SAN BENITO COUNTY
BEHAVIORAL HEALTH

Quality Improvement Work Plan

Fiscal Year 2016-2017

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I. QUALITY IMPROVEMENT PROGRAM OVERVIEW

A. Quality Improvement Program Characteristics

San Benito County Behavioral Health (SBCBH) has implemented a Quality Improvement (QI) Program in accordance with state regulation for evaluating the appropriateness and quality of services, including over-utilization and underutilization of services. The QI Program meets these requirements through the following process:

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

It is the goal of SBCBH to build a structure that ensures the overall quality of services. This goal is accomplished by realistic and effective quality improvement activities and data-driven decision making; collaboration amongst staff, including consumer/family member staff; and utilization of technology for data analysis. Through data collection and analysis, significant trends are identified; and policy and system-level changes are implemented, when appropriate.

Executive management and program leadership is crucial to ensure that findings are used to establish and maintain the overall quality of the service delivery system and organizational operations. The QI program is accountable to the SBCBH Director.

B. Quality Improvement Annual Work Plan Components

The Annual Work Plan for Quality Improvement activities of SBCBH provides the blueprint for the quality management functions designed to improve both client access and quality of care. This Plan is evaluated annually and updated as necessary.

The SBCBH annual QI Work Plan includes the following components:

1. An annual evaluation of the overall effectiveness of the QI Program, utilizing data to demonstrate that QI activities have contributed to meaningful improvement in clinical care and client services;
2. Objectives and activities for the coming year;
3. Previously identified issues, including tracking issues over time; and
4. Activities for sustaining improvement.

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

This Quality Improvement Plan ensures the opportunity for input and active involvement of clients, family members, licensed and paraprofessional staff, providers, and other interested stakeholders in the Quality Improvement Program. The QI members participate in the planning, design, and execution of the QI Program, including policy setting and program planning. The Plan activities also serve to fulfill the requirements set forth by the California Department of Health Care Services, Mental Health Services Division, and Specialty Mental Health Services Contract requirements, as related to the contract's Annual Quality Improvement Program description. The SBCBH QI Work Plan addresses quality assurance/improvement factors as related to the delivery of culturally-competent specialty mental health services.

C. Quality Management Committees

Two committees, the Quality Improvement Committee (QIC) and the Quality Leadership Committee (QLC), are responsible for the key functions of the SBCBH Quality Improvement Program. These committees are involved in the following functions:

1. The Quality Improvement Committee is charged with implementing the specific and detailed review and evaluation activities of the agency. On a quarterly basis, the QIC collects, reviews, evaluates, and analyzes data and implements actions that frequently involve handling information that is of a sensitive and confidential nature. The QIC also provides oversight to QI activities, including the development and implementation of the Performance Improvement Projects (PIPs).

   The QIC recommends policy decisions; reviews and evaluates the results of QI activities; and monitors the progress of the PIPs. The QIC institutes needed actions and ensures follow-up of QI processes. The QIC documents all activities through dated and signed minutes to reflect all decisions and actions.

   The QIC assures that QI activities are completed and utilizes a continuous feedback loop to evaluate ongoing quality improvement activities, including the PIPs. This feedback loop helps to monitor previously identified issues and provides an opportunity to track issues over time. The QIC continuously conducts planning and initiates new activities for sustaining improvement.

   Designated members of the QIC include the SCBHS Director, representatives from Adult and Children's Services, Access Team, Crisis Services, Medical Services, Mental Health Services Act (MHSA), Compliance, Fiscal, Business Office, electronic health records (EHR), contracted providers, Patient Rights, and client/family member(s). A Confidentiality Statement is integrated into the QIC Sign-In sheet, which is collected at the beginning of each meeting. This Confidentiality Statement insures the privacy of protected health information.

