VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Quality Assessment and Performance Improvement

FY 2021-2022 Work Plan

Updated December 2021

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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) Work Plan is to provide a working document for the monitoring, implementation, and documentation of efforts to improve service delivery for both Mental Health and Substance Use Services programs and services from VCBH.

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.

In response to COVID-19, from March 2020 to date, clinical operations were 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 2020-21 QAPI was not as much as anticipated and the goals are being carried forward into this year's plan.

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.

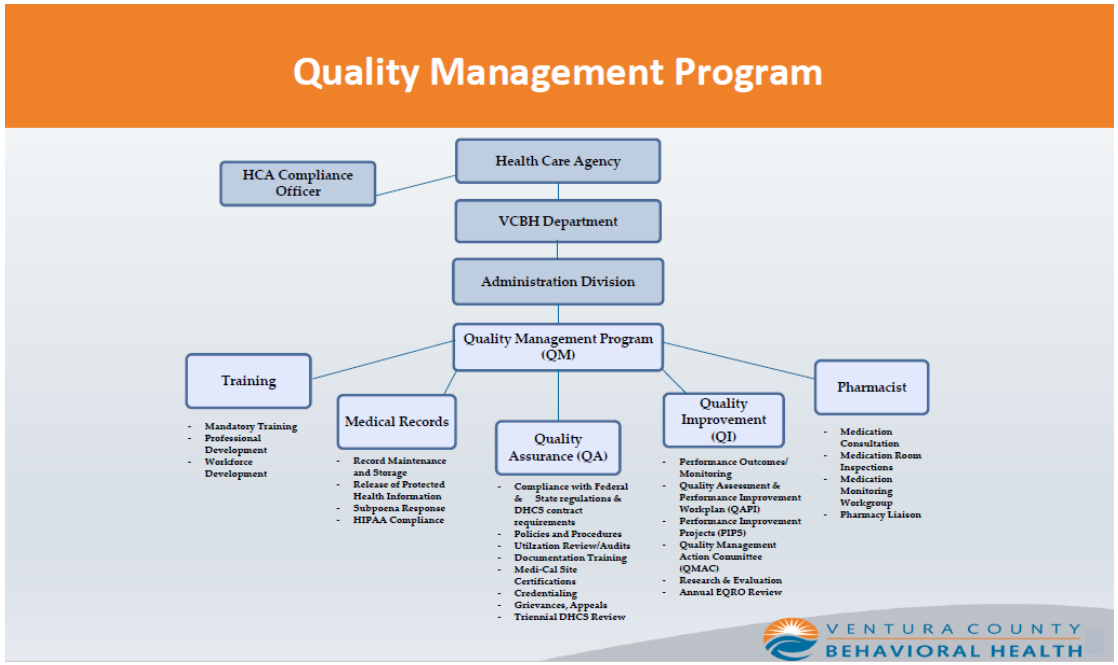
Quality Assurance (QA) – QA activities include monitoring compliance with contract requirements, federal and state regulations, and Department policies and procedures. QA staff are responsible for policy and procedure development; utilization review (UR); inpatient and outpatient service authorization; 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 20-21 the QMAC on a quarterly basis and this schedule will continue for FY 21-22.

FY 21-22 Performance Improvement Projects (PIPs)

VCBH conducts Performance Improvement Projects (PIPs) for both Substance Use and Mental Health 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 2021-22 are summarized as follows:

Substance Use Services:

Non-Clinical PIP

- *Reducing no-shows to assessment and appointments for outpatient care* (began April 2021). Goal: Decrease the average length of time that it takes clients to begin SUS outpatient treatment after their initial request for service.

Clinical PIP

- *Study of client engagement and retention in early outpatient treatment* (began April 2021). Goal: Reduce the percentage of cancellations and no-shows to assessment appointments for outpatient treatment.

Mental Health Services:

Non-Clinical

- *Client Engagement after Intake Assessment Project* (began April 2021). Goal: To reduce the length of time between a new client's intake assessment and first outpatient or recommended appointment.

Clinical PIPs

- *Post-Hospitalization Case Management Performance Improvement Project* (began July 2020). Goal: Enhance the care coordination and services provided to consumers discharged from an inpatient psychiatric unit (IPU) to decrease the rate of 7 and 30-day readmissions.

