VENTURA COUNTY

BEHAVIORAL HEALTH

A Department of Ventura County Health Care Agency

Quality Assessment and Performance Improvement (QAPI)

FY 2021-2022 Work Plan Evaluation

Updated October 2022

Prepared by VCBH Quality Improvement – vcbh.quality@ventura.org

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 (see description below) 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 this annual Quality Assessment and Performance Improvement (QAPI) Work Plan Evaluation is to update the working document used to guide monitoring, implementation, and documentation of efforts to improve service delivery for both Mental Health and Substance Use Services programs and services from VCBH. The evaluation also informs the development on the QAPI Work Plan for 2022-23.

In response to COVID-19, clinical operations were modified, beginning March 2020 and conitnuening in some part to today, moving some services to telehealth and enabling staff to telecommute if and when possible. In addition, leadership from administrative and clinical divisions were compelled to shift their attention to matters 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 anticipated; consequently, some of these previous goals were being carried forward into the FY 2021-22 plan and are now being evaluated.

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 and SUS 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 now also convenes smaller, topic-focused meeting, named the QMAC Special Interest Group or Q-SIG to allow for deeper discussion.

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 provided the framework for monitoring, implementing, and documenting of efforts to improve VCBH service delivery across the continuum of Mental Health (MH) and Substance Use Services (SUS) divisions.
These goals, and accompanying objectives, were embedded at the operational program level and address overarching priorities related to improving access, timeliness, quality of care, health equity, and acuity levels. The specific QAPI goal focus areas for FY 2021-2022 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 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. This QAPI Work Plan Evaluation provides an update on progress toward, or accomplishment of the 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

<table>
<tr><th colspan="3">Goal: Beneficiaries will have timely access to services.</th></tr>
<tr><th>Objective</th><th>FY 21-22 Planned Steps & Actions</th><th>FY 21-22 Evaluation/Update</th></tr>
<tr>
<td>a. Consumers can request services at any outpatient service location

<u>Division:</u>
☒SUS ☒MH

<u>Responsible parties:</u>
▪ VCBH QM Team
▪ VCBH Regional Managers

<u>Metric for progress:</u>
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.

<u>Goal:</u>
Conduct analysis and summary of RFS by location, as well as mechanisms for regularly monitoring this (targeted completion: June 30, 2022).</td>
<td>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.</td>
<td>SUS:
• RFS metrics for outpatient services, including time from RFS to first offered appointment and time from RFS to 1st rendered appointment, are reported on at least biannually. Currently this data is tracked for all county-operated sites and one contractor site.
• A new RFS screening tool was implemented in June 2020. While this allowed more assessment data to be collected in the initial screening, it also required the client to spend more time on the phone. Starting in March 2022, the new RFS screening was streamlined to take less time while still helping to capture more assessment data than the previous form.
• A report on RFS by clinic location is regularly reviewed by the Treatment Services Manager.

MH:
• Refining data used in reporting and the use of RFS data continues to ensure accuracy and applicability of results.
• With the implementation of California Advancing and Innovating Medi-Cal (CalAIM), the “No Wrong Door” initiative was implemented January of 2022.</td>
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I. Timely Access to Services

Goal: *Beneficiaries will have timely access to services.*		
Objective	FY 21-22 Planned Steps & Actions	FY 21-22 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 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: • See Table 1 for Assessment of Timely Access results, which show improvement in the % of clients meeting the standard for first Narcotic Treatment Program (NTP) service and standard for follow-up service after residential discharge. • Table 1 indicates a slight decrease in the % of clients meeting the standard for routine service, and a large decrease in the % of clients meeting the standard for urgent service. These decreases are partially due to continued refinement of the methodology for measuring time to service; additionally, requests for urgent services for the reporting period make up a very small proportion of total requests for service (7% overall and 3% for youth). • QI worked with Electronic Health Records (EHR) staff to create an automated report to facilitate more regular monitoring of timeliness data. This report is in the final stages of testing. • Clinic administrators are provided with timeliness findings on a biannual basis and are encouraged to 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. ○ Within the Youth & Family division, the Engagement after Assessment non-clinical PIP is focused on creating efficiencies in the notification process

