## Drug Medi-Cal Organized Delivery System (DMC-ODS)

# QUALITY IMPROVEMENT WORK PLAN 2022/23

**BHRS Vision**

Our Vision is to continue to be a leader in Behavioral Health and to be recognized for excellence in our community, state, and nation.

**BHRS Mission**

In partnership with our community, our mission is to provide and manage effective prevention and behavioral health services that promote the community's capacity to achieve wellness, resilience, and recovery outcomes.

STANISLAUS COUNTY
BEHAVIORAL HEALTH AND RECOVERY SERVICES (BHRS)

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# Overview

The Quality Improvement Work Plan serves as the foundation of the Stanislaus County Behavioral Health & Recovery Services (BHRS) to continuously improve the quality of treatment and services provided to our beneficiaries. The programs provided through BHRS are based on BHRS's Mission Statement, Vision Statement, and our Core Values.

# Mission Statement

In partnership with our community, our mission is to provide and manage effective prevention and behavioral health services that promote the community's capacity to achieve wellness, resilience, and recovery outcomes.

# Vision Statement

Our Vision is to continue to be a leader in Behavioral Health and to be recognized for excellence in our community, state, and nation.

# Core Values

We, the employees of Stanislaus County Behavioral Health & Recovery Services, value:

- Trustworthiness
- Respect
- Responsibility
- Fairness
- Caring
- Citizenship

# Required Elements for the Quality Management Program

According to the California State Department of Health Care Services (DHCS), the Quality Management (QM) Program clearly defines the BHRS QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The QM Program shall be evaluated annually and updated as necessary per Title 9, CCR, Section 1810.440(a)(6) and Title 42, CFR, Section 438.240(e).

# Quality Management Program Description

The QM Program shall be accountable to the Behavioral Health and Recovery Services Director as described in Title 9 CCR, Section 1810.440(a) (1). Operation of the QI program shall include substantial involvement by a licensed mental health staff person, as described in Title 9 CCR, Section 1810.440(a)(4). The QI Program shall include active participation by practitioners and providers, as well as beneficiaries and family members in the planning, design and execution of the QI Program, as described in Title 9 CCR, Section 1810.440(a)(2)(A-C).

There shall be a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in Title 42, CFR, Section 438.240(b)(1) and (d). Each performance improvement project shall focus on a clinical area, as well as one non-clinical area.

The QM Program shall;

- Conduct performance monitoring activities throughout its operations.
- Activities shall include but not be limited to;
    - Service Satisfaction

- Safety and Effectiveness of Medication Practices
    - Coordination of Care
    - Quality of Care
    - Service Capacity
    - Timeliness of Services
    - Training of staff
- Ensure continuity and coordination of care with physical health care providers.
- Coordinate with other community providers used by its beneficiaries.
- Assess the effectiveness of our MOUs with Health Net and Health Plan of San Joaquin, to ensure the highest quality of services for both physical and mental health.
- Have mechanisms to detect both underutilization and overutilization of services, as required by Title 42, CCR, Section 438.240(b)(3).
- Implement mechanisms to assess beneficiary/family satisfaction. The BHRS shall assess beneficiary/family satisfaction by:
    - Surveying beneficiary/family satisfaction with the BHRS's services at least annually;
    - Evaluating beneficiary grievances, appeals and fair hearings at least annually; and
    - Evaluating requests to change persons providing services at least annually; and
    - Inform providers of the results of beneficiary/family satisfaction activities.
- Implement mechanisms to monitor the safety and effectiveness of medication practices.
    - The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs.
    - Monitoring shall occur at least annually.
- Implement mechanisms to address meaningful clinical issues affecting beneficiary's system-wide.
    - Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.
    - Take appropriate follow-up action when such an occurrence is identified.
    - Results of the intervention shall be evaluated by BHRS at least annually.

# Quality Management Work Plan

BHRS has a QM Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. The QM plan was established for meeting the DMC- ODS requirements within the State and County contract.

The QM Work Plan includes the following:

- Evidence of the monitoring activities including, but not limited to,
    - Review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Title 9, CCR, Section 1810.440(a)(5) and Title 42, CFR, section 438.416;
- A description of mechanisms that has been implemented to assess the accessibility of services within its service delivery area as related to the commencement of the DMC-ODS system for SUD services. This shall include;
    - Goals for responsiveness for the BHRS's 24-hour access line number,
    - Timeliness for scheduling of routine appointments,
    - Timeliness of services for urgent conditions, and
    - Access to after-hours care.
- Evidence of compliance with the requirements for cultural competence and linguistic competence specified in Title 9, CCR, Section 1810.410.

