
# LAKE COUNTY
# BEHAVIORAL HEALTH

## Quality Improvement
## Work Plan Evaluation

Fiscal Year 2018 – 2019

FINAL 9/11/2020

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# I. QUALITY IMPROVEMENT PROGRAM OVERVIEW

## A. Quality Improvement Program Characteristics

The function of the Quality Improvement Work Plan is to plan and monitor compliance with the Lake County Behavioral Health Services (LCBHS) program goals regarding access to services, improvements to service delivery, and enhancements to quality of care. This purpose is accomplished by following a planned and systematic process of collecting data, setting objectives, and monitoring progress.

Monitoring quality improvement, compliance activities, and consumer rights issues occurs through regular management oversight, as well as through Quality Improvement Committee (QIC) reviews. Feedback is also obtained through the following:

- Consumer, youth, and family surveys
- Utilization review activities
- Chart audits
- Medical peer reviews
- Regular QIC and Compliance Program Committee Meetings
- Mental Health Board (MHB) review
- Review of consumer and provider complaints
- Review of special incidents
- Periodic clinical training

The FY 2018-2019 Quality Improvement Work Plan includes activities as required by the Mental Health Plan (MHP) contract with the California Department of Health Care Services (DHCS). Quality Improvement (QI) projects, whenever possible, incorporate the processes outlined in the contract between LCBHS and DHCS. These processes include the following techniques:

- Collecting and analyzing data to measure access, quality, and outcomes, against goals or identified prioritized areas of improvement,
- Identifying opportunities for improvement and determine which opportunities to pursue,
- Designing and implementing interventions to improve its performance,
- Measuring the effectiveness of interventions, and
- Integrating successful interventions in the service delivery system, as appropriate.

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

## B. Quality Improvement Annual Work Plan Components

The Annual Work Plan for QI activities of LCBHS provides the blue print for the quality management functions designed to improve both client access and quality of care. This plan is evaluated annually and updated as necessary.

The LCBHS Annual QI Work Plan includes at least the following components:

1. An annual evaluation of the overall effectiveness of the QI Program, utilizing data to demonstrate the 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 via data analysis; and
4. Activities for sustaining improvement.

The QI Work Plan is posted on the LCBHS website and is available upon request. It is provided to the External Quality Review Organization (EQRO) during its annual review of the LCBHS system. The QI Work Plan is also available to auditors during the triennial Medi-Cal review. This QI Work Plan ensures the opportunity for input and active involvement of clients, family members, licensed and paraprofessional staff, providers, and other interested stakeholders in the Quality Improvement Program. The QI members participate in the planning, design, and execution of the QI Program, including policy setting and program planning. The planned activities are able to serve and fulfill the requirements set forth by the California Department of Health Care Services Division, and LCBHS Specialty Mental Health Services contract requirements, as related to the LCBHS's Annual Quality Improvement Program description. The LCBHS QI Work Plan addresses quality assurance/improvement factors related to the delivery of culturally-competent specialty mental health services.

## C. Quality Management Committees and Sub-Committees

Essential to the performance of the QI program is a complete information feedback loop wherein information flows across clinical, programmatic, and administrative channels. LCBHS has established two committees, the QIC and the Compliance Program Committee, which includes representation from the MHP (clinician's, management, etc.), organizational providers, consumers, family members, and stakeholders to ensure the effective implementation of the QI Work Plan. These committees are involved in the following functions:

1. The Compliance Program Committee is assigned with ensuring Medi-Cal services are billed appropriately and in compliance with all state and federal regulations. Please refer to the LCBH Compliance Plan for the roles and responsibilities of this committee.

2. The Quality Improvement Committee (QIC) is assigned with implementing the QI activities of the agency. Quarterly, the QIC collects, reviews, evaluates, and analyzes data and implements actions that frequently involve handling sensitive and confidential information. 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 PIPs. The QIC documents all activities through dated and signed minutes to reflect all QIC decisions and actions. Specific responsibilities of the QIC include, but are not limited to the following:

