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

Quality Assessment and Performance Improvement

FY 20-21 Work Plan Evaluation

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 and Evaluation 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. The year-end evaluation of the QAPI describes progress towards overarching goals and highlights accomplishments for specific projects and activities. The year-end evaluation also supports development of the following year's QAPI Work Plan.

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 the FY 2021-22 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

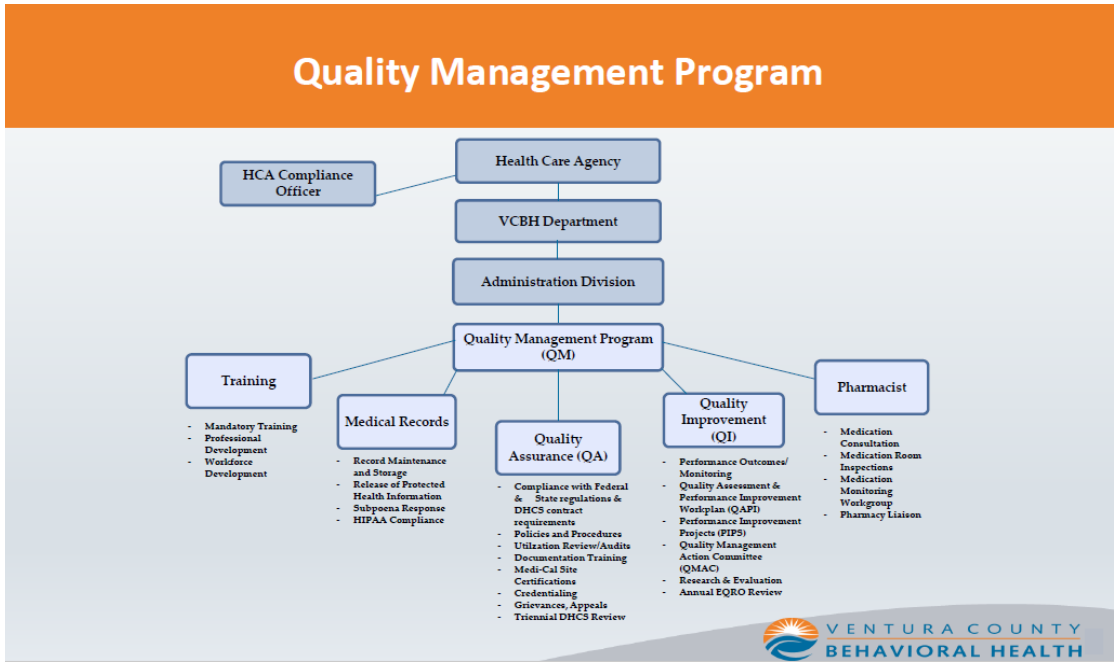
identified, QA staff make a report to the HCA Compliance Officer and assist with investigation activities, as needed, to identify procedures to prevent future incidents and resolve quality of care issues.

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 met in September 2020, December 2020, April 2021, and June 2021. Topics covered included care coordination post-residential discharge, grievances and appeals, and client engagement.

FY 20-21 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 2020-21 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.

2020-2021 QAPI Goals and Objectives

The Quality Assessment and Performance Improvement (QAPI) Work Plan goals for 2020-21 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 2020-2021 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 that involves many leaders across VCBH, as well as stakeholder input. Additionally, this year-end evaluation describes progress toward goals and objectives and 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 20-21 Planned Steps & Actions**	**FY 20-21 Evaluation/Update**
a. Consumers can request services at any outpatient service location **Division:** ☒SUS ☒MH **Responsible parties:** ▪ VCBH QM Team ▪ VCBH Regional Managers **Metric for progress:** 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. **Goal:** Analysis and summary of RFS by location, as well as mechanisms for regularly monitoring this, will be in place by June 30, 2021	SUS: • Monitor RFS data and communicate timeliness findings to operational staff. • Contract providers will input RFS data into the same EHR system used by county-operated 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.	SUS: • Location of RFS is tracked for SUS county-operated clinics and one contractor site. • 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. • A report on RFS by clinic location is regularly reviewed by the Treatment Services Manager and DMC-ODS Plan Manager. MH: • Operationally, consumers can request services at any outpatient service location. • Request for Services (RFS) tracking reports have been revised and are in place to allow for tracking by program.

