



Tuolumne
County
Behavioral
Health

Quality Assessment
& Performance
Improvement
(QAPI) Work Plan

Our Mission is to provide respectful, culturally sensitive and strength based behavioral health services which provide wellness, self-sufficiency and recovery from mental illness and/or addiction.

FY 2019-2020

Executive Overview: QM Work Plan and Components FY 2019-2020

Quality Assessment and Performance Improvement Program (QAPI) Overview:

QAPI is designed to address quality improvement and quality management topics to assure to all stakeholders that the processes for obtaining services are fair, efficient, cost-effective, and produce results consistent with the belief that people with mental illness may recover. Tuolumne County Behavioral Health's (TCBH) overall mission is to provide respectful, culturally sensitive and strength based behavioral health services which provide wellness, self-sufficiency and recovery from mental illness and/or addiction.

QAPI is responsible for monitoring MHP effectiveness through the upkeep and implementation of performance monitoring activities in all levels of the organization, including but not limited to: beneficiary and system access, network adequacy, timeliness, quality, clinical outcomes, utilization and clinical records review, monitoring and resolution of beneficiary grievances, and fair hearings and appeals. Reports shall include both TCBH and contractor data where applicable.

QAPI is accountable for upholding and monitoring the requirements of the Mental Health Plan contract with the State Department of Health Care Services (DHCS) for the expenditure of Medi-Cal dollars and to the DHCS Audits and annual EQRO On-Site Reviews. The QAPI team shall consist of key participants from each TCBH team such as Clinical, Quality Improvement, Electronic Health Record, Compliance, Administrative persons, and contractors as applicable. Feedback is also sought through various venues as listed below.

Annual QAPI Work Plan Evaluation:

The QAPI team utilizes the work plan as a living project list which is ongoing and updated throughout the year and progress and completion of such progress are evaluated annually. There is an annual evaluation of the overall effectiveness which examines activities and whether they have contributed to meaningful improvement in the clinical care and quality of service of those served by the MHP. Objectives and planned activities for evaluation of the MHP are contained in a QAPI Work Plan which is updated as areas of concern are identified, or removed after corrective action plans have proven consistently successful. Goals and objectives are integrated from various audits and QAPI team input. The following list provides a high level overview of QAPI initiatives:

Commented [LL1]: Move down and insert county demographics to show county overview

Executive Overview: QM Work Plan and Components FY 2019-2020

Work Plan Components:

- I. ~~Monitoring Service Delivery Capacity~~
- II. ~~Monitoring Access to Care Standards~~
- III. ~~Monitoring Beneficiary Rights (Grievances, Appeals, Fair Hearings, and Change of Providers) and Beneficiary Satisfaction (Consumer Perception Survey/POQI)~~
- IV. ~~Monitoring Quality of Care (Utilization Review & Medication Monitoring)~~
- V. ~~Continuity and Coordination of Care with Primary Care Providers and Community Resources~~
- VI. ~~Performance Improvement Projects~~
- VII. ~~Dedication to Overall Quality of Services~~
- VIII. ~~Monitoring Measureable Clinical and Functional Outcomes~~

Commented [LL2]: Items to be more detailed to show the QM and QAPI process through TCBH. New sections to be developed for additional clarification on process

QAPI Steps

1. Collects and analyzes data to measure against the goals or prioritized areas of improvement
2. Identifies opportunities for improvement and decides which opportunities to pursue
3. Designs and implements interventions to improve its performance
4. Measures the effectiveness of interventions
5. Reports on information collected to key stakeholders

Commented [LL3]: Additional language to be added to explain steps of QM activities and QAPI oversight

Executive Overview: QM Work Plan and Components FY 2019-2020

The TCBH QAPI work plan is executed through the coordination of the following Committees, Councils, and Regular Meetings:

All-Staff

This meeting is used to communicate general program updates, complete cultural competence trainings, customer service excellence, inform staff about local resources and contractor projects, and works in concert with the in-service calendar as needed to assure any additional mandatory trainings are completed (Beneficiary Rights, Compliance, HIPAA, Safety, Mandated Reporter, etc.). Goals and objectives are tracked through Quality Management, the Cultural Competency Work Plan, as well as the Workforce Education and Training Work Plan. All-Staff Meetings are held the 3rd Wednesday of each month for 75 minutes.

