Calaveras County Behavioral Health

Quality Assessment & Performance Improvement Program & Quality Improvement Work Plan

2025 – 2026

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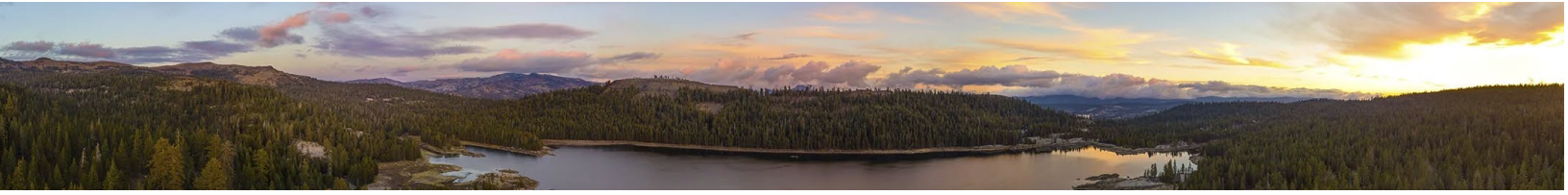


Calaveras County Behavioral Health Services
Quality Management Program

Quality Assessment and Performance Improvement Program &
Quality Improvement Work Plan

July 1, 2025 – June 30, 2026

Mission Statement

The mission of Calaveras County Behavioral Health Services (CCBHS) is to use the Five Guiding Principles listed below to empower consumers and their families to create more satisfying, fulfilling, and productive lives by supporting wellness, recovery, and hope.

1. **Cultural Competency:**
   Services will reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.

2. **Client, Consumer & Family Involvement:**
   Services will engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery and evaluation.

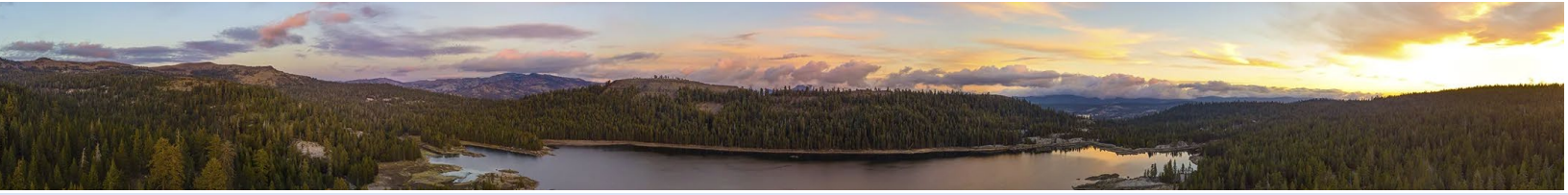
3. **Community Collaboration:**
   Services will strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.

4. **Integrated Service Delivery:**
   Services will reinforce coordinated agency efforts to create seamless experience for clients, consumers, and families.

5. **Wellness and Recovery:**
   Services will promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.

Calaveras County Behavioral Health Services

Calaveras County Behavioral Health Services (CCBHS) maintains an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for the services it furnishes to members. This plan is reviewed and updated annually as part of our continuous quality improvement efforts. The information is used to develop the annual Quality Improvement (QI) Work Plan to guide performance improvement activities. The QI Work Plan describes CCBH Quality Management (QM) activities in detail, including identified and needed performance indicators, ongoing or time limited performance improvement projects, and other performance monitoring to ensure quality care. QI Plan activities are developed from multiple sources of information about quality of care, access to services, and identified issues, including State and Federal Requirements, Department initiatives, client and family feedback, and stakeholder input.



2025-2026 Quality Assessment and Performance Improvement Program

Structure of the CCBH Quality Assessment and Performance Improvement (QAPI) Program

The QAPI Program identifies the structures and processes used to monitor and evaluate the quality of mental health, substance use, and administrative services provided. The QAPI Program includes active participation by CCBH's practitioners and providers, quality management staff, members, family members, and other stakeholders in the planning, design, and execution of the QAPI Program. CCBH engages stakeholders to identify gaps, analyze data, and seek input for planning and implementation.

2025-2026 Quality Assessment and Performance Improvement Plan

The FY 24-25 QAPI has been evaluated by the QIC and is available for review. This current report reflects a combined QAPI and work plan for Calaveras County for both SMHS and DMC State Plan quality management activities for FY 25-26.

