QUALITY IMPROVEMENT WORK PLAN

FY 2019-20 Evaluation

QUALITY IMPROVEMENT WORK PLAN GOALS
FOR FISCAL YEAR 2019-2020

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. The CA Dept of Finance (COF) population data of 2019 indicates that Santa Cruz County's population is 273,545; and projects a decrease in 2020 to 273,999. 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. Santa Cruz is ranked one of the most expensive counties for housing and cost of living. 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.

Santa Cruz County Behavioral Health Services (BHS), inclusive of MHP and DMC-ODS, holds the mission 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. BHS continues to work towards service integration although privacy rules and claiming processes remain siloed based on MH or SUD treatment.

FY19-20 was a memorable year. During this year review, BHS experienced additional changes of leadership both at the department and agency level. In early March 2020, BHS experienced the loss of BHS' Chief of Psychiatry for the last seven years and our Adult Mental Health Director, who had over 30 years of BHS knowledge. June 2020 brought a new BHS Adult Mental Health Director from out of the area. Most significant was the onset of COVID-19 in mid-March 2020. This national emergency activated a County wide response to a Shelter-in-Place mandate, and shifted BHS focuses on staff and client safety. Urgent BHS planning and implementation included design of remote work restructuring, essential worker safety protocols, obtaining PPE supplies, ensuring safe client service delivery and COVID exposure notifications and processes.

FY19-20 Evaluation Note: COVID-19 Impact for Work Plan Initiatives:

In March 2020, as a response to State governance and to prevent the spread of COVID-19, Santa Cruz County initiated a Shelter in Place (SIP) mandate for all residents except essential workers. Behavioral Health services and staff delivering these services were, and remain, classified as essential. Immediately, BHS leadership began working on workforce strategies for minimizing staff and client COVID-19 exposure while performing essential services. Two barriers needed to be addressed: Lack of PPE (Personal Protective Equipment) and Lack of Telehealth service practices. Prior to March 2020, Behavioral Health Services delivered predominantly in-person care with the client. Addressing these critical barriers superseded other unrelated program and organizational goals and improvement initiatives. In addition, with the increased flexibility in service modality regulations by OCR, HHS and DHCS, Santa Cruz County BHS pivoted to ensuring safe and effective COVID-19 response workforce activities, resulting in less focus on QI Work Plan and other QA monitoring activities.

SECTION 2: Quality Improvement Work Plan

Our integrative Quality Improvement team and BHS leadership focus on quality of care/service improvement initiatives as well as compliance monitoring that incorporates DHCS requirements for both MHP and DMC-ODS. The FY19-20 Quality Improvement (QI) Work Plan included new improvement focus areas as well as continued to focus on completing interventions from prior 18-19 goals. The goals identified in this work plan speak to continuous quality improvement efforts to identify and meet the mental health and substance use disorder treatment needs of our community. The goals described here were not intended to be all encompassing but are important to our overarching quality improvement efforts for Fiscal Year 2019-2020 (July 1, 2019-June 30 2020). Identified were 6 main Areas of Focus, 6 Objectives, 17 Goals to address for the 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: FY 19-20: Develop a mechanism to monitor cultural and demographic specifications to evaluate under/over utilization of services and delivery of care. Review and analyze Medi-Cal service data and EQRO data reports.

- Measurement: Monitoring network provider ratios at least monthly. Quarterly review of NACT material. Annual review of state and EQRO penetration rates. Quarterly review of monthly service utilization monitoring and trend detection.

- Outcome: New interventions established for FY19-20. Ongoing monitoring.

- **EVALUATION**: Although this goal remains important, the identified intervention was not addressed during the year due to limited resources and conflicting priorities. As penetration rate calculations will include a baseline of enrolled Medi-Cal residents, BHS aims to develop such a monitoring mechanism through the use of data from the local managed care plan and service utilization data from our electronic health record (EHR/Avatar) to support real-time penetration data.

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. Review and analyze NACT materials to evaluate cultural competency capacity standards compliance. Monitor and update provider directory as needed to reflect current network capacity.

- 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: New interventions established for FY19-20. Ongoing monitoring.

- **EVALUATION**: BHS continues to focus on this goal as well as County Personnel. Bi-lingual staff, and bi-cultural preferred, continues to be a recruitment focus for County employment, especially direct service position. BHS met the compliance standards of the DHCS Network Adequacy for both MHP and DMC-ODS regarding language capacity through bi-lingual staff and language assistance resources.

Goal 1.3: FY19-20: Increase and maintain bi-lingual bi-cultural staff within Quality Improvement to conduct culturally aware quality assurance and improvement activities, such as documentation monitoring and addressing complaints in threshold language.

