QUALITY IMPROVEMENT WORK PLAN FY23-24 – EVALUATION

County of Santa Cruz Behavioral Health Division
Mental Health Plan and Drug Medi-Cal Organized Delivery System

PURPOSE

Santa Cruz County Behavioral Health Division Quality Improvement Work Plan: Santa Cruz County Behavioral Health Division (BHD) in a Behavioral Health Plan in which leadership and staff value operational excellence and sustainable quality of care.
The purpose of the QI Work Plan's activities includes, but is not limited to:

- Ensuring that beneficiaries have timely access to appropriate and quality services which are authorized in a timely manner and meet network adequacy standards;
- Promoting evidence-based practices and monitoring the effectiveness of treatment;
- Ensuring coordination of appropriate care;
- Including beneficiary involvement through monitoring beneficiary satisfaction and review of beneficiary grievances, appeals and requests to change treatment staff;
- Ensuring compliance with documentation standards;
- Review and improve Behavioral Health's utilization management systems, including prevention of fraud, waste and abuse;
- Monitoring Performance Improvement Projects for BH;
- Ensure on-going development of BH workforce, including cultural and linguistic competence.

BH Quality Improvement branch / QI Steering Committee is responsible for monitoring the MHP's and DMC-ODS' effectiveness and for providing support to all areas of MHP/DMC-ODS operations by conducting performance monitoring activities.

The committee's activities are guided by the relevant sections of federal and state regulations, including the Code of Federal Regulations Title 42, California Code of Regulations Title 9, California Welfare and Institutions Code, as well as DHCS' relevant MHP/DMC-ODS contract requirements and performance measures. These activities are performed by the Quality Improvement

branch in partnership with MHP and/or DMC-ODS branches to ensure compliance and promote department and BH agency quality improvement initiatives.

Quality Improvement Work Plan: The intent of the Quality Improvement (QI) Work Plan is to ensure data relevant to the performance of the MHP and DMC-ODS Plans is available to MHP and DMC-ODS branch leadership, contract partner leadership, community members and individuals with lived experience. Elements of the Plan are informed by quality improvement requirements of the MHP and DMC-ODS contracts and agreements, feedback from the External Quality Reviewer, DHCS MHP/DMC-ODS audit findings & recommendations, and the Quality Improvement Committee.
The QI Work Plan goals are **s**pecific, **m**easurable, **a**chievable, **r**elevant and **t**ime-bound (SMART) and focus on service and operational improvement initiatives that align with our core trauma-informed guiding principles, Health Service Agency (HSA) values and BH staff surveyed value priorities.

Behavioral Health Values & Core Guiding Principles

Inclusion & Engagement	Cultural humility & responsiveness ● Human connection and relationship ● Universal dignity, respect, kindness, and compassion ● Offerings of support and gratitude ● Transparency and collective communication ● Timely accessibility ● Inclusion of client voice/choice ● Dependability
Operational Excellence & Service Stewardship	Excellent effective care and customer service delivery ● Adaptability ● Ethics ● Responsibility ● Accountability ● Innovation ● Utilize outcomes to improve care, support program decisions and share with other healthcare providers and the greater community.
Targeted Treatment & Evidence-Based Services	Trauma-informed care ● Individualized “Voice & Choice” care ● Targeted Health ● Clinical quality & fidelity to EB practices ● Utilize data outcome to inform decisions ● Workforce Training
Equity & Sustainability	Promote resiliency and recovery (personal/social/environmental/economic) ● Collective impact ● Equity for All ● Justice ● Integrity ● Collaboration ● Holding hope & Eliminating stigma ● Positivity ● Capacity building
Safety	For all who provide and receive services from SCCBHS, including staff, clients, contractors, partners, stakeholders, and our community at large. Safety includes physical, emotional and self-care when at county facilities, remote work setting and/or in community

WORK PLAN GOAL CATEGORIES

1. **Access to 24/7 Services (Timeliness, Crisis Services, Authorization, Network Adequacy)**
2. **Coordination of Care**
3. **Beneficiary Rights & Satisfaction**
4. **Documentation Standards Compliance & Utilization Management**
5. **Quality Improvement**
6. **Cultural & Linguistic Competence**

GOALS

Category #1: Access to 24/7 Services (Timeliness, Crisis Services, Authorization, Network Adequacy)

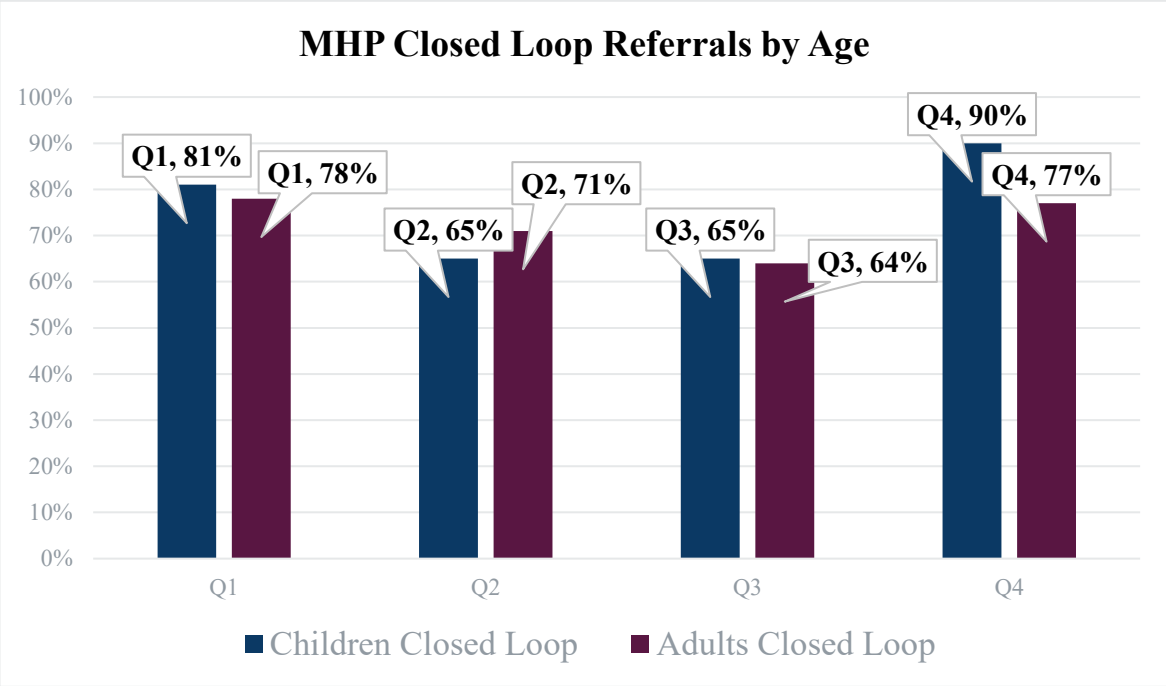
Goal / Requirement	Plan	Goal Sponsor	Action Steps	Measurement
1.1a: BH MHP Access teams will have a closed-loop referral tracking system with the MCP which includes documentation that the beneficiary was linked to treatment 90% of the time by June 30, 2025. **Requirement: CalAIM** (Also aligns with Strategic Plan Goal #3)	MHP	MHP Access Teams	❖ County MHP will work with the MCP and community partners to maintain a closed-loop referral tracking system.	Quarterly review of MHP / MCP tracking spreadsheets to determine % of referrals where the beneficiary was linked to treatment.

Review Findings: ☐ Met ☒ Partially Met / Further work ☐ Not Met

We've identified the need to refine our goal by excluding clients who declined services or those we were unable to reach because of disconnected or incorrect contact information.

FY 24-24=5 Data: Closed Loop Referral Outcome – Linkage to services

	Q1	Q2	Q3	Q4	Annual Average
Children / Youth documented to have closed-loop referral	**81%**	**65%**	**65%**	**90%**	**75%**
Children/Youth unable to contact or declined services	19%	35%	35%	10%	25%
Adults documented to have closed-loop referral	**78%**	**71%**	**64%**	**77%**	**73%**
Adults unable to contact or declined services	22%	29%	36%	23%	27%

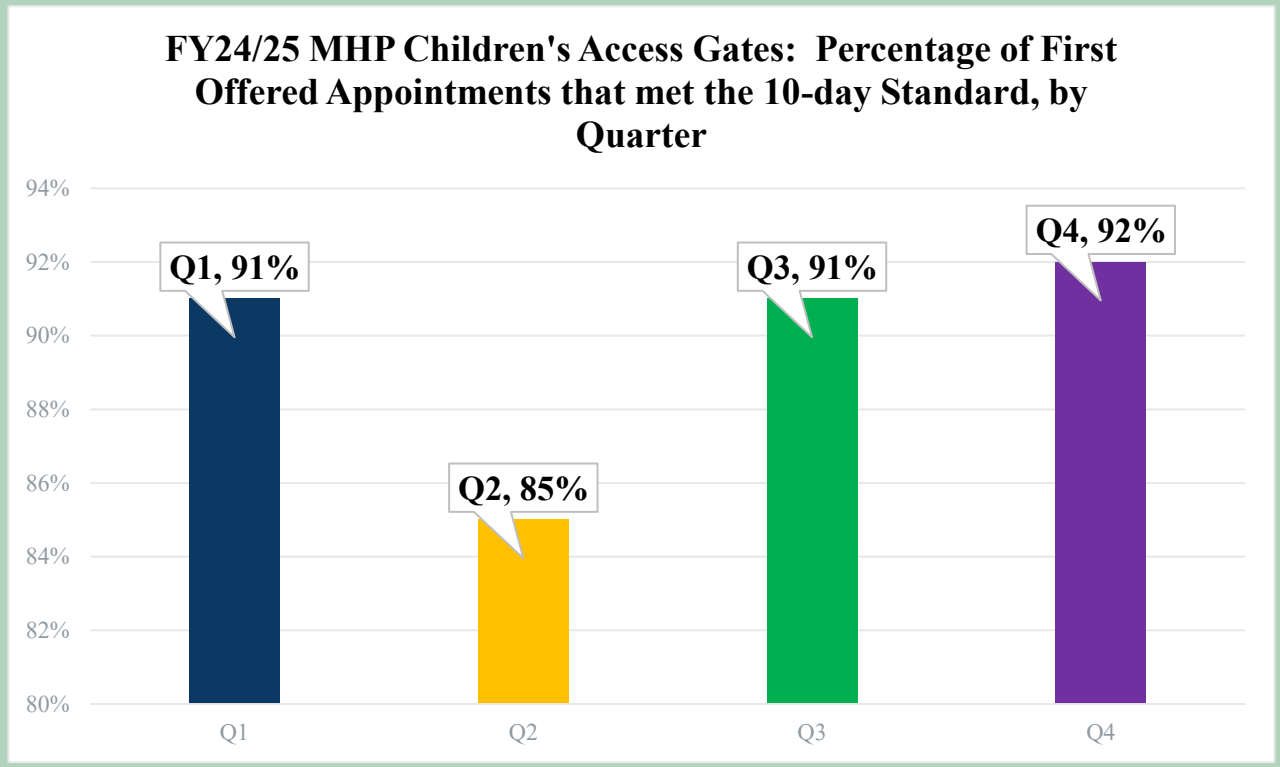


1.1b: Children's Access Team and Children's contract partner gates (PVPSA, Encompass, Parents Center) will utilize the EHR Service Request & Disposition Log (SRDL) to document referrals between County and contract partner agencies for youth who are screened to be assessed by the MHP. For youth referred to Pacific Clinics, Children's Access Team staff will ensure SRDL is completed and finalized as Pacific Clinics staff do not utilize the SRDL.	MHP	MHP Children's Access Team & contract partner gates for Children's BH	❖ The Children's Access Team will work with contract partner gates to utilize the SRDL with accuracy to track referrals.	Quarterly review of SRDL to track referrals from County BH Access to youth contract partners intake teams.

