Behavioral Health and Recovery Services (BHRS)

Quality Assessment & Performance Improvement (QAPI) Program:

Quality Improvement (QI) Program Description and Work Plan

2023-2024

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Quality Improvement (QI) Program Description 2023-2024

Overview

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

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

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

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

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

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

Vision

Our vision is to continue to be a leader in behavioral health and to be recognized for excellence in our community, state, and nation.

Mission

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

Organizational Values

Clients are the Focus

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

Excellence

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

Respect

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

Cultural Competence

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

Proactive and Accountable Community Participation

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

Integrity and Compliance

We conduct our operations with the highest standards of honesty, fairness, and personal responsibility in our interactions with each other and the community. Our work also requires a high standard of ethical behavior and compliance with legal statutes, regulatory

requirements and contractual obligations. We are committed to compliance and to ensuring that all services are provided in a professional, ethical manner.

Competitive and Efficient Service Delivery

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

Responsive and Creative in a Changing Environment

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

MHSA Essential Elements

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

Structure

A. Authority and Responsibility

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

BHRS is a member of the Stanislaus County Priority Team charged with responsibility for ensuring the BOS priority for a healthy community is achieved. Quality improvement processes and projects sanctioned by the QMT support this goal and BHRS staff interfaces with the Chief Executive Office and other County departments to ensure alignment with Stanislaus County process improvement initiatives.

B. Organization Structure

1. Behavioral Health Director

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

2. Senior Leadership Team (SLT)

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

C. Quality Improvement Program Structure

1. Behavioral Health Director

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

2. Senior Leadership Team (SLT)

   i. This Team is responsible for ensuring that QI activities in each division are established, maintained and supported. Each Division has a Quality Improvement Council (QIC), which is designed to address the quality issues of that division.
   ii. SLT oversees the Quality Improvement Program (QIP) through the activities of the Quality Management Team (QMT).
   iii. SLT meets weekly unless the schedule is otherwise modified.

3. Quality Operations Director

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

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

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

5. Quality Management Team (QMT)

   i. The Quality Management Team (QMT) provides direction, support and coaching to the various BHRS QICs. This may involve identification of key processes, especially cross-functional processes.
   ii. The QMT reviews and evaluates each QICs activity. The QMT receives routine reports from the QICs, which delineate quality management activities, actions taken and reassessments to ensure there is continuous quality improvement. The QMT holds each QIC accountable for the quality activities in the respective divisions. In addition, the QMT receives reports from the Medication Monitoring Committee of the Department.
   iii. The QMT acts on recommendations from QICs and process improvement work groups that require SLT review and approval.
   iv. Membership includes all SLT members, QS/RM, chairs of division QICs, the Strategic Implementation Team Manager, QS Specialist(s), and Mental Health Board members representing consumers and families.
   v. The QMT meets a minimum of ten times each year, except in extreme circumstances (e.g., global pandemic).

6. Quality Improvement Councils (QIC)

   i. Each division of BHRS participates on a QIC. The QICs oversee the overall program effectiveness and performance of their divisions. Each QIC also reviews and develops an annual action plan.
   ii. The membership of most councils includes the Chief of the System of Care or Division (or designee), staff providers, consumers and family members of consumers. Consumer and family member participation is an expected and vital component of QIC.

iii. Each QIC meets at least ten times each year, except in extreme circumstances (e.g., global pandemic).

7. Behavioral Health Equity Committee (BHEC)

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

8. Process Improvement Project (PIP) Work Groups

   PIP work groups are no longer managed and overseen by the Strategic Implementation Team Manager as this role has now shifted to the Quality Services Manager. These PIP work groups are formed when functions and processes needing improvement cross divisions or County Departments. PIPs are to be time-limited and cross functional and focus on the processes in questions. These teams use continuous process improvement principles and tools and make recommendations to QMT.

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

9. Medication Monitoring Committee

   i. This committee is responsible for the medication management functions of BHRS and reports to QMT. The committee is supervised by the Medical Director and the Behavioral Health Plan Administrative Chief (or designee).
   ii. The committee is chaired by a psychiatrist or pharmacist and is composed of psychiatrists, nurses, and pharmacists.
   iii. The committee meets at least once annually.

Process

A. Overall Philosophy and Approaches

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

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

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

B. Quality Improvement Plan

Each QIC develops an action plan, which supports the overall QI Work Plan for BHRS. BHRS QI Work Plan identifies quality improvement goals and objectives for the succeeding year, including a schedule of the specific quality improvement related activities and studies that are to occur. It is the responsibility of the QS/RM to assist QICs in developing action plans and to assist the Behavioral Health Plan Administrative Chief in developing the overall BHRS QI work plan. The BHRS QI Work Plan is submitted to the QMT for approval. The QIC action plans identify the focus of improvement or monitoring for the year.

C. Process by Structure

1. Quality Management Team (QMT)

The QMT identifies key processes, assigns responsibility for monitoring and improvement using continuous quality improvement principles to QICs, process improvement work groups and other quality improvement functions. The QMT may also approve QIC-initiated key processes. The QMT hears presentations and receives reports regarding each of the identified key processes. The QMT is also responsible for tracking the process of improvement and for trending the resulting data. They also act 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 can 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 Plan: 2023-2024

Overview

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

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

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

Below is the department work plan with an evaluation/summary of activities and outcomes for ***FY 2023-2024*** *(pg.13-38)*.

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

1: MONITORING THE SERVICE CAPACITY AND SERVICE DISTRIBUTION OF THE MHP (*Source: MHP*)

- **Conducts performance monitoring activities that evaluate beneficiary and system outcomes and indicators of wellbeing.**
- **Describes and provides information regarding the current type, number and geographic distribution of Mental Health Services in the system.**
- **Evaluates and monitors the capacity of the MHP.**
- **Makes program recommendations based on capacity indicators.**
- **Participates in the county planning process which identifies expanded service populations.**
- **Monitors the number of Medi-Cal beneficiaries receiving services and works with Performance Measurements to distribute information to Program Managers and the Quality Management Team (QMT).**

Objective 1	To describe the current type, number, and geographic distribution of Mental Health Services in the MHP System of Care to ensure appropriate allocation of MHP resources in providing adequate behavioral health access to all beneficiaries.
Goal 1	To identify service provision to Children, Youth, and Adult Medi-Cal/Uninsured beneficiaries by types of services and service locations by geographic regions. To track service provision against service demand and ensure resources are appropriately allocated to provide for access.
Responsible Partners	SOC QICs; Performance Measurements (OEM)
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include data dashboards. (Source Data: SSRS 1627)
FY 2023/2024 Evaluation	During FY 23-24, 100% of beneficiaries were located within 30 miles or 60 minutes of a mental health provider. Of the 7,127 unduplicated clients served, 9.0% were served in Ceres, 8.3% on the Eastside, 61.4% in Modesto, 12.4% in Turlock, and 4.6% on the westside.
Recommendations	Stanislaus County BHRS will continue to serve beneficiaries and meet time and distance standards.

