LAKE COUNTY
BEHAVIORAL HEALTH SERVICES

Quality Improvement Work Plan and Evaluation Report

Annual Work Plan for FY 2020/2021 and
Evaluation Report for FY 2019/2020

FINAL 10/01/2021

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A. QUALITY IMPROVEMENT PROGRAM OVERVIEW

1. *Quality Improvement Program Characteristics*

Lake County Behavioral Health Services (LCBHS) has implemented a Quality Improvement (QI) program in accordance with state requirements for evaluating the appropriateness and quality of the mental health services system, including monitoring utilization of services; timeliness; access; effectiveness of clinical care; client grievances and appeals; state fair hearings; and provider appeals.

The goal of the LCBHS QI program is to build a structure that ensures the overall quality of services. This goal is accomplished by realistic and effective QI activities and data-driven decision making; collaboration among staff, contract providers, clients, and their family members; and the utilization of technology for data and analysis. Through data collection and analysis, significant trends are identified; and policy and system-level changes are implemented, when appropriate.

QI activities include:

1. Identifying opportunities for improvement;
2. Collecting and analyzing data to measure against goals or identified areas of improvement;
3. Designing and implementing interventions to improve performance;
4. Measuring the effectiveness of the interventions; and
5. Incorporating successful interventions in the system, as appropriate.

The LCBHS QI program is designed to address quality improvement and quality management to ensure that the processes for obtaining services are fair, efficient, and cost-effective; and that they produce results consistent with the belief that people with mental illness may recover.

The QI program is crucial for upholding and monitoring the requirements of state and federal regulations regarding timeliness and quality of care; the Medi-Cal Mental Health Plan (MHP) contract with the California Department of Health Care Services (DHCS); the state plan contract with DHCS for the delivery of Drug Medi-Cal (DMC) services; and the contract between LCBHS and DHCS for the delivery of Substance Abuse Prevention and Treatment Block Grant (SABG) services.

Executive management and program leadership is crucial to ensure that QI activities and findings are used to establish and maintain the overall quality of the service delivery system and organizational operations. As a result, the QI program is directly accountable to the LCBHS Administrator.

2. *Quality Management Committees and Sub-Committees*

a. The Quality Improvement Committee (QIC) is charged with implementing and overseeing the quality improvement activities of the agency. The QIC collects, reviews, evaluates, and analyzes data; and implements actions that frequently involve handling sensitive and confidential information. The QIC recommends policy decisions; reviews and evaluates the results of QI activities; and monitors the progress of QI projects.

- QIC Meeting Frequency – The QIC meets quarterly, for a total of four (4) meetings annually.

- QIC Responsibilities – Specific responsibilities of the QIC include, but are not limited to, the following:
    - Identify and address systems issues
    - Review quality of care concerns and initiate timely interventions to mitigate issues
    - Review and recommend action regarding issues that involve:
        - High-risk clients 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
    - Plan, develop, and implement required Performance Improvement Projects (PIPs)
    - Review and update, as necessary, the Implementation Plan for Specialty Mental Health Services (SMHS)
    - Monitor grievances and appeals
    - Collect and analyze consumer survey responses
    - Promote consumer and family voice to improve wellness and recovery
    - Initiate corrective action plans adopted by the QIC for the purpose of improving access to services and quality of care
    - Report data collection and monitoring activity outcomes to staff, providers, agency partners, Behavioral Health Board and other stakeholders
    - Develop strategies to integrate health care throughout Lake County

- QIC Membership – Designated members of the QIC include the QI Coordinator; management/supervisory staff; clinical staff; case management staff; clerical and support staff; clients; family members; and other stakeholders.

