Calaveras County

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT WORK PLAN

2024 - 2025

ANNUAL EVALUATION

(209) 754-6525

891 Mountain Ranch Rd. Bldg M
San Andreas, CA 95249

https://behavioralhealth.calaverasgov.us/

Behavioral Health
CALAVERAS COUNTY

Calaveras County Behavioral Health Services

Quality Management Program Annual Quality Assessment and Performance Improvement Plan and Quality Improvement Work Plan

Fiscal Year 2024-2025 ANNUAL EVALUATION – *Notes in Green Throughout*

Mission Statement

The mission of Calaveras County Behavioral Health Services (CCBHS) is to use the Five Guiding Principles 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 beneficiaries. 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.

FY 2024-2025 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, CCBH quality management staff, beneficiaries, 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.

FY 2024-2025 Quality Assessment and Performance Improvement Plan

The FY 23-24 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 24-25.

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 addition, CCBHS is continuing our participating in the Early Implementation Work group, moving towards a more integrated system for whole client care in our Mental Health and Substance Use programs to create a more dynamic and responsive system for the clients we serve. 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).

***Annual Review notes**: CCBH's participation in the Early Implementation Work Group resulted in termination of the previous MHP and DMC-State Plan contracts and execution of a new, integrated contract covering both SMHS and DMC services. 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.*

Last year, CCBH added an additional Quality Management Specialist (QMS) position to enhance and support the QAPI Program. The team now has two full-time, non-clinical 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. 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.

***Annual Review notes**: In FY 24-25, the CCBH Quality Management team was impacted by a series of staff departures and faced challenges filling the empty positions. 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.*

As we move into FY 24-25, there are two current initiatives that have the potential to significantly impact CCBH's Quality Management Program.

1. BH Administrative Restructuring: We are in the midst of an examination of the BH organizational structure which will most likely result in some significant changes in the current administrative structure and has the potential to address many of our current workforce challenges; this effort is part of a larger county class and compensation study being conducted by an outside organization, as well as a targeted review of the Health and Human Services Department, of which CCBH is a division.

***Annual Review notes**: Calaveras County chose to implement many of the recommendations from the class and compensation study, including wage increases, which has helped in recruiting, hiring and retaining staff. The targeted review of Health and Human Services was completed near the end of FY 24-25; the resulting restructuring included formation of an HHSA Compliance Team to strengthen and support compliance efforts throughout the HHSA divisions.*

2. BH CONNECT: CCBH is preparing to conduct a self-assessment, the first step in the statewide effort toward improving the overall strength and quality of behavioral health systems. Our participation in this process will inform our next steps in the movement toward evidence based practices and expansion of current data collection and evaluation efforts.

***Annual Review notes**: Calaveras County Completed self assessment and first BH Connect Payment was received; after reviewing administrative capacity, we have determined we will not be going any further with BH Connect at this time due to competing priorities.*

Last year the QM team focused on rebuilding many elements of the QAPI program that had been affected by pandemic shut downs and staffing changes. This year we plan to continue to build upon the foundations of those efforts, 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
    - Continue monthly SUD Utilization Management reviews and including reviews of paid claims documentation (this step was delayed last year during the implementation of a new EHR and payment reform changes).
    - Implement monthly SMHS Utilization Management process.

- Medication Monitoring
    - Continue to utilize contractor to perform monthly Medication Monitoring, to be reviewed by QM team and UM Committee.
    - Analysis and dissemination of results is still in process and will be continued as a goal for the coming year.
- Cultural Competence Plan (CCP) and Committee (CCC)
    - The CCBH Cultural Competence Plan was updated for FY 23-24 and will be updated again for FY 24-25. Cultural Competence Committee meetings are currently being included within the larger QIC meeting as members are recruited, with the goal of establishing a separate CCC meeting time in the coming year.
- 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 so it is current and complete.
    - Practice guidelines – Compile practice guidelines into a central resource to support delivery of quality services to members.
- Member Rights
    - Continue monitoring of specific beneficiary rights program elements listed below. Continue to report quarterly statistics and trends to BH Mental Health 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.*

***Annual Review notes**: Each of the items above will be carried forward into the coming year; while some progress was made towards each of them, the staffing issues in the QM team had a significant impact and they were only partially completed.*

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, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances. Performance monitoring activities are conducted by the QM team and reported to the Administration team and Management team monthly, to the QIC and MH 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 clients without services for a specified period of time, review frequency and types of services being provided, and address any documentation or coding errors.

