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

Quality Assessment and Performance Improvement

FY 2020-2021 Work Plan

Updated February 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. 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 2019-20 QAPI did not occur 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.

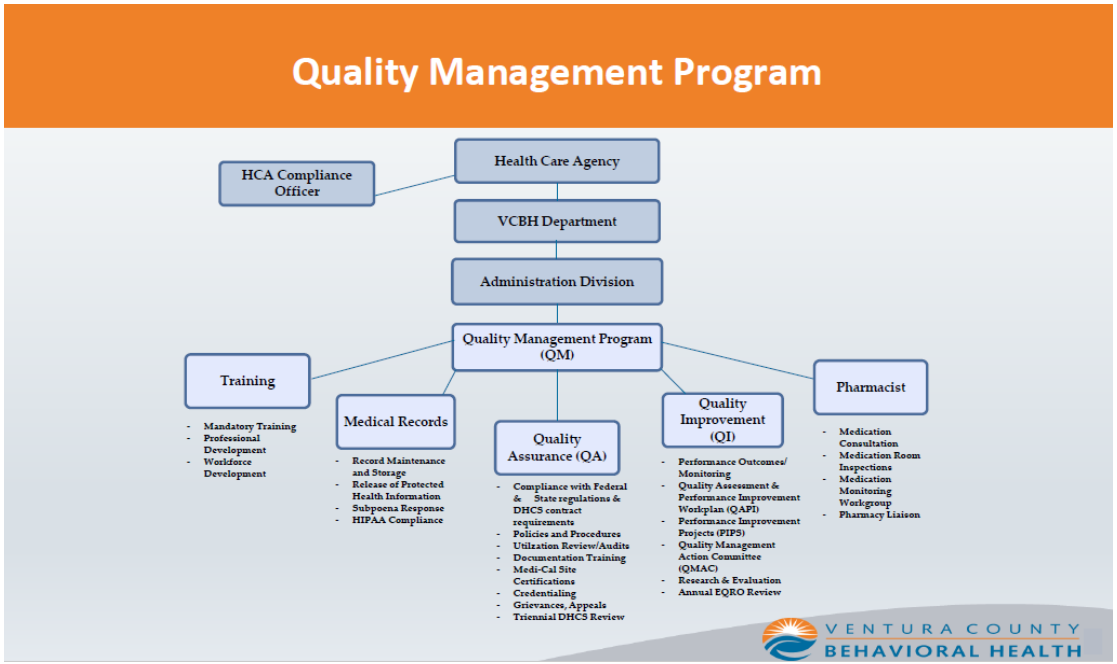
Quality Assurance (QA) – QA activities include monitoring compliance with contract requirements, federal and state regulations, and Department policies and procedures. QA staff are responsible for policy and procedure development; utilization review (UR); inpatient and outpatient service authorization; 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 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 20-21 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 2020-21 are summarized as follows:

Non-Clinical

- *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.

- *Mental Health (Concluded August 2020) - 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.
    - 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.

- *Mental Health (In Development) – Client Progress Summary Performance Improvement Project*. Goal: Enhance client engagement and satisfaction through the use of a Client Progress Summary tool that displays client status and progress and supports collaborative service and treatment planning.

Clinical PIPs

- *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.

- *Mental Health (Active) - Post-Hospitalization Case Management Performance Improvement Project*. 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 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 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, 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	**Measurement / Metrics**	**FY 20-21 Planned Steps & Actions**
a. Consumers can request services at any outpatient service location Division: ☒SUS ☒MH Responsible parties: ▪ VCBH QM Team ▪ VCBH Regional Managers	Current State: MH: • Operationally, consumers can request services at any outpatient service location. • Request for Services (RFS) tracking reports have been revised to allow for tracking by program. However, training related to the use of these forms has been limited due to the impact of COVID. 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. Method: 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: Analysis and summary of RFS by location, as well as mechanisms for regularly monitoring this, will be conducted by June 30, 2021	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: • 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**	**FY 20-21 Planned Steps & Actions**
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>Current state:</u> MH: • See Table 1a for FY 18-19 & FY 19-20 Assessment of Timely Access results • Two Timely Access reports that are focused on the time from RFS to first service were developed in 19-20. They demonstrate 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 Operations were informed of the availability of the reports and QI will monitor their use and support further development, as identified. SUS: • See Table 1b for FY 18-19 & FY 19-20 Assessment of Timely Access results. • In FY19-20 a timeliness report was built and tested in VCBH's EHR system. It is available to all operational and QI staff on demand. o The report can be filtered by request type (urgent vs routine), time period, assessment site, and demographics. o Report helped to identify successes and areas for continued improvement. o Several of the identified barriers have been 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. <u>Method</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 20-21 Timely Access results will indicate maintenance or improvement of rates when reviewed at the conclusion of the fiscal year.	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: • 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 • Share results with stakeholders and at the Quality Management Action Committee (QMAC)

