QUALITY IMPROVEMENT WORK PLAN EVALUATION

FY 2018-19

COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

CONDADO DE SANTA CRUZ
Salud Mental y Tratamiento del Uso de Sustancias
PARA NIÑOS Y ADULTOS

OUTCOME OF QUALITY IMPROVEMENT WORK PLAN GOALS
FOR FISCAL YEAR 2018-2019

SECTION 1: Introduction and Overview

Santa Cruz County is a medium-size county which lies on the central coast of the Pacific Ocean and forms the northern part of Monterey Bay, with Monterey County forming the southern part. It is located just south of the San Francisco Bay Area region and has a land mass of 445 square miles. Santa Cruz is ranked 24th in size amongst all California counties with a population of 262,382 of which 72 percent are White and 32 percent are of Latino/Hispanic ethnicity (U.S. Census, 2010).

While Santa Cruz County is well educated with 38 percent of residents age 25 or older possessing a Bachelor's degree or higher, 68 percent of those residing in the southern part of the county have a high school diploma or less. Though the county has recently seen job growth, 21 percent of its workforce are employed outside of its borders. The average wage is $60,166 which is 30 percent lower than the statewide average. Housing remains difficult for area residents; with a median monthly rent of $3,000. The county was designated in 2008 and again in 2017 by the National Renters Association report as the least affordable county in the country to live in. The largest employers in Santa Cruz County in terms of total jobs are from the healthcare, retail, agriculture, education, tourism and hospitality industries. Low wage jobs are the fastest growing job sector in the county with an annual salary of just $25,000 per year. While 21 percent of north county residents earn $150,000 or more per year, only eight percent do so in the south county where the greatest concentration of the Latino/Hispanic population reside. Santa Cruz shares a renowned wine region in this area of the state, has a thriving tourist sector and is home to a University of California campus in its county seat.

In 2018 Santa Cruz County Mental Health and Substance Abuse Service Division took a symbolic step to accelerate integration by renaming itself Behavioral Health Services (BHS). Santa Cruz County Behavioral Health Services (SCCBHS) mission is to become a comprehensive integrative mental health and substance use disorder service delivery system so that there is "no wrong door" for the person(s) seeking support and services.

During the 2018-19 fiscal year SCCBHS experienced changes of leadership both at the department and agency level. This has included appointment of a new agency director and chief financial officer along with a new quality improvement director at BHS replacing the retiring incumbent of more than 30 years. Changes at the health agency level led to some reorganization and centralization of core functions, specifically impacting BHS' information technology and data analytic capacities.

Our integrative Quality Improvement team and SCCBHS leadership focus on quality of care/service improvement initiatives as well as compliance monitoring that incorporates DHCS requirements for both MHP and DMC-ODS. Fiscal year 2018-19 was a year of significant change within SCCBHS with the launch of DMC-ODS services only 6 months

old and the retirement of two division senior leadership managers, specifically Quality Improvement, mid-year. The established FY18-19 Quality Improvement (QI) Work Plan remained in effect for the completion of the year to be assessed and evaluated by the new QI Director regarding relevancy and effectiveness.

SECTION 2: Quality Improvement Work Plan

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. The goals described here are not intended to be all encompassing but are important to our overarching quality improvement efforts for Fiscal Year 2018-2019 (July 1, 2018-June 30, 2019). We have identified 6 main Areas of Focus, 6 Objectives, 17 Goals to address for this year with a behavioral health vision.

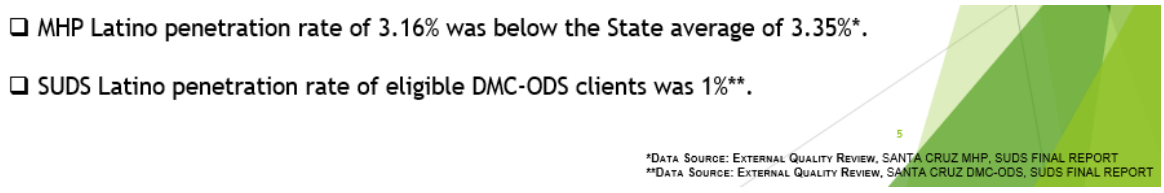
1. Area of Focus: Monitoring/Improving Access to Services

Objective 1: Monitoring cultural service delivery capacity of the Mental Health & DMC-ODS Plans

Goal 1.1: Improve access for Latino populations of Santa Cruz County as evident by Latino service penetration rate equal or greater than state average and other Medium size counties.

