VENTURA COUNTY

BEHAVIORAL HEALTH

A Department of Ventura County Health Care Agency

Quality Assessment and Performance Improvement

Work Plan Evaluation

FY 2019-2020

October 2020

Introduction

Ventura County Behavioral Health (VCBH), a department of the Ventura County Health Care Agency (HCA), provides a system of coordinated services to address the mental health and substance use treatment needs of Ventura County. The department is committed to excellence through "best practices" and a consumer-driven and culturally competent approach to service delivery. VCBH staff are dedicated to reducing suffering and enhancing recovery from mental illness, alcohol, and/or other substance use problems. VCBH believes that consumer and family member involvement is critical to meeting our commitment to excellence and for profound change in consumers' lives. Therefore, VCBH is dedicated to integrating consumers and family members across the Department's organization and activities.

The VCBH Quality Management Program is focused on the successful implementation of the mission, goals, and commitment of the Behavioral Health Department. The Quality Management Program is responsible for: quality improvement projects; performance outcome tracking and analyses; ensuring compliance with federal, state and contractual standards and Department policies; and ensuring overall quality in service delivery. The principles of wellness, recovery, resiliency, and cultural competency are embedded within and direct all Quality Management activities and projects.

The *purpose of the annual Quality Assessment and Performance Improvement (QAPI) Evaluation is to provide updates on the yearly QAPI Work Plan*. The QAPI Work Plan is a working document that guides the monitoring, implementation, and documentation of efforts to improve service delivery for VCBH Mental Health and Substance Use Service programs. This year-end QAPI evaluation describes progress towards the overarching QAPI goals and highlights accomplishments for specific projects and activities. In turn, the QAPI Evaluation supports the development of the following year's QAPI Work Plan through a collaborative review of progress and identification of areas of improvement.

It is important to note that early in 2019, organizational changes were made to create a broader VCBH Quality Management program that encompasses Quality Improvement and Quality Assurance work units. A description of the revised program is provided below. In addition, there have been efforts to align and combine work related to Mental Health and Substance Use Services, as evidenced by this QAPI reflecting goals for both. This evaluation demonstrates the progress made by the Quality Management program teams in its first full year staffed as such, as well as the continued opportunities for growth.

In response to COVID-19, clinical operations had to be modified, moving a great proportion of services to tele-health and many staff began telecommuting. In addition, leadership from administrative and clinical divisions had to shift their attention to things related to, or impacted by, COVID-19. As a result, progress towards some of the objectives in the FY 2019-20 QAPI did not occur.

Quality Management Program

The VCBH Quality Management Program (QM) is accountable to the VCBH Director and is responsible for reviewing the quality of behavioral health services provided to Medi-Cal beneficiaries and ensuring compliance with contract requirements and relevant Federal and State regulations. The QM program resides within the Administration Division and is overseen by the Administration Division Chief and Compliance Senior Manager.
The QM program consists of five units that work collaboratively to achieve the goals of the annual Quality Assessment and Performance Improvement Work Plan. The units, described in further detail below include: Quality Assurance, Quality Improvement, Medical Records, Training, and Pharmacist.

Quality Assurance (QA) – QA activities include monitoring compliance with contract requirements, federal and state regulations, and Department policies and procedures. QA staff are responsible for policy and procedure development; utilization review (UR); inpatient and outpatient service authorization; documentation training; processing provider appeals and beneficiary grievances and appeals; provider credentialing; monitoring provider network adequacy; and ensuring the completion of Medi-Cal site certifications for all internal county programs and contracted providers. In the event that fraud, waste, or abuse are suspected or

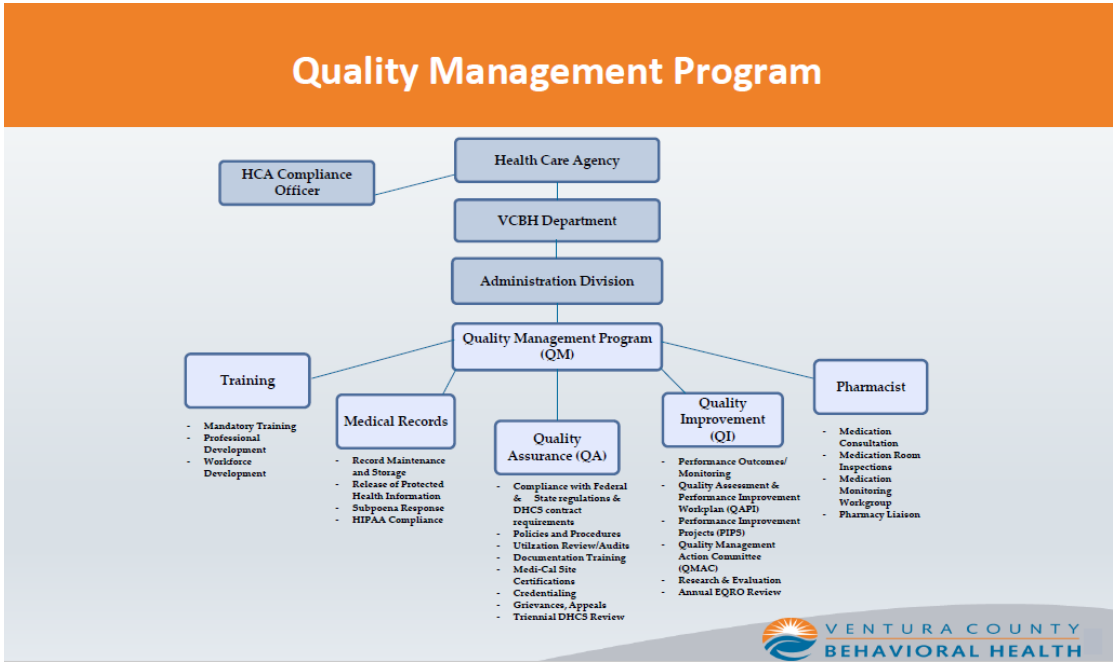
identified, QA staff make a report to the HCA Compliance Officer and assist with investigation activities, as needed, to identify procedures to prevent future incidents and resolve quality of care issues.

Quality Improvement (QI) – QI activities include the use of performance measures and outcome data to identify and prioritize areas of strength and areas for improvement. The QI unit prepares the annual Quality Assessment and Performance Improvement Work Plan (QAPI) after evaluating progress on the prior year's QAPI goals. The QAPI includes current state, measurable goals, and data which guide QI/QM activities throughout the year. Additionally, QI staff led Performance Improvement Projects (PIPs), as well as the Quality Management Action Committee (QMAC), the multidisciplinary entity including community stakeholders and beneficiaries that makes policy and performance improvement recommendations. Other activities include collecting beneficiary/family satisfaction surveys, informing providers of the results, and evaluating beneficiary grievances, appeals and fair hearings at least annually to ensure that practices are in place to address any identified quality of care concerns.

Medical Records – The Medical Records unit is responsible for the maintenance and storage of medical records in compliance with the Health Insurance Portability and Accountability Act, 42 CFR Part 2 confidentiality safeguards, and State record retention requirements. Activities include processing requests for release of protected health information and responding to subpoenas.

Training – The Training unit is responsible for overseeing the Department's mandatory staff training as well as providing opportunities for professional development. Training staff ensure that requirements are met to offer continuing education units to staff and contribute to overall workforce development.

Pharmacist – The pharmacist is responsible for monitoring the safety and effectiveness of medication practices through activities including: providing medication consultation to prescribers, conducting medication room inspections, facilitating the Medication Monitoring Workgroup and serving as a liaison to county pharmacies.



