SAN BENITO COUNTY
BEHAVIORAL HEALTH

# Quality Improvement Work Plan

## Mental Health and Substance Use Disorder Services

## Fiscal Year 2017-2018

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# I. QUALITY IMPROVEMENT PROGRAM OVERVIEW

## A. Quality Improvement Program Characteristics

The function of the San Benito County Behavioral Health (SBCBH) Quality Improvement (QI) Mental Health (MH) and Substance Use Disorder (SUD) Work Plan (referred to as the "SBCBH 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), Quality Leadership Committee (QLC), 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
- Behavioral Health Advisory Board (BHAB) review
- Review of consumer and provider complaints
- Review of special incidents
- Periodic clinical training

The SBCBH 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 SBCBH 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 SBCBH 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 SBCBH 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.

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 the SBCBH Director.

### B. Annual Work Plan Components

The SBCBH 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 SBCBH 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 through data analysis; and
4. Activities for sustaining improvement.

The QI Work Plan is posted on the SBCBH website; and is also available upon request. It is also provided to the External Quality Review Organization (EQRO) during its annual review of the SBCBH system, and to the Department of Health Care Services (DHCS) 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 QI Program. QIC members participate in the planning, design, and execution of the QI Program, including policy setting and program planning. The SBCBH QI Work Plan addresses quality assurance/improvement factors as related to the delivery of culturally-competent MH and SUD services.

### C. 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. SBCBH has established two (2) committees that include representation from the MHP (licensed MH clinicians, licensed and/or certified SUD counselors, 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)/Compliance Committee is charged with implementing the quality improvement activities of the agency. Quarterly, 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). In addition, the QIC is charged with ensuring that Medi-Cal and Drug Medi-Cal services are billed appropriately and in compliance with all state and federal regulations. The QIC recommends policy decisions; reviews and evaluates the results of QI activities; and monitors the progress of the PIPs. The QIC documents all activities through dated and signed minutes to reflect all QIC decisions and actions.

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

Specific responsibilities of the QIC include, but are not limited to, the following:

- Review quality of care concerns
- Collect and analyze consumer survey responses
- Be a resource to individual programs
- Report data collection and outcome monitoring activities to Behavioral Health to improve system performance
- Formulate corrective action plans as necessary to improve consumer-driven care
- Plan, develop, and implement PIPs
- Review and update the Implementation Plans for Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS)
- Initiate corrective action plans adopted by the QIC to improve consumer access to services and quality of care
- Review and recommend action regarding issues involving:
    - High-risk and individuals with high utilization of services
    - Unresolved clinical issues
    - Unresolved complaints
    - Evidence of treatment that is not within professional or ethical standards
    - Denials of service
    - Treatment that appears to be inadequate or ineffective
    - Utilization of inpatient and IMD services
- Identify and address systems issues
- Monitor grievances and appeals
- Promote consumer and family voice to improve wellness and recovery
- Develop strategies to integrate health and behavioral health care throughout San Benito County
- Review Katie A./CCR service activities and assess outcomes

Designated members of the QIC include the SBCBH Director; the QI Supervisor; representatives from MH, SUD, Access Team, Crisis, Medication Support, and Fiscal; contract providers; Patient Rights advocate; and client/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.
SBCBH procures contracts with individual, group, and organizational providers, SUD treatment providers, and for psychiatric inpatient care. As a component of these contracts, these entities are required to cooperate with the QI program and allow access to relevant clinical records to the extent permitted by state and federal laws.

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

*QIC Subcommittee*: Management staff meet as a subcommittee of the QIC Committee to discuss QI related topics on a more frequent basis than the quarterly meetings. This subcommittee discusses topics such as Medi-Cal documentation; electronic health record implementation; preparing and responding to state and federal reviews; critical incidents; and other pertinent QI activities. A summary of these activities is shared with the QIC and QLC members.

