NEVADA County
Behavioral Health

Quality Improvement Work Plan

Mental Health and Substance Use Disorder Services

Calendar Year 2021

FINAL
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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
   - 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)
   - 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 Institution for Mental Diseases (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 Pathways to Wellbeing/Continuum of Care Reform (CCR) service activities and assess outcomes

Designated members of the QIC include the Quality Assurance Manager; clinical staff; case management staff; management team 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, 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.

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 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 four (4) Performance Improvement Projects (PIP) (2 for MH and 2 for SUD);
    - Review data from Access Logs showing responsiveness of the 24-hour phone line and for services in the prevalent non-English languages
    - Timeliness of first initial contact to face to face appointments; and responses to urgent conditions;
    - Review data from Inpatient/IMD/Residential programs relating to census, utilization, and lengths of stay;
    - 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 Pathways to Wellbeing/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 (child, adult and SUD charts completed monthly by supervisors and/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. 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. Clinical Review QI Checklists (and plans of correction)
10. Peer Chart Review Checklists (and plans of correction)
11. Client Grievance/Appeal Logs; State Fair Hearing Logs
12. Change of Provider Forms and Logs
13. Special Reports from DHCS or studies in response to contract requirements
14. EQRO and Medi-Cal audit results
15. Annual DMC-ODS site review and 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 next meeting.

IV. QI Activities, Goals, and Data

The Quality Improvement program for Calendar Year (CY) 2021 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: Per the Nevada DMC approved claims report for CY 2018, Nevada County had a 0.45% penetration rate for youth in the 12-17 age group. By continuing to review the claim report, working with providers to create more youth specific, youth friendly offsite options for substance use treatment; instituting a warm hand-off process and regular coordination meetings to improve engagement and access to services for youth, the penetration rate will be monitored.
    - **Goal for Fiscal Year (FY) 19/20: NCBH system of care will increase the penetration rate for youth in the 12-17 age group to 0.9%.**
        - Data Analysis: Goal not met. The penetration rate for this age group FY 18/19 was 0.73% and the FY 19/20 penetration rate is not yet available. NCBH will continue to monitor this goal as it has been identified as an important area to focus clinical services and to monitor the continued increase in NCBH SUD services to the 12-17 age group. The goal for 2021 will be kept at 0.9% until the goal can be reached.
    - **Goal for 2021: NCBH system of care will increase the penetration rate for youth in the 12-17 age group to 0.9%.**

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 for FY 19/20: NCBH will provide an assessment appointment within 14 calendar days (10 business days) for all clients requesting mental health services 90% of the time.**
        - Baseline Data (FY 2017-2018): 77% of clients referred for mental health received an assessment within 14 calendar days in FY 2017-2018.

- Comparison Data (FY 2018-2019): 74% of clients referred for mental health received an assessment within 14 calendar days in FY 2018-2019. In FY 2019-2020 NCBH provided an assessment appointment within 14 calendar days (10 business days) 92% of the time for FY 19/20 (Adults) and 70% of the time for Children.
  - Data Analysis: Goal was met. NCBH will continue to monitor this goal. The NCBH supervisors and managers are working with the clinical staff to ensure appointments are provided within the 10 business days that are the new requirements per DHCS.
- **Goal for 2021: NCBH will provide an assessment appointment within 14 calendar days (10 business days) for all clients requesting mental health services 75% of the time.**

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 or FY 19/20: 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): 92% of clients referred for SUD services received an assessment within 14 calendar days in FY 2018-2019,
     - Comparison Data (FY 2019-2020): The Request for Service (RFS) to intake within 10 days was 92% overall to include NCBH and its contractors. There was a total of 862 RFS with a total of 794 intakes within the 10-day time frame; 68 were not scheduled within the 10 days.
       - Data Analysis: Goal not met. The average number of days from RFS to face to face appointment for NCBH was 22.8 days with a range of 6 to 46 days; for Common Goals – the average number of days was 4.5 with a range of 2.7-9; for GWC – the average number of days was 11.2 with a range of 3 – 21.3 days; for Aegis the average number of days was 2.21 with a range of .7 to 4.5 days. NCBH will continue to monitor this goal. NCBH has been working with the SUD community contractors regarding improving their timeliness for RFS to appointment. NCBH also established a walk-in clinic in March of 2019 in order to improve the timeliness for RFS to appointment (results=same day). NCBH will continue to monitor this goal in 2021.
   - **Goal for 2021: 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**.

