Behavioral Health & Recovery Services

Quality Improvement Work Plan for FY 2019/2020

Includes: Quality Improvement Evaluation for FY 2018/2019

Table of Contents

OVERVIEW

The Quality Improvement Work Plan serves as the foundation of the Merced County Behavioral Health & Recovery Services (MCBHRS) to continuously improve the quality of treatment and services provided to our beneficiaries. The programs provided through MCBHRS are based on our Mission Statement, Vision Statement, and our Core Values.

MISSION STATEMENT

Behavioral Health and Recovery Services is committed to empowering our diverse community with hope, recovery and wellness by providing comprehensive, holistic care.

VISION STATEMENT

Inspiring hope and recovery for those we serve as the premier provider for quality whole person care.

CORE VALUES

We, the employees of Merced County Behavioral Health & Recovery Services, value:

- Humility
- Integrity
- Compassion
- Innovation
- Customer Service
- Inclusion

REQUIRED ELEMENTS FOR THE QUALITY MANAGEMENT PROGRAM

According to the California State Department of Health Care Services (DHCS), the Quality Management (QM) Program clearly defines the MCBHRS QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The QM Program shall be evaluated annually and updated as necessary per Title 9, CCR, Section 1810.440(a)(6) and Title 42, CFR, Section 438.240(e).

QUALITY MANAGEMENT PROGRAM DESCRIPTION

The QM Program shall be accountable to the Behavioral Health and Recovery Services Director as described in Title 9 CCR, Section 1810.440(a)(1). Operation of the QI program shall include substantial involvement by a licensed mental health staff person, as described in Title 9 CCR, Section 1810.440(a)(4). The QI Program shall include active participation by practitioners and providers, as well as beneficiaries and family members in the planning, design and execution of the QI Program, as described in Title 9 CCR, Section 1810.440(a)(2)(A-C).

There shall be a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in Title 42, CFR, Section 438.240(b)(1) and (d). Each performance improvement project shall focus on a clinical area, as well as one non-clinical area.

The QM Program shall;

- Conduct performance monitoring activities throughout its operations.
- Activities shall include but not be limited to;
    - Service Satisfaction
    - Safety and Effectiveness of Medication Practices
    - Coordination of Care
    - Quality of Care
    - Service Capacity
    - Timeliness of Services
    - Training of staff
- Ensure continuity and coordination of care with physical health care providers.
- Coordinate with other human services agencies used by its beneficiaries.
- Assess the effectiveness of our MOU with the Central California Alliance for Health (CCAH), a physical health care plan, to ensure the highest quality of services for both physical and mental health.
- Have mechanisms to detect both underutilization and overutilization of services, as required by Title 42, CCR, Section 438.240(b)(3).
- Implement mechanisms to assess beneficiary/family satisfaction. The MHP shall assess beneficiary/family satisfaction by:
    - Surveying beneficiary/family satisfaction with the MHP's services at least annually;
    - Evaluating beneficiary grievances, appeals and fair hearings at least annually; and
    - Evaluating requests to change persons providing services at least annually; and
    - Inform providers of the results of beneficiary/family satisfaction activities.
- Implement mechanisms to monitor the safety and effectiveness of medication practices.
    - The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs.

  - Monitoring shall occur at least annually.
- Implement mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.
  - Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.
  - Take appropriate follow-up action when such an occurrence is identified.
  - Results of the intervention shall be evaluated by the Contractor at least annually.

QUALITY MANAGEMENT WORK PLAN

MCBHRS has a QM Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. The QM Work Plan receives input and feedback by the Quality Improvement Committee and is reviewed and approved by the Executive Team.

The QM Work Plan includes the following:

- Evidence of the monitoring activities including, but not limited to,
  - Review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Title 9, CCR, Section 1810.440(a)(5) and Title 42, CFR, section 438.416;
  - Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;
- A description of completed and in-process QM activities, including performance improvement projects. The description shall include:
  - Monitoring efforts for previously identified issues, including tracking issues over time;
  - Objectives, scope, and planned QM activities for each year; and,
  - Targeted areas of improvement or change in service delivery or program design.
- A description of mechanisms that has been implemented to assess the accessibility of services within its service delivery area. This shall include;
  - Goals for responsiveness for the MHP's 24-hour toll-free telephone number,
  - Timeliness for scheduling of routine appointments,
  - Timeliness of services for urgent conditions, and
  - Access to after-hours care.
- Evidence of compliance with the requirements for cultural competence and linguistic competence specified in Title 9, CCR, Section 1810.410.