Quality Management Action Committee (QMAC)

The purpose of the QMAC is to provide recommendations and oversight of Behavioral Health's QAPI and other quality management activities. QMAC representation includes MHP practitioners, providers, consumers, and family members. The QMAC reviews, evaluates, and advises on results of QI/QM activities designed to improve the access, quality of care, and outcomes of the service delivery system.

The QMAC meets throughout the year for all member sessions that include focused data review and guidance on process improvement efforts and quality of care areas of focus, such as, grievances/appeals, change of provider trends, access, satisfaction, and quality data. The QMAC also convenes ad hoc committees on a time-limited basis for focused discussion to support carrying out QAPI-related activities. During FY 19-20 the QMAC met in October 2019 and June 2020; additional meetings were canceled due to the impact of COVID-19. Topics covered included time to service, grievances and appeals, and cultural competency service needs.

FY 19-20 Performance Improvement Projects (PIPs)

VCBH conducts Performance Improvement Projects (PIPs) for both Mental Health and Substance Use Services. A PIP is a project designed to assess and improve service delivery and outcomes of care. For each division, there is one clinical and one non-clinical project. There is an ongoing cycle of developing, implementing, and analyzing project related data for the PIPs. The PIPs for FY 2019-20 are summarized as follows:

Non-Clinical

- *Mental Health (Active) - Enhanced Access Performance Improvement Project.* Goal: Improve timeliness from request for service to first service appointment to specialty mental health services for Medi-Cal beneficiaries in the predominantly Latino communities of Santa Paula, North Oxnard, and South Oxnard.
    - Update: This PIP concluded July 31, 2020. The interventions applied at each of the clinics yielded marked improvement in the number of requests for services that were fulfilled within the 10-day state standard.
    - In FY 2020-21 a new PIP will begin focused on creating client reports that will support practitioners with data-driven services and treatment planning.
- *Substance Use Services (Active) – Timeliness to First Clinical Service Performance Improvement Project.* Goal: Decrease the average length of time that it takes clients to begin SUS outpatient treatment after their initial request for service.

Clinical PIPs

- *Mental Health (Concept) - Post-Hospitalization Case Management Performance Improvement Project*. Goal: Enhance the services provided to specific consumers discharged from an inpatient psychiatric unit (IPU) to decrease the rate of 7 and 30-day readmissions.
    - *Update*: As of July 6, 2020 phase 1 interventions began, moving the PIP towards active status.

  Substance Use Services (Active) – Post-Discharge Care Coordination Performance Improvement Project. Goal*:* Increase the percentage of clients following up into outpatient treatment after leaving SUS residential care.

Special Projects

In FY 19-20, VCBH launched a number of pilot projects in the Mental Health division that employ various access models at outpatient clinics with the goal of improving timely access and client experience in the access process throughout the county. Some of these efforts were folded into the Enhanced Access PIP

through the expansion of applied interventions into the North Oxnard Adults and South Oxnard Youth and Family clinics. Due to the impact of COVID-19 Spring 2020, efforts in the second half of the fiscal year were halted. However, the roll out of similar interventions to additional clinics are planned for FY 20-21.

2019-2020 QAPI Goals and Objectives

The Quality Assessment and Performance Improvement (QAPI) Work Plan goals for 2019-20 provided the framework for monitoring, implementing, and documenting of efforts to improve VCBH service delivery across the continuum of Mental Health (MH) and Substance Use Services (SUS) divisions.
These goals, and accompanying objectives, were embedded at the operational program level and address overarching priorities related to improving access, timeliness, quality of care, health equity, and acuity levels. The specific QAPI goal focus areas for FY 2019-2020 were as follows:

- Timely Access to Services
- Care Coordination
- Cultural and Linguistic Competence
- Contract Provider Information Workflow Improvement
- Beneficiary Outcomes and Satisfaction with Services
- Utilization Review of Overutilization of Services
- Grievances and Appeals
- Employee Engagement

Within each goal the objectives are noted and details information on a) the division(s) it relates to, b) the measurement or metrics for monitoring progress or success, c) responsible parties, and d) the planned steps or actions.

The creation and application of the goals and objectives is an ongoing and iterative process throughout the year that involves many leaders across VCBH, as well as stakeholder input. The year-end evaluation marks progress toward goals and objectives and identifies areas where further work is needed. In turn, the evaluation informs the next year's QAPI work plan.

I. Timely Access to Services

Goal: *Beneficiaries will have timely access to services.*			
Objective	**Measurement / Metrics**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**
a. Consumers can request services at any outpatient service location Division: ☒SUS ☒MH Responsible parties: ▪ VCBH QM Team ▪ VCBH Regional Managers	Current state: All requests for services have been tracked under one program. Goal: 100% by March 31, 2020 Method: Request for Services (RFS) Tracking Reports with fields for location or program RFS was processed.	RFS Tracking reports will be updated to include the location/program that fulfilled the request and built to monitor volume and method of service request.	MH: • Operationally, consumers can request services at any outpatient service location. • RFS tracking reports have been revised to allow for tracking by program. However, the implementation of COVID-19 protocols has halted progress on training all relevant outpatient BH staff on the completion of RFS forms. This training will commence when protocols allow. SUS: • Clients can request services via SUS Access Care Beneficiary Access Line, or directly at all county-operated clinics. • Location of RFS is tracked for SUS county-operated clinics. • A new RFS screening tool was implemented in June 2020 which allows more assessment data and level of care determinations to be collected in the initial screening. SUS next steps: • Continue to monitor RFS data and communicate findings to operational staff • RFS data will be collected from contract providers using the same EHR system as county-operated sites.

I. Timely Access to Services

Goal: *Beneficiaries will have timely access to services.*			
Objective	**Measurement / Metrics**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**

b. Increase percentage of consumers who have timely access to services per DHCS standards
 	
Division:
☒ SUS ☒ MH
 	
Responsible parties:
▪ VCBH QM Team
▪ VCBH Regional Managers
	Current state MH: see Table 1a for FY 18-19 Assessment of Timely Access results
	
	Current state SUS: see Table 1b for FY 18-19 Assessment of Timely Access results
	
	Goal: Maintain or increase by rates by June 2020
	
	Method: Timely access reports and regular meetings to discuss results. For SUS, regular meetings are used to monitor and implement process improvement via SUS Year 1 Required Performance Measures;
	Dissemination of results to operations staff.
		Timely Access Reports will be developed for use by all programs
		
		Managers / Clinic Administrators will be trained on use of reports for monitoring compliance and process improvements
		
		Timely Access Data will be reviewed at QMAC meetings
			MH:
			• FY19-20 data for metrics identified in Table 1a are pending.
			• Two Timely Access reports that are focused on the time from RFS to first service were developed this year. They demonstrate the number of requests that meet the 10-business day standard.
			  ○ The first provides an overview of this data, including reasons why a RFS may not have resulted in a first service.
			  ○ A second version of this report was created that includes more detail related to the program associated with the RFS and first service
			  ○ Operations were informed of the availability of the reports and QI will monitor their use and support further development, as identified.
			
			MH next steps:
			• In FY 20-21 additional timely access reports will be built for other metrics and continued communication and training with operations will occur.
			• Develop mechanism to track use and impact of report availability
			
			SUS:
			• See Table 1b for Assessment of Timely Access results for FY 19-20
			• A timeliness report was built and tested in VCBH's EHR system. It is available to all operational and QI staff on demand.
			  ○ The report can be filtered by request type (urgent vs routine), time period, assessment site, and demographics.
			• Results for % of routine appointments seen within 10 days decreased by 7% since FY 18-19

			• Results for % of urgent appointments seen within 2 days increased by 8% since FY 18-19
			• Barriers to meeting timeliness standards include
			  ○ High no-show rates due to unstable client population
			  ○ Redundancies and inefficiencies in the EHR system. The new RFS form implemented in July 2020 addresses these issues and collects more assessment data at the time of first contact.
			  ○ High demand for outpatient services and lack of staff to take assessment appointments.
			  ○ Inconsistency in entering no-show notes which inflates time to service data.
			  ○ Evolving data definitions – for instance, the marker for first appointment switching from face to face appointment to first billable service after Covid-19.
			  ○ Adjustment period for clients and staff to be familiarized with teleconference software, after the switch to telehealth due to Covid-19.
			  ○ Several of these barriers are addressed in the intervention for the non-clinical PIP. For example, staff are expected to have more time for following up with clients who no-show, and data entry for no-show notes is expected to become more systematic.
			