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 for FY 19/20: Maintain the percentage of urgent requests with an appointment within one (1) day.**
  - Baseline Data (FY 2017-2018): Forty percent (40%) of urgent requests received an appointment within one (1) day in FY 2017-2018.
  - Comparison Data (FY 2018-2019): Eighty percent (80%) of urgent requests received an appointment within one (1) day in FY 2018-2019.
    - Data Analysis: Goal met. NCBH provides appointments within 1 day of Request for Services for urgent need 100% of the time. Although NCBH met this goal, it is important to continue to monitor this service and the outcomes.
- **Goal for 2021: NCBH will provide appointments within 1 day to all clients requesting services that meet the criteria for urgent need for services 100% of the time.**

4. Access to DMC-ODS services
   - Activity: This indicator is measured by reviewing the percentage of DMC-ODS linked to outpatient treatment/aftercare. This indicator will be implemented by the following activities: Institute discharge planning groups at Lovett Recovery Center; institute field trips to outpatient campus; facilitate warm-hand offs with outpatient SUD counselor prior to residential discharge; provide recovery residencies (clean and sober housing) to individual discharging from residential treatment.
   - **Goal for FY 19/20: Increase the percentage of individuals linked to outpatient treatment/aftercare from 14.5% to 28% in FY 19/20.**
     - Comparison Data (FY 2019-2020): In FY 19/20, 55% of individuals were linked to outpatient treatment and aftercare from discharge from residential services.
       - Data Analysis: NCBH successfully met this goal in FY 2019-2020.
   - **Goal for 2021: Increase the percentage of individuals linked to outpatient treatment/aftercare from 55% to 70% in 2021.**

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 for FY 19/20: The NCBH 24-hour telephone service will provide information to the caller regarding the NCBH clinic location, phone and hours 100% of the time.** The line is tested monthly.
     - Baseline Data (FY 2019-2020): Callers were provided information regarding access to services 91.67% of the time for FY 19/20.
       - Data Analysis: NCBH did not meet this goal in FY 2019-2020. We will continue to monitor this goal and provide additional training and resources to staff who answer the 24/7 line. Through the Compliance Committee

meeting, the monthly Providers/Contractor meetings and the monthly meetings between program managers and contractors, we will conduct further analysis to identify who may need more focused training.

- **Goal for 2021: The NCBH 24-hour telephone service will provide information to the caller regarding the NCBH clinic location, phone and hours 100% of the time.**

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 Spanish test calls to the 24-hour telephone service.**
     - Baseline Data (FY 2017-2018): 10 Spanish test calls were conducted in FY 2017-2018, with 8 (80%) that were successful overall.
     - Comparison Data (FY 2018-2019): There were a total of 8 Spanish test calls that were conducted in FY 2018-2019 with 7 of the calls conducted successfully (linked to an interpreter) which is 88%.
       - Data Analysis: Goal met. In FY 2019-2020 100% of the test calls in Spanish were successful. Although NCBH met this goal, it is important to continue to monitor this service and the outcomes.
   - **Goal for 2021: Maintain 90% successful test calls to the 24 hour telephone service (Spanish).**

C. Monitor Client Satisfaction

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

1. Monitor Client Satisfaction
   - Activity:
     - Using the DHCS Performance Outcomes and Quality Improvement (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 DHCS. This data is reviewed twice each year, after the surveys have been analyzed.
     - Utilization of the DHCS POQI Youth Services Survey (YSS) and Youth Services Survey for Families (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 DHCS. This data is reviewed after each survey administration.

