Butte County Department of Behavioral Health

Quality Assurance and Performance Improvement Work Plan

FY 18-19

Introduction

As required by the California State Department of Health Care Services and the Medi-Cal Managed Care Plan, the following document describes the quality improvement activities, goals and objectives for Butte County Department of Behavioral Health for Fiscal Year 2018-19.

The Butte County MHP is responsible for authorizing and ensuring that inpatient and outpatient services are appropriately provided.

The purpose of this Quality Assurance and Performance Improvement (QAPI) Work Plan is to provide up-to-date and useful information that can be used by stakeholders as a resource and practical tool for informed decision making and planning. The work plan consists of the following elements:

I. Quality Management Program Description
II. Annual Quality Management Work plan
III. Goals and Objectives by:
    - Accessibility of Services
    - Service Delivery Capacity
    - Monitoring of Beneficiary Satisfaction
    - Service Delivery System and Meaningful Clinical Issues

I. Quality Management Program Description

Managed Care and Compliance staff are responsible for facilitating the Quality Improvement Committee (QIC) meetings and ensuring participants receive timely and relevant information. In addition, the QIC ensures that scheduled program updates are provided to the director, the executive team, and the leadership team.

The QIC is responsible for monitoring MHP effectiveness. This involves review and evaluation of QI activities, auditing, tracking and monitoring, communication of findings, implementation of needed actions, ensuring follow-up for Quality Improvement (QI) Program processes, and recommending policy or procedural changes related to these activities.

The QIC monitors:

- 24/7 Crisis Line Response
- Accessibility to Services
- Timeliness to Services

- Assessments of Beneficiary and Provider Satisfaction
- Clinical Documentation and Chart Review
- Practice Guidelines
- Credentialing Processes
- Cultural Competency Activities
- Notices of Adverse Beneficiary Determination (NOABD)
- Performance Improvement Projects
- Resolution of Grievances, Appeals, and Fair Hearings
- Resolution of Provider Appeals
- Training
- Utilization Management/Review

The QIC is comprised of representatives from Adult and Children's Services, Access Team, Crisis Services, Medical Services, Mental Health Services Act (MHSA), Managed Care & Compliance, Fiscal, Business Office, Systems Performance, Contracted Providers, Patient Rights, and client/family members.

It is the goal of the QIC to build a structure that ensures the overall quality of services, including detecting both underutilization and overutilization of services. This will be accomplished by realistic and effective quality improvement activities and data-driven decision making; collaboration amongst staff, including beneficiary/family member staff; and utilization of technology for data analysis. Executive management and program leadership must be present in order to ensure that analytical findings are used to establish and maintain the overall quality of the service delivery system and organizational operations.

The QIC meets monthly to monitor the status of the above items and make recommendations for improvement. Meeting reminders, information, and minutes are sent in advance and reflect all activities, reports, and decisions made by the QIC. The QIC ensures that client confidentiality is protected at all times during meetings, in minutes, and all other communications related to QIC activities. QIC meeting minutes are kept in the QI folder on the DBH intranet. Committee minutes are filed in the Quality Management and Compliance Division, and in the QI Folder on the DBH intranet. These are kept for a period of not less than three (3) years, both in digital and hard copy forms.

Each participant is responsible for communicating QIC activities, decisions, and policy or procedural changes to their program areas and reporting back to the QIC on action items, questions, and/or areas of concern. In an effort to ensure that ongoing communication and progress is made to improve service quality, the QIC defines goals and objectives on an annual basis that may be directed toward improvement in any area of operation providing specialty

mental health services.

The Quality Assurance and Performance Improvement Work Plan is evaluated and updated annually by the Quality Assurance Coordinator, QIC, and the Executive Team. The QIC will rely on the input and subject matter expertise of program and other work groups as needed to ensure an appropriate plan is written. In addition, QIC will collaborate with other stakeholders, work groups, and committees including, but not limited to:

- Systems Performance Research and Evaluation Department
- MHP Cultural Competency Committee and all subcommittees
- Compliance Committee
- Billing Department
- Medical Services Staff Meetings
- MHP & Public Guardian Placement Meetings
- MHP Clinical Care Meetings
- MHP Electronic Medical Records
- MHP Leadership Team
- MHSA Advisory Committee
- Organizational Provider Meetings
- Performance Improvement Process Work Groups
- Utilization Review Committee

II. Annual Quality Management Work Plan

The Quality Assurance Coordinator completes an annual QAPI/QI Work Plan. There is an annual evaluation of the overall effectiveness of the QAPI Program activities and whether they have contributed to meaningful improvement in clinical services and in the quality of services provided by the MHP.

