BEHAVIORAL HEALTH&RECOVERY SERVICES

Kern Behavioral Health and Recovery Services

Quality Improvement

Work Plan Evaluation

FY 2021 – 2022

KERN COUNTY

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FY 21-22 Work Plan Evaluation

BEHAVIORAL HEALTH&RECOVERY SERVICES

Mission

Working together to achieve hope, healing, and a meaningful life in the community.

Vision

People with mental illness and addictions recover to achieve their hope and dreams, enjoy opportunities to learn, work, and contribute to their community.

Statement

We honor the potential in everyone. We value the whole person - mind, body and spirit. We focus on the person, not the illness. We embrace diversity. We acknowledge that relapse is not a personal failure. We recognize that authority over our lives empowers us to make choices, solve problems and plan for the future.

INTRODUCTION TO
KERN BEHAVIORAL HEALTH AND RECOVERY SERVICES
WORK PLAN EVALUATION PROCESS

Exhibit A-Attachment 1-Appendix A, Part B of the MHP Contract with the State requires each MHP to have a written annual evaluation of the overall effectiveness of the QI/QM Program demonstrating how QI/QM activities contributed to meaningful improvement in clinical care and beneficiary service and describes completed and in-process QI/QM activities through monitoring of previously identified issues and tracking of issues over time, planning and initiation of activities for sustaining improvement, and establishing objectives, scope, and planned activities for the coming year in accordance with Title 42, Code of Federal Regulations (CFR), Section 438.240(a)(2), and shall meet the criteria identified in Title 42, CFR, Section 438.240(d).

At the completion of the fiscal year, the Quality Improvement Committee evaluates its effectiveness at achieving the goals and objects outlined in the QI Workplan. Using a report template titled 'Annual Report' each responsible party gathers and analyzes data, assesses performance, reviews effectiveness of actions and identifies future steps. Each Work Plan goals is rates as "Met" or "Not Met."

The Quality Improvement Committee and subcommittees review the Annual Reports then sets the Work Plan Goals for the following fiscal year.

Goal #1 Consumer and Family Satisfaction - CPS

1. **Quality Improvement Goal:**
   Each MHP service provider will each achieve a minimum satisfaction rating of 85% or greater on the bi-annual Consumer Perception Survey.

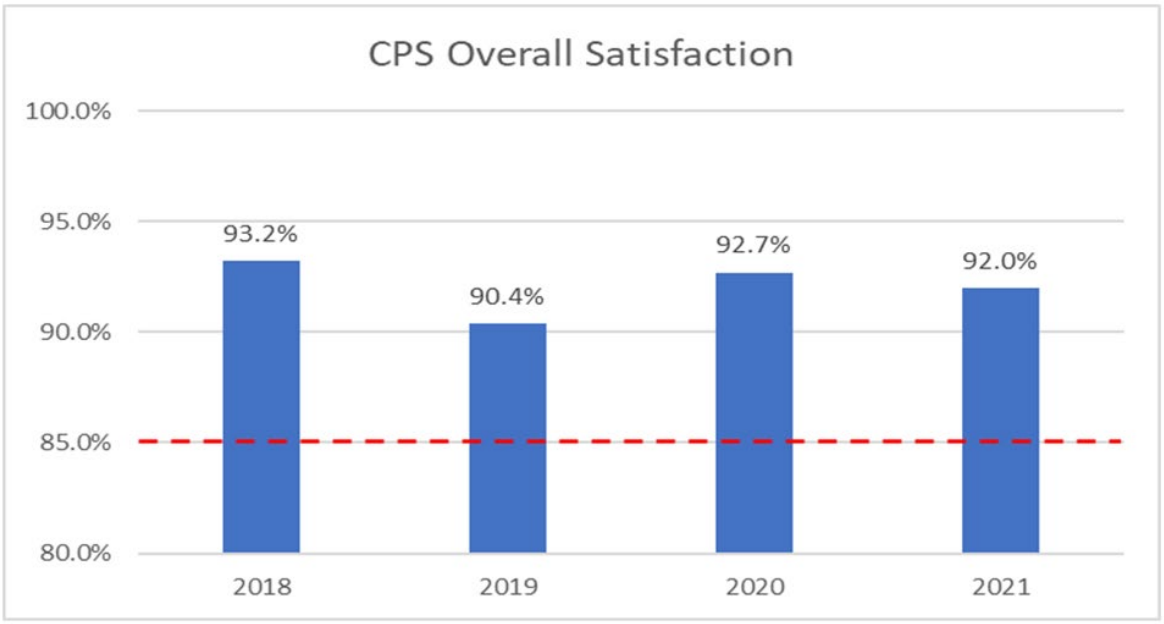
2. **2021/2022 The Goal Was:**

   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**

   - The annual CPS was administered June 21-25, 2021. UCLA oversaw the survey process and delivered results to counties in December 2021.
   - QID delivered results to MHP and contract providers in January 2022. QID prepared and delivered lobby posters to MHP and contract providers in March 2022. These lobby posters inform consumers of division-wide satisfaction results, and that the CPS will next take place in Spring 2022.
   - The Spring 2022 CPS took place May 16-20, 2022. UCLA will transmit data to kern county in Fall 2022.

4. **Data Used to Measure the Outcome of this QI Goal:**



5. **Summarize the Results of Actions Taken**
   - MHP and contract providers achieved a cumulative satisfaction rating of 92% for the Spring 2021 reporting period.
   - The KPIC committee utilizes CPS data to measure client satisfaction and other areas of consumer perception related to recovery principles, access to care, and progress in treatment. The KPIC committee will continue to monitor client perception and act should the rater drop significantly.

- QID conducts an additional satisfaction survey monthly, the Local Recovery Survey (LRS), which provides frequent feedback to the individual teams so they can make improvements as needed.
- QID no longer requires individual providers to submit corrective action plans in regard to their CPS score, as they are held to this standard quarterly via the Local Recovery Survey (LRS).

6. **Plan for Current Goal:**

☒ Change goal

The CPS annual goal should change to: "The Mental Health Plan and its contract providers will achieve a cumulative minimum satisfaction rating of 85% or greater on the Consumer Perception Survey," which aligns with the current goal of the TPS.

Goal # 2 Consumer and Family Satisfaction – LRS

1. **Quality Improvement Goal:**
   Each MHP service provider will each achieve a minimum satisfaction rating of 85% or greater on the annual Local Recovery Survey (LRS)

2. **2021/2022 The Goal Was:**

   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   - One percent of the team's annual caseload average was surveyed during the second week of each month. Teams with less than two (2) clients scheduled for appointments during the survey period were not surveyed for that month; as a result, a make-up week was assigned the third week of June. One hundred twenty-eight individual teams were surveyed throughout the year, including 98 MHP teams and 30 SUD teams, allowing to 82 service providers.
   - A quarterly report was sent out to the supervisors and their administrators. The report contained the results of the quarterly survey and any individual comments from the client or clients' family. The survey results contain a cumulative score from the calls placed each month during that quarter. Any team out of compliance was requested to send a CAP detailing how they plan on correcting the deficiency.
   - Service providers who did not meet the goal each quarter were reviewed to ensure that their performance has improved.
   - Service providers that did not meet the goal took several steps to improve their scores, including providing additional training for staff to learn techniques and intervention to assist clients and parents who may be more challenging; staff attending training for reframing, which often involves recognizing a client's positive intentions and communicating an understanding that client is doing the best they can at the time; site-implemented weekly high risk review meetings to address high-risk clients and ensure they are receiving appropriate MH services; and the hiring of new staff and continued engagement in recruitment strategies.

