San Joaquin County Behavioral Health Services

Drug Medi-Cal Organized Delivery System &
Specialty Mental Health Services

SAN JOAQUIN
COUNTY
Behavioral Health Services

Integrated Quality Assessment & Performance Improvement Program Description and Work Plan

January 1, 2025 – December 31, 2026

San Joaquin County Behavioral Health Services
Quality Assessment and Performance Improvement Program Description and Work Plan

Overview

San Joaquin County Behavioral Health Services (SJCBHS) is committed to the provision of a well-designed and well-implemented Quality Assessment & Performance Improvement (QAPI) Program. Toward this end, SJCBHS has developed and implemented a range of quality assessment & performance improvement activities to monitor, measure and improve the timeliness, access, quality, satisfaction and outcomes of its services, including the following activities:

- Collecting and analyzing data to measure against the goals, or prioritized areas of improvement that have been identified;
- Identifying opportunities for improvement and deciding which activities to pursue;
- Identifying relevant committees internal or external to ensure appropriate exchange of information with the Quality Assessment & Performance Improvement Council (QAPIC);
- Obtaining input from providers, beneficiaries, and family members in identifying barriers to delivery of clinical care and administrative services;
- Designing and implementing interventions for improving performance;
- Measuring the effectiveness of the interventions;
- Incorporating successful interventions into SJCBHS' operations as appropriate; and
- Reviewing the results of member grievances, appeals, expedited appeals, State Hearings, expedited State Hearings, provider appeals and clinical record reviews.

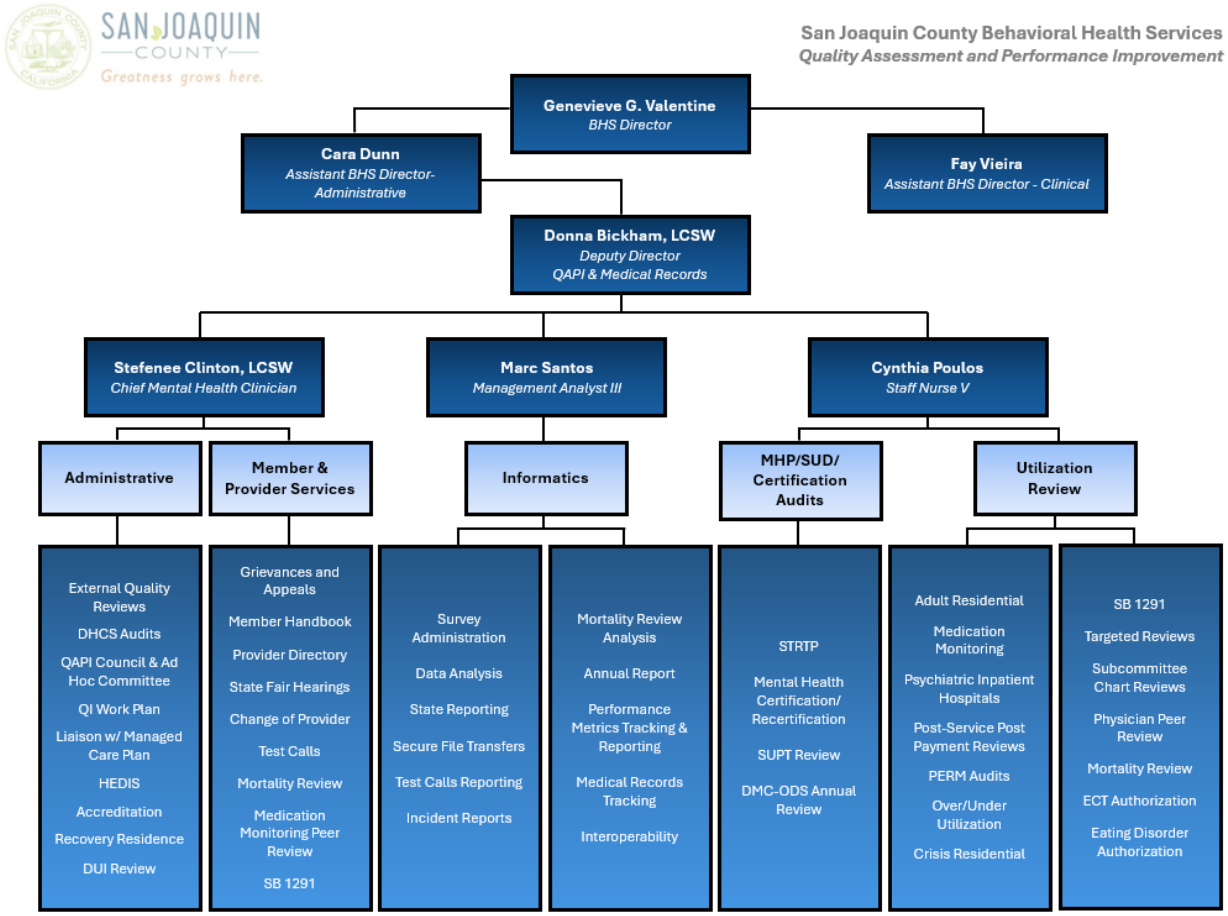
Quality Improvement Principles

SJCBHS' approach to quality improvement is based on the following principles:

- Recovery-oriented: Services provided should promote and preserve wellness and expand choices to meet individually defined goals.
- Stakeholder Empowerment: Effective quality improvement initiatives should involve people at all levels of the organization in improving quality.
- Leadership Involvement: Strong leadership, direction and support of quality improvement activities are essential to performance improvement. Involving organizational leadership assures that quality improvement initiatives are consistent with SJCBHS' mission, vision, and values.
- Data Driven Decision-Making: Successful quality improvement processes should incorporate feedback loops, using data to develop practices and measure results.
- Prevention over Correction: Continuous quality improvement includes designing processes that achieve positive outcomes rather than fixing processes that do not produce desired results.

