Summary: This is a summary of the PCBH executed work plan for the 20-21 program year. The findings are separated by the following seven subsections: Service Capacity, Access to Care, Beneficiary Satisfaction, Cultural and Linguistic Competence, Medication Practices, Services Deliver and Clinical issues and Continuity and Coordination of Care.

The Plumas County Behavioral Health's Quality Improvement and Compliance Program monitor's service delivery with the purpose of improving the process of providing care and better meeting the needs of our county's beneficiaries. The Quality Assurance and Compliance Manager (QACM) oversees this program and chairs the Quality Improvement Committee (QIC). The Quality Improvement Committee is comprised of advisory board members, County staff members, The Patient's Rights Advocate and Contracted Providers to ensure the highest quality of services delivered to our communities. The QIC meets on a monthly basis and is informed by the Quality Improvement Plan. QIC activities include:

- Collecting and analyzing data to measure against the goals or prioritized areas of improvement that have been identified; identify opportunities for improvement and deciding which opportunities to pursue; obtaining input from providers, consumers and community stakeholders in identifying barriers to accessing services or administrative processes.
- Reviewing beneficiary grievances, second opinion requests, appeals, expedited appeals, State Fair Hearing requests, expedited State Fair Hearing requests and clinical records reviews.
- Reviewing timeliness of services, client satisfaction, penetration rates, service accessibility and other service trends.
- Works in collaboration with the Cultural Competency Committee and MHSA coordinator to monitor and improve the quality of offered trainings and education for its workforce, inclusive of promoting greater cultural diversity, humility, and competency.

As a result of the monitoring activities outlined above, the QIC recommends policy decisions, reviews and evaluates the results of quality improvement activities including performance improvement projects (PIPS), institutes needed quality improvement activities, ensures follow-up of QI process, and documents QIC meeting minutes regarding decisions and actions taken.

Guided by the above, Plumas County Behavioral Health (PCCBH) developed in 2020-2021 a Quality Improvement Plan. The contents of the Quality Improvement Plan were also informed by County efforts to better meet beneficiaries needs and incorporate feedback received from its annual External Quality Review Organization (EQRO) report and any ongoing direction from the Department of Health Care Services (DHCS). The Quality Improvement Plan provides a process for PCBH management and supervising staff to: 1) meet quality improvement requirements specified in the Mental Health Contract with the Department of Health Care Services for the expenditure of Medicaid (Medi-CAL) dollars; 2) meet quality improvement requirements specified under the Drug Medi-CAL Organized Delivery System (DMC-ODS) waiver; and 3) address and resolve quality issues raised in the monitoring of the PCBH and DMC-ODS Plans. The QI Plan is evaluated annually to assess progress towards identified goals and actions. The quality improvement activities are divided into the following sections:

Service Capacity

Behavioral Health DHCS Contractual Element: Assess the capacity of service delivery for beneficiaries, including monitoring the number, type, and geographic distribution of services with the delivery system.

Goal 1: Monitor service delivery capacity				
Objectives	**Actions/Frequency**	**Data/Progress**		
1.1. 100% of PCBH enrollees will be determined to have access to Behavioral Health Services based on time and distance standards.	Gather and evaluate data on numbers and types of services by Geographic area to ensure all beneficiaries. **Staff Responsible**: • Information Systems Technician • Quality Assurance and Compliance Manger (QACM) [ongoing] [MHP-Quarterly; SUD-Annually]	July 2020 PCBH passed NACT-100%	Dec 2020 PCBH continues to pass-100%	June 2021 PCBH continues to pass-100%
1.2. PCBH will maintain adequate capacity for delivery of medically necessary specialty mental health services based on geographic area, that are appropriate in number and type of service per DHCS Network Adequacy provider ratio requirements.	1. Gather and evaluate data on numbers and types of services by: a. Geographic area b. Number of Services c. Service type d. Gender e. Race/Ethnicity f. Age 2. Adjust capacity and/or service delivery if need is determined. **Staff Responsible:** • QI Committee • PCBH Director and Managers • Unit Supervisors [ongoing] [Annually]	July 2020 PCBH passed NACT	Dec 2020 Clerical error on last submission required a CAP for psychiatry-waiting for CAP response and clearance all resolved through accurate reporting-100%	June 2021 NACT submitted awaiting feedback-pending

1.3. PCBH will expand access to include eligibility to the senior population	PCBH will submit Medicare certification application by the end of F/Y 2021 **Staff Responsible:** • QACM • PCBH case manager/staff member assigned Quality Improvement (QI) duties [ongoing]	July 2020 0% progress	Dec 2020 0% progress	
1.4. PCBH will maintain adequate capacity for delivery of medically necessary Medication Assisted Treatment (MAT) and Substance Use Disorder Services (SUDS) beneficiaries'	1. Gather and evaluate data on numbers and types of services by level of care recommendations 2. Adjust capacity and/or service delivery if need is determined. **Staff Responsible:** • QI Committee • PCBH Director • Medical Director • Unit Supervisors [New] [Annually]	July 2020 0% waitlist 20% capacity	Dec 2020 0% waitlist 14% capacity	June 2021 0% waitlist 8% capacity
1.5. Staff productivity is evaluated via productivity reports generated by the Cerner program. Managers/Supervisors receive at minimum monthly reports to assure service capacity.	1. Identify productive and nonproductive activities to be tracked through the EHR for each PCBH direct care provider. 2. Achieve a staff productivity of 50% to be increased fiscal year 21/22 to achieve a 65% productivity rate **Staff Responsible:** • PCBH Director and Management Staff • QIC • Clinical Unit Supervisors • PCBH clinical providers [Ongoing] [monthly]	July 2020 26% agency average- Manual reports by QAM	Dec 2020 25% agency average- Manual reports by QAM	June 2021 25% agency average- Manual reports by QAM
1.6. Implement use of the American Society of	1. Train staff to administer and use the ASAM to determine level of care for	July 2020 0% progress	Dec 2020 0% progress	June 2021 0% progress

