QUALITY ASSESSMENT & PERFORMANCE IMPROVEMENT (QAPI) PROGRAM

Quality Improvement (QI) Program Description and Work Plan

Stanislaus County Behavioral Health and Recovery Services

2024-2025

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Quality Improvement (QI) Program Description 2024-2025

Overview

The Quality Improvement Program (QIP) encompasses the quality improvement activities of the Stanislaus County Behavioral Health and Recovery Services (BHRS) Department, including Medi-Cal Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS). The QIP aligns with BHRS's Vision, Mission, Values, Strategic Plan, Core Treatment Model (CTM) Results-Based Accountability (RBA), the Stanislaus County Board of Supervisors (BOS), and the Mental Health Services Act. The QAPI and Workplan serve as the foundation of Stanislaus County BHRS to continuously improve the quality of treatment and services provided to its members while prioritizing the detection of both overutilization and underutilization.

The Quality Management Team (QMT) oversees the program to ensure compliance with care standards. The QIP aims to identify and address quality of care issues through continuous improvement, ensuring that services meet established standards.

Quality is assessed in terms of access, satisfaction, continuity, and quality care , with specific expectations for each area that are tracked through an ongoing improvement plan.

The QIP is multidisciplinary, involving providers, consumers, family members of consumers, and BHRS staff responsible for care management, quality assurance, and administration. Consumer and family input is actively sought as it is considered essential for achieving quality of care.

Continuous improvement principles the program follows:

- Prioritize the needs and experiences of the member
- Involve those closest to the issue in problem-solving
- Implement data-driven process improvement strategies
- Leverage both quantitative and qualitative insights
- Employ a holistic, systematic approach to improvements

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.

Quality Improvement Program Structure

Stanislaus County BHRS is responsible for establishing, maintaining, and supporting an effective QIP, as delegated by the State Department of Health Care Services (DHCS) for Medi-Cal members. The BHRS QMT ensures that the program meets the standards and goals set by the delegating authority.

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Behavioral Health Director – serves as the CEO of BHRS and oversees all BHRS activities. They report to both the County CEO and the Board of Supervisors.

SLT - This team includes the Behavioral Health Director, all BHRS Senior Leaders, and the Executive Assistant to the Behavioral Health Director. They are scheduled to meet weekly and are responsible for ensuring all QI activities are established, maintained, and supported.

Quality Operations Directors – Consists of both the SMHS and DMC-ODS Plan Administrators. They are responsible for the overall operations of BHRS QI functions and supervise the plan administration teams.

QMT –Monitors and ensures accountability for all Quality Improvement (QI) efforts and receives regular reports on their progress and reviews recommendations to take to SLT. . The team includes SLT leaders, clinical system of care (SOC) Quality Improvement Committee (QIC), Medication Monitoring Team, Process Improvement Projects (PIP) Committee Lead, and Behavioral Health Equity Committee (BHEC) Lead and other key staff.

Medication Monitoring Team – This team is responsible for the QI activities related to medication management functions of BHRS. The team is supervised by the Medical Director and the BH Plan Administrative Chief (or designee) and is composed of UM clinical staff.

PIPs – PIP Committee's are formed and facilitated by the Quality Services Manager when processes needing improvement across divisions are identified. PIPs must follow the framework and structure provided by the Health Services Advisory Group in adherence to DHCS and federal regulations.

QIC – Each clinical system of care of BHRS participates in a QIC. The QICs oversee the overall program effectiveness and the performance of its delivery systems. They are comprised of division staff, senior leaders, providers, and members/their family members. Each QIC reviews and develops an annual action plan. Each QIC meets at least ten times each year.

BHEC – This committee is responsible for overseeing BHRS cultural competence initiatives and ensuring adherence to DHCS Cultural Competence Plan requirements. It is comprised of division staff, senior leaders, providers, and members/their family members. BHEC meets at least ten times a year.

QI Program Process and Evaluations

The QIP adopts the concept of continuous process improvement with a systematic framework. This process is employed to identify important aspects of care and service through focused audits and evaluations. This process involves a continuous feedback loop, which should be completed as efficiently as possible. Elements of the process are:

1. Define and clarify the problem.
2. Analyze potential contributing factors.
3. Identify solutions, utilizing cross-functional collaboration where applicable.
4. Select the most effective option(s).
5. Implement the solution(s).
6. Establish a timeline for reassessment.
7. Evaluate data to assess the solution(s) effectiveness.
8. Based on the results of the data analysis:
    a. If problem is resolved, establish a monitoring plan to prevent recurrence.
    b. If unresolved, repeat the process until the issue is addressed.

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

Communication/structure throughout the QI Program that aids in the continuous quality improvement efforts includes (but is not limited to):

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 focuses for the next fiscal year that aligns with the QI work plan.
3. The Quality Services Manager supports the Plan Administrators in completing the evaluations of the overall BHRS QI work plan.
4. Members and their families will meaningfully participate in the quality improvement process at all levels of the organization.
5. Performance will be measured, and the results will be used to develop corrective actions, improve processes, and set goals.
6. Improvements will be documented, analyzed, and monitored.

