COUNTY OF SANTA CRUZ
Behavioral Health Services
FOR CHILDREN & ADULTS

CONDADO DE SANTA CRUZ
Salud Mental y Tratamiento del Uso de Sustancias
PARA NIÑOS Y ADULTOS

Integrative Behavioral Health Quality Improvement Work Plan Evaluation

FY22-23

Mental Health Plan and Drug Medi-Cal Organized Delivery System Improvement Initiatives

Health and Safety is our top priority

MH and SUD Initiatives, 8/10/2023

FY22-23 BHS Quality Improvement Work Plan

Purpose

Santa Cruz County Behavioral Health Services (SCCBHS) Quality Management Program: Santa Cruz County Behavioral Health Services (BHS) in an integrative service delivery model in which leadership and staff value operational excellence and sustainable quality of care. The purpose of the QM plan's activities is to ensure that beneficiaries have timely access to appropriate and quality services, verify qualified providers, promote best practices in treatment and coordination of care, and recovery and/or prevention of behavioral health illness(es). The BH Quality Management (QM) program 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 which include, but are not limited to: utilization management, utilization review, provider appeals, credentialing and monitoring, fraud prevention monitoring, network adequacy, resolution of beneficiary grievances, and analysis of beneficiary and system outcomes. The QM program'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 agreement requirements and performance measures. These QM activities are performed by Quality Improvement team in partnership with MHP and/or DMC-ODS departments 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 create systems whereby data relevant to the performance of the MHP/DMC-ODS is available in an easy interpretable and actionable form. The elements of this QI work Plan are informed by the quality improvement requirements of the MHP/DMC-ODS performance contract, and feedback from the CalEQRO, DHCS MHP/DMC-ODS audit findings & recommendations, and 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, and understanding of our DHCS MHP and DMC-ODS agreements. In addition, the County of Santa Cruz Operational Plan FY21-22 promotes a mission for an open and responsive government which delivers quality data-driven services that strengthen our community and enhance opportunity.

Behavioral Health Values & Core Guiding Principles incorporated into ongoing MHP/DMC-ODS operational gains.

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

The goals identified in this work plan speak to our continuous quality improvement efforts to identify and meet the mental health and substance use disorder treatment needs of our community. QI Workplan reflects BH priorities, in alignment with the County Operational Plan, informed by valued-based focus areas and data outcome metrics, to achieve equitable, sustainable improvements that positively impact quality of service delivery, BH transparency and satisfaction for county residents and workforce. The goals described here are not intended to be all encompassing but are important to our overarching quality improvement efforts for Fiscal Year 2022-2023 (July 1, 2022-June 30, 2023). Some goals are carried over from previous plan's work of improving the capture, analysis and use of data to support contractual compliance, performance management and ongoing quality improvement initiatives. *We have identified 6 monitoring categories, 5 main Areas of Focus, and 15 Goals to address for this year with aligned behavioral health values.*

Monitoring Categories:
1. Access to 24/7 services, 2. Effectiveness of Care, 3. Coordination of Care, 4. Beneficiary Satisfaction & Involvement,
5. Utilization Management, and 6. Quality Improvement & Workforce Development.

Value-Based Focus areas:
1. Inclusion & Engagement, 2. Equity & Sustainability, 3. Operational Excellence, 4. Targeted Treatment and Evidence-Based Services,
5. Safety

COVID-19 Impact: COVID-19 continues to impact county-wide resources greatly, including BHS workforce and budget capacity. BHS leadership and key staff responsibilities expand into COVID-19 response initiatives to ensure safety to the community and workforce. The continuation of COVID priorities impacts available resources for the below QI Workplan activity.

BH QI WORKPLAN:

1. Monitoring Category: Access to 24/7 services

Goal 1.1: By June 30, 2023, the MHP and DMC-ODS Networks will improve tracking Urgent Prior Authorization requests by 20% to obtain baseline data to evaluate timely-response performance. The standard response time of Medi-Cal prior-authorization service requests is 96-hours, including authorization decision to approve/decline request, offer and document appointment time.
Baseline: Average FY20-21 MHP Network: 0% SMH prior-auth urgency (no data available).
Baseline: Average FY20-21 DMC-ODS Network: 0% prior auth urgent (no data available) [Initial service request time compared to offered admission time when residential service approved.]

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☐ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	**Outcome Measurements**	**Est. Completion Date**
1. BH and stakeholders will continue to identify MH and SUD workflow improvements as needed to improve tracking of timeliness of prior-authorization decisions and approved service delivery. 2. BH and stakeholders to continuously modify Avatar SRDL form as needed to improve user comprehension. 3. County BH will design an electronic database to log SMH and DMC-ODS prior-authorizations. 4. QI staff to provide training/TA support to staff conducting prior-authorizations to ensure knowledge of 96-hour timeliness standard and accurate data collection. 5. QI will modify as needed SRDL training materials in conjunction with Network "Gate" provider feedback to improve provider understanding of various timeliness standards for Urgent, Urgent with Prior Auth, Routine, NTP and Psychiatry service requests; and distribute to providers. 6. QI will continue to provide trainings on Timeliness standards, Avatar SRDL utilization and data monitoring tools so MHP and DMC-ODS Network Gate supervisors and staff can monitor the timeliness rate by request standard in Avatar Service Request and Disposition Log (SRDL).	1. 20% increase of MHP's 1st offered appointment within 96 hours to Initial Prior-Authorization Urgent Request for MHP Services. (Target of 10-25%) 2. 20% increase of DMC's 1st offered appointment within 96 hours to Initial Prior-Authorization Urgent Request for DMC Services. (Target of 45%)	June 30, 2023 **Review Committee:** Quality Improvement Committee (QIC) BH Sr. Leadership **Frequency of Review:** Quarterly **Responsible Parties:** DMC-ODS Gates BH ACCESS CMH (MHP Contractor Gates) QI

7. MHP and DMC-ODS Network Gate leadership to review data at least quarterly to monitor Prior-Authorization service timeliness standard adherence. 8. QI to present timely access data to stakeholders, including DMC-ODS and MHP Providers and the Quality Improvement Committee.		

