Tulare County Behavioral Health Plan

Quality Assessment and Performance Improvement Plan

2024/25

Table of Contents

Overview 3

Cultural Competency 4

Cultural Competency Training 4

Client Satisfaction and Protections 6

Satisfaction Surveys 6

Timely Access NOABDs 8

Access and Timeliness 10

Timely Access – 1st Offered 10

Test Calls 15

Program Integrity 16

Service Verification 16

Performance Improvement Projects 19

Non-Clinical PIP 19

Clinical PIP 20

Overview

The Tulare County Behavioral Health Plan (TCBHP) is committed to providing quality improvement throughout the Specialty Mental Health Services and Drug Medi-Cal Organized Delivery Systems of Care. This Quality Assessment and Performance Improvement Plan (QAPI) is a framework for ongoing system improvement. TCBHP strives to provide a culturally competent; client and family member guided community-based system of care for children/youth and their family/care providers, transitional age youth, adults, and older adults. TCBHP serves a number of populations within the County of Tulare including eligible Medi-Cal and Medicare clients, the unserved/underserved in rural locations, and the unsponsored and indigent populations.

The goal of the TCBHP Quality Improvement (QI) Program is to ensure clients have appropriate access to quality and timely specialty mental health and substance use disorder services as demonstrated through outcome measures and ongoing monitoring activities such as maintaining, and reviewing member grievances, appeals, expedited appeals, State Hearings, expedited State Hearings, provider appeals, and clinical records reviews. The department has identified and prioritized area(s) for improvement on the following pages.

In FY 2023-2024 TCBHP implemented a new electronic health record (EHR) system, SmartCare. The QI and EHR Teams continue working to develop reports to monitor the behavioral health system of care. As is often the case when implementing a new software system, the conversion to SmartCare has presented both challenges and opportunities. One of the challenges we face is data reporting as most of the reports we relied on in the previous system are not available in SmartCare. We are using this opportunity to reevaluate our data needs and develop reports that provide a clear picture of our system of care.

Cultural Competency

Goal: To provide culturally and linguistically appropriate services to clients.

Cultural Competency Training

	Objective 1.1	Performance Indicator and Baseline	Action Steps	
Workplan	95% of direct service providers will complete Cultural Competency training in FY 24/25.	Percentage (%) of direct service providers who completed Cultural Competency training in FY 23/24. 72.4% (370/511)	Work with the Cultural Competency Committee to provide training Cultural Competency Training opportunities. Monitor compliance and work with management staff to ensure staff attend offered trainings. Providers to submit attendance records for outside trainings to QI. Collaborate with the Cultural Competency Committee to develop new training materials based on topics/results that arise of the meetings/ Continue to encourage staff to participate in training and work with management to follow up on completion of training.	
	Data Results	**Analysis: Action Steps, Data, Results**	**Status**	**Recommendations/Final Outcome**
Evaluation	Percentage (%) of direct service providers who completed Cultural Competency training. 55.7% (357/641 YTD)	The completion rate at the end of Q2 is slightly above the pro rata completion rate of 50.0%.	On going	Continue monitoring and communicating with providers for completion of required training.
	Responsible Partners	**Data Governance**	**Policy Governance**	

Reference	QI staff Cultural Competency Committee Management staff	Relias training reports Training attendance logs	42 C.F.R. § 438.206(c)(2). 42 C.F.R. § 438.416(a) CCR, tit. 9, § 1810.410, subd. (c)(4).)

Client Satisfaction and Protections

Goal: To increase client satisfaction and ensure adherence to client protections.

Satisfaction Surveys

<table>
<tr><th></th><th>Objective 2.1</th><th>Performance Indicator and Baseline</th><th colspan="2">Action Steps</th></tr>
<tr><td>Workplan</td><td>Increase the number of surveys submitted by 10%.