Goal statements: All youth referrals will have a first offered appointment within 10 business days from the original service request date 90% of the time by June 30, 2025. **Requirement: CalAIM** (Also aligns with Strategic Plan Goal #3)				

Review Findings: ☒ Met ☐ Partially Met / Further work ☐ Not Met

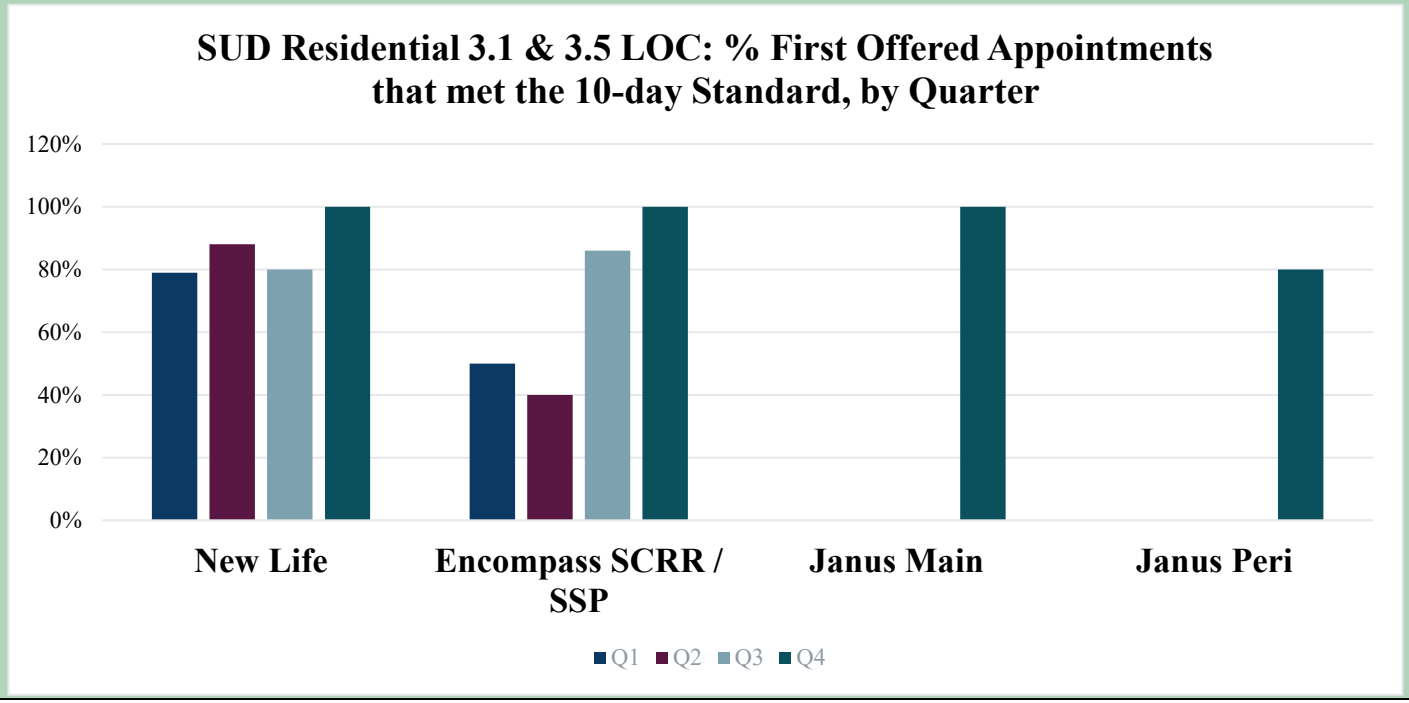
Children's BH was able to offer appointments within timely access standards (80%) & also meet their goal of 90% in 3 of 4 quarters.



1.2: DMC-ODS residential treatment (3.1 and 3.5 LOC) will meet the 10-day first offered initial appointment standard 90% of the time by June 30, 2025. **Requirement: BH DMC-ODS Contract (IA) & 42 CFR § 438.68**	DMC-ODS	DMC-ODS Clinical Teams	❖ Network providers to utilize the SRDL for all requests for services, including residential treatment (3.1 & 3.5). ❖ QI team to review monthly reports of residential treatment service utilization and cross-reference with SRDL to ensure accurate data entry.	Data Sources: SRDL Timeliness Report; billing data

Review Findings: ☐ Met ☐ Partially Met / Further work ☒ Not Met

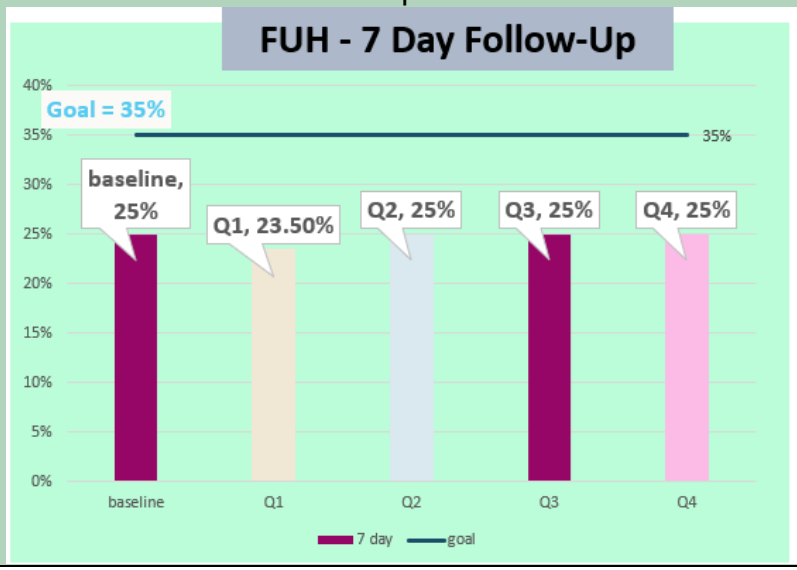
Much of the work on this goal this fiscal year was to bring SUD residential providers into compliance with completing data entry so that the Plan can accurately measure timely access to residential treatment. Janus had not been entering timely access data at the beginning of the fiscal year – by the end of the fiscal year both Janus programs were completing required data entry.

