treatment providers and for psychiatric inpatient care. As a component of these contracts, these entities are required to cooperate with the QI program and allow access to relevant clinical records to the extent permitted by State and Federal laws.

The QIC ensures that QI activities are completed and utilizes a continuous feedback loop to evaluate ongoing quality improvement activities, including the PIPs. This feedback loop helps to monitor previously identified issues and provides an opportunity to track issues over time. The QIC conducts planning and initiates new activities on a quarterly basis for sustaining improvement.

2. The Compliance Program Committee is charged with ensuring that Medi-Cal and Drug Medi-Cal services are billed appropriately and in compliance with all state and federal regulations. Please refer to the *NCBH Compliance Plan* for the roles and responsibilities of this committee.

C. Annual Work Plan Components

The NCBH QI Work Plan provides the blueprint for the quality management functions designed to improve both client access and quality of care. This Plan is evaluated annually and updated as necessary.

The NCBH QI Work Plan includes the following components:

1. An annual evaluation of the overall effectiveness of the QI Program, utilizing data to demonstrate that QI activities have contributed to meaningful improvement in clinical care and client services;
2. Objectives and activities for the coming year;
3. Previously identified issues, including tracking issues over time; and
4. Activities for sustaining improvement.

The most recent QI Work Plan is posted on the NCBH website, and is available upon request. It is provided to the External Quality Review Organization (EQRO) during its annual review of the NCBH system. The QI Work Plan is also available to auditors during the triennial Medi-Cal review.

This Quality Improvement Work Plan ensures the opportunity for input and active involvement of clients, family members, licensed and paraprofessional staff, providers, and other interested stakeholders in the QI Program. QIC members participate in the planning, design, and execution of the QI Program, including policy setting and program planning. The NCBH QI Work Plan addresses quality assurance/improvement factors as related to the delivery of culturally-competent specialty mental health services.

II. Quality Improvement Program Evaluation

A. Evaluation of Overall Program Effectiveness

Evaluation of the overall effectiveness of the QI program is accomplished routinely, as well as annually, to demonstrate that:

- QI activities have contributed to improvement in clinical care;
- QI activities have contributed to timely access to services;
- QI activities have contributed to improvement in client services;
- QI activities have been completed, or are in process; and
- QI activities have incorporated relevant cultural competence and linguistic standards to match clients' cultural and linguistic needs with appropriate providers and services.

B. Specific Evaluation Activities

1. Quality Improvement Committee (QIC): The monthly QIC meetings may include, but are not limited to, the following agenda items:
    - Review reports to help identify trends in client care, in timeliness of medication treatment plan submissions, services, and trends related to the utilization review and authorization functions;
    - Review and evaluate summary results of QI activities, including progress on the development and implementation of the two (2) Performance Improvement Projects (PIP);
    - Review data from Access Logs showing responsiveness of the 24-hour phone line; timeliness of first initial contact to face to face appointments; and responses to urgent conditions;
    - Review 24-hour telephone access line for services in the prevalent non-English languages;
    - Review data from Inpatient/IMD/Residential programs relating to census, utilization, and lengths of stay;
    - Review data regarding the number of Treatment Authorizations Requests, approvals, and denials;
    - Review number, percent, and timeliness of DMC-ODS authorization requests that are denied;

- Review summary data on the medication monitoring process to assure appropriateness of care, supervised by person licensed to prescribe or dispense prescription medications;
- Review Katie A./CCR services to show program implementation;
- Review number of children in placement, level of care, and changes in placement at least quarterly
- Review new Notices of Adverse Benefit Determination (NOABDs), focusing on their appropriateness and any significant trends;
- Review trends in change of provider requests;
- Review summary data from Utilization Review authorization decisions (5 child and 5 adult charts completed monthly by supervisors or designee) to identify trends in client care, timeliness of services, trends related to utilization review and authorization functions, and compliance with documentation requirements.
- Assess client satisfaction surveys results for assuring access, quality, and outcomes;
- Review any issues related to grievances and/or appeals. The QIC reviews the appropriateness of the NCBH response and significant trends that may influence policy- or program-level actions, including personnel actions;
- Review any requests for State Fair Hearings, as well as review of any results of such hearings;
- Review any provider appeals and satisfaction surveys;
- Review client and system-level performance outcome measures for adults and children to focus on any significant findings and trends;
- Review other clinical and system-level issues of concern that may affect the quality of service delivery. The information reviewed also allows the QIC to evaluate trends that may be related to culturally-sensitive issues and may require prescriptive action;
- Review potential or required changes in policy;
- Review the annual credentialing process to assure that all licensed staff follow their licensing requirements;
- Review annual reports regarding QI review of the Office of Inspector General's Exclusion List and the Medi-Cal List of Suspended or Ineligible Providers lists, prior to Medi-Cal certification of any individual or organizational provider, other federal lists; and;
- Review HIPAA compliance issues or concerns;
- Review cultural competency issues or concerns;
- Monitor issues over time and make certain that recommended activities are implemented, completing the Quality Improvement feedback loop;
- Review coordination of physical and mental health services with waiver services at the provider level; and
- Monitor number of days to first DMC-ODS service at appropriate level of care after referral.