- Review quality of care concerns
- Collect and analyze consumer survey responses
- Be a resource to individual programs
- Report data collection and outcome monitoring activities on Behavioral Health to improve system performance
- Formulate corrective action plans as necessary to improve consumer-driven care
- Plan, develop, and implement PIPs
- Review and update the LCBHS Implementation Plan, as necessary
- Initiate corrective action plans adopted by the QIC to improve consumer access to services and quality of care
- Review and recommend actions regarding issues involving the following:
  - High-risk individuals with high utilization of services
  - Unresolved clinical issues
  - Unresolved complaints
  - Evidence of treatment that is not within professional or ethical standards
  - Denials of service
  - Treatment that appears to be inadequate or ineffective
  - Utilization of inpatient and IMD services
- Identify and address systems issues
- Monitor grievances and appeals
- Promote consumer and family voice to improve wellness and recovery
- Develop strategies to integrate health and behavioral health care throughout Lake County
- Review Katie A./CCR service activities and assess

Designated members of the QIC include the Quality Improvement Coordinator; management/supervisory staff; clinical staff; case management staff; clerical and support staff; clients; family members; and other stakeholders. Members sign a confidentiality statement to insure the privacy of protected health information. This confidentiality statement is integrated into the QIC program and allows access to relevant clinical records to the extent permitted by State and Federal laws.

***QIC Sub-Committee***

a. Cultural Competency Committee identifies cultural variations and satisfaction with/use of services across cultures; identify culturally-relevant issues surrounding the design and delivery of services; develops staff cultural competency; develops and implements a Cultural and Linguistic Competency Plan; and provides quarterly reports to QIC and Behavioral Health (BH) Director. Meeting minutes are recorded and maintained.
b. Medication Monitoring meets quarterly and reviews a sample size of the medication services provided by the psychiatrist and/or other medical staff; maintains the medication room safety environment; and monitors medication practices. Results are

directly reviewed with the contracted provider, psychiatrist, medication support staff, and the Compliance and QI coordinator. A summary report is shared with the QIC.

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

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# II. QUALITY IMPROVEMENT PROGRAM COMPONENTS

## A. Evaluation of Overall Effectiveness

The evaluation of the overall effectiveness of the QI program is accomplished routinely, as well as annually, demonstrate the QI activities have accomplished the following:

- Contributed to improving clinical care;
- Contributed to timely access to services;
- Contributed to improving client services;
- Incorporated relevant cultural competence and linguistic standards to match clients' cultural and linguistic needs with appropriate providers and services;
- QI activities have been completed, or are in process.

## B. Specific QI Activities

1. The quarterly QIC meetings may include, but are not limited to, the following agenda items:
    - Review reports to help identify trends in client care, timeliness of medication treatment plan submissions, services, and trends related to the utilization review and authorization functions;
    - Review and evaluate summary results of QI activities, including progress on the development and implementation of the two (2) Performance Improvement Projects (PIP);
    - Review data from Access Logs showing responsiveness of the 24-hour access line, timeliness of appointments, and responses to urgent conditions;
    - Review data from Inpatient/IMD/Residential programs relating to census, utilization, and lengths of stay;
    - Review data regarding the number of Treatment Authorization Requests (TARs), approvals, and denials;
    - Review summary data on the medication monitoring process to assure appropriateness of care;
    - Review Katie A./CCR services to show program implementation;
    - Review number of children in placement, level of care, and changes in placement at least quarterly;

- Review new Notices of Adverse Benefit Determination, focusing on their appropriateness and any significant trends;
- Review trends in change of provider requests;
- Review summary data from utilization review authorization decisions to identify trends in client care, timeliness of services, trends related to utilization review and authorization functions, and compliance with documentation requirements;
- Assess client satisfaction surveys results for assuring access, quality, and outcomes;
- Review any issues related to grievances and/or appeals. The QIC reviews appropriateness of the LCBHS response and significant trends that may influence policy- or program-level actions, including personnel actions;
- Review any requests for State Fair Hearings, as well as review results of such hearings;
    - Review any provider appeals and satisfaction surveys;
- Review clinical- and system-level performance outcome measures for adults and children to focus on any significant findings and trends that may be related to culturally-sensitive issues and may require prescriptive action;
- Review potential or required changes in policy;
- Review annual credentialing process to assure all licensed staff follow their licensing requirements;
- Review annual reports regarding QI monitoring of licensure, exclusion lists, and status lists for individual and organizational providers that deliver Medi-Cal services;
- Review cultural competency issues or concerns;
- Review HIPAA compliance issues or concerns;
    - Monitor issues over time and make certain recommended activities are implemented, completing the QI feedback loop.

