



TUOLUMNE COUNTY
BEHAVIORAL HEALTH DEPARTMENT

Quality Assurance Performance Improvement (QAPI)
Annual Update FY 20-21

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1. Tuolumne County Behavioral Health Mission

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.

2. County Profile and Demographics

Tuolumne County is located in the central Sierra Nevada, with major rivers to the north and south. The Sierra Nevada range forms the border on the east, with the county flowing into the great central valley in the west. The diverse terrain includes the Columbia and Railtown 1897 State Historic Parks, Bureau of Land Management lands, American Indian Rancherias and much of the Stanislaus National Forest and Yosemite National Park. According to the U.S. Census Bureau, the county has a total area of 2,274 square miles (5,891 km²), of which 2,235 square miles (5,790 km²) is land and 39 square miles (101 km²), or 1.71%, is water. The elevation ranges from 300 feet to more than 12,000 feet. Federal, state, and local governments own most of the land (77%) in Tuolumne.

Tuolumne County has a population of 53,804. According to the US Census, demographics for Tuolumne County have shifted only slightly from 2016 to 2019. Tuolumne County is predominately Caucasian representing 80% of its population. The second highest reported ethnicity for Tuolumne is Hispanic at 13%. Tuolumne County has a large older adult population with 26% of the population being 65 or older, the state of California is at 14% for this age group as seen in the table below.

	Tuolumne County CY 2016	Tuolumne County CY 2019	California CY 2016	California CY 2019
White	80.4%	79.8%	37.7%	36.8%
Hispanic	12.2%	12.7%	38.9	39.3%
Two or more races	3.5%	3.6%	3.8%	3.9%
Black	2.1%	2.0%	6.5%	6.5%
American Indian	2.2%	2.3%	1.7%	1.6%
Asian	1.3%	1.4%	14.8%	15.3%
Pacific Islander	0.2%	0.3%	0.5%	0.5%
Over 65 Years Old	24.7%	26.2%	13.6%	14.3%
Veterans	10%	11.04%	4.5%	4.8%
Live below Poverty line	14.5%	12.5%	14.3%	12.8%
Per Capita Income	\$27,054	\$31,570	\$30,318	\$31,570

3. Quality Assurance Meetings

Tuolumne County Behavioral Health (TCBH) holds several Quality Assurance meetings that are essential in executing the QAPI.

- All-Staff Meeting
 - This meeting is used to communicate general program updates to all TCBH staff and is chaired by the Director. The meeting addresses an array of topics from cultural competence trainings, informing staff about local resources and contractor projects, audit findings and current quality improvement initiatives. Goals and objectives are ongoing agendas and meeting minutes. All-Staff Meetings are held the 3rd Wednesday of each month for 75 minutes.
- Business Administrative Meeting
 - Business Administrative Meetings (BAM) are held the first Tuesday of each month when agenda items are presented. This results often in BAM being an ad-hoc meeting that is chaired by the Medical Records Supervisor. Topics include, but are not limited to, E.H.R. documentation, policies, procedures, implementation of new procedures, updating of existing procedures, and form updates. Meeting minutes are distributed to all TCBH staff.
- Clinical Supervisors Meeting
 - Meetings are held Tuesday afternoons and are attended by all Clinical Supervisors, the Clinical Manager, and Behavioral Health Director as needed. Goals of the meeting are to address current and ongoing clinical concerns and quality assurance issues. Agendas and sign-in sheets are kept for this meeting.
- Community Cultural Collaborative
 - Community Cultural Collaborative (CCC) is 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 Quality Improvement (QI) teams collaborate to review beneficiary access through “penetration rates” of Medi-Cal 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 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.
- Management Meeting

