Integrative Behavioral Health Quality Improvement Work Plan

FY20-21 Evaluation

Mental Health Plan and Drug Medi-Cal Organized Delivery System Improvement Initiatives

Health, Safety and Equity are our top priorities

Purpose

Santa Cruz County Behavioral Health Services (BHS) Quality Management Program: Santa Cruz County Behavioral Health Services (BHS) in an integrative service delivery model in which leadership and staff value operational excellence and sustainable quality of care. The purpose of the QM plan's activities is to ensure that beneficiaries have timely access to appropriate and quality services, verify qualified providers, promote best practices in treatment and coordination of care, and recovery and/or prevention of behavioral health illness(es). The BH Quality Management (QM) program is responsible for monitoring the MHP's and DMC-ODS' effectiveness and for providing support to all areas of MHP/DMC-ODS operations by conducting performance monitoring activities which include, but are not limited to: utilization management, utilization review, provider appeals, credentialing and monitoring, fraud prevention monitoring, network adequacy, resolution of beneficiary grievances, and analysis of beneficiary and system outcomes. The QM program's activities are guided by the relevant sections of federal and state regulations, including the Code of Federal Regulations Title 42, California Code of Regulations Title 9, California Welfare and Institutions Code, as well as DHCS' relevant MHP/DMC-ODS agreement requirements and performance measures. These QM activities are performed by Quality Improvement team in partnership with MHP and/or DMC-ODS departments to ensure compliance and promote department and BH agency quality improvement initiatives.

Quality Improvement Work Plan: The intent of the Quality Improvement (QI) Work Plan is to create systems whereby data relevant to the performance of the MHP/DMC-ODS is available in an easy interpretable and actionable form. The elements of this QI work Plan are informed by the quality improvement requirements of the MHP/DMC-ODS performance contract, and feedback from the CalEQRO, DHCS MHP/DMC-ODS audit findings & recommendations, and Quality Improvement Committee. The QI Work Plan goals are **s**pecific, **m**easurable, **a**chievable, **r**elevant and **t**ime-bound (SMART) and focus on service and operational improvement initiatives that align with our core trauma-informed guiding principles, Health Service Agency (HSA) values and BH staff surveyed value priorities, and understanding of our DHCS MHP and DMC-ODS agreements. In addition, the County of Santa Cruz Operational Plan FY19-21 promotes a mission for an open and responsive government which delivers quality data-driven services that strengthen our community and enhance opportunity.

Behavioral Health Values & Core Guiding Principles incorporated into ongoing MHP/DMC-ODS operational gains.

Inclusion & Engagement	Cultural humility & responsiveness ● Human connection and relationship ● Universal dignity, respect, kindness, and compassion ● Offerings of support and gratitude ● Transparency and collective communication ● Timely accessibility ● Inclusion of client voice/choice ● Dependability

Operational Excellence & Service Stewardship	Excellent effective care and customer service delivery ● Adaptability ● Ethics ● Responsibility ● Accountability ● Innovation ● Utilize outcomes to improve care, support program decisions and share with other healthcare providers and the greater community.
Targeted Treatment & Evidence-Based Services	Trauma-informed care ● Individualized "Voice & Choice" care ● Targeted Health ● Clinical quality & fidelity to EB practices ● Utilize data outcome to inform decisions ● Workforce Training
Equity & Sustainability	Promote resiliency and recovery (personal/social/environmental/economic) ● Collective impact ● Equity for All ● Justice ● Integrity ● Collaboration ● Holding hope & Eliminating stigma ● Positivity ● Capacity building
Safety	For all who provide and receive services from SCCBHS, including staff, clients, contractors, partners, stakeholders, and our community at large. Safety includes physical, emotional and self-care when at county facilities, remote work setting and/or in community

The goals identified in this work plan speak to our continuous quality improvement efforts to identify and meet the mental health and substance use disorder treatment needs of our community. QI Workplan reflects BH priorities, in alignment with the County Operational Plan, informed by valued-based focus areas and data outcome metrics, to achieve equitable, sustainable improvements that positively impact quality of service delivery, BH transparency and satisfaction for county residents and workforce. The goals described here are not intended to be all encompassing but are important to our overarching quality improvement efforts for Fiscal Year 2020-2021 (July 1, 2020-June 30, 2021). Some goals are carried over from previous plan's work of improving the capture, analysis and use of data to support contractual compliance, performance management and ongoing quality improvement initiatives. *We have identified 6 monitoring categories, 5 main Areas of Focus, and 11 Goals to address for this year with aligned behavioral health values.*

Monitoring Categories:
1. Access to 24/7 services, 2. Effectiveness of Care, 3. Coordination of Care, 4. Beneficiary Satisfaction & Involvement,
5. Utilization Management, and 6. Quality Improvement & Workforce Development.

Value-Based Focus areas:
1. Inclusion & Engagement, 2. Equity & Sustainability, 3. Operational Excellence, 4. Targeted Treatment and Evidence-Based Services,
5. Safety

COVID-19 Impact: COVID-19 has impacted county-wide resources greatly during fiscal year 2020-21, including BHS workforce and budget capacity. BHS leadership and key staff responsibilities expand into COVID-19 response initiatives to ensure safety to the community and workforce. The continuation of COVID priorities impacts available resources for the below QI Workplan activity.

BH QI WORKPLAN:

1. Monitoring Category: Access to 24/7 services

Goal 1.1: By June 30, 2021, the MHP and DMC-ODS Networks will process Medi-Cal service requests by offering and documenting a first service appointment in alignment of timeliness standard at a 90% success rate.

Baseline:

- **Q4 FY19-20 MHP:** Routine (10 bus. Day response) equal: Adult Access 92% (96/104 entries); Children Access 89% (119/133 entries); Psychiatry (15 bus. Day) equal: Adult 87% (40/46 entries), Children 61% (19/31 entries); Urgent requests = MERT only entries (48-hour response): Adult 93% (50/54) & Youth 85% (29/34 entries). No prior-auth data.
- **Q4 FY19-20 DMC-ODS:** Routine (10 bus. Day) equal: Adult Access 91% (63/69 entries); Youth Access 71% (20/28 entries); NTP (3-day response) equals 67% (8/12 entries). Zero no prior auth (48-hour) urgent request data. 100% Prior-Auth Residential response within 24 hours.