The annual QAPI/QI Work Plan allows the MHP to regularly review its QI activities. Each of the four areas of the QAPI Work Plan is reported to the QIC.

Quality Management Chart Review Committee

Chart review activities occur monthly at Quality Management Committee (QM) meetings. The QM committee reviews charts for appropriate treatment and documentation of services being provided by BCDBH and contracted organizational providers. The QM Committee is chaired by the Quality Assurance Coordinator, who reports to the Compliance Officer. The QM committee is

composed of staff from both the adult and youth divisions of BCDBH and may include: Licensed Marriage and Family Therapists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Psychologists, and a Psychiatrist or Pharmacist. The Compliance Officer is a member. All committee members are carefully selected for their ability to evaluate clinical documentation.

Systems Performance and Research Evaluation (SPRE) is responsible for a random selection of 30 consumers. A three-month rotation schedule ensures geographical and provider review: BCDBH North County (Chico & Paradise), BCDBH South County (Oroville and Gridley), and Contractors (Youth for Change, Valley Oak Children's Services, Counseling Solutions, Victor Community Support Services, Northern Valley Catholic Social Services). Programs are queried for consumers based on the rotation schedule. Service cost must accumulate $250.00 or more per consumer and randomly selected consumers had to have received services within the past three months of the data run date. This sample will include clients who have received $2000 or more of services, and will include: Clients using crisis services more than two (2) times in a month, Clients having more than two (2) hospitalizations in a year, a Non-English speaking client and clients who receive Intensive case management services.

The QM committee utilizes the Quality Management Report to review and record the quality of care, clinical practices, and adequacy of clinical documentation. Some of the areas reviewed include evidence of medical and service necessity, timeliness of required assessments and client plans, cultural competence issues, appropriate authorization for services when required, coordination of services, and evidence of improvement in client's quality of life. Clinical chart documentation deficiencies, problems, or concerns, as well as suggestions for changes in the type or modality of care are noted in the QM Report.

Provider charts are also evaluated to insure that established authorization procedures have been adhered to. Required authorization documents and authorization timelines will be reviewed.

Required Corrective Actions are also noted on the QM Report. When chart audit/review is completed, necessary Corrective Action Forms are sent to the appropriate manager for review and distribution to the clinician/counselor who is to complete the corrective actions. Corrections are made by the clinician/counselor and then noted on the Corrective Action Form. The Corrective Action Form is reviewed and co-signed by the program manager or supervisor. The Corrective Action Form is then returned to the QA Coordinator. Corrective Actions reports are used for documentation training purposes.

The Medication Monitoring Checklist is utilized for chart review by the psychiatrist or pharmacist. The Checklist provides a means of peer review for medical staff in which medication and

psychiatric issues for consideration are noted. Chart documentation deficiencies/problems are noted on the Medication Monitoring Checklist and a copy is given to the attending psychiatrist. The attending psychiatrist then returns the Checklist to QA for review by the QM Committee psychiatrist/pharmacist.

Training

The Behavioral Health Training Coordinator oversees department training activities to ensure on going professional development, compliance with regulatory requirements and industry standards, and the effective allocation of resources. The training coordinator works with the Cultural Competency Committee and the Leadership Team to develop an annual training plan. The Training Coordinator maintains and oversees continuing education accreditation and processing provided through three continuing educational boards.

Specific areas of focus include:

- Wellness and Recovery
- Job Specific Training
- E-Learning Management & Reporting
- Leadership and Supervisory Development
- Cultural Competence & Compliance
- Clinical Internship Coordination
- FEMA Training and Compliance

The Training Coordinator reports training activities and plans at the QI Committee meeting.

Organizational Providers

The Butte County Specialty Mental Health Plan contracts with organizational providers (certified by Butte County Behavioral Health) that provide services for the plan's beneficiaries. All providers are required by contract to meet standards established by the Butte County Specialty Mental Health Plan. Before being certified, they must agree to participate in the Quality Improvement (QI) Program and to provide access to relevant clinical records to the extent permitted by State and Federal laws. Contracts for MHSA services identify the need to adhere to the five fundamental philosophies of MHSA in all aspects of planning, development, and implementation of services. Data that may potentially be monitored includes:

- Authorization Processes
- Billing Issues

- Change of Provider requests
- Clinical Documentation and Chart Review
- Service Utilization
- Credentialing
- NOABDs
- Performance Outcome Measures
- Incident and Unusual Occurrence Reports
- Contract Compliance
- Grievances
- Appeals and tracking level of resolution
- State Fair Hearings

A Provider Appeal Process and a Provider Problem Resolution Process are in place as required by the Managed Care Contract with the State Department of Mental Health. These processes provide service providers with an appeal process and problem resolution process that enables providers to formally appeal a decision of the Butte County Department of Behavioral Health Mental Health Plan (MHP) regarding a denied or modified treatment authorization request, a dispute concerning the process or payment of a provider's claim or resolve issues, complaint or concerns a service provider may have.