LOCATION SERVED	PERCENTAGE SERVED
Ceres	9.0%
Eastside	8.3%
Modesto	61.4%
Turlock	12.4%
Westside	4.9%
Total	100%

<table>
<tr><td colspan="2">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.</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 2023/2024 Evaluation</td><td>During FY23/24, BHRS tracked and monitored offered appointments in addition to scheduled appointments. Below are the data for both offered and scheduled appointments.

Beneficiaries requesting a comprehensive assessment are offered an appointment and scheduled within 10 business days:
<table>
<tr><th>System of Care (SOC)</th><th>Percentage of Offered & Scheduled Appt w/in 10 Business Days</th><th>Average Number of Days</th></tr>
<tr><td>Adult SOC</td><td>81% (1597/1982)</td><td>7</td></tr>
<tr><td>Children SOC</td><td>91% (1639/1799)</td><td>6</td></tr>
</table></td></tr>
<tr><td>Recommendations</td><td>During FY 24/25, BHRS will continue to track and monitor the offered and scheduled appointments. QIC's will continue to monitor and make changes to ensure beneficiaries offered an appointment within established timeframes.</td></tr>
<tr><td>Goal 2.1</td><td>To ensure beneficiaries discharging from psychiatric hospitalization are given an outpatient appointment within 7 business days of discharge.</td></tr>
<tr><td>Responsible Partners</td><td>SOC QICs; Performance Measurements; Hospital Rate Committee</td></tr>
<tr><td>Evaluation Methods/Tool(s)</td><td>Mechanisms for monitoring services and activities include hospitalization reports, Medi-Cal key indicators, and SSRS reports. (Source Data: MKI Continuity of Care #1 & 3)</td></tr>
</table>

<table>
<tr><td>FY 2023/2024 Evaluation</td><td>During FY 23-24, the data for timeliness of post-hospitalization appointments are below.

“Beneficiaries discharging from psychiatric hospitalization are given an outpatient appointment within 7 business days of discharge.”
<table>
<tr><th rowspan="2">System of Care</th><th colspan="2">Appointment within 7 business days of discharge.</th></tr>
<tr><th>Percent Met</th><th>Average # of Days</th></tr>
<tr><td>Adult</td><td>57%
(807/1418)</td><td>30</td></tr>
<tr><td>Children</td><td>86%
(267/312)</td><td>11</td></tr>
</table></td></tr>
<tr><td>Recommendations</td><td>During FY 24/25, Stanislaus County BHRS will continue to track and monitor that beneficiaries discharging from psychiatric hospitalization are given an outpatient appointment within 7 business days of discharge. Stanislaus County BHRS will ensure quality improvement efforts are being made to improve appointments times within established timeframes.</td></tr>
<tr><td>Objective 2B</td><td>To conduct performance monitoring activities that gauge the system’s effectiveness at providing timely access to services for urgent conditions.</td></tr>
<tr><td>Goal 2B</td><td>To ensure that all requests for urgent mental health services are responded to within 48 hours for services that do not require an authorization and within 96 hours for services that do require an authorization.</td></tr>
<tr><td>Responsible Partners</td><td>SOC QICs; Performance Measurements</td></tr>
<tr><td>Evaluation Methods/Tool(s)</td><td>Mechanism for monitoring services and activities is the Medi-Cal key indicators and SSRS reports. (Source Data: MATA #3-Timeliness to Urgent Services)</td></tr>
<tr><td>FY 2023/2024 Evaluation</td><td>Stanislaus County BHRS’s standard is to meet the 48-hour timeframe whether the urgent service requires prior authorization or not (48 hours vs 96 hours). BHRS is not tracking urgent appointments that required prior authorization separately. See data table below.
<table>
<tr><th rowspan="2">System of Care</th><th colspan="2">Urgent Mental Health Services Requests</th></tr>
<tr><th>Percent Met</th><th>Average # of Hours</th></tr>
<tr><td>Adult</td><td>0%
(0/35)</td><td>350</td></tr>
<tr><td>Children</td><td>33%
(1/3)</td><td>121</td></tr>
</table></td></tr>
</table>

<table>
<tr><td>Recommendations</td><td>Stanislaus County BHRS will continue to monitor and 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 through quality improvement efforts.</td></tr>
<tr><td>Objective 2C</td><td>To ensure that beneficiaries are provided with information on how to access specialty mental health services after business hours, including weekends and holidays.</td></tr>
<tr><td>Goal 2C</td><td>To confirm that all MHP providers have after-hours telephone message systems that provides information in English and Threshold language(s) on how to access emergency and routine mental health services for BHRS.</td></tr>
<tr><td>Responsible Partners</td><td>Quality Services; SOC QICs</td></tr>
<tr><td>Evaluation Methods/Tool(s)</td><td>Mechanisms for monitoring services and activities include ongoing after-hours test calls and documentation of compliance to standards outlined in the After-Hours Policy and SSRS reports. (Source Data: SSRS After Hours Report & Test Call Data)</td></tr>
<tr><td>FY 2023/2024 Evaluation</td><td>One method Stanislaus County BHRS utilized to monitor this area was by conducting after-hour test calls to our access line. BHRS went live with 24/7 coverage at the Access Line as the primary destination for all 800 line calls in Q2 of the FY (10/2023), with the contracted answering service receiving rollover calls only. It was identified that since this change began, after hour call performance has been improving. BHRS since discontinued the use of a contracted answering service during Q4 of the FY. This has improved the achievement of metrics.
<table>
<tr><th>TEST CALL CATEGORY</th><th>% REQUIREMENT MET</th></tr>
<tr><td>Info about Accessing SMHS</td><td>100%</td></tr>
<tr><td>Info about Urgent services</td><td>N/A</td></tr>
<tr><td>Info about Prob Res & SFH</td><td>50%</td></tr>
</table>
BHRS 24/7 Access Line also documented 209 after-hour services for FY 23-24. Below is the data:
Summary of After Hours Services During FY 2023-2024.
<table>
<tr><td>Sub Unit: 2502 - MH – 24/7 Access Line Billable</td><td>154</td></tr>
<tr><td>Sub Unit: 2502 - MH – 24/7 Access Line Non Billable</td><td>55</td></tr>
<tr><td>Total</td><td>209</td></tr>
</table></td></tr>
<tr><td>Recommendations</td><td>Regarding the after-hours telephone line, monthly review of test calls is conducted between the BHRS Compliance division and the BHRS Access Line coordinator to identify areas of improvement and provide guidance on requirements. Stanislaus County BHRS will continue to provide after-hour services as appropriate.</td></tr>
</table>