- The Management meeting is held every Wednesday and chaired by the Behavioral Health Director and attended by the Behavioral Health Management and Supervisor team. Quality Management is a standing agenda item for this meeting where weekly updates are given to the team. Several quality assurance initiatives are tracked through this meeting. Ongoing reports regarding compliance, caseloads, staffing, policies, etc. are discussed in this meeting.
- Quality Management
 - Quality Management (QM) 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. QI is responsible for gathering data and with the Clinical Manager 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. 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 Quality Improvement 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.
- Quality Improvement Committee
 - The Quality Improvement Council (QIC) provides a structured forum for the exchange of QI-related information between Behavioral Health staff, the QI team, Community Liaisons, clients, family members, community members, and other stakeholders. QIC's goal is to improve the processes of providing care and better meeting client needs. Members of the committee help to identify opportunities for improvement and give feedback on current QI initiatives. Items that are regularly reviewed for feedback by the committee are audit findings, the Quality Improvement Work Plan, Performance Improvement Projects, and ongoing Behavioral Health system reports. Agendas and meeting minutes are kept for this monthly meeting.
- Utilization Review Committee

- Utilization Review Committee (URC) is responsible for monitoring the utilization and quality of treatment services provided by 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 and Department of Health Care services 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. QI and Medical Records support the operation of URC by providing randomized charts for review and URC tools that assure that at least 5% of clinical charts are reviewed on an annual basis.
- Case Administration Team
 - Case Administration Team (CAT) reviews clinical assessments and plans of care, initial and annuals, in addition to any other relevant information to determine medical necessity. They determine medical necessity for referred clients for mental health services, medication services, targeted case management and other offered Specialty Mental Health Services (SMHS). After a review, CAT will assign clinical/treatment and/or case management/staff support, as appropriate and necessary. During CAT meetings reviews are conducted of the clinical documentation to ensure that clients receive medically necessary services in the amount, duration, and scope that is appropriate to meet their needs.
- Data Coordination
 - This team meets on the third Tuesday of each month and includes the Compliance and Information Systems Manager, Medical Records and Billing Supervisor, Quality Improvement Coordinator and the Quality Improvement Analyst. This meeting is dedicated to new or ongoing data requests, policy and procedure review, EHR updates or changes, administrative system changes, system monitoring, reports, and new and ongoing contract obligations not limited to information notice review. This team develops and implements new initiatives for administrative needs and others as necessary. This team reports out to all other committees and standing meetings as necessary.

4. QAPI / Quality Management

QAPI

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.

Quality Management (QM)

QM is committed to assessing services and system processes to ensure quality of care to all clients. QM is responsible for monitoring current Quality Assurance issues. These issues can be uncovered through regular reports, ongoing monitoring, or any of the continuous Quality Assurance meetings.

QM is responsible for the annual evaluation of the QAPI. QM evaluates the effectiveness of the QAPI, the progress associated with each goal and objective within the plan, and any initiatives or actions taken to improve the system. QM is responsible for making any necessary revisions that may be a result of the evaluation. Areas that are reviewed are as followed but not limited to:

- Collection and analysis of data – data will be used to measure against goals and prioritize areas of improvement that have been identified
- Obtaining Input – ongoing feedback received by ongoing Quality Assurance meetings
- The design and implementation of interventions – identifying areas of success and areas for improvement
- Measuring the effectiveness of initiatives and interventions
- Consumer satisfaction – reviewing ongoing consumer reports (i.e. change of provider reports, grievance reports, consumer surveys, etc.)
- Audit findings – evaluated audit recommendations in correlation with current efforts and interventions
- Reporting of information to key stakeholders

Each year during the evaluation, current and potential new goals will be reviewed and selected for the upcoming year.

5. Quality Management Initiatives and Current Monitoring

Current QM Initiatives

- Quality Assurance Monitoring Forms – May 2020 QI presented a new form for the QM team to review and to ensure that data reviews and clinical observations were followed up and if necessary, when making system changes. The

purpose of the new process is to put in place a tracking mechanism for quality assurance and quality of care issues that arose during either the QM meeting or through data reviews. The Quality Assurance Monitoring form was drafted and after reviewing the form, the committee approved the form. The form will be used immediately. In turn, QI will finalize the tracking log for the form and present the new log to the committee to show how all issues will be tracked for the system.