2. Compliance/Utilization Management Committee: In coordination with the Compliance Officer, the NCBH Compliance/Utilization Management Committee performs vital functions to assure compliance with state and federal regulations around documentation and billing through various monitoring activities. Please refer to the NCBH Compliance/Utilization Management Committee Program Plan for the roles and responsibilities of this committee. The goals of the UM Program are to ensure that: a) MH and SUD services are medically necessary and provided at the appropriate level of care; b) MH and SUD services are provided in a timely manner; c) available resources are utilized in an efficient manner; and d) admission criteria, continuing stay criteria, and discharge planning criteria are used to assure that maximum benefit is obtained by consumers at each level of care, and that transitions between levels of care and program services occur in a coordinated manner.

3. Monitoring Previously Identified Issues and Tracking over Time: Minutes of all QIC meetings include information regarding:
    - An identification of action items;
    - Follow-up on action items to monitor if they have been completed;
    - Assignments (by persons responsible); and
    - Due date.

    To assure a complete feedback loop, completed and incomplete action items are identified on the agenda for review at the next meeting. Chart reviews pending further action to implement plans of correction are identified for follow-up and reporting. NCBH has developed a meeting minute template to ensure that all relevant and required components are addressed in each set of minutes. Meeting minutes are also utilized to track action items and completion dates.

    Due to the diverse membership of the QIC and Compliance/Utilization Review Committee, information sharing will not breach client confidentiality regulations; consequently, information of a confidential nature will be provided in summary form only.

C. Inclusion of Cultural and Linguistic Competency in QI Program

On a regular basis, the QIC reviews collected information, data, and trends relevant to the National Standards for Culturally and Linguistically Appropriate Services in health and health Care (CLAS) to help address cultural competence and linguistic preferences.

III. Data Collection – Sources and Analysis

A. Data Collection Sources and Types

Data collection sources and types include, but are not be limited to:

1. Utilization of services by type of service, age, gender, race, ethnicity, and primary language
2. Access Log (Initial contact log)
3. Crisis Log
4. Test call logs
5. Notice of Adverse Benefit Determination Forms and Logs
6. Second Opinion requests and outcomes
7. Electronic Health Record Reports
8. Medication Monitoring forms and logs
9. Treatment Authorization Requests (TAR) and Inpatient Logs
10. Clinical Review QI Checklists (and plans of correction)
11. Peer Chart Review Checklists (and plans of correction)
12. Client Grievance/Appeal Logs; State Fair Hearing Logs
13. Change of Provider Forms and Logs
14. Special Reports from DHCS or studies in response to contract requirements
15. EQR and Medi-Cal audit results
16. Data from annual onsite monitoring /review of services, contracted services, and subcontracted services for programmatic and fiscal requirements

B. Data Analysis and Interventions

1. Data analysis is conducted in several ways. Anasazi has a number of standard reports which managers and supervisors can utilize. NCBH uses an internal administrative analyst to analyze client- and system-level data to track clients, services, outcomes and costs over time. If the subject matter is appropriate, clinical staff are asked to implement plans of correction. Policy changes may also be implemented, if required. Subsequent reviews are performed by the QIC.

2. New interventions receive input from individual staff, from committee meetings (including representatives of external agencies and consumers), and from management. Interventions have the approval of the Behavioral Health Director prior to implementation.