Last year, CCBH contracted with a psychiatrist (not providing services for CCBH clients) to perform monthly reviews of up to 10 charts (5 youth and 5 adult charts) each month, utilizing a CCBH form containing all required medication monitoring elements. The charts are selected from the total of all clients receiving medication services in the month being reviewed. Results of the reviews 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 Program Manager or designee.

CCBHS maintains the following mechanisms to assess beneficiary/family satisfaction and is enhancing some of these during FY 23-24 as noted below:

1. Surveying beneficiary/family satisfaction with CCBH services at least annually.
    a. Administer the annual DHCS Consumer Survey and review results with the QIC, MH board, and making the results available to beneficiaries in clinics and on the CCBH Website.
    The Annual Consumer Perception survey was conducted but low number of responses will impact final data. The survey is administered during the same time period as a large county event and is challenging for members to complete, so this survey has historically not provided meaningful data. After this year's survey, a QIC subcommittee was formed to design a county-specific survey to be administered over a longer period of time and to include both the MH and SUD programs with the hopes of gleaning additional insight and feedback to better inform QAPI efforts.
    b. Review MHSA annual stakeholder survey results and provide recommendations for changes or improvements as applicable.
    The MHSA annual stakeholder survey confirmed many previous findings, prioritizing housing, drug and alcohol treatment and services for special populations such as veterans.

c. A new General Feedback Survey was created in FY 23-24 that is available in the CCBH lobbies, on the CCBH website and is also accessible through a QR code. Responses will be reviewed and monitored to address any issues, review suggestions and identify potential trends.
The survey has provided primarily positive feedback and messages of gratitude. These were passed along as applicable to staff members and administration.

2. Evaluating beneficiary grievances, appeals and State Hearings at least annually
   a. Review beneficiary grievances, appeals and state hearings quarterly and report to QIC and MH Board
   b. Provide recommendations and feedback and monitor any interventions/changes as appropriate.
   Periodic reviews of member grievances identified a few trends specific to personnel which were forwarded to the appropriate supervisor for further action. While only a few appeals were received, they provided opportunity for further review of the intended action. In addition, numerous members reengaged after receiving a NOABD for non-participation.
3. Evaluating requests to change persons providing services at least annually.
   Periodic reviews of requests to change providers have reflected similar trends specific to personnel and were forwarded to the appropriate supervisor for further action. These requests also highlighted the need to ensure alternate providers are available in areas such as Psychiatric services where internal resources are limited.
4. Informing providers of the results of beneficiary/family satisfaction activities.
   Survey outcomes were shared with all staff after results were received.

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 and consumer review.

- Elicits and responds to employee and consumer 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 Mental Health Clinic; meetings are open to the public and we encourage stakeholder and beneficiary 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

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

Client Satisfaction Monitoring

Client satisfaction monitoring includes several activities that help CCBH leadership detect consumer satisfaction with essential components such as services, treatment, customer service, and access. The client satisfaction monitoring system will include a routine review of the client 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 client satisfaction is achieved and the monitoring system is effective.

Goal 1: Ensure Timeliness Standards are achieved for Beneficiary Rights processes	
Measurement	• Four quarterly reviews of timeliness related to Beneficiary 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 % of problem/resolutions resolved by their respective timeliness standard • Timely submission of DHCS quarterly reports for Grievances & 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, 2025
Responsible	Quality Management Team
FY 24-25 Review	*Continue goal in FY 25-26; quarterly reports to QIC will continue and will be shared with Advisory Board upon request.* *FY 24-25 Annual Report presented to QIC in November. No notable trends.*

Goal 2: Monitor client satisfaction through the Annual Consumer Perception Survey and ongoing General Feedback Survey responses	
Measurement	• Results and recommendations shared with staff • 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 • Distribute/notify/share the results with all leadership and staff • Ongoing monitoring of general feedback surveys to identify potential issues
Due Date	July 31, 2025
Responsible	Quality Management Team
FY 24-25 Review	*FY 23-24 results received in late Dec. 2024 and reported to staff in January 2025. Most satisfaction/access goals were reached; however, results were based on small number of respondents. In FY 25-26 we will expand this goal to include the QIC county-specific survey.*

Goal 3: Monitor consumer 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, 2025
Responsible	Quality Management Team
FY 24-25 Review	*No providers represented more than 25% of total requests so no trend analysis was conducted. However, instances where multiple requests were received related to similar issues were forwarded to management for review. Continue goal in FY 25-26.*