- **Goal for FY 19/20: Maintain the mean score of consumers/families reporting General Satisfaction.**
  - Baseline Data (FY 2017-2018): A) 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. B) The mean score was 4.3 (out of 5) for Youth consumers and 4.5 for Families reporting General Satisfaction in FY 2017-2018.
  - Comparison Data: A) For FY 19/20, the mean score of 4.5 for General Satisfaction for Consumers/Families was maintained and exceeded.. B) For FY 19/20, the mean score (3.5) for General Satisfaction was maintained or exceed the mean score.
    - Data Analysis: Although NCBH met this goal, it is important to continue to monitor this service and the outcomes. This goal and the second goal below will be combined into one goal for client satisfaction in the 2021 QI work plan.
- **New (second) goal for FY 19/20: The NCBH system of care will increase the total number of participants by 15% for the Adult, Older Adult, Youth and Family Consumer Perception Surveys from the number of participants from fall of 2018. (total Fall 2018: 174).**
    - Data Analysis: Goal was met. Number of participants FY 19/20 (Spring/Fall CPS): Adult: 529; Older Adult: 107; Youth: 102; Family: 271; Total of all categories: 1009. Greater than 15% increase in surveys completed. See new goal combining this item and the first goal.
- **Goal for 2021: A) Maintain the mean score of consumers/families reporting General Satisfaction. B) The NCBH system of care will increase the total number of participants by 15% for the Adult, Older Adult, Youth and Family Consumer Perception Surveys from the number of participants from fall of 2018. (Total Fall 2018: 174.)**

2. 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 for FY 19/20: NCBH will respond to all MH and SUD grievances in writing to the beneficiary within 5 days of receipt of the grievance.**
     - Data Analysis: Goal partially met. There was a total of 8 MH Grievances which required a letter with 7 letters sent within 5 days of receipt of grievance. There were -0- SUD grievances that required a letter. This is a new goal from last year that we should continue to monitor. Through the QIC we

will determine the best ways to ensure that all MH and SUD grievances result in a written response to the beneficiary within 5 days.

- **Goal 2021: NCBH will respond to all MH and SUD grievances in writing to the beneficiary within 5 days of receipt of the grievance**.

3. 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 for FY 19/20: Beneficiary Requests for Change of Provider are monitored annually including reasons given by consumers for their Change of Provider requests.**
     - Baseline 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.
     - Comparison Data (FY 2018-2019): There were 15 total Requests for Change of Provider. There were 11 Requests for Change of Provider for Adult Behavioral Health; 3 for Children's Behavioral Health; Turning Point had 0; Sierra Forever Families had 0; and Victor Community Support Services had one. The trends were primarily scheduling, provider specialty, and "not a good fit".
       - Data Analysis: Goal met. There were 9 Change of Provider requests for Adults (7 for psychiatrists, one for clinician and one due to client temporarily stopping services). There was one change of provider for Children's for a clinician. These Change of Provider reports are monitored quarterly at the QIC meeting. NCBH will continue to monitor this goal in order to evaluate the number of requests, reasons for requests and the quality of services provided.
   - **Goal for 2021: Beneficiary Requests for Change of Provider are monitored annually including reasons given by consumers for their Change of Provider requests.**

4. Monitor Cultural and Linguistic Sensitivity
   - Activity: In order to adequately ensure appropriateness of care for cultural and linguistic competency, NCBH and contractor staff will complete the minimum requirements for cultural competence training and this will be monitored.
   - **Goal for FY 19/20: NCBH staff and contractor MH and SUD staff will complete a minimum of 3 CEU's of cultural competency training per FY.**
     - Data Analysis: Goal partially met. NCBH offered a Cultural Competency training to all staff during FY 19/20. Of the MH and SUD contractors, 12 of the 13 offered a Cultural Competency training in FY 19/20. This is a new goal and an important service area so we will continue to monitor this goal. The QIC and Cultural Competency committees will discuss ways to ensure all contractors are provided 3 CEUs of cultural competency training.

