Lassen County Quality Improvement Work Plan

BACKGROUND

Purpose and Intent of Work Plan

The purpose of the Work Plan is to comply with the requirements California State Department of Health Care Services and the Medi-Cal Managed Care Plan, the Lassen County Behavioral Health (LCBH) annually prepares a Quality Management Work Plan which describes the quality improvement activities, goals and objectives. The purpose of the Quality Management Work Plan is to provide up-to-date and useful information that can be used by internal stakeholders as a resource and practical tool for informed decision making and planning.

Specifically, Lassen County Behavioral Health (LCBH) provides an Annual Quality Improvement Work Plan to improve the quality and outcomes of care for Medi-Cal beneficiaries by performing the following activities and initiatives throughout FY2018/2019, FY2019/2020, FY2020/2021, FY2021/2022 and continuing in FY2022/2023.

- Assess and evaluate the capacity and capacity utilization of the MHP service delivery system to ensure timely access to and utilization of mandated and optional MHS/DMC services for beneficiaries;
- Survey beneficiaries and families to evaluate their satisfaction with the MHS/DMC service
- Monitor and evaluate the safety and effectiveness of medication practices and intervene when issues of care are identified
- Collect and analyze data to measure against the goals, objectives, and prioritized areas of improvement that have been identified
- Conduct Performance Improvement Projects (PIP's) to comply with the requirements of 42 CFR, 438.240 to improve quality of care, system performance and outcomes
- Identify and establish relevant committees internal and/or external to the MHP/DMCP to ensure transparency and ensure appropriate exchange of information across systems of care and the Quality Improvement Committee (QIC)
- Establish mechanisms and obtain input from staff, providers, beneficiaries, families, and stakeholders in identifying barriers to delivery of clinical care and administrative services
- Design and implement interventions to improve performance, quality and outcomes of care rendered
- Measure and report the effectiveness of interventions and initiatives
- Incorporate and imbed successful interventions and initiatives into the MHP/DMCP operations as appropriate

- Review and analyze beneficiary grievances, appeals, and expedited appeals, fair hearings, and expedited fair hearings, provider appeals, and clinical records review as required by CCR, Title-9, Section 1810.440(a)(5)

The following Sections describe the strategies, goals, objectives, interventions, activities and, the data and measures for evaluating the work plan's achievement of the goals and objectives identified herein. It is the goal of the Quality Improvement Committee (QIC) to build a structure that ensures the overall quality of services, including detecting both underutilization of services and overutilization of services. This is accomplished by realistic and effective quality improvement activities and data-driven decision making; collaboration amongst staff, including consumer/family member participants; utilization of technology for data analysis. Executive management and program leadership must be present 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 weekly to monitor the status of the above items and make recommendations for improvement. Meeting reminders, information, and minutes are sent in advance and available on the LCBH share drive reflecting all activities, reports, and decisions made by the QIC. The QIC ensures that client confidentiality is protected during meetings, in minutes, and all other communications related to QIC activities.

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. 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 QM Work Plan is evaluated and updated annually by the Quality Improvement Coordinator, QIC, and Management Team. The analyst is responsible for finalization and submission of the QM Work Plan but 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:

- Cultural Competency Committee
- Compliance Committee
- Medical Services Staff Meetings
- Lassen County Behavioral Health Boards

This QM Work Plan is a living document and is updated on a quarterly basis. For this reason the QM Work Plan contains updates for multiple years. There is an annual evaluation for each year at the end of each section. This QM Work Plan is completed for each calendar year.

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Service Delivery – Capacity and Timeliness	
Goal 1	The MHP 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.
Objective 1.a.	Monitor the number and type of service by geographic area and race/ethnicity, gender, and age and evaluate for appropriate level of service and penetration rates. Adjust service delivery when appropriate.
Action Steps: 1. Gather and evaluate data on numbers and types of services by: a. Geographic area (Geo-maps): Susanville/Westwood/Big Valley Area/Fort Sage region 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.	
Monitoring Method	1. Client zip code and service type will be gathered from Echo system. 2. Medi-Cal penetration rate data.
Reporting Frequency	Quarterly
Responsible Partners	Analyst & QI Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 1. Provision of Services, 2. Availability and Accessibility of Services
Report **2019 Quarter 1** LCBH produces quarterly reports on Network Adequacy, which visually displays utilization of services by geographic area and by age.	

LCBH will continue developing a method to include services information and other demographic traits in the reports.

2019 Quarter 2
LCBH submitted its Network Adequacy report for Q2 to DHCS in July 2019 and is awaiting response from DHCS. LCBH received report from DHCS that we were in compliance for Network Adequacy.

2019 Quarter 3
LCBH submitted its Network Adequacy report for Q3 to DHCS in October 2019 and is awaiting response from DHCS. LCBH received report from DHCS that we were in compliance for Network Adequacy.

2019 Quarter 4
LCBH will submit its Network Adequacy report for Q4 in January 2020.

2020 Quarter 1
LCBH submitted its Network Adequacy report for Q4 of 2019 to DHCS on January 16, 2020. Please see the response below received from DHCS regarding their review of LCBH Network Adequacy.

DHCS has reviewed Lassen County MHP's submission of its NACT and supporting documentation and determined that MHP's submission is missing or incomplete. The attached submission checklist, and supporting documents, details DHCS' findings from this preliminary review.

*Please note, Lassen MHP does **not** need to submit a correction for January submission. The above list is feedback DHCS is providing to assist MHPs in preparation for the annual certification submission due on April 1st, 2020.*

2020 Quarter 2
LCBH submitted its now annual Network Adequacy report to DHCS in April 2020. DHCS determined that LCBH had conditionally passed but we were out of compliance in the following areas:

- Time and distance
- Alternative Access Standards

LCBH has submitted supplemental documentation to DHCS in order to resolve the out of compliance issues and are waiting on a response from DHCS.

2020 Quarter 3
LCBH will not submit a Network Adequacy report for Quarter 3 as it is now only submitted once annually in April.

2020 Quarter 4
LCBH will not submit a Network Adequacy report for Quarter 4 as it is now only submitted once annually in April.

2021 Quarter 1
DHCS has changed the Network Adequacy submission from Quarterly to Annual. LCBH will Submit its now annual Network Adequacy submission in July 2021.

2021 Quarter 2
DHCS has changed the Network Adequacy submission from Quarterly to Annual. LCBH will Submit its now annual Network Adequacy submission in July 2021.

2021 Quarter 3
LCBH submitted its annual Network Adequacy Submission to the Network Adequacy Oversight Section (NAOS) on 07/01/2021. NAOS found some items out of compliance which LCBH corrected and resubmitted. LCBH is waiting on a response from DHCS with the Final status of the submission.

2021 Quarter 4
LCBH received our findings letter from DHCS on 11/24/2021. LCBH received a pass on all but 4 items. The four items which did not received a Pass received a Conditional Pass based on reporting of Full Time Employment (FTE) positions for adult and youth Therapists and Adult and Youth Psychiatrists. LCBH had a technical assistance call with DHCS on 12/20/2021 to discuss what was needed to move these items from a Conditional Pass to a Pass. LCBH will update our NACT FTE spreadsheet to accurately count how many FTE positions LCBH has.

2022 Quarter 1
DHCS has changed the Network Adequacy submission from Quarterly to Annual. LCBH will Submit its now annual Network Adequacy submission in July 2022.

2022 Quarter 2
DHCS has changed the Network Adequacy submission from Quarterly to Annual. LCBH will Submit its now annual Network Adequacy submission in July 2022.

2022 Quarter 3
LCBH submitted its annual Network Adequacy Submission to the Network Adequacy Oversight Section (NAOS) on 07/01/2022. LCBH is waiting on a response from DHCS with the Final status of the submission.

2022 Quarter 4
DHCS has changed the Network Adequacy submission from Quarterly to Annual. LCBH is awaiting response from DHCS on the final status of the submission

2023 Quarter 1
LCBH received our findings letter from DHCS on 1/09/2023. LCBH received a conditional pass with corrections needed to update the Contract dates and Timely Access Tracking. LCBH updated our NACT to accurately represent the network for the reporting period specified and submitted to the Network Adequacy Oversight

Section (NAOS) 3/2/2023. NAOS accepted the submission and LCBH is awaiting any further response.

2019 Year Analysis
LCBH has submitted Network Adequacy reports to DHCS for Quarter1, Quarter 2, and Quarter 3. LCBH will submit the report for Quarter 4 in January 2020. Quarter one all requirements were met except for we currently do not contract with a language translation service. LCBH currently uses the AT&T Translation line and receives invoices for the services they provide on a service to service basis. LCBH Is currently waiting on response from DHCS on the Quarter 2 and Quarter 3 reports to verify compliance.

2020 Year Analysis
DHCS has changed this reporting requirement from Quarterly to Annually. LCBH submitted our Annual Report in April 2020. DHCS found we were out of compliance in some areas including Time and Distance and Alternative Access Standards, which LCBH submitted supplemental documentation to DHCS to try to Resolve these out of compliance areas and are waiting on a response from DHCS in regards to the supplemental documentation submitted.

2021 Year Analysis
LCBH submitted the now annual Network Adequacy submission on July 1, 2021. After a preliminary review the Network Adequacy Oversight Section (NAOS) found the areas of the Submission that were in complete including: The Providers listed in one of the submitted documents were missing Provider Types. The date format used for two documents submitted were incorrect. Finally, they requested a detailed explanation on how LCBH and Lassen Indian Health reached a referral agreement. The Administrative assistant and analyst worked together to correct and resubmit the items listed above. LCBH is waiting on a response from DHCS about the final status of the submission. LCBH received a findings report from DHCS in November 2021. All but 4 items were a Pass and LCBH had a technical assistance call with DHCS on 12/20/2021 on correcting the 4 conditional pass items. LCBH will correct these items and submit to DHCS.

2022 Year Analysis
LCBH submitted the now annual Network Adequacy submission on July 1, 2022. After a preliminary review the Network Adequacy Oversight Section (NAOS) found the areas of the Submission that were out-of-compliance including: Time and Distance Standards, Adult Psychiatry Provider Capacity, Children/Youth Psychiatry Provider Capacity, Adult Outpatient Specialty Mental Health Services (SMHS) Provider Capacity, and Children/Youth Outpatient SMHS Provider Capacity. These areas that were out of compliance were found to be the result of incorrect contract dates listed on the NACT and a lack of data collected on timely access for the period of September 1, 2022 - November 30, 2022. These areas have been corrected and

submitted to DHCS. DHCS has notified LCBH of receipt of this submission and LCBH is awaiting any further response.

Service Delivery – Capacity and Timeliness

Goal 2	The MHP will maintain adequate capacity for timely delivery of routine specialty mental health services.
Objective 2.a.	To ensure that 80% of the scheduled appointments for initial non-urgent and non-psychiatry assessment appointments are scheduled within 10 business days from the date of request by the beneficiary assessment appointment.
Objective 2.b.	To ensure that 80% of the scheduled appointments for initial non-urgent and non-psychiatry Therapy first appointments are scheduled within 10 business days from the date of request by the beneficiary assessment appointment.
Objective 2.c.	To ensure that 80% of the scheduled appointments for initial non-urgent psychiatry appointments are scheduled within 15 business days from the date of request.
Action Steps: 1. Gather and evaluate data on when adult clients receive their first Assessment, Therapy First, and Psychiatric appointment based on EHR scheduling data. 2. Share data analysis results with Program. 3. If goal is not met, Adult Outpatient will plan and implement actions to achieve the goal. .	
Monitoring Method	1. Initial Assessment data from EHR. 2. Initial Psychiatric appointments from EHR Scheduler. 3. Initial Therapy First data from EHR. 4. Scheduler data on availability of organizational provider initial appointments.
Reporting Frequency	Monthly

Responsible Partners	Analyst & QI Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 1. Provision of Services, 2. Availability and Accessibility of Services

Report:

2019 Quarter 1
January 2019:

- 38 Registrations. Registration to 1st offered assessment- 100% timeliness within 14 business days.
- 10 Kept Therapy 1st appointments: 70% timeliness within 14 business days of assessment.

February 2019:

- 34 Registrations: Registration to 1st offered assessment- 90.32% timeliness within 14 business days for those who were offered assessments.
- 22 Kept Therapy 1st appointments: 77.27% timeliness within 14 business days of assessment.

March 2019:

- 42 Registrations: Registration to 1st offered assessment- 96.96% timeliness within 14 business days for those who were offered assessments.
- 18 Kept Therapy 1st appointments: 22.22% timeliness within 14 business days of assessment.

2019 Quarter 2
April 2019

- 48 Registrations: Registration to 1st offered assessment- 77.08% timeliness within 14 business days for those who were offered assessments.
- 12 Kept Therapy 1st appointments: 100% timeliness within 14 business days of assessment.

May 2019

- 38 Registrations: Registration to 1st offered assessment- 72.41% timeliness within 14 business days for those who were offered assessments.
- 20 Kept Therapy 1st appointments: First Offered Therapy 1st - 85% timeliness within 14 business days of assessment.

June 2019

- 29 Registrations: Registration to 1st offered assessment- 86.11% timeliness within 14 business days for those who were offered assessments.
- 15 Kept Therapy 1st appointments: First Offered Therapy 1st – 93.33% timeliness within 14 business days of assessment.

2019 Quarter 3
July 2019

- 28 Registrations: Registration to 1st offered assessment- 92.86% timeliness within 14 business days for those who were offered assessments.
- 14 Kept Therapy 1st appointments: 56.25% timeliness within 14 business days of assessment.

August 2019

- 44 Registrations: Registration to 1st offered assessment- 97.73% timeliness within 14 business days for those who were offered assessments.
- 20 Kept Therapy 1st appointments: 60% timeliness within 14 business days of assessment.

September 2019

- 24 Registrations: Registration to 1st offered assessment- 95.83% timeliness within 14 business days for those who were offered assessments.
- 12 Kept Therapy 1st appointments: 33.33% timeliness within 14 business days of assessment.

2019 Quarter 4
October 2019

- 39 Registrations: Registration to 1st offered assessment- 94.87% timeliness within 14 business days for those who were offered assessments.
- 14 Kept Therapy 1st appointments: 64.29% timeliness within 14 business days of assessment.

November 2019

- 31 Registrations: Registration to 1st offered assessment- 90.32% timeliness within 14 business days for those who were offered assessments.
- 12 Kept Therapy 1st appointments: 50% timeliness within 14 business days of assessment.

December 2019

- 39 Registrations: Registration to 1st offered assessment- 70.59% timeliness within 14 business days for those who were offered assessments.
- 14 Kept Therapy 1st appointments: 40% timeliness within 14 business days of assessment.

2020 Quarter 1
January 2020:

- 47 Registrations completed. 43/47 (91.5 %) Registrations to 1st offered assessment met timeliness within 10 business days.
- 17 offered Therapy 1st appointments. 3/17 (17.6%) met timeliness offered within 10 business days of assessment.
- 19 non-urgent Psychiatric appointment requested. 19/19 (100 %) met timeliness within 15 business days.

February 2020:

- 38 Registrations completed. 33/38 (86.8%) Registrations offered an Assessment. 31/33 (93.9 %) Registrations to 1st offered assessment met timeliness within 10 business days.
- 9 offered Therapy 1st appointments. 2/9 (22.2%) met timeliness offered within 10 business days of assessment.
- 9 non-urgent Psychiatric appointment requested. 9/9 (100 %) met timeliness within 15 business days.

March 2020 (COVID Restrictions):

- 29 Registrations completed. 23/29 (79.3%) Registrations offered an Assessment. 20/23 (87%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 15 offered Therapy 1st appointments. 5/15 (33.3%) met timeliness offered within 10 business days of assessment.
- 7 non-urgent Psychiatric appointment requested. 7/7 (100 %) met timeliness within 15 business days.

2020 Quarter 2
April 2020 (COVID Restrictions):

- 22 Registrations completed. 21/22 (95.5%) Registrations offered an Assessment. 16/21 (76.2%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 12 offered Therapy 1st appointments. 9/12 (75%) met timeliness offered within 10 business days of assessment.
- 1 non-urgent Psychiatric appointment requested. 1/1 (100 %) met timeliness within 15 business days.

May 2020 (COVID Restrictions):

- 25 Registrations completed. 22/25 (88%) Registrations offered an Assessment. 20/22 (90.9 %) Registrations to 1st offered assessment met timeliness within 10 business days.
- 4 offered Therapy 1st appointments. 2/4 (50%) met timeliness offered within 10 business days of assessment.
- 9 non-urgent Psychiatric appointment requested. 9/9 (100 %) met timeliness within 15 business days.

June 2020 (COVID Restrictions):

- 21 Registrations completed. 19/21 (90.5%) Registrations offered an Assessment. 19/19 (100%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 9 offered Therapy 1st appointments. 3/9 (33.3%) met timeliness offered within 10 business days of assessment.
- 4 non-urgent Psychiatric appointment requested. 4/4 (100 %) met timeliness within 15 business days.

2020 Quarter 3
July 2020 (COVID Restrictions):

- 33 Registrations completed. 26/33 (78.8%) Registrations offered an Assessment. 26/26 (100%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 11 offered Therapy 1st appointments. 4/11 (36.4%) met timeliness offered within 10 business days of assessment.
- 3 non-urgent Psychiatric appointment requested. 3/3 (100 %) met timeliness within 15 business days.