Specific responsibilities of the QIC include, but are not limited to, the following:

- Consumer survey results;
- Consumer and family voice;
- Performance Outcome Measures;
- Access and quality of care;
- Utilization of outpatient services;
- Utilization of inpatient and IMD services;
- Grievances and appeals;
- Primary and Behavioral Health Care integration;
- HIPAA and compliance;
- Cultural and linguistic competency, including trends regarding cases of cultural concern presented in the Clinical Team meetings;
- Notice of Actions and State Fair Hearings;
- Brochure distribution;
- Psychiatrist/Physician access ;
- Medication review;
- Review out of county mental health authorizations;
- PIP's and EQRO review;
- Staff and supervisor annual credentialing process (including private provider network);
- OIG Exclusions & Suspended Medi-Cal Providers;
- Medi-Cal verification (integrity) activities;
- 24/7 toll free line monitoring report;
- Drug Medi-Cal requirements;
- Change of provider request review;
- Peer chart review;
- Supervisor chart review report

QIC Subcommittee: Management staff meet as a subcommittee of the QIC Committee to discuss QI related topics on a more frequent basis than the quarterly meetings. This subcommittee discusses topics such as Medi-Cal documentation; electronic health record implementation; preparing and responding to state and federal reviews; critical incidents; and other pertinent QI activities. A summary of these activities is shared with the QIC and QLC members.

2. The Quality Leadership Committee (QLC) is integrated into the QIC Program through involvement in a general oversight and evaluation capacity. The QLC members review summaries of data and other critical information provided through the QIC functions. This information includes, but is not limited to, number of clients served, service utilization patterns, and significant incidents and trends that allow the QLC to evaluate the overall quality of care and service delivery of SBCBH mental health services.

   The QLC also receives periodic updates on the progress of the Performance Improvement Projects. This information allows the QLC to have informed input

on policy, system level changes, planning, and design of the mental health service delivery system. Members include clients, family members of clients, community representatives, external service providers of care, a psychiatrist, and representatives of other agencies.

Each quarterly meeting of the QLC shall include a verbal summary of significant QIC findings, decisions, actions, and recommendations, in accordance with Policy CLN: 27:00. In addition, written information may also include data summaries, as available.

The QIC and QLC are both accountable to the SBCBH Director. SBCBH procures contracts with individual, group, and organizational providers, and for psychiatric inpatient care. As a component of the contract, these entities are required to cooperate with the QI program and allow access to relevant clinical records to the extent permitted by State and Federal laws.

II. PROGRAM COMPONENTS

A. Evaluation of Overall Effectiveness

Evaluation of the overall effectiveness of the QI program is accomplished routinely, as well as annually, to demonstrate that:

- QI activities have contributed to improvement in clinical services;
- QI activities have contributed to improvement in access to services;
- QI activities have been completed or are in process; and
- QI activities have incorporated relevant cultural competence and linguistic standards to match clients' cultural and linguistic needs with appropriate providers and services.

B. Specific QI Evaluation Activities for Both Mental Health and Substance Use Disorder Services

1. Quality Improvement Committee (QIC)
   The quarterly QIC meetings may include, but are not limited to, the following agenda items:

   - Review reports to help identify trends in client care, in timeliness of treatment plan submissions, and trends related to the utilization review and authorization functions;
   - Review client and provider satisfaction surveys, and client change of provider request to assure access, quality, and outcomes;
   - Review the responsiveness of the 24-hour, toll-free telephone line;
   - Review and evaluate results of QI activities, including progress on the development and implementation of the PIPs;
   - Review QI actions and follow-up on any action plans;
   - Review at least six (6) charts to focus on appropriateness of care, appropriateness of reviewer comments, any plans of correction following initial review, and any significant trends of concern;
   - Review client- and system-level Performance Outcome Measures for adults and children to focus on any significant findings and trends;
   - Review medication monitoring processes to assure appropriateness of

care, appropriateness of reviewer comments, any plans of correction following initial review, and any significant trends of concern;

- Review new Notices of Action, focusing on their appropriateness and any significant trends;

- Review any grievances or appeals submitted. The QIC reviews the appropriateness of the SBCBH response and significant trends that may influence policy or program-level actions, including personnel actions;

- Review provider satisfaction surveys (annually) and any provider appeals;

- Review any requests for State Fair Hearings, as well as review of any results of such hearings;

- Monitor the distribution of EPSDT brochures;

- Review other clinical and system level issues of concern that may affect the quality of service delivery. The information reviewed also allows the QIC to evaluate trends that may be related to culturally-sensitive issues and may require prescriptive action;

- Review potential or required changes in policy;

- Review issues related to the Compliance Program, including compliance issues such as fraud or inappropriate billing; staff licensure; status and exclusions lists; and other program integrity items; and

- Monitor issues over time and make certain that recommended activities are implemented, completing the Quality Improvement feedback loop.