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☒ Further Work

Due to CalAIM implementation and 30% staffing deficiency in Behavioral Health, we were not able to implement the SRDL updates / trainings we had hoped to do this fiscal year.

FY 22-23 Data: Timeliness Response

Department	Q1	Q2	Q3	Q4	FY Avg
MHP :					
Standard (10 day)	**86%**	**85%**	**81%**	**68%**	**80%**
Urgent – 96 pre-auth	**Not measured yet; no MHP SRDL yet for res prior auth**	**Not measured yet; no MHP SRDL yet for res prior auth**	**Not measured yet; no MHP SRDL yet for res prior auth**	**Not measured yet; no MHP SRDL yet for res prior auth**	**Did not meet this part of goal**
DMC-ODS:					
Adult Standard (10 day)	**95%**	**94%**	**94%**	**84%**	**92%**
Youth Standard (10 day)	**80%**	**50%**	**75%**	**80%**	**71%**
Urgent– 96 pre-auth	**No res auth requests selected as urgent**	**No res auth requests selected as urgent**	**No res auth requests selected as urgent**	**No res auth requests selected as urgent**	**n/a**

Goal 1.2: By June 30, 2023, the MHP and DMC-ODS Networks will improve tracking Urgent Psychiatry requests by 20% to obtain baseline data and evaluate timely-response performance. The response time of Medi-Cal urgent service requests is 48-hours, including offering and documenting a first service appointment in a SRDL Finalized entry.
Baseline: Average FY20-21 MHP Network: 0% Urgent Psychiatry service request (no SRDL data available).

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☐ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☒ MHP ☐ Both	**Outcome Measurements**	**Est. Completion Date**
1. BH and stakeholders will continue to modify MHP Access Avatar SRDL form use, and Psychiatry workflows as needed to improve data collection and service delivery. 2. QI will continue to provide targeted training on Timeliness standards, Avatar SRDL utilization and data monitoring tools so MHP Network Gate supervisors and staff can monitor the timeliness rate of Urgent Psychiatry requests performance [in Avatar Service Request and Disposition Log (SRDL)]. 3. MHP Network Gate leadership to review data at least quarterly to monitor 1st offered appointment for Urgent Psychiatry request timeliness standard adherence. 4. QI to present timely access data to stakeholders, including MHP Providers and the Quality Improvement Committee.	1. Establish data collection method for baseline data 2. 20% increase of MHP's 1st offered appointment within 48 hours to Initial Urgent Request for MHP Services, including Psychiatry Service Requests. (Target of 60%)	June 30, 2022 **Review Committee:** Quality Improvement Committee (QIC) BH Sr. Leadership **Frequency of Review:** Quarterly **Responsible Parties:** DMC-ODS Gates BH ACCESS CMH Gates (MHP Contractor Gates) QI

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☒ Further Work

Due Due to CalAIM implementation and extreme child psychiatry staff shortages, not able to meet this goal.

Data Source(s): Data comparison of request in FINAL SRDL to first service appointment offered for appointment offered for appropriate service type and urgency level.

FY 22-23 Data: Timeliness Response

Department	**Q1**	**Q2**	**Q3**	**Q4**	**FY Avg**
MHP:					
Child Psychiatry Standard (15 day)	**96%**	**23%**	**47%**	**48%**	**54%**
Adult Psychiatry Standard (15 day)	**100%**	**100%**	**83%**	**95%**	**95%**
Child Psychiatry Services Urgent – 48	**Not measured yet**	**Not measured yet**	**Not measured yet**	**Not measured yet**	**n/a**

	Adult Psychiatry Services Urgent – 48	**Not measured yet**	**Not measured yet**	**Not measured yet**	**Not measured yet**	**n/a**

Goal 1.3: During FY22-23, After-hour test call success rate will increase by 20% to 75% or greater of all test calls to BH 800#, resulting in total BH rate of at least 88% or greater. Call will be responded to according to request, timeliness and language requirements, and logged appropriately, with specific focus on after-hours and weekend MH and SUD test calls.
Baseline: FY21-22 Data: MHP 79% (53% after-hour test calls); & DMC-ODS = 85% (60% after-hour test calls)

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☐ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	**Outcome Measurements**	**Est. Completion Date**
1. BHS continue contract with Community Connections for EN & SP test calls to BHS 24/7 hour 800# by peers to conduct at least 10 MH and 5 SUD test calls a month during after-hours and business hours. 2. Community Connections to increase EN/SP test calls at non-business hours to a minimum of 20 per quarter. 3. QI staff to continue supporting test callers with scenario scripts to support range of test calls, including informational access to care requests and complaint test calls. 4. Each test call will be documented by tester as to urgency, MHP or SUD treatment request, complaint or information requests. Documents submitted to QI team monthly. 5. QI staff to continue supporting BH and After-hour call center staff with training to support response success, including informational, urgent requests and complaint callers. 6. BH business hour staff to document all calls in SRDL, including name of caller, call type and disposition.	1. # of test call conducted in EN and SP, during business hours and after-hours. 2. # of test calls met the call response requirements: urgency level, MHP or SUD treatment request, complaint or information requests & call documented in SRDL, including name of caller, call type and disposition.	June 30, 2023 **Review Committee:** Quality Improvement Committee (QIC) BH Sr. Leadership **Frequency of Review:** Quarterly **Responsible Parties:** BH Fee Clerks/Call Responders After-Hour Vender Community Connection QI

7. QI staff to utilize test call documents and SRDL entries to evaluate performance. 8. QI staff to follow up with call center staff /vender to review test call finding and improvement recommendations. 9. QI staff to submit test call data to DHCS quarterly for compliance. 10. Quarterly Test Call Results presented and discussed in QIC Meeting with MH and DMC-ODS Stakeholders.		