		between the assessment team and clinic teams with the goal of decreasing the time to first outpatient service; for this effort, an automated report has been created to allow for more visibility on the assessment, appointment completion, and no-show status. o The timeliness from the Request for Service (RFS) to assessment is shared with the staff of Front Door programs monthly to identify any gaps in services and inform areas of improvement. o The clinical MH PIP has improved communication between the IPUs and VCBH through the implementation of a care coordination team. Through the efforts of the PIP and the care coordination team, all hospitalizations are tracked and information is relayed to clinics in order to ensure clients receive outpatient follow-up in a timely manner. • Table 2 below shows a comparison of MH timeliness measures from FY20-21 to FY21-22. o A marked decrease in time to routine and urgent services is observed, and can be attributed to high staff vacancy rate following the pandemic. o Operational changes have been made and recruiting efforts have been strengthened to combat this workforce shortage.

Table 1: FY 21-22 Timely Access to Substance Use Services compared to FY 20-21

Metric	DHCS Standard	% Meeting DHCS Standard					
		All Services		Adult Services		Children's Services	
		FY 20-21	FY 21-22	FY 20-21	FY 21-22	FY 20-21	FY 21-22
1. Initial request to first offered routine appointment (if tracked)	10 business days	89.9%	90.5%	89.9%	90.1%	89.6%	85.6%
2. Initial request to first face to face routine visit/appointment	10 business days	93.4%	78.3%	92.7%	79.3%	98.1%	70.0%
3. Initial routine MAT request to NTP appointment/contact	3 business days	69.8%	81.4%	69.8%	81.4%	N/A	N/A
4. Service request for urgent appointment to actual face to face encounter	48 hours	80.5%	53.5%	80.7%	55.9%	77.3%	16.7%
5. Follow-up services post-residential treatment discharge	7 calendar days	11.1%	14.3%	11.3%	14.3%	0.0%	N/A

Table 2: FY 21- 22 Standards for Timely Access to Mental Health Services Compared to FY 20-21

Metric	DHCS/MHP Standard	% Meeting DHCS Standard					
		All Services		Adult Services		Children's Services	
		FY20-21	FY21-22	FY20-21	FY21-22	FY20-21	FY21-22
1. Initial request to first offered routine appointment	10 business days	81%	57%	84%	62%	76%	52%
2. Initial request to first rendered service	10 business days	68%	44%	76%	51%	60%	37%
3. Time to first offered non-urgent psychiatry appointment	15 business days	89%	77%	95%	95%	76%	63%
4. Time to first rendered psychiatry service	15 business days	64%	38%	63%	28%	65%	46%
5. Service request for urgent appointment to first offered appointment	48 hours	74%	70%	74%	71%	76%	67%
6. Follow-up services after psychiatric hospitalization	7 calendar days	70%	90%	66%	89%	87%	94%

I. Timely Access to Services

<table>
<tr><th colspan="3">Goal: Beneficiaries will have timely access to services.</th></tr>
<tr><th>Objective</th><th>FY 21-22 Planned Steps & Actions</th><th>FY 21-22 Evaluation/Update</th></tr>
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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.
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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, at a rate of at least 3 per month.

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.
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SUS:
• SUS Call Center tracking shows the following:
    ○ Average wait time: 43 seconds
    ○ Average call duration: 11m:36s
    ○ Percent calls abandoned: 20%.
• These figures indicate increases compared to the previous FY. These are due to a shift in the screening process starting in March of 2022. The change, combined with consistently high demand for services, resulted in longer wait times than usual. The dropped call rate increased due to agents spending more time on each call and longer times on hold when clients first call. Hence current figures are not entirely representative of system performance. For example, in the year prior to the new screening process, the dropped call rate was much lower at 12%.
• Access Line has been merged with call center for VCBH Mental Health in July 2021.
• SUS-specific test call protocols were developed and patterned after similar protocols for MH.
• VCBH staff started test calls for SUS in November 2021. There were 21 test calls made between then and the end of FY 21-22, meeting the target rate of 3 test calls per month.
• Regular analysis of test call data is planned for the next FY.
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		MH:
		• Beginning in July 2021 the test calls are being made by a team of VCBH staff, instead of contractors.
		  ○ The Test Call team developed and implemented training or these staff and monitors calls.
		  ○ 10 Spanish and English calls are made every month, and each call simulates calls that the Crisis and Access line team receive, namely: specialty mental health requests/inquiries, urgent situations, and grievances.
		• The Test Call team continues to review and report quarterly data to DHCS.
		  ○ Areas identified in the report as 'in need of improvement' are addressed by Access Line management and staff.

