

Kern Behavioral Health and Recovery Services

Quality Improvement **Work Plan Evaluation**

FY 2023 – 2024

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MISSION VISION VALUES



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

As the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) for the County of Kern, we are required to have a written annual evaluation of the overall effectiveness of the QAPI Program. This annual evaluation demonstrates how QAPI activities contributed to meaningful improvement in clinical care and beneficiary services. It describes QAPI activities through the monitoring and evaluation of previously identified issues. The evaluation allows us to track issues over time and implement improvements.

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

The Quality Improvement Committee and subcommittees review the Annual Reports and uses the information to establish the Work Plan Goals for the following fiscal year.

Goal #1 24/7 Hotline Test Calls

1. Quality Improvement Work Plan Goal:

The MHP 24/7 access line logs will contain the names, disposition, date, and time of 100% of test calls.

2. 2023/2024 The Goal Was:

☐ MET ☒ NOT MET

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

Throughout the quarter, the Access Line supervisor provided continuing education to staff on Medi-Cal regulations and the necessary actions to meet each regulation.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
57	60	95.6%

5. Summarize the Results of Actions Taken:

During quarter three, there was one test call that missed three items necessary to meet regulations. The Access Line supervisor addressed this in individual supervision with the identified staff, and also reiterated regulation expectations at the team level. Quarter four saw significant improvement in that all regulations were met for test calls, showing that ongoing coaching was effective.

6. Plan for Current Goal:

☒ Keep the goal with no change for the upcoming year

Goal #2 Access to After Hours Service

1. Quality Improvement Work Plan Goal:

90% of service providers will have service available outside the typical service hours (8-5. Mon-Fri).

2. 2023/2024 The Goal Was:

☒ MET ☒ NOT MET

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

Service provider clinics have implemented a variety of techniques to ensure clients can receive services outside of traditional service hours. The following is a list of the common techniques used this fiscal year:

- offering Saturday and weekend hours
- offering services after 5:00 on weekdays
- having on-call telephone numbers available
- Flexing staff schedules to allow more coverage on evenings and weekends.

Staff from the various provider clinics reported business hours monthly using the NACT application. QID monitored the information submitted to ensure hours were being offered outside of typical service hours.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
28	32	87%

5. Summarize the Results of Actions Taken:

Four Kern BHRS clinics reported not providing services outside of business hours. All 4 clinics are specialty sites that operated in partnership with a community provider such as probation or a school. Clients in these programs are provided with clinics sites they might utilize should a client want to change providers and receive services after hours.

6. Plan for Current Goal:

- ☒ Change goal

I recommend lowering the number to 85% in order to account for programs that partner with community providers and do not have control of office hours.

Goal #3 Consumer & Family Satisfaction-CPS

1. **Quality Improvement Work Plan Goal:**

The Mental Health Plan and its contract providers will achieve a cumulative minimum satisfaction rating of 85% or greater on the Consumer Perception Survey.

2. **2023/2024 The Goal Was:**

☒ MET ☐ NOT MET

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

The annual CPS was administered May 15-19, 2023. UCLA oversaw the survey process and delivered results to counties in February 2024.

QID delivered results to MHP and contract providers in March 2024. QID also prepared and delivered lobby posters to MHP and contract providers in March 2024. These lobby posters informed consumers of division-wide satisfaction results and that the CPS would next take place in Spring 2024.

CPS results were also published on the KernBHRS.org website.

QID will present results at the System Quality Improvement Committee (SQIC) meeting in September 2024.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
264	283	93%

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

MHP and contract providers achieved a cumulative satisfaction rating of 93% for the Spring 2023 reporting period.

QID conducts an additional satisfaction survey monthly, the Local Recovery Survey (LRS), which provides feedback to the individual teams so they can make improvements as needed.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #4 Consumer & Family Satisfaction-LRS

1. Quality Improvement Work Plan Goal:

The Mental Health Plan and its contract providers will achieve a cumulative minimum satisfaction rating of 85% or greater on the annual Local Recovery Survey

2. 2023/2024 The Goal Was:

☒ MET ☐ NOT MET

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

Approximately five percent of each subunit's annual caseload was surveyed biannually, leading to approximately ten percent surveyed at the end of the fiscal year.