I. Timely Access to Services

Goal: *Beneficiaries will have timely access to services.*		
Objective	**FY 20-21 Planned Steps & Actions**	**FY 20-21 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 <u>Metric for progress:</u> • Operational staff will have regular access to timely access reports. • Meetings will be scheduled to discuss results to determine successes, barriers and mechanisms for continued improvements. <u>Goal:</u> FY 20-21 Timely Access results will indicate maintenance or improvement of rates when reviewed at the conclusion of the fiscal year.	SUS: • Continued monitoring of 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. • Continue to share results with stakeholders and at the Quality Management Action Committee (QMAC). 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. • Continue to share results with stakeholders and at the Quality Management Action Committee (QMAC)	SUS: • See Table 1 for Assessment of Timely Access results, which show improvement in the % of clients meeting the 10-day standard for routine service and 2-day standard for urgent service. • Online data dashboards can be accessed by managers and clinic administrators to monitor current timeliness metrics, including time from RFS to first service and time from residential discharge to a lower level of care. • 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. This has significantly decreased the time for clients to access services. MH: • See Table 1a for FY 20-21 Assessment of Timely Access results • Two Timely Access reports that are focused on the time from RFS to first service are reviewed by operations staff to assess the number of requests that meet the 10-business day standard. o The first provides an overview of this data, including reasons why a RFS may not have resulted in a first service. o A second version of this report was created that includes more detail related to the program associated with the RFS and first service o QI monitors the use of these reports and supports further development, as identified. o Results are shared with stakeholders and at the Quality Management Action Committee (QMAC)

Table 1: FY 20-21 Timely Access to Substance Use Services compared to FY 19-20

Metric	DHCS Standard	% Meeting DHCS Standard					
		All Services		Adult Services		Children's Services	
		FY19-20	FY20-21	FY19-20	FY20-21	FY19-20	FY20-21
1. Initial request to first offered routine appointment (if tracked)	10 business days	N/A	90%	N/A	90%	N/A	90%
2. Initial request to first face to face routine visit/appointment	10 business days	53%	93%	55%	93%	38%	98%
3. Initial routine MAT request to NTP appointment/contact	3 business days	79%	70%	79%	70%	N/A	N/A
4. Service request for urgent appointment to actual face to face encounter	48 hours	51%	81%	50%	81%	60%	77%
5. Follow-up services post-residential treatment discharge	7 calendar days	7%	11%	7%	11%	N/A	0.0%

Table 2: FY 20-21 Timely Access to Mental Health Services compared to FY 19-20

Metric	DHCS Standard	% Meeting DHCS Standard							
		All Services		Adult Services		Children's Services		Foster Services	
		FY19-20	FY20-21	FY19-20	FY20-21	FY19-20	FY20-21	FY19-20	FY20-21
1. Initial request to first offered routine appointment	10 business days	79%	81%	86%	84%	71%	76%	79%	75%
2. Initial request to first rendered service	10 business days	67%	63%	70%	76%	59%	60%	53%	43%
3. Time to First Offered Non-Urgent Psychiatry Appointment	15 business days	75%	89%	80%	95%	62%	76%	67%	69%
4. Time to First Rendered Psychiatry Service	15 business days	n/a	64%	n/a	63%	n/a	65%	n/a	45%
5. Service request for urgent appointment to actual face to face encounter	48 hours	100%	74%	100%	74%	100%	76%	N/A	N/A
6. Follow-up services after psychiatric hospitalization	7 calendar days	65%	70%	44%	66%	72%	87%	86%	77%

I. Timely Access to Services

Goal: *Beneficiaries will have timely access to services.*		
Objective	**FY 20-21 Planned Steps & Actions**	**FY 20-21 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
 	
Metric for progress:
• Continue to monitor call-center metrics and share results with operations for improvement efforts. Progress towards implementation of test-call procedure similar to MH.
 	