2. The Quality Leadership Committee (QLC) is integrated into the QIC Program through involvement in a general oversight and evaluation capacity. Members include clients, family members of clients, community representatives, external service providers of care, a psychiatrist, and representatives of other agencies. The QLC reviews summaries of data and other critical information provided through the QIC functions, including number of clients served, service utilization patterns, and significant incidents and trends that allow the QLC to evaluate the overall quality of care and service delivery of SBCBH services.

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

# II. QI 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 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 QI Evaluation Activities

1. Quality Improvement Committee (QIC): The monthly QIC meetings may include, but are not limited to, the following agenda items:
    - Address QIC action items, recommended policy and system-level changes, and assignments from last QIC meeting
    - Review and evaluate summary results of QI activities, including progress on the development and implementation of the PIPs
    - Review Access Log for MH and SUD timeliness and access standards
        - Review calendar days for first appointment
        - Assess response for urgent conditions (during regular hours and after-hours)
        - Review requests for cultural/linguistic services and assess results
    - Review Inpatient / IMD / Residential programs: census, utilization, and length of stay
    - Review processed TARs for utilization and documentation compliance
    - Review medication monitoring process to assure appropriateness of care
    - Review DMC-ODS data to analyze access, service utilization, and care coordination across all levels of care
    - Review grievances or appeals (client or provider) for appropriateness of response and trends
    - Review requests for (or results of) state fair hearings
    - Monitor Change of Provider Requests
    - Review Notices of Adverse Benefit Determination (NOAs) for appropriateness, documentation and timeliness compliance, and trends
    - Review UM decisions for quality, timeliness, and utilization management issues
    - Conduct random chart review for quality and appropriateness of client care; timeliness of services; and compliance with documentation standards (assessments, service plans, etc.)
    - Monitor UR Return for Review and Correction process through summary format
    - Review clinical peer reviews and plans of correction for approval or further action
    - Assess client and family satisfaction surveys for access and cultural/linguistic competence issues
    - Discuss Patient's Rights issues

- Review provider satisfaction surveys (annually)
- Review data for client- and system-level performance outcome measures
- Review Compliance and HIPAA/privacy issues
- Other items for discussion
- Recommend identified program policy and system-level changes; assign new action items

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

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

    To assure a complete feedback loop, completed and incomplete action items are identified on the agenda for review at the next meeting. Chart reviews pending further action to implement plans of correction are identified for follow-up and reporting. SBCBH 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 All QI Activities**

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. QI DATA COLLECTION – SOURCES AND ANALYSIS

## A. Data Collection Sources and Types

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

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

## 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 and QLC.

2. The changes to programs and/or interventions are discussed with individual staff, committee members (including consumers and family members), and management. A Plan Do Study Act (PDSA) model of change is utilized to help identify strategies that are effective and appropriate for a larger system application.

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

4. Effectiveness of program changes are evaluated by the QIC and QLC. Input from committees is documented in the minutes. These minutes document the activity, person responsible, and timeframe for completion. Each activity and the status for follow-up are discussed at the beginning of each meeting.

# IV. QI ACTIVITIES, GOALS, AND DATA

The Quality Improvement program for Fiscal Year 2017-2018 includes the following activities, goals, baseline FY 2015-2016 data, and updated FY 2016-2017 data.

**A. Ensure SBCBH Service Delivery Capacity** – Annually, the SBCBH QI program monitors services to assure service delivery capacity in the following areas:

1. Utilization of Services – Mental Health Services
   - Activity: Review and analyze reports from the Kings View Cerner program. The data includes the current number of clients served each fiscal year and the types of mental health services delivered. Data is analyzed by age, gender, ethnicity, primary language, LGBTQ, veterans, and diagnosis; it is compared to the goals set by the QIC for service utilization.
   - Goal: Increase the number of mental health services received by Transition Age Youth (TAY) in FY 2016-2017.
   - FY 2015-2016 Data: There were an average of 13 mental health services received by TAY clients in FY 2015-2016. We will review this data annually to assess improvement in the measure.
   - FY 2016-2017 Data: There were an average of 12 mental health services received by TAY clients in FY 2016-2017. We will review this data annually to assess improvement in the measure.