			SUS next steps:
			• Continue to monitor time to service data and communicate findings to operational staff
			• Distribute quarterly data updates to staff, and publish online data dashboards
			• Improve time to routine service by implementing appropriate interventions via the non-clinical PIP, as well as other process improvements identified via regular data monitoring
			• Track time to first offered appointment (this data was made available in our EHR in winter of 2019 and will be added to monthly monitoring report)

Table 1a: FY 19-20 Timely Access to Mental Health Services compared to FY 18-19

Metric	DHCS Standard	% Meeting DHCS Standard							
		All Services		Adult Services		Children's Services		Foster Youth	
		FY18-19	FY19-20	FY18-19	FY19-20	FY18-19	FY19-20	FY18-19	FY19-20
1. Initial request to first offered appointment	10 business days	57%	79%	54%	86%	61%	71%	96%	79%
2. Initial request to first kept appointment	10 business days	38%	67%	36%	70%	39%	59%	54%	53%
3. Initial request to first psychiatry appointment	15 business days	23%	n/a	26%	n/a	12%	n/a	17%	n/a
4. Service request for urgent appointment to actual encounter	48 hours	23%	n/a	26%	n/a	12%	n/a	17%	n/a
5. Follow-up appointments post-psychiatric inpatient discharge	7 calendar days	100%	100%	100%	100%	n/a	n/a	n/a	n/a

Table 1b: FY 19-20 Timely Access to Substance Use Services compared to FY 18-19

Metric	DHCS Standard	% Meeting DHCS Standard					
		All Services		Adult Services		Children's Services	
		FY18-19	FY19-20	FY18-19	FY19-20	FY18-19	FY19-20
1. Initial request to first offered routine appointment (if tracked)	10 business days	N/A	N/A	N/A	N/A	N/A	N/A
2. Initial request to first face to face routine visit/appointment	10 business days	60%	53.2%	59.5%	54.6%	74.4%	38.0%
3. Initial routine MAT request to NTP appointment/contact	3 business days	91.2%	79.3%	91.2%	79.3%	N/A	N/A
4. Service request for urgent appointment to actual face to face encounter	48 hours	42.9%	50.6%	43.3%	50.2%	28.6%	60.0%
5. Follow-up services post-residential treatment discharge	7 calendar days	16.7%	6.5%	15.8%	6.5%	33.3%	N/A

I. Timely Access to Services

Goal: *Beneficiaries will have timely access to services.*			
Objective	**Measurement / Metrics**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**

c. **The 24-hour toll-free access lines will be responsive to all callers and provide after-hours care for crisis and referrals**
 	
Division:
☒ SUS ☒ MH
 	
Responsible parties:
▪ VCBH Test Call Team
▪ MH Crisis and Referral Line Leadership
▪ SUS Access Line Leadership
	MH Current state: FY 19-20 Quarter 1 and 2 DHCS 24/7 Access Line Test Call reports demonstrate that most requirements are met between 90% -100% of the time.
	
	MH Goal: DHCS test call requirements will be met 100% of the time by June 2020.
	
	MH Method: Quarterly DHCS 24/7 Access Line Test Call reports; Test call team meetings and process improvement efforts.
	
	SUS Current state: Monthly monitoring of access line metrics indicates performance is mostly consistent with similarly sized counties.
	
	SUS Goal: Improve metrics related to timely access (e.g. average wait time, % of dropped calls).
	
	SUS Method: Continue to monitor call-center metrics; Work with operations staff to implement test-call procedure.
		MH: On a quarterly basis, Test Call team will:
		• Ensure sub=contractor test calls are high-quality and meet criteria being assessed.
		• Provide feedback and training to Crisis and Referral Line staff based on findings from test call report.
		• Create mechanism for monitoring call volume, dropped calls and average wait time for MH in line with SUS metrics.
		
		SUS:
		• Develop test-call procedures for SUS similar to MH to examine quality of calls.
			MH:
			• Test Call Results for FY 19-20 Quarters 1 -4: The 24/7 Access Line Test Call reports showed high compliance with each metric. Most requirements are met between 100% of the time, with a few at 90%.
			• Each quarter, data is collected from 36 test calls completed in both English and Spanish.
			  ○ QI works with Access Line staff to analyze the call details and complete the DHCS report form. The calls attempt to test for responses to the following types of needs: Urgent, Specialty Mental Health, and Beneficiary Problem Resolution.
			• Each quarter feedback is provided to the contracted test callers and Access Line staff to discuss areas for improvement and reestablish goals and objectives for the test call process.
			
			SUS:
			• SUS Call Center tracking shows the following:
			  ○ Average wait time: 19 seconds (decrease of 6 seconds from FY 18-19)
			  ○ Percent calls dropped or abandoned: 21% (increase of 7% since FY 18-19)
			  ○ The dropped call rate is not defined the same way across counties. For instance, VCBH was counting calls abandoned while the client listens to menu options. This does not reflect system performance because the agent has not interacted with the client at that point. Excluding that metric decreases the dropped call rate substantially (down to 10.5% by October 2020).
			  ○ Average call duration: 7m:23s (decrease of 2 minutes from FY 18-19)

			○ Monthly monitoring of Access Line metrics indicates performance is mostly consistent with similarly sized counties. ○ Dropped call rate increased substantially at the start of the Covid-19 pandemic due to shift to telehealth. Specifically, the system switched to routing calls to counselors' cell phones instead of the office. There was a glitch where if the staff hung up the phone first, it registered as a call dropped on hold. Staff were trained to always wait for the client to hang up. The rate of calls dropped on hold has improved since this glitch was identified and targeted. SUS next steps: • Continue to monitor time to service data and communicate findings to operational staff • Improve % of dropped calls to below 10% as per EQRO recommendation • Develop test-call procedures for SUS similar to MH to examine quality of calls. • Look into monitoring of audio data for quality assurance purposes. Audio data is currently recorded but not analyzed regularly. • Add a field to EHR screen to track call source type (e.g., client, family member, clinician).

II. Care Coordination

Goal: *VCBH will monitor and maintain care coordination activities with all county partners to ensure continuity of care for all VCBH beneficiaries and to comply with state standards.*			
Objective	**Measurement / Metric**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**
a. **VCBH will work with county partners (e.g., Gold Coast, Tri-Counties) to strengthen collaboration and ensure quality in care coordination for shared beneficiaries.** Division: ☒ SUS ☒ MH Responsible parties: ▪ VCBH Executive Team ▪ VCBH QM Team ▪ VCBH Contracts Team ▪ Collaborative Partners and Administrators	Current state: Memorandum of Agreement (MOA) in draft Goal: Completed MOA by January 31, 2020 Goal: Quarterly Collaborative meetings in place by March 31, 2020 Goal: Communication Plan in place by March 31, 2020 Method: Meetings, at least annually, with each contractor to discuss contractual requirements, updates, and system-wide clinical issues. Tracked via evidence such as agendas, minutes, and emails.	Review / revise existing MOA Identify collaborative participants / schedule meetings Draft / employ communication plan Finalize documents by April 30, 2020	• VCBH representatives met with Gold Coast and Tri-Counties this year for contractual and operational purposes related to care coordination. • The MOA with Gold Coast is currently in the process of being revised and the one with Tri-Counties is in progress, currently under review. • Operationally, executive leadership for both MH and SUS communicate with partners on a regular basis, as needed. Next steps: • Finalize MOA's and implement a regular, annual, schedule of meetings. • Establish system for holding, tracking, and documenting meetings for contractual and operational purposes. • Finalize Care Coordination policy and procedure (see next item)

b. **Develop a Care Coordination Policy and train all staff on related procedures.**
 	
Division:
☒ SUS ☒ MH
 	
Responsible parties:
▪ VCBH QM Team
▪ VCBH Executive Team
▪ VCBH Training Manager
	Current state: SUS Care Coordination Policy implemented; MH version in development.
	