One hundred twenty-four individual teams were surveyed throughout the year, including 96 MHP teams and 28 SUD teams, allowing to 82 service providers.

Service providers that did not meet the goal the previous fiscal year took several steps to improve their scores, including providing additional training for staff to learn techniques and intervention to assist clients and parents who may be more challenging; site-implemented weekly high risk review meetings to address high-risk clients and ensure they are receiving appropriate MH services; and the hiring of new staff and continued engagement in recruitment strategies.

An annual overview report and individual team reports will be sent out to MHP and SUD supervisors and their administrators this month. The reports will contain results of the survey and any individual comments from the client or clients' family. The survey results will contain a cumulative score from the calls placed throughout the year. Any team out of compliance will be requested to send a CAP detailing how they plan on correcting the deficiency.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
1455	1635	89%

5. Summarize the Results of Actions Taken:

MHP and SUD teams and contract providers achieved a cumulative satisfaction rating of 89% for FY 2023-2024.

6. Plan for Current Goal:

☒ Keep the goal with no change for the upcoming year

Goal # 5 Credentialing

1. **Quality Improvement Work Plan Goal:**

100% of Kern BHRS staff and contract provider staff will complete the credentialing process.

2. **2023/2024 The Goal Was:**

☒ MET ☐ NOT MET

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

Credentialing staff reduced the amount of process time needed to complete each application, by improving team communication, centralizing tracking systems, and developing written procedures to ensure consistent processes.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
Total Credentialing Applications Processed = 213	Total Applications Approved = 213	100%

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

100% of Credentialing Applications were Approved in FY23-24. 60% of staff credentialed were staff of System of Care contract providers (128 staff); 40%, were BHRS staff (85 staff). 45% more applications were processed/approved in FY24-25 than in FY23-24 (213 applications in FY24-25 compared to 145 applications in FY23-24).

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #6 Fair Hearing

1. **Quality Improvement Work Plan Goal:**

100% of State Fair Hearings will be conducted within 90 calendar days of the request

2. **2023/2024 The Goal Was:**

☒ MET ☐ NOT MET

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

We have continued monitor both MH & SUD Appeals Case Management System (ACMS) website daily.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
0	0	100%

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

No appeals have been submitted to Kern County during FY23-24

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #7 Foster Care Penetration Rates

1. Quality Improvement Work Plan Goal:

Increase foster care annual penetration rate from 52.49 to 53.00%. (this is a 1% growth rate consistent with our other established penetration rate growth)

2. 2023/2024 The Goal Was:

☐ MET ☒ NOT MET

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

- Reminded BHRS and contract provider staff that all foster youth should receive, at minimum, monthly services.
- Encouraged staff that caseloads including older foster youth with younger siblings, should also include screenings for the younger siblings.
- Worked with Department of Human Services (DHS) by providing monthly lists to facilitate updating Medi-Cal aid codes for foster youth.
- Provided continued support to eleven STRTPs including monthly provider meetings and weekly visits to STRTPs to train and support providers.
- Continued work with partner agencies through AB 2083 (Collaborative MOU) to create innovative models to address youth with complex needs.
- Continued cross-system coordination of referrals by co-locating Behavioral Health (BH) staff at DHS sites and DHS staff in BH treatment teams. Foster Care supervisor attended bi-monthly meetings with DHS to promote BH referrals for children 0-5 years of age.
- Worked with DHS to provide a regularly occurring outreach and education to all new social workers, and commenced pairing of a Recovery Specialist with new social workers to review caseloads and assist in identifying youth that may benefit from a referral.
- Continued to monitor screening of Pathways to Well-Being services for all youth including ICC, IHBS and TFC at intake and every 6 months thereafter.
- ITS developed a new FC Penetration Rate report that communicates with SmartCare and includes new methodology. The new report is currently being piloted.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
803	2174	36.94%

5. Summarize the Results of Actions Taken:

Due to the transition to a new electronic health record, a new Foster Care Penetration Rate report was created during the fourth quarter. Per updated guidance from EQRO in 2023, this report, which will be piloted over the coming months to monitor for accuracy, includes revised methodology with new Medi-Cal aid codes to be used for monitoring penetration rates for foster youth. Due to the methodology updates in the new report, this has impacted our penetration rate. With the

development of the new report, it more closely mirrors the penetration rate provided to us by EQRO during our last review in 2023 (34.03%).

