GLENN COUNTY
HHSA
HEALTH & HUMAN SERVICES AGENCY

Glenn County
Specialty Mental Health Plan
FY 2023/24
Quality Improvement Work Plan
and FY 2022/23
Work Plan Evaluation

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM AND DESCRIPTION

The Glenn County Specialty Mental Health Plan (GCSMHP) has seven (7) county sites, of which two (2) are drop-in centers and one is a (1) satellite site. The GCSMHP is responsible for authorizing and providing inpatient and outpatient specialty mental health services to Glenn County Medi-Cal clients. The GCSMHP is also responsible for maintaining an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for the services it provides to its clients, and will improve outcomes through structural and operational processes and activities that are consistent with current standards of practice and professional knowledge.

The QAPI Program will conduct performance monitoring activities through the GCSMHP, including but not limited to client and system outcomes; utilization management; utilization review; service authorization; provider appeals; credentialing and monitoring; and resolution of client change of provider requests, grievances, appeals, and expedited appeals. The QAPI Program will also include collection and submission of performance measurement data required by the Department of Health Care Services (DHCS). This QAPI Program written description clearly defines the QAPI Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize areas for improvement. The QAPI Program will be evaluated annually and updated as necessary, to ensure the goals of the GCSMHP are being met, and includes the establishment of a Quality Improvement Committee (QIC).

-Quality Improvement Committee

The Quality Improvement Committee (QIC) is responsible for reviewing and overseeing the quality of specialty mental health services provided to clients. The QIC provides a forum for the GCSMHP providers, staff, consultants, clients, family members, volunteers, Mental Health Advisory Board members, and community members to actively participate in the planning, design, and execution of the QAPI Program by attending various meetings, committees, and staff meetings in which data is reviewed and evaluated. The Compliance and Quality Improvement Manager and the Compliance and Quality Improvement Coordinator share responsibility for the clinical oversight of the QAPI Program, and the Compliance and Quality Improvement Manager convenes the QIC meetings. The QAPI Program is accountable to the GCSMHP Director.

The QIC will recommend policy changes, review, and evaluate the results of QI activities including performance improvement projects (PIPs), institute needed QI actions, ensure follow up of QI processes, and document QIC meeting minutes reflective of its decisions and actions taken. The QIC will also monitor the utilization management (UM) and service authorization processes to ensure that the GCSMHP meets the established standards for authorization decision making or take action to improve performance if the timeframes are not met. The QIC will meet quarterly, for a total of four (4) meetings annually.

QIC activities will include:

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) *Identifying relevant committees internal or external to the GCSMHP to ensure appropriate exchange of information with the QIC.*
4) *Obtaining input from providers, clients, and family members in identifying barriers to delivery of clinical care and administrative services.*
5) *Designing and implementing interventions for improving performance.*
6) *Measuring effectiveness of the interventions.*
7) *Incorporating successful interventions into the GCSMHP operations as appropriate.*
8) *Reviewing client grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required.*

-Chart Review

Chart review activities may occur within the QI Department, QIC, Medication Monitoring, staff meetings, peer chart review, and as necessary. A formal chart review is conducted monthly that includes key QI staff and may include other staff members who are trained on the process.

Chart review will include a minimum annual sample of 10% of open cases. Selection of charts may be random or targeted as necessary. Staff reviewing the charts will use a the CalMHSA developed Utilization Management Tool compliant with 2022 documentation reform standards. Chart deficiencies/problems are noted at the bottom of the Chart Review Checklist and a copy is given to the appropriate staff to correct. An ongoing feedback loop between staff and supervisors is used to track identified chart review issues and to document progress toward resolution over time.

-Service Authorizations

QI staff will monitor and approve out of county authorizations. QI staff will monitor contracted provider, CalMHSA with Acentra Health, who provide concurrent review and authorization of psychiatric inpatient hospitalization requests to ensure that consistent and cost-effective quality services are provided.

-Organizational Providers

All providers are required by contract to meet standards established by the GCSMHP and State and Federal regulations. These standards are detailed in the Glenn County Mental Health (GCMH) Provider Handbook that providers receive with their contract annually. Providers are also required to cooperate with the GCSMHP QAPI Program, and must allow the GCSMHP and other relevant parties to access relevant clinical records to the extent permitted by State and Federal laws. Prior authorization is required for all clients. Data that may potentially be studied includes: access and authorization process, billing, certifications and re-certifications, change of provider requests, chart review, contracts, credentialing, DHCS consumer perception surveys, documentation, grievances/appeals/expedited appeals,

incident reports, notices of adverse benefit determinations (NOABDs), provider appeals, and state fair hearings.

-Performance Improvement Projects

The GCSMHP will conduct a minimum of two Performance Improvement Projects (PIPs) each year, including any PIPs required by DHCS. One (1) PIP will focus on a clinical area and one (1) on a non-clinical area. The GCSMHP will report the status and results of each performance improvement project to DHCS as requested, but not less than once per year.

Each PIP will:

1) *Be designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction;*
2) *Include measurement of performance using objective quality indicators;*
3) *Include implementation of interventions to achieve improvement in the access to and quality of care;*
4) *Include an evaluation of the effectiveness of the interventions based on the performance measures collected as part of the PIP; and*
5) *Include planning and initiation of activities for increasing or sustaining improvement.*

-Practice Guidelines

The GCSMHP will adopt practice guidelines, and disseminate the guidelines to all affected providers and upon request, to clients and potential clients. The GCSMHP will take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other areas to which the guidelines apply will be consistent with the guidelines.