2. Utilization of Services – Substance Use Disorder Services
   - Activity: Review and analyze reports from the Kings View Cerner program. The data includes the current number of clients served each fiscal year and the types of substance use disorder services delivered. Data is analyzed by age, gender, ethnicity, primary language, LGBTQ, veterans, and diagnosis; it is compared to the goals set by the QIC for service utilization.
   - Goal: This goal will be determined after an analysis of available data to identify significant trends or issues.
   - Data: SBCBH will add this data after the baseline Fiscal Year.

3. Service Delivery Capacity
   - Activity: Staff productivity is evaluated via productivity reports generated by the Kings View Cerner program. Managers/Supervisors receive periodic reports to assure service capacity.
   - Goal: Maintain the number of clients served by Telepsychiatry in FY 2016-2017.
   - FY 2015-2016 Data: Twenty-six (26) clients received Telepsychiatry services in FY 2015-2016. Note: The Telepsychiatrist is Spanish speaking and is able to deliver services in client's preferred language.
   - FY 2016-2017 Data: Thirty (30) clients received Telepsychiatry services in FY 2016-2017. Note: The Telepsychiatrist is Spanish speaking and is able to deliver services in client's preferred language.

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

**B. Monitor Accessibility of Services** – The SBCBH QI program monitors accessibility of services in accordance with statewide standards and the following local goals:

1. Timeliness of routine mental health appointments
   - Activity: This indicator is measured by analyzing a random sample of new requests for services from the Access Log. This data is reviewed quarterly.
   - Goal: Maintain the number of clients referred for mental health services who receive an Assessment appointment within 21 business days.
   - July – December 2016 Data: 317 of the 351 (90.3%) clients referred for mental health services in July – December 2016 received an Assessment appointment within 21 days.
   - FY 2016-2017 Data: 545 of the 630 (86.5 %) clients referred for mental health services in FY 2016-2017 received an Assessment appointment within 21 days.

2. Timeliness of requests for SUD services
   - Activity: Analyze the rate of retention for SUD clients. This indicator is measured by analyzing data from Kings View Cerner on the number of new SUD clients who, after receiving an initial service, return for a second service. This data is reviewed quarterly.
   - Goal: At least 50% of new SUD clients who receive a first service will be retained.
   - Data: SBCBH will add this data after the baseline Fiscal Year.

3. Timeliness of services for urgent or emergent conditions during regular clinic hours
   - Activity: This indicator is measured by analyzing a random sample of urgent or emergent requests for services from the Crisis Log. This data is reviewed quarterly.
   - Goal: Maintain the percentage of business-hours crisis requests with a response time of two hours or less.
   - FY 2015-2016 Data: 477 of the 477 (100%) business-hours crisis requests had a response time of two hours or less in July – December 2016.
   - FY 2016-2017 Data: 337 of the 340 (99.1 %) business-hours crisis requests had a response time of two hours or less in FY 2016-2017.

4. Access to after-hours Emergency services
   - Activity: This indicator is measured by analyzing a random sample of after-hour requests for services from the Crisis Log and/or the Access Log. Data is reviewed quarterly.
   - Goal: Increase the percentage of after-hours crisis requests with a response time of two (2) hours or less by 3% (87.2%).
   - FY 2015-2016 Data: 149 of the 177 (84.2%) after-hours crisis requests had a response time of two (2) hours or less in July – December 2016.

- FY 2016-2017 Data: 153 of the 196 (78.1 %) after-hours crisis requests had a response time of two (2) hours or less in FY 2016-2017.

5. Responsiveness of the 24-hour, toll-free telephone number
   - Activity: 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. This data is reviewed at each quarterly QIC meeting.
   - Goal: The SBCBH after-hours 24-hour telephone service answers the call within one (1) minute. The line is tested monthly.
   - September 2016 – January 2017 Data: Twenty-five (25) test calls were conducted in September 2016 – January 2017, with all 25 (100%) being answered by staff within one (1) minute.
   - February – June 2017 Data: Twenty-six (26) test calls were conducted in February – June 2017, with all 26 (100%) being answered by staff within one (1) minute.