4. **Data Used to Measure the Outcome of this QI Goal:**

FY '21-'22 Results - Local Recovery Survey	
Service providers that met goal	82
Service providers that did not meet goal	0
Total number of service providers surveyed	82

5. **Summarize the Results of Actions Taken:**
   - All surveyed MHP and SUD units exceeded the 85% satisfaction goal for the calendar year.
   - All service providers that did not meet the goal during the quarter did meet the goal the following quarter; therefore, all service providers surpassed the minimum satisfaction rating of 85%.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #3 Credentialing

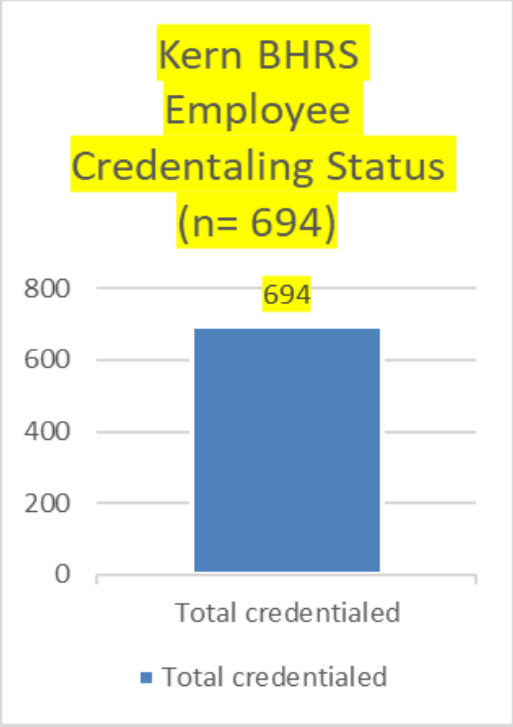
1. **Quality Improvement Goal:**
   100 % of all applicable staff will complete the credentialing process.

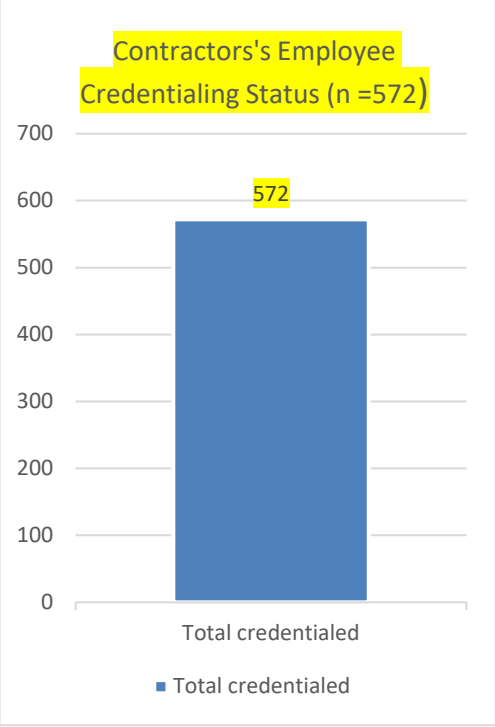
2. **2021/2022 The Goal Was:**

   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   1. Rolled out the Credentialing software app, which allows staff the ability to upload documents directly from their phones instead of having to scan documents
   2. Began utilizing Docu-Sign for the current credentialing application, making the application process totally paperless
   3. Continue to work diligently with KernBHRS HR, as well as contracted providers to ensure that credentialing is notified as soon as possible about the hiring of a new employee to get the credentialing process started
   4. Worked with our Electronic Health Record team to restrict access to Cerner for any employees that were required to complete a credentialing application but had not done so. This ensured that all required employees were not providing services without beginning the credentialing process.

4. **Data Used to Measure the Outcome of this QI Goal:**





5. **Summarize the Results of Actions Taken:**

This year, the Credentialing team continued to streamline and improve the previous process. By utilizing various advances in technology and partnering with various teams within KernBHRS, the credentialing team was successful in ensuring that all required staff were credentialed.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #4 Fair Hearings

1. **Quality Improvement Goal:**
   100% of State Fair Hearings will be performed within the mandated time frame.

2. **2021/2022 The Goal Was:**

   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   - QID continued to check the Appeal Case Management System (ACMS) website daily
   - When notified of a hearing, QID coordinated with appropriate system representative to gather and review evidence.
   - QID and system representative participated in the review

4. **Data Used to Measure the Outcome of this QI Goal:**

State Fair Hearings					
Fiscal Year: 21-22	**Q1 July-Sep**	**Q2 Oct-Dec**	**Q3 Jan-Mar**	**Q4 Apr-Jun**	**FY Total**
# State Fair Hearing Appeals Submissions	0	1	1	0	2
Result: MET/NOT MET	MET	MET	MET	MET	MET

5. **Summarize the Results of Actions Taken:**
   Kern BHRS were not found out of compliance on any Fair Hearings. In both cases, we were able to work with the client to ensure needs were met. When appropriate, all services continued.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #5 Foster Care Penetration Rates

1. **Quality Improvement Goal:**
   Increase foster youth penetration rate to an overall monthly average of 50% or greater.

2. **2021/2022 The Goal Was:**

   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**

   Since July 2021, the 50% Foster Care Penetration Rate goal has continuously been met and exceeded due to the actions listed below:

   - Collaboration with the Department of Human Services (DHS) to increase utilization of Child and Adolescent Needs and Strengths (CANS) assessment tool to support decision making in Child and Family Team (CFT) meetings, including a new process to ensure sharing of CANS between agencies through a dedicated CANS submission email.
   - Ensured staff availability to attend both open and unopened CFTMs by behavioral health staff.
   - Provided monthly lists to DHS of identified foster youth that needed Medi-Cal and foster care aid codes updated.
   - KernBHRS staff and providers attended staff/supervisor meetings at DHS to increase coordination and communication between agencies.
   - Worked with DHS to identify a single point of contact for follow up on foster youth.
   - Coordinated with DHS about educating resource parents on BH services to assist in engagement and provided training for resource parents in the TFCO model to increase options for youth that have complex needs.
   - Provided continued support of transitioning STRTPs; six (6) STRTPs have received their mental health approvals as of 6/30/2022.
   - Continued work with partner agencies to implement AB 2083 (Collaborative MOU) and Family Urgent Response System (FURS).
   - Behavioral Health staff located on site at DHS in order to engage social workers and assist with supporting cross system coordination of referrals.
   - Implemented Family First Prevention Services Act (FFPSA) and ongoing collaborative meetings with DHS and Probation to coordinate.
   - Created CCR Foster Youth Engagement team including two positions funded to serve as Qualified Individual (QI) and provide support to STRTPs.
   - Updated and strengthened protocols in SMART in order to expedite QI referrals.
   - TAY Team assisted with transition and worked collaboratively to get housing for foster youth whose AB12 was ending.