Outcome Status

Review Findings: ☒ Met ☐ Almost Met ☐ Further Work

FY 22-23 24/7 Toll-free Test Call Responsiveness

Quarter	Total Calls Made	Bus-Hr	After-Hr	EN	SP	# of calls meet requirement	% of successful test calls
MHP Q1	**39**	**20**	**19**	**30**	**9**	**33**	**85%**
MHP Q2	**33**	**11**	**17**	**30**	**3**	**27**	**82%**
MHP Q3	**35**	**12**	**23**	**26**	**8**	**27**	**77%**
MHP Q4	**20**	**6**	**14**	**16**	**4**	**14**	**70%**
							79%
ODS Q1	**12**	**6**	**6**	**9**	**3**	**9**	**75%**
ODS Q2	**8**	**7**	**1**	**7**	**1**	**5**	**63%**
ODS Q3	**16**	**8**	**8**	**10**	**6**	**12**	**75%**
ODS Q4	**14**	**6**	**8**	**7**	**7**	**13**	**92%**
							76%

Data Source(s): Test calls to occur during business hours, weekends and after business hours in both English (EN) and Spanish,(SP) threshold language.

Goal 1.4: By June 30, 2023, MHP will aim to have a 75% rate or greater of successful **screened** referral linkages as the result of establishing documented workflows, training, service procedures and data collection methodology to ensure that CalAIM screening and transition tool are successfully utilized by Access Gates and SMH providers, including incorporation of Brief ASAM screening tool as needed for potential SUD provider referral. This goal will begin January 1, 2023.

Baseline: No prior data; new CalAIM item.		
Value-Based Focus Area (check all that apply): ☒ Inclusion/Engagement ☐ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☐ Targeted Treatment/EB Services		
Key Steps/Strategies: ☐ DMC-ODS ☒ MH ☐ Both	**Outcome Measurements**	**Est. Completion Date**
1. MHP leadership to modify procedural workflow and data collection methodolgy to track Screening tool utilization (such as SRDL& EHR forms). 2. MHP leadership, QI and Intrepid Ascent to develop training content on procedures and tools and conduct trainings with targeted staff conducting screenings and transitions. 3. MHP Access Gate staff and SMH staff to provide care coordination services to ensure successful linkage to another system of care as a result of completed screening. 4. MHP Access Gate leadership, QI and HSA IT to collaboratively identify data collection elements, data sources and develop needed report(s) to review and analyze data to performance and identify clinical and administrative strategies for improving successful rate. 5. MHP CMH and AMH leadership, QI and Intrepid Ascent staff to identify and/or develop and utilize case review tools for determining clinical readiness for referral to NSMHS and or DMC-ODS services. 6. MHP CMH and AMH leadership, QI and HSA IT to collaboratively identify data collection elements, data sources and develop needed report(s) to review and analyze data to transition rate performance and identify clinical and administrative strategies for improving successful rate. 7. QI to compile and present goal performance in QIC meeting at least on a quarterly basis.	1. # of screening tools completed 2. # of completed screening enrolled in SMHS 3. # of completed screenings referred to NSMHS (Beacon/CCAH provider) 4. # of completed screening referred to DMC-ODS 5. % of referred individuals successfully linked to Beacon/CCAH 6. % of referred individuals successfully linked to DMC-ODS provider.	June 30, 2023 **Review Committee:** Quality Improvement Committee (QIC) **Frequency of Review:** Quarterly **Responsible Parties:** Access Gates AMH & CMH DMC-ODS Gates QI HSA IT
Outcome Status		

Review Findings: ☒ Met ☐ Almost Met ☐ Further Work

Data Source(s): TBD.

ADULT Screenings

Screenings	Q1	Q2	Q3	Q4	%
Total Number of screening tools completed	N/A	N/A	**Tools being completed**	**127**	
Number referred to Specialty MH.	N/A	N/A	**Tools being completed**	**17**	**14%**
Number referred to Managed Care Plan.	N/A	N/A	**Tools being completed**	**18**	**14%**
Number referred to DMC-ODS provider.	N/A	N/A	**Tools being completed**	**92**	**72%**

YOUTH Screenings

Screenings	Q1	Q2	Q3	Q4	
Total Number of screening tools completed	N/A	N/A	**Tools being completed**	**70**	
Number referred to Specialty MH.	N/A	N/A	**Tools being completed**	**35**	**50%**
Number referred to Managed Care Plan.	N/A	N/A	**Tools being completed**	**31**	**44%**
Number referred to DMC-ODS provider.	N/A	N/A	**Tools being completed**	**4**	**6%**

Goal 1.5: By June 30, 2023, MHP will establish workflows and data collection methodology to ensure that CalAIM **transition** tool is successfully utilized by SMH provider, including incorporation of Brief ASAM screening tool as needed for potential SUD provider referral. This goal will begin January 1, 2023.
Baseline: New CalAIM Item