- Intervention: Recruit and hire bi-lingual and/or bi-cultural staff in QI staff. Develop a process to review culturally specific services utilization to monitor service trends, barriers and identify improvement recommendations. Review chart auditing tools and modify as needed to capture threshold language monitoring. Train qualified bi-lingual staff on engaging with beneficiaries on quality of care issues in threshold language if preferred.

- Measurement: Quarterly review of personnel activity in QI department. Quarterly review of utilization review practices.

- Outcome: New interventions established for FY19-20.

- **EVALUATION:** BHS Quality Improvement hired two bi-lingual and bi-cultural staff during this year as effort to establish an ethnically diverse CLAS Coordinator position and to increase Spanish language documentation and service delivery monitoring, response to monolingual Spanish client grievances, appeal and other requests, as well as meet translation service demands.

Goal 1.4: 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. FY19-20: Provide at least four (4) CLAS trainings in a fiscal year that are accessible to all network staff. Conduct staff pre and post competency surveys associated with the training. County supervisors to ensure approval of training attendance to align with County CLAS policies.

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

- Outcome: New interventions established in FY19-20.

- **EVALUATION:** Quality Improvement's CLAS Coordinator activities were interrupted briefly midway through the fiscal year with the sudden departure of staff and the need to hire into the position. Prior to this change, the offering of electronic online CLAS courses were piloted with the use of available Think Culture Health free trainings. There were five hours of credit available and staff had the flexibility to complete the courses within their unique work schedule. This pilot was very successful with an increase in staff attendance/completion of CLAS hours (52 staff from diverse departments & a combined total of 251 completed training hours); as well as positive feedback on quality of courses and completion flexibility. The pre and post-test development remains a pending action.

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: SCCBHS to outsource test calls to vender to conduct test calls based on urgency level, language, type of call (information or service request) and mental health or substance use disorder inquiry and complete test call form. QI to monitor the responsiveness of the Santa Cruz County Behavioral Health Services' 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: New interventions established in FY19-20. Ongoing monitoring.

- **EVALUATION:** BHS contracted with a local CBO to conduct test calls for our Call Center 24/7 800# on behalf of BHS (MHP and DMC-ODS) beginning the fiscal year. This resource change has significantly increased the volume of test calls in both English and Spanish languages during business and non-business hours. The blue/grey tables are the fiscal year sum of test calls. B= business hour & A = after hour calls. Overall, BHS compliance for FY19-20 was 84.5% for MHP and DMC-ODS for information and access to care test calls.

MHP Test Calls: 41% 55/135 test calls for MHP were in threshold language, Spanish. Overall compliance rate of 88% (706/800).

NAME OF COUNTY:		Santa Cruz		# TEST CALLS MADE DURING BUSINESS HOURS:			91
TESTING PERIOD:		July 1, 2019 - June 30, 2020		# TEST CALLS MADE DURING AFTER-HOURS:			44
DID MHP TEST A CONTRACTOR?:		No		TOTAL TEST CALLS MADE:			135
IF YES, CONTRACTOR NAME(S):				NON-ENGLISH TEST CALLS:			55
Does the 24/7 Statewide Toll-Free Access Line provide: *(Note: Compliance Protocol: Section D - Subsection VI - Access Question B (1-4))*				Number of test calls made	Number of test calls where requirements were met		Percentage of test calls where requirements were met
1	Language capability in all languages (NON-ENGLISH) spoken by beneficiaries of the County?	NON-ENGLISH Language(s) Tested:	B	27	27		100.00%
		Spanish	A	28	23		82.14%
2	Information about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met? (e.g. directing the caller where they can obtain a clinical assessment, providing clinic locations and hours of operation, information about walk-in services, etc.)		B	77	68		88.31%
			A	29	24		82.76%
3	Information about services needed to treat a beneficiary's urgent condition? (e.g. crisis services)		B	6	5		83.33%
			A	8	7		87.50%
4	Information about how to use the beneficiary problem resolution and fair hearing process?		B	8	8		100.00%
			A	6	5		83.33%

DMC-ODS Test Calls: 47% 17/36 test calls for MHP were in threshold language, Spanish. Overall compliance rate of 81% (646/800)

NAME OF COUNTY:	Santa Cruz	# TEST CALLS MADE DURING BUSINESS HOURS:	24
TESTING PERIOD:	July 1, 2019 - June 30, 2020	# TEST CALLS MADE DURING AFTER-HOURS:	12
DID DMC-ODS TEST A CONTRACTOR?:	No	TOTAL TEST CALLS MADE:	36
IF YES, CONTRACTOR NAME(S):		NON-ENGLISH TEST CALLS:	17