Addiction Medicine (ASAM)	Substance use services. **Staff Responsible** • Medical Director • PCBH SUDs providers • QACM • Unit Supervisors			

Summary: PCBH achieved 4/6 proposed Objective goals in Service Capacity. Objective 1.5 and 1.6 did not make significant progress, however goal 1.5 could be considered partially met as current productivity rates equate to be ½ that of the goal and PCBH administration successfully identified and published productive-billable vs productive-non billable. Next steps are to train and require reconciling of each staff's day through the EHR to capture and calculate true productivity data. Goal 1.6 on hold due to DIXIE FIRE Emergency that greatly impacted Plumas county for the majority of the program year.

Access to Care

Behavioral Health Contractual Elements: Access (accessibility of services within service delivery area, including):

- *Timeliness of routine appointments;*
- *Timeliness of services for urgent conditions;*
- *Access to after-hours care; and*
- *Responsiveness of the 24-hour, toll-free telephone number*

Goal 2: PCBH will Maintain adequate capacity for timely delivery of routine and urgent specialty mental health services.		**Data/Progress**		
2.1. 100% of Plumas County beneficiaries seeking PCBH Services will be offered their first clinical appointment within 10 business days of initial request.	1. Gather and evaluate data on when clients receive their first clinical assessment based on EHR CSI Journal Assessment and PCBH Access Excel log, 2. Share data analysis results with QIC and Behavioral Health Commission. 3. If goal is not met, the QIC will plan and implement actions to achieve the goal. **Staff Responsible:** • QI Committee • PCBH case manager/staff assigned care coordination responsibilities • PCBH Director and Managers [ongoing] [MHP-Monthly; SUD-Monthly]	July 2020 100% through Open Access	Dec 2020 98% 193/195 met criteria CSI dashboard data	June 2021 99% 385/388 requests met criteria CSI dashboard data
2.2. 100% of beneficiaries	1. QIC will set parameters for indicators/measures.	July 2020 100%	Dec 2020 100%-	June 2021 87%-

presenting with an urgent condition, as defined in Title 9, Subsection 1810.253, will be seen within 48 hours.	2. Collect data on indicators/measures and evaluate for timeliness. 3. If current goal is met, maintain goal of all requests for services 4. Urgent condition will be seen within 48 hours of received request. 2. If current goal is not met, establish baseline and improvement goal. **Staff Responsible**: • QI Committee • Utilization Management Committee • PCBH case manager/staff assigned Care coordination responsibilities • PCBH Director and Managers • Unit Supervisors • Clinical Providers • Nursing Staff • SUD providers [ongoing] [MHP-Monthly]		Average wait time was 15 minutes	Average wait is 14 hrs greatest wait 72hr
2.3. 100% of Plumas County beneficiaries seeking psychiatry appointments will be offered their first psychiatry appointment within	1. Gather and evaluate data on when clients receive their initial psychiatry assessment based on PCBH Tele-psychiatry Access Excel log 2. Share data analysis results with QIC and Behavioral Health Commission.	July 2020 100%- avg wait is 1 day, most is 2 days.	Dec 2020 100%-avg wait is 3 days, most is 9	June 2021 100%- avg wait is 2 days, most is 11 June days

14 business days of initial request.	3. If goal is not met, the QIC will plan and implement actions to achieve the goal. **Staff Responsible:** • QI Committee • PCBH Nursing staff • PCBH Director and Managers [ongoing] [MHP-Monthly]			
2.4. 100% of Plumas County beneficiaries seeking PCBH services through the 24/7 Access Line will be documented and offered an intake appointment within 10 business days for routine access services and within 72 hours for urgent access services.	1. Gather and evaluate data on when clients are offered their first clinical assessment appointment date based on Request for Services forms and Access Call logs. 2. Share data analysis results with QIC and Behavioral Health Commission. **3.** If goal is not met, the QIC will plan and implement actions to **Staff Responsible:** • Access Line Staff, including direct PCBH staff and contracted staff. • QI Committee • PCBH case manager/staff assigned care coordination responsibilities • PCBH Director and Managers [ongoing] [MHP-Monthly; SUD-Monthly]	July 2020 100% through contracted provider	Dec 2020 100% through contracted provider	June 2021 100% through contracted provider
2.5. 100% of Plumas County	1. Gather and evaluate capacity and timeliness data on client's	July 2020 100% noted	Dec 2020 100% noted	June 2021 100% noted