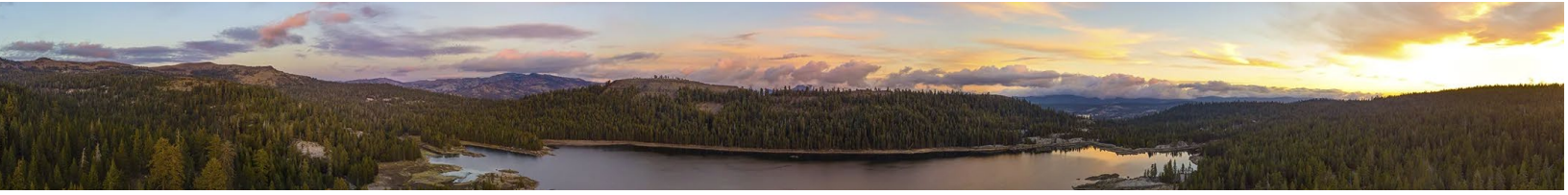
This year's QAPI Plan and QI Work Plan are part of a continuing effort to strengthen and enhance the CCBH QAPI Program as we incorporate the ongoing changes and additions to California's Medi-Cal Behavioral Health programs. In FY 24-25, CCBH participated in the Early Integration work group, moving towards a more integrated system for whole client care in our Mental Health and Substance Use Disorder programs to create a more dynamic and responsive system for the members we serve. This resulted in termination of the previous MHP and DMC-State Plan contracts effective 12/31/24 and execution of a new, integrated contract covering both SMHS and DMC services effective 1/1/25 - 12/31/26. The most significant changes include:

- Expansion of the 24/7 Access Line to support DMC/SUD.
- Renaming the Mental Health Advisory Board to Behavioral Health Advisory Board and expanding the scope of the board to include the DMC program.
- Quality Improvement Committee meeting and activities incorporating additional DMC/SUD requirements.

Therefore, this year's QAPI and QI Work Plan continues to include goals for both the Mental Health Plan's (MHP) Specialty Mental Health Services (SMHS) and Drug Medi-Cal (DMC) State Plan Substance Use Disorder Services (SUDS).

The CCBH Quality Management Team is comprised of two full-time, non-clinical Quality Management Specialist (QMS) positions dedicated to all aspects of the QAPI Program for both the MHP Specialty Mental Health Services and DMC State Plan Substance Use Services. The team also includes one half-time Clinical QMS position for oversight of clinical aspects of the QAPI Program, such as Utilization Management and Review, Change of Provider requests and clinical components of Grievances and Appeals.

In FY 24-25, the CCBH Quality Management Team was impacted by a series of staff departures and faced challenges filling the empty positions. Quality management tasks were covered by



other administrative staff with input and support from the acting clinical supervisor and Behavioral Health Director. In the spring of 2025, adjustments were made to the QMS position requirements, providing a larger pool of applicants; however, these vacancies impacted the capacity of the QM program throughout the fiscal year. In FY 25-26, both non-clinical positions are now filled, and the clinical QM position continues to be covered by clinical supervisor and the CCBH Director.

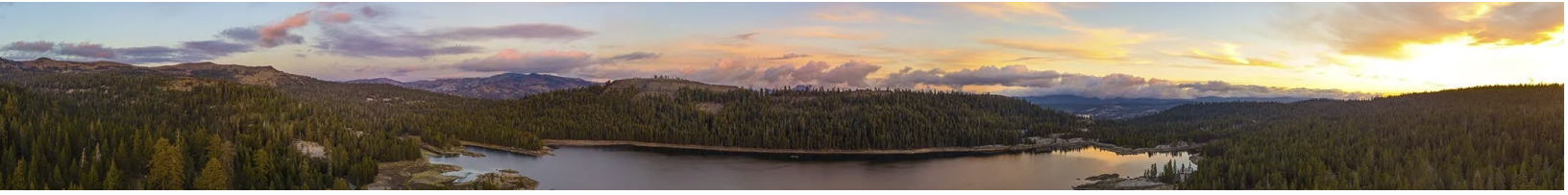
The Behavioral Health Management Team and administrative staff (including both MHP and DMC State Plan representatives) consistently participate in the QIC meetings and related QAPI activities. CCBH's QAPI Program aims to improve the department's established outcomes through structural and operational processes and activities that are consistent with current standards of practice.

As we move into FY 25-26, there are a few factors with potential to significantly impact CCBH's Quality Management Program.

1. HHSA has created a separate Compliance Division, including appointment of a Compliance Officer to update and expand compliance efforts throughout HHSA. For CCBH, this will facilitate needed program integrity policy updates and trainings, as well as allow for increased support in developing and monitoring state contracts, subcontracts, and division polices.
2. The transition of Mental Health Services Act to Behavioral Health Services Act involves corresponding funding and program changes affecting many CCBH programs such as Full Service Partnership; we anticipate a number of needed to our policies and procedures, practice guidelines, and other program modifications to support implementation.