2. Quality Leadership Committee (QLC)
   Each quarterly meeting of the QLC includes a verbal summary of significant QIC findings, decisions, actions, and recommendations. In addition, written information may also include data summaries, as available. Photocopies of the QIC meeting minutes are provided for QLC members for review and comment.

3. Monitoring Previously Identified Issues and Tracking over Time
   Minutes of all QIC and QLC meetings shall include information regarding:
   - An identification of action items;
   - Follow-up on action items to monitor if they have been resolved;
   - Assignments (by persons responsible);
   - Due date; and
   - Completion date.

To ensure a complete feedback loop, completed and incomplete action items shall be identified on the agenda for review at the next meeting. Chart reviews pending further action to implement plans of correction are identified for follow-up and reporting. SBCBH has developed a meeting minute template to ensure that all relevant and required components are addressed in each set of minutes. Meeting minutes are also utilized to track action items and completion dates.

Due to the diverse membership of the QIC and QLC, information sharing with the QLC will not breach client confidentiality regulations; consequently, information of a confidential nature are provided in summary form only. The QIC minutes are provided at the QLC meetings and assists to provide structure to the QLC meetings.

C. Inclusion of Cultural and Linguistic Competency in All QI Activities

On a regular basis, the QIC reviews collected information, data, and trends relevant to standards of cultural and linguistic competency.

III. Data Collection – Sources and Analysis

A. Data Collection

Data sources and types include, but not are limited to, the following:

1. Utilization of services by type of service, age, gender, race, ethnicity, primary language, veterans, and LGBTQ
2. Access Log (initial contact log)
3. Crisis Log
4. Test call logs
5. Notice of Action Forms and Logs
6. Second Opinion requests and outcomes
7. Anasazi Electronic Health Record Reports
8. Medication Monitoring forms and logs
9. Treatment Authorization Requests (TAR) and Inpatient Logs
10. Clinical Review QI Checklists (and plans of correction)
11. Peer Chart Review Checklists (and plans of correction)
12. Client Grievance/Appeal Logs; State Fair Hearing Logs
13. Change of Provider Forms and Logs
14. Special Reports from DHCS or studies in response to contract requirements
15. EQR and Medi-Cal Audit results

B. Data Analysis and Interventions

1. Administrative staff perform preliminary analysis of data to review for accuracy and completion. If there are areas of concern, the QIC discusses the information. Clinical staff may be asked to implement plans of correction, as needed. Policy changes may also be implemented, if required. Subsequent review is performed by the QIC and QLC.

2. The changes to programs and/or interventions are discussed with individual staff, committee members (including consumers and family members), and management. A Plan Do Study Act (PDSA) model of change is utilized to help identify strategies that are effective and appropriate for a larger system application.

3. Program changes have the approval of the Behavioral Health Director prior to implementation.

4. Effectiveness of program changes are evaluated by the QIC and QLC. Input from committees is documented in the minutes. These minutes document the activity, person responsible, and timeframe for completion. Each activity and the status for follow-up are discussed at the beginning of each meeting.

IV. Quality Improvement Activities, Goals, and Data

The Quality Improvement program for Fiscal Year 2016/2017 includes the following activities, goals, and baseline FY 2015-2016 data.

A. Ensure SBCBH Service Delivery Capacity – Annually, the SBCBH QI program monitors services to assure service delivery capacity in the following areas:

1. Utilization of Services

- Activity: Review and analyze reports from the Kings View Cerner program. The data includes the current number of clients served each fiscal year and the types of mental health and substance use disorder services delivered. Data is analyzed by age, gender, ethnicity, primary language, LGBTQ, veterans, and diagnosis; it is compared to the goals set by the QIC for service utilization.
- Goal: Increase the number of mental health services received by Transition Age Youth (TAY) in FY 2016-2017.
- Data: There were an average of 13 mental health services received by TAY clients in FY 2015-2016. We will review this data annually to assess improvement in the measure.

2. Service Delivery Capacity

- Activity: Staff productivity is evaluated via productivity reports generated by the Kings View Cerner program. Managers/Supervisors receive periodic reports to assure service capacity.
- Goal: Maintain the number of clients served by Telepsychiatry in FY 2016-2017.
- Data: Twenty-six (26) clients received Telepsychiatry services in FY 2015-2016. Note: The Telepsychiatrist is Spanish speaking and is able to deliver services in client's preferred language.

