Behavioral Health and Recovery Services (BHRS)

Quality Assessment & Performance Improvement (QAPI) Program:

Quality Improvement (QI) Program Description and Work Plan

2023-2024

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Quality Improvement (QI) Program Description 2023-2024

Overview

This Quality Improvement Program (QIP) applies to the range of quality improvement activities of the Stanislaus County Behavioral Health and Recovery Services (BHRS) Department. The focus is on the structure, processes and outcomes applicable to all quality improvement activities of BHRS including Medi-Cal Specialty Mental Health Services. The QIP and its activities flow from the overall Vision, Mission and Values developed and adopted by BHRS, the Stanislaus County BHRS Strategic Plan, the Core Treatment Model (CTM), which was developed using the Results-Based Accountability (RBA) framework, the Stanislaus County Board of Supervisors (BOS), and the Mental Health Services Act (MHSA) essential elements. There is an overall Quality Management Team (QMT), which monitors the activities of the various quality improvement efforts within BHRS to ensure adherence to appropriate care standards.

This QIP is designed to ensure that quality of care issues are identified and monitored and that appropriate corrective actions are taken. The QIP is designed to pursue continuous quality improvement and to ensure that behavioral health services provided to members meet established quality of care standards.

Quality will be evaluated in the areas of access, satisfaction, continuity of care and quality of care. Each area of BHRS has specific expectations for the delivery of behavioral health services, which will be identified and monitored through a continuous quality improvement work plan.

The QIP is multi-disciplinary. Providers, consumers, family members and BHRS staff with direct responsibilities for care management, quality assurance and administration are involved. Consumer and family members, representing our diverse community and participating at all levels of the organization, are instrumental in helping us achieve our quality goals.

The QIP of Stanislaus County BHRS operates using the following continuous process improvement principles as guidelines:

- Focus on the customer
- People orientation to problem solving (involve people closest to the problem)
- Process improvement principles
- Use of quantitative as well as qualitative methods

- Systematic approach

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.

Mission

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

Organizational Values

Clients are the Focus

Our clients and their families drive the development of our services.

Excellence

We are continuously improving to provide the highest quality of services, which exceeds the expectations of our customers.

Respect

We believe that respect for all individuals and their cultures is fundamental. We demonstrate this in our daily interactions by treating every individual with dignity.

Cultural Competence

Our organization acknowledges and incorporates the importance of culture at all levels.

Proactive and Accountable Community Participation

We actively work together with the community to identify its diverse needs and we are willing to respond, deliver and support what we have agreed to do. We take responsibility for results and outcomes with our community partners, peers, colleagues, consumers, families and the community to achieve a superior product.

Integrity and Compliance

We conduct our operations with the highest standards of honesty, fairness, and personal responsibility in our interactions with each other and the community. Our work also requires a high standard of ethical behavior and compliance with legal statutes, regulatory requirements and contractual obligations. We are committed to compliance and to ensuring that all services are provided in a professional, ethical manner.

Competitive and Efficient Service Delivery

Stanislaus County Behavioral Health and Recovery Services provide the highest quality, best integrated behavioral health service of its kind.

Responsive and Creative in a Changing Environment

We listen and respond to our customers. We are innovative, flexible and socially responsible in our efforts to overcome challenges. We are always open to change through continuous learning.

MHSA Essential Elements

- Community Collaboration
- Cultural Competence
- Client and Family Driven Services
- Wellness Recovery and Resiliency Focus
- Integrated Services for Clients and Families

Structure

A. Authority and Responsibility

Authority and responsibility for ensuring that an effective QIP is established, maintained and supported is delegated to the Stanislaus County BHRS by the State Department of Health Care Services (DHCS) for Medi-Cal beneficiaries. This plan shall also apply to others for whom BHRS is financially and legally responsible for providing care. It is the responsibility of BHRS QMT to ensure that the program adheres to the standards and goals of the delegating authority.

BHRS is a member of the Stanislaus County Priority Team charged with responsibility for ensuring the BOS priority for a healthy community is achieved. Quality improvement processes and projects sanctioned by the QMT support this goal and

BHRS staff interfaces with the Chief Executive Office and other County departments to ensure alignment with Stanislaus County process improvement initiatives.

B. Organization Structure

1. Behavioral Health Director

   The Behavioral Health Director (Director), appointed by the Board of Supervisors for Stanislaus County, functions as the CEO of Behavioral Health and Recovery Services (BHRS). In this role, the Director is responsible for providing guidance for and oversight of all activities of BHRS. The Director reports to the CEO for Stanislaus County and to the Board of Supervisors.

2. Senior Leadership Team (SLT)

   The Senior Leadership Team (SLT) of Stanislaus County BHRS develops and articulates the Department's vision and mission. This team, composed of the Behavioral Health Director, Chief Operations Officer, Behavioral Health Plan Administrative Chief, Chief Fiscal and Administrative Officer, Chiefs of Systems of Care, Medical Director, Data Outcomes and Technology Services Chief, Human Resources, Support Services Division Chief, and Executive Assistant to the Behavioral Health Director, communicates continuous process improvement principles, identifies performance expectations and acts on process improvement project recommendations.

C. Quality Improvement Program Structure

1. Behavioral Health Director

   The Behavioral Health Director (Director) ensures the implementation of the Stanislaus County BHRS Strategic Plan and the continuous process improvement principles within BHRS. The Director instructs the senior leadership team to demonstrate the adoption and utilization of these principles in all activities and work products of the various divisions. The Director is instrumental in assuring that the feedback loop is closed.

2. Senior Leadership Team (SLT)

i. This Team is responsible for ensuring that QI activities in each division are established, maintained and supported. Each Division has a Quality Improvement Council (QIC), which is designed to address the quality issues of that division.

ii. SLT oversees the Quality Improvement Program (QIP) through the activities of the Quality Management Team (QMT).

iii. SLT meets weekly unless the schedule is otherwise modified.

3. Quality Operations Director

   The Behavioral Health Plan Administrative Chief is responsible for the overall operations of BHRS quality improvement functions and supervises the Quality Services/Risk Manager.

4. Quality Services/Risk Manager (QS/RM)

   The QS/RM has overall responsibility for implementation of BHRS quality improvement functions as well as risk management. The QS/RM assists the Behavioral Health Plan Administrative Chief in supervising BHRS quality improvement activities. In addition, the QS/RM (or his/her designee) provides consultation, coordination, staff support and documentation to the QMT, QICs, process improvement projects (PIPs) work groups, Medication Monitoring and other quality improvement functions. The QS/RM is an integral part of the QIP for BHRS. The QS/RM tracks the status of all BHRS PIPs. This individual also tracks and reports on Adverse Incident Data to Senior Leadership. The QS/RM provides technical assistance to the various QICs. In addition, the QS/RM may collect and report data on specified indicators. S/he has overall supervisory responsibility for the Quality Services unit, is a member of the Quality Management Team and reports to the Behavioral Health Plan Administrative Chief.

5. Quality Management Team (QMT)

   i. The Quality Management Team (QMT) provides direction, support and coaching to the various BHRS QICs. This may involve identification of key processes, especially cross-functional processes.

   ii. The QMT reviews and evaluates each QICs activity. The QMT receives routine reports from the QICs, which delineate quality management activities, actions taken and reassessments to ensure there is continuous quality improvement. The QMT holds each QIC accountable for the quality activities in the respective

divisions. In addition, the QMT receives reports from the Medication Monitoring Committee of the Department.

iii. The QMT takes action on recommendations from QICs and process improvement work groups that require SLT review and approval.

iv. Membership includes all SLT members, QS/RM, chairs of division QICs, the Strategic Implementation Team Manager, QS Specialist(s), and Mental Health Board members representing consumers and families.

v. The QMT meets a minimum of ten times each year, except in extreme circumstances (e.g., global pandemic).

6. Quality Improvement Councils (QIC)

i. Each division of BHRS participates on a QIC. The QICs oversee the overall program effectiveness and performance of their divisions. Each QIC also reviews and develops an annual action plan.
ii. The membership of most councils includes the Chief of the System of Care or Division (or designee), staff providers, consumers and family members of consumers. Consumer and family member participation is an expected and vital component of QIC.
iii. Each QIC meets at least ten times each year, except in extreme circumstances (e.g., global pandemic).

7. Behavioral Health Equity Committee (BHEC)

i. This committee is responsible for overseeing BHRS cultural competence initiatives to ensure effectiveness and promote transformation of the behavioral health system. This committee also monitors adherence to DHCS Cultural Competence Plan requirements.
ii. The membership includes Senior Leadership representatives, staff providers, partner agency staff, consumers and family members of consumers. Consumer and family member participation is an expected and vital component of BHEC.
iii. The Committee meets at least 10 times each year, except in extreme circumstances (e.g., global pandemic).

8. Process Improvement Project (PIP) Work Groups

PIP work groups are no longer managed and overseen by the Strategic Implementation Team Manager as this role has now shifted to the Quality Services Manager. These PIP work groups are formed when functions and processes needing improvement cross divisions or County Departments. PIPs are to be time-limited and cross functional and

focus on the processes in questions. These teams use continuous process improvement principles and tools and make recommendations to QMT.

The contributions of consumers and family members to process improvement work groups are essential in achieving our goals and fulfilling our vision.

9. Medication Monitoring Committee

    i. This committee is responsible for the medication management functions of BHRS and reports to QMT. The committee is supervised by the Medical Director and the Behavioral Health Plan Administrative Chief (or designee).

    ii. The committee is chaired by a psychiatrist or pharmacist and is composed of psychiatrists, nurses, and pharmacists.

    iii. The committee meets at least once annually.

Process

A. Overall Philosophy and Approaches

The QIP adopts the concept of continuous process improvement and a systematic framework for improving processes. This process is employed to identify important aspects of care and service and to prioritize studies and focused audits. This process involves a continuous feedback loop, which should be completed as quickly as possible. Elements of the process are:

1. Identify and carefully define a problem.
2. Analyze the possible factors contributing to this problem.
3. Determine all options to deal with the problem, using cross-functional problem-solving where possible.
4. Select the best option(s).
5. Implement solution(s).
6. Establish a time frame for reassessment.
7. Evaluate the data to determine the effectiveness of the solution(s).
8. Based on the results of the data analysis:
    a. If problem is resolved, determine monitoring schedule to ensure that problem does not recur.
    b. If the problem is still unresolved, begin the process again until problem is solved.