Program Structure

As an integral component of SJCBHS Administration, the QAPI Office is responsible for overseeing the monitoring of service quality and resource utilization, as well as facilitating improvements in areas identified as deficient. The quality management program is overseen by the Deputy Director of Quality Assessment & Performance Improvement and Medical Records. The department is staffed with Licensed Professionals of the Healing Arts, Nurses, Analysts and support staff.



The quality management department is comprised of five primary functions: administrative, member and provider services, informatics, certification & audits and utilization review.

Administrative Services

Administrative services functions include coordinating External Quality Reviews and audits conducted by the Department of Health Care Services, facilitating the QAPIC meetings, monitoring the implementation and evaluation of the QI Work Plan and serving as a liaison between the managed care plans.

Member and Provider Services
Member and Provider Services staff oversee the grievance and appeals process, ensure the availability of informing materials (including in alternative formats), monitor and update the provider directory, monitor and analyze the results of test calls and process requests to change providers.

Informatics
The Informatics Team within the QAPI department at San Joaquin County Behavioral Health Services (SJCBHS) plays a vital role in supporting data-driven decision-making processes across mental health and substance use disorder services. The team's primary focus is to ensure accurate, timely, and actionable data collection, validation, and analysis that supports the agency's quality improvement initiatives, compliance requirements, and overall service delivery effectiveness.

Certification and Audits
The department is responsible for certifying and recertifying contract organizations and practice sites to ensure the delivery of appropriate and safe care. QAPI staff members conduct initial visits to these provider sites when the contract commences and subsequently revisit them every annually as part of routine assessments. Additional visits may be scheduled as required to uphold the standards of quality and safety.

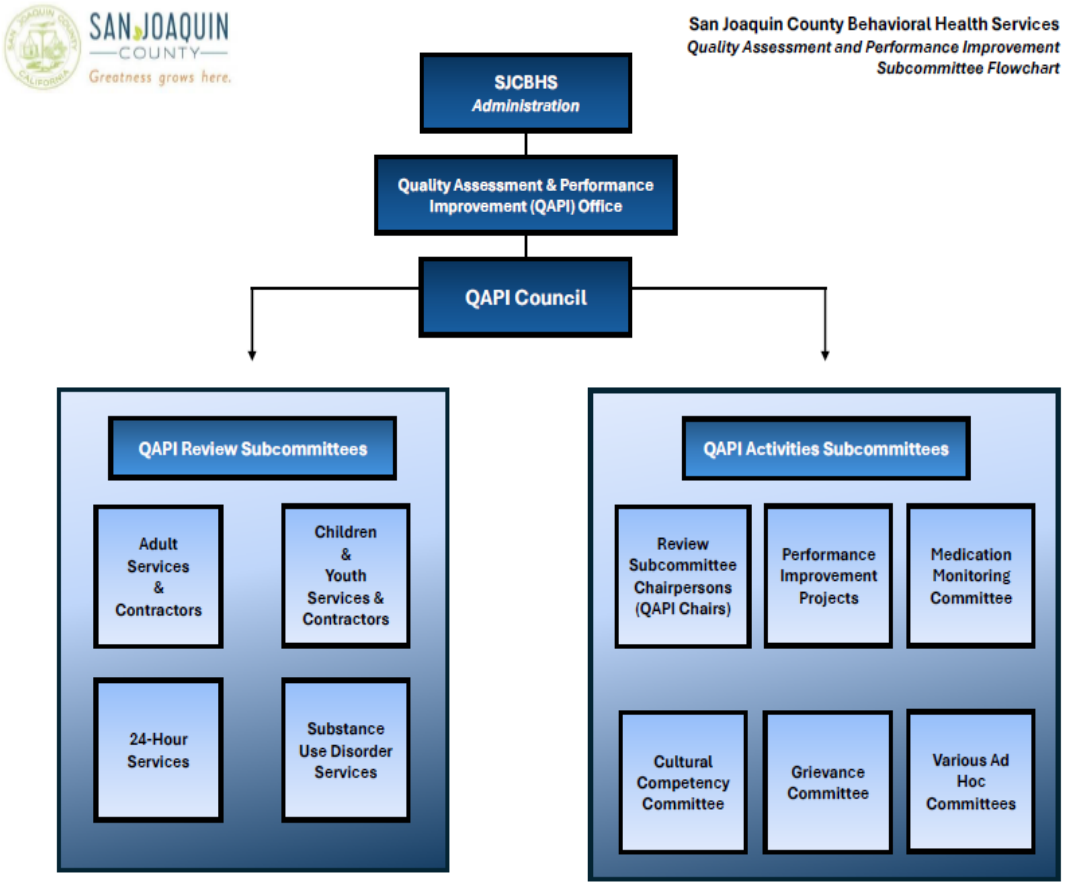
Utilization Management
San Joaquin County Behavioral Health Services (SJCBHS) Utilization Management (UM) program evaluates the medical necessity, appropriateness and efficiency of services provided to Medi-Cal members prospectively or retrospectively. Services evaluated include inpatient, residential and outpatient Specialty Mental Health Services (SMHS), as well as Substance Use Disorder (SUD) residential and outpatient services. Services are reviewed and authorization decisions are made in accordance with state regulations. SMHS and SUD outpatient services are evaluated for detection of overutilization and underutilization of services, fraud, waste and abuse.