- Intervention: Complete construction and open new Santa Cruz County Behavioral Health building in south county city of Watsonville for expanded outpatient service capacity. Review and analyze Medi-Cal service data and EQRO data reports.

- Measurement: Annual review of state and EQRO penetration rates. Quarterly review of monthly service utilization monitoring and trend detection.



- Outcome: Not Met. Penetration data from 2019 EQRO Report indicated Santa Cruz County Behavioral Health rate was below the state average for Latino population. Limited data analysis resources impacted development of evaluation tools during this fiscal year. SCCBHS shall continue this goal in FY19-20 to evaluate need for services, engagement barriers and design outreach strategies to the community at large to increase service engagement as appropriate.

Goal 1.2: Maintain and increase number of bi-lingual and/or bi-cultural staff within provider networks.

- Intervention: Establish ongoing recruitment efforts for County bi-lingual clinical staff by identifying the job classifications as continuous hiring status. Outreach potential recruitments through job and internship placement events. BH Supervisors ensure accurate staff gender, ethnicity and language profile within Avatar, EHR.

- Measurement: Quarterly review of personnel outreach and recruitment activities. Avatar data analysis regarding staffing bi-lingual profiles. Quarterly review of MHP and DMC-ODS NACT data to identify status.

- Outcome: As of June 2019, County Behavioral Health bi-lingual Spanish language staffing is evident across all divisions and department levels, including 55 direct care staff, 7 supervisor roles and 16 administrative support positions. Continue goal.

Goal 1.3: Improve cultural & linguistic awareness in service delivery through cultural competency trainings, including ethnicity, non-binary gender, age, sexual orientation, cultural illness and recovery healing practices, co-morbidity (MH & SUD & physical health complexity) and other topics.

- Intervention: Increase the number of staff attending CLAS trainings and improve staff competency in delivering culturally sensitive services, with a minimum of 7 credit hours per staff per year.

- Measurement: Training attendance records. Monitor staff CLAS and cultural competencies with beneficiary needs and preferences.

- Outcome: Goal not Met, continue in FY19-20. Quality Improvement hosted 2 in-person CLAS trainings during FY18-19 fiscal year.

Objective 2: Monitoring the accessibility of services within MHP and DMC-ODS.

Goal 1.2.1: Ensure 800# callers receive timely and linguistically appropriate responses.

- Intervention: County BH management staff to conduct test calls to monitor the responsiveness of the Santa Cruz County Behavioral Health's 24/7 toll-free number available to the community based on urgency level, language, type of call (information or service request), and mental health or substance use disorder inquiry. Provide scenario scripts to test callers to support range of test calls.

- Measurement: Test calls to occur during business hours, weekends and after business hours in both English and Spanish, threshold language. 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.

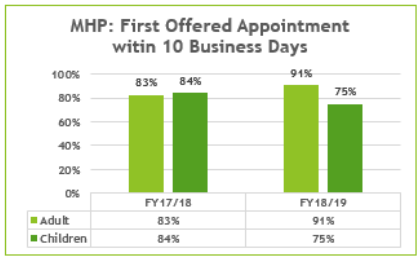
- Outcome: Overall, 89% of the Behavioral Health 800# test calls were conducted and logged appropriately during the fiscal year. A test call improvement was identified by regarding the test caller report form needing a clear separation between MH calls and SUD calls. This feedback resulted in the form modification and re-distribution to all test callers. The test calling process resulted in low volume of test calls occurring each quarter due to low test call performance but county management, even with reminders from QI management. Goal to continue in next fiscal year with recommended changes to the process.

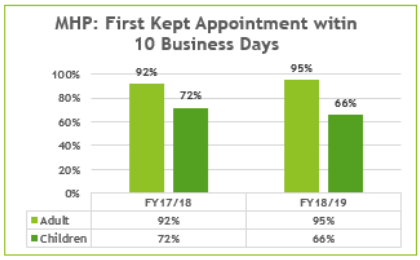
Goal 1.2.2: Assure appropriate and timely access to MH and SUD routine, specialty, urgent and crisis services.