Goal:
• Improve metrics related to timely access of call center (e.g., average wait time, % of dropped calls).
• By June 30, 2021 there will be a plan for conducting test calls for quality assurance monitoring, similar to MH.
	SUS:
	• 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).
	
	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.
	  ○ 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: 24 seconds
		  ○ Average call duration: 7m:09s (decrease of 1.5 minutes from FY 19-20)
		  ○ Percent calls dropped or abandoned: 25%. In the 15 months prior to the pandemic, the dropped call rate was 15%. However, dropped call rate increased substantially at the start of the Covid-19 pandemic due to shift to telehealth. Specifically, there was a glitch where agents had calls transferred remotely to their personal phones, and call registered as abandoned if the agent hung up before the client. Agents were trained to always wait for the client to hang up. Dropped call rates improved immediately after this process improvement was implemented. Dropped call rates for the months of June, July, and August 2021 were 11%, 3%, and 2% respectively, reflecting a decrease towards pre-pandemic numbers.
		
		• 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.
		• Monthly monitoring of access line metrics per DMC-ODS requirements, indicates performance is mostly consistent with similarly sized counties.
		• Report was identified for monitoring call source type (taken from RFS screening report).

		MH: • DHCS mandated test call results for FY 20-21 Quarters 1 -4: The 24/7 Access Line Test Call reports showed 100% compliance with each metric related to the access line staff responding to beneficiary appropriately. For the call log metric, results ranged from 68% to 87% in the first two quarters and 81%-100% in the last two. • 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.

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 20-21 Planned Steps & Actions**	**FY 20-21 Evaluation/Update**
a. VCBH will work with county partners (e.g., Gold Coast Health Care Plan, Tri-Counties) to strengthen collaboration and ensure quality in care coordination for shared beneficiaries. <u>Division:</u> ☒ SUS ☒ MH	• 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).	• VCBH representatives met with Gold Coast for contractual and operational purposes related to care coordination. • The MOA with Gold Coast was finalized. • Operationally, executive leadership for both MH and SUS communicate with partners on a regular basis, as needed.

<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. • MOA/Communication Plan in place by December 31, 2021		
b. Develop a Care Coordination Policy and train all staff on related procedures. <u>Division:</u> ☒ SUS ☒ MH <u>Responsible parties:</u> ▪ VCBH QM Team ▪ VCBH Executive Team ▪ VCBH Training Manager <u>Metric for progress:</u> Meetings to track and monitor progress and implementation <u>Goal:</u> Develop, implement and train staff on an integrated Coordination of Care Policy by December 31, 2021.	• Continue to gather stakeholder input to refine policy and procedure. • Integrate learnings from the Gold Coast meetings and contract revisions. ○ Estimated approval in 2021, with staff training to follow. • Tracking to monitor implementation and progress will be developed as part of the policy and procedure. • Integrate Coordination of Care tracking fields into the Electronic Health Record (EHR).	FY 20-21 Evaluation/Update • A Coordination of Care between care settings policy that will apply to both SUS and MH is was 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 20-21 Planned Steps & Actions**	**FY 20-21 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 Metric for progress: Develop and track milestones towards expanded structure. Goal: To assess needs and begin discussion and next steps with regard to OHED team expansion to support OHED related activities and tasks by June 30, 2021.	• 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.	• QI continues to meet with OHED to collaborate on research and evaluation of SUS and MH metrics, conduct SUS and MH specific needs assessment, and initiate outreach to schools on SUS and MH related topics. • A county-wide Health Equity Advisory committee is being formed and representatives from SUS and MH are being recruited to join. • OHED has grown into a team including an Equity Services Manager, Program Administrator, and Logrando Bienestar program who onboarded 5 additional Community Services Coordinators to serve more school districts and areas within the county with the goal of reaching unserved/underserved community members. • Team coverage has increased from 2 school districts to 13 throughout the county. Services focus on Santa Clara Valley, Oxnard, Hueneme, El Rio, and Ventura and have newly expanded focus to East County Latinx/ Indigenous communities.
	• Provide opportunities for input via the Cultural Equity Committee and other stakeholder groups.	Office of Health Equity Committee and Stakeholder Group Representation • Diversity Equity Inclusion Task Force (in development) • Action Plan Covid-19 Task Force- Led by PLAN and VCPH • VCOE Social Justice Task Force • VUSD Mental Health Committee • VCOE Director of Student Services Committee • Justice Community Collaborative Group • Youth Equity and Success Committee

