TUOLUMNE COUNTY
BEHAVIORAL HEALTH DEPARTMENT

Quality Assurance Performance Improvement (QAPI)
Annual Update FY 21-22

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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 54,478. 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) is ~~are~~ held ~~the first Tuesday of each~~ every other Thursday, here~~month~~ ~~when~~ agenda items are presented. This results often in BAM being an ad-hoc meeting that is chaired by ~~the~~ the Business and Operations Staff Analyst ~~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 once a week ~~Tuesday afternoons as needed~~ and are attended by all Clinical Supervisors, the Clinical Deputy Director ~~Manager~~, and other managers ~~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~~once a 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 Committee
  - Quality Management Committee (QM) meets once a month and 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: the full Management team, ~~Behavioral Health Director, Clinical Manager, Behavioral Health Program Supervisors, Compliance Manager, Quality Improvement Coordinator, Medical Records Supervisor, MHSA Coordinator, and~~ Quality Improvement Analysts, Business and Operations Analysts, Ethnic Services Coordinator, and additional staff as needed. 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) meets each morning and 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 weekly ~~on the third Tuesday of each month~~ and includes the -full Quality Improvement team. ~~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:~~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

- Policy Process Updates
  - Throughout the year the policies have taken a large transition. First change made was the organization of how policies were updated. A point person was made for checking out any policies that needed to be reviewed or updated. Previously without a point person the tracking of what policies were being updated and what the most current version was tended to be difficult. The next meant creating a new environment to place all PDF versions of final policies. Though previously policies were available in a shared space for all staff it was not monitored regularly to ensure that only the most current version was available. Allowing a point person made the cleanup of these current files easier and allowed for only one person to update polices, ensuring ongoing consistency. Efforts were made to ensure tracking occurred for what policies were currently being worked on. Also, we addressed the time that it took to process policies. TCBH needed to get policies signed quickly once they were reviewed to ensure that we met requirements for CAP's, DHCS updates, internal process changes, etc. The policy on policies was updated to clearly reflect the review process between the management team, the staff, the Director and the union. Once the review process was complete and the policy was completed with signatures a clear all staff communication is sent out to show what is new, where to find the policy and a brief description of the change and updates or new content. This message is sent out to ensure all staff are always aware when a policy change is being made and guarantee communication between teams. Finally, the policies template was updated to reflect the new procedure, allow for review and update times, ensure all signature lines were included and made sure all policies were formatted the same. This creates clear messaging and consistency with all policies and procedures.

- Online Training Launch
  - Due to the Covid-19 pandemic mandated lock down, gatherings of multiple people could no longer take place. As TCBH struggled technologically to react to the pandemic, trainings and meetings were cancelled. Yet, TCBH was still obligated to provide mandated trainings to staff. To utilize the technology that TCBH had access to, QI began to create and post trainings through Target Solutions for TCBH staff. Target Solutions is an online learning management system that the county operates. Previously Target Solutions was only used for county mandated trainings, while mandated mental health trainings and programs trainings for TCBH took place in person. In August, QI began drafting a training that would be launched internally and focused on TCBH specific content, its topic was cultural competency. This first presentation was beneficial as it allowed QI to develop the format that trainings would be uploaded as well as the amount of time trainings took to create. PowerPoint was used as the training medium to allow staff to move through the presentation at their own speed. Each slide also featured an audio recorded reading of the slide. As it was an original presentation, it took quite a while to create. Creation and launch of the training also forced QI to properly learn how to use all the

technological features of Target Solutions, this included creating post-tests that would be administered to staff and adding additional documents for staff to download and review. In November 2020, TCBH uploaded and assigned the first online training. Throughout the training QI staff provided technical assistance to staff. Despite the small amount of complications, the training was successful. Following the cultural competency training, QI began work on additional trainings that would be posted during the first months of 2021. The first of these trainings being beneficiary rights.