August 2020 (COVID Restrictions):

- 27 Registrations completed. 25/27 (92.6%) Registrations offered an Assessment. 21/25 (84 %) Registrations to 1st offered assessment met timeliness within 10 business days.

- 13 offered Therapy 1st appointments. 7/13 (53.8%) met timeliness offered within 10 business days of assessment.
- 11 non-urgent Psychiatric appointment requested. 11/11 (100 %) met timeliness within 15 business days.

September 2020 (COVID Restrictions):

- 26 Registrations completed. 26/26 (100%) Registrations offered an Assessment. 25/26 (96.1%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 17 offered Therapy 1st appointments. 10/17/ (58.8%) met timeliness offered within 10 business days of assessment.
- 10 non-urgent Psychiatric appointment requested. 9/10 (90 %) met timeliness within 15 business days.

2020 Quarter 4
October 2020 (COVID Restrictions):

- 31 Registrations completed. 30/31 (96.8%) Registrations offered an Assessment. 30/30 (100%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 11 offered Therapy 1st appointments. 6/11 (54.5%) met timeliness offered within 10 business days of assessment.
- 12 non-urgent Psychiatric appointment requested. 12/12 (100 %) met timeliness within 15 business days.

November 2020 (COVID Restrictions):

- 39 Registrations completed. 36/39 (92.3%) Registrations offered an Assessment. 35/36 (97.2 %) Registrations to 1st offered assessment met timeliness within 10 business days.
- 18 offered Therapy 1st appointments. 12/18 (66.7%) met timeliness offered within 10 business days of assessment.
- 12 non-urgent Psychiatric appointment requested. 12/12 (100 %) met timeliness within 15 business days.

December 2020 (COVID Restrictions):

- 34 Registrations completed. 28/34 (82.3%) Registrations offered an Assessment. 28/28 (100 %) Registrations to 1st offered assessment met timeliness within 10 business days.
- 14 offered Therapy 1st appointments. 14/14 (100%) met timeliness offered within 10 business days of assessment.
- 11 non-urgent Psychiatric appointment requested. 11/11 (100 %) met timeliness within 15 business days.

2021 Quarter 1
January 2021 (COVID Restrictions):

- 37 Registrations completed. 33/37 (89.2%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 20 offered Therapy 1st appointments. 15/20 (75%) met timeliness offered within 10 business days of assessment.
- 11 non-urgent Psychiatric appointment requested. 9/9 (100 %) met timeliness within 15 business days.

February 2021 (COVID Restrictions):

- 27 Registrations completed. 26/27 (96.2%) Registrations offered an Assessment. 26/26 (100 %) Registrations to 1st offered assessment met timeliness within 10 business days.
- 8 offered Therapy 1st appointments. 6/8 (75%) met timeliness offered within 10 business days of assessment.
- 18 non-urgent Psychiatric appointment requested. 18/18 (100 %) met timeliness within 15 business days.

March 2021 (COVID Restrictions):

- 36 Registrations completed. 35/36 (97.2%) Registrations offered an Assessment. 34/35 (97.1%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 14 offered Therapy 1st appointments. 10/14 (71.4%) met timeliness offered within 10 business days of assessment.
- 14 non-urgent Psychiatric appointment requested. 14/14 (100 %) met timeliness within 15 business days.

2021 Quarter 2
April 2021 (COVID Restrictions):

- 33 Registrations completed. 30/33 (90.9%) Registrations offered an Assessment. 26/30 (86.6%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 16 offered Therapy 1st appointments. 11/16 (68.75%) met timeliness offered within 10 business days of assessment.
- 13 non-urgent Psychiatric appointment requested. 13/13 (100 %) met timeliness within 15 business days.

May 2021 (COVID Restrictions):

- 46 Registrations completed. 45/46 (97.8%) Registrations offered an Assessment. 43/46 (93.4 %) Registrations to 1st offered assessment met timeliness within 10 business days.
- 18 offered Therapy 1st appointments. 14/18 (77.7%) met timeliness offered within 10 business days of assessment.
- 13 non-urgent Psychiatric appointment requested. 12/13 (92.3 %) met timeliness within 15 business days.

June 2021 (COVID Restrictions):

- 30 Registrations completed. 30/30 (100%) Registrations offered an Assessment. 30/30 (100%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 8 offered Therapy 1st appointments. 8/8 (100%) met timeliness offered within 10 business days of assessment.
- 13 non-urgent Psychiatric appointment requested. 11/13 (84.6 %) met timeliness within 15 business days.

2021 Quarter 3
July 2021 (COVID Restrictions and Dixie/Beckworth Fire):

- 29 Registrations completed. 28/29 (96.5%) Registrations offered an Assessment. 27/28 (96.4%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 17 offered Therapy 1st appointments. 11/17 (64.7%) met timeliness offered within 10 business days of assessment.
- 10 non-urgent Psychiatric appointment requested. 10/10 (100 %) met timeliness within 15 business days.

August 2021(COVID Restrictions and Dixie/Beckworth Fire)::

- 26 Registrations completed. 23/26 (88.5%) Registrations offered an Assessment. 22/23 (95.6%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 16 offered Therapy 1st appointments. 12/16 (75%) met timeliness offered within 10 business days of assessment.
- 7 non-urgent Psychiatric appointment requested. 7/7 (100 %) met timeliness within 15 business days.

September 2021 (COVID Restrictions and Dixie Fire:

- 28 Registrations completed. 28/28 (100%) Registrations offered an Assessment. 26/28 (92.8%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 17 offered Therapy 1st appointments. 14/17 (82.3%) met timeliness offered within 10 business days of assessment.

- 14 non-urgent Psychiatric appointment requested. 14/14 (100%) met timeliness within 15 business days.

2021 Quarter 4
October 2021:

- 30 Registrations completed. 27/30 (90%) Registrations offered an Assessment. 27/27 (100%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 18 offered Therapy 1st appointments. 16/18 (88.9%) met timeliness offered within 10 business days of assessment.
- 11 non-urgent Psychiatric appointment requested. 11/11 (100 %) met timeliness within 15 business days.

November 2021:

- 29 Registrations completed. 28/29 (96.5%) Registrations offered an Assessment. 28/28 (100%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 19 offered Therapy 1st appointments. 16/19 (84.2%) met timeliness offered within 10 business days of assessment.
- 17 non-urgent Psychiatric appointment requested. 13/17 (76.5 %) met timeliness within 15 business days.

December 2021:

- This metric runs three to four weeks behind therefore cannot be calculated at this time.

2022 Quarter 1
January 2022

- 37 Registrations completed. 25/37 (68%) Registrations offered an Assessment. 23/25 (92%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 8 offered Therapy 1st appointments. 8/8 (100%) met timeliness offered within 10 business days of assessment.
- 6 non-urgent Psychiatric appointment requested. 6/6 (100 %) met timeliness within 15 business days.

February 2022

- 27 Registrations completed. 20/27 (74%) Registrations offered an Assessment. 19/20 (95 %) Registrations to 1st offered assessment met timeliness within 10 business days.
- 5 offered Therapy 1st appointments. 4/5 (80%) met timeliness offered within 10 business days of assessment.
- 5 non-urgent Psychiatric appointment requested. 5/5 (100 %) met timeliness within 15 business days.

March 2022:

- 36 Registrations completed. 32/36 (88.9%) Registrations offered an Assessment. 30/32 (93.8%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 13 offered Therapy 1st appointments. 12/13 (92.3%) met timeliness offered within 10 business days of assessment.
- 9 non-urgent Psychiatric appointment requested. 9/9 (100 %) met timeliness within 15 business days.

2022 Quarter 2

April 2022

- 36 Registrations completed. 28/36 (77.8%) Registrations offered an Assessment. 24/28 (85.7%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 18 offered Therapy 1st appointments. 18/18 (100%) met timeliness offered within 10 business days of assessment.
- 7 non-urgent Psychiatric appointment requested. 6/7 (85.7 %) met timeliness within 15 business days.

May 2022

- 45 Registrations completed. 40/45 (88.9%) Registrations offered an Assessment. 33/40 (82.5 %) Registrations to 1st offered assessment met timeliness within 10 business days.
- 24 offered Therapy 1st appointments. 21/24 (87.5%) met timeliness offered within 10 business days of assessment.
- 8 non-urgent Psychiatric appointment requested. 6/8 (75 %) met timeliness within 15 business days.

June 2022

- 41 Registrations completed. 37/41 (90.2%) Registrations offered an Assessment. 31/37 (83.8%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 18 offered Therapy 1st appointments. 15/18 (83.3%) met timeliness offered within 10 business days of assessment.

- 10 non-urgent Psychiatric appointment requested. 10/10 (100 %) met timeliness within 15 business days.

2022 Quarter 3
July 2022

- 36 Registrations completed. 35/36 (97.2%) Registrations offered an Assessment. 31/35 (88.6%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 13 offered Therapy 1st appointments. 10/13 (76.9%) met timeliness offered within 10 business days of assessment.
- 13 non-urgent Psychiatric appointment requested. 11/13 (84.6 %) met timeliness within 15 business days.

August 2022

- 54 Registrations completed. 50/54 (92.6%) Registrations offered an Assessment. 45/50 (90%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 23 offered Therapy 1st appointments. 21/23 (91.3%) met timeliness offered within 10 business days of assessment.
- 13 non-urgent Psychiatric appointment requested. 13/13 (100 %) met timeliness within 15 business days.

September 2022

- 17 Registrations completed. 17/17 (100%) Registrations offered an Assessment. 15/17 (88.2%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 20 offered Therapy 1st appointments. 13/20 (65%) met timeliness offered within 10 business days of assessment.
- 6 non-urgent Psychiatric appointment requested. 6/6 (100%) met timeliness within 15 business days.

2022 Quarter 4
October 2022:

- 38 Registrations completed. 23/38 (60.5%) Registrations offered an Assessment. 14/23 (60%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 9 offered Therapy 1st appointments. 8/9 (88.9%) met timeliness offered within 10 business days of assessment.
- 12 non-urgent Psychiatric appointment requested. 12/12 (100 %) met timeliness within 15 business days.

November 2022:

- 24 Registrations completed. 22/24 (91.7%) Registrations offered an Assessment. 20/22 (91%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 11 offered Therapy 1st appointments. 6/11 (54.5%) met timeliness offered within 10 business days of assessment.
- 3 non-urgent Psychiatric appointment requested. 3/3 (100 %) met timeliness within 15 business days.

December 2022:

- 21 Registrations completed. 17/21 (80.9%) Registrations offered an Assessment. 17/17 (100%) Registrations to 1st offered assessment met timeliness within 10 business days.
- 14 offered Therapy 1st appointments. 10/14 (71.4%) met timeliness offered within 10 business days of assessment.
- 13 non-urgent Psychiatric appointment requested. 12/13 (92.3%) met timeliness within 15 business days.

2019 Year Analysis
In 2019 LCBH was able to meet the goal of 80% of beneficiaries receiving an initial assessment appointment in all four quarters. However, LCBH was not able to meet the goal of 80% of clients being offered a therapy first appointment within 14 days of kept assessment appointment. LCBH believes we were unable to meet this goal due to losing many of our Therapists over the year and not being able to fill the vacated positions. LCBH is actively recruiting for Therapists and looking into other options for providing therapy to our beneficiaries. LCBH is closing out 2019 with only 2 Adult Therapist, 2 Youth/adolescent therapists, and a contacted tele-health Therapist who is here two days a week.

2020 Year Analysis
In 2020 LCBH was able to meet the goal of 80% of beneficiaries receiving an initial assessment appointment within 10 business days in all four quarters except in one month of Q2. However, LCBH was not able to meet the goal of 80% of clients being offered a therapy first appointment within 10 days of kept assessment appointment in any of the 4 quarters. LCBH believes we were unable to meet this goal due to various reasons. One reason could include the inability to reach client to schedule the therapy 1st appointment once client is assigned to a therapist at Access. Another reason is that LCBH has a contracted telehealth provider completing all assessments on Monday through Wednesday, access meetings occur on Wednesday so if a client was seen for an assessment on Wednesday they would

not be assigned to a provider for therapy 1st until the following Wednesday at the Access meeting which is already 5 days after assessment. LCBH will Review this Data and explore the idea of implementing a PIP to improve this timeliness. LCBH was able to meet and exceed the goal of 80% of beneficiaries being offered a non-urgent psychiatric appointment within 15 business days of request. The COVID 19 pandemic began in March 2020 and LCBH feels this could have impacted our numbers.

2021 Year Analysis

In 2021 LCBH was able to meet goal 2a offering beneficiaries an assessment appointment within ten business days in all four quarters. Goal 2b, offering a client a therapy first appointment within 10 business days was met in Q4 but was not completely met for any of the other 3 quarters. There are multiple factors (Dixie/Beckworth Fire) that could account for lack of scheduling client within 10 business days and LCBH is not able to determine at this time what the root cause of this is. Goal 2c, offering a client who requested a non-emergent psychiatry appointment in 15 business days was met in all quarters except Q4. LCBH feels that this goal fell short in Q4 as our youth Psychiatrist is only here on Fridays. In November and December there were more county and federal holidays that caused the clinic to be closed on Fridays therefore pushing out the date that a youth could be scheduled for a non-emergent Psychiatry first appointment.

2022 Year Analysis

In 2022, LCBH met goal 2a for three out of the four quarters. Goal 2a, offering beneficiaries an assessment appointment within ten business days was not met on average in Q1 but was met for remaining quarters. Goal 2b, offering a client a therapy first appointment within 10 business days was met on average in Q1 and Q2 but was not completely met for the other 2 quarters. Goal 2c, offering a client who requested a non-emergent psychiatry appointment in 15 business days was met in all four quarters. LCBH believes we were unable to meet this goal due to various reasons. One reason could include the inability to reach client to schedule the therapy 1st appointment once client is assigned to a therapist at Access. Another reason for clients stopping participation before an appointment offer has been issues with transportation that has arisen for many clients. Currently when clients are unable to provide their own transportation, they are provided transportation through the Managed Care Provider. However, the transportation company used by the MCP has had multiple grievances and many clients have not been able to arrange for adequate transportation to meet their appointments.

Service Delivery – Capacity and Timeliness

Goal 3	All beneficiaries presenting with an urgent condition will be seen within 60 minutes from initial call.
Objective 3.a.	To ensure that 80% of urgent conditions are seen within 60 minutes at both clinics, jail/JV Hall and at the ER. (In 2019 the Juvenile Hall closed down)

Action Steps:
1. Collect data on indicators/measures and evaluate for timeliness.
2. If current goal is met, maintain goal of all requests for services to address urgent condition will be offered a rebound appointment at LCBH within 3 working days.
3. If current goal is not met, establish baseline and improvement goal.

Monitoring Method	1. Initial urgent condition data from EHR.
Reporting Frequency	Quarterly
Responsible Partners	Analyst & QI Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 1. Provision of Services, 2. Availability and Accessibility of Services

Report

2019 Quarter 1
Adults: 75 Crises in 1st quarter 2019 as reported on the Crisis Spreadsheet. 47 have wait times listed. 100% of the 47 wait times are within the 60-minute standard.

Youth: 30 Crises in 1st quarter 2019 as reported on the Crisis Spreadsheet. 12 have wait times listed. 100% of the 12 wait times are within the 60-minute standard.

2019 Quarter 2
Adults: 42 Crises in 2nd quarter 2019 as reported on the Crisis Spreadsheet. 21 have wait times listed. 100% of the 21 wait times are within the 60-minute standard.

Youth: 13 Crises in 2nd quarter 2019 as reported on the Crisis Spreadsheet. 8 have wait times listed. 100% of the 8 wait times are within the 60-minute standard.

2019 Quarter 3
Adults: 67 Crises in 3rd quarter 2019 as reported on the Crisis Spreadsheet. 44 have wait times listed. 97.73% of the 44 wait times are within the 60-minute standard.

Youth: 27 Crises in 3rd quarter 2019 as reported on the Crisis Spreadsheet. 16 have wait times listed. 87.5% of the 16 wait times are within the 60-minute standard.

2019 Quarter 4
Adults: 55 Crises in 4th quarter 2019 as reported on the Crisis Spreadsheet. 45 have wait times listed. 97.78% of the 45 wait times are within the 60-minute standard.

Youth: 29 Crises in 4th quarter 2019 as reported on the Crisis Spreadsheet. 24 have wait times listed. 100% of the 24 wait times are within the 60-minute standard.

2020 Quarter 1
Business Hours Adult Crisis: 31 Crises in 1st quarter 2020 as reported on the Crisis Spreadsheet. 31/31 (100%) have wait times listed. 31/31 (100%) of the wait times listed are within the 60-minute standard.

After Hours Adult Crisis: 31 Crises in 1st quarter 2020 as reported on the Crisis Spreadsheet. 31/31 (100%) have wait times listed. 31/31 (100%) of the wait times listed are within the 60-minute standard.

Business Hours Youth Crisis: 21 Crises in 1st quarter 2020 as reported on the Crisis Spreadsheet. 21/21 (100%) have wait times listed. 20/21 (95.24%) of the wait times listed are within the 60-minute standard.

After-hours Youth Crisis: 13 Crises in 1st quarter 2020 as reported on the Crisis Spreadsheet. 13/13 (100%) have wait times listed. 12/13 (92.31%) of the wait times listed are within the 60-minute standard.