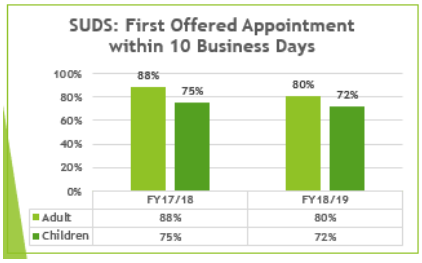
- Intervention: Train county and contractor staff on urgent service request. Revise Avatar Service Request and Disposition Log (SRDL) to reflect timeliness standards for initial requests for mental health and substance use disorder services. Develop a SRDL User Manual. Train county and contractor staff on revised SRDL form and associated user manual.

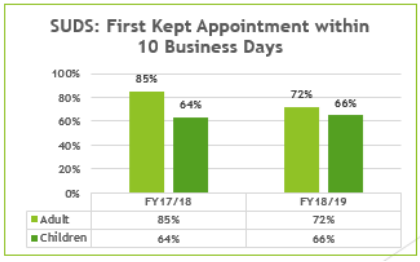
- Measurement: Quarterly Data analysis of SRDL entries by service access program, otherwise known as "gate", compared with first offered appointment and/or completed service data. Analysis of NOABD Timely Access letters from gate programs.

- Outcome: Routine appointment data for FY18-19:









An AVATAR Process Improvement Workgroup began in May 2019 to address inconsistent data collection standards:

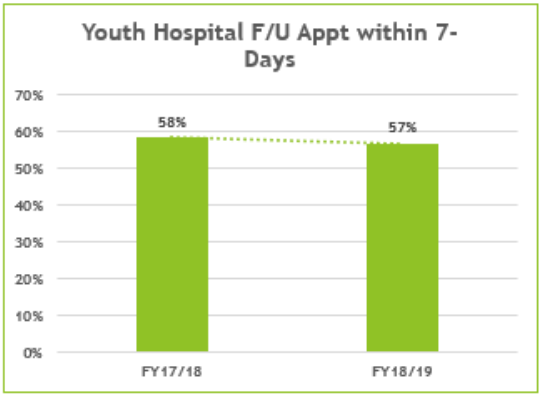
- ❑ *Revise the Service Request and Disposition Log*
- ❑ *Increase MHP and DMC-ODS timeliness measures*
- ❑ *Focused training for consistent usage.*

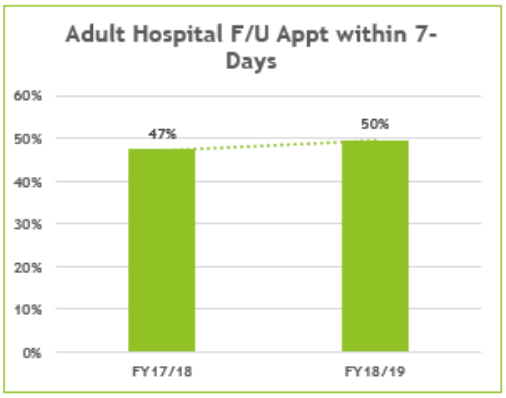
There were minimal urgent service requests identified in this fiscal year, which may be accurate or under reporting of the presented need. The Avatar SRDL form is the key tracking tool for both the MH and ODS network service requests, therefore; competency in use is essential to increase user comfort and consistency regarding how service requests are documented in the SRDL. This goal will continue into FY19-20 as the work on the SRDL form revision, data entry training and manual design is in process.

Goal 1.2.3: MHP- Psychiatry/NP Appointment post inpatient hospital stays will be no longer than 7 county business days from discharge. Target: at least 75%

- Intervention: Recruitment of more psychiatry staff. Change psychiatry scheduling protocol to allow for more intake appointments. Outreach individual upon discharge to link to appointment scheduling.

- Measurement: Data analysis of SRDL entries and claimed psychiatry services post hospital discharge. Challenge to this goal measurement is that not all inpatient patients are eligible for Santa Cruz Co SMHS or a Santa Cruz Co resident, therefore are not linked to county MHP.





For those Santa Cruz County clients enrolled in our outpatient programs, the 7-day appt % increases to 95% for Youth and 83% for Adults.

- Outcome: Continual progress on this goal. Of those clients linked to Santa Cruz county SMHS outpatient program, 95% youth and 83% adults received an appointment within 7 business day from discharge. This goal will continue in FY19-20 with additional goals focused on inpatient concurrent review activities.