6. **Plan for Current Goal:**

☒ Change goal

It is recommended that, due to the new reporting methodology for this measure and the current measured rate, the goal be changed to 39%.

Goal #8 Grievance & Appeals

1. **Quality Improvement Work Plan Goal:**

98% of all grievances and appeals will be resolved within 90 calendar days from receipt of complaint.

2. **2023/2024 The Goal Was:**

☒ MET ☐ NOT MET

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

The goal for the PR office is to increase the number of grievances being submitted by the KernBHRS System of Care and Contracted Providers.

Each Grievance and Appeal will be submitted within the web application by the supervisor within one business day or via Grievance and Appeal Paper form from the client or team.

Patients' Rights will continue to encourage KernBHRS teams and Contracted Providers to input all dissatisfactions/grievances and appeals into the web application and/or Paper form.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
483	483	100%

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

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #9 Medication Monitoring

1. **Quality Improvement Work Plan Goal:**

Each provider will achieve a combined rating of 90% or higher on peer review medication monitoring evaluation.

2. **2023/2024 The Goal Was:**

☒ MET ☐ NOT MET

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

242 charts were reviewed during this reporting period, covering 58 prescriber reviews.

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

1--Drug/Allergy Hx	2a--Meds are appropriate for dx, etc.	2b--Medication and medical condition	3--Consent forms	4--Dosage level	5--Med changes	6--Side effects noted	6a--AIMS completed	7--Tx improving/ maintaining functioning	8--Lab tests ordered	9--Lab tests utilized	10--Follow up on abnormal labs	11--Re-evaluation every 90 days
100%	100%	100%	90%	99%	100%	100%	97%	100%	98%	99%	99%	100%

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

Overall, all prescribers met the departmental standard of 85% or higher in the reporting period.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #10 Asian Islander Service Access

1. Quality Improvement Work Plan Goal:

Increase penetration rate of the Asian Pacific Islander population into MH treatment from 1.25% to 1.5% by implementing culturally specific outreach and engagement strategies.

2. 2023/2024 The Goal Was:

☐ MET ☐ NOT MET

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

Developed community partnership with Jakara Movement. Conducted outreach at Sikh Women's Association Walk. Presented at California State University, Bakersfield cultural clubs including Kaibigan Filipino Club, to talk about Cultural Competence Resource Committee (CCRC) as well as potential employment and volunteer opportunities. Cross-promoted cultural events with Kaibigan for KBHRS events held during May is Mental Health Month as well as promoted Kaibigan's AA/PI celebration event to CCRC partners. May is Mental Health month events included decorations, performances, and activities from various Asian cultures. Hosted AA/PI Lunch & Learn events across 4 worksites within the department to increase KBHRS staff cultural awareness of the Punjabi/Indian community. Assisted Dr. Madhanagopal with translation of documents into Punjabi for a study on the disparity in the Punjabi community seeking access to mental health and substance use services.

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

Unable to select if goal was met or not met due to the data not yet available in SmartCare

Performance Toward Goal:		
Numerator	Denominator	Percentage

5. Summarize the Results of Actions Taken:

Partnership with Jakara Movement has led to joint hosting an event at a school with Jakara Movement and KBHRS Prevention team on how to use Narcan and how to access mental health services, to one of their staff regularly attending CCRC committee and AA/PI subcommittee meetings, as we as a staff agreeing to be a guest speaker at the Lunch & Learn events.