	beneficiaries seeking PCBH services will be provided access to afterhours care for night and weekends.	seeking and receiving afterhours care for when the outpatient clinics are closed. 2. Share and solicit feedback on data analysis results with QIC, the Behavioral Health Commission, and department management meetings. 3. Adjust service delivery as appropriate and feasible. **Staff Responsible:** • Access Line Staff, including direct PCBH staff and contracted staff. • PCBH On-Call providers, including direct and contracted staff • QI Committee • PCBH case manager/staff assigned care coordination responsibilities • PCBH Director and Managers	Emergency requests received by answering service were directed to the ED and received 5150 eval when warranted/requested	Emergency requests received by answering service were directed to the ED and received 5150 eval when warranted/requested	Emergency requests received by answering service were directed to the ED and received 5150 eval when warranted/requested
2.6	**Develop strategies to reduce avoidable hospitalization for adults with mental illness.**	1. Provide emergency tele-psychiatry services in Emergency Room Departments after hours and on-call consults by the end of CY 2020. [continued] **Staff Responsible:** • PCBH Director and Managers 2. Compare hospitalization	July 2020 Align onboard at 1/3 hospitals.	Dec 2020 Align onboard 2/3 hospitals.	June 2021 Align onboard 2/3 hospitals

	rates for the 6 months before starting tele-psychiatry in the Eds and 6 months after starting tele-psychiatry **Staff Responsible:** • QACM • PCBH Case manager/staff assigned Care coordination duties • PCBH Case manager/staff assigned QI coordination duties • QIC • PCBH Director and Management staff [NEW] [MHP-Quarterly]			
2.8 100% of Plumas County medi-CAL beneficiaries discharging from a psychiatric hospital will be followed provided an appointment for outpatient services and initial telepsychiatry evaluation within 7 calendar days of their discharge.	1. Gather and evaluate data on when clients receive their initial psychiatry assessment based on PCBH Hospitalization Access Excel log 2. Share data analysis results with QIC and Behavioral Health Commission. 3. If goal is not met, the QIC will plan and implement actions to achieve the goal. **Staff Responsible:** • PCBH Case manager/staff assigned Care coordination responsibilities	July 2020 • 100%-No in county Hospitalizations to date	Dec 2020 • 100% of clients were offered an appointment within 7 days, average 2.6 days, max 7 days	June 2021 • 100% of clients were offered appointment within 7days. Average 3 days, most 7 days.

	• QI Committee • PCBH Director and Management Staff • PCBH Nursing staff [ongoing] [MHP-Monthly]			
2.9 100% beneficiaries discharging from psychiatric inpatient will not be re-hospitalized within 30 days.	1. Gather and evaluate data from the EHR and PCBH Hospitalization Access Excel Log 2. Share data analysis results with QIC 3. If goal is not met, Program will plan and implement actions to achieve the goal. **Staff Responsible** • PCBH case manager/staff assigned Care coordination duties • QI Committee • PCBH Director and Managers [ongoing] [MHP-Monthly]	July 2020 • 100%-No in county Hospitalizations to date	Dec 2020 • 94% of in County clients were not re-hospitalized within 30 days. 17/18 met criteria.	June 2021 • 96.8% of in County clients were not re-hospitalized within 30 days. 31/32 met criteria.
2.10 100% of charts of beneficiaries hospitalized will have concurrent review activities initiated following business day of being hospitalized.	1. Gather and evaluate data to support all hospitalizations of Plumas County beneficiaries meet medical necessity requirements and could not be treated at a lower level of care for each day hospitalized. [New] 2. Coordinate discharge plan and follow up services [New] **Staff Responsible:** • PCBH Intensive Care	July 2020 • 100%-No in county Hospitalizations to date	Dec 2020 100% of medi-CAL beneficiaries hospitalized received CCR services and notes. Including out of county placements.	June 2021 100% of medi-CAL beneficiaries hospitalized received CCR services and notes. Including out of county placements.

	Coordinator • PCBH Nurse • UM committee [Ongoing]			

Summary: 6/9 Objective goals in Access to care were considered met. Goal 2.2, 100% of beneficiaries presenting with an urgent condition, as defined in Title 9, Subsection 1810.253, will be seen within 48 hours is considered partially met. Timeliness reports support that by June, PCBH had met this goal 87% of the time, average wait was 14 hours while greatest wait was 72 hours. Goal 2.6, Develop strategies to reduce avoidable hospitalization for adults with mental illness is considered partially met due to the lack of a telepsychiatry contract with Seneca Healthcare. Data still needs to be evaluated to determine if hospitalization rates were directly affected by the Align service being available. Goal 2.8, 100% beneficiaries discharging from psychiatric inpatient will not be re-hospitalized within 30 days, also considered partially met. 31/32 hospitalization admits met the standard of not being re-hospitalized within 30 days, for 96.8% success rate.