Value-Based Focus Area (check all that apply):

☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☐ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	**Outcome Measurements**	**Est. Completion Date**
1. BH and stakeholders will modify Avatar SRDL form as needed to improve user comprehension. 2. QI will develop a training plan in conjunction with Network "Gate" provider feedback to improve provider compliance of various timeliness standards for Urgent, Urgent with Prior Auth, Routine, NTP and Psychiatry service requests. 3. QI to provide training of data monitoring tools so MHP and DMC-ODS Network Gate supervisors and staff can monitor the timeliness rate by request standard in Avatar Service Request and Disposition Log (SRADL). 4. Network Gate programs to increase and maintain Access staffing to 100% of budgeted positions. 5. MHP and DMC-ODS Network Gate leadership to review data monthly to monitor 1st offered appointment timeliness standard adherence.	1. 90% of Days from Initial Request for DMC-ODS or MHP Routine Services to 1st offered appointment (Standard: 10 business days) 2. 90% of Days from Initial Urgent Request for no-authorization services to MHP or DMC-ODS to 1st offered appointment (Standard:48 hours) 3. 90% of Days from Initial Urgent Request for authorization services to DMC-ODS or MHP to 1st offered appointment (Standard:96 hours) 4. 90% of Days from Initial Request to 1st dose of NTP [DMC-ODS] (Standard:3 business days) 5. 90% of Days from Initial Request to Specialty Psychiatry Service to 1st	June 30, 2021 **Collaborating Depts:** DMC-ODS and MHP County and Contract Network Gates, QI **Responsible Parties:** QI DMC-ODS AMH/Access CMH Gates (County & Contractor Gates)

6. QI to present 1st offered and 1st service timely access data to stakeholders, including DMC-ODS and MHP Providers and the Quality Improvement Committee to review results and discuss continual improvement needs.	offered appointment (Standard: 15 business days)	

Outcome Status

FY20/21 Data Network Timeliness Response

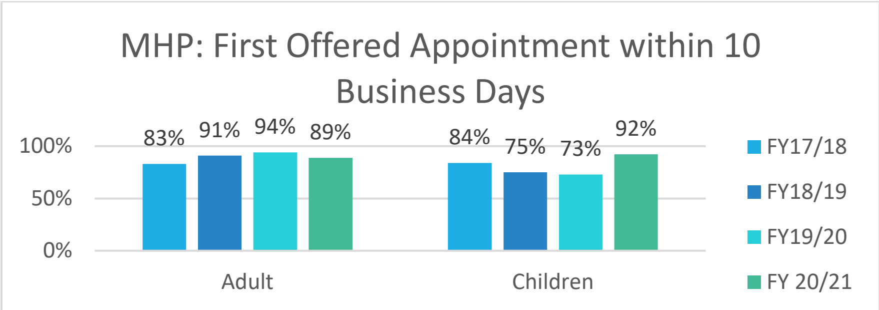
(Combined Children/Adult, County and Contractor)

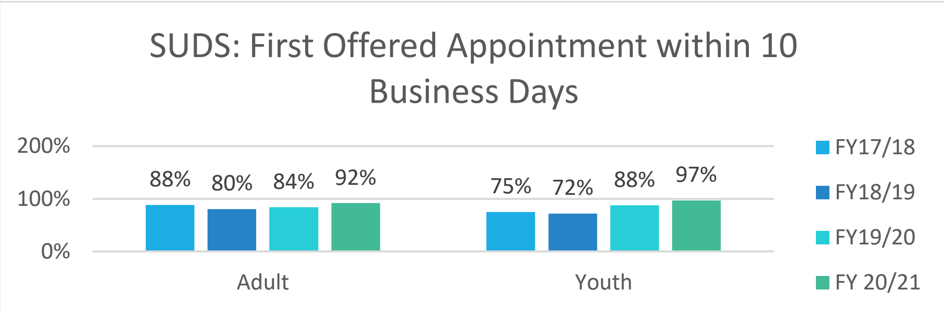
System of Care	% of Appt. that met the Standard				
MHP	**Q1**	**Q2**	**Q3**	**Q4**	**FY Q Ave**
Routine Offered (10-day)	79%	80%	92%	93%	86%
Urgent (48-hr)	93%	91%	86%	93%	91%
Urgent (96-hr)	0%	0%	0%	0%	0%
Psych Eval (15-day)	84%	76%	89%	79%	82%

Data Source(s): Data comparison of request in FINAL SRDL: First service appointment offered for appointment offered for appropriate service type and urgency level.

System of Care	% of Appt. that met the Standard				
DMC-ODS	**Q1**	**Q2**	**Q3**	**Q4**	**FY Q Ave**
Routine Offered (10-day)	78%	96%	95%	93%	90%
Urgent (48-hr)	0%	40%	0%	50%	23%
Urgent (96-hr)	0%	60%	50%	52%	41%
NTP (3-day)	70%	50%	86%	58%	66%

Data Source(s): Data comparison of request in FINAL SRDL: First service appointment offered for appointment offered for appropriate service type and urgency level.





Review Findings: ☐ Met ☐ Almost Met ☒ Further Work
MHP:

Routine: Timeliness performance improved each quarter throughout the fiscal year. Overall performance slightly under the target outcome.
Analysis indicates that SRDL users are appropriately utilizing the SRDL tool for the MHP network; entering the required data elements accurately and timely; as well as finalizing their SRDL entries.

Urgent: Target outcome was met three out of four quarters, with a fiscal year average greater than the 90% target date. Analysis indicates MERT crisis response team has incorporated the SRDL entries into the workflow and task responsibilities.

Prior Auth Urgent: There were zero finalized SRDL throughout the fiscal year that indicated an urgent request for services that need a prior authorization. Analysis indicates need for immediate follow up to learn more about current practices, identify and solve barriers and identify appropriate staff to execute SRDL function. Some initial questions to explore: what services require a prior authorization is this timeliness information being captures already but not in the BH EHR; is this information not being captures; what barriers are present impacting tracking and recording activity, what workforce workflows and system changes need to occur to execute the tracking and reporting of this timeliness standard?

Psychiatry/Specialty: Performance moved each quarter slightly between high 70% to low 80% with fiscal year average of 82%. Data is inclusive of both service requests to adult and children system of care. Although below target goal of 90%, results are positive, especially with unexpected psychiatry staff changes during the year. Analysis indicates further work required to ensure appointment times are available and identifiable on the calendar for each population specialization.

Review Findings: ☐ Met ☐ Almost Met ☒ Further Work
DMC-ODS:

Routine: Timeliness performance greatly improved from Q1 to Q2 and throughout the fiscal year. Overall performance average MET the target outcome of 90%. Analysis indicates that SRDL users have been appropriately utilizing the SRDL tool for the DMC-ODS network; entering the required data elements accurately and timely; as well as finalizing their SRDL entries.