EVALUATION

- Annual evaluations are completed at the end of each fiscal year. The annual evaluation is conducted by Quality Improvement Program.

The evaluation summarizes the following;

- The goals and objectives of the programs/service's Quality Improvement Plan,
- The quality improvement activities conducted during the past year, including the targeted process.
- The performance indicators utilized,
- The findings of the measurement, data aggregation, assessment and analysis processes, and
- The quality improvement initiatives taken in response to the findings.
- The progress towards meeting the Department's Annual Objectives.
    - For each of the objectives; a brief summary of progress including progress in relation to the objective(s).
    - A brief summary of the findings for each of the indicators used during the year. These summaries include both the outcomes of the measurement process and the conclusions and actions taken in response to these outcomes.
    - A summary of the progress toward the objectives.
- Recommendations: Based upon the evaluation, the actions deemed necessary to improve the effectiveness of the Department's program services.

CONTINUOUS QUALITY IMPROVEMENT ACTIVITIES

QI activities to improve outcomes of existing services and/or to design new services shall include:

- Collecting and analyzing data to measure against the goals stated in the QI/QM annual work plan, which prioritized areas of improvement that have been identified;
- Identifying opportunities for improvement and deciding which opportunities to pursue;
- Identifying relevant committees internal or external to ensure appropriate exchange of information with the QI Committee;
- Obtaining input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services;
- Ensuring practice guideline are adhered to;
- Designing and implementing interventions for improving performance;
- Measuring effectiveness of the interventions;
- Monitor the inclusion of cultural competency concerns;
- Incorporating successful interventions into the MCBHRS operations as appropriate

- Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by title 9, CCR, Section 1810.440(a)(5).

QUALITY IMPROVEMENT COMMITTEE CHARTER

The Quality Improvement (QI) Committee shall monitor the service delivery system with the aim of improving the processes of providing care and better meeting the needs of its clients. The QI Committee shall;

- Review the quality of specialty mental health services provided to beneficiaries.
- Recommend policy decisions;
- Review and evaluate the results of QI activities, including;
    - Performance improvement projects;
    - Institute needed QI actions;
    - Ensure follow-up of QI processes; and
    - Document QI Committee meeting minutes regarding decisions and actions taken.

QIC meeting agendas may include, but are not limited to, the following agenda items:

- Grievances, appeals, state fair hearings
- Expedited appeals and state fair hearings
- Requests for change of provider
- Notice of actions
- Contract Provider services
- Recidivism
- Appointments after Discharge
- Consumer Satisfaction Questionnaire Survey results
- Utilization Review of documentation results
- Timeliness to services outcomes
- Service delivery capacity, trends, quality and outcomes
- Policies and procedures
- Performance Improvement Projects
- Utilization of Specialty Mental Health Services
- Verification of services
- Cultural and Linguistic Competence needs and services
- Automation Services report
- Training updates

The QIC meets at least monthly and consists of the following individuals:

- BHRS Director
- BHRS Assistant Director
- BHRS Assistant Director-Administration
- Medical Director
- Quality & Performance Management Director
- BHRS Program Manager – QPM:QI/MC
- Compliance Officer
- MHSA Coordinator
- BHRS Division Directors
- BHRS Program Managers
- UM Staff
- QI/QA staff
- Beneficiaries/Consumers/Family Members/Stakeholders
- Behavioral Health Board Members
- Community Service Providers
- Automation Services Staff
- Wellness Center Consumer Advisory Board Members
- Patients' Rights Advocate
- Other BHRS leadership and direct provider staff

DEPARTMENT COMMUNICATION OF QUALITY IMPROVEMENT ACTIVITIES

The Department supports QI activities through the planned coordination and communication of the results of measurement of QI Initiatives. The overall efforts are to continually improve the quality of care provided to our beneficiaries. The planned communication may take place through the following methods:

- Recipients participating in the QIC report back to recipient groups
- Emails
- Presentations to the Mental Health Board
- Posters, brochures, notices and surveys displayed in common areas
- Sharing of the Department's annual QI Work Plan
- Distribution of meeting minutes

OTHER DEPARTMENT QUALITY IMPROVEMENT COMMITTEES

The Department has the following standing committees where QI/UM activities occur:

- Performance Improvement Projects (PIP) Committee
- High Frequency User Committee
- Data Committee
- Compliance Committee
- Psychological Autopsy Committee
- High Cost Beneficiary Committee
- Cultural Competency Committee
- Inter-Disciplinary Treatment (IDT) Team Committee
- Institute for Mental Diseases (IMD) Placement Committee
- Community Partner Committee
- Medication Management Review
- Utilization Review
- Interagency Primary Care and BHRS Meetings
- Central Intake and POE Workgroup
- Beacon-Merced Clinical Collaborative Meetings
- Employee Training Program- Documentation Training
- Clinical Management Team Meeting
- Performance Indicator Work Group

QUALITY ASSURANCE (QA)

MCBHRS shall set standards and implement processes that will support understanding of, and compliance with, documentation standards set forth in the DHCS contract and any standards set by MCBHRS. QA activities may include monitoring performance so that the documentation of care provided will satisfy the requirements set forth in the State Department of Health Care Service's contract. The documentation standards for client care are minimum standards to support claims for the delivery of specialty mental health services. All standards shall be addressed in the consumer record.

UTILIZATION MANAGEMENT (UM) PROGRAM

The Utilization Management Program shall;

- Be responsible for assuring that beneficiaries have appropriate access to specialty mental health services as required in Title 9, CCR, Section 1810.440(b)(1-3).
- Evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively or retrospectively.
- Implement mechanisms to assess the capacity of service delivery for its beneficiaries. This includes monitoring the number, type, and geographic distribution of mental health services within the Department's delivery system.
- Implement mechanisms to assess the accessibility of services within its service delivery area. This shall include the assessment of responsiveness of the MHP's 24 hour toll-free telephone number, timeliness of scheduling routine appointments, timeliness of services for urgent conditions, and access to after-hours care.
- Implement mechanisms to assure authorization decision standards are met. Authorization of services shall include all of the following:
    - Pursuant to Title 42, CFR, Section 438.210(b)(1), the Contractor and its subcontractors must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services.
    - Pursuant to Title 42, CFR, Section 438.210(b)(2), the Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate.
    - Pursuant to Title 42, CFR, Section 438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition or disease.
    - Decisions must be made within the timeframes outlined for service authorizations in Title 42, CFR Section 438.210(d), and notices of action related to such decisions must be provided within the timeframes set forth in Title 42, CFR, Section 438.404.(c).
- BHRS currently has one Quality Performance and Management (QPM) division that oversees all mental health programs. The SUD programs have been operating separate quality performance and management functions led by the BHRS Division Director and/or BHRS Program Manager. With the additional requirements of the future DMC-ODS program, the SUD quality assurance activities and additional quality improvement and performance management functions, the goal is to incorporate all tracking functions within the BHRS Quality and Performance Management Division by July 1, 2019.
    - Currently, the SUD Division of BHRS conducts monthly utilization reviews which are held the 2nd Friday of every month. Charts are randomly pulled by the medical records technician for each outpatient clinic. The monthly reviews consist of pulling charts that were open within 30 days of the current review month, charts that have been opened between 90-120 days during the review month, charts that have been open 180 days during the review month, and charts that were closed within the last 30 days of the review month.
    - The BHRS Substance Use Division QPM/UR team consists of one BHRS Division Director, one BHRS Program Manager, one QPM Mental Health Clinician, one Staff Services Analyst, one Medical Records Technician and at least four certified Alcohol and Other Drug Counselors. The BHRS Division Director, BHRS Program Manager and the QPM Mental Health Clinician are licensed practitioners of the healing arts.

- Charts are reviewed to ensure compliance with Title 22 DMC regulations and CHRS SUD policies and procedures. Medical records reviews all completed utilization review forms and compiles a summary of the findings, which are then placed in the minutes and sent to the program managers, division director, and the quality performance and management department. Any disallowances and/or voids are completed by the quality performance and management department.

PERFORMANCE IMPROVEMENT PROJECTS (PIPS)

The MCBHRS has following Performance Improvement Projects (PIPs). These include the following:

IMPROVING OUTCOMES OF HIGH FREQUENCY USERS (HFU) - CLINICAL

The MHP is conducting a two (2) year PIP that started in FY 2017/2018 and will continue to October 2020 to reduce High Frequency Users (HFU) of crisis services and hospitalizations.