4. **Data Used to Measure the Outcome of this QI Goal:**

						12 Month cumulative			
Year	Month	Actual MMEF Eligible Foster Kids	CAEQRO MMEF Eligible Foster Kids [1]	Unique Foster Kids Served	Total services	Unique Foster Kids Served	Penetration rate [2]	Total services	Total eligible months
2022	6	2,406	2,486	681	4,709	1,296	52.13%	53,589	29,835
2022	5	2,394	2,492	662	4,946	1,303	52.29%	53,175	29,902
2022	4	2,447	2,499	667	4,862	1,298	51.95%	52,984	29,982
2022	3	2,509	2,496	650	4,575	1,293	51.81%	53,520	29,946
2022	2	2,460	2,488	627	4,272	1,276	51.28%	53,675	29,858
2022	1	2,470	2,486	607	4,481	1,267	50.97%	54,024	29,827
2021	12	2,565	2,480	583	3,617	1,262	50.89%	54,300	29,759
2021	11	2,540	2,466	613	4,326	1,263	51.21%	54,250	29,596
2021	10	2,520	2,451	593	4,348	1,262	51.49%	53,437	29,412
2021	9	2,506	2,437	587	4,046	1,252	51.37%	53,540	29,246
2021	8	2,522	2,424	624	4,825	1,257	51.86%	53,447	29,084
2021	7	2,496	2,409	643	4,582	1,249	51.86%	52,788	28,903

5. **Summarize the Results of Actions Taken:**

The Foster Care Penetration Rate report for FY 21/22 shows that the penetration rate was met for all 12 months. The highest month reported was at 52.29% for May of 2022. Continued coordination with DHS, Probation department, and BH geographic providers has allowed the screening and assessment of more foster youth with high level needs to be referred and treated as needed. Continued interagency case planning and monthly review of penetration rates provides real time information and allows for coordinated treatment planning. Identifying incorrect aid codes and updating through collaboration with DHS has also improved our process for increasing the penetration rate for foster youth accessing behavioral health services.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #6 Grievance and Appeals- Problems Resolution

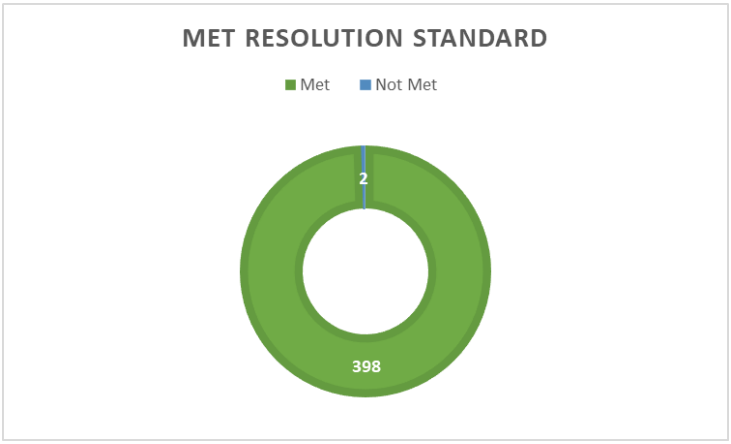
1. **Quality Improvement Goal:**
   100% of Grievance and Appeals will be addressed within the prescribed timeframes.

2. **2021/2022 The Goal Was:**

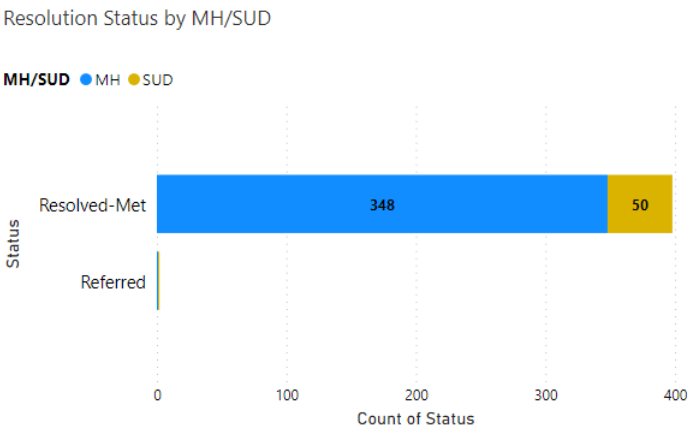
   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   Through the Grievance and Appeal web database, The Patients' Rights Office was able to review and resolve all incoming grievances and appeals within the state mandated timeframes. Each grievance and appeal were independently monitored by staff and electronically monitored by the web database to ensure they were resolved and meeting our goal of 100% within the appropriate timeframes.

4. **Data Used to Measure the Outcome of this QI Goal:**
   In review of the Grievance and Appeal web database, for FY21-22, data shows 400 total grievances with 2 being appeals. The Patients' Rights Office resolved 99.5% of the grievances and appeals within the state mandated timeframes. The Grievance and Appeal database has proven success for monitoring timeliness.



Review of data shows a 7% increase in submitted Grievances from FY 20/21 (373) to FY21/22 (400).



5. **Summarize the Results of Actions Taken:**

For FY 20-21, The Patients' Rights Office provided grievance and appeal trainings to KernBHRS staff and contract providers which resulted in a positive response. The goal was to ensure staff were able to maneuver the Grievance and Appeal web database with ease and understand importance of reporting and/or resolving grievances and appeals promptly.

During the DHCS audit, the PR office discovered that two grievances were not resolved in a timely manner. This resulted in our office now reviewing resolutions daily.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #7 Outreach Efforts to the Homeless and Hard to Reach - AOT

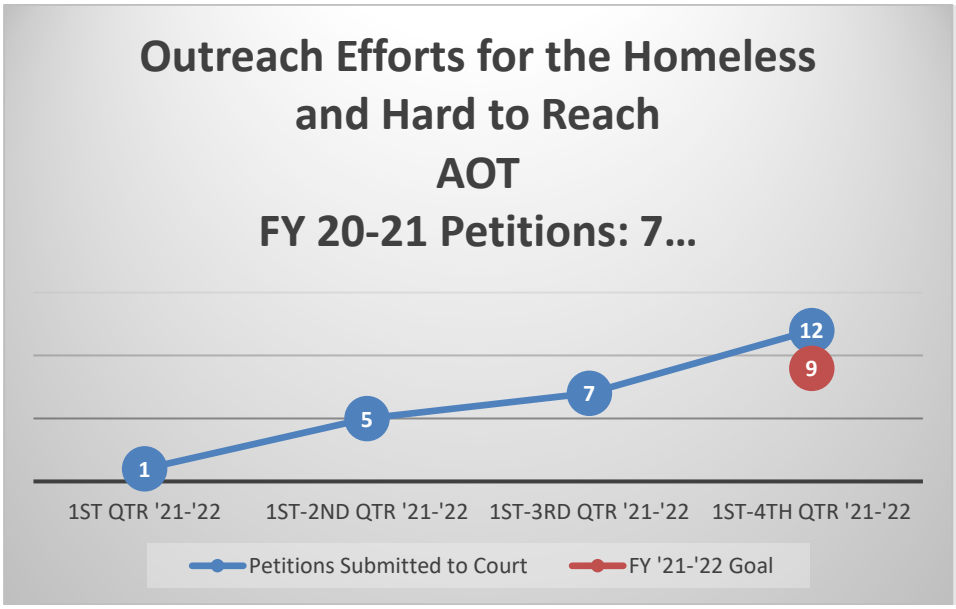
1. **Quality Improvement Goal:**
   In an effort to ensure system access to the hard to reach individuals, the AOT team will increase the numbers of petitions submitted to the courts by 15%.

2. **2021/2022 The Goal Was:**

   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   - Participated in the 40-Hour Crisis Intervention Team Training to educate Kern County Law Enforcement agencies about the AOT processes and program.
   - Attended a meeting with the Kern Superior Court Judges to provide information about the referral process, due to recent changes in the AOT law.
   - Provided in depth trainings to Mental Health Systems and Good Samaritan Hospital regarding the AOT Program.
   - Ongoing monthly meetings with county counsel to coordinate before and during petition process.
   - Rebranded Quarterly AOT meeting as the AOT Stakeholders meeting in August 2021 and expanded the audience to include family members, law enforcement, Patient's Rights, Kern BHRS staff.
   - Increased AOT staffing (RS) to allow Therapist additional availability to complete checklists for petitions.
   - Improved collaboration and communication with the Correctional Behavioral Health Team to streamline the process of providing in-custody evaluations of potential AOT clients. The result is a new system that was put in place in which requests are sent to OD to coordinate/schedule visits.
   - Continued to provide AOT presentations to community medical and psychiatric hospitals to increase awareness and understanding of program.
   - Began planning the development of a client and family handbook regarding the AOT Program as well as the creation of an AOT Family Night.

