MODOC COUNTY BEHAVIORAL HEALTH

Quality Improvement Work Plan

Our Mission is to provide high quality, culturally appropriate, linguistically inclusive mental health and substance use disorder care in the least restrictive setting, with the participation of our clients and their support system where suitable.

2017-2018

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I. QUALITY IMPROVEMENT PROGRAM OVERVIEW

Quality Improvement Program Characteristics

Modoc County Behavioral Health (MCBH) has implemented a Continuous Quality Improvement (CQI) Program in accordance with state regulations for evaluating the appropriateness and quality of services, including over-utilization and underutilization of services. The CQI Program meets these requirements through the following process:

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. Designing and implementing interventions to improve performance;
4. Measuring the effectiveness of the interventions; and
5. Incorporating successful interventions in the system, as appropriate.

The Modoc County Behavioral Health (MCBH) CQI Program is designed to address quality improvement and quality management to assure to all stakeholders that the processes for obtaining services are fair, efficient, cost-effective, and produce results consistent with the belief that people with mental illness may recover. The MCBH CQI Program is responsible for monitoring Mental Health Plan's (MHP) effectiveness through the upkeep and implementation of performance monitoring activities in all levels of the organization, including but not limited to: beneficiary and system access, timeliness, quality, clinical outcomes, utilization and clinical records review, monitoring and resolution of beneficiary grievances, fair hearings and provider appeals, and assessment of beneficiary.

The CQI Program is accountable for upholding and monitoring the requirements of the Mental Health Plan contract with the State Department of Health Care Services (DHCS) for the expenditure of Medi-Cal dollars and to the DHCS Audits and annual EQRO On-Site Reviews.

Executive management and program leadership is crucial to ensure that findings are used to establish and maintain the overall quality of the service delivery system and organizational operations. The QI program is accountable to Edward P. Richert, MD, Medical Director of Modoc County Health Services, and Karen Stockton, Ph.D., Health Services Director, who have substantial involvement in the implementation of the Quality Improvement Program.

Quality Improvement Annual Work Plan Components

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

This Quality Improvement Plan ensures the opportunity for input and active involvement of clients, family members, licensed and paraprofessional staff, providers, and other interested stakeholders in the Quality Improvement Program. The QI members participate in the planning, design, and execution of the QI Program, including policy setting and program planning. The Plan activities also serve to fulfill the requirements set forth by the California Department of Health Care Services, Mental Health Services Division, and Specialty Mental Health Services Contract requirements, as related to the contract's Annual Quality Improvement Program description. The MCBH QI Work Plan addresses quality assurance/improvement factors as related to the delivery of culturally-competent specialty mental health services.

A. QUALITY IMPROVEMENT COMMITTEES

Four committees comprise the CQI program, the Management Team/Compliance Committee, QI Staff Trainings, Quality Improvement Committee and the Mental Health Advisory Board. These forums are responsible for the key functions of the MCBH Continuous Quality Improvement Program. These committees are involved in the following functions:

1. Quality Management Committee (QMC) is responsible for addressing programs policy and procedural changes and compliance adherence. This committee includes the Director of Health Services, Branch Director of Behavioral Health, Clinical Director/Compliance Officer, Branch Director of Public Health/QI Coordinator, Environmental Health Director, Substance Use Disorder Program Manager and Nurse Supervisor. This committee meets at least every other month and addresses:
    a. Operations and workflow needs
    b. Policy and Procedural Changes
    c. Electronic Health Record (EHR) implementation and enhancements
    d. Monitoring the Compliance Plan
    e. Use of outcome data to inform program planning decisions
    f. Capacity needs

The information from this meeting is documented and forwarded to the Health Services All Staff meeting and to the QI Staff Trainings to assure consistency and quality of services.

