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 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), on behalf of the Behavioral Health Plan, oversees the program to ensure compliance with quality improvement requirements related to service delivery. The QIP aims to identify, monitor and address quality of care issues through a structured and continuous improvement process to ensure services meet established regulatory and clinical 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

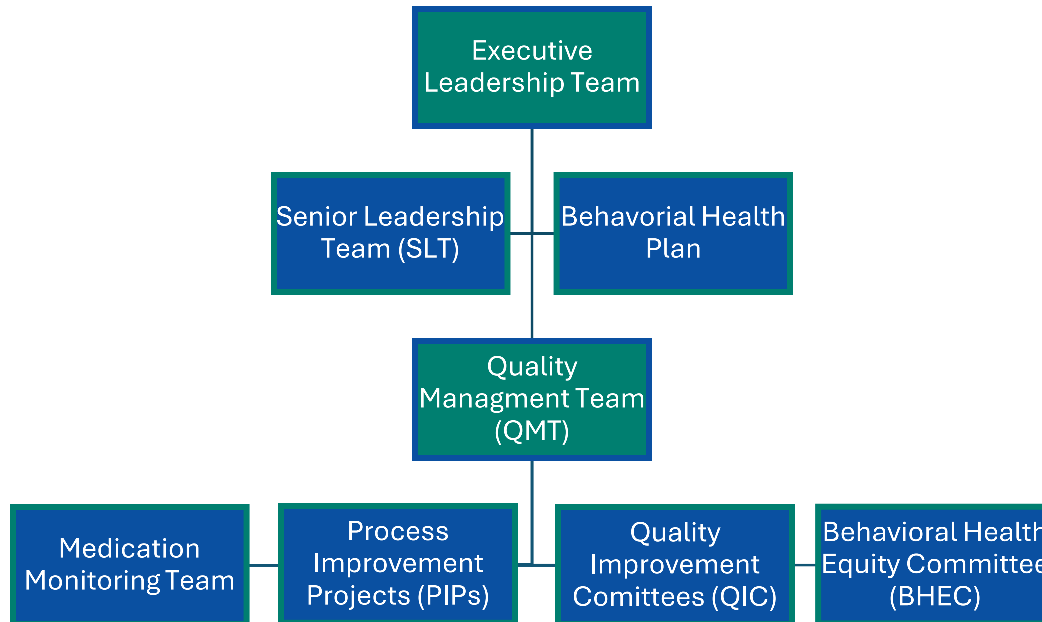
Our vision is to continue to be a leader in behavioral health and to be recognized for excellence in our community, state, and nation.

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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Executive Leadership Team – This team includes the Behavioral Health Director, Medical Director, Associate Director of Clinical Operations, and Assistant Directors. This team serves as the oversight for 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.

Behavioral Health Plan – The plan is responsible for plan functions for the Mental Health and DMC-ODS Plan, ensuring implementation of applicable regulatory and contractual requirements.

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 Committees 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 commitment to quality improvement initiatives. Consistent with requirements outlined in the Integrated Contract, each system of care and/or division will develop an action plan 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

<table>
<tr><th colspan="3">1. Service Capacity and Accessibility</th></tr>
<tr><td>Goal</td><td colspan="2">Conduct monitoring to assess the accessibility of SMHS and DMC-ODS services to ensure adequate access for all members.</td></tr>
<tr><th>Objective</th><th>DHCS Standard</th><th>DHCS Standard Met?
(Met or Not Met)</th></tr>
<tr><td>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.</td><td>Ensure resources are appropriately allocated for member access.</td><td>Met</td></tr>
<tr><td>Evaluation of Data
FY 2024-2025</td><td>During FY 24-25, 100% of beneficiaries were located within 30 miles or 60 minutes of a mental health provider.
Of the 8,254 unduplicated clients served 13.6% were served in Ceres, 12.2% on the Eastside, 49.2% in Modesto, 16.6% in Turlock, and 8.3% on the westside.</td><td>

Location Served	Percentage Served
Ceres	13.6%
Eastside	12.2%
Modesto	49.2%
Turlock	16.6%
Westside	8.4%
Total	**100%**

</td></tr>
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QI Action Plan	Stanislaus County BHRS will continue to serve beneficiaries and meet time and distance standards.