As with many health care systems, equal distribution of resources and services can be a challenging problem when the main focus of your organization is a positive outcome for all your consumers. Chronic mental illness is one of the hardest diseases to tackle when consumers go into denial of their disease and ultimately end up in crisis and or hospitalized. Changing a consumer's perspective in their individual care can be a considerable challenge when they only seek "quick fixes", instead of applying a steady routine of management therapy and medication.

In order to reduce BHRS HFU's of crisis care and hospitalizations, the MHP will use this two (2) year PIP to focus on changing the habits of consumers who frequently seek crisis services and hospitalization by applying interventions that are aimed at high intense outpatient services that ultimately break the cycle of decompensation; and in turn; start consumers on improving their mental health wellbeing.

HFU's are identified by utilizing services greater than $30,000 in a twelve (12) month period and having more than three (3) crisis services / hospitalization. At-Risk consumers will be identified by utilizing services less than $30,000 in a twelve (12) month period with at least one (1) crisis service / hospitalization.

Resources and services referred to these consumers will be tracked to identify what outcomes were achieved and if improvement or decompensation occurred and when to make modifications as such to their care.

The following interventions are being applied:

- HFU Committee – reviews consumer charts as identified as above to determine any clinical interventions that can be applied.
- Innovative Strategist Network (ISN) – High intense services to consumer who have had a crisis or hospitalization.
- Expansion of medication walk-in clinic (pending).
- Expansion of case management (pending).

IMPROVE TIMELINESS OF PSYCHIATRIC REFERRALS – ADMINISTRATIVE - CONCEPT

In February 2018, DHCS implemented new parity timeliness standards for all MHP's to follow. These included psychiatric referrals with a new standard being 15 working days. Prior to this, the MHP had a timeliness standard of 30 calendar days for psychiatric referrals. While the MHP has always struggled with the timeliness of psychiatric referrals, this new standard has exasperated the problem with a current compliance of 8%. The average number of days to appointments is 41.

The MHP has the following historical compliance for scheduled psychiatric referrals:

FY 2017/2018	# of Referrals	Within 30 days	All Compliance
July	47	11	23%
August	42	9	21%
September	40	4	10%
October	61	8	13%
November	40	8	20%
December	43	6	14%
January	54	2	4%
February	57	2	4%
March	52	4	8%
April	60	3	5%
May	64	5	8%
June	52	4	8%
Total	**612**	**66**	**11%**

FY 2018/2019	# of Referrals	Within 15 working days	All Compliance
July	32	1	3%
August	43	2	5%
September	49	3	6%
October	54	3	6%
November	49	3	6%
December	26	4	15%
January	69	1	1%
February	52	4	8%
March	67	6	9%
April	38	10	26%
May	50	4	8%
June	36	6	17%
Total	**565**	**47**	**8%**

INCREASE MEDICATION/PSYCHIATRIC SERVICE PARTICIPATION – ADMINISTRATIVE - COMPLETED

During the FY 2018/2019, the MHP conducted a PIP to apply systematic interventions to help reduce the overall no show rate for medication appointments. This PIP ended June 30, 2019, with the following activities and results:

The MHP implemented five (5) interventions.

- Update the No Show Policy to include new programs and assist staff with navigation of consumers to corrective courses of action when a no show occurs.
- Implemented a Consumer Participation Agreement to re-enforce the importance of attending appointment; especially medication appointments, and how it improves their overall wellbeing.
- Increased reminder calls to two (2) calls for all appointments - three (3) days before and one (1) day before.
- Implementation of nursing staff to increase engagement with Meds Only clients to ensure contact between medication appointments.
- Implementation of a new telehealth contract to increase the number of psychiatrists available for medication appointments.

Overall, the PIP did reduce the no show rate of psychiatry appointment by 0.30% to an overall average of 18.45% from 18.75% in FY 2017/2018. The MHP will continue to monitor and track no show rates and implement strategies to further reduce client not showing for appointments.

PERFORMANCE INDICATORS

A performance indicator is a type of quantifiable measurement that provides information regarding a program/services process, functions or outcomes. Selection of a Performance Indicator for services within BHRS is based on the following considerations:

- Relevance to the Department's mission.
- Required monitoring item by DHCS and EQRO.
- Clinical importance - whether it addresses a clinically important process that is:
    - High volume
    - High risk
    - Measuring client satisfaction
    - Assess the cultural competency of services, linguistics, etc.

Once the performance of a selected process has been measured, assessed and analyzed, the information gathered by the above performance indicator(s) is used to identify a continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon program/service priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones.

