Behavioral Health and Recovery Services (BHRS)

Quality Assessment & Performance Improvement (QAPI) Program:

Quality Improvement (QI) Program Description and Work Plan

2021-2022

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Quality Improvement (QI) Program Description 2021-2022

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. Cultural Competency, Equity and Social Justice Committee (CCESJC)

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 CCESJC.
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 managed and overseen by the Strategic Implementation Team 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: 2020-2021 and 2021-2022

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) ***2020-2021 and 2021-2022***. 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 2020-2021*** *(pg.16-48)*. The last section summarizes the QI Work Plan goals and objectives for the current ***FY 2021-2022*** *(pg.49-59).*

Quality Improvement (QI) Work Plan FY 2020-2021: Objectives, Goals, and Evaluation

<table>
<tr><td colspan="2">1: MONITORING THE SERVICE CAPACITY AND SERVICE DISTRIBUTION OF THE MHP (Source: MHP)</td></tr>
<tr><td colspan="2">

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).

</td></tr>
<tr><td>Objective 1</td><td>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.</td></tr>
<tr><td>Goal 1</td><td>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.</td></tr>
<tr><td>Responsible Partners</td><td>SOC QICs; Performance Measurements (OEM)</td></tr>
<tr><td>Evaluation Methods/Tool(s)</td><td>Mechanisms for monitoring services and activities include data dashboards. (Source Data: SSRS 1627)</td></tr>
<tr><td>FY 2020/2021 Evaluation</td><td>During the FY 20-21, 100% of beneficiaries were located within 30 miles or 60 minutes of a mental health provider. Of the 6,260 unduplicated clients served 11.5% were served in Ceres, 10.3% on the Eastside, 55.3% in Modesto, 15.4% in Turlock, and 7.6% on the westside.
<table>
<tr><th>LOCATION SERVED</th><th>PERCENTAGE SERVED</th></tr>
<tr><td>Ceres</td><td>11.5%</td></tr>
<tr><td>Eastside</td><td>10.3%</td></tr>
<tr><td>Modesto</td><td>55.3%</td></tr>
<tr><td>Turlock</td><td>15.4%</td></tr>
<tr><td>Westside</td><td>7.6%</td></tr>
<tr><td>Total</td><td>100%</td></tr>
</table>
</td></tr>
<tr><td>Recommendations</td><td>Stanislaus County BHRS will continue to serve beneficiaries and meet time and distance standards.</td></tr>
</table>

<table>
<tr><th colspan="2">2: MONITORING TIMELY ACCESS FOR ROUTINE AND URGENT SERVICE NEEDS (Source: MHP)</th></tr>
<tr><td colspan="2">

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.

</td></tr>
<tr><td>Objective 2</td><td>To conduct performance monitoring activities that gauge the system's effectiveness at providing timely access to routine specialty mental health appointments.</td></tr>
<tr><td>Goal 2</td><td>To ensure that all beneficiaries requesting a comprehensive assessment are offered an appointment within 10 business days.</td></tr>
<tr><td>Responsible Partners</td><td>Quality Services; Access Line team; SOC QICs; Performance Measurements</td></tr>
<tr><td>Evaluation Methods/Tool(s)</td><td>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)</td></tr>
<tr><td>FY 2020/2021 Evaluation</td><td>During FY20/21, BHRS tracked and monitored offered and scheduled appointments when a comprehensive assessment was requested. Below are the data for both offered and scheduled appointments.

Beneficiaries requesting a comprehensive assessment are offered an appointment within 10 business days:

<table>
<tr><th>System of care (SOC)</th><th>Percentage OF Offered APPT W/IN 10 BUSINESS DAYS</th></tr>
<tr><td>Adult SOC*</td><td>98% (723/740)</td></tr>
<tr><td>Children SOC</td><td>94% (1623/1719)</td></tr>
<tr><td>Older Adult SOC</td><td>98% (43/44)</td></tr>
</table>
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</table>

FY 2020/2021 Evaluation

Beneficiaries requesting a comprehensive assessment are scheduled an appointment within 10 business days:

System of care (SOC)	Percentage OF *SCHEDULED* APPT W/IN 10 BUSINESS DAYS
Adult SOC*	98% (723/740)
Children SOC	94% (1623/1719)
Older Adult SOC	98% (43/44)

*Includes Forensics

Recommendations

During the FY 21/22, BHRS will continue to track and monitor the offered and scheduled appointments. To better monitor and track these areas the recommendation continues to be to update the Contact Log, and staff will be (re-) trained to ensure these areas are monitored appropriately.