The QIP follows accepted industry standards for gathering, sorting and analyzing information. Each indicator of key processes is operationally defined, i.e., measurable. Other studies may be initiated as the result of information gathered from ongoing monitoring, through member surveys, provider surveys, records audits, telephone surveys, focus groups, and/or analysis of complaints and grievances. Whenever possible, results will be presented quantitatively as well as qualitatively.

B. Quality Improvement Plan

Each QIC develops an action plan, which supports the overall QI Work Plan for BHRS. BHRS QI Work Plan identifies quality improvement goals and objectives for the succeeding year, including a schedule of the specific quality improvement related activities and studies that are to occur. It is the responsibility of the QS/RM to assist QICs in developing action plans and to

assist the Behavioral Health Plan Administrative Chief in developing the overall BHRS QI work plan. The BHRS QI Work Plan is submitted to the QMT for approval. The QIC action plans identify the focus of improvement or monitoring for the year.

C. Process by Structure

1. Quality Management Team (QMT)

   The QMT identifies key processes, assigns responsibility for monitoring and improvement using continuous quality improvement principles to QICs, process improvement work groups and other quality improvement functions. The QMT may also approve QIC-initiated key processes. The QMT hears presentations and receives reports regarding each of the identified key processes. The QMT is also responsible for tracking the process of improvement and for trending the resulting data. They also take action on cross-functional recommendations resulting from improvement activities.

2. Quality Improvement Committees (QIC)

   Each QIC will develop an action plan, using continuous quality improvement principles and tools, each council will monitor, assess, design (or redesign), implement and evaluate processes identified in their action plan. The QIC maintains documentation of its activities, e.g., minutes of QIC meetings, and reports periodically to the QMT.

3. Continuous Process Improvement

   When there is a need to improve a cross-functional process, i.e., a process that crosses more than one functional area or division, a team composed of persons from all involved areas is convened. These teams "map" the process as it exists, identify improvement, redesign the process, implement the redesign and evaluate the effectiveness of the improvements. Prior to implementation of the redesign, the team reports to the QMT, which reviews the proposed recommendations, offers suggestions if needed, and celebrates accomplishments. The QMT also assigns monitoring responsibilities to a QIC.

4. Medication Monitoring Committee

   The Medication Monitoring Committee monitors and improves medication prescribing and administration processes. Improvement strategies are identified, and action taken. Results are reported to the QMT.

D. Quality Improvement Outcome and Evaluation

1. QIC chairs are members of the QMT and present routine reports to the QMT on the activities of their respective QICs.

2. Each QIC will complete and submit to the QMT an annual report on evaluations and accomplishments for the year and recommended focus for the next year, which is in line with the overall BHRS QI work plan.

3. QS/RM will assist the Behavioral Health Plan Administrative Chief in completing the evaluations/summaries of the overall BHRS QI work plan.

Outcomes

A. Quality Improvement Program Outcomes

1. The QIP will assist BHRS in moving toward its vision and in achieving the transformative goals of MHSA.

2. Consumers and family members will meaningfully participate in the quality improvement process at all levels of the organization.

3. Staff, consumers, family members and providers of service will participate in the quality improvement process.

4. Performance will be measured, and the results of the measurements used to develop corrective actions, if necessary.

5. An overall annual work plan is developed and used to guide the quality improvement activities of BHRS.

6. Improvements will be documented and celebrated.

B. Performance Outcomes

The annual BHRS QI work plan will establish methods of monitoring and measuring the following expected outcomes for beneficiaries. Results of these monitoring and measuring activities will be reported to stakeholders, QMT, QICs and process improvement work groups to be utilized in process improvement activities. Performance outcome measures established by other regulatory agencies will also be monitored and measured, and data will be collected, reported and used in a similar manner to improve performance. The expected outcomes are as follows:

1. To the extent possible, service capacity exists to meet the needs of beneficiaries.

2. Beneficiaries are able to access a continuum of services within the scope of their benefits in a timely, geographically convenient, culturally, linguistically, age and clinically appropriate manner. To the extent possible, beneficiaries will find that they are able to get what they need in a straightforward manner.

3. Beneficiaries and family members are satisfied with services, including being treated with dignity and respect.

4. Grievances are processed according to regulatory standards.

5. Effective coordination and collaboration exist between behavioral health providers and others who are dealing with the same beneficiary.

6. Identified clinical and service outcomes are met. Improved functioning and symptom management via the Core Treatment Model (CTM) framework, which is central to BHRS' strategy to strengthen treatment capabilities and describes the expected outcomes that will be produced because of the delivery of treatment services, improved quality of life, and appropriate administration of medications are examples of such outcomes. These examples are reflective of BHRS' commitment to and belief in wellness, recovery and resiliency for consumers, family members and staff.

Quality Improvement (QI) Work Plans: 2023-2023 and 2023-2024

Overview

The scope of this work plan is the overarching Quality Improvement aspects of the Stanislaus County Behavioral Health and Recovery Services (BHRS) for the fiscal years (FY) ***2022-2023 and 2023-2024***. The QI Work Plans outlined in this document involves a Department-wide focus on quality initiatives. In addition, each system of care and division will develop an action plan that is more specific to the functions of the respective systems. BHRS is committed to providing high quality care and services to all its customers.

Our Mental Health Services Act (MHSA) programs are fully implemented. We continue our efforts to integrate the essential elements of MHSA into every facet of our organization. These elements are community collaboration, cultural competence, client/family-driven systems and services, wellness for recovery and resilience, and an integrated services experience. We believe our Quality Improvement Work Plan supports the ongoing transformation of our department.

Consumer and family member involvement in quality improvement process continues to be very important to our organization. Consumers and family members have participated in the various Quality Improvement Committee (QIC) meetings held during the year when able. This is expected to continue in the current fiscal year. It is also expected that consumers and family members will continue to participate in work groups and stakeholder meetings in which consumers and family members provide valuable feedback and assistance to the department.

This work plan is formatted as follows. The first section provides the department work plan with an evaluation/summary of activities and outcomes for ***FY 2022-2023*** *(pg.16-48)*. The last section summarizes the QI Work Plan goals and objectives for the current ***FY 2023-2024*** *(pg.49-59).*

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

1: MONITORING THE SERVICE CAPACITY AND SERVICE DISTRIBUTION OF THE MHP (*Source: MHP*)	
• **Conducts performance monitoring activities that evaluate beneficiary and system outcomes and indicators of wellbeing.** • **Describes and provides information regarding the current type, number and geographic distribution of Mental Health Services in the system.** • **Evaluates and monitors the capacity of the MHP.** • **Makes program recommendations based on capacity indicators.** • **Participates in the county planning process which identifies expanded service populations.** • **Monitors the number of Medi-Cal beneficiaries receiving services and works with Performance Measurements to distribute information to Program Managers and the Quality Management Team (QMT).**	
Objective 1	To describe the current type, number, and geographic distribution of Mental Health Services in the MHP System of Care to ensure appropriate allocation of MHP resources in providing adequate behavioral health access to all beneficiaries.
Goal 1	To identify service provision to Children, Youth, and Adult Medi-Cal/Uninsured beneficiaries by types of services and service locations by geographic regions. To track service provision against service demand and ensure resources are appropriately allocated to provide for access.
Responsible Partners	SOC QICs; Performance Measurements (OEM)
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include data dashboards. (Source Data: SSRS 1627)

FY 2022/2023 Evaluation	During FY 22-23, 100% of beneficiaries were located within 30 miles or 60 minutes of a mental health provider. Of the 6,286 unduplicated clients served 11.4% were served in Ceres, 10.2% on the Eastside, 55.3% in Modesto, 15.4% in Turlock, and 7.7% on the westside.
Recommendations	Stanislaus County BHRS will continue to serve beneficiaries and meet time and distance standards.

LOCATION SERVED	PERCENTAGE SERVED
Ceres	11.4%
Eastside	10.2%
Modesto	55.3%
Turlock	15.4%
Westside	7.7%
Total	100%

2: MONITORING TIMELY ACCESS FOR ROUTINE AND URGENT SERVICE NEEDS (*Source: MHP*)	
• **Conducts and coordinates performance monitoring activities to test timeliness and access to services within the MHP.** • **Tests the ability of the appointment system through the mechanisms of test calls and internal audits of contact logs.** • **Reports findings and suggested solutions for systems issues which negatively impact access.** • **Tests and evaluates the ability of the system to respond to calls to 24/7 Toll Free Phone Number.** • **Reviews timeliness to service for all appointment types within the system including routine appointments and services for urgent conditions.**	
Objective 2	To conduct performance monitoring activities that gauge the system's effectiveness at providing timely access to routine specialty mental health appointments.
Goal 2	To ensure that all beneficiaries requesting a comprehensive assessment are offered an appointment within 10 business days.
Responsible Partners	Quality Services; Access Line team; SOC QICs; Performance Measurements
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include test calls, internal audit of contact logs, SSRS reports, and Medi-Cal key indicators. (Source Data: MKI Access #1, Contact Log/MATA #1)

<table>
<tr><td>FY 2022/2023 Evaluation</td><td>During FY22/23, BHRS tracked and monitored offered appointments in addition to scheduled appointments. Below are the data for both offered and scheduled appointments.