Urgent: Throughout the fiscal year, there were low performance results, including 0% results in two quarters, for finalized SRDL that indicated an urgent request for SUD services. Analysis indicates need for immediate follow up to learn more about current practices, identify and solve barriers and identify appropriate staff to execute SRDL function. Some initial questions to explore: what caller situations/scenarios require an urgent response; is this timeliness information being captures already but not in the BH EHR; is this information not being captures; what barriers are present impacting tracking and recording activity, what workforce workflows and system changes need to occur to execute the tracking and reporting of the urgent timeliness standard? Also, are supervisors/program utilizing the SRDL training, SRDL reports and staff monitoring tools available to ensure compliance of job performance?

Prior Auth Urgent: This performance is similar to the Urgent category with low results overall; however, the data shows an improvement in Q2 post County BH QI training on timeliness/SRDL and Prior Auth at residential level of care. There is a need to incorporate this timeliness standard into the follow up work for "urgent" improvement described above.

NTP: Performance moved each quarter between 50% to 86% with fiscal year average of 66%. Data is inclusive of requests received for services at the four NTP programs in the county, (two non-Peri and two Peri). NTP programs have shown improvement in completing SRDL entries to capture this measurement. Analysis indicates further work required to ensure appointment times are available and recorded in the SRDL for each population specialization.

This goal will continue into next fiscal year work plan.

Goal 1.2: During FY20-21, 90% or greater of all test calls to BH 800# will be responded to according to information and language requirements and logged appropriately, including business hours, after-hours and weekend test calls.

Baseline: Q4 FY19-20: DMC-ODS data: 86% (12/14 English/Spanish test calls); MHP data: 78% (35/45 English/Spanish test calls)

Value-Based Focus Area (check all that apply):

☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☐ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	Outcome Measurements	Est. Completion Date
1. BHS continue contract with Community Connections for test calls to BHS 24/7 hour 800# by peers to conduct at least 10 test calls a month, diversely conducted in English and Spanish during business and non-business hours. 2. QI to provide scenario scripts to test callers to support range of test calls 3. Each test call will be documented by tester as to urgency, MHP or SUD treatment request, complaint or information requests. Documents submitted to QI team monthly. 4. QI staff to utilize test call documents and SRDL entries to evaluate performance. 5. QI staff to submit test call data to DHCS quarterly for compliance.	1. Daily, BHS 800# call responders to document call activity in SRDL and indicate language, urgency, MHP or ODS service request, or complaint. 2. Monthly, QI staff to measure test call reports against the documented business-hour call within Avatar and the after-hours logs submitted by the answering service. 3. Quarterly, QI staff to report test call findings to DHCS.	June 30, 2021 **Collaborating Depts:** BHS Fee Clerk and Access line staff, Access, QI **Responsible Parties:** Fee Clerks QI Answering Service

Outcome Status

FY 20-21 24/7 Toll-free Test Call Responsiveness

Quarter	Total Calls Made	English	Spanish	# of calls meet requirement	% of successful test calls
MHP Q1	**35**	**27**	**8**	**24**	**69%**
ODS Q1	**7**	**5**	**2**	**4**	**57%**
MHP Q2	**36**	**21**	**15**	**31**	**86%**
ODS Q2	**10**	**8**	**2**	**9**	**90%**
MHP Q3	**45**	**22**	**23**	**43**	**96%**
ODS Q3	**10**	**8**	**2**	**9**	**90%**
MHP Q4	**37**	**27**	**10**	**31**	**84%**
ODS Q4	**19**	**16**	**3**	**16**	**84%**
FY Total/ %Avg	**199**	**134**	**65**	**167**	**83.9% (84%) MHP= 83.75% DMC=80.25%**

Data Source(s): :Test calls to occur during business hours, weekends and after business hours in both English (EN) and Spanish,(SP) threshold language.

Review Findings: ☐ Met ☒ Almost Met ☒ Further Work

Behavioral Health Services is required to provide a statewide, toll-free telephone number 24 hours a day, seven days per week, with language capability in all languages spoken by beneficiaries of the county. To ensure compliance for requirements, including response to calls and the logging of call information, BHS conducts test calls during both business and after-hour periods in both English and Spanish languages. BHS Business Hours is currently defined as Monday-Friday 8-5pm and After-Hours includes M-F from 5pm-8am, Weekends, County Holidays and furlough days that close BHS for routine business operations and customer services. These separate time groups will be referred to “hour groups”. Deeper data review indicate that there were 144 test calls conducted during business hours and 55 test calls occurred after-hours. The overall 84% outcome is inclusive of all test calls, both those handles by BHS staff (business hours) and those handled by our after-hour vender (Santa Cruz Answering Services).

Quality Improvement (QI) staff have presented test call results quarterly in the QIC Steering Committee and contacted each hour group to share test call results and identified areas of improvement to meet compliance; and offered/provided training to team supervisor and staff to review call response requirements, address correction needs and discuss supervisor monitoring of staff’s call response performance. Analysis of data results as well as feedback from DHCS audit test call results indicate that although both hour groups had deficiencies in both call response components and logging all the required elements, the After-Hour answering service vender had more test call deficiencies than Business-Hour calls throughout the fiscal year. BHS QI initiated a CAP with our After-Hour vender due to continued non-compliance in many call response areas with minimal correction in staff performance and test call results. As a result of continued outstanding deficiencies and minimal response to correct issues, BHS has decided to discontinue services with the after-hour vender and have initiated contracting with a new vender, Answernet. BHS anticipates this change to occur by end of the 2021 calendar year.

This work will continue into the next fiscal year work plan.

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2. Monitoring Category: Effectiveness of Care

Goal 2.1: By June 30, 2021, DMC-ODS network providers will perform 80% rate of sampled EBP compliance marker. (Standard: utilize at least 2 EBP [Motivational Interviewing, Cognitive Behavioral, Relapse Prevention, Trauma-Informed Care] interventions per non-group treatment service & document interventions in Progress Note)
Baseline: To Be Determined. (BHS unable to capture reliable FY19-20 baseline data due to inconsistency of documentation practices among DMC-ODS network providers.)