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 2020/2021 Evaluation

During FY 20-21, 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"

SOC/Population	***English speaking***	***Limited English speaking***
Adult	83% (574/692) Avg # of days: 5	85% (17/20) Avg # of days: 4
Children	95% (208/219) Avg # of days: 3	100% (10/10) Avg # of days: 2
Forensic	88% (57/65) Avg # of days: 4	100% (1/1) Avg # of days: 2
Older Adult	87% (34/39) Avg # of days: 4	100% (1/1) Avg # of days: 4

Recommendations	For FY 21-22 BHRS will continue to track and monitor that beneficiaries discharging from psychiatric hospitalization are given an outpatient appointment within 7 business days of discharge.
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 2020/2021 Evaluation	This is the first FY of full data that reflects the 48/96-hour standard. BHRS's standard is to meet the 48-hour timeframe whether the urgent service requires prior authorization or not. BHRS was collecting and reporting urgent appointment to encounter data using days (2 days) rather than hours (48 hours). The methodology was changed after the 2019 EQRO review to address the Timeliness Recommendation #3. The change required a revision to the data collection form in the EHR and additional training, so the methodological change went into effect January 2020. BHRS is not tracking urgent appointments that required prior authorization separately. See data table below.

FY 2020/2021 Evaluation	

Urgent Services – 48 Hour Standard for all Urgent Services				
	All Services	**Adult Services**	**Children's Services**	**Foster Care Services**
Hours from urgent request (that do not require prior authorization) to *first offered appointment* *Please report in decimals rather than minutes (e.g. "1.25" rather than "1 hour 15 minutes")*	4.6 Average Hours 1 Median Hours Range 1 to 115 hours	11 Average Hours 1 Median Hours Range 1 to 115 hours	1.9 Average Hours 1 Median Hours Range 1 to 15 hours	1 Average Hours 1 Median Hours Range 1 to 1 hours
DHCS standard	48-Hours			
Count of urgent service requests (not requiring prior authorization)	31	13	7	11
Count of offered appointments that met this standard	29	11	7	11
Percent of services that met this standard	94%	85%	100%	100%

Recommendations	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.
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.

<table>
<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 2020/2021 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. BHRS contracted with a new answering service that began providing their services in November 2020. Regular quality review is conducted, and weekly calls are scheduled with the answering service to review areas of improvement. The answering service has had turnover recently and is working to increase staffing and training on these requirements. BHRS staff are provided feedback on test call results in order to improve outcomes.
<table>
<tr><td>TEST CALL CATEGORY</td><td>% REQUIREMENT MET</td></tr>
<tr><td>Info about Accessing SMHS</td><td>50%</td></tr>
<tr><td>Info about Urgent services</td><td>N/A</td></tr>
<tr><td>Info about Prob Res & SFH</td><td>0%</td></tr>
</table>
</td></tr>
</table>

FY 2020/2021 Evaluation

BHRS also documented 1,291 after-hour services for FY 20-21. 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 2020-2021

Sub Unit: 1009 - MH - OP - Total Billing Type A Services:	1
Sub Unit: 1301 - MH - Intensive - Total Billing Type A Services:	6
Sub Unit: 3002 - MH - ACT - Total Billing Type A Services:	90
Sub Unit: 3003 - MH - Intensive - Total Billing Type A Services:	4
Sub Unit: 3011 - MH - ACT - Total Billing Type A Services:	56
Sub Unit: 3012 - MH - Intensive - Total Billing Type A Services:	6
Sub Unit: 3053 - MH - ACT - Total Billing Type A Services:	7
Sub Unit: 3120 - MH - Access/Engagement - Total Billing Type A Services:	12
Sub Unit: 3122 - MH - ACT - Total Billing Type A Services:	354
Sub Unit: 3802 - MH - Other - Total Billing Type A Services:	2
Sub Unit: 4609 - MH - ACT - Total Billing Type A Services:	54
Sub Unit: 4610 - MH - Intensive - Total Billing Type A Services:	70
Sub Unit: 4611 - MH - Wellness - Total Billing Type A Services:	11
Sub Unit: 6602 - MH - ACT - Total Billing Type A Services:	19
Sub Unit: 6603 - MH - ACT - Total Billing Type A Services:	32
Sub Unit: 6604 - MH - ACT - Total Billing Type A Services:	44
Sub Unit: 6612 - MH - Access/Assessment - Total Billing Type A Services:	501
Sub Unit: 6614 - MH - ACT - Total Billing Type A Services:	4
Sub Unit: 6619 - MH - Intensive - Total Billing Type A Services:	10
Sub Unit: 6630 - MH - Inpatient - Total Billing Type A Services:	2
Sub Unit: 6802 - MH - Intensive - Total Billing Type A Services:	1
Sub Unit: 9601 - MH - Intensive - Total Billing Type A Services:	4
Sub Unit: 9602 - MH - Wellness - Total Billing Type A Services:	1
Total	1,291