Beneficiaries requesting a comprehensive assessment are offered an appointment and scheduled within 10 business days:
<table>
<tr><th>System of care (SOC)</th><th>Percentage of Offered & Scheduled Appt w/in 10 Business Days</th></tr>
<tr><td>Adult SOC</td><td>80% (831/1033)</td></tr>
<tr><td>Children SOC</td><td>91% (1163/1273)</td></tr>
</table></td></tr>
<tr><td>Recommendations</td><td>During FY 23/24, BHRS will continue to track and monitor the offered and scheduled appointments.</td></tr>
<tr><td>Goal 2.1</td><td>To ensure beneficiaries discharging from psychiatric hospitalization are given an outpatient appointment within 7 business days of discharge.</td></tr>
<tr><td>Responsible Partners</td><td>SOC QICs; Performance Measurements; Hospital Rate Committee</td></tr>
<tr><td>Evaluation Methods/Tool(s)</td><td>Mechanisms for monitoring services and activities include hospitalization reports, Medi-Cal key indicators, and SSRS reports. (Source Data: MKI Continuity of Care #1 & 3)</td></tr>
<tr><td>FY 2022/2023 Evaluation</td><td>During FY 22-23, the data for timeliness of post-hospitalization appointments are below.
“Beneficiaries discharging from psychiatric hospitalization are given an outpatient appointment within 7 business days of discharge.”
<table>
<tr><th>SOC</th><th>Appointment within 7 business days of discharge.</th></tr>
<tr><td>Adult</td><td>36% (474/1328)
Avg # of days: 7</td></tr>
<tr><td>Children</td><td>56% (109/193)
Avg # of days: 5</td></tr>
</table></td></tr>
</table>

<table>
<tr><td>Recommendations</td><td>Stanislaus County BHRS will continue to track and monitor that beneficiaries discharging from psychiatric hospitalization are given an outpatient appointment within 7 business days of discharge.</td></tr>
<tr><td>Objective 2B</td><td>To conduct performance monitoring activities that gauge the system's effectiveness at providing timely access to services for urgent conditions.</td></tr>
<tr><td>Goal 2B</td><td>To ensure that all requests for urgent mental health services are responded to within 48 hours for services that do not require an authorization and within 96 hours for services that do require an authorization.</td></tr>
<tr><td>Responsible Partners</td><td>SOC QICs; Performance Measurements</td></tr>
<tr><td>Evaluation Methods/Tool(s)</td><td>Mechanism for monitoring services and activities is the Medi-Cal key indicators and SSRS reports. (Source Data: MATA #3-Timeliness to Urgent Services)</td></tr>
<tr><td>FY 2022/2023 Evaluation</td><td>Stanislaus County BHRS's standard is to meet the 48-hour timeframe whether the urgent service requires prior authorization or not (48 hours vs 96 hours). BHRS is not tracking urgent appointments that required prior authorization separately.

See data table below.

<table>
<tr><th>SOC</th><th>Urgent Mental Health Services are responded to within 48 hours</th></tr>
<tr><td>Adult</td><td>59% (13/22)
Avg # of hours: 106</td></tr>
<tr><td>Children</td><td>93% (13/14)
Avg # of hours: 11</td></tr>
</table>
</td></tr>
<tr><td>Recommendations</td><td>BHRS will continue to ensure that all requests for urgent mental health services are responded to within 48 hours for services that do not require an authorization and within 96 hours for services that do require an authorization.</td></tr>
<tr><td>Objective 2C</td><td>To ensure that beneficiaries are provided with information on how to access specialty mental health services after business hours, including weekends and holidays.</td></tr>
</table>

<table>
<tr><td>Goal 2C</td><td>To confirm that all MHP providers have after-hours telephone message systems that provides information in English and Threshold language(s) on how to access emergency and routine mental health services for BHRS.</td></tr>
<tr><td>Responsible Partners</td><td>Quality Services; SOC QICs</td></tr>
<tr><td>Evaluation Methods/Tool(s)</td><td>Mechanisms for monitoring services and activities include ongoing after-hours test calls and documentation of compliance to standards outlined in the After – Hours Policy and SSRS reports. . (Source Data: SSRS After Hours Report & Test Call Data)</td></tr>
<tr><td>FY 2022/2023 Evaluation</td><td>One method BHRS utilized to monitor this area was by conducting after-hour test calls to our access line. It was identified that this is an area for improvement.
<table>
<tr><td>TEST CALL CATEGORY</td><td>% REQUIREMENT MET</td></tr>
<tr><td>Info about Accessing SMHS</td><td>45%</td></tr>
<tr><td>Info about Urgent services</td><td>N/A</td></tr>
<tr><td>Info about Prob Res & SFH</td><td>20%</td></tr>
</table></td></tr>
</table>

FY 2022/2023 Evaluation

BHRS also documented 405 after-hour services for FY 22-23 Programs document after-hour calls using Billing Type "A", and below are the data by Subunit/Program for after-hour calls:

Summary of Services with Billing Type A During FY 2022-2023.

Sub Unit: 1312 - MH - ACT - Total Billing Type A Services:	2
Sub Unit: 1402 - MH - Access/Assessment - Total Billing Type A Services:	1
Sub Unit: 1409 - MH - Access/Engagement - Total Billing Type A Services:	1
Sub Unit: 1410 - MH - Access/Engagement - Total Billing Type A Services:	2
Sub Unit: 1611 - MH - OP - Total Billing Type A Services:	1
Sub Unit: 3016 - MH - ACT - Total Billing Type A Services:	152
Sub Unit: 3017 - MH - Intensive - Total Billing Type A Services:	30
Sub Unit: 5628 - MH - ACT - Total Billing Type A Services:	6
Sub Unit: 5629 - MH - Intensive - Total Billing Type A Services:	18
Sub Unit: 6608 - MH - Access/Assessment - Total Billing Type A Services:	1
Sub Unit: 6641 - MH - ACT - Total Billing Type A Services:	55
Sub Unit: 6642 - MH - Intensive - Total Billing Type A Services:	16
Sub Unit: 6643 - MH - Wellness - Total Billing Type A Services:	1
Sub Unit: 6644 - MH - ACT - Total Billing Type A Services:	37
Sub Unit: 6645 - MH - Intensive - Total Billing Type A Services:	10
Sub Unit: 6646 - MH - Wellness - Total Billing Type A Services:	3
Sub Unit: 6647 - MH - ACT - Total Billing Type A Services:	39
Sub Unit: 6648 - MH - Intensive - Total Billing Type A Services:	6
Sub Unit: 6653 - MH - Access/Engagement - Total Billing Type A Services:	2
Sub Unit: 6654 - MH - ACT - Total Billing Type A Services:	13
Sub Unit: 6655 - MH - Intensive - Total Billing Type A Services:	5
Sub Unit: 7041 - MH - ACT - Total Billing Type A Services:	2
Sub Unit: 7042 - MH - Intensive - Total Billing Type A Services:	1
Sub Unit: 7044 - MH - ACT - Total Billing Type A Services:	1
Total	405

Recommendations

Regarding the after-hours telephone line, monthly review of test calls is conducted between the BHRS Compliance division, the BHRS Access Line coordinator, and the contracted answering service leadership to identify areas of improvement and provide guidance on requirements.

Stanislaus County BHRS will continue to provide after-hour services as appropriate.

<table>
<tr><td>Objective 2D</td><td>To provide a Toll-Free Telephone Line that operates 24/7 and meets all required elements of the MHP contract.</td></tr>
<tr><td>Goal 2D</td><td>To ensure that the 24/7 Telephone Line provides information, in beneficiary's language of choice, on how to access specialty mental health services, beneficiary resolution process and responds to urgent conditions.</td></tr>
<tr><td>Responsible Partners</td><td>Quality Services; Access Line Team; Ethnic Services Manager</td></tr>
<tr><td>Evaluation Methods/Tool(s)</td><td>Mechanisms for monitoring services and activities include monthly test calls made throughout various times of the day and night with test callers following a script and presenting a myriad of problems varying in complexity, scope and requiring a response. Call details are logged, and the success of test calls is determined by the callers' ability to be directed to the appropriate services.</td></tr>
<tr><td>FY 2022/2023 Evaluation</td><td>BHRS conducts monthly test calls throughout various times of the day and night to ensure that the 24/7 Telephone Line provides information, in beneficiary's language of choice, on how to access specialty mental health services, beneficiary resolution process and urgent services. It was identified that this is an area for improvement.
<table>
<tr><td>TEST CALL CATEGORY</td><td>% REQUIREMENT MET</td></tr>
<tr><td>Info about Accessing SMHS</td><td>66.67%</td></tr>
<tr><td>Info about Urgent services</td><td>N/A</td></tr>
<tr><td>Info about Prob Res & SFH</td><td>60%</td></tr>
</table>
<table>
<tr><td>WRITTEN LOG INCLUDED:</td><td>% REQUIREMENT MET</td></tr>
<tr><td>Name of beneficiary</td><td>66.67%</td></tr>
<tr><td>Date of call</td><td>87.50%</td></tr>
<tr><td>Disposition of call</td><td>45.83%</td></tr>
</table></td></tr>
<tr><td>Recommendations</td><td>Regarding the after-hours telephone line, monthly review of test calls is conducted between the BHRS Compliance division, the BHRS Access Line coordinator, and the contracted answering service leadership to identify areas of improvement and provide guidance on requirements.</td></tr>
<tr><td></td><td></td></tr>
</table>

3: MONITORING BENEFICIARY SATISFACTION (*Source: MHP*)	
• **Conducts and evaluates findings from satisfaction surveys.** • **Identifies areas of improvement as identified by beneficiary feedback and provides long term and short-term solution planning.** • **Conducts and evaluates findings from grievances/appeals/State Fair Hearings.**	
Objective 3	To conduct performance monitoring activities using mechanisms that assess beneficiary satisfaction with behavioral health services provided as an indicator of beneficiary and system outcomes.
Goal 3	To ensure beneficiaries are receiving excellence in behavioral healthcare services as indicated by satisfaction surveys. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.
Responsible Partners	Quality Services; SOC QICs; Performance Measurements
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include Consumer Perception Survey (youth, families of youth, adult, and older adult versions), dashboards, and survey results reports. (Source Data: MKI Beneficiary Satisfaction #1)
FY 2022/2023 Evaluation	Stanislaus County BHRS has mechanisms to assess beneficiary/family satisfaction by surveying beneficiary/family satisfaction at least annually. Stanislaus County BHRS conducted the Consumer Perception Survey once during FY 2022/2023 from May 15th–19th, 2022. The data for this Consumer Perception Survey was:
Recommendations	Stanislaus BHRS will continue to conduct the Consumer Perception Surveys annually and review the data for any opportunities for improvement.