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☐ Equity/Sustainability ☐ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies: ☒ DMC-ODS ☐ MH ☐ Both	Outcome Measurements	Est. Completion Date
1. Review and revise Avatar Progress Note template to ensure ODS EBP indicators are clearly accessible by 12/18/20. 2. Revise current documentation training materials for network provider to enhance how to capture EBPs in progress notes by 1/29/21. 3. Provide ODS network-wide training on #2 material & post on County Internet page for access by 2/26/21. 4. Modify Chart review audit form to capture both EBP indicator and documented EBP intervention effectiveness. 5. SUDS ODS provider contract language to include EBP utilization tracking and data quarterly submission practices.	1. % of sampled Progress Notes (PN) obtaining identified EBP indicator. 2. % of sample PN with EBP described in intervention section of NP 3. % of sampled staff who wrote PN have been trained in the selected EBP	June 30, 2021 **Collaborating Depts:** SUDS, Contract providers & QI **Responsible Person:** SUDS OP ODS Network – QI/UR staff representatives
Outcome Status		

Review Findings: ☐ Met ☐ Almost Met ☒ Further Work

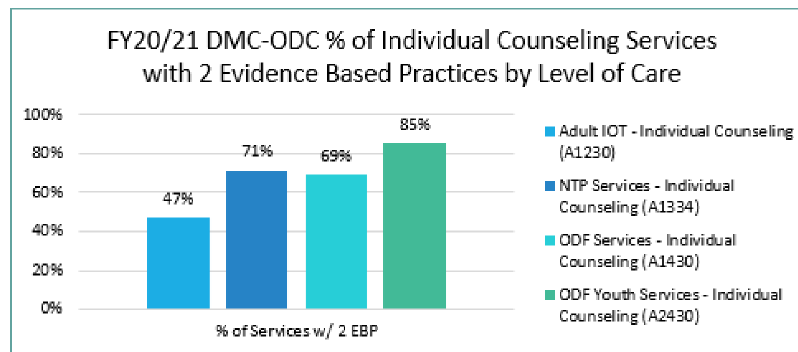
This goal received minimal focus during the fiscal year due to leadership and staffing resources redirected towards COVID response priorities. Data collection and analysis was the primary focus to establish methodology for establishing baselines and ongoing monitoring practices. QI conducted various data sampling and analysis activities, such as a program specific FY 20-21 6-month (7/1-12/31/20) review of County SUDS OP utilization of EBP types, as well as a network wide review of individual counseling services. In

addition, network providers, SUDS leadership and QI staff met to discuss how EBPs are documented in the collective EHR/Avatar progress notes to focus on identifying any challenges and improvement that could be addressed to increase documentation practices and charting outcomes by staff. Below are results of these inquiries. This goal will be continued in FY21-22.

County - SUD Outpatient / Evidenced-Based Practice	% of EBP PNs
Motivational Interviewing	43%
Mindfulness-Based Stress Reduction	40%
Relapse Prevention Therapy (ADP only)	6%
Seeking Safety	4%
Eye Movement Desensitization Reprocessing (EMDR)	3%
Other	3%
Cognitive Behavioral Therapy (CBT)	1%
Matrix (ADP only)	0%
Dialectical Behavioral Therapy (DBT)	0%
Seven Challenges	0%
Grand Total	**100%**

Below table shows a Network score of 71% for Individual Counseling services with 2 Evidence Based Practices per service by DMC-ODs program.

FY20/21 DMC-ODS System-Wide Individual Counseling Services	Count of Services w/2 EBP	Total Services	% of Services w/ 2 EBP
Adult IOT - Individual Counseling (A1230)	138	295	47%
Janus - Main-IOT (DayCare)	1	2	50%
Janus - Main-Perinatal IOT (DayCare)	87	122	71%
Sobriety Works - Adult IOT	30	136	22%
Sobriety Works - Adult IOT SEQ	20	35	57%
NTP Services - Individual Counseling (A1334)	5081	7132	71%
Janus - Clinic South-Peri Methadone	1	6	17%
Janus - Clinic South-Peri Methadone SEQ	40	69	58%
Janus - Clinic-Perinatal Methadone	34	104	33%
Janus - Clinic-Perinatal Methadone SEQ	87	193	45%
Janus - Comm Clinic South-Methadone SEQ	959	1092	88%
Janus - Comm Clinic-Methadone	745	1060	70%
Janus - Comm Clinic-Methadone SEQ	2777	4139	67%
Janus - Community Clinic South-Methadone	438	469	93%
ODF Services - Individual Counseling (A1430)	937	1358	69%
County - SUD Outpatient	248	257	96%
Encompass - Alto North-Outpatient	174	261	67%
Encompass - Alto North-Outpatient SEQ	229	269	85%
Encompass - Alto South-Outpatient	45	85	53%
Encompass - Alto South-Outpatient SEQ	61	151	40%
Sobriety Works - Adult ODF	148	291	51%
Sobriety Works - Adult ODF SEQ	32	44	73%
ODF Youth Services - Individual Counseling (A2430)	383	450	85%
Encompass - ADP Youth Svcs North OP	2	2	100%
Encompass - ADP Youth Svcs North OP SEQ	213	241	88%
Encompass - ADP Youth Svcs South-OP SEQ	168	207	81%
Total	**6539**	**9235**	**71%**



3. Monitoring Category: Coordination of Care

Goal 3.1: By June 30, 2021, MHP client will receive a follow up behavioral health appointment post inpatient hospital stays no longer than 7 county calendar days from discharge (MHP open clients only). Target: < 7 calendar days & 90% of discharges.
Baseline: Santa Cruz County SMHS Open Clients – FY19-20 Q4: 100% (26/26) youth and 82% (106/129) adults received an appointment within 7 business day from discharge.