3. Effectiveness of interventions are evaluated by the QIC. Input from the QIC committee is documented in the minutes. These minutes document the activity, person responsible, and timeframe for completion. Each activity and the status for follow up are discussed at the beginning of each meeting.

IV. QI Activities, Goals, and Data

The Quality Improvement program for Fiscal Year 2018-2019 includes the following activities, goals, baseline data, and updated data, when available.

NOTE: The relevant data period for each goal's baseline data varies with each goal, depending on the year of implementation, data availability, and required changes to the goals or activities (for example, changes in timeliness standards).

A. Ensure Service Delivery Capacity

Annually, the NCBH QI program monitors services to assure service delivery capacity in the following areas:

1. Utilization of Services
    - Activity: Review and analyze reports from the Kings View Cerner program. The data includes the current number of clients served each fiscal year and the types and geographic distribution of mental health services and SUD services delivered within the delivery system. Data is analyzed by age, gender, ethnicity, primary language, veterans, LGBTQ, and diagnosis; it is compared to the goals set by the QIC for service utilization.
    - Goal: NCBH will increase the number of Transition Age Youth (TAY) who receive MH services.
        - Baseline Data (FY 2016-2017): There were 229 TAY clients who received MH services in FY 2016-2017. The QIC committee will continue to monitor these services and trends.
        - Comparison Data (FY 2017-2018): There were 367 TAY clients who received MH services in FY 2017-2018.
            - Data Analysis: NCBH successfully met this goal in FY 2017-2018. We will continue to monitor this goal in FY 2018-2019.

These issues are also evaluated to ensure that the cultural and linguistic needs of clients are met.

B. Monitor Accessibility of Services

The NCBH QI program monitors accessibility of services in accordance with statewide standards and the following local goals:

1. Timeliness of routine mental health appointments
    - Activity: This indicator is measured by analyzing a random sample of new requests for services from the Access Log. This data is reviewed quarterly.
    - Goal: Maintain the percentage of clients referred for mental health services who receive an assessment appointment within 10 business days. NOTE: In 2017, the timeliness standard for this goal changed from 14 business days to 10 business days.

- Baseline Data (FY 2017-2018): NCBH will analyze FY 2017-2018 data when available.
- Comparison Data (FY 2018-2019): FY 2018-2019 data will be added when available.
  - Data Analysis: In 2017, this standard changed from 14 business days to 10 business days. When FY 2017-2018 data is available, NCBH will set a new baseline for the 10-day standard. NCBH will then analyze FY 2018-2019 data to compare, monitor, and mitigate, as necessary.

2. Timeliness of requests for SUD services
   - Activity: This indicator is measured by analyzing a random sample of new requests for SUD services from the Access Log. This data is reviewed monthly.
   - Goal: The percentage of requests for services that were within the 10-business day time frame (no more than 10 business days from request for service to first face-to-face face appointment) shall not be less than 95% of total requests.
     - Baseline Data (FY 2018-2019): Baseline FY 2018-2019 data will be added at a later date.
       - Data Analysis: An analysis will occur when data is available.

3. Timeliness of services for urgent or emergent conditions
   - Activity: This indicator is measured by analyzing a random sample of urgent or emergent requests for services from the Crisis Log. This data is reviewed quarterly.
   - Goal: Maintain the percentage of urgent requests with an appointment within one (1) day.
     - Baseline Data (FY 2016-2017): Thirty-six percent (36%) of urgent requests had an appointment within one (1) day in FY 2016-2017.
     - Comparison Data (FY 2017-2018): FY 2017-2018 data will be added at a later date.
       - Data Analysis: A data analysis will occur when FY 2017-2018 data is available.

4. Access to DMC-ODS services
   - Activity: This indicator is measured by reviewing the total number of DMC-ODS authorization requests and the percentage of requests that are denied.
   - Goal: The percentage of the DMC-ODS authorization requests that are denied will be no more than 5% of total authorizations.
     - Baseline Data (FY 2017-2018): None (0) of the DMC-ODS authorization requests were denied in FY 2017-2018.
     - Comparison Data (FY 2018-2019): FY 2018-2019 data will be added when available.
       - Data Analysis: This indicator was new in FY 2017-2018; we will continue to monitor this goal in FY 2018-2019.