4. **Data Used to Measure the Outcome of this QI Goal:**



5. **Summarize the Results of Actions Taken:**

The total number of petitions submitted to the courts for 4th quarter FY 21-22 was two (2). As the workplan goal is to increase the number of petitions by 15%, the number of petitions needed for FY 21-22 is nine (9). This goal was met. For the year, a total of 12 petitions were submitted for the program, exceeding the goal by 3 petitions.

6. **Plan for Current Goal:**

☒ Discontinue goal

We have successfully met the goals for the past few years.

Goal #8 Outreach Efforts to the Homeless and Hard to Reach

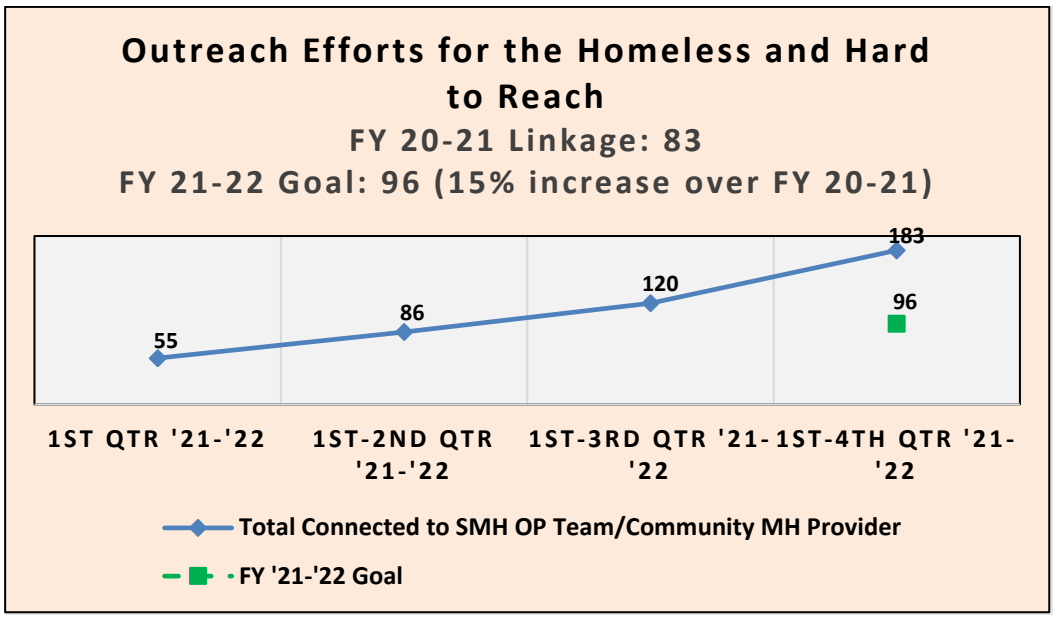
1. **Quality Improvement Goal:**
   In an effort to ensure system access to the hard to reach individuals, the Bakersfield Referral team and the Community Referral Network will increase linkage to specialty mental health mental health programs by 15%.

2. **2021/2022 The Goal Was:**

   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   - Went live with Outreach web application; continuously updated referral sources, community contacts, and outcome options to improve quality and accuracy of data being collected; enhanced web application to include tracking for community partner outreach efforts.
   - Developed and disseminated marketing material (i.e.: posters, flyers, cards) for the Bakersfield Referral Team and Community Referral Network to create consistency and standardization.
   - Ensured all teams had dedicated outreach hotline numbers for referrals.
   - Presented at the Behavioral Health Board, an MHSA Stakeholders meeting, and to the Director and Management team to ensure widespread knowledge of program.
   - Coordinated delivery of ROEM training and job shadowing for all Bakersfield and Community Referral staff.
   - Provision of individualized training to teams experiencing turnover, struggling to understand the program, and/or needing general support to ensure accuracy in data collection and consistency in program operations across all sites.
   - Purchased and disseminated supplies (i.e.: hygiene kits, socks, hats, umbrellas, blankets, water, snacks) to Bakersfield and Community Referral staff to be utilized for client engagement.
   - Purchased and disseminated Bakersfield and Community Referral Team T-shirts and pop-up banners detailing the program/services to be utilized at community events.

4. **Data Used to Measure the Outcome of this QI Goal:**



5. **Summarize the Results of Actions Taken:**
   - Development, launch and continued enhancements of web application allowed for accurate and comprehensive tracking of client referrals and outcomes.
   - Development and dissemination of marketing materials (i.e.: posters, flyers, cards) allowed for expansion of education and awareness to community members regarding services available, thereby increasing client referrals.
   - Provision of ROEM training and job shadowing for all Bakersfield and Community Referral staff increased knowledge and skillsets, allowing for utilization of additional and improved engagement techniques, and thereby increasing the effectiveness of staff's interaction with referred clients.
   - Purchase and dissemination of Bakersfield and Community Referral Team T-shirts and pop-up banners detailing the program/services resulted in increased visibility in the community and at events, thereby strengthening community education and awareness and the opportunity for increased client referrals.

6. **Plan for Current Goal:**

   ☒ Change goal

   Given the ongoing support of the ROEM team, the plan to continue with consistent dissemination of marketing materials and provision of education and awareness to communities, and the unanticipated availability of supplies for socialization, it is expected that referrals will increasingly result in successful client engagement and linkage to Specialty MH outpatient teams and Community MH providers.

   Proposed new goal:

   Community outreach efforts in each of the 5 MH sites (Taft, Lake Isabella, Arvin/Lamont, Delano, Bakersfield) will increase the number of initial requests received and logged, by 10% over the identified baseline for each site.

Goal #9 Provider Appeals

1. **Quality Improvement Goal:**
   100% of Provider Appeals will be resolved in a timely manner

2. **2021/2022 The Goal Was:**

   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**

   Providers are notified of the appeals process found in their agreement.

4. **Data Used to Measure the Outcome of this QI Goal:**

   Number of Appeals filed = 0

5. **Summarize the Results of Actions Taken:**
   KernBHRS Finance division ensured providers are aware of their right to appeal financial decisions and the process for filing the appeal. This information was communicated on a number of occasions. No appeals were filed in FY 21-22

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #10 SUD Access Line – Test Calls

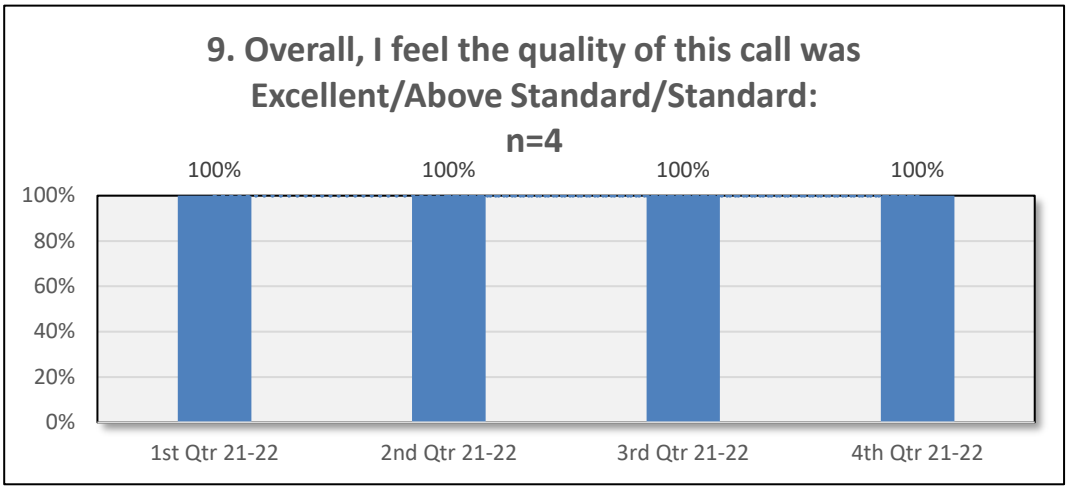
1. **Quality Improvement Goal:**
   95% of all access test calls will be given a customer service rating of standard or above.