<table>
<tr><td>Recommendations</td><td>BHRS will continue to ensure that beneficiaries are provided with information on how to access specialty mental health services after business hours, including weekends and holidays. BHRS contracted with a new answering service that began providing their services in November 2020. Regular quality review is conducted, and weekly calls are scheduled with the answering service to review areas of improvement. The answering service has had turnover recently and is working to increase staffing and training on these requirements. BHRS staff are provided feedback on test call results in order to improve outcomes.</td></tr>
<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 2020/2021 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.
<table>
<tr><td>TEST CALL CATEGORY</td><td colspan="3">% REQUIREMENT MET</td></tr>
<tr><td></td><td>Business Hours</td><td>After Hours</td><td>Combined</td></tr>
<tr><td>Language Capabilities</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Info about Accessing SMHS</td><td>78%</td><td>50%</td><td>65%</td></tr>
<tr><td>Info about Urgent Services</td><td>N/A</td><td>N/A%</td><td>N/A%</td></tr>
<tr><td>Info about Prob Res & SFH</td><td>100%</td><td>0%</td><td>50%</td></tr>
</table></td></tr>
</table>

Recommendations	BHRS contracted with a new answering service that began providing their services in November 2020. Regular quality review is conducted, and weekly calls are scheduled with the answering service to review areas of improvement. The answering service has had turnover recently and is working to increase staffing and training on these requirements. BHRS staff are provided feedback on test call results in order to improve outcomes.

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 2020/2021 Evaluation	Typically, BHRS conducts Consumer Perception Survey twice a year, but due to the COVID-19 crisis, the survey was conducted once this year. BHRS conducted the Consumer Perception Survey in Spring of 2021. During the FY 20/21, surveys were received with the following percentage stating they were satisfied with services:

	FY17/18	FY18/19	FY19/20	FY20/21
Adult	82%	90%	93%	99%
Older Adult	85%	98%	97%	86%
Forensics	83%	96%	89%	85%
Child/Family	83%	91%	91%	94%

<table>
<tr><td>Recommendations</td><td>BHRS will continue to conduct Consumer Perception Surveys to ensure beneficiaries are satisfied with services.</td></tr>
<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 2020/2021 Evaluation</td><td>BHRS has processed 100% of grievances, appeals, and state fair hearings timely for FY 20-21. BHRS has also reported out quarterly 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 zero (0) Expedited Appeals for FY 20/21. There were two (2) Appeals for FY 20/21 which were all processed within DHCS timeliness standards. Of these 2 Appeals, 1 was upheld and 1 was overturned.
There was a total of 27 Medi-Cal Grievances for FY 20/21 which was fewer than the amount from FY 19/20 (80) in which a specific beneficiary utilized the Problem Resolution Process as a coping mechanism.

The following is the grievance data for FY 20/21:

<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>9</td><td>2</td><td>15</td><td>1</td><td>27</td></tr>
<tr><td>Other</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</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>9</td><td>2</td><td>15</td><td>1</td><td>27</td></tr>
</table>
</td></tr>
</table>

FY 2020/2021 Evaluation

The following is the grievance data for FY 20/21 continued:

Severity	Q1	Q2	Q3	Q4	Totals
Appropriate Practice/Care	4	3	12	1	20
Opportunity to Improve	1	3	2	1	7
Unknown	0	0	0	0	0
Significant Deviation from Std	1	0	0	0	1
Total	6	6	14	2	28

Complaint Category	Q1	Q2	Q3	Q4	Totals
Staff Behavior	4	0	2	0	6
Medication Concerns	0	1	1	0	2
Access/Accessibility	1	0	0	0	1
Confidentiality Concern	1	0	1	0	2
Treatment Issues	0	0	1	1	2
Other Quality of Care	1	0	3	0	4
Financial	1	0	0	0	1
Operational	0	0	6	0	6
Peer Behavior	1	0	0	0	1
Patient Rights	0	1	0	0	1
Physical Environment	0	0	0	0	0
Lost Patient Property	0	0	0	0	0
Other	0	0	1	0	1
Totals	9	2	15	1	27

FY 2020/2021 Evaluation

The following is the grievance data for FY 20/21 continued:

Complaint By SOC	Q1	Q2	Q3	Q4	Totals
ASOC/OASOC	2	1	1	0	4
CSOC	0	0	0	0	0
Forensics	0	0	1	0	1
SUD	6	0	13	1	20
Consumer & Family Affairs	0	0	0	0	0
Managed Care	1	0	0	0	1
BHRS/QS	0	0	0	0	0
BHRS	0	1	0	0	1
Totals	9	2	15	1	27