Mental Health Consumer Perception Survey - May 2023

Subscale	English	Spanish	Answered	Agreed	Favorable
Access	709	55	2362	2047	87%
Satisfaction	709	55	3698	3156	85%
Connectedness	709	55	2795	2250	81%
Quality and Appropriateness	238	5	2016	1800	89%
Cultural	471	49	1899	1752	92%

<table>
<tr><td>Objective 3A</td><td>To conduct performance monitoring activities using mechanisms that assess the number of grievances (and their resolution), appeals and requests for State Fair Hearings. To analyze the nature of the causes for concern as an indicator of beneficiary and system outcomes.</td></tr>
<tr><td>Goal 3A</td><td>To ensure that beneficiary grievances, appeals, and requests for State Fair Hearings are being resolved expeditiously and appropriately within the MHP. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.</td></tr>
<tr><td>Responsible Partners</td><td>Quality Services; Patients' Rights</td></tr>
<tr><td>Evaluation Methods/Tool(s)</td><td>Mechanisms for monitoring services and activities include monthly reports on grievances, appeals and requests/outcomes for State Fair Hearings.</td></tr>
<tr><td>FY 2022/2023 Evaluation</td><td>BHRS has processed 74 % of Medi-Cal grievances timely for FY 22-23. BHRS has also reported out FY 22/23 data on grievances, appeals, and state fair hearings at the Quality Management Team (QMT) meetings as well as annually to DHCS. There was one (1) State Fair Hearing and (1) Expedited Appeal for FY 22/23 which were all processed within DHCS timeliness standards. The 1 Expedited Appeal was upheld.
There was a total of 23 Medi-Cal Grievances and 2 Other Grievances for FY 22/23.

The following is the grievance data for FY 22/23:

<table>
<tr><th>Complaint Type</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>Totals</th></tr>
<tr><td>Formal Complaint</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Medi-Cal Grievances</td><td>5</td><td>4</td><td>6</td><td>8</td><td>23</td></tr>
<tr><td>Other Grievance</td><td>0</td><td>0</td><td>2</td><td>0</td><td>2</td></tr>
<tr><td>Positive Compliment</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Totals</td><td>5</td><td>4</td><td>8</td><td>8</td><td>25</td></tr>
</table>
</td></tr>
</table>

FY 2022/2023 Evaluation

The following is the grievance data for FY 22/23 Continued:

Severity	Q1	Q2	Q3	Q4	Totals
Appropriate Practice/Care	2	2	2	4	10
Opportunity to Improve	3	0	0	2	5
Unknown	0	0	0	1	1
Signif. Deviation from Std	1	1	1	0	3
Total	6	3	3	7	19

Complaint Category	Q1	Q2	Q3	Q4	Totals
Staff Behavior	1	1	1	2	5
Medication Concerns	1	0	1	0	2
Access/Accessibility	1	0	0	0	1
Confidentiality Concern	0	0	0	0	0
Treatment Issues	2	0	2	2	6
Other Quality of Care	0	1	0	1	2
Financial	0	0	0	0	0
Operational	0	0	1	0	1
Peer Behavior	0	0	0	0	0
Patient Rights	0	0	0	1	1
Physical Environment	0	0	0	0	0
Lost Patient Property	0	0	0	0	0
Change of Provider	0	1	0	1	2
Other	0	1	1	1	3
Totals	5	4	6	8	23

The following is the grievance data for FY 22/23 Continued:

Complaint By SOC	Q1	Q2	Q3	Q4	Totals
Medication Services	1	0	2	1	4
ASOC	2	2	2	2	8
CSOC - TAY	1	0	0	0	1
SUD	1	2	2	3	8
Supportive Services Div	0	0	0	2	2
Office of Public Guardian	0	0	0	0	0
BH Plan Administration	0	0	0	0	0
Totals	5	4	6	8	23

Complaint By Disposition	Q1	Q2	Q3	Q4	Totals
Satisfied/Resolved	4	3	2	4	13
Unable to Contact Client	0	0	1	3	4
Dissatisfied/Not Resolved	0	0	0	0	0
Unknown	0	0	0	0	0
Withdrawn	2	0	0	0	2
Totals	6	3	3	7	19

Timeliness	Q1	Q2	Q3	Q4	Totals
Closed w/in Regulatory Standard	6	3	3	2	14
Not Closed w/in Reg Standard	0	0	0	5	5
Total	6	3	3	7	19

The following is the Appeals Data for FY 2022/23:

Appeal Type	Q1	Q2	Q3	Q4	Total
Appeal	0	0	0	0	0
Expedited Appeal	0	0	1	0	1
Other	0	0	0	0	0
Positive Compliment	0	0	0	0	0
Total	0	0	1	0	1

Appeal By Disposition	Q1	Q2	Q3	Q4	Total
Satisfied/Resolved	0	0	1	0	1
Unable to Contact Client	0	0	0	0	0
Dissatisfied/Not Resolved	0	0	0	0	0
Unknown	0	0	0	0	0
Withdrawn	0	0	0	0	0
Total	0	0	1	0	1

Timeliness	Q1	Q2	Q3	Q4	Total
Closed w/in Reg. Standards	0	0	1	0	1
Not Closed w/in Reg. Standards	0	0	0	0	0
Total	0	0	1	0	1

Severity	Q1	Q2	Q3	Q4	Total
Appropriate Practice/Care	0	0	1	0	1
Opportunity to Improve	0	0	0	0	0
Unknown	0	0	0	0	0
Total	0	0	1	0	1

The following is the Appeals Data for FY 2022/23 continued:

OutCome	Q1	Q2	Q3	Q4	Total
Appeal Upheld	0	0	1	0	1
Appeal Overturn	0	0	0	0	0
Unknown	0	0	0	0	0
Total	0	0	1	0	1

Recommendations	BHRS will continue to ensure that beneficiary grievances, appeals, expedited appeals, and requests for State Fair Hearings are being resolved expeditiously and appropriately within the MHP and continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.

4: MONITORING THE SERVICE DELIVERY SYSTEM FOR MEANINGFUL CLINICAL & ETHICAL ISSUES (*Source: MHP*)

- **Monitors, anticipates and evaluates clinical aspects and implications of departmental policies, procedures, and actions.**
- **Reviews clinical issues, quality of care, utilization and utilization management issues that surface as a result of chart review and program review.**
- **Considers the ethical implications of departmental and staff activities.**
- **Prepares reports of findings and recommendations for submission to the Quality Management Team (QMT).**

Objective 4	To conduct performance monitoring activities of the safety and effectiveness of the service delivery system related to clinical and ethical issues in the Inpatient system of care.
Goal 4	To identify and address issues affecting quality of care through the review of findings from incident reports, Patients' Rights investigations, inpatient authorization review, and applicable root cause analysis proceedings. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.
Responsible Partners	SOC QICs, Medical Director, Compliance Officer, Quality Services, Patients' Rights Advocate
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include meeting minutes, QMT meeting minutes, applicable reports/dashboards, chart and on-site monitoring report summaries.

FY 2022/2023 Evaluation

BHRS risk Management processes incident reports for the agency including unusual occurrences from contract agencies. Any quality-of-care issues or incident trends are reported at QMT and/or SLT meetings. During the calendar year 2022, there were a total of 229 Incident Reports (including Adverse Incident). As of October 11, 2023, there have been 167 Incident Reports.

Total # of Incident Reports per year:

Year	2017	2018	2019	2020	2021	2022	2023 (as of October 11, 2023)
# of Incident Reports	357	334	298	190	209	229	167

# of Incidents by Incident Type for 2021:

Incident Type	# of Incidents for 2022	
Abuse/Neglect/Exploitation (Actual or Alleged)	5 (2.1%)	
Client Injury (Excluding Falls)	19 (8.3%)	
Deaths	36 (15.8%)	
Falls	4 (1.7%)	
Inappropriate Behaviors	7 (3.0%)	
Medical Care Issues	34 (14.9%)	
Medication Errors	18 (7.9%)	
Property Loss/Damage	27 (11.8%)	
Security Related	64 (28.0%)	
Visitor/Other Injury (Non-Employee)	0 (0%)	
Other	15 (6.6%)	
Unknown	0 (0%)	
Total	229	

	2022/2023 Inpatient Chart Reviews: In December of 2022, BHRS contracted with CalMHSA for the Program Inpatient Concurrent Review project which utilizes a technology-assisted concurrent review process with its contractor Acentra, formerly known as Kepro. Acentra provides a web-enabled utilization platform and clinical services to carry out psychiatric inpatient concurrent review and authorization services. Hospitals submit clinical authorization request and clinical documentation via a web-enabled platform. Acentra reviewers provide feedback to hospitals to assist with meeting documentation standards to provide decrease in the amount of denied days for hospitals. BHRS's Utilization Management program provides oversight and monitoring of Acentra by use of side-by-side reviews and the performance of random audits. Quality standard issues are addressed with Acentra as they arise and reviewed in a bi-weekly meeting, by the liaison between BHRS and Acentra.
Recommendations	BHRS will continue to monitor its service delivery system. BHRS Risk Management will continue having quarterly Adverse Incident work group meetings in which adverse incidents are processed and Root Cause Analyses are completed. In addition, BHRS's Utilization Management program will continue to provide oversight and monitor Acentra as the contractor for concurrent review. Acentra will continue to review inpatient documentation on a concurrent review basis according to guidance provided by DHCS. Support to hospitals around documentation standards will be provided with regards to BHIN 22-017 and documentation standards set forth by Title 9.
Objective 4A	To conduct performance monitoring activities of the mechanisms responsible for the safety and effectiveness in the Outpatient system of care.
Goal 4A	To identify and address issues which may affect the quality of care provided to beneficiaries, underutilization of services, overutilization of services and utilization management. To implement corrective measures as appropriate. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting consumer needs.
Responsible Partners	Medical Director, Quality Services, Compliance Officer, Utilization Management, and SOC Program Managers
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include meeting minutes, QMT meeting minutes, chart and on-site monitoring report summaries.

FY 2022/2023 Evaluation

For FY 22/23, BHRS was not able to consistently conduct monthly mental health chart audits. Our focus and efforts were placed on the implementation of the California Advancing and Innovative Medi-Cal (CalAIM), documentation redesign, the implementation of a new EHR, and preparation in transitioning peer review audits to the Utilization Management (UM) program. During this transition, the UM program launched a pilot project utilizing the new audit tool released by the California Mental Health Services Authority (CalMHSA). The UM team is reviewing our existing auditing process and plans to develop a new audit process incorporating the use of the new audit tool. The new UM Audit Review Process will be implemented in phases once finalized.