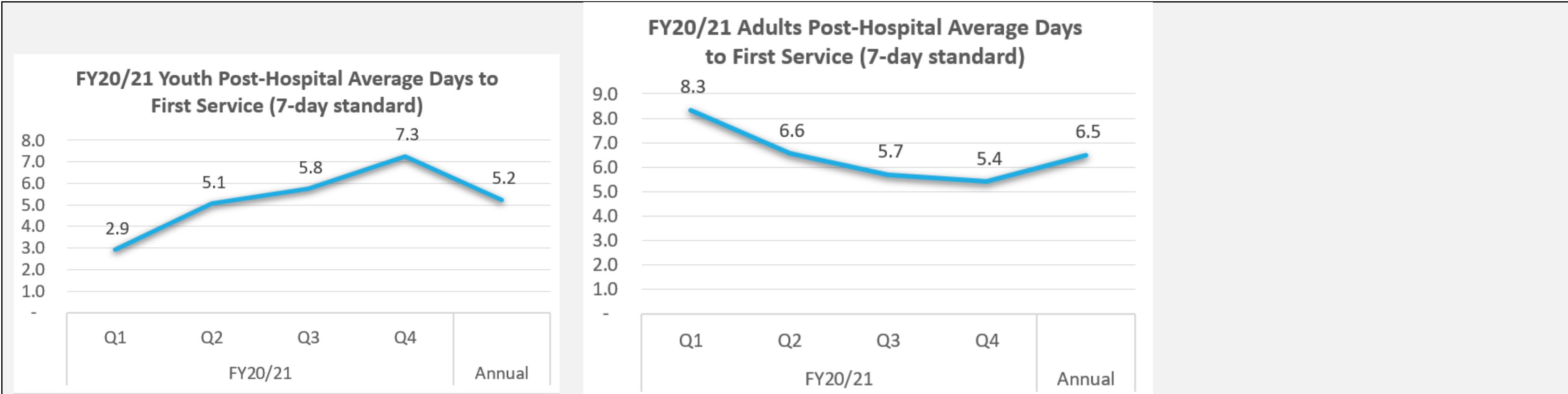
Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☒ MHP ☐ Both	Outcome Measurements	Est. Completion Date
1. Continue appointment outreach efforts to all youth and adults upon discharge from inpatient psychiatric health facility to include repeat calls and possibly mailing (Rapid Connect only PHF). 2. Increase appointment outreach efforts to all non-SMHS youth and adults upon discharge from inpatient psychiatric acute facility (Beacon Aftercare staff). 3. Increase monitoring of after-care appointments through Beacon Concurrent Review reporting. 4. Recruitment of more psychiatry staff. 5. Change psychiatry scheduling protocol to allow for more intake appointments.	1. % of active SMH client discharges that secure an after-care appointment (Avatar) 2. % of active non-SMH client discharges that secure an after-care appointment (Beacon) 3. % of Rapid Connect outreach secures appointment information (PHF)	June 30, 2021 **Collaborating Depts:** All BH Gates, QI **Responsible Person:** Psychiatry = Dr. Nair Access/MERT = Catherine Louise QI = Cybele

Outcome Status

FY 20-21 7 day After Care Appt Rate

Service Area	Aftercare service within 7 calendar days for SMH Clients	Aftercare service within 7 calendar days for Non-SMH Clients
Youth	90%	79%
Adult	74%	56%
Overall MHP %	77%	59%
7-day Timeliness Data below:		



Data Source(s): At least quarterly review of monthly Avatar service utilization.

Review Findings: ☐ Met ☒ Almost Met ☒ Further Work

MHP data indicated that the overall rate for a timely service for open SMH clients was 82%, 8 percent points below the target goal of 90%. The Adult System of Care had a lower performance rate, 74%, then that of Children SOC, 90%. Further investigation and data analysis is needed to determine root cause for the specific challenges for successfully scheduling an adult client for aftercare, post hospitalization, service and addressing these challenges to improve linkage. Anecdotal feedback from the MHP Access and Rapid Connect staff identify key challenges to include lack of phone/outreach communication method with client and loss of whereabouts and houselessness, which make locating the person difficult.

This goal will continue in the next fiscal year work plan.

Goal 3.2: By June 30, 2021, BH SMHS and ODS SUDS will conduct successful coordination of care activity with the local Managed Care Plan, CCAH/Alliance, to ensure beneficiary receives appropriate level of care treatment continuum.
Baseline: County BH and CCAH/Alliance has monthly coordination of care meetings & quarterly collaborative leadership meetings.

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	Outcome Measurements	Est. Completion Date
1. Review and modify (if necessary) C of C policies, especially level of care transfers. 2. Review and modify (if necessary) referral form and process to CCAH/Beacon 3. Increase collaboration with Health Plan, CCAH, regarding barriers to care that arise for Med-Cal beneficiaries, including transportation to services, interpretive services, physical exam timeliness, co-morbidity eating disorder cases, non-SMI MH services, and MOU/DHCS compliance.	1. # of quarterly meetings between MHP/ODS and CCAH leadership to monitor MOU C of C activities. 2. # of monthly meetings between MHP/ODS ACCESS team and CCAH/Beacon to coordinate level-of-care transfers, referral/linkage to services, unique case consults.	June 30, 2021 **Collaborating Depts:** All BH Gates, QI **Responsible Parties:** Leadership of Psychiatry, CMH, AMH, DMC-ODS & QI
Outcome Status		

Review Findings: ☒ Met ☐ Almost Met ☐ Further Work

During the 20-21 fiscal year, County Behavioral Health, MHP and DMC-ODS, leadership and Central California Alliance for Health, (CCAH) known as the "Alliance", significantly improved communication practices and collaboration of key care coordination initiatives. With both parties experiencing leadership staffing changes during the year, establishing ongoing meetings was a mutual priority to ensure effective and timely outreach and response for clinical and operational shared items. In addition to the quarterly meetings, monthly meetings were re-established for referral coordination and specific case collaboration needs. There was an increase in shared Eating Disorder cases in 20-21 due to residential and hospital admission activity, resulting in collaboration regarding authorization and payment of services since the Alliance was responsible for the medical coverage and County for the SMH needs.

The updating of the MOU between parties has also been a shared activity during FY20-21. This is still in draft review process at the time of this writing. Finalization is expected to occur in FY21-22.

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4. Monitoring Category: Beneficiary Satisfaction & Involvement

Goal 4.1: During FY20-21, BHS will respond to 100% of beneficiary complaints and seek to improve client satisfaction by decreasing MHP and/or ODS beneficiary grievances, change of provider, appeals and fair hearings by at least 20% in collaboratively with the provider for timely response and implementing potential improvement outcomes.

Baseline: MHP FY19-20 Data: 30 Grievances; 1 Appeal; 140 Change of Providers; 1 State Fair Hearing
DMC-ODS FY19-20 Date: 12 Grievances; 14 Appeals; 1 Change of Provider; State Fair Hearing

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	Outcome Measurements	Est. Completion Date
1. QI staff to review training needs of county and contractor staff on reporting process when beneficiary raises a grievance, change of provider, appeal request or fair hearing. 2. QI staff to conduct grievance/appeal/change of provider/fair hearing resolution protocol within timeframe, including documenting activity in database. 3. Quarterly analysis of complaints and timely submissions to DHCS. 4. Prepare and submit grievance report related to Access for NACT delivery.	1. 100% response to all received request by beneficiary or support person. 2. Continual analysis of trends and improvement needs. Track 100% of total # of each type (Grievance, Change of Provider, Appeal and Fair Hearing) for MHP and ODS. 3. Submit data to DHCS quarterly and annual NACT	June 30, 2021 **Collaborating Depts:** All BH and Contractors, QI **Responsible Person:** BHS = Various QI = QI Staff

Outcome Status

FY 20-21

Received	Q1	Q2	Q3	Q4	FY
MHP G	9	8	5	10	32
ODS G	4	9	5	5	23
MHP Change	18	32	26	37	113
ODS Change	0	0	0	0	0
MHP A	1	0	0	3	4
ODS A	15	7	0	10	32
MHP FH	0	0	0	0	0
ODS FH	1	0	1	1	3

Data Source(s): QI Complaint and Request Databases.