2020 Quarter 2
Business Hours Adult Crisis: 39 Crises in 2nd quarter 2020 as reported on the Crisis Spreadsheet. 39/39 (100%) have wait times listed. 39/39 (100%) of the wait times listed are within the 60-minute standard.

After Hours Adult Crisis: 20 Crises in 2nd quarter 2020 as reported on the Crisis Spreadsheet. 20/20 (100%) have wait times listed. 20/20 (100%) of the wait times listed are within the 60-minute standard.

Business Hours Youth Crisis: 7 Crises in 2nd quarter 2020 as reported on the Crisis Spreadsheet. 7/7 (100%) have wait times listed. 7/7 (100%) of the wait times listed are within the 60-minute standard.

After-hours Youth Crisis: 7 Crises in 2nd quarter 2020 as reported on the Crisis Spreadsheet. 7/7 (100%) have wait times listed. 7/7 (100%) of the wait times listed are within the 60-minute standard.

2020 Quarter 3
Business Hours Adult Crisis: 52 Crises in 3rd quarter 2020 as reported on the Crisis Spreadsheet. 52/52 (100%) have wait times listed. 52/52 (100%) of the wait times listed are within the 60-minute standard.

After Hours Adult Crisis: 23 Crises in 3rd quarter 2020 as reported on the Crisis Spreadsheet. 14/23 (60.87%) have wait times listed. 11/14 (78.57%) of the 47 wait times are within the 60-minute standard.

Business Hours Youth Crisis: 7 Crises in 3rd quarter 2020 as reported on the Crisis Spreadsheet. 7/7 have wait times listed. 7/7 (100%) of the wait times listed are within the 60-minute standard.

After-hours Youth Crisis: 6 Crises in 3rd quarter 2020 as reported on the Crisis Spreadsheet. 5/6 (83.33%) have wait times listed. 5/5 (100%) of the wait times listed are within the 60-minute standard.

2020 Quarter 4
Business Hours Adult Crisis: 35 Crises in 4th quarter 2020 as reported on the Crisis Spreadsheet. 35/35 (100%) have wait times listed. 35/35 (100%) of the wait times listed are within the 60-minute standard.

After Hours Adult Crisis: 14 Crises in 4th quarter 2020 as reported on the Crisis Spreadsheet. 10/14 (71.42%) have wait times listed. 9/10 (90%) of the wait times listed are within the 60-minute standard.

Business Hours Youth Crisis: 12 Crises in 4th quarter 2020 as reported on the Crisis Spreadsheet. 12/12 (100%) have wait times listed. 12/12 (100%) of the wait times listed are within the 60-minute standard.

After-hours Youth Crisis: 10 Crises in 4th quarter 2020 as reported on the Crisis Spreadsheet. 4/10 (40%) have wait times listed. 4/4 (100%) of the wait times listed are within the 60-minute standard.

2021 Quarter 1
Business Hours Adult Crisis: 28 Crises in 1st quarter 2021 as reported on the Crisis Spreadsheet. 17/28 (60.7%) have wait times listed. 17/17 (100%) of the wait times listed are within the 60-minute standard.

After Hours Adult Crisis: 18 Crises in 1st quarter 2021 as reported on the Crisis Spreadsheet. 10/18 (55.5%) have wait times listed. 9/10 (90%) of the wait times listed are within the 60-minute standard.

Business Hours Youth Crisis: 16 Crises in 1st quarter 2021 as reported on the Crisis Spreadsheet. 13/16 (81.1%) have wait times listed. 13/13 (100%) of the wait times listed are within the 60-minute standard.

After-hours Youth Crisis: 9 Crises in 1st quarter 2021 as reported on the Crisis Spreadsheet. 6/9 (66%) have wait times listed. 6/6 (100%) of the wait times listed are within the 60-minute standard.

2021 Quarter 2
Business Hours Adult Crisis: 25 Crises in 2nd quarter 2021 as reported on the Crisis Spreadsheet. 17/25 (68%) have wait times listed. 17/17 (100%) of the wait times listed are within the 60-minute standard.

After Hours Adult Crisis: 11 Crises in 2nd quarter 2021 as reported on the Crisis Spreadsheet. 8/11 (72.7%) have wait times listed. 8/8 (100%) of the wait times listed are within the 60-minute standard.

Business Hours Youth Crisis: 17 Crises in 2nd quarter 2021 as reported on the Crisis Spreadsheet. 15/17 (88.2%) have wait times listed. 15/5 (100%) of the wait times listed are within the 60-minute standard.

After-hours Youth Crisis: 3 Crises in 2nd quarter 2021 as reported on the Crisis Spreadsheet. 2/3 (66.7%) have wait times listed. 2/2 (100%) of the wait times listed are within the 60-minute standard.

2021 Quarter 3
Business Hours Adult Crisis: 38 Crises in 3rd quarter 2021 as reported on the Crisis Spreadsheet. 38/38 (100%) have wait times listed. 38/38 (100%) of the wait times listed are within the 60-minute standard.

After Hours Adult Crisis: 18 Crises in 3rd quarter 2021 as reported on the Crisis Spreadsheet. 17/18 (94.4%) have wait times listed. 17/17 (100%) of the wait times listed are within the 60-minute standard.

Business Hours Youth Crisis: 6 Crises in 3rd quarter 2021 as reported on the Crisis Spreadsheet. 6/6 (100%) have wait times listed. 6/6 (100%) of the wait times listed are within the 60-minute standard.

After-hours Youth Crisis: 8 Crises in 3rd quarter 2021 as reported on the Crisis Spreadsheet. 6/8 (75%) have wait times listed. 6/6 (100%) of the wait times listed are within the 60-minute standard.

2021 Quarter 4
Business Hours Adult Crisis: 21 Crises in 4th quarter 2021 as reported on the Crisis Spreadsheet. 20/21 (95.2%) have wait times listed. 20/20 (100%) of the wait times listed are within the 60-minute standard.

After Hours Adult Crisis: 13 Crises in 4th quarter 2021 as reported on the Crisis Spreadsheet. 12/13 (92.3%) have wait times listed. 12/12 (100%) of the wait times listed are within the 60-minute standard.

Business Hours Youth Crisis: 13 Crises in 4th quarter 2021 as reported on the Crisis Spreadsheet. 10/13 (76.9%) have wait times listed. 10/10 (100%) of the wait times listed are within the 60-minute standard.

After-hours Youth Crisis: 10 Crises in 4th quarter 2021 as reported on the Crisis Spreadsheet. 8/10 (80%) have wait times listed. 8/8 (100%) of the wait times listed are within the 60-minute standard.

2022 Quarter 1
Business Hours Adult Crisis: 22 Crises in 1st quarter 2022 as reported on the Crisis Spreadsheet. 21/22 (95.5%) have wait times listed. 20/20 (100%) of the wait times listed are within the 60-minute standard.

After Hours Adult Crisis: 10 Crises in 1st quarter 2022 as reported on the Crisis Spreadsheet. 8/10 (80%) have wait times listed. 7/8 (87.5%) of the wait times listed are within the 60-minute standard.

Business Hours Youth Crisis: 8 Crises in 1st quarter 2022 as reported on the Crisis Spreadsheet. 5/8 (62.5%) have wait times listed. 10/10 (100%) of the wait times listed are within the 60-minute standard.

After-hours Youth Crisis: 7 Crises in 1st quarter 2022 as reported on the Crisis Spreadsheet. 7/7 (100%) have wait times listed. 7/7 (100%) of the wait times listed are within the 60-minute standard

2022 Quarter 2
Business Hours Adult Crisis: 31 Crises in 2nd quarter 2022 as reported on the Crisis Spreadsheet. 31/31 (100%) have wait times listed. 31/31 (100%) of the wait times listed are within the 60-minute standard.

After Hours Adult Crisis: 15 Crises in 2nd quarter 2022 as reported on the Crisis Spreadsheet. 14/15 (93.3%) have wait times listed. 14/14 (100%) of the wait times listed are within the 60-minute standard.

Business Hours Youth Crisis: 4 Crises in 2nd quarter 2022 as reported on the Crisis Spreadsheet. 4/4 (100%) have wait times listed. 4/4 (100%) of the wait times listed are within the 60-minute standard.

After-hours Youth Crisis: 7 Crises in 2nd quarter 2022 as reported on the Crisis Spreadsheet. 7/7 (100%) have wait times listed. 7/7 (100%) of the wait times listed are within the 60-minute standard

2022 Quarter 3
Business Hours Adult Crisis: 38 Crises in 3rd quarter 2022 as reported on the Crisis Spreadsheet. 34/38 (89.5%) have wait times listed. 34/34 (100%) of the wait times listed are within the 60-minute standard.

After Hours Adult Crisis: 14 Crises in 3rd quarter 2022 as reported on the Crisis Spreadsheet. 13/14 (92.9%) have wait times listed. 13/13 (100%) of the wait times listed are within the 60-minute standard.

Business Hours Youth Crisis: 14 Crises in 3rd quarter 2022 as reported on the Crisis Spreadsheet. 12/14 (85.7%) have wait times listed. 12/12 (100%) of the wait times listed are within the 60-minute standard.

After-hours Youth Crisis: 5 Crises in 3rd quarter 2022 as reported on the Crisis Spreadsheet. 4/5 (80%) have wait times listed. 4/4 (100%) of the wait times listed are within the 60-minute standard

2022 Quarter 4
Business Hours Adult Crisis: 31 Crises in 4th quarter 2022 as reported on the Crisis Spreadsheet. 29/31 (93.5%) have wait times listed. 29/29 (100%) of the wait times listed are within the 60-minute standard.

After Hours Adult Crisis: 16 Crises in 4th quarter 2022 as reported on the Crisis Spreadsheet. 14/16 (87.5%) have wait times listed. 14/14 (100%) of the wait times listed are within the 60-minute standard.

Business Hours Youth Crisis: 7 Crises in 4th quarter 2022 as reported on the Crisis Spreadsheet. 7/7 (100%) have wait times listed. 7/7 (100%) of the wait times listed are within the 60-minute standard.

After-hours Youth Crisis: 8 Crises in 4th quarter 2022 as reported on the Crisis Spreadsheet. 8/8 (100%) have wait times listed. 8/8 (100%) of the wait times listed are within the 60-minute standard

2019 Year Analysis
LCBH met our goal that 80% of all crisis will be seen within a 60 minute response time standard for all four quarters of 2019.

2020 Year Analysis
LCBH met our goal that 80% of all crisis will be seen within a 60 minute response time standard for all four quarters of 2020 during business hours. After hours crisis response met the 80% goal in three of the four quarters but fell short of the goal in quarter 3. LCBH feels this is due to some of the after-hours providers living out of the local area and having to drive to the crisis. Times will vary depending on road conditions and the time the crisis worker received the call from the after-hours crisis

line to advise there was a crisis in the hospital. LCBH is working on a plan to more accurately track this metric. The COVID 19 pandemic began in March 2020 and LCBH feels this could have impacted our numbers.

2021 Year Analysis
LCBH met our goal that 80% of all crisis will be seen within a 60-minute response time standard for all four quarters of 2021.

2022 Year Analysis
LCBH met our goal that 80% of all crisis will be seen within a 60-minute response time standard for all four quarters of 2022. In Q1, Youth Crises during Business hours did not meet the 80% goal, however the percentage of the combined crises for the quarter, Youth/Adult and Business/After hours, do exceed the 80% goal amounting to 87% in total for Q1.

Service Delivery – Capacity and Timeliness

Goal 4	To improve client assessment retention rates from 50-60% to 70-80%.
Objective 4.a.	Compare client attendance status of assessments to current baselines while implementing the interventions described below.
Action Steps: 1. Collect data from EHR. 2. Establish a workgroup (providers and beneficiaries) to complete a study of best practices to increase access to BH services. 3. Develop interventions using best practices and data collected from workgroup	
Monitoring Method	1. Survey beneficiaries to determine factors and barriers to showing up for scheduled appointments
Reporting Frequency	Quarterly
Responsible Partners	Analyst, QI Committee, and PIP Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 1. Provision of Services, 2. Availability and Accessibility of Services
Report **2019 Quarter 1**	

Regarding Monitoring Method: LCBH has conducted 2 surveys whose questions address this issue. LCBH will continue seeking consumer feedback on the issue of appointment attendance.

LCBH is currently collecting and analyzing data on reasons for missed assessment appointments. Retention rate at assessment for January 2019 is 55.26%. Average retention rate for Nov. 2018 through Jan. 2019 is 60.91%.

February and March had assessment retention rates of 55.88% and 48.78%, respectively.

2019 Quarter 2
April: 91.6% retention rate at Assessment.
May: 76.32% retention rate at Assessment.
June: 71.43% retention rate at Assessment.

2019 Quarter 3
July: 75% retention rate at assessment
August: 70.45% retention rate at assessment
September: 75% retention rate at assessment

2019 Quarter 4
October: 79.49% retention rate at assessment
November: 65.71% retention rate at assessment
December: 67.65% retention rate at assessment

2020 Quarter 1
January: 47 Registrations were completed. 47/47 completed Registrations were offered an Assessment. 35/47 Assessments were completed for a 74.47% retention rate at assessment.
February: 38 Registrations were completed. 33/38 completed Registrations were offered an Assessment. 16/33 Assessments were completed for a 48.48% retention rate at assessment.
March: 29 Registrations were completed. 23/29 completed Registrations were offered an Assessment. 18/23 Assessments were completed for a 78.26% retention rate at assessment.

2020 Quarter 2
April: 22 Registrations were completed. 21/22 completed Registrations were offered an Assessment. 19/21 Assessments were completed for a 90.48% retention rate at assessment.
May: 25 Registrations were completed. 22/25 completed Registrations were offered an Assessment. 16/22 Assessments were completed for a 72.72% retention rate at assessment.

June: 21 Registrations were completed. 19/21 completed Registrations were offered an Assessment. 15/19 Assessments were completed for a 78.95% retention rate at assessment.

2020 Quarter 3
July: 33 Registrations were completed. 26/33 completed Registrations were offered an Assessment. 20/26 Assessments were completed for a 76.92% retention rate at assessment.
August: 27 Registrations were completed. 25/27 completed Registrations were offered an Assessment. 17/25 Assessments were completed for a 68% retention rate at assessment.
September: 26 Registrations were completed. 26/26 completed Registrations were offered an Assessment. 22/26 Assessments were completed for an 84.61% retention rate at assessment.

2020 Quarter 4
October: 31 Registrations were completed. 30/31 completed Registrations were offered an Assessment. 17/30 Assessments were completed for a 56.67% retention rate at assessment.
November: 39 Registrations were completed. 36/39 completed Registrations were offered an Assessment. 17/36 Assessments were completed for a 47.22% retention rate at assessment.
December: 34 Registrations were completed. 28/34 completed Registrations were offered an Assessment. 21/28 Assessments were completed for a 75% retention rate at assessment.

2021 Quarter 1
January: 37 Registrations were completed. 34/37 completed Registrations were offered an Assessment. 30/34 Assessments were completed for an 88.2% retention rate at assessment.
February: 27 Registrations were completed. 26/27 completed Registrations were offered an Assessment. 21/26 Assessments were completed for an 80.7% retention rate at assessment.
March: 36 Registrations were completed. 35/26 completed Registrations were offered an Assessment. 32/35 Assessments were completed for a 91.4% retention rate at assessment.

2021 Quarter 2
April: 33 Registrations were completed. 30/33 completed Registrations were offered an Assessment. 28/30 Assessments were completed for a 93.3% retention rate at assessment.
May: 46 Registrations were completed. 45/46 completed Registrations were offered an Assessment. 36/45 Assessments were completed for an 80% retention rate at assessment.

June: 30 Registrations were completed. 30/30 completed Registrations were offered an Assessment. 23/30 Assessments were completed for a 76.6% retention rate at assessment.

2021 Quarter 3
July: 29 Registrations were completed. 28/29 completed Registrations were offered an Assessment. 25/28 Assessments were completed for an 89% retention rate at assessment.
August: 26 Registrations were completed. 23/26 completed Registrations were offered an Assessment. 22/23 Assessments were completed for a 96% retention rate at assessment.
September: 28 Registrations were completed. 28/28 completed Registrations were offered an Assessment. 23/28 Assessments were completed for an 82% retention rate at assessment.

2021 Quarter 4
October: 30 Registrations were completed. 27/30 completed Registrations were offered an Assessment. 21/27 Assessments were completed for a 78% retention rate at assessment.
November: 29 Registrations were completed. 28/29 completed Registrations were offered an Assessment. 23/28 Assessments were completed for an 82% retention rate at assessment.
December: This metric runs three to four weeks behind therefore cannot be calculated at this time.

2022 Quarter 1
January: 37 Registrations were completed. 25/37 completed Registrations were offered an Assessment. 23/25 Assessments were completed for an 92% retention rate at assessment.
February: 27 Registrations were completed. 20/27 completed Registrations were offered an Assessment. 19/20 Assessments were completed for an 95% retention rate at assessment.
March: 36 Registrations were completed. 32/36 completed Registrations were offered an Assessment. 30/32 Assessments were completed for a 93.8% retention rate at assessment.

2022 Quarter 2
April: 36 Registrations were completed. 28/36 completed Registrations were offered an Assessment. 23/28 Assessments were completed for an 82.1% retention rate at assessment.
May: 45 Registrations were completed. 40/45 completed Registrations were offered an Assessment. 35/40 Assessments were completed for an 87.5% retention rate at assessment.