Increase Outcome satisfaction score to 4.0 for MH & increase SUD.</td><td>Mental Health (May 2023)
<table><tr><th></th><th># Submitted</th><th>Outcome Satisfaction Score</th></tr><tr><td>Family</td><td>224</td><td>3.94</td></tr><tr><td>Youth</td><td>451</td><td>3.81</td></tr><tr><td>Adult</td><td>342</td><td>3.92</td></tr><tr><td>Older Adult</td><td>21</td><td>4.44</td></tr><tr><td>Total</td><td>1038</td><td>3.88</td></tr></table>
DMC-ODS (October 2023)
<table><tr><th></th><th># Submitted</th><th>Outcome Satisfaction Score</th></tr><tr><td>Youth</td><td>17</td><td>4.32</td></tr><tr><td>Adult</td><td>156</td><td>4.53</td></tr><tr><td>Older Adult</td><td>27</td><td>-</td></tr><tr><td>Total</td><td>200</td><td>4.42</td></tr></table></td><td colspan="2">Provide surveys/links to all clients/ family members receiving services during the survey period.

Encourage clients/family members to complete surveys.</td></tr>
<tr><th></th><th>Data Results</th><th>Analysis: Action Steps, Data, Results</th><th>Status</th><th>Recommendations/Final Outcome</th></tr>
</table>

Evaluation

Mental Health (May 2024)

	# Submitted	Outcome Satisfaction Score
Family	308	3.87
Youth	421	3.91
Adult	397	3.97
Older Adult	12	4.17
Total	1138	3.98

DMC-ODS (October 2024)

	# Submitted	Outcome Satisfaction Score
Youth	15	4.5
Adult	308	4.58
Older Adult	14	-
Total	337	4.54

Results of the May 2024 Mental Health Surveys indicate an overall satisfaction score of 3.98. While not yet meeting the MH goal, the satisfaction scores are showing the department is moving in a positive direction. In 2023 the overall outcome satisfaction score was 3.88 and increased for 2024 at 3.98, an improvement of 0.1. In addition to an increase in surveys completed by 1.09%.

Results of the October 2024 DMC-ODS Treatment Perception Surveys indicate an overall satisfaction score of 4.54. While meeting the DMC-ODS goal of increasing surveys by 10%, the dept continues to work on increasing the number of surveys completed each year. For 2023 the total submitted surveys were 200. For 2024 we had a total of 337 surveys completed, which is an increase of 59.3% and an increase in the Outcome satisfaction score by 0.12. In 2023 the overall outcome satisfaction score was 4.42 an for 2024 it was at 4.54. The satisfaction scores show the department is moving in a positive direction.

Partially met Goal

The department will continue to focus on increasing the additional 10% of surveys completed and increase MH to 4.0, DMC-ODS will remain at 4.5 or above. We will work with our providers on how to optimize client participation.

Reference

Responsible Partners	Data Governance	Policy Governance
QI Staff Providers	Client Perception Surveys (MH) Treatment Perception Surveys (DMC-ODS)	CFR, Title 42 Section 438.66 W&I Code Section 5898 CCR Title 9 Section 3530.40 42 C.F.R. § 438.206(c)(2). 42 C.F.R. § 438.416(a) CCR, tit. 9, § 1810.410, subd. (c)(4).)

Timely Access NOABDs

<table>
<tr><th></th><th>Objective 2.2</th><th>Performance Indicator and Baseline</th><th colspan="2">Action Steps</th></tr>
<tr><td>Workplan</td><td>Establish baseline for compliance with issuance of NOABDs for failure to meet Timely Access standards.</td><td>Baseline to be established in FY 24/25

% of Timely Access NOABDs issued:

<table><tr><td>Appt Type</td><td>Standard not met ( )</td><td># NOABDs issued</td><td>% issued</td></tr><tr><td>MH</td><td></td><td></td><td></td></tr><tr><td>Sud</td><td></td><td></td><td></td></tr></table></td><td colspan="2">Implement issuing NOABDs through the EHR to enable accurate reporting.