	MH Goal: Develop, implement and train staff on an integrated MH Care Coordination Policy by June 30, 2020.
	
	MH Method: Meeting tracking to monitor progress and implementation.
		Draft policy with QM Team
		
		Finalize policy with Executive Team
		
		Train relevant staff
			• A Care Coordination policy that will apply to both SUS and MH is in development.
			  ○ The Initial draft as was completed March 2020.
			  ○ The policy will include operational guidelines for both MH and SUS implementation. Elements of the current SUS policy (SUTS 02) will be integrated.
			
			Next steps:
			• Gather stakeholder input to refine policy and procedure.
			  ○ Estimated approval early 2021, with staff training to follow.
			  ○ Tracking to monitor implementation and progress will be developed within the policy and procedure.

II. Care Coordination

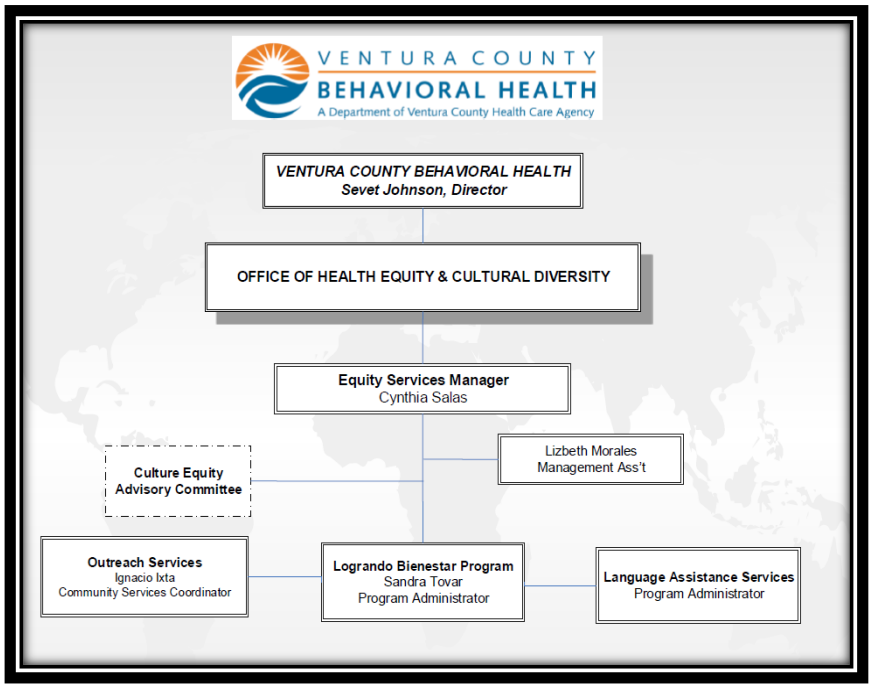
Goal: *VCBH will monitor and maintain care coordination activities with all county partners to ensure continuity of care for all VCBH beneficiaries and to comply with state standards.*			
Objective	**Measurement / Metric**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**
c. **Develop a Care Coordination tracking tool.** Division: ☒ SUS ☒ MH Responsible parties: ▪ VCBH QM Team ▪ VCBH MH Leads ▪ VCBH SUS Leads	Current state: No current tool Goal: Completed tracking tool by June 30, 2020 Method: Meeting tracking to monitor progress and implementation.	Draft tool to track referrals, dispositions, etc. Build tool in Avatar for report generation	Due to COVID-19, the development of a Care Coordination tracking tool did not commence. Tracking will reflect what is established as noted in objectives a. and b. above.

III. Cultural and Linguistic Competence

Goal: VCBH will ensure beneficiaries receive services that meet their cultural and linguistic needs and implement strategies for improvement, as needed.			
Objective	**Measurement / Metric**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**
a. **Expand VCBH Office of Health Equity (OHED) and Cultural Diversity staff and programs to support efforts to meet the cultural and linguistic needs of the consumers.** Division: ☒ SUS ☒ MH Responsible parties: ▪ VCBH OHED Manager ▪ VCBH Executive Team	Current state: See Figure 3 OHED Organization Chart for structure as of February 2020. Goal: *In development* Method: *In development*	Hire staff and plan programs that support the provision of timely access to services and linkages in a culturally and linguistically appropriate way. Provide opportunities for input via the Cultural Equity Committee and other stakeholder groups.	• OHED is currently composed of the Equity Services Manager and one Program Administrator who completes invoices for linguistic services and oversees the Logrando Bienestar Program. ○ Logrando Bienestar has now onboarded five additional Community Services Coordinators to serve additional school districts with the goal of reaching unserved/underserved community members. Next steps: • Continue OHED team expansion to allow for continuous engagement with community, VCBH staff and sites in support of cultural and linguistic needs. • Create an education section within OHED and a specific team assigned to linguistic needs.

			• Develop and track milestones towards new expanded structure.

Figure 3: VCBH Office of Health Equity& Cultural Diversity Structure (February 2020)



III. Cultural and Linguistic Competence

Goal: VCBH will ensure beneficiaries receive services that meet their cultural and linguistic needs and implement strategies for improvement, as needed.			
Objective	**Measurement / Metric**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**
b. **Build capacity to provide the Cross Cultural Health Care Programs' *Bridging the Gap* interpreter training for all VCBH staff.**	Current state: Training model not utilized; VCBH health care specific cultural and linguistic competence trainings are not widely offered. Goal: Key VCBH staff participate in a Training of Trainers and implement training model.	*In development*	• Due to the impact of COVID, this training model is still in development, but plans are underway for FY20-21 to hold the trainings • Curriculum and matrix of implementation to be predetermined. A pre/post assessment will be used to track progress and impact once trainings begin

Division: ☒ SUS ☒ MH Responsible parties: ▪ VCBH OHED Manager ▪ VCBH Training Manager	Method: *In development*		
c. Cultural Competency Plan describes how data-driven best practices are utilized to meet the cultural and linguistic needs of consumers. Division: ☒ SUS ☒ MH Responsible parties: ▪ VCBH OHED Manager ▪ VCBH Executive Team	Current state: 3 Year Plan (2018-2021) Goal: Ongoing evaluation examines and updates areas as needed to reflect current needs and practices. Method: *In development*	*In development*	• The Cultural Competency Plan is under review to determine update needs. • A goal is to collect data that is specific to the county community representation instead of only using State data collection outline o Information will be collected across the VCBH system through referral or initial client information form. (Still in development) o A dashboard would allow access to available data for internal staff and the community when seeking to understand the needs of our community
d. VCBH staff are responsive to consumers' linguistic needs by being certified Level II or III interpreters and providing resources to support non-certified clinical staff. Division: ☒ SUS ☒ MH Responsible parties: ▪ VCBH OHED Manager ▪ VCBH Executive Team ▪ VCBH Human Resources & Administration	Current state: *Pending updated numbers of certified interpreters from HR.* Goal: *In development* Method: *In development*	Create a mechanism for tracking and communicating staff certification levels. Update and expand clinical terminology library in Avatar Implement use a of Spanish Clinical Language Resource Manual	• Bridging the Gap Train the Trainer Training in development, progress impacted by responses to COVID-19 Next steps: • To have key VCBH staff participate in a Training of Trainers and implement training model. • Trainer will train all clinical/nonclinical staff on how to interpret in a culturally and linguistic appropriate manner. o Certified bilingual staff II & III to be identified for each clinic and division. o Encourage all other noncertified staff and level II to test for level III certification so we have more staff able to interpret when necessary. o Explore use of HR data to identify all certified staff and assess who needs training.