		• Wellness Collaborative within all Ventura School Districts • Southern Region Equity Services Manager Collaborative Group • CCESJC ESM Onboarding Workgroup • Latinx Disparities Committee • Ventura County Quality Management Action Committee
	• If appropriate, hire additional staff and plan programs that support the provision of timely access to services and linkages in a culturally and linguistically appropriate way.	Recent offers placed for three Community Services Coordinators who are trilingual (Mixteco Alto, Spanish, English) (Mixteco Bajo, Spanish, English). Bringing experience with human services outreach/public health outreach/community education experience via Mexican Consulate (Ventania de Salud program). Knowledge of human resources programs such as Medi-Cal, Cal-Fresh, and Cal-Works. Other considerations were equitable gender representation.

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 20-21 Planned Steps & Actions**	**FY 20-21 Evaluation/Update**
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	• Revise 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. Submitted to DHCS March 2021. • The CCP 3 Year Plan (2018-2021) is under review to determine update needs. • Logrando Bienestar program evaluation data points and overall monitoring developed, and evaluation was recently completed.

▪ VCBH Executive Team Metric for progress: Updated Cultural Competency Plan (CCP) Goal: Ongoing evaluation to examine and update areas as needed to reflect current needs and practices will occur in FY 20-21.		

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 20-21 Planned Steps & Actions**	**FY 20-21 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 Metric for progress: Tracking of meetings about and mechanisms for building out contractor use of Avatar for RFS. Goal: All willing contracted providers will be able to access the RFS form for referrals to SUS services by December 31, 2021.	• Assess contracted providers to determine their desire to use the RFS form • Based on interest, establish access, provide trainings on use, then support implementation. • Explore feasibility of and interest in other options for expanded access or use of Avatar for contracted providers (e.g., view only access to client records).	• One contracted provider (Alternative Action Programs) currently uses the new RFS screening tool. • To date, all willing contract providers are able to use the new RFS form.

V. Beneficiary Outcomes and Satisfaction with Services

Goal: *Effectively collect outcomes data to measure service effectiveness*.		
Objective	**FY 20-21 Planned Steps & Actions**	**FY 20-21 Evaluation/Update**
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 for outpatient treatment, and d) annually for Narcotic Treatment Programs. Division: ☒ SUS ☐ MH Responsible parties: ▪ VCBH Substance Use Services Leads ▪ VCBH QM 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 FY20-21.	• Produce quality performance reports/dashboards to monitor compliance and implement a process for utilizing results for quality improvement. • Clinic administrators will continue to 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.	• Biweekly Level of Care (LOC) reports are 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 Metrics. Analysis indicates that the match between indicated and actual level of care placement for initial ASAM assessment was 82% for FY 21-22, indicating a very high level of accuracy for assessments. • Clinic administrators review automated reports of when assessments are due to ensure they are completed on time.

V. Beneficiary Outcomes and Satisfaction with Services

Goal: *To increase beneficiary satisfaction.*		
Objective	**FY 20-21 Planned Steps & Actions**	**FY 20-21 Evaluation/Update**

a. Maintain consumer perception survey administrations biannually (MH) or annually (SUS) as required by DHCS and utilize results for quality improvement efforts related to beneficiary satisfaction.
 	
<u>Division:</u>
☒ SUS ☒ MH
 	
<u>Responsible parties:</u>
▪ VCBH Substance Use Services Division Leads
▪ VCBH QM Team
 	
<u>Metric for progress:</u>
Reports of the number of surveys collected per tool and administration period and summary reports, providing detail by site where possible, will demonstrate success.
 	