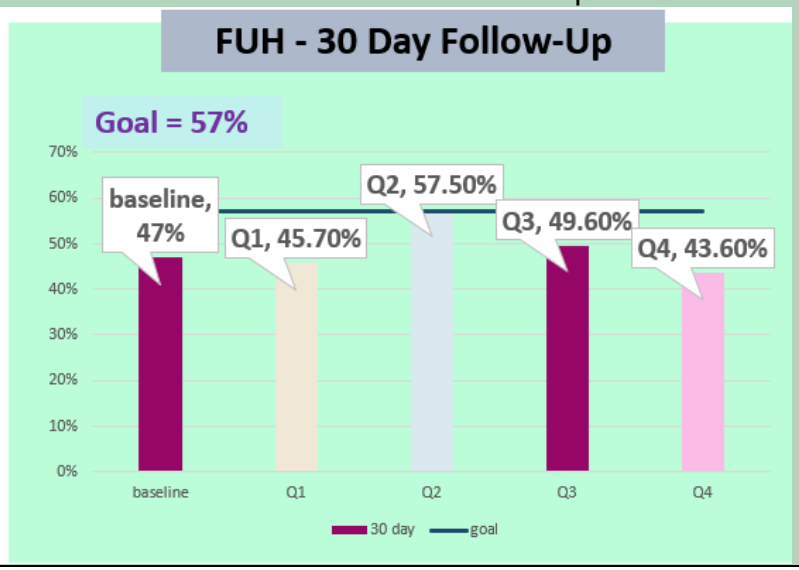


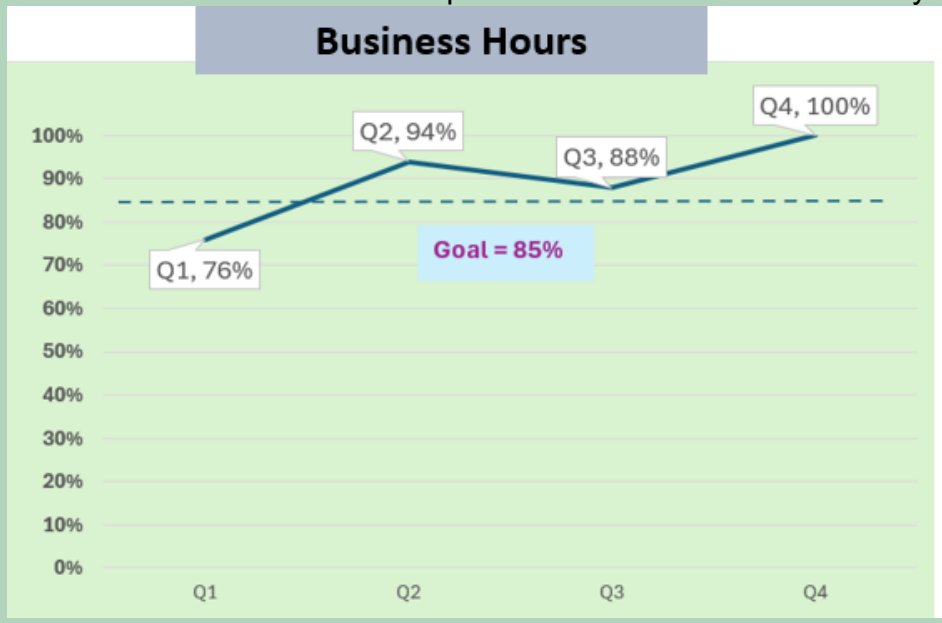
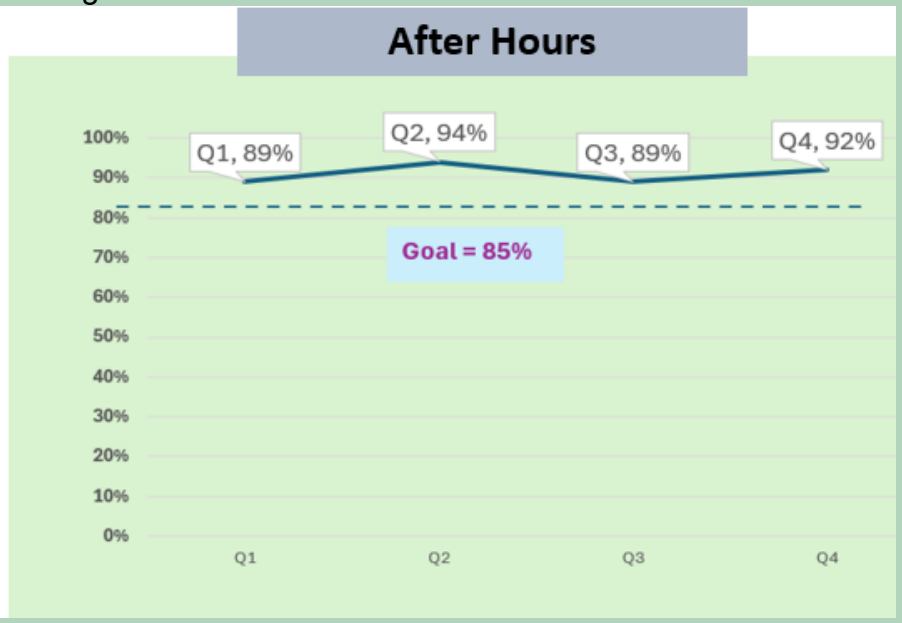
1.3: BH MHP will improve post-inpatient hospitalization BH appointment completion within 7 & 30 days of discharge for Medi-Cal beneficiaries & indigent Santa Cruz County residents. **1.3a:** First rendered service post inpatient hospitalization will occur within 7 days of discharge 35% of the time by June 30, 2025. **1.3b:** First rendered service post inpatient hospitalization will occur within 30 days of discharge 57% of the time by June 30, 2025. Baseline for 7 days = 25% (FY 23-24) Baseline for 30 days = 47% (FY 23-24) **Requirement: MHP Contract; NCQA HEDIS Measure FUH**	MHP	QI, Access Teams, Clinical Teams	❖ MHP Adult Access teams to work with inpatient social workers on discharge planning and discharge documentation ❖ Utilize contract with Carelon, including their reports to understand the data regarding post-inpatient hospital completion of appointment rates to create strategies to impact follow up appointment rates.	Carelon concurrent review reports (FUH Discharges and quarterly JOM reviews).

Review Findings: ☐ Met ☐ Partially Met / Further work ☒ Not Met

The MHP will continue work on this required HEDIS measure in FY 25-26 Work Plan as we were not able to improve in FY 24-25.



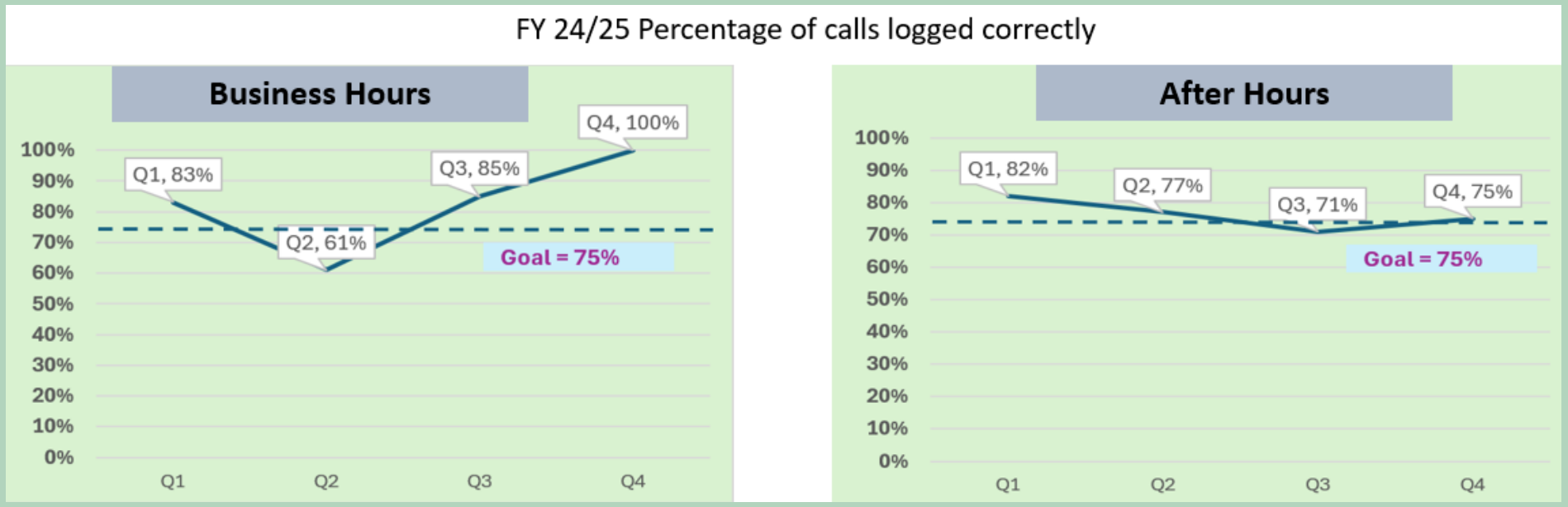


1.4a: The Plan will monitor success of 24/7 crisis / access 800# as measured by 85% of business & after-hours test callers (English & Spanish) will receive information on how to access services when requested by June 30, 2025. **Requirement: BH MHP & DMC-ODS contract; CCR Title 9, § 1810.440(a)(5) and 42 C.F.R. § 438.416(a)**	MHP & DMC-ODS	BH Quality Improvement & Contract Partner Community Connections	❖ Conduct test calls (English & Spanish; business hours / after-hours). ❖ Track performance ❖ After-Hours contract partner will provide QI with their internal QA analysis x2/month & BH QI will review.	Data source: DHCS 800# test call report & DMC-ODS tracking report
Review Findings: ☒ Met ☐ Partially Met / Further work ☐ Not Met Both Business and After-Hours operators were able to successfully meet this goal.   				
1.4b: Business and after-hours 800# operators will appropriately record phone calls, including name, data and	MHP & DMC-ODS	BH Quality Improvement & Contract Partner Community Connections	❖ Conduct test calls (English & Spanish; business hours / after-hours). ❖ Track performance	Data source: DHCS 800# test call report & DMC-ODS tracking report

disposition of call 75% of the time by June 30, 2025. **Requirement: BH MHP & DMC-ODS contract; CCR Title 9, § 1810.440(a)(5) and 42 C.F.R. § 438.416(a)**			❖ After-Hours contract partner will provide QI with their internal QA analysis x2/month & BH QI will review.	

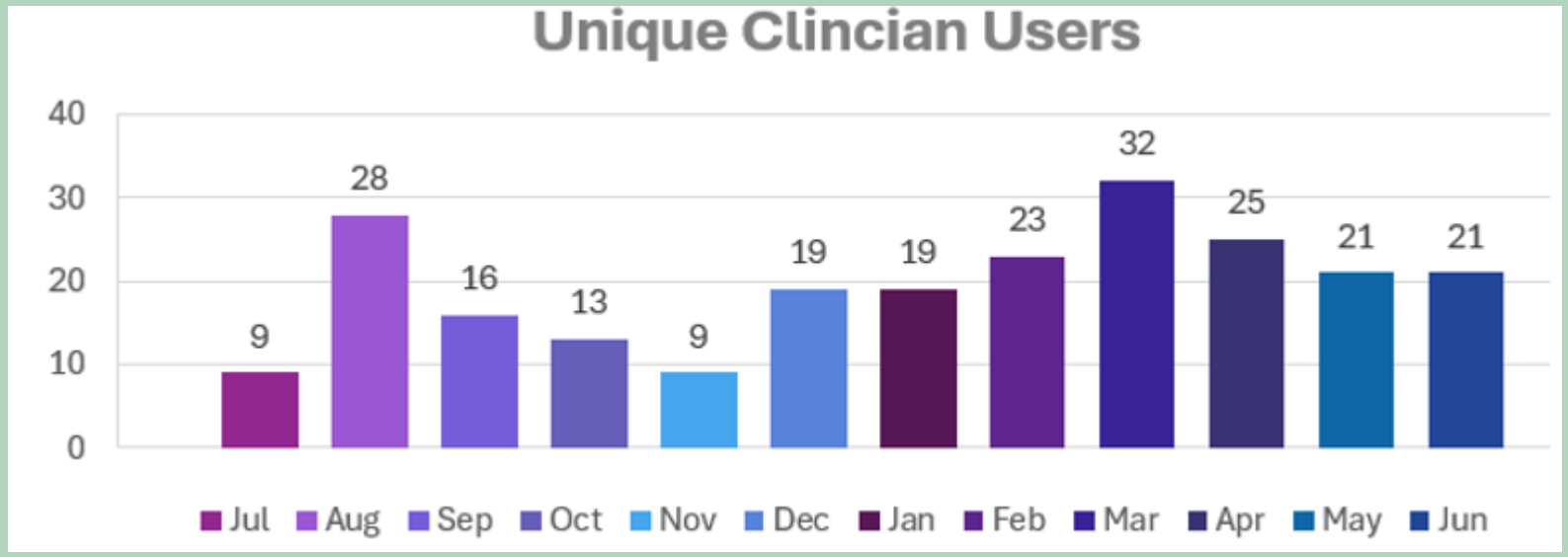
Review Findings: ☒ Met ☐ Partially Met / Further work ☐ Not Met

Both Business and After-Hours operators were able to successfully meet this goal.