VI. Contract Provider Information Workflow Improvement

Goal: *All remaining agreeable contracted providers will have: a) full use of VCBH's Electronic Health Record (EHR) Avatar system or b) full viewing rights of records associated with the beneficiaries that are referred to their programs for services.*			
Objective	**Measurement / Metric**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**
a. **All willing contracted providers will make their own referrals for services using the Avatar system RFS form.** Division: ☐ SUS ☒ MH Responsible parties: ▪ VCBH QM Team ▪ VCBH Avatar Team ▪ VCBH Training Manager	Current state: No current providers are using the Avatar system to complete a RFS Goal: All willing providers will be able to access the RFS form for referrals to VCBH by March 31, 2020 Method: Tracking of meetings and trainings	Assess 100% of the contracted providers to determine their desire to use the RFS form Allow access based on assessment Train providers	The implementation of COVID-19 protocols has halted progress on this objective. It is expected that efforts on this objective will reconvene in January 2021 with the goal of achieving this objective by April 30th, 2021.
b. **Transition all agreeable contracted providers into the Avatar Clinical Work Station system.** Division: ☐ SUS ☒ MH Responsible parties: ▪ VCBH QM Team ▪ VCBH Avatar Team ▪ VCBH Training Manager	Current state: Four contracted providers have fully transitioned. Goal: Bring remaining providers into Avatar system by June 30, 2020 Method: Tracking of meetings and trainings	Assess 100% of the remaining contracted providers to determine their interest in using the Avatar system for clinical documentation Allow access based on assessment Train providers	A survey of contracted providers indicated that no additional providers are wanting to use the Avatar Clinical Work Station for clinical documentation at this time.

VI. Contract Provider Information Workflow Improvement

Goal: *All remaining agreeable contracted providers will have: a) full use of VCBH's Electronic Health Record (EHR) Avatar system or b) full viewing rights of records associated with the beneficiaries that are referred to their programs for services.*			
Objective	**Measurement / Metric**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**
c. **All contracted providers will have view-only access to all client records in Avatar.** Division: ☐ SUS ☒ MH Responsible parties: ▪ VCBH QM Team ▪ VCBH Avatar Team ▪ VCBH Training Manager	Current state: View-only access to Avatar not available. Goal: By March 31, 2020, contracts will be updated, Avatar access will be granted, and trainings for use of additional Avatar functionality will be in development. Method: Tracking of meetings, contracts, and trainings.	Hold meetings to develop and finalize updated contracts with providers. Update Avatar access. Develop and hold trainings.	The implementation of COVID-19 protocols has halted progress on this objective. It is expected that efforts on this objective will reconvene in January 2021 with the goal of achieving this objective by April 30th, 2021.

V. Beneficiary Outcomes and Satisfaction with Services

Goal: *Effectively collect outcomes data to measure service effectiveness*.			
Objective	**Measurement / Metric**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**
a. **All MH adult consumers shall have a Milestones of Recovery Scale (MORS) and BASIS evaluation tool administered annually and at discharge.** Division: ☐ SUS ☒ MH Responsible parties: ▪ VCBH Adult Division Leads ▪ VCBH QM Team ▪ VCBH Avatar Team	Current state: New tool, implemented July 2019 Goal: For MORS, 100% compliance by March 31, 2020 For BASIS, 100% compliance by July 2020 Method: Avatar Reports Metrics Dashboard	Identify and train staff by January, 2020 Produce quality performance reports/dashboards to monitor compliance Provide ongoing outcomes training to relevant staff Require all programs to have at least one outcome	• Prior to the implementation of the Milestones of Recovery Scale (MORS) implementation, VCBH staff were trained in the use of MORS for tracking client recovery. o To support ongoing training needs, selected staff have participated in the MORS train the trainer program. • For FY 19-20, a total of 4,017 MORS assessments were completed. This was the initial year implementation, which was also impacted by COVID-19, so completion rates in each category are lower than expected. The types of MORS were as follows: ▪ Admission: (1431, 36%) ▪ Annual: (1341, 33%) ▪ Discharge: (223, 6%)

		measure that they monitor regularly.	▪ Missing: (761, 19%) • For FY 19-20, a total of 701 BASIS*Plus+* assessments were completed. They included conducted at the following timepoints. ▪ Admission: (320, 46%) ▪ Annual: (348, 49%) ▪ Discharge: (33, 5%) • The VCBH Avatar Team developed a MORS screen in the Avatar system allowing VCBH staff to enter the MORS scores. Next steps: • Support implementation to increase numbers completed, according to the operational guides. • Further develop Avatar reporting structures and dashboards to track and share results for these assessments
b. **All MH youth consumers (age 0-21) shall have Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC-35) administered every 6 months and at discharge.** Division: ☐ SUS ☒ MH Responsible parties: ▪ VCBH Youth & Family Division Leads ▪ VCBH QM Team ▪ VCBH Avatar Team	Current state: Implementation began October, 2018. Data entered into Avatar. Goal: 100% compliance by December 31, 2019 Method: Metrics Dashboard FY 18-19 vs. FY 19-20	Produce quality performance reports/reports/dashboards to monitor compliance	• Implementation began with CWS in April 2018. County-wide implementation effective October 2018. • Administration results are seen in the tables that follow. The 6-month period prior to FY19-20 is presented to demonstrate progress or change over time. Next steps: • Report development currently in progress and will continue with the creation of multiple versions of CANS reports to demonstrate both individual and program level data.

FY18-19: Open Y&F episodes and CANS / PSC-35 finalized tools: January 1 - June 30, 2019*

* Tool done in the fiscal year during the implementation period are counted

	N	CANS	PSC-35
Total open clients with finalized tool	4206	78%	50%
Of total, clients with 1 finalized tool	4206	50%	41%
Of total, clients with 2+ finalized tool	4206	28%	9%
Total discharged clients with finalized discharge tool	1077	42%	12%

FY19-20: Open Y&F episodes and CANS / PSC-35 finalized tool: July 1, 2019 – June 30, 2020

	N	CANS	PSC-35
Total open clients with finalized tool	5414	86%	29%
Of total, clients with 1 finalized tool	5414	40%	24%
Of total, clients with 2+ finalized tool	5414	46%	5%
Total discharged clients with finalized discharge tool	2175	69%	15%

V. Beneficiary Outcomes and Satisfaction with Services

Goal: *Effectively collect outcomes data to measure service effectiveness*.