2. Area of Focus: Monitoring beneficiary satisfaction of MHP and DMC-ODS

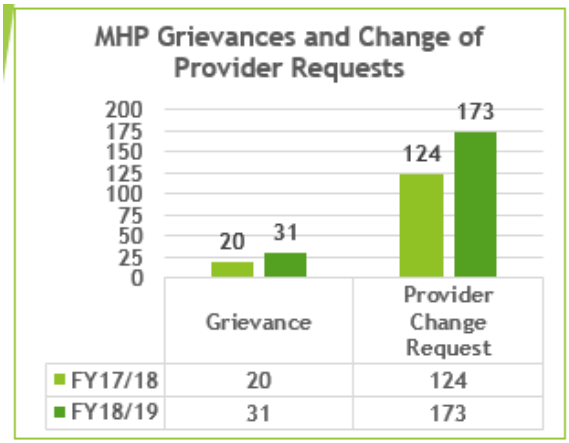
Objective 2.1: Improve beneficiary satisfaction across all ethic, cultural, linguistic, age and gender groups.

Goal 2.1: Address beneficiary grievances collaboratively with the provider for timely response and potential improvement outcomes.

- Intervention: Train county and contractor staff on grievance reporting process, common quality of care issues and improvement outcomes. QI staff to conduct grievance resolution protocol within timeframe. Quarterly analysis of complaints

and timely submission of reports to DHCS. Prepare and submit grievance report related to Access for NACT delivery.

- Measurement: Quarterly data analysis of MHP and ODS grievance entries.



MHP Annual Grievances increased 35%; Provider Changes Requests increased 28%. Client Appeals grew from 1 to 7 year over year.

DMC-ODS Grievances, client appeals and Fair Hearings

DMC-ODS	FY17/18	FY18/19*
Grievances	0	6
Appeals	0	16
Fair Hearings	0	1

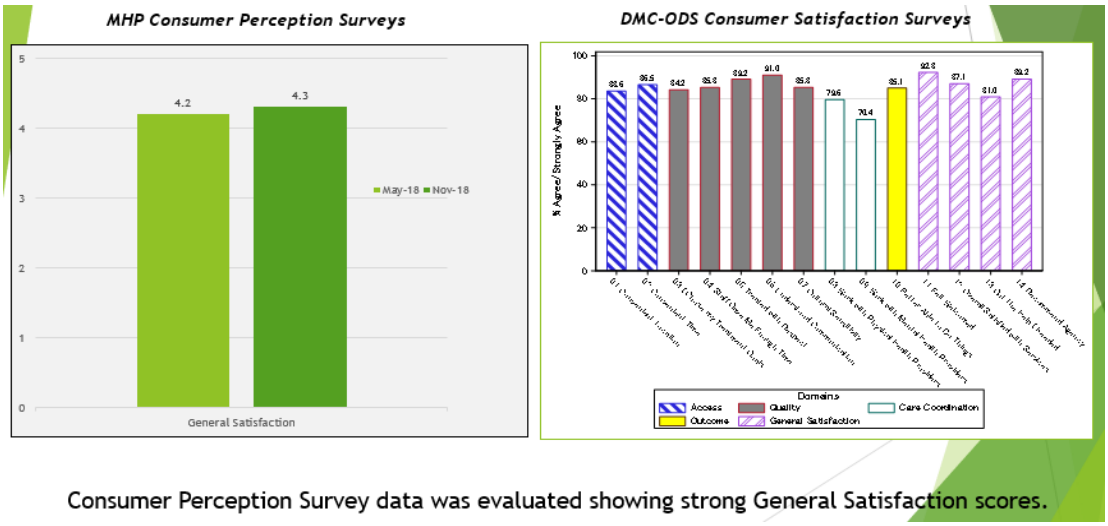
**DMC-ODS launch January 2018, first appeal in August 2018*

- Outcome: Continual monitoring, analysis of trends and reporting. Continuation of task training and regulation education to establish competency of new DMC-ODS activities in current QI team functions. Goal to continue in FY19-20.

Goal 2.2: Review beneficiary and family feedback & recommendations to potentially incorporate into quality of care service improvements.