Complaint by Disposition	Q1	Q2	Q3	Q4	Totals
Satisfied/Resolved	2	3	2	1	8
Unable to Contact Client	2	0	6	1	9
Dissatisfied/Not Resolved	0	1	0	0	1
Unknown	0	1	0	0	1
Withdrawn	2	1	6	0	9
Totals	6	6	14	2	28

Recommendations

BHRS will continue to ensure that beneficiary grievances, 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 2020/2021 Evaluation	***BHRS Risk Management:*** 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 2020, there were a total of 190 Incident Reports (including Adverse Incident). As of September 14, 2021, there have been 64 Incident Reports. **Total # of Incident Reports per year:**

Year	2017	2018	2019	2020	2021 (As of Sept. 14, 2021)
# of Incident Reports	357	334	298	190	64

Over the past 5 years, the number of incident reports has been decreasing.

FY 2020/2021 Evaluation

BHRS Risk Management Continued:

# of Incidents by Incident Type for 2020:

Incident Type	# of Incidents for 2020
Client Injury (Excluding Falls)	2 (1%)
Deaths	22 (12%)
Falls	6 (3%)
Inappropriate Behaviors	2 (1%)
Medical Care Issues	38 (21%)
Medication Errors	33 (17%)
Property Loss/Damage	18 (9%)
Security Related	41 (22%)
Visitor/Other Injury (None-Employee)	1 (0%)
Other	27 (14%)
Total	190

2020/2021 Inpatient Chart Reviews:

BHRS's Utilization Management program has a pilot process set up to review inpatient documentation on a concurrent basis. This process will be utilized until DHCS provides further guidance. Hospitals are asked to fax inpatient documentation for review and authorization Monday through Friday. The UM reviewers provide daily feedback to assist with meeting documentation standards for medical necessity of the services provided to decrease the amount of denied days for hospitals stays. Quality of care issues are addressed with the hospital's utilization review departments designee, during the hospital rate meeting, and QMT meetings. These meetings include the medical director, compliance officer, senior leaders, and system of care (SOC) managers.

Recommendations

BHRS will continue to monitor its service delivery system. One area of focus and improvement that will be continued for FY 21/22 is the processing and reporting out of adverse incidents. This will also lead to re-establishing the root cause analysis process and oversight committee. BHRS has struggled with being consistent with this process, and due to COVID it wasn't addressed in 20/21, yet understands the value it can bring to meaningful discussions about clinical and ethical issues.

In addition, BHRS will continue to review inpatient documentation on a concurrent review basis according to our pilot process until DHCS provides further guidance. BHRS will continue to provide support to hospitals with regard to documentation standards set forth by Title 9 and Informational Notice 19-026.

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 2020/2021 Evaluation	BHRS conducted monthly mental health chart audits for FY 20/21 for a total of 30 programs audited. All MH programs were reviewed to ensure appropriateness to Title 9, Medi-Cal, Managed Care and Federal requirements. In effort to monitor documentation standards, assessments, progress notes, and treatment plans are reviewed for medical necessity. If it is 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) so all programs were identified as needing improvement in documentation. See below for the overall program compliance scores for each program audited in the 20/21 MH Peer Review.

FY 2020/2021 Evaluation

Below are the overall program compliance scores for each program audited in the 20/21 MH Peer Review:

SubUnits	Overall Compliance Score
5601	97%
5617	96%
1204	99%
1208	99%
1209	96%
1211	96%
1003	94%
1005	98%
1006	91%
7601	95%
6604	88%
5203	98%
1601	89%
1602	89%
1610	96%
5002, 6603, 6605, 6607, 6614, 6619	85%
6402	84%
5604	97%
5613	92%
3002, 3004, 3006, 3010, 3011, 3012	81%

In addition to documentation standards, authorizations are reviewed by the Utilization Management (UM) team to ensure regulations are adhered to. If it is determined a correction needs to be made to the authorization, the UM team will make the correction at that time. In 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.

Recommendations

BHRS will continue to focus on this area and Peer Review results will be reported out 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 2020/2021 Evaluation	BHRS monitors the safety and effectiveness of medication practices at least once annually but had scheduled quarterly MD/RN chart reviews to monitor and obtain information regarding the safety and effectiveness of medication practices. This year, BHRS implemented an electronic chart review process to allow more detailed reporting to the Medical Director and Quality Services related to medication monitoring practices and staff performance. Due to problems with the electronic surveys, reviews for Q3 and Q4 were cancelled to allow time for maintenance on the electronic surveys. BHRS was able to conduct reviews on July 8, 2020 (Q1) and December 9, 2020 (Q2). See results below