<u>Goal</u>:
Continued efforts to maximize client response rate, analysis and reporting, and use of findings for quality improvement efforts will occur in FY 20-21.
	SUS:
	• Plans to optimize survey delivery and response rates given implementation barriers due to the COVID-19 pandemic.
	• Continue to analyze quantitative and qualitative data to identify service highlights and areas for improvement.
	• Follow up with SUS leadership to plan for dissemination of survey results to staff at county and contractor sites.
	
	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.
		SUS:
		In FY 20-21 progress was made standardizing a process for reviewing, communicating, or utilizing results of SUS TPS perceptions survey.
		• Findings from the Fall 2020 Treatment Perceptions Survey (TPS) Administration period
		  ○ Number of responses (*N* = 239) was lower compared to the previous year (*N* = 681), due to the procedural changes in survey administration post-COVID-19.
		  ○ Findings were uniformly high across items (*M* = 4.4 / 5.0)
		  ○ Comments indicated overall high satisfaction with services.
		• Results of the TPS were shared with VCBH management, line staff, and contracted providers.
		• We developed strategies to increase the response rate for the 2021 TPS. One strategy was for survey administrators to speak to clients directly at the end of group counseling sessions to encourage participation. Preliminary results indicate that this strategy was effective in increasing the number of online responses.
		
		MH
		• In spite of several improvements made during FY 19-20 to improve the survey distribution and collection process and create efficiencies to ensure the highest return rates possible, the Spring 2020 consumer perception survey administration period was impacted by COVID-19 needs and response rates were lower than expected.
		• The QI team prepared an executive report summarizing the results of the Spring 2020 administration period. Key findings include:

		○ Overall, the majority of the consumers rated VCBH services above the 3.5 threshold/goal ○ Most satisfaction rates are above 70% ○ There are less reported school suspensions/expulsions and arrests ○ There was a great number of consumer participation • This report has been shared with VCBH management, line staff and contracted providers.

Objective	FY 20-21 Planned Steps & Actions	FY 20-21 Evaluation/Update
▪ Administer the Treatment Perceptions Survey (TPS) to adult and youth Mental Health beneficiaries annually and at discharge. Utilize results for quality improvement efforts related to beneficiary satisfaction. <u>Division:</u> ☐ SUS ☒ MH <u>Responsible parties:</u> ▪ VCBH Adult Division Leads ▪ VCBH Youth & Family Division Leads ▪ VCBH QM Team <u>Metric for progress:</u> Trainings will have been provided to support expanded use. Reporting structures will be in place to monitor completion rates, due dates, and present survey findings. <u>Goal</u>: Continue administration, training and support for expanded administration, and build reporting structures by December 31, 2021.	• 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.	Due to the provision of services via telehealth and phone, fewer TPS were collected in FY20-21. The Youth and Families division initially halted collection of the Youth-TPS but relaunched early in FY 21-22. Adult Services Mental Health: • Division continues to administer the 14 item Treatment Perceptions Survey (TPS). • In FY 20-21, 1,156 TPS surveys were completed at the following timepoints: ○ Annual: 1,071, 92.6% ○ Discharge: 85, 7.4% **Domain** / **Average Score** (1-5)** Access — 4.35 Quality — 4.43 Care Coordination — 4.29 Outcome — 4.27 General Satisfaction — 4.41 ** Higher average score reflects greater agreement

		Youth and Family Services Mental Health:
		• In FY 20-21, 188 Youth-TPS surveys were completed at the following timepoints:
		  ○ Annual: 83, 44.1%
		  ○ Discharge: 101, 53.7%
		  ○ Administration period not reported: 4, 2.1%

Domain	Average Score** (1-5)
Access	4.63
Quality	4.65
Therapeutic Alliance	4.68
Care Coordination	4.56
Outcome	4.47
General Satisfaction	4.68