	Does the 24/7 Statewide Toll-Free Access Line provide: *(Note: Compliance Protocol: Section D - Subsection VI - Access Question B (1-4))*			Number of test calls made	Number of test calls where requirements were met	Percentage of test calls where requirements were met
1	Language capability in all languages (NON-ENGLISH) spoken by beneficiaries of the County?	NON-ENGLISH Language(s) Tested:	B	24	19	79.17%
		Spanish	A	12	11	91.67%
2	Information about how to access DMC-ODS services, including SUD services required to assess whether medical necessity criteria are met? (e.g. directing the caller where they can obtain a clinical assessment, providing clinic locations and hours of operation, information about walk-in services, etc.)		B	20	17	85.00%
			A	10	9	90.00%
3	Information about services needed to treat a beneficiary's urgent condition? (e.g. crisis services)		B	2	1	50.00%
			A	1	1	100.00%
4	Information about how to use the beneficiary problem resolution and fair hearing process?		B	2	1	50.00%
			A	1	1	100.00%

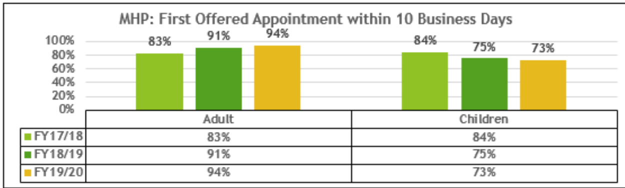
Goal 1.2.2: Assure appropriate and timely access to MH and SUD routine, specialty, urgent and crisis services.

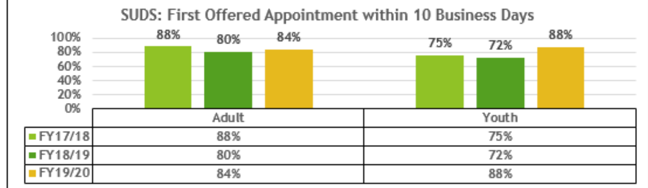
- Intervention: Train county and contractor staff on urgent service request. Revise Avatar Service Request and Disposition Log (SRDL) to reflect timeliness standards for initial requests for mental health and substance use disorder services. Develop a SRDL User Manual. Train county and contractor staff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

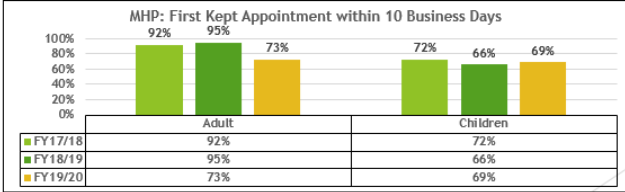
- Measurement: Quarterly Data analysis of SRDL entries by service access program, otherwise known as "gate", compared with first offered appointment and/or completed service data. Analysis of NOABD Timely Access letters from gate programs.

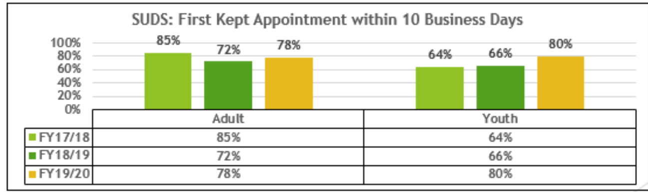
- Outcome: Revision of form and training pending completion. Established interventions continued in FY19-20.

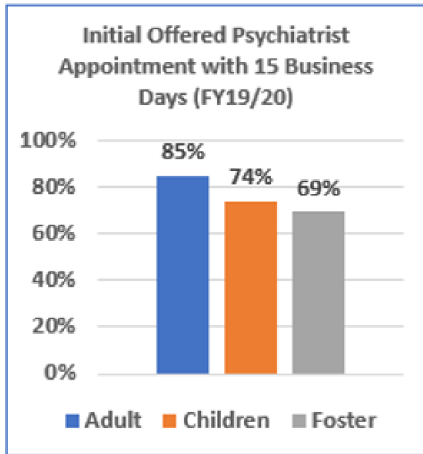
- **EVALUATION:** BHS continued to train and monitor staff regarding timely access to care response and data tracking. During FY19-20, MHP's overall rate of first offered routine appointment (within 10 business days of the request) was 84% & 71% were successfully completed services. For DMC-ODS, the overall 1st offered routine rate was 86% with 79% successfully completed services.