In FY 25-26, CCBH plan to continue to build upon the foundations of previous year's efforts to strengthen the Quality Management Program, enhancing and strengthening current processes and incorporating new programs and initiatives. This includes but is not limited to the following:

- Quality Improvement Committee
    - Increase the participation and involvement of Members, Family Members, Contracted Providers, Community Partners, and Stakeholders.
    - Create and utilize subcommittees for policy development, form creation and revision (both paper and EHR), and data gathering and review to support and inform the quality assurance and performance improvement program.
- Utilization Management (UM)
    - Continue monthly SUD and SMHS Utilization Management reviews and meetings.
    - Perform timely reviews of paid claims documentation; this step was previously delayed during the implementation of a new EHR and payment reform changes and impacted by the QM staffing challenges in FY 24-25.
- Medication Monitoring
    - Continue to utilize contractor to perform monthly Medication Monitoring, to be reviewed by QM Team and UM Medication Services Committee. Finalize Medication Monitoring Practice Guidelines and policy updates.



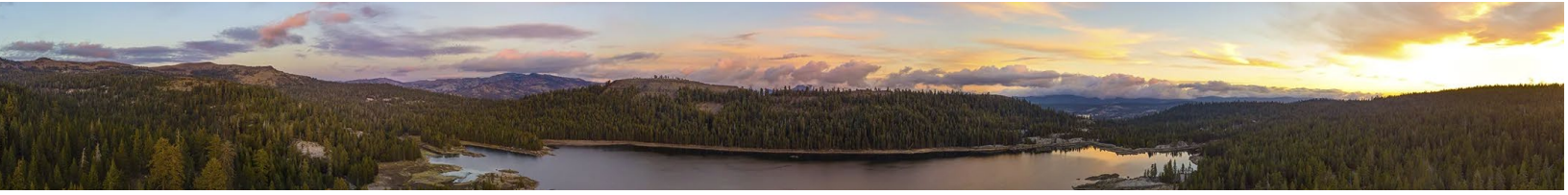
- Cultural Competence Plan (CCP) and Committee (CCC)
    - The CCBH Cultural Competence Plan was updated for FY 24-25 and will be updated again for FY 25-26.
    - Cultural Competence Committee meetings occur monthly with the goal of including culturally diverse voices of the community to promote discussion about cultural awareness and concerns. Community organizations can share events and initiatives within their programs.
- Level of Care determination
    - Implementation of LOCUS to inform and assist with level of service determinations for adult SMHS services and better inform client program assignments.
- Improve staff guidance and resources:
    - Policy and Procedures – Review and update current policies or create new policies as needed. Organize online policy manual to ensure it is current and complete.
    - Practice Guidelines – Finalize Practice Guidelines; review and update annually.
- Member Rights
    - Continue monitoring of specific member rights program elements listed below. Continue to report quarterly statistics and trends to BH Advisory Board.
        - *Access to Care – Improve compliance with No Wrong Door and Closing the Loop in screening services, referral assistance, and transitions to managed care plans. Continue to improve 24/7 Access line test call results as part of the continuing 2024 Non-clinical PIP.*
        - *Change of Provider – Continue to track and address any trends or identified issues.*
        - *NOABD – Incorporate NOABD forms and processes into EHR; update reference guides and provide staff training as applicable.*

Performance Monitoring

CCBHS collects and submits performance measurement data required by the department including but not limited to:

- Network Adequacy
- Timeliness of services
- Grievances and Appeals
- 24/7 Access line
- CSI data
- CalOMS data
- Other reporting as required and/or requested

CCBHS conducts additional performance monitoring activities throughout our operations. These activities include, but are limited to, member and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of member grievances. Performance monitoring activities are conducted by the QM Team and reported to



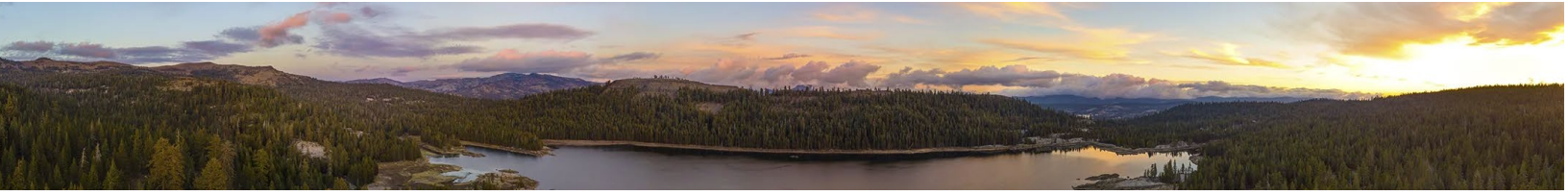
the Administration and Management Teams monthly, to the QIC and Behavioral Health Advisory Board quarterly, and disseminated to staff as appropriate. These are also reported to DHCS when required and/or requested and provided for auditors when applicable.