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☐ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☐ Targeted Treatment/EB Services

Key Steps/Strategies: ☐ DMC-ODS ☒ MH ☐ Both	**Outcome Measurements**	**Est. Completion Date**

<table>
<tr>
<td>
1. MHP leadership to establish or modify procedural workflow and data collection methodolgy to track SMH Transition tool utilization (such as SRDL and/or EHR Forms.)
2. MHP CMH and AMH leadership, QI and Intrepid Ascent staff to identify and/or develop and utilize case review tools for determining clinical readiness for transition to NSMHS and or DMC-ODS services.
3. MHP leadership, QI and Intrepid Ascent to develop training content on procedures and tools and conduct trainings with targeted staff conducting transitions to NSMHS and/or DMC-ODS services.
4. SMH staff to provide care coordination services to support successful linkage to another system of care.
5. MHP CMH and AMH leadership, QI and HSA IT to collaboratively identify data collection elements, data sources and develop needed report(s) to review and analyze data to transition rate performance and identify clinical and administrative strategies for improving successful rate.
6. QI to compile and present goal performance in QIC meeting at least on a quarterly basis.
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<td>
1. # of transition tool completed by SMH
2. # of identified transitions referred to NSMHS (Beacon/CCAH provider), filtered by subgroups Meds-Only, Therapy only and these with case management.
3. % of referred transition individuals successfully linked to Beacon/CCAH, including % by subgroup
4. # of MH transitions referred to SMHS from NSMHS.
5. # of MH transition referrals enrolled into SMHS
6. # of SUD transitions referred to DMC-ODS from NSMHS.
7. # of SUD transition referrals enrolled into DMC-ODS
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<td>
June 30, 2023

Review Committee:
Quality Improvement Committee (QIC)
Frequency of Review:
Quarterly
Responsible Parties:
Access Gates
QI
HSA IT
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<tr>
<td colspan="3">Outcome Status</td>
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<tr>
<td colspan="2">
Review Findings: ☒ Met ☐ Almost Met ☐ Further Work

Data Source(s): TBD.
</td>
<td>
FY 22-23 Data: SMH Transition Tool Outcomes
<table>
<tr><th>Transitions</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>Number of transition tools completed</td><td>N/A</td><td>N/A</td><td>Staff trained</td><td>8</td></tr>
<tr><td>Total # of transitions referred to another system of care</td><td>N/A</td><td>N/A</td><td>On tool March & April</td><td>8</td></tr>
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2. Monitoring Category: Effectiveness of Care

Goal 2.1: By June 30, 2023, In alignment with CalAIM, BH will improve co-occurring (SMH/NSMH-SUD) diagnostic and treatment practices by 20%.
FY21-22 Baseline: 22% (532/2,454) of all SMH clients have a SUD Dx & 64% (688/1,075) of all DMC-ODS clients have a MH Dx.

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	**Outcome Measurements**	**Est. Completion Date**
1. Diagnosing staff shall complete CalMHSA' s training and utilize County QI training guides to learn how CalAIM has expanded diagnosing and co-occurring treatment practices. 2. QI to draft additional written guidance as identified to address diagnosing staff and BH culture adjustment to this CalAIM initiative. 3. MHP and DMC-ODS clinical programs will support co-occurring treatment care and complete referrals as needed to appropriate provider. 4. LMHP/LPHAs to increase accurate documentation of all relevant Dx in EHR Diagnosis Form at time of initial assessment and when clinically indicated during treatment. 5. Provider to increase documentation/data collection of co-occurring referrals and ensure successful linkage. 6. Provider to increase obtaining signed ROIs for care coordination needs between MH and SUD services 7. QI, HSA IT and Stakeholder collaboration will develop report for data analysis	1. Increased appropriate co-occurring diagnosing at Access by 20% 2. Increase MH-SUD care coordination services by 20% to ensure co-occurring treatment success.	June 30, 2023 **Review Committees:** Quality Improvement Committee (QIC) Frequency of Review: Quarterly **Responsible Parties:** MHP – Access, CMH, AMH, Psychiatry DMC-ODS Network HSA IT

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☒ Further Work

This measure did not turn out to be a good way to determine if there has been an increase in co-occurring conditions.

FY 22-23 Co-Occurring Diagnosis Data (Total Clt. count per Qtr.)

	Q1	Q2	Q3	Q4	FY
MHP	**16%**	**14%**	**15%**	**13%**	**15%**
DMC-ODS	**54%**	**59%**	**59%**	**57%**	**57%**
Total BH	**27%**	**28%**	**30%**	**35%**	**30%**

Goal 2.2: By June 30, 2023, DMC-ODS and MHP service providers will improve documentation timeliness of non-crisis services within Avatar by 20% to meet the CalAIM 3-business day timeliness standard, which was implemented 7/1/22, above 80% overall goal. **Baseline: FY21-22 Q4 Avatar sampling "meet 3 bus-day" timeframe: Overall 69% [County (MHP & SUDS) 66%, Contractors: EN 79%, FSI 61%, HoH 44%, Janus 81%, NL 74%, ParC 43%, PVPSA 80%, SW 43%, Telecare 98%, VolC 89%]**		
Value-Based Focus Area (check all that apply): ☒ Inclusion/Engagement ☐ Equity/Sustainability ☐ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services		
Key Steps/Strategies: ☐ DMC-ODS ☐ MH ☒ Both	**Outcome Measurements**	**Est. Completion Date**
1. Modify Avatar PN Aging Report to reflect new CalAIM timeliness standards. 2. QI to inform and educate providers on timeframe change to ensure that staff receive and implement training. 3. QI to inform and educate supervisors and staff of updated Avatar aging report to ensure ongoing monitoring of individual provider performance. 4. QI staff to present performance data to QIC meeting.	1. Rate of program meeting the new CalAIM 3-business day timeframe for non-crisis services for both outpatient and residential settings. 2. Dated will be sorted by program and Plan (County SUDS / County Child MH, County Adult MH and Contract partner)	June 30, 2023 **Review Committee:** Quality Improvement Committee (QIC) **Frequency of Review:** Quarterly **Responsible Parties:** All MHP and DMC-ODS Providers QI HSA IT
Outcome Status		