Training Documents: <S:\Public Files\BH STAFF LIBRARY\STAFF TRAININGS>

Commented [LL4]: Remove all doc locations due to change

Business Administrative Meeting

Business Administrative Meetings (BAM) are held the first Tuesday of each month and chaired by the Medical Records Supervisor. Topics include, but are not limited to, E.H.R. documentation, policies, procedures, implementation of new procedures, and updating of existing procedures. Meeting minutes are distributed to all TCBH staff.

Agendas/Meeting Minutes: <S:\Public Files\BH STAFF LIBRARY\MINUTES\Business Admin Meeting Minutes>

Clinical Supervisor Meeting

Ad-hoc meetings are held Tuesday afternoons and are attended by all Clinical Supervisors, the Clinical Manager, and BH Director as needed.

Commented [LL5]: Needs expansion

Community Cultural Collaborative Committee

Community Cultural Collaborative are every other month where participants review local cultural events, share special presentations, review training opportunities, and discuss broader trends within the community and agency. The CCC and QI teams collaborate to review beneficiary access through “penetration rates” of medical eligible persons into the mental health system and compare demographic information such as race, ethnicity, age, and primary language to assure that persons being served by mental health closely match the make-up of the local population. Such reviews assure the

Executive Overview: QM Work Plan and Components FY 2019-2020

needs of beneficiaries are being appropriately met either through the agency or other local partners. The CCC invites a variety of community members (i.e. from local tribes, community agencies, etc.), peers, and staff to attend and meets quarterly.

Agendas/Meeting Minutes: [S:\Admin\Administration\Cultural Competency\Community Cultural Collaborative](#)

~~In-Service Trainings~~

~~In service trainings offer a mix of both the mandated annual trainings and also special topics that have been identified as target areas by QI and Management. In services are offered three (3) times a month to allow for flexibility around staff schedules both day and night: 3pm the second Friday, 8am the third Thursday, or 4pm the fourth Wednesday.~~

~~Training Documents: [S:\Public Files\BH STAFF LIBRARY\STAFF TRAININGS](#)~~

Commented [LL6]: Is not completed monthly and on an add needed basis once identified trainings are conducted. Not a meeting but result of QM activities

~~5th Wednesday~~

~~5th Wednesdays are utilized on an ad hoc basis for special training or meeting opportunities.~~

~~Agendas/Meeting Minutes: [S:\Public Files\BH STAFF LIBRARY\STAFF TRAININGS](#)~~

Commented [LL7]: No longer in session

Management Meetings

The Management Meetings are chaired by the Behavioral Health Director and attended by all Supervisors and Managers on Wednesday mornings. Special topics are discussed per request and standing items such as Staffing, Committees, Compliance, Safety, Caseloads, and Policy/Procedure review are ongoing.

Agendas are available: [S:\Public Files\BH STAFF LIBRARY\MINUTES](#)

Executive Overview: QM Work Plan and Components FY 2019-2020

Mental Health Advisory Board

~~This meeting is chaired by the TCBH Advisory Board Chairperson, or in their stead, the TCBH Advisory Board Vice-Chairperson. Meetings are attended by the TCBH Director, a Board of Supervisors Representative, Community stakeholders, and clients and/or client representatives and are open to the public. The TCBH Advisory Board reviews and evaluates the community's mental health needs, services, facilities and special problems. The Advisory Board also reviews and comments on the county's performance outcome data and communicates its findings to the CA Mental Health Planning Council. Advisory Board meetings take place the first Wednesday of the month from 4:00 pm – 5:00 pm in the TCBH Community Conference Room. All members of the public are welcome to attend.~~

Commented [LL8]: QM attends on an as needed basis and if QM issues arise they will be reported out to QM

Quality Improvement Council

The Quality Improvement Council (QIC) provides a structured forum for the exchange of QI-related information between Behavioral Health staff, the Quality Improvement team, Community Liaisons, clients, family members, community members, and other stakeholders. It is an opportunity for the community to provide feedback as well as to hear about the latest QAPI Work Plan activities. The QIC meets the third Monday of the month at 10:00 a.m. in the Enrichment Center. All members of the public are welcome to attend.