These issues are also evaluated to ensure that the cultural and linguistic needs of clients are met.

B. Monitor Accessibility of Services – The SBCBH QI program monitors accessibility of services in accordance with statewide standards and the following local goals:

1. Timeliness of routine mental health appointments

- Activity: This indicator is measured by analyzing a random sample of new requests for services from the Access Log. This data is reviewed quarterly.
- Goal: Maintain the number of clients referred for mental health services who receive an Assessment appointment within 21 business days.

- Data: 317 of the 351 (90.3%) clients referred for mental health services in July – December 2016 received an Assessment appointment within 21 days.

2. **Timeliness of services for urgent or emergent conditions during regular clinic hours**
   - Activity: This indicator is measured by analyzing a random sample of urgent or emergent requests for services from the Crisis Log. This data is reviewed quarterly.
   - Goal: Maintain the percentage of business-hours crisis requests with a response time of two hours or less.
   - Data: 477 of the 477 (100%) business-hours crisis requests had a response time of two hours or less in July – December 2016.

3. **Access to after-hours Emergency services**
   - Activity: This indicator is measured by analyzing a random sample of after-hour requests for services from the Crisis Log and/or the Access Log. Data is reviewed quarterly.
   - Goal: Increase the percentage of after-hours crisis requests with a response time of two (2) hours or less by 3% (87.2%).
   - Data: 149 of the 177 (84.2%) after-hours crisis requests had a response time of two (2) hours or less in July – December 2016.

4. **Responsiveness of the 24-hour, toll-free telephone number**
   - Activity: During non-business hours, the answering service answers the crisis line immediately, and links urgent and/or emergent calls to the on-call mental health staff person. If required, an interpreter and/or the Language Line Solutions is utilized. This indicator is measured by conducting random calls to the toll-free number, both after hours and during business hours. At least five (5) test calls are made per month; split between English and Spanish. This data is reviewed at each quarterly QIC meeting.
   - Goal: The SBCBH after-hours 24-hour telephone service answers the call within one (1) minute. The line is tested monthly.
   - Data: Twenty-five (25) test calls were conducted in September 2015 – January 2017, with all 25 (100%) being answered by staff within one (1) minute.

5. **Provision of culturally and linguistically appropriate services**
   - Activity: This indicator is measured by random review of the Access Log and/or the Crisis Log, as well as the results of test calls. The focus of these reviews is to determine if a successful and appropriate response was provided which adequately addressed the client's cultural and linguistic needs. In addition, requests for the need for interpreters are reviewed (via the Access Log) to assure that staff are aware of the need for an interpreter

and that clients received services in their preferred language, whenever feasible. This information is reviewed quarterly.

- Goal: Maintain the percentage of successful test calls to the toll free hotline in FY 2016-2017 at the same capacity as in FY 2015-2016.
- Data: Twenty-five (25) test calls were conducted in September 2015 – January 2017, with 20 (80%) that were overall successful.

6. Increasing client access

- Activity: SBCBH endeavors to improve client access to mental health services, targeting high-need populations. This indicator is measured through an analysis of clients who received FSP services in the fiscal year. This information is reviewed annually.
- Goal: Increase FSP enrollment by 10% in FY 2016-2017.
- Data: Seventy (70) clients received FSP services in FY 2015-2016.

C. Monitor Client Satisfaction – The QI program monitors client satisfaction via the following modes of review:

1. Monitor Client Satisfaction

- Activity: Using the DHCS POQI instruments in threshold languages, clients and family members are surveyed twice each year, or as required. This indicator is measured by annual review and analysis of at least a one week sample. Survey administration methodology will meet the requirements outlined by the CA DHCS. This data is reviewed twice each fiscal year, after the surveys have been analyzed.
- Goal: Maintain the percentage of consumers/families reporting that they are able to receive services at convenient locations in FY 2016-2017 at the same capacity as in FY 2015-2016.
- Data: Seventy percent (70.2%) of consumers/families reported that they were able to receive services at convenient locations in FY 2015-2016.

2. Monitor Youth and/or Family Satisfaction

- Activity: Utilization of the DHCS, POQI YSS and YSS-F measurement instruments assures the use of instruments that are accepted statewide as the basis for satisfaction surveys. The YSS and YSS-F are collected from youth ages 12 and older and the children's families. Survey administration methodology will meet the requirements outlined by the CA DHCS. This data is reviewed after each survey administration.
- Goal: Maintain the percentage of consumers/families reporting overall satisfaction with services provided in FY 2016-2017 at the same capacity as in FY 2015-2016, and continue year to year trending of the data.
- Data: Eighty-three percent (82.8%) of consumers/families reported overall satisfaction with services provided in FY 2015-2016.