Develop reporting mechanism to monitor compliance with issuance of NOABDs for not meeting Timely Access standards</td></tr>
<tr><th></th><th>Data Results</th><th>Analysis: Action Steps, Data, Results</th><th>Status</th><th>Recommendations/Final Outcome</th></tr>
</table>

<table>
<tr><td rowspan="1">Evaluation</td>
<td>% of Timely Access NOABDs issued:

FY 2425

Mental Health

<table>
<tr><th></th><th>Standard Not Met (#)</th><th>#NOABDs Issued</th><th>% Issued</th></tr>
<tr><td>Q1</td><td>----------</td><td>------------</td><td>------------</td></tr>
<tr><td>Q2</td><td>103</td><td>40</td><td>38%</td></tr>
<tr><td>Q3</td><td></td><td></td><td></td></tr>
<tr><td>Q4</td><td></td><td></td><td></td></tr>
</table>

DMC-ODS
<table>
<tr><th></th><th>Standard not met (#)</th><th># NOABDs issued</th><th>% issued</th></tr>
<tr><td>Q1</td><td>------------</td><td>-------------</td><td>---------</td></tr>
<tr><td>Q2</td><td>2</td><td>0</td><td>0%</td></tr>
<tr><td>Q3</td><td></td><td></td><td></td></tr>
<tr><td>Q4</td><td></td><td></td><td></td></tr>
</table>
</td>
<td>Effective January 1, 2025, all NOABDs were to be completed or scanned into SmartCare to allow tracking and monitoring of NOABDs issued and compliance with required standards.

During Q3 the following issues were identified:

Technical issues within the system – working with vendor to resolve
Providers are not utilizing NOABDs within SmartCare consistently – Ongoing training being provided to increase utilization of SmartCare forms
Providers are not completing the Timely Access form or are not completing it correctly – Ongoing training being provided to ensure providers are completing the form correctly and reinforce the requirement to complete.
</td>
<td>Not Met</td>
<td>Continue efforts to establish a baseline for compliance with issuance of NOABDs for failing to meet Timely Access standards.</td></tr>
<tr><td></td><td>Responsible Partners</td><td>Data Governance</td><td colspan="2"></td></tr>
<tr><td>Reference</td><td>QI Staff
Providers</td><td>NOABD Reports in SmartCare
Timely Access Reports</td><td colspan="2">42 C.F.R. § 438.416(a)
CCR., Title 9, §1810.440(a)(5)
42 C.F.R. § 438.206(c)(2).</td></tr>
</table>

Access and Timeliness

Goal: To ensure clients receive timely access to services.

Timely Access – 1st Offered

<table>
<tr><th></th><th>Objective 3.1</th><th>Performance Indicator and Baseline</th><th>Action Steps</th></tr>
<tr><td>Workplan</td><td>Obtain 90% compliance with timely access standards</td><td>Date of request to first offered (avg # business days/hours):

FY 23/24 baseline

Mental Health
<table>
<tr><td>Modality</td><td>Standard</td><td>Avg</td><td>Compliance</td></tr>
<tr><td>Outpatient</td><td>10 days</td><td>7.3</td><td>81%</td></tr>
<tr><td>Urgent Outpatient</td><td>48 or 96 hours*</td><td>54.0</td><td>80%</td></tr>
<tr><td>Psychiatry</td><td>15 days</td><td>9.6</td><td>87%</td></tr>
<tr><td>Urgent Psychiatry</td><td>48 or 96 hours*</td><td>177.3</td><td>24%</td></tr>
<tr><td>Non-Urgent Outpatient follow-up</td><td>10 days</td><td>9.3</td><td>70%</td></tr>
</table>
* 48 hours-without prior authorization; 96 hours-with prior authorization