<table>
<tr><td>Objective 2D</td><td>To provide a Toll-Free Telephone Line that operates 24/7 and meets all required elements of the MHP contract.</td></tr>
<tr><td>Goal 2D</td><td>To ensure that the 24/7 Telephone Line provides information, in beneficiary's language of choice, on how to access specialty mental health services, beneficiary resolution process and responds to urgent conditions.</td></tr>
<tr><td>Responsible Partners</td><td>Quality Services; Access Line Team; Behavioral Health Equity 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 2023/2024 Evaluation</td><td>BHRS conducts monthly test calls throughout various times 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. BHRS went live with 24/7 coverage at the Access Line as the primary destination for all 800 line calls in Q2 of the FY (10/2023), with the contracted answering service receiving rollover calls only. It was identified that since this change began, call performance has been improving. BHRS since discontinued the use of a contracted answering service during Q4 of the FY. This has improved the achievement of contractual metrics.
<table>
<tr><td>TEST CALL CATEGORY</td><td>% REQUIREMENT MET</td></tr>
<tr><td>Info about Accessing SMHS</td><td>96.30%</td></tr>
<tr><td>Info about Urgent services</td><td>100%</td></tr>
<tr><td>Info about Prob Res & SFH</td><td>88.89%</td></tr>
</table>
<table>
<tr><td>WRITTEN LOG INCLUDED:</td><td>% REQUIREMENT MET</td></tr>
<tr><td>Name of beneficiary</td><td>96.43%</td></tr>
<tr><td>Date of call</td><td>100%</td></tr>
<tr><td>Disposition of call</td><td>100%</td></tr>
</table></td></tr>
<tr><td>Recommendations</td><td>Regarding the 24/7 telephone line, monthly review of test calls is conducted between the BHRS Compliance division and the BHRS Access Line coordinator to identify areas of improvement and provide guidance on requirements.</td></tr>
<tr><td colspan="2">3: MONITORING BENEFICIARY SATISFACTION (Source: MHP)</td></tr>
<tr><td colspan="2">• 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.</td></tr>
<tr><td>Objective 3</td><td>To conduct performance monitoring activities using mechanisms that assess beneficiary satisfaction with behavioral</td></tr>
</table>

<table>
<tr><td></td><td>health services provided as an indicator of beneficiary and system outcomes.</td></tr>
<tr><td>Goal 3</td><td>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.</td></tr>
<tr><td>Responsible Partners</td><td>Quality Services; SOC QICs; Performance Measurements</td></tr>
<tr><td>Evaluation Methods/Tool(s)</td><td>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)</td></tr>
<tr><td>FY 2022/2023 Evaluation</td><td>Stanislaus County BHRS has mechanisms to assess beneficiary/family satisfaction by surveying beneficiary/family satisfaction at least annually. Stanislaus County BHRS conducted the Consumer Perception Survey once during FY 2023/2024 in May 2024. The data for this Consumer Perception Survey was:
<table>
<tr><th colspan="6">Mental Health Consumer Perception Survey - May 2024</th></tr>
<tr><th>Subscale</th><th>English</th><th>Spanish</th><th>Answered</th><th>Agreed</th><th>Favorable</th></tr>
<tr><td>Access</td><td>598</td><td>65</td><td>2329</td><td>2015</td><td>87%</td></tr>
<tr><td>Participation</td><td>598</td><td>65</td><td>1584</td><td>1366</td><td>86%</td></tr>
<tr><td>Outcomes</td><td>598</td><td>65</td><td>4063</td><td>2698</td><td>66%</td></tr>
<tr><td>Functioning</td><td>598</td><td>65</td><td>3029</td><td>2065</td><td>68%</td></tr>
<tr><td>Satisfaction</td><td>598</td><td>65</td><td>3016</td><td>2632</td><td>87%</td></tr>
<tr><td>Connectedness</td><td>598</td><td>65</td><td>2439</td><td>1914</td><td>78%</td></tr>
<tr><td>Quality and Appropriateness</td><td>271</td><td>10</td><td>2363</td><td>2006</td><td>85%</td></tr>
<tr><td>Cultural</td><td>327</td><td>55</td><td>1373</td><td>1294</td><td>94%</td></tr>
</table></td></tr>
<tr><td>Recommendations</td><td>Stanislaus BHRS will continue to conduct the Consumer Perception Surveys annually and review the data for any opportunities for improvement.</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>
</table>

Responsible Partners	Quality Services; Patients' Rights
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include monthly reports on grievances, appeals and requests/outcomes for State Fair Hearings.
FY 2023/2024 Evaluation	BHRS has processed 49% of Medi-Cal grievances timely for FY 23/24. For those grievances not processed timely, 100% of those grievances had a Timeliness Notice of Adverse Benefit Determination (NOABD) sent out. BHRS Risk Management was placed on a CAP by BHRS Compliance to ensure timely resolution of grievances in accordance with regulatory standards. BHRS Risk Management was able to clear the CAP. There was additional training provided to staff and process changes to ensure the sustainability of the CAP. All grievances have been processed within regulatory standards since then. BHRS has also reported out FY 23/24 data on grievances, appeals, and state fair hearings at the Quality Management Team (QMT) meetings as well as annually to DHCS. There was one (1) State Fair Hearing, one (1) beneficiary Appeal, and zero (0) Expedited Appeals for FY 23/24 which were all processed within DHCS timeliness standards. There was a total of 47 Medi-Cal Grievances received for FY23/24 and 47closed for FY 23/24. **The following is the Grievance data for FY 23/24:**