Goal 3: Improve the Behavioral Health Access Line triaging and referral processes into the behavioral health system of care				
3.1 100% of beneficiaries will have access to a 24/7 Toll free Access line to gain information about how to access specialty mental health or Substance use services required to assess whether medical necessity criteria are met; about services needed to treat a beneficiary's urgent condition; and about how to use the beneficiary problem and resolution fair hearing process.	1. PCBH will maintain access to a 24/7 toll free access line service to provide beneficiaries with necessary information. **Staff Responsible** • PCBH QACM [ongoing][Annually]	July 2020 • 100%- Nevada County contract	Dec 2020 100% Nevada County Contract.	June 2021 100% Nevada County Contract
3.2 Access Line test call results made for both daytime and after-hours will have an 100% success rate to ensure adequate information is provided to the	1. On quarterly basis conduct 10 test calls, 6 (including 1 using a non-English language) during business hours and 4 (Including 1 using a non-English language) after hours to test compliance in the following areas: specialty mental health services, urgent condition services, beneficiary	July 2020 • 10/10 Calls conducted.- 100% • 0/2 non-English test calls made • 3 Access calls made- 100% met standard • 4 Urgent	Dec 2020 • 7/10 Calls conducted.- 70% • 0/2 non-English test calls made • 4 Access calls made- 100% met standard • 2 Urgent	July 2021 • 8/10 Calls conducted.- 80% • 0/2 non-English test calls made • 2 Access calls made- 100% met standard • 4 Urgent

caller for: Specialty mental health services, urgent condition services, beneficiary problem resolution information, Substance Use Services and urgent substance use conditions.	problem resolution information, Substance Use Services and urgent substance use conditions. At minimum one test call per area to be conducted quarterly, while adhering to the overall 10 test call minimum. 2. New test callers will receive training on conducting test calls. 3. QIC members will be trained annually on conducting test calls. 4. Gather and evaluate responses for consistency or areas needing improvement. Areas needing improvement will be addressed through a Plan of Correction approved by the QI committee 5. Evaluate the Access Line test call protocol annually for effectiveness. **Staff Responsible** • QI Committee • PCBH Director and Managers 2. [ongoing] [MHP-Quarterly]	Condition calls made- 100% met standard. • 3 beneficiary problem resolution calls made- 100% met standard • 6/7 calls logged beneficiary name when required.-85.7% • 7/7 calls logged dates.-100% • 7/7 calls logged initial disposition-100%	Condition calls made- 50% met standard. • 2 beneficiary problem resolution calls made- 100% met standard-0 Business hours calls made • 2/6 calls logged beneficiary name when required.-33% • 2/6 calls logged dates.-33% • 2/6 calls logged initial disposition-33%	Condition calls made- 100% met standard. • 2 beneficiary problem resolution calls made- 100% met standard- • 6/6 calls logged beneficiary name when required.-100% • 6/6 calls logged dates.-100% • 2/6 calls logged initial disposition-33%
3.3 100% of beneficiaries referred for PCBH services will have referral source documented.	1. Gather and document referral sources received on intake appointment or new requests for services on Demographic form inside Cerner EHR system 2. Update referral source of status. Active or closed. **Staff Responsible**	July 2020 • 8/8 referral sources-100% documented • Data not collected	Dec 2020 • 40/54 referral sources-74% documented. • Data not collected.	June 2021 • 118/166 referral sources-71% documented. • Data not collected.

	• PCBH Access Staff • Community Partners • MHSA funded partners • Organizational Providers • PCBH case manager/staff assigned Care coordination responsibilities [Ongoing][Monthly]			

Summary: PCBH met 1/3 objective Goals under Beneficiary Satisfaction. Goals 3.2 and 3.3 both considered partially met. Goal 3.2, nearly met, area of weakness is logging initial disposition. Only met goal 33% of the time. QAM to improve tracking and timely training when needs are identified. Goal 3.3 71 % met for collecting referral sources. Data still needing to be collected and reviewed for reporting back to sources. QIC to identify solutions due to staffing shortages.

Beneficiary Satisfaction

Behavioral Health DHCS Contractual Elements: Assess beneficiary or family satisfaction at least annually by:

- Surveying beneficiary/family satisfaction with services;
- Evaluating beneficiary grievances, appeals, and fair hearings;
- Evaluating requests to change persons providing services; and
- Informing providers of the results of beneficiary/family satisfaction activities.

Goal 4: Evaluate client grievances, unusual occurrence notifications, and change of provider and appeals requests				
4.1 Review and respond to 100% of grievances, change of provider and appeal requests within the policy guidelines and state regulations to identify system improvement issues.	1. Collect and analyze behavioral health service grievances, unusual occurrence notifications, change of provider, appeals and fair hearing requests to examine patterns that may inform the need for changes in policy or programming 1. Respond to 100% of grievances 2. Present findings to the QIC on a monthly basis to identify strategies to improve reporting and address issues. **Staff responsible:** • QACM • QIC Committee • PCBH Director and Managers [ongoing] [MHP and SUD-Monthly]	July 2020 • 100% received were responded to timely	Dec 2020 • 100% received were responded to timely	June 2021 • 100% received were responded to timely
4.2 Review 100% of unusual occurrences to identify trends	Collect and analyze trends in unusual occurrences. **Staff responsible:** • QACM • QIC Committee • PCBH Director and Managers [Ongoing][MHP and SUD-Monthly]	July 2020 Non received	Dec 2020 Non received	June 2021 Non received