2. **2021/2022 The Goal Was:**

   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   - QID ensured that an equal number of test calls were completed during business hours (Monday-Friday 8:00 A.M.-5:00 P.M.) and after hours (outside business hours, including early morning, late night, and weekends), with an average of three test calls placed during business hours and three calls placed outside business hours each quarter. QID completed one grievance call each quarter, alternating business and after-hours each quarter. QID also tested in a language other than English (Spanish). The Quality Improvement goal was MET, with 100% of test callers rating their call as standard or above.
   - SUD continued to ensure customer satisfaction by working to increase Gateway staffing to include holidays and weekends ensuring that the full gamut of services is expanded. Crisis hotline staff received an updated resource list, ensuring they are able to assist members of the public in need of community resources.

4. **Data Used to Measure the Outcome of this QI Goal:**



5. **Summarize the Results of Actions Taken:**
   - Satisfaction scores for each quarter met the goal of standard or above 100% of the time.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #11 SUD Adult Satisfaction TPS

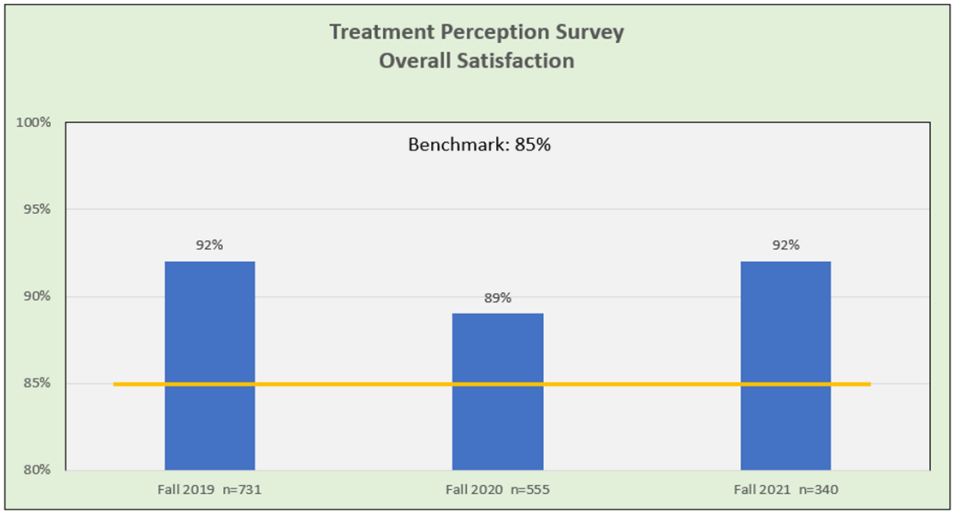
1. **Quality Improvement Goal:**
   The Substance Use Division and its contract providers will achieve a cumulative minimum satisfaction rating of 85% or greater on the Treatment Perception Survey.

2. **2021/2022 The Goal Was:**

   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   • The annual TPS was administered September 20-24, 2021. UCLA oversaw the survey process and delivered results to counties in March 2022.
   • QID delivered results to SUD and contract providers in March 2022.
   • QID prepared and delivered lobby posters to SUD and contract providers in March 2022. These lobby posters inform consumers of division-wide satisfaction results and that the TPS will next take place in Fall 2022.

4. **Data Used to Measure the Outcome of this QI Goal:**



5. **Summarize the Results of Actions Taken:**
   • SUD and contract providers achieved a cumulative satisfaction rating of 92% for the Fall 2021 reporting period.
   • The KPIC committee utilizes TPS data to measure and monitor client satisfaction and other areas of consumer perception related to recovery principles, access to care, and progress in treatment.
   • QID conducts an additional satisfaction survey monthly, the Local Recovery Survey (LRS), which provides frequent feedback to the individual teams so they can make improvements as needed.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year
   QIC has implemented the goal of a minimum 85% satisfaction rating for systems and teams. QID recommends that this goal continues.

Goal #12 SUD Outcome Measures – Access Line

1. **Quality Improvement Goal:**

At least 30% of individuals contacting the SUD treatment access line through Gateway will attend assessment.

2 **2021/2022 The Goal Was:**

☒ MET ☐ NOT MET

3 **Quality Improvement Activities / Actions Taken Over the Past Year:**

- At the end of the last fiscal year, reminder texts for scheduled appointments were implemented by Gateway and were continued this fiscal year.
- On November 1, 2021, Gateway began emailing providers client names, phone numbers and appointment information prior to assessment to increase successful linkages.
- Gateway began calling clients for urgent appointments the day before and day of scheduled appointment.

4 **Data Used to Measure the Outcome of this QI Goal:**

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	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	April 22	May 22	Jun 22	Average
Total referred	785	858	753	787	692	547	631	646	822	625	741	704	707.58
Total attended	265	275	235	267	250	204	241	276	349	256	306	278	266.83
Successful linkage	33.76 %	32.05 %	31.21 %	33.93 %	36.13 %	37.29 %	38.19 %	42.72 %	42.46 %	40.96 %	40.30 %	39.49 %	37.71 %

5 **Summarize the Results of Actions Taken:**

With the implementation of reminder texts to clients, successful linkages were at 30% or higher. With the implementation of informing providers of scheduled appointments, successful linkages significantly increased. Starting in February 2022 and throughout the remainder of the fiscal year, successful linkages were above or near 40%, exceeding the goal by 10%.

6 **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #13 SUD Outcome Measures - MAT

1. **Quality Improvement Goal:**

Increase the number of referrals to community-based MAT providers by 5% (from 100 to at least 105) for fiscal year 21-22

2 **2021/2022 The Goal Was:**

☒ MET ☐ NOT MET

3 **Quality Improvement Activities / Actions Taken Over the Past Year:**

- MAT meeting was held quarterly with Clinica Sierra Vista and Omni Family Health to discuss coordination and provide updates and information
- A Medication Assisted Treatment training was offered in October 2021 for SUD line staff to provide additional information on this modality of treatment and inform them of resources and referrals available through Gateway and the community
- Reminded SUD providers of new FY22-23 DMC-ODS requirements to provide warm handoffs to MAT programs, not just provide a number

4. **Data Used to Measure the Outcome of this QI Goal:**

	Jul -21	Aug -21	Sep -21	Oct -21	Nov -21	Dec -21	Jan -22	Feb -22	Mar -22	Apr -22	May -22	Jun -22	Total
Referred to CSV by KernBHRS	5	6	12	12	13	40	42	45	52	57	36	49	369
Referred to Omni by KernBHRS	0	0	25	22	21	8	22	3	5	6	4	7	123
Referred to CSV by Providers	5	2	2	8	9	3	4	5	3	5	5	2	53
Referred to Omni by Providers	1	0	0	0	0	0	0	0	0	0	1	0	2
Referred to Other by Providers	2	5	2	0	5	7	5	5	8	5	6	7	67
Totals	13	13	41	42	48	58	73	58	68	73	52	65	604

5 **Summarize the Results of Actions Taken:**

The Gateway team continues to provide most of the referrals to these community providers and have had much better results with Clinica Sierra Vista versus Omni Family Health. Another resource that is available temporarily is the CA Bridge program at various hospitals, which is a helpful link for those that may be waiting to be seen in the primary care setting. For this goal, consistent discussion about MAT resources in the community continued in SUD Supervisors Meetings, SUD Monthly Provider meetings and Individual bi-monthly provider meetings. The goal was exceeded by a large margin due to more staff being familiar with community resources available, and more clients requesting these services. The increase of fentanyl use and overdoses over the past year may have contributed to the rise in referrals from Gateway.