Goals continue on next page

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 Evaluation/Update
a. **VCBH will work with county partners (e.g., Gold Coast, Tri-Counties) to strengthen collaboration and ensure quality in care coordination for shared beneficiaries.** Division: ☒ SUS ☒ MH Responsible parties: ▪ VCBH Executive Team ▪ VCBH QM Team ▪ VCBH Contracts Team ▪ Collaborative Partners and Administrators Metric for progress: 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. Goal: • 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. • Driven by changes implemented by CalAIM initiatives, there has been increased collaboration with partners, including Gold Coast starting in Spring of FY21-22 and monthly care coordination meetings with Beacon. • Reflective of the changes to referral processes and improved data sharing brought upon by CalAIM, a memorandum of understanding (MOU) was updated and has been implemented. Meetings between Gold Coast and Executive Leadership are occurring four times/year to help facilitate CalAIM changes and improve data sharing. • Overall, the relationship with Gold Coast has been enhanced from a care coordination standpoint.

Objective	FY 21-22 Planned Steps & Actions	FY 21-22 Evaluation/Update
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.	• The policy (CA-80) was developed and went into effect on 02/08/2022 – this document serves as a living document in progress. It was sent to all staff (and supervisors) to review and attest to via Vector Solutions. This policy was updated to include unifying practices and language (for both MH and SUS services, including SUS policy – SUTS-02). Additionally, the CalAIM initiative of "No Wrong Door" was added and incorporated into this policy. Additionally, all policies and procedures are intended to reflect the integration of diversity and cultural literacy throughout VCBH. Treatment teams will assess for, consider, and work to mitigate all relevant cultural and/or linguistic barriers, as applicable.

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 Evaluation/Update
a. **Expand VCBH Office of Health Equity and Cultural Diversity (OHECD) staff and programs to support efforts to meet the cultural and linguistic needs of the consumers.** Division: ☒ SUS ☒ MH	• Collaborate with OHECD 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.	• A OHECD liaison team was formed by the Equity Services Manager (ESM) and representation from all divisions were recruited to join. • Streamlined linguistic services, including SUS Division. Previously, clinics had varying processes and providers were utilizing the language line for interpreter services. Key staff are appointed at each clinic to ensure

Responsible parties: ▪ VCBH OHECD Manager ▪ VCBH Executive Team **Metric for progress:** Further develop and track milestones towards expanded structure. **Goal:** Assess needs and continue discussion and next steps with regard to OHECD team expansion to support OHECD-related activities and tasks (targeted completion: June 30, 2022).	• Assess needs and continue OHECD 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.	language services are schedule well in advance. Additionally, monolingual clients are more integrated into group sessions for indigenous languages using technology. Prior to this, these client had one-on-one sessions with the DUI counselor. The ESM is working with the Public Defenders office to ensure clients receive the correct information about scheduling an appointment in advance and can access free linguistic services in place of the language line. • A uniform protocol to support linguistic services is in progress for next FY. • Meeting with SUS-Division chief in progress to outline a plan for incorporating SUS-specific metrics into the CCP (comparable to that of the MH-side) • Expansion of the OHECD office is in process.
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Evaluation/Update**

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 OHECD Manager
▪ VCBH Executive Team
 	
Metric for progress:
Updated Cultural Competency Plan (CCP)
	• 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.
	  ○ Information will be collected across the VCBH system through referral or initial client information form.
	  ○ 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,
		• Structure for the Cultural Competency Plan (CCP) has been developed and will be utilized to collect data from different units to produce reports. The OHECD liaison will report at scheduled meetings discussion around data tied to their areas/clinics, that on focus CLAS and CCPR topics.
		• Regular meetings between QI and OHECD have been ongoing and will continue throughout the next year as outlined in the FY22-23 QAPI work plan – with the objective to develop and report on SUS-specific metrics as well (comparable to MH reporting).