2. Monitoring previously identified issues and tracking over time.

    To assure a complete feedback loop, completed and incomplete action items are 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 reporting. LCBHS has developed a meeting minute template to ensure all relevant and required components are addressed in each set of minutes. Meeting minutes are also utilized to track action items and completion dates. Minutes of all QIC meetings include information regarding the following:

    - An identification of action items;
    - Follow-up on action items to monitor if they have been completed;
    - Assignments (by persons responsible); and
    - Due date.

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

### 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 the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care to help address cultural competence and linguistic preferences.

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## III. DATA COLLECTION – SOURCES AND ANALYSIS

### A. Data Collection Sources and Types

1. Utilization of services by type of service, age, gender, race, ethnicity, and primary language
2. Access Log
3. Crisis Log
4. Test call logs
5. Compliance Log
6. Notice of Adverse Benefit Determination
7. Second Opinion requests and outcomes
8. Electronic Health Record Reports
9. Medication Monitoring form and logs
10. Treatment Authorization Requests (TAR) and Inpatient Logs
11. Peer Chart Review Checklists (and plans of correction)
12. Clinical Review QI Checklists (and plans of correction)
13. Client Grievance/Appeal Logs; State Fair Hearing Logs
14. Change of Provider Forms and Logs (aka: Transfer Log)
15. Special Reports from DHCS or studies in response to contract requirements
16. Annual EQRO audit results
17. Triennial Medi-Cal audit results

### B. Data Analysis and Interventions

Data analysis is conducted in several ways. Anasazi has a number of standard reports which managers and supervisors can utilize. LCBHS uses an internal administrative analyst to analyze client- and system-level data to track clients, services, outcomes and costs over time. If the subject matter is appropriate, clinical staff are asked to implement plans of correction. Policy changes may also be implemented, if required. Subsequent reviews are performed by the QIC.

New interventions receive input from individual staff from committee meetings (including representatives of external agencies and consumers) and management. Interventions have the approval of the Behavioral Health Directory prior to implementation.

Effectiveness of interventions are evaluated by the QIC. Input from the QIC are 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 2018-2019 includes the following activities and goals.

### A. Ensure Service Delivery Capacity

Annually, the LCBHS QI program monitors services to assure service delivery capacity in the following areas:

| Activity | Goal | Results | Status |
|---|---|---|---|
| Utilization of Services | | | |
| Review and analyze reports from the Cerner program. The data includes the current number of clients served each fiscal year and the types and geographic distribution of mental health services delivered within the delivery system. Data is analyzed by age, gender, ethnicity, primary language, veterans, LGBTQ, and diagnosis; it is compared to the goals set by the QIC for service utilization. | LCBHS will increase the number of Transition Age Youth (TAY) who receive mental health services. | For FY 17/18, the number of Transition Age Youth (TAY) who received services was 200.<br><br>For FY 18/19, the number of Transition Age Youth (TAY) who received services was 200. | Unsatisfied |
| Service Delivery Capacity | | | |
| Staff productivity is evaluated via productivity reports generated by the Cerner program. Managers/Supervisors receive periodic reports to assure service capacity. | Achieve a staff productivity rate of 70%. | For FY 17/18, the total productivity for Mental Health Services was 51%.<br><br>For FY 18/19, the total productivity for Mental Health Services was 45%*.<br>**Note that results for 9/21-10/20/18 were removed from the tally due to data inaccuracies in the reports.* | Unsatisfied |

## B. Monitor Accessibility of Services

The LCBHS QI program monitors accessibility of services in accordance with statewide standards and the following local goals:

| Activity | Goal | Results | Status |
|---|---|---|---|
| Access Line will be Answered in a Timely Manner | | | |
| This indicator is measured by test calls. | All of our calls will be answered in a timely manner. | There were 49 test calls in FY 18/19; 5 of which went to voicemail and the average wait time was 10 seconds for the 44 answered calls. | Unsatisfied |
| Timeliness of Routine Mental Health Appointments | | | |
| This indicator is measured by analyzing a random sample of new requests for services from the Access Log. This data is reviewed quarterly. | In FY 18/19, the goal is to provide the first mental health intake assessment within the first 10 business days. | For FY 18/19, there were 221 initial requests for service with an average of 27 days between the initial request and the first appointment. | Unsatisfied |
| Timeliness of Services for Urgent or Emergent Conditions During Regular Clinic Hours | | | |
| 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. | 75% of first psychiatry appointments will meet the department standard. | The crisis log was reviewed for FY 18/19. Of those, 17 appointments were designated as first psychiatry appointments. Three appointments did not meet the timeliness standard (15 days from date of request). 82% or 14 appointments did met the standard. | Satisfied |