The Utilization Review tools for both DMC-State Plan SUDS and MHP SMHS include mechanisms for identifying and examining frequency of service to highlight potential instances of overutilization or underutilization of services. The UM committee reviews outcomes of Utilization Reviews and Medication Monitoring and addresses any identified instances of overutilization or underutilization of services. Additionally, while direct service providers are encouraged to monitor their caseloads independently, the CCBH Administration Team (to include data and billing staff) runs reports to identify members without services for a specified period of time, review frequency and types of services being provided, and address any documentation or coding errors.

For Medication Monitoring, CCBH contracts with a psychiatrist (not providing services for CCBH members) to perform monthly reviews of up to 10 charts (5 youth and 5 adult charts), utilizing a CCBH form containing all required medication monitoring elements. The charts are selected from the total of all members receiving medication services in the month being reviewed. Results are disseminated to the BH Program Director and QM Team; overall findings are shared with the UM committee and summary results are shared with the QIC. Feedback and corrections are shared with medication service providers by the BH Business Administrator or designee.

CCBHS maintains the following mechanisms to assess member/family satisfaction and is enhancing some of these during FY 25-26 as noted below:

1. Surveying member/family satisfaction with CCBH services at least annually.
    a. Administer the annual DHCS Consumer Survey and review results with the QIC, BH Advisory Board, and make the results available to members in clinics and on the CCBH Website.
    b. Administer the new CCBH Consumer Survey developed by QIC; this county-specific survey will be administered over a longer period of time and will include both the MH and SUD programs with the hopes of gleaning additional insight and feedback to better inform QAPI efforts.
    c. Review MHSA annual stakeholder survey results and provide recommendations for changes or improvements as applicable.
    d. Ensure the General Feedback Survey is available in the CCBH lobbies, on the CCBH website and accessible by QR code. Review and monitor responses to address any issues, review suggestions and identify potential trends.
2. Evaluating member grievances, appeals and State Hearings at least annually
    a. Review member grievances, appeals and state hearings quarterly and report to QIC and BH Advisory Board.
    b. Provide recommendations and feedback and monitor any interventions/ changes as appropriate.
3. Evaluating requests to change persons providing services at least annually.
4. Informing providers of the results of member/family satisfaction activities.



The QM Team has also implemented mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. Significant findings of any of the CCBHS performance monitoring activities may result in further actions, such as developing and implementing a performance improvement plan, reporting to appropriate departments or agencies, or modifying programs if needed. The results of these interventions shall be evaluated at least annually.

CCBH Quality Improvement Committee (QIC):

The role and function of the Quality Improvement Committee (QIC) is to plan and evaluate the results of quality improvement activities, recommend policy changes, institute needed QI actions, ensure follow-up of QI processes, and provide stakeholder input to the Calaveras County Behavioral Health (CCBH) Quality Assessment and Performance Improvement Program.

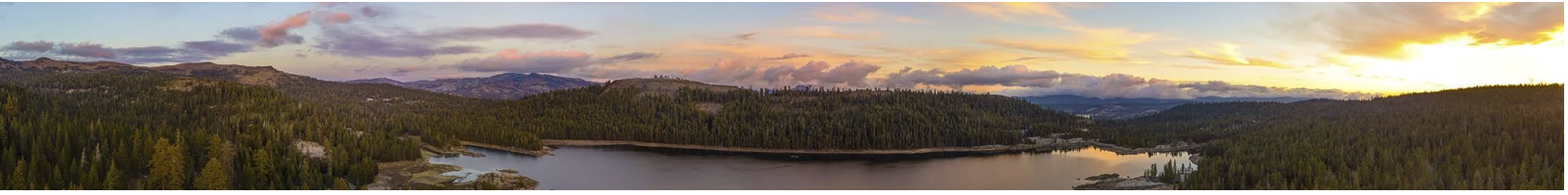
QIC's responsibilities are as follows:

- Provides oversight of all QI activities within mental health, substance use, and administrative service functions.
- Ensures that the results of various studies are publicized for employee, member, and community review.
- Elicits and responds to employee, member, and community input regarding areas requiring improvement.
- Reviews data and information collected through surveys and data management and utilizes outcome measure results in the QAPI Program.
- Makes recommendations to senior management, identifying needed resources for full implementation of continuous quality improvement.
- Monitors the problem resolution process.
- Monitors utilization management information regarding CCBH's contract with the State Department of Health Care Services.
- Conducts and reviews specialized quality improvement activities.