- Intervention: Outreach and invite beneficiary and/or family stakeholders to participate in a quarterly QIC Steering Committee meeting with County Behavioral Health Senior Leadership. Conduct DHCS surveys accordingly. Conduct data analysis of bi-annual MHP consumer surveys and ODS annual survey reports. Train county and contractor staff on survey results and identified areas of success and improvements. Implement methodology for frequent feedback on service delivery.

- Measurement: Data analysis of MHP and ODS survey results for positive/negative quality of care trending.



Consumer Perception Survey data was evaluated showing strong General Satisfaction scores.

- Outcome: Overall, strong general satisfaction scores, with care coordination an improvement area for DMC-ODS. Continual review, analysis and implementation. Goal to continue in FY19-20 to ensure accessibility to DHCS survey results with changes to DHCS data portal and conduct year to year analysis.

3. Area of Focus: Monitor Appropriate and Effective Service Delivery

Objective 3.1: Delivery the appropriate level and dosing of services that match the beneficiary's needs (Adults and Children)

Goal 3.1: Adult and youth MHP consumers shall receive an initial CANS/ANSA evaluation to identify services delivery based on treatment strengths and needs.

- Intervention: Train county and contractor staff on a collaborative CANS/ANSA evaluation methodology and how it informs treatment planning and service delivery. Update Avatar CANS/ANSA form. Develop client-facing CANS/ANSA report to review. Develop staff and supervisor compliance report to track task completion. RFP process for partnering with a vender to design client-facing CANS/ANSA outcomes and system evaluation data analysis reports.

- Measurement: Quarterly chart reviews and data analysis of CANS/ANSA evaluation entries, service dose and incorporation into treatment plans.

- Outcome: Goal partially met. County leadership, in partnership with a Praed Foundation consultant, designed and scheduled a Q1 FY19-20 training for county and contractor staff and supervisors training in CANS/ANSA evaluation, clinical focusing and incorporation into treatment plan. QI chart audit tools revised to incorporate monitoring treatment plans with CANS/ANSA indicators on treatment plan. Avatar compliance report designed in collaboration with users

and currently in testing period. RFP complete and vender selected to design reporting tools. Goal to continue in FY19-20.

Goal 3.2: Adult and youth ODS beneficiaries shall receive an initial ASAM level-of-care (ALOC) evaluation to identify service delivery needs based on ASAM dimension ratings.

- Intervention: IT staff to rebuild ALOC EHR tool in Avatar to be "episodic" to ensure privacy of sequestered treatment records are contained in episode. Train county and contractor staff on a collaborative ALOC evaluation methodology and how it informs treatment planning and service delivery. Train network staff on new Avatar ALOC form. Develop client facing ASAM report to review. Develop staff and supervisor compliance report to track task completion.

- Measurement: Quarterly chart reviews and data analysis of ALOC evaluation entries, level of care indication and incorporation into treatment plans.

- Outcome: Continual progress. IT and BH network staff collaboratively rebuild ALOC to ensure episodic protection. ALOC users trained and form activated in EHR. County and contractor staff, supervisors and management training on ASAM evaluations and reassessment, clinical focusing and incorporation into treatment plan. QI chart audit tools incorporate monitoring treatment plans with ASAM indicators on treatment plan. Avatar compliance report designed in collaboration with users and currently in testing period.

Goal 3.3: Increase consumer and family involvement in policy and decision-making through participation in quality improvement processes.

- Intervention: Establish mechanism to solicit and retrieve feedback from consumers and family. Outreach and invite consumer and/or family representation to QI Steering Committee. Review and incorporate feedback and suggestion into improvement initiatives.

- Measurement: DHCS Survey results and annual EQRO focus groups feedback.

- Outcome: Goal not met during FY18-19. Minimal activity on this goal prior to QI leadership change. Goal to continue in FY19-20.

4. Area of Focus: Monitor service delivery system and meaningful clinical issues affecting beneficiaries

Objective 4.1: Monitor quality of care provided to beneficiaries. (MH and ODS)

Goal 4.1: DMC-ODS County Plan will conduct all residential treatment authorization reviews for adult and youth ODS beneficiaries needing residential level of care within 24 hours of the request.

- Intervention: Train county and contractor staff on a collaborative prior-authorization methodology based on ASAM medical necessity. Design authorization workflow and tracking/monitoring log. Develop mechanism in Avatar to track and document prior authorizations.