Goal: Ongoing evaluation to examine and update areas as needed to reflect current needs and practices will occur in FY 21-22.	evaluating and updating the plan on an ongoing basis.	

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 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 (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.

Goals continue on next page

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 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 ▪ 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.	• 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. • QI and EHR staff collaborated to create an automated report to analyze congruence between indicated and actual level of care placement, to align with one of the DMC-ODS Year 2 Performance Metrics. • 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 Evaluation/Update**
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	• 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

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. **Goal:** Improve MORS and Basis completion rates and create reports for monitoring and reporting by June 30, 2022.		refreshers for managers and clinical staff, including a special session for psychiatrists). • Clinical staff continue to utilize Avatar to enter MORS scores. • The EHR Team developed a report in Avatar (Report 6030) to help track MORS completions. Ongoing efforts include the QI team's collaboration with Adult Division operations to develop outcomes reporting to assess improved functionality of clients.
Objective	**FY 21-22 Planned Steps & Actions**	**FY 21-22 Evaluation/Update**
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 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. • VCBH has contracted with Opeeka, an online data reporting application for CANS, to support collaobarative and ongoing review, monitoring, and planning utitlizing CANS results. • Improved PSC-35 data reporting to DHCS.

VI. Beneficiary Outcomes and Satisfaction with Services

<table>
<tr><th colspan="3">Goal: To increase beneficiary satisfaction</th></tr>
<tr><th>Objective</th><th>FY 21-22 Planned Steps & Actions</th><th>FY 21-22 Evaluation/Update</th></tr>
<tr>
<td>
a. Maintain consumer perception survey administrations biannually (MH) and 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
▪ VCBH Adult Division Leads
▪ VCBH Youth & Family Division Leads

<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>:
Continue efforts to maximize client response rate, analysis and reporting, and use of findings for quality improvement efforts will occur in FY 21-22.
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SUS:
• Discuss the feasibility of multiple TPS administrations throughout the year, beyond the required annual administration.
• 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.
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SUS:
• Results of the 2021 Treatment Perceptions Survey (TPS) were shared with VCBH management, line staff, and contracted providers. Findings were reported at both the division and clinic level.
• Findings were uniformly high across items (M = 4.4 / 5.0), while comments indicated overall high satisfaction with services.
• Though total responses (N = 174) decreased from the previous year (N = 239), responses from outpatient sites (N = 43) were quadrupled from the previous TPS (N = 11).

MH:
• In FY 21-22 continued efforts were made to follow a standardized process for training staff, communicating protocols, and reviewing and utilizing results of the MH Treatment Perceptions Survey (TPS):
    o Trainings were offered to all front line and management staff of participating clinics, and all training modules were made available through an online platform.
    o All TPS-related training was also made mandatory for staff members involved in administering the survey.
    o An on-demand report is being developed to share site-specific analysis of the TPS responses; the development of the report is scheduled to be completed in the coming months.
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		- A standard template is being developed to share additional detail from survey responses which cannot be incorporated into an on-demand report, such as a qualitative analysis of survey comments. - The most recent Consumer Perception Survey administration week took place in May 2022. Prior to the administration period, efforts were made to ameliorate the training and communication process in order to increase response rate and clinic participation. - Specialized materials were created to help guide clinic staff on administration protocols. Pamphlets were distributed to clinics to be given to any clients interested in learning more about the context and purpose of the CPS. - QI arranged trainings for staff members and managers prior to administration week and made training materials available via email. - A post-administration survey was developed to inform process improvements for future administration periods and an executive summary was created to summarize findings. 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.

VI. Beneficiary Outcomes and Satisfaction with Services (continued)

Objective	FY 21-22 Planned Steps & Actions	FY 21-22 Evaluation/Update
▪ **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 ▪ 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.	• 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.	• In addition to the updates noted above, the Adult Division continues to administer the 14 item Treatment Perceptions Survey (TPS). • The Adult Division also administers a shorter "on the spot" 4-item version of the TPS via an iPad at participating clinics. QI developed the administration and training involved for the administration of this brief version of the TPS. • Youth and Family division re-launched the TPS-Youth. QI developed and provided trainings and is monitoring implementation. • Summary and on-demand reporting are in development.