Review Findings: ☐ Met ☒ Almost Met ☒ Further Work

Met goal of timeliness & unmet goal of a 20% decrease in requests.

FY20-21 data comparison to FY19-20 baseline numbers indicate:

- MHP – slight increase in Grievances; slight decrease in change of provider requests; and equal State Fair Hearing activity
- DMC-ODS – Significant increase in Grievances (doubled); significant increase in Appeals (more than doubled); decrease in change of provider request; and decrease in State Fair Hearing activity.

Santa Cruz County Behavioral Health's Quality Improvement (QI) division processes all beneficiary right requests for both the MHP and DMC-ODS networks, which includes County and Contractor client services. Due to the increasing volume of requests, FY20-21 focus for the BH QI team was to expand staffing resources to process of these requests timely and appropriately. Training occurred for all licensed clinical QI staff roles, with ongoing mentoring on a case-by-case basis. The QI team continued to conduct beneficiary right trainings in FY20-21, as performed in previous years, for all providers/service program staff when newly contracted, when indicated by monitoring and upon request. Additionally, QI leadership enhanced monitoring practices by expanding and increasing database report

reviews to ensure compliance and accuracy of data entry and regulatory compliance. QI monitors these activities closely and frequently as QI is required to submit BH benefit right activity reports to DHCS for both MHP and DMC-ODS plans.

Further data tracking and analysis is needed to have a deeper understanding of reasons for requests and if there are any trends regarding provider and/or program quality of care concern. The current database report extract does not filter information to this detail.

Recommendation: Continue goal in FY21-22 to do further work on enhancing data collection reporting tools and deeper analysis of reason trends to identify any additional quality of care improvement areas.

Goal 4.2: By June 30, 2021, BH will increase consumer and family input by 10% regarding service quality, policy and decision-making feedback in quality improvement initiatives.

Baseline: MHP FY19-20 November Survey Return Results: Adult 300 total (297/466 EN & 3/79 SP); Older Adult 69 total (68/184 EN & 1/42 SP), Family 0, Youth 80
DMC-ODS FY19-20 November Results: Adult 171 (167 English/4 Spanish); Youth 18 (18 English/0 Spanish)

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	**Outcome Measurements**	**Est. Completion Date**
1. Conduct DHCS surveys accordingly for MHP and DMC-ODS with a 70% return rate. 2. Outreach and survey MHAB, NAMI and other consumer groups. 3. Conduct feedback data analysis for improvement indicators. 4. Inform QIC Steering Committee, workforce and community stakeholders of survey results and identified areas of success and improvements.	1. QI Survey Results 2. MHSA feedback results. 3. Community stakeholder survey results. 4. DHCS MHP and DMC-ODS Survey return results. 5. DHCS MHP and DMC-ODS Survey feedback scorecard results. 6. Current focus group/MHSA	June 30, 2021 **Collaborating Depts:** QI, BH Department, NAMI, MHCAN, MHP & DMC-ODS Network Providers MHAB **Responsible Person:**

5. Incorporate feedback into continued improvements initiatives.		QIC Committee MHSA = Cassandra

Outcome Status

FY 20-21 Survey Data:

Department	Return Rate May	Return Rate Nov	General Satisfaction %	Top Growth Area
MHP Network May 2020	**486**	**N/A**	**85%**	**Social Connection domain**
MHP Network Nov 2020	**Cancelled by DHCS**	**N/A**	**N/A**	**N/A**
MHP Network June 2021	**334 out of 1500 (22%)**	**N/A**	**TBD**	**TBD**
DMC-ODS Network Annual- Nov 2020	**N/A**	**172**	**97%**	**Welcoming & Cultural Sensitivity**

Review Findings: ☐ Met ☐ Almost Met ☒ Further Work
Data Source(s): MHP, DMC-ODS & MHSA survey activity & QIC meeting minutes

COVID-19 has greatly impacted County BH activities geared towards obtaining feedback and input by clients and family member representatives regarding the quality and satisfaction of MHP and DMC-ODS services. Due to the significant decline of in-person interaction, survey and feedback outreach methods have needed to transition to methods that require technology, such as a computer for online surveys and phone for call-in survey options. The direct-feedback survey portals, known as the Happy or Not Kiosks, at both North and South BH clinics were deactivated during FY20-21 to minimize possible transmission of the COVID-19 virus and limit the sanitizing need by staff. Conducting In-Person survey outreach has been a challenge due to pandemic safety concerns for both consumer and staff, plus uncertainty of direct connection due to barriers to appointment coordination and confirmation. The decrease in in-person survey opportunities and increase in technological needs have been identified during 20-21 fiscal year as great barriers for consumer voice equity and accessibility.

Behavioral Health leadership has leaned into utilizing a variety of opportunities and platforms for seeking beneficiary and family input. The MHSA stakeholder feedback process was converted into a SurveyMonkey which received a higher response from those in the community with technology access. BH leadership has increased engagement with both NAMI and Mental Health Advisory Board meeting opportunities to seek feedback on the community's perspective of BH's service delivery strengths and challenges and explore collaborative activities to address improvement initiatives. Lastly, the County BH QIC Committee recruited additional stakeholders who bring a lived experience voice and perspective to the Committee's work.

This goal will continue into next fiscal year work plan.

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5. Monitoring Category: Utilization Management

Goal 5.1: By June 30, 2021, MHP- Psychiatry team will incorporate Metabolic Monitoring for Minors on Antipsychotics (S. Bill 484) into routine treatment services for targeted foster care population to establish as baseline based on caseload sampling.

Baseline: This is a new MHP EQRO measurement.