# Evaluation

Annual evaluations are completed at the end of each fiscal year. The annual evaluation is conducted by Quality Improvement Program.

The evaluation summarizes the following;

- The goals and objectives of the programs/service's DMC-ODS Quality Improvement Plan,
- The quality improvement activities conducted during the past year, including the targeted process.
- The Medi-Cal key indicators utilized,
- The findings of the measurement, data aggregation, assessment and analysis processes, and
- The quality improvement initiatives taken in response to the findings.
- The progress towards meeting the Department's Annual Objectives.
- Recommendations: Based upon the evaluation, the actions deemed necessary to improve the effectiveness of the Department's program services.

# Continuous Quality Improvement Activities

QI activities to improve outcomes of existing services and/or to design new services shall include:

- Collecting and analyzing data to measure against the goals stated in the QI/QM annual work plan, which prioritized areas of improvement that have been identified;
- Identifying opportunities for improvement and deciding which opportunities to pursue;
- Identifying relevant committees internal or external to ensure appropriate exchange of information with the QI Committee;
- Obtaining input from providers, beneficiaries and family members in identifying barriers to delivery of DMC-ODS services;
- Ensuring practice guidelines are adhered to;
- Designing and implementing interventions for improving performance;
- Measuring effectiveness of the interventions;
- Monitor the inclusion of cultural competency;
- Incorporating successful interventions into the BHRS operations as appropriate;
- Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by title 9, CCR, Section 1810.440(a)(5).

# Quality Improvement Committee/Quality Management Team

The Quality Improvement (QI) Committee/Quality Management (QM) Team shall monitor the service delivery system with the aim of improving the processes of providing quality care for beneficiaries receiving DMC-ODS treatment services. The QI Committee shall:

- Review the quality of DMC-ODS services provided to beneficiaries.
- Recommend policy decisions;
- Review and evaluate the results of QI activities, including;
    - Performance improvement projects;
    - Institute needed QI actions;
    - Ensure follow-up of QI processes; and
    - Document QI Committee meeting minutes regarding decisions and actions taken.

QIC/QMT meeting agendas may include, but are not limited to, the following agenda items:

- Grievances, appeals, state fair hearings
- Expedited appeals and state fair hearings
- Requests for change of provider

- Notice of Adverse Benefit Determination (NOABD)
- Contract Provider services
- Consumer Satisfaction Survey Outcomes
- Utilization Review of documentation results
- Timeliness to services, referrals to residential
- Service delivery capacity, trends, quality and outcomes
- Policies and procedures
- Performance Improvement Projects
- Utilization of DMC-ODS Services
- Verification of services
- Cultural and Linguistic Competence needs and services
- Training updates

The QIC/QMT meets at least monthly and may include the following individuals:

- BHRS Director
- BHRS Medical Director
- BHRS Assistant Director
- BHRS Assistant Director-Administration
- BHRS Senior Leaders
- BHRS Program Managers
- MHSA Coordinator
- Compliance Officer
- Quality Services/Risk Manager
- Utilization Management Mental Health Coordinator
- UM Staff
- QI/QA staff
- Beneficiaries/Family Members
- Treatment Providers

# Department Communication of Quality Improvement Activities

BHRS supports QI activities through the planned coordination and communication of the results of the measurement of QI Initiatives. The overall efforts are to continually improve the quality of care provided to our beneficiaries to ensure that BHRS's mission is achieved. The planned communication may take place through the following methods:

- Recipients participating in the QIC report back to prospective recipient groups
- Emails
- Presentations to the Behavioral Health Board that addressed both Mental Health and Substance Use Disorder Services
- Posters, brochures, notices and surveys displayed in clinic locations
- Distribution of the Department's annual DMC-ODS QI Work Plan
- Distribution of meeting minutes

# Other Department Quality Improvement Committees

The Department has the following standing committees where QI/UM/QA activities occur:

- Performance Improvement Projects (PIP) Committee
- Compliance Committee

- Cultural Competency Committee
- Treatment Provider Meeting
- Peer Review
- Health Plan of San Joaquin/ Beacon – BHRS Collaborative Meeting
- Health Net/MHN – BHRS Collaborative Meeting
- Integrated Electronic Health Record Navigation/Documentation Training
- 800/Contact Log Oversight Committee
- SAPT Committee Calls
- DMC-ODS Technical Assistance (TA) Call
- BHRS SUD Leadership Meeting
- DMC-ODS Framework Committee
- DMC-ODS Oversight Committee
- Quarterly in person SAPT Committee Meetings
- Youth Advisory Committee
- Medi-Cal Key Indicators meeting

# Quality Assurance (QA)

BHRS shall set standards and implement processes that will support understanding of, and compliance with, documentation standards set forth in the DHCS contract and any standards set by BHRS. QA activities may include monitoring performance so that the documentation of care provided will satisfy the requirements set forth in the State and County DMC-ODS contract. The documentation standards for beneficiary care are minimum standards to support claims for the delivery of specialty mental health and substance use disorder services. All standards shall be addressed within the beneficiary record.