6 **Plan for Current Goal:**

☒ Change goal

The goal was exceeded by a wide margin. The goal should be changed to maintaining the number of referrals to MAT community providers for FY 22-23, as this is a new DMC-ODS requirement. Providers are expected to provide warm handoffs to MAT services. The new goal can be "Continue referrals to MAT community providers with a minimum of 500 for Fiscal Year 22-23"

Goal #14 SUD Outcome Measures – Penetration Rate

1 **Quality Improvement Goal:**

Increase penetration rate of the Latino/Hispanic population into SUD treatment team from 0.76% to 0.85% by implementing culturally sensitive outreach and engagement strategies.

2 **2021/2022 The Goal Was:**

☐ MET ☒ NOT MET

3 **Quality Improvement Activities / Actions Taken Over the Past Year:**

- Review recommendations from Listening Sessions for Hispanic/Latinx Community.
  - Listening Sessions were offered in English and Spanish (2 sessions for Hispanic/Latinx out of 4 sessions to pilot this format)
  - Discussion of how to access the services in the system of care
  - Important treatment considerations per attendees:
    - inclusion of their religious/spiritual background & inclusion of family
    - Importance of privacy and related to this was also the theme of stigma, reputability, and job security as deterrents for seeking services
  - Request for information on community trainings
- Provided outreach materials to community partners such as Vision y Compromiso- Kern's Community Health Workers also known as "Promotores"
  - Pathway to care, accessing the Crisis Hotline and the Gateway Substance Use Hotline
  - Vision y Compromiso participation in September 2021 Hispanic Heritage Month Virtual Behavioral health talk
  - Bi-directional information sharing inclusive of the services both agencies offer, the populations served, and the scope of our work
- Assisted contract providers with annual Cultural Competence Plan and CLAS Standards training
  - Live and pre-recorded video training
  - Template and list of documents for submission
  - Strengthening system-wide equity efforts
- Participation in 2nd Annual Multi-County Suicide Prevention summit planning
  - Spanish-language suicide prevention workshop
- Various May Mental Health Events and activities provided.
  - "May is Mental Health Month" planning committee, Art in the Park Event
  - Collaboration with Fresno Department of Behavioral Health Equity services for on-going regional equity trainings

4 **Data Used to Measure the Outcome of this QI Goal:**

Penetration Rate Report SUD in progress

Baseline .57% (in 2020)	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	**YTD**
Goal. 0.85%	0.75 %	0.78 %	0.80 %	0.80 %	0.78 %	0.78 %	0.79 %	0.60 %	0.48 %	0.45 %	0.44 %	0.44 %	**0.65 %**

5 **Summarize the Results of Actions Taken:**

- Penetration rate data has decreased, but EQRO claims data rate showed an improvement
- Concern about denominator increase over the last 1-2 years.
- Strategic countywide Outreach led by Mental Health Services Act team for specific demographics such as Hispanic/Latinx, LGBTQ+ for example and while we are engaging with community members regularly via these events, we are not seeing this have a positive impact on the internal penetration rate report numbers.
- Additional Cultural Competence Team staffing- Supervisor/Ethnic Coordinator Role Filled
- Voluntarily added CLAS standards in a "cross-walk" format with our Cultural Competence Plan Requirements so that it is easily evident where our actions align with both state and federal regulations.
- Proactively including considerations from the "California County Leaders Declaration of Racism as a Public Health Crisis" to ensure ethno-racial equity considerations are the the forefront of our decision-making.

Successes in the past year:

- Strengthened collaboration with Vision y Compromiso Kern. In prior FY, we participated in their virtual behavioral health townhall, so we invited them to participate in our virtual Hispanic Heritage Month event which was structured as a community talk on accessing our system, mental health, substance use, and suicide prevention
    - Hispanic Heritage Month Event had 94 attendees via Zoom which included 51 system of care staff and 43 community partners and community members
- Regular meetings with VyC to discuss how each other's programs work, what services we offer, and how we can collaboratively support the behavioral wellness of our Hispanic/Latinx community.
- Department participation in 2nd Annual Multi-County Suicide Prevention Summit which included a longer Spanish-language suicide prevention workshop
- Increased collaboration with Substance Use Division, including Contract partners to more fully integrate substance use disorder considerations into our cultural competence and equity efforts.
    - Substance Use services destigmatizing marketing on tv and radio
    - Substance use staff research free equity webinars and share with Cultural Competence and department as appropriate

6 **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year.

Goal #15 SUD Points in Time Surveys

1. **Quality Improvement Goal:**
   Client satisfaction with various points in time (Admission, During Treatment, at Discharge and at Follow Up) during SUD treatment will obtain positive ratings at a rate of 85% or higher.

2. **2021/2022 The Goal Was:**

   ☐ MET ☒ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   - During the first quarter, SUD Administrator met with staff to discuss the surveying process since very few surveys were received in June. The survey process was clarified, and it was determined that the SUD Provider Liaison team would run all reports for distribution to most teams with a call log to track which individuals have been contacted.
   - A protocol was developed in the second quarter to ensure all staff are following the same process when conducting surveys. Also reminded internal teams and contracted providers, during bi-weekly contractor meetings, to inform clients they will be receiving survey calls during various points during and post-treatment.
   - During the third quarter, the new protocol and script were sent out to staff conducting PIT surveys to standardize the process. All staff were asked to complete a minimum of 20 surveys per month.
   - In the last quarter, SUD Administrator updated the consent for treatment to include an acknowledgement that surveys will be conducted but are voluntary. Additionally, a do not call list was developed to exclude those who do not wish to participate.
   - Additionally, after reviewing client comments internally, results were shared with BRS and KCHC to review with their staff.

4. **Data Used to Measure the Outcome of this QI Goal:**
   The tables below represent the total numbers of surveys collected at each point in time (top) and the percentage of surveys that indicated positive responses (agree, strongly agree)

Point in Time	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Average
Admission	6	12	28	33	28	36	31	24	34	42	31	24	27.42
During Treatment	8	23	61	45	18	7	11	10	14	8	11	6	18.5
Discharge	11	14	11	22	20	21	19	18	20	7	19	21	16.92
Follow up	4	8	17	45	21	25	32	24	24	26	29	35	24.17

Point in Time	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Average
Admission	95.8%	91.7%	91.1%	93.2%	92.9%	96.5%	85.5%	93.8%	95.6%	96.4%	100%	92.7%	93.77%
During Treatment	87.5%	94.2%	83.6%	94.8%	87%	90.5%	97%	90%	88.1%	83.3%	69.7%	94.4%	88.34%
Discharge	59.1%	85.7%	81.8%	81.8%	70%	81%	86.8%	86.1%	60%	85.7%	92.1%	83.3%	79.45%
Follow up	100%	87.5%	76.5%	93.3%	88.1%	92%	89.1%	87.5%	93.8%	82.7%	94.8%	82.9%	89%

5. **Summarize the Results of Actions Taken:**

- As the year progressed, the adjustments made to the process yielded an effective workflow from report running, to providing surveying staff with lists separated by each of the points in time, to setting a minimum number of surveys to obtain per staff. Providers also appreciated receiving results of their own surveys during bi-monthly meetings. This provided an opportunity to clarify specific positive and negative comments about staff, and for opportunities to discuss ways to improve client satisfaction in general with facility staff. The area where the goal was not met was at discharge, appears to have stemmed from lack of communication about processes and disagreements with counselors. This will continue to be addressed in order to meet the standard consistently in the future.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #16 Unusual Occurrence Reports – Outpatient SUD

1. **Quality Improvement Goal:**
   100% of all SUD Outpatient UOR will be addressed in an appropriate manner.