Quality Improvement Council
In compliance with requirements established by the Department of Healthcare Services (DHCS), the QAPIC convenes on a regular basis to thoroughly assess and evaluate the outcomes of the QAPI Review Subcommittees and the QAPI Activities Subcommittees. The QAPIC is tasked with recommending policy decisions, reviewing and evaluating the results of Quality Improvement (QI) activities, including Performance Improvement Projects, instituting needed QI actions, ensuring follow up of QI processes and documenting in QAPI Council meeting minutes decisions and actions taken.

The QAPIC and its committees include Senior Management personnel, Program Managers and/or their delegates, as well as designated providers, members, and family members. It serves as a vital platform for effective communication and information dissemination to stakeholders.

Committees

The QAPI department coordinates and facilitates the Quality Assessment & Performance Improvement Council meetings as well as its subcommittees. The QAPIC and each subcommittee play a crucial role in supporting the growth and development of the organization by assisting in identifying areas for improvement and implementing strategies to achieve higher levels of quality. A description of the QAPIC and each committee is as follows:



Review Subcommittees

To assess the quality of services, SJCBHS employs chart review activities as part of its QAPI Review Subcommittees. These subcommittees are established across various divisions within SJCBHS, and staff members are assigned by Program Managers to serve as active members.

Participation as a QAPI Review Subcommittee member offers valuable learning opportunities for all clinical employees, enabling them to gain a deeper understanding of the overall system. The

subcommittees strive to review five percent of charts from their respective areas annually, utilizing the QAPI Review Subcommittee Worksheet as an assessment tool. The Program Manager or an assigned representative review the completed Worksheet and, if necessary, formulates a Plan of Correction (POC). The Worksheet and POC are then submitted to the QAPI office. A dedicated QAPI staff member reviews the Worksheet and POC and completes the Multiuse Complete Feedback Loop (McFloop) form. Additionally, QAPI staff conduct a 30-day follow-up if a POC is required. The QAPI Office maintains a comprehensive record of all Worksheets, McFloops, and POCs for reference and documentation purposes.

Activities Subcommittees
The QAPI Activities Subcommittees are comprised of working groups that convene regularly to address concerns identified within the QAPI Review Subcommittees or other relevant platforms. These subcommittees can either be standing committees or formed as Ad Hoc committees to address short-term issues. A description of each subcommittee is as follows:

Performance Improvement Project Subcommittee
The Performance Improvement Project (PIP) Subcommittee focuses on two major projects each year. These projects involve examining the current quality level of services provided and exploring the potential for improvement by implementing specific interventions. The PIP Subcommittee plays a crucial role in supporting the growth and development of the organization by assisting in identifying areas for improvement and implementing strategies to achieve higher levels of quality.

The QAPI Chairs Subcommittee
Routine and consistent oversight of utilization management activities is overseen by the Chart Review Subcommittee, which reports to the QAPIC and ultimately the Executive Staff. Regular meetings of the Chairpersons and committee members are conducted. Within this forum, chairpersons share concerns and issues uncovered by their respective subcommittees. This collaborative effort serves as a valuable means of identifying systemic problems and various types of concerns. Once identified, potential solutions can be explored and implemented. Contractor staff also participate in the QAPI Chairs meeting on a regular basis, ensuring a comprehensive and inclusive approach to addressing these matters.

Grievance and Appeals Committee
The Grievance and Appeals Committee is a subcommittee of the QAPIC and is responsible for tracking and analysis of member grievances and appeals, including type, timeliness of resolution and making recommendations regarding corrective actions as needed. The Committee meets quarterly and provides summary reports to the QAPIC.

Medication Monitoring Committee
The Medication Monitoring Committee monitors the safety and effectiveness of medication practices. This committee meets monthly and reviews a sample size of the medication services provided by the psychiatrist and/or other medical staff and monitors medication practices. Results are directly reviewed with providers, psychiatrists, medication support staff, and the Compliance and QI Coordinator. A summary report is also shared with the QAPIC.

Quality Assessment & Performance Improvement Work Plan

The Quality Assessment & Performance Improvement department and Council facilitate the development and implementation of the QI Work Plan and the QI activities. The QI Work Plan ensures the opportunity for input and active involvement of members, family members, licensed and paraprofessional staff, providers, and other interested stakeholders in the Quality Assessment and Performance Improvement program. The QI Work Plan addresses quality assurance/improvement initiatives related to the delivery of behavioral health services. The overarching strategies guiding the development and implementation of the work plan include:

1. Collaborating between divisions and disciplines to ensure quality services;
2. Coordinating with SJCBHS divisions and the Information Systems unit, to develop reliable reports that provide monthly data for each initiative's measurable objectives;
3. Reviewing data reports with QAPIC to identify the greatest discrepancies between current findings and goals;
4. Developing real-time strategies to address areas of concern;
5. Implementing Performance Improvement Projects for areas of greatest need;
6. Revising goals annually or as needed to meet regulatory expectations and stakeholder expectations; and
7. Fostering staff participation in and commitment to quality assessment and performance improvement initiatives.