- Agenda – The QIC uses a standing meeting agenda to ensure that all required QI components are addressed at each QIC meeting. The agenda includes at least the following:
    - Review Access Log information
    - Review Clinical Team Meeting Assessments (CANS, PSC, etc.)
    - Review Inpatient / IMD / Residential programs: census, utilization, and length of stay
    - Review processed TARs
    - Review medication monitoring/med chart review process
    - Review grievances and appeals (client or provider), including change of provider requests
    - Review NOABDs
    - Review requests for (or results of) state fair hearings; requests for aid paid pending
    - Conduct chart reviews; monitor any Corrective Action Plans (CAPs)
    - Assess client and family satisfaction surveys
    - Review Performance Improvement Projects (PIPs); progress; and related data
    - Review data for client- and system-level performance outcome measures
    - Review results of Medi-Cal service verification process
    - Review compliance; fraud/waste; patient's rights; and HIPAA/privacy issues
    - Review county and contract provider certification/recertification status; credentialing
    - Review new regulations and standards, including DHCS notices and publications
    - Review and update SMHS Implementation Plan, as necessary (annually)
    - Review provider satisfaction surveys, as necessary (annually)
    - Review results of audits and other reviews (triennial; EQR; SUD)
    - Discuss consumer participation in services, system planning, QIC, etc.
    - Other items for discussion
    - Recommend identified program changes; assign new action items

- QIC Meeting Sign-In Sheet – A Sign-In Sheet is collected at the beginning of each QIC meeting. A Confidentiality Statement is integrated into the QIC sign-in sheet to ensure the privacy of protected health information.

- QIC Meeting Minutes – The QIC uses a meeting minute template to ensure that all relevant and required components are addressed in each set of minutes.
    - Meeting minutes are utilized to track action items and completion dates.
    - Minutes are maintained by designated QI staff and are available for required annual audits and triennial reviews.

- 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 a mechanism to track issues over time. The QIC continuously conducts planning and initiates new activities for sustaining improvement.

- Due to the diverse membership of the QIC, information sharing will not breach client confidentiality regulations consequently, information of a confidential nature will be provided in summary form only.

- ***QIC Sub-Committees***

  - Cultural Competency Committee – This committee identifies cultural variations and satisfaction with/use of services across cultures; identifies culturally-relevant issues surrounding the design and delivery of services; develops staff cultural competency; develops and implements a Cultural and Linguistic Competency Plan; and provides quarterly reports to the QIC and LCBHS Administrator. Meeting minutes are recorded and maintained.

  - Medication Monitoring – This committee meets quarterly and reviews a sample size of the medication services provided by the psychiatrist and/or other medical staff; maintains the medication room safety environment; and monitors medication practices. Results are directly reviewed with the contracted provider, psychiatrist, medication support staff, and the Compliance and QI Coordinator. A summary report is also shared with the QIC.

  - Special Incident Sub-Committee – This committee meets as needed to respond to requests for review of special incidents/unusual occurrences. The committee may initiate and/or conduct a peer review of the event. A Log of Unusual Occurrences is maintained by the QI Coordinator.

b. The Compliance Program Committee is charged with ensuring that Medi-Cal services are billed appropriately and in compliance with all state and federal regulations. Please refer to the *LCBHS Compliance Plan* for the roles and responsibilities of this Committee.

3. Behavioral Health Advisory Board

The Behavioral Health Board (BHB) meets at least six (6) times annually. The members of the BHB include appointed consumers; representative from the Lake County Board of Supervisors; LCBHS Administrator; QI Staff and support staff. The BHB receives information from the QIC and provides feedback on access findings and policy change proposals. The comments from this forum are documented in the meeting minutes and reported back to the QIC to finalize and

policy changes. A QIC member regularly presents information to the BHB to ensure that quality issues are discussed.

4. *Quality Improvement Annual Work Plan Components*

The Annual Work Plan for Quality Improvement activities of LCBHS 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 LCBHS annual QI Work Plan includes at least the following components:

a. 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 service;
b. Objectives and activities for the coming year;
c. Progress on previously-identified issues, including tracking issues over time through data analysis; and
d. Activities for sustaining improvement.

The LCBHS QI Coordinator facilitates the implementation of the QI Work Plan and the QI activities. Sufficient time to engage in QI activities will be allocated to this position (e.g., conducting chart reviews, coordinating Performance Improvement Projects, facilitating the committee, monitoring activities).

The QI Work Plan ensures the opportunity for input and active involvement of clients, family members, licensed and paraprofessional staff, providers, and other interested stakeholders in the Quality Improvement program. QIC members participate in the planning, design, and implementation of the QI program, including policy setting and program planning. The LCBHS QI Work Plan addresses quality assurance/improvement factors as related to the delivery of timely, effective, and culturally-competent specialty mental health services.