- Telework Implementation
    - Prior to CY 2020 there were no telehealth options for clients to receive SMHS other than psychiatry and little to no telework option for staff. With the onset of COVID there was a need to shift service models and staffing plans to maintain the same quality of care and consistent service delivery to our clients. This change prompted the agency to be both flexible and innovative to ensure quality of care and staff safety. As many other counties did, Tuolumne launched into telehealth and telework. The agency was able to rapidly produce policies that outlined telework guidelines as staff shifted. In the beginning there was mostly shift work set into place. Shifts were limited because technology was a barrier for the agency. At the time the TCBH did not have enough laptops and cell phones to deploy all staff to home simultaneously. In addition, there was need to ensure that there was still staff on site to respond to crisis and crisis evaluations at the hospital. Within a short period of time TCBH was able to acquire the technologies needed, solidifying the organization around how both telehealth and telework would be accomplished going forward. As telework was launched TCBH monitored not only staff productivity, but client outcomes closely. Reports were generated on a more than normal frequency to understand if no show rates were being affected by the telehealth shift. Crisis counts and hospitalization counts were monitored closely through Quality Management. When issues or trends were identified the team launched a Quality Assurance form to ensure that further inquiry took place. Contacts were monitored closely on how many phone and face to face interactions took place. Team meetings were still conducted to ensure that if any problem areas arose that they could be addressed immediately. Policies and procedures were quickly drafted around how to document time, how to transfer documentation, etc. These were distributed and reviewed in detail with all teams. Supervisors continued to meet weekly with all staff to be sure to address all questions and barriers to working from home. Additional shifts were necessary to continue to provide ongoing services throughout the department. Due to the pandemic and lack of technology, SUD groups stopped abruptly. Telephonic methods were put in place immediately at the start of the pandemic for staff to stay in touch with clients. As TCBH had not yet provided virtual groups, the right technology needed to be gathered as well as a training for staff to be able to properly conduct virtual groups. September 2020 became the targeted launch date for the SUD groups. Zoom was obtained through the county and was deemed HIPPA

compliant, by the Spring but there were barriers to launching it for SUD groups. The biggest hurdle was proper equipment for providers, as many became effected by the pandemic webcams were on back order. Webcams were eventually attained in late spring/early summer. Once the technology piece was addressed the next piece was confidentiality. Typically, SUD treatment is done in a group setting, moving in person groups to a virtual platform took a lot of planning and training to ensure that each clients confidentiality was maintained. This launched several work groups on how to launch meetings, send meeting invites where other recipients were not shared, etc. QI created training materials for the SUD providers and a training was given to make sure they entered virtual groups with the necessary knowledge. SUD staff were given access to two administrative Zoom accounts that had the necessary features and the ability to hold the meetings to the required length. As trainings and the setup was complete ahead of schedule, virtual groups officially launched the last week of August.

- Behavioral Health Reorganization
    - On December 15, 2020 the Health and Human Services, HHSA, Director presented to the Board of Supervisors a full HHSA reorganization that included four position changes to Behavioral Health. Over the last year the Behavioral Health Director has worked together with the HHSA Director to establish new and more agency wide beneficial changes to the department. The goal of this change is to unify the agency of HHSA and create larger capacity with each department. As the recession provided several mid management cuts in the budget, years later these cuts have remained unchanged. In plans to address these deficiencies, create more capacity and a more integrated HHSA, changes throughout the agency were made. Two Deputy Director positions and two Agency Manager positions were added to Behavioral Health. These positions create unison throughout HHSA, meaning those tasked with the same type of responsibilities have the same title rather than unique ones. This will allow staff to move more freely throughout HHSA and create more depth within departments to equalize workloads. This will allow TCBH and other HHSA departments to better serve the community with greater quality and efficiency. In addition to these changes, TCBH administrative tasks were reorganized as well. The cause of this change was prompted after a full review of how resource related tasks were assigned to each staff and an evaluation of current and future projects. The intent of the redistribution of tasks is to ensure that the correct supports are assigned to the right program areas for the department's current and future needs. There was great consideration made to guarantee that the proper tasks were assigned to the right team or staff member(s) based on their individual skill sets, interests, and common areas of responsibility defined within individual job classifications. Moving forward this same approach is being reviewed for the clinical teams. Current plans are being reviewed with the HHSA Director, TCBH Director and the TCBH Deputy Directors on additional changes that could take place to better support the department overall. Though reorganization has taken place in the last year, it continues to be a significance project for the new fiscal year.