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
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.	Met

Evaluation of Data FY 2024-2025	See tables below

SMHS

Test Call Category	% Requirement Met
Provided Information in Member's Language	81.82%
Info About Accessing SMHS	91.67%
Info about Urgent Services	100.00%
Info about Prob Res & SFH	100.00%
Provided Information in Member's Language	81.82%
Written Log Included	**% Requirement Met**
Name of Beneficiary	93.75%
Date of Call	96.88%
Disposition of Call	93.75%

DMC-ODS

Test Call Category	% Requirement Met
Provided Information in Member's Language	100.00%
Info About Accessing SMHS	95.65%
Info about Urgent Services	100.00%
Info about Prob Res & SFH	100.00%
Provided Information in Member's Language	100.00%
Written Log Included	**% Requirement Met**
Name of Beneficiary	95.83%
Date of Call	100.00%
Disposition of Call	100.00%

Total Averages

Test Call Category	% Requirement Met
Provided Information in Member's Language	90.91%
Info About Accessing SMHS	93.66%
Info about Urgent Services	100.00%
Info about Prob Res & SFH	100.00%
Provided Information in Member's Language	90.91%
Written Log Included	**% Requirement Met**
Name of Beneficiary	94.79%
Date of Call	98.44%
Disposition of Call	96.88%

QI Action Plan	Test calls will be reviewed upon receipt and feedback regarding non-compliance will be provided to the coordinator within 1-2 business days. Quarterly meetings with coordinator to review the results of the test calls will continue. If trends are identified, meetings will be moved to monthly until performance improves to 90%.
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); BHIN 24-020; BHIN 23-018; BHIN 22-019; DHCS External Quality Review (EQR) Requirements; Integrated Behavioral Health Contract, Exhibit A (Attachments 5, 7, & 8)*

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)
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 Minimum 80% Compliance	Met

Evaluation of Data FY 2024-2025

During FY 24-25, 90% of beneficiaries were offered their first appointment within 10 days.
Of the 8539 clients served, 7653 (90%) were offered an appointment within the DHCS Standard timeframe.

1st Offered Appt Within:	Client Appointments
0 - 10 Days	7653
11 – 30 Days	740
31 – 60 Days	26
61 – 90 Days	2
> 90 Days	4
No Offer	114

QI Action Plan

During FY 25/26, BHRS will continue to track and monitor the offered and scheduled appointments.

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
2. SMHS urgent appointments are scheduled within regulated timeframes with prior authorization (PA) and without.	48 hours without PA 96 hours with PA	Not Met

Evaluation of Data FY 2024-2025

First Offered Appointment in Hours w/out PA		
0 – 48 Hours	31	24%
49 – 120 Hours	30	23%
> 120 Hours	70	53%
No Offer	0	0%

First Offered Appointment in Hours with PA		
0 – 96 Hours	1	100%
97 – 120 Hours	0	0%
> 120 Hours	0	0%
No Offer	0	0%

QI Action Plan

BHRS will continue to ensure that all requests for urgent mental health services are responded to within 48 hours for services that do not require an authorization and within 96 hours for services that do require an authorization.

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
3. Opioid Treatment Program members are offered a timely appointment.	3 business days from request	Met
Evaluation of Data FY 2024-2025	During FY 24-25, 99% of clients were offered their first appointment within 3 business days. Of the 755 clients served, 751 were offered an appointment within the DHCS Standard timeframe.	
QI Action Plan	During FY 25/26, BHRS will continue to track and monitor the offered and scheduled appointments.	

Opioid - First Offered Appointment Within Business Days		
0 – 3 Business Days	751	99.5%
4 – 10 Business Days	3	0.04%
> 10 Business Days	1	0.01%

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
4. Evaluate program specific data regarding average number of days from initial member contact to completed SUD assessment.	Not specified	N/A
Evaluation of Data FY 2024-2025	During FY 24-25, 85% of beneficiaries had their first rendered service appointment within 10 days. Of the 1,862 clients served, 1,580 had completed SUD assessment within 10 days of initial contact.	
QI Action Plan	During FY 25/26, BHRS will continue to track and monitor the offered and scheduled appointments from initial member contact to completed SUD assessment.	

First Rendered Appt and SUD Assessment Within Days of Initial Contact		
0 – 10 Days	1580	85%
11 – 20 Days	228	12%
21 – 30 Days	40	2%
> 30 Business Days	14	1%

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
5. Number of days from first service following initial request or referral.	Not specified	N/A
Evaluation of Data FY 2024-2025	During FY 24-25, 87% of beneficiaries had their first rendered service appointment within 10 days. Of the 7,137 clients with initial requests/referrals, 6,186 had their first service within 10 days.	
QI Action Plan	During FY 25/26, BHRS will continue to track and monitor the days from initial member request or referral to first service.	

Days from First Service following Initial Request or Referral		
0 – 10 Days	6186	87%
11 – 30 Days	825	12%
31 – 60 Days	99	< 1%
61 – 90 Days	20	< 1%
> 90 Business Days	7	< 1%

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
6. Monitor the number/percentage of no-shows for initial SUD assessment.	Not specified	N/A

Evaluation of Data FY 2024-2025

During FY 24-25, a total of 5,036 SUD appointments were offered with 1,785 (35%) of those appointments being unattended.