| Activity | Goal | Results | Status |
|---|---|---|---|
| Access to After-Hours emergency Services | | | |
| 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 twice a year. | Respond to 75% of crisis calls within one hour of initial call for a risk assessment. | For FY 18/19, the crisis team responded to 736 calls. Of those calls, the amount of time it took for them to respond was calculated and averaged resulting in an average response of 58 minutes per call over 12 months. | Satisfied |
| Provision of Culturally- and Linguistically Appropriate Services | | | |
| This indicator is measured by random review of the Access Log and/or the Crisis Log, as well as the results of the test calls. The focus of these reviews are to determine if a successful and appropriate response was provided adequately addressing the client's cultural and linguistic needs. In addition, requests requiring interpreters are reviewed (via the Access Log) to assure staff are aware of the need for an interpreter. This information is reviewed quarterly. | Maintain 75% compliance in responding appropriately to test calls. | For FY 17/18, the percentage of test calls responded appropriately were 18% for Spanish and 59% for English.<br><br>For FY 18/19, the percentage of test calls responded appropriately were 13% for Spanish and 44% for English. | Unsatisfied |
| Increasing Client Access | | | |
| LCBHS 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. | Increase FSP enrollment by 10% in FY 18/19. | In FY 18/19, 104 total clients received FSP services (of which, 50 were new clients to the program). This results in an increase of 33.3% for FY 18/19 to the caseload. | Satisfied |

## C. Monitor Client Satisfaction

The QI program monitors client satisfaction via the following modes of review:

| Activity | Goal | Results | Status |
|---|---|---|---|
| Monitor Client Satisfaction | | | |
| Using the DHCS MHSIP instruments in threshold languages, clients and family members are surveyed twice each year or as required. This indicator is measured by annual review and analyzed at least a one-week sample. Survey administration methodology meet the requirements outlined by the CA DHCS. This data is reviewed twice each fiscal year, after the surveys have been analyzed. | Improve percentage (96%) from FY 17/18 of consumers/ families reporting they are able to receive services at convenient locations in FY 18/19. | In FY 18/19, the percentage of consumers reported receiving services in convenient locations decreased to 84%. | Unsatisfied |
| Monitor Youth and/or Family Satisfaction | | | |
| Utilization of the DHCS MHSIP YSS and YSS-F measurement instruments assures the use of instruments 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 meet the requirements outlined by the CA DHCS. This data is reviewed after each survey administration. | Improve percentage of consumers/families reporting overall satisfaction with services provided, and continue year to year trending of the data. | The percentage of consumers/families reported being satisfied with their services decreased from 83% in FY 17/18 to 81% in FY 18/19. | Unsatisfied |
| Monitor Beneficiary Grievances, Appeals, and State Fair Hearings | | | |
| 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 response timelines. In addition, the nature of complaints and resolutions are 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 monthly and annually. | The MHP will respond in writing to 100% of all appeals from providers within 60 calendar days from the date of receipt of the appeal. | There were no appeals received in FY 18/19. | Satisfied |

| Activity | Goal | Results | Status |
|---|---|---|---|
| Monitor Requests to Change Providers | | | |
| 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. | Beneficiary requests for change of providers are monitored annually, including reasons given by consumers for their Change of Provider Requests. | Beneficiary requests for change of providers are monitored annually. There were no trends identified due only receiving one requests for FY 18/19. | Satisfied |
| Inform Providers of Survey Results | | | |
| The results of client and family satisfaction surveys are routinely shared with providers. Monitoring is accomplished by reviewing the results of the MHSIP surveys as related to clients who have received services from contract specialty mental health service providers. Survey results are shared at the QIC meeting, and with providers, consumers, family members, the Mental Health Board, and the Children's System of Care Policy Committee. 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. | Share survey results on LCBHS Compliance website. | The survey results for FY 18/19 have been published to the Lake County Behavioral Health website at http://lcbh.lakecountyca.gov/ under "Compliance." | Satisfied |
| Monitor Cultural and Linguistic Sensitivity | | | |
| When conducting reviews 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. | Maintain the percentage of consumer/families reporting that staff were sensitive to their cultural/ethnic background in FY 18/19 at the same capacity as in FY 17/18. | The percentage in FY 18/19 increased to 79% from FY 17/18 where of 60% of consumer/families reporting satisfied with their cultural/ethnic background. | Satisfied |