Such guidelines will meet the following requirements:

1) *They are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field;*
2) *They consider the needs of the beneficiaries;*
3) *They are adopted in consultation with contracting health care professionals, and*
4) *They are reviewed and updated periodically as appropriate.*

-System Improvement Committee

The System Improvement Committee (SIC) also provides a forum for the GCSMHP providers, staff, consultants, clients, family members, volunteers, Mental Health Advisory Board members, and community members to review and analyze QI and cultural competency data and information in areas identified as needing improvement, in order to make informed program choices and system improvement. The SIC will recommend policy changes, review and evaluate the results of QI activities including (PIPs, institute needed QI actions, and ensure follow up of QI processes. The SIC will monitor the requirements of the Full-Service Partnership (FSP) program, which is a mandate of the California MHSA to provide integrated mental health and other support services to individuals whose needs are not met through other funding sources. The SIC will review and monitor the provision of services to

all mental health clients and will recommend clients to become a FSP, monitor the percentage of CSS funding used for the FSP program, maintain an accurate FSP client list, ensure mental health staff complete the required paperwork for their FSP clients, and review FSP flex fund and MHSA housing funds access requests for approval or denial. In addition, the SIC will review and provide input on the MHSA annual plan and the MHSA 3-year plan as needed. The SIC will meet quarterly, for a total of four (4) meetings annually.

-Compliance Committee

In coordination with the Compliance Officer, the Compliance Committee (CC) performs vital functions to assure compliance with State and Federal regulations. The CC is responsible for the following compliance activities: Receiving reports on compliance violations and corrective actions from the Compliance Officer, advising the Compliance Officer on matters of compliance violations and corrective actions, advising the Director on compliance matters, advising staff on compliance matters, developing and maintaining the Compliance Plan and policies, ensuring that an appropriate record keeping system for compliance files is developed and maintained, ensuring that compliance training programs are developed and made available to employees annually and that such training is documented, ensuring that a developmental review and audit system is developed and implemented to ensure the accuracy of claims documentation and submission process to all payers which includes identifying compliance issues, recommending corrective action, and reviewing the implementation of corrective action. Compliance is also on the agenda and discussed at QIC/SIC meetings. The CC aims to meet monthly, but no less than six (6) times per year.

This committee will review, monitor, and work to ensure the following: Documentation is accurately coded and reflects the services provided, documentation is being completed correctly and in a timely manner, services provided meet medical necessity criteria, and incentives for unnecessary billing do not exist. Monthly data on staff productivity, service data (i.e. procedures used), and service verification information may be reviewed. Medi-Cal Denial Reports help to identify any potential compliance issues and the denials are reviewed and resolved on an ongoing basis as the EOBs are made available by DHCS on ITWS. Health Insurance Portability and Accountability Act (HIPAA) is a standard agenda item for this committee and we will continue to keep informed of HIPAA requirements impacting the GCSMHP.

-Cultural Diversity and Equity Committee

The Cultural Diversity and Equity Committee (CDEC) monitors the implementation of the GCSMHP Cultural and Linguistic Competence Plan (CLCP). The CDEC is responsible for developing, implementing, and monitoring cultural competency throughout all levels of the agency. Additional responsibilities include reviewing goals and objectives which promote culturally competent services and agency culture as set forth by the CDEC annually. The CDEC will be involved in planning consumer and/or community events which focus on cultural awareness. The CDEC will also review data reports on access, retention, and client outcomes across age, race, ethnicity, gender, income, and town of residence. Recommendations will be made to outreach to disparate groups and to provide presentations to Executive Committee (EC), Mental Health Advisory Board, SIC, and QIC, as needed.

The CDEC may also recommend policy changes to the appropriate committees, review and evaluate the results of the cultural competency activities, institute needed actions as specified by the QIC and SIC, ensure follow up of cultural competency processes, and provide training and awareness building for agency staff and the community. The CDEC meets quarterly.

-Ethnic Services Committee

In coordination with the CDEC, the Ethnic Services Committee (ESC) provides assistance and consultation in the development of linguistically and culturally appropriate services delivered by bilingual/bicultural staff. The ESC intention is to provide better client care, staff care, training, and oversight on all components of the delivery of bilingual services. ESC members meet regularly to coordinate the use of language services, such as identifying people who are available to provide translation and interpretation on an ongoing basis. The ESC also provides an opportunity for bilingual staff to come together and ask questions, discuss how others are translating complex mental health terms, and ensures consistency across all interpreters. This helps to improve the quality of care and standardize language for our clients, staff, and psychiatrists. ESC is also tasked with implementing actions identified and recommended by the Cultural Diversity and Equity Committee, as well as the External Quality Review Organization (EQRO) and the Department of Health Care Services (DHCS) reviews and audits. ESC focuses on meeting recommendation deadlines set forth by reviews. ESC also assists in providing the needed trainings identified by the CDEC with the use of its bilingual/bicultural staff members. ESC aims to meet on a monthly basis, but no less than six times per year. The ESC Mission statement is: To reduce disparities and provide equitable services Ethic Services Committee (ESC) provides culturally relevant services that meet consumers cultural and linguistic needs.