Goal 5: Monitor Client/Family satisfaction				
5.1 Monitor Survey results and focus group themes indicate clients and or their family's level of satisfaction with care.	1. Conduct a mental health client/family satisfaction survey to gather quantitative and qualitative data about satisfaction with services [ongoing] [Bi-annually] 2. Conduct focus groups with clients at each county-operated service locations annually to gather feedback about services. [ongoing] [Annually] 3. Report satisfaction survey findings to all staff. [ongoing][Annually] 4. Report findings from focus groups to all staff. [ongoing] [Annually] 5. Conduct in-depth program and fiscal review of MHSA funded programs, including site visit and client interviews and surveys. [ongoing] [Every 3 years] **Staff responsible** • MHSA coordinator • Peer Support workers • Lead Site Coordinator • QIC Committee • PCBH Director and Managers	July 2020 COVID-19	Dec 2020 COVID-19	June 2021 CPS Spring conducted-waiting feedback
5.2 PCBH will develop and/or maintain two active Program Improvement Projects(PIPs), one Clinical and one non-clinical, as defined by the CalEQRO and DHCS contract	1. Ensure that PCBH maintains active status with CalEQRO for PIPs a. Quarterly communication with the EQRO staff or PIP liaison to discuss progress and or challenges. b. Report feedback to QIC to inform PIP planning c. Monthly QIC PIP discussions to address progress or challenges. d. Monthly Staff and Stakeholder	July 2020 a) 0 meetings with EQRO staff b) 0% compliance c) 0% Compliance d) 0% compliance	Dec 2020 a) 0 meetings with EQRO staff b) 0% compliance c) 0% Compliance d) 0% compliance	July 2021 a) 0 meetings with EQRO staff b) 0% compliance c) 0% Compliance d) 0% compliance

requirements.	memos to communicate PIP progress and benchmarks.			

Summary: PCBH met goal 4, Evaluate client grievances, unusual occurrence notifications, and change of provider and appeals requests as evidenced by a 100% compliant rate as indicated in the goal objectives. 5.1 objective goals is considered met for Cultural and Linguistic Competence. Goal 5.2 is considered not met as PIPS have not been able to be addressed due to COVID and staffing changes/availability. QIC to identify solutions for PIP leadership.

Cultural and Linguistic Competence

Behavioral Health DHCS Contractual elements: comply with the requirements for cultural and linguistic competence.

Goal 6: Provide all clients with welcoming, engaging, and culturally and linguistically appropriate recovery-centered care				
6.1 All services are delivered in a culturally-competent manner.	1.Update the cultural competence plan, incorporating DHCS cultural competency plan requirements. **Staff responsible:** • Cultural Competency Committee • PCBH MHSA coordinator [ongoing] [annually]	July 2020 0% progress- MHSA coordinator resigned	Dec 2020 0% progress- MHSA coordinator resigned	July 2021 100%- Plan submitted and approved by DHCS
6.2 100% of beneficiaries are served in their preferred language.	1. Monitor accessibility of Access Line and services to non-English speakers 2. Train access line staff and all service providers on how to utilize language services **Staff Responsible:** • QACM • QIC Committee [ongoing] [quarterly]	July 2020 • Language line contract in place • 100% of access staff trained on language services annually	Dec 2020 • Language line contract in place. • 100% of access line staff trained on language services annually. Scheduled for Jan 2021	June 2021 • Language line contract in place. • 100% of access line staff trained on language services annually. Completed Jan 2021
6.3 100% staff and organizational providers complete annual cultural competence training	Track individual staff who complete cultural competence training. **Staff Responsible:** • QACM • Cultural Competence Committee • PCBH MHSA coordinator [ongoing] [quarterly]	July 2020 • 0% of staff have received cultural competence training for	Dec 2020 • 11% of County Staff received CC training.	June 2021 • 41% 16/39 completed assigned CC

		20/21 FY- tracking through NACT for all		trainin g
6.4 100% Behavioral Health beneficiaries/families report they agree that staff are respectful and supportive of culture, values, beliefs, lifeways and lifestyles.	1. Survey beneficiaries/family members to establish an amount of beneficiaries/family member who agree strongly or agree that staff are respectful and supportive to the total number of respondents. 2. If goal is not met, the QIC and CCC will plan and implement actions to achieve the goal **Staff Responsible:** • QACM • Cultural Competence Committee • QIC [ongoing] [Bi-annually]	July 2020 COVID-19	Dec 2020 COVID-19	June 2021 Spring survey conducted waiting on results
6.5 Identify underserved populations and develop strategies to increase penetration when appropriate and feasible.	1. Identify underserved populations and develop action plans to target outreach and engagement. **Staff Responsible** • CC • QIC • QAM • MHSA coordinator • PCBH Director and management staff	July 2020 0% progress- MHSA coordinator resigned	Dec 2020 0% progress- MHSA coordinator resigned	June 2021 0% progress- MHSA position filled Spring 2021

Summary: PCBH met 2/5 objective goals, 1 goal excluded due to COVID. 2/4 goals met adjusted. Goal 6.3, 100% staff and organizational providers complete annual cultural competence training. 41% of PCBH network provider (direct and contracted) have received at least 1 hour of cultural competence, Staff not meeting this requirement will be addressed by their supervisor. Contracted providers will develop a

corrective action plan at contract renewal. Goal 6.4, 100% Behavioral Health beneficiaries/families report they agree that staff are respectful and supportive of culture, values, beliefs, lifeways and lifestyles, put on hold due to COVID statewide emergency. CPS surveys conducted in June, still awaiting results. Goal 6.5, Identify underserved populations and develop strategies to increase penetration when appropriate and feasible. Goal not met, Cultural Competence meeting have been suspended for the year due to COVID and staffing changes/availability.