3. **Monitor Beneficiary Grievances, Appeals, and State Fair Hearings**
    - Activity: All processed beneficiary grievances, expedited appeals, standard appeals, and fair hearings are reviewed at QIC meetings. Monitoring is accomplished by ongoing review of the Grievance Log for adherence to timelines for response. In addition, the nature of complaints and resolutions is reviewed to determine if significant trends occur that may influence the need for policy changes or other system-level issues. This review includes an analysis of any trends in cultural issues addressed by our clients. This information is reviewed quarterly, as available.
    - Goal: The MHP will respond in writing to 100% of all grievances within 60 calendar days from the date of receipt.
    - Data: There were four (4) grievances in FY 2015-2016, with 100% responded to within 60 calendar days from the date of receipt.

4. **Monitor Requests to Change Providers**
    - Activity: Quarterly, patterns of client requests to change practitioners/providers are reviewed by the QIC. Measurement is accomplished by review of QIC minutes summarizing activities of the Access Team and through annual review of the Change of Provider Request forms.
    - Goal: Monitor Beneficiary Requests for Change of Provider including reasons given by consumers for their Change of Provider requests.
    - Data: Review patterns of Beneficiary Requests for Change of Provider quarterly to look for trends.

5. **Inform Providers of Survey Results**
    - Activity: The results of client and family satisfaction surveys are routinely shared with providers. Monitoring is accomplished by review of the results of the POQI surveys as related to clients who have received services from contract specialty mental health service providers. Survey results are shared with staff, consumers, family members, QIC, QLC, and the Behavioral Health Advisory Board. This information is distributed on an annual basis and in the form of cumulative summaries to protect the confidentiality of clients and their families. This process is reviewed annually.
    - Monitor the percentage of providers who report satisfaction with SBCBH policies and monitoring activities.
    - Goal: Survey results are to be shared with identified stakeholders.
    - Data: Survey results were shared with staff, consumers, family members, QIC, QLC, and the Behavioral Health Advisory Board in FY 2015-2016.

6. **Monitor Cultural and Linguistic Sensitivity**
    - Activity: In conducting review in the above areas, analysis occurs to determine if cultural or linguistic issues may have influenced results. Surveys will be provided in English and in Spanish. This process is reviewed annually.

- Goal: Maintain the percentage of consumers/families reporting that staff were sensitive to their cultural/ethnic background in FY 2016-2017 at the same capacity as in FY 2015-2016.
- Data: Seventy-eight percent (77.6%) of consumers/families reported that staff was sensitive to their cultural/ethnic background in FY 2015-2016.

D. Monitor the Service Delivery System – The QI program monitors the SBCBH service delivery system to accomplish the following:

1. Review Safety and Effectiveness of Medication Practices

- Activity: Annually, meaningful issues for assessment and evaluation, including safety and effectiveness of medication practices and other clinical issues are identified. Medication monitoring activities are accomplished via review of at least ten (10) percent of cases involving prescribed medications. These reviews are conducted by a person licensed to prescribe or dispense medications. In addition, peer review of cases receiving clinical and case management services occur at QIC meetings. An analysis of the peer reviews occur to identify significant clinical issues and trends.
- Goal: Continue to conduct medication monitoring activities on 10% of medication charts.
- Data: Fifty (50) medication charts were reviewed for medication monitoring activities in FY 2015-2016.

2. Identify Meaningful Clinical Issues

- Activity: Quarterly, meaningful clinical issues are identified and evaluated. Appropriate interventions are implemented when a risk of poor quality care is identified. Monitoring is accomplished via review of QIC minutes for satisfactory resolutions in the areas of grievances, medication monitoring, and peer chart review cases where plans of correction are requested. Re-occurring quality of care issues are discussed in staff meetings and at the QIC to address concerns in a timely manner.
- Goal: Clinical staff participate in at least two (2) clinical trainings each year.
- Data: Staff participated in 46 clinical trainings in FY 2015-2016.