ACTIVITIES FOR FY 2018/2019

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
OBJECTIVE 1: SERVICE SATISFACTION				
A. Surveys Assess, evaluate, and report beneficiary / family satisfaction with the MHP at least annually. Review cultural and linguistic results for barriers in conducting surveys.	The MHP's goal is 75% satisfaction for all areas. 17/18 Access – 76% Quality of Care – 76% Outcomes – 63% Overall Satisfaction – 78% 18/19 Access – 83% Quality of Care – 85% Outcomes – 70% Overall Satisfaction – 82% **Evaluation of FY 18/19:** Surveys met three goals with an overall satisfaction increase of 4%. **Goal for FY 19/20:** QIC will to conduct surveys to track satisfactions of consumers	The MHP conducts the following surveys: 1. DHCS Performance Outcome Quality Improvement Surveys semi-annually. 2. The MHP also conducts an internal Consumer Satisfaction Survey semi-annually using the same process as DHCS. 3. Report results for review and evaluation to QIC including Contract Providers.	QPM Division	Quarterly / Annual

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
Objective 1: Service Satisfaction				
B. Grievances, Appeals, and Fair Hearings Monitor, evaluate, and report beneficiary grievances, appeals, and fair hearings at least annually.	The MHP's goal is to complete 100% of all grievances and appeals within timeframes, and to ensure services are continued during State Fair Hearings. Grievances 17/18 – 100% 18/19 – 100% Appeals 17/18 – 100% 18/19 – 100% **Evaluation of FY 18/19:** Grievance, appeals shows 100% compliance. This is due to the change in standards from 60 days to 90 days. **Goal for FY 19/20:** The QI program will continue to work to ensure 100% compliance.	1. Log grievances, appeals within one (1) business day of receipt. 2. Notify beneficiary and/or representative within three (3) business days upon of receipt of grievance. 3. Make determination within regulatory standards of 90 calendar days. 4. Notify beneficiary and provider of the grievance and outcome. 5. Standard Appeals will be resolved according to regulatory standards of 30 calendar days. 6. Expedited Appeals will be resolved according to regulatory standards of 72 hours. 7. Ensure services are continued during a State Fair Hearing. 8. Report results for review and evaluation to QIC including Providers.	QPM Division	Quarterly / Annual

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
Objective 1: Service Satisfaction				
C. Change of Provider Monitor, evaluate, and report beneficiary requests to change persons providing services at least annually.	The MHP's goal is to complete 100% of all change of provider requests within 60 days. 17/18 – 100% 18/19 – 100% **Evaluation of FY 18/19:** Processing of Change of Provider requests met the goals for both fiscal years. **Goal for FY 19/20:** Continue processing all Change of Provider requests within 60 days.	1. Make determination of all Change of Provider requests within regulatory standards of 60 calendar days. 2. Inform beneficiaries of decision upon resolution. 3. Report results for review and evaluation to QIC including Providers.	QPM Division	Quarterly / Annual