- **Goal 2021: NCBH staff and contractor MH and SUD staff will complete a minimum of 3 CEU's of cultural competency training per FY.**

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 for FY 19/20: Conduct medication monitoring activities on 10% of medication charts.**
     - Baseline Data (FY 2017-2018): 83 of the 331 (25.1 %) medication charts were reviewed for medication monitoring activities in FY 2017-2018.
     - Comparison Data (FY 2018-2019): 110 of the 532 (20.7 %) medication charts were reviewed for medication monitoring activities in FY 2018-2019.
       - Data Analysis: Goal met. There were a total 527 clients that were seen by the psychiatrists in FY19/20, with a total of 70 medication, which is 13% of the charts that were audited. NCBH will continue to monitor this goal in order to ensure safe and effective medication practices are continued.
   - **Goal for 2021: Conduct medication monitoring activities on 10% of medication charts.**

2. Identify Meaningful Clinical Issues
   - Activity: It was identified by EQRO that NCBH has a high percentage of high cost beneficiaries that are receiving services. NCBH will conduct an analysis of high cost beneficiaries to determine they are receiving the appropriate level of care.
   - **Goal for FY 19/20: NCBH System of Care (SOC) will reduce the number of high cost beneficiaries (HCB) that are receiving services by 10%.**
     - Baseline data: In FY 18/19, there were 99 HCB clients in NCBH System of Care.
       - Data Analysis: In FY 19/20, the HCB decreased to 9.7% from 99 clients to 90 clients. Although NCBH met this new goal, it is important to continue to monitor this service and the outcomes.
   - **Goal for 2021: NCBH SOC will reduce the number of high cost beneficiaries (HCB) that are receiving services by 10%.**

   - Activity: Retention in Treatment measures how long the system of care is able to retain clients in DMC ODS services. Motivation is key to substance use behavior

change. Motivation is not a static character trait but a dynamic changing process that can be enhanced and elicited. The DMC ODS will introduce additional motivational interviewing training for SUD counselor to focus on developing a therapeutic relationship with clients that builds on client autonomy and enhances motivation to change.

- **Goal for 2021: NCBH DMC ODS will increase the number of clients with at least a 90-day LOS (length of stay) by 20%**.
  - Baseline data: In FY 18/19, there were 265 clients (42%) with at least a 90-day length of stay.

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. In addition to monitoring documentation of treatment plan and participation by the beneficiaries, NCBH will provide mandatory Medi-Cal documentation trainings to all NCBH staff.
   - **Goal FY 19/20: Each NCBH staff will attend one mandatory Medi-Cal documentation training FY 19/20.**
     - Data Analysis: This goal was not met. Of 40 clinical staff providing MH services FY19/20, 24 took the training for an average of 60%. The training is offered quarterly. Two of the trainings were canceled due to the Coronavirus Disease (COVID-19) pandemic (March and June 2020). For future trainings, a recorded video training has been developed and now available for staff.
   - **Goal for 2021: Each NCBH staff will attend one mandatory Medi-Cal documentation training in 2021.**

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 for FY 19/20: NCBH staff will show a decrease in the number of days for late note entry (there is no more than 14 days from the date of service to the date of entry of the note) evidenced by a decrease in 59 days to 14 days for FY 19/20.**
     - Data Analysis: Goal met. 10% of notes were late. It appears that most of the notes were done within 30 days with a few outliers (17 notes of out the 2,658), so we did reduce the number of days from 59.
   - **Goal for 2021: NCBH staff will show a decrease in the percentage of late entry notes (late defined as more than 14 days from the date of service to the date of entry of the note).**

- Comparison Data (FY 2019-2020): 10% of the notes were later than 14 days.

