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

Integrative Behavioral Health Quality Improvement Work Plan

FY20-21

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

Health and Safety is our top priority

MH and SUD Initiatives, 7/1/2020

FY20-21 BHS Quality Improvement Work Plan

Purpose

Santa Cruz County Behavioral Health Services (SCCBHS) 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, 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. 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.	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 offered appointment (Standard: 15 business days)	June 30, 2021 **Collaborating Depts:** DMC-ODS and MHP County and Contract Network Gates, QI **Responsible Person:** QI = Cybele & QI staff DMC-ODS = Casey AMH = Barbara/Andrea CMH Gates = Lisa (County & Contractor Gates)
Outcome Status		

Review Findings: ☐ Met ☐ Almost Met ☐ Further Work

During Q1 of FY20-21:

During Q2 of FY20-21:

During Q3 of FY20-21

During Q4 of FY20-21

Annual FY20-21

FY 20-21 Data: Timeliness Response

Department	Q1	Q2	Q3	Q4	FY
MHP: Routine- 10D Urgent – 48 Urgent – 96 Specialty – 15D					
DMC-ODS: Routine – 10D Urgent – 48 Urgent– 96 NTP – 3D					

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

Goal 1.2: During FY20-21, 90% or greater of all test calls to BH 800# will be responded to timely and linguistically appropriately, including business hours, after-hours and weekend test calls.
Baseline: Q4 FY19-20: DMC-ODS data: 86% (12/14 En/Sp test calls); MHP data: 78% (35/45 En/Sp 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 Person:** Fee Clerks = Angela QI = Subé

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☐ Further Work

During Q1:
During Q2:
During Q3:
During Q4:

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

Quarter	Total Calls Made	# of calls meet requirement	% of successful test calls
MHP Q1			
ODS Q1			
MHP Q2			
ODS Q2			
FY Avg			

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

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: Get Q4FY19-20 & Q1 FY20-21 data from QI

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= Casey/Erik ODS Network – QI/UR staff representatives QI= Sara A. & Cybele

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☐ Further Work

During Q1:
During Q2:
During Q3:
During Q4:

FY 20-21 Data: 2+ EBP identified in service delivery documentation

Department	Q1	Q2	Q3	Q4	FY
SUDS					
ODS Network					

Data Source(s): Quarterly review of monthly sample chart reviews.

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: at least 90%
Baseline: Santa Cruz County SMHS 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

Review Findings: ☐ Met ☐ Almost Met ☐ Further Work

During Q1:
During Q2:
During Q3:
During Q4:

FY 20-21 7 day After Care Appt Rate

Service Area	**Q1**	**Q2**	**Q3**	**Q4**	**FY**
Youth					
Adult					
Total					

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

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 Person:** Psychiatry = CMH= AMH= DMC-ODS = QI =

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☐ Further Work

During the quarter of …… (NARRATIVE)

- Data Source(s): Beacon and CCAH referral form activity. Including referrals to IBH services from SMH.

FY 20-21 Coordinated Care Activities

	Q1	**Q2**	**Q3**	**Q4**	**FY**
Meetings					
Other					

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

Review Findings: ☐ Met ☐ Almost Met ☐ Further Work

During Q1:
During Q2:
During Q3:
During Q4:

FY 20-21

Received	Q1	Q2	Q3	Q4	FY
MHP G					
ODS G					
MHP Change					
ODS Change					
MHP A					
ODS A					
MHP FH					
ODS FH					

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

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

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☐ Further Work

During the quarter of …… (NARRATIVE)

FY 20-21 Survey Data:

Department	Return Rate May	Return Rate Nov	General Satisfaction %	Top Growth Area
MHP CO		**Cx**		
MHP Contractors		**CX**		
DMC-ODS CO				

Data Source(s): MHP, DMC-ODS, MHSA survey activity & QIC meeting minutes

DMC-ODS Contractors				

FY 20-21 Policy Improvement/ Input Opportunities:

# of Input on Improvement Initiative/policy	NAMI	Consumer/MHAB	Town Hall

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. Modify data pull for chart sampling to include Foster Care youth. 2. Review EHR for data entry indicators for easier chart monitoring. 3. Coordinate with STRTP providers to obtain PCP monitoring activities and communicate in team collaboration. 4. Train staff on new SB 484 Metabolic Monitoring requirement for targeted population 5. Incorporate new monitoring activity into routine patient care practices. 6. Develop and utilize a tracking tool for peer review.	% of charts with evidence of Metabolic Monitoring completed by staff	June 30, 2021 **Collaborating Depts:** All BH Gates, QI **Responsible Person:** Psychiatry = QI = Dave C.

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☐ Further Work

During the quarter of …… (NARRATIVE)

Data Source(s): Quarterly peer review chart sampling results.

FY 20-21 Chart Review Rate

Chart %	**Q1**	**Q2**	**Q3**	**Q4**	**FY**
Youth					

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: AVATAR Reports available to users, Limited licenses for Avatar KPI users within BH organization, Limited licenses for Power BI accounts within BH. (Budget/ Resources Barriers due to COVID demands)

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

FY 20-21 Data: Data Report Development & Utilization

Department	**Q1**	**Q2**	**Q3**	**Q4**	**FY**

During the quarter of …… (NARRATIVE)

- Data Source(s): Avatar Report Access Activty

Avatar					
Power BI					
KPI					

FY20-21 Data: Communication Releases

Department	**Q1**	**Q2**	**Q3**	**Q4**	**FY**
Workforce					
Public					

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

During the quarter of ……

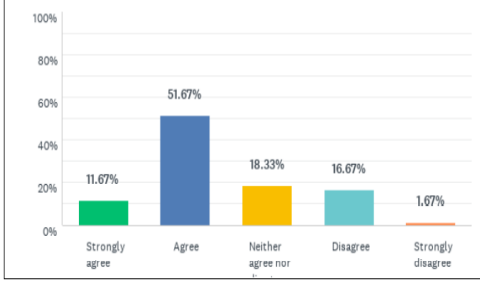
BH FY 20-21 Cultural Humility, CLAS and SOGIE Staff Training Data:

Trainings	**Q1**	**Q2**	**Q3**	**Q4**	**FY**

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

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



# of P&Ps	Q1	Q2	Q3	Q4	FY

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

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

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☐ Further Work

During the quarter of …… (NARRATIVE)

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

FY 20-21

CLAS Hrs.	**Q1**	**Q2**	**Q3**	**Q4**	**FY**
7 hrs.					
>7 hrs.					
< 7 hrs.					