June: 41 Registrations were completed. 37/41 completed Registrations were offered an Assessment. 29/37 Assessments were completed for a 78.4% retention rate at assessment.

2022 Quarter 3
July: 36 Registrations were completed. 35/36 completed Registrations were offered an Assessment. 30/35 Assessments were completed for an 85.7% retention rate at assessment.
August: 54 Registrations were completed. 50/54 completed Registrations were offered an Assessment. 42/50 Assessments were completed for an 84% retention rate at assessment.
September: 17 Registrations were completed. 15/17 completed Registrations were offered an Assessment. 16/17 Assessments were completed for a 94.1% retention rate at assessment.

2022 Quarter 4
October: 38 Registrations were completed. 23/38 completed Registrations were offered an Assessment. 18/23 Assessments were completed for a 78.3% retention rate at assessment.
November: 24 Registrations were completed. 22/24 completed Registrations were offered an Assessment. 20/22 Assessments were completed for a 91% retention rate at assessment.
December: 32 Registrations were completed. 27/32 completed Registrations were offered an Assessment. 22/27 Assessments were completed for an 81.5% retention rate at assessment.

2019 Year Analysis
LCBH met our goal of improving retention rates at assessment from 50-60% to 70-80% for 2 of the 4 quarters. Quarter one was not met. LCBH implemented new assessment procedures in Quarter 2. Quarter 2 and Quarter 3 met our goal of 70-80% retention. Quarter 4 had one month of the two that were able to be measured that was not met. LCBH is looking into the data for November to see why the goal of 70-80% retention was not met to be able to implement a change to ensure that our retention rate returns to 70-80%. LCBH found that surveying the clients was not helpful as they all said that services were great and there is nothing they would change other than transportation issues which LCBH cannot control.

2020 Year Analysis
LCBH was able to maintain a retention rate above 70% in two of the three months in Q1. Q2 LCBH met the goal retention rate of between 70-80% in all three months but again in Q3 only met this goal for two of the three Months.Q4 numbers are not accurate as this metric can take up to three months at times to be measured as we wait for clients to complete their appointments who have cancelled and rescheduled their appointments for various reasons. LCBH also implemented a Performance Improvement Project (PIP) on improving this metric by having a case manager

contact client between Registration and completed Assessment. LCBH continues to monitor these numbers to see if the PIP will have a positive impact on the retention rate percentage. The COVID 19 pandemic began in March 2020 and LCBH feels this could have impacted our numbers.

2021 Year Analysis
In 2021 LCBH was able to maintain an Assessment retention rate on 70-80% in all four quarters. LCBH revised its existing PIP to have a case manager call and do a follow up and check in with clients when they miss their assessment appointment. When the case manager completes the check in with the client they will ask the client if they are still interested in receiving services with LCBH. This PIP seems to have helped retention at assessment a significant amount as there were some months in 2021 that LCBH had over a 90% retention Rate. Due to COVD 19 LCBH also started offering clients Assessments via phone which could have had a positive impact on the Assessment retention rates as well.

2022 Year Analysis
In 2022 LCBH was able to maintain an Assessment Retention rate of 70-80% in all four quarters. Case managers have followed direction to contact clients when an Assessment Appointment is missed and this is having positive results. For the whole 1st quarter LCBH maintained a retention rate in excess of 90%. Months following have been positive with only June and October having less than 80% retention. Year-over-year comparison does not demonstrate significant change from 2021, but from 2020, prior to establishing this PIP, retention has significantly improved. Prior to this PIP, yearly average retention for 2019 was 74%, 2020 was 71%. After beginning this PIP, yearly average retention for 2021 was 85.2% and for 2022 it was 87%. This increase demonstrates the positive impact of this PIP and other potential factors such as offering Assessment via phone.

Service Delivery – Capacity and Timeliness

Goal 5	Evaluate crisis prevention and discharge planning activities for clients at risk of hospitalization or that have been hospitalized in the previous 12 months. This is to reduce the inappropriate utilization of emergency, crisis and inpatient services, including psychiatric hospitalization bed days.

Objective 5.a.	70% of Lassen County adult/youth beneficiaries who choose LCBH for follow-up care will receive a follow-up appointment within 3 business days of discharge from a psychiatric inpatient facility or a crisis on the County level. (Data will not reflect those individuals who receive psychiatric care from providers other than Lassen County Behavioral Health.)
Action Steps: 1. Gather and evaluate data from EHR Scheduler. 2. Verify clients are seen within 3 working days post crisis if beneficiary chooses to receive follow-up care at LCBH. 3. Share data analysis results with QI Program. 4. QI Program will engage in continuous quality improvement process until goal is reached and ongoing to maintain the goal.	
Monitoring Method	Monitor using EHR system, TARS, and Excel Spreadsheets.
Reporting Frequency	Quarterly
Responsible Partners	Analyst & QI Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 1. Provision of Services, 2. Availability and Accessibility of Services

Report

2019 Quarter 1
LCBH maintains spreadsheets for Crisis and Hospitalization Follow-ups.

Youth 2019 Quarter 1 Crises: 30 Crises. 11 came in for services following the crisis. 9 of the 11 (81.8%) were seen within 3 business days following the crisis.

Youth 2019 Quarter 1 Hospital Discharges: 3 discharged in-county. 2 of the 3 came in for services after discharge. 2 of the 2 (100%) were seen within 3 business days of discharge.

Adult 2019 Quarter 1 Crises: 72 Crises. 44 came in for services following the crisis. 35 of the 44 (79.54%) were seen within 3 business days.

Adult 2019 Quarter 1 Hospital Discharges: 12 in-county discharges. 8 of the 12 discharges came in for services after discharge. 5 of the 8 (62.5%) were seen within 3 business days of discharge.

2019 Quarter 2

Youth 2019 Quarter 2 Crises: 19 Crises. 7 came in for services following the crisis. 4 of the 7 (57.1%) were seen within 3 business days following the crisis.

Youth 2019 Quarter 2 Hospital Discharges: 8 discharges in-county. 3 of the 8 came in for services after discharge. 2 of the 3 (66.7%) were seen within 3 business days of discharge.

Adult 2019 Quarter 2 Crises: 61 Crises. 31 came in for Rebound services following the crisis. 22 of the 31 (70.96%) were seen within 3 business days.

Adult 2019 Quarter 2 Hospital Discharges: 12 discharges in-county. 6 of the 12 discharges came in for services after discharge. 3 of the 6 (50%) were seen within 3 business days of discharge.

2019 Quarter 3

Youth 2019 Quarter 3 Crises: 27 Crises. 6 came in for Services following the crisis. 6 of the 6 (100%) were seen within 3 business days following the crisis.

Youth 2019 Quarter 3 Hospital Discharges: 4 discharges in-county. 2 of those came in for services after discharge. 0 of 2 (0%) were seen within 3 business days of discharge.

Adult 2019 Quarter 3 Crises: 67 Crises. 20 came in for services following the crisis. 15 of 20 (75%) were seen within 3 business days.

Adult 2019 Quarter 3 Hospital Discharges: 19 discharges in-county. 7 of the 19 discharges came in for services after discharge. 6 of the 7 (85.71%) were seen within 3 business days of discharge.

2019 Quarter 4

Youth 2019 Quarter 4 Crises: 27 Crises. 7 came in for services following the crisis. 7 of the 7 (100%) were seen within 3 business days following the crisis.

Youth 2019 Quarter 4 Hospital Discharges: 3 discharges in-county. 3 of those came in for services after discharge. 2 of the 3 (66.7%) were seen within 3 business days of discharge.

Adult 2019 Quarter 4 Crises: 61 Crises. 31 came in for services following the crisis. 22 of 31 (70.96%) were seen within 3 business days.

Adult 2019 Quarter 4 Hospital Discharges: 9 discharges in-county. 6 of the 9 discharges came in for services after discharge. 5 of the 6 of (83.33%) were seen within 3 business days of discharge.

2020 Quarter 1

Youth 2020 Quarter 1 Crises: 31 Crises. 21 came in for services following the crisis.13/21 (61.90%) were seen within 3 business days following the crisis.

Youth 2020 Quarter 1 Hospital Discharges.5 discharges chose to follow up with services at LCBH 4 of the 5 (80%) were offered an appointment to be seen within 3 business days of discharge.

Adult 2020 Quarter 1 Crises: 59 Crises. 32 came in for services following the crisis. 25 of 32 (78.12%) were seen within 3 business days.

Adult 2020 Quarter 1 Hospital Discharges: 9 discharges chose to follow up with services at LCBH. 9 of the 9 of (100%) were offered an appointment to be seen within 3 business days of discharge.

2020 Quarter 2

Youth 2020 Quarter 2 Crises: 14 Crises. 9 came in for services following the crisis. 7 of the 9 (78.78%) were seen within 3 business days following the crisis.

Youth 2020 Quarter 2 Hospital Discharges. 1 discharge chose to follow up with services at LCBH. 1 of the 1 (100%) were offered an appointment to be seen within 3 business days of discharge

Adult 2020 Quarter 2 Crises: 58 Crises. 26 came in for services following the crisis. 18 of 26 (69.23%) were seen within 3 business days.

Adult 2020 Quarter 2 Hospital Discharges: 6 discharges chose to follow up with services at LCBH. 6 of the 6 of (100%) were offered an appointment to be seen within 3 business days of discharge.

2020 Quarter 3

Youth 2020 Quarter 3 Crises: 13 Crises. 5 came in for services following the crisis. 2 of the 5 (40%) were seen within 3 business days following the crisis.

Youth 2020 Quarter 3 Hospital Discharges. 6 discharges chose to follow up with services at LCBH. 5 of the 6 (83.33%) were offered an appointment to be seen within 3 business days of discharge

Adult 2020 Quarter 3 Crises: 73 Crises. 47 came in for services following the crisis. 30 of 47 (63.83%) were seen within 3 business days.

Adult 2020 Quarter 3 Hospital Discharges: 17 discharges chose to follow up with services at LCBH. 15 of the 17 of (88.23%) were offered an appointment to be seen within 3 business days of discharge.

2020 Quarter 4

Youth 2020 Quarter 4 Crises: 22 Crises. 13 came in for services following the crisis. 10 of the 13 (76.92%) were seen within 3 business days following the crisis.

Youth 2020 Quarter 4 Hospital Discharges.1 discharge chose to follow up with services at LCBH. 1 of the 1 (100%) were offered an appointment to be seen within 3 business days of discharge

Adult 2020 Quarter 4 Crises: 51 Crises. 31 came in for services following the crisis. 19 of 31 (61.29%) were seen within 3 business days.

Adult 2020 Quarter 4 Hospital Discharges: 5 discharges chose to follow up with services at LCBH. 3 of the 5 of (60%) were offered an appointment to be seen within 3 business days of discharge.

2021 Quarter 1

Youth 2021 Quarter 1 Crises: 26 Crises. 11 came in for services following the crisis. 8/11 (72.72%) were seen within 3 business days following the crisis.

Youth 2021 Quarter 1 Hospital Discharges: 6 Hospital Discharges. 4 discharges chose to follow up with services at LCBH 4 of the 4 (100%) were offered an appointment to be seen within 3 business days of discharge.

Adult 2021 Quarter 1 Crises: 46 Crises. 20 came in for services following the crisis. 14/20 (70%) were seen within 3 business days.

Adult 2021 Quarter 1 Hospital Discharges: 11 Hospital Discharges: 5 discharges chose to follow up with services at LCBH. 5 of the 5 of (100%) were offered an appointment to be seen within 3 business days of discharge.

2021 Quarter 2

Youth 2021 Quarter 2 Crises: 20 Crises. 10 came in for services following the crisis. 8/10 (80%) were seen within 3 business days following the crisis.

Youth 2021 Quarter 2 Hospital Discharges: 6 Hospital Discharges. 3 discharge chose to follow up with services at LCBH. 3 of the 3 (100%) were offered an appointment to be seen within 3 business days of discharge

Adult 2021 Quarter 2 Crises: 37 Crises. 18 came in for services following the crisis. 10 /18 (55.5%) were seen within 3 business days.

Adult 2021 Quarter 2 Hospital Discharges: 9 Hospital Discharges: 4 discharges chose to follow up with services at LCBH. 4 of the 4 (100%) were offered an appointment to be seen within 3 business days of discharge.

2021 Quarter 3

Youth 2021 Quarter 3 Crises: 14 Crises. 7 came in for services following the crisis. 4/7 (57.1%) were seen within 3 business days following the crisis.

Youth 2021 Quarter 3 Hospital Discharges: 5 Hospital Discharges. 2 discharges chose to follow up with services at LCBH 2 of the 2 (100%) were offered an appointment to be seen within 3 business days of discharge.

Adult 2021 Quarter 3 Crises: 56 Crises. 28 came in for services following the crisis. 11/28 (39.2%) were seen within 3 business days.

Adult 2021 Quarter 3 Hospital Discharges: 10 Hospital Discharges: 5 discharges chose to follow up with services at LCBH. 3 of the 5 of (60%) were offered an appointment to be seen within 3 business days of discharge.

2021 Quarter 4

Youth 2021 Quarter 4 Crises: 23 Crises. 16 came in for services following the crisis. 14/16 (87.5%) were seen within 3 business days following the crisis.

Youth 2021 Quarter 4 Hospital Discharges: 6 Hospital Discharges. 3 discharge chose to follow up with services at LCBH. 3 of the 3 (100%) were offered an appointment to be seen within 3 business days of discharge

Adult 2021 Quarter 4 Crises: 34 Crises. 10 came in for services following the crisis. 7 /10 (70%) were seen within 3 business days.

Adult 2021 Quarter 4 Hospital Discharges: 6 Hospital Discharges: 1 discharges chose to follow up with services at LCBH. 0 of the 1 (0%) were offered an appointment to be seen within 3 business days of discharge.

2022 Quarter 1

Youth 2022 Quarter 1 Crises: 15 Crises. 7 came in for services following the crisis. 6 of the 7 (85.7%) were seen within 3 business days following the crisis.

Youth 2022 Quarter 1 Hospital Discharges: 5 Hospital Discharges. 1 discharge chose to follow up with services at LCBH. 0 of the 1 (0%) were offered an appointment to be seen within 3 business days of discharge

Adult 2022 Quarter 1 Crises: 32 Crises. 10 came in for services following the crisis. 8 of the 10 (80%) were seen within 3 business days.

Adult 2022 Quarter 1 Hospital Discharges: 6 Hospital Discharges: 5 discharges chose to follow up with services at LCBH. 3 of the 5 (60%) were offered an appointment to be seen within 3 business days of discharge.

2022 Quarter 2

Youth 2022 Quarter 2 Crises: 12 Crises. 6 came in for services following the crisis. 6 of the 6 (100%) were seen within 3 business days following the crisis.

Youth 2022 Quarter 2 Hospital Discharges: 3 Hospital Discharges. 2 discharge chose to follow up with services at LCBH. 2 of the 2 (100%) were offered an appointment to be seen within 3 business days of discharge

Adult 2022 Quarter 2 Crises: 47 Crises. 33 came in for services following the crisis. 27 of the 33 (81.8%) were seen within 3 business days.

Adult 2022 Quarter 2 Hospital Discharges: 9 Hospital Discharges: 9 discharges chose to follow up with services at LCBH. 6 of the 10 (60%) were offered an appointment to be seen within 3 business days of discharge.

2022 Quarter 3

Youth 2022 Quarter 3 Crises: 18 Crises. 10 came in for services following the crisis. 8 of the 10 (80%) were seen within 3 business days following the crisis.

Youth 2022 Quarter 3 Hospital Discharges: 2 Hospital Discharges. 2 discharge chose to follow up with services at LCBH. 2 of the 2 (100%) were offered an appointment to be seen within 3 business days of discharge

Adult 2022 Quarter 3 Crises: 52 Crises. 30 came in for services following the crisis. 22 of the 30 (73.3%) were seen within 3 business days.

Adult 2022 Quarter 3 Hospital Discharges: 9 Hospital Discharges: 9 discharges chose to follow up with services at LCBH. 6 of the 9 (66.6%) were offered an appointment to be seen within 3 business days of discharge.

2022 Quarter 4

Youth 2022 Quarter 4 Crises: 15 Crises. 7 came in for services following the crisis. 6 of the 7 (85.7%) were seen within 3 business days following the crisis.

Youth 2022 Quarter 4 Hospital Discharges: 4 Hospital Discharges. 2 discharge chose to follow up with services at LCBH. 2 of the 2 (100%) were offered an appointment to be seen within 3 business days of discharge

Adult 2022 Quarter 4 Crises: 46 Crises. 27 came in for services following the crisis. 18 of the 27 (66.6%) were seen within 3 business days.

Adult 2022 Quarter 4 Hospital Discharges: 13 Hospital Discharges: 11 discharges chose to follow up with services at LCBH. 8 of the 11 (72.7%) were offered an appointment to be seen within 3 business days of discharge.

2019 Year Analysis
LCBH goal of 70% of Adult/Youth beneficiaries receiving an appointment within 3 business days of discharge from inpatient facility or a county level crisis were not completely met for any of the 4 Quarters. The data we use for this metric is dependent on whether the client choose to come in for follow-up services or not. This goal is not something the county has control over as it is determined by the client and when the client chooses to come in. In the future the county will measure the first offered appointment to clients after discharge or crisis to insure we are offing a client who was seen for a crisis on the county level or has been discharged from an inpatient facility a timely follow up appointment.