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 offered psychiatry appointment	15 business days	n/a	75%	n/a	80%	n/a	62%	n/a	67%
4. Initial request to first psychiatry appointment	15 business days	23%	n/a	26%	n/a	12%	n/a	17%	n/a
5. Service request for urgent appointment to actual encounter	48 hours	100%	100%	100%	100%	n/a	n/a	n/a	n/a
6. Follow-up appointments post-psychiatric inpatient discharge	7 calendar days	47%	65%	44%	44%	73%	72%	86%	86%

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**	**FY 20-21 Planned Steps & Actions**
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	Current state: MH: • DHCS mandated 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. 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: • Monthly monitoring of access line metrics per DMC-ODS requirements, indicates performance is mostly consistent with similarly sized counties. • SUS Call Center tracking shows the following: o Average wait time: 19 seconds (decrease of 6 seconds from FY 18-19) o 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). o Average call duration: 7m:23s (decrease of 2 minutes from FY 18-19) o 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. Method: 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:	MH: • On a quarterly basis, Test Call team will: o Ensure sub-contractor test calls are high-quality and meet criteria being assessed. o 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. 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: 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: Continue to monitor call-center metrics and share results with operations for improvement efforts. Progress towards implementation of test-call procedure similar to MH. <u>Goal:</u> MH: • DHCS test call requirements will continue to be met 90-100% for each Quarterly report in FY 20-21. • By June 30, 2021, there will be a plan for tracking call center metrics similar to SUS. SUS: • 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 implementing test calls similar to MH.	

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**	**FY 20-21 Planned Steps & Actions**
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	<u>Current state</u>: • In FY 19-20, VCBH representatives met on with Gold Coast for contractual and operational purposes related to care coordination. • The MOA with Gold Coast is currently in the process of being revised. • Operationally, executive leadership for both MH and SUS communicate with partners on a regular basis, as needed. <u>Method:</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. • Communication Plan in place by December 31, 2021	• 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)