2021-2022 QAPI Goals and Objectives

The Quality Assessment and Performance Improvement (QAPI) Work Plan goals for 2021-22 provides 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 2021-2022 are 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 Under and 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 iterative process that involves many leaders across VCBH, as well as stakeholder input. Additionally, the year-end evaluation which progress toward goals and objectives identifies areas where further work is needed to inform the next year's QAPI work plan.

I. Timely Access to Services

Goal: *Beneficiaries will have timely access to services.*		
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
a. Consumers can request services at any outpatient service location **Division:** ☒SUS ☒MH **Responsible parties:** ▪ VCBH QM Team ▪ VCBH Regional Managers **Metric for progress:** SUS: Monitoring and analysis of Request for Services (RFS) Tracking Reports by location or program fulfilling RFS to assess how consumers are utilizing various sites to access services. MH: Monitoring and analysis of Request for Services (RFS) Tracking Reports by location or program fulfilling of RFS to assess how consumers are utilizing various sites to access services. **Goal:** Conduct analysis and summary of RFS by location, as well as mechanisms for regularly monitoring this (targeted completion: June 30, 2022).	SUS: • Continue to monitor RFS data, identify process improvements, and communicate findings to staff. • Explore options for collecting RFS data from additional contract providers using the county EHR system. • Implement use of new RFS screening tool at contractor outpatient sites. MH: • Continue with goal and refine mechanisms for collecting RFS data by location/program. • Analysis and summary of RFS by location will be shared with operational staff to determine successes or areas for improvement. • Develop training related to the use of these forms.	SUS: • A report on RFS by clinic location continues to be regularly reviewed by the Treatment Services Manager and DMC-ODS Plan Manager. MH: • Refining data used in reporting and the use of RFS data continues to ensure accuracy and applicability of results.

I. Timely Access to Services

Goal: *Beneficiaries will have timely access to services.*		
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
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 <u>Metric for progress:</u> • Operational staff will have regular access to timely access reports. • Meetings are scheduled to discuss results to determine successes, barriers and mechanisms for continued improvements. <u>Goal:</u> FY 21-22 Timely Access results will indicate maintenance or improvement of rates when reviewed at the conclusion of the fiscal year.	SUS: • Continue to monitor time to service data and communicate findings to operational staff • Implement monthly automated data exports that are received by clinic administrators to review and share with their staff. • Improve in time to routine service by implementing appropriate interventions via the non-clinical PIP, as well as other process improvements identified via regular data monitoring • Develop consistent data collection methods to track additional timeliness measures from contract providers, including time from RFS to first clinical service at residential facilities. MH: • Build additional on-demand timely access reports for other metrics and continue communication and training with operations. • Regularly discuss the use of the reports and the report results at existing meetings and hold specific meetings focused on timely access data as well. • Share results with stakeholders and at the Quality Management Action Committee (QMAC)	SUS: • QI is working with Electronic Health Records (EHR) staff on an automated report to facilitate more regular monitoring of timeliness data • Clinic administrators are being encouraged to review timeliness findings on a monthly basis and discuss trends and developments with staff. • Online data dashboards continue to be monitored regularly by managers. MH: • Multiple efforts, including the PIPs, are focused on elements of timely access. • Other department collaborations continue to review timely access data and identify areas for improvement.

I. Timely Access to Services

Goal: *Beneficiaries will have timely access to services.*		
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
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 <u>Responsible parties:</u> ▪ VCBH Test Call Team ▪ MH Crisis and Referral Line Leadership ▪ SUS Access Line Leadership <u>Metric for progress:</u> As noted above, access line responsiveness differs for MH and SUS. This based on what has been required by DHCS. Accordingly, the methods for monitoring progress will be as follows: SUS: • Continue to monitor call-center metrics and share results with operations for improvement efforts. Progress towards implementation of test-call procedure similar to MH. MH: • Quarterly DHCS 24/7 Access Line Test Call reports, VCBH Test Call team meetings and process improvement efforts. Progress toward tracking call quality similarly to SUS.	SUS: • Access Line metrics will continue to be monitored and reported on monthly. • Dropped/abandoned call rate will continue to be a target for process improvement. • Test calls will be implemented starting in the fall of 2021 and will be conducted and reported on regularly. 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 Access 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. • Each quarter, data is collected from 36 test calls completed in both English and Spanish. o 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: • Access Line has been merged with call center for VCBH Mental Health. • SUS-specific test call protocols were developed and patterned after similar protocols for MH. • Test calls for SUS were started in November 2021, at a rate of approximately 3 calls per month. MH: • Beginning in July 2021 the test calls are being made by a team of VCBH staff, instead of contractors. o The Test Call team developed and implemented training or these staff and monitors calls. • The Test Call team continues to review and report quarterly data to DHCS. o Areas identified in the report as in need of improvement are address by Access Line management and staff.