** Higher average score reflects greater agreement

VI. Utilization Review of Overutilization of Services

Goal: *Identify High-Cost Beneficiaries and employ interventions, as indicated, to reduce excessive service utilization.*		
Objective	FY 20-21 Planned Steps & Actions	FY 20-21 Evaluation/Update
a. High-Cost Beneficiaries (HCB) clients will be reviewed quarterly at the Quality of Care meeting <u>Division:</u>	SUS: • Create system for analyzing patterns of HCB based on demographics and treatment needs. • Review current data and build mechanisms to identify over- and under- utilization.	SUS: • HCB's are identified and reported on as part of SUS Year 1 Required Performance Measures. • Number of high-cost beneficiaries (HCB) for CY 2020: 24, or .7% of total clients served for CY 2020. This compares favorably to 6.9% statewide.

☒ SUS ☒ MH Responsible parties: ▪ VCBH QM Team ▪ VCBH UR Team ▪ VCBH Fiscal and Billing Teams Metric for progress: Monitoring of claims data and reporting of HCB to operational and executive staff. Goal: All HCBs will be identified through ongoing reporting and evaluation and reviewed quarterly by June 30, 2021.	• Underutilization will be 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. MH: • Develop HCB Avatar reports (MH) for tracking and review by Compliance and Utilization Review team and operations. • Create system for analyzing patterns of HCB based on demographics and treatment needs. • Review current data and build mechanisms to identify over- and under- utilization. • Underutilization will be 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.	MH: • Currently not employing a standardized review process • Due to the impact of COVID-19 this objective was not addressed during this year; the goal will carry over into FY 21-22.

VII. Grievances and Appeals

Goal: *VCBH will monitor and respond to beneficiary grievances and appeals in a timely and systematic manner.*		
Objective	**FY 20-21 Planned Steps & Actions**	**FY 20-21 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	• 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	• The Grievance Form is now included in the intake packet that every client receives. • On the Consent to Treatment form, clients are now asked to acknowledge that they have been informed about and received the Notice of Problem Resolution Processes • 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.

<u>Metric for progress:</u> Meetings and review of recent Grievances and appeals logged into Avatar and response letters. <u>Goal:</u> Continue to expand implementation and monitoring of updated system for processing and responding to grievances and appeals, per QM 18		• Two licensed behavioral health clinicians are assigned to oversee the problem resolution processes. • 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.
Objective	**FY 20-21 Planned Steps & Actions**	**FY 20-21 Evaluation/Update**
b. Create and implement continuous quality improvement practices based on issues and themes identified in grievances and appeals. <u>Division:</u> ☒ SUS ☒ MH <u>Responsible Parties:</u> ▪ VCBH QM Team ▪ VCBH QI Team ▪ VCBH Operational Leads <u>Metric for progress:</u> Meeting records and documented process improvement efforts and outcomes. <u>Goal:</u> 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 FY20-21.	• Conduct analysis of CY 2020 grievances and share findings. • Continue to develop process for analyzing, reporting and implementing process improvement strategies in response to grievances and appeals.	• Quality Management and Quality Improvement have established a long-term plan for collaborative data analysis and monitoring of grievances and appeals. • Quality Improvement conducted an independent analysis to identify patterns in the CY2020 grievances data and presented findings to QM staff and at a QMAC in June 2021.

VIII. Employee Engagement

Goal: *Enhance employee satisfaction by utilizing yearly Employee Engagement Survey findings to develop action steps.*		
Objective	**FY 20-21 Planned Steps & Actions**	**FY 20-21 Evaluation/Update**
a. Distribute 2nd annual Employee Engagement Survey then analyze, share results and create plan of action based on findings. 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 by June 30, 2021.	• Distribute the 2020 Employee Engagement Survey, conduct analysis, and share results. • Based on key findings, collaborative action planning with employees will occur. • Results of collaborative actions will be reviewed with the VCBH executive team and shared department-wide.	• 2nd Annual VCBH Employee Engagement Survey was sent to all VCBH employees in December 2020. • Data were analyzed and an executive summary of findings was shared with the department in June of 2021. • 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 and action steps based on their recommendations are being finalized.