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 the percentage of successful test calls to the toll-free hotline in FY 2016-2017 at the same capacity as in FY 2015-2016.
   - September 2016 – January 2017 Data: Twenty-five (25) test calls were conducted in September 2016 – January 2017, with 20 (80%) that were overall successful.
   - February – June 2017 Data: Twenty-six (26) test calls were conducted in February – June 2017, with 17 (65.4%) that were overall successful.

7. Increasing client access
   - Activity: SBCBH endeavors to improve client access to mental health services, targeting high-need populations. This indicator is measured through an analysis of clients who received FSP services in the fiscal year. This information is reviewed annually.
   - Goal: Increase FSP enrollment by 10% in FY 2016-2017.
   - FY 2015-2016 Data: Seventy (70) clients received FSP services in FY 2015-2016.
   - FY 2016-2017 Data: Seventy-eight (78) clients received FSP services in FY 2016-2017.

**C. Monitor Client Satisfaction** – The QI program monitors client satisfaction via the following modes of review:

1. Monitor Client Satisfaction
   - Activity: Using the DHCS POQI instruments in threshold languages, clients and family members are surveyed twice each year, or as required. This indicator is measured by annual review and analysis of at least a one-week sample. Survey administration methodology will meet the requirements outlined by the CA DHCS. This data is reviewed twice each fiscal year, after the surveys have been analyzed.
   - Goal: Maintain the percentage of consumers/families reporting that they are able to receive services at convenient locations in FY 2016-2017 at the same capacity as in FY 2015-2016.
   - FY 2015-2016 Data: Seventy percent (70.2%) of consumers/families reported that they were able to receive services at convenient locations in FY 2015-2016.
   - FY 2016-2017 Data: Seventy-three percent (72.7%) of consumers/families reported that they were able to receive services at convenient locations in FY 2016-2017.

2. Monitor Youth and/or Family Satisfaction
   - Activity: Utilization of the DHCS, POQI YSS and YSS-F measurement instruments assures the use of instruments that are accepted statewide as the basis for satisfaction surveys. The YSS and YSS-F are collected from youth ages 12 and older and the children's families. Survey administration methodology will meet the requirements outlined by the CA DHCS. This data is reviewed after each survey administration.
   - Goal: Maintain the percentage of consumers/families reporting overall satisfaction with services provided in FY 2016-2017 at the same capacity as in FY 2015-2016; and continue year-to-year trending of the data.
   - FY 2015-2016 Data: Eighty-three percent (82.8%) of consumers/families reported overall satisfaction with services provided in FY 2015-2016.
   - FY 2016-2017 Data: Seventy-two percent (71.6 %) of consumers/families reported overall satisfaction with services provided in FY 2016-2017.

3. Monitor Beneficiary Grievances, Appeals, and State Fair Hearings
   - Activity: All processed beneficiary grievances, expedited appeals, standard appeals, and fair hearings are reviewed at QIC meetings. Monitoring is accomplished by ongoing review of the Grievance Log for adherence to timelines for response. In addition, the nature of complaints and resolutions is reviewed to determine if significant trends occur that may influence the need for policy changes or other system-level issues. This review includes an analysis of any trends in cultural issues addressed by our clients. This information is reviewed quarterly, as available.
   - Goal: The MHP will respond in writing to 100% of all grievances within 60 calendar days from the date of receipt.

- FY 2015-2016 Data: There were four (4) grievances in FY 2015-2016, with 100% responded to within 60 calendar days from the date of receipt.
- FY 2016-2017 Data: There were nine (9) grievances in FY 2016-2017, with 100 % responded to within 60 calendar days from the date of receipt.

4. Monitor Requests to Change Providers
   - Activity: Quarterly, patterns of client requests to change practitioners/providers are reviewed by the QIC. Measurement is accomplished by review of QIC minutes summarizing activities of the Access Team and through annual review of the Change of Provider Request forms.
   - Goal: Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their Change of Provider requests.
   - FY 2015-2016 Data: Quarterly, reviewed patterns of Requests for Change of Provider to look for trends. No issues were identified.
   - FY 2016-2017 Data: Quarterly, reviewed patterns of Requests for Change of Provider to look for trends. No issues were identified.