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Work Plan at a glance	
Goal Domains- 05	**Objectives- 40**

Goal 1: Ensure timely access to services				
Section I: Timeliness (19 Objectives)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Outpatient Non-Urgent, Non-Psychiatry, Adults 21+			
OBJECTIVE 1:	Offer an initial appointment within 10 business days of request for services. **Target**: At least 85% or greater.			
BASELINE	88% (Network Adequacy Findings Report 7/1/22-3/31/23)			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement Council (QAPIC) • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly.			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Non-Urgent, Non-Psychiatry, Children & Youth 0-20			
OBJECTIVE 2:	Offer an initial appointment within 10 business days of request for services. **Target**: At least 80% or greater			
BASELINE	97% (Network Adequacy Findings Report 7/1/22-3/31/23)			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

<table>
<tr><th colspan="5">Section I: Timeliness (continued)</th></tr>
<tr><td>BHS SYSTEM</td><td colspan="4">☐ DMC-ODS ☒ SMHS ☐ BOTH</td></tr>
<tr><td>SERVICE CATEGORY</td><td colspan="4">Follow up – Non-Urgent, Non-Psychiatry Adult 21+</td></tr>
<tr><td>OBJECTIVE 3:</td><td colspan="4">Offer an appointment within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition.
<u>Target</u>: At least 80% or greater</td></tr>
<tr><td>BASELINE</td><td colspan="4">68% (Network Adequacy Findings Report 7/1/22-3/31/23)</td></tr>
<tr><td>ACTION PLAN</td><td colspan="4">• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data related to follow-up appointments.
• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards for follow up appointments are met.
• Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council
• Ongoing, barriers to timely access to follow up appointments and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council.
• If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.</td></tr>
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<tr><td rowspan="2">QUARTERLY METRICS</td><td>Quarter 1</td><td>Quarter 2</td><td>Quarter 3</td><td>Quarter 4</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="3">ANNUAL EVALUATION</td><td>Annual Metric:
##.# %</td><td>☐ Objective Met</td><td>☐ Partially Met</td><td>☐ Not Met</td></tr>
<tr><td colspan="4">Narrative:</td></tr>
<tr><td>RESPONSIBLE PARTIES</td><td colspan="4">All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors</td></tr>
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Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Follow up – Non-Urgent, Non-Psychiatry Children & Youth 0-20			
OBJECTIVE 4:	Offer an appointment within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition. **Target**: At least 80% or greater			
BASELINE	100% (Network Adequacy Findings Report 7/1/22-3/31/23)			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to the Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
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	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Non-Urgent Psychiatry – Adult 21+			
OBJECTIVE 5:	Offer an appointment within 15 business days. **Target**: At least 80% or greater			
BASELINE	89% (Network Adequacy Findings Report 7/1/22-3/31/23)			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
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	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Non-Urgent Psychiatry – Youth 0-20			
OBJECTIVE 6:	Offer an appointment within 15 business days. **Target**: At least 80% or greater			
BASELINE	100% (Network Adequacy Findings Report 7/1/22-3/31/23)			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
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RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Urgent Psychiatry – Adult 21+			
OBJECTIVE 7:	Schedule appointment within 48 hours without prior authorization; Schedule appointment within 96 hours with prior authorization **Target**: At least 80% or greater			
BASELINE	TBD			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
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	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Urgent Psychiatry – Children/Youth 0-20			
OBJECTIVE 8:	Schedule appointment within 48 hours without prior authorization; Schedule appointment within 96 hours with prior authorization **Target**: At least 80% or greater			
BASELINE	TBD			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
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	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Urgent Non-Psychiatry – Adult 21+			
OBJECTIVE 9:	Schedule appointment within 48 hours without prior authorization; Schedule appointment within 96 hours with prior authorization **Target**: At least 80% or greater			
BASELINE	100% (Network Adequacy Findings Report 7/1/22-3/31/23)			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
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	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Urgent Non-Psychiatry – Children/Youth 0-20			
OBJECTIVE 10:	48 hours without prior authorization; 96 hours with prior authorization **Target**: At least 80% or greater			
BASELINE	100% (Network Adequacy Findings Report 7/1/22 -3/31/23)			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
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	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Outpatient Substance Use Disorder Services (Youth 0-17)			
OBJECTIVE 11:	Offer an initial appointment within 10 business days of request for services. **Target**: At least 80% or greater			
BASELINE	TBD			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
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QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Outpatient Substance Use Disorder Services (Adult 18+)			
OBJECTIVE 12:	Offer an initial appointment within 10 business days of request for services. **Target**: At least 80% or greater			
BASELINE	TBD			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
DATA SOURCE / TIME FRAME	Network Adequacy Findings Report (annual measure); SJCBHS Mental Health Timeliness App. Measured monthly and quarterly			
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ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Residential (Youth 0-17)			
OBJECTIVE 13:	Offer an appointment within 10 business days of request for services. **Target**: At least 80% or greater			
BASELINE	TBD			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
DATA SOURCE / TIME FRAME	SJCBHS Mental Health Timeliness App. Measured monthly and quarterly.			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

<table>
<tr><th colspan="5">Section I: Timeliness (continued)</th></tr>
<tr><td>BHS SYSTEM</td><td colspan="4">☒ DMC-ODS ☐ SMHS ☐ BOTH</td></tr>
<tr><td>SERVICE CATEGORY</td><td colspan="4">Residential (Adult 18+)</td></tr>
<tr><td>OBJECTIVE 14:</td><td colspan="4">Offer an appointment within 10 business days of request for services.
<u>Target</u>: At least 80% or greater</td></tr>
<tr><td>BASELINE</td><td colspan="4">98.08% (Resubmitted Timely Access Data Tool 7/1/23 – 3/31/24)</td></tr>
<tr><td>ACTION PLAN</td><td colspan="4">• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data.
• At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met.
• Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council
• Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council.
• If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.</td></tr>
<tr><td>DATA SOURCE / TIME FRAME</td><td colspan="4">SJCBHS Mental Health Timeliness App. Measured monthly and quarterly.</td></tr>
<tr><td rowspan="2">QUARTERLY METRICS</td><td>Quarter 1</td><td>Quarter 2</td><td>Quarter 3</td><td>Quarter 4</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">ANNUAL EVALUATION</td><td>Annual Metric:
##.# %</td><td>☐ Objective Met</td><td>☐ Partially Met</td><td>☐ Not Met</td></tr>
<tr><td colspan="4">Narrative:</td></tr>
<tr><td>RESPONSIBLE PARTIES</td><td colspan="4">All Access and Points of Entry Managers and Supervisors</td></tr>
</table>