2020 Year Analysis

LCBH goal of 70% of Adult/Youth beneficiaries receiving an appointment within 3 business days of discharge from inpatient facility or a county level crisis were not completely met for any of the 4 Quarters. The data we use for this metric is dependent on whether the client choose to come in for follow-up services or not. This goal is not something the county has control over as it is determined by the client and when the client chooses to come in. In the future the county will measure the first offered appointment to clients after discharge or crisis to insure we are offing a client who was seen for a crisis on the county level or has been discharged from an inpatient facility a timely follow up appointment. LCBH offers all Hospital Discharges a Rebound Appointment within 3 business days of Discharge. It is up to the client if they choose to come in within 3 business days or not. Due to this metric being dependent on when the client chooses to come in for follow up and LCBH not having control of this metric LCBH will be Exploring a new option to replace this goal with. The COVID 19 pandemic began in March 2020 and LCBH feels this could have impacted our numbers.

2021 Year Analysis
LCBH goal of 70% of Adult/Youth beneficiaries receiving an appointment within 3 business days of discharge from inpatient facility or a county level crisis were not completely met for any of the 4 Quarters. The data we use for this metric is dependent on whether the client choose to come in for follow-up services or not. This goal is not something the county has control over as it is determined by the client and when the client chooses to come in. In the future the county will measure the first offered appointment to clients after discharge or crisis to insure we are offing a client who was seen for a crisis on the county level or has been discharged from an inpatient facility a timely follow up appointment. LCBH offers all Hospital Discharges a Rebound Appointment within 3 business days of Discharge. It is up to the client if they choose to come in within 3 business days or not. Due to this metric being dependent on when the client chooses to come in for follow up and LCBH not having control of this metric LCBH will be Exploring a new option to replace this goal with.

2022 Year Analysis
LCBH goal of 70% of Adult/Youth beneficiaries receiving an appointment within 3 business days of discharge from inpatient facility or a county level crisis were not completely met for any of the 4 Quarters. The data we use for this metric is dependent on whether the client chooses to come in for follow-up services or not. This goal is not something the county has control over as it is determined by the client and when the client chooses to come in. The initiative over 2022 to continually track when appointments were first offered did not result in consistent data. Entries for dates of contact were sparse and not being enforced consistently prior to the 3 days post-discharge marker. Ensuring that first contact attempts are consistently tracked will be necessary going forward if this metric stays in place. Due to this metric being dependent on when the client chooses to come in for follow up and LCBH not having control of this metric LCBH will continue exploring a new option to replace this goal with.

Service Delivery – Capacity and Timeliness	
Goal 6	To reduce 30-day readmission rates at acute psychiatric hospitals by utilizing intensive case management.
Objective 6.a.	Intensive case management will insure that there are no more than 2 30 day readmissions per quarter per youth/adult.
Action Steps: 1. Gather and evaluate data from EHR Scheduler. 2. Review experience of a sample of hospital patients with recidivism histories. 3. Identify resources that might be developed to serve hospital discharges and promote stability and wellness. 4. Program will engage in continuous quality improvement process until goal is reached and ongoing to maintain the goal.	
Monitoring Method	Monitor using EHR system, Crisis Excel spreadsheets.
Reporting Frequency	Quarterly
Responsible Partners	Analyst & QI Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 1. Provision of Services, 2. Availability and Accessibility of Services

2019 Quarter 1
Adult Hospitalizations 2019: 2 of the 21 hospitalizations (9.5%) were within 30 days of the previous discharge.

Youth Hospitalizations 2019: 1 of the 5 hospitalizations (20%) were within 30 days of the previous discharge.

2019 Quarter 2
Adult Hospitalizations 2019 Quarter 2: 2 of the 17 hospitalizations (11.8%) were within 30 days of the previous discharge.

Youth Hospitalizations 2019 Quarter 2: 0 of the 9 hospitalizations (0%) were within 30 days of the previous discharge.

2019 Quarter 3
Adult Hospitalizations 2019: 2 of the 28 hospitalizations (7.1%) were within 30 days of the previous discharge.

Youth Hospitalizations 2019: 0 of the 6 hospitalizations (0%) were within 30 days of the previous discharge.

2019 Quarter 4
Adult Hospitalizations 2019: 2 of the 12 hospitalizations (16.7%) were within 30 days of the previous discharge.

Youth Hospitalizations 2019: 1 of the 7 hospitalizations (14.2%) were within 30 days of the previous discharge.

2020 Quarter 1
Adult Hospitalizations 2020: 3 of the 19 hospitalizations (15.8%) were within 30 days of the previous discharge.

Youth Hospitalizations 2020: 0 of the 5 hospitalizations (0%) were within 30 days of the previous discharge.

2020 Quarter 2
Adult Hospitalizations 2020 Quarter 2: 1 of the 14 hospitalizations (7.1%) were within 30 days of the previous discharge.

Youth Hospitalizations 2020 Quarter 2: 0 of the 3 hospitalizations (0%) were within 30 days of the previous discharge.

2020 Quarter 3
Adult Hospitalizations 2020: 1 of the 19 hospitalizations (5.3%) were within 30 days of the previous discharge.

Youth Hospitalizations 2020: 0 of the 11 hospitalizations (0%) were within 30 days of the previous discharge.

2020 Quarter 4
Adult Hospitalizations 2020: 0 of the 10 hospitalizations (0%) were within 30 days of the previous discharge.

Youth Hospitalizations 2020: 0 of the 4 hospitalizations (0%) were within 30 days of the previous discharge.

2021 Quarter 1
Adult Hospitalizations 2021 Quarter 1: 0 of the 11 hospitalizations (0%) were within 30 days of the previous discharge.

Youth Hospitalizations 2021 Quarter 1: 0 of the 6 hospitalizations (0%) were within 30 days of the previous discharge.

2021 Quarter 2

Adult Hospitalizations 2021 Quarter 2: 2 of the 9 hospitalizations (22.2%) were within 30 days of the previous discharge.

Youth Hospitalizations 2021 Quarter 2: 0 of the 6 hospitalizations (0%) were within 30 days of the previous discharge.

2021 Quarter 3
Adult Hospitalizations 2021 Quarter 3: 0 of the 10 hospitalizations (0%) were within 30 days of the previous discharge.

Youth Hospitalizations 2021 Quarter 3: 0 of the 5 hospitalizations (0%) were within 30 days of the previous discharge.

2021 Quarter 4
Adult Hospitalizations 2021 Quarter 4: 0 of the 6 hospitalizations (0%) were within 30 days of the previous discharge.

Youth Hospitalizations 2021 Quarter 4: 1 of the 5 hospitalizations (20%) were within 30 days of the previous discharge.

2022 Quarter 1
Adult Hospitalizations 2022 Quarter 1: 0 of the 7 hospitalizations (0%) were within 30 days of the previous discharge.

Youth Hospitalizations 2022 Quarter 1: 0 of the 6 hospitalizations (0%) were within 30 days of the previous discharge.

2022 Quarter 2
Adult Hospitalizations 2022 Quarter 2: 0 of the 10 hospitalizations (0%) were within 30 days of the previous discharge.

Youth Hospitalizations 2022 Quarter 2: 0 of the 6 hospitalizations (0%) were within 30 days of the previous discharge.

2022 Quarter 3
Adult Hospitalizations 2022 Quarter 3: 0 of the 9 hospitalizations (0%) were within 30 days of the previous discharge.

Youth Hospitalizations 2022 Quarter 3: 0 of the 3 hospitalizations (0%) were within 30 days of the previous discharge.

2022 Quarter 4
Adult Hospitalizations 2022 Quarter 4: 2 of the 13 hospitalizations (15.4%) were within 30 days of the previous discharge.

Youth Hospitalizations 2022 Quarter 4: 1 of the 5 hospitalizations (20%) were within 30 days of the previous discharge.

2019 Year Analysis
LCBH met its goal of no more than 2 adult (age 18+) or 2 youth (ages 0-17) beneficiary 30 day readmissions per quarter in all four quarters.

2020 Year Analysis
LCBH met its goal of no more than 2 adult (age 18+) beneficiary 30 day readmissions per quarter in all three of four quarters but fell short of this goal in Quarter 1 with 3 clients being readmitted into a hospital within 30 days of their previous discharge
LCBH met its goal of no more than 2 youth (ages 0-17) beneficiary 30 day readmissions per quarter in all four quarters. The COVID 19 pandemic began in March 2020 and LCBH feels this could have impacted our numbers. This metric includes all LCBH Hospitalizations regardless of insurance status.

2021 Year Analysis
LCBH met its goal of no more than 2 adult (age 18+) or 2 youth (ages 0-17) beneficiary 30 day readmissions per quarter in all four quarters.

2022 Year Analysis
LCBH met its goal of no more than 2 adult (age 18+) or 2 youth (ages 0-17) beneficiary 30-day readmissions per quarter in all four quarters.

Service Delivery – Capacity and Timeliness	
Goal 7	Ensure access to after-hours care and the effectiveness of the 24/7 toll-free number.
Objective 7.a.	80% of test calls made during after-hours will be answered and all necessary elements logged on log sheet or in EHR system.
Objective 7.b.	80% of test calls made during business hours will be answered and all necessary elements logged on log sheet or in EHR system.
Action Steps: 1. Quarterly training of staff who answers the 24/7 line on required elements and correct logging of information. 2. A minimum of two (2) total test calls will be performed monthly in English or in Spanish testing specific knowledge elements. 3. Gather and evaluate data.	

4. If goal not reached, plan and implement actions to achieve goal.	
Monitoring Method	1. EHR system 2. Test Call Log
Reporting Frequency	Quarterly
Responsible Partners	Analyst & QI Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 1. Provision of Services, 2. Availability and Accessibility of Services

Report

2019 Quarter 1
11 (73.33%) the 15 test calls in Q1 had all required items met. Only 1 of these instances was during business hours and pertained to information about services available to treat beneficiaries' urgent conditions. A training on this topic was held on 01/28/2019 for clerical staff. LCBH requested a Plan of Correction from our contracted after-hours phone services provider.

12 (85.71%) of the 14 test calls in Q1 required to be logged met requirements. Both of the calls that did not meet requirements occurred during business hours and a training for clerical staff was held on 01/28/2019.

2019 Quarter 2
14 (93.33%) of the 15 test calls in Q2 had all required items met. 1 call that did not meet requirements was during after-hours and a Plan of Correction was requested from our After-hours phone services provider.

10 (66.67%) of the 15 test calls in Q2 required to be logged met requirements. 3 calls that did not meet logging requirements were during business hours and a training was held with clerical staff on 05/29/2019. 2 calls that did not meet logging requirements were during after-hours, a Plan of Correction was requested from our after-hours phone services provider.

2019 Quarter 3
13 (86.67%) of the 15 test calls in Q3 had all required items met. 1 call that did not meet requirements occurred during business hours and a training with clerical staff was held on 07/31/2019. 1 Call that did not meet requirements occurred suing after-hours and a Plan of Correction was requested from our after-hours phone services provider.

12 (85.71%) of the 14 test calls in Q3 required to be logged met requirements. 1 call that did not meet logging requirements were during business hours and a training

was held with clerical staff on 07/31/2019. 1 call that did not meet logging requirements were during after-hours, a Plan of Correction was requested from our after-hours phone services provider.

2019 Quarter 4
12 (85.71%) of the 14 test calls in Q4 had all required items met. 2 calls that did not meet requirements occurred during after-hours and a Plan of Correction was requested from our after-hours phone services provider.

9 (64.29%) of the 14 test calls in Q4 required to be logged met requirements. 3 calls that did not meet logging requirements were during business hours and a training was held with clerical staff on 07/31/2019. 2 calls that did not meet logging requirements were during after-hours, a Plan of Correction was requested from our after-hours phone services provider.

2020 Quarter 1
LCBH received 7 test calls required to be logged. 5/7 (71.43%) test calls received required to be logged met logging requirements. LCBH to hold a clerical training on test call logging to resolve this issue.
The after-hours crisis line contracted provider received 6 test calls required to be logged. 6/6 (100%) of the calls required to be logged met logging requirements.

2020 Quarter 2
LCBH received 6 test calls required to be logged. 4/6 (66.67%) test calls received required to be logged met logging requirements. LCBH exploring the option of implementing a new policy and procedure on test calls and logging requirements. LCBH to hold another training on test calls and logging requirements.
The after-hours crisis line contracted provider received 6 test calls required to be logged. 4/6 (67.67%) of the calls required to be logged met logging requirements. LCBH has requested a corrective action plan be submitted by the After-hours contracted crisis line provider.

2020 Quarter 3
LCBH received 9 test calls required to be logged. 9/9 (100%) test calls received required to be logged met logging requirements
The after-hours crisis line contracted provider received 2 test calls required to be logged. 2/2 (100%) of the calls required to be logged met logging requirements.

2020 Quarter 4
LCBH received 8 test calls required to be logged. 6/8 (75%) test calls received required to be logged met logging requirements.
The after-hours crisis line contracted provider received 5 test calls required to be logged. 3/5 (60%) of the calls required to be logged met logging requirements.

2021 Quarter 1
LCBH received 8 test calls required to be logged. 6/8 (75%) test calls received required to be logged met logging requirements.
The after-hours crisis line contracted provider received 5 test calls required to be logged. 4/5 (80%) of the calls required to be logged met logging requirements.

2021 Quarter 2
LCBH received 5 test calls required to be logged. 4/5 (80%) test calls received required to be logged met logging requirements.
The after-hours crisis line contracted provider received 6 test calls required to be logged. 6/6 (100%) of the calls required to be logged met logging requirements.

2021 Quarter 3
LCBH received 7 test calls required to be logged. 4/7 (57.14%) test calls received required to be logged met logging requirements.
The after-hours crisis line contracted provider received 6 test calls required to be logged. 2/6 (33.33%) of the calls required to be logged met logging requirements.

2021 Quarter 4
LCBH received 4 test calls required to be logged. 4/4 (100%) test calls received required to be logged met logging requirements.
The after-hours crisis line contracted provider received 1 test calls required to be logged. 1/1 (100%) of the calls required to be logged met logging requirements.

2022 Quarter 1
LCBH received 8 test calls required to be logged. 7/8 (87.5%) test calls received required to be logged met logging requirements.
The after-hours crisis line contracted provider received 6 test calls required to be logged. 3/6 (50%) of the calls required to be logged met logging requirements.

2022 Quarter 2
LCBH received 6 test calls required to be logged. 4/6 (66.7%) test calls received required to be logged met logging requirements.
The after-hours crisis line contracted provider received 6 test calls required to be logged. 5/6 (83.3%) of the calls required to be logged met logging requirements.

2022 Quarter 3
LCBH received 7 test calls required to be logged. 5/7 (71.4%) test calls received required to be logged met logging requirements.
The after-hours crisis line contracted provider received 6 test calls required to be logged. 5/6 (83.3%) of the calls required to be logged met logging requirements.

2022 Quarter 4
LCBH received 7 test calls required to be logged. 7/7 (100%) test calls received required to be logged met logging requirements.

The after-hours crisis line contracted provider received 6 test calls required to be logged 5/6 (83.3%) of the calls required to be logged met logging requirements.

2019 Year Analysis
LCBH only met its goal of 80% of all test calls being appropriately answered and logged in Quarter 3. Quarter 1 we reached the 80% goal when logging the calls but missed the goal of meeting all requirements of the test call by about 7%. In quarter 2 we exceeded our 80% goal when meeting all the requirements of the test call. However LCBH fell short of the 80% goal when logging the test calls by about 14%. In quarter 4 we exceeded our 80% goal when meeting all the requirements of the test call. However LCBH again fell short of the 80% goal when logging the test calls by about 16%. LCBH has held multiple trainings for clerical staff throughout 2019 and will be holding another training for Clerical staff in January 2020. If obtaining our 80% goal continues to be a problem a new policy and procedure will be put in place. LCBH has requested multiple Plans of correction from our after-hours phone services provider to bring the items that they were not in compliance on into compliance.

2020 Year Analysis
LCBH has been experiencing issues with compliance from the After-hours contracted crisis line and felt it was best to break the metric out to show business hours test calls and after hours test calls separately to determine the training needed by LCBH staff and the training needed by the After-hours staff. LCBH business hours did not meet the 80% goal in quarter one, quarter two, or quarter four. The administrative manager spoke with staff and held another training on test calls and logging requirements and was able to successfully meet the 80% goal in quarter three. The contracted After-hours crisis line met the 80% goal in quarters one and three but fell short of this goal in quarters two and four. LCBH requested that the contracted provider submit a corrective action plan to LCBH to bring the items out of compliance into compliance. LCBH received a corrective action plan from our afterhours contracted provider in which they outlined steps taken to ensure this issue does not happen again

2021 Year Analysis
LCBH met the 80% goal of logging all requirements for Q2 and Q4. LCBH fell short of this goal by 5% in Quarter 1 and provided a training to staff in May 2021. LCBH fell short of this goal by a significant amount in Q3. LCBH feels the reason that we fell short of this goal in Q3 was due to the Dixie Fire that ravaged 5 counties including Lassen county. LCBH also experienced an entire week without power and phones during this quarter.

2022 Year Analysis
LCBH met the 80% goal of logging all requirements completely for Q4. However, LCBH failed to meet this goal for the remaining quarters. In Q1 after-hours fell significantly short of the 80% goal while in Q2 and Q3 business hours fell short.