Complaint Type	Q1	Q2	Q3	Q4	Totals
Formal Complaint	0	0	0	0	0
Medi-Cal Grievances	5	4	6	8	23
Other Grievance	0	0	2	0	2
Positive Compliment	0	0	0	0	0
Totals	5	4	8	8	25

Severity of Resolved Grievances 23/24:

Severity	Q1	Q2	Q3	Q4	Total
Appropriate Practice/Care	0	5	8	3	16
Opportunity to Improve	0	7	19	3	29
Unable to Contact	0	0	0	0	0

Care not Acceptable	0	1	0	0	1
Withdrawn	0	0	0	0	0
Unknown	0	0	0	1	1
Signif. Deviation from STD	0	0	0	0	0
Total	0	13	27	7	47

Complaint Category for Grievances Received for FY 23/24:

Complaint Category	Q1	Q2	Q3	Q4	Total
Abuse	0	0	0	0	0
Access/Accessibility	0	0	0	0	0
Change of Provider	0	0	0	0	0
Confidentiality Concern	0	0	0	0	0
Cultural Appropriateness	1	0	0	0	1
Ethical	0	0	0	0	0
Financial	0	0	0	0	0
Lost Patient Property	0	0	0	1	1
Medication Concerns	0	1	2	0	3
Operational	0	1	1	0	2
Other	1	1	0	1	3
Other Access Issues	0	0	1	0	1
Other Quality of Care	0	0	3	1	4
Patient Rights	0	1	0	0	1
Peer Behavior	0	1	1	0	2
Physical Environment	0	0	1	0	1
Practice/Care problem	0	0	1	0	1
Service not available	0	0	0	0	0
Staff Behavior	9	5	0	1	15
Timeliness of Service	0	0	0	0	0
Treatment Issues	5	4	0	2	11
Total	16	14	10	6	46

SOC Grievances Received for FY 23/24:

Complaint By SOC	Q1	Q2	Q3	Q4	Total
ASOC	3	6	4	1	14
Adult Med Clinic	2	0	0	0	2
Children Med Clinic	1	1	0	0	2
CSOC – TAY	3	0	0	1	4
DMC – ODS	6	5	3	4	18
Consumer & Family Affairs	0	0	0	0	0
Contract Agencies	1	2	3	0	6
Supportive Services Division	0	0	0	0	0
Office of Public Guardian	0	0	0	0	0
BH Plan Administration	0	0	0	0	0
Total	16	14	10	6	46

Resolved Grievance Dispositions for FY 23/24:

Complaint By Disposition	Q1	Q2	Q3	Q4	Total
Satisfied/Resolved	0	11	21	4	36
Unable to Contact Client	0	2	4	2	8
Dissatisfied/Not Resolved	0	0	0	0	0
Unknown	0	0	0	1	1
Withdrawn	0	0	2	0	2
Total	0	13	27	7	47

Timeliness for Resolved Grievances FY 23/24:

Timeliness	Q1	Q2	Q3	Q4	Total
Closed within Regulatory Standard	0	1	15	7	23
Not Closed within Reg. Standard	0	12	12	0	24
Total	0	13	27	7	47

The following is the Appeals Data for FY 23/24:

Appeal Data by Appeal Type for FY 23/24:

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

Appeal Data by Disposition for FY 23/24:

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

Appeal Data by Timeliness Standards for FY 23/24:

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

Appeal Data by Severity for FY 23/24:

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

Appeal Data by Outcome for FY 23/24:

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

Data Related to State Fair Hearing:

The state fair hearing received in FY 23/24 was for the program Turning Point. Case result was dismissed.

Recommendations	BHRS will continue to ensure that beneficiary grievances, appeals, expedited appeals, and requests for State Fair Hearings are being resolved expeditiously, timely, 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 2023/2024 Evaluation

BHRS Risk Management processes incident reports for the agency including unusual occurrences from contract agencies. Any quality-of-care issues or incident trends are reported at QMT and/or SLT meetings. During FY 23/24, BHRS Risk Management implemented a new system, symplr, to track and monitor incident reports. This went live November 1, 2023. From January 1 – October 31, 2023, there were a total of 188 Incident Reports (including Adverse Incidents). There was a total of 45 Incident Reports in symplr (including Adverse Incidents) from November 1, 2023 to December 31, 2023. This gave us a total of 233 Incident Reports for the calendar year of 2023. From January 1, 2024 – June 30, 2024, there were a total of 48 Incident Reports, including adverse.

Total # of Incident Reports per year:

Year	2020	2021	2022	2023	Jan. 1 – June 30, 2024
# of Incident Reports	190	209	229	symplr: 55 Previous IR Database: 188 Total: 243	151

# of Incidents by Incident Type January 2023 – June 2024:

Incident Type	# of Incidents for Jan. – Oct. 2023 (old database)	# of Incident Nov. 2023 – June 2024 (symplr)
Abuse/Neglect/Exploitation (Actual or Alleged)	3 (1.6%)	2 (0.9%)
Client Injury (Excluding Falls)	9 (4.8%)	4 (1.9%)
Deaths	25 (13.3%)	26 (12.6%)
Falls	1 (0.5%)	4 (1.9%)
Inappropriate Behaviors	3 (1.6%)	6 (2.8%)
Medical Care Issues	42 (22.3%)	54 (26.2%)
Medication Errors	7 (3.7%)	10 (4.8%)
Property Loss/Damage	9 (4.8%)	17 (8.2%)
Security Related	59 (31.4%)	43 (20.8%)
Visitor / Other Injury (Non-Employee)	0 (0%)	0 (0%)
Other	30 (16.0%)	40 (19.4%)
Unknown	0 (0%)	0 (0%)
Total	188	206