DMC-ODS
<table>
<tr><td>Modality</td><td>Standard</td><td>Avg</td><td>Compliance</td></tr>
<tr><td>Outpatient</td><td>10 days</td><td>5.4</td><td>94%</td></tr>
<tr><td>OTP</td><td>3 days</td><td>1.4</td><td>95%</td></tr>
<tr><td>Residential</td><td>10 days</td><td>4.7</td><td>92%</td></tr>
<tr><td>Urgent (all svcs)</td><td>72 hours</td><td colspan="2">None*</td></tr>
<tr><td>Non-Urgent Outpatient follow-up</td><td>10 days</td><td>5.7</td><td>91%</td></tr>
</table>
*No urgent requests were received</td><td>Develop and implement timely access tracking mechanism within EHR.

Train staff on timely access tracking.

Review and analyze data for accuracy and identify areas of concern.</td></tr>
</table>

	Data Results	Analysis: Action Steps, Data, Results	Status	Recommendations/Final Outcome
Evaluation	(see data below)	ASR 10/16/2024 - CalMHSA added an Urgent checkbox to the DMC Outpatient and DMC Opioid Timeliness forms to provide clinics the ability to identify urgent condition related appointments and services. ASR 10/17/2024 - the DMC ODS system of care was determined to be in compliance with all quarter 4 timeliness standards outside of the post residential discharge follow-up metrics. ASR 11/14/2024 - the DMC ODS system of care is facing challenges with the following areas: timeliness to offered urgent outpatient services (no data available), timeliness to offered urgent residential services (no data available), timeliness to offered urgent NTP/OTP services (no data available), and timeliness to post residential services (28%).	This will be an ongoing area of focus as we continue to navigate SmartCare and work out challenges with providers.	QI/EHR will provide monthly and/or as needed training to providers with completing timely access forms and monitoring timely access to assist with compliance. A BHP wide TADT training will occur on 3/31/25 with all providers. A training guide has been completed by the QI team and will be distributed by end of March 2025

FY 24/25 – Q1

Mental Health

Modality	Standard	Avg	Compliance
Outpatient	10 days	8.1	73%
Urgent Outpatient	48 or 96 hours*	24.0	85%
Psychiatry	15 days	7.6	94%
Urgent Psychiatry	48 or 96 hours*	180.7	25%
Non-Urgent Outpatient follow-up	10 days	8.3	70%

* 48 hours-without prior authorization; 96 hours-with prior authorization

DMC-ODS

Modality	Standard	Avg	Compliance
Outpatient	10 days	4.6	98%
OTP	3 days	1.0	100%
Residential	10 days	2.5	98%
Urgent (all svcs)	72 hours	None*	
Non-Urgent Outpatient follow-up	10 days	4.3	95%

*No urgent requests were received

FY 24/25 Q2

Mental Health

Modality	Standard	Avg	Compliance
Outpatient	10 days	8.3	75%
Urgent Outpatient	48 or 96 hours*	61.8	51%
Psychiatry	15 days	11.5	88%

Urgent Psychiatry	48 or 96 hours*	222.1	14%
Non-Urgent Outpatient follow-up	10 days	10.4	60%

* 48 hours-without prior authorization; 96 hours-with prior authorization

DMC-ODS

Modality	Standard	Avg	Compliance
Outpatient	10 days	3.4	99%
OTP	3 days	1.2	98%
Residential	10 days	2.6	98%
Urgent (all svcs)	72 hours	None*	
Non-Urgent Outpatient follow-up	10 days	3.3	98%

FY 24/25 Q3

Mental Health

Modality	Standard	Avg	Compliance
Outpatient	10 days		
Urgent Outpatient	48 or 96 hours*		
Psychiatry	15 days		
Urgent Psychiatry	48 or 96 hours*		
Non-Urgent Outpatient follow-up	10 days		