LCBH feels staff shortage might have played an impact on the success rate. LCBH is taking steps to address what elements in training have not been demonstrating results and will be further discussing test call requirements with clerical staff. As after-hours was only under 80% for Q1, results will continue to be monitored for the After-hours crisis line contracted provider to determine if any corrective action is needed.

Service Delivery – Capacity and Timeliness	
Goal 8	80% of test calls requiring an interpreter will be completed successfully. Success is defined as: Correct language interpreter successfully engages with the caller.
Objective 8.a.	80% of test calls will be answered and all necessary elements logged on log sheet or in EHR system.
Action Steps: 1. Quarterly training of staff who answer the 24/7 line on required elements and correct logging of information. 2. A minimum of one (1) Spanish language test call performed quarterly. 3. Gather data and monitor staff performance and language line performance. 4. If goal not reached, plan and implement actions to achieve goal.	
Monitoring Method	1. EHR system 2. Test Call Log
Reporting Frequency	Quarterly
Responsible Partners	Analyst & QI Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 1. Provision of Services, 2. Availability and Accessibility of Services

Report

2019 Quarter 1
50% of calls requiring language translation were handled successfully. The instances of failure were during the after-hours. LCBH met with its after-hours phone services contractor to bring this situation into compliance.

2019 Quarter 2
100% of calls requiring language translation were handled successfully.

2019 Quarter 3
100% of calls requiring language translation were handled successfully.

2019 Quarter 4

60% of calls requiring language translation were handled successfully. The instances of failure were during the after-hours. LCBH met with its after-hours phone services contractor this situation into compliance.

2020 Quarter 1
LCBH received 2 test calls requiring language translation. 2/2 (100%) of the calls requiring language translation were handled successfully.
The after-hours crisis line contracted provider received 2 test calls requiring language translation. 1/2 (50%) of the calls requiring language translation were handled successfully.

2020 Quarter 2
LCBH received 4 test calls requiring language translation. 4/4 (100%) of the calls requiring language translation were handled successfully.
The after-hours crisis line contracted provider received 2 test calls requiring language translation. 2/2 (100%) of the calls requiring language translation were handled successfully.

2020 Quarter 3
LCBH received no test calls requiring language translation.
The after-hours crisis line contracted provider received 1 test calls requiring language translation. 1/1 (100%) of the calls requiring language translation were handled successfully.

2020 Quarter 4
LCBH received 4 test calls requiring language translation. 4/4 (100%) of the calls requiring language translation were handled successfully.
The after-hours crisis line contracted provider received 2 test calls requiring language translation. 1/2 (50%) of the calls requiring language translation were handled successfully.

2021 Quarter 1
LCBH received 1 test calls requiring language translation. 1/1 (100%) of the calls requiring language translation were handled successfully.
The after-hours crisis line contracted provider received 5 test calls requiring language translation. 4/5 (80%) of the calls requiring language translation were handled successfully.

2021 Quarter 2
LCBH received 1 test calls requiring language translation. 1/1 (100%) of the calls requiring language translation were handled successfully.
The after-hours crisis line contracted provider received 4 test calls requiring language translation. 4/4 (100%) of the calls requiring language translation were handled successfully.

2021 Quarter 3

LCBH received 2 test calls requiring language translation. 2/2 (100%) of the calls requiring language translation were handled successfully.
The after-hours crisis line contracted provider received 4 test calls requiring language translation. 3/4 (75%) of the calls requiring language translation were handled successfully.

2021 Quarter 4
LCBH received 4 test calls requiring language translation. 4/4 (100%) of the calls requiring language translation were handled successfully.
The after-hours crisis line contracted provider received 1 test calls requiring language translation. 1/1 (100%) of the calls requiring language translation were handled successfully.

2022 Quarter 1
LCBH received 1 test calls requiring language translation. 1/1 (100%) of the calls requiring language translation were handled successfully.
The after-hours crisis line contracted provider received 4 test calls requiring language translation. 2/4 (50%) of the calls requiring language translation were handled successfully.

2022 Quarter 2
LCBH received 1 test calls requiring language translation. 1/1 (100%) of the calls requiring language translation were handled successfully.
The after-hours crisis line contracted provider received 5 test calls requiring language translation. 5/5 (100%) of the calls requiring language translation were handled successfully.

2022 Quarter 3
LCBH received 1 test calls requiring language translation. 1/1 (100%) of the calls requiring language translation were handled successfully.
The after-hours crisis line contracted provider received 4 test calls requiring language translation. 3/4 (75%) of the calls requiring language translation were handled successfully.

2022 Quarter 4
LCBH received 4 test calls requiring language translation. 4/4 (100%) of the calls requiring language translation were handled successfully.
The after-hours crisis line contracted provider received 2 test calls requiring language translation. 2/2 (100%) of the calls requiring language translation were handled successfully.

2019 Year Analysis
LCBH met its goal of 80% of all non- English calls requiring language translation services in quarter 2 and quarter 3. Quarter 1 and Quarter 4 did not meet our goal. Both of the Quarters that did not meet had an issue with the after-hours phone

services contractor. LCBH requested a Plan of Correction from our contractor for both of the quarters that we did not meet our goal.

2020 Year Analysis
LCBH met its goal of 80% of all calls requiring language translation being handled successfully in all three quarters that have calculated data. LCBH's after-hours crisis line contracted provider met the 80% goal in quarters two and three but did not meet the 80% goal in quarter 1. The contracted provider feels this is the result of their employees working from home due to the COVID 19 pandemic. LCBH has had issues with the after-hours contracted provider in more than one occurrence and felt we needed to break out the metric to show that LCBH is in compliance during our regular business hours. LCBH is working with the after-hours contracted provider to correct the issues that were not in compliance by requesting the contracted provider submit a corrective action plan to LCBH. LCBH received a corrective action plan from our afterhours contracted provider in which they outlined steps taken to ensure this issue does not happen again

2021 Year Analysis
LCBH met its goal of 80% of all calls requiring language translation in Q1, Q2, and Q4. LCBH daytime staff met the 80% goal in Q3 however the after-hours answering services did not meet this goal. It is unclear at this time what happened with the 1 phone call that did not meet language translation services. LCBH director had a meeting with the Manager of the after-hours answering service who stated they will provide a training to their staff on the use of translation services.

2022 Year Analysis
LCBH met its goal of 80% of calls requiring language translation in Q2, Q3, and Q4. LCBH did not meet the 80% in Q1 due to after hours only handling half of calls successfully. In both quarters where 100% of test calls weren't successful, it was only the after-hours answering service that failed to meet the 80%. LCBH will be recommending additional training to after-hours staff and continue monitoring for if corrective action is needed.

Service Delivery – Capacity and Timeliness	
Goal 9	90% of calls to the 24/7 Access line will be answered by a live person.
Objective 9.a.	90% of the calls made during after-hours will be answered and will not go to the answering machine.
Objective 9.b.	90% of the calls made during business hours will be answered and will not go to the answering machine.

Action Steps:
1. Answer log will be kept by access line staff.
2. Rate of calls answered will be monitored and reported by staff supervisor and reported to QIC.
3. Supervisor and staff will implement strategies to meet goal.
4. After-hours contract staff will keep log of calls answered.
5. Rate of calls answered will be monitored and reported by contract monitor and reported to QIC.
6. If goal is not met, contract monitor and contract employees will implement strategies to meet goal.

Monitoring Method	1. EHR system and after hour crisis contract 2. Test Call Log
Reporting Frequency	Quarterly
Responsible Partners	Analyst & QI Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 1. Provision of Services, 2. Availability and Accessibility of Services

Report

2019 Quarter 1
LCBH has not yet compiled Test Call data into a reportable format.

2019 Quarter 2
Of the 15 test calls conducted, one call failed to connect to the after-hours phone line.

2019 Quarter 3
Of the 15 test calls conducted, all 15 calls connected to a live staff person.

2019 Quarter 4
Of the 15 test calls conducted, all 15 calls connected to a live staff person

2020 Quarter 1
LCBH received 9 test calls during business hours 8/9 (88.89 %) test calls were answered by a live person. One call was not answered by a live person due to an unexpected power outage.
The after-hours crisis line contracted provider received 6 test calls. 6/6 (100%) Test calls were answered by a live person.

2020 Quarter 2
LCBH received 8 test calls. 8/8 (100%) of test calls were answered by a live person.
The after-hours crisis line contracted provider received 6 test calls. 5/6 (83.33%) were answered by a live person.

2020 Quarter 3
LCBH received 9 test calls. 9/9 (100%) of the test calls were answered by a live person.
The after-hours crisis line contracted provider received 2 test calls. 2/2 (100%) were answered by a live person.

2020 Quarter 4
LCBH has not received and Calculated test call Data for quarter 4 at this time.

2021 Quarter 1
LCBH received 8 test calls during business hours 8/8 (100%) test calls were answered by a live person. One call was not answered by a live person due to an unexpected power outage.
The after-hours crisis line contracted provider received 5 test calls. 5/5 (100%) Test calls were answered by a live person.

2021 Quarter 2
LCBH received 5 test calls. 5/5 (100%) of test calls were answered by a live person.
The after-hours crisis line contracted provider received 6 test calls. 6/6 (100%) were answered by a live person.

2021 Quarter 3
LCBH received 8 test calls. 8/8 (100%) of test calls were answered by a live person.
The after-hours crisis line contracted provider received 6 test calls. 5/6 (83.3%) were answered by a live person.

2021 Quarter 4
LCBH received 4 test calls. 4/4 (100%) of test calls were answered by a live person.
The after-hour crisis line contracted provider received 1 test calls. 1/1 (100%) were answered by a live person.

2022 Quarter 1
LCBH received 8 test calls during business hours 8/8 (100%) test calls were answered by a live person. One call was not answered by a live person due to an unexpected power outage.
The after-hours crisis line contracted provider received 7 test calls. 7/7 (100%) Test calls were answered by a live person.

2022 Quarter 2
LCBH received 8 test calls. 8/8 (100%) of test calls were answered by a live person.
The after-hours crisis line contracted provider received 6 test calls. 6/6 (100%) were answered by a live person.

2022 Quarter 3

LCBH received 8 test calls. 8/8 (100%) of test calls were answered by a live person. The after-hours crisis line contracted provider received 6 test calls. 6/6 (100%) were answered by a live person.

2022 Quarter 4
LCBH received 9 test calls. 9/9 (100%) of test calls were answered by a live person. The after-hour crisis line contracted provider received 6 test calls. 6/6 (100%) were answered by a live person.

2019 Year Analysis
LCBH met its goal of 90% of all calls being connected to a live staff person in quarter 3 and quarter 4. In quarter 1 there was no data that was measurable collected and in Quarter 2 a call that failed to connect to the after-hours phone line. LCBH had their IT department look into the issue and correct it.

2020 Year Analysis
LCBH was able to meet our goal of 90% of test calls being answered by a live person in two of the three quarters with calculated data. In the instance of not meeting the goal was due to a test call being made to LCBH during a power outage. LCBH is exploring options to correct this issue to prevent any calls being missed in the future in the event of an unexpected power outage. LCBH after-hours contracted provider met the 90% goal in two of the three quarter. In the instance of not meeting this goal in Quarter 2 the contracted provider felt it was due to their staff working from home due to the COVID 19 pandemic and would provide their staff training on the importance of still being able to answer incoming calls while working from home. LCBH has had issues with the after-hours contracted provider in more than one occurrence and felt we needed to break out the metric to show that LCBH is in compliance during our regular business hours. LCBH is working with the after-hours contracted provider to correct the issues that were not in compliance by requesting the contracted provider submit a corrective action plan to LCBH. LCBH received a corrective action plan from our after-hours contracted provider in which they outlined steps taken to ensure this issue does not happen again.

2021 Year Analysis
LCBH and the After-hours answering service met the goal of 90% of all test calls being answered in Q1, Q2, and Q4. In Q3 the after-hours crisis line had one call go to a voicemail. LCBH met with the after-hours provider and discussed this issue. The after-hours providers were going to have their IT look into the issue but did not get back to LCBH with an outcome.

2022 Year Analysis
LCBH and the After-hours answering service met the goal of 90% of all test calls being answered in all 4 quarters

Beneficiary/Family Satisfaction	
Goal 1	Conduct client satisfaction surveys (POQI) annually or semi-annually as required by DHCS
Objective 1.a.	The number of Beneficiary/family Client Satisfaction Surveys (POQI) will increase by 10% from the baseline of 2019.
Action Steps: 1. Provide a quiet area for beneficiaries/families to complete the survey. 2. Explore ideas for incentives for beneficiaries/families to complete the survey. 3. Evaluate survey completion data. 4. Share data with Programs and Organizational Providers. 5. Plan and implement actions to increase beneficiary/family participation.	
Monitoring Method	1. Data on survey completion rates. 2. Data analysis from DHCS.
Reporting Frequency	Semi-Annually, or as results are received from DHCS.
Responsible Partners	Analyst & QI Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 22. Quality Management Program, 23. Quality Improvement Program Title 9, Section 1810.440

Report

2019 Quarter 1
LCBH conducted its Autumn 2018 POQI survey and has received the responses, and conducted an analysis of questionnaires presenting negative responses.

2019 Quarter 2
LCBH conducted its Spring 2019 POQI survey on time and is waiting for the results.

2019 Quarter 3
LCBH conducted its Spring 2019 POQI survey and has received the responses. LCBH was without an analyst for this quarter so no analysis of the questionnaires have been completed at this time.

2019 Quarter 4
LCBH conducted its Autumn 2019 POQI survey on time in November and is waiting for the results.

2020 Quarter 1
LCBH has nothing to report at this time.

2020 Quarter 2
LCBH collected 15 paper surveys from clients and 11 were submitted online. COVID 19 made it difficult for clients to complete the survey in person.

2020 Quarter 3
LCBH has nothing to report at this time.

2020 Quarter 4
Due to COVID 19 POQI surveys were cancelled. LCBH decided to have clients complete a one page survey created by LCBH. We were able to collect 33 surveys from consumers.
Most surveys agreed that services were meeting their needs. However, two clients stated that they did not feel they choose their treatment goals with their therapist, two clients stated they did not feel comfortable with their provider, One client felt staff were not culturally sensitive to their background, two clients did not feel they were able to receive all services they needed, one client felt their therapist was not able or willing to see them as often as the client felt was necessary, One client felt the services they receive do not help them become better able to do the things they would like to do.

2021 Quarter 1
LCBH has nothing to report at this time.

2021 Quarter 2
LCBH collected 27 paper surveys from clients and 0 were submitted online. COVID 19 made it difficult for clients to complete the survey in person.

2021 Quarter 3
LCBH has nothing to report at this time.

2021 Quarter 4
LCBH received and email that our POQI survey data was compiled and uploaded to our Box folder on 12/10/2021. These were uploaded in an excel spreadsheet format and the LCBH analyst is in the process of reviewing and sorting this data.

2022 Quarter 1
LCBH has nothing to report at this time.

2022 Quarter 2
LCBH received 35 paper surveys from clients, 0 were submitted online. LCBH conducted its Spring 2022 POQI survey on time in May and awaiting the results.

2022 Quarter 3

LCBH has nothing to report at this time.

2022 Quarter 4
Lassen County CPS report for 2022 (received February 2023). Satisfaction Score by domain were generally high across demographics with Access, Participation in Treatment Planning, and Quality being the top scores for Adults and Participation in Treatment plan and Cultural Appropriateness being the top scores for Youth. Lowest scores for all groups were attributed to Satisfaction in the domain of "Functioning" and in "Outcome". In regards to encounters with Police, adults reported that after beginning to receive Mental Health services police encounters have increased at a rate higher than the statewide average. For youth, those reporting that police encounters have reduced since starting services is less than the statewide average and those reporting it has increased is less than the state average. For youth, the impression is that receiving mental health services has had little to no impact in changing amounts of police encounters.

2019 Year Analysis
LCBH is unable to determine if this goal was met as this time. LCBH lost their former analyst in July of 2019 and did not fill the position until the end of October 2019. The former analyst did not leave baseline data for current analyst to measure and compare current data against.

2020 Year Analysis
COVID 19 and Shelter in place orders made it difficult to have the clients' complete POQI surveys. LCBH was not able to meet the goal to increase the number of completed surveys. LCBH took initiative to have a consumer survey completed in November even though POQI surveys were cancelled. Most surveys agreed that services were meeting their needs. However, two clients stated that they did not feel they choose their treatment goals with their therapist, two clients stated they did not feel comfortable with their provider, One client felt staff were not culturally sensitive to their background, two clients did not feel they were able to receive all services they needed, one client felt their therapist was not able or willing to see them as often as the client felt was necessary, One client felt the services they receive do not help them become better able to do the things they would like to do.

2021 Year Analysis
LCBH completed our consumer perception surveys in June with our clients. Clients had to opportunity to complete the surveys in person if they come in to the office for their appointments or online if they chose not to come into the office for inpatient services. LCBH was only able to collect very few surveys from clients who came in. COVID 19 is still affecting the way clients are choosing to receive services. In Lassen County most of our clients do not have access to a computer or internet and are not able to complete these surveys online. LCBH received our complied data from UCLA on 12/10/2021. The data was received in an excel spreadsheet format and the LCBH analyst is in the process of sorting and reviewing the data.