-Staff Unit Meetings

Meetings occur at different frequencies depending on the staff and program, with most programs meeting at least monthly. These meetings include: All Behavioral Health, Substance Use Disorders Services (SUDS), Mental Health Services, Harmony House Adult Drop In Center, Transition Age Youth (TAY) Drop In Center, Promoting Resiliency and Investing in Student Mental Health (PRISM), Katie A., System-wide Mental Health Assessment and Response Team (SMART), Crisis Team (Innovation), Behavioral Health Treatment Court (BHTC) and CARE Court, Case Consultation, Group Supervision, Wellness Teams, Behavioral Health Leadership Team, Program Managers, Case Assignments, Telepsychiatry, Support Staff, and Quality Improvement Team. Many of these meetings include discussions of treatment, culture, primary language, age, gender, and diagnostic issues, which allow training and collaborative problem-solving to take place. Difficult cases are followed closely and frequently, and feedback is used to discuss issues and to assure that quality care is continuously delivered.

Staff meetings provide for a system-wide team approach involving multi-disciplinary staff to help develop appropriate goals based on a client's current medical, psychiatric, psychosocial, and substance use history. These meetings provide a coordinated system of care approach in order to avoid duplication of services regarding the planning, formulation, and development of comprehensive client treatment plans. Referrals are made to physical health care

providers, Substance Use Disorders Services, Probation, Juvenile Hall, Social Services, and other agencies as indicated, to assure coordination and continuity of care and to provide our clients with the highest quality of services available.

-Service Coordination and Service Delivery

It is a value of the GCSMHP to ensure continuity and coordination of care with physical health care providers, Substance Use Disorders Services, Probation, Juvenile Hall, and other departments within the Health and Human Services Agency (HHSA). The GCSMHP will coordinate with other human services agencies and departments used by its clients. Referrals are made to these agencies and departments as necessary, to provide our clients with the highest quality of services available. We have an MOU with AMPLA Health Care, Inc., and we continue to make referrals. The goal of the program is to ensure that persons with mental illness have a medical home, and that physical health outcome indicators show improvement for consumers. The GCSMHP will assess its effectiveness annually.

The GCSMHP utilizes the Contact Log (a Microsoft Access database) and electronic health record for data, reports, and claims, and as mechanisms to detect both underutilization and over utilization of services.

- *Additionally, the GCSMHP now submits the Network Adequacy Certification Tool (NACT) and associated documents to the DHCS annually, as well as the 274 Expansion Project monthly.*

The GCSMHP has implemented the following mechanisms to survey and assess client and family satisfaction:

- *Consumer Perception Surveys are administered at least annually, as required by the DHCS. Results are reviewed by staff in a number of meetings.*
- *QIC quarterly summaries are reviewed to discuss and evaluate the following items: HIPAA complaints; client grievances, appeals, and expedited appeals; state fair hearings; NOABDs; change of provider requests; 24/7 Crisis Line testing; trainings; incident reports; and reports of morbidity and mortality. Results are shared with staff in meetings, by phone, email, and as needed.*
- *Additionally, the GCSMHP submits the quarterly 24/7 test call update report forms, the Annual Beneficiary Grievance and Appeal Report, and any other reports to DHCS as requested. Results are shared with staff as appropriate.*

The GCSMHP has implemented a mechanism to monitor the safety and effectiveness of medication practices, under the supervision of a person licensed to prescribe or dispense prescription drugs, and will occur no less than annually.

- *Medication monitoring is performed using a QIC-approved Medication Monitoring Checklist. The GCSMHP has a contract with a local pharmacist who reviews a minimum annual sample of 10% of all clients receiving medication services. Selection of charts may be random or targeted as necessary. The medication monitoring checklists are shared with medical staff to resolve any issues raised by the medication review and to make appropriate recommendations for responsive action in those cases where psychiatric medication prescribing practices or patterns vary from accepted clinical practices. QI*

staff review the medication monitoring checklists at the end of each fiscal year to take an in depth look at issues noted and to see if trends occur. These medication monitoring checklists are summarized and this information is shared at the next QIC meeting.

The GCSMHP has implemented mechanisms to address meaningful clinical issues affecting clients including:

- *Chart Review, Performance Improvement Projects, Medication Monitoring activities, Utilization Review, and staff meetings.*

The GCSMHP continues to monitor for appropriate and timely intervention of individual occurrences that raise quality of care concerns. The GCSMHP will take appropriate follow up action when an individual occurrence is identified. The results of the intervention will be evaluated by the GCSMHP at least annually.

- *Individual occurrences of potential poor quality may be handled differently, depending on how the occurrence of potential poor quality was identified. Occurrences of potential poor quality may be identified in Chart Review, Performance Improvement Projects, Medication Monitoring activities, Utilization Review, staff meetings, monitoring and auditing activities, or raised by clients and staff. Based on the occurrence that was identified, interventions will be implemented as appropriate, and evaluated at least annually.*

CalAIM

-CalAIM Training Plan

As part of the California Advancing and Innovating Medi-Cal (CalAIM), Glenn County Specialty Mental Health Plan (GCSMHP) commits to provide ongoing training to staff and contracted providers. The multi-year initiative will transform and strengthen behavioral health services to offer a more equitable, coordinated, and person-centered approach to the delivery system. GCSMHP will strive to ensure compliance with CalAIM policy and procedures, as well as implement high-quality, coordinated care for consumers.

GBSMHP utilizes CalMHSA developed tools and resources to support training and education of providers and staff in CalAIM policies and procedures. All staff complete a one-time on-boarding training through the CalMHSA Learning Management System (LMS), and review relevant CalAIM policies annually through the Glenn County managed system, Vector's Targeted Solutions.