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

5. *Accountability*

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

LCBHS contracts with North American Mental Health Services (NAMHS), Locum Tenens, and with hospitals in the region and state for inpatient services. As a component of the contracts,

these entities are required to cooperate with the QI program and allow access to relevant clinical records to the extent permitted by state and federal regulations.

B. DATA COLLECTION – SOURCES AND ANALYSIS

1. Data Collection Sources

Data sources and types may include, but not are limited to, the following (as available):

- Client and service utilization data by type of service, age, gender, race, ethnicity, primary language, veterans, and LGBTQ
- Electronic Health Record (EHR) reports
- Access Log
- Crisis Log
- Test call logs
- Treatment Authorization Requests (TARs) and Inpatient logs
- Service Authorization Request (SAR) logs
- Change of Provider forms and logs
- Client Grievance/Appeal logs; State Fair Hearing logs
- Client and family satisfaction surveys
- Notice of Adverse Benefit Determination (NOABD) forms and logs
- Second Opinion requests and outcomes
- QI Chart Review Checklists (and any corrective action plans [CAPs])
- Medication Chart Review Checklists (and any related CAPs)
- Staff training logs
- Staff productivity reports
- Compliance logs
- Policies and procedures
- QIC and other meeting minutes
- EQR and Medi-Cal Audit results
- Special reports from DHCS or other required studies

2. Data Analysis and Interventions

a. Data analysis is conducted in several ways.
    - Cerner has a number of standard reports which managers and supervisors utilize.
    - LCBHS uses an internal administrative analyst to analyze client- and system-level data to track clients, services, outcomes and costs over time.
    - If there are areas of concern, the QIC discusses the information. Clinical staff may be asked to implement CAPs, as needed.

b. Proposed changes to programs and/or interventions are discussed with individual staff; QIC members (including consumers and family members); Behavioral Health Board members; and management.

- Program changes obtain approval of the LCBHS Administrator prior to implementation.

c. Effectiveness of program changes are evaluated by the QIC.
    - Input from QIC is documented in the meeting minutes, which include the activity, person responsible, and timeframe for completion.
    - Each activity and the status for follow-up are discussed at the beginning of the next meeting.

C. DELEGATED ACTIVITIES STATEMENT

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

D. QI EVALUATION REPORT AND ACTION PLAN – GOALS, DATA, AND INTERVENTIONS

<table>
<tr><th colspan="4">Goal 1: Persons requesting non-crisis mental health services who are new to LCBHS are offered an initial assessment appointment within ten (10) business days of the request</th></tr>
<tr><td>Objective</td><td colspan="3">To monitor timeliness of new requests for routine outpatient mental health services to ensure accessibility</td></tr>
<tr><td>Numerator</td><td colspan="3">Total number of persons requesting mental health services who are new to LCBHS and were offered an initial assessment appointment within 10 business days in a given fiscal year</td></tr>
<tr><td>Denominator</td><td colspan="3">Total number of persons requesting mental health services who are new to LCBHS mental health services in a given fiscal year</td></tr>
<tr><td>Performance Indicator/Target Goal</td><td colspan="3">To offer an initial assessment appointment within 10 business days of request</td></tr>
<tr><td rowspan="3">Data</td><td>Number and percent of new requests who met this standard in FY 2018-2019</td><td>25 requests</td><td>17.9%</td></tr>
<tr><td>Number and percent of new requests who met this standard in FY 2019-2020</td><td>599 requests</td><td>87.8%</td></tr>
<tr><td>Number and percent of new requests who met this standard in FY 2020-2021</td><td>TBD</td><td>TBD</td></tr>
<tr><th colspan="4">Evaluation</th></tr>
<tr><td colspan="4">Analysis: The percent of persons requesting mental health services who are new to LCBHS and who were offered an assessment appointment within 10 business days greatly increased from 17.9% in FY 2018-2019 to 87.8% in FY 2019-2020. LCBHS has improved in this area; however, because timely access is a key component, LCBHS will continue to monitor this goal in FY 20/21.</td></tr>
<tr><td colspan="4">Quality Improvement Action Plan: In FY 20/21, LCBHS will maintain and/or improve the percent of requests that are offered an initial assessment appointment within 10 business days.</td></tr>
<tr><td colspan="4">Planned Interventions:
• Conduct staff training on scheduling new requests for services, with an emphasis on the 10-day standard.
• Provide feedback to staff at monthly staff meetings on the percent of requests that were offered within 10 business days.
• Review staff schedules and block assessment times each week to allow admin staff to schedule appointments within 10 business days.
• Review data weekly with management staff and monthly via QAPI to identify any barriers to meeting the 10-day timeframe; document data review.
• Develop prompt or reminder regarding the 10-day rule on the Access Log; train staff on the updated Access Log.</td></tr>
</table>