BHRS audited three programs for the fiscal year 22/23. All MH programs were audited to Title 9, Medi-Cal, Managed Care and Federal requirements. The audits monitored and reviewed documentation standards, assessments, progress notes, and treatment plans to align with the CalAIM documentation reform requirements. If it was identified during the review that documentation standards are not met, immediate corrective actions are set (lower than 90% on any line item on the peer review tool results in a CAP), requiring programs to address the areas of concern. See table for the overall program compliance scores for each program audited in the FY 22/23 MH Peer Review.

Sub-Units	Overall Compliance Score
1602	94%
1611	90%
7801	87%

In addition to documentation standards, authorizations were reviewed by the UM team during chart audits to ensure regulations are adhered to. If it is determined a correction needs to be made to the authorization, the UM team will collaborate with the program to ensure the program has made all the necessary corrections to be in compliance with regulation. Additionally, in an effort to monitor disallowances and/or suspended services the BHRS Business Office consistently runs disallowance and/or suspended services reports to identify areas for improvement as well.

Stanislaus BHRS also had their MHP Triennial review in June 2023 in which the MHP was found to be 100% compliant in the chart review portion of the audit.

Recommendations

BHRS will continue to focus on this area and Peer Review results will be reported quarterly at QMT.

5: MONITORING THE MHP SERVICE DELIVERY SYSTEM FOR THE SAFETY & EFFECTIVENESS OF MEDICATION PRACTICES (*Source: MHP*)	
• **Under the supervision of a person licensed to prescribe or dispense prescription drugs, evaluates and monitors the safety and effectiveness of medication practices.** • **Reviews cases involving medication issues and tracks medication issues over time.** • **Recommends and institutes needed actions involving medication procedures and policies.** • **Conducts Peer Reviews regarding medication practices.**	
Objective 5	To conduct performance monitoring activities of the mechanisms responsible for the safety and effectiveness of medication practices**.**
Goal 5	To obtain information regarding the safety and effectiveness of medication practices. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting consumer needs.
Responsible Partners	Medical Director, MD/RN Team; Quality Services
Evaluation Methods/Tool(s)	Mechanisms to monitor the safety and effectiveness of medication practices at least annually which include chart review summaries and reports that are inclusive of medications prescribed to adults and youth and are under the supervision of a person licensed to prescribe or dispense prescription drugs.
FY 2022/2023 Evaluation	BHRS monitors the safety and effectiveness of medication practices through our MD/RN chart reviews. This is completed at least once annually. BHRS was only able to facilitate one review for FY 22/23 due to other priorities identified by the department. BHRS completed a chart review on December 12, 2022. The results are as follows: Charts requested: 6 Charts reviewed: 6 # of staff reviewed: 1 Charts requiring corrections/follow-up: 0 # of staff responsible for corrections/follow-up: N/A Orders/Labs/Etc. Subscale Compliance score: 100% Medication Progress Notes Subscale Compliance score: 100% Overall Score: 100%

Recommendations	BHRS will continue to conduct MD/RN chart reviews at least annually to collect and analyze data for the medication monitoring process. The BHRS Medical Director will identify areas of improvement in order to provide additional guidance to medical staff. The MD/RN chart review facilitation will be transitioned from QS to UM.

6: MONITORING COORDINATION OF CARE BETWEEN THE MHP AND PHYSICAL HEALTHCARE AGENCIES (*Source: MHP*)	
• **Manages the continuity and coordination of care between physical health care agencies and the MHP across the department.** • **Develops department-wide processes to link physical health care into ongoing operating procedures.** • **Assesses the effectiveness and facilitates the improvement of MOU's with physical health care plans.**	
Objective 6	To conduct performance monitoring activities of the mechanisms responsible for enhancing continuity and increasing the coordination of care between the MHP and Physical Healthcare agencies/providers as an indicator of beneficiary and system outcomes.
Goal 6	Update MOU's with physical health plans in order to create a mechanism for exchange of information between BHRS & primary care with regards to individual client care. To enhance any additional continuity and coordination of care activities. To assess effectiveness of MOU with physical health care providers and revise as appropriate to improve the processes of providing care and better meeting consumer needs.
Responsible Partners	Medical Director; Privacy Officer; Quality Services
Evaluation Methods/Tool(s)	The completed draft of Health Plan of San Joaquin and Health Net MOUs, updated Coordination of Care policy, data reports, training sign in sheets, Coordination of Care protocol.
FY 2022/2023 Evaluation	BHRS monitors program staff contact with client's Primary Care Physician (PCP) through its Medi-Cal Key Indicators (MKI). Programs are continuing to follow the PCP process. Due to staff shortage, the department was not able to finalize the data collection and reporting process; efforts were placed on the implementation of a new EHR. The BHRS PCP Steering Committee continues to consistently work collaboratively with our IT department to resolve the existing challenges that arise. Once the methodology is finalized, BHRS will be able to track and monitor PCP contact that is currently occurring more accurately.

Recommendations	BHRS will work towards the development of data collection (completing the revision of the data extraction) and reporting process as we transition into a new EHR. For FY 23/24 BHRS will continue to work on developing in this area.

7: MONITORING PROVIDER APPEALS (*Source: MHP*)	
• **Reviews provider appeals submitted to the utilization management department.** • **Evaluates the provider appeals process for efficiency and effectiveness.** • **Makes recommendations based on group findings and review of provider appeals that ensures equity and fairness in due process.**	
Objective 7	To conduct performance monitoring activities which review provider appeals and concerns on an ongoing basis as an indicator of the effectiveness of the provider appeal resolution process.
Goal 7	To provide an effective means of identifying, resolving and preventing the recurrence of provider concerns/appeals with the MHP's authorization and other processes. To continue to use this information to identify and prioritize areas for improving the processes of providing care.
Responsible Partners	Quality Services; Utilization Management; Managed Care QIC
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include Provider appeal log and provider appeal summaries.
FY 2022/2023 Evaluation	BHRS identifies, resolves and works towards preventing the recurrence of provider concerns/appeals on an ongoing basis by providing immediate feedback to providers by way of concurrent review, conducting chart reviews, providing DHCS's documentation training to providers, and creating a list of common denial reasons which reference the DHCS documentation training. Appeals are processed and tracked within the regulatory timeframes. In December of 2022, BHRS contracted with CalMHSA for the Program Inpatient Concurrent Review project which utilizes a technology-assisted concurrent review process with its contractor Acentra, formerly known as Kepro. Acentra provides a web-enabled utilization platform and clinical services to carry out psychiatric inpatient concurrent review and authorization services. Hospitals submit clinical authorization request and clinical documentation via a web-enabled platform. Acentra reviewers provide feedback to hospitals to assist with meeting documentation standards to provide decrease in the amount of denied days for hospitals leading to decreased provider appeals. BHRS's Utilization Management program provides oversight and monitoring of Acentra by use of side-by-side reviews and the performance of random audits. Quality standard issues are addressed with Acentra as they arise and reviewed in a bi-weekly meeting, by the liaison between BHRS and Acentra.

Recommendations	BHRS will continue to conduct performance monitoring activities which review provider appeals and concerns on an ongoing basis as an indicator of the effectiveness of the provider appeal resolution process. Continue to provide support to our providers around documentation standards. Encourage providers to utilize the second level appeal process.

8: MONITORING MENTAL HEALTH NEEDS IN SPECIFIC CULTURAL GROUPS	
• **Assumes responsibility for ensuring trainings designed to enhance cultural competence are being offered.** • **Conducts outreach activities to unserved, underserved, inappropriately served, and minority populations.** • **Monitors the implementation of cultural competence plan goals.** • **Participates as necessary in other committee activities.**	
Objective 8	To conduct performance monitoring activities of the mechanisms used to identify access barriers among specified ethnic/cultural groups that are currently unserved, underserved or inappropriately served.
Goal 8	To evaluate the effectiveness of current outreach activities in engaging diverse cultural groups into mental health treatment. To review and monitor the provision of cultural competency trainings to providers. To continue using this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.
Responsible Partners	Ethnics Services Manager, Quality Services Manager; Performance Measurements; Cultural Competency Social Equality Justice Committee (CCESJC)
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include training reports, CCESJC meeting minutes, and dashboard/reports.

FY 2022/2023 Evaluation	The Behavioral Health Equity Manager (BHEM) is responsible for ensuring that the County meets cultural and linguistic competency standards in the delivery of community-based behavioral health services, including Medi-Cal Specialty Mental Health Services (SMHS), DMC-ODS substance use disorder (SUD) services, and MHSA services. The BHEM promotes and monitors quality and equitable care as it relates to diverse racial, ethnic, and cultural populations served by both county-operated and contracted behavioral health programs. The BHEM's priority for Fiscal Year 2023-2024 will be to develop a strategy to ensure all programs continue to fully implement the CLAS standards. The BHEC agenda will include education on CLAS, review of best practices, and presentations from programs on their CLAS standards program development activities and progress. The initial strategies will focus on ensuring program are adhering and further developing the initial recommendation CLAS standards. Additionally, the BHEC and BHEM will support the Department's efforts to launch a Cultural Competency training. The training will introduce BHRS' commitment to cultural competency, including a discussion about CLAS Standards and the Cultural Competence Program for Stanislaus County – to include all policies and training requirements. In addition, the Department will work with local diverse PEI Community Collaboratives (PEICC) to further expand their scope of practice to include supporting the Department in community stakeholder participation that will inform the further development and strengthening of treatment services for diverse community populations. The Department will work with PEICC to develop and provide educational sessions for treatment providers on the local diverse community experience in accessing and receiving behavioral health treatment services. To develop these educational sessions, the Department will partner PEICC to convene learning sessions with BHRS clients and community members to learn and gain insight into diverse community member and client challenges and successes in accessing behavioral health services. The educational sessions will vary in topic and include information on local, natural community supports for clients and families, and how treatment providers can connect clients to these community supports. The PEICC includes, but is not limited to:

- Stanislaus Asian America Community Resources
- LGBTQIA+/2S Collaborative
- NAACP
- Assyrian Wellness Collaborative
- Jakara Movement
- Peer Recovery Art Project
- Khmer Youth of Modesto
- Cricket's Hope
- MJC Latina + LGBTQ
- MoPRIDE
- Youth for Christ
- Promotores/CBHOW
- Youth Empowerment Program
- Community-based Continuum of Care Project
- LGBTQIA+/2S Collaborative Youth Support groups

The Department is committed to strategies that embrace cultural diversity, inclusion, and to provide welcoming behavioral health and compassionate recovery services that are effective, equitable, and responsive to individuals' cultural health beliefs and practices. The BHEC works to improve the quality of services and eliminate inequities and barriers to behavioral health care for marginalized cultural and ethnic communities. Based on established best practices, such as the CLAS standards, BHEC developed recommendations on strategies to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Due to the implications of COVID-19, the initial recommendations put forth from the committee were identified as quick actions that could be implemented as part of the Strategic Plan.