III. 2017-2018 QI Work Plan Evaluation/Summary

The 2017-2018 Quality Improvement Work Plan looked at these areas of service:

1) **Accessibility of Services**
2) **Service Delivery Capability**
3) **Beneficiary Satisfaction**
4) **Service Delivery System and Meaningful Clinical Issues**

One of the BCDBH QI Work Plan goals continues to be a Performance Improvement Projects (PIP). The Clinical PIP measures whether client outcome measures (CANS and MORS) are utilized to inform treatment planning (**Service Delivery System and Meaningful Clinical Issues**). Last year the PIP workgroup utilized an audit tool for tracking the consistency of the outcome measures (CANS and MORS) with the assessment, diagnosis, and treatment plan. There has been a report generated by our electronic health record to reflect the "golden thread" that links the CANS with the client's diagnosis, outcome measures, and treatment planning into one document (The CANS

Supervision Report) in order to improve consistency throughout the entire client's record. Currently, the data collected is showing an improvement and consistency between the assessment, diagnosis and treatment plan with the CANS outcome measure in our Children's System of Care.

BCDBH has finished a non-clinical PIP this past year and has started a new PIP. The previous non-clinical PIP was designed to measure the timeliness of services (**Accessibility of Services**). The workgroups looked into clinic practices for standardization across the system of care.

- The initial contact logs were updated and are now used consistently at every BCDBH clinic to ensure qualitative outcomes and data collection consistency. The new contact/referral logs were:
    - ✓ MH Request for Service Log
    - ✓ SUD Request for Service Log
    - ✓ Access/Crisis Call Log (Education and grievance information have been added for ease of use.)
- Psychiatric discharges were tracked and system changes have occurred for better data collection and client service (e.g. Crisis Triage Connect Team).

The new non-clinical PIP narrowed down the previous Metrics data to further measure the timeliness of services of psychiatric hospitalization discharges (**Accessibility of Services**). The hospitalization discharge log is being updated to be used for all hospital discharges to ensure qualitative outcomes and data collection consistent. System changes have occurred for better data collection and client service through our Crisis Triage Connect Team. Both PIPs have ongoing monthly workgroups comprised of a diversity of system delivery agents.

Quality Improvement Committee objectives, such as timely resolution of consumer grievances (**Beneficiary Satisfaction**), conducting consumer satisfaction surveys, test calls to the 24/7 crisis line (**Accessibility of Services**), and QM audit results are monitored and reported to the QI Committee monthly meetings at least quarterly by lead personnel in those areas. The Cultural Competency Committee continues to updated their Work Plan (**Service Delivery Capability**) and the MHSA Team has obtained grant funds for innovation projects. The QI Committee is also utilized as a platform to promote new service teams, update existing program innovations and streamlining for better service delivery and referral, and promote member participation and partnership involvement (**Accessibility of Services** and **Service Delivery Capability**). Teams/Programs that have been added to the agenda include our PHF services, SUD services, new Crisis services, Contract Provider services and highlighting changes, Final Rule/Parity

updates to keep all stakeholders informed of system changes.

Other areas of improvement:

- Treatment Authorization Requests (TARs) and Short-Doyle hospitalizations are now tracked in an ACCESS database for timeliness measures (**Accessibility of Services**) but will soon be completed in Avatar for better tracking (with Concurrent Review) and will be part of the Non-Clinical PIP process change.
- A Provider Manual has been created to assist our Contract Providers with the necessary tools and training for continuity of care throughout the system (**Service Delivery Capability**).
- Provider certification and recertification has been formalized/standardized and a manual is being created for monitoring and training (**Service Delivery System and Meaningful Clinical Issues**).
- A new Documentation Manual is being rolled out based on collaborative feedback and frequently asked questions. New sections are included (and trained to) to ensure the new state and federal regulations are known and understood (**Service Delivery System and Meaningful Clinical Issues**).
- Increased chart audits for the PHF and CSU for compliance and training purposes (**Service Delivery System and Meaningful Clinical Issues**).
- Increased Cultural Competency training opportunities (**Service Delivery System and Meaningful Clinical Issues**).
- Monitoring and training of new state and federal grievance/resolution guidelines and NOABDs (**Beneficiary Satisfaction**).
- Establishing a New Employee Orientation (NEO) for new employees for standard methodology and consistency in service (**Service Delivery System and Meaningful Clinical Issues**).