# DMC-ODS Program Managers/ Utilization Management (UM) Program

DMC-ODS Program Managers with assistant from the Utilization Management Program shall;

- Be responsible for assuring that beneficiaries have appropriate access to substance use disorder services and specialty mental health services as required in Title 9, CCR, Section 1810.440(b)(1-3).
- Evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively or retrospectively.
- Implement mechanisms to assess the capacity of service delivery for its beneficiaries. This includes monitoring the number, type, and geographic distribution of mental health and substance use disorder services within the BHRS's delivery system.
- Implement mechanisms to assess the accessibility of services within its service delivery area. This shall include the assessment of responsiveness of the BHRS's 24-hour access line number, screening of calls to determine the appropriate level of care, timeliness of scheduling initial appointments, timeliness of DMC-ODS services.
- Implement mechanisms to assure authorization decision standards are met. Authorization of services shall include all of the following:
    - Pursuant to Title 42, CFR, Section 438.210(b)(1), the Contractor and its subcontractors must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services.
    - Pursuant to Title 42, CFR, Section 438.210(b)(2), the Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

- Pursuant to Title 42, CFR, Section 438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition or disease.
- Decisions must be made within the timeframes outlined for service authorizations in Title 42, CFR Section 438.210(d), and notices of action related to such decisions must be provided within the timeframes set forth in Title 42, CFR, Section 438.404.(c).

# Performance Improvement Projects (PIPs)

BHRS will develop Performance Improvement Projects that will be designed to achieve significant improvement in clinical and non-clinical health outcomes and beneficiary satisfaction. BHRS will establish an ongoing quality assessment and performance improvement program consistent with 42 CFR 438.240. BHRS will maintain a minimum of two active PIPS's overseen by the QI Committee/QM Team with one being clinical and one addressing an administrative area.

# Medi-Cal Key Indicators

A Medi-Cal key indicator is a type of quantifiable measurement that provides information regarding a program/services process, functions or outcomes. Selection of a Medi-Cal Key Indicator for services within BHRS is based on the following considerations:

- Relevance to the Department's mission.
- Required monitoring item by DHCS and EQRO.
- Clinical importance - whether it addresses a clinically important process that is:
  - High volume
  - High risk
  - Measuring consumer satisfaction
  - Assess the cultural competency of services, linguistics, etc.

Once the performance of a selected process has been measured, assessed and analyzed, the information gathered by the above Medi-Cal key indicator(s) is used to identify a continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon program/service priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones.

# Quality Improvement (QI) Work Plan with Evaluation/Summary
# FY 2021-2022

| **1: Access** | |
|---|---|
| • **1.1 - Number of days from initial referral/contact to completed assessment**<br>• **1.2 - Number of no-shows to initial SUD assessment**<br>• **1.3 - Number of days from assessment to first service** | |
| **Objective 1.1** | **Access:** Average number of days from initial beneficiary contact to completed assessment (measurements are program specific). |
| **Goal** | Evaluate program specific data regarding average number of days from initial beneficiary contact to completed assessment. |
| **Responsible Party** | SUD QIC |
| **Evaluation Methods/Tool(s)** | Timeliness Data from Contact Log. |
| **FY 2021/2022 Evaluation** | The QIC does not have access to automated data or reports to review this data, data that was brought in this fiscal year was manually ran by the Outcomes Evaluation Measurement staff or by each program. |
| **Recommendations** | QIC members have access to an internal tracking document to assist with self-monitoring number of days from initial beneficiary contact to completed assessment. Fiscal year 21/22 data found:<br>• There are issues related to data regarding number of days from initial beneficiary contact to completed assessment due to inaccurate/incomplete completion of contact log form, this is an on-going barrier and conversation with programs.<br>• Due to lack of consistency with attendance/participation in monthly QIC meeting not all program information has been available, although attendance has improved, this still remains a barrier to gathering and reporting all data. Attached is 20/21 data due to FY 21/22 not available.<br>Recommendation for fiscal year 2022/2023 is to continue to evaluate self-reported program specific data regarding average number of days from initial beneficiary contact to completed assessment and obtain access to automated reports to review this data. |