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 Evaluation/Update**
• **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 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.	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: • High Cost Beneficiary (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. • 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.	SUS: • HCBs continue to be identified and reported on at least biannually as part of QI's regular data monitoring and reporting. Results are reviewed by the VCBH Billing/Fiscal team. • Number of high-cost beneficiaries for calendar year (CY) 2021 = 200, or 5.2% of total clients served. This compares favorably to 5.4% statewide. • Process for creating a system for the SUS division to identify over and underutilization of services is in process. 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. • Updated Operational Processes and Guidelines were drafted to assess for over- and under- utilization of services • 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. • Operational oversight ensures the ongoing ability for both county and contracted providers to regularly monitor for over and

• On at least an annual basis, Quality Improvement will analyze over/underutilization of services and summarize findings for QM and UR teams.		underutilization of services and address as appropriate. • A possible target percentile for identifying over utilizers for mental health services may be a comparison to percentiles published by the state for CY 2020 (e.g., aim for < 30% of the total cost of claims as a goal)

VII. Grievances

Goal: *VCBH will monitor and respond to beneficiary grievances in a timely and systematic manner.*		
Objective	FY 21-22 Planned Steps & Actions	FY 21-22 Evaluation/Update
Enhance the system for processing and responding to grievances. Division: ☒ SUS ☒ MH Responsible Parties: ▪ VCBH QM Team ▪ VCBH QI Team Metric for progress: Meetings and review of recent Grievances logged into Avatar and response letters. Goal: Continue to expand implementation and monitoring of updated system for processing and responding to grievances, 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. • Establish a standard format for writing grievance response letters that are descriptive, concise, and client-centered. • Ensure staff are trained to and supported with use of letters and tracking	• 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 continues, and findings are discussed with QM staff at least annually. • Results from the annual Treatment Perceptions Survey are used to supplement findings from grievances data and identify patterns in client-reported issues. • QM is revisiting the objectives of Grievances to streamline • QM collected semi-annual and quarterly Grievance data from contractors (CBOs) • DHCS updated the format and criteria for collecting Grievances and Appeals – going from two separate processes into one consolidated/integrated process known as the MCPAR. This is a required submission and VCBH will submit this updated format by September 1, 2022.

Objective	FY 21-22 Planned Steps & Actions	FY 21-22 Evaluation/Update
b. **Create and implement continuous quality improvement practices based on issues and themes identified in grievances.** 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, 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.	• Regarding process improvements for Grievances, QM has been reviewing response times from the Operations Team – paying close attention to timelines and how quickly VCBH is responding to filed grievances • QM has focused efforts on conveying the importance of the Grievance process to providers and conveying it's within a patients' rights (not a strike against them) • The role of G&A team shifted this past FY – the team provides more direct guidance regarding delineating the problem and what's the desired resolution. The team now supports both ends of the process bridging the gap (both the provider side as well as the patient side) • Quality Management and Quality Improvement continue to collaborate on a long-term data analysis and monitoring plan for grievances. • Quality Improvement helps to support analysis on an annual basis to identify patterns in the Grievances data and presents findings to QM staff and other VCBH stakeholders on a regular basis. • Grievance 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 in the summer of 2022. • Feedback from QMAC stakeholders will inform process improvements to the grievance process.

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 Evaluation/Update**
a. Finalize and carry out plan of action based on findings from 2nd annual Employee Engagement Survey <u>Division:</u> ☒ SUS ☒ MH <u>Responsible Parties:</u> ▪ VCBH QM Team ▪ VCBH Executive Team <u>Metric for progress:</u> Evidence of survey distribution, results reporting, and action planning will demonstrate success. <u>Goal:</u> 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.	• An Employee Engagement Advisory Committee was established in the spring of 2022 and convenes quarterly to discuss VCBH efforts and action items pertaining to employee retention and engagement. Findings and recommendations are shared with executive leadership. • The QI team, in collaboration with BH Personnel Services, implemented an Employee Exit Survey, which has been offered to all exiting employees starting July 1, 2022. An updated employee engagement townhall and survey is in the planning stages for the upcoming fiscal year.