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	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
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. <u>Division:</u> ☒ SUS ☒ MH <u>Responsible parties:</u> ▪ VCBH Executive Team ▪ VCBH QM Team ▪ VCBH Contracts Team ▪ Collaborative Partners and Administrators <u>Metric for progress:</u> 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. <u>Goal:</u> • At least two collaborative meetings by the end of the fiscal year. • Revisions as needed to Communication Plan in place by June 30, 2022.	• Executive leadership will continue to communicate and meet with partners on a regular basis. • Evidence of collaboration with partners, in the form of agendas, minutes, and emails, will continue to be collected.	• VCBH representatives continue to meet with Gold Coast for contractual and operational purposes related to care coordination. • Operationally, executive leadership for both MH and SUS continue to communicate with partners on a regular basis, as needed.

Objective	FY 21-22 Planned Steps & Actions	FY 21-22 Current Progress
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 Metric for progress: Meetings to track and monitor progress and implementation Goal: Develop, implement and train staff on an integrated Coordination of Care Policy by June 30, 2022.	• Implement new Coordination of Care policy and train staff on new policy.	• A Coordination of Care between care settings policy that will apply to both SUS and MH is being developed. The policy includes operational guidelines for both MH and SUS implementation. Elements of the current SUS policy (SUTS 02) were integrated.

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	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
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:	• Collaborate with OHED to identify SUS-specific performance metrics for assessing cultural competence of services and providers. • Develop a system for monitoring and continuous quality improvement in response to gaps in service as indicated by performance metrics. • Continue to evaluate cultural competence and demographic disparities in key focus areas such as time to service and quality of care.	• QI continues to meet with OHED to collaborate on research and evaluation of SUS metrics, conduct SUS-specific needs assessment, and initiate outreach to schools on SUS-related topics. • A county-wide Health Equity Advisory committee is being formed and representatives from SUS are being recruited to join.

▪ VCBH OHED Manager ▪ VCBH Executive Team <u>Metric for progress:</u> Further develop and track milestones towards expanded structure. <u>Goal</u>: Assess needs and continue discussion and next steps with regard to OHED team expansion to support OHED-related activities and tasks (targeted completion: June 30, 2022).	• Assess needs and continue OHED team expansion to allow for continuous engagement with community and to support of cultural and linguistic needs VCBH staff and sites. • Provide opportunities for input via the Cultural Equity Committee and other stakeholder groups.	

Objective	FY 21-22 Planned Steps & Actions	FY 21-22 Current Progress
b. Cultural Competency Plan describes how data-driven best practices are utilized to meet the cultural and linguistic needs of consumers. <u>Division:</u> ☒ SUS ☒ MH <u>Responsible parties:</u> ▪ VCBH OHED Manager ▪ VCBH Executive Team <u>Metric for progress:</u> Updated Cultural Competency Plan (CCP) <u>Goal</u>: Ongoing evaluation to examine and update areas as needed to reflect current needs and practices will occur in FY 21-22.	• Continue to focus on SUS-specific metrics and related targets for improvement in the Cultural Competency Plan. • A goal is to collect data that is specific to the county community representation instead of only using State data collection. o Information will be collected across the VCBH system through referral or initial client information form. o A dashboard is being developed to allow access to available data for internal staff and the community when seeking to understand the needs of our community. • Revise Cultural Competency Plan (CCP) and continue to build mechanism for tracking, evaluating and updating the plan on an ongoing basis.	• CCP has been fully reviewed and revised and new standard structure rolling out FY 2021-22 for quarterly oversight, identification of barriers and solutions to CCP goals, and update progresses. Smaller plan, do, study, act movement toward the goals. • The CCP 3 Year Plan (2018-2021) is under review to determine update needs.