Agendas/Meeting Minutes: <S:\Public Files\Staff QI Meetings\QI Council>

Quality Management Committee (QM)

QM Committee is responsible for the overall quality review and ongoing monitoring of the QAPI program and TCBH services. This committee's goal is to monitor and evaluate the quality and appropriateness of services to beneficiaries, pursue opportunities to improve services, and resolve identified problems. Quality Improvement is responsible for gathering data and making presentations to staff, supervisors, and managers on beneficiary and system outcomes as well as beneficiary and provider satisfaction. Reports may be previewed at appropriate venues for stakeholder feedback and then finalized at QM Committee, or vice versa. QM may recommend policy or procedure updates; review and evaluate the results of QI activities; institute needed QI actions; and ensures the follow-up of QI processes. On an annual basis QM reviews the QAPI and assesses its effectiveness as well as pursues opportunities to improve. The results of this review are communicated to the Behavioral Health Director as soon after the close of the fiscal year as possible, with

Executive Overview: QM Work Plan and Components FY 2019-2020

consideration to results which may be pending for audits, regulations, etc. Further planning may take place at an annual Supervisory retreat.

QM is composed of the following staff: Behavioral Health Director, Clinical Manager, Behavioral Health Program Supervisors, Compliance Manager, Quality Improvement Coordinator, Medical Records Supervisor, MHSA Coordinator, and Staff Analyst. If the MHP elects to delegate any services and/or QI activity to a separate entity, the MHP will describe via a contract or MOU how the relationship meets DHCS standards. QM Committee meets on the fourth Thursday of each month.

Agendas/Meeting Minutes: <S:\Admin\Administration\QM Program\QM\QM Committee\QM Minutes>

Utilization Review Committee

Utilization Review Committee is responsible for monitoring the utilization and quality of treatment services provided by the TCBH. URC reviews client records and makes recommendations for actions when patterns of over, under, or mis-utilization might have occurred. Client charts are audited against agency documentation standards in a consistent way to assure inter-rater reliability. The Committee is intended to assure the most efficient and effective use of the TCBH clinical care resources are provided. The Quality Management and Utilization Review Committees review process and formulate recommendations as necessary. Utilization Review Committee is composed of the following: Clinical Manager, Planned Services Supervisor, CAIP Crisis / Walk-In Supervisor, CAIP FSP / Access Supervisor, Psychiatric Tech or representative, Rotational Basis: Clinical Providers from Children's, Adult, CAIP Crisis / Walk-In, CAIP FSP / Access, and the Director as needed. Quality Improvement and Medical Records support the operation of URC by providing randomized charts and URC tools that assure 5% of clients are reviewed on an annual basis. 5% of charts will include medication, FSP, and children's services and a mix of ethnic, racial, and linguistic components.

Agendas/Meeting Minutes: <S:\Public Files\Utilization Review Committee>

Commented [LL9]: Additional meetings need to be added
Data coordination
Case Administration Team

Commented [LL10]: Incorporate Quality Management
Initiatives and Current Monitoring to showcase all efforts
throughout FY

Executive Overview: QM Work Plan and Components FY 2019-2020

Work Plan Tasks and Status:

Items will be tracked in various meeting forums and meeting minutes until the end of year review.

In Progress – Initiatives, Policies, or Procedures have been identified and are in development

Complete – Initiatives, Policies, or Procedures are effectively in place and ongoing

Commented [LL11]: These will be monitoring activities within the work plan and new goals need to be established