2022 Year Analysis
The Baseline measurement of Consumer Perception Surveys was the Autumn 2018 POQI Survey where 26 individuals responded. In 2022, 35 surveys were collected from clients. This is a 34.6% increase from the baseline measurement, meeting and surpassing the goal of increasing numbers of Consumer Perception Surveys received by 10%. Of the 2022 surveys, common perceptions revolved around lower satisfaction on Outcome and Functioning. These 2 factors are paramount in measuring the effectiveness of services and being that they both received lower scores, LCBH will need to discuss this matter in depth. As clients, Adult and Youth, did not report mental health services having any positive impact on police encounters, it can be posited that clients are not feeling that services are creating tangible outcomes.

Beneficiary/Family Satisfaction	
Goal 2	Evaluate beneficiary grievances, appeals, fair hearings and change of provider requests for quality of care issues.
Objective 2.a.	100% of grievances, appeals, fair hearings, and change of provider requests will be resolved within the timeframes specified by state and federal regulating agencies.
Action Steps: 1. Review grievances and change of provider requests quarterly. 2. Identify possible quality of care issues. 3. Share issues with concerned staff/programs. 4. Collaborate with staff/programs to address issues. 5. Analyst will prepare and present a report quarterly to the QI Committee documenting issues and trends of grievances and change of provider requests. 6. QI Committee will review report and evaluate for quality of care issues. 7. Any issues deemed appropriate for follow up will be addressed and outcomes will be tracked.	
Monitoring Method	1. Managed Care grievance and change of provider logs 2. QI Committee meeting minutes 3. Quality of Care Items for follow up on QI Agendas 4. Development of a recording process for issues identified, actions taken, and resolution.
Reporting Frequency	Semi-Annually
Responsible Partners	Analyst & QI Committee

	Programs and staff
Reference	DHCS Contract, Exhibit A Attachment 1; 22. Quality Management Program, 23. Quality Improvement Program Title 9, Section 1810.440

Report

2019 Quarter 1
Date received: 1/23/19. 1 Grievance for Access- Service not Accessible (Transportation Scheduling Issues)
Date Acknowledgment letter sent: 1/23/19.
Investigation and Resolution: 2/13/19
Date Resolution Notice sent: 2/13/19

2019 Quarter 2
Date received: 5/7/19. 1 Grievance for Compliance- concerns for paperwork completion.
Date Acknowledgment letter sent: 5/8/19
Investigation and Resolution: 5/8/19
Date Resolution Notice sent: 5/8/19

Date received: 5/15/19. 1 Grievance for Access- Transportation issue.
Date Acknowledgment letter sent: 5/20/19
Investigation and Resolution: 5/21/19
Date Resolution Notice sent: 5/21/19

2019 Quarter 3
No Grievances filed in Q3

2019 Quarter 4
Date received: 10/02/2019. 1 Grievance for Access-Issue with after-hours provider.
Date Acknowledgment letter sent: 10/03/2019
Investigation and Resolution: 10/08/2019
Date Resolution Notice sent: 10/08/2019

2020 Quarter 1
Date received: 01/29/2020
Grievance Type: Quality of Care
Date Acknowledgment letter sent:01/29/2020
Investigation and Resolution: 01/29/2020
Date Resolution Notice sent: 02/05/2020
How many days from receipt to resolution(state standard 60 days): 5 business days

2020 Quarter 2
Date received: 05/04/2020
Grievance Type: Other
Date Acknowledgment letter sent:05/04/2020
Investigation and Resolution: 05/06/2020
Date Resolution Notice sent: 05/06/2020
How many days from receipt to resolution(state standard 60 days): 2 business days

2020 Quarter 3
Date received: 08/07/2020
Grievance Type: Quality of Care
Date Acknowledgment letter sent: 08/07/2020
Investigation and Resolution: 08/07/2020
Date Resolution Notice sent: 08/07/2020
How many days from receipt to resolution (state standard 60 days): This issue was resolved on the same business day.

Date received: 08/17/2020
Grievance Type: Quality of Care
Date Acknowledgment letter sent: 08/17/2020
Investigation and Resolution: 08/17/2020
Date Resolution Notice sent: 08/17/2020
How many days from receipt to resolution (state standard 60 days): This issue was resolved on the same business day.

Date received: 09/14/2020
Grievance Type: Quality of Care
Date Acknowledgment letter sent: 09/14/2020
Investigation and Resolution: 09/21/2020
Date Resolution Notice sent: 09/21/2020
How many days from receipt to resolution(state standard 60 days): 5 business days

2020 Quarter 4
Date received: 11/03/2020
Grievance Type: Quality of Care
Date Acknowledgment letter sent: 11/04/2020
Investigation and Resolution: 11/17/2020
Date Resolution Notice sent: 11/17/2020
How many days from receipt to resolution(state standard 60 days): 10 business days

Date received: 12/11/2020
Grievance Type: Other
Date Acknowledgment letter sent: 12/11/2020
Investigation and Resolution: 12/16/2020

Date Resolution Notice sent: 12/16/2020
How many days from receipt to resolution(state standard 60 days): 3 business days

2021 Quarter 1
Date received: 01/08/2021
Grievance Type: Quality of Care
Date Acknowledgment letter sent:01/08/2021
Investigation and Resolution: 01/13/2021
Date Resolution Notice sent: 01/13/2021
How many days from receipt to resolution(state standard 60 days): 3 business days

Date received: 02/01/2021
Grievance Type: Quality of Care
Date Acknowledgment letter sent:02/02/2021
Investigation and Resolution: 02/02/2021
Date Resolution Notice sent: 02/03/2021
How many days from receipt to resolution(state standard 60 days): 2 business days

Date received: 02/09/2021
Grievance Type: Patient's Rights
Date Acknowledgment letter sent:02/09/2021
Investigation and Resolution: 02/10/2021
Date Resolution Notice sent: 02/10/2021
How many days from receipt to resolution(state standard 60 days): 1 business days

Date received: 02/05/2021
Grievance Type: Quality of Care
Date Acknowledgment letter sent:02/09/2021
Investigation and Resolution: 02/11/2021
Date Resolution Notice sent: 02/11/2021
How many days from receipt to resolution(state standard 60 days): 4 business days

Date received: 03/09/2021
Grievance Type: Patient's Rights
Date Acknowledgment letter sent:03/09/2021
Investigation and Resolution: 03/09/2021
Date Resolution Notice sent: 03/10/2021
How many days from receipt to resolution(state standard 60 days): 1 business days

Date received: 03/22/2021
Grievance Type: Quality of Care
Date Acknowledgment letter sent:03/22/2021
Investigation and Resolution: 03/22/2021
Date Resolution Notice sent: 03/22/2021
How many days from receipt to resolution(state standard 60 days): 0 business days

2021 Quarter 2
Date received: 06/23/2021
Grievance Type: Quality of Care
Date Acknowledgment letter sent:06/23/2021
Investigation and Resolution: 06/25/2021
Date Resolution Notice sent: 06/25/2021
How many days from receipt to resolution(state standard 60 days): 2 business days

Date received: 06/24/2021
Grievance Type: Quality of Care
Date Acknowledgment letter sent:06/25/2021
Investigation and Resolution: 06/25/2021
Date Resolution Notice sent: 06/25/2021
How many days from receipt to resolution (state standard 60 days): 1 business days

2021 Quarter 3
Date received: 07/14/2021
Grievance Type: Quality of Care
Date Acknowledgment letter sent: 07/14/2021
Investigation and Resolution: 07/15/2021
Date Resolution Notice sent: 07/15/2021
How many days from receipt to resolution (state standard 60 days): 1 business days

Date received: 08/09/2021
Grievance Type: Patient's Rights
Date Acknowledgment letter sent: 08/09/2021
Investigation and Resolution: 08/09/2021
Date Resolution Notice sent: 08/10/2021
How many days from receipt to resolution (state standard 60 days): 1 business days

2021 Quarter 4
Date received: 12/16/2021
Grievance Type: Patient's Rights
Date Acknowledgment letter sent: 12/16/2021
Investigation and Resolution: 12/17/2021
Date Resolution Notice sent: 12/20/2021
How many days from receipt to resolution (state standard 60 days): 2 business days

2022 Quarter 1
No Grievances filed in Q1

2022 Quarter 2
Date received: 4/7/2022
Grievance Type: Quality of Care
Date Acknowledgment letter sent: 4/8/2022
Investigation and Resolution: 5/19/2022

Date Resolution Notice sent: 5/19/2022
How many days from receipt to resolution (state standard 60 days): 31 business days

Date received: 5/18/2022
Grievance Type: Quality of Care
Date Acknowledgment letter sent: 5/19/2022
Investigation and Resolution: 5/20/2022
Date Resolution Notice sent: 5/20/2022
How many days from receipt to resolution (state standard 60 days): 2 business days

2022 Quarter 3
Date received: 7/1/2022
Grievance Type: Quality of Care
Date Acknowledgment letter sent: 7/1/2022
Investigation and Resolution: 7/7/2022
Date Resolution Notice sent: 7/7/2022
How many days from receipt to resolution (state standard 60 days): 5 business days

Date received: 7/21/2022
Grievance Type: Patient's Rights
Date Acknowledgment letter sent: 7/21/2022
Investigation and Resolution: 7/25/2022
Date Resolution Notice sent: 7/25/2022
How many days from receipt to resolution (state standard 60 days): 3 business days

Date received: 8/2/2022
Grievance Type: Quality of Care
Date Acknowledgment letter sent: 8/2/2022
Investigation and Resolution: 8/3/2022
Date Resolution Notice sent: 8/3/2022
How many days from receipt to resolution (state standard 60 days): 1 business days

Date received: 4/7/2022
Grievance Type: Quality of Care
Date Acknowledgment letter sent: 4/8/2022
Investigation and Resolution: 5/19/2022
Date Resolution Notice sent: 5/19/2022
How many days from receipt to resolution (state standard 60 days): 31 business days

2022 Quarter 4
Date received: 11/7/2022
Grievance Type: Quality of Care
Date Acknowledgment letter sent: 11/7/2022
Investigation and Resolution: 11/15/2022

Date Resolution Notice sent: 11/15/2022
How many days from receipt to resolution (state standard 60 days): 7 business days

2019 Year Analysis
LCBH was able to resolve all grievances within the timeframes specified by state and federal regulating agencies for all four quarters.

2020 Year Analysis
LCBH was able to resolve all grievances within the timeframes specified by state and federal regulating agencies for all four quarters.

2021 Year Analysis
LCBH was able to resolve all grievances within the timeframes specified by state and federal regulating agencies for all four quarters. LCBH would like to note that four of the eleven grievances received in 2021 came from a person who is not a client of LCBH and the client is grieving about an employee of Lassen County but not LCBH.

2022 Year Analysis
LCBH was able to resolve all grievances within the timeframes specified by state and federal regulating agencies for all four quarters

Beneficiary/Family Satisfaction	
Goal 3	The Analyst and QI Program will monitor appeals.
Objective 3.a.	100% of appeals will be resolved within the timeframes specified by state and federal regulating agencies.
Action Steps: 1. Analyst will prepare and present a report quarterly to the QI Committee on appeal issues, trends, and resolutions.	
Monitoring Method	1. Managed Care appeal log
Reporting Frequency	Semi-Annually
Responsible Partners	Analyst QI Committee

Reference	DHCS Contract, Exhibit A Attachment 1; 22. Quality Management Program, 23. Quality Improvement Program Title 9, Section 1810.440

Report

2019 Quarter 1
No appeals were filed in Q1 2019.

2019 Quarter 2
No appeals were filed in Q2 2019.

2019 Quarter 3
No appeals were filed in Q3 2019.

2019 Quarter 4
No appeals were filed in Q4 2019.

2020 Quarter 1
No appeals were filed in Q1 2020.

2020 Quarter 2
No appeals were filed in Q2 2020.

2020 Quarter 3
No appeals were filed in Q3 2020.

2020 Quarter 4
No appeals were filed in Q4 2020.

2021 Quarter 1
No appeals were filed in Q1 2021.

2021 Quarter 2
Date received: 06/25/2021
Grievance Type: Appeal
Date Acknowledgment letter sent:06/25/2021
Investigation and Resolution: 06/25/2021
Date Resolution Notice sent: 07/08/2021
How many days from receipt to resolution (state standard 60 days): 8 business days

2021 Quarter 3
No appeals were filed in Q3 2021.

2021 Quarter 4

No appeals were filed in Q4 2021.

2022 Quarter 1
No appeals were filed in Q1 2020.

2022 Quarter 2
No appeals were filed in Q2 2020.

2022 Quarter 3
No appeals were filed in Q3 2020.

2022 Quarter 4
No appeals were filed in Q4 2020

2019 Year Analysis
LCBH did not have any appeals filed in 2019.

2020 Year Analysis
LCBH did not have any appeals filed in 2020.

2021 Year Analysis
LCBH only received one appeal in Q3 filed in 2021. This appeal was an appeal of a NOABD that was sent to client due to them not meeting medical necessity to receive services at LCBH. A second opinion appointment was completed and client was scheduled to receive services through a provider at LCBH.

2022 Year Analysis
LCBH did not have any appeals filed in 2022.

QI Program and QI Committee	
Goal 1	Establish a relationship with community partners to identify quality of care issues and develop resolutions to these issues.
Objective 1.a.	The Analyst and QI Committee will work with community partners to develop a method for identifying, addressing, tracking, and evaluating quality of care issues, and together come up with a resolution for the issues identified.

Action Steps:
1. Analyst will delegate a subcommittee.
2. The analyst and subcommittee will meet and put together recommendations for how to effectively:
    a) identify quality of care issues,
    b) monitor actions taken,
    c) track issues and actions taken over time, and
    d) evaluate and report on effectiveness of actions taken.
3. Analyst and subcommittee will report recommendations to QIC.
4. QIC will adopt a method to achieve the goal, test it, and evaluate for effectiveness.

Monitoring Method	1. QIC will evaluate on an ongoing basis the tools and methods for improving the effectiveness of the QI Program. 2. Sign-in sheets for meetings. 3. Program/Organizational Provider reports of QI activities.
Reporting Frequency	Identifying, tracking QI issues and assure participation of staff in QI activities – Quarterly Increase beneficiary and family member involvement – Semi-Annually Report of Cultural Competency Coordinator - Annually
Responsible Partners	Analyst QI Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 22. Quality Management Program, 23. Quality Improvement Program □ Title 9, Section 1810.440

Report

2019 Quarter 1
LCBH has nothing at this time to report on this issue.
2019 Quarter 2
LCBH has identified its referral process with community entities as a subject that needs to be addressed. LCBH will attempt to meet with Lassen High School personnel to discuss changes in counseling staff and come to an agreement on how to manage student needs.
2019 Quarter 3
LCBH continues to work with community partners to implement a new referral process.
2019 Quarter 4
LCBH continues to work with community partners to implement a new referral process.

2020 Quarter 1
LCBH has nothing at this time to report on this issue.

2020 Quarter 2
LCBH started discussions on becoming involved in the second DDRP Cohort Committee which will involve them with the local Justice System agencies to address issues involving repeat criminal activity by clients with Mental Health issues.

2020 Quarter 3
LCBH started holding meetings with the person in charge of the second DDRP Cohort as well as other small counties who will be doing the same thing in their counties. LCBH also is working with Lassen County Child Family Services (CFS) and Lassen County Probation (LCP) Department to streamline Our CANS and CFT process. LCBH has moved its Cultural Competency Committee from interagency to the Lassen County Mental Health Advisory Board Meetings to include and involve for Community partners.

2020 Quarter 4
LCBH continues its efforts with DDRP Cohort Committee, CFS, and Lassen County Sheriff's Department. LCBH started working with Wraparound, CFS, Probation, and representatives from Susanville Indian Rancheria on the FURS project to create a mobile crisis response team for youth who are currently involved in foster care or youth who were in foster care in the past.

2021 Quarter 1
LCBH continues its efforts with DDRP Cohort Committee, CFS, and Lassen County Sheriff's Department. LCBH continues to work with community partners to implement new ways to better care for clients.

2021 Quarter 2
LCBH continues its efforts with DDRP Cohort Committee, CFS, and Lassen County Sheriff's Department. LCBH continues to work with community partners to implement new ways to better care for clients.

2021 Quarter 3
LCBH continues its efforts with DDRP Cohort Committee, CFS, and Lassen County Sheriff's Department. LCBH continues to work with community partners to implement new ways to better care for clients.

2021 Quarter 4
LCBH continues its efforts with DDRP Cohort Committee, CFS, and Lassen County Sheriff's Department. LCBH continues to work with community partners to implement new ways to better care for clients.

2022 Quarter 1
LCBH continues its efforts with DDRP Cohort Committee, CFS, Lassen County Sheriff's Department, Wraparound, Probation, and representatives from Susanville Indian Rancheria to implement new ways to better care for clients. LCBH is also working with the Housing Department and is performing outreach at Crossroads Ministries once a month to work on a joint effort to address homelessness in the county.

2022 Quarter 2
LCBH continues its efforts with DDRP Cohort Committee, CFS, Lassen County Sheriff's Department, housing department, Crossroads, Wraparound, Probation, and representatives from Susanville Indian Rancheria to implement new ways to better care for clients.

2022 Quarter 3
LCBH continues its efforts with DDRP Cohort Committee, CFS, Lassen County Sheriff's Department, housing department, Crossroads, Wraparound, Probation, and representatives from Susanville Indian Rancheria to implement new ways to better care for clients.