Training Topics and Objectives Include:

Screening Tool Training Objectives

Participants of this training will increase their understanding of the following:

1. Access criteria for services
2. When to complete screening activities
3. Why standardized screenings are important

Transition Tool Training Objectives

Participants of this training will increase their understanding of the following:

1. Standardized transition of care tool requirements
2. Benefits of using standardized transition of care tools
3. When to use transition of care tools

Annual review of relevant CalAIM policies include:

- Documentation Requirements for all SMHS, DMC, and DMC-ODS Services
- No Wrong Door for Mental Health Services
- Criteria for Beneficiary Access to Specialty Mental Health Services_Medical Necessity
- Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services

Further support for providers can be accessed in GCSMHP share file system. Documentation guides and other communication materials developed by CalMHSA are available to all providers for reference, and provided via email when updated.

-CalAIM Implementation Plan

In FY 23-24, Glenn County Specialty Mental Health Plan (GCSMHP) will embark on payment reform implementation beginning July 1, 2023. GCSMHP will implement new Current Procedural Technology/Healthcare Common Procedure Coding System (CPT/HCPCS) procedure codes, modifiers, place of service codes, and taxonomy codes. Updates to the CPT/HCPCS system to align with CalAIM payment reform will necessitate updating the county claiming system. GCSMHP has contracted with CalMHSA's electronic health system, SmartCare, and included billing support to ensure compliance with these updates. GCSMHP will begin utilizing the Intergovernmental Transfer agreement protocol.

Continuing from FY 22-23, GCSMHP has been implementing CalAIM behavioral health policy changes including changes to documentation requirements, no wrong door, access criteria, and use of the screening and transition tools. DHCS continues to issue clarifying guidance regarding these policies. GCSMHP will continue to monitor updates from DHCS, and operationalize changes as appropriate to policies, procedures, and workflows.

GCSMHP has partnered with CalMHSA to operationalize CalAIM data exchange goals. The SmartCare system is FHIR API and USCDI compliant. GCSMHP intends to work with CalMHSA for the interoperability solution being developed which will provide GCSMHP a means of exchanging data with relevant entities for care coordination and client access.

As a means of monitoring progress toward these objectives of CalAIM, GCSMHP is participating in the Behavioral Health Quality Improvement Plan (BHQIP) incentive program. BHQIP includes commitment to monitoring three performance improvement projects (PIPs) based on HEDIS measure goals.

- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse of Dependence (FUA)
- Follow-Up After Emergency Department Visit for Mental Illness (FUM)
- Pharmacotherapy for Opioid Use Disorder (POD)

These PIPs will be ongoing until the conclusion of BHQIP which is estimated to have final submission in March of 2024.

UTILIZATION MANAGEMENT (UM) PROGRAM

The Glenn County Specialty Mental Health Plan (GCSMHP) operates a Utilization Management (UM) Program to assure clients have appropriate access to specialty mental health services as required.

The Compliance and Quality Improvement Manager and the Compliance and Quality Improvement Coordinator are responsible for all UM activities, and evaluate medical necessity, appropriateness, and efficiency of services provided to Medi-Cal clients prospectively and retrospectively. Any problems or issues identified by this team will be reviewed in Quality Improvement Committee (QIC). Charts can also be referred for UM by the QIC or any other staff, when there are concerns about the quality of care, specifically the authorization, provision, or documentation of specialty mental health services to a particular client.

The GCSMHP has structured UM activities in accordance to Title 42, CFR, Section 438.210(e), which states that compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any client.

The GCSMHP may place appropriate limits on a service based on criteria applied under the State Plan, such as medical necessity and for the purpose of utilization control, provided that the services furnished are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

-Service Authorization

The Glenn County Specialty Mental Health Plan (GCSMHP) has implemented mechanisms to assure authorization decision making standards are met.

The GCSMHP has and follows written policies and procedures for processing requests for initial and continuing authorizations of services.

- *See Authorization Process for Outpatient Mental Health Services P&P (MH-154).*
- *See Concurrent Review of Psychiatric Inpatient Hospital, Psychiatric Health Facility, Crisis Residential Treatment, and Adult Residential Treatment Services P&P (MH-160).*
- *See Coordination and Continuity of Medi-Cal Specialty Mental Health Services P&P (MH-156).*
- *See Single Case Agreements and Out of Network Access for Outpatient Services P&P (MH-142).*

- *See No Wrong Door for Mental Health Services Policy P&P (BH-1037).*
- *See Criteria for Beneficiary Access to SMHS, Medical Necessity and other coverage Requirements (MH-110).*
- *See Adult and Youth Screening and Transition of Care Tools for Medi-Cal Mental Health Services (MH-166).*

The GCSMHP has mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and will consult with the requesting provider when appropriate.

- *Concurrent Review contracted provider supplies GCSMHSP with portal which allows for review of specific and aggregated UM data.*
- *QI Staff maintain a log of SAR requests and approvals in and out of county which captures all pertinent information including CIN, client name, authorized service, and dates of authorization.*
- *QI Staff maintain a log of all continuity of care agreement requests which captures all pertinent information including CIN, client name, authorized service, and dates of authorization.*
- *Presumptive Transfers are monitored through the CalMHSA Presumptive Transfer Portal, as well as a back-up log maintained by QI Staff of in and out of county presumptive transfer youth.*

All logs and reports are periodically monitored by the QI Manager and provided to other program managers as needed for system and quality review.

Any decision made by the GCSMHP to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a health care professional who has appropriate clinical expertise in treating the client's condition or disease.