5. Inform Providers of Survey Results
   - Activity: The results of client and family satisfaction surveys are routinely shared with providers. Monitoring is accomplished by review of the results of the POQI surveys as related to clients who have received services from contract specialty mental health service providers. Survey results are shared with staff, consumers, family members, QIC, QLC, 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 clients and their families. This process is reviewed annually.
   - Monitor the percentage of providers who report satisfaction with SBCBH policies and monitoring activities.
   - Goal: Survey results are to be shared with identified stakeholders.
   - FY 2015-2016 Data: Survey results were shared with staff, consumers, family members, QIC, QLC, and the Behavioral Health Advisory Board in FY 2015-2016.
   - FY 2016-2017 Data: Survey results were shared with staff, consumers, family members, QIC, QLC, and the Behavioral Health Advisory Board in FY 2016-2017.

6. Monitor Cultural and Linguistic Sensitivity
   - Activity: In conducting review in the above areas, analysis occurs to determine if cultural or linguistic issues may have influenced results. Surveys will be provided in English and in Spanish. This process is reviewed annually.
   - Goal: Maintain the percentage of consumers/families reporting that staff were sensitive to their cultural/ethnic background in FY 2016-2017 at the same capacity as in FY 2015-2016.
   - FY 2015-2016 Data: Seventy-eight percent (77.6%) of consumers/families reported that staff was sensitive to their cultural/ethnic background in FY 2015-2016.

- FY 2016-2017 Data: Sixty-six percent (65.6%) of consumers/families reported that staff was sensitive to their cultural/ethnic background in FY 2016-2017.

**D. Monitor the Service Delivery System** – The QI program monitors the SBCBH service delivery system to accomplish the following:

1. Review Safety and Effectiveness of Medication Practices
   - Activity: Annually, meaningful issues for assessment and evaluation, including safety and effectiveness of medication practices and other clinical issues are identified. Medication monitoring activities are accomplished via review of at least ten (10) percent of cases involving prescribed medications. These reviews are conducted by a person licensed to prescribe or dispense medications. In addition, peer review of cases receiving clinical and case management services occur at QIC meetings. An analysis of the peer reviews occurs to identify significant clinical issues and trends.
   - Goal: Continue to conduct medication monitoring activities on 10% of medication charts.
   - FY 2015-2016 Data: 50 medication charts were reviewed for medication monitoring activities in FY 2015-2016.
   - FY 2016-2017 Data: 67 medication charts were reviewed for medication monitoring activities in FY 2016-2017.

2. Identify Meaningful Clinical Issues
   - Activity: Quarterly, meaningful clinical issues are identified and evaluated. Appropriate interventions are implemented when a risk of poor quality care is identified. Monitoring is accomplished via review of QIC minutes for satisfactory resolutions in the areas of grievances, medication monitoring, and peer chart review cases where plans of correction are requested. Re-occurring quality of care issues are discussed in staff meetings and at the QIC to address concerns in a timely manner.
   - Goal: Clinical staff participate in at least two (2) clinical trainings each year.
   - FY 2015-2016 Data: Staff participated in 46 clinical trainings in FY 2015-2016.
   - FY 2016-2017 Data: Staff participated in 58 clinical trainings in FY 2016-2017.

3. Review Documentation and Medical Records System
   - Activity: Client documentation and medical records system fulfills the requirements set forth by the DHCS and San Benito County Specialty Mental Health Services Contract requirements. Documentation of the client's participation in and agreement with their client treatment plan will be included. When the client is unavailable for signature or refuses signature, the client treatment plan includes a written explanation of the refusal or unavailability. Signatures of the individual providing service or the team/representative providing services are recorded.
   - Goal: Maintain the percentage of completed and signed Treatment Plans in FY 2016-2017 at the same capacity as in FY 2015-2016.