Data Source: Access Log**; Frequency:** Quarterly

<table>
<tr><th colspan="3">Goal 2: Increase the number of outpatient mental health services received by Transition Age Youth (TAY)</th></tr>
<tr><td>Objective</td><td colspan="2">To offer TAY engaging outpatient mental health services to increase TAY utilization of services and LCBHS service delivery capacity</td></tr>
<tr><td>Numerator</td><td colspan="2">Total number of outpatient mental health services delivered to TAY in a given fiscal year</td></tr>
<tr><td>Denominator</td><td colspan="2">Total number of TAY clients served in a given fiscal year</td></tr>
<tr><td>Performance Indicator/Target Goal</td><td colspan="2">To maintain to the number of outpatient mental health services received by TAY to at least 20 mental health services per TAY client each year</td></tr>
<tr><td rowspan="3">Data</td><td>Average number of outpatient mental health services received by TAY clients in FY 2018-2019</td><td>20.4 services per TAY client</td></tr>
<tr><td>Average number of outpatient mental health services received by TAY clients in FY 2019-2020</td><td>18.0 services per TAY client</td></tr>
<tr><td>Average number of outpatient mental health services received by TAY clients in FY 2020-2021</td><td>TBD</td></tr>
<tr><th colspan="3">Evaluation</th></tr>
<tr><td colspan="3">Analysis: The average number of outpatient mental health services received by TAY decreased from 20.4 services in FY 2018-2019 to 18 services in FY 2019-2020. Because this population is at high risk, LCBHS will continue to monitor this goal in FY 20/21.</td></tr>
<tr><td colspan="3">Quality Improvement Action Plan: In FY 2020-2021, LCBHS will maintain or increase the number of outpatient mental health services received by TAY at 20 or more mental health services per TAY client per year.</td></tr>
<tr><td colspan="3">Planned Interventions:
Convene a QIC sub-committee around services currently being offered to the TAY population.
Offer staff training on designing services that help engage TAY in services.
Conduct TAY focus groups at least quarterly to generate ideas for TAY activities.
Identify and deliver engaging TAY activities (e.g., hiking, snow sports, weekend trips to regional events, etc.).
Identify TAY activities for TAY and families to create positive experiences (e.g., bowling; evening hiking; picnics; Karaoke).
Develop Peer Mentor positions (0.5 FTEs) to help engage TAY and create engaging TAY activities.</td></tr>
</table>

Data Source: Cerner; **Frequency:** Annually

<table>
<tr><th colspan="4">Goal 3: Ensure timely access to a Medication Assessment</th></tr>
<tr><td>Objective</td><td colspan="3">To monitor timeliness of new referrals to a medication assessment through psychiatry to ensure access to medication services</td></tr>
<tr><td>Numerator</td><td colspan="3">Total number of persons assigned to a psychiatrist who receive a medication assessment within 15 business days of the assignment</td></tr>
<tr><td>Denominator</td><td colspan="3">Total number of persons assigned to a psychiatrist</td></tr>
<tr><td>Performance Indicator/Target Goal</td><td colspan="3">To ensure clients who need to be assessed for medications receive a medication assessment within 15 business days.</td></tr>
<tr><td rowspan="3">Data</td><td>Number of clients who received an on-time med assessment in FY 2018-2019</td><td colspan="2">Data not available</td></tr>
<tr><td>Number of clients who received an on-time med assessment in FY 2019-2020</td><td colspan="2">Data not available</td></tr>
<tr><td>Number of clients who received an on-time med assessment in FY 2020-2021</td><td>TBD</td><td>TBD</td></tr>
<tr><th colspan="4">Evaluation</th></tr>
<tr><td colspan="4">NOTE: This goal is new to the QI Work Plan. LCBHS is currently working with its EHR vendor to develop the means to gather the data needed for this important indicator. The data, time-bound targets, and related plan and interventions will be added at that time. Estimated roll-out is in FY 2020/21 or early FY 2021/22.