Objective	Measurement / Metric	Planned Steps & Actions	FY 19-20 Evaluation/Update
c. **All SUS consumers will receive an American Society of Addiction Medicine (ASAM) assessment at a) admission, b) every 30 days for residential treatment, c) every 90 days for outpatient treatment, and d) annually for Narcotic Treatment Programs.** Division: ☒ SUS ☐ MH Responsible parties: ▪ VCBH Substance Use Services Leads ▪ VCBH QM Team	Current state: Rates of completion not tracked Goal: 100% compliance by June 30, 2020 Method: Metrics Dashboard FY 18-19 vs. FY 19-20 monitored internally by operations.	Produce quality performance reports/dashboards to monitor compliance and implement a process for utilizing results for quality improvement.	• Biweekly Level of Care (LOC) reports are produced and submitted to DHCS. • All clients must have a complete assessment, with ASAM administration, and have been determined to meet medical necessity before starting treatment. On rare occasions, an assessment is not completed because the client does not show or does not respond to outreach. However, services cannot be billed unless the assessment is completed. • Operational staff has advised that monitoring completion rates is not necessary: clients cannot start treatment without an assessment and therefore it is not an issue needing process improvement. However, clinic administrators review automated reports of when assessments are due to ensure they are completed on time.

			Next steps: • Clinic administrators will continue to monitor monthly assessment completion reports and encourage staff to complete assessments on time • Barriers to completing assessments on time (e.g., LPHA not available for final signature) will be identified and targeted for process improvement

V. Beneficiary Outcomes and Satisfaction with Services

Goal: *To increase beneficiary satisfaction.*			
Objective	**Measurement**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**

a. **Administer the adult Treatment Perceptions Survey (TPS) to adult MH beneficiaries annually.**
 	
Division:
☐ SUS ☒ MH
 	
Responsible parties:
▪ VCBH Adult Division Leads
▪ VCBH QM Team
	Current state: New tool, implemented August 2019
	
	Goal: 75% by June 30, 2020
	
	Method: Metrics Reports/dashboards
	TPS surveys will be quantified by sites and areas of satisfaction.
		Implement TPS Survey	• August 2019 the 14 item Treatment Perceptions Survey (TPS) was adopted and replaced the VCOS Perceptions of Care survey (28 items).
			• During the implementation period, site visits to the MH Adult clinics were made to introduce the new survey. In addition, a survey administration guideline was rolled out to support implementation of the TPS.
			• In FY 19-20, 1423 TPS surveys were completed at the following timepoints:
			  ○ Annual: (719, 51%)
			  ○ Discharge: (57, 4%)
			  ○ Admin. period not reported: (647, 45%)
			• Given this was the first year of administration, and due to the impact and operational changed as a result of COVID-19, initial use of the tool is low.
			
			Next steps:
			• Provide continued support for the implementation of the TPS according to the administration guide to increase the number of surveys collected annually.
			• Analyze and build reports to share and monitor results.

<table>
<tr><td colspan="4">Goal: To increase beneficiary satisfaction.</td></tr>
<tr><td>Objective</td><td>Measurement</td><td>Planned Steps & Actions</td><td>FY 19-20 Evaluation/Update</td></tr>
<tr><td>b. Administer the Youth and Family Treatment Perceptions Survey (TPS) to youth and family MH beneficiaries annually.

Division:
☐ SUS ☒ MH

Responsible parties:
▪ VCBH Youth & Family Division Leads
▪ VCBH QM Team</td><td>Current state: New tool, implemented January 2020

Goal: 75% by June 30, 2020

Method: Metrics Reports/dashboards
TPS surveys will be quantified by sites and areas of satisfaction.</td><td>Implement TPS Surveys</td><td>• Treatment Perceptions Survey (Youth TPS) administration began in January 2020 but paused due to COVID and modification of service delivery processes.
• Between January 1 – February 29, 2020, 50 TPS surveys were collected. Results are summarized below:

<table><tr><th>Domain</th><th>Average Score ** (1-5)</th></tr><tr><td>Access</td><td>4.7</td></tr><tr><td>Quality</td><td>4.7</td></tr><tr><td>Therapeutic Alliance</td><td>4.8</td></tr><tr><td>Care Coordination</td><td>4.6</td></tr><tr><td>Outcome</td><td>4.6</td></tr><tr><td>General Satisfaction</td><td>4.8</td></tr></table>** Higher average score reflects greater agreement

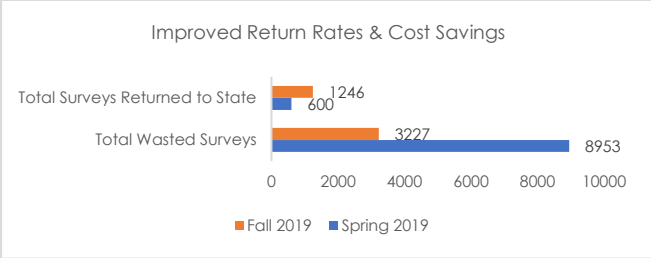
Next steps:
• Resume survey administration
• Develop report structures for monitoring completion and results, once survey resumes and data are collected.</td></tr>
<tr><td>c. Maintain consumer perception survey administrations biannually (MH) or annually (SUS) as required by DHCS and increase beneficiary participation.

Division:
☒ SUS</td><td>Current state: No standard process for reviewing, communicating, or utilizing results.

Method: CPS surveys will be quantified by sites, areas of satisfaction, and a summary of general comments.

Consumer response rate will be determined by the percentage of clients expected to participate (clients who had service</td><td>Analyze consumer perception survey results to identify areas of concern and integrate or compare results to guide improvement services.

Present reports/dashboards to community and staff as appropriate.</td><td>MH:
• The QI team is currently preparing an executive report summarizing the results of the Spring and Fall 2019 administration periods. Key findings include:
o Overall, the majority of the consumers rated VCBH services above the 3.5 threshold/goal
o Most satisfaction rates are above 70%
o There are less reported school suspensions/expulsions and arrests
o There was a great number of consumer participation</td></tr>
</table>

☒ MH Responsible parties: ▪ VCBH Adult Division Leads ▪ VCBH Youth & Family Division Leads ▪ VCBH Substance Use Services Division Leads ▪ VCBH QM Team	appointments during the data collection weeks were available to participate).		• In FY 19-20 several improvements were made to improve this survey distribution and collection process and create efficiencies and ensure the highest return rates possible by: • Updated Survey Volume Estimate data request ensured accurate delivery to in scope sites in line with DHCS guidelines • Updated contact and site vetting for clear communication during survey distribution • Early delivery of surveys (minimum one week prior to the start of the administration period) to allow staff ample time to prepare and organize materials • Staff and contractors are encouraged to arrange client's early arrival to appointments during survey administration week. Early arrival affords clients the opportunity to begin completing the survey before they start their session.  Return Rate Improvement: 547 more surveys sent to State Cost Savings: $1,660.54 saved since Spring 2019 • A description of the process improvement efforts for CPS distribution will be shared with the VCBH executive team. SUS: • Findings from the Fall 2019 TPS Administration period • Response rate = 62% (*N* = 581), which is consistent with responses rates from similar-sized DMC-ODS counties. However, we aim to increase the response rate in future

			administrations. One strategy will be to train office staff on encouraging client participation in the survey. • Findings were uniformly high across items (*M* = 4.4 / 5) • Comments indicated overall high satisfaction with services • Focus areas for improvement include access (transportation and location) and coordination with mental health providers SUS next steps: • Continue to analyze quantitative and qualitative data to identify service highlights and areas for improvement • Plans to optimize survey delivery and response rates given implementation barriers due to the COVID-19 pandemic • Follow up with SUS leadership to plan for dissemination of survey results to staff at county and contractor sites • Develop action plan to ensure that process improvements identified from feedback are put into use