Category #2: Coordination of Care

Goal / Requirement	Plan	Goal Sponsor	Action Steps	Measurement
2.1a: The MHP will utilize the CANS / ANSA at 6-month intervals as an assessment tool to support increased transitions for beneficiaries to a lower level of care.	MHP	MHP Clinical Teams & Access Teams	❖ Clarify expectation that staff will log into DataPool portal and download CANS / ANSA	2.1a: Unique clinician log-ins into DataPool to download/print

Goal: Clinicians will increase their use of DataPool reports by 25% by June 30, 2025 as measured by unique # of clinicians logging into DataPool at baseline (11.2) vs June 2025 (goal = 14) Baseline: average of 11.2 reports / month (CY 2022, CY 2023 & Jan-June CY 2024) Goal = 25% increase (2.8) or 14. **DHCS Requirement: CalAIM** (aligns with Strategic Plan Goal #1)			"Take Home Reports" for use in client interactions. ❖ Offer training, as needed, to staff about how to use CANS / ANSA within client interactions.	"Take Home Reports" each month/quarter
Review Findings: ☒ Met ☐ Partially Met / Further work ☐ Not Met MHP had enhanced consistency of data during FY 24-25; by the end of FY 24-25 we were meeting our goal for # of unique clinicians logging into DataPool each month.  				
2.1b: 100% of clients who have received Specialty Mental Health treatment from the MHP and transfer from the MHP to MCP will have a completed Transition of Care Tool during FY 2024-2025.	MHP	MHP Clinical Teams & Access Teams	Add button to avatar transition tool form to demonstrate if Transition of Care Tool was at intake or	2.1b: Data Source: AVATAR Transition Tool Outcome Report

DHCS Requirement: CalAIM (aligns with Strategic Plan Goal #1)			step-down after treatment episode	

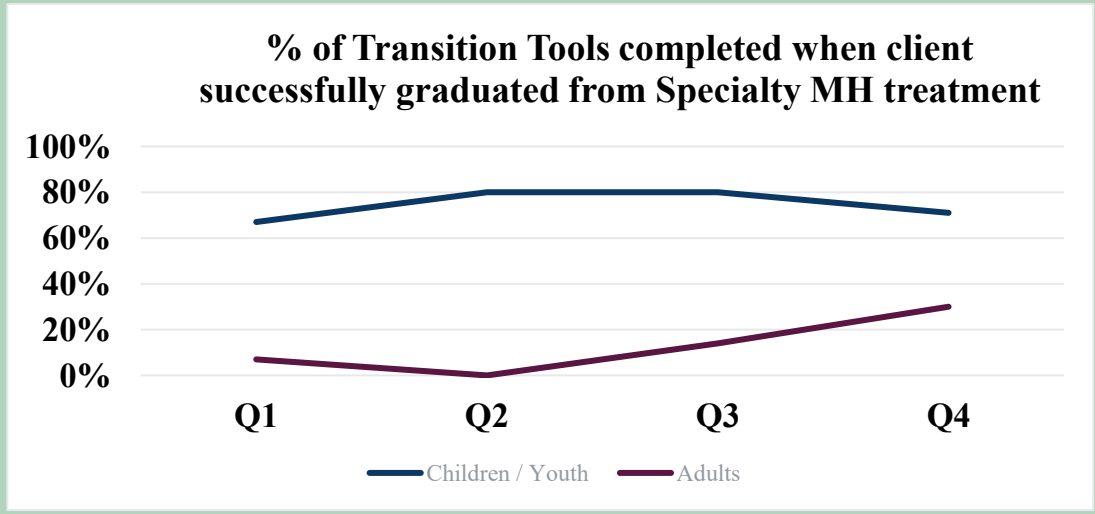
Review Findings: ☒ Met ☐ Partially Met / Further work ☐ Not Met

At the start of FY 24-25, the MHP primarily used the Transition Tool prior to a member's entry into Specialty Mental Health (SMH) treatment. When a Medi-Cal member's screening tool score indicated the need for an SMH assessment, and that assessment determined the member would be better served by the Managed Care Plan (MCP), Access staff appropriately used the Transition Tool to refer the member for MCP mental health services.

As the year progressed, more clients completed treatment with the SMH Plan, with clinical staff using the Transition Tool to step members down to MCP for a lower level of care. Behavioral Health was encouraged by the increase in members successfully completing treatment and transitioning to MCP care.

The Plan met the goal of consistent use of the Transition Tool at 100% every quarter.

Additionally the QI Team collected data on the % of Transition Tools utilized to step clients down to lower level of care after successful treatment with the SMH Plan.



2.2: BH DMC-ODS will utilize the SRDL to document closed loop referrals when beneficiaries initially requesting treatment are referred to another program 75% of the time by June 30, 2025. **Requirement: CalAIM** (Also aligns with Strategic Plan Goal #3)	DMC-ODS	DMC-ODS Clinical Teams	❖ County BH DMC-ODS will work with contract partner DMC-ODS agencies to ensure closed-loop referrals occur and are tracked.	Tracking referrals through SRDL report.

Review Findings: ☐ Met ☐ Partially Met / Further work ☒ Not Met
Early in the work plan, the QI Team identified inconsistent use of the Service Request & Disposition Log (SRDL) across the DMC-ODS network, which hindered referral tracking. In response, the team developed and implemented a standardized workflow, provided targeted SRDL training, and established accountability measures for all programs. By year-end, the workflow was fully in place, all relevant staff were trained, and initial data showed improved accuracy and consistency in referral documentation.

2.3: BH medication support team will implement and maintain a tracking system for the HEDIS measure APM (Metabolic Monitoring for Children and Adolescents on Antipsychotics) to ensure appropriate monitoring of care by June 30, 2025. **DHCS Requirement: EQRO / HEDIS measure tracking**	MHP	MHP Medication Support Team / Medical Directors	❖ Medical Directors (MDs) to identify data to track ❖ MDs to create tracking log & identify how data will be added to log ❖ MDs will report out at quarterly QIC	Data source: tracking log

Review Findings: ☒ Met ☐ Partially Met / Further work ☐ Not Met
Q1: The Medical Director gathered anecdotal feedback from the psychiatry team regarding current practices. Together with QI staff, they developed a data collection strategy, created a standardized template, and established a plan for the Medication Support Analyst to track data monthly.
Q2: QI staff collaborated with IT, who provided sample data sets capable of identifying the cohort of youth prescribed antipsychotic medications. The Medication Support Analyst would then use these data and the collection tool to determine whether metabolic monitoring had been completed.
Q3: Formal data collection and review commenced.

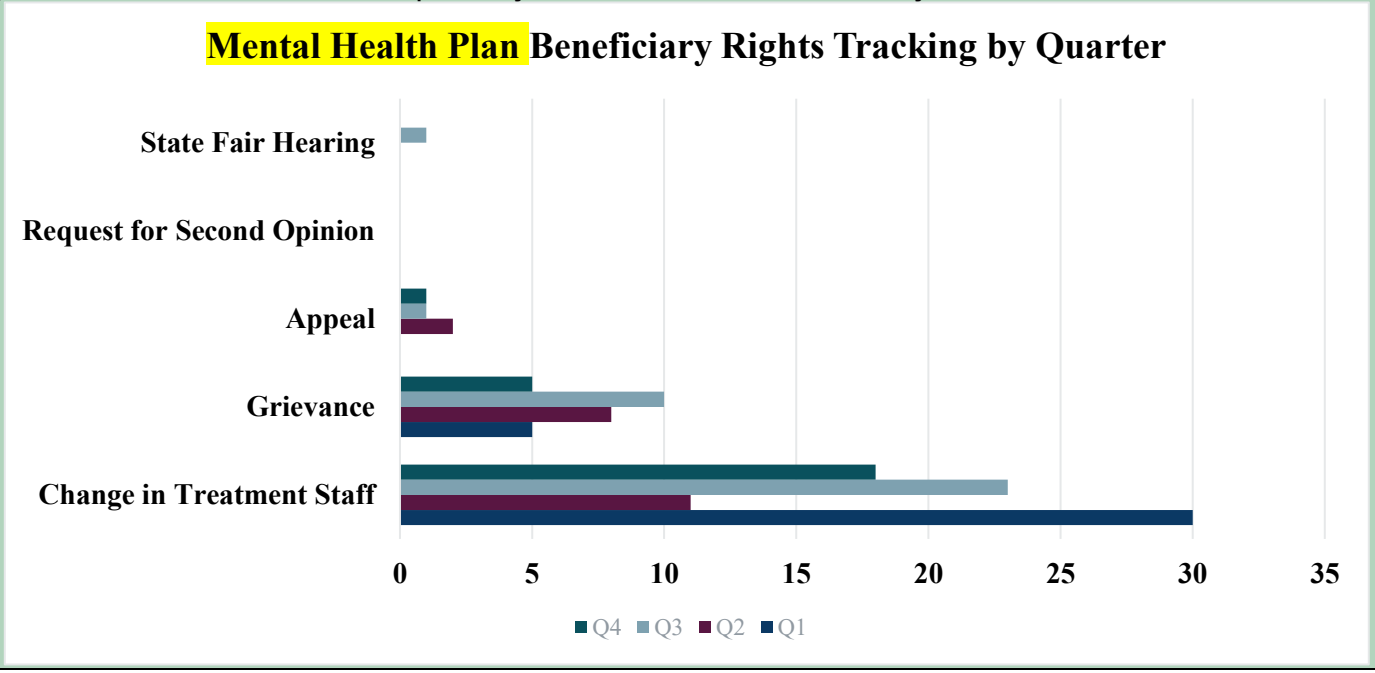
	Q3	Q4
Total # of Youth who received antipsychotic medication	**23**	**28**
Metabolic Monitoring Fully achieved	**69%**	**57%**
Body Mass Indices present	**91%**	**100%**
Complete labs present	**83%**	**57%**
Appropriate actions taken by MD regarding metabolic consequences of the medication	**100%**	**100%**