IV. 2018-2019 Goals and Objectives

The following goals and objectives are based upon the four DHCS Managed Care contract requirements for quality improvement work plans:

1. **Accessibility of Services**

   The MHP is responsible for monitoring accessibility of services. In addition to meeting statewide standards, the MHP will set goals for timeliness of routine mental health appointments and urgent care conditions; access to afterhours care; and 24-hour

responsiveness.

2. **Service Delivery Capacity**

   The MHP is responsible for the monitoring of service delivery capacity. The MHP will evaluate the distribution of mental health services by type of service and geography of client within its delivery system.

3. **Beneficiary Satisfaction**

   The MHP is responsible for monitoring beneficiary satisfaction and ensuring that beneficiaries are informed of their rights and the problem resolution process. The MHP reports annually to DHCS on all grievances and appeals and their outcomes. The findings are reported to the QIC for review and implementation of new or revised policies and procedures.

4. **Service Delivery System and Meaningful Clinical Issues**

   The MHP, in partnership with QIC, is responsible to monitor the service delivery system and meaningful clinical issues affecting beneficiaries, including the safety and effectiveness of medication practices. The MHP shall annually identify meaningful clinical issues that are relevant to its beneficiaries for assessment and evaluation.

Accessibility of Services

Address Metrics as Identified by Department of Health Care Services

Lead: QA Coordinator

Strategic Plan Core Issue: *Access, Utilization and Integration; Standardization and Compliance*

Value: Beneficiary outcomes are better with timely access to services.

Goal: Beneficiaries will have timely access to the services they need.

Objective	Measurement	Responsible Entity	Planned Steps and Activities

1. Meet the standard of non-urgent specialty mental health services (SMHS) appointments offered within 15 business days of the initial request by the beneficiary or legal representative. GOAL: 99%
 	
<u>Baseline FY16-17</u>
All: 2.55 days (mean) / 99.65%
Adults: 0.49 days (mean) / 99.77%
Children: 7.43 days (mean) / 99.65%
 	
<u>FY17-18</u>
All: 2.81 days (mean) / 94.75% ↓
Adults: 0.64 days (mean) / 93.09% ↓
Children: 6.01 (mean) / 97.25% ↓
 	
2. Meet goal of 10% acute psychiatric discharges that are followed by a psychiatric readmission within 30 days during a one year period. GOAL: 10%
<u>Baseline FY16-17</u>
All: 13.43%
Adult: 13.97%
Children: 8.62%
	Metrics dashboard will show whether or not we are meeting the required standards.	Systems Performance
		
		Clerical Supervisors
		
		QMD staff
		
		QM Clinician III and Crisis Supervisor
			• Systems Performance will define and standardize method of capturing data.
			• Systems Performance will capture data and report the progress by sites at both the QIC and administrative meetings.
			  ○ Objectives 1-4.
			• Clerical Supervisors will provide ongoing training and monitoring of utilization of forms within electronic health record to capture data.
			  ○ Objective 1
			• Quality Management will utilize tracking system to ensure timeliness of completion of TARS and the timeliness of certification and recertification.
			  ○ Objective 5 & 7
			• Utilize tracking system to identify discharge planning efforts of linking post-hospitalized beneficiaries to outpatient by Crisis Triage Team.
			  ○ Objective 2-4
			• Track the crisis call log to identify language line utilization and quality of calls.