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
OBJECTIVE 2: SAFETY AND EFFECTIVENESS OF MEDICATION PRACTICES				
A: Safety and Effectiveness of Medication Practices Monitor and evaluate the safety and effectiveness of medication practices at least annually.	The MHP's goal is to review 10% of all open beneficiaries and review all deficiencies above 5%. 17/18 – 11/31 indicators above 5% for deficiencies 18/19-11/31 indicators above 5% for deficiencies **Evaluation of FY 18/19:** The same number of deficiencies continue to be out of compliance **Goal for FY 19/20:** Review with Medical Director the indicators out of compliance and determine any barriers or breakdowns in the process.	1. Identify and make recommendations regarding clinical areas that need improvement. 2. Implement appropriate interventions/changes when individual occurrences of poor quality are identified. 3. Complete site reviews and evaluate the safety of the facility and the storage and dispensing of medication in compliance with current laws and regulations. 4. Report results for review and evaluation to QIC including Providers.	QPM Division QI/MMR/UR Committees Medical Director Medical Staff Compliance Officer PHF Manager Pharmacist Contract Review	Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
OBJECTIVE 3: COORDINATION OF CARE				
A: Physical Healthcare Coordination Coordinate services with physical health care and other agencies utilized by MHP beneficiaries.	The MHP's goal is to ensure 100% of all coordination of services with Primary Care Physicians are done in a timely manner and review all deficiencies above 5%. 17/18 – 79/294 – 27% 18/19 – 58/253 – 24% **Evaluation of FY 18/19:** PCP coordination continues to be an issue; however, improved 4% from the last fiscal year. **Goal for FY 19/20:** – In 17/18, the MHP implemented a new "Onboarding" training for new staff which includes PCP coordination. In 18/19, the MHP implemented a Staff Notification within the EHR to alert staff of pending documentation. Further analysis of the problem will continue to be tracked.	1. Evaluate coordination with physical health care providers through the UR and MMR process. 2. Evaluate referral process for appropriateness and timeliness of exchange of information. 3. Evaluate disposition/referral when an individual does not meet medical necessity/service criteria. 4. Provide staff training to improve coordination with PCP. 5. Report results for review and evaluation to QIC including Providers.	QPM Division QI/MMR/UR Committees Medical Director Medical Staff Compliance Officer PHF Manager Pharmacist Contract Review	Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
OBJECTIVE 4: QUALITY OF CARE				
A: Utilization Review Conduct utilization review on beneficiary medical records to ensure compliance of all standards.	The MHP's goal is to ensure a 10% sample of unbilled Medi-Cal claims from the current month will be reviewed to determine if claims meet documentation, medical necessity, and other requirements for claim submission and review all deficiencies above 5%. 17/18 – 360 charts 817 services 6% disallowance 18/19 – 371 charts 472 services 9% disallowed **Evaluation of FY 18/19:** The MHP's disallowance rate increased from 6% to 9%. **Goal for FY 19/20:** Continue to educate staff on proper documentation procedures and identify any barriers or breakdowns in processes.	1. Evaluate coordination with physical health care providers through the UR and MMR process. 2. Evaluate referral process for appropriateness and timeliness of exchange of information. 3. Evaluate disposition/referral when an individual does not meet medical necessity/service criteria. 4. Evaluate that services are conducted in preferred language. 5. Report results for review and evaluation to QIC including Providers.	QPM Division QI/MMR/UR Committees Medical Director Contract Providers BHRS Leadership	Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
OBJECTIVE 5: SERVICE CAPACITY				
A: Beneficiary Penetration Prepare and analyze beneficiary penetration reports to identify needed areas of expansion or reduction of services.	The MHP's goal is to ensure all Medi-Cal beneficiaries are provided with adequate clinic locations to ensure continued wellbeing and recovery. **Enrollment Penetration** 17/18 – 3.90% - 4,903 18/19 – 4.17% - 5,154 **Hispanic Penetration** 17/18 – 1.88% - 2,361 18/19 – 2.02% - 2,497 **Evaluation of FY 18/19:** The MHP's enrollment penetration rates increased 0.27%. Hispanic penetration increased 0.14%. **Goal or FY 19/20:** Continue to monitor rates for any deviations to gains or reductions.	1. Evaluate and analyze beneficiary penetration reports for trends related to services and beneficiaries based on demographic and geographic region. 2. Report results for review and evaluation to QIC including Providers.	QPM Division	Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
OBJECTIVE 5: SERVICE CAPACITY				
B: Service Utilization Prepare and analyze service utilization reports to identify needed areas of expansion or reduction of services.	The MHP's goal is to ensure all Medi-Cal beneficiaries are provided with adequate services to ensure continued wellbeing and recovery. 17/18 – 67,557 services 4903 cons. / 13.8 services 18/19 – 74,553 services 5,154 cons / 14.5 services **Evaluation of FY 18/19:** Services increased 0.66 services per client. **Goal for FY 19/20:** Continue to evaluate and monitor the number of services per consumer to determine any barriers or breakdowns in receiving services.	1. Evaluate and analyze service utilization reports for trends related to services and beneficiaries based on geographic region. 2. Report results for review and evaluation to QIC including Providers.	QPM Division	Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