## D. Monitor the Service Delivery System

The QI program monitors the LCBHS service delivery system to accomplish the following:

| Activity | Goal | Results | Status |
|---|---|---|---|
| Review Safety and Effectiveness of Medication Practices | | | |
| Annually identify meaningful issues for assessment and evaluation, including safety, effectiveness of medication practices, and other clinical issues. 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 occurs to identify significant clinical issues and trends. | Continue to conduct medication monitoring on at least 10% of medication charts. | 12% of medication charts were reviewed for medication monitoring activities in FY 18/19. | Satisfied |

| Activity | Goal | Results | Status |
|---|---|---|---|
| Identify Meaningful Clinical Issues | | | |
| 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 and QIC meetings to address concerns in a timely manner. | Ensure clinical staff participate in clinical documentation training for FY 18/19. | Clinical Documentation trainings were provided to clinical staff on February 13th, March 13th, April 10th, and June 12th of 2019. | Satisfied |
| Review Documentation and Medical Records System | | | |
| Client documentation and medical records system fulfills the requirements set forth by the California Department of Health Care Services and LCBHS 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 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. | Maintain the percent of completed and signed Treatment Plans for FY 18/19 at the same capacity as in FY 17/18 (100%). | In FY 18/19, 79% of treatment plans were signed. | Unsatisfied |

| Activity | Goal | Results | Status |
|---|---|---|---|
| Implement and Maintain Efficient Work Flow Standards | | | |
| Office work flow standards are implemented and maintained to efficiently and consistently serve clients from first contact through discharge. Work flow processes are documented in flowcharts and implemented through policies and procedures. Monitoring is conducted through annual review of work flow processes and procedures. | Create DUI workflow procedure. | A "Leave of Absence" guideline was created for the DUI program on May 29th 2019. | Satisfied |
| Assess Performance | | | |
| Quantitative measures are identified to assess performance and identify areas for improvement, including the PIPs and other QI activities. LCBHS monitors both under- and over-utilization of services. The BH Director reviews data on review loss reports, productivity reports, and late treatment plan 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. | Achieve a billing rate of 55% for billable services delivered by staff in FY 18/19. | A billing rate of 49% was achieved in FY 18/19. | Unsatisfied |
| Support Stake holder Involvement | | | |
| As members of the QIC, 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 MHSA Steering Committee provides input on access and barriers to services. Measurement is accomplished via review of QIC minutes, and occurs annually. | Increase attendance to QIC to have at least one (1) consumer and one (1) family member at each meeting in FY 18/19. | The QIC sign-in sheets and minutes indicate LCBHS did not have at least one (1) consumer and one (1) family member attend each meeting in FY 18/19. | Unsatisfied |
| Conduct Frequent Peer Reviews | | | |
| LCBHS evaluates the quality of the service delivery by conducting four (4) peer reviews every quarter. Reviews are conducted by staff. Issues and trends found during these reviews are addressed at the QIC meetings. | Review 24 charts annually. | LCBHS staff were unable to conduct peer reviews in any MH charts in FY 18/19. | Unsatisfied |

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.

| Activity | Goal | Results | Status |
|---|---|---|---|
| Monitor Coordination of Care | | | |
| Regular Integrated Health Care Committee meetings are held to discuss care coordination, and 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. | Maintain regular Integrated Health Care Committee meetings, as evidenced by meeting minutes and tracking action items. | Regular Integrated Health Care Committee meetings were held and attended by LCBHS staff in FY 18/19. | Satisfied |

### F. Monitor Provider Appeals

LCBHS providers may file appeals or complaints regarding payment authorizations, timeliness, and other issues.

| Activity | Goal | Results | Status |
|---|---|---|---|
| Monitor Provider Appeals | | | |
| 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. | Monitor the number of TAR appeals in FY 18/19. | There were four (4) TAR appeals in FY 18/19. In reviewing the TAR appeals no trends were identified. | Satisfied |

## V. DELEGATED ACTVITIES STATEMENT

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