- *All authorizations of specialty mental health services decisions are made by licensed or waivered GCSMHP staff, using the statewide medical necessity criteria, the Mental Health Assessment, and any other relevant clinical information. The assessment is used to document the client's medical necessity and symptomology and also document relevant information when the client does not meet medical necessity. A denial of services based upon medical necessity is clearly documented in the chart. The State required transition of care tool is used when client's do not meet SMHS criteria, and may benefit from NSMHS through their managed care provider.*

GCSMHP will notify the requesting provider, and give the client written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

- *See Notices of Adverse Benefit Determination P&P (MH-104).*
- *As required by the State Department of Health Care Services (DHCS), the GCSMHP will send a Notice of Adverse Benefit determination when denying or limiting a service authorization. Information about the Client Problem Resolution Process, which includes grievances, appeals, expedited appeals, and state fair hearings, will also be included with any written notice of adverse benefit determination for lack of timely service.*

For standard authorization decisions, the GCSMHP will provide notice as expeditiously as the client's condition requires not to exceed fourteen (14) calendar days following the receipt of the

request for the service, with a possible extension of up to fourteen (14) additional calendar days when:

- *The client, or the provider, requests extension, or*
- *The GCSMHP justifies (to the department upon request) a need for additional information and how the extension is in the client's interest.*

  - ***The following are the GCSMHP and statewide timeliness standards:***
    - *Clients requesting non-hospital specialty mental health services will be seen within ten (10) business days of request for services, and authorized within sixty (60) days.*
    - *Clients requesting medication services will be seen within fifteen (15) business days of request for services.*
    - *Clients requesting urgent or emergent services will be seen and authorized within one (1) hour.*
    - *Authorizations for services for adopted KINGAP or AAP children or youth placed outside of his/her county will be made within three (3) business days following the date of request for service and will notify the host county and the requesting provider of the authorization decision. If the GCSMHP documents the need for additional information to evaluate the client's need for the service, an extension may be granted up to three (3) business days from the date the additional information is received, or fourteen (14) calendar days from the receipt of the original Treatment Authorization Request, whichever is less. The GCSMHP must arrange reimbursement for the services provided to the child or youth within thirty (30) calendar days of the date of authorization of service.*
    - *Day Treatment and Day Rehabilitation services must be preauthorized and will be authorized upon receipt and review of the Request for Utilization Review Authorization of Services packet.*

For cases in which a provider indicates, or the GCSMHP determines, that following the standard timeframe could seriously jeopardize the client's life or health or ability to attain, maintain, or regain maximum function, the GCSMHP will make an expedited authorization decision and provide notice as expeditiously as the client's health condition requires and no later than 72 hours after the receipt of the request for service. The GCSMHP may extend the 72-hour time period by up to fourteen (14) calendar days if the client requests an extension, or if the GCSMHP justifies (to the department upon request) a need for additional information and how the extension is in the client's interest.

The GCSMHP will act on an authorization request for treatment for urgent conditions within one hour of the request.

The GCSMHP will not require prior authorization for an emergency admission for psychiatric inpatient hospital services, whether the admission is voluntary or involuntary. The Contractor that is the MHP of the client being admitted on an emergency basis will approve a request for payment authorization if the client meets the criteria for medical necessity and the client, due to a mental disorder, is a current danger to self or others, or immediately unable to provide for, or utilize, food, shelter or clothing.

The GCSMHP may not require prior authorization for an emergency admission to a psychiatric health facility when the client has an emergency psychiatric condition.

The GCSMHP will authorize out of network services when a client with an emergency psychiatric condition is admitted on an emergency basis for psychiatric inpatient hospital services or psychiatric health facility services.

The GCSMHP will define service authorization request in a manner that at least includes a client's request for the provision of a service.

If the GCSMHP's provider network is unable to provide necessary services to a particular client, the GCSMHP will adequately and timely cover the services out of network, for as long as the GCSMHP's provider network is unable to provide them.

The GCSMHP will require that out-of-network providers coordinate authorization and payment with the GCSMHP. The GCSMHP must ensure that the cost to the client for services provided out of network pursuant to an authorization is no greater than it would be if the services were furnished within the GCSMHP's network.

The GCSMHP will permit Indian clients who are eligible to receive services from an Indian health care provider (IHCP) participating as a network provider, to choose that IHCP as his or her provider, as long as that provider has capacity to provide the services.

-Provider Network

The GCSMHP has implemented mechanisms to assess the capacity of service delivery for its clients. This includes monitoring the number, types, and geographic distribution of mental health services within the GCSMHP delivery system.

- *The Contact Log (a Microsoft Access database) and electronic health record serve as the primary mechanisms for monitoring the capacity of the service delivery system. This log and the EHR contain data on all requests for services including requests for mental health services, psychiatric services, and urgent and emergent services (crisis), and allows for Quality Improvement (QI) staff to monitor timeliness of services and the capacity of the service delivery system. The GCSMHP submits the Network Adequacy Certification Tool (NACT) and associated documents to the DHCS annually, which assess the capacity of the service delivery system. Further, the GCSMP submits the 274 expansion project monthly which provides in-depth data on service delivery system.*
- *Penetration rate and service data is reviewed in Quality Improvement Committee (QIC), which shows the number of Medi-Cal beneficiaries in our county and the number we have served. This data also includes the numbers and types of services that are provided.*
- *Weekly case assignments meetings also help to ensure that the GCSMHP is monitoring the service delivery capacity and making changes as necessary.*

The GCSMHP will maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services for all clients, including those with limited English proficiency or physical or mental

disabilities. The GCSMHP will ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal clients with physical or mental disabilities, and ensure that all services are available and accessible to clients in a timely manner. The GCSMHP will adhere to, in all geographic areas within the county, the time and distance standards for adult and pediatric mental health providers developed by DHCS.

-Accessibility of Services

The GCSMHP has implemented mechanisms to assess the accessibility of services within its service delivery area. This includes an assessment of responsiveness of the GCSMHP 24-hour toll-free telephone number, timeliness of scheduling routine appointments, timeliness of services for urgent conditions, and access to after-hours care.