| Objective 1.2 | **Access:** Number/percentage of no-shows for initial SUD assessment. |
|---|---|
| Goal | Evaluate program specific data regarding no shows for initial assessment appointment |
| Responsible Partners | SUD QIC |
| Evaluation Methods/Tool(s) | Evaluating no-show data for initial SUD assessments. |
| FY 2021/2022 Evaluation | SSRS report access was provided to all SUD QIC members with the expectation of each participant bringing program specific reports to the SUD QIC committee for evaluation. Some programs shared their "no show" rate during monthly QIC meetings and this continues to be an area that needs improvement. This data was gathered manually, as there are not any electronic reports at this time. |
| Recommendations | During monthly SUD QIC review of the limited program specific data, it was found:<br>• Many contractors did not have access to the SSRS report needed to review no-show data.<br>• If a staff neglects to enter a no-show note in the EHR the data would not be captured in an automated report. Contact log entry continues to be problematic and continues to be addressed. During QIC it was discovered that staff still need training when completing contact logs.<br>• Contact log data is not matching program reported no shows and/or there are missing no show notes creating inaccurate reports.<br>Committee member access to reports and participant attendance has been addressed.<br>Recommendation for FY 2022/2023 is to continue evaluating no-show data for initial SUD assessments. This is also a PIP topic. Developing electronic reports would be beneficial in data gathering for now show rates. |

| Objective 1.3 | **Access:** Average number of days from assessment to first treatment service. |
|---|---|
| Goal | Evaluate program specific data regarding number of days from completed assessment to first treatment service. |
| Responsible Partners | SUD QIC |
| Evaluation Methods/Tool(s) | Evaluating timeframe from SUD assessment service code to first treatment service code. |
| FY 2021/2022 Evaluation | The QIC does not have access to automated data or reports to review this data, data that was brought in this fiscal year was manually ran by the SUD data analysis staff. Attached is FY20/21 with this information. |
| Recommendations | The limited data available regarding average number of days from completed assessment to first treatment service has not been thoroughly review/discussed by the SUD QIC.<br>Recommendation for FY 2022/2023 is to develop a process that all programs can utilize to gather this information and to obtain access to automated reports for SUD QIC members to evaluate this data. |

| 2: MONITORING REGULATORY COMPLIANCE | |
|---|---|
| • **2.1 – Development and monitoring SUD key indicators**<br>• **2.2 – Monitoring average residential length of stay** | |
| **Objective 2.1** | **Monitoring Regulatory Compliance:** SUD Medi-Cal Key Indicators will be developed in order to stay in compliance with state-required elements. |

| **Goal** | In effort to meet regulatory requirements, the QIC will develop SUD Medi-Cal Key Indicators to identify/monitor the following:<br>•Timeliness of first initial contact to appointment service.<br>• Frequency of follow-up appointments in accordance with individualized treatment plans<br>• Timeliness of services of the first dose of NTP services<br>• Access to after-hours care<br>• Responsiveness of the beneficiary access line<br>• Strategies to reduce avoidable hospitalizations<br>• Coordination of physical and mental health services with waiver services at the provider level<br>• Assessment of the beneficiaries' experiences, including complaints, grievances and appeals<br>• Telephone access line and services in the prevalent non-English languages. |
|---|---|
| **Responsible Partners** | SUD QIC |
| **Evaluation Methods/Tool(s)** | SUD Medi-Cal Key Indicator workgroup to report progress. |
| **FY 2021/2022 Evaluation** | SUD Medi-Cal Key Indicator workgroup meetings have been deferred since March 2020 due to the BHRS department and SUD Contracted Provider response to the COVID-19 public health emergency. |

| Recommendations | Recommendation for FY 2022/2023 is to resume the Medi-Cal Key Indicator workgroup to identify/monitor the following:<br>•Timeliness of first initial contact to appointment service.<br>• Frequency of follow-up appointments in accordance with individualized treatment plans<br>• Timeliness of services of the first dose of NTP services<br>• Access to after-hours care<br>• Responsiveness of the beneficiary access line<br>• Strategies to reduce avoidable hospitalizations<br>• Coordination of physical and mental health services with waiver services at the provider level<br>• Assessment of the beneficiaries' experiences, including complaints, grievances and appeals<br>• Telephone access line and services in the prevalent non-English languages. |
|---|---|