FY 2020/2021 Evaluation	The results are as follows: **Q1:** Charts requested: 45 Charts reviewed: 45 # of staff reviewed: 25 Charts requiring corrections/follow-up: 24 # of staff responsible for corrections/follow-up: 20 Orders/Labs/Etc. Subscale Compliance score: 84% Medication Progress Notes Subscale Compliance score: 98% Overall Score: 91% **Q2:** Charts requested: 64 Charts reviewed: 54 # of staff reviewed: 30 Charts requiring corrections/follow-up: 46 # of staff responsible for corrections/follow-up: 28 Orders/Labs/Etc. Subscale Compliance score: 72% Medication Progress Notes Subscale Compliance score: 95% Overall Score: 83%
Recommendations	Recommendations: BHRS will continue to schedule quarterly MD/RN chart reviews to collect and analyze data for the medication monitoring process. BHRS Medical Director will identify areas of improvement in order to provide additional guidance to medical staff.

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 2020/2021 Evaluation	BHRS monitors program staff contact with client's Primary Care Physician (PCP) through its Medi-Cal Key Indicators (MKI). Last year (19/20) the PCP Steering Committee changed the goal for PCP contact on the MKIs from 45% to 75% so the goal would reflect higher expectations for the coordination of care and to align with the goal the PCP Committee has set. For FY 19/20, the process of contacting the PCP was changed substantially. Programs are continuing to follow the new process, but the department continues to work on developing the data collection and reporting process. The new PCP Contact form in the EHR continues to be utilized by programs. After the initial implementation, the EHR form and monitoring process was re-evaluated to more accurately collect, monitor, and report data. The data extraction and reporting is still being revised due to the impacts of the COVID-19 pandemic. Once the revised form and reporting is implemented, BHRS will be able to track and monitor PCP contact that is currently occurring more accurately. For FY 20/21 due to the impacts of COVID-19, BHRS continues to work on developing in this area.
Recommendations	Complete new PCP reporting mechanisms and updates to the EHR form for improved monitoring of 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 2020/2021 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. There was an increase in the number of appeals processed for FY 20-21 (634) from previous FY 19/20 (540). There has been an increase in the number of hospitalizations during this year as well as a lack of availability in placement options due to the COVID-19 pandemic, which could be the reasons for the increase in the number of appeals.
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 2020/2021 Evaluation	Facing long-term systemic fiscal and community mental health need challenges and realizing the emerging opportunities with the implementation of CalAIM and other State historic behavioral health investments, BHRS developed a Strategic Plan that aligns program operations and services with sustainable funding. The Strategic Plan outlines BHRS's behavioral health services, organizational restructure, and fiscal resources to fulfill the mandated behavioral health plan role in the community of Stanislaus County. Mental health and substance use and addiction are central to the community's dialogue in addressing issues such as homelessness, crime, and the long-term impacts of COVID-19 on mental health. Central to the Strategic Plan is the development of the Core Treatment Model (CTM) framework, which is a primary strategy to strengthen treatment capabilities as well as navigate the pathway to fiscal sustainability. The CTM clearly describes the population BHRS is mandated to serve and the expected outcomes as a result of treatment services. The CTM applies to both mental health and substance use disorders. The BHRS Strategic Plan outlined actions to ensure core cultural competency initiatives, such as CLAS standards, cultural competency training, diverse workforce, etc., are integrated in the restructured systems of care. The Strategic Plan also outlines the role of CCESJC in further developing the integration of the CLAS standards and strengthen our partnerships with diverse community collaboratives providing input and insight into how BHRS services diverse and ethnic communities.

FY 2020/2021 Evaluation	The Department continued to nurture our partnerships with diverse community stakeholders through the development of cultural collaborative partnerships with the Assyrian, faith-based organizations, Latino, National Association for the Advancement of Colored People (NAACP), Southeast Asian, Lesbian Gay Bisexual Transgender and Queer (LGBTQ) and other diverse communities. These partnerships, supported by the Prevention & Early Intervention Division, have continually provided overall community feedback to the Department on the further development of the local behavioral health system to meet the needs of Stanislaus County's diverse communities, and integrating community practice into current treatment programs. Our efforts to be culturally competent are also reflected in our updated Mental Health Services Act (MHSA) updated plan: • Continued technical support and funding for the Promotora Program for Prevention and Early Intervention. The program works at the community level to provide social support and guidance for individuals who may be isolated or in need of services. Promotoras are trusted community members who are able to facilitate referrals to mental health services. • The department expanded the Promotora model and approach by developing the Community Collaborative Plan that expands MHSA small/micro funding opportunities for diverse community partners to implement PEI strategies, such as Outreach for Increasing Recognition of Early Signs of Mental Illness and Access & Linkage to appropriate mental health services, that target Mental Health Services Act (MHSA) priority populations. These funding opportunities range from a $2,000 to $20,000. In addition, the department will work with key PEI Community Collaborative (PEICC) partners to facilitate community conversations with peers/consumers and strengthening access to treatment services strategies. The PEICC partners supported the department and the overall County outreach efforts to diverse communities through Covid-19 for both accessing mental health services and Covid-19 related information. The performance of some of the PEICC has led to other County Departments and organizations to explore how to integrate the Department's Promotores/Community Health Outreach model into their services. The PEICC include but not limited to: ○ Stanislaus Asian America Community Resources ○ LGBTQ Collaborative ○ National Association for the Advancement of Colored People Assyrian Wellness Collaborative ○ Jakara Movement ○ Peer Recovery Art Project ○ Khmer Youth of Modesto