IV. Contract Provider Information Workflow Improvement

Goal: *All agreeable contracted providers will have expanded use of VCBH's Electronic Health Record (EHR) Avatar system*		
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
a. All willing contracted providers will make their own referrals for services using the Avatar system RFS form. <u>Division:</u> ☒ SUS ☐ MH <u>Responsible parties:</u> ▪ VCBH QM Team ▪ VCBH Avatar Team ▪ VCBH Training Manager <u>Metric for progress</u>: Tracking of meetings about and mechanisms for building out contractor use of Avatar for RFS. <u>Goal</u>: All willing contracted providers will be able to access the RFS form for referrals to SUS services (targeted completion: June 30, 2022).	• Continue to explore and expand options for contracted providers to use the Avatar system to complete a request for service (RFS).	• To date, all willing contract providers are able to use the new RFS form. • VCBH SUS continues to encourage uptake of Avatar EHR with additional contractors.

V. Beneficiary Outcomes and Satisfaction with Services

Goal: *Effectively collect outcomes data to measure service effectiveness.*		
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
a. 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	• Quality Improvement staff will work with the EHR team to develop an automated report that can produce a summary of congruence between indicated and actual level of care placement, to allow for continuous quality improvement monitoring.	• Biweekly Level of Care (LOC) reports continue to be produced and submitted to DHCS. • Quality Improvement developed a system for analyzing congruence between indicated and actual level of care placement, to align with one of the DMC-ODS Year 2 Performance

for outpatient treatment, and d) annually for Narcotic Treatment Programs. Division: ☒ SUS ☐ MH Responsible parties: ▪ VCBH Substance Use Services Leads ▪ VCBH QM Team ▪ VCBH QI Team ▪ VCBH Avatar Team Metric for progress: . Metrics Dashboard monitored internally by operations and improvement efforts implemented when needed. Goal: Continued monitoring, expansion of reporting structures, and improvement efforts will occur throughout FY 21-22.		Metrics. An automated report is currently being developed through collaboration between QI and EHR staff. • Clinic administrators continue to review automated reports of when assessments are due to ensure they are completed on time.
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
b. Ensure all MH adult consumers 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 QI Team ▪ VCBH Avatar Team Metric for progress: . MORS and Basis Avatar reports that monitor due date, completion rates, and results for operational and data analysis and reporting.	• Support implementation to increase numbers completed, according to the operational guides. • Assess staff training needs and provide additional training as needed. • Develop Avatar reporting structures and dashboards to track completion rates and share results for these outcomes tools.	• Despite the challenges of the pandemic, a contingent of VCBH staff (representative from all the Adult clinics/programs) completed the requisite training to become trainers on the Milestones of Recovery Scale (MORS). This "in-house" team subsequently conducted eleven (11) MORS trainings in 2021. Nearly 300 staff attended (i.e., first-time training and refreshers for managers and clinical staff, including a special session for psychiatrists). • Clinical staff continue to utilize Avatar to enter MORS scores. • The QI team will be working with Adult division operations to develop reporting of these tools that can track completion and inform clinical practices.

Goal: Improve MORS and Basis completion rates and create reports for monitoring and reporting by June 30, 2022.		
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
c. Ensure 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 QI Team Metric for progress: . CANS and PSC-35 reports that monitor due date, completion rates, and results for operational and data analysis and reporting. Goal: Improve CANS and PSC-35 completion rates and create/expand reports for monitoring and reporting by June 30, 2022.	• Continue with and expand the production of quality performance reports/reports/dashboards to monitor compliance and convey results.	• CANS and PSC-35 data continue to be entered into Avatar. • QI developed an individual narrative report that is used to support data review and discussion during Child-Family Team meetings. Additional CANS reporting is in development. • Beginning implementation of PSC-35 DHCS data reporting.