- *The Crisis Line Testing Log serves as the primary mechanism for monitoring the accessibility of the responsiveness of the GCSMHP's 24-hour toll-free telephone number. The GCSMHP utilizes IDEA Consulting to randomly call the 24 hour toll-free telephone number at least three (3) times per month and record the following information: Test call date, time, caller, name given, person answering the call, reason for the call, if the staff member asked if it was a crisis or an emergency, if the caller was linked to interpreter services (if applicable), comments, if the test call was logged, if a crisis note was written, and if the test call passed or failed and if not, the reason why.*
    - *The results of these calls are shared with the Crisis Team supervisor, the staff who took the call, and the Quality Improvement and System Improvement Committees.*
- *The Contact Log (a Microsoft Access database) serves as the primary mechanism for monitoring the accessibility of urgent and emergent mental health and crisis services.*
    - *The Crisis Log within the Contact Log, captures all pertinent information including client #; client name; date of birth; gender; primary language; date of service; service code; contact location; time client contact requested; actual time of contact; end time; time billed to client; business hours; after hours; crisis disposition; crisis worker's name; and crisis comments.*
- *Electronic health record (EHR) and Access database serve as the primary mechanism for monitoring the accessibility of routine mental health services including medication services.*
    - *The CSI Assessment Record within the EHR captures all pertinent information including client #; client name; date of first contact; referral source; assessment appointment 1st/2nd/3rd offer dates; assessment appointment accepted date; assessment start/end dates; medical necessity met (yes/no); treatment appointment 1st/2nd/3rd offer dates; treatment appointment accepted date; treatment appointment start date; close assessment process (successful process, or administrative close); if administrative close, reason, date, and referred to; and signature of staff entering information.*
    - *The Medication Services Referral captures all pertinent information including client #; client name; date of birth; age; caregiver or contact person name; primary phone number; financial eligibility; language; interpreter needed; is this a priority referral due to an inpatient hospitalization/discharge; information about prior psychiatric care; date of first contact; medication evaluation appointment 1st/2nd/3rd offer dates; medication evaluation appointment accepted date; name of assigned psychiatrist;*

appointment location; medication evaluation kept date; medication evaluation closed date; and referral processor scheduling comments.

This information is periodically monitored by the clinical supervisors and managers, and is reviewed quarterly in the Quality Improvement and System Improvement Committees.

FY 2022/23 QUALITY IMPROVEMENT WORK PLAN EVALUATION

-FY 2022/23 Review of Grievances, Appeals, Expedited Appeals, Change of Provider Requests, Notices of Adverse Benefit Determinations (NOABDs), Fair Hearings, Provider Appeals, and Clinical Records Review

Monitoring of these activities occurred monthly and the results were reviewed in quarterly Quality Improvement Committee (QIC) meetings.

- **Twenty-two (22) Grievances**
  - *Quality of Care*
  - *Quality of Care/Access to Care*
- **Zero (0) Appeals**
- **Zero (0) Expedited Appeals**
- **Forty-Two (42) Change of Provider Requests**
  - *(4) Gender Preference*
  - *(22) Little/No Connection*
  - *(2) Little/no connection and Gender Preference*
  - *(1) Gender preference and Scheduling Difficulty*
  - *(1) Scheduling Difficulty*
  - *(6) Scheduling Difficulty and Little/no connection*
  - *(5) Staff/Client Conflict*
  - *(1) Declined to State*
  - *NOTE: 8 of the requests were not assigned to new provider, after communication with client, the client decided to keep current provider.*
- **Thirty-Five (35) NOABDs**
  Thirteen (13) MH NOABDs Encl. 4: Delivery System Notices (9 English, 4 Spanish) 9 of those were referred to Mild to Moderate (6 Youth 3 Adults)
  Twenty-two (22) MH NOABD Encl. 7: Timely Access Notice (19 English, 3 Spanish) (16 Psychiatry)
- **Zero (0) Fair Hearings**
- **Zero (0) Provider Appeals**

- **Clinical Records Review** occurs monthly, and the results are documented in the monthly chart review summaries and reviewed in quarterly QIC.

-FY 2022/23 Service Delivery Goals

- Increase provision of therapy and rehabilitation outpatient groups to adults and youth. One adult rehab group was offered 4x a year in FY 21/22, GCBH aims to increase this to one adult therapy group offered 2x a year, and 2 rehab groups offered 4x a year. For youth, two therapy groups were offered, and 3 ongoing rehab groups in FY 21/22. GCBH aims to increase this to 3 therapy groups and 4 rehab groups for youth.

In FY 22/23, Glenn County MHP adult services offered 4 therapy groups, and 2 rehab groups which ran for twelve weeks four times a year. Youth services offered 4 therapy groups, and 12 rehab groups.

- Receive infrastructure grant which will allow service expansion of capacity to serve youth and families by average of 12% per year.

  Glenn County was awarded $17 Million Grant through the Department of Health Care Services' (DHCS) Behavioral Health Continuum Infrastructure Program (BHCIP) to develop a new Children's System of Care building.

- Increase the provision of IHBS to the number of youths who qualify for Pathways to Wellness EPSDT services from a baseline of 42% of all qualifying youth in FY 21/22 receiving at least one IHBS service to 60% of all qualifying youth in FY 22/23.