- Contract Monitoring - TCBH contracts previously were completed by a unit within the Health and Human Services Agency called the General Services Unit (GSU). This unit is part of the umbrella agency in which TCBH resides in. GSU is not located on the same campus as TCBH. In June 2019, discussion began around bringing contracts on campus at TCBH. The discussion was to have contracts be created and monitored by existing TCBH staff that have program knowledge and access to the Management team. This change could potentially decrease the time it takes to complete contracts due to program knowledge and access to key staff and management members. This change would also increase overall monitoring of contract performance. In July 2019, it was decided that QI would absorb contracts. Having QI oversee contracts could eliminate questions that are asked by the current contract writer regarding program knowledge that slows down the contract process. In addition, contracts could now be embedded in ongoing management meetings and conversations in ways it could previously not when having the contract writer off site. In November 2019, QI created structural administrative changes to how contracts were monitored both during the contract writing process and the ongoing monitoring of contract performance. Two contract monitoring tools were developed by the QI Analyst to be shared with the entire Management staff to keep all team members aware of current proceedings. New files were created that are now dedicated to editing and reviewing new contracts and amendments. Having these folders allows for less versions and duplications to be lost amongst emails. Contracts and contract performance are now a standing item on the weekly management agenda and a standing item of Quality Management every month.
- Cultural Competency Monitoring Tool – In December 2019 a Cultural Competency Monitoring tracking tool was developed to ensure tracking of ongoing interventions that were directly related to the goals set in the Cultural Competency Plan (CCP). The tool is updated on a quarterly basis and reflects the efforts of QM and the CCC. This tool will assist in writing CY 2020 CCP when evaluating the effectiveness of interventions related to goals set.
- CSI Assessments - In CY 2019, TCBH undertook large process changes to come into compliance with the new CSI reporting requirements. The Data Coordination meeting is where the changes that were necessary for the new requirements for reporting first offered, first accepted, etc. appointments, were discussed. Several years ago, TCBH had implemented an Initial Contact Form that tracked first offered and first accepted assessment dates for all new

clients. This form, however, did not track the additional items that were required for the CSI reporting. Through working with our E.H.R vendor, a new form was created to track all elements. The Medical Records Supervisor led the process change on how all appointment times would be captured. TCBH successfully met all reporting requirements.

- Productivity Standards - Throughout CY 2019, productivity has been a standing item discussed in Managers, All Staff meetings, team meeting discussions, and QM. Development of reports on how best to track, trend, and see productivity amongst staff began in CY 2018. In CY 2019, reports were finalized utilizing the Power BI platform. These reports allowed supervisors to view their staff's time spent in all service codes. Reports were developed to see how much time was being spent in productive services, direct services, and billable services. We identified how much time was spent with clients face to face, on the phone, or even in the field. These interactive reports gave light to how productivity standards could be developed. These reports were placed on the Managers meeting agenda to be discussed monthly. The goal was to review services and understand the strengths and opportunities for improvement within the current working system, where and how were staff spending their time, and how to improve the delivery of services to clients. During an All Staff meeting in CY 2019, the reports were shown on a projector so that the reports that were being reviewed in Managers meeting could be transparent with the staff and feedback could be solicited. After the reports were introduced to the staff and final edits were made, supervisors were tasked with reviewing these reports with each staff member during their supervision time. During June 2019, Tuolumne County converted to Office 365 which put a delay on providing future reports. This switch resulted in all Supervisors not being able to log onto the reporting site. The site is still visible for QI and a monthly discussion continued with supervisors. Additionally, to help navigate this issue, there were print outs of reports distributed to staff member by their Supervisor to continue individual discussion of productivity. This issue was discussed with IT and ongoing dialogue continues around possible solutions to providing accessible electronic reports. Now that reports could be utilized by management with line staff to understand staff time and utilization, productivity standards could be set. A Productivity Policy was drafted to standardize productivity measurements for staff. The Policy was in pending union review and finalization as of June 2020.
- CAT - CAT was developed in January 2020 to reduce authorization and assignment time. The development of this team will reduce assessment review and client assignment time and decrease the wait time from initial request to first offered Specialty Mental Health appointment. In addition, this will also enhance review and feedback to staff on assessments.
 - The CAT was initiated and now meets every morning, all newly opened cases in each system of care will be reviewed and assigned to a Primary Clinician by CAT.
 - CAT will verify medical necessity and determine appropriate assignment. After review, feedback is given to the clinician that completed the assessment for enhanced education and training.