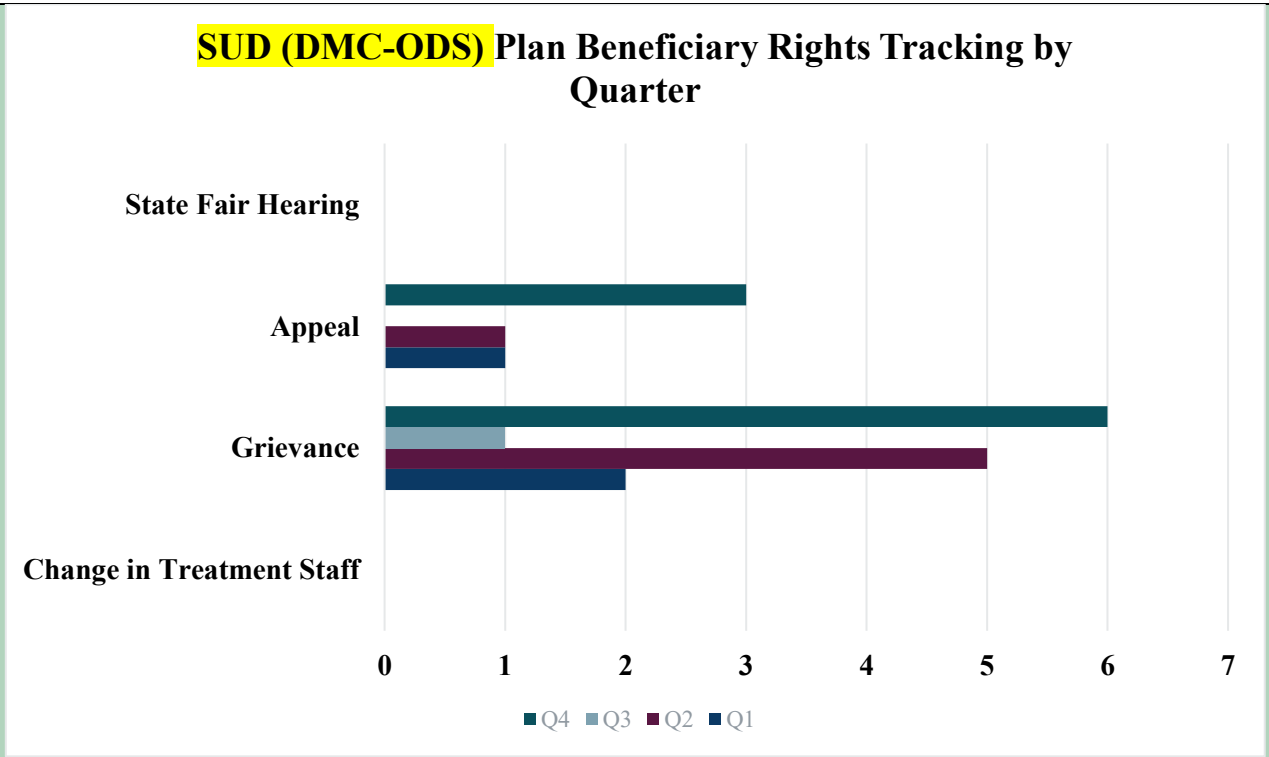
Category #3: Beneficiary Rights & Satisfaction

Goal / Requirement	Plan	Goal Sponsor	Action Steps	Measurement
3.1: The Plan will evaluate beneficiary requests to change treatment providers, grievances, appeals and fair hearings in accordance with the Managed Care Program Annual Report (MCPAR) requirements throughout FY 2024-2025 and will report data to the QIC. **DHCS Requirement: BH MHP & DMC-ODS contracts & CCR Title 9 § 1810.440**	MHP & DMC-ODS	BH Quality Improvement	❖ Utilize data tracking (BHET database) method to track & review beneficiary rights items. ❖ Grievances, appeals, & change in treatment staff requests will be reviewed & evaluated quarterly to identify any trends.	Data source: BHET Database

Review Findings: ☒ Met ☐ Partially Met / Further work ☐ Not Met

All beneficiary rights items were tracked on a quarterly basis and closed in a timely manner; here is the data:





3.2: The Quality Improvement team will track all sentinel events for MHP & DMC-ODS. The QI team will report to the QIC the types of sentinel events by program and the types of sentinel events that led to a review. **DHCS Requirement: BH MHP & DMC-ODS contracts & CCR Title 9 § 1810.440**	MHP & DMC-ODS	BH Quality Improvement	❖ Utilize data tracking (BHET database) method to track & review beneficiary rights items.	Data source: BHET Database

Review Findings: ☒ Met ☐ Partially Met / Further work ☐ Not Met

All sentinel events were logged and tracked on a quarterly basis; here is the data:

Sentinel Event Reporting

FY2025 totals: July 1, 2024 –June 30, 2025

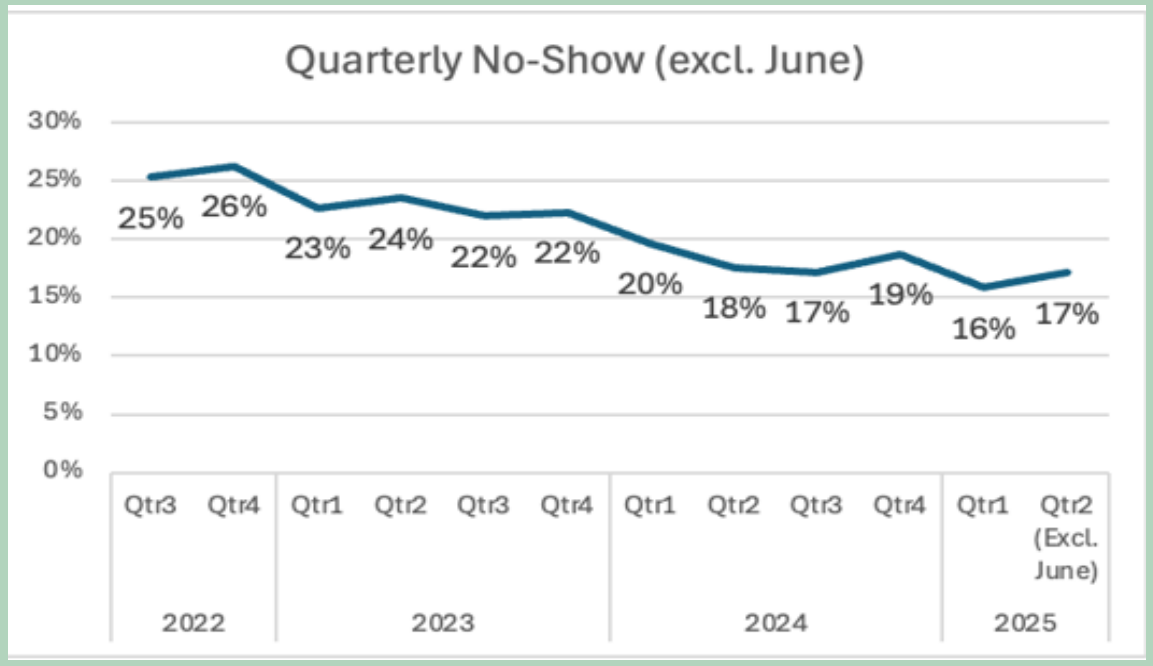
Sentinel Event Report Types (Q1-Q4)	Mental Health Services	Substance Use Disorders Services	Total
Emergency medical treatment	48	21	69
Other	33	5	38
Client AWOL	20	0	20
Event involving Law enforcement	16	2	18
Serious Injury from Assault	10	1	11
Death-Unknown Cause	8	1	9
Non-Suicide Death	8	7	15
Suicide Attempt with Injury	6	0	6
Self-Injury Non-Suicide	5	0	5
Sexual Assault/Abuse	4	0	4
Suicide Death	4	0	4
Med Error No Injury	4	1	5
Accidental Injury	3	3	6
Death from Overdose	1	0	1
Homicide Attempt	1	0	1
Grand Total	171	41	212

*Other includes threats of violence, CPS reports, & non-categorical incidents.

3.3: BH MHP will decrease the no-show rate for medication support staff appointments (MD / NP) by CY 2024 close by 4 percentage points to 20.2% The MHP will have a Performance Improvement Project (PIP) to support this effort. Baseline med support no-show rate FY 2023-2024 = 23.7% **DHCS Requirement: BH MHP contract; CCR Title 42 § 438.240**	MHP	MHP Medication Support Team / Medical Directors And BH Quality Improvement	❖ Define intervention ❖ Train med support staff (MD / NP / MA) regarding intervention ❖ Track data ❖ Adjust intervention(s) as indicated	Data Source: Avatar scheduling calendar and billing codes from medical progress notes Data tracking log (spreadsheet) that MAs fill out

Review Findings: ☒ Met ☐ Partially Met / Further work ☐ Not Met

The MHP successfully decreased no-show rates for medication support staff by over 4 percentage points.