5. Responsiveness of the 24-hour, toll-free telephone number
    - Activity: During non-business hours, the 24/7 line is answered immediately by Triage workers. If required, an interpreter and/or Language Line is utilized. This indicator is measured by conducting random calls to the toll-free number, both after hours and during business hours. At least six (6) test calls are made per quarter, split between English and Spanish. This data is reviewed at each quarterly QIC meeting.
    - Goal: The NCBH after-hours 24-hour telephone service answers the call within 30 seconds. The line is tested monthly.
        - Baseline Data (FY 2016-2017): 11 test calls were conducted after hours in FY 2016-2017, with 11 (100 %) being answered by staff within 30 seconds.
        - Comparison Data (FY 2017-2018): 12 test calls were conducted after hours in FY 2017-2018, with 12 (100%) being answered by staff within 30 seconds.
            - Data Analysis: NCBH successfully met this goal in FY 2017-2018. We will continue to monitor this goal in FY 2018-2019.

6. Provision of culturally- and linguistically-appropriate services
    - Activity: This indicator is measured by random review of the Access Log and/or the Crisis Log, as well as the results of test calls. The focus of these reviews is to determine if a successful and appropriate response was provided which adequately addressed the client's cultural and linguistic needs. In addition, requests for the need for interpreters are reviewed (via the Access Log) to assure that staff are aware of the need for an interpreter and that clients received services in their preferred language, whenever feasible. This information is reviewed quarterly.
    - Goal: Maintain 90% successful test calls to the toll-free hotline.
        - Baseline Data (FY 2016-2017): 10 Spanish test calls were conducted in FY 2016-2017, with 9 (90%) that were successful overall.
        - Comparison Data (FY 2017-2018): 10 Spanish test calls were conducted in FY 2017-2018, with 8 (80%) that were successful overall.
            - Data Analysis: NCBH did not meet this goal in FY 2017-2018. In FY 2018-2019, we will strive to meet this goal through the following activity: Continued training of the ACCESS, Triage and Health Technician staff on the use of the language lines (AT&T and TeleLanguage) that are available.

C. Monitor Client Satisfaction

The QI program monitors client satisfaction via the following modes of review:

1. Monitor Client Satisfaction
    - Activity: Using the DHCS POQI instruments in threshold languages, clients and family members are surveyed twice each year, or as required. This indicator is measured by annual review and analysis of at least a one-week sample. Survey administration methodology meets the requirements outlined by the CA DHCS. This data is reviewed twice each fiscal year, after the surveys have been analyzed.

- Goal: Maintain the mean score of consumers/families reporting General Satisfaction.
  - Baseline Data (FY 2016-2017): The mean score was 4.4 (out of 5) for consumers/families reporting General Satisfaction in FY 2016-2017.
  - Comparison Data (FY 2017-2018): The mean score was 4.4 (out of 5) for Adults and 4.5 for Older Adult consumers reporting General Satisfaction in FY 2017-2018.
    - Data Analysis: NCBH successfully met this goal in FY 2017-2018. We will continue to monitor this goal in FY 2018-2019.

2. Monitor Youth and/or Family Satisfaction
   - Activity: Utilization of the DHCS POQI YSS and YSS-F measurement instruments assures the use of instruments that are accepted statewide as the basis for satisfaction surveys. The YSS and YSS-F are collected from youth ages 12 and older and the children's families. Survey administration methodology meets the requirements outlined by the CA DHCS. This data is reviewed after each survey administration.
   - Goal: Maintain the mean score of consumers/families reporting General Satisfaction.
     - Baseline Data (FY 2016-2017): In Fall 2017, the mean score was 4.3 (out of 5) for consumers/families reporting General Satisfaction in FY 2016-2017.
     - Comparison Data (FY 2017-2018): The mean score was 4.3 (out of 5) for Youth consumers and 4.5 for Families reporting General Satisfaction in FY 2017-2018.
       - Data Analysis: NCBH successfully met this goal in FY 2017-2018. We will continue to monitor this goal in FY 2018-2019.