Review Findings: ☒ Met ☐ Almost Met ☐ Further Work

FY 22-23 Data: 3-busness day Progress Note Timeliness Outcomes

Dept.	Q1	Q2	Q3	Q4	FY
SUDS	New report being built	New report being built	90%	96%	93%
ODS CBOs	" "	" "	No data	95%	95%
Co MHP	" "	" "	71%	97%	84%
MHP CBOs	" "	" "	82%	89%	86%

Data Source(s): Quarterly review of service report.

Goal 2.3: By June 30, 2023, DMC-ODS and MHP service providers will improve documentation timeliness of crisis services within Avatar by 20% above baseline data to ensure adherence of this CalAIM 24-hour timeliness standard, which was implemented 7/1/22.
Baseline: FY21-22 Q4 Avatar 24-hour sampling: BH (MHP and DMC-ODS) system wide N=1547 crisis services, 67% met standard (1034/1547). Overall timeliness average = 58 hours (2+days) to finalize crisis progress note in EHR.

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☐ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies: ☐ DMC-ODS ☐ MH ☒ Both	**Outcome Measurements**	**Est. Completion Date**
1. Modify Avatar PN form to capture start time stamp of crisis service. 2. Develop new Avatar PN Crisis Services Report to reflect new CalAIM timeliness standards. 3. QI to inform and educate providers on timeframe change to ensure that staff receive and implement training. 4. QI to inform and educate managers, supervisors and staff of updated Avatar Crisis Service report to ensure ongoing monitoring of individual provider performance, including utilization of Avatar KPI dashboard for ongoing monitoring practices of team performance. 5. QI staff to compile quarterly data and present performance data to QIC meeting.	1. Rate of programs meeting the new CalAIM 24-hour timeframe for crisis services for both outpatient and residential settings in MHP and DMC-ODS and <21 and 21+ age range. 2. # of completed crisis service notes by plan (MHP and DMC-ODS) and age group. 3. # of completed crisis service notes that include service time stamp by plan and age group. 4. # of completed crisis service notes that are completed within 24-hours of service and # completed later then 24-hours of service by plan and age demographic.	June 30, 2023 **Review Committee:** Quality Improvement Committee (QIC) **Frequency of Review:** Quarterly **Responsible Parties:** All MHP and DMC-ODS Providers QI HSA IT

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☒ Further Work

It is taking staff longer to adjust to the 24 hour standard for crisis service progress note completion.

FY 22-23 Data: Crisis Note timeliness Rate

Plan	Q1	Q2	Q3	Q4	FY
MHP Contracts	New report being built	New report being built	**67%**	No crisis services	**67%**
ODS Contracts	" "	" "	No crisis services	No crisis services	**n/a**
County MHP	" "	" "	**38%**	**100%**	**69%**
County MERT/Y	" "	" "	**87%**	**85%**	**86%**
County SUDS	" "	" "	No crisis services	No crisis services	**n/a**

Data Source(s): Quarterly review of crisis service report.

3. Monitoring Category: Coordination of Care

Goal 3.1: By June 30, 2023, MHP will improve post-hospitalization BH appointment completion within 7 days by 20% to meet the goal of 90% success rate for active SMHS clients. MHP to aim for 100% of success rate within 30 days of hospitalization discharge.
Baseline: FY21-22 Q4 Results for Santa Cruz County SMHS Clients: 73% adult SMH clients received an appointment within 7 days from discharge (93% within 30 days); 75% children/youth clients received an appointment within 7 days from discharge (100% within 30 days).

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☒ MHP ☐ Both	**Outcome Measurements**	**Est. Completion Date**
1. Increase alert method to SMH provider when active caseload client has been admitted to the local CSP and qualifies for an inpatient setting admission. 2. Increase discharge coordination efforts between County SMH Coordinator and inpatient setting for post-discharge appointment setting. 3. SMH treatment team to continue outreach to all youth and adults upon discharge from inpatient	1. Total # of Inpatient Hospitalization Discharges (including non-SMH and SMH patients). 2. Adult SMH client appointment rate within 7 days by at least 20% (Target: at least 88%) 3. Increase Children/Youth SMH client appointment rate by at least 20% (Target: at least 90%) 4. Increase Rapid Connect successful outreach	June 30, 2023 **Review Committee:** QIC **Frequency of Review:** Quarterly

psychiatric health facility who do not have a scheduled follow up appointment with their SMH provider. 4. Establish information sharing method between QI/Beacon and SMH provider when hospitalized SMH client is identified through inpatient Concurrent Review process. 5. Recruitment of more psychiatry staff for adult and minor specialization. 6. Change psychiatry scheduling protocol to allow for more intake appointments.	to secures appointment information by 20% (PHF)	**Responsible Parties:** Psychiatry Access/MERT QI Beacon Health Options

Outcome Status

Review Findings: ☐ Met ☐ Almost Met ☒ Further Work

Data Source(s): At least quarterly review of monthly Avatar service utilization.