2. **2021/2022 The Goal Was:**

   ☐ MET ☒ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   - QID reviewed each individual UOR for concerning reports that might require individual follow up. When a report was identified, we worked with the Administrator and the team to make any identified improvements.
   - Due to staffing issues, QID was unable to analysis and trend the aggregate data.

4. **Data Used to Measure the Outcome of this QI Goal:**

   none

5. **Summarize the Results of Actions Taken:**

   none

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #17 Unusual Occurrence Reports – Outpatient MH

1. **Quality Improvement Goal:**
   100% of all MHP Outpatient UOR will be addressed in an appropriate manner.

2. **2021/2022 The Goal Was:**

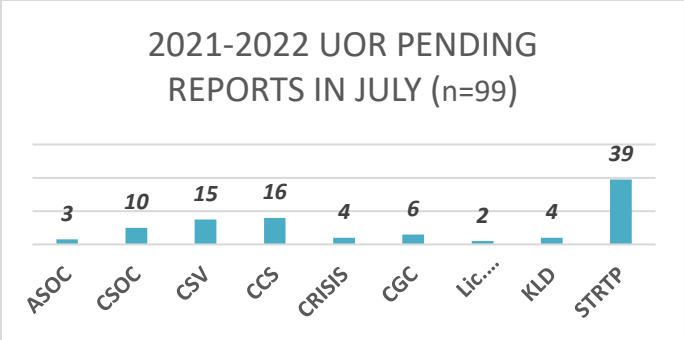
   ☐ MET ☒ NOT MET

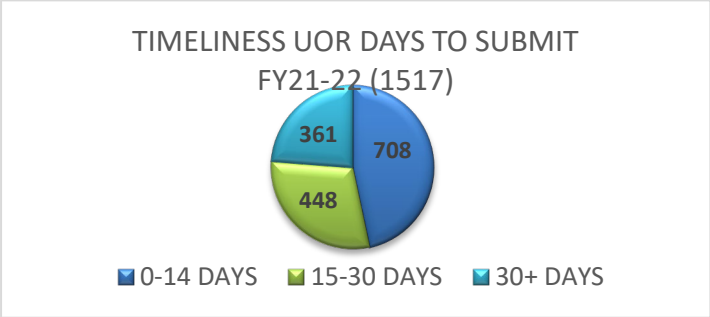
3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   - QID reviewed all UOR submitted during the FY to ensure all incidents were being addressed appropriately and no additional actions steps were necessary to address the incident or to prevent future incidents from happening.
   - QID sent out recommendation letters to teams and administrators when a protocol, or a policy was not followed or when there was an action step that the team could do to improve the incident.
   - QID sent weekly reminders to supervisors and administrators of pending UOR's to remind them to complete these in a timely manner.
   - QID made corrections (changed names of supervisors/administrators) when staff entered this information wrong to ensure there were no delays on the approval of the forms.
   - All UORs submitted due to deaths or suicide attempts were automatically routed to the chair of the M&M committee for a complete investigation/review.
   - All UORS submitted due to Confidentiality, PHI potential breaches or unethical conduct by the staff were routed to the corporate and compliance officer for further investigations.
   - The system addressed concerns illuminated in the UORs by proving direction, training, and guidance during supervision and/or team meetings.
   - QID collaborated with our training department to ensure all staff who work at PEC were provided a specific de-escalation technique training, this training was also available for other staff in other teams.

4. **Data Used to Measure the Outcome of this QI Goal:**

UORs FY 21-22					
QTR	**KernBHRS**	**Contract Providers**	**Total Submitted**	**Total # Addressed Appropriately**	**GOAL 100%**
1Q	**209**	**212**	**421**	**382**	**91%**
2Q	**159**	**196**	**355**	**322**	**92%**
3Q	**140**	**165**	**305**	**303**	**99%**
4Q	**194**	**229**	**423**	**375**	**87%**
Annual Total	**702**	**802**	**1504**	**1382**	**92%**

- Reason for goal not met for each qtr is due to UORs not being submitted within prescribed timeframes. Teams addressed incidents appropriately. When reports are not fully completed, QID is unable to review if actions steps taken by team, or administration are appropriate for the incident.





5. **Summarize the Results of Actions Taken:**

- Unable to obtain goal of 100% due to reports awaiting approval at time of completing quarterly report.
- Reasons for goal not met for each quarter are due to timeliness as the reports were not completed on time and action steps or steps taken by the team were not able to be reviewed at time of QIC reports. After all actions steps were completed, full reviews were done on all reports and actions taken by teams were appropriate for the incidents.
- Discrepancies in report. We had a total of 1517 UORs reported in FY 21-22, however only 1504 were noted in table of section 4. This is due to 13 reports that were submitted in the app after the QIC reports were completed for the quarters.
- Overall, this year we have seen an increase in contracted providers submission of reports compared to last year's total of 582. This is due to adding more contract provider access to the app.

6. **Plan for Current Goal:**

☒ Change goal

Due to timeliness issues with completion of reports each quarter, and the need to monitor that the teams addressed those incidents in a timely manner, QID recommends making changes to the goal to include that these reports are completed within 14 days from incident.

The new recommended goal is: 98% of all completed and signed MHP Outpatient UORs will be addressed in an appropriate manner.

The recommend new goal of 95% of UOR will be completed and signed by Contract Administrator and KernBHRS administrator within the required timeframes.

Goal #18 Utilization Management MHP

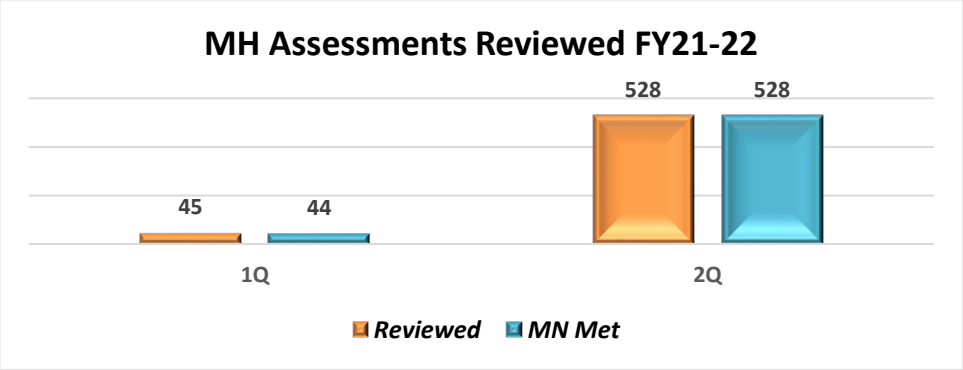
1. **Quality Improvement Goal:**
   95% of all reviewed MH assessments will have an appropriate determination on Medical Necessity documented.

2. **2021/2022 The Goal Was:**

   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   - QID provided training to system of care and contracted providers to include new Access to Care criteria and difference between this and Medical Necessity for Specialty Mental Health Services to ensure all clinicians are using new criteria to assess clients.
   - QID developed a new mental health assessment to help clinicians in their assessment process to expedite the assessment period and improve access time for clients.
   - QID continued to provide monthly assessment training to all new clinicians for all internal and contracted providers to ensure everyone is evaluating all beneficiaries in a similar manner.
   - QID updated training material to reflect changes to the new DHCS Domains and new form.
   - Due to staffing shortages and other duties, QID was not able to do clinical assessment UM reviews by an LPHA every quarter this year but sought the help of other clinicians in the department when possible.