Medication Practices

Behavioral Health DHCS Contractual Elements: Monitor safety and effectiveness of medication practices.

Goal 7: Promote safe and effective medication practices				
7.1 Develop and implement a medication monitoring tool.	1. All (100%) medical staff to have a minimum of 10% of their open charts reviewed once a year [ongoing] [annually] **Staff Responsible**: • PCBH Nursing staff • QACM • QIC Committee 2. Conduct follow up with psychiatrist with the lowest compliance rates. [New] **Staff Responsible** • PCBH Medical Director for SUD charts • QACM for MH Charts [New] [monthly]	July 2020 0% progress-	Dec 2020 0% progress-	June 2021 0% progress
7.2 Identify behavioral health beneficiaries who are stable on medications.	1. Develop reporting on beneficiaries prescribed psychotropic medications [New] **Staff Responsible**: • PCBH Nursing staff • QACM 2. Collaborate with treating psychiatrists and primary care doctors to review 100% of charts of beneficiaries who are stable on anti-depressant medication for possible step-down. [ongoing] [Annually] 3. Step down beneficiaries deemed to be good candidates for medication support through primary care. **Staff Responsible**: • PCBH nursing staff • PCBH direct care providers	July 2020 0% Progress	Dec 2020 0% Progress	June 2021 0% progress

	• Organizational direct care providers			
7.3 Establish and ensure safe medication practices	1. maintain safe prescription standards for Benzodiazepines for the PCBH MAT clinic. [New] **Staff Responsible**: • PCBH Nursing staff • PCBH Medical Director • PCBH case manager/ staff member assigned QI coordinator duties 2. Monitor labs of beneficiaries receiving anti-psychotic medication. [Ongoing] **Staff Responsible**: • PCBH Nursing staff • QACM	July 2020 • 100% of MAT clients meet standard • 100% of open Med clients have labs reviewed	Dec 2020 • 100% MAT clients meet standard • 100% of open Med clients have labs reviewed.	June 2021 • 100% MAT clients meet standard • 100% of open Med clients have labs reviewed.
7.4 Develop a Disaster Medication Plan by the end of F/Y 2020-2021	1. Develop a plan to provide clients with medication replacement during a disaster. [New] [Annually] **Staff Responsible:** 1. PCBH Nursing Staff 2. PCBH Staff 3. QACM 4. QIC Committee 2. 100% of clinic staff will know where they can refer beneficiaries where to access medications in a disaster. [New] [Annually] **Staff Responsible:** 5. PCBH Nursing Staff 6. QACM 3. Provide medication beneficiaries with a brochure explaining how they can get medication replacement in event of a disaster. [New] [Bi-Annually -Winter and Summer] **Staff Responsible:** 7. PCBH Nursing Staff	July 2020 1. 0 % 2. 0% 3. 0%	Dec 2020 1. 0 % 2. 0% 3. 0%	June 2021 1. 100 % 2. 100% 3. 0%

Summary: PCBH met ¼ objective goals for Medication Practices. Goal 7.1, Develop and implement a medication monitoring tool, was not met. 0% progress towards a tool was made. Possible contract identified and is in discussions. Delayed and placed on hold due to the DIXIE FIRE emergency that greatly impacted Plumas for the majority of the year starting in July and ending in Oct. Goal 7.2, Identify behavioral health beneficiaries who are stable on medications considered not met. Delayed and placed on hold due to the DIXIE FIRE emergency that greatly impacted Plumas for the majority of the year starting in July and ending in Oct. Goal 7.4, Develop a Disaster Medication Plan by the end of F/Y 2020-2021, considered partially met. To develop plan for regular distribution of medication brochures.

Service Delivery and Clinical Issues

Behavioral Health DHCS Contractual Elements:

a) Address meaningful clinical issues affecting beneficiary's system wide.
b) Monitor appropriate and timely intervention for occurrences that raise quality of care concerns.