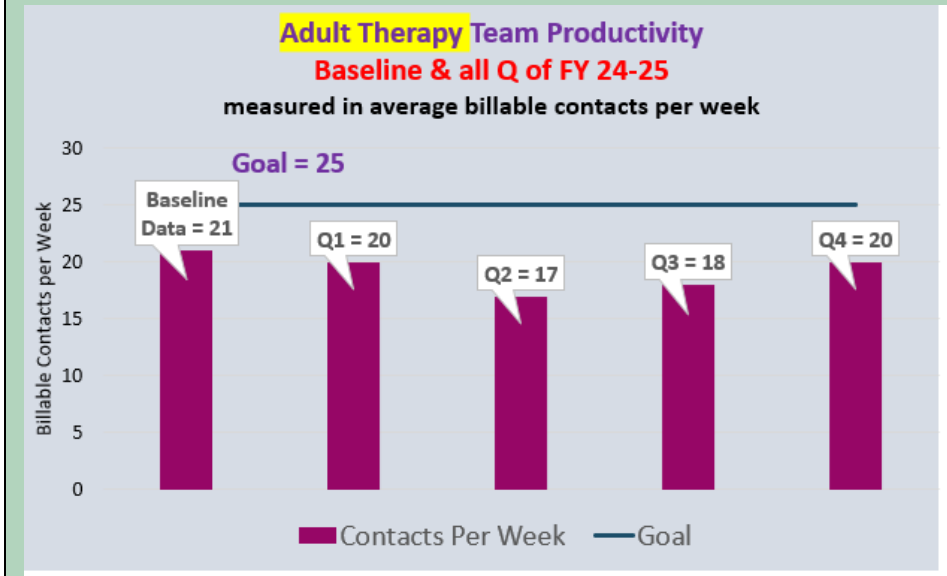


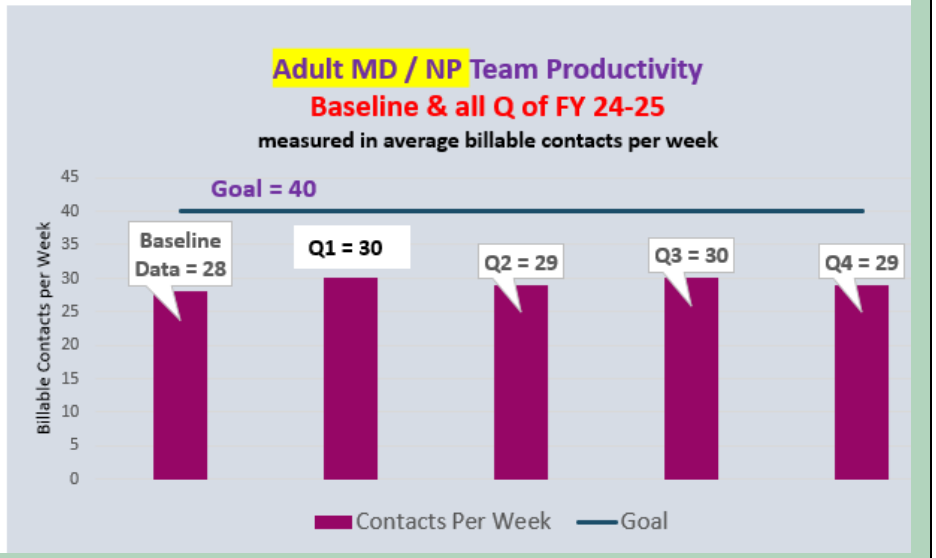
Category #4: Documentation Standards Compliance & Utilization Management

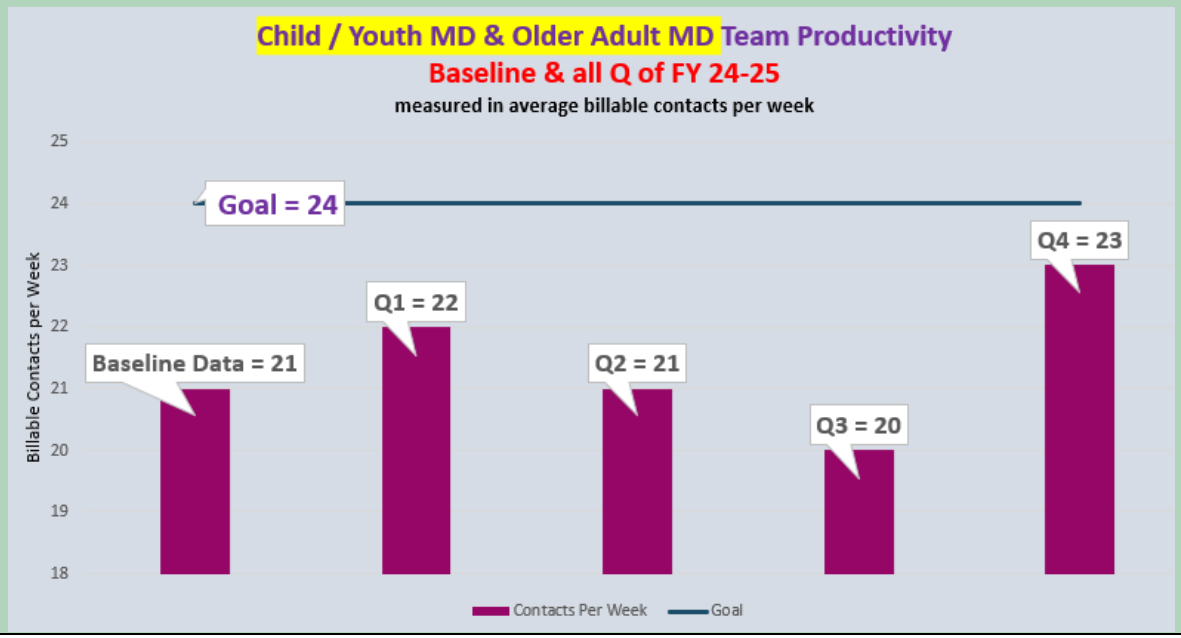
Goal / Requirement	Plan	Goal Sponsor	Action Steps	Measurement
4.1: BH will improve County provider productivity to meet BH standards set in policy by June 30, 2025. Policy Standards / Baselines from Q4 FY 23-24): **FQHC therapy** = 25 billable contacts / week (baseline = 7 contacts / week) **Adult FQHC MD/NP (non-geriatric)** = 40 billable contacts / week (baseline = 11 contacts / week) **Child FQHC & Adult Geriatric MD/NP** = 24 billable contacts / week (baseline = 5.75 billable contacts / week) **Adult Access Team staff** = 25% of time worked (baseline = 7%) **Children's Access Team staff =** 10% of time worked (baseline = 6%) **Crisis Team staff** = 20% of time worked (baseline = 6%) **MHP & DMC-ODS Service Team staff** = 50% of time worked (Adult MHP baseline = 36.5% Children's MHP baseline = 24% DMC-ODS baseline = 12%) **DHCS Requirement: CalAIM & CCR Title 9 § 1810.440**	MHP & DMC-ODS	BH Quality Improvement	❖ Hold bi-weekly leadership meeting in which leadership shares on-going team productivity and discusses / operationalizes change management strategies. ❖ Use of Power BI reports to track / report back to providers in supervision ❖ Leadership to develop and test change strategies with goal to increase billable services	Data source: Power BI

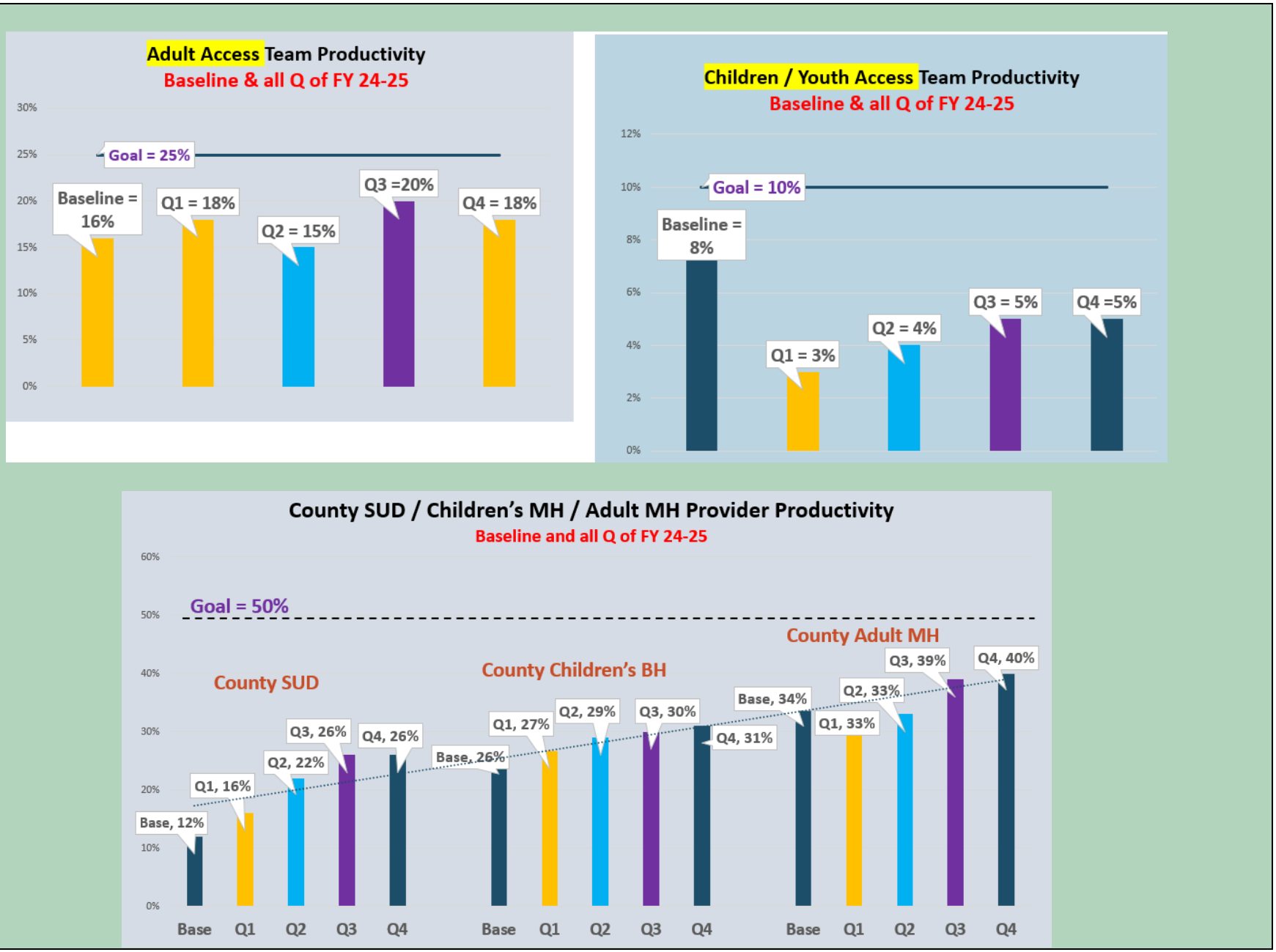
Review Findings: ☐ Met ☐ Partially Met / Further work ☒ Not Met

BH was not able to meet BH productivity standards discussed in policy. Here is the data:


Adult Therapy Team Productivity
Baseline & all Q of FY 24-25
measured in average billable contacts per week
Goal = 25
Baseline Data = 21
Q1 = 20
Q2 = 17
Q3 = 18
Q4 = 20
Billable Contacts per Week
Contacts Per Week
Goal


Adult MD / NP Team Productivity
Baseline & all Q of FY 24-25
measured in average billable contacts per week
Goal = 40
Baseline Data = 28
Q1 = 30
Q2 = 29
Q3 = 30
Q4 = 29
Billable Contacts per Week
Contacts Per Week
Goal


Child / Youth MD & Older Adult MD Team Productivity
Baseline & all Q of FY 24-25
measured in average billable contacts per week
Goal = 24
Baseline Data = 21
Q1 = 22
Q2 = 21
Q3 = 20
Q4 = 23
Billable Contacts per Week
Contacts Per Week
Goal