- A policy was drafted for CAT in April 2020 and reviewed in Managers meeting.

Current Monitoring Activities

Tabled below are all the current ongoing monitoring activities that are reported in various meeting forums and monitored through QM.

Section Title	Description of Task
<p>I. Monitoring Service Delivery Capacity</p>	<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
<p>II. Monitoring Access to Care Standards</p>	<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

Section Title	Description of Task
	<ol style="list-style-type: none"> 4. Out of Network Provider Request 5. Continuity of Care Request 6. Underserved Populations 7. High Cost beneficiaries 8. Caseload Management
<p>III. Monitoring Beneficiary Protection, Appeals, and Satisfaction</p>	<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)
<p>IV. Monitoring Quality of Care Standards</p>	<ol style="list-style-type: none"> 1. Clinical & Functional Outcome Measures 2. Utilization Review Trends & Reporting 3. Medication Monitoring & Medication Utilization 4. Data Informed Clinical Decisions 5. Hospitalization 6. Re-Hospitalization 7. Contractor Performance 8. Policy / Procedure Review & Development
<p>V. Coordination with Primary Care Providers, Managed Care, and Community Resources</p>	<ol style="list-style-type: none"> 1. Continuity of Care 2. Referral Process with Managed Care 3. Consumer run/driven programs to enhance wellness
<p>VI. Performance Improvement Projects</p>	<ol style="list-style-type: none"> 1. Clinical PIP 2. Non-Clinical PIP
<p>VII. Dedication to Overall Quality Services</p>	<ol style="list-style-type: none"> 1. Annual Evaluation of QAPI Program Effectiveness 2. Key Performance Indicators

Section Title	Description of Task
VIII. Monitoring of Measurable Outcomes	<ol style="list-style-type: none">1. Key Performance Metric Reports / Dashboards2. SUD Outcomes3. Grant Evaluations4. Community Project Evaluations

6. Quality Assurance Performance Improvement Work Plan Goals

Area of Concern	Goal	Responsible	Intervention	Outcomes
1. PIP	1. Clinical PIP is slated to end mid-year 2020 and new area of focus to be vetted and finalized.	Clinical Manager and QI Analyst Meetings: Clinical Supervisors Meeting and QM		
2. Cultural Competency	1. Update CCP to have more focused goals highlighting baseline measurements for each goal. 2. Update work plan monitoring tool with clear objectives to measure the impact of each activity. 3. Define CCC role within system to ensure outcomes for CCP. 4. Investigate low penetration of minority communities. After identifying barriers, implement solutions if necessary.	Management Team, MHSA Coordinator and QI Meetings: QM and Managers Meeting		
3. Timeliness	1. Decrease wait time for first offered psychiatry appointment. 2. Monitor timeliness and develop new strategies and interventions to lower wait times.	Management Team Meetings: QM, Managers and Clinical Supervisors		

<p>4. Quality of Care</p>	<ol style="list-style-type: none"> 1. Establish aggregated dashboard for completed medication monitoring forms to be review in a URC arena on a ongoing basis. 2. Aggregate diagnoses and establish baseline measurements within TCBH to understand current patterns within the system 3. Study TCBH diagnostic patterns in comparison to other small counties and state averages. Implement changes if necessary. 	<p>Management Team Meetings: Data Coordination and QM</p>		
<p>5. Clinical</p>	<ol style="list-style-type: none"> 1. Establish baseline measurement for current co-occurring diagnosis. 2. Launch co-occurring diagnose training for both all clinical teams. 3. Review current policies and procedures for diagnostic language and update if necessary, for dual diagnosis. 	<p>Clinical Supervisors Meetings: QM, BAM and Clinical Supervisors</p>		
<p>6. Quality Improvement</p>	<ol style="list-style-type: none"> 1. Gain consistent completion throughout all programs of current TCBH required outcome tools; CANS, PSC 35 and LOCUS. 2. Establish through review and evaluation how best to utilize these outcome tools to make ongoing clinical decisions. 	<p>Management Team Meetings: Data Coordination, QM, Clinical Supervisors</p>		