Of the 1,785 unattended appointments, 1,349 (76%) of those were due to the "No Show" reason.

Non-Urgent Routine	No Show to 1st Appt	Percentage
Total Offered	5036	100%
Unattended Appts	1785	35.44% of total appts
"No Show" Reason	1349	75.57% of unattended appts for "No Show" Reason

QI Action Plan

During FY 25/26, BHRS will continue to track and monitor the number of no-shows for initial SUD assessment.

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
7. Members discharging from psychiatric hospitalization are given a timely outpatient appointment.	Within 7 Days After Discharge	Not Met

Evaluation of Data FY 2024-2025

During FY 24-25, 67% of beneficiaries had their outpatient appointment within 7 days of discharge. Of the 1,697 clients discharged from psychiatric hospitalization that received an outpatient appointment, 1,130 had their appointment within 7 days.

Days After Discharge to First Service Outpatient Appointment		
0 – 7 Days	1130	67%
8 – 30 Days	307	18%
31 – 60 Days	107	6%
61 – 90 Days	52	3%
> 90 Business Days	101	6%

QI Action Plan

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.

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)
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	Met

Evaluation of Data FY 2024-2025

During FY 24-25, of the 6 subscales rated, an overall member average of 84.6% was shown to be favorable towards DMC-ODS Access, Satisfaction, Participation, Quality, Outcomes, and Functioning.

Subscale	Answered	Agreed	Favorable
Access	2,879	2,486	86%
Satisfaction	2,209	1,931	87%
Participation	722	624	86%
Quality	3,672	3,095	84%
Outcomes	1,431	1,154	81%
Functioning	1,449	1,211	84%

QI Action Plan: Stanislaus BHRS will continue to conduct the Treatment Perception Surveys annually and review the data for any opportunities for improvement.

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
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	Met

Evaluation of Data FY 2024-2025

During FY 24-25, of the 8 subscales rated, an overall member average of 84.6% was shown to be favorable towards SMHS Access, Satisfaction, Participation, Outcomes, Quality, Functioning, Connectedness, Quality & Appropriateness, and Cultural.

Subscale	Answered	Agreed	Favorable
Access	2515	2232	89%
Satisfaction	2924	2556	87%
Participation	1599	1377	86%
Outcomes	4231	2786	66%
Functioning	3099	2062	67%
Connectedness	2522	1985	79%
Quality & Appropriateness	2718	2419	89%
Cultural	1295	1206	93%

QI Action Plan: Stanislaus BHRS will continue to conduct the Consumer Perception Surveys annually and review the data for any opportunities for improvement.

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
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	Met

Evaluation of Data FY 2024-2025	During Fiscal Year (FY) 2024–2025, Behavioral Health and Recovery Services (BHRS) received a total of 48 Medi-Cal grievances and closed/resolved 50. BHRS achieved 100% timely processing of all grievances in accordance with regulatory requirements. BHRS received one (1) appeal during FY 2024–2025. The appeal was processed within DHCS timeliness standards and was overturned in favor of the member.
QI Action Plan	BHRS will continue to ensure that beneficiary grievances, appeals, expedited appeals, and requests for State Fair Hearings are being resolved expeditiously and appropriately within the MHP and continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
4. Identify and address quality of care issues by reviewing findings from incident reports.	Unusual occurrences to be reported to DHCS within 24 hours	Met

Evaluation of Data FY 2024-2025	During Fiscal Year (FY) 2024–2025, Behavioral Health and Recovery Services (BHRS) received a total of 302 Incident Reports with 33 of them being Adverse Incidents and 269 being regular incidents.
QI Action Plan	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.

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
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	Met

Evaluation of Data FY 2024-2025	During Fiscal Year (FY) 2024–2025, Behavioral Health and Recovery Services (BHRS) received a total of 98 Change of Provider requests (63 change of staff and 35 change of location) and closed 99 within that FY. BHRS achieved 97% timely processing of all requests in accordance with regulatory requirements. In addition, BHRS reported Change of Provider request data quarterly for FY 2024–2025 at the Quality Management Team (QMT) meetings.
QI Action Plan	BHRS will continue to monitor the Change of Provider requests and will continue providing quarterly data to the Quality Management Team meetings.
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)
1. Establish and require adherence to a uniform credentialing and recredentialing policy that addresses all clinical providers.	A documented process be implemented and followed	Not Met

Evaluation of Data FY 2024-2025	BHRS HR utilizes National Practitioner Data Base (NPDB) for verification of credentials and recredentialing, however the NPBP access is currently unavailable due a delay in providing the required peer review policy. The team is currently checking credentials for clinical providers through the Department of Consumer Affairs (DCA), California SUD Counselor Certification (CADTP), and California Mental Health Service Agency (CalMHSA) websites.
QI Action Plan	The peer review policy has been provided to NPB on 10/31/25. The team will continue to follow the manual process for validating clinical providers credentials until the NPDB account is reactivated. The NPDB account should be re-activated by 11/14/25.