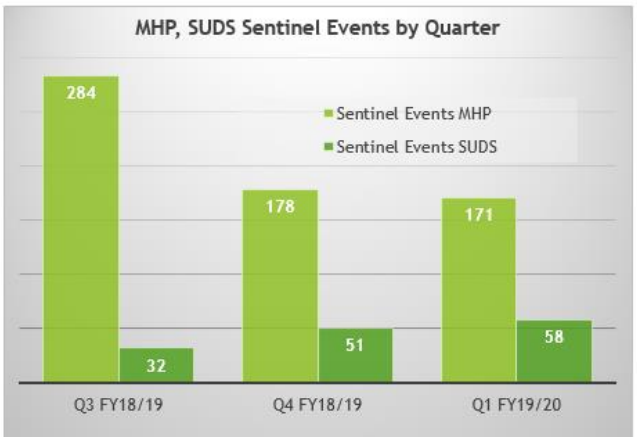
- Measurement: Quarterly data analysis of prior authorization entries and timeliness of response.

- Outcome: Goal met at 99.5% completion within 24 hours for fiscal year. Staff training completed and tracking spreadsheet established. Avatar form pending. Continual progress.

Goal 4.2: Track and trend occurrences of poor care/other Sentinel Events for MHP and DMC-ODS. Increase education on form use by county and contract staff.

- Intervention: Develop data collection mechanism for Sentinel Event type, location, and review outcome. Identify any barriers to improvement: clinical or administrative. Identify criteria for SE review need and any barriers to timely SE review sessions. Develop multi-media meeting platform to decrease SE review attendance barriers.

- Measurement: Quarterly data analysis of SE reported volume, type, provider and outcomes.



Sentinel Events

Quarter	MHP	ODS	Total	Reviews
Q3 FY18/19	284	32	316	8 MHP -0 SUDs
Q4 FY18/19	178	51	229	3 MHP - 1 SUDs
Q1 FY19/20	171	58	229	11 MHP -1 SUDs
Total	633	141	774	22 Reviews

22 Sentinel Event Reviews in the last three Quarters

- Outcome: Goal partially met. QI developed an electronic SE excel tracking system that allows easier data analysis on occurrences and trends by provider or type. This goal continues in FY19-20 to establish a database with reporting capability. Also, the SE Review meeting structure will be reviewed for improved effectiveness and follow-up accountability.

Goal 4.3: Conduct consistent use of appropriate medication consents by psychiatry staff as indicated by chart content.

- Intervention: Establish a meeting series on a quarterly basis for psychiatry chart reviewing. Establish workflow for signed consent forms to be accessible in EHR. Train psychiatry staff on patient medication education and consent, use of consent form, including timing for initial and updated medication regimes. Review and revise psychiatry peer review process and associated utilization chart review tools.

- Measurement: Quarterly outcome analysis of peer chart review of psychiatry services and completed consent forms located in EHR chart.

- Outcome: Peer review process and forms have been established, as well as the workflow for scanning paper copies into chart. Seventy charts were reviewed this fiscal year, with an overall success rate of 52%. Each quarter there was an increase in performance, with one quarter having a 70% success rate. Limited staff resources, in both psychiatry and administrative divisions, were unexpected factors impacting the implementation and timeliness of scanning chart consent forms. Goal to continue in FY19-20 to ensure consistency of process compliance and chart monitoring to meet target success rate.

5. Area of Focus: Monitor coordination of care with physical health care providers and other human service agencies

Objective 5.1: Improve coordination of care between behavioral health and primary care (MH and ODS)

Goal 5.1: MHP: Inclusion of BMI, weight, medical condition(s), name of PCP and med list in medical record.

- Intervention: Recruit and hire Medical Assistant (MA) position(s) to provide psychiatry services support, including conducting and recording vitals of active patients, and coordinating communication with patient's PCP. Train MA staff on EHR documentation and Release of Information forms. Inform/educate patients of new staff role. Develop a monitoring and data analysis mechanism.

- Measurement: Identified incorporation into quarterly peer chart review process.

- Outcome: Partially complete. Psychiatry division hired and trained MA staff in support role and documentation of vitals and coordinated care activities. The peer chart review form is pending revision to incorporate elements and therefore the measurement has not been developed during this fiscal year. Goal to

continue in FY19-20 to revise chart audit form and incorporate in EHR peer review process to measure outcome.