3. Monitor Beneficiary Grievances, Appeals, and State Fair Hearings
   - Activity: All processed beneficiary grievances, expedited appeals, standard appeals, and fair hearings are reviewed at QIC meetings. Monitoring is accomplished by ongoing review of the Grievance Log for adherence to timelines for response. In addition, the nature of complaints and resolutions is reviewed to determine if significant trends occur that may influence the need for policy changes or other system-level issues. This review includes an analysis of any trends in cultural issues addressed by our clients. This information is reviewed monthly and annually.
   - Goal: The MHP will respond in writing to 100% of all appeals from beneficiaries within 60 calendar days from the date of receipt of the appeal.
     - Baseline Data (FY 2016-2017): 100% of FY 2016-2017 appeals by beneficiaries were responded to within 60 calendar days from the date of receipt of the appeal.
     - Comparison Data (FY 2017-2018): There were no appeals in FY 2017-2018.
       - Data Analysis: There were no appeals in FY 2017-2018. We will continue to monitor this goal in FY 2018-2019.

4. Monitor Requests to Change Providers
    - Activity: Quarterly, patterns of client requests to change practitioners/providers are reviewed by the QIC. Measurement is accomplished by review of QIC minutes summarizing activities of the Access Team and through annual review of the Change of Provider Request forms.
    - Goal: Beneficiary Requests for Change of Provider are monitored annually including reasons given by consumers for their Change of Provider requests.
        - Baseline Data (FY 2016-2017): This data was reviewed at the May 2017 QIC meeting. There were 12 Requests for Change of Provider for Adult BH, (primarily psychiatrists); 4 for Children's BH; Uplift Family Services had 1; and VCSS had 1. The trends were primarily change of doctors due to wanting a change in medications, "not a good fit," or wanting a male/female doctor. There were no trends in the other requests reported.
        - Comparison Data (FY 2017-2018): There were 23 total Requests for Change of Provider (20 were for psychiatrists). The trends were primarily change of doctors, wanting a change in medications, and relationship concerns.
            - Data Analysis: We will continue to monitor this goal in FY 2018-2019.

5. Inform Providers of Survey Results
    - Activity: The results of client and family satisfaction surveys are routinely shared with providers. Monitoring is accomplished by review of the results of the POQI surveys as related to clients who have received services from contract specialty mental health service providers. Survey results are shared at the QIC meeting, and with providers, consumers, family members, the Mental Health Board, and the Children's System of Care Policy Committee. This information is distributed on an annual basis and in the form of cumulative summaries to protect the confidentiality of clients and their families. This process is reviewed annually.
    - Goal: Survey results are to be shared with identified stakeholders.
        - Baseline Data (FY 2016-2017): Survey results were shared at the QIC meetings with staff, consumers and family members in FY 2016-2017. The results were also shared with staff at an All Staff meeting.
        - Comparison Data (FY 2017-2018): Survey results were shared at the QIC meetings with staff, consumers and family members in FY 2017-2018.
            - Data Analysis: Survey results were shared with identified stakeholders. We will continue to monitor this goal in FY 2018-2019.

6. Monitor Cultural and Linguistic Sensitivity
    - Activity: In conducting review in the above areas, analysis occurs to determine if cultural or linguistic issues may have influenced results. Surveys are provided in English and in Spanish. This process is reviewed annually.
    - Goal: Maintain a high mean score (4.0 or higher) for General Satisfaction from consumers/families who used the Spanish surveys. (5.0 is the maximum possible score.)
        - Baseline Data (FY 2017-2018): The mean score reported for General Satisfaction in surveys completed in Spanish was 4.9 for Adult consumers and 4.8 for Families.

- Comparison Data (FY 2018-2019): FY 2018-2109 data will be added when available.
  - Data Analysis: A data analysis will occur when FY 2018-2019 data is available.

D. Monitor the Service Delivery System

The QI program monitors the NCBH service delivery system to accomplish the following:

1. Review Safety and Effectiveness of Medication Practices
   - Activity: Annually, meaningful issues for assessment and evaluation, including safety and effectiveness of medication practices and other clinical issues are identified. Medication monitoring activities are accomplished via review of at least ten (10%) percent of cases involving prescribed medications. These reviews are conducted by a person licensed to prescribe or dispense medications. In addition, peer review of cases receiving clinical and case management services occur at QIC meetings. An analysis of the peer reviews occurs to identify significant clinical issues and trends.
   - Goal: Continue to conduct medication monitoring activities on 10% of medication charts.
     - Baseline Data (FY 2016-2017): 26 of the 535 (4.8%) medication charts were reviewed for medication monitoring activities in FY 2016-2017 by contract psychiatrists and the Medical Director. This number is less than the goal of 10% due to a decrease in the number of contracted psychiatrist hours FY 2016-2017 and more hours of the available psychiatrist time was dedicated to client services.
     - Comparison Data (FY 2017-2018): 83 of the 331 (25.1 %) medication charts were reviewed for medication monitoring activities in FY 2017-2018.
       - Data Analysis: NCBH successfully met this goal in FY 2017-2018. We will continue to monitor this goal in FY 2018-2019.