FY 22-23 7 day After Care Appt Rate

SMH Service Area	Youth (7- day/all)	Adult (7-day/all)	FY BH Average
Q1	50%	71%	69%
Q2	65%	72%	71%
Q3	46%	69%	64%
Q4	58%	67%	65%

FY22-23 30-day After Care Appt Rate

SMH Service Area	Youth (30-day/all)	Adult (30-day/all)	FY BH Average
Q1	67%	94%	91%
Q2	100%	92%	93%
Q3	69%	98%	92%
Q4	83%	95%	92%

Goal 3.2: By June 30, 2023, BH (MHP and ODS) will improve data sharing practices with the local Managed Care Plan, CCAH/Alliance, to ensure beneficiary receives appropriate access to treatment at appropriate level of care (to align with CalAIM data sharing changes).
Baseline: County BH and CCAH/Alliance has monthly coordination of care meetings & quarterly collaborative leadership meetings.

Value-Based Focus Area (check all that apply):

FY22-23 BHS Quality Improvement Work Plan

☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	**Outcome Measurements**	**Est. Completion Date**
1. CCAH to work with BH vender, BHO, to improve data filtering for referrals sent to County BH to evaluate # of County referrals are SMH or DMC-ODS. 2. CCAH/BHO/County BH to review and incorporate new CalAIM Screening and Transition referral forms, and modify care coordination process between CCAH/Beacon and County referrals to identified level of care. 3. County to increase collaboration with Health Plan, CCAH, regarding barriers to care that arise for Medi-Cal beneficiaries, including transportation to services, interpretive services, physical exam timeliness, co-morbid eating disorder cases, non-SMI MH services, and MOU/DHCS compliance. 4. County and CCAH to finalize amend 2017 MOU to ensure information sharing, care coordination, dispute resolution and cost sharing agreements for shared co-occurring clients, such as EDO conditions.	1. County to receive identifiable SMH or DMC referral data 2. MHP and CCAH leadership to secure clear and fair accountability practices for shared co-occurring beneficiaries. 3. BH and CCAH to finalize updated MOU agreement. 4. CCAH and County to establish ECM agreement for CalAIM readiness	June 30, 2023 **Review Committee:** CCAH-County Meetings **Frequency of Review:** At least Quarterly **Responsible Parties:** CCAH leadership BH Sr. Leadership

Outcome Status

Review Findings: ☐ Met ☒ Almost Met ☐ Further Work

ECM work still to begin.
Closed loop referral tracking Unite Us project began.

- Data Source(s): Beacon and CCAH meeting outcomes, referral data sharing and executed agreements.

FY 22-23 Completed Activities

Item:	**Outcome Status**	**Date of completion**
Screening Tool Adopted, trained and implementd	**Completed**	**March 15, 2023**
Closed loop referral tracking	**In Process**	**Work began FY 22-23 Q4**
MOU updates	**Completed**	**11.14.2022**
ECM utilization	**Not completed**	**n/a**

4. Monitoring Category: Beneficiary Satisfaction & Involvement

Goal 4.1: During FY22-23, BH will decrease in MHP the # of beneficiary requests to change of provider and in DMC-ODS will decrease residential treatment grievance requests by at least 20% by improving provider-client communication practices to resolve issues that may cause client to file the request.
Baseline: MHP FY21-22 Data: Grievances – 22; Appeal (4); **151 Change of Providers (25% decrease – 113**); S Fair H(0)
DMC-ODS FY21-22 Data: Grievances - 26 (**13 of the 22 grievances 60% were relational complaints in RES setting**; Appeals - 31; Change of Provider (0); State Fair Hearing - 5

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☐ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	**Outcome Measurements**	**Est. Completion Date**
1. QI staff to develop report presentation for QIC meeting and to utilize data for identifying improvement recommendation for identified area. 2. QI staff to outreach program management to review request trend for MHP and DMC-ODS to provide TA on identifying collaborative strategies for improving provider-client relationship satisfaction to minimize requests. 3. QI staff review training needs of county and contractor staff regarding client-provider feedback practices and collaboration in care decisions. Provide training as needed. 4. QI staff to process all grievance/appeal/change of provider/fair hearing resolution requests within timeframe, including documenting activity in database at a 100% rate. 5. QI to timely annual MCPAR data to DHCS (required). 6. QI to prepare and submit grievance report related to Access for NACT delivery.	1. Analyze data trends of MHP and DMC-ODS & track improvement recommendations. 2. Rate of FY22-23 total # of each type (Grievance, Change of Provider, Appeal and Fair Hearing) for MHP and ODS compared to baseline FY21-22 marker. 3. Percent/# of MHP and DMC-ODS requests resolved by improved provider-client communication or treatment satisfaction.	June 30, 2023 **Review Committee:** QIC DHCS **Frequency of Review:** At least Quarterly **Responsible Parties:** QI & HSA IT BHS & Contractor Staff (various involvement)

Outcome Status

Review Findings: ☐ Met ☒ Almost Met ☐ Further Work

There was a decrease, overall, in both DMC-ODS grievances and MHP change in treatment staff, but not the amount we were hoping for.