* 48 hours-without prior authorization; 96 hours-with prior authorization

DMC-ODS

Modality	Standard	Avg	Compliance

Outpatient	10 days		
OTP	3 days		
Residential	10 days		
Urgent (all svcs)	72 hours	None*	
Non-Urgent Outpatient follow-up	10 days		

FY 2425 Q4

Mental Health

Modality	Standard	Avg.	Compliance
Outpatient			
Urgent Outpatient			
Psychiatry			
Urgent Psychiatry			
Non-Urgent Outpatient Follow-up			

Modality	Standard	Avg	Compliance
Outpatient			
OTP			
Residential			
Urgent (all svcs)			
Non-Urgent Outpatient follow-up			

	Responsible Partners	Data Governance	Policy Governance

Reference	QI Staff Providers	TDAT Tool Timely Access Dashboard	42 C.F.R. § 438.206(c)(1) CCR Title 9 Sections 1810.405, 1810.435 BHIN 24-020 BHP Contract

Test Calls

Workplan

Objective 3.2

100% of Test Calls to the 24/7 Access Line for SMHS and Urgent Condition (MH) will be logged and include:

- Name of the beneficiary
- Date of the request
- Initial Disposition

Performance Indicator and Baseline

Test calls logged and compliant with required elements (FY 23/24)

SMHS and Urgent Conditions (MH)

	# Calls*	# met req.	% Comp.
FY 23/24	41	29	70.7

Action Steps

Conduct monthly test calls to the 24/7 Access Line.

Monitor Inquiries to ensure calls are logged.

Provide feedback to Access Line provider at least monthly. Report concerns to the Access Line Provider within 1 business day.

Increase contract to increase dedicated access line staffing. Provide incentives to contractor for meeting target standards.

Evaluation

Data Results

Test calls logged and compliant with required elements (FY 24/25)

SMHS and Urgent Conditions (MH)

	# Calls*	# met req.	% Comp.
Q1	14	10	71.4%
Q2	10	6	60.0%
Q3			
Q4			
YTD	24	16	66.7%

Analysis: Action Steps, Data, Results

FY 24/25 contract includes payment incentive for reaching 100% compliance.

Multiple trainings have occurred with the Access Line staff in Aug and Sept 2024. At this time, they still are falling out of compliance.

QI will continue with addressing out of compliance with the Access Line with feedback to them via email. We have requested training be provided to staff that did not meet the requirements and provide proof of the training and outcome. QI will monitor for CAP.

Status

Ongoing

Recommendations/Final Outcome

Reference

Responsible Partners	Data Governance	Policy Governance
QI Staff Access Line provider (Kings View)	DHCS 24/7 Access Line Test Call Report	CCR, Title 9 Chapter 11, Section 1810.405 (f)

Program Integrity

Goal: To verify that services represented to have been delivered were received by clients.

Service Verification

	Objective 4.1	Performance Indicator and Baseline	Action Steps	
Workplan	95% of selected services will be verified, either by signature or contacting the client. 100% of contested services will be investigated for disallowance.	% of selected services verified (FY 23/24) (see table below) Contested services: 0	Verify services quarterly in accordance with the procedures outlined in the Program Integrity policy. Investigate contested services for possible fraud. Review the contested services for possible disallowance.	
	Data Results	**Analysis: Action Steps, Data, Results**	**Status**	**Recommendations/Final Outcome**

	MH	SUD
# Selected	133	19
# Verified	92	5
% Verified	69%	26%
# No response from client	41	14
% No response from client	31%	74%

Evaluation

% of selected services verified (FY 24/25)

MH

	Q1	Q2	Q3	Q4	YTD
# Selected	63	17			80
# Verified	41	4			45
% verified	65%	24%			56%
# No Response	22	13			35
% No response	35%	76%			43%

YTD Contested services: 0

DMC-ODS

	Q1	Q2	Q3	Q4	YTD
# Selected	19	15			34
# Verified	7	15			22
% verified	37%	100%			65%
# No Response	12	0			12
% No response	63%	-			35%

YTD Contested services: 0

Results for Mental Health Q1 indicate 41 clients verified services, which is .44% of the total verified for FY 2324. The department will continue to monitor and assess if modifications are needed. Q2 results are pending.