Goal 8: Standardize processes and communication throughout referrals				
8.1 Strengthen internal and external referral process.	1. Develop standardized referral process. [New] **Staff Responsible:** 4. PCBH case manager/ staff member with Care coordination duties 5. QACM 6. QIC Committee	July 2020 • Form developed, PNP to follow.	Dec 2020 • Form developed, PNP to follow.	June 2021 • Form developed, PNP to follow
Goal 9: Effectively collect data and communicate data findings to staff and the community				
9.1 Continue the deployment of EHR resources, including outcome tools, to all parts of the system of care, especially contract organizational providers	1. Ensure organizational providers have access to behavioral health history. [ongoing] 2. Ensure that all direct service providers are adequately trained to use and navigate EHR system. [Ongoing] **Staff Responsible:** • QIC Committee • PCBH Organizational providers • PCBH director and managers • PCBH Information Technician	July 2020 • 100% of organizational providers have access. • 100% of organizational providers are provided routine training	Dec 2020 • 100% of organizational providers have access. • 100% of organizational providers are provided routine training	Dec 2020 • 100% of organizational providers have access. • 100% of organizational providers are provided routine training
9.2 Develop capacity to regularly examine quality, access, and	1. Prioritize data and reporting needs, ensuring that the data system captures individual and program level data. [ongoing] [monthly]	July 2020 1/10 Dashboard completed	Dec 2020 1/10 Dashboard 2 pending Dashboards being	June 2021 10/10 dashboards active

timeliness data.	**Staff Responsible:** • QIC Committee • QACM • Information Systems Technician • Case manager/staff member with QI coordinator duties		developed	
9.3 Begin administering levels of care and outcome measure(s) to assess client performance.	1. Identify Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC) data collection and reporting needs. [NEW] 2. Update forms and policies to reflect administration of CANS and PSC. [As needed] 3. Develop and implement training plan for the CANS and PSC. [annually] 4. Identify and develop educational and communication materials. [NEW] **Staff Responsible:** • QACM • QIC Committee • PCBH Children's Unit Supervisor • Children's Unit Clinical Staff • Organizational providers serving the youth population	July 2020 1. 100% 2. 100% 3. 100% 4. Dashboard reports to supervisor monthly.	Dec 2020 1. 100% 2. 100% 3. 100% 4. Dashboard reports to supervisor monthly.	Dec 2020 1. 100% 2. 100% 3. 100% 4. Dashboard reports to supervisor monthly. .
Goal 10: Improve Client and Community Communication, collaboration and education				
10.1 Provide Mental Health First Aid [MHFA] to the community.	1. Provide Community trainings. [Ongoing] **Staff Responsible:** • MHSA coordinator	July 2020 100% met community trainings offered quarterly	Dec 2020 100% met community trainings offered	June 2021 100% met community trainings offered quarterly

			quarterly	
10.2 Establish family support groups specific to Full-Service Partnership clients	1. Provide quarterly family and collateral training on topics specific to navigating the PCBH systems of care and improving outcomes of beneficiaries in PCBH services **Staff Responsible:** • MHSA Coordinator [new]	July 2020 0% progress-	Dec 2020 0% progress-	June 2021 0% progress
Goal 11: Maintain effective and consistent utilization management practices				
11.1 Improve communication with those who interface with or are part of the Utilization Management (UM) Team.	1. Hold weekly scheduled UM meetings on authorization and centralized reviews. [ongoing] **Staff Responsible:** • UM committee 2. Arrange Documentation Training quarterly and by request at County-operated service locations [New] **Staff Responsible:** • QACM • PCBH Unit Supervisors 3. Attend County and community-based organization meetings to announce and communicate UM regulatory changes as they occur. [ongoing] **Staff Responsible:** • PCBH Director • QACM 4. Identify data of what percentage of requests for new services result in denials **Staff Responsible:**	July 2020 1. 100% met- biweekly meetings 2. 0 % progress 3. 100% met 4. 0%	Dec 2020 1. 100% met- biweekly meetings 2. 0% progress 3. 100% met 4. 0%	June 2021 1. 100% met- biweekly meetings 2. 0% progress 3. 100% met 4. 0%

	• QACM • UM Committee • QIC Committee			
11.2 Train 100% of staff on the departments Privacy and Compliance program policies and procedures	1. Track percentage of staff who complete HIPAA, CFR 42 and behavioral health compliance training. [ongoing] [Annually] **Staff Responsible:** • QACM • case manager/ staff member with assigned QI duties 2. Review the PCBH Privacy and Compliance program for updates and revisions at minimum annually. **Staff Responsible:** • QACM • PCBH Director • PCBH Medical Director for SUD related regulations. • QIC	July 2020 1. 0% met-tracked through Relias	Dec 2020 1. 0% tracked through Relias	June 2021 26% met, tracked through Relias

Summary: PCBH met 4/8 objective goals for Service Delivery and Clinical Issues. Goal 8.1, Strengthen internal and external referral process is considered partially met as form update has been processed, however, PNP development still pending. To be completed 21-22 program year. Goal 10.2, Establish family support groups specific to Full-Service Partnership clients was considered not met. No progress made on this goal partially due to the COVID-19 emergency and the DIXIE Fire emergency. Goal 11.1, Improve communication with those who interface with or are part of the Utilization Management (UM) Team, considered partially met. 2/4 sub goals met, including bi/weekly meetings of the Utilization Management, where providers can sit in on case review and authorizations and attending community based forums to inform stakeholders on changes as they occur. Additional progress to be made to schedule quarterly documentation training and to review UM outcomes data. Goal 11.2, Train 100% of staff on the departments Privacy and Compliance program policies and procedures, considered

partially met. 26% of PCBH providers completed Privacy and Compliance trainings. Supervisors to address individual staff and identify a plan to bring up to compliance.