Objective 5: Service Capacity				
C: Retention Monitor and evaluate retention of beneficiaries.	The MHP's goal is to improve retention rates of beneficiaries to ensure that beneficiaries seeking services with the MHP, continuing receiving services for their wellbeing and recovery. Retention: 17/18 - 77.91% 18/19 - 79.13% **Evaluation of FY 18/19:** In FY 16/17-FY 17/18 a PIP was completed with an intervention to schedule appointments immediately after SMI assessment. Retention continues to increase with a 1.22% increase over FY 17/18 and a 3.18% increase since FY 16/17. **Goal for FY 19/20:** Continue to monitor retention rates for continued improvement.	1. Evaluate retention rates monthly to identify any barriers to services. 2. Report results for review and evaluation to QIC including Providers.	QPM Division BHRS Div. Director BHRS Program Manager	Monthly / Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
OBJECTIVE 6: TIMELINESS OF SERVICES				
A: Initial Routine Assessments Monitor and evaluate initial routine assessments to ensure they are scheduled within the MHP goal.	The MHP's goal is to ensure 95% of all Medi-Cal beneficiaries are provided a scheduled initial assessment within the DHCS standard of 10 working days from initial contact. 17/18 – 90% 18/19 – 97% **Evaluation of FY 18/19:** Timeliness of routine assessment exceeded the goal of 95%. **Goal for FY 19/20:** Continue to monitor timeliness of assessments.	1. Track and trend timeliness of initial routine assessments to identify any barriers to services. 2. Report results for review and evaluation to QIC including Providers.	QPM Division	Monthly / Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
OBJECTIVE 6: TIMELINESS OF SERVICES				
B: Urgent Appointments Monitor and evaluate urgent Appointments to ensure they are scheduled within the MHP goal.	The MHP's goal is to ensure 95% of all Medi-Cal beneficiaries are provided a scheduled urgent appointment within the new DHCS standard of 48 hours from initial contact. 17/18 – 94% 18/19 – 81% **Evaluation of FY 18/19:** Timeliness of urgent appointments declined from 17/18. This is due to small amount of urgent appointments scheduled and the change from a goal of 3 working days to a new DHCS standard of 48 hours. **Goal for FY 19/20:** Improve timeliness of urgent appointments to meet or exceed the goal of 95% within the new standard.	1. Track and trend timeliness of urgent assessments to identify any barriers to services. 2. Implement strategies and processes to improve timeliness of urgent appointments. 2. Report results for review and evaluation to QIC including Providers.	QPM Division	Monthly / Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
Objective 6: Timeliness of Services				
C: 24/7 Test Calls Perform test calls during business and after-hours to monitor staff for 24-7 toll-free number responsiveness and providing access to after-hours care.	The MHP's goal is ensure 100% of all calls are answered beneficiaries are provided with the appropriate SMHS information and services. 17/18 – 18% 18/19 – 29% **Evaluation of FY 18/19:** The MHP implemented the following processes to improve test calls: 1) retraining of all front line staff 2) installed additional rollover lines Test calls compliance increased11%. **Goal for FY 19/20:** 24/7 Access to Services Log was updated to help staff with following the DHCS/ODS guidelines to ensure 100% compliance.	1. Perform monthly test calls during business hours and after-hours; samples are also performed in languages other than English. 3. Continue to re-inforce logging of all contacts by staff. 2. Report results for review and evaluation to QIC including Providers.	QPM Division BHRS Division Director	Monthly / Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
Objective 6: Timeliness of Services				
D: Appointments after Hospital Discharge Monitor and evaluate appointments following a hospital discharge to ensure they are scheduled within the MHP goal.	The MHP's goal is to ensure 75% of all Medi-Cal beneficiaries are provided an appointment within 7 days from a hospital discharge. 17/18 – 29% med / 52% clinical 18/19 – 27% med / 41 % clinical / 45% first appointment **Evaluation of FY 18/19:** Analysis shows a decrease in both medical and clinical appointments. **Goal for FY 19/20:** Continue to monitor timeliness standards for both medical and clinical. The MHP will change the reporting format to match EQRO of tracking just first appointment within 7 days.	1. Track and trend timeliness of appointments following a hospital discharge to identify any barriers to services. 2. Continue to evaluate and make process changes to improve timeliness of appointment after discharge. 3. Report results for review and evaluation to QIC including Providers.	QPM Division	Monthly / Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
Objective 6: Timeliness of Services				