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 Goal selected as Non-Clinical PIP topic.	• At least 60 test calls completed in FY 24/25 (five test calls per month) • Training provided during onboarding and at least once annually for CCBH and after hours agency staff • Four quarterly reports to QIC, CCBH leadership and 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 tests call outcomes to DHCS, CCBH Leadership and 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, 2025
Responsible	Quality Management Team
FY 24-25 Review	*Test calls were performed, reports presented and submitted as planned; test calls continued to highlight issues, and some categories were out of compliance on quarterly DHCS reports. However, there was some improvement in logging of daytime calls and accuracy of information provided after hours. Continue goal in FY 25-26.*

Goal 5: Monitor timeliness of access to services to ensure compliance with all timeliness measures	
Measurement	• Timely submission of TADT • 80% of clients being offered or receiving an appointment 10 days from request to first appointment • 80% of clients offered a follow-up appointment with a non- physician within 10 business days of the first/prior appointment • 80% of new clients with a 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, 2025
Responsible Parties	Quality Management Team
FY 24-25 Review	*TADT submitted timely, timeliness goals reached in most categories. Continue goal in FY 25-26.*

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	July 31, 2025
Responsible parties	Quality Management Team, QIC
FY 24-25 Review	*NACT and 274 submitted timely; out of compliance on specific provider types (Crisis Stabilization and Day Rehab) but are actively seeking providers. Continue goal in FY 25-26*

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
Intervention	• Monitor penetration rates for trends when data received from the EQRO • 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	July 31, 2025
Responsible parties	Quality Management Team
FY 24-25 Review	*Staff completed Cultural Competence training as required, including TGI training. No threshold language identified in FY 24-25 but resources continue to be provided in both English and Spanish. Continue goal in FY 25—26.*

Utilization and Care Quality

Utilization and care quality monitoring activities encapsulate indicators related to authorizations for routine and hospitalization services and care quality 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 under-utilization 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 • NOABD processing shifted to Medical Records team • 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 • Provide guidance to Medical Records team to facilitate NOABD processing • Prepare quarterly report for QIC and Board
Due Date	Quarterly reports to QIC as indicated above Forms, training completed by June 30, 2025
Responsible parties	Quality Management Team
FY 24-25 Review	*Incorporation of NOABDS into EHR is still in development. Staff training provided on NOABD process outside of EHR. NOABD processing shifted to Medical Records team; however, after review it was shifted back to QM. Quarterly reports completed as planned. Goal will be modified to focus on incorporation into EHR.*

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 ○ ICC, IHBS, TFC, TBS, SARS, TARS • Review of Denial/Delivery System NOABDs and any related beneficiary 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, 2025
Responsible parties	Quality Management Team, Utilization Management Team

FY 24-25 Review	*Monitoring showed more tracking and training may be needed to ensure authorizations are in place to allow for needed services. Continue goal in FY 25-26.*

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, 2025
Responsible parties	Quality Management Team, Utilization Management Team
FY 24-25 Review	*Goal not reached due to staffing challenges and pending DHCS guidance on tools. Continue goal in FY 25-26.*

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, 2025
Responsible parties	Quality Management Team, Utilization Management Team
FY 24-25 Review	*UM reviews conducted as planned; identified issues allowed for corrections and informed training and process improvement. Continue goal in FY 25-26.*

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 • By June 30, 2025, QM will have all current policies uploaded and organized in the online P&P manual and will create a timeline for addressing any policies that still need to be updated, created or replaced.
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 begin a weekly Policy and Procedure meeting in Jan. 2024 to work on polices towards the goals listed above.
Due Date	June 30, 2025
Responsible parties	Quality Management Team, Utilization Management Team
FY 24-25 Review	*Only some polices updated due to staffing challenges; continue goal in FY 25-26 with modification to include updates to P&P development process with Compliance Division.*

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 Dec. 31, 2024, with the goal to have final Practice Guidelines disseminated to staff by Jan. 31, 2025
Due Date	June 30, 2025
Responsible parties	Quality Management Team, Utilization Management Team
FY 24-25 Review	*Not completed due to staffing challenges; continue in FY 25-26.*

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 beneficiary 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	• Examination of system issues and root cause analysis conducted • Two PIP topics selected, at least one clinically focused *Improve timely access from first contact from any referral source to first offered appointment for any SUD service or SMHS.*

	Follow-Up After Emergency Department Visit for Mental Illness (FUM) • PIP document completed through implementation stage
Intervention	• Conduct system review to identify potential topics and conduct analysis • Consult with EQRO to review topic and supporting data to refine topic and inform documentation • Implement PIP intervention(s) by mid-year if possible.
Due Date	January 31, 2025 and June 30, 2025
Responsible parties	Quality Management Team
FY 24-25 Review	*DHCS process changed in FY 24-25; PIP topics preselected and will be done over three years. Modify goal for 25-26 to incorporate updates.*

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.