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Opioid Treatment Program (Youth 0-17)			
OBJECTIVE 15:	Offer an appointment within 3 business days of request. **Target**: At least 80% or greater			
BASELINE	TBD			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
DATA SOURCE / TIME FRAME	SJCBHS Substance Use Disorder Services Timeliness App. Measured monthly and quarterly.			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Opioid Treatment Program (Adult 18+)			
OBJECTIVE 16:	Offer an appointment within 3 business days of request. **Target**: At least 80% or greater			
BASELINE	98% (Network Adequacy Findings Report 7/1/22 – 3/31/23)			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
DATA SOURCE / TIME FRAME	SJCBHS Substance Use Disorder Services Timeliness App. Measured monthly and quarterly.			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Non-Urgent Follow-Up Appointments (Youth 0-17)			
OBJECTIVE 17:	Offer an appointment within 10 business days of request for services. **Target**: At least 80% or greater			
BASELINE	TBD			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
DATA SOURCE / TIME FRAME	SJCBHS Substance Use Disorder Services Timeliness App. Measured monthly and quarterly.			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Non-Urgent Follow-Up Appointments (Adult 18+)			
OBJECTIVE 18:	Offer an appointment within 10 business days of request for services. **Target**: At least 80% or greater			
BASELINE	TBD			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
DATA SOURCE / TIME FRAME	SJCBHS Substance Use Disorder Services Timeliness App. Measured monthly and quarterly.			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; Outpatient Services Managers and Supervisors			

Section I: Timeliness (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Request for Urgent Conditions			
OBJECTIVE 19:	Offer an appointment within 48 hours of request for services without prior authorization; 96 hours with prior authorization. **Target**: At least 80% or greater			
BASELINE	Outpatient 82.86% (Timely Access Data Tool 7/1/23-3/31/24)			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
DATA SOURCE / TIME FRAME	SJCBHS Substance Use Disorder Services Timeliness App. Measured monthly and quarterly.			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Goal 2: Ensure members have *access* to comprehensive high-quality behavioral health services.				
Section II: Access (02 Objectives)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Access to After Hours Care			
OBJECTIVE 1:	Members in crisis will receive a crisis intervention within 120 minutes of request. **Target**: 85%			
BASELINE	TBD			
ACTION PLAN	• By April 30, 2025, quality management and information services staff will enhance mechanisms to track timely access data. • At least monthly, Program Managers will conduct performance monitoring activities to determine effectiveness in ensuring timely access standards are met. • Quarterly, quality management staff will present outcome data to Quality Assessment & Performance Improvement (QAPI) Council • Ongoing, barriers to timely access and proposed interventions will be presented to Senior Managers for guidance and discussed at QAPI Council. • If warranted, by May 30, 2025, develop and implement data quality campaign to improve the accuracy of timeliness data entries.			
DATA SOURCE / TIME FRAME	TBD			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	24-Hour Services Managers and Supervisors			

Section II: Access (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Responsiveness of the Access Line, including with prevalent non-English language(s)			
OBJECTIVE 2:	Calls to the 24/7 Access Line will receive timely and accurate information. **Target**: 100% (business and after hours)			
BASELINE	89% (business hours); 93% (after hours) (QI Work Plan Evaluation July 2024)			
ACTION PLAN	• Conduct monthly monitoring of the responsiveness of the 24/7 Access Line • Monthly, provide feedback to the 24/7 Access Line staff regarding test call findings. • Annually, review the Access to Services training to ensure the information is accurate. • By July 1, 2025, develop and implement a "test caller" training. • Request Corrective Action Plans for when performance falls below expectation in any area			
DATA SOURCE / TIME FRAME	Test Call Reports; quarterly and monthly			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	24/7 Access Line Staff, Supervisors and Managers; QAPI Managers and Supervisors			