4. **Data Used to Measure the Outcome of this QI Goal:**



. **Summarize the Results of Actions Taken:**
   - All Teams were reviewed at least once during this year.
   - A total of 573 Assessments were reviewed this fiscal year.
   - All assessments, with the exception of 1, documented appropriate determination of medical necessity for the clients.
   - 1 Assessment did not document medical necessity, but team was contacted to ensure client was linked to the appropriate service provider.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #19 Utilization Management SUD

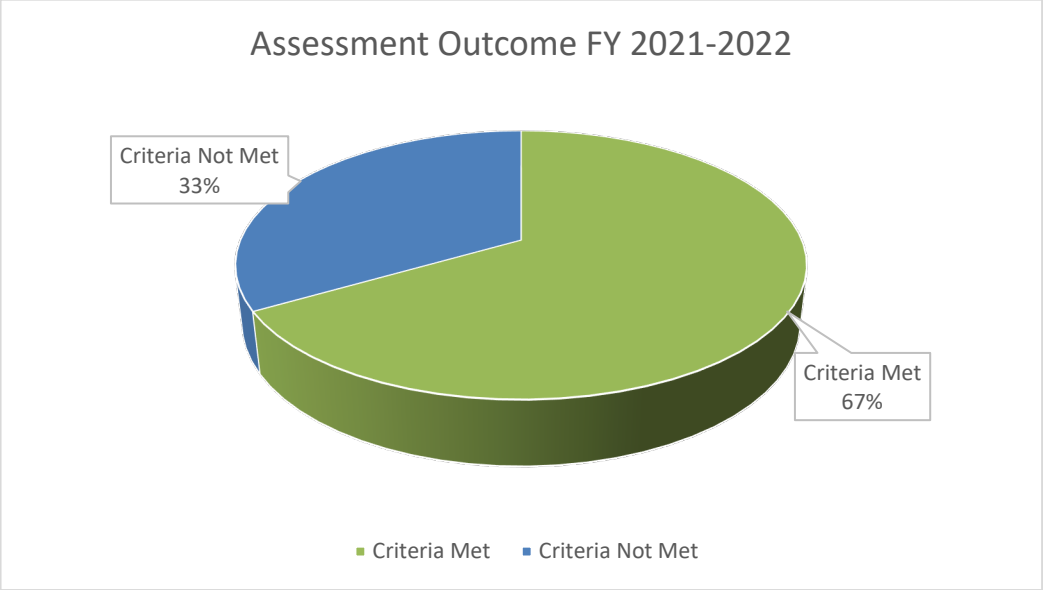
1. **Quality Improvement Goal:**
   95% of all SUD ASAM Assessments reviewed will document appropriate medical necessity for services.

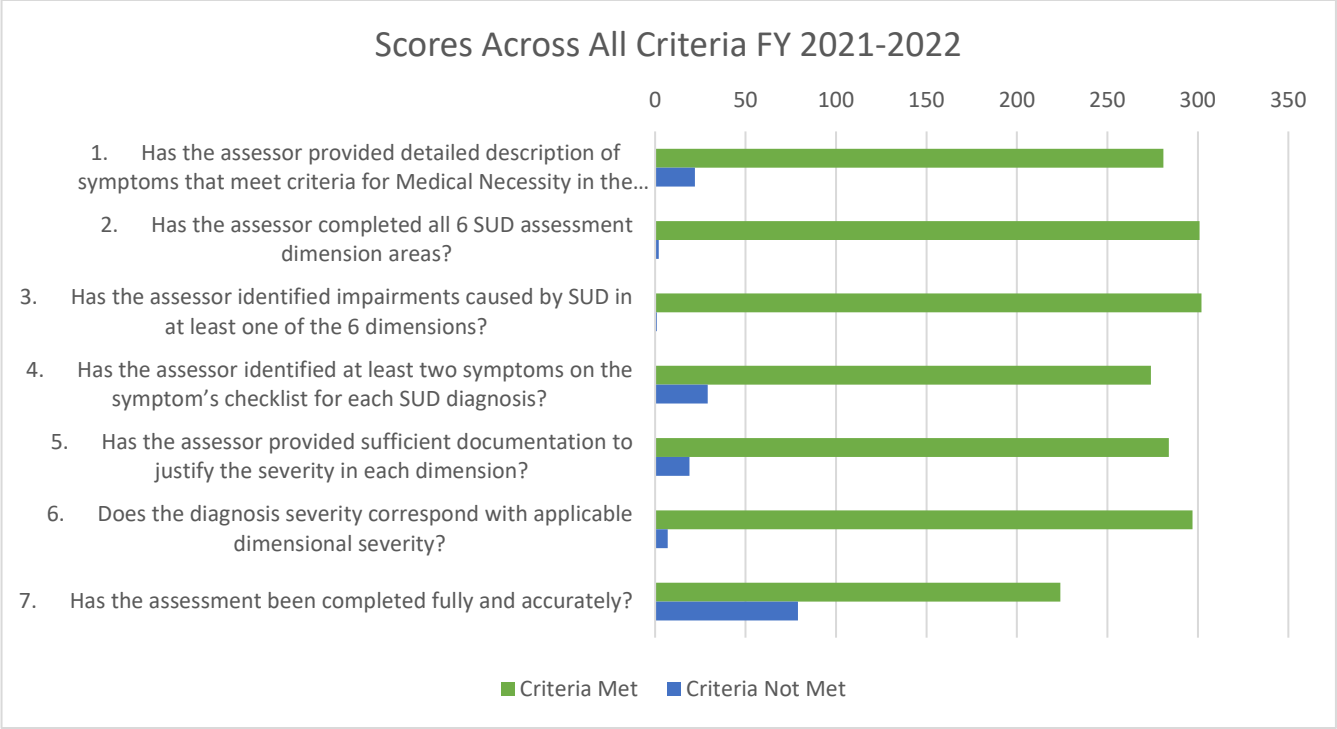
2. **2021/2022 The Goal Was:**

   ☐ MET ☒ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   During fiscal year 2021 to 2022 the following steps were taken to affect change and meet the workplan goal.
   - An audit tool was developed using the mental health audit tool to assist in identifying elements that would be related to determine medical necessity.
   - The plan worked to audit 10% of all assessments completed by each provider quarterly
   - Throughout the fiscal year the audit tool was refined to remove criteria that did not inform the goal and allowed staff to continue to audit the same volume of assessments.
   - The plan began providing audit summary results to treatment providers in July.

4. **Data Used to Measure the Outcome of this QI Goal:**





5. **Summarize the Results of Actions Taken:**

- Of the 95% percent goal established 67% of the assessments reviewed documented appropriate medical necessity for FY 2021-2022.
- Of the criteria rated, criteria 7 was missed with higher frequency across all providers each quarter.
- Criteria 1,2, and five showed improvements from quarter 1 to quarter 4.
- During the second quarter steps were taken to reduce criteria being rated allowing the plan to exclude criteria that did not inform the goal and allow the plan to maintain similar sample sizes during all four quarters.
- During the second quarter the plan contacted provider staff directly to discuss errors found in their assessments.
- The plan successfully provided audit summaries to each provider site supervisor with a break down on the errors found and tips to empower them to provide target training to staff.
- Beginning next fiscal year, the plan will begin providing detailed audit reports that will provide the clients identifying information, date of assessment, the name of the staff who completed the assessment, criteria evaluated and detailed comments on errors found.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year