<u>FY17-18</u> All: 12.62% ↓ Adult: 12.86% ↓ Children: 10.81% ↑ 3. Meet goal of 60% eligible acute (psych inpatient and PHF) discharges that receive a follow up outpatient SMHS (face to face, phone or field) within 7 days of discharge. GOAL: 60% <u>Baseline FY16-17</u> All: 36.88% Adults: 35.60% Children: 48.28% <u>FY17-18</u> All: 64.57% ↑ Adult: 63.11% ↑ Children: 75.82% ↑ 4. Increase percentage of acute (psych inpatient and PHF) discharges that receive a follow up outpatient SMHS (face to face, phone or field) within <u>30 days</u> of discharge. <u>Baseline FY16-17: 67%</u> GOAL: 80% FY17-18: 68.43% ↑ 5. Ensure that all TARs are approved or denied within 5 calendar days of receipt. GOAL: 100%			• Training with Crisis Access Line team to review Policy and Procedure #264: Access to 24 hour crisis and urgent care services. • Quality Management Clinician III to administer test calls and report to QI quarterly. • Quality Management Clinician III to meet with Crisis Staff monthly to discuss results and troubleshoot any issues. • Crisis Supervisor will discuss results of test calls in staff meeting and provide re-training as needed. ○ Objective 6 • Report Metrics to QIC quarterly.

Baseline FY14-15: 100% FY16-17: 100% FY1718: 100% 6. Improve the 24/7 access line and language availability to meet DHCS standards. GOAL: 100% Baseline FY14-15: 60% FY16-17: 81% FY1718: 89% 7. All Provider certification and recertification to will meet the standard set by DHCS. GOAL: 0 Baseline FY1415: 0 providers were identified as out of compliance FY1617: 3 providers were identified as out of compliance during the year and reported to DHCS. At end of fiscal year, all were in compliance. FY1718: 5 providers were identified as out of compliance during the year and reported to DHCS. At end of fiscal year, all were in compliance.			

Service Delivery Capacity

Cultural Competency and Service Delivery

Lead: Cultural Competency Coordinator

Strategic Plan Core Issue: *Access, Utilization and Integration; Standardization and Compliance*

Value: To provide all beneficiaries will appropriate and culturally relevant services.

Goal: Ensure that MHP services and resources are appropriately allocated to address mental health treatment needs

Objective	Measurement	Responsible Entity	Planned Steps and Activities
1. Assess population needs using the Organization Assessment by increasing survey penetration rates to inform Cultural Competency strategies and initiatives. a. GOAL: Increase consumer survey participation by 100% (132 surveys) Baseline: 66 consumer participants b. GOAL: Increase staff survey participation by 25% (233 surveys) Baseline: 186 staff participants	Number of survey participants Survey responses	SPRE, Cultural Competency Coordinator, Cultural Competency Committee	• Strengthening the 2015 Organizational Assessment process to gather consumer and staff input. • Utilizing the results of the Assessment to inform and update strategies specified in the Cultural Competency Plan: Criterion 3. • Sharing results of the Assessment with the Cultural Competency Committee to solicit recommendations on initiatives and strategies for Criterion 3.
2. Calculate staff to consumer demographic ratios and language capabilities to ensure the populations are congruent. a. GOAL: Obtain 100% of full staff demographics Baseline: (to be determined in FY1819)	Ratios of staff demographics to consumer demographics Ratios of bilingual staff to monolingual consumers	SPRE, Cultural Competency Coordinator, QMAC	• Collect full staff demographics. ○ Race/ethnicity demographics to match client demographics located in the Avatar admissions screen. ○ Fluent languages spoken • Compare demographic ratios to identify any discrepancies.

Beneficiary Satisfaction

Provide a Meaningful Experience for Individuals Who Receive Mental Health Services in Butte County

Lead: QA Coordinator

Strategic Plan Core Issue: *Access, Utilization and Integration; Standardization and Compliance*

Value: To ensure that beneficiaries are treated in accordance to Butte County Behavioral Health's core values

Goal: To increase beneficiary satisfaction

Objective	Measurement	Responsible Entity	Planned Steps and Activities
1. Conduct client satisfaction surveys (POQI) bi-annually as required by DHCS and increase beneficiary participation. GOAL: Increase survey to include 100% of clients Baseline FY16-17: November 2016 – 896/76% May 2017 – 1,431/76.69% FY17-18: November 2017 1,282/76% = May 2018 1,642/ 83.36% ↑ 2. Make client feedback opportunity available to clients in multiple facilities in threshold languages. Goals a. 10 locations b. Collect 100 surveys c. Minimum 2 languages Baseline FY16-17	• POQI surveys will be quantified by sites, areas of satisfaction, areas for improvement, and a summary of general comments • BCDBH will post satisfaction surveys in the lobbies of all clinics available in the identified threshold languages. • Timely resolution of all client grievances	Each Clinical Site bi-annually Systems Performance Patient's Rights: designated QMD staff	• Count of participants in annual POQI surveys will be compared to 2014 baseline. • MHP and clinic results will be posted at each site. • Review grievance log to count the percent of grievances appropriately resolved within 90 days, or within the approved 14 day extension • Report to QIC quarterly

a. 18 locations b. 36 surveys c. English, Hmong, Spanish FY17-18 a. 18 locations = b. 102 surveys ↑ c. English, Hmong, Spanish = 3. Timely resolution of all client grievances. GOAL: Timely resolution of 100% of grievances Baseline FY14-15: 100% FY16-17: 100% FY1718: 100%			