MHP: First Offered Appointment within 10 Business Days
100%
80%
60%
40%
20%
0%
83%
91%
94%
84%
75%
73%
Adult
Children
FY17/18 83% 84%
FY18/19 91% 75%
FY19/20 94% 73%


SUDS: First Offered Appointment within 10 Business Days
100%
80%
60%
40%
20%
0%
88%
80%
84%
75%
72%
88%
Adult
Youth
FY17/18 88% 75%
FY18/19 80% 72%
FY19/20 84% 88%


MHP: First Kept Appointment within 10 Business Days
100%
80%
60%
40%
20%
0%
92%
95%
73%
72%
66%
69%
Adult
Children
FY17/18 92% 72%
FY18/19 95% 66%
FY19/20 73% 69%


SUDS: First Kept Appointment within 10 Business Days
100%
80%
60%
40%
20%
0%
85%
72%
78%
64%
66%
80%
Adult
Youth
FY17/18 85% 64%
FY18/19 72% 66%
FY19/20 78% 80%

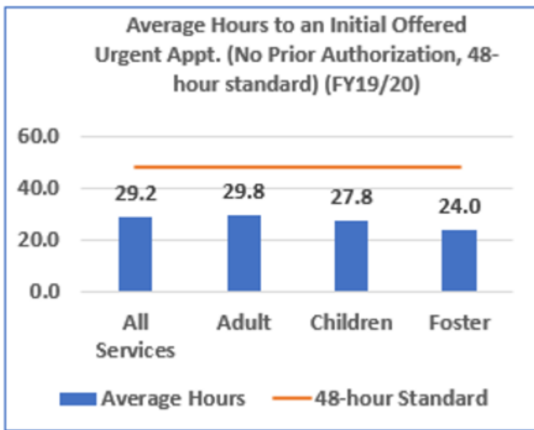


Adult Psychiatry 85% (167/197), Child Psychiatry 74% (20/27), Foster 69% (9/13).

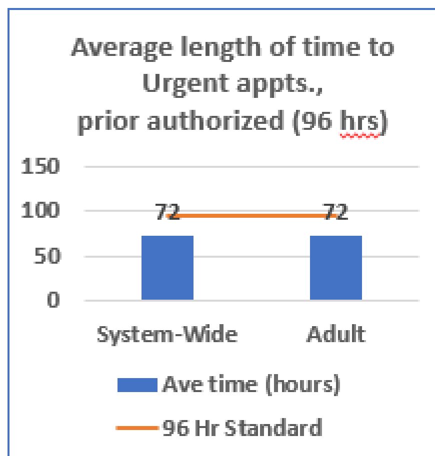
For Specialty psychiatry 1st offered appointments (within 15 business days of the request), overall MHP compliance rate is 80% of all specialty psychiatry requests receive an appointment within 15 business days. Foster care subgroup within the Children's sum, indicate a 69% success rate to offered care. Further review into this result is indicated to identify possible coordination of care barriers and resolute solutions.

BHS Urgent Service Response:

MHP:
Based on Service Request and Disposition Log (SRDL) entries, documented Urgent services consisted of crisis intervention services. No prior-authorization services received an urgent service request.
SRDL data entry has been a focus during FY19-20 and into FY20-21 to ensure all BHS staff and contractors understand level of urgent requests and how to document in SRDL.



Urgent non-auth appt. standard 138/144 (96%) county-wide.
[Zero data found for 96-hour standard for urgent appointments that require prior authorization.]



Zero 48-hr Urgent (no prior auth) data found. 72-hr Avg for the 96-hour standard (prior-auth service) Standard performance was 80% (4/5) system-wide.

DMC-ODS:
The DMC-ODS network gate providers as a whole have struggled to accurately and consistently document service request activity in the EHR' Service Request and Disposition Log (SRDL). This deficiency includes all request levels and especially urgent requests and NTP.

Corrective Actions: BHS QI team has been alerting all DMC-ODS network providers and SUDS leadership of this necessary data for our network adequacy tracking and has provided extensive training on SRDL usage and request level timeliness standards. DMC-ODS providers also have a related performance measure inserted into their County FY20-21 contracts.

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: FY19-20: Establish psychiatric after-care appointment protocol as part of inpatient stay concurrent UM activities. Develop a mechanism for capturing hospital discharge appointment data for individuals not linked to SCCBHS. Recruit and maintain more psychiatry staff. Change psychiatry scheduling protocol to allow for more intake appointments. Outreach individual upon discharge to link to appointment scheduling.

- Measurement: Quarterly monitoring. Data analysis of SRDL entries and claimed psychiatry services post hospital discharge. Data analysis of inpatient concurrent review UM activities specific to discharge planning and aftercare psychiatry appointments.