The CCBH Quality Improvement Committee meets on the first Tuesday of each month at 1:30 in the Health and Human Services (HHSA) Sequoia Room; meetings are open to the public and we encourage stakeholder and member participation. The committee includes the following representatives:

Stakeholders:
Behavioral Health Plan Members (clients)
Community Member(s)
Contracted Providers
Family Members
Advisory Board Member

Behavioral Health Representatives:
Quality Management Specialist(s)
Mental Health Clinical Staff
Substance Use Disorder Staff
Case Management Staff
Peer Support Staff
Administrative Support Staff
Other Program Staff as needed



QIC includes the following subcommittees:

Community Voices
Community Partners
Ad-Hoc, topic specific committees
Utilization Management
Cultural Competence

Quality Improvement (QI) Work Plan

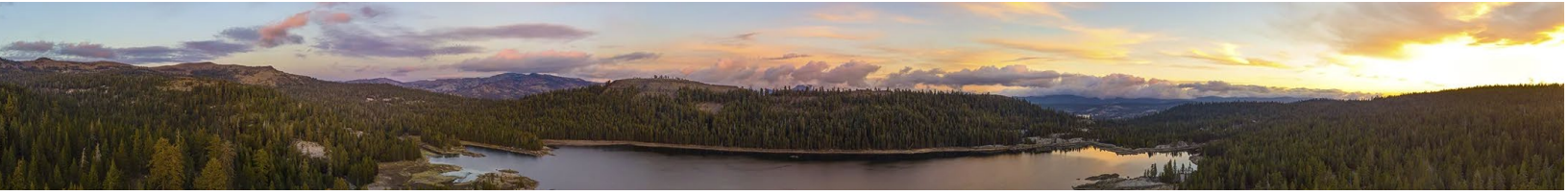
CCBHS has developed a Quality Improvement (QI) Work Plan covering the current contract cycle, which will be updated with documented annual evaluations and documented revisions as needed. The QIC provides oversight to ensure the implementation of the QAPI Work Plan. QIC sets priorities and delegates authority to the various staff, who then study processes, implement interventions for improvement, and subsequently analyze the effectiveness of any changes which may have occurred. There are two main categories in the CCBH Work Plan: Quality Monitoring and Performance Improvement Projects.

Quality Monitoring

Member Satisfaction Monitoring

Member satisfaction monitoring includes several activities that help CCBH leadership detect member satisfaction with essential components such as services, treatment, customer service, and access. The member satisfaction monitoring system will include a routine review of the member problem resolutions, the Consumer Perception Survey Results, and Change of Provider Requests. In addition, the quality program creates a framework to use benchmarks and targets to ensure member satisfaction is achieved and the monitoring system is effective.

Goal 1: Ensure Timeliness Standards for Member Rights processes	
Measurement	• Four quarterly reviews of timeliness related to Member Rights processes. • Quarterly and Annual reports to QIC and the BH Advisory Board for all NOABDs, Change of Provider requests, grievances, appeals, and State Fair Hearings to include percent of problem/resolutions resolved by their respective timeliness standard. • Timely submission of DHCS quarterly reports for Grievances and Appeals and Access line test calls.
Intervention	• Monitor cases at risk of being out of compliance, review any out of compliance for reasons and trends. • Quarterly report prepared (October, January, April, and July) for the QIC and BH Advisory Board for the following month's meeting (November, February, May and August). • Annual report for the August QIC and Advisory Board meeting to include any notable trends.
Due Date	Quarterly reports to QIC as indicated above Annual Report in August, 2026
Responsible	**Quality Management Team**



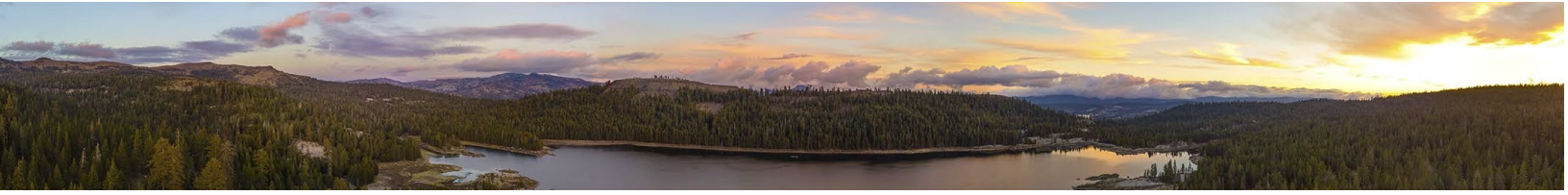
Goal 2: Monitor member satisfaction through the Annual Statewide Consumer Perception Survey, Annual CCBH Member Survey and ongoing General Feedback Survey responses	
Measurement	• Results and recommendations shared with staff for all surveys. • Meet or exceed 80% overall satisfaction rate. • Meet or exceed 80% satisfaction with access to language. • Meet or exceed 80% satisfaction with cultural sensitivity. • Meet or exceed 80% received access in preferred written language.
Intervention	• Collect the findings and analyze the data upon release of state survey results. • Collect the findings and analyze the data upon completion of county survey. • Distribute/notify/share the results with all leadership and staff. • Monitor general feedback surveys to identify potential issues.
Due Date	June 30, 2026
Responsible	**Quality Management Team**