| Objective 2.2 | **Monitoring Regulatory Compliance:** Monitoring average residential length of stay |
|---|---|
| Goal | Evaluate average residential length of stay to determine if we are within the 30-day range |
| Responsible Partners | SUD QIC |
| Evaluation Methods/Tool(s) | Evaluating average residential length of stay data |
| FY 2021/2022 Evaluation | Data gathered from Electronic Health Record during FY 20/21 showed that average length of stay for: Nirvana 32 days, Redwoods 21 days, and SRC 31.<br><br>Length of stay reflects number of calendar days that has passed since client first opened to program. LOS is based solely on the assignment opened/closed date. A break in service (new assignment) will resent client's length of stay. Assignments with same day opened/closed date are excluded |
| Recommendations | The data available regarding the average residential length of stay is incomplete and has not been review/discussed by the SUD QIC.<br>Recommendation for FY 2022/2023 is to explore meaningful ways to measure average length of stay and obtain access to automated reports regarding number of days in residential for SUD QIC members and to continue to monitor average residential length of stay. |

# Quality Improvement (QI) Work Plan FY 2022-2023:
# Goals and Objectives

**1: Access**

- **1.1 - Number of days from initial referral/contact to completed assessment**
- **1.2 - Number of no-shows to initial SUD assessment**
- **1.3 - Number of days from assessment to first service**

| | |
|---|---|
| **Objective 1.1** | **Access:** Average number of days from initial beneficiary contact to completed assessment (measurements are program specific). |
| **Goal** | Evaluate program specific data regarding average number of days from initial beneficiary contact to completed assessment. |
| **Responsible** | SUD QIC |
| **Evaluation Methods/Tool(s)** | Timeliness Data from Contact Log. |
| **FY 2022/2023 Evaluation** | TBD |
| **Recommendations** | In Progress |
| **Objective 1.2** | **Access:** Number/percentage of no-shows for initial SUD assessment. |
| **Goal** | Evaluate program specific data regarding no shows for initial assessment appointment |
| **Responsible Partners** | SUD QIC |
| **Evaluation Methods/Tool(s)** | Evaluating no-show data for initial SUD assessments. |
| **FY 2022/2023 Evaluation** | TBD |

| Recommendations | In Progress |
|---|---|
| **Objective 1.3** | **Access:** Average number of days from assessment to first treatment service. |
| **Goal** | Evaluate program specific data regarding number of days from completed assessment to first treatment service. |
| **Responsible Partners** | SUD QIC |
| **Evaluation Methods/Tool(s)** | Evaluating timeframe from SUD assessment service code to first treatment service code. |
| **FY 2022/2023 Evaluation** | TBD |
| **Recommendations** | In Progress |

| 2: MONITORING REGULATORY COMPLIANCE | |
|---|---|
| • **2.1 – Development and monitoring SUD key indicators**<br>• **2.2 – Monitoring average residential length of stay** | |
| **Objective 2.1** | **Monitoring Regulatory Compliance:** SUD Medi-Cal Key Indicators will be developed in order to stay in compliance with state-required elements. |
| **Goal** | In effort to meet regulatory requirements, the QIC will develop SUD Medi-Cal Key Indicators to identify/monitor the following:<br>•Timeliness of first initial contact to appointment service.<br>• Frequency of follow-up appointments in accordance with individualized treatment plans<br>• Timeliness of services of the first dose of NTP services<br>• Access to after-hours care<br>• Responsiveness of the beneficiary access line<br>• Strategies to reduce avoidable hospitalizations<br>• Coordination of physical and mental health services with waiver services at the provider level<br>• Assessment of the beneficiaries' experiences, including complaints, grievances and appeals<br>• Telephone access line and services in the prevalent non-English languages. |
| **Responsible Partners** | SUD QIC |
| **Evaluation Methods/Tool(s)** | SUD Medi-Cal Key Indicator workgroup to report progress. |
| **FY 2022/2023 Evaluation** | TBD |
| **Recommendations** | In Progress |

| Objective 2.2 | **Monitoring Regulatory Compliance:** Monitoring average residential length of stay |
| --- | --- |
| **Goal** | Evaluate average residential length of stay to determine if we are within the 30-day range |
| **Responsible Partners** | SUD QIC |
| **Evaluation Methods/Tool(s)** | Evaluating average residential length of stay data |
| **FY 2022/2023 Evaluation** | TBD |
| **Recommendations** | In Progress |