Continuity and Coordination of Care

Behavioral Health DHCS Contractual Elements: Work to ensure continuity of care with physical care providers. Coordinate with other human services agencies used by beneficiaries.

Goal 12: Integrate MHSA-supported programs into the Behavioral Health EHR				
12.1 Better track MHSA-supported programs and services through EHR data	1. Identify MHSA-supported programs that can be placed in the EHR system 2. Track services provided per unit or program. 3. Use data to inform administrative and fiscal processes **Staff Responsible:** • QIC • PCBH Director and Management Staff • Information System Technician [Ongoing] [Annually]	July 2020 100% met- continue to evaluate	Dec 2020 100% met- continue to evaluate	June 2021 100% met- continue to evaluate
Goal 13: Integrate behavioral health services with other County systems				
13.1 Coordinate Drug Medi-Cal services with primary care and mental health services	1. Conduct outreach and training to primary care on referrals and coordination of care. 2. Conduct outreach to all community partners and stakeholders. 3. Educate Access Line staff on how to address calls from Primary Care. 4. Screen 100% of mental health clients entering services for symptoms of substance use disorders and make appropriate referrals. **Staff Responsible:** • case manager/ Staff member with assigned QI duties • QACM • PCBH Management staff • Direct care service providers	July 2020 1. 0% 2. 0% 3. 0% 4. 100%	Dec 2020 1. 0% 2. 0% 3. 0% 4. 100%	June 2021 1. 0% 2. 0% 3. 0% 4. 100%

	[New]			
Goal 14: Improve services to youth in foster care				
14.1 Monitor the use of Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS)	1. Staff complete Child and Family Team Meeting activities. **Staff Responsible:** • PCBH Children providers • Organizational provider Plumas Rural Services • QACM • QIC [ongoing]	July 2020 • Lead clinician attends CFT meeting need to add ICC	Dec 2020 • Lead clinician attends CFT meeting need to add ICC	June 2021 Lead clinician attends CFT meeting need to add ICC
14.2 Identify outcome measures(s) to assess client performance	1. Start providing ICC and IHBS service to all Plumas County qualifying youth 2. Train Staff on ICC and IHBS service delivery and documentation expectations 3. Identify Children and TAY that would benefit from ICC and IHBS services through screener[new] 4. Monitor percentage of children identified vs served [New] **Staff Responsible:** • PCBH organizational provider PRS • UM • Children Unit Supervisor • Clinical providers • QIC [New]	July 2020 1. 0% Progress 2. 100%- staff provided with handbook and training 3. 0%- 4. 0%	Dec 2020 1. 0% Progress 2. 100%- staff provided with handbook and training 3. 0%- 4. 0%	June 2021 1. 0% Progress 2. 100%- staff provided with handbook and training 3. 0% 4. 0%
14.3 Track Access to service information for Foster Youth	1. Identify foster youth programs that can be tracked through the EHR system 2. Monitor and report timeliness to services	July 2020 1. 100%- Katie A	Dec 2020 1. 100%- Katie A youth are	June 2021 1. 100%- Katie A youth are

separately to ensure timeliness to service standards are targeted to the foster youth population.	data per unit or program. 3. Use data to inform administrative and fiscal processes **Staff Responsible:** • QI Committee • Utilization Management Committee • PCBH case manager/staff assigned Care coordination responsibilities • PCBH Director and Managers • Unit Supervisors • Clinical Providers	youth are identified 2. 0% progress 3. 100%-Monthly reports & meetings	identified 2. 0% progress 3. 100%-Monthly reports & meetings	identified 2. 0% progress 3. 100%-Monthly reports & meetings

Goal 15: Improve functionality and relevancy of EHR data				
15.1 Staff will resolve notifications for chart tasks by indicated due date but no later than 5 business days past due date.	1. Implement documentation standards to include clearing Electronic Health Record notifications timely. 2. Monitor for compliance **Staff Responsible** • Clinical providers • Unit Supervisors [New]	July 2020 0%-	Dec 2020 0%	July 2021 84% met standard
15.2 Resolve 100% of past due notifications.	1. Resolve 100% of 2000 outstanding staff notifications. **Staff Responsible** • Clinical providers • Unit Supervisors • QAM • IT [New]	July 2020 75%	Dec 2020 62%	July 2021 45%

Summary: PCBH met 1/4 objective goals for Continuity and Coordination of Care. Goal 13.1, Coordinate Drug Medi-Cal services with primary care and mental health services, considered not met. Zero progress made due to limited staffing availability. Goal 14.2, Identify outcome measures(s) to assess client performance, considered partially met. Need to identify and document children qualifying for IHBS and ICC services and then ensure service delivery. Screening and reporting to be developed. Goal 14.3, Track Access to service information for Foster Youth separately to ensure timeliness to service standards are targeted to the foster youth population, not met. Zero progress made, due to staffing availability. Goal 15.1 Staff will resolve notifications for chart tasks by indicated due date but no later than 5 business days past due date. Goal partially met, but continues to fluctuate as new notifications add to the outstanding total. Goal must be addressed prior to launch of new EHR.