- Outcome: Continual focus on this goal in FY19-20. New UM/Concurrent Review intervention established for FY19-20. 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.

- **EVALUATION:** For those Santa Cruz County BHS clients enrolled in our outpatient programs, the 7-day appt %, the FY results were 95% for Youth and 83% for Adults, an overall rate of 89%. The challenge presented to this particular goal has been the inclusion of data for all inpatient hospital discharged population and not narrowing the data focus to currently enrolled BHS clients, resulting in an overall rate of 55%. BHS is not able to obtain post-hospital appointment information for non-BHS enrolled individuals. Ongoing monitoring of this HEDIS measure will be modified to filter data

analysis to current enrolled BHS clients who have been hospitalized and need a post-hospital appointment within 7 business days.

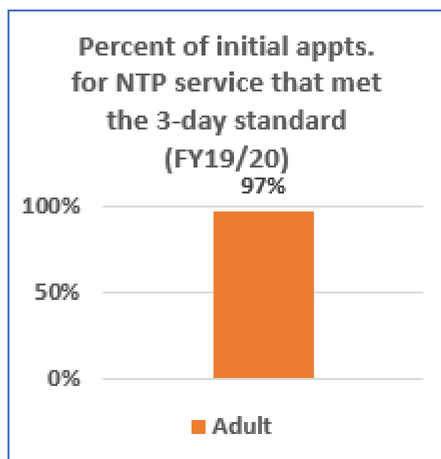
Goal 1.2.4: FY19-20: ODS- Access to NTP services will occur within 3 business days of request. Target: at least 75%

- Intervention: Train contractor staff on access timeliness standard and issuing of NOABD letters. Collaborate with NTP programs to support timely scheduling protocol to allow for more intake appointments. Develop an automatic reporting methodology to capture information.

- Measurement: Data analysis of SRDL entries and claimed NTP services. Analysis of NOABD Timely Access letters from NTP programs.

- Outcome: New goal for FY19-20.

- **EVALUATION:**



Percent of initial appts. for NTP service that met the 3-day standard 97% (38/39)

DMC-ODS:
As mentioned previously, the DMC-ODS network gate providers as a whole have struggled to accurately and consistently document service request activity in the EHR' Service Request and Disposition Log (SRDL). This deficiency includes all request levels and especially NTP's 3-day timeliness.

Corrective Actions: BHS QI team has been alerting our DMC-ODS NTP network provider and SUDS leadership of this necessary data for our network adequacy tracking and has provided extensive training on SRDL usage and request level timeliness standards. The NTP DMC-ODS provider also have a related performance measure inserted into their County FY20-21 contract.

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: FY 19-20: Train bi-lingual QI staff on education monolingual beneficiaries on grievance, appeal, change of provider, second opinion, and fair hearing policies and procedures. 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.

- 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.

- **EVALUATION:**

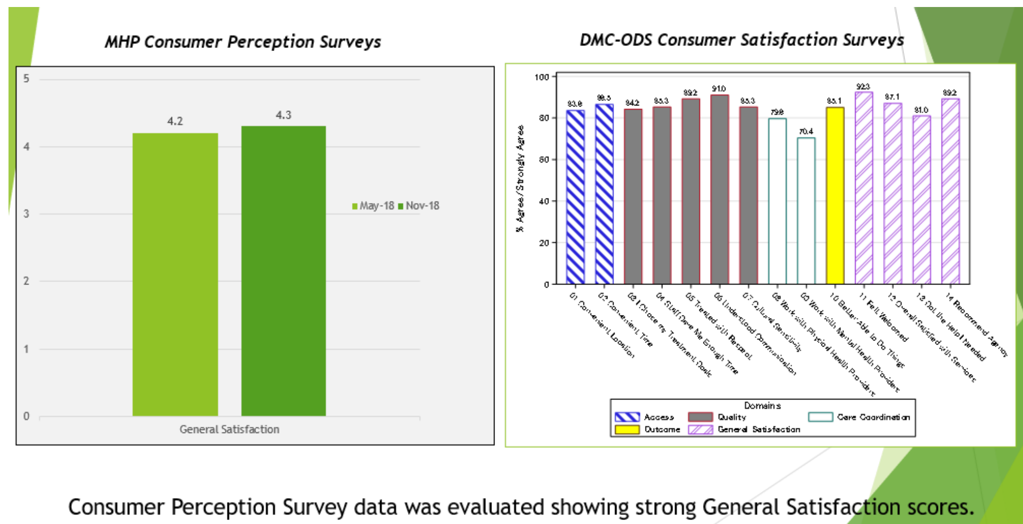
Goal 2.2: Review beneficiary and family feedback & recommendations to potentially incorporate into quality of care service improvements.