The BHEC will also support the Department in the implementation of strategies that are responsive to the Mental Health Services Act (MHSA) stakeholder priority that consumers access and receive behavioral health services and peer/community support in ways that are reflective and responsive to their cultures, languages, and worldviews. It was determined that one of several key benchmarks that will measure success will be the number of clinical providers that speak the County's Medi-Cal threshold language of Spanish. As seen in the table below, BHRS has 265 full-time clinical provider staff, and of those, 84 or 32% are bilingual. Going forward, BHRS will continue to monitor this data to ensure that consumers are able to access services that are culturally and linguistically appropriate.

Bilingual Staff in Clinical Provider Roles	Number of FTE Allocated Positions	Number of Bilingual Staff	Percentage
Behavioral Health Specialist I/II	99	42	42%
Clinical Services Technician I/II	44	11	25%
Mental Health Clinician I/II/III	96	30	31%
Psychiatric Nurse I/II	22	1	5%
Psychiatrist	4	0	0%
Total Direct Service Staff	**265**	**84**	**32%**

The Department has also nurtured partnerships with diverse community stakeholders through the development of cultural collaborative partnerships with Assyrian, faith-based organizations, Latino, National Association for the Advancement of Colored People (NAACP), Southeast Asian, Lesbian Gay Bisexual Transgender Questioning Intersex Asexual and Two-Spirit (LGBTQIA+/2S) and other diverse communities. These partnerships, supported by MHSA Prevention and Early Intervention (PEI) funding, have continually provided community feedback to BHRS on further development of the local behavioral health system to meet the needs of Stanislaus County's diverse communities, and the goal of integrating community practices into current treatment programs.

The Department's efforts to be culturally competent are also reflected in the updated MHSA Program and Expenditure Plan (PEP):

- Continued technical support and funding for the Promotora Program, otherwise known as Community Behavioral Health Outreach Workers (CBHOWs), as part of the MHSA PEI component. The program works at the community level to provide social support and guidance for individuals who may be isolated or in need of services. Promotora/CBHOWs are trusted community members who can facilitate referrals to mental health services.

- BHRS expanded the Promotora/CHBOW model and approach by developing a Community Collaborative Plan that offers small/micro MHSA funding opportunities for diverse community partners to implement PEI strategies. Outreach for increasing recognition of early signs of mental illness and access and linkage to appropriate mental health services will target MHSA priority populations, which include historically unserved and underserved residents. These funding opportunities range from a $2,000 to $20,000. In addition, BHRS has been working with key Community Collaborative partners to facilitate community conversations with peers/consumers and the general public to develop strategies to strengthen access to treatment services.
- Develop a standard program description template that describes the program and key points of information for clients both in Spanish and English. BHRS has begun drafting these documents and will provide an update in future plans.
- Develop referral database that is updated regularly and tested for accuracy. BHRS has not yet begun to address this recommendation.
- Develop Treatment Guidance on base standard of communication to the client about the assessment process, treatment planning, and supporting documents, fact sheets and videos. These videos could be viewed at clients wait for assessment. BHRS has not yet begun to address this recommendation.
- Develop Spanish language treatment summary as a proxy for a printed treatment plan. BHRS is exploring the capability of the new EHR in order to address this recommendation.
- Develop target of the percentage of clients that will receive treatment services in their preferred language without interpreter. BHRS has not yet begun to address this recommendation.
- Define the number of staff that speak threshold language to meet the needs of the community. BHRS has committed to developing a list of current BHRS staff who are bilingual. As of September 2022, the Department had 133 Spanish speaking staff and staff that speak a variety of other languages, as outlined in the table below. BHRS is committed to continue to expand culturally and linguistically appropriate services to create a inclusive atmosphere to ensure sure clients are serviced in their primary language. BHRS has begun to research the possibility of adding interpretation resources via a contracted agency.

	Assyrian	Cambodian	Hindi	Hmong	Laotian	Punjabi	Spanish	Grand Total
Total Number of Bilingual Staff	5	7	1	1	2	2	133	151
Total Number of Allocated Full Time Equivalent (FTE) Positions as of 2023 Adopted Budget								492
% of Allocated FTEs with Bilingual Capabilities								31%

Listed below are data elements for FY22/23 related to different cultural groups:

The percentage of total clients served (unduplicated) by Race/Ethnicity for FY 22/23:

Race/ethnicity	**FY21/22**
African-American	6.8%
Asian	0.6%
Native American	1.1%
White American	35.5%
Other/Unknown	55.9%
Hispanic Origin	
Hispanic	100%

The percentage of total client served (unduplicated) by age for FY22/23:

Age Group	**FY21/22**
0-17	39.1%
18-59	54.3%
60+	6.6%

Listed below are data elements for FY22/23 related to different cultural groups Continued:

The client retention rate for FY22/23 by ethnicity is listed below:

	FY22/23
Overall	68%
African-American	72%
Asian /Pacific Islander	70%
Hispanic	67%
Native American	61%
White American	69%
Other	61%

BHRS Staff Race/Ethnicity composition for FY22/23:

Race/ethnicity	**County Population**	**Overall Staff**	**Admin/Mgmt**	**Direct Services**	**Support services**	**N/A**
Asian	5.1%	9.5%	8.6%	9.3%	8.4%	17.6%
Black/African American	2.4%	4.5%	4.9%	4.5%	3.6%	8.8%
Native American/Alaska Native	0.4%	1.2%	2.5%	1.4%	0%	0%
Hispanic	42.6%	39%	33.3%	34.6%	48.2%	29.4%
White	38.9%	39.9%	46.9%	41.4%	35.4%	41.2%
Other/Unknown	10.7%	6.0%	3.7%	8.8%	4.2%	2.9%
TOTAL	530,561	582	81	442	166	34

Recommendations	Stanislaus County BHRS BHEM will continue to monitor this area.

9: PERFORMANCE IMPROVEMENT PROJECTS (PIP)	
• **Facilitates clinical and administrative PIP activities.** • **Uses data as a foundation for the PIP Implementation and Submission Tool.** • **Evaluates progress on PIP stages and reviews final reports.** • **Shares information about PIP activities with QMT that may be used in policy making.**	
Objective 9	To maintain two (2) active Performance Improvement Projects (PIPs); one (1) clinical and one (1) administrative, per fiscal year.
Goal 9	To complete the appropriate steps in the CAEQRO PIP Validation Tool for each PIP.
Responsible Partners	SOC QICs; PIP chairs; Quality Services
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include CAEQRO PIP summary reports and Implementation and Submission Tool.
FY 2022/2023 Evaluation	During the FY 22/23, the department shifted the project management of the PIPs to the BHRS Quality Services Department. Stanislaus County Behavioral Health and Recovery Services (BHRS) understands the Title 42, CFR, Section 438.330, Department of Health Care requirements as having two active Performance Improvement Projects (PIP's) for the MHP. This past year Stanislaus County has developed and has implemented both the MH Clinical and Non-Clinical PIPs. For our Non-Clinical Mental Health Plan (MHP) Performance Improvement Project (PIP), the focus is on ensuring that a Child/Adolescent beneficiary has had their initial psychiatry appointment scheduled within 15 business days of initial request. The Psychiatric Medication Services Referral (PMSR) form in the Electronic Health Record (EHR) is used to track these requests. The PIP Committee has implemented the PMSR Script/Questionnaire that clinical staff would utilize when a client/parent made an initial request for psychiatry services. This Non-Clinical PIP has been active since Oct. 10, 2022 and the committee currently meets twice a month to discuss updates around this PIP. For our Clinical MHP PIP or FUM PIP, the focus is to bridge care coordination gaps between MHP and the Emergency Department (ED) to decrease ED visits for beneficiaries. The PIP Committee has implemented the offering of care coordination services to beneficiaries upon discharge from the ED in efforts to provide linkage to Access Crisis and Support (ACS) services. The Clinical MHP PIP is currently active and the committee meets weekly to discuss updates around this PIP.

Recommendations	Stanislaus County BHRS will ensure PIPs are active in the upcoming FY 2023/2024.

10: MONITORING QUALITY IMPROVEMENT AND DOCUMENTATION REVIEW	
• **Reviews new regulations which may affect documentation issues** • **Works to build standardized procedures for new legislation when implemented in MHP.** • **Serves as a review body for audit results which go to appeal after the first plan of correction.**	
Objective 10	To conduct performance monitoring activities using mechanisms that assess if all chart documentation and audit review findings are in congruence with State and Federal regulations.
Goal 10	To review all current chart documents for ease of use and to ensure appropriateness to Title 9, Medi-Cal, Managed Care and Federal requirements; make revisions based on new legislation and State guidance as needed. To enhance department quality improvement practices, infrastructure and QI work plan fidelity. To continue to use this information to identify and prioritize areas for improving the process of providing care and better meeting consumer needs.
Responsible Partners	Quality Services; Utilization Management; SOC managers
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include chart audits (peer review), treatment plan authorization review, and disallowance reports and/or suspended services for outpatient services and denied days for inpatient services, reports, and dashboards.