- Quality Assurance Activity Monitoring
    - In April 2020 the Quality Assurance Form was launched to monitoring ongoing Quality Assurance issues. These forms were launched in Quality Management in May 2020. The forms were launched to ensure that data reviews and clinical observations were followed up and if necessary, system changes are made in response. 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 forms were launched and immediately used to ensure that quality of care issues is not only addressed, but resolutions were made and tracked. Each form gives a description of the issues, where the issue was found and who is responsible for the follow up. It also describes the steps and actions that were taken to investigate the issue and resolve it. If additional follow up is needed the form is updated to reflect this. There is also a log that tracks all the actions within the form to ensure that trends can be identified if necessary. This change allows for seamless communication between the Quality Management team and the Clinical Supervision Meeting

- Enhanced Relationship with CWS
    - Behavioral Health and Child Welfare Services have made large strides in strengthening the existing working relationship to enhance services for foster youth. Behavioral Health and Child Welfare Deputy Directors came together over the last year to collaborate on several initiatives surrounding the foster youth population. Several communication gaps were identified, and efforts were made to provide higher quality services and have more fluidity between Behavioral Health and Child Welfare Services. Efforts to revitalize the Interagency Placement Committee (IPC) were established. The IPC meets monthly, and Multidisciplinary Team Meetings are scheduled as needed. This committee focuses on creating a stronger collaborative partnership to ensure access to care and wrap around services for foster youth. The meeting focuses on more effective ways to share data, ensure close collaboration, and collectively build a Children's System of Care with Child Welfare Services. Through this strong partnership several shared trainings have been rolled out. The first was for the management team of each agency. A contractor was brought in to review current practices and establish new fundamentals for both the Children System of Care program development and how to respond to the Family Urgent Response System (FURS). This training took place over several weeks with different sessions each week. Both CWS and TCBH Deputy Directors attended the ongoing training. Meeting with the consultant on children's system of care development will continue through 2021. An integrated system of care training was launched in January 2021 for both CWS and TCBH staff. In attendance was management and clinical staff from TCBH as well as managers and social workers from CWS. This joint training was to better understand the development and goals of the Children's System of Care and to develop skills toward Integrated Core Practice Model based engagement and service planning behaviors. Over the next year a large initiative of Behavioral Health

Department and Child Welfare Services will be to collectively strengthen their relationship to better serve foster youth. In addition, they are working together to develop a closely coordinated Children's System of Care that incorporates both CWS and Behavioral Health services appropriate to the child's level of care needs. The process of closing the gap for youth continues to be a priority project for TCBH.

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
I. Monitoring Service Delivery Capacity	1. Penetration Rates 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) a. Gender b. Race 3. Cultural Competence Monitoring & Reporting 4. Network Adequacy a. Time and Distance Standards b. NACT Submissions 5. Capacity Monitoring a. Full Time Equivalent Licensed b. Full Time Licensed Equivalent Eligible c. Other Qualified Providers

Section Title		Description of Task
II.	Monitoring Access to Care Standards	1. 24/7 Access Line Test Calls 2. Timeliness 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
III.	Monitoring Beneficiary Protection, Appeals, and Satisfaction	1. Beneficiary Satisfaction Survey(s) & Reporting 2. Grievance, Appeals, State Fair Hearings 3. Change Providers 4. Notices of Adverse Benefit Determinations (NOABDs)
IV.	Monitoring Quality of Care Standards	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
V.	Coordination with Primary Care Providers, Managed Care, and Community Resources	1. Continuity of Care 2. Referral Process with Managed Care 3. Consumer run/driven programs to enhance wellness

Section Title	Description of Task
VI. Performance Improvement Projects	1. Clinical PIP 2. Non-Clinical PIP
VII. Dedication to Overall Quality Services	1. Annual Evaluation of QAPI Program Effectiveness 2. Key Performance Indicators
VIII. Monitoring of Measurable Outcomes	1. Key Performance Metric Reports / Dashboards 2. SUD Outcomes 3. Grant Evaluations 4. Community Project Evaluations