3. Review Documentation and Medical Records System

- Activity: Client documentation and medical records system fulfills the requirements set forth by the DHCS and San Benito County Specialty Mental Health Services Contract requirements. Documentation of the client's participation in and agreement with their client treatment plan will be included. When the client is unavailable for signature or refuses signature, the client treatment plan includes a written explanation of the refusal or unavailability. Signatures of the individual providing service or the team/representative providing services are recorded.

- Goal: Maintain the percentage of completed and signed Treatment Plans in FY 2016-2017 at the same capacity as in FY 2015-2016.
- Data: 875 of the 999 (87.6%) Mental Health Treatment Plans due in FY 2015-2016 where completed and signed.

4. Implement and Maintain Efficient Workflow Standards

- Activity: Office and billing workflow standards are implemented and maintained to efficiently and consistently serve clients from first contact through discharge, and bill correctly and consistently. Workflow processes are documented and implemented through policies and procedures. Monitoring is conducted through annual review of related policies and procedures; and updated as necessary.
- Goal: The review of billing and workflow policies and procedures occurs annually, as scheduled, and that procedures are updated as necessary.
- Data: The Work Flow review is evidenced by the number and percent of workflow and billing policies and procedures that were reviewed annually.

5. Assess Performance

- Activity: Quantitative measures are identified to assess performance and identify areas for improvement, including the PIPs and other QI activities. SBCBH monitors both under-utilization of services and over-utilization of services. The BH Director reviews data on the percentage of billable services (productivity reports). These areas are measured through the quarterly review of the timeliness of assessments and treatment plans; completeness of charts; client surveys; and productivity reports. The results of these reviews dictate areas to prioritize for improvement.
- Goal: Maintain the percentage of billable services delivered by service delivery staff in FY 2016-2017.
- Data: Fifty-two percent (52%) of services delivered by staff were billable services in July – December 2015.

6. Support Stakeholder Involvement

- Activity: Staff, including licensed mental health professionals, paraprofessionals, providers, clients, and family members review the evaluation data to help identify barriers to improvement. As members of the QLC, providers, clients, and family members help to evaluate summarized data. This ongoing analysis provides important information for identifying barriers and successes toward improving administrative and clinical services. In addition, the Behavioral Health Advisory Board provides input on access and barriers to services. Measurement is accomplished via review of QIC and QLC minutes and rosters, and occurs annually.
- Goal: Increase attendance at QLC to fill at least one (1) consumer slot at each meeting in FY 2016-2017.
- Data: One (1) consumer slot was filled at approximately 50% of the QLC meetings in calendar year 2016.

7. **Conduct Frequent Peer Reviews**
    - Activity: SBCBH evaluates the quality of the service delivery by conducting six (6) peer reviews every quarter. Reviews are conducted by staff. Clinical Supervisors review charts annually. Issues and trends found during these reviews are addressed at the QIC meetings.
    - Goal: Maintain 24 client charts to be reviewed by staff annually.
    - Data: Twenty-four client charts were reviewed by staff in FY 2015-2016.

The activities and processes outlined above will maintain sensitivity to the identification of cultural and linguistic issues.

E. Monitor Continuity and Coordination of Care with Physical Health Care Providers – When appropriate, information is exchanged in an effective and timely manner with other health care providers used by clients.

1. **Monitor Coordination of Care**
    - Activity: Measurement is accomplished during ongoing review of the clinical assessments and discharge summaries. These reviews identify referrals to alternative resources for treatment or other services whenever requested, or when it has been determined that an individual may benefit from referral to other health care providers. In addition, the Access Log includes tracking requests for psychiatric consults with physical healthcare providers. Appropriateness of exchange of information is measured during peer chart review by assuring the presence of a signed consent form. This information is reviewed annually.
    - Goal: Monitor documentation of psychiatric consults with physical healthcare providers quarterly.
    - Data: SBCBH will add this information at a later date.

F. Monitor Provider Appeals

1. **Monitor Provider Appeals**
    - Activity: Provider appeals and complaints are reviewed as received by the QIC. A recommendation for resolution will be made to the Behavioral Health Director. The resolution and date of response are recorded in the QIC meeting minutes. The QIC reviews the provider appeals and complaints annually for any trends and addresses these issues.
    - Goal: Monitor the number of TAR appeals in FY 2016-2017.
    - Data: There were three (3) TAR appeals in FY 2015-2016.

V. Delegated Activities Statement

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