Value-Based Focus Area (check all that apply):

☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☒ MHP ☐ Both	Outcome Measurements	Est. Completion Date
1. Train staff on new SB 484 Metabolic Monitoring requirement for targeted population 2. Incorporate new monitoring activity to Peer Review chart review tools. Data Source(s): Quarterly peer review chart sampling results.	% of charts with evidence of Metabolic Monitoring completed by staff	June 30, 2021 **Collaborating Depts:** All BH Gates, QI **Responsible Person:** Psychiatry Staff QI Staff

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☒ Further Work

Behavioral Health needing to priorities staffing and time resources to client and staff safety during 20-21 fiscal year due to the COVID-19 pandemic. The BH leadership, and primarily the medical/psychiatric leadership, transitioned focused to establishing protocols and guidelines for shelter-in-place care, transition to telehealth services and ensuring appropriate PPE availability and utilization for all essential BH workers. With this shift to COVID-19 priorities, this goal's work focused on ensuring that prescribers were trained on the requirements and incorporating metabolic monitoring activities into care, including discussing the need for lab tests with the legal guardian and caregivers and documenting this discussion in the medical record, along with documenting the review of available lab results when available. Since metabolic monitoring lab tests fall under medical care, BH staff are not able to conduct such test directly with the FC client, but rely on the caregiver, social worker and/or legal guardian to facilitate the completion of this medical care. Additional goal activity included the review and update of the psychiatric chart review tools to ensure capturing the metabolic monitoring, as well as the chart sampling methodology was reviewed to ensure FC sampling was included in the peer reviews.

Related metabolic monitoring activities was also conducted by a designated Foster Care Nurse (FCN) within the Human Service Department's Family and Children's Services (FCS) agency. FCS is responsible for ensuring the foster child's wellbeing, including monitoring the foster child's placement and overall care. BH QI team has coordinated the sharing of medical records with the FCN for case monitoring and has put forth the request to receive results of the case review, including targeted action steps for the completion of lab test appointments and results.

This goal will continue into next fiscal year work plan.

6. Quality Improvement and Workforce Development

Goal 6.1: By June 30, 2021, Behavioral Health will utilize at least three (3) innovation and continuous improvement tools across all departments to optimize operations, data-driven decisions, transparency/communication and maintain fiscal stability.

Baseline: >15 of AVATAR Reports available to users, 4 of KPI users within BH organization, 1 of Power BI license account within BH (SUDS).

Value-Based Focus Area (check all that apply):

☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☐ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	**Outcome Measurements**	**Est. Completion Date**
1. Enhance technology (KPI, Power BI, Avatar) accessibility to all BH leadership (or delegate) for analysis, evaluation, and data collection a. Ensure the data necessary for meeting grant or initiative goals is collected b. Develop reports in dashboard format for visual management (set targets with green/yellow/red for progress c. Identify leading indicators for sustainability or other external requirements for measurement and add to dashboard (i.e. productivity, capacity) d. Develop Avatar Report Directory inclusive of all report purpose and elements 2. Improve communication to workforce/public on key updates and department performance results on agreed upon metrics across BH services. a. Develop and sustain regular All Staff communication and presentation on operational excellence metrics and metrics b. Develop training material and distribute to Avatar Users to increase access to reports and Directory.	1.1 # of identified data collection indicators per dept for KPI, AVATAR and/or Power BI reports. 1.2 # of identify data collection gaps for reporting requirements and developed collection method. 1.3 # of KPI, AVATAR and Power BI users across BH departments for data reporting functions. 2.1 # of communication releases to workforce regarding BH updates 2.2 # of communication releases to workforce on BH performance metric results 2.3 # of communication releases to public regarding BH updates 2.4 # of communication releases to public on BH performance metric results	June 30, 2021 **Collaborating Depts:** All **Responsible Person:** BH Leadership = Erik QI= Cybele & staff IT=Jorge/Gian/Melissa/Dave AMH= Karen/Cassandra CMH= Lisa SUDS= Shaina
Outcome Status		

Review Findings: ☐ Met ☐ Almost Met ☒ Further Work

This first goal received minimal focus during the fiscal year due to leadership and fiscal resources redirected towards COVID response priorities. BH Sr. Leadership Team received an Avatar review for available monitoring reports and was provided access to Avatar's KPI data analysis system. Leaders received an overview KPI tutorial to learn how to navigate data filtering by specificity of demographics, service type and other features. Due to fiscal challenges as a result of the cost of COVID response needs and drop in revenue, additional Power BI licensing accounts were not pursued and will be revisited in the new work plan year. QI's newly hired Business System IT Analyst was tasked with creating an Avatar Report Library Manual that aims to list all available reports in Avatar, plus purpose of report and intended user. This project has unfortunately been put on hold at the end of the year when staff resigned from the department until it is reassigned for completion.

BH Leadership has improved communication with the BH workforce during this fiscal year by launching a quarterly series for all-BH staff Town Halls, surveys and increased solicitation for work culture feedback. In addition, during the peak of the COVID crisis, Leadership generated a communication template for ongoing updates, including but not limited to COVID response updates, PPE guidelines and safe work environment information. These regular communication materials were distributed to all BH through email, posted on the BH Staff intranet page, printed and posted, and communicated down to line staff through division management and supervisors.

In addition, the QI team drafted and distributed several information notices to BH staff and contractors regarding the changes set forth by the Department if Health Care Services (DHCS) for documentation and client consenting practices during the pandemic, as well as attended provider team meetings to provide Q&A on such changes.

This goal will continue next fiscal year to increase communication transparency between staff and management.

Goal 6.2: By June 2021, Behavioral Health staff and leadership will enhance understanding of its own cultural responsiveness to language, racial/ethnic equity, sexual orientation, and gender identity and expression (CLAS & SOGIE) with BH customers, workforce, and service delivery policies.

Baseline: FY19-20 BH Workforce Survey results on Cultural Humility training and discussion in workforce: 11.67% Strongly Agree, 51.67% Agree, 18.33% Neutral, 16.67% Disagree, and 1.67% Strongly Disagree

Value-Based Focus Area (check all that apply):

☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☐ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	Outcome Measurements	Est. Completion Date
1. Expand CLAS & SOGIE learnings and training opportunities to maximize workforce development. 2. Identify trainings to address racial and ethnic disparities, implicit systemic biases, and effective culturally humble responses to heal. 3. Survey workforce on agency's cultural responsiveness to CLAS & SOGIE and analyze feedback for improvement to trainings, practices and policies. 4. Seek and develop volunteer staff trainer list for CLAS & SOGIE topics 5. Collaborate with HSD and HSA on training goals and resources, incorporate TIS measures into annual workforce staff survey. 6. Review and modify Paper and EHR forms to increase non-binary gender (gender neutral) identification 7. Develop baseline improvement measures	1. Track % of BH training attendance for FY on SOGIE topics. 2. Collect and analyze survey data 3. % of department representation in Cultural Humility Committee activities 4. % of revised forms for SOGIE reflection 5. Identify #% of policies reflective of CH responsiveness to SOGIE focus and # to be improved or established.	June 30, 2021 **Collaborating Depts:** All BH, QI **Responsible Person:** CLAS Coordinator = Martha BH Leadership= Erik AMH=Karen/Cassandra CMH= Lisa SUDS= Shaina QI = Cybele