Recommendations	BHRS will continue to monitor its service delivery system. BHRS Risk Management will continue having quarterly Adverse Incident work group meetings in which adverse incidents are processed and Root Cause Analyses are completed. In addition, BHRS's Utilization Management program will continue to provide oversight and monitor Acentra as the contractor for concurrent review. Acentra will continue to review inpatient documentation on a concurrent review basis according to guidance provided by DHCS. Support to hospitals around documentation standards will be provided with regards to BHIN 22-017 and documentation standards set forth by Title 9.
Objective 4A	To conduct performance monitoring activities of the mechanisms responsible for the safety and effectiveness in the Outpatient system of care.
Goal 4A	To identify and address issues which may affect the quality of care provided to beneficiaries, underutilization of services, overutilization of services and utilization management. To implement corrective measures as appropriate. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting consumer needs.
Responsible Partners	Medical Director, Quality Services, Compliance Officer, Utilization Management, and SOC Program Managers
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include meeting minutes, QMT meeting minutes, chart and on-site monitoring report summaries.
FY 2023/2024 Evaluation	For FY 23/24, UM went live with the UM Audit Review in July of 2023, with the first round of audits in August 2023. From August 2023 to February of 2024, UM was able to complete audit reviews for all existing programs that bill Medi-Cal. In creating the schedule, UM reviewed the past audit schedule provided by Quality Services as QS used to manage Peer Reviews prior to July 2023. UM Audit Reviews were scheduled by date order, from oldest date of review to newest date of review. UM completed a total of 48 audits, UM reviewed a total of 41 programs (subunits) between August 2023 and July 2024. All MH programs were audited to CalAIM Standards, Medi-Cal, Managed Care and Federal requirements. The audits utilized the CalMHSA UM Audit Review Tools. Two versions of the tools were utilized, one created for SMHS programs, and one created for SUD/DMC-ODS programs. If the documentation standards are not met, immediate corrective actions are set (lower than 90% on any line item on the UM Audit Review tool results in a CAP), requiring programs to address the areas of concern. As part of the current process, the Compliance Division provided oversight and management of the CAPs. Once the findings reports were finalized, programs had 30 days to provide a completed CAP to the Compliance Division. Compliance staff reviewed the CAPs for completeness and applicability. For any CAPs needing to be updated, Compliance communicated to the program coordinator the updates needed and provided a one (1) week deadline. For any programs that did not submit the CAPs within 30 days, Compliance staff emailed the program coordinator with a 2-day deadline. Upon approval of a program's CAPs, programs were expected to complete CAPs within 90 days.

	Once all evidence, or notification of corrections, was received, the Compliance staff reviewed the EHR for corrections. The Compliance staff also reviewed evidence as it came in from programs, prior to the 90 days, and provided the program updates on any outstanding evidence. Once all evidence/corrections were completed, the Compliance staff provided programs with a letter documenting the completion of the CAPs. The BHRS Business Office consistently runs disallowance and/or suspended services reports to identify areas for improvement as well. Stanislaus BHRS also had their MHP Triennial review in June 2023 in which the MHP was found to be 100% compliant in the chart review portion of the audit.
Recommendations	BHRS will continue to focus on this area for progress improvement and UM Audit Review results will be reported quarterly at QMT.

5: MONITORING THE MHP SERVICE DELIVERY SYSTEM FOR THE SAFETY & EFFECTIVENESS OF MEDICATION PRACTICES (*Source: MHP*)	
• **Under the supervision of a person licensed to prescribe or dispense prescription drugs, evaluates and monitors the safety and effectiveness of medication practices.** • **Reviews cases involving medication issues and tracks medication issues over time.** • **Recommends and institutes needed actions involving medication procedures and policies.** • **Conducts Peer Reviews regarding medication practices.**	
Objective 5	To conduct performance monitoring activities of the mechanisms responsible for the safety and effectiveness of medication practices**.**
Goal 5	To obtain information regarding the safety and effectiveness of medication practices. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting consumer needs.
Responsible Partners	Medical Director, Utilization Management
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. Utilization Management adopted the Medication Monitoring process from the Quality Services department. UM made changes to the previous review process, with the intention to increase the number of charts/providers reviewed and provide feedback to the medical providers. The intention is to improve safety and effectiveness of medication practices and improve patient care.

FY 2023/2024 Evaluation	The BHRS Utilization Management Department monitors the safety and effectiveness of medication practices through our Medication Monitoring Audits (formerly called MD/RN chart reviews). These audits were completed quarterly. Different medical providers were reviewed with each audit. UM was able to conduct a total of 4 audits for FY 23/24. **The results are as follows:** Charts requested: 78 Charts reviewed: 54 # of staff reviewed: 26 Charts requiring corrections/follow-up: 44 # of staff responsible for corrections/follow-up: 25 Orders/Labs/Etc. Subscale Compliance score: 78.8% Medication Progress Notes Subscale Compliance score: 82.6% Overall Score: 80.7%
Recommendations	BHRS UM department will continue to conduct Medication Monitoring Audits at a minimum of an annual audit in order to collect and analyze data for the medication monitoring process. The BHRS Medical Director will identify areas of improvement 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 2023/2024 Evaluation	BHRS monitored program staff contact with client's Primary Care Physical (PCP) through it's Medi-Cal Key Indicators (MKI). Due to staff shortage, the department was not able to finalize a reporting process; efforts were placed in implementation of a new EHR. Efforts in collaboration was made with the Emergency Departments at Emanuel Medical Center, Doctor's Medical Center, and Memorial Medical Center for FUM and FUA PIP's to allow for linkages for patients from ED's to SUD and MH Services. MOU's with Health Plan of San Joaquin, Health Net, and Kaiser are underway to being finalized. Monthly meetings continued to happen for discussion and collaboration on MOU's with the health care plans.
Recommendations	BHRS will work towards the development of data collection and reporting infrastructure within the new Electronic Health Record that was implemented during FY23/24. For FY 24/25 BHRS will reevaluate current efforts in Coordination of Care between MHP and Physical Healthcare Agencies and create a timeline and project charter for further implementation and monitoring.