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 for FY 19/20: NCBH staff will provide an average of 80% billable services.**
     - Baseline Data (FY 2017-2018): Fifty-seven percent (57%) of services delivered by staff were billable services in FY 2017-2018.
     - Comparison Data (FY 2018-2019): Eighty-one percent (81%) of services delivered by staff were billable services in FY 2018-2019.
       - Data Analysis: Goal not met. The average billable services % for Adult is 65%; for Children's is 57% and for Doctors is 48% for FY 19/20. The Benchmarks for Adult are 45-85% with an average benchmark of 53%; for Children's is 45-75% with an average benchmark of 55% and for the Doctors 60-75% with an average benchmark of 51%. We re-evaluated these goals for 2021 and decided to change the goals to align with our Performance Improvement Projects. See new goal for 2021.
   - **New Goal for 2021: A) NCBH Children's Services, utilizing the Child and Adolescent Needs and Strengths (CANS) tool will increase the number of children and youth correctly identified with co-occurring substance use issues from 3% to 6%.**
     - Baseline Data: (FY 2018-19 data for PIP baseline): 3% of children/youth were identified with a co-occurring substance use disorder.
   - **New Goal for 2021: B) NCBH Children's Services, utilizing the Child and Adolescent Needs and Strengths (CANS) tool will identify children and youth with co-occurring substance use issues and offer the parent/guardian a referral for services with a SUD contract provider, 100% of the time.**
     - Baseline Data (FY 2019-2020): No current data available as we were not tracking this information.

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 for FY 19/20: Increase attendance at the QIC to have at least two (2) consumers and two (2) family members at each meeting**.
  - Baseline Date (FY 2017-2018): One (1) consumer and one (1) family member attended QIC meetings in FY 2017-2018.
  - Comparison Data (FY 2018-2019) One consumer and family member attended the QIC meetings regularly for FY 2018-2019.
    - Data Analysis: Goal not met. During FY 19/20, there was one Family member who consistently attended the meetings from July 2019 to March 2020. During April to June 2020, there was no attendees at the meeting (during COVID). The QIC committee made the decision to provide a gift card monthly to the consumer/family members that attend as a stipend for their attendance. Continue active recruitment of consumers and family members who may be willing to regularly attend QIC meetings.
- **Goal for 2021: Increase attendance at the QIC to have at least two (2) consumers and two (2) family members at each meeting.**

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 for FY 19/20: Identified NCBH staff will review a minimum of 6 charts per month for adult and 6 charts for children services to monitor quality of services and compliance with Medi-Cal documentation with a goal of no more than 5% disallowances for services from these chart audits.**
     - Data Analysis: This goal was partially met. NCBH averaged far less than 5% disallowance of the charts audited, but due to COVID-19 pandemic, live monthly audits were suspended thus for a several month period no charts were audited in either division. It is important to continue to monitor this service and the outcomes. The Compliance Committee, Management Team and QIC will discuss potential strategies to ensure this goal is met despite the pandemic.
   - **Goal for 2021: Identified NCBH staff will review a minimum of 6 charts per month for adult and 6 charts for children services to monitor quality of services and compliance with Medi-Cal documentation with a goal of no more than 5% disallowances for services from these chart audits.**

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 for FY 19/20: Monitor documentation of psychiatric consults with physical healthcare providers quarterly.**
        - Baseline 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.
        - Comparison Data (FY 2018-2019) There were a total of 64 hours of consultations that were provided by the children's psychiatrist to community primary care physicians (PCPs).
            - Data Analysis: This goal was met. Documentation of psychiatric consults with physical healthcare providers is being monitored quarterly. The documentation of psychiatric consults between both the children's psychiatrist and adult psychiatrists and community physical health care providers is logged consistently and reviewed by the QA Manager. There were no psychiatric consults with PCP's by the adult psychiatrists in FY 19/20 and a total of 60 consults by the children's psychiatrist. We will continue to monitor this goal and discuss in the monthly Compliance Meeting, Management team meetings and QIC strategies to provide consultations by adult psychiatrists.
    - **Goal for 2021: Monitor documentation of psychiatric consults with physical healthcare providers quarterly.**

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.