2. QI Staff Trainings is a quality assurance/improvement meeting conducted once a week. The QI staff training provides an opportunity for program staff to review information from the Quality Management Committee and items from the work plan. This forum reviews confidential, critical incident reports to ensure the quality of services for our consumers. Program staff attend this meeting and evaluate both consumer-focused issues (e.g. cultural diversity; clinical case review; clinical training issues, performance outcome measurement; clinical record audit results; consumer satisfaction results; denial of service; etc.) as well as system-focused topics (e.g. improvement of the QI format, employee suggestions/recommendations, partner concerns, clinic/site audit results, etc.). At QI staff trainings there is a review and recommendations are made for action regarding issues such as:
    - Specific case histories for high risk and high utilizing beneficiaries
    - Clarification and feedback for Policies and Procedures
    - Clinical quality improvement topics for integrated treatment of consumers
    - Medication Monitoring issues specific to a consumer
    - Legal and ethical issues such as potential boundary violations
    - Denials of service
    - Improved recovery focused treatment
    - Treatment that is inappropriate or inadequate for an individual's needs
    - Possible system level issues that relate to client care and access

- Review and identification of QI items/ and summary issues to be sent to CQIC

3. The Quality Improvement Committee (QIC) is charged with implementing the specific and detailed review and evaluation activities of the agency.

   On a quarterly basis, the QIC:
   - Collects, reviews, evaluates, analyzes information and implements actions that frequently involve the handling of information that is of a sensitive and confidential nature.
   - Provides oversight to Quality Improvement (QI) activities, including the development and implementation of the Performance Improvement Projects.
   - Recommends policy decisions, reviews and evaluates the results of QI activities, and monitors the progress of the Performance Improvement Projects.
   - Institutes needed QI actions and ensures follow-up of QI processes.
   - Documents all activities through dated and signed minutes to reflect all QI decisions and actions made by all four QIC meetings.
   - Promote consumer and family voice to improve wellness and recovery
   - Develop strategies to integrate health care and Behavioral Health to improve services

The CQIC provides oversight and is involved in QI activities. The CQIC conducts an annual evaluation of the overall effectiveness of the QI program. This helps to demonstrate that QI activities, including Performance Improvement Projects, contribute to meaningful improvement in clinical care and consumer services.

The CQIC assures that QI activities are completed and utilizes a continuous feedback loop to evaluate ongoing quality improvement activities, including the Performance Improvement Projects. 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.

Each quarterly meeting of the QIC shall include a verbal summary of significant QIC meeting findings, decisions, actions, and recommendations. In addition, written information may also include data summaries, as available.

Members include the Health Services Director, MCBH Branch Director, Medical Director, Clinical Supervisor, QI Coordinator, designated clinical staff, designated case management staff, MHSA Coordinator, SUD Program Manager, designated administrative staff, Patient's Rights Advocate and community members (including consumers and family members). A Confidentiality Statement is integrated into the QIC Sign-In sheet, which is collected at the beginning of each meeting. This Confidentiality Statement insures the privacy of protected health information.

A QIC member presents information to the Mental Health Advisory Board to ensure that

quality issues are discussed.

4. The Behavioral Health Advisory Board meets at least 10 times annually. The members of the Behavioral Health Advisory Board include appointed consumers, representative from the Modoc County Board of Supervisors, Health Services Director, Behavioral Health Branch Director and consumers. The Board receives information from the QIC member and provides feedback on access findings and policy change proposals. The comments from this forum are documented in the meeting minutes and reported back to the Management Team/Compliance Committee to finalize any policy changes.

B. SUBSTANCE ABUSE DISORDER INTEGRATION

The recognition of substance abuse as a factor in the treatment of persons with mental illness has gained increased attention through the above referenced Quality Improvement activities. The prevalence of persons with co-occurring disorders and the need for continued integrated service programs have been noted at all levels. This is fully integrated into the QIC meetings as well through other meetings with partners in Social Services, Law Enforcement and Probation, the Jail and hospitals.

C. ACCOUNTABILITY

The QIC is accountable to the Modoc County Health Services Director and Medical Director. The QI program coordinates performance monitoring activities throughout the program and includes client and system level outcomes, implementation and review of the utilization review process, credentialing of licensed staff, monitoring and resolution of beneficiary grievances, fair hearings, and provider appeals, periodically assessing consumer, youth, and family satisfaction, and reviewing clinical records.

MCBH contracts with a part-time psychiatrist for outpatient care, and hospitals in the region and state for inpatient services. In addition, MCBH has a contract with Lassen County to provide outpatient services to Modoc County clients who are living near the county border. As a component of the 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.