Goal 5.2: MHP & DMC-ODS: 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, non-SMI MH services, and MOU/DHCS compliance.

- Intervention: Quarterly meetings between MHP/ODS and CCAH leadership to monitor MOU activities. Monthly meetings between MHP/ODS ACCESS team and Beacon to coordinate level-of-care transfers, referral/linkage to services, unique case consults.

- Measurement: Meeting attendance by MHP/ODS staff and CCAH minutes.

- Outcome: County leadership attended quarterly meetings with CCAH. SSCBHS Access management and Beacon staff meetings continue to occur on a monthly basis. Ongoing goal for FY19-20.

Goal 5.3: DMC-ODS: Providers will ensure each beneficiary has a physical exam within 30 business days of admission due to high risk population for untreated medical conditions.

- Intervention: Meet with DMC-ODS network providers to emphasize goal purpose. Collaborate with ODS providers to identify timeliness barriers regarding PCP exam appointment. Collaborate with CCAH as needed. Develop an EHR form to capture physical exam information. Monitor medical records monthly to audit success rate. Report UR chart review outcomes in quarterly QIC steering committee meeting.

- Measurement: Percent of completed physical exams per quarter found during monthly UR chart reviews sampling.

- Outcome: Goal needs continues focus. Successful effort by ODS providers to obtained PCP exam records are scanned into EHR by provider to show proof if completion. ODS residential level programs who have implemented IMS services conduct a physical exam as part of intake process when needed. Identified challenges include PCP appointment scheduling and lack of physical exam form in EHR. Timeliness for a routine initial PCP physical exam appointments average to be scheduled at least 45 day from request date.

SECTION 2: Performance Improvement Projects (PIP)

Clinical Mental Health PIP:

- Title: Reducing Hospitalization of Youth from Crisis Stabilization Program (CSP)

- Goal: To reduce youth inpatient psychiatric hospitalizations to 35% or less through the use of clinical interventions to stabilize youth at a level that can be safely managed in outpatient services.

- Intervention: There are several clinical interventions identified for the PIP including:
  1. Training of CSP staff, including doctors, by MERT team related to 5585 Holds and factors necessary to release those holds;
  2. Establishing a safety plan tool that can be utilized by both CSP and MERT staff;
  3. Youth appropriate clinical interventions, such as TBS, for stabilization and safety discharge to home;
  4. review CSP admissions for unique population needs, such as youth from STRTP, to evaluate discharge outcome.

- Outcome: FY18-19 Average: CSP Admissions: Total 69 admissions
  - Youth Discharges results: Home = 19, Hospital = 42. Avg to Home = 39%
  - Youth Hospitalization rate: 61%. Goal not met.
  - Analysis: CSP intermittently includes MERT engagement to provide support in stabilization interventions; CSP numbers include all admission types, including private insurance which impacts discharge resources to community services; increase post-hospitalization interventions as well to minimize repeat CSP admission. CSP representation not yet participating in PIP meetings as invited, which impacts engagement in improvement discussions and intervention implementation; Development of consumer feedback mechanism on process improvement still pending, such as adding survey questions to County MERT youth Rapid Connect outreach protocol.

Non-Clinical Mental Health PIP:

- Title: Client Engagement in Psychiatric Medication Services

- Goal: To increase medication treatment engagement outcome for active clients who have not completed a routine F2F monitoring appointment within 4.5 months. Target 80%

- Intervention: There are several non-clinical interventions identified for the PIP including:
  1. Evaluating current caseload assignments for each prescriber to ensure all active clients are appropriately assigned as there may be a request to change providers.
  2. Developing a tracking mechanism that triggers the provider when a client has not completed a F2F appointment with the prescriber beyond 3 months.

3. Developing and implementing an engagement outreach letter that will be generated and mailed by the psychiatry department to the client to request contact to schedule an appointment.
4. Designing and implementing a workflow for psychiatry staff to ensure outreach letter is sent timely and prior to a NOABD Termination letter when indicated.
5. Train staff on workflow and NOABD letter content.
6. Develop a 1-page client brochure on the importance

- Outcome: Initial PIP – Outcome evaluation pending

Clinical DMC-ODS PIP:

- Title: Coordinated ASAM Clinical Screening and Referrals with SCCBHS MH and SUDS staff

- Goal: To ensure Medi-Cal beneficiaries who are linked to Specialty MH services with co-occurring substance use disorder issues are appropriately screened using AASAM criteria and successfully referred to DMC-ODS service network.