VI. Beneficiary Outcomes and Satisfaction with Services

Goal: *To increase beneficiary satisfaction*		
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
a. Maintain consumer perception survey administrations biannually (MH) and annually (SUS) as required by DHCS and	SUS: • Discuss the feasibility of multiple TPS administrations throughout the year, beyond the required annual administration.	SUS: • Results of the 2021 TPS will be shared with VCBH management, line staff, and contracted

utilize results for quality improvement efforts related to beneficiary satisfaction. Division: ☒ SUS ☒ MH Responsible parties: ▪ VCBH Substance Use Services Division Leads ▪ VCBH QM Team ▪ VCBH Adult Division Leads ▪ VCBH Youth & Family Division Leads Metric for progress: Reports of the number of surveys collected per tool and administration period and summary reports, providing detail by site where possible, will demonstrate success. Goal: Continue efforts to maximize client response rate, analysis and reporting, and use of findings for quality improvement efforts will occur in FY 21-22.	• Continue to strategize methods for maximizing response rates given the limitations of telehealth. • Summarize and share the results of the 2021 TPS with county and contract providers, and promote use of findings to inform and improve service delivery. MH: • Apply strategies to ensure high response rates for the FY 20-21 survey administration. • Analyze consumer perception survey results to identify areas of concern and integrate or compare results to guide improvement services. • Present reports to VCBH and contracted providers, as well as the community as appropriate.	providers when the data becomes available from UCLA. • QI will continue to explore strategies to maximize response rate for future TPS administrations. MH: • In FY 20-21 continued efforts were made to follow a standardized process for reviewing, communicating, and utilizing results of the MH consumer perceptions survey: • 2021 CP Survey data has recently become available from UCLA. An analysis and summary will be forthcoming and will be shared with VCBH management, line staff, and contracted providers as available.
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
▪ Administer the Treatment Perceptions Survey (TPS) to adult and youth MH beneficiaries annually and at discharge and utilize results for quality improvement efforts related to beneficiary satisfaction. Division: ☐ SUS ☒ MH Responsible parties: ▪ VCBH Adult Division Leads	• Provide continued support for the implementation of the TPS according to the administration guide to increase the number of surveys collected annually. • Build and analyze reports to monitor survey implementation and share survey findings.	• Adult Division continues to administer the 14 item Treatment Perceptions Survey (TPS). • Youth and Family division re-launched the Y-TPS. QI developed and provided trainings and is monitoring implementation. • Summary and on-demand reporting are in development.

▪ VCBH Youth & Family Division Leads ▪ VCBH QM Team **Metric for progress:** Trainings provided to support expanded use. Reporting structures to monitor completion rates, due dates, and present survey findings. **Goal:** Continue administration, support for expanded administration, and build reporting structures by June 30, 2022.		

VI. Utilization Review

Goal: *Identify over and underutilization of services and employ interventions, as indicated.*		
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
• **Processes will be in place to identify over and underutilization of services and employ interventions, as indicated.** **Division:** ☒ SUS ☒ MH **Responsible parties:** • VCBH QM Team • VCBH UR Team • VCBH Fiscal and Billing Teams **Metric for progress:** • Documentation of county and contracted providers method(s) for identifying over and underutilization and methods for addressing. **Goal:** • By June 30, 2022, the Quality Improvement team will review and document the full scope of monitoring and reporting practices (both county and contracted	SUS: • Quality Improvement will research additional methods county and contractor providers have for monitoring over and underutilization and document the ability to detect and address as appropriate. • Quality Improvement will assess whether more frequent monitoring is needed beyond annual updates as done currently. • A system will be created for analyzing patterns of over and underutilization based on demographics and treatment needs. MH: • HCB Avatar reports will be developed, as needed, for tracking and review by Compliance and Utilization Review team and operations. • A system will be created for analyzing patterns of over and underutilization based on demographics and treatment needs.	SUS: • HCB's continue to be identified and reported on as part of QI's regular data monitoring and reporting. Results are reviewed by the VCBH Billing/Fiscal team. MH: • In November of 2021, the Quality Improvement and Utilization Review teams, in consultation with VCBH Administration and Operations, completed an assessment of the current state and ways over and underutilization is reviewed. • This review identified existing Electronic Health Record reports, and review processes that allow for regular monitoring of service over and underutilization. The accuracy and utility of these reports and processes are reviewed by operations on an ongoing basis. The development of additional reports and review processes was found to not be needed at this time.

providers) for over and underutilization of services, and propose methods to expand these as needed. This review will cover: - Methods to identify over and underutilization. - Methods to identify and carry out Interventions, as indicated. - Analysis of patterns of over and underutilization based on demographics and treatment needs. - Monitoring of over and underutilization patterns, for helping to determine whether appropriate levels of care are being provided. • On at least an annual basis, Quality Improvement will analyze over/underutilization of services and summarize findings for QM and UR teams.	• Complete an additional assessment of contracted providers' ability to detect over and underutilization within their programs and confirm that each identified county developed oversight report is available for contracted provider use.	• Operational oversight ensures the ongoing ability for both county and contracted providers to regularly monitor for over and underutilization of services and address as appropriate.