II. QUALITY IMPROVEMENT PROGRAM COMPONENTS

A. Evaluation of Overall 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 services;
- QI activities have contributed to improvement in access to 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 QI Evaluation Activities

1. Quality Improvement Committee (QIC)
   The quarterly 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, and trends related to the utilization review and authorization functions;
   - Review client and provider satisfaction surveys, and client change of provider request to assure access, quality, and outcomes;
   - Review the responsiveness of the 24-hour, toll-free telephone line;
   - Review and evaluate results of QI activities, including progress on the development and implementation of the PIPs;
   - Review QI actions and follow-up on any action plans;
   - Review client- and system-level Performance Outcome Measures for adults and children to focus on any significant findings and trends;
   - Review medication monitoring processes to assure appropriateness of care, appropriateness of reviewer comments, any plans of correction following initial review, and any significant trends of concern;
   - Review new Notices of Action, focusing on their appropriateness and any significant trends;

- Review any grievances or appeals submitted. The QIC reviews the appropriateness of the MCBH response and significant trends that may influence policy or program-level actions, including personnel actions;

- Review provider satisfaction surveys (annually) and any provider appeals;

- Review any requests for State Fair Hearings, as well as review of any results of such hearings;

- Monitor the distribution of EPSDT/ TBS brochures;

- 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;

- Ensure that Medi-Cal services are routinely verified and tracked as actually provided to beneficiaries, and appropriate actions are taken upon discovery that services reimbursed were not actually furnished to the recipients;

- Review and discuss any issues emerging from the weekly CT/UR Committee related to the following:

    - Review and discuss all new clients, Treatment Plans, and any urgent and unusual events at the weekly Clinician's Meeting. This helps to coordinate services and address urgent situations in a timely manner:

    - Feedback from direct services staff regarding proposed policy and procedures.

    - Conduct a minimum six (6) peer chart reviews (utilizing the chart review checklist) every quarter during staff team meetings to focus on appropriateness of care, appropriateness of reviewer comments, any plans of correction following initial review, and any significant trends of concern;

- Review issues related to the Compliance Program, including compliance issues such as fraud or inappropriate billing; staff licensure; status and exclusions lists; and other program integrity items; and

- Monitor issues over time and make certain that recommended activities are implemented, completing the Quality Improvement feedback loop.

2. 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 resolved;
   - Assignments (by persons responsible);
   - Due date; and completion date.

   To ensure a complete feedback loop, completed and incomplete action items shall be 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. MCBH 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.

C. Inclusion of Cultural and Linguistic Competency in All QI Activities

On a regular basis, the QIC shall review collected information, data, and trends relevant to standards of cultural competence and linguistic preferences in service delivery and quality of care.

III. OBJECTIVES, SCOPE, AND PLANNED ACTIVITES

The Quality Improvement activities for Fiscal Year 2017/2018 includes the following objectives:

A. **Ensure MCBH Service Delivery Capacity**

The MCBH QI program shall monitor services in this county to assure service delivery capacity in the following areas:

1. **Utilization of Services** – Review and analyze reports from the Electronic Health Record (EHR) System and utilization of data from the DHCS Client Services Information system (CSI), as available.

2. **Service Capacity** – Staff productivity will be evaluated via productivity reports generated by the EHR System and fiscal staff. Fiscal and Program staff will meet monthly to review productivity reports and goal attainment.

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

B. Monitor Accessibility of Services

The MCBH QI program shall monitor accessibility of MCBH services in accordance with statewide standards and the following local goals:

1. **Timeliness of routine mental health appointments** – The goal for routine appointments is no more than 21 work days between the initial request and the intake appointment. This indicator will be measured by analyzing a random sample of new requests for services from the EHR.

2. **Timeliness of services for urgent or emergent conditions during regular clinic hours** – The goal for urgent or emergent conditions is no more than one (1) elapsed hour from the initial request until an actual staff response is provided. In the case of requests for authorization by a provider, an authorization decision is rendered within one (1) hour. This indicator will be measured by analyzing a random sample of urgent or emergent requests for services from the EHR.

3. **Access to after-hours services** – The goal for access to after-hours care for urgent or emergent conditions is no more than one (1) elapsed hour from the initial request until an actual staff response is provided. A protocol specific to suicide precautions in the Modoc County Jail mandates a face-to-face response within 24 hours and once per every 24 hours following for each person placed on this Suicide Watch. Inpatient hospitalizations do not require prior authorization for services. Requests for authorization for urgent specialty mental health services

will receive an authorization decision within one (1) hour. Non-emergency requests shall be referred for planned services during normal clinic hours. This indicator will be measured by analyzing a random sample of after-hours requests for services from the EHR.