FY 22-23 Total Request activity

Received	Q1	Q2	Q3	Q4	FY
MHP G	3	4	7	6	20
ODS G	6	5	6	4	21
MHP Change	29	30	46	35	140

ODS Change	**0**	**0**	**0**	**0**	**0**
MHP A	**2**	**0**	**0**	**0**	**2**
ODS A	**8**	**2**	**2**	**0**	**12**
MHP FH	**0**	**1**	**0**	**0**	**1**
ODS FH	**1**	**0**	**0**	**0**	**1**

FY22-23 MHP Change of Provider Focus-specific to relationships

MHP Change Requests	# Received	# Resolved by Provider-Client communication	# Not resolved via communication	Rate resolved due to communication
Q1	**15**	**7**	**8**	**47%**
Q2	**16**	**4**	**12**	**33%**
Q3	**21**	**10**	**2**	**83%**
Q4	**35**	**5**	**21**	**14%**
Total	**87**	**26**	**43**	**44%**

FY22-23 DMC-ODS RES Tx Setting Grievances Focus

DMC-ODS RES Grievance Requests	# Received	# Resolved by Provider-Client communication	# Not resolved via communication	Rate resolved due to communication
Q1	**4**	**3**	**1**	**75%**
Q2	**4**	**2**	**2**	**50%**
Q3	**6**	**6**	**0**	**100%**
Q4	**4**	**4**	**0**	**100%**
Total	**18**	**15**	**3**	**81%**

Data Source(s): QI Complaint and Request Database and outcome data.

Goal 4.2: By June 30, 2023, BH will increase consumer and family input opportunities regarding service quality, policy and decision-making feedback in quality improvement initiatives, plus increase lowest MHP and DMC-ODS client survey rates by 10%.
Consumer/family participation Baseline: NAMI and consumers involvement is 4 out of 15 QIC meeting members. MHSA townhalls/surveys conducted annually, MHP DHCS survey conducted 2x/yr and DMC-ODS DHCS survey annually.
MHP June 2021 Survey Return Results: 509 returns out of 1200. May 2021 General Satisfaction rate of 88% (all ages) & lowest ratings in perceived benefit of treatment (78%) and social engagement (78%).

<table>
<tr><td colspan="3">DMC-ODS FY21-22 November Results: 327 returns out of 600. 2021 Overall General Satisfaction rate of 91% (all ages) & lowest ratings in MH Care coordination and Family engagement.</td></tr>
<tr><td colspan="3">Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services</td></tr>
<tr><td>Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both</td><td>Outcome Measurements</td><td>Est. Completion Date</td></tr>
<tr><td>1. Conduct DHCS surveys accordingly for MHP and DMC-ODS with a 50% return rate.
2. Establish data-driven priorities within the Behavioral Health Equity Collaborative (BHEC) committee to establish data-driven priorities of addressing equity issues with consumer feedback.
3. BHEC and BH to develop customer satisfaction feedback survey and implement with community representatives (MHAB, SUDC, NAMI, MHCAN, Mariposa, BHEC), and other consumer/family groups.
4. Conduct feedback data analysis for improvement indicators.
5. BH QI and BHEC to work with HSA IT to establish a feedback method on public BH internet page.
6. Inform QIC Steering Committee, workforce and community stakeholders of survey results and identified areas of success and improvements.
7. Incorporate feedback into continued improvements initiatives.
8. Recruit at least 2 additional members to the QIC or other BH Committees who will contribute lived experience wisdom.</td><td>1. DHCS MHP and DMC-ODS Survey return results of at least 50% of distributed volume.
2. At least 85% of beneficiaries surveyed will report overall satisfaction with received services.
3. At least a 10% improvement in lowest rating areas from FY21-22.
4. At least 85% response from additional BH Surveys with aim of 85% General Satisfaction result
5. At least 2 new consumer/family representative members to the QIC meeting and Cultural Humility Committee.</td><td>June 30, 2023
Review Committee:
QIC & MHSA
BH Equity Committee Committee
Trauma Informed System Committee
Frequency of Review:
Quarterly progress reports Survey: 1st QIC meeting post obtaining the DHCS survey results.
Responsible Parties:
MHP Providers – Survey return rate
DMC-ODS Providers – Survey return rate
MHSA Coordinator
BH Happy or Not Kiosks
QI and HSA IT</td></tr>
<tr><td colspan="3">Outcome Status</td></tr>
<tr><td colspan="2"></td><td>FY 22-23 Survey Data:</td></tr>
</table>

Review Findings: ☐ Met ☒ Almost Met ☒ Further Work

MHP met their survey number goal while DMC did very poorly.

Data Source(s): Outreach results, MHP, DMC-ODS, MHSA survey activity & QIC meeting minutes

Department	Return # 2022	Return # 2023	% Change
MHP CO / Contractors	**469**	**578**	**+19%**
DMC-ODS CO/ Contractors	**312**	**132**	**-58%**

FY 22-23 Improvement / Input Opportunities:

Type of Activity	Description
BHEC	Membership remained consistent
Feedback Surveys	Overall positive

5. Monitoring Category: Utilization Management

Goal 5.1: By June 30, 2022, MHP to provide evidence that outcome tools are used consistently in clinical practices, as evident by a CANSA score improvement over a 12-month period for MHP case managed adults, youth and foster care youth.
Measure: Improve CANS/ANSA Percent Improvement overall annual score by 10% for FY21-22 as indicated in CANS/ANSA Data Round Table Dashboard.
(**Baseline: Unknown (new measurement)**

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☒ MHP ☐ Both	**Outcome Measurements**	**Est. Completion Date**
1. Work with Community Data Roundtable (CRT) vender for data analysis and technical assistance for isolating measurement. 2. MHP County Management and CANSA taskforce to identify best data methodolgy to isolate overall improvement measurement by population. 3. Ensure all managing staff has access to CRT dashboard view that aligns with data tracking methodolgy.	1. Identify CANSA baseline scoring by population (21+ Adult, Older Adult, <21 Children, Youth, Foster Care & 18-21TAY) 2. % of clients who showed improvement in CANSA scores.	June 30, 2022 **Review Committee:** QIC **Frequency of Review:** Quarterly to 6-months, Annual **Responsible Person:**