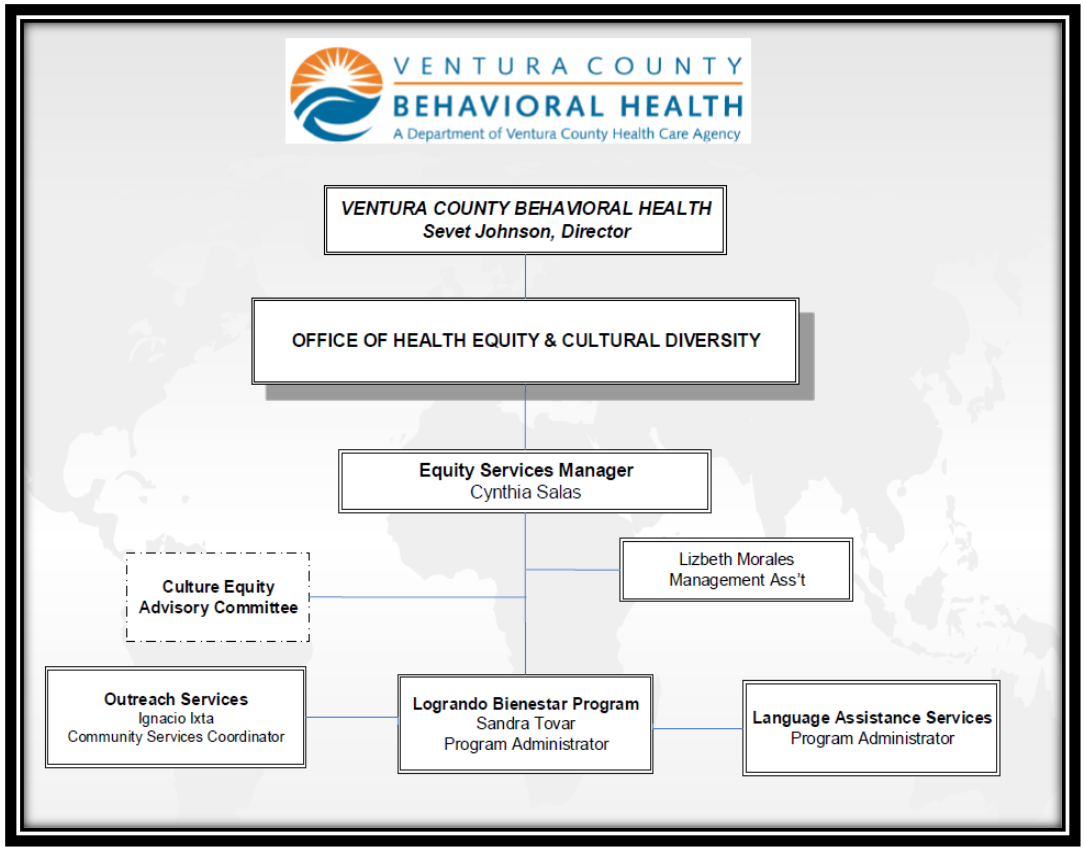
Responsible parties: ▪ VCBH Executive Team ▪ VCBH QM Team ▪ VCBH Contracts Team ▪ Collaborative Partners and Administrators		
b. Develop a Care Coordination Policy and train all staff on related procedures. Division: ☒ SUS ☒ MH Responsible parties: ▪ VCBH QM Team ▪ VCBH Executive Team ▪ VCBH Training Manager	Current state: • A Coordination of Care between care settings policy that will apply to both SUS and MH is in development. o The Initial draft was completed March 2020. o The 2nd draft was completed in November 2020 o The 3rd draft is currently being revised. o The policy will include operational guidelines for both MH and SUS implementation. Elements of the current SUS policy (SUTS 02) will be integrated. Method: Meetings to track and monitor progress and implementation Goal: 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. o 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).

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**	**FY 20-21 Planned Steps & Actions**
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.	Current state: See Figure 1 OHED Organization Chart for structure as of February 2020. • OHED is currently composed of the Equity Services Manager and 1 Program Administrator who completes invoices for linguistic services and oversees the Logrando Bienestar program expansion. o The Logrando Bienestar program has 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. Method: Develop and track milestones towards expanded structure.	• 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.

Division: ☒ SUS ☒ MH Responsible parties: ▪ VCBH OHED Manager ▪ VCBH Executive Team	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.	• 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. • Begin to create an education section within OHED and a specific team assigned to linguistic needs.

Figure 1: 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**	**FY 20-21 Planned Steps & Actions**
b. 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: • The Cultural Competency 3 Year Plan (2018-2021) 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 Method: Updated Cultural Competency Plan Goal: Ongoing evaluation to examine and updates areas as needed to reflect current needs and practices will occur in FY 20-21. .	• Revise Cultural Competency Plan and continue to build mechanism for tracking, evaluating and updating the plan on an ongoing basis.

VI. Contract Provider Information Workflow Improvement

Goal: *All agreeable contracted providers will have expanded use of VCBH's Electronic Health Record (EHR) Avatar system*		
Objective	**Measurement / Metric**	**FY 20-21 Planned Steps & Actions**
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: • The implementation of COVID-19 protocols has halted FY19-20 progress on this objective. • Continuing to explore and expand options for contracted providers to use the Avatar system to complete a request for services (RFS). Method: 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 MH or 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).