- Intervention: 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. Review and incorporate feedback and suggestion into improvement initiatives.

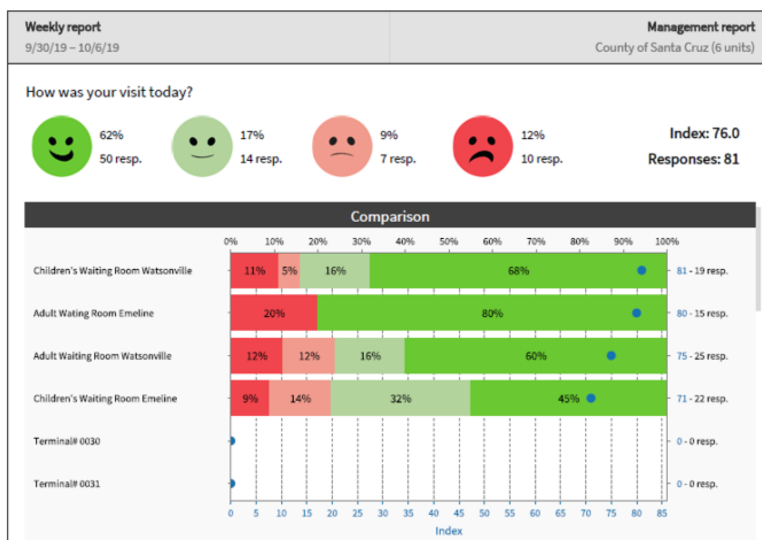
- Measurement: Data analysis of MHP and ODS survey results for positive/negative quality of care trending.

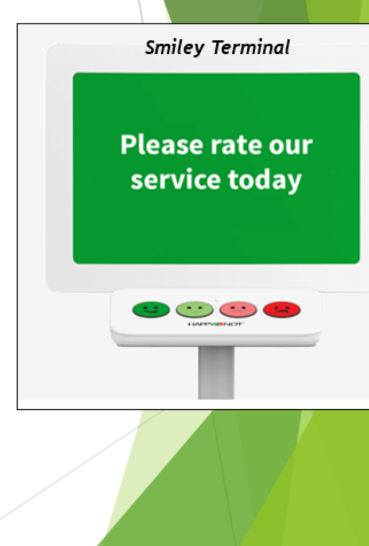
- Outcome: Goal to continue in FY19-20 to increase consumer/family participation in meetings and feedback options, as well as ensuring accessibility to DHCS survey results with changes to DHCS data portal and conduct year to year analysis.

- **EVALUATION:** BHS and contracted network providers for MHP and DMC-ODS continue to conduct the DHCS survey cycles as indicated for each benefit. Survey history has been performed in-person with the client who is being seen for services that particular survey week. Overall, each network survey results indicate that served clients experience a high level of General Satisfaction. The great challenge in FY19-20 was attempting to conduct the MHP survey during a Shelter-in-Place order in the first months of the COVID-19 pandemic. Great efforts went into training staff and clients on how to utilize an online survey portal, mailing surveys and attempting to conduct in session over telehealth/phone, which resulted in increased stress for SMH clients, staff and low outcomes.



Additionally, BHS initiated a contract for the installation and monitoring of feedback kiosk stations at each North and South BHS clinic to solicit immediate feedback from served individuals/families. These kiosks were available for just a short time before COVID impacted a significant decrease of on-site in-person services. BHS looks forward to having these survey kiosks up and running again with safe services.





Goal 2.3: Increase consumer and family involvement in policy and decision-making through participation in quality improvement processes.

- Intervention: Outreach and invite consumer and/or family representation to QI Steering Committee. Establish mechanism to solicit and retrieve feedback from consumers and family.

- Measurement: Establishment of new consumer/family representation on Steering Committee and participation in quarterly meetings. Monthly, quarterly and annual data analysis of consumer feedback solicitations.

- Outcome: New interventions established in FY19-20. Goal to continue.

- **EVALUATION:** QI Steering Committee Chair conducted outreach efforts to increase consumer/family representatives for MHP and DMC-ODS, which resulted in two new Committee members who have lived experience with MH and SUD challenges. The Committee continues to discuss and define best mechanisms for soliciting feedback and collaborative efforts across stakeholders. This work will continue in the next FY.

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: Complete training for county and contractor staff on a collaborative CANS/ANSA 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. Goal to continue in FY19-20.