  Available data indicates 34% of qualifying youth received an IHBS service in FY 22/23. *It should be noted to interpret these results with caution due to change in EHR service data is not available for March 2023- June 2023. Inconsistencies in data analysis due to changes in data collection and reporting has created significant likelihood of available data not accurately reflecting services provided.*

-FY 2022/23 Accessibility of Services Goals

- Responsiveness of the 24/7 toll-free Access Line.
  - *The 24/7 toll-free Access Line will be tested with a minimum of three test calls monthly, with **80% of all test calls answered successfully**. All test calls are recorded in the 24/7 Testing Call Log and scored on 5 criteria. In order for a test call to pass, all five criteria must be met.*

87% of test calls were completed successfully.

Timeliness of routine mental health outpatient appointments.

- *80% of clients requesting routine mental health outpatient services will be offered a face-to-face assessment within **ten (10) business days** of the initial request for services.*

85.36% met this goal with an average first non-urgent appointment offered being 6.3 business days.

- *70% of clients requesting routine outpatient services will be seen for a face-to-face assessment within **ten (10) business days** of the initial request for services.*

75.36% met this goal with an average first non-urgent appointment attended being 7.5 business days.

- *70% of clients requesting medication services will be seen for a face-to-face assessment within **fifteen (15) business days** of the initial request for services.*

61.79% met this goal with an average first non-urgent psychiatry services rendered being 18.5 business days.

- Timeliness of services for urgent conditions and access to afterhours care.
  - *90% of clients presenting during business hours in crisis or with an urgent condition will be **seen within one (1) hour**, although all efforts are made to see the client immediately. All clients requesting after-hours crisis and urgent services will call the GCSMHP 24-hour toll-free telephone number. The GCSMHP will have an on-call crisis worker handle the crisis. If the crisis is determined to be a 5150 or in need of a face-to-face evaluation, the client will be seen in person **within one (1) hour**.*

100% of client's presenting during business hours with an urgent condition were seen within 1 hour, with average being 0.06 hours.

-FY 2022/23 Targeted Areas of Improvement, Change in Service Delivery, or Program Design (Strategic Initiatives)

1) Transition to the CalMHSA Semi-Statewide EHR, with a Go Live target date of January 2023. Complete go-live of March 1
2) Finalize and execute a contract for our afterhours crisis services with Sierra Mental Wellness Group. Complete
3) Continuing to develop CalAIM deliverables, in partnership with CalMHSA, and implementing new policies and procedures related to CalAIM. Complete-BHQIP successful submissions 9/2022 and 3/2023
4) Finalizing a needs assessment from our Behavioral Health Continuum Infrastructure Project (BHCIP) Planning Grant, and preparing to apply for the next round of funding targeting youth and family program infrastructure. Complete
5) Starting initial planning with Partnership Health as they will become the new Managed Care Medi-Cal plan in Glenn County. Complete
6) Exploring DMC-ODS options for our county and how this will be affected by the change to Partnership Health by 2024. Ongoing
7) Purchase use of Mobile Crisis Vehicles, large enough to conduct direct services from, through use of the Crisis Care Mobile Units grant. Complete
8) Beginning initial planning with our county Public Guardian and County Counsel offices to update LPS processes, plan for in-county restore to competency for misdemeanors, Murphy Conservatorship, and begin Care Court planning. Ongoing
9) Improve data collection and plan for service delivery next school year with our MHSSA program. Complete
10) Assist the Glenn County Office of Education with utilization of Student Behavioral Health Incentive Program (SBHIP) funds to further enhance school-based services in Glenn County. Complete

-FY 2022/23 Performance Improvement Projects

- **Improving FSP Services** (Clinical PIP)

This PIP's goal is to improve treatment outcomes for our FSP youth consumers by incorporating animal assisted intervention into group process using WRAP curriculum.

Provisional findings indicate positive impact on retention rates of FSP youth. Additional intervention may be warranted to increase initial engagement of FSP in groups for future PAWS groups. Further analysis on barriers to completion of PROMIS outcome measures is needed to inform future group procedure for gathering accurate data.

- **CalAIM BHQIP** (Non-Clinical PIP)

This PIP aims to improve follow-up care after emergency department visit for beneficiaries with primary presentation reason of mental health diagnosis through improved care coordination with hospital, managed care plans, and other community medical services.

Two process measures were monitored in this ongoing PIP

- Number of successful data exchanges with the MCP
- Number of referrals received through the referral tracking system and % complete

Of the 11 exchanges, 8 were received successfully for a success rate of 73%. Neither MCP has yet been able to successfully return demographic, diagnostic, or service data.
As of June 22, 2023, this PIP is in process, and continues to be monitored with interventions actively being implemented. To date, preliminary process measure data shows improvement to the baseline measure of FY 21-22 which included 1 direct referral for MH services provided to the MHP by the local hospital, in FY 22-23 Glenn County has received 5 MH short referrals since December 2022 when the ED began use. 20% of these referrals followed through with completing an assessment. While this may seem like low utilization, it represents expected numbers based on prior year service utilization data from DHCS. Looking at the FUM baseline data total ED visits for Mental Illness in 2021 was 28.

-FY 2022/23 Cultural and Linguistic Standards

The GCSMHP will promote the delivery of services in a culturally competent manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

The GCSMHP will comply with all provisions of the Cultural Competence Plan submitted and approved by the Department of Health Care Services (DHCS).

The GCSMHP will follow the national standards (below) for culturally and linguistically appropriate services (CLAS) to advance health equity, improve quality, and help eliminate health care disparities.