Goal 2 (contd): Ensure members have access to comprehensive *high-quality* behavioral health services.				
Section III: Quality (15 Objectives)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Follow-Up after Emergency Department Visit for Mental Illness (FUM)			
OBJECTIVE 1:	Maintain or increase the percentage of members that receive a follow up service within 30 days after discharge from an emergency department when the member has a mental health diagnosis. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rates are not available. However, the MY 2023 rate from CalMHSA is as follows: 79.5% (30 days)			
ACTION PLAN	• Ongoing, develop resources for obtaining Emergency Department visit information from local hospitals • Ongoing, develop systems to track follow-up services after an emergency department visit • Meet at least quarterly with collaborative partners to review outcomes and process improvement opportunities			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI/Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Managers and Supervisors, Outpatient Services Managers and Supervisors; QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Follow-Up after Hospitalization for Mental Illness (FUH)			
OBJECTIVE 2:	Maintain or increase the percentage of members that receive a follow up service within 30 days after discharge from a hospital where the member was treated for a mental illness. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rates are not available. However, the MY 2023 rate from CalMHSA is as follows: 77.7% (30 day follow up)			
ACTION PLAN	• Ongoing, develop systems to track follow-up services after hospitalization • Meet at least quarterly with collaborative partners to review outcomes and process improvement opportunities			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI/Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Managers and Supervisors, Outpatient Services Managers and Supervisors; QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
OBJECTIVE 3:	Maintain or increase the percentage of children and adolescents 1-17 years of age who had a new prescription for antipsychotic medication and had documentation of psychosocial care as first-line treatment. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rates are not available. However, the MY 2023 rate from CalMHSA is as follows: 87.5%			
ACTION PLAN	• Ongoing, develop systems to track the use of first-line psychosocial care for children and adolescents who had a new prescription for antipsychotics. • Continuously monitor and implement strategies to address any identified barriers.			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI Informatics; Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Children and Youth Services Supervisors and Managers; QAPI Supervisors and Managers			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)			
OBJECTIVE 4:	Maintain or increase the percentage of adults 18 years of age and older who have schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80 percent of their treatment period. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rates are not available. However, the MY 2023 rate from CalMHSA is as follows: 74.9%			
ACTION PLAN	• By June 30, 2025, explore developing systems to track adherence to medications for individuals with Schizophrenia, such as a medication monitoring system to track refills to identify possible non-adherence. • Provide patient education on the importance of medication adherence, managing side effects, and the risks of discontinuing treatment			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI Informatics; Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Outpatient Services Managers and Supervisors; QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Pharmacotherapy of Opioid Use Disorder (POD)			
OBJECTIVE 5:	Maintain or increase the percentage of new opioid use disorder (OUD) pharmacotherapy episodes that resulted in 180 or more covered treatment days among members 16 years of age and older with a diagnosis of OUD. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rates are not available. However, the MY 2023 rate from CalMHSA is as follows: 34.2%			
ACTION PLAN	• Ongoing, develop systems to track pharmacotherapy episodes that resulted in 180 or more covered treatment days among members 16 years of age and older with a diagnosis of OUD. • Meet at least quarterly with collaborative partners to review outcomes and process improvement opportunities.			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI Informatics; Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Substance Use Disorder Services Managers and Supervisors; QAPI Managers and Supervisors			

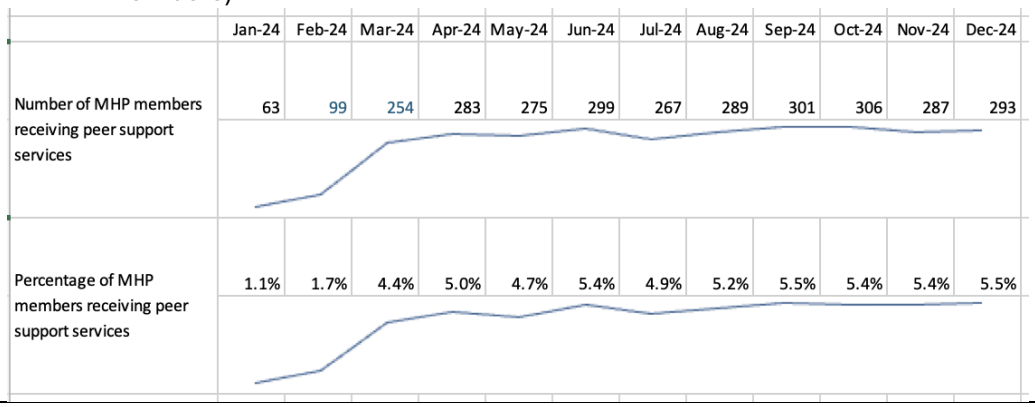
Section III: Quality (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Use of Pharmacotherapy for Opioid Use Disorder			
OBJECTIVE 6:	Maintain or increase the percentage members, aged 18 years and older, who have been diagnosed with an opioid use disorder (OUD) who filled a prescription for, were administered, or dispensed, a Food and Drug Administration (FDA)-approved medication to treat or manage an OUD. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rates are not available. However, the MY 2023 rate from CalMHSA is as follows: 89.5%			
ACTION PLAN	• Ongoing, develop systems to track the percentage members, aged 18 years and older, who have been diagnosed with an opioid use disorder (OUD) who filled a prescription for, were administered, or dispensed, a Food and Drug Administration (FDA)-approved medication to treat or manage an OUD. • Meet at least quarterly with collaborative partners to review outcomes and process improvement opportunities.			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI Informatics; Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Substance Use Disorder Services Managers and Supervisors, QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☒ **DMC-ODS**	☐ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Initiation and Engagement of Substance Use Disorder			
OBJECTIVE 7:	Maintain or increase the percentage of new substance use disorder episodes that result in treatment initiation and engagement. Initiation: Episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visits or medication management. Engagement: Percentage of new SUD episodes that have evidence of a treatment engagement within 34 days of initiation. **Target**: Maintain >50th percentile or 5% increase over baseline if <50th percentile			
BASELINE	Measurement Year (MY) 2024 rates are not available. However, the MY 2023 rate from CalMHSA is as follows: Initiation: 67.9% Engagement: 54.5%			
ACTION PLAN	• Ongoing, develop systems to track the percentage of new substance use disorder episodes that result in treatment initiation and engagement. • Ongoing, develop and implement patient engagement strategies such as motivational interviewing strategies and outreach for patients who miss appointments. • Ongoing, develop and offer resources such as brochures, videos, and online portals to educate members about behavioral health issues, treatment options, and the importance of ongoing care.			
DATA SOURCE / TIME FRAME	CalMHSA Annual HEDIS Calculations; QAPI Informatics; Measured quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Substance Use Disorder Services Managers and Supervisors; QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Clinical Record Reviews			
OBJECTIVE 8:	Ensure compliance with documentation requirements. **Target**: 90%			
BASELINE	95% (Chart Review Subcommittee Reports – QI Work Plan Evaluation 11/2024)			
ACTION PLAN	• Conduct monthly Utilization Reviews (total 5% of open charts) • Information gleaned from monthly reviews will be presented at the Chart Review Subcommittee meetings. • Continuously, use data analysis to identify trends, gaps in documentation, and opportunities for improvement, and share this information with stakeholders to guide staff development			
DATA SOURCE / TIME FRAME	Chart Review Subcommittee Data/ Monthly, Quarterly and Annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Programs; QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Develop and implement strategies to reduce avoidable hospitalizations			
OBJECTIVE 9:	Develop and implement strategies to reduce avoidable hospitalizations **Target**: TBD			
BASELINE	TBD			
ACTION PLAN	• By July 30, 2025, research, develop and implement a self-management tool designed to improve symptom management. • By December 30, 2025, research and consider implementing tools and strategies aimed at helping members improve their well-being by implementing self-management strategies such as tracking behavior patterns and moods and identifying triggers for increased mental health symptoms. • Continuously, offer mental health crisis management support lines to help prevent future emergency visits. • Continuously, educate the community about how to access available outpatient behavioral health services to reduce the need for emergency care.			
DATA SOURCE / TIME FRAME	TBD			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	QAPI Managers and Supervisors; 24-Hour Services Managers and Supervisors; Outpatient Services Managers and Supervisors			