Results for DMC-ODS for Q2 represent clients in Residential Treatment. Q1 data represents clients who are in Outpatient Programs.

Ongoing

The department may need to modify objectively to 10% of services provided on the selected date will be verified.

Responsible Partners	Data Governance	Policy Governance

Reference	QI Staff Providers		42 C.F.R. §438.608(a), (a)(5) BHP Contract Program Integrity policy [01-001]

Performance Improvement Projects

Goal: NON-CLINICAL-To improve timely access from first contact from any referral source to first offered appointment for any SMHS.

Non-Clinical PIP

<table>
<tr><th></th><th>Objective 5.1</th><th>Performance Indicator and Baseline</th><th colspan="2">Action Steps</th></tr>
<tr><td>Workplan</td><td>To Improve timely access from first contact from any referral source to first offered appointment for outpatient services.</td><td>Modality Type: MH Outpatient
• 10 Business Days
• Numerator – 216
• Denominator-319
• Rate 67.71%</td><td colspan="2">1. Participate in monthly PIP meetings with CalMHSA to discuss PIP development and implementation.
2. Schedule our internal stakeholders meeting for PIP implementation.
3. Collaborate on the drafting and revision of the PIP Forms.
4. Develop standard SmartCare report identifying client population.</td></tr>
<tr><th></th><th>Data Results</th><th>Analysis: Action Steps, Data, Results</th><th>Status</th><th>Recommendations/Final Outcome</th></tr>
<tr><td>Evaluation</td><td></td><td>Tulare County Behavioral Health is collaborating with CalMHSA with the draft of the PIPS submission form.

Tulare County has completed our sections of the PIP submission form and provided to CalMHSA for feedback and completion of CalMHSA’s sections.</td><td></td><td></td></tr>
<tr><th></th><th>Responsible Partners</th><th>Data Governance</th><th colspan="2">Policy Governance</th></tr>
<tr><td>Reference</td><td>QI Staff, other PIP Committee members</td><td>Electronic Health Records system, program data collection</td><td colspan="2">42 C.F.R. § 438.206(c)(1)
BHP Contract</td></tr>
</table>

Goal: clinical-**Improve Follow-Up After Emergency Department Visit for Substance Use**

Clinical PIP

	Objective 5.2	Performance Indicator and Baseline	Action Steps	
Workplan	Improve the FUA measure rate 30 Percentage of Emergency Department visits for which the client received follow-up within 30 days of the Emergency Department visit for Substance Use (31 total days). A follow-up visits with any practitioner, with a principal diagnosis of AOD abuse or dependence within 7 days after the Emergency Department visit (8 total days). Include visits that occur on the date of the Emergency Department Visit.	FUA 30 – 01/01/2025 TO 12/31/2025 • Numerator – 224 • Denominator - 363 • Rate – 61.7%	1. Participate in monthly PIP meetings with CalMHSA to discuss PIP development and implementation. 2. Schedule our internal stakeholders meeting for pip implementation. 3. Collaborate on the drafting and revision of the PIP Forms. 4. Develop standard SmartCare report identifying client population	
	Data Results	**Analysis: Action Steps, Data, Results**	**Status**	**Recommendations/Final Outcome**
Evaluation		Tulare County Behavioral Health is collaborating with CalMHSA with the draft of the PIPS submission form. Tulare County has completed our sections of the PIP submission form and provided to CalMHSA for feedback and completion of CalMHSA's sections.		
	Responsible Partners	**Data Governance**	**Policy Governance**	

Reference	QI Staff, other PIP Committee members	Electronic Health Records system, program data collection	42 C.F.R. § 438.206(c)(1) BHP Contract