Possible Collection Strategies and Data Sources:
• Implement a log specifically for Medication Requests, or add a column on MH Access Log to specify if Medication is requested.
• Upgrade EHR to allow coding of Medication/Psychiatry requests and/or tracking of psychiatry assignment.</td></tr>
</table>

Data Source: TBD; **Frequency:** Annually

<table>
<tr><th colspan="4">Goal 4: Persons assessed for mental health services receive a first service within ten (10) business days of assessment</th></tr>
<tr><td>Objective</td><td colspan="3">Ensure that persons receive a first service within 10 business days of the assessment</td></tr>
<tr><td>Numerator</td><td colspan="3">Total number of persons assessed for outpatient mental health services who received a first service within 10 business days of the assessment in a given fiscal year</td></tr>
<tr><td>Denominator</td><td colspan="3">Total number of clients assessed for outpatient mental health services who received a service in a fiscal year</td></tr>
<tr><td>Performance Indicator/Target Goal</td><td colspan="3">To receive an outpatient mental health service within 10 business days of the mental health assessment</td></tr>
<tr><td rowspan="3">Data</td><td>Number and percent of services that met this standard in FY 2018-2019</td><td>43 out of 83</td><td>51.8% met goal</td></tr>
<tr><td>Number and percent of services that met this standard in FY 2019-2020</td><td>205 out of 354</td><td>57.9% met goal</td></tr>
<tr><td>Number and percent of services that met this standard in FY 2020-2021</td><td>TBD</td><td>TBD</td></tr>
<tr><th colspan="4">Evaluation</th></tr>
<tr><td colspan="4">Analysis: The percent of persons assessed for outpatient mental health services who received a service within 10 business days of a mental health assessment increased from 51.8% in FY 18/19 to 57.9% in FY 19/20. LCBHS has improved in this area; however, because timely access is a key component, LCBHS will continue to monitor this goal in FY 20/21.</td></tr>
<tr><td colspan="4">Quality Improvement Action Plan: In FY 20/21, LCBHS will continue to improve the percent of services that met this standard.</td></tr>
<tr><td colspan="4">Planned Interventions:
• Conduct staff training on scheduling and documenting services within the 10-day standard.
• Instruct staff to call the client 24 to 48 hours before a scheduled service appointment, to remind the client of the appointment.
• Review timeliness data quarterly at QIC meetings and other relevant committees to identify ongoing barriers; improve quality; and provide immediate support, training, and feedback.
• Provide feedback to staff at monthly staff meetings on the percent of persons who received a first service within 10 business days.</td></tr>
</table>

Data Source: Access Log; Cerner; **Frequency:** Annually

Goal 5: Increase Full-Service Partnership (FSP) program enrollment for clients of all ages			
Objective	To increase the number and percent of clients who are enrolled in the FSP program to help improve health, wellness, and recovery.		
Numerator	Number of FSP mental health clients served in a given fiscal year		
Denominator	Total number of all mental health clients served in a given fiscal year		
Performance Indicator/Target Goal	To increase the number of clients who are enrolled in the Full-Service Partnership (FSP) program		
Data	Number and percent of FSP clients in FY 2018-2019	104 of 1,488 clients	7.0%
	Number and percent of FSP clients in FY 2019-2020	121 of 1,462 clients	8.3%
	Number and percent of FSP clients in FY 2020-2021	TBD	TBD

Evaluation

Analysis: The percent of clients who are enrolled in the FSP program increased from 7% in FY 2018-2019 to 8.3% in FY 2019-2020.