VI. Utilization Review of Overutilization of Services

Goal: *Identify High-Cost Beneficiaries and employ interventions, as indicated, to reduce excessive service utilization.*			
Objective	**Measurement / Metric**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**
a. High-Cost Beneficiaries (HCB) clients will be reviewed quarterly at the Quality of Care meeting Division: ☒ SUS ☒ MH Responsible parties: ▪ VCBH QM Team ▪ VCBH UR Team ▪ VCBH Fiscal and Billing Teams	MH Current state: Currently not employing a standardized review process SUS Current State: HCB's are identified and reported on as part of SUS Year 1 Required Performance Measures Goal: All HCBs will be identified and reviewed quarterly by March 31, 2020 Method: Avatar Report and standing agenda Item at quarterly Compliance and Utilization Review Report meeting by March 31, 2020 SUS Method: Claims data is monitored and HBC are reported to operational and executive staff.	Develop HCB Avatar Reports for tracking and review by Compliance and Utilization Review Report team. Create system for analyzing patterns of HCB based on demographics and treatment needs.	Due to the impact of COVID-19 this objective was not addressed during this year; the goal will carry over into FY 20-21. Next steps: • Review current data and build mechanisms to identify over- and under- utilization. Underutilization is added to this objective as it can indicate whether the appropriate level of care is being provided. • Consider how over- and under- utilization is defined and linked to the client plan.

b. Triage identified HCBs at regional clinics and deploy outreach / intensive case management services Division: ☒ SUS ☒ MH Responsible parties: ▪ VCBH QM Team ▪ VCBH Regional Managers & Clinic Administrators	Current state: Not tracked Goal: 100% tracking of identified HCBs by March 31, 2020 Method: Avatar Report	Develop Avatar Reports for tracking HCB for review by regional clinics	Due to the impact of COVID-19 this objective was not addressed during this year; the goal will carry over into FY 20-21.

VII. Grievances and Appeals

Goal: VCBH will monitor and respond to beneficiary grievances and appeals in a timely and systematic manner.			
Objective	**Measurement / Metric**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**
a. Enhance the system for processing and responding to grievances and appeals. Division: ☒ SUS ☒ MH Responsible Parties: ▪ VCBH QM Team ▪ VCBH QI Team ▪ VCBH Operational Leads	Current state: QM 18 "Beneficiary Problem Resolution Processes: Grievances, Appeals and Expedited Appeals" Policy and Procedure updated 1/20/2020 to outline procedures. Goal: Implement and monitor use of updated system per QM 18. Method: Meetings and review of recent Grievances and Appeals logged into Avatar and response letters.	Per Final Rule, update Avatar/EHR system to create efficiencies, ensure staff process and respond to grievances and appeals. Establish a standard format for writing grievance and appeal response letters that are descriptive, concise, and client-centered.	• The Grievance and Appeals team was assessed for appropriate staffing. As a result, two licensed behavioral health clinicians were assigned to oversee the problem resolution processes. • The policy and procedure, and operational guideline were revised to clarify state and county requirements. • Grievance staff and providers were trained on how to operationalize the problem resolution processes. ○ Weekly meetings between the behavioral health clinicians and supervisor were initiated to review recent grievance and appeals and discuss trends. ○ Grievance and Appeals staff provide ongoing technical support to decision makers to ensure cases are resolved appropriately.
b. Create and implement continuous quality improvement practices based on issues and themes	Current state: See Figures 7a and 7b for details on CY 2019 grievances and themes of the MH grievances. System for analyzing and utilizing information in development.	Create a protocol for qualitatively and quantitatively reviewing themes of grievances and	• Grievance staff and supervisor review trends during weekly meetings ○ Trends were presented to stakeholders during a Quality Management Action Committee (QMAC) meeting.

identified in grievances and appeals. Division: ☒ SUS ☒ MH Responsible Parties: ▪ VCBH QM Team ▪ VCBH QI Team ▪ VCBH Operational Leads	Goal: Develop and implement a system to analyze topics of grievances and appeals, as well as, a method for establishing quality improvement efforts. Method: Meetings and documented process.	appeals to identify areas for process improvement	○ Feedback from QMAC stakeholders will inform process improvements to the grievance and appeal processes. Next steps: • Update Figures 7a and 7b based on CY2020 data • Continue to develop process for analyzing, reporting and implementing process improvement strategies in response to grievances and appeals

Figure 7a: Summary of CY 2019 MH and SUS Grievances

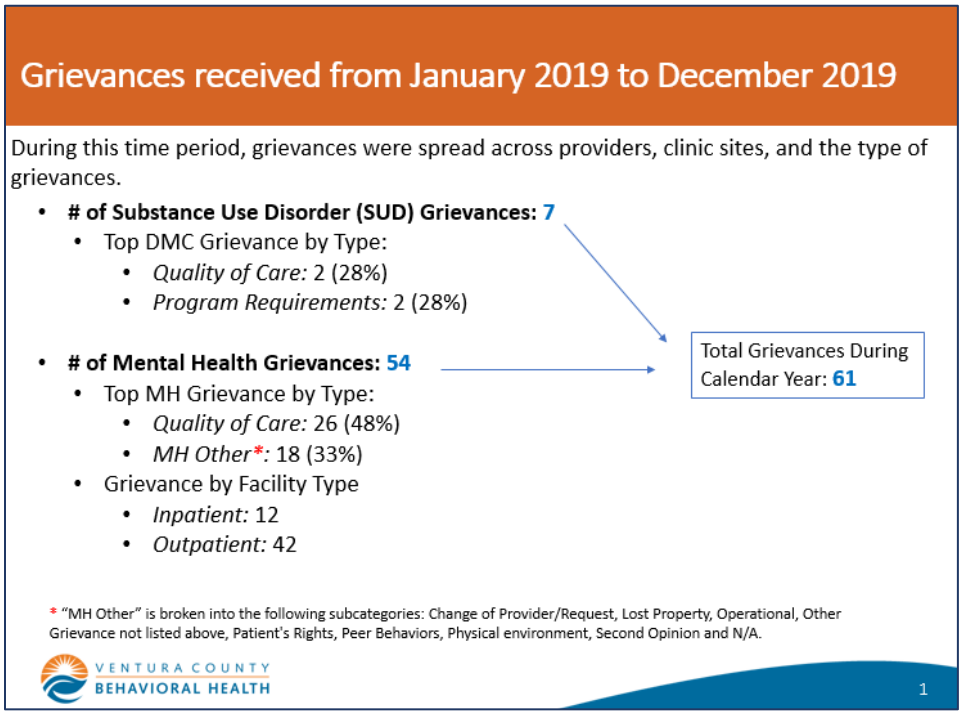
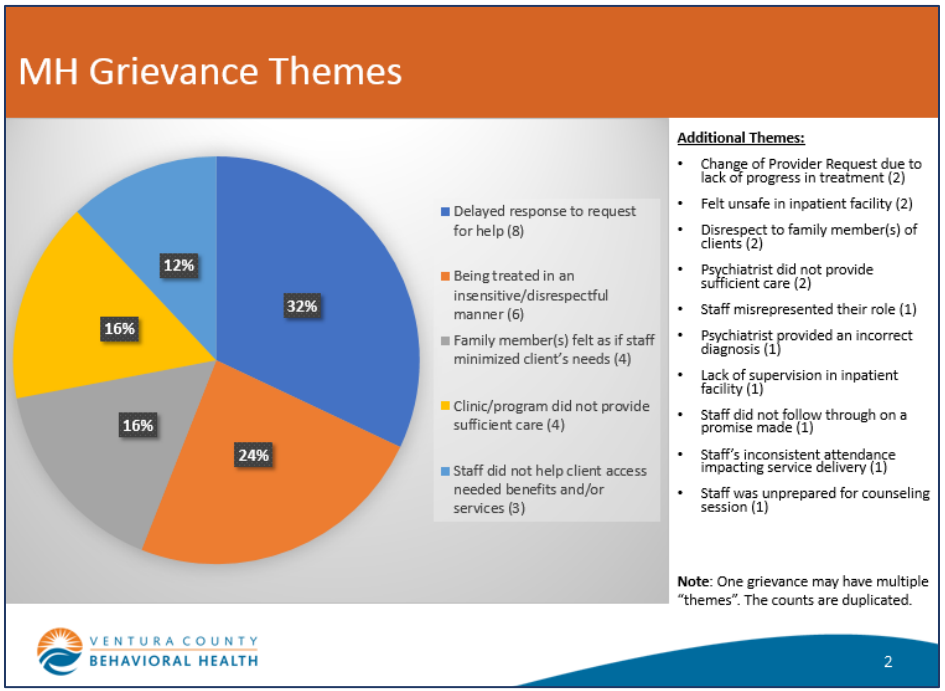
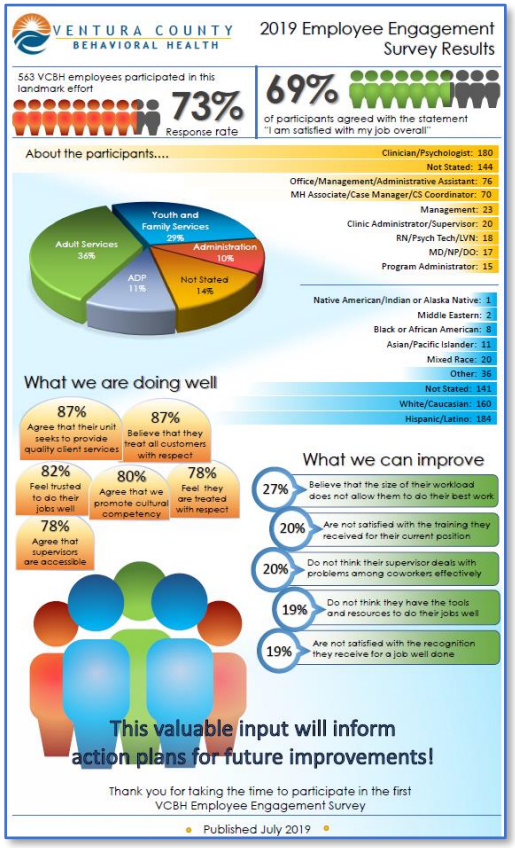