FY 2020/2021 Evaluation	○ MJC Latina + LGBTQ ○ MoPRIDE ○ Faith-based Sector ○ Promotores ○ Youth Empowerment Program ○ Community-based Continuum of Care Project In FY 2019/2020, the CCESJC developed recommendations for the Principle CLAS Standard. As part of the planning process the CCESJC was educated on the core treatment services outlined in the Mental Health Plan contract with the State of California. BHRS provided this education to ensure a shared understanding on what treatment entails so the CCESJC could provide applicable recommendations on the Principle CLAS Standard. The education on the core treatment services and Principle Class Standard and subsequent brainstorming and discussion primarily unfolded before the COVID-19 emergency was declared. Given the Department did not have a projected timeline when the safety measures would be lifted, allowing for in-person gatherings, the CCESJC decided to create a list of recommendations that could be implemented quickly. The CCESJC realizes that the initial recommendations do not include strategies that address all of the issues raised in the discussion. However, the committee developed these recommendations to provide the Department options for quick actions, even as the pandemic limited the ability for the committee to plan further. The recommendations were endorsed by CCESJC in their meeting on September 13, 2020 and submitted to the BHRS Senior Leadership for implementation planning. These recommendations were included in the Strategic Plan and will be included in benchmarks for program development planning. The CCESJC will play an active role in the implementation process as well. In 2020/2021 the CCESJC reviewed program data throughout the year to review impacts related to Covid-19 and any potential impacts specific to diverse community populations. The LGBTQ representatives highlighted that the Departments' and program reports did not include Sexual Orientation, Gender Identity data (SOGI). Although the department has increased some capabilities to collect and report on SOGI data, the CCESJC recommended incorporating targeted activities to increase SOGI data collection and reporting capabilities. The Department will respond to this stakeholder advocacy by develop plans to incorporate SOGI data collection capacity-building as part of the BHRS Strategic Plan data and outcomes planning.

FY 2020/2021 Evaluation	Currently BHRS is continuing to recruit for the Ethnic Services Manager position. When the ESM is hired, the priority is to implement the Introduction to Cultural Competency training in addition to the implementation of the Principle CLAS Standard recommendations. The ESM will be responsible for ensuring BHRS meets cultural and linguistic competence standards in the delivery of community-based mental health services, including Medi-Cal specialty mental health services, and Mental Health Services Act services. The ESM will promote and monitor 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 Cultural Competence Program, currently in draft form due to Covid-19 staffing impacts, will have training requirements delineated. The requirements will be part of the employee evaluation process to ensure staff continues to take trainings to enhance understanding of cultures. The department completed a Strategic Planning process that led to a substantive restructuring of treatment programs. These two policies will be implemented as part of the departments Strategic Plan implementation. • Welcoming Framework BHRS, including management, staff, and providers, will be committed to creating and sustaining a welcoming environment designed to support recovery and resiliency for individuals seeking services, and their families. Our intent is to let individuals and family members know that they are "in the right place" regardless of when and where they arrive for support services. • Translation of Written Materials BHRS is committed to honoring diversity and to ensuring culturally and linguistically competent services. The California Department of Mental Health requires that beneficiaries whose primary language is a threshold language have services available to them in their primary language. Where a need is demonstrated that translation of written materials into other languages is critical to client care, every effort will be made to accommodate the need.