Expected Performance Outcomes

The QI Work Plan will establish methods of monitoring and measuring QI outcomes. Results of these activities will be reported to QMT to be utilized in process improvement activities. This process will include measures established by other regulatory agencies. The expected outcomes are as follows:

1. Service capacity exists to meet the needs of members.
2. Members can access a continuum of services within the scope of their benefits in a timely, geographically convenient, culturally, linguistically, age and clinically appropriate manner.
3. Services provided are evaluated for medical necessity and appropriateness.
4. Members and family members are satisfied with services.
5. Grievances are processed according to regulatory standards.
6. Clinical and service outcomes are achieved, including improved functioning and symptom management through the Core Treatment Model (CTM).
7. Ensure authorization decisions meet required standards, including:
    a. Written policies and procedures for initial and continuing service authorizations, as outlined in Title 42, CFR, Section 438.210(b)(1).
    b. Mechanisms to ensure consistent application of review criteria and consultation with the requesting provider when needed, as stated in Title 42, CFR, Section 438.210(b)(2).
    c. Service denial or modifications (in amount, duration, or scope) must be made by a healthcare professional with appropriate expertise, per Title 42, CFR, Section 438.210(b)(3).
    d. Authorization decisions must comply with the timelines in Title 42, CFR, Section 438.210(d), and notices of action must be provided within the timeframes in Title 42, CFR, Section 438.404(c).

Quality Improvement Work Plan: 2024-2025

Overview

The QI Work plan outlined in this document involves an agency-wide focus on quality initiatives. Each system of care and/or division will develop an action plan that is specific to the functions of their respective systems.

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 while we plan our future implementation of Behavioral Health Services Act (BHSA) in the FY 2026-2027. In addition, BHRS has remained fully invested in implementing integrated quality improvement initiatives that focus on improving both DMC-ODS and SMHS programs.

Involvement in developing, monitoring, reporting, and action planning for the QI Work Plan is multi-faceted. It includes consumer and family member involvement along with staff, providers, and administrators. Each team/group in the QI Program Structure is invested in the QI Work Plan and remain active contributors and owners.

Quality Improvement Work Plan: 2024-2025 Goals and Objectives

1. Service Capacity and Accessibility				
Goal	Conduct monitoring to assess the accessibility of SMHS and DMC-ODS services to ensure adequate access for all members.			
Objective	**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**	**Evaluation of Data**	**QI Action Plan**
		FY 2024-2025	**FY 2024-2025**	**FY 2025-2026**
1. Track the provision of services to children, youth, and adult Medi-Cal/Uninsured members by service type and location, comparing it to service demand.	Ensure resources are appropriately allocated for member access.	TBD	TBD	TBD
2. Verify that the 24/7 telephone line offers information, in members preferred language on accessing SMHS and DMC-ODS services, assists with the resolution process, and provides appropriate guidance for urgent conditions.	Maintain a 24/7 toll-free number that members may call seeking access to SMHS and/or DMC-ODS services.	TBD	TBD	TBD
Responsible Partners	SOC QIC's,, Compliance			
Evaluation Methods/Tools	Monthly Test Calls, SSRS Reports, MHSA Data, BHEC Data			
Regulations	*42 CFR § 438.206(b)(1)*			

2. Timeliness Standards of Access				
Goal	Conduct monitoring on the timeliness of referrals and services following initial assessments or requests to improve on overall timeliness standards.			
Objective	**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**	**Evaluation of Data**	**QI Action Plan**
		FY 2024-2025	**FY 2024-2025**	**FY 2025-2026**
1. Outpatient, residential, non-urgent, referral, follow-up, and non-psychiatric SMHS and SUD service members are offered a timely appointment.	10 business days from request	TBD	TBD	TBD
2. SMHS urgent appointments are scheduled within regulated timeframes with prior authorization (PA) and without.	48 hours with PA 96 hours without PA	TBD	TBD	TBD
3. Opioid Treatment Program members are offered a timely appointment.	3 business days from request	TBD	TBD	TBD
4. Evaluate program specific data regarding average number of days from initial member contact to completed SUD assessment.	Not specified	N/A	TBD	TBD
5. Number of days from first service following initial request or referral.	Not specified	N/A	TBD	TBD
6. Monitor the number/percentage of no-shows for initial SUD assessment.	Not specified	N/A	TBD	TBD
7. Members discharging from psychiatric hospitalization are given a timely outpatient appointment.	Within 7 days after discharge	TBD	TBD	TBD
Responsible Partners	SOC QICs			
Evaluation Methods/Tools	Electronic Health Records Data Collection, TDAT Forms, NACT Reporting, SSRS Reports			
Regulations	*BHIN 24-020; BHIN 23-018 HCS 1367.03(a)(5)(H); 28 CCR section 1300.67.2.2(c)(5)(H)*			