2. Identify Meaningful Clinical Issues
   - Activity: Quarterly, meaningful clinical issues are identified and evaluated. Appropriate interventions are implemented when a risk of poor quality care is identified. Monitoring is accomplished via review of QIC minutes for satisfactory resolutions in the areas of grievances, medication monitoring, and peer chart review cases where plans of correction are requested. Re-occurring quality of care issues are discussed in staff meetings and at the QIC to address concerns in a timely manner.
   - Goal: Clinical staff participate in at least 2 clinical trainings each year.
     - Baseline Data (FY 2016-2017): Staff participated in 65 clinical trainings in FY 2016-2017
     - Comparison Data (FY 2017-2018): Staff participated in 38 clinical trainings in FY 2017-2018.
       - Data Analysis: NCBH successfully met this goal in FY 2017-2018. We will continue to monitor this goal in FY 2018-2019.

3. Review Documentation and Medical Records System
    - Activity: Client documentation and medical records system fulfills the requirements set forth by the California Department of Health Care Services and NCBH contract requirements. Documentation of the client's participation in and agreement with their client treatment plan will be included. When the client is unavailable for signature or refuses signature, the client treatment plan includes a written explanation of the refusal or unavailability. Signatures of the individual providing service or the team/representative providing services are recorded.
    - Goal: Maintain the percent of completed and signed Treatment Plans.
        - Baseline Data (FY 2016-2017): 84% of the Mental Health Treatment Plans that were due in FY 2016-2017 were completed and signed. (80% of Adult and 88% of Children's clients). This number did not include treatment plans that were developed by contractors for BH clients.
        - Comparison Data (FY 2017-2018): 99.6 % of the Mental Health Treatment Plans that were due in FY 2017-2018 were completed and signed.
            - Data Analysis: NCBH successfully met this goal in FY 2017-2018. We will continue to monitor this goal in FY 2018-2019.

4. Review Documentation and Timeliness of Entry of Services
    - Activity: Client documentation fulfills the requirements set forth by the California Department of Health Care Services and NCBH Policy and Procedures related to timely documentation. Timely documentation of client services ensures the medical record accurately documents the services provided to the client, the interventions applied and the medical necessity of the client to receive the services. Late documentation reports are received monthly by the Supervisors of all staff that enters services and documentation in the electronic health record (Anasazi). These reports are reviewed monthly in the Compliance/Utilization Review Committee meeting.
    - Goal: Decrease the percentage of late notes (greater than 14 days from date of service to entry of documentation) that are entered/documented by 50%.
        - Baseline Data (FY 2016-2017): Current baselines FY 2016-2017 is 29% overall for NCBH. (20% for Adult Services and 62% for Children's Services).
        - Comparison Data (FY 2017-2018): In FY 2017-2018, 20% of notes were late for NCBH
            - Data Analysis: NCBH successfully met this goal in FY 2017-2018. We will continue to monitor this goal in FY 2018-2019.

5. Assess Performance
    - Activity: Quantitative measures are identified to assess performance and identify areas for improvement, including the PIPs and other QI activities. NCBH monitors both under-utilization of services and over-utilization of services. The BH Director reviews data on review loss reports; productivity reports; and late treatment plan reports. These areas are measured through the quarterly review of the timeliness of assessments and treatment plans; completeness of charts; client surveys; and productivity reports. The results of these reviews dictate areas to prioritize for improvement.

- Goal: Maintain the percent of billable services delivered by service delivery staff.
  - Baseline Data (FY 2016-2017): An average of 67% of services delivered by staff were billable services in FY 2016-2017.
  - Comparison Data (FY 2017-2018): Fifty-seven percent (57%) of services delivered by staff were billable services in FY 2017-2018.
    - Data Analysis: NCBH did not meet this goal in FY 2017-2018. In FY 2018-2019, we will strive to meet this goal through the following activities: Maintaining a full staff and hiring as soon as possible when vacancies arise so that overall productivity will improve. Continuing to monitor the productivity of staff in the monthly Compliance Meeting with follow up for staff who are below their productivity expectations.