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 2023/2024 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. In December of 2022, BHRS contracted with CalMHSA for the Program Inpatient Concurrent Review project which utilizes a technology-assisted concurrent review process with its contractor Acentra, formerly known as Kepro. Appeals are processed and tracked through Acentra. Acentra provides a web-enabled utilization platform and clinical services to carry out psychiatric inpatient concurrent review and

	authorization services. Hospitals submit clinical authorization request and clinical documentation via a web-enabled platform. Acentra reviewers provide feedback to hospitals to assist with meeting documentation standards to provide decrease in the amount of denied days for hospitals leading to decreased provider appeals. BHRS's Utilization Management program provides oversight and monitoring of Acentra by use of side-by-side reviews and the performance of random audits. Quality standard issues are addressed with Acentra as they arise and reviewed in a bi-weekly meeting, by the liaison between BHRS and Acentra.
Recommendations	BHRS will continue to conduct performance monitoring activities which review provider appeals and concerns on an ongoing basis as an indicator of the effectiveness of the provider appeal resolution process. Continue to provide support to our providers around documentation standards. Encourage providers to utilize the second level appeal process.

8: MONITORING MENTAL HEALTH NEEDS IN SPECIFIC CULTURAL GROUPS	
• **Assumes responsibility for ensuring trainings designed to enhance cultural competence are being offered.** • **Conducts outreach activities to unserved, underserved, inappropriately served, and minority populations.** • **Monitors the implementation of cultural competence plan goals.** • **Participates as necessary in other committee activities.**	
Objective 8	To conduct performance monitoring activities of the mechanisms used to identify access barriers among specified ethnic/cultural groups that are currently unserved, underserved or inappropriately served.
Goal 8	To evaluate the effectiveness of current outreach activities in engaging diverse cultural groups into mental health treatment. To review and monitor the provision of cultural competency trainings to providers. To continue using this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.
Responsible Partners	Ethnics Services Manager, Quality Services Manager; Performance Measurements; Cultural Competency Social Equality Justice Committee (CCESJC)
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include training reports, CCESJC meeting minutes, and dashboard/reports.
FY 2023/2024 Evaluation	The Behavioral Health Equity Committee (BHEC) is dedicated to fostering an inclusive environment in behavioral health services, ensuring that care is not only accessible but also culturally sensitive and linguistically appropriate. By adhering to the Culturally and Linguistically Appropriate Services (CLAS) standards, the BHEC has set forth a framework that prioritizes the delivery of healthcare in a manner that respects the diverse cultural health beliefs, practices, preferred languages, health literacy, and other communication needs of individuals. This commitment is further exemplified by the BHEC's support for the Behavioral Health Services Act (BHSA), which emphasizes the importance of providing services that resonate with the consumers' cultural backgrounds and linguistic needs. The benchmark of having a significant percentage of clinical providers who are bilingual, particularly in Spanish, is a testament to the ongoing efforts to bridge the gap in healthcare disparities. Continual monitoring and adaptation of

these strategies are crucial for the sustained improvement of behavioral health services, ensuring they remain effective, equitable, and respectful of the rich tapestry of cultures they serve. The Department's commitment to fostering inclusive partnerships has significantly contributed to the enrichment of the local behavioral health system. By engaging with a wide array of cultural and community groups, including Assyrian, Latino, Southeast Asian, and LGBTQIA+/2S communities, among others, the Department has embraced a multifaceted approach to healthcare. This strategy not only ensures that diverse perspectives are heard and valued but also facilitates the integration of community-specific practices into existing treatment programs. Such inclusivity is vital for a holistic approach to health, recognizing the unique challenges and strengths within each community, and tailoring services to better meet their specific needs. The ongoing dialogue between the Department and these communities, supported by BHSA Prevention funding, exemplifies a dynamic and responsive healthcare system that prioritizes the well-being of all its members.

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

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

Cultural Competency Data by Bilingual Staff in Clinical Provider Roles for FY 2023-2024:

Bilingual Staff in Clinical Provider Roles	Number of FTE Allocated Positions	Number of Bilingual Staff	Percentage
Behavioral Health Specialist I/II	143	60	42%
Clinical Services Technician I/II	57	11	19.3%
Mental Health Clinician I/II/III	111	45	40%
Psychiatric Nurse I/II	19	2	10%
Psychiatrist	4	0	0%
Total Direct Service Staff	**232**	**84**	**50.9%**

The Behavioral Health Services Act (BHSA) is actively working towards enhancing cultural competence within its Program and Expenditure Plan. Initiatives include creating bilingual program descriptions, establishing a reliable referral database, and developing treatment guidance with supportive multimedia resources. Although some projects are in the preliminary stages, progress is evident in the commitment to bilingual staff development and exploration of additional interpretation services. This approach not only aligns with the agency's dedication to inclusivity but also ensures that clients receive services in their primary language, fostering a supportive and understanding environments for all.

	Assyrian	Cambodian	Hindi	Hmong	Laotian	Punjabi	Spanish	Grand Total
Total Number of Bilingual Staff	**5**	**8**	**3**	**2**	**5**	**4**	**168**	**195**
Total Number of Allocated Full Time Equivalent (FTE) Positions as of 2024 Adopted Budget								492
% of Allocated FTEs with Bilingual Capabilities								40%

Listed below are data elements for FY23/24 related to different cultural groups:

The percentage of total clients served (unduplicated) by Race/Ethnicity for FY 23/24:

Race/ethnicity	**FY23/24**
African-American	3.0%
Asian	1.0%
Native American	1.1%
White American	28.0%
Other/Unknown	68.0%
Hispanic Origin	
Hispanic/Latino	35.0%
Non Hispanic/Latino	42.0%
Unknown	23.0%

The percentage of total client served (unduplicated) by age for FY23/24:

Age Group	**FY23/24**
0-17	29.0%
18-24	9.0%
25-75	62.0%
76+	<1%
Total	100

The client retention rate for FY23/24 by ethnicity is listed below:

	FY23/24
Overall	80%
African-American	77%
Asian /Pacific Islander	75%
Hispanic	84%
Native American	61%
White American	81%
Other	83%

BHRS Staff Race/Ethnicity composition for FY23/24:

Race/ethnicity	County Population	Overall Staff	Admin/Mgmt	Direct Services	Support services	N/A
Asian	26864	63 (9.6%)	11 (11.7%)	44 (9.2%)	19	6
Black/African American	12654	29 (4.4%)	3 (3.2%)	21 (4.4%)	6	4
Native American/Alaska Native	2069	6 (.9%)	2 (2.1%)	7 (1.5%)	0	0
Hispanic	225987	258 (39.3%)	27 (28.7%)	203 (42.6%)	89	9
White	206386	272 (41.4%)	49 (52.1%)	177	80	21
Other/Unknown	56601	29 (4.4%)	2 (2.1%)	25	7	0
TOTAL	530,561	657	94	477	201	40

Evaluation

Stanislaus County BHRS BHEC will continue to monitor this area.