Adult Access Team Productivity
Baseline & all Q of FY 24-25
30%
25%
20%
15%
10%
5%
0%
Goal = 25%
Baseline = 16%
Q1 = 18%
Q2 = 15%
Q3 =20%
Q4 = 18%
Children / Youth Access Team Productivity
Baseline & all Q of FY 24-25
12%
10%
8%
6%
4%
2%
0%
Goal = 10%
Baseline = 8%
Q1 = 3%
Q2 = 4%
Q3 = 5%
Q4 =5%
County SUD / Children's MH / Adult MH Provider Productivity
Baseline and all Q of FY 24-25
60%
50%
40%
30%
20%
10%
0%
Goal = 50%
County SUD
County Children's BH
County Adult MH
Base, 12%
Q1, 16%
Q2, 22%
Q3, 26%
Q4, 26%
Base, 26%
Q1, 27%
Q2, 29%
Q3, 30%
Q4, 31%
Base, 34%
Q1, 33%
Q2, 33%
Q3, 39%
Q4, 40%
Base
Q1
Q2
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Category #5: Quality Improvement

Goal / Requirement	Plan	Goal Sponsor	Action Steps	Measurement
5.1: BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one clinical and one non-clinical for each Plan and will report-out to the QIC regarding PIPs. **DHCS Requirement: BH MHP & DMC-ODS contracts; CCR Title 42 § 438.240**	MHP & DMC-ODS	BH Quality Improvement & BH Clinical Teams	❖ Coordination with PIP workgroups	Data Source: PIP workgroup reports & BHQIP reports
Review Findings: ☒ Met ☐ Partially Met / Further work ☐ Not Met BH consistently had two PIPs per Plan & the QI Steering Committee provided quarterly updates for all four each quarter. Slides with information about the PIPs is provided at the end of this evaluation as an appendix.				
5.2: BH will measure required quality performance measures for MHP & DMC-ODS, including for the MHP FUM, FUH, AMM, APP and SAA and for DMC-ODS FUA, POD, OUD, and IET. **DHCS Requirement: BHIN 24-004; CFR Title 42 § 438 subpart E**	MHP & DMC-ODS	BH Quality Improvement & BH IT staff	❖ Coordination with CalMHSA and IT to gather / input data ❖ Create system for tracking / analyzing measures to impact change.	Data Source: Monthly MMEF files; Monthly service data files (8371 files)
Review Findings: ☒ Met ☐ Partially Met / Further work ☐ Not Met BH contracted with CalMHSA to measure required HEDIS measures; here is the data for Measurement Year 2024 for Santa Cruz:				

Santa Cruz County MHP HEDIS Performance Measure Year 2024 vs Minimum Performance Level (MPL)

Table 1. MY24 MPL Rate Comparison

Measure	Denominator	Numerator	CalMHSA Rate	MY24 MPL
AMM_Acute	156	86	55.13%	Below MPL (62.43%)
AMM_Cont	156	57	36.54%	Below MPL (44.25%)
APP	20	17	85.00%	Above MPL (60.22%)
FUH30	335	218	65.07%	Above MPL (59.85%)
FUM30	186	107	57.53%	Above MPL (53.82%)

Chart 1. MY24 MPL Rate Comparison

Santa Cruz County DMC-ODS HEDIS Performance for Measure Year 2024 vs Minimum Performance Level (MPL)

Table 1. MY24 MPL Rate Comparison

Measure	Denominator	Numerator	CalMHSA Rate	MY24 MPL
FUA30	382	205	53.66%	Above MPL (36.18%)
IET_Eng	729	93	12.76%	Below MPL (14.39%)
IET_Init	729	316	43.35%	Below MPL (44.51%)
OUD_Total	1191	834	70.03%	Above MPL (60.20%)
POD	439	99	22.55%	Below MPL (25.28%)
SAA	295	191	64.75%	Above MPL (62.56%)

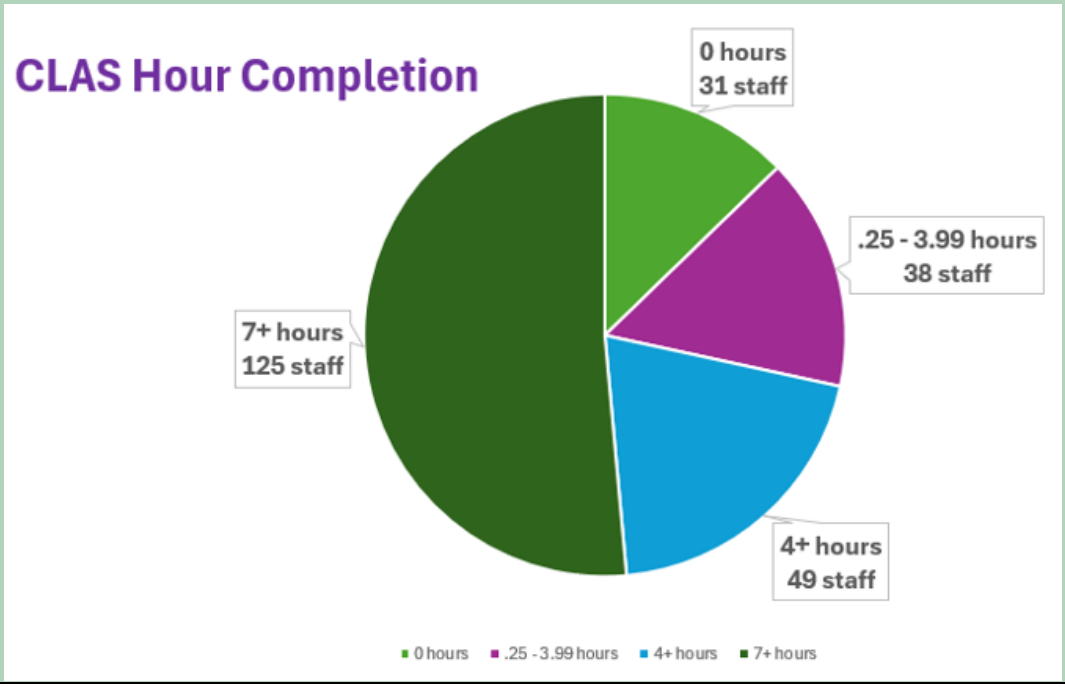
Chart 1. MY24 MPL Rate Comparison

Category #6: Cultural & Linguistic Competence

Goal / Requirement	Plan	Goal Sponsor	Action Steps	Measurement
6.1: BH staff will demonstrate compliance with CLAS requirements by increasing overall full completion of 7 CLAS training hours from 58% of BH staff to 68% of BH staff by June 30, 2025. Baseline FY 2023-24 = 58% of staff completed required CLAS hours. **DHCS Requirement: BH MHP & DMC-ODS contracts**	MHP & DMC-ODS	BH Supervisors, Managers & Directors	❖ Supervisors of all levels to require completion of CLAS hours and ensure staff have work hours to complete the training. ❖ Supervisors to receive monthly staff transcripts regarding CLAS hour completion	Data source: Relias report showing the staff CLAS hour completion rates

Review Findings: ☐ Met ☐ Partially Met / Further work ☒ Not Met

By the close of FY 24-25 51% of staff completed the required 7 hours of CLAS training.



6.3 BH (MHP & DMC-ODS) will increase outreach activities to Latinx/e & Hispanic, Mixteco and Triqui Medi-Cal beneficiaries to increase accessibility of services to these populations during FY 2024-25. **Goal:** BH Plans will increase the number of Hispanic/Latinx/e Medi-Cal beneficiaries served by the MHP & DMC-ODS as measured by improved penetration rate(s) for each Plan. MHP CY 2022 baseline = penetration rate (PR) of 2.47% (Statewide PR = 3.51%) **MHP goal = PR of 3.51%** DMC-ODS CY 2022 baseline = penetration rate (PR) of .69% (Statewide PR = .69%) **DMC-ODS goal = PR of 1.0%** **DHCS Requirement: EQRO recommendation**	MHP & DMC-ODS		❖ Increase outreach activities to Latinx/e / Hispanic individuals ❖ Increase outreach activities in communities where individuals are monolingual speakers of Spanish, Mixteco, Triqui ❖ Engage the Alliance & other community partners (Community Connections, PVPSA, CAB, Watsonville Works, Community Bridges) to learn of and partner in their outreach activities ❖ Increase evening hours of BH clinic(s)	

Review Findings: ☒ Met ☐ Partially Met / Further work ☐ Not Met

The Department of Health Care Services (DHCS) terminated their contract with BH Concepts, who previously provided counties with information about penetration rates. QI learned through communication with DHCS that the new contract partner, Health Services Advisory Group (HSAG) will not be providing penetration rates to counties. Therefore we are unable to determine if our penetration rate improved based on BH efforts this fiscal year.

Here is a summary of the outreach efforts by BH branches this year:

Children's BH: Q1: National Night Out at Pinto Lake park on August 6th 2024; 800 participants. Population included a significant number of indigenous language speakers. **Q1 & Q2:** Weekly: County clinician facilitates Spanish language parent/family groups at Community Action Board in Watsonville'; began in September; attended by 12-25 people; **Q2:** Extended Hours Pilot

Adult MH: Q1: Reiter Affiliated Companies' Spanish-Educational Resource Fair (July & Sept); 300 contacts across both sessions El Mercado on June 25th; 25 contacts; National Night Out on August 6th 2024; 20 contacts. **Q2**: Center for Farmworker Families Monthly Distribution; 300 contacts; combo of Spanish, Mixteco and Triqui; Day Worker Center of Santa Cruz County (CAB); 20 contacts; all Spanish speakers. **Q3:** NAMI Spanish language provider panel; support provided to 4 people; Day Worker Center of Santa Cruz County (CAB); 29 contacts; all Spanish speakers. Q4: Reiter Affiliated Companies' Spanish-Educational Resource Fair (May & June); 280 participants.

SUD / DMC-ODS: Q1: International Overdose Awareness Day in Watsonville on August 30th ;60 contacts. **Q2:** Pilot of Outpatient group services at Board and Care facility in South County. **Q3:** Bilingual client newsletter launched; developed and circulated Spanish language program brochure and provider network flyer.