Quality Improvement Action Plan: In FY 20/21, LCBHS will continue to increase the number of clients who are enrolled in the FSP program, to ensure that the highest risk clients are receiving the necessary supports and level of care.

Planned Interventions:
- Provide ongoing training to staff to assess all clients for FSP eligibility.
- Train staff around FSP services, case management, and use of flex funds.
- Identify and enroll clients who could benefit from FSP services.
- Provide feedback to staff at monthly staff meetings on the number and percent of persons who are identified as FSP and discuss the types of activities that have helped improve health, wellness, and recovery. Discuss other clients who could benefit from FSP services.

Data Source: Cerner; **Frequency:** Quarterly

Goal 6: Resolve and respond in writing to 100% of all filed grievances within 60 calendar days			
Objective	To evaluate client grievances, appeals, and requests for state fair hearings, to ensure access and quality of care		
Numerator	Number of grievances that were resolved, and client and provider notified in writing, within 60 calendar days of receipt in a given fiscal year		
Denominator	Total number of grievances in a given fiscal year		
Performance Indicator/Target Goal	100% of filed grievances are resolved, and client and provider notified in writing, within 60 calendar days of receipt		
Data	Number of grievances and percent that met standard in FY 2018-2019	10 received	8 / 10 = 80%
	Number of grievances and percent that met standard in FY 2019-2020	12 received	9 / 12 = 75%
	Number of grievances and percent that met standard in FY 2020-2021	TBD	TBD
Evaluation			
Analysis: The percent of grievances that were resolved within 60 calendar days decreased slightly from 80% in FY 18/19 to 75% in FY 19/20.			
Quality Improvement Action Plan: In FY 20/21, LCBHS will increase the percent of grievances that were resolved within 60 calendar days.			
Planned Interventions: • Provide staff training on grievances, appeals, and state fair hearings and how to document and resolve each event. • Review grievances, appeal, and state fair hearings during QIC to evaluate services and develop strategies for improving services.			

Data Source: Grievance and Appeal Log; **Frequency:** Quarterly

Goal 7: Increase the percentage of clients (adults, older adults, and youth) and youths' families reporting overall satisfaction with services			
Objective	Increase the percentage of clients (adults, older adults, and youth) and youths' families who report overall satisfaction with services on the Consumer Perception Surveys (CPS)		
Numerator	Number of clients (adults, older adults, and youth) and youths' families who agreed to the survey question: "Overall, I am satisfied with the services I received"		
Denominator	Number of clients (adults, older adults, and youth) and youths' families who responded to the survey question: "Overall, I am satisfied with the services I received"		
Performance Indicator/Target Goal	Increase the percentage of clients (adults, older adults, and youth) and youths' families who report overall satisfaction with services across the 2 CPS administrations annually		
Data	Number and percent of clients/families who reported overall satisfaction with services in FY 2018-2019	22 of 26	84.6%
	Number and percent of clients/families who reported overall satisfaction with services in FY 2019-2020	16 of 23	69.6%
	Number and percent of clients/families who reported overall satisfaction with services in FY 2020-2021	TBD	TBD
Evaluation			
Analysis: The percent of clients (adults, older adults, and youth) and youths' families who agreed to the survey question: "Overall, I am satisfied with the services I received" decreased from 84.6% in FY 2018-2019 to 69.6% in FY 2019-2020. Because this component is key to gauging quality of care, LCBHS will continue to monitor this goal in FY 2020-2021.			
Quality Improvement Action Plan: In FY 20/21, LCBHS will increase the number and percent of clients (adults, older adults, and youth) and youths' families who report overall satisfaction with services.			
Planned Interventions: • Convene a QIC sub-committee around improving client satisfaction; review full survey results and poll random clients/families to identify possible reasons for dissatisfaction; develop interventions to mitigate the identified reasons. • Offer staff training on engaging clients and providing excellent services that meet client needs.			