2022 Quarter 4
LCBH continues its efforts with DDRP Cohort Committee, CFS, Lassen County Sheriff's Department, housing department, Crossroads, Wraparound, Probation, and representatives from Susanville Indian Rancheria to implement new ways to better care for clients. LCBH has begun work to establish connection with ED for the purpose of better care coordination and data exchange.

2019 Year Analysis
LCBH worked with community partners to determine that the referral process to our services was not in place. Together LCBH and Community partners created a referral from for all to use to refer beneficiaries to our clinic for services. Currently LCBH is tracking referral data to determine if the new referral process is improving access to services for our clients. Once data has been collected we will review and determine any changes that are needed in the process to insure success of the referral process.

2020 Year Analysis
LCBH has involved itself with more community partners in 2020. The projects that LCBH has started in 2020 with other agencies in Lassen county will require MOU's to be put in place that will help continue the partnership with these agencies after these projects are completed. LCBH is excited to be involved in with the Second DDRP Cohort which will help look at our data and the Data of the Justice Systems agencies in Lassen County to address issues with repeat offenders who might have Mental Health issues to see if there is a Program that LCBH can offer to help decrease the number of repeat offenses. LCBH continues its partnership with Lassen County

Sherriff in the continuation of the BOTVIN program. LCBH worked throughout 2020 with Partnership on issues with MTM Transportation to get clients to and from appointments. The COVID 19 pandemic began in March 2020 and LCBH feels this could have impacted our numbers.

2021 Year Analysis
LCBH continued working with community partners in 2021. LCBH made progress with community partners in the DDRP project. We were able to compare our de-identified data with our justice system partner's de-identified data to see which generic clients were touching each service multiple times. We had a large meeting with all partners involved in the DDRP to identify issues and gaps where clients might be falling through the cracks between services. LCBH is currently working with our partnering agencies to correct the issues identified. Our psychiatrists have started consulting with primary care doctors on mental health medications and needs. LCBH continues to work with community partners to improve the referral process. LCBH continues to work with the Sherriff's Department in the continuation of the BOTVIN program.

2022 Year Analysis
LCBH continued working with community partners to increase capacity for care coordination and to meet the needs of clients engaged in multiple services between community partners. LCBH has been working with the MCP on issues with MTM transportation to get clients to and from appointments. In 2022, LCBH began work on developing a Performance Improvement Project (PIP) to work with our ED and MCP to establish multi-directional data exchange to be able to identify shared beneficiaries that are not receiving needed services and/or follow up post-hospitalization. LCBH has put great effort towards participating in meetings with the DDRP Cohort Committee, Housing Department, and performing homeless outreach at Crossroad Ministries to address homelessness in the County. An HMIS system has been established with Housing to be able to track homelessness.

QI Program and QI Committee	
Goal 2	The QI Committee will increase beneficiary and family member involvement in the QI Committee activities, decisions, and oversight.
Objective 2.a.	To encourage beneficiary and family member participation.
Action Steps: 1. Analyst and QI Committee will create a plan for engaging in various activities to seek out and involve beneficiary and family members. This may include, but is not limited to, surveys, subgroups, reach out to organizations, hire consumer/family members.	

2. Create action items with responsible parties and due dates. 3. Report back to QI Committee. 4. QI Committee will evaluate effectiveness.	
Monitoring Method	1. QIC will evaluate on an ongoing basis the tools and methods for improving the effectiveness of the QI Program. 2. Sign-in sheets for meetings. 3. Program/Organizational Provider reports of QI activities.
Reporting Frequency	Identifying, tracking QI issues and assure participation of staff in QI activities – Quarterly Increase beneficiary and family member involvement – Semi-Annually Report of Cultural Competency Coordinator - Annually
Responsible Partners	Analyst QI Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 22. Quality Management Program, 23. Quality Improvement Program Title 9, Section 1810.440

Report

2019 Quarter 1
LCBH has nothing at this time to report on this issue.

2019 Quarter 2
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee.

2019 Quarter 3
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee.

2019 Quarter 4
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee.

2020 Quarter 1
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee. COVID-19 started in the US in January 2020 and a state mandated

shelter in place order was mandated in CA in March 2020 making it difficult to approach clients.

2020 Quarter 2
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee. The LCBH analyst approached providers about clients they feel would make a great addition to the QA/QI Committee. However due to COVID-19 and the state mandated shelter in place order currently LCBH is not seeing clients in office for services other that Crisis.

2020 Quarter 3
LCBH approached three consumers about becoming involved in the QAQI Committee but all three clients declined to become involved for various reasons.

2020 Quarter 4
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee. A new county mandated shelter in place order was put in place in November 2020 so LCBH is not seeing clients in office for any services other than Crisis or Psychiatric 1st making it difficult to approach clients for involvement.

2021 Quarter 1
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee.

2021 Quarter 2
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee.

2021 Quarter 3
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee.

2021 Quarter 4
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee.

2022 Quarter 1
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee.

2022 Quarter 2
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee.

2022 Quarter 3

LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee.

2022 Quarter 4
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee.

2019 Year Analysis
LCBH continues its attempts to include beneficiaries and/or family members on its QAQI committee. LCBH has approached multiple candidates who showed very little interest in being involved. LCBH is currently working with one client family member to hopefully include them in future meetings.

2020 Year Analysis
COVID 19 and state and county mandated shelter in place orders have made it difficult for LCBH to approach clients about involvement in the QAQI committees. LCBH approached three clients in Q3 but all three clients declined to be involved for various reasons.

2021 Year Analysis
LCBH has continued to approach clients and family members about participating on various committees with no success. LCBH continues to brainstorm ways to include clients or family members on our committees.

2022 Year Analysis
LCBH has continued to approach clients and family members about participating on various committees with no success. LCBH has been offering incentives such as gift cards but has not succeeded in achieving beneficiary engagement in its QA/QI process. LCBH continues to brainstorm ways to include clients or family members on our committees. LCBH will begin issuing surveys for current beneficiaries with questions pertaining to Quality Improvement to get feedback on processes, services, and Performance Improvement.

Medi-Cal/Drug Medi-Cal Documentation and Standards of Clinical Practice	
Goal 1	To improve clinical documentation practices to reduce audit disallowances and denied services.
Objective 1.a.	To conduct 5 chart reviews/audits quarterly to reduce disallowance rates and loss revenues regarding productivity.
Action Steps: 1. Analyst and QI Committee will complete a review of charts documentations for LCBH quarterly using a random selected number of charts. 2. Produce audit reports, plans of correction and technical assistance to improve audit results. 3. Conduct trainings and technical assistance for staff to improve their knowledge and skills relevant to clinical documentation.	
Monitoring Method	1. Audit reports, committee findings and minutes, quality management systems assessment reports.
Reporting Frequency	Quarterly
Responsible Partners	Analyst QI Committee
Reference	DHCS Contract, Exhibit A Attachment 1; 22. Quality Management Program, 23. Quality Improvement Program □ Title 9, Section 1810.440

Report

2019 Quarter 1
LCBH has nothing at this time to report on this issue.

2019 Quarter 2
LCBH completed 2 chart reviews between Compliance Committee meetings on June 7th and June 14th.

2019 Quarter 3
LCBH completed 2 chart reviews in Compliance Committee meeting on July 19th 2019

2019 Quarter 4
LCBH completed 2 chart reviews between Compliance committee meetings on September 19th and October 11th.

2020 Quarter 1
LCBH completed 2 chart reviews in Compliance Committee meetings, one was completed on 02/01/2020 and one was completed 02/21/2020.

2020 Quarter 2
LCBH has nothing at this time to report on this issue.

2020 Quarter 3
LCBH has nothing at this time to report on this issue.

2020 Quarter 4
The LCBH Medical Director reviewed 8 Charts for the Medication Management Portion and Psychiatric portions. The LCBH Compliance Committee has also reviewed 2 of the 8 charts the Medical Director started to review all other aspects of the chart including Assessment, Treatment Plan, Medical Necessity, and Progress notes.

2021 Quarter 1
LCBH Reviewed 3 client charts on 03/05/2021.LCBH Reviewed 3 Charts on 03/05/2021.

2021 Quarter 2
LCBH Reviewed 2 client charts on 04/09/2021.

2021 Quarter 3
LCBH has nothing to report this Quarter.

2021 Quarter 4
LCBH reviewed 2 charts in Q4 one on 11/05/2021 and another on 11/29/2021.

2022 Quarter 1
LCBH reviewed charts in Q1, however due to staff shortage in 2022, data on these charts are not able to be produced

2022 Quarter 2
LCBH reviewed charts in Q2, however due to staff shortage in 2022, data on these charts are not able to be produced

2022 Quarter 3
LCBH reviewed 4 charts in Q3 on 7/19/22, 7/20/2022, 7/21/2022, and 7/26/2022

2022 Quarter 4
LCBH reviewed 5 charts in Q4 pm 10/25/2022, 10/31/2022, 11/29/2022, and 2 on 11/30/2022.

2019 Year Analysis
LCBH did not meet its goal of reviewing at least 5 charts per quarter in any of the 4 Quarters. Chat reviews are completed during compliance meetings which are scheduled to occur every week but does not always occur. During these meetings LCBH also discusses all other compliance issues and does not always have time for chart reviews. In the future LCBH will schedule half of the time scheduled for compliance meetings to go over only chart audits and the other half of the meeting time for any other compliance issues that need to be addressed.

2020 Year Analysis
LCBH has hired a new Medical Director who began to review the Medication Support and Psychiatric portion of the charts. LCBH Compliance Committee did not meet our goal of reviewing five charts per quarter. COVID 19 has made it difficult for the Compliance Committee to meet on a regular basis to complete the chart reviews. LCBH has decided to have the Nurse review the charts with a chart review checklist and just bring the charts to compliance committee for oversite of the review. LCBH found in their chart reviews that some staff were billing Rehab for services which should have been bill Case Management. LCBH will implement an annual training on this topic.

2021 Year Analysis
LCBH did not meet its goal of reviewing at least 5 charts per quarter in any of the 4 Quarters. LCBH will continue to work on ways to ensure the goal of reviewing 5 charts a quarter are reviewed.

2022 Year Analysis
LCBH met its goal of reviewing at least 5 charts per Quarter in Q4, but failed to meet this goal in the remaining quarters. With LCBH hiring on new Analysts, tracking will restart for chart reviews and notifications will be sent to ensure that a minimum of 5 charts are reviewed per quarter going forward.

Medi-Cal/Drug Medi-Cal Documentation and Standards of Clinical Practice	
Goal 2	Provide guidance and training to county-operated and county-contracted providers on all new behavioral health polices, as outlined by DHCS in Behavioral Health Information Notices
Objective 1.a.	To create a system for tracking/monitoring DHCS BHINs, and develop and track completed trainings on CalAIM policies

Action Steps:
1. Analyst and QI Committee will develop documentation that will outline the strategy for training/support/monitoring.
2. Stakeholders will collaborate to determine the preferred method of ensuring ongoing training, support, and monitoring of new CalAIM policies.
3. Analyst and QI Committee will finalize documents to submit to DHCS

Monitoring Method	1. DHCS BHIN tracking, committee findings and minutes, training plans, completed training/attestation monitoring
Reporting Frequency	Quarterly
Responsible Partners	Analyst QI Committee
Reference	DHCS BHQIP Deliverable; Milestone 2e, goal 2e(iv).

2022 Quarter 1
LCBH has nothing to report this quarter

2022 Quarter 2
LCBH has nothing to report this quarter

2022 Quarter 3
LCBH hired a new Analyst and has begun work on reviewing and tracking CalAIM policies. Analysts have begun optimizing the process for collecting and organizing the tracking for trainings and training attestations.

2022 Quarter 4
LCBH hired a second Analyst and has continued work on reviewing and tracking DHCS CalAIM policies. Analysts, QI/QA, and CalMHSA have been working on developing/updating training plans and policies to meet CalAIM standards. These training plans include CPT Code Training, IGT training, new Screening and Transition Tool Trainings, and trainings on updated CalAIM Documentation Requirements and CalAim Policies. Policies will be broken down by what elements and trainings will need to be provided and for what staff it is necessary.

2022 Year Analysis
In fall of 2022 LCBH began work to track and implement DHCS CalAIM policies as they are released. Prior to hiring the new Analysts, policy tracking was not being done in an efficient manner. With the hiring of 2 new Analysts, LCBH has begun monitoring and updating a CalAIM policies tracking sheet and has been working with CalMHSA, Analysts and QA/QI committee to establish training plans and identify necessary participants. Analysts have been tracking trainings and attestations as they are completed. With consistent tracking of trainings-required and trainings-completed, LCBH will be able to ensure staff are informed and up-to-date on changes within CalAIM to meet new requirements by DHCS.

Coordination of Care	
Goal 1	Improve the coordination of care between LCBH, physical health care agencies and Indian Health Care.
Objective 1.a.	To improve the coordination of care between LCBH and physical health care agencies by establishing an MOU to formalize relationships roles and responsibilities.
Action Steps: 1. Identify best practices in data sharing providers and EHR systems used by current Behavioral Health/Primary Care collaboration projects. 2. Participate in the whole person model. 3. Develop an MOU among primary care agencies.	
Monitoring Method	Develop an MOU
Reporting Frequency	Quarterly
Responsible Partners	Analyst QI Committee
Report **2019 Quarter 1** LCBH has nothing at this time to report on this issue. **2019 Quarter 2** LCBH continues its efforts for coordinate better care between LCBH, physical healthcare agencies, and Indian Health care. **2019 Quarter 3** LCBH continues its efforts for coordinate better care between LCBH, physical healthcare agencies, and Indian Health care. **2019 Quarter 4** LCBH continues its efforts for coordinate better care between LCBH, physical healthcare agencies, and Indian Health care. **2020 Quarter 1** LCBH starting using Beacon referrals more frequently to refer clients to local community partners for lower levels of care if needed. LCBH has an already	

established MOU with Partnership Health from 2018. LCBH established an MOU with Banner Lassen Emergency Room for Crisis services.

2020 Quarter 2
LCBH continues its efforts for coordinate better care between LCBH, physical healthcare agencies, and Indian Health care.

2020 Quarter 3
LCBH sent an MOU to Susanville Indian Rancheria and are awaiting a response.

2020 Quarter 4
LCBH continues its efforts for coordinate better care between LCBH, physical healthcare agencies, and Indian Health care.

2021 Quarter 1
LCBH continues its efforts for coordinate better care between LCBH, physical healthcare agencies, and Indian Health care. LCBH doctors have been consulting with client's Physical Healthcare Staff as needed.

2021 Quarter 2
LCBH continues its efforts for coordinate better care between LCBH, physical healthcare agencies, and Indian Health care. LCBH doctors continue consulting with client's physical healthcare staff as needed. LCBH has established a new contact with Lassen Indian Health and is working to get an MOU signed.

2021 Quarter 3
LCBH and LIH were able to sign an MOU in September of 2021. LCBH and LIH are working to collaborate programs to better coordinate care between agencies.

2021 Quarter 4
LCBH continues its efforts to coordinate better care between LCBH, physical healthcare agencies, and Indian Health care.

2022 Quarter 1
LCBH continues its efforts to coordinate better care between LCBH, physical healthcare agencies, and Indian Health care.

2022 Quarter 2
LCBH continues its efforts to coordinate better care between LCBH, physical healthcare agencies, and Indian Health care.

2022 Quarter 3
LCBH continues its efforts to coordinate better care between LCBH, physical healthcare agencies, and Indian Health care. LCBH began work on developing a Performance Improvement Project (PIP) to provide the framework for better

communication and data exchange between the ED, MCP, and MHP. LCBH hired a new Analyst to begin growing the capacity for data tracking and exchange.

2022 Quarter 4
LCBH continues its efforts to coordinate better care between LCBH, physical healthcare agencies, and Indian Health care. LCBH continued work on a Performance Improvement Project (PIP) to provide the framework for better communication and data exchange between the ED, MCP, and MHP. A second Analyst was hired, helping to build the capacity for data exchange and has begun optimizing tracking system for crises, hospitalizations, referrals, and follow up contact/services for the purpose of bettering care coordination between the MHP and health care agencies.

2019 Year Analysis
LCBH is currently in the process of working on a MOU with Lassen Indian Health, Banner Lassen Medical Center, and also other county agencies to insure the best quality of care for our beneficiaries.

2020 Year Analysis
LCBH has made progress in coordinating a better relationship between LCBH and Indian Health care. LCBH has an already established MOU with Partnership Health from 2018. LCBH established an MOU with Banner Lassen Emergency Room for Crisis services.

2021 Year Analysis
LCBH was able to secure a signed MOU with Lassen Indian health. The two agencies are now working to coordinate programs to better serve clients. LCBH continues efforts to coordinate with other physical health care agencies to better care for the clients in Lassen County.

2022 Year Analysis
In September of 2022, LCBH began working on a Performance Improvement Project (PIP) to increase communication with, and build the capacity for data exchange with the ED and MCP. Prior to introducing the PIP, communication between the MHP and ED was haphazard with clients being discharged but not consistently being referred or followed up with the MHP. Working to achieve proper data exchange and communication with the ED and MCP will decrease likelihood of any clients falling between the cracks in terms of care coordination and being provided the necessary MH services that are needed post-hospitalization for MH or SUD crisis. LCBH hired on two new Analysis in 2022 helping to build this capacity.