V. Beneficiary Outcomes and Satisfaction with Services

Goal: *Effectively collect outcomes data to measure service effectiveness.*		
Objective	**Measurement / Metric**	**FY 20-21 Planned Steps & Actions**
a. Ensure all MH adult consumers have a Milestones of Recovery Scale (MORS) and BASIS evaluation tool administered annually and at discharge. Division: ☐ SUS ☒ MH	Current state: • MORS was implemented July 2019 and first year of implementation was impacted by operational changes in response to COVID-19. However, progress was made in FY19-20. • Prior to the implementation MORS, VCBH staff were trained in the use of the tool for tracking client recovery. ○ To support ongoing training needs, selected staff have participated in the MORS train the trainer program. • The VCBH Avatar Team developed a MORS screen in the Avatar system allowing VCBH staff to enter the MORS scores. • 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	• 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.

Responsible parties: ▪ VCBH Adult Division Leads ▪ VCBH QI Team ▪ VCBH Avatar Team	rates in each category are lower than expected. The types of MORS were as follows: o Admission: (1431, 36%) o Annual: (1341, 33%) o Discharge: (223, 6%) o Type Missing: (761, 19%) • For FY 19-20, a total of 701 BASIS*Plus+* assessments were completed. They included conducted at the following timepoints. o Admission: (320, 46%) o Annual: (348, 49%) o Discharge: (33, 5%) <u>Method</u>: MORS and Basis Avatar reports that monitor due date, completion rates, and results for operational and data analysis and reporting. <u>Goal</u>: Improve MORS and Basis completion rates and create reports for monitoring and reporting by December 31, 2021.	
b. 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 ▪ VCBH Avatar Team	<u>Current state</u>: • Implementation of CANS and PSC-35 began October, 2018; data are entered into Avatar and some reporting structures exist. • 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. • Report development currently in progress; creating multiple versions of CANS reports to demonstrate both individual and program level data. <u>Method</u>: CANS and PSC-35 reports that monitor due date, completion rates, and results for operational and data analysis and reporting. <u>Goal</u>: Improve CANS and PSC-35 completion rates and create/expand reports for monitoring and reporting by December 31, 2021.	• Continue with and expand the production of quality performance reports/reports/dashboards to monitor compliance and convey results.

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	FY 20-21 Planned Steps & Actions
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: • 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. Method: 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 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**	**FY 20-21 Planned Steps & Actions**
a. **Administer the adult Treatment Perceptions Survey (TPS) to adult MH beneficiaries annually and at discharge.** Division: ☐ SUS ☒ MH Responsible parties: ▪ VCBH Adult Division Leads ▪ VCBH QM Team	Current state: • 14 item Treatment Perceptions Survey (TPS) was adopted August 2019; the TPS replaced the previously administered 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: o Annual: (719, 51%) o Discharge: (57, 4%) o Administration 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. Method: Reporting structures to monitor completion rates, due dates, and present survey findings. Goal: Continue administration, 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.

V. Beneficiary Outcomes and Satisfaction with Services

Goal: *To increase beneficiary satisfaction.*		
Objective	**Measurement**	**FY 20-21 Planned Steps & Actions**
b. **Administer the Youth and Family Treatment Perceptions Survey**	Current state: • 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:	• Provide continued support for the implementation of the TPS according to the administration guide to increase the number of surveys collected annually.

<table>
<tr>
<td>(TPS) to youth and family MH beneficiaries annually.

Division:
☐ SUS ☒ MH

Responsible parties:
▪ VCBH Youth & Family Division Leads
▪ VCBH QM Team</td>
<td>
<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

Method: Trainings provided to support expanded use. Reporting structures to monitor completion rates, due dates, and present survey findings.

<u>Goal</u>: Continue administration, support for expanded administration, and build reporting structures by December 31, 2021.
</td>
<td>• Build and analyze reports to monitor survey implementation and share survey findings.</td>
</tr>
<tr>
<td>c. 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.

Division:
☒ SUS
☒ MH

Responsible parties:
▪ VCBH Adult Division Leads</td>
<td><u>Current state</u>:
In FY 19-20 great progress was made standardizing a process for reviewing, communicating, or utilizing results of MH and SUS perceptions survey. Description follows:

MH:
• In FY 19-20 several improvements were made to improve this survey distribution and collection process and create efficiencies to ensure the highest return rates possible.
o The Spring 2020 administration period was impacted by COVID-19, but still data were collected and are being analyzed.
• The QI team has prepared 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
• This report, as well as one summarizing the Spring 2020 administration period are being shared with VCBH management, line staff and contracted providers.