6. Quality Assurance Performance Improvement Work Plan Goals

Area of Concern	Goal	Intervention	Monitoring
1. Timeliness	1. By end of fiscal year 2021-2022 improve first offered SMH appointments to an average of 15 days.	1. All case managers will meet with their Supervisor on identifying their specialty and preferences. Their Supervisor will sit in on the CAT sessions each day to ensure clients are assigned to the most appropriate case manager. 2. All clients will be assigned a Case Managers and will be notified by CAT of the new assignment. The Case Manager will then be responsible for rendering the first offered appointment within 2 days. (See Clinical PIP) 3. Reception will be responsible for scheduling first offered appointments rather than the Case Managers. CAT will notify not only the Case Managers of new assignments, but also reception simultaneously. This will ensure that the client is contacted about their first appointment the same day as the assignment.	1. A weekly meeting will be held with all case managers and their direct supervisor to review weekly schedules. This will ensure ongoing availability in case managers schedules for the first offered appointment. 2. Business and Operations team will track every first offered SMH appointment through the current CSI tracking method. This tracking will be completed daily. 3. In addition to weekly monitoring timeliness for first offered SMH appointments will be reported out quarterly to full management team.
2. Dual Diagnosis	1. Increase the dual diagnosis rate for clients from 17% to 30% by the end of fiscal year 21-22.	1. By September 1, 2021 TCBH will co-locate the SUD and MH service providers. Both services will be provided at the same location with one entrance. This will ensure no wrong	1. All new and annual assessments will be reviewed in CAT for Medical Necessity and authorization. With the single assessment the team will be

		door entrance for clients and allow for easier ongoing integration of services. 2. By the end of December 2021 TCBH will launch a new assessment. This will be a single comprehensive assessment for both SUD and MH. This will eliminate the need for two separate assessments and can launch an immediate opening into either program. 3. By the end of December 2021 all MH and SUD assessment staff will be fully trained on the new single assessment, which will include a dual diagnosis training for staff.	reviewing both the SUD and MH assessments together. If a dual opening is necessary and there is not one, then a notification will be sent out to the assessment clinician by CAT. 2. Once the new assessment and training are in place monthly reports on current dual diagnosis trends will be collected and reviewed in Quality Management.
3. Quality Assurance	1. By the end of Fiscal Year 21-22 when children assessments are reviewed in CAT, 100% will be accompanied by a tool that will assist in determining service eligibility.	1. By the end of September 2021, the tool will be drafted and reviewed by DHCS for standards. 2. By end of November 2021there will be a final version of the tool. At this time all the necessary staff will be trained on the use of the tool. 3. By December 2021 the tool will be implemented with every child assessment that is reviewed by CAT.	1. The Business Administration Meeting will review the proposed draft tool by October. This meeting will monitor the completion and finalization of the tool. 2. Quality Improvement will track the training for the tool to ensure all needed staff are trained on the use of the tool by December. 3. After the implementation of the tool CAT will track the use of the tool for every annual and new assessment for children.

7. Data Analysis informing each goal selection.

1. Timeliness
    a. Over the years different strategies were put in place to reduce timeliness for accessing specialty mental health (SMH) services. In 2017 the average time for first offered SMH appointment was 50 days and in 2018 it was reduced to 42. In 2019 reception began scheduling for all clinicians to help further reduce wait times. By the end of the year the wait time had been reduced to 24 days but is was very far from both the mandate and ensuring quality of care. Timeliness has become an increasingly large concern for the QM team around how long it was taking clients to get into services. To achieve the goal of better timeliness for first offered SMH appointment a delivery system shift will take place. After a client is authorized for SMH services the client will then be assigned a case manager. Reception will be notified of the assignment and call the client the same day to schedule their first appointment. This is a shift from the previous model where the first SMH appointment was offered by the clinician. To help foster client engagement and meet mandated timelines, interventions will be put in place over the next year to decrease the average timeliness for first offered SMH appointment to 15 days.

2. Dual Diagnosis
    a. TCBH had received feedback for several years from the EQRO audit around dual diagnosis, the feedback created discussion and analyzation within the team. It was discovered that the current dual diagnosis rate within TCBH was 13.4%. As many counties in the state differ by population, land size, and land use, the dual diagnosis rates of counties comparable to Tuolumne were researched in order to see where Tuolumne stood. It was found that in 2018 the dual diagnosis rate of Mariposa was 12%. Although that is a similar rate to TCBH, it was decided that there was room for improvement as according to the National Survey on Drug Use and Health (NSDUH), 45% of people in the United States struggle with a dual diagnosis. This left TCBH roughly 32% behind the national average. The goal is to improve quality of care of clients by properly identifying and diagnosing both mental health and substance use disorders (SUD) in assessments. To achieve this goal, TCBH will be implementing a single assessment and training staff on dual diagnosis. Through staff education and a single point of contact for service, the QM team is looking to see the dual diagnosis rate at TCBH increase to 30%.