Goal 3: Monitor member satisfaction through Change of Provider Requests	
Measurement	• Identify providers that represent 25% or more of total requests and refer to CCBH Management Team for review. • Trend analysis of reasons for requests of those representing 25% or more of all requests. • Quarterly report prepared (October, January, April, and July) for the QIC and BH Advisory Board for the following month's meeting.
Intervention	• Quarterly analysis of change of provider requests. • Results to be shared and interventions developed around concerns or trends.
Due Date	Quarterly reports to QIC as indicated above Annual Report in August, 2026
Responsible	**Quality Management Team**

Access and Timeliness

The Access and Timeliness Monitoring System will be composed of activities that help CCBH leadership gauge and monitor for barriers people may face when seeking care. These components together help tell a story of our ability to meet our communities' behavioral health needs and demands. The activities include monitoring our 24/7 access line, cultural competence presence and training, timeliness to accessing service targets and monitoring, and watching the provider network to ensure it is adequate to meet the community needs.

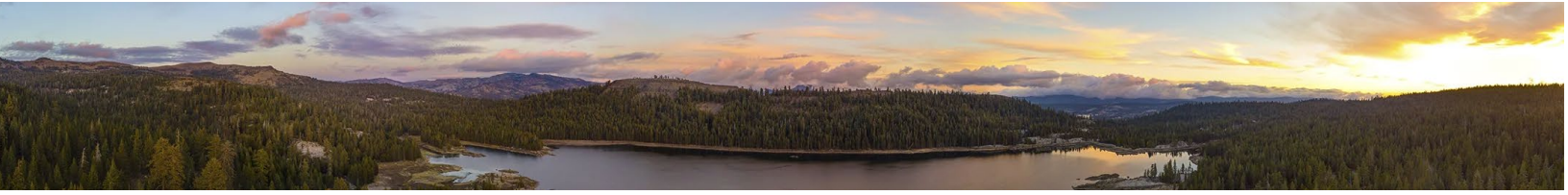
Goal 4: Improve the compliance rate of 24/7 access line test calls	
Measurement	• At least 60 test calls completed in FY 25-26 (five test calls per month) testing all access elements (Access, Urgent, Language Line, Grievance/Appeals). • Training provided during onboarding and at least once annually for CCBH and after hours agency staff. • Four quarterly reports to QIC, CCBH leadership, and BH Advisory Board.



	• Annual outcomes and analysis shared with QIC.
Intervention	• Review test calls; provide and document feedback/training as needed. • Maintain formal training for access line staff to take upon hire and annually after that; update training as needed. • Report outcomes to DHCS, CCBH Leadership, and BH Advisory Board quarterly. • Report tests call results to QIC quarterly and summary results annually; institute any recommended QIC actions.
Due Date	Quarterly reports to QIC as indicated above Annual Report in August, 2026
Responsible	**Quality Management Team**

Goal 5: Monitor timeliness of access to services to ensure compliance with all timeliness measures	
Measurement	• Timely submission of TADT. • 80% of members being offered or receiving an appointment 10 days from request to first appointment. • 80% of members offered a follow-up appointment with a non-physician within 10 business days of the first/prior appointment. • 80% of new members receiving Psychiatry Services within 15 days from request/referral for psychiatry to first psychiatric service. • Monthly monitoring of data entry to identify issues and/or training needed.
Intervention	• Routine timeliness monitoring of non-urgent services; update process as needed to sync with data from new electronic health record. • Review timeliness data to monitor for access and data quality issues. • Provide training for administrative and clinical staff on Urgent Requests for Services.
Due Date	Quarterly reports to QIC as indicated above Annual Report in August, 2026
Responsible	**Quality Management Team**

Goal 6: Monitor the provider network adequacy	
Measurement	• Timely submission of 274, NACT reflecting compliance with network adequacy standards. • Annual reporting of timeliness data and any identified issues to QIC.
Intervention	• Monitor submission of 274, NACT and TADT; review data to identify potential issues and monitor capacity. • Monitor the number of providers and corresponding caseloads monthly; forward findings to BH Management if action is needed.
Due Date	June 30, 2026
Responsible	**Quality Management Team, QIC**