***Goal 5.1 Appendix:**

Q1:

Category 5: Quality Improvement

Goal #	Goal Statement	Plan	Goal Sponsors	Q1 update
5.1	BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.	MHP & DMC-ODS	QI leadership **MHP:** Access leadership Medical Directors **DMC-ODS:** SUD leadership	**FUA (SUD) / FUM (Mental Health):** • SCHIO (Health Information Data Exchange) is delivering daily discharge reports which includes data from both Watsonville and Dominican Emergency Departments. This took a year of weekly meetings with IT, SCHIO and CCAH. • We have fostered authentic SUD / MH integration for Access by collaborating with our sister counties. • Access follow-up workflows have been developed, which include SUD follow up. • Next steps include Access to move forward with follow up with Medi-Cal beneficiaries who had Emergency Department visits.

Q2:

Category 5: Quality Improvement

Goal 5.1: BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.

Q2 updates:

- November - BH Division submitted and received approval for PIP plans
- **Non-clinical** Timeliness PIPs
  - **MHP**: Outpatient MH Non-Urgent, Non-psychiatric, all ages
    - Improve timely access from first contact from any referral source to first offered appointment for an SUD service or Specialty MH service
  - **DMC-ODS**: Residential DMC-ODS Non-Urgent, Adults
    - Improve timely access from first contact from any referral source to first offered appointment for an SUD service or Specialty MH service
- DHCS Timeline: begin in 2024 and conclude in 2027

Category 5: Quality Improvement

Goal 5.1: BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.

Q2 updates:

- November - BH Division submitted and received approval for PIP plans
- **Clinical** PIPs
  - **MHP:** FUM – 30-day Follow-Up after Emergency Department Visit for Mental Illness
  - **DMC-ODS**: FUA – 30-day Follow-Up after Emergency Department Visit for Substance Use
- DHCS Timeline: begin in 2024 and conclude in 2027

Category 5: Quality Improvement

Goal #	Goal Statement	Plan	Ongoing PIPS	Q2 updates
5.1	BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.	MHP & DMC -ODS	FUM and FUA	• Validated ED data from HIE • Designed and tested ED visit alert to emails to care team members • Finalized workflow for Adult and Children's Access teams, including SUD follow up • Developed a single data repository for Access teams to capture their contact attempts • Plan to train Access staff to do brief ASAMs

Category 5: Quality Improvement

Goal 5.1: FUM and FUA PIP updates

ED Alert email language to existing care team for both MH and SUD diagnoses at ED:

Client **(Name of Client / Avatar #)**, to whom you recently provided a service, was admitted to the emergency department on **(Date)** due to an urgent mental health or substance use disorder need. Please follow up within 7 days to offer support to your client. If you feel there is another provider who is better suited to connect with the client, please forward this message to that provider.

Next steps

- ❑ **Go live in February for alert emails**
- ❑ **Training Access staff in brief ASAM**
- ❑ **Capture and track Access contacts**

Q3:

Category 5: Quality Improvement

Goal 5.1: BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.

Q3 updates:

- **HSAG has paused their PIP efforts to focus on EQR virtual audit sessions**
- **Non-clinical** Timeliness PIPs (plans approved by HSAG in November 2024)
  - **MHP**: Outpatient MH Non-Urgent, Non-psychiatric, all ages
    - Improve timely access from first contact from any referral source to first offered appointment for an SUD service or Specialty MH service
  - **DMC-ODS**: Residential DMC-ODS Non-Urgent, Adults
    - Improve timely access from first contact from any referral source to first offered appointment for an SUD service or Specialty MH service
- DHCS Timeline: begin in 2024 and conclude in 2027

Category 5: Quality Improvement

Goal 5.1: BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.

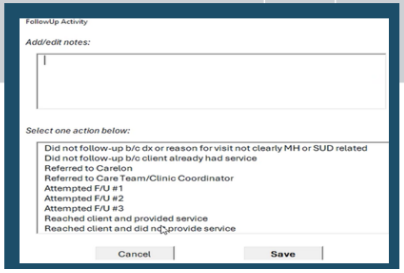
Q3 updates:

- **HSAG has paused their PIP guidance efforts to focus on EQR virtual audit sessions**
- **Clinical** PIPs
  - **MHP:** FUM – 30-day Follow-Up after Emergency Department Visit for Mental Illness
  - **DMC-ODS**: FUA – 30-day Follow-Up after Emergency Department Visit for Substance Use

HSAG Virtual Audit (4/2/25) was focused on Performance Measure Validation

Category 5: Quality Improvement

Goal #	Goal Statement	Plan	Ongoing PIPS	Q3 updates
5.1	BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.	MHP & DMC -ODS	FUM and FUA	• Went "live" with both **Admit ED alerts** and **Discharge ED alerts** to care team members • Access staff trained to do brief ASAMs • Access staff cohort trained in workflows to respond to ED Discharge alerts and in use of a data tracker to capture their contact attempts • Adult and Children's Access teams began contacting beneficiaries and clients



Q4:

Category 5: Quality Improvement

Goal 5.1: BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.

Q4 update:

- **BH Division submitted required reports about PIPs with a focus on baseline data analysis to HSAG**
- **Non-clinical** Timeliness PIPs (plan/topics approved by HSAG in November 2024)
  - **MHP**: Outpatient MH Non-Urgent, Non-psychiatric, all ages
    - **Improve timely access** from first contact from any referral source to first offered appointment for an SUD service or Specialty MH service
  - **DMC-ODS**: Residential DMC-ODS Non-Urgent, Adults
    - **Improve timely access** from first contact from any referral source to first offered appointment for an SUD service or Specialty MH service
- **Clinical** PIPs
  - **MHP: FUM – 30-day Follow-Up** after Emergency Department Visit for Mental Illness
  - **DMC-ODS**: **FUA – 30-day Follow-Up** after Emergency Department Visit for Substance Use

Category 5: Quality Improvement

Goal #	Goal Statement	Plan	Ongoing PIPS	Q4 updates
5.1	BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.	MHP & DMC -ODS	FUM and FUA	• **Admit ED alerts** and **Discharge ED alerts** to care team members are ongoing • For alerts to care team members, the goal is for the clinician to provide a **billed service** (see codes in table) • Adult and Children's Access teams are **contacting beneficiaries and using a data tracker tool** to capture responses • The ED Discharge tracking tool is a **Process Measure**, deemed important due to complexity and time-lag of HEDIS measure availability

Service Codes for FUM follow up

BHP Grouping	BHP Service Codes
Crisis Stabilization	S9484
Psychosocial Rehab	H2017
Crisis Intevention Svcs	H2011
Mental Health Svcs	H2015
Theapeutice Behavioral Svcs	H2019

Source: CalMHSA MY2024 Descriptive Analysis Report Overview

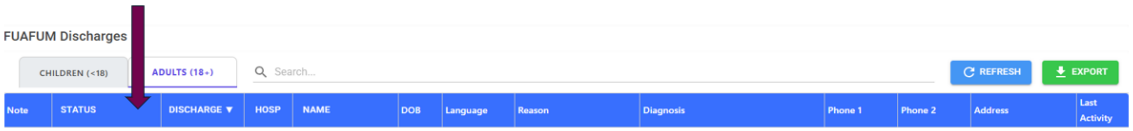
Category 5: Quality Improvement

Goal 5.1: BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.

FUM/FUA Process Measure = ED Discharge tracker

Intervention Done by Access Clinicians

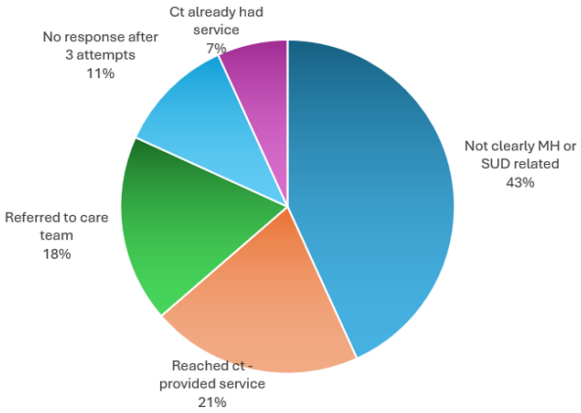
1. Log into tracker
2. Consider dx/reason for visit included in ED alert
3. Look up beneficiary name in Avatar
4. *If open to MH care team* – route message to care team
5. *If* not *open to MH care team* – call the beneficiary
6. Document **"status"** of contact or attempts in tracker



Goal: BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.

Data via ED Discharge Tracker: March 1-April 30, 2025)

Children's Access
44 Discharge Alerts from Local EDs



Impacts of intervention

- 9 members (21%) received a service
- 8 members (18%) referred to existing MH care team

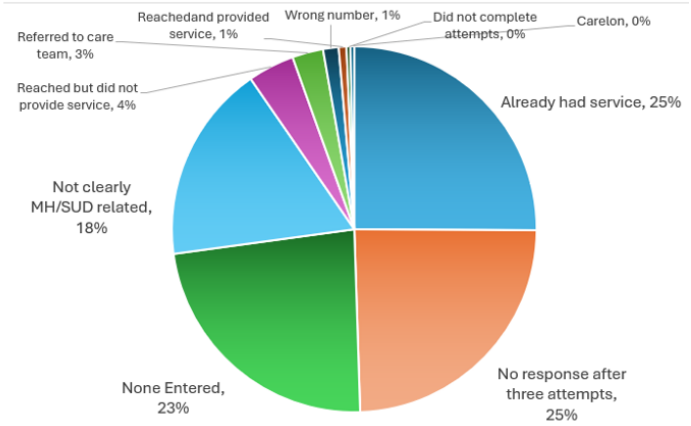
Potential Areas for Improvement

- All discharges had a recorded follow-up

Goal: BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.

Data via ED Discharge Tracker: March 1-April 30, 2025)

Adult Access
291 Discharge Alerts from Local EDs



Impacts of intervention

- 2 members (1%) received a service
- 12 members (4%) reached and declined a service
- 8 members (3%) referred to existing MH care team

Potential Areas for Improvement

- 23% did not have recorded follow-up status

Goal: BH will meet the annual External Quality Review requirement for Performance Improvement Projects (PIPs) during FY 24-2025, one active clinical and one active non-clinical for each Plan and will report-out to the QIC regarding PIPs.

Data via ED Discharge Tracker: March 1-April 30, 2025)

335 Discharge Alerts from Local EDs

Spanish-Speakers versus General Population

- Spanish speakers were much less likely than the general population to have a documented follow-up effort (56% vs 80%)
- 3% of Spanish speakers had had a BH service by the time Access was notified vs. 23% of the general population
- When reached, Spanish speakers were more likely to receive (less likely to reject) a service than the general population