- **EVALUATION:** MHP in collaboration with ongoing partners has make significant progress in report design and accessibility. Our partnerships with a national CANSA data report developer, Community Data Roundtable, and local consulting services through Health Improvement Partnerships (HIP) continue to focus efforts on educating and coaching increased service providers utilization of reports to share in client-facing sessions and incorporate into treatment planning. The client-facing CANS/ANSA report is complete as well as a Supervisor compliance report that tracks completion of CANS/ANSA. Next steps is supporting supervisors use of monitoring reports in staff supervision sessions and also records review monitoring to ensure CANS/ANSA data in being incorporated into care and medical records. Goal to continue into next year.

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: Design and incorporate additional data elements to EHR tools to capture beneficiary mental, physical, SUD, trauma historical information during assessment phase. Develop client facing ASAM report to review. Develop staff and supervisor

compliance report to track task completion. Train BH staff who provide mental health services on ASAM criteria to increase linking to SUD services when it is a co-occurring issue for client. Develop a referral and tracking mechanism for BH MH providers.

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

- Outcome: New interventions established for FY 19-20

- **EVALUATION:** This work has been delayed due to IT and Avatar development resource allocation to other priorities. Work to continue in FY20-21.

Goal 3.3: Adult and youth ODS beneficiaries shall receive an ASAM level-of-care re-evaluation at time of discharge to ensure readiness of next level of treatment services to identify discharge planning needs based on ASAM dimension ratings.

- Intervention: Collaborate with DMC-ODS network providers to implement an ASAM reassessment into program workflows and clinical care. Train county and contractor SUD staff on EHR form usage and incorporation of identified dimensional needs in discharge pan. Develop staff and supervisor compliance report to track task completion.

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

- Outcome: New interventions established for FY 19-20

- **EVALUATION:** Collaboration and training has occurred with ODS network providers. Training material on discharge planning and ASAM reassessment have been disseminated and posted on County Avatar Internet page for resource. County SUDS leadership discussed and negotiated measurement goal with ODS contracted providers prior to inserting a performance measure for this item in ODS provider contracts. Contract Measurement below:

LOC	Percentage of beneficiaries who showed score improvement in LOC via reassessment	Data comparison of intake LOC to most recent LOC reassessment as show in standardized report

Goal 3.4: FY 19-20: Establish and maintain provider competency for NOABD letter delivery and tracking system.

- Intervention: Design and implement processes/workflows for NOABD letter delivery and tracking for county and contractor staff. Develop training material and resources to support staff adherence. Train county and contractor staff on NOABD letter types, purpose and QI functions. Collaborate with each BH service division to establish delivery and monitoring practices.

- Measurement: Quarterly data analysis of NOABD activity, level of care indication and incorporation into treatment plans.

- Outcome: New interventions established for FY 19-20

- **EVALUATION:** BHS Quality Improvement has completed all interventions. No further work required.

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: FY19-20: Incorporate into Avatar this requirement: DMC-ODS residential treatment authorization reviews for adult and youth ODS beneficiaries needing residential level of care completed within 24 hours of the request.

- Intervention: Develop mechanism in Avatar to track and document prior authorizations to incorporate in EHR. Current mechanism is an excel spreadsheet managed by County SUDS.

- Measurement: Quarterly data analysis of prior authorization entries and timeliness of response located on excel spreadsheet.

- Outcome: New interventions established for FY19-20.

- **EVALUATION:** This work has been delayed due to IT and Avatar development resource allocation to other priorities. Work to continue in FY20-21.

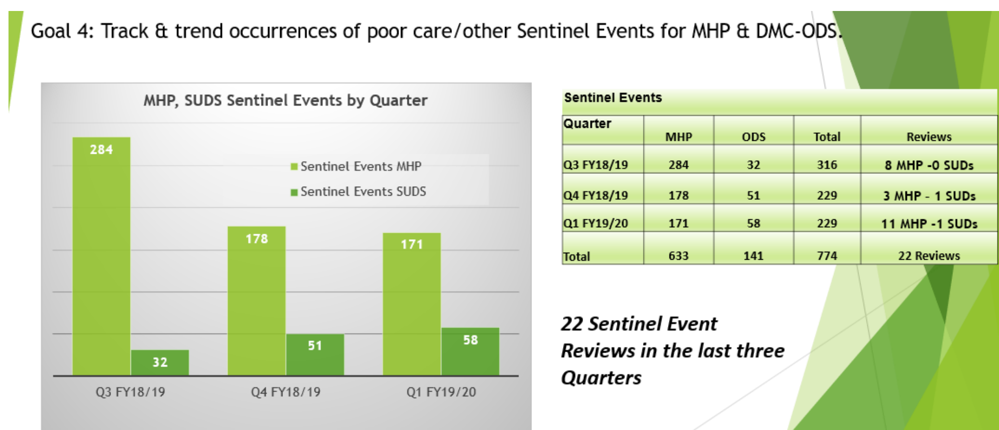
Goal 4.2: Track and trend occurrences of poor care/other Sentinel Events for MHP and DMC-ODS. Increase education on form use by county and contract staff.