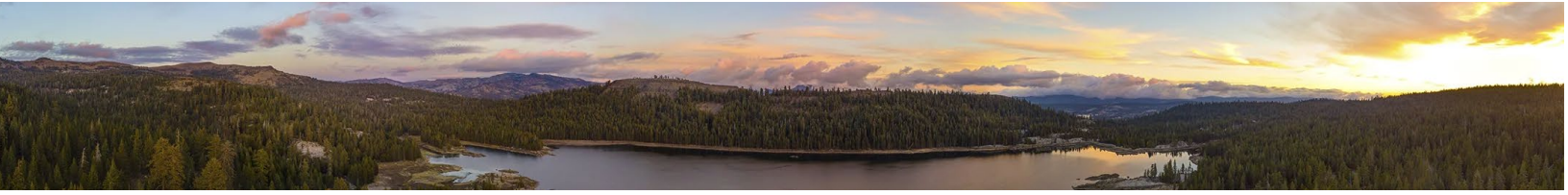
Goal 7: Ensure a culturally competent workforce	
Measurement	• Monitor penetration rates for potential threshold languages annually. • Examine and analyze penetration rates and identify potential underserved populations annually; share with QIC and CCC. • Staff completion of at least 4 hours of CC training, including TGI training upon hire and biannually or in response to a verified complaint.
Intervention	• Monitor penetration rates for trends when data received from the External Quality Review (EQR) Organization • Increase outreach to identified unserved population(s) as appropriate • Assign applicable training for staff in Relias; provide at least one in-person CC training opportunity annually
Due Date	June 30, 2026
Responsible	**Quality Management Team**

Utilization and Care Quality

Utilization and care quality monitoring activities encapsulate indicators related to authorizations for routine and hospitalization services and care quality Healthcare Effectiveness Data and Information Set (HEDIS) measures related to medication and readmission rates. Utilization monitoring utilizing various indicators of our authorization system allows us to look for trends of over and underutilization while also monitoring for inconsistencies or trends that may impact care quality. In addition, implementing measures aligning with HEDIS measurement monitoring standards allows us to monitor care quality issues.

Goal 8: Ensure compliance with NOABD issuance	
Measurement	• NOABD forms available in EHR by end of fiscal year. • One mandatory staff training on EHR NOABD process provided. • Quarterly report to QIC of NOABD rates, reasons.
Intervention	• Work with EHR vendor to create templates and test functionality. • Adapt previous staff training to incorporate EHR process. • Prepare quarterly report for QIC and BH Advisory Board.
Due Date	Quarterly reports to QIC as indicated above Forms, training completed by June 30, 2026
Responsible	**Quality Management Team**

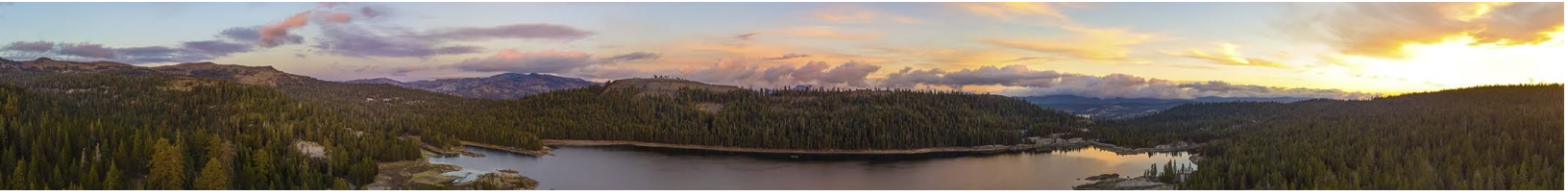
Goal 9: Ensure consistency in the authorization/assignment system	
Measurement	• Tracking is current and sufficient for services needing authorization. • Utilization Management incorporates authorization reviews.
Intervention	• Review and update as needed monitoring systems for all authorization types: • Review of Denial/Delivery System NOABDs and any related member appeals to identify potential inconsistencies in authorization process. • Utilization Management reviews authorizations and assignments to ensure they are appropriate and consistent.
Due Date	June 30, 2026
Responsible	**Quality Management Team, Utilization Management Team**



Goal 10: Ensure appropriate level of care assignments for outpatient SMH services	
Measurement	• Level-of care tools are utilized during the assessment process for each system of care by the end of the fiscal year. • Staff are trained to utilize level of care tools and certified upon implementation and as needed thereafter.
Intervention	• Purchase and implement LOCUS for adult outpatient mental health LOC determinations. • Monitor staff LOC tool certifications. • Ensure staff training is completed for applicable LOC tools.
Due Date	June 30, 2026
Responsible	**Quality Management Team, Utilization Management Team**

Goal 11: Monitor Quality of Care and Service Documentation Through Monthly Utilization Management and Medication Monitoring reviews	
Measurement	• SMH and SUD UM tools fully completed each month. • UM Committee Monthly Minutes reflect completed reviews and discussion of identified issues. • Medication Monitoring incorporated into UM process – monthly reviews. completed, findings disseminated, and trends/interventions reported to QIC.
Intervention	• Expand SUD UM reviews to incorporate billing review section. • Implement monthly SMHS reviews. • UM committee meets monthly to review outcomes and reports trends and interventions to QIC. • Include Medication Monitoring results in UM Meeting. • Identified issues are forwarded to staff/supervisors for correction and/or training; monitored by QM Team for completion.
Due Date	June 30, 2026
Responsible	**Quality Management Team, Utilization Management Team**