The role of the Behavioral Health Equity Manager (BHEM) is crucial in ensuring that the delivery of behavioral health services across the county is culturally and linguistically competent. This position not only oversees the adherence to standards but also actively promotes quality care that respects the diversity of the community.
For the fiscal year 2024-2025, the BHEM will focus on conducting annual site visits to ensure the continuous implementation of the CLAS standards across all programs. This includes educational initiatives, sharing best practices, and tracking the progress of program development related to these standards. The launch of Cultural Competency training is a significant step towards reinforcing the commitment to cultural sensitivity within Behavioral Health and Recovery Services (BHRS) and its collaborative partners. By offering this training multiple times a year, the department aims to foster an environment where diverse racial, ethnic, and cultural populations receive equitable and effective treatment. Additionally, the collaboration with Prevention Community Collaboratives (PCC) will broaden the department's outreach and enhance the quality of treatment services through community engagement. This comprehensive approach signifies a proactive effort to integrate cultural competence into the fabric of community-based behavioral health services.
The Behavioral Health and Recovery Services (BHRS) is set to enhance its Cultural Competency training, a crucial step in ensuring that service providers are equipped with the necessary skills and knowledge to effectively serve diverse populations. This training, mandatory for BHRS and collaborative provider partners, will be held three times in December 2024 and then four times annually. It aims to familiarize participants with BHRS' dedication to cultural competency, including adherence to CLAS Standards and the Cultural Competence Program specific to Stanislaus County. The updated eight-hour training module underscores the importance of understanding cultural nuances and

	the provision of respectful and responsive health care services. Furthermore, the Department's collaboration with Prevention Community Collaboratives (PCC) will broaden the scope of practice to include community stakeholder engagement, thereby enhancing the development and fortification of treatment services for varied community groups. These educational sessions, developed in partnership with PCC, will offer treatment providers insights into the local diverse community's experiences with behavioral health services, focusing on both the challenges and successes. Topics will cover a range of issues, including the integration of local, natural community support systems, and strategies for connecting clients and families to these valuable resources. The initiative reflects a comprehensive approach to fostering an inclusive and culturally competent healthcare environment. Additionally, the BHEC and BHEM will support the Department's efforts to launch a Cultural Competency training. The training will introduce BHRS' commitment to cultural competency, including a discussion about CLAS Standards and the Cultural Competence Program for Stanislaus County – to include all policies and training requirements. In addition, the Department will work with local diverse PEI Community Collaboratives (PEICC) to further expand their scope of practice to include supporting the Department in community stakeholder participation that will inform the further development and strengthening of treatment services for diverse community populations. The Department will work with PEICC to develop and provide educational sessions for treatment providers on the local diverse community experience in accessing and receiving behavioral health treatment services. To develop these educational sessions, the Department will partner PEICC to convene learning sessions with BHRS clients and community members to learn and gain insight into diverse community member and client challenges and successes in accessing behavioral health services. The educational sessions will vary in topic and include information on local, natural community supports for clients and families, and how treatment providers can connect clients to these community supports.

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	Mechanisms for monitoring services and activities include CAEQRO PIP summary reports and Implementation and

Methods/Tool(s)	Submission Tool.
FY 2023/2024 Evaluation	Stanislaus County Behavioral Health and Recovery Services (BHRS) understands the Title 42, CFR, Section 438.330, Department of Health Care requirements as having two Performance Improvement Projects (PIP's) for the MHP. For our Non-Clinical Mental Health Plan (MHP) Performance Improvement Project (PIP), the focus is on ensuring that a Child/Adolescent beneficiary has had their initial psychiatry appointment scheduled within 15 business days of initial request. The Psychiatric Medication Services Referral (PMSR) form in the Electronic Health Record (EHR) is used to track these requests. The PIP Committee had implemented the PMSR Script/Questionnaire that clinical staff would utilize when a client/parent made an initial request for psychiatry services. This Non-Clinical PIP had been active since Oct. 10, 2022 and the committee decided to end this intervention December 2023. Upon completion of this PIP, a transition was made January 2024 to explore a new PIP topic. During the rest of FY, efforts were made to review data and identify a PIP Topic. Upon review of the EQR reports, the committee decided to explore Penetration Rates as a new PIP topic. A new committee with several stakeholders was created that met twice a month. During the last several years, the Penetrate Rate for Stanislaus County reported by Behavioral Health Concepts during EQR continued to fall below the statewide and similar-sized county Penetration Rate. The committee reviewed data, reports, and prevention efforts to gather baseline data and further explored Penetration Rates for racial/ethnic and all age groups. During this FY, this PIP is still in the planning phase. For our Clinical MHP PIP, the topic chosen was on the HEDIS Measure FUM (Follow-up After Emergency Department Visit for Mental Health) PIP, the focus is to bridge care coordination gaps between MHP and the Emergency Department (ED) to decrease ED visits for beneficiaries. The PIP Committee has implemented the offering of care coordination services to beneficiaries upon discharge from the ED in efforts to provide linkage to Access Crisis and Support (ACS) services. The Clinical MHP PIP is currently active and the committee meets weekly to discuss updates around this PIP to further improve coordination.
Recommendations	Stanislaus County BHRS will ensure PIPs are active in the upcoming FY 2024/2025 in compliance with DHCS EQR requirements while adopting Health Services Advisory Group's process. With Stanislaus County being an early implementer to BH Administrative Early Integration, there will be changes to requirements for topic selection and quantity of PIP's.