FY 2022/2023 Evaluation	BHRS conducted one chart audit related to medication monitoring for FY 22/23. A total of 6 charts for one staff was audited. The medical staff was reviewed to Title 9, Medi-Cal, Managed Care and Federal requirements and was 100% in compliance. For FY 22/23, BHRS was not able to consistently conduct monthly mental health chart audits. Our focus and efforts were placed on the implementation of the California Advancing and Innovative Medi-Cal (CalAIM), documentation redesign, the implementation of a new EHR, and preparation in transitioning peer review audits to the Utilization Management (UM) program. During this transition, the UM program launched a pilot project utilizing the new audit tool released by the California Mental Health Services Authority (CalMHSA). The UM team is reviewing our existing auditing process and plans to develop a new audit process incorporating the use of the new audit tool. The new UM Audit Review Process will be implemented in phases once finalized. BHRS audited three programs for the fiscal year. All MH programs were audited to Title 9, Medi-Cal, Managed Care and Federal requirements. The audits monitored and reviewed documentation standards, assessments, progress notes, and treatment plans to align with the CalAIM documentation reform requirements. If it was identified during the review that documentation standards are not met, immediate corrective actions are set (lower than 90% on any line item on the peer review tool results in a CAP), requiring programs to address the areas of concern. See table for the overall program compliance scores for each program audited in the FY 22/23 MH Peer Review.

Overall program compliance scores for each 22/23 MH Peer Review:

Sub-Units	Overall Compliance Score
1602	94%
1611	90%
7801	87%
1602	94%

The BHRS Business Office consistently runs disallowance and/or suspended services reports to identify areas for improvement as well.

During 2022 BHRS UM staff in collaboration with QS during the monthly Peer Review completed manual audits of delegated activities (initial authorizations of assessments, treatment plans, and transfer authorizations). UM focused on monitoring the delegated activities of entering and maintaining MH authorizations. During this time UM audited the same charts as QS during the peer review process for each of the selected programs with a total of 3 audits (3 programs were audited), due to staff changes and cancellation of some audits, reviews were limited during this time period. All MH health programs were reviewed for accuracy in entering the authorizations and adhering to all standards and protocol. Out of the 3 audits, 3 of those audits required corrections due to data entry errors related to the manual entry of authorization dates. The feedback/outcome was provided to each of the program/authorizers needing corrections and monitored until corrections were completed. BHRS UM staff also continued to conduct review of all annual and subsequent authorizations during the treatment plan annual review to ensure all regulations are being met. During 2023 and the implementation of CalAIM guidelines UM focused on reviewing the new guidelines and responsibilities with the new audit process. This included reviewing policies, CalMHSA Audit Tool training, working on developing practice guidelines, and developing an implementation timeline.

Recommendations	BHRS will continue to monitor this area. BHRS will continue to attempt to facilitate monthly MH program peer reviews and at least annual MD/RN peer reviews to ensure accuracy in documentation. BHRS UM staff to continue to work on the new audit process. UM developed two phases to implement the new Audit process. Two Phases were set to be implemented starting July 2023 and October 2023: Phase 1 (July 2023) UM Audit Reviews and Phase 2 (October 2023) Internal Program Reviews. Focus will be to continue to work on fully implementing and monitoring these processes.

11: CREDENTIALING AND MONITORING OF PROVIDERS	
• **Completes database checks of all providers.** • **Monitors providers at required intervals and follows guidelines for any negative reports for providers.** • **Follows appeal process for any corrective action taken against providers.**	
Objective 11	To conduct database checks in congruence with State and Federal regulations as an indicator of adherence to credentialing and monitoring standards.
Goal 11	To review all required databases for all providers at time of application/hire and at required intervals to identify any providers who are identified as not appropriate for providing care to beneficiaries. To monitor provider quality of treatment at appropriate intervals to identify any quality of care issues in order to ensure appropriateness for continued treatment of beneficiaries.
Responsible Partners	Human Resources; Quality Services; Utilization Management; SOC managers
Evaluation Methods/Tool(s)	Mechanisms for monitoring include National Plan and Provider Enumeration System (NPPES), National Practitioner Data Bank (NPDB), Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), Medi-Cal Suspended and Ineligible Provider List, Licensing board websites, chart audits (peer review), treatment plan authorization review, and disallowance reports and/or suspended services for outpatient services and denied days for inpatient services, reports, and dashboards.
FY 2022/2023 Evaluation	For FY 2022/2023, processes have continued and remain in place, per BHRS Policy 60.2.129. This includes monthly recorded checks of OIG, LEIE, and Licensure status; routine recorded checks in PAVE for licensed new hires and/or employees who have obtained licensure status; NPPES review of enrollment and taxonomy compliance for new hires and current staff for compliance to ensure claims can be adequately billed and processed for payment.

	Review of credentialing includes the appropriate audit of EHR to confirm credentials are current and listed correctly for each provider. If evidence is found of potential fraud, Stanislaus County BHRS/HR will notify the employee of corrective action, which includes the ineligibility of the employee to provide clinical privileges, be denied access to the EHR, and/or claim/bill for services under their respective credential. NPDB enrollment is still pending.
Recommendations	Stanislaus County BHRS/HR will continue to monitor and record findings, including evidence of fraud followed by corrective action, per Policy 60.2.129. Complete NPDB enrollment by end of 11/2023.
Objective 11A	To review the PAVE portal for all applicable licensed providers at time of application/hire and upon licensing of current unlicensed providers who will be or are for providing care to beneficiaries.
Goal 11A	To ensure all applicable licensed staff are enrolled in the DHCS Provider Application and Validation for Enrollment (PAVE) portal.
Responsible Partners	Human Resources; SOC managers; Quality Services
Evaluation Methods/Tool(s)	Mechanisms for monitoring include the PAVE open data portal on the DHCS website, screenshots of provider portals showing completion of applications, and copies of the DHCS approval letters.
FY 2022/2023 Evaluation	For FY 22/23, Stanislaus County BHRS/HR continues to review the PAVE portal and record enrollment for licensed new hires and employees who have obtained licensure since original hire. This includes all eligible licensed disciplines, such as LCSW, LMFT, LPCC, and MD.
Recommendations	Stanislaus County BHRS will continue to monitor and record PAVE enrollment for compliance.

Quality Improvement (QI) Work Plan FY 2023-2024: Objectives and Goals

1: MONITORING THE SERVICE CAPACITY AND SERVICE DISTRIBUTION OF THE MHP (*Source: MHP*)	
• **Conducts performance monitoring activities that evaluate beneficiary and system outcomes and indicators of wellbeing.** • **Describes and provides information regarding the current type, number and geographic distribution of Mental Health Services in the system.** • **Evaluates and monitors the capacity of the MHP.** • **Makes program recommendations based on capacity indicators.** • **Participates in the county planning process which identifies expanded service populations.** • **Monitors the number of Medi-Cal beneficiaries receiving services and works with Performance Measurements to distribute information to Program Managers and the Quality Management Team (QMT).**	
Objective 1	To describe the current type, number, and geographic distribution of Mental Health Services in the MHP System of Care to ensure appropriate allocation of MHP resources in providing adequate behavioral health access to all beneficiaries.
Goal 1	To identify service provision to Children, Youth, and Adult Medi-Cal/Uninsured beneficiaries by types of services and service locations by geographic regions. To track service provision against service demand and ensure resources are appropriately allocated to provide for access.
Responsible Partners	SOC QICs; Performance Measurements (OEM)
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include data dashboards. (Source Data: SSRS 1627)
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined

2: MONITORING TIMELY ACCESS FOR ROUTINE AND URGENT SERVICE NEEDS (*Source: MHP*)	
• **Conducts and coordinates performance monitoring activities to test timeliness and access to services within the MHP.** • **Tests the ability of the appointment system through the mechanisms of test calls and internal audits of contact logs.** • **Reports findings and suggested solutions for systems issues which negatively impact access.** • **Tests and evaluates the ability of the system to respond to calls to 24/7 Toll Free Phone Number.** • **Reviews timeliness to service for all appointment types within the system including routine appointments and services for urgent conditions.**	
Objective 2	To conduct performance monitoring activities that gauge the system's effectiveness at providing timely access to routine specialty mental health appointments.
Goal 2	To ensure that all beneficiaries requesting a comprehensive assessment are offered an appointment within 10 business days.
Responsible Partners	Quality Services; Access Line team; SOC QICs; Performance Measurements
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include test calls, internal audit of contact logs, SSRS reports, and Medi-Cal key indicators. (Source Data: MKI Access #1, Contact Log/MATA #1)
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined
Goal 2.1	To ensure beneficiaries discharging from psychiatric hospitalization are given an outpatient appointment within 7 business days of discharge.
Responsible Partners	SOC QICs; Performance Measurements; Hospital Rate Committee
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include hospitalization reports, Medi-Cal key indicators, and SSRS reports. (Source Data: MKI Continuity of Care #1 & 3)
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined

Objective 2B	To conduct performance monitoring activities that gauge the system's effectiveness at providing timely access to services for urgent conditions.
Goal 2B	To ensure that all requests for urgent mental health services are responded to within 48 hours for services that do not require an authorization and within 96 hours for services that do require an authorization.
Responsible Partners	SOC QICs; Performance Measurements
Evaluation Methods/Tool(s)	Mechanism for monitoring services and activities is the Medi-Cal key indicators and SSRS reports. (Source Data: MATA #3-Timeliness to Urgent Services)
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined
Objective 2C	To ensure that beneficiaries are provided with information on how to access specialty mental health services after business hours, including weekends and holidays.
Goal 2C	To confirm that all MHP providers have after-hours telephone message systems that provides information in English and Threshold language(s) on how to access emergency and routine mental health services for BHRS.
Responsible Partners	Quality Services; SOC QICs
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include ongoing after-hours test calls and documentation of compliance to standards outlined in the After – Hours Policy and SSRS reports. . (Source Data: SSRS After Hours Report & Test Call Data)
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined
Objective 2D	To provide a Toll-Free Telephone Line that operates 24/7 and meets all required elements of the MHP contract.
Goal 2D	To ensure that the 24/7 Telephone Line provides information, in beneficiary's language of choice, on how to access specialty mental health services, beneficiary resolution process and responds to urgent conditions.