FY 2020/2021 Evaluation

Listed below are data elements for FY20/21 related to different cultural groups:

The percentage of total clients served (unduplicated) by Race/Ethnicity for FY 20/21:

Race/ethnicity	**FY20/21**
African-American	7.2%
Asian	3.2%
Native American	0.9%
White American	37%
Other/Unknown	51.6%
Hispanic Origin	
Hispanic	44.6%
Not Hispanic/Latino	49.8%
Unknown/Not Reported	5.6%

The percentage of total client served (unduplicated) by age for FY20/21:

Age Group	**FY20/21**
0-17	38.5%
18-59	55%
60+	6.5%

The client retention rate for FY20/21 by ethnicity:

	FY20/21
Overall	73%
African-American	77%
Asian /Pacific Islander	74%
Hispanic	74%
Native American	73%
White American	74%
Other	60%

FY 2020/2021 Evaluation

Listed below are data elements for FY20/21 related to different cultural groups continued:

BHRS Staff Race/Ethnicity composition for FY20/21:

Race/ethnicity	County Population	Overall Staff	Admin/Mgmt	Direct Services	Support services	NA
Asian	5.1%	7.6%	11.3%	7.8%	8.3%	10.0%
Black/African American	2.4%	5.8%	4.2%	6.8%	3.8%	6.7%
Native American/Alaska Native	0.4%	0.9%	0%	1.1%	0.8%	0%
Hispanic	42.6%	36.4%	33.8%	34.6%	40.6%	20.0%
White	38.9%	42.2%	43.7%	42.4%	41.4%	60.0%
Other/Unknown	10.7%	7.1%	7.0%	7.3%	5.3%	3.3%
TOTAL	530,561	536	71	370	133	30

Recommendations

BHRS will continue to recruit an ESM in order to monitor this area fully.

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 2020/2021 Evaluation	During the October 2020 MH EQRO, Stanislaus County Behavioral Health and Recovery Services (BHRS) had two active PIPs that were reviewed. These PIPs came to an end in FY 20/21. Stanislaus County BHRS understands the requirement of having two active Performance Improvement Projects (PIP's); however, the onset of COVID-19 prompted some unforeseen barriers that posed significant challenges departmentwide and imposed significant limitations in our ability to fulfill this obligation in tandem with maintaining the continuity of care for our beneficiaries and ensuring the safety and well-being of our workforce. A primary identified barrier was the lack of staffing capacity to participate in PIP activities, as low-staffing capacity was invariable throughout the department. Client care during the height of the COVID-19 Pandemic was placed at the highest-priority and spearheaded an expansion effort consistent with mitigating historical barriers and access to care for our beneficiaries. The Executive and Senior Leadership Team were instrumental in the ability to pivot and implement a viable plan moving forward to have two active Mental Health PIP's. In lieu of the COVID-19 Pandemic, the department explored enlisting a Consulting Firm to provide Project Management with the intended goal of leading the MH PIP's. However, the department determined enlisting a consulting firm would not be a viable option as the department stakeholders hold the fund of knowledge as to our beneficiaries and data compilation.

FY 2020/2021 Evaluation	As of July 1, 2021, Stanislaus County, BHRS developed a new program, Strategic Implementation Team comprised of a Manager III, Manager II, and a Program Coordinator. The impetus of the Strategic Implementation Team was determined to be conducive to the BHRS Strategic Plan, therein making behavioral health and substance abuse services available and streamline access to our beneficiaries while mitigating historical barriers to access treatment services. The Strategic Implementation Team acts as a liaison and yields project management support to the Executive and Senior Leadership Team in the following areas: ➢ Tracking department-wide needs and supports to foster strategic problem solving amongst the leadership team. ➢ Facilitate and Prepare State Governed Audit Activities as well as internal audit activities i.e. Performance Improvement Projects (PIP's) and Quality Improvement Committees. ➢ Develop innovative approaches to complex department obstacles. ➢ Participate in department workgroup meetings designed to put into operation new state and federal regulations that pose impacts across department systems and contract partners. The new MH Non-Clinical and Clinical PIP topics have been identified to date; however, the AIM statements will need to be developed and can be considered within the conceptual phase at this time.
Recommendations	Stanislaus County BHRS's Strategic Implementation Team will work with the PIP committees to ensure the current MH Clinical and Non-Clinal PIPS become active for FY 21/22.

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 2020/2021 Evaluation	BHRS conducted chart audits related to medication monitoring for FY20/21. A total of 99 charts across 30 staff were audited. All medical staff were reviewed to ensure appropriateness to Title 9, Medi-Cal, Managed Care and Federal requirements. For FY20-21 the overall department compliance score was 87%. BHRS conducted monthly mental health chart audits for FY 20/21 for a total of 30 programs audited. All MH programs were reviewed to ensure appropriateness to Title 9, Medi-Cal, Managed Care and Federal requirements. In effort to monitor documentation standards, assessments, progress notes, and treatment plans are reviewed for medical necessity. If it is 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) so all programs were identified as needing improvement in documentation.