3. Quality Assurance

a. To ensure consistent assignment and ongoing services are properly authorized to all children a tool will be implemented to assist in determining service eligibility. This tool will be used during the CAT teams review of all children's new and annual assessments. This tool will support ongoing consistency in ensuring that each child is receiving the services they need. Whether these services be ICC, IHBS, TBS or others, there will be a consistent use of determining need. This allows TCBH to comply with DHCS standards and gives ongoing monitoring and assurance opportunities for TCBH around children's services. By implementing this tool TCBH will be able to gather baseline data around service authorization for these services, which will continue to inform and help make data-based decisions.

Evaluation of QAPI Goals

1. Timeliness – By end of fiscal year 2021-2022 improve first offered SMH appointments to an average of 15 days.
    a. There was a transition to having case managers complete the first appointment for new clients. Case managers had dedicated time slots in their calendars for reception to call and schedule initial appointments for all new clients. This program shift was to introduce clients to case management, reduce wait times, and provide more quality of care to address immediate needs for clients. When reports were completed months later, timeliness had not changed.

       This lack of change was discussed in QM to understand whether the program shift had been successful. One of the identified issues was that the appointments were made after clients were assigned to case managers. Reception explained that many clients were not responsive. Clients either did not answer, have working numbers, etc. With underutilization of the times reserved for new clients, the appointment times began to be taken up by other appointments. Within a year there had been program drift. It was decided this goal was not met and would remain on the QAPI for another fiscal year to continue the opportunity to address the timeliness issue.

2. Dual Diagnosis – Increase the dual diagnosis rate for clients from 17% to 30% by the end of fiscal year 21-22.
    a. Throughout the fiscal year many shifts were made to increase the dual diagnosis rate. During this time TCBH began working on creating a new integrated assessment. The assessment would encompass both MH and SUD assessment criteria. Originally the process for receiving both MH and SUD services was separate and extensive. Previously, clients came in for a MH assessment that would take around two hours and if the client needed SUD services, they would then be scheduled a two-hour SUD assessment. This process could be overwhelming for clients and make accessing each service more time consuming.

Prior to the implementation of the assessment, MH clinicians needed to be trained on the ASAM, CalOMS data and more. In January 2022 all clinicians both MH and SUD were trained in the ASAM and CalOMS and the assessment was released. Now all clients would only receive a single assessment. This reduces the clients need to participate in two separate assessments and referrals could be made to either MH or SUD services with the single assessment.

Additional changes were made in 2021 to remove access barriers for clients. Formerly MH and SUD services were separated physically. MH services took place on the first floor while SUD services took place on the second. As the programs were located on separate floors, there were two different entrances for services which created even more divide for dually diagnosed clients. In 2021 all services became located on the first floor. TCBH undertook a mass move for not only SUD staff, but also for administration and MH staff.

These moves took months of planning for the full management team to ensure that all service providers could be accommodated on the first floor. The moves took place in October 2021 and included moving over fifteen different staff offices. In collaboration with the moves, reception areas and staff were shifted from two different reception and lobby areas to one. All services are now completed on the first floor and a single entrance is used for all services and assessments. There is now one door, one reception window, and one access point for all client needs.

Once SUD staff were moved the mission to cross train on SUD and MH began. Each SUD counselor was assigned to a different MH program to attend their weekly meetings. The purpose of this was to have a more open dialogue between the teams for both education and treatment team purposes.

At the end of the year a measurement was taken, however 30% was not reached. There was not a big increase in the percent of clients that were dually diagnosis but the percent of clients that were dually enrolled in both MH services and SUD went from 6% to 12%. This increase showed improvement for the system and though the goal was not met the interventions were deemed successful by the QM Committee.

3. Quality Assurance – By the end of fiscal Year 21-22 when children assessments are reviewed in CAT, 100% will be accompanied by a tool that will assist in determining service eligibility.
    a. A screening tool was created and in use by the end of 2021. After the tool was released it was discussed whether it was being used consistently with each assessment. It was found that the tool was not being used for all assessments. It was decided that the Business and Operations Analyst would assist during CAT to ensure there was a complete screening tool with all children's assessments. This was done through the analyst preparing all the documentation that CAT

would review each morning. If all documentation was not completed the analysts reported it to CAT, entered it into a tracking system, and then requested the documentation from staff. The email requesting documentation would include staff's direct supervisor for ongoing support. By the end of the fiscal year all youth assessments were accompanied by a screening tool. This goal was met.