Responsible Partners	Quality Services; Access Line Team; Ethnic Services Manager
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include monthly test calls made throughout various times of the day and night with test callers following a script and presenting a myriad of problems varying in complexity, scope and requiring a response. Call details are logged, and the success of test calls is determined by the callers' ability to be directed to the appropriate services.
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined

3: MONITORING BENEFICIARY SATISFACTION (*Source: MHP*)	
• **Conducts and evaluates findings from satisfaction surveys.** • **Identifies areas of improvement as identified by beneficiary feedback and provides long term and short-term solution planning.** • **Conducts and evaluates findings from grievances/appeals/State Fair Hearings.**	
Objective 3	To conduct performance monitoring activities using mechanisms that assess beneficiary satisfaction with behavioral health services provided as an indicator of beneficiary and system outcomes.
Goal 3	To ensure beneficiaries are receiving excellence in behavioral healthcare services as indicated by satisfaction surveys. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.
Responsible Partners	Quality Services; SOC QICs; Performance Measurements
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include Consumer Perception Survey (youth, families of youth, adult, and older adult versions), dashboards, and survey results reports. (Source Data: MKI Beneficiary Satisfaction #1)
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined

Objective 3A	To conduct performance monitoring activities using mechanisms that assess the number of grievances (and their resolution), appeals and requests for State Fair Hearings. To analyze the nature of the causes for concern as an indicator of beneficiary and system outcomes.
Goal 3A	To ensure that beneficiary grievances, appeals, and requests for State Fair Hearings are being resolved expeditiously and appropriately within the MHP. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.
Responsible Partners	Quality Services; Patients' Rights
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include monthly reports on grievances, appeals and requests/outcomes for State Fair Hearings.
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined
4: MONITORING THE SERVICE DELIVERY SYSTEM FOR MEANINGFUL CLINICAL & ETHICAL ISSUES (*Source: MHP*)	
• **Monitors, anticipates and evaluates clinical aspects and implications of departmental policies, procedures, and actions.** • **Reviews clinical issues, quality of care, utilization and utilization management issues that surface as a result of chart review and program review.** • **Considers the ethical implications of departmental and staff activities.** • **Prepares reports of findings and recommendations for submission to the Quality Management Team (QMT).**	
Objective 4	To conduct performance monitoring activities of the safety and effectiveness of the service delivery system related to clinical and ethical issues in the Inpatient system of care.
Goal 4	To identify and address issues affecting quality of care through the review of findings from incident reports, Patients' Rights investigations, inpatient authorization review, and applicable root cause analysis proceedings. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.
Responsible Partners	SOC QICs, Medical Director, Compliance Officer, Quality Services, Patients' Rights Advocate
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include meeting minutes, QMT meeting minutes, applicable reports/dashboards, chart and on-site monitoring report summaries.

FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined
Objective 4A	To conduct performance monitoring activities of the mechanisms responsible for the safety and effectiveness in the Outpatient system of care.
Goal 4A	To identify and address issues which may affect the quality of care provided to beneficiaries, underutilization of services, overutilization of services and utilization management. To implement corrective measures as appropriate. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting consumer needs.
Responsible Partners	Medical Director, Quality Services, Compliance Officer, Utilization Management, and SOC Program Managers
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include meeting minutes, QMT meeting minutes, chart and on-site monitoring report summaries.
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined

5: MONITORING THE MHP SERVICE DELIVERY SYSTEM FOR THE SAFETY & EFFECTIVENESS OF MEDICATION PRACTICES (*Source: MHP*)	
• **Under the supervision of a person licensed to prescribe or dispense prescription drugs, evaluates and monitors the safety and effectiveness of medication practices.** • **Reviews cases involving medication issues and tracks medication issues over time.** • **Recommends and institutes needed actions involving medication procedures and policies.** • **Conducts Peer Reviews regarding medication practices.**	
Objective 5	To conduct performance monitoring activities of the mechanisms responsible for the safety and effectiveness of medication practices**.**
Goal 5	To obtain information regarding the safety and effectiveness of medication practices. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting consumer needs.

Responsible Partners	Medical Director, MD/RN Team; Quality Services
Evaluation Methods/Tool(s)	Mechanisms to monitor the safety and effectiveness of medication practices at least annually which include chart review summaries and reports that are inclusive of medications prescribed to adults and youth and are under the supervision of a person licensed to prescribe or dispense prescription drugs.
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined

6: MONITORING COORDINATION OF CARE BETWEEN THE MHP AND PHYSICAL HEALTHCARE AGENCIES (*Source: MHP*)	
• **Manages the continuity and coordination of care between physical health care agencies and the MHP across the department.** • **Develops department-wide processes to link physical health care into ongoing operating procedures.** • **Assesses the effectiveness and facilitates the improvement of MOU's with physical health care plans.**	
Objective 6	To conduct performance monitoring activities of the mechanisms responsible for enhancing continuity and increasing the coordination of care between the MHP and Physical Healthcare agencies/providers as an indicator of beneficiary and system outcomes.
Goal 6	Update MOU's with physical health plans in order to create a mechanism for exchange of information between BHRS & primary care with regards to individual client care. To enhance any additional continuity and coordination of care activities. To assess effectiveness of MOU with physical health care providers and revise as appropriate to improve the processes of providing care and better meeting consumer needs.
Responsible Partners	Medical Director; Privacy Officer; Quality Services
Evaluation Methods/Tool(s)	The completed draft of Health Plan of San Joaquin and Health Net MOUs, updated Coordination of Care policy, data reports, training sign in sheets, Coordination of Care protocol.
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined

7: MONITORING PROVIDER APPEALS (*Source: MHP*)	
• **Reviews provider appeals submitted to the utilization management department.** • **Evaluates the provider appeals process for efficiency and effectiveness.** • **Makes recommendations based on group findings and review of provider appeals that ensures equity and fairness in due process.**	
Objective 7	To conduct performance monitoring activities which review provider appeals and concerns on an ongoing basis as an indicator of the effectiveness of the provider appeal resolution process.
Goal 7	To provide an effective means of identifying, resolving and preventing the recurrence of provider concerns/appeals with the MHP's authorization and other processes. To continue to use this information to identify and prioritize areas for improving the processes of providing care.
Responsible Partners	Quality Services; Utilization Management; Managed Care QIC
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include Provider appeal log and provider appeal summaries.
FY 2022/2023 Evaluation	In Progress
Recommendations	To Be Determined

8: MONITORING MENTAL HEALTH NEEDS IN SPECIFIC CULTURAL GROUPS	
• **Assumes responsibility for ensuring trainings designed to enhance cultural competence are being offered.** • **Conducts outreach activities to unserved, underserved, inappropriately served, and minority populations.** • **Monitors the implementation of cultural competence plan goals.** • **Participates as necessary in other committee activities.**	
Objective 8	To conduct performance monitoring activities of the mechanisms used to identify access barriers among specified ethnic/cultural groups that are currently unserved, underserved or inappropriately
Goal 8	To evaluate the effectiveness of current outreach activities in engaging diverse cultural groups into mental health treatment. To review and monitor the provision of cultural competency trainings to providers. To continue using this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.

Responsible Partners	Ethnics Services Manager, Quality Services Manager; Performance Measurements; Cultural Competency Social Equality Justice Committee (CCESJC)
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include training reports, CCESJC meeting minutes, and dashboard/reports.
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined

9: PERFORMANCE IMPROVEMENT PROJECTS (PIP)	
• **Facilitates clinical and administrative PIP activities.** • **Uses data as a foundation for the PIP Implementation and Submission Tool.** • **Evaluates progress on PIP stages and reviews final reports.** • **Shares information about PIP activities with QMT that may be used in policy making.**	
Objective 9	To maintain two (2) active Performance Improvement Projects (PIPs); one (1) clinical and one (1) administrative, per fiscal year.
Goal 9	To complete the appropriate steps in the CAEQRO PIP Validation Tool for each PIP.
Responsible Partners	SOC QICs; PIP chairs; Quality Services
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include CAEQRO PIP summary reports and Implementation and Submission Tool.
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined

10: MONITORING QUALITY IMPROVEMENT AND DOCUMENTATION REVIEW
• **Reviews new regulations which may affect documentation issues** • **Works to build standardized procedures for new legislation when implemented in MHP.** • **Serves as a review body for audit results which go to appeal after the first plan of correction.**

Objective 10	To conduct performance monitoring activities using mechanisms that assess if all chart documentation and audit review findings are in congruence with State and Federal regulations.
Goal 10	To review all current chart documents for ease of use and to ensure appropriateness to Title 9, Medi-Cal, Managed Care and Federal requirements; make revisions based on new legislation and State guidance as needed. To enhance department quality improvement practices, infrastructure and QI work plan fidelity. To continue to use this information to identify and prioritize areas for improving the process of providing care and better meeting consumer needs.
Responsible Partners	Quality Services; Utilization Management; SOC managers
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include chart audits (peer review), treatment plan authorization review, and disallowance reports and/or suspended services for outpatient services and denied days for inpatient services, reports, and dashboards.
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined

11: CREDENTIALING AND MONITORING OF PROVIDERS	
• **Completes database checks of all providers.** • **Monitors providers at required intervals and follows guidelines for any negative reports for providers.** • **Follows appeal process for any corrective action taken against providers.**	
Objective 11	To conduct database checks in congruence with State and Federal regulations as an indicator of adherence to credentialing and monitoring standards.
Goal 11	To review all required databases for all providers at time of application/hire and at required intervals to identify any providers who are identified as not appropriate for providing care to beneficiaries. To monitor provider quality of treatment at appropriate intervals to identify any quality of care issues in order to ensure appropriateness for continued treatment of beneficiaries.
Responsible Partners	Human Resources; Quality Services; Utilization Management; SOC managers

Evaluation Methods/Tool(s)	Mechanisms for monitoring include National Plan and Provider Enumeration System (NPPES), National Practitioner Data Bank (NPDB), Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), Medi-Cal Suspended and Ineligible Provider List, Licensing board websites, chart audits (peer review), treatment plan authorization review, and disallowance reports and/or suspended services for outpatient services and denied days for inpatient services, reports, and dashboards.
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined
Objective 11A	To review the PAVE portal for all applicable licensed providers at time of application/hire and upon licensing of current unlicensed providers who will be or are for providing care to beneficiaries.
Goal 11A	To ensure all applicable licensed staff are enrolled in the DHCS Provider Application and Validation for Enrollment (PAVE) portal.
Responsible Partners	Human Resources; SOC managers; Quality Services
Evaluation Methods/Tool(s)	Mechanisms for monitoring include the PAVE open data portal on the DHCS website, screenshots of provider portals showing completion of applications, and copies of the DHCS approval letters.
FY 2023/2024 Evaluation	In Progress
Recommendations	To Be Determined