Goal 12: Ensure Policies and Procedures are current and accessible	
Measurement	• Online policy manual is complete and reflects current versions of all policies. • Policies updated or created in response to new program direction, BHIN guidance, audits or CAPs are incorporated into the policy manual. • Online P&P manual reorganized to align with integrated contract
Intervention	• When policies are updated are created, they are added to the online P&P manual and distributed to staff for review and signature. • QM will create a tracking mechanism to ensure policies created, updated or eliminated are added or replaced in the online P&P manual. • QM Team will include a Policy and Procedure category in the weekly QM Team Meeting to facilitate updates, creation and processing.
Due Date	June 30, 2026
Responsible	**Quality Management Team, Utilization Management Team**



Goal 13: Develop and disseminate comprehensive Practice Guidelines	
Measurement	• Practice guidelines are comprehensive and current. • Staff have been trained on how to access and utilize practice guidelines. • Practice guidelines are utilized to guide service delivery and documentation.
Intervention	• QM will compile and review previous guidance materials; determine what should be updated and incorporated into Practice Guidelines. • QM will reference Practice Guideline samples, previous guidance materials and current guidance requirements in order to create current guidance. • QM Team will complete Practice Guidelines by Oct. 1, 2025, with the goal to have final Practice Guidelines disseminated to staff by Dec. 1, 2025. • Practice Guidelines will be reviewed and updated at least annually.
Due Date	Dec. 1, 2025 (Dissemination) and June 30, 2026 (Annual Review)
Responsible	**Quality Management Team, Utilization Management Team**

Performance Improvement Projects (PIPs)

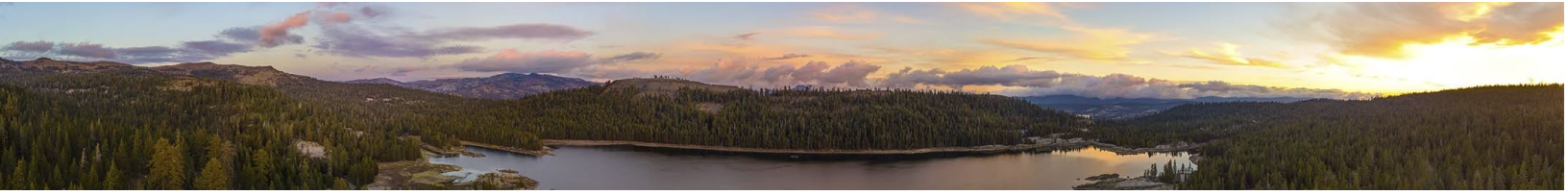
CCBH will conduct a minimum of two formal Performance Improvement Projects (PIPs) each year, including any PIPs required by DHCS. At least one of the two PIPs will focus on a clinical area and one of the two may focus on clinical or non-clinical areas. CCBH will report the status and results of each performance improvement project to DHCS as requested, but not less than once per year. Each PIP will:

1. Be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction;
2. Include measurement of performance using objective quality indicators;
3. Include implementation of interventions to achieve improvement in the access to and quality of care;
4. Include an evaluation of the effectiveness of the interventions based on the performance measures collected as part of the PIP; and
5. Include planning and initiation of activities for increasing or sustaining improvement.

Goal 14: SMHS Performance Improvement Projects (PIPs)	

Measurement	• Clinical PIP
	  ○ Follow-Up After Emergency Department Visit for Mental Illness (FUM): increasing the percentage of members receiving timely follow-up.
	• Non-Clinical PIP
	  ○ Peer Support Services (PSS): Increasing the number of services delivered by Certified Peer Support Specialists.
	• Work with EQR Organization on formal PIP Submission processes.
	• PIP document completed through implementation stage.

Intervention	• Complete initial PIP submissions as required. • Implement PIP intervention(s) by January 1, 2026 • Monitor intervention and outcomes for first year reporting
Due Date	January 31, 2026 (Interventions) and June 30, 2026 (Reporting)
Responsible	**Quality Management Team**



QAPI Plan and Work Plan Reviews and Revisions

The CCBH QAPI Plan and Work Plan Goals will be discussed at QIC at least quarterly to examine progress towards goals and prioritize projects. The QAPI Program and plans will be reviewed annually after the close of the fiscal year; review results will be disseminated to staff and examined in QIC, as well as made available to community members and stakeholders through the CCBH website. Review outcomes and staff/stakeholder/community input will be utilized to inform the FY 25-26 plan.