Section III: Quality (continued)

BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Performance Improvement Project: PEER Support Services			
OBJECTIVE 10:	Increase the percentage of Behavioral Health Plan (BHP) members who receive at least one Peer Support Service **<u>Target</u>**: • 2025: Collect and monitor CY 2025 data • 2026: Increase over CY 2025 rate			
BASELINE	CY 2025 rate not yet available. However, CY2024 monthly rates are: • 0% of DMC-ODS clients • Between 63 and 306 MCP members per month (1.1% and 5.5% of MHP members)  			
ACTION PLAN	2025: • Monitor peer support service data monthly and analyze CY 2025 baseline rate • All BHOWs working in FSPs are certified within one year of hire. 2026 • Interventions TBD but are likely to include recruitment			
DATA SOURCE / TIME FRAME	SmartCare service data, analyzed monthly, quarterly and annually. *(Note, annual rates are likely to be significantly higher than monthly rates because over the course of a year, a significantly larger number of clients receive at least one service.)*			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Outpatient Services Supervisors and Managers			

Section III: Quality (continued)

BHS SYSTEM	☒ **DMC-ODS**	☒ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Performance Improvement Project: (Follow-up after ED visit for Substance Use - (FUA)			
OBJECTIVE 11:	Maintain or increase the percentage of members, age 13 and older, who receive a follow up service within 30 days of discharge from an ED for a substance use or drug overdose diagnosis (FUA). **Target**: Increase above MY 2025 baseline in both MY 2026 and 2027			
BASELINE	MY2025 rates are not yet available. However, MY 2023 rates from CalMHSA are as follows: • 30-Day FUA rate 53.1% (>National 50th percentile MPL = 36.3%)			
ACTION PLAN	2025: • Collaborate with HIOs, MCPs, and Hospitals to acquire *real-time* Admission, Discharge, Transfer (ADT) data to support follow-up with Medi-Cal members who discharge from the ED for substance-use related concerns AND to follow up with *BH-enrolled* members who admit to the ED for other reasons, as clinically appropriate. • Collaborate with MCPs and HIOs to acquire claims data to permit a comprehensive measurement of the MY 2025 FUA rate 2026: • Develop and implement clinical strategies using ADT data. Specific strategies TBD			
DATA SOURCE / TIME FRAME	Emergency Department ADT data and MCP claims data from one or more Health Information Organization. • ADT data acquired hourly • Claims data acquired monthly Interim data from DHCS's Planned Data Feed, provided monthly to CalMHSA (data does not include members not enrolled in BH programs)			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	All Access and Points of Entry Supervisors and Managers, Outpatient Services Supervisors and Managers			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☒ **SMHS**	☐ **BOTH**	
SERVICE CATEGORY	Readmission to Psychiatric Hospitals			
OBJECTIVE 12:	Develop and implement strategies to maintain or reduce the percentage of members that readmit to an inpatient psychiatric facility within 30 days of discharge. **Target**: Children less than 9% Adults less than 14%			
BASELINE	Children less than 1%; Adults 11% (QI Work Plan Evaluation July 2024)			
ACTION PLAN	• By July 30, 2025, research, develop and implement a self-management tool designed to improve symptom management. • By December 30, 2025, research and consider implementing tools and strategies aimed at helping members improve their well-being through self-management strategies such as tracking behavior patterns and moods and identifying triggers for increased mental health symptoms. • Continuously, offer mental health crisis management support lines to help prevent future emergency visits. • Continuously, educate the community about how to access available outpatient behavioral health services to reduce the need for emergency care.			
DATA SOURCE / TIME FRAME	SmartCare; quarterly and annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	24-Hour Services Managers and Supervisors; Outpatient Services Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Develop and implement strategies to coordinate physical, mental health and SUD services.			
OBJECTIVE 13:	Develop and implement strategies to increase the percentage of members whose physical, mental health and SUD services are coordinated. **Target**: TBD			
BASELINE	TBD			
ACTION PLAN	• Continue ongoing efforts to exchange information with managed care partners. • By August 2025, develop. implement and monitor a system to refer individuals to and between appropriate systems of care via a coordinated care referral request. • Ongoing, implement and monitor a closed loop referral system for transitioning care to and from managed care plans.			
DATA SOURCE / TIME FRAME	TBD			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors;			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Medication Monitoring			
OBJECTIVE 14:	Ensure the safe, effective, and consistent use of medications in behavioral health and substance use disorder services, including psychotropic medications and those used in Medication-Assisted Treatment and Narcotic Treatment Programs. **Target**: Review two charts per prescriber by the end of 2025			
BASELINE	Completed monitoring reports			
ACTION PLAN	• Track medication monitoring activities per SB 1291 • Develop, implement and expand methods to monitor medication prescribed • Annually, review two charts per behavioral health services and county contract prescribers.			
DATA SOURCE / TIME FRAME				
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Medication Monitoring Committee; QAPI Managers and Supervisors			