Section Title	Description of Task	Status
I. Monitoring Service Delivery Capacity	<ol style="list-style-type: none"> 1. Penetration Rates <ol style="list-style-type: none"> a. Penetration b. MMEF Eligible c. Served (CSI) d. Received at least on service e. Engaged (Received 5 or more services) 2. Demographic Distributions (Served vs. Eligible) <ol style="list-style-type: none"> a. Gender b. Race 3. Cultural Competence Monitoring & Reporting 4. Network Adequacy <ol style="list-style-type: none"> a. Time and Distance Standards b. NACT Submissions 5. Capacity Monitoring <ol style="list-style-type: none"> a. Full Time Equivalent Licensed b. Full Time Licensed Equivalent Eligible c. Other Qualified Providers 	Task 1 – Complete Task 2 – Complete Task 3 – In progress Task 4 – Complete Task 5 – Complete
II. Monitoring Access to Care Standards	<ol style="list-style-type: none"> 1. 24/7 Access Line Test Calls 2. Timeliness <ol style="list-style-type: none"> a. Initial Request to first offered appointments b. Crisis to Follow Up c. Follow up Post Hospitalization d. Response to Crisis (Phone, Walk-In, E.R) 3. Track/Trend No Show Rates 4. Out of Network Provider Request 5. Continuity of Care Request 6. Underserved Populations 7. High Cost beneficiaries 8. Caseload Management 	Task 1 – Complete Task 2 – Complete Task 3 – Complete Task 4 – Complete Task 5 – Complete Task 6 – In progress Task 7 – In progress Task 8 – Complete
III. Monitoring Beneficiary Protection, Appeals, and Satisfaction	<ol style="list-style-type: none"> 1. Beneficiary Satisfaction Survey(s) & Reporting 2. Grievance, Appeals, State Fair Hearings 3. Change Providers 4. Notices of Adverse Benefit Determinations (NOABDs) 	Task 1 – Complete Task 2 – Complete Task 3 – Complete Task 4 – Complete

Commented [LL12]: New goals to be established around this item
Discussed for FY 20-21 goals

Commented [LL13]: Monitoring is being completed but additional work to be done

Commented [LL14]: Discussed in managers additional reports may be needed

Executive Overview: QM Work Plan and Components FY 2019-2020

Section Title	Description of Task	Status
IV. Monitoring Quality of Care Standards	<ol style="list-style-type: none"> Clinical & Functional Outcome Measures Utilization Review Trends & Reporting Medication Monitoring & Medication Utilization Data Informed Clinical Decisions Hospitalization Re-Hospitalization Contractor Performance Policy / Procedure Review & Development 	Task 1 – <u>In progress</u> Task 2 – <u>Complete</u> Task 3 – <u>In Progress</u> Task 4 – <u>In progress</u> Task 5 – <u>Complete</u> Task 6 – <u>Complete</u> Task 7 – <u>In progress</u> Task 8 – <u>Complete</u>
V. Coordination with Primary Care Providers, Managed Care, and Community Resources	<ol style="list-style-type: none"> Continuity of Care Referral Process with Managed Care Consumer run/driven programs to enhance wellness 	Task 1 – <u>Complete</u> Task 2 – <u>Complete</u> Task 3 – <u>Complete</u>
VI. Performance Improvement Projects	<ol style="list-style-type: none"> Clinical PIP Non-Clinical PIP 	Task 1 – <u>In progress</u> Task 2 – <u>Complete</u>
VII. Dedication to Overall Quality Services	<ol style="list-style-type: none"> Annual Evaluation of QAPI Program Effectiveness Key Performance Indicators 	Task 1 – <u>Complete</u> Task 2 – <u>Complete</u>
VIII. Monitoring of Measureable Outcomes	<ol style="list-style-type: none"> Key Performance Metric Reports / Dashboards SUD Outcomes Grant Evaluations Community Project Evaluations 	Task 1 – <u>Complete</u> Task 2 – <u>In progress</u> Task 3 – <u>Complete</u> Task 4 – <u>Complete</u>

Commented [LL16]: CANS and LOCUS outcomes to be added to FY 20-21 goals, reports development started, but additional reports need with clinical decisions

Commented [LL17]: Med Monitoring forms to be reviewed

Commented [LL15]: Monitored through other items and end of year reported to EQRO

Commented [LL18]: QA form developed to increase data informed decisions

Commented [LL19]: Tracking log developed but utilization of the log to be exercised

Commented [LL20]: Tracked ongoing meetings will be monitored there

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Commented [LL21]: New PIP idea to be developed

Commented [LL22]: Will be incorporated into

Commented [LL23]: ASAM training scheduled for FY 20-21 and productivity reports produced – SUD will be incorporated into all monitoring activities and no longer stand alone

Commented [LL24]: Will be included in other areas of monitoring

Commented [LL25]: No new items identified for FY 20-21

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Commented [LL26]: Goals for FY 20-21 Developed by the QM team will be incorporated after ongoing monitoring details. New goals outside of regular monitoring to highlight areas of agency needed improvement