- Intervention: Review and enhance data collection mechanism for Sentinel Event type, location, and review outcome to improve data analysis and reporting capabilities. 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.

- Outcome: New interventions established in FY19-20. 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.

- **EVALUATION:** Quality Improvement established a SE tracking data collection log to capture each SE report by date, program, type of SE and if further review/follow-up action is needed. Teleconferencing and file sharing mechanism developed during time of COVID remote/social distancing work encouragement. Beginning data analysis conducted to determine trends. Further work to continue next FY.



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

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. Goal to continue in FY19-20 to ensure consistency of process compliance and chart monitoring to meet target success rate.

- **EVALUATION:** This goal activity has not been a primary focus for BHS during FY19-20 Q3-4 due to staffing changes and unset of COVID-19. Peer review of psychiatric services continued during the year on a quarterly basis, however, the review of chart audit tools and process have been postponed until a new Chief of Psychiatry is onboarded and able to review current practices to determine goal status and outcome. Medication consent form is an identified project on the Avatar Improvement Committee Work Plan, but it has not yet been addresses.

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: 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: Goal to continue in FY19-20 to revise chart audit form and incorporate in EHR peer review process to measure outcome.
- **EVALUATION:** This goal is complete. No further action needed.

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: Ongoing goal for FY19-20.
- **EVALUATION:** Several coordination activities occurred during fiscal year with the Managed Care Plan, CCAH. Summary list includes:
  Highlights:
  - ✓ DMC-ODS requires clients to have a Physical Exam within 30 days (or as a treatment goal).
  - ✓ CCAH partnership on coordinated cases: PCP assignment, Co-Morbidity care, Eating Disorder & ECT cases, HSA Clinic collaboration, MHP Psychiatry & medical work-ups
  - ✓ MHP clients are assessed for access to Primary Care
  - ✓ Whole Person Care

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: 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 continues for FY19-20 to address identified challenges include PCP appointment scheduling and lack of physical exam form in EHR.

- **EVALUATION:** Challenge: Obtaining appointment within 30 days, let alone successful completion of appointment when scheduled. Continued coordination with CCAH on timeliness need. Work around – Residential settings established IMS services.

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.

- **EVALUATION: This PIP was retired at the end of FY19-20.**

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

- **EVALUATION:** This PIP continues through FY19-20 and next fiscal year. PIP progress has been impacted by loss of Chief of Psychiatry in March 2020 and onset of other urgent priorities due to COVID-19.

  EQRO report on both PIPs as of end of FY19-20.

Table 6: PIP Validation Review Summary		
Summary Totals for PIP Validation	**Clinical PIP**	**Non-clinical PIP**
Number Met	13	4
Number Partially Met	8	7
Number Not Met	1	6
Unable to Determine	3	8
Number Applicable (AP) (Maximum = 28 with Sampling; 25 without Sampling)	25	25
Overall PIP Ratings ((#M*2)+(#PM))/(AP*2)	**68%**	**30%**

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.

- **EVALUATION:** This PIP was retired at the end of FY19-20. PIP did successfully increase referral and linkage to MH providers when ASAM Dim 3 indicated need and individual was receptive to a referral to services. Data entry across all participating DMC-ODS network providers was challenging as follow up linkage data elements were not consistently entered.

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.

- **EVALUATION: This PIP focus was discontinued after consultation with EQRO reviewer.**

  - Santa Cruz SUDS and QI leadership had conceptualized a clinical PIP. The focus was on improving care coordination and case management services between MHP specialty mental health services (SMHS) and DMC-ODS SUDS outpatient (OP) programs to improve co-occurring clinical issues. Initial data analysis was conducted, and initial ASAM e-module trainings were completed for SMHS staff.
  - Although progressing, at the time of this writing SUDS has decided, with the support of EQRO, to change course due to the COVID-19 pandemic and the county's response to transition in-person services to telehealth/telephonic services as a result of Social Distancing and Shelter in Place orders. This change occurred in mid-March 2020 therefore, this clinical PIP will focus on how telehealth services have improved access to, engagement with and satisfaction with SUD services, in comparison to pre-COVID in-person service methodology. Please see clinical PIP Outline for more details.