FY 2023/24 QUALITY IMPROVEMENT WORK PLAN

The Glenn County Specialty Mental Health Plan (GCSMHP) will have a Quality Improvement (QI) Work Plan covering the current contract cycle, with documented annual evaluations and updates as needed. The QI Work Plan will include:

1) Evidence of the monitoring activities including, but not limited to, review of client grievances, appeals, expedited appeals, fair hearings, provider appeals, and clinical records review as required.

2) Evidence that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and client service.

3) A description of completed and in-process QI activities, including performance improvement projects. The description will include:
    a. *Monitoring previously identified issues, including tracking issues over time;*
    b. *Objectives, scope, and planned QI activities for each year; and*
    c. *Targeted areas of improvement or change in service delivery or program design.*

4) A description of mechanisms to assess the accessibility of services within the service delivery area, including the responsiveness of the 24-hour toll-free number, timeliness for scheduling routine appointments, timeliness of services for urgent condition, and access to after-hours care.

5) Evidence of compliance with the requirements for cultural competence and linguistic competence.

OBJECTIVES, SCOPE, AND PLANNED QI ACTIVITIES FOR FY 2023/24

-FY 2023/24 Grievances, Appeals, and Expedited Appeals, Fair Hearings, Provider Appeals, and Clinical Records Review

Monitoring of these activities will occur monthly and the results will be reviewed in quarterly Quality Improvement Committee (QIC) meetings.

-FY 2023/24 Service Delivery Goals

1) Increase direct service time delivered by case managers evidenced by 10% average increase in productivity of all case managers in the next fiscal year.
2) Increase crisis or unscheduled services provided in field or community locations by 5% over the next fiscal year.

-FY 2023/24 Accessibility of Services Goals

- Responsiveness of the 24/7 toll-free Access Line.
    - *The 24/7 toll-free Access Line will be tested with a minimum of three test calls monthly, with **80% of all test calls answered successfully**. All test calls are recorded in the 24/7 Testing Call Log and scored on 5 criteria. In order for a test call to pass, all five criteria must be met.*

- Timeliness of routine mental health outpatient appointments.
    - *80% of clients requesting routine mental health outpatient services will be offered a face-to-face assessment within **ten (10) business days** of the initial request for services.*
    - *70% of clients requesting routine outpatient services will be seen for a face-to-face assessment within **ten (10) business days** of the initial request for services.*
    - *70% of clients requesting medication services will be seen for a face-to-face assessment within **fifteen (15) business days** of the initial request for services.*

- Timeliness of services for urgent conditions and access to afterhours care.
    - *90% of clients presenting during business hours in crisis or with an urgent condition will be **seen within one (1) hour**, although all efforts are made to see the client immediately. All clients requesting after-hours crisis and urgent services will call the GCSMHP 24-hour toll-free telephone number. The GCSMHP will have an on-call crisis worker handle the crisis. If the crisis is determined to be a 5150 or in need of a face-to-face evaluation, the client will be seen in person **within one (1) hour**.*

-FY 2023/24 Targeted Areas of Improvement, Change in Service Delivery, or Program Design *(Strategic Initiatives)*

- Complete a needs assessment in preparation for mobile crisis implementation
- Review PEI programs and advocate for continued flexibility of MHSA dollars to prepare for MHSA modernization
- Explore options for contracting patient's rights advocate duties as part of AB2275 requirement for hearings with emergency department
- Work with local partners to increase Glenn County capacity to serve beneficiaries in need of opioid related treatement through participation in the Opioid Consortium
- Pilot first full year of Glenn County fatality review board as part of suicide prevention plan.
- Expand peer delivered services with certified peer service specialists.
- Develop capacity to comply with interoperability goals of CalAIM though technological advancement and continued staff education.
- Monitor outcomes as a pilot county for CARE Court, and provide feedback and advocacy to inform larger state-wide implementation.
- Expand housing opportunities through BHBH project.
- Expand crisis continuum of care to better meet needs of beneficiaries.
- Refine closed loop referral process with schools, expand network of providers for schools to refer non-Medi-Cal beneficiaries.
- Expand threat assessment into schools using community-based threat assessment model.
- Break ground on new Children's System of Care Building.

-FY 2023/24 Performance Improvement Projects

- **PAWS to Improve FSP Outcomes** (Clinical PIP)

  This PIP's goal is to improve treatment outcomes for our FSP youth consumers by incorporating animal assisted intervention into group process using WRAP curriculum, and monitor changes in client's sense of meaning and purpose in their life.

- **Increase Timely Access to Services** (Non-Clinical PIP)

  This PIP is intended to increase beneficiary timely access to assessment by reducing no show rates to first service appointments through the use of access and linkage case management.

-FY 2023/24 Cultural and Linguistic Standards

The GCSMHP will promote the delivery of services in a culturally competent manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

The GCSMHP will comply with all provisions of the Cultural Competence Plan submitted and approved by the Department of Health Care Services (DHCS).

The GCSMHP will follow the national standards (below) for culturally and linguistically appropriate services (CLAS) to advance health equity, improve quality, and help eliminate health care disparities.

-Principal Standard:

- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

-Governance, Leadership, and Workforce:

- Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

- Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in Glenn County.

- Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

-Communication and Language Assistance:

- Offer language assistance to clients who have limited English proficiency (LEP) and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

- Inform all clients of the availability of language assistances services clearly and in their preferred language, verbally and in writing.

- Ensure the competence of staff providing language assistance service, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

- Provide easy to understand print and multimedia materials and signage in the languages commonly used by the populations in Glenn County.

-Engagement, Continuous Improvement, and Accountability:

- Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the GCSMHP's planning and operation.

- Conduct ongoing assessments of the GCSMHP's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.

- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.

- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.

- Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.

- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.

- Communicate GCMHP's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.