6. Support Stakeholder Involvement
   - Activity: Staff, including licensed mental health professionals, paraprofessionals, providers, clients, and family members review the evaluation data to help identify barriers to improvement. As members of the QIC, providers, clients, and family members help to evaluate summarized data. This ongoing analysis provides important information for identifying barriers and successes toward improving administrative and clinical services. In addition, the MHSA Steering Committee provides input on access and barriers to services. Measurement is accomplished via review of QIC minutes, and occurs annually.
   - Goal: Increase attendance at the QIC to have at least two (2) consumers and two (2) family members at each meeting.
     - Baseline Data (FY 2016-2017): One (1) consumer and one (1) family member attended QIC meetings in FY 2016-2017. NCBH is continuously trying to increase the attendance of consumers and family members at this meeting.
     - Comparison Data (FY 2017-2018): One (1) consumer and one (1) family member attended QIC meetings in FY 2017-2018.
       - Data Analysis: NCBH did not meet this goal in FY 2017-2018. In FY 2018-2019, we will strive to meet this goal through the following activity: Continue active recruitment of consumers and family members who may be willing to regularly attend QIC meetings.

7. Conduct Frequent Peer Reviews
   - Activity: NCBH evaluates the quality of the service delivery by conducting at least six (6) peer reviews every quarter (a total of 24 each year). Reviews are conducted by staff. Issues and trends found during these reviews are addressed at the QIC meetings.
   - Goal: At least 24 client charts to be peer reviewed by staff annually.
     - Baseline Data (FY 2016-2017): Client charts at Behavioral Health are to be reviewed monthly starting in FY 2016-2017. There were a total of 42 peer reviews that were completed in FY 2016-2017.
     - Comparison Data (FY 2017-2018): There were a total of 65 peer chart reviews completed in FY 2017-2018: 33 adult charts and 32 child charts.

        - Data Analysis: NCBH successfully met this goal in FY 2017-2018. We will continue to monitor this goal in FY 2018-2019.

The activities and processes outlined above will maintain sensitivity to the identification of cultural and linguistic issues.

E. Monitor Continuity and Coordination of Care

When appropriate, information is exchanged in an effective and timely manner with other health care providers used by clients.

1. Monitor Coordination of Care
    - Activity: Measurement is accomplished during ongoing review of the clinical assessments and discharge summaries. These reviews identify referrals to alternative resources for treatment or other services whenever requested, or when it has been determined that an individual may benefit from referral to other health care providers. Exchange of information is measured during peer chart review by assuring the presence of a signed consent form. If there is a lack of this information in the peer chart reviews, it is documented and will be monitored by the Quality Assurance Manager. This information is also logged when the psychiatrists meeting with primary care physicians.
    - Goal: Monitor documentation of psychiatric consults with physical healthcare providers quarterly.
        - Baseline Data (FY 2016-2017): For the FY 2016-2017, there were a total of 30 hours of consultation that were provided by the child psychiatrist to community primary care physicians. These hours were documented and reviewed by the Quality Assurance Manager.
        - Comparison Data (FY 2017-2018): For the FY 2017-2018, there were a total of 160 hours of consultation that were provided by the psychiatrists to community primary care physicians.
            - Data Analysis: NCBH met this goal in FY 2017-2018. We will continue to monitor this goal in FY 2018-2019.

F. Monitor Provider Appeals

NCBH providers may file appeals or complaints regarding payment authorizations, timeliness, and other issues.

1. Monitor Provider Appeals
    - Activity: Provider appeals and complaints are reviewed as received by the QIC. A recommendation for resolution will be made to the Behavioral Health Director. The resolution and date of response are recorded in the QIC meeting minutes. The QIC reviews the provider appeals and complaints annually for any trends and addresses these issues.
    - Goal: Monitor the number of TAR appeals each year.

- Baseline Data (FY 2016-2017): There were zero (0) TAR appeals in FY 2016-2017.
- Comparison Data (FY 2017-2018): There were zero (0) TAR appeals in FY 2017-2018.
  - Data Analysis: We will continue to monitor this goal in FY 2018-2019.

V. Delegated Activities Statement

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