Data Source: Completed and combined CPS results; **Frequency:** Twice each year, totaled annually

Goal 8: Delivers services that are culturally sensitive to each client's cultural/ethnic background and in their preferred language			
Objective	To ensure staff deliver services that are culturally and linguistically sensitive to help improve access and quality of care		
Numerator	Number of respondents who agreed to the consumer perception survey (CPS) question: "Staff were sensitive to my cultural/ethnic background" in a given fiscal year		
Denominator	Total number of respondents who responded to the survey question: "Staff were sensitive to my cultural/ethnic background"		
Performance Indicator/Target Goal	To increase and/or sustain the number and percent of CPS respondents who agree to the question: "Staff were sensitive to my cultural/ethnic background"		
Data	Number and percent of respondents who report that staff met this measure in FY 2018-2019	22 out of 26	84.6%
	Number and percent of respondents who report that staff met this measure in FY 2019-2020	9 out of 21	42.9%
	Number and percent of respondents who report that staff met this measure in FY 2020-2021	TBD	TBD

Evaluation

Analysis: The percent of clients who agreed to the survey question: "Staff were sensitive to my cultural/ethnic background" greatly decreased from 84.6% in FY 2018-2019 to 42.9% in FY 2019-2020.

Quality Improvement Action Plan: In FY 20/21, LCBHS will improve the number and percent of clients who agree to the survey question: "Staff were sensitive to my cultural/ethnic background."

Suggested Interventions:

- Train staff on cultural sensitivity and responsiveness.
- Identify cultures and languages that are underrepresented in the county.
- Train staff on strategies for delivering culturally-relevant services to each of the cultural groups in the county.
- Invite members of cultural groups in the county to provide training on improving services and creating culturally-appropriate services.
- Regularly assess and report to the QIC the number of staff who represent each of the primary cultures and languages in the county; develop strategies for hiring individuals to strengthen the diversity of staff.

Data Source: Completed and combined CPS results; **Frequency:** Twice each year, totaled annually

Goal 9: Conduct medication monitoring activities on at least 10% of medication charts each year			
Objective	To assess the safety and effectiveness of medication practices in LCBHS to ensure quality of care		
Numerator	Number of medication charts reviewed in a given fiscal year		
Denominator	Total number of persons receiving medication services in a given fiscal year		
Performance Indicator/Target Goal	To increase the number of medication charts reviewed through medication monitoring to represent 10% the persons receiving medication services.		
Data	Number and percent of medication charts reviewed in FY 2018-2019	80 charts	19%
	Number and percent of medication charts reviewed in FY 2019-2020	80 charts	16%
	Number and percent of medication charts reviewed in FY 2020-2021	TBD	TBD
Evaluation			
Analysis: The percent of medication charts being reviewed was 19% in FY 2018-2019. This number decreased to 16% in FY 2019-2020, but the overall goal was met. Medication monitoring continues to be a focus of LCBHS; as a result, LCBHS will continue to monitor this goal in FY 2020-2021.			
Quality Improvement Action Plan: In FY 20/21, LCBHS plans to meet or exceed the number of medication charts reviewed through medication monitoring activities at 10% of all medication charts to ensure quality of care.			
Suggested Interventions: • Continue to contract with a third-party prescriber (psychiatrist or pharmacist) to complete medication monitoring activities at least quarterly. • Train staff and third-party reviewer on the importance of medication monitoring activities, including target goals. • Review medication monitoring results at QIC at least quarterly; provide feedback to third-party reviewer if goals are not met. • Review contractor budget and revise third-party review schedule as needed and allowed to meet the goal of reviewing 10% of charts.			

Data Source: Cerner; **Frequency:** Annually

Goal 10: Track denial rates to ensure compliance with timely and accurate billing standards	
Objective	Ensure compliance with timely and accurate billing standards
Numerator	Parameters under development
Denominator/Comparison	Parameters under development
Performance Indicator/Target Goal	Goal under development
Data	Baseline data – under development
	Year 2 data – to be added in future updates
	Year 3 data – to be added in future updates
Evaluation	
NOTE: This goal is new to the QI Work Plan. LCBHS is currently working with IT staff to gather the baseline EHR data needed for this important indicator. The data, time-bound targets, and related plan and interventions will be added at that time.	

Data Source: Cerner; **Frequency:** Quarterly