4. **Responsiveness of the 24-hour, toll-free telephone number** –During non-business hours, the answering service answers the crisis line immediately, and links urgent and/or emergent calls to the on-call mental health staff person. If required, an interpreter and/or the Language Line Solutions is utilized. This indicator is measured by conducting random calls to the toll-free number, both after hours and during business hours. At least five (5) test calls are made per month; split between English and Spanish. The goal for responsiveness of the MCBH after hours, 24-hour telephone service is to answer the calls within one (1) minute.

5. **Implement and Maintain Efficient Work Flow Standards** – Office workflow standards will be implement, maintained and monitor to efficiently and consistently serve clients from first contact through discharge.

6. **Support Stakeholder Involvement** – Staff, providers, consumers, and family members review the evaluation data to help identify barriers to improvement. As members of the CQIC, providers, consumers, 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 Advisory Committee provides input on access and barriers to services. Measurement will be accomplished via review of Management Team Compliance Committee, QI Staff Trainings, CQIC and Mental Health Advisory Board minutes. The CQIC will show findings quarterly and a summary annually.

C. Monitor Client Satisfaction

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

1. **Consumer Survey** – Using the DHCS Consumer Perception Survey (POQI) in threshold languages, clients and family members are surveyed twice each year, or as required. This indicator will be measured by annual review and analysis of at least a two-week sample. Survey administration methodology will meet the requirements outlined by the CA DHCS. This data is reviewed twice each fiscal year and will contribute to continuous quality improvement activities

2. **Informing providers of satisfaction survey results** – The results of consumer and family satisfaction surveys are routinely shared with Staff and other providers. Monitoring will be accomplished by review of the results of the Consumer Perception Surveys. Survey results will be shared with staff, providers, consumers, family members, QIC, and the Behavioral Health Advisory Board.

This information is distributed on an annual basis and in the form of cumulative summaries to protect the confidentiality of consumers and their families.

3. **Beneficiary grievances, appeals, and fair hearings** – All processed beneficiary grievances, expedited appeals, standard appeals, and fair hearings will be reviewed by the Branch Director of Behavioral Health and may include Modoc County Risk Management. Monitoring shall be accomplished by ongoing review of the complaint/grievance log for adherence to timelines for response. In addition, the nature of complaints and resolutions will be reviewed to determine if significant trends occur that may influence the need for policy changes or other system-level issues. This review will include an analysis of any trends in cultural issues or disparity in care addressed by our consumers. A summary of trends will be presented to the QIC meetings as appropriate for feedback on policy changes. A summary of these findings will be recorded in the CQIC meeting minutes.

4. **Requests to change practitioners/providers** – At least quarterly, patterns of consumer requests to change practitioners/providers will be reviewed by the QIC. Measurement will be accomplished by review of CQIC minutes summarizing activities of the Access Team and through annual review of the Change of Provider Request forms.

5. **Cultural sensitivity** – In conducting review in the above areas, analysis will occur to determine if cultural issues may have influenced results. Surveys will be provided in English and also in Spanish, Modoc County's threshold language. The results of the Consumer Perception Surveys will be analyzed to determine if Spanish speaking consumers had access to written information in their primary language.

D. Monitor the Service Delivery System

The QI program shall monitor the MCBH service delivery system to accomplish the following:

1. **Safety and Effectiveness of Medication Practices** – Annually, meaningful issues for assessment and evaluation, including safety and effectiveness of medication practices and other clinical issues are identified. Medication monitoring activities will be accomplished via review of cases involving prescribed medications. These reviews will be conducted by a licensed Pharmacist. Results of this review will be shared with staff and the agency staff who are contracted to provide telepsychiatry services to our beneficiaries, and Native American Mental Health. Review of cases receiving medication support will occur at weekly staff meetings. An analysis of the peer review will occur to identify significant clinical issues and trends.

2. **Identify Meaningful Clinical Issues** – Quarterly, meaningful clinical issues will be identified and evaluated. Appropriate interventions will be implemented when

a risk of poor quality care is identified. Monitoring will be 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.

3. **Assess Performance** – Quantitative measures will be identified to assess performance and identify areas for improvement, including the Performance Improvement Projects and other QI activities. For example, Behavioral Health Branch Director reviews data on review loss reports; productivity reports; and late service plan reports. These areas will be measured through the quarterly review of the timeliness of assessments and service plans, completeness of charts, consumer surveys, and productivity reports. The results of these reviews will dictate areas to prioritize for improvement.