VII. Grievances and Appeals

Goal: *VCBH will monitor and respond to beneficiary grievances and appeals in a timely and systematic manner.*		
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
Enhance the system for processing and responding to grievances and appeals. Division: ☒ SUS ☒ MH Responsible Parties: ▪ VCBH QM Team ▪ VCBH QI Team Metric for progress: Meetings and review of recent Grievances and appeals logged into Avatar and response letters. Goal: Continue to expand implementation and monitoring of updated system for processing and responding to grievances and appeals, per QM 18	• Quality Management will continue to offer technical assistance to sub-contractors as needed. • Staff will continue to advise clients about their rights and options regarding grievances. • 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. • Ensure staff are trained to and supported with use of letters and tracking	• Quality Management has initiated quarterly technical assistance meetings with sub-contractors. Grievance and Appeals has been discussed at every meeting to ensure that subcontractors are in compliance with QM 18 and appropriately tracking and reporting grievances and appeal that are investigated by their site. • There continues to be a minimal number of grievances for SUS, following ongoing efforts to educate staff and maximize client awareness of the process. Monitoring and analysis will continue. • Results from the annual Treatment Perceptions Survey are being used to supplement findings from grievances data and identify patterns in client-reported issues.

Objective	FY 21-22 Planned Steps & Actions	FY 21-22 Current Progress
b. Create and implement continuous quality improvement practices based on issues and themes identified in grievances and appeals. Division: ☒ SUS ☒ MH Responsible Parties: ▪ VCBH QM Team ▪ VCBH QI Team ▪ VCBH Operational Leads Metric for progress: Meeting records and documented process improvement efforts and outcomes. Goal: To continue to develop and implement a system of analyzing topics of grievances and appeals, as well as a method for establishing quality improvement efforts throughout FY 21-22.	• Quality Improvement's independent analysis will be repeated at least annually and possibly on a more frequent basis depending on the volume of grievances, and availability of data from CBO's. Quality Management will use the findings to determine what/if action steps are needed.	• Quality Management and Quality Improvement continue to collaborate on a long-term data analysis and monitoring plan for grievances and appeals. • Quality Improvement intends to conduct an independent analysis on an annual basis to identify patterns in the Grievances data and present findings to QM staff and other VCBH stakeholders on a regular basis. • Grievance and appeal staff and supervisor review trends during weekly meetings to determine areas for continuous quality improvement. • Trends were presented to stakeholders during a Quality Management Action Committee (QMAC) meeting. • Feedback from QMAC stakeholders will inform process improvements to the grievance and appeal processes.

VIII. Employee Engagement

Goal: *Enhance employee satisfaction by utilizing yearly Employee Engagement Survey findings to develop action steps.*		
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Current Progress**
a. **Finalize and carry out plan of action based on findings from 2nd annual Employee Engagement Survey** Division: ☒ SUS ☒ MH Responsible Parties: ▪ VCBH QM Team ▪ VCBH Executive Team Metric for progress: Evidence of survey distribution, results reporting, and action planning will demonstrate success. Goal: Analyze, share results, and collaborate with employees on action steps (projected completion: June 30, 2022)	• Discuss focus group outcomes with executive team and determine a final set of action items to be implemented for FY 21-22. • Discuss the feasibility of an advisory group of employees that would meet semi-regularly to work on employee engagement issues. • Continue to implement and make progress on each action step and involving employees for feedback, where applicable. • Monitor progress on each action step, refocusing when needed. • Communicate progress and outcomes of efforts to employees on at least two separate occasions, to demonstrate the department's commitment and follow-through regarding employee engagement.	• All employees were invited to participate in focus group sessions to provide deeper feedback on employee engagement issues and to collaborate on action items to implement for FY 21-22. Four focus groups were convened in the summer of 2021. • Action items are currently being reviewed by VCBH executive leadership, who will then provide feedback on next steps for initiating these plans. Four focus groups were convened in the summer of 2021 and action steps based on their recommendations are being finalized.