- Intervention: There are several non-clinical interventions identified for the PIP including:
  1. Train Co BH clinical staff on ASAM criteria and LOC within DMC-ODS network
  2. Train Co BH clinical staff on referral method
  3. Set up data entry method for screening and referral information
  4. Design and conduct survey to individuals with SUD symptoms who receive SMHS
  5. Design a brochure for co-occurring population

- Outcome: Initial PIP – outcome evaluation pending. Data tracking element is in development phase. Expectation is that data extraction and analysis will occur on a quarterly basis.

Non-Clinical DMC-ODS PIP:

- Title: SUD Treatment participant access to MH assessments

- Goal: To ensure DMC-ODS beneficiaries with ASAM dimension 3 scores of 2 and higher are referred for mental health assessment and receive services as indicated.

- Intervention: There are several non-clinical interventions identified for the PIP including:
  1. Survey consumers to obtain feedback regarding interest in MH services and challenges with successful engagement in MH services

2. MH Referral form – Beacon (mild-moderate MH services) to improve coordination of care between SUD and Beacon MH network providers, including communication on referral and appointment status
3. MH Referrals to County SMHS to improve coordination of care between SUD and County SMHS treatment providers, including outcome of referral
4. MH Referral tracking spreadsheet for data collection and analysis
5. Design a MH brochure for DMC population to reduce stigma barriers and improve education on positive benefits of MH wellness and how to access MH services

- Outcome: Ongoing data collection and analysis on a quarterly basis. There are two (2) providers with multiple service programs who are the primary participants in the PIP activity. Comprehensive data entry has been a barrier to collecting data elements relevant to measuring success rate. PIP stakeholders reviewed and provided additional training to direct care staff on need for full activity record.

Janus Data: January through September 2019

FY18-19	# of Dim 3 2+	# Referred to MH Assessment	% Referred	# rec'd service by MH provider after referral	% Seen after referral
Q3 (Jan-Mar)	44	21	21/44 = 47%	21	21/21 = 100%
Q4 (Apr-Jun)	15	11	11/15 = 73%	10	10/11 = 90%
FY19-20					
Q1 (Jul-Sept)	10	6	6/10 = 60%	2	2/6 = 33%
Totals	69	38	33/69 = 55%	33	33/38 = 87%

- Several entries with no Dimension level indicated – not counted
- Several Dim 3 2+ had no follow-up info on referral status
- Internal Beacon Referrals
- 13 internal Beacon referrals on "Beacon waitlist" [question: why not referred to Beacon network?]
- 2 referrals to County Access for assessment – 2 Access assessments completed

Encompass Data: January-September 2019

FY18-19	# of Dim 3 2+	# Referred to MH Assessment	% Referred	# rec'd service by MH provider after referral	% Seen after referral
Q3 (Jan-Mar)	4	3	3/4 = 75%	1	1/3 = 33%
Q4 (Apr-Jun)	10	10	10/10 = 100%	8	8/10 = 80%
FY19-20					
Q1 (Jul-Sept)	8	8	8/8 = 100%	5	5/8 = 63%
Totals	22	21	21/22 = 95%	14	14/21 = 66%

- Small data source
- Several entries with Dim 3 2+ with no referral date indicated – not counted
- Several Dim 3 2+ had no follow-up info on referral status – unable to identify if complete referral
- 13 referrals were to County Access for assessment – 12 Access appointment logged as completed = 92%

FY2018-19 QI Work Plan Conclusion

The above dimensions of the QI Work Plan combines clinical and non-clinical focuses and interventions, integrative values for client care and supporting data tools into a process that can evaluate and affect change to client care performance standards.

Reflecting back over the past year, there were many goals that were close to actualizing and others completed but require ongoing monitoring to ensure achievement. Two key factors that contributed to the fiscal year results include a change to SCCBHS quality improvement leadership roles and the continued lack of identified IT data extract and analysis support, which impacted oversight of work plan goals and establishing outcome measuring components. FY19-20 Work Plan will focus on completing remaining items from FY18-19 progress as well as including new focus areas.