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☐ Further Work

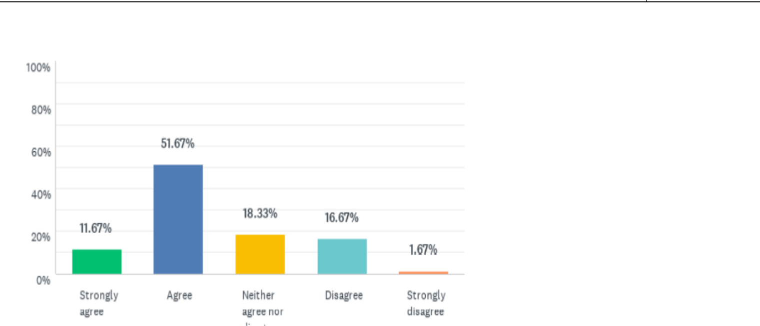
BH FY 20-21 Cultural Humility, CLAS and SOGIE Staff Training Data:

Trainings	Q1	Q2	Q3	Q4	FY
TIS Survey	**79% response**				
Online CLAS	**20+**				

BH FY 20-21 CH, CLAS and SOGIE Policy Revisions Data:

# of P&Ps	Q1	Q2	Q3	Q4	FY

I have received training or information on how to discuss workplace issues related to social, racial, and cultural differences.	
Mean	2.45
Standard Deviation	0.96



CLAS policies – new & revised	0	6	0	1	7

Data Source(s): 2020 BH survey with 79% workforce return rate

Review Findings: ☐ Met ☐ Almost Met ☒ Further Work

This goal received minimal focus during the fiscal year due to leadership and staffing resources redirected towards COVID response priorities. Early in the fiscal year, QI reviewed all current BH CLAS policies, including CLAS service delivery, interpretive services, training hours, and updated accordingly to reflect current practices and culturally appropriate language. A new CLAS Training Plan policy was developed to include a broader range of approved training methods, including online courses, experiential learning and book club activities. Policies were again reviewed against the MHP and DMC-ODS/SABG audit protocols to ensure inclusion of all culturally competency requirements. Also in this year, QI was able to hire into the vacant BH Trainer position in Q1 who works in collaboration with the QI staff in CLAS Coordinator role regarding the logistically aspects to delivering trainings during COVID times. The new BH Trainer immediately developed a new ProLearn Partnership training initiative to streamline training requests and increase collaboration efforts with BH divisions and community partners. Core training plan was developed that identified to capture BH EBPs, essential trainings and CLAS training priorities. In Q1 of FY20-21, The TIS Committee launched the BH staff survey and Cultural Humility trainings was identified as a high request. Also, during the fiscal year, the BH Trainer began to research the possibility of a Learning Management System (LMS) for HSA, specifically for BH staff to receive leadership, clinical and state compliance training.

County Health Service Agency, which includes BH and other service divisions, plans to participate in GARE. The CLAS Coordinator and TIS Committee representative will participate in this HSA DEI initiative as well. Below is more of GARE.

This goal will continue into next fiscal year work plan.

Government Alliance on Race and Equity (racialequityalliance.org)

Goal 6.3: By June 30, 2021, 90% or greater of all BHS employees will complete the minimum of 7 CLAS hours.
Baseline: CY2020, top BH workforce team (Clerical) ranked at 40% of team completed at least 7 CLAS hours within the employee's annual evaluation year.

Value-Based Focus Area (check all that apply):

☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	Outcome Measurements	Est. Completion Date
1. CLAS Coordinator approved on-line CLAS training options will be posted and available to all BHS employees. 2. CLAS Coordinator to distribute email notifications on available approved trainings for BH employees. 3. CLAS Coordinator to modify CLAS form to be accessible through DocuSign for remote work access. 4. BH leadership to have access to completed CLAS hour records for monitoring and tracking rate. 5. BH direct supervisor to monitor staff compliance, including determining employee performance on evaluation as "Other" item, indicating that "meeting	1. Total % of BHS employees completing at least 7 hours of CLAS hours annually per policy. 2. Total % of BHS employees below policy standard.	June 30, 2021 **Collaborating Depts:** All BH Management, QI **Responsible Person:** All BH Managers QI = CLAS Coordinator

standards" equals 7 hours completed & less than 7 hours equals below standard rating.		

Outcome Status

FY 20-21

CLAS Training Hour Avg.	# completing CH	# CLAS Hours	Average #
All BH staff	137	792.85	5.8 hours
MH staff (CMH & AMH)	76	506.25	6.7 hours
DMC-ODS staff	11	42.5	3.9 hours
Other/admin staff	19	107.25	5.6 hours
Uncategorized staff (inclusive of QI and HSA PH staff)	31	136.85	4.4 hours

BH Staff-Completed CLAS trainings	# completing CLAS Hrs	Division Size (current estimates provided by Sr. Manager)	% of Staff completing at least 1 CLAS training
All BH staff	124	227	55%
MH staff CBH	40	46	87%
MH Staff ABH	36	75	48%
DMC-ODS staff	11	22	50%
Psychiatry staff	5	25	2%
Other/admin staff	19	46	41%
QI	13	13	100%
HSA IBH/PH/Clinic	22	Removed from Total count	

Data Source(s): CLAS Training Database and Completed CLAS credit email notification to employee and direct supervisor.

Review Findings: ☐ Met ☐ Almost Met ☒ Further Work

In response to COVID social distancing limitation to trainings, the CLAS Coordinator developed an online training option that included researching and vetting CLAS appropriate YouTube video trainings, TED talks and linkage to other free online webinar CLAS events. Most courses were an hour in time, which required less time away from client care. In addition, the CLAS hour Credit form was revised to modify format to be DocuSign and to increase measurability of training outcome. The course list and credit form were posted on the

BH staff intranet page for easy access. The benefit to this online shift was an increase in flexibility for staff time to complete a brief training.

Specifically, this expansion of online trainings resulted in an increase in administrative and clinical staff completing trainings where before they struggled to leave their posts to attend an in-person training.

- ✓ Top Admin Teams: 80% of Clerical staff; 50% of Billing staff;
- ✓ Top Clinical Teams: 48% of Child North staff, 17% of Adult North staff

An unexpected challenge to further progress with this goal was the sudden departure of the staff who held the CLAS Coordinator role at the end of Q2. This departure left the position vacant for the remaining 6-months of the fiscal year.

This work will continue in the next year's work plan.