FY 2020/2021 Evaluation

Below are the overall program compliance scores for each 20/21 MH Peer Review:

SubUnits	Overall Compliance Score
5601	97%
5617	96%
1204	99%
1208	99%
1209	96%
1211	96%
1003	94%
1005	98%
1006	91%
7601	95%
6604	88%
5203	98%
1601	89%
1602	89%
1610	96%
5002, 6603, 6605, 6607, 6614, 6619	85%
6402	84%
5604	97%
5613	92%
3002, 3004, 3006, 3010, 3011, 3012	81%

In 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.

FY 2020/2021 Evaluation	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 of the MH authorizations. During this time UM audited the same charts during the peer review process for each of the selected programs with a total of 7 audits. All MH health programs were reviewed for accuracy in entering of the authorizations and adhering to Title 9, Medi-cal, Managed Care and Federal requirements. Out of the 7 audits 5 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 continues to conduct review of all annual and subsequent authorizations during the treatment plan annual review to ensure all regulations are being met.
Recommendations	BHRS will continue to monitor this area. BHRS Quality Services will continue to facilitate monthly MH program peer reviews and at least annual MD/RN peer reviews to assure accuracy in documentationBHRS UM staff will collaborate with DOTS program to review possibilities of changing the process of the manual auditing to an electronic process. Due to continued staff changes and the COVID-19 pandemic there was no progress. However, this will continue to be a recommendation and UM will work on this project. BHRS UM will continue to monitor and conduct monthly authorization audits in collaboration with QS. BHRS UM will also continue to provide support around treatment plans and authorizations.

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 2020/2021 Evaluation	BHRS/HR has implemented Policy & Procedure (P&P) 60.2.129 - Monitoring and Verification of BHRS Employees and Organizational Contractor Providers' Eligibility to Participate in Federal Health Care Programs. This policy outlines the following processes: 1. New Hires - Prior to hire, as part of background, OIG, LEIE, and Licensure status are checked for each candidate, which includes exclusion from hire if candidate is found to be on any exclusion database list and/or with an invalid/cancelled registration/license with the CA Dept of Consumer Affairs Board. Evidence of these checks are documented on our internal document, New Employee Appointment Form (NEAF), which is placed in the employee's personnel file. 2. Monthly Checks – All staff are subject to monthly checks to determine if they are listed within the OIG, LEIE, and/or if registration/licensure is current and valid with the CA Dept of Consumer Affairs Board. Evidence of these checks is conducted and documented by HR. 3. Access to the National Practitioner Data Bank (NPDB) has not yet established, although it is in the process of being finalized and is part of the P&P 60.2.129. Any violation, meaning if the employee is found to be on any exclusion list and/or registration/licensure status has been deemed invalid/cancelled, will immediately result in the employee being restricted from claiming, deactivated from the EHR, and investigated for any appropriate corrective action and/or disciplinary action. NPPES is maintained within our Electronic Health Record which is maintained by our IT division (Data Outcomes and Technology Services (DOTS) Held Desk). All BHRS clinical staff requesting accessing to the EHR supply their NPI on the Jira ticket request which is submitted to DOTS. This NPI is verified for each staff requesting access on the NPPES NPI Registry https://npiregistry.cms.hhs.gov/registry/ and then inputted into the Billing Parameters field of the Staff Maintenance Record.

FY 2020/2021 Evaluation	During the monthly peer review audits as well as the annual treatment plan reviews credentials are reviewed and if it is identified that credentials are missing from our EHR documentation, UM contacts the program/staff directly. UM recommends the program/staff to contact our IT department to address this issue immediately and Quality Services gets notified to follow up with the program/staff. Managed Care checks monthly on Medi-Cal Suspend and Ineligible Provider List on the Medi-Cal DHCS web site when the provider submits Fee For Service (FFS) claims to Managed Care for processing of payment to ensure that the provider is not on the Suspend list. If a provider is found to be on the Suspend list, claims will not be processed for payment and a letter is sent to the provider for denial of payment. When Credentialing or Re-Credentialing a provider, MD license is checked on the CA Breeze web site to ensure that the MD is current before any claims are processed for payment.
Recommendations	Access to the National Practitioner Data Bank will be completed by end of year (2021). BHRS will continue to reach out to neighboring counties or outside entities for assistance. All other processes in P&P 60.2.129 will be continued. Develop a process to monitor, track, and address "missing credentials" to reduce the instances where credentials are not being stamped and are missing from our EHR.

Quality Improvement (QI) Work Plan FY 2021-2022:
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 2021/2022 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 2021/2022 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 2021/2022 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 2021/2022 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 2021/2022 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 2021/2022 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 2021/2022 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 2021/2022 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 2021/2022 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 2021/2022 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 2021/2022 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 2021/2022 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 2021/2022 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 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 2021/2022 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 2021/2022 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 2021/2022 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 2021/2022 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 2021/2022 Evaluation	In Progress
Recommendations	To Be Determined