SUS:</td>
<td>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:
• 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.</td>
</tr>
</table>

▪ VCBH Youth & Family Division Leads
▪ VCBH Substance Use Services Division Leads
▪ VCBH QM Team
	• Findings from the Fall 2019 TPS Administration period
	  o 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.
	  o Findings were uniformly high across items (*M* = 4.4 / 5)
	  o Comments indicated overall high satisfaction with services
	  o Focus areas for improvement include access (transportation and location) and coordination with mental health providers
	• Results of the TPS are being shared with VCBH management, line staff and contracted providers
	
	Method: 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: Continued efforts to maximized client participation in perceptions, enhanced analysis and reporting, and use of findings for quality improvement efforts will occur in FY 20-21.	

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**	**FY 20-21 Planned Steps & Actions**
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	Current state: 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 20-21. SUS: • HCB's are identified and reported on as part of SUS Year 1 Required Performance Measures. Method: MH: • Avatar report and standing agenda item at quarterly Compliance and Utilization Review meetings. SUS:	• 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.

▪ VCBH Fiscal and Billing Teams	• Monitoring of claims data and reporting of HBC to operational and executive staff. Goal: • All HCBs will be identified through ongoing reporting and evaluation and reviewed quarterly by June 30, 2021.	

VII. Grievances and Appeals

Goal: *VCBH will monitor and respond to beneficiary grievances and appeals in a timely and systematic manner.*		
Objective	**Measurement / Metric**	**FY 20-21 Planned Steps & Actions**
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: • In January 2020, QM 18 "Beneficiary Problem Resolution Processes: Grievances, Appeals and Expedited Appeals" Policy and Procedure was updated and the procedures and operational guideline were revised to clarify state and county requirements. • In FY19-20 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. • 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. Method: Meetings and review of recent Grievances and Appeals logged into Avatar and response letters. Goal: Continue to expand implementation and monitoring of updated system per QM 18 throughout FY20-21.	• 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
b. Create and implement continuous quality improvement practices	Current state: • See FY19-20 QAPI Evaluation for further details of grievance themes in CY 2019. • In FY19-20, the system for analyzing and utilizing information from grievances and appeals was established.	• Conduct analysis of CY 2020 grievances and share findings.

based on issues and themes identified in grievances and appeals. Division: ☒ SUS ☒ MH Responsible Parties: ▪ VCBH QM Team ▪ VCBH QI Team ▪ VCBH Operational Leads	• 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. o Feedback from QMAC stakeholders will inform process improvements to the grievance and appeal processes. Method: 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 FY20-21.	• Continue to develop process for analyzing, reporting and implementing process improvement strategies in response to grievances and appeals.

VIII. Employee Engagement

Goal: *Enhance employee satisfaction by utilizing yearly Employee Engagement Survey findings to develop action steps.*		
Objective	**Measurement / Metric**	**FY 20-21 Planned Steps & Actions**

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 VCBH Employee Engagement survey was distributed, analyzed, reported in 2019. Actions steps/goals were identified and began to be implemented throughout 2020.
	• The action steps are:
	  o Create a standing section on Employee Engagement in the VCBH quarterly newsletter.
	  o Embark on the development of a VCBH orientation and onboarding process.
	  o Communicate the "why" in the rollout of new or updated policies and procedures or operational processes
	• Progress towards each action step was made as detailed in the FY19-20 QAPI Evaluation
	
	Method: Ongoing monitoring and assessment of action step implementation.
	
	Goal:
	• Continue to make marked progress on each of the 2019 Action Steps throughout FY 20-21
		• Continue to implement and make progress on each action steps, involving employees for feedback, where applicable.
		• Monitor progress on each action step, refocusing when needed.
		• Communicate progress and outcomes of efforts to employees.

VIII. Employee Engagement

Goal: *Enhance employee satisfaction by utilizing yearly Employee Engagement Survey findings to develop action steps.*		
Objective	**Measurement / Metric**	**Planned Steps & Actions**
b. 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	Current state: 2nd Annual VCBH Employee Engagement Survey will was sent to all VCBH employees in December 2020. Method: Evidence of survey distribution, results report, and action planning will demonstrate success. Goal: Analysis, 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.