Section III: Quality (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Quality Management			
OBJECTIVE 15:	Develop and implement an annual Quality Assessment and Performance Improvement Program Review **Target**: Present recommendations to QAPI Council at the August 2025 meeting Complete review by January 2026			
BASELINE	Completed Annual Evaluation			
ACTION PLAN	• By May 2025, establish a tracking system to monitor progress toward quality improvement initiatives. • Annually, prepare and distribute an annual evaluation of the Quality Improvement Program and Work Plan to leadership, staff, and stakeholders. • Update the Quality Improvement Work Plan as needed to address emerging issues related to quality improvement.			
DATA SOURCE / TIME FRAME	Completed Assessment January of each year			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	QAPI Managers and Supervisors			

Goal 3: To ensure members are satisfied with their services.				
Section IV: Satisfaction (03 Objectives)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Member Satisfaction			
OBJECTIVE 1:	Increase member satisfaction with services. **Target**: 90% of members will report satisfaction with services			
BASELINE	Consumer Perception Survey (CPS) 2023 (mental health) - 78% of individuals surveyed were satisfied with the overall services in the following domains: Quality, Access, General Satisfaction, Participation in Tx Planning, Social Connectedness, Outcome and Functioning Treatment Perception Survey (TPS) 2023 (substance use services), 89% of individuals surveyed were satisfied with the overall services in the following domains: Access, Quality, Care Coordination, Outcome and General Satisfaction			
ACTION PLAN	• By July 2025, develop and implement a plan to communicate satisfaction survey outcomes to members, providers, and other stakeholders. • Ongoing, identify and implement strategies to address areas that require improvement.			
DATA SOURCE / TIME FRAME	TPS and CPS Surveys/Annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	QAPI Managers and Supervisors; Outpatient Services Managers and Supervisors; 24-Hour Services Managers and Supervisors			

Section IV: Satisfaction (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Grievances and Appeals			
OBJECTIVE 2:	Develop and implement a system to evaluate grievances, appeals, expedited appeals, state hearings, expedited state hearings and provider appeals. **Target**: Present quarterly analysis at QAPI Council Meetings beginning in February 2025			
BASELINE	Quarterly Reports to QAPI Council			
ACTION PLAN	• Continuously, track, trend, and analyze member grievance, appeal, and State Fair Hearing information, including tracking by type, ethnicity and language. • Ongoing, develop and implement strategies to resolve grievances and appeals within 30 days. • Conduct quarterly Grievance Committee Meetings to review grievances and appeals and make recommendations to address areas of concern.			
DATA SOURCE / TIME FRAME	Grievance Committee Reports, Reports to QAPI Council/Quarterly and Annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	QAPI Managers and Supervisors; Grievance Committee Members			

Section IV: Satisfaction (continued)				
BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Request for Change of Providers			
OBJECTIVE 3:	Develop and implement a system to evaluate requests to change persons providing services. **Target**: Present quarterly analysis at QAPI Council Meetings beginning in April 2025			
BASELINE	Quarterly Reports to QAPI Council			
ACTION PLAN	• Track, trend, and analyze change of provider request data by demographics, reasons, location, providers, and language. • Continuously, plan and implement strategies to address any identified barriers. • Ongoing, ensure that 100% of requests to change providers are processed within 30 days.			
DATA SOURCE / TIME FRAME	Change of Provider Reports/Quarterly and Annually			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	QAPI Managers and Supervisors; Program Managers and Directors			

Goal 4: Identify and implement strategies to increase access and engagement among ethnic/cultural groups that are underserved or inappropriately served.

Section V: Cultural Competency (01 Objective)

BHS SYSTEM	☐ **DMC-ODS**	☐ **SMHS**	☒ **BOTH**	
SERVICE CATEGORY	Cultural Competency			
OBJECTIVE 1:	Develop and implement a Cultural Competence plan to ensure that behavioral health services are accessible, equitable, and effective for individuals from diverse cultural and linguistic backgrounds. **Target**: Complete by December of each year			
BASELINE	Completed Cultural Competence Plan			
ACTION PLAN	• Annually, develop a single Cultural Competence Plan that addresses both individuals with specialty mental health services needs and individuals with substance use disorder needs. • Ongoing, identify and implement strategies and resources to increase access and engagement activities among specified ethnic/cultural groups that are currently unserved, underserved or inappropriately served. • Ongoing, monitor Cultural Competency Training completion rates. • Provide language services training to all new employees to ensure members receive services in their preferred language.			
DATA SOURCE / TIME FRAME	Cultural Competence Plan/Quarterly and Annual Progress Updates			
QUARTERLY METRICS	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**
ANNUAL EVALUATION	**Annual Metric:** **##.# %**	☐ **Objective Met**	☐ **Partially Met**	☐ **Not Met**
	Narrative:			
RESPONSIBLE PARTIES	Ethnic Services Manager; Cultural Competence Committee			

QAPI Work Plan Change Log			
#	**Section**	**Change Description**	**Revision Date**
1			
2			
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4			
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