4. **Support Stakeholder Involvement** – Staff, providers, consumers, and family members review the evaluation data to help identify barriers to improvement. 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. This is reported to the Mental Health Advisory Board and to the other QIC meetings.

5. **Conduct Frequent Peer Reviews** – MCBH will evaluate the quality of the service delivery by conducting chart audit peer reviews on a regular basis, at least quarterly. Reviews will be conducted by staff during staff meetings and at QI Staff Training. Issues and trends found during these reviews will be addressed at the QIC meetings to review need for policy or procedural changes.

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

E. Monitor Continuity and Coordination of Care with Physical Health Care Providers

When appropriate, information will be exchanged in an effective and timely manner with health care providers used by consumers.

1. Review of data collection through the Continuum of Care Program (CCP) treatment team for interaction between primary care physicians and MCBH for psychiatric consultation or continuity of care.

2. MCBH will meet with the Rural Health Centers (RHCs), private practice clinics and hospital staff in Modoc at least annually and to identify continuity of care process issues.

3. Review health assessment and clinical treatment plan data for beneficiaries that receive medication support services at MCBH. 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. Appropriateness of exchange of information is measured during peer chart review by assuring the presence of a signed consent form.

F. Monitor Provider Appeals

Provider appeals will be recorded in a Provider Complaint Log and will be reviewed by the appropriate entity (e.g., the Quality Management Team/Compliance Officer) and a recommendation for resolution will be made to the Health Services Director and Medical Director. The resolution and date of response shall be recorded in the Log. The QIC reviews the Log for any trends and addresses these issues.

IV. DATA COLLECTION

A. Data Collection
Data sources and types include, but not are limited to, the following:

1. Utilization of services by type of service, age, gender, race, ethnicity, primary language, veterans, and LGBTQ
2. Access Log (initial contact log)
3. Crisis Log
4. Test call logs
5. Notice of Action Forms and Logs
6. Second Opinion requests and outcomes
7. Anasazi 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. EQRO and Medi-Cal Audit results

B. Data Analysis and Interventions

1. Administrative staff perform preliminary analysis of data to review for accuracy and completion. If there are areas of concern, the QIC discusses the information. Clinical staff may be asked to implement plans of correction, as needed. Policy changes may also be implemented, if required. Subsequent review is performed by the QIC.

2. The changes to programs and/or interventions are discussed with individual staff, committee members (including consumers and family members), and management.

3. Program changes have the approval of the Director of Health Services prior to implementation.

4. Effectiveness of program changes are evaluated by the QIC. Input from 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.

V. DELEGATED ACTIVITIES

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

VI. WORK PLAN ACTIVITIES

DESCRIPTION	GOAL	METHOD
ACCESS- QI committee emphasizes the access to services. Community outreach efforts to inform Hispanic and Native American populations of services to increase admissions of these underserved populations. Mental Health and SUD Services	Goal: 5% increase in Hispanic and Native American access.	Quarterly: Examine and graph new admissions and case load indicate AGE, RACE, GENDER, LANGUAGE, AIDE CODE/PAYOR and LOCATION of residence.
Track Foster Care Services	Goal: 75 % Foster Children to be assessed for service need.	Quarterly: Examine number of Foster Children with county code 25 and their access to service needs.
Timeliness of routine mental health appointments- The goal for routine appointments is no more	Goal: 75% goal of routine appointments	Quarterly: Compare the date of initial contact to the first assessment date offered. Client cancellations/no