3. Member Satisfaction				
Goal	Monitor member satisfaction to improve the quality of care, division operations, and effectiveness of services provided.			
Objective	**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**	**Evaluation of Data**	**QI Action Plan**
		FY 2024-2025	**FY 2024-2025**	**FY 2025-2026**
1. Utilize the Treatment Perception Survey for DMC-ODS to assess member and family satisfaction, identify areas for improvement, and develop a plan to address and monitor key areas of focus for the upcoming fiscal year if necessary.	Survey clients annually for satisfaction	TBD	TBD	TBD
2. Utilize the Consumer Perception Survey for SMHS to assess member and family satisfaction, identify areas for improvement, and develop a plan to address and monitor key areas of focus for the upcoming fiscal year if necessary.	Survey clients annually for satisfaction	TBD	TBD	TBD
3. Evaluate the quantity of member grievances, appeals, and State Fair Hearings and ensure they are being resolved in accordance with regulated time frames.	Grievances – 30 days Appeals – 30 days Expedited appeals – 72 hours	TBD	TBD	TBD
4. Identify and address quality of care issues by reviewing findings from incident reports.	Unusual occurrences to be reported to DHCS within 24 hours	TBD	TBD	TBD
5. Resolve member requests to change persons providing services in accordance with regulated time frames.	Evaluate requests to change persons providing services at least annually	TBD	TBD	TBD
Responsible Partners	Quality Services, Risk Management, SOC QICs			
Evaluation Methods/Tools	Symplr Reporting, ABGAR, Consumer Perception Survey, Treatment Perception Survey			
Regulations	*42 C.F.R. § 438.242(a) & 438.416(a); 9 C.C.R. § 1810.376; MHSUDS IN 18-010E, BHIN 24-020; BHIN 24-009; BHIN 24-026*			

4. Credentialing and Monitoring of Providers				
Goal	Perform database checks in accordance with State and Federal regulations, ensuring compliance with provider credentialing and monitoring standards.			
Objective	**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**	**Evaluation of Data**	**QI Action Plan**
		FY 2024-2025	**FY 2024-2025**	**FY 2025-2026**
1. Establish and require adherence to a uniform credentialing and recredentialing policy that addresses all clinical providers.	A documented process be implemented and followed	TBD	TBD	TBD
2. Ensure all applicable licensed staff are enrolled in the DHCS Provider Application and Validation for Enrollment (PAVE) portal.	All licensed staff be enrolled in PAVE	TBD	TBD	TBD
Responsible Partners	Human Resources, SOC Leadership, SUD Leadership			
Evaluation Methods/Tools	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			
Regulations	*42 C.F.R. part 438.214; BHIN 18-019; BHIN 24-023; 9 C.C.R section 1810.435(a)*			

5. The Service Delivery System's Clinical Integrity & Safety				
Goal	Monitor the safety and effectiveness of clinical practices in both SUD and SMHS programs.			
Objective	**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**	**Evaluation of Data**	**QI Action Plan**
		FY 2024-2025	**FY 2024-2025**	**FY 2025-2026**
1. Audit medication practices under the supervision of a licensed prescriber or dispenser to ensure regulatory prescriber and documentation practices.	Medication monitoring shall occur at least once annually	TBD	TBD	TBD
2. Assess the effectiveness of existing strategies aimed at reducing avoidable hospitalizations and implement additional measures, if needed, to further minimize overutilization.	Monitoring of avoidable hospitalizations shall occur	TBD	TBD	TBD
3. Monitor the average residential length of stay to ensure it is within the 30-day guideline.	Length of stays shall be monitored with a focus on a 30-day goal	TBD	TBD	TBD
Responsible Partners	Medication Monitoring Team, SUD QIC			
Evaluation Methods/Tools	MD/RN Audits, SUD QIC Monitoring			
Regulations	*42 C.F.R. § 438.330(b)(3); BHIN 23-065; 42 USC 1396 (A)(30-33), 42 CFR 456.2-456.6*			

6. Performance Improvement Projects (PIPs)				
Goal	Conduct PIPs that contribute to meaningful improvement.			
Objective	**DHCS Standard**	**DHCS Standard Met? (Met or Not Met)**	**Evaluation of Data**	**QI Action Plan**
		FY 2024-2025	**FY 2024-2025**	**FY 2025-2026**
1. Conduct two PIPs designed to achieve quality improvement in clinical and member outcomes. An evaluation and intervention of the PIPs shall be properly documented.	One clinical and non-clinical PIP be conducted annually and proper DHCS/CMS/or HSAG tools be completed.	TBD	TBD	TBD
Responsible Partners	PIP Committees, Quality Services Manager			
Evaluation Methods/Tools	PIP Meeting Minutes, PIP Tool			
Regulations	*42 C.F.R. § 438.330*			