4. Identify workflow for consistent data monitoring goals and incorporate into clinical practices. 5. MHP SMH Staff and Supervisors to utilize CANSA data to evaluate clinical readiness to transition to lower level of care. 6. Train / Coach CANSA users of new monitoring goal. 7. Query data every 6-months (CANSA frequency) by population to monitor change in scoring.		MHP Teams Psychiatry CANSA Taskforce CRT QI
Outcome Status		
Review Findings: ☐ Met ☐ Almost Met ☒ Further Work The CANSA coordinator left employment during this FY and we were not able to work on this goal. Data Source(s): CANSA, medical records.		

Goal 5.2: By June 30, 2023, the MHP, in coordination with HSD's FCS program designated RN, will improve monitoring of client's access to medical care & lab work for metabolic monitoring of Foster Care minors who are prescribed Antipsychotics (S. Bill 484). **Baseline: No available data: MHP FC clients who are prescribed antipsychotic medication have challenges completing required medical lab workups that influence prescriber's medication and metabolic monitoring.**		
Value-Based Focus Area (check all that apply): ☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services		
Key Steps/Strategies ☐ DMC-ODS ☒ MHP ☐ Both	**Outcome Measurements**	**Est. Completion Date**
This goal's key strategies include collaborative work between two different County divisions – Human Services Department (HSD) Family Children Services and Health Service Agency (HSA) MHP to develop a	1. % of charts with evidence of Metabolic Monitoring completed by staff 2. # of HSD FCS reviewed charts 3. # of HSD FC Chart reviews with	June 30, 2023 **Review Committee:** HSD FC – CMH collaboration meetings

data-sharing and communication agreement and process so that the HSD's RN who is appointed for monitoring care of court-dependent shared youth clients could access client-specific medical records easily and communicate with MHP Children's MH and Psychiatry departments regarding BH treatment and medication monitoring findings. 1. MHP and FCS to establish information sharing practices for Court-Ordered RN's review of clinical documentation & submitting chart review findings to MHP provider. 2. MHP and FCS to establish case referral and linkage practices for FC minors who need medical care for medication monitoring needs. 3. Track HSD monitoring activity and feedback loop to SMH providers. 4. Coordinate with STRTP providers to obtain PCP monitoring activities and scan into SMH EHR.	completed metabolic monitoring documentation 4. # of HSD FCS reviewed cases with medical follow-up needs	HSD Chart Review QIC **Frequency of Review:** Quarterly **Responsible Person:** HSD FCS Psychiatry CMH QI HSA IT
Outcome Status		
Review Findings: ☒ Met ☐ Almost Met ☐ Further Work During this FY we learned that the Family & Children's Services Nurse is currently collecting and tracking this required data. BH will liaise at least quarterly with HDS FCS Nurse to obtain metabolic monitoring data for foster care youth who are prescribed antipsychotic medication by the MHP. Data Source(s): Quarterly peer review chart sampling results.		

6. Quality Improvement and Workforce Development

Goal 6.1: By June 30, 2023, BHS will increase success rate by at least 20% for all workforce employees to complete the minimum of 7 CLAS hours.
Baseline: FY21-22, 108 out of 269 (40%) BH workforce completed at least 1 CLAS hour within year & 20% of the 108 (55/108) completed 7 hours or more of CLAS training.

Value-Based Focus Area (check all that apply):
☒ Inclusion/Engagement ☒ Equity/Sustainability ☒ Safety ☒ Operational Excellence ☒ Targeted Treatment/EB Services

Key Steps/Strategies ☐ DMC-ODS ☐ MHP ☒ Both	**Outcome Measurements**	**Est. Completion Date**
1. Beginning 7/1/22, BH Managers will actively support staff scheduling at least 2 hours a quarter for CLAS trainings, in accordance with the April 2021 Sr. Leadership Memo to complete at least 7 hours by end of FY. 2. BH Sr. Trainer to collaborate with HSA Personnel to transition CLAS data tracking to a FY calendar (7/1/22-6/30/23) cycle and inform BH workforce of change. 3. BH direct supervisors will increase monitoring staff's completion of CLAS hours on quarterly basis in Relias and raise completion need in supervision as indicated. 4. Sr. Leadership to establish standardized BH workforce evaluation measure for CLAS hour completion on annual performance evaluations. (Such as: employee performance on evaluation as "Other" item, indicating that "meeting standards" equals 7 hours completed, less than 7 hours equals below standard rating, above 7 equals above standard rating). 5. CLAS Coordinator and BH Sr. Trainer will expand approved CLAS training options and inform all BHS employees of availability. 6. CLAS Coordinator/BH Sr, Trainer to distribute email notifications on available approved trainings for BH employees. 7. Sr. Trainer to manage Relias (a Learning Management System (LMS)) for BH training platform, including CLAS courses and support staff access as needed.	1. Total % of BHS employees completing at least 7 hours of CLAS hours annually per policy. 2. Total % of BHS employees below policy standard.	June 30, 2022 **Review Committee:** QIC TIS / CHC **Frequency of Review:** Quarterly **Responsible Parties:** All BH Managers & Staff CLAS Coordinator Sr. BH Trainer
Outcome Status		

Review Findings: ☒ Met ☐ Almost Met ☐ Further Work

- Data Source(s): CLAS Training Database and Completed CLAS credit email notification to employee and direct supervisor.