Figure 7b: Summary of MH Grievance Themes



VIII. Employee Engagement

Goal: *Enhance employee satisfaction by utilizing yearly Employee Engagement Survey findings to develop action steps.*			
Objective	**Measurement / Metric**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**

a. Implement and monitor progress towards 2019 Employee Engagement Survey action plans/goals.
 	
Division:
☒ SUS ☒ MH
 	
Responsible Parties:
▪ VCBH QM Team
▪ VCBH Executive Team
	Current state: First survey was distributed, analyzed, reported in 2019. See below for Infographic summary. Actions steps/goals were identified and are being implemented.
	
	Method: Ongoing evaluation of implementation.
	
	 
	
		Create a standing section on Employee Engagement in the VCBH quarterly newsletter.
		
		Embark on the development of a VCBH orientation and onboarding process.
		
		Communicate the "why" in the rollout of new or updated policies and procedures or operational processes.
			• Employee Engagement section was included in the January VCBH News e-newsletter to provide an update to all employees on the agreed upon next steps, one of which was to create a standing section in the quarterly newsletter (see example below)
			  ○ Another update for the 2nd quarter e-newsletter was drafted but due to COVID-19 the newsletter was not distributed.
			• The Training Department has made progress on the development of VCBH-specific orientation and onboarding processes.
			  ○ A list of policies/procedures that are related to job specific roles to support new employees acclimate has been created.
			  ○ A recording of the documentation training has been made available online with live Q&A sessions each month; this minimizes the time new employees need to wait to gain this important information.
			  ○ Starting in November 2020 the Training Manager will meet with Senior Managers monthly and form work groups to develop role specific onboarding materials and processes.
			  ○ Developing a Customer Service training for staff with direct interaction with clients.
			  ○ Compiling/updating a page on the intranet for key documents and trainings.
			• Regarding communicating the "why" -Policy and Procedure (PnP) staff have significantly revised the framing information used when uploading documents to Target Solutions, the PnP Training platform. These updates provide information critical to understanding why changes were made and impact of those changes on day to day operations, if applicable. Specifically, each PnP update identifies the following:
			  ○ Reason for the Updates/Creation:
			  ○ Specifically, the policy affects:

			○ Divisions affected: ○ Who determined the need for revisions: ○ Revisions included: ○ Policy Category: ○ Implementation (if applicable)

January 2020 VCBH News Employee Engagement Section

Employee Engagement Survey Action Steps

In October, four focus groups were convened to discuss the 2019 VCBH Employee Engagement survey findings and gather employees' ideas about how to address identified areas for growth by creating actionable steps, or goals. We thank those who participated in the focus groups for their contributions. The ideas generated were then presented to VCBH leadership and actions that address the themes of improved communication and access to resources were agreed upon and are being implemented.

These 3 action steps aim to provide more clear communications that further inform and engage employees, as well as, support new and existing employees with enhanced resources:

Create a standing section on Employee Engagement in the VCBH quarterly newsletter.

Embark on the development of a VCBH orientation and onboarding process.

- A VCBH orientation and tailored onboarding process will be developed to respond to survey and focus group findings related to an expressed desire for more supportive department- and job-specific information.
- Existing VCBH employees will benefit from an enhanced and standardized process that supports new VCBH employees as they acclimate to work in the department and their role. When new employees are better trained, informed, and supported from the get-go they will be able to do their job well, resulting in less strain on the resources of existing employees.
- This work will be done in consultation with a broad representation of employees to ensure the orientation and onboarding processes include what will be most helpful in the day-to-day lives of VCBH employees.

Communicate the "why" in the rollout of new or updated policies and procedures or operational processes.

- Recognizing that new or updated policies and procedures (e.g., CA 38 related to the lobby posting of information for beneficiaries) or operational process (e.g., new data entry form in Avatar) can impact employees' roles and workload, the goal of communicating the "why" is to provide clarity by providing more background information and context.
- Initial steps will include the addition of a brief description of why new or revised policies and procedures or processes are being implemented, who was involved in the development or change process, what the changes are, and how they will impact employees in certain divisions or roles, as applicable.
- This description will be included with the release of policies and procedures on Target Solutions as well as the provision of trainings on operational processes.

Once again we thank those who participated in the 2019 VCBH Employee Engagement survey and focus groups. Your input is invaluable! The 2020 survey will be coming out in early spring so we can continue to gather your feedback, celebrate what is working well, and consider areas for continued growth.

...And don't forget to look for employee engagement related updates in the next newsletter!

VIII. Employee Engagement

Goal: *Enhance employee satisfaction by utilizing yearly Employee Engagement Survey findings to develop action steps.*			
Objective	**Measurement / Metric**	**Planned Steps & Actions**	**FY 19-20 Evaluation/Update**
b. Update survey materials for 2020 2nd annual Employee Engagement Survey distribution. Division: ☒ SUS ☒MH Responsible Parties: ▪ VCBH QM Team ▪ VCBH Executive Team	Goal: Distribute, analyze and report on 2020 Employee Engagement Survey between February through July 2020	Review the processes by which the 2019 Employee Engagement Survey was implemented, analyzed, the results were distributed, and focus group findings to consider modifications to the survey and/or process to inform the 2020 survey. Distribute the 2020 Employee Engagement Survey and create a timeline for analysis, distribution of results, and action planning.	• The 2020 Employee Engagement Survey is slated to be sent in November/December. It was delayed due to responses COVID. • Following data collection, analysis and reporting, action planning will occur.