E: Appointments for Psychiatric Referral Monitor and evaluate psychiatric referrals to ensure they are scheduled within the MHP goal.	The MHP's goal is to ensure 95% of all Medi-Cal beneficiaries are provided an appointment within the new DHCS standard of 15 working days when referred to a psychiatrist. 17/18 – 11% Ave wait time – 55 days 18/19 – 8% Ave wait time – 41 days **Evaluation of FY 18/19:** The MHP continues to face challenges scheduling psychiatric referrals. **Goal for FY 19/20:** The MHP has initiated a PIP for this indicator to implement interventions to improve timeliness of referrals.	1. Track and trend timeliness of appointments for psychiatric referrals to identify any barriers to services. 2. Report results for review and evaluation to QIC including Providers. 3. Initiate PIP for FY 19/20 to improve the timeliness of psychiatric referrals by applying system wide interventions.	QPM Division	Monthly / Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
Objective 6: Timeliness of Services				
F: No Shows (Failed to Keep Appointment / FKA) Monitor and evaluate No Show (FKA) appointments to identify trends.	To ensure less than 10% of all appointments are cancelled or No Show. Clinical 17/18 – 12% 18/19 – 10% Medical 17/18 – 19% 18/19 – 18% **Evaluation of FY 18/19:** The MHP did not meet the goal for medical appointments **Goal for FY 19/20:** MHP started a PIP and current interventions are in place which has resulted in a drop of 1% in no show rates.	1. Track and trend No Show appointments to identify any barriers to services. 2. Implement PIP interventions. 3. Report results for review and evaluation to QIC including Providers.	QPM Division	Monthly / Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
Objective 6: Timeliness of Services				
G: Readmission after Hospital Discharge Monitor Readmission following a hospital discharge to ensure they are scheduled within the MHP goal.	The MHP's goal is to ensure less than 9% readmission rate within 7 days from hospital discharge and less than 15% readmission rate within 30 days from hospital discharge. 7 days readmission 17/18 – 4% 18/19 – 2% 30 days readmission 17/18 – 11% 18/19 – 7% **Evaluation of FY 18/19:** The MHP met the goals for both fiscal years. **Goal for FY 19/20:** Continue to monitor readmissions for any increases.	1. Track and trend readmissions following a hospital discharge to identify any barriers to services. 2. Report results for review and evaluation to QIC including Providers.	QPM Division	Monthly / Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
Objective 6: Timeliness of Services				
H: Contract Provider Referrals Monitor Contract Referrals to ensure beneficiaries are being seen within the contract requirements and that the contract providers are meeting the MHP's goal.	The MHP's goal is to ensure 100% of all contract provider referrals are seen within the specified timeframes of the contract 14 days for youth and 60 days for adult. Adult 17/18 – 100% 18/19 – 95% Youth 17/18 – 98% 18/19 – 98% **Evaluation of FY 18/19:** Adult referrals dropped by 5% to 95% compliance. Youth maintained a compliance of 98%. **Goal for FY 19/20:** Continue to monitor contract providers to ensure compliance with their contracts.	1. Track and trend contract providers to ensure compliance with contracts. 2. Continue to meet with Contract Providers to identify any barriers to the referral process to improve compliance. 3. Report results for review and evaluation to QIC including Providers.	QPM Division	Monthly / Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
Objective 6: Timeliness of Services				
I: Treatment Authorization Requests and Service Authorization Requests Monitor all Managed care authorizations to ensure they are meeting the MHP's goal.	The MHP's goal is to ensure 100% all managed care authorizations are meeting the timeframes set by DHCS. TARs 17/18 - 100% 18/19 – 100% SARs 17/18 – 96% 18/19 – 100% **Evaluation of FY 18/19:** TARs continue the goal of 100% for 18/19. SARs increased to full compliance of 100% for 18/19. **Goal for FY 19/20:** Continue to monitor TARs and SARs to ensure 100% compliance in the MHP goal.	1. Track and trend TARS and SARS to ensure they are completed within the required timeframes. 2. Report results for review and evaluation to QIC including Providers.	QPM Division	Monthly / Quarterly / Annually

Indicator	Goal	Planned Activity	Responsible Party	Monitoring/ Review Process
Objective 6: Timeliness of Services				
J: SB1291 – Foster Youth Monitor all Foster Youth to ensure all approved authorizations for requests for services are being provided services timely within the MHP.	The MHP's goal is to ensure 95% all approved Foster Youth authorizations for requests for services are meeting the timeframes set by SB1291 and Network Timeliness Standards for services. 18/19 – 158/164 – 96% **Evaluation of 18/19**: The MHP created a streamlined process to ensure communication of the approval process and communicating appointment to youth staffing. This provided a compliance of 96%. **Goal for FY 18/19:** MHP will continue to track and monitor all approved Foster Youth requests for services and that they are receiving services within the appropriate timeframes.	1. Track and trend services to Foster Youth to ensure those services are provided within the required timeframes. 2. Report results for review and evaluation to QIC including Providers.	QPM Division	Monthly / Quarterly / Annually