Service Delivery System and Meaningful Clinical Issues

Utilize Outcome Measures to Inform Treatment Planning

Lead: QA Coordinator

Strategic Plan Core Issue: *Access, Utilization and Integration; Standardization and Compliance*

Value: Outcome measures are a means by which client progress toward goals can be tracked to ascertain whether our clients getting better. The data collected guides clinical work by informing treatment planning and communication with clients

THIS CONTINUES TO BE A CLINICAL PERFORMANCE IMPROVEMENT PROJECT (PIP) FOR THE QUALITY IMPROVEMENT COMMITTEE

Goal: Utilize the CANS and MORS to inform treatment planning

Objectives	Measurement	Responsible Entity	Planned Steps and Activities
1. MORS and CANS are administered to 95% of clients who meet respective criteria (for clients open over 60 days). GOAL: 95% Baseline from PIP Proposal data dated July 1, 2016 MORS: 59.0% CANS: 55.0% Most recent chart review – July 2018: MORS: 82.1% ↑ CANS: 90.6% ↑ 2. Correspondence rates: Percentage of charts that have a correspondence between the outcome measure (CANS for youth and MORS for adults) and the treatment plan. GOAL: 95% Baseline April 2017 a) 71.4% (20/28) – 2 congruent goals b) 75.0% (21/28) – 1 congruent goal	Training sign-in sheets Implementation workgroup meeting minutes QM Chart review Avatar reports	Training Coordinator CANS and MORS trainers CANS and MORS implementation teams Clinical Supervisors QMD staff	• Performance Measure P&P • Workgroup meetings with monthly updates • Staff training • Supervisor training • Clinical supervision and consultation • Quality Management Chart Review – review and track utilization and integration of CANS and MORS in clinical practice. Report results to respective implementation team. • Report to QIC quarterly

Most recent chart review – June 2018: a) 83.3% (20/24) – 2 congruent goals ↑ b) 83.3% (20/24) – 1 congruent goal ↑ 3. Correspondence rates: Percentage of charts that have a correspondence between the outcome measure (CANS for youth, MORS for adults) and the primary diagnosis. Goal: 95% Baseline May 2017: 75.0% (21/28) Most recent chart review – June 2018: 75.0% (18/24) = 4. Correspondence between trauma in initial assessment and outcome measures (e.g., CANS, MORS) Goal: 95% Baseline 3 month average/April-June 2018: 91.4% (64/70) Most recent chart review – June 2018: 87.5% (21/24) ↓			

Service Delivery System and Meaningful Clinical Issues

Ensure BCDBH Provides Adequate Accessibility to After hours and 24/7 Care as Needed

Lead: QA Coordinator

Strategic Plan Core Issue: *Access, Utilization and Integration; Standardization and Compliance*
Value: To meet the needs of our beneficiaries 24/7 to ensure quality and continuity of care

Goal: Monitor the accessibility of 24/7 and urgent services to beneficiaries CSU and our PHF

Objectives	Measurement	Responsible Entity	Planned Steps and Activities
1. Monthly PFH chart audits and provider certifications visits annually. GOAL: 12 Baseline FY14-15: 0 FY1617: 10 FY1718: 12 with 94% compliance 2. Monthly CSU chart audits and provider certifications visits annually. GOAL: 12 Baseline FY14-15: 0 FY1617: 3 FY1718: 12 with 73% compliance 3. Monitor consumer concerns/complaints and grievances specific to access of these 24/7 services. GOAL: 0 Baseline FY14-15: 0 FY1617: 0 FY1718: 7	QM PHF Chart Audit tool/DHCS PHF site audit protocol QM CSU outpatient Chart Audit tool/DHCS CSU site audit protocol QIC Minutes	Quality Management Staff/PHF Manager Quality Management Staff/Crisis Services Manager Patients' Rights Advocate and Beneficiary Protection Designee	• Provide at monthly audits and annual site review of BCDBH Psychiatric Health Facility • Provide at monthly audit/annual site review of Crisis Stabilization Unit • Review any beneficiary complaints about care and ensure corrective action is completed and reviewed at QI quarterly