- FY 2015-2016 Data: 875 of the 999 (87.6%) Mental Health Treatment Plans due in FY 2015-2016 where completed and signed.
- FY 2016-2017 Data: 788 of the 942 (83.7 %) Mental Health Treatment Plans due in FY 2016-2017 where completed and signed.

4. Maintain Efficient Workflow Standards
   - Activity: Office and billing workflow standards are implemented and maintained to efficiently and consistently serve clients from first contact through discharge, and bill correctly and consistently. Workflow processes are documented and implemented through policies and procedures. Monitoring is conducted through annual review of related policies and procedures; and updated as necessary.
   - Goal: The review of billing and workflow policies and procedures occurs annually, as scheduled, and that procedures are updated as necessary.
   - FY 2015-2016 Data: 100% of workflow and billing policies and procedures were reviewed. Updates were made as needed.
   - FY 2016-2017 Data: 100% of workflow and billing policies and procedures were reviewed. Updates were made as needed.

5. Assess Performance
   - Activity: Quantitative measures are identified to assess performance and identify areas for improvement, including the PIPs and other QI activities. SBCBH monitors both under-utilization of services and over-utilization of services. The BH Director reviews data on the percentage of billable services (productivity reports). These areas are measured through the quarterly review of the timeliness of assessments and treatment plans; completeness of charts; client surveys; and productivity reports. The results of these reviews dictate areas to prioritize for improvement.
   - Goal: Maintain the percentage of billable services delivered by service delivery staff in FY 2016-2017.
   - FY 2015-2016 Data: 52% of services delivered by staff were billable services in July – December 2015.
   - FY 2016-2017 Data: 26% of services delivered by staff were billable services in FY 2016-2017.

6. Support Stakeholder Involvement
   - Activity: Staff, including licensed professionals, paraprofessionals, providers, clients, and family members review the evaluation data to help identify barriers to improvement. As members of the QLC, 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 Behavioral Health Advisory Board provides input on access and barriers to services. Measurement occurs annually; and is accomplished via review of QIC and QLC minutes and rosters.
   - Goal: Increase attendance at QLC to fill at least one (1) consumer slot at each meeting in FY 2016-2017.

- CY 2016 Data: One (1) consumer slot was filled at approximately 50% of the QLC meetings in calendar year 2016.
- FY 2016-2017 Data: One (1) consumer slot was filled at approximately 50% of the QLC meetings in FY 2016-2017.

7. Conduct Frequent Peer Reviews
   - Activity: SBCBH evaluates the quality of the service delivery by conducting six (6) peer reviews every quarter. Reviews are conducted by staff. Clinical Supervisors review charts annually. Issues and trends found during these reviews are addressed at the QIC meetings.
   - Goal: Maintain 24 client charts to be reviewed by staff annually.
   - FY 2015-2016 Data: 24 client charts were reviewed by staff in FY 2015-2016.
   - FY 2016-2017 Data: 24 client charts were reviewed by staff in FY 2016-2017.

**E. Monitor Continuity and Coordination of Care with Other Providers –** When appropriate, information is exchanged in an effective and timely manner with other providers used by clients.

1. Monitor Coordination of Care
   - Activity: DMC Steering Committee meetings are held to discuss care coordination and 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 providers.
   - Goal: Maintain regular DMC Steering Committee meetings, as evidenced by meeting minutes and tracking action items.
   - Data: SBCBH will add this information after implementation of the DMC-ODS program.

**F. Monitor Provider Appeals**

2. Monitor Provider Appeals
   - Activity: Provider appeals and complaints are reviewed as received by the QIC. A recommendation for resolution will be made to the Behavioral Health Director. The resolution and date of response are recorded in the QIC meeting minutes. The QIC reviews the provider appeals and complaints annually for any trends and addresses these issues.
   - Goal: Monitor the number of TAR appeals in FY 2016-2017.
   - FY 2015-2016 Data: There were three (3) TAR appeals in FY 2015-2016.
   - FY 2016-2017 Data: There were six (6) TAR appeals in FY 2016-2017.

# V. DELEGATED ACTIVITIES STATEMENT

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