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	Utilization Management; SOC managers
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include chart audits (UM Audit Review Process), and disallowance reports and/or suspended services for outpatient services and denied days for inpatient services, reports, and dashboards.
FY 2023/2024 Evaluation	During the previous 22/23, the UM program launched a pilot project utilizing the new audit tool released by the California Mental Health Services Authority (CalMHSA). The UM team is reviewed our existing auditing process and developed a new audit process incorporating the use of the new audit tool. The new UM Audit Review Process was implemented during 23/24-time frame. UM audited both Specialty Mental Health Programs and SUD/DMC-ODS programs. For FY 23/24, UM went live with the UM Audit Review in July of 2023, with the first round of audits in August 2023. From August 2023 to February of 2024, UM was able to complete audit reviews for all existing programs that bill Medi-Cal. In creating the schedule, UM reviewed the past audit schedule provided by Quality Services as QS used to manage Peer Reviews prior to July 2023. UM Audit Reviews were scheduled by date order, from oldest date of review to newest date of review. UM completed a total of 48 audits, UM reviewed a total of 41 programs (subunits) between August 2023 and July 204. All MH programs were audited to CalAIM Standards, Medi-Cal, Managed Care and Federal requirements. The audits utilized the CalMHSA UM Audit Review Tools. Two versions of the tools were utilized, one created for SMHS programs, and one created for SUD/DMC-ODS programs. If the documentation standards are not met, immediate corrective actions are set (lower than 90% on any line item on the UM Audit Review tool results in a CAP), requiring programs to address the areas of concern. As part of the current process, the Compliance Division provided oversight and management of the CAPs. Once the findings reports were finalized, programs had 30 days to provide a completed CAP to the Compliance Division. Compliance staff reviewed the CAPs for completeness and applicability. For any CAPs that needed to be updated, the Compliance staff communicated to the program coordinator the updates needed and provided a one (1) week deadline. For any programs that did not submit the CAPs within 30 days, the Compliance staff emailed the program coordinator with a 2-day deadline. Upon approval of a program's CAPs, programs were expected to complete the CAPs within 90 days. Once all evidence, or notification of corrections, was received, the Compliance staff reviewed the EHR for corrections. The Compliance staff also reviewed evidence as it came in from programs, prior to the 90 days, and provided the program updates on any outstanding evidence. Once all evidence/corrections were completed, the Compliance staff provided programs with a letter documenting the

	completion of the CAPs. The BHRS Business Office consistently runs disallowance and/or suspended services reports to identify areas for improvement as well. Inpatient reviews are a delegated UM task to a BHRS contracted with CalMHSA for the Program Inpatient Concurrent Review project which utilizes a technology-assisted concurrent review process with its contractor Acentra, formerly known as Kepro. Acentra reviews the documentation and provides authorization according to Title 9 and BHIN 22-017. BHRS's Utilization Management program provides oversight and monitoring of Acentra by use of side-by-side reviews and the performance of random audits. Quality standard issues are addressed with Acentra as they arise and reviewed in a bi-weekly meeting, by the liaison between BHRS and Acentra.
Recommendations	BHRS will continue to monitor this area. BHRS will continue to conduct UM Audit Reviews and monitoring of Acentra to ensure accuracy in documentation. BHRS UM staff to continue to improve on the new audit process.

11: CREDENTIALING AND MONITORING OF PROVIDERS	
• **Completes database checks of all providers.** • **Monitors providers at required intervals and follows guidelines for any negative reports for providers.** • **Follows appeal process for any corrective action taken against providers.**	
Objective 11	To conduct database checks in congruence with State and Federal regulations as an indicator of adherence to credentialing and monitoring standards.
Goal 11	To review all required databases for all providers at time of application/hire and at required intervals to identify any providers who are identified as not appropriate for providing care to beneficiaries. To monitor provider quality of treatment at appropriate intervals to identify any quality of care issues in order to ensure appropriateness for continued treatment of beneficiaries.
Responsible Partners	Human Resources; Quality Services; Utilization Management; SOC managers
Evaluation Methods/Tool(s)	Mechanisms for monitoring include National Plan and Provider Enumeration System (NPPES), National Practitioner Data Bank (NPDB), Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), Medi-Cal Suspended and Ineligible Provider List, Licensing board websites, chart audits (peer review), treatment plan authorization review, and disallowance reports and/or suspended services for outpatient services and denied days for inpatient services, reports, and dashboards.

FY 2023/2024 Evaluation	For FY 2023-2024, processes outlined in BHRS Policy 60.2.129 continue to be followed and remain in place. These include: • Monthly recorded checks of OIG, LEIE and licensure status • Routine checks in PAVE for licensed new hires and employees who have obtained licensure. • NPPES reviews to ensure new hires and current staff meet enrollment and taxonomy compliance, ensuring claims can be billed and processed for payment. • Credentialing audits within the HER system to confirm credentials are current and accurately listed for each provider. HR continues to track credentialing using the Access-HR Database and regularly provides information to update the NACT-274 Web App. In cases where evidence of potential fraud is identified, Stanislaus County BHRS/HR will notify the employee, imitating corrective actions. These may include revoking the employee's clinical privileges, denying access to the EHR, and restricting their ability to claim or bill for services under their credentials. NPDB enrollment remains pending.
Recommendations	Stanislaus County BHRS/HR will continue to monitor and record findings, including evidence of fraud followed by corrective action, per Policy 60.2.129. NPDB enrollment is still pending.
Objective 11A	To review the PAVE portal for all applicable licensed providers at time of application/hire and upon licensing of current unlicensed providers who will be or are for providing care to beneficiaries.
Goal 11A	To ensure all applicable licensed staff are enrolled in the DHCS Provider Application and Validation for Enrollment (PAVE) portal.
Responsible Partners	Human Resources; SOC managers; Quality Services
Evaluation Methods/Tool(s)	Mechanisms for monitoring include the PAVE open data portal on the DHCS website, screenshots of provider portals showing completion of applications, and copies of the DHCS approval letters.
FY 2023/2024 Evaluation	For FY 23/24, Stanislaus County BHRS/HR continues to review the PAVE portal and record enrollment for licensed new hires and employees who have obtained licensure since original hire. This includes all eligible licensed disciplines, such as LCSW, LMFT, LPCC, and MD.
Recommendations	Stanislaus County BHRS will continue to monitor and record PAVE enrollment for compliance.