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
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	Not Met

Evaluation of Data FY 2024-2025	All applicable licensed staff will be enrolled in Certify OS once the account is reactivated. Manual validation of licensure is the current process for the department until the NPDB resource is reactivated and allows for enrollment in Certify OS.
QI Action Plan	Enroll all applicable licensed staff in the PAVE portal and Certify OS, if needed.
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)
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	Met

Evaluation of Data FY 2024-2025	BHRS monitors the safety and effectiveness of medication practices through our MD/RN chart reviews. This is completed at least once annually. The results are as follows: Total Chart Compliance: 10 out of 14 charts required follow-up. Total Chart Compliance for Diagnoses: 29% Total Compliance for Medication Progress Notes section: 92% Total Compliance Orders/Labs/Etc. section: 83%
QI Action Plan	BHRS will continue to conduct MD/RN chart reviews at least annually to collect and analyze data for the medication monitoring process. The BHRS Medical Director will identify areas of improvement to provide additional guidance to medical staff.

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
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	Met
Evaluation of Data FY 2024-2025	This measure was newly introduced and required foundational development. The Quality Improvement Committee's (QIC) continue to engage in preliminary work to explore how avoidable hospitalization and overutilization could be defined and measured, including discussion of protentional utilization indicators, data sources and methodological considerations.	
QI Action Plan	The QIC's will continue this work with the goal of implementing measurement and evaluation as part of ongoing QAPI activities.	

Objective	DHCS Standard	DHCS Standard Met? (Met or Not Met)
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	Met
Evaluation of Data FY 2024-2025	Total enrollment counts all enrolled during the date range selected, including clients that haven't been discharged yet. Length of Stay (LOS) is measured by the total number of residential bed day procedure code "Residential Treatment - Substance Use" documented. Average LOS and Median LOS exclude clients that have not been discharged from program within the timeframe of this report.	
QI Action Plan	Stanislaus County BHRS will continue to track and monitor client residential stay to ensure within the 30-day guidelines.	
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*	

Measure	Value
Total Resident Enrollments	1599
Total Resident Discharges	1588
Unique Client Count	824
Average Bed Days Lenth of Stay in Days	15.1
Average CalOMS Lenth of Stay in Days	17.7
Average Clients Programs Length of Stay in Days	17.2
Median Bed Days Length of Stay in Days	4
Medical CalOMS Length of Stay in Days	6
Median Clients Programs Length of Stay in Days	7

<table>
<tr><th colspan="4">6. Performance Improvement Projects (PIPs)</th></tr>
<tr><td>Goal</td><td colspan="3">Conduct PIPs that contribute to meaningful improvement.</td></tr>
<tr><th colspan="2">Objective</th><th>DHCS Standard</th><th>DHCS Standard Met? (Met or Not Met)</th></tr>
<tr><td colspan="2">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.</td><td>One clinical and non-clinical PIP be conducted annually and proper DHCS/CMS/or HSAG tools be completed.</td><td>Met</td></tr>
<tr><td>Evaluation of Data FY 2024-2025</td><td>During FY 2024-2025, two new PIP committees were formed to align with new External Quality Review and Department of Healthcare Services (DHCS) requirements. The PIP process was started for both new PIP's to meet the first submission for baseline and AIM statements due July 2026.</td><td colspan="2">Non Clinical PIP: Increase the Percentage of Members who Receive at least One Certified Peer Support Service
Pre Baseline Measurement Period 1/1/24 – 12/31/24 8.3%
Developed AIM Statement: Do targeted interventions increase the percentage of members accessing Specialty Mental Health Services (SMHS) or Substance Use Disorder (SUD) services who also receive at least one peer support service provided by a certified Peer Support Specialist during the reported remeasurement period?
Clinical PIP: Pharmacotherapy for Opioid Use Disorder (POD)
Pre Baseline Measurement Period 1/1/24 – 12/31/24 22.9%
Developed AIM Statement: Do targeted interventions increase the percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days without a gap in treatment of 8 or more consecutive days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event during the reported remeasurement period?</td></tr>
<tr><td>QI Action Plan</td><td colspan="3">Stanislaus County BHRS will continue to ensure PIPs remain active in the upcoming FY 2025/2026.</td></tr>
<tr><td>Responsible Partners</td><td colspan="3">PIP Committees, Quality Services Manager</td></tr>
<tr><td>Evaluation Methods/Tools</td><td colspan="3">HSAG EQR PIP Tools</td></tr>
<tr><td>Regulations</td><td colspan="3">42 C.F.R. § 438.330</td></tr>
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