than (21) days between the initial request and the intake appointment. Mental Health and SUD services	conducted within 21 days. Identify: gender, age, race (Hispanic/Native American) and language (Spanish) of those impacted greater than 21 days.	shows are accepted as a good faith contact. Calculate average response days % that met standard Range in Days
Timeliness of telepsychiatry appointments- The goal is a telepsychiatry appointment within 21 work days.	Goal: 75% of routine Psychiatry appointments conducted within (21) calendar days.	Quarterly: Days from authorization date on auth form to EHR Progress note by telepsychiatry provider. Cancellation/ No shows are accepted as a good faith contact. % appointment that met standard Range in days
No Show for telepsychiatrist	Goal set for: Cancel/No show=10%	Quarterly: Run and review report on Cancel/ No show appointments.
DESCRIPTION	**GOAL**	**METHOD**
Timeliness of follow-up to Hospitalization- The goal is to have contact within 2 work days following discharge from a Psychiatric Hospitalization.	Goal: 80% of cases follow up within 2 work days	Quarterly: Date of discharge from Hospital on LOG compared to EHR scheduled date. Average length of time for follow-up appointment and % of appointments that met standard.
Review of re-admissions to hospitalizations No more than 10% re-admission within 30 days	Goal 10%	Quarterly: Examine Hospital admissions for re-admission within 30 days.
Timeliness of services for Urgent or Emergent conditions during regular clinic hours- Clinic hours are defined as 8:00-6:00 pm Monday, Tuesday, Thursday and Wednesdays 8:00 am-7:00 pm excluding holidays. Both Urgent and Emergent have the same response timeframes. Urgent is defined (9CCR 1810.253*)* *"Urgent condition means a situation*	Goal of 75% of responses within 1 hour.	Quarterly: Reviewing date/time on Log for Crisis Intervention Contacts. Calculate Average response time

experienced by a beneficiary that without timely intervention, is highly likely to result in an immediate emergency psychiatric condition." Emergent is defined (9CCR 1810.216) *"Emergency Psychiatric Condition" means a condition that meets the criteria in section 1820.205 when the beneficiary with the condition, due to a mental disorder, is a current danger to self or others, or immediately unable to provide food or utilize, food shelter or clothing, and requires psychiatric inpatient or psychiatric health facility services."*		
Timeliness of response to after hours Urgent/Emergent requests-After hours response is defined all other time outside the above clinic hours. Both Urgent and Emergent have the same response timeframes. (see definitions above)	Goal is 75% of responses to be within the time frame. 1 hour response. 15 minute phone or in-person contact to discuss plan of response.	Quarterly: Reviewing date/time on Log for Crisis Intervention Contacts. Calculate Average response time
DESCRIPTION	**GOAL**	**METHOD**
Responsiveness of the 24-hour, toll-free telephone number	Goal is 80% of all test calls are successfully answered 1. Calls to be answered within 1 minute. 2. Quality of response indicators: identified agency/self. Appropriate resource and safety concerns addressed 100% of the time.	1. This indicator is measured by conducting random calls to the toll-free number, both after hours and during business hours. At least five (5) test calls are made per month; split between English and Spanish. This data is reviewed at each quarterly CQIC meeting. 2. DHCS has a quarterly report to be completed and submitted.
MH Performance expectations- Initial assessment/Diagnosis Within 30 calendar days of Admission SUD Performance expectations- Initial assessment/Diagnosis	Goal 90%	Quarterly: EHR date of admission compared to date of assessment.

Within 30 calendar days of Admission Admission Diagnosis date to be the first date of a service within the admission.		
MH Performance expectations- Treatment plan Within 60 calendar days of Initial assessment. Time frame to start at date of 1st service in admission. SUD Performance expectations- Treatment plan Within 30 calendar days of Initial assessment. Time frame to start at date of 1st service in admission.	Goal 90%	Quarterly: EHR date of admission compared to date of treatment plan signed by consumer.
MH Performance expectations- Annual review SUD Performance expectations- 90 days for treatment plan	Goal: 100% to be reviewed in the Month they are due or by next service date.	MH: Review assessment and treatment plan dates to ensure they are updated within 364 days or prior assessment and treatment plan SUD: Review assessment and treatment plan dates to ensure they are updated within 89 days or prior assessment and treatment plan
DESCRIPTION	**GOAL**	**METHOD**
Performance expectations-Timeliness of progress notes.	MH Goal 80% for completion on same day or next day of service. SUD Goal 80% for completion on same day of service.	Bi-monthly review of date of service and date note signed
Beneficiary Protection- Complaints and grievances	Goal: 100% handled according to policy	Quarterly: Examine complaints and grievances for trends and compliance
Beneficiary Protection- Notices of action (NOAs)	Goal: 100% issued according to policy	Quarterly: Examine NOAs for trends and compliance
Organizational providers are certified and recertified in compliance with title 9	Goal: 100% compliance	Monthly: Examine provider certification Report
Diagnosis Trends	QIC review goal is to monitor	Quarterly: Monitor diagnosis report at the end of the quarter to see trends in diagnosis and if array of services and group content fits clinical needs.

Program Integrity-Are services actually provided to consumers?	Goal: Obtain 100% service verification signatures	Bimonthly chart review