Outreach at the Sikh Women's Association led to members of the Punjabi community inquiring about KBHRS mental health and substance use disorder services. Presentation at Kaibigan Club led to university student club members inquiring about employment/volunteer opportunities during the meeting and to the club president attending CCRC meetings. Cross promotion of events with Kaibigan led to possible increase attendance at both Kaibigan and

KBHRS events in May. Inclusion of Asian activities, decorations, and performers in May is Mental Health Month AA/PI Lunch & Learn events led to recruiting more staff to the CCRC AA/PI subcommittee and feedback was a general increased awareness of Punjabi Indian culture. Assisting Dr. Madhanogopal has led to consent documents being produced and for Dr. Madhanogopal to submit the study for approval to Kern Medical Institutional Review Board.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #11 Provider Appeals

1. **Quality Improvement Work Plan Goal:**

100% of Provider appeals will be processed and sent final response within 60 calendar days of appeal.

2. **2023/2024 The Goal Was:**

☒ MET ☐ NOT MET

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

Providers were notified of the appeals process as detailed in their agreements.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
# of Provider Appeals = Zero (0)	# Processed and Sent Final Responses within 60 Calendar Days = All of Zero	100%

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

There were no provider appeals in FY23-24.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #12 DMC-ODS Access Line

1. Quality Improvement Work Plan Goal:

95% of all DMC-ODS access test calls will be given a customer service rating of standard or above.

2. 2023/2024 The Goal Was:

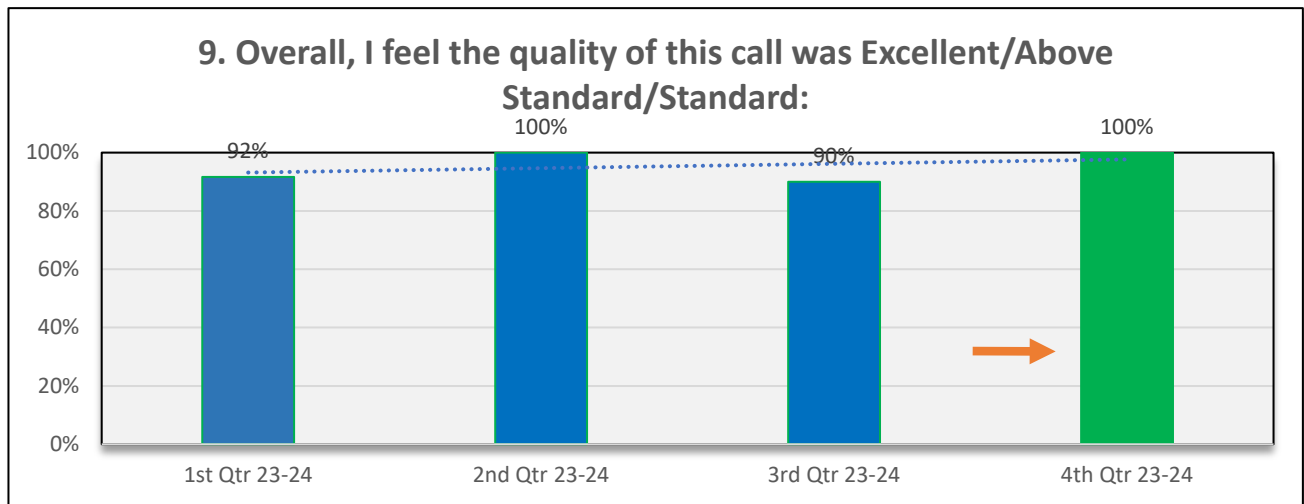
☒ MET ☐ NOT MET

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

QID ensured that an equal number of test calls were completed during business hours (Monday-Friday 8:00 A.M.-5:00 P.M.) and after hours (before 8:00 A.M. and after 5:00 P.M. on weekdays and all-day weekends). QID also tested in a language other than English (Spanish). The SUD Access Line continued to ensure customer satisfaction by working to increase staffing.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
39	41	95%



5. Summarize the Results of Actions Taken:

Quarterly satisfaction scores average 96%, which exceeds the Work Plan goal of 95%.

6. Plan for Current Goal:

☒ Keep the goal with no change for the upcoming year

Goal #13 DMC-ODS Client and Family Satisfaction Rate

1. Quality Improvement Work Plan Goal:

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

2. 2023/2024 The Goal Was:

☒ MET ☐ NOT MET

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

The annual TPS was administered October 16-20, 2023. UCLA oversaw the survey process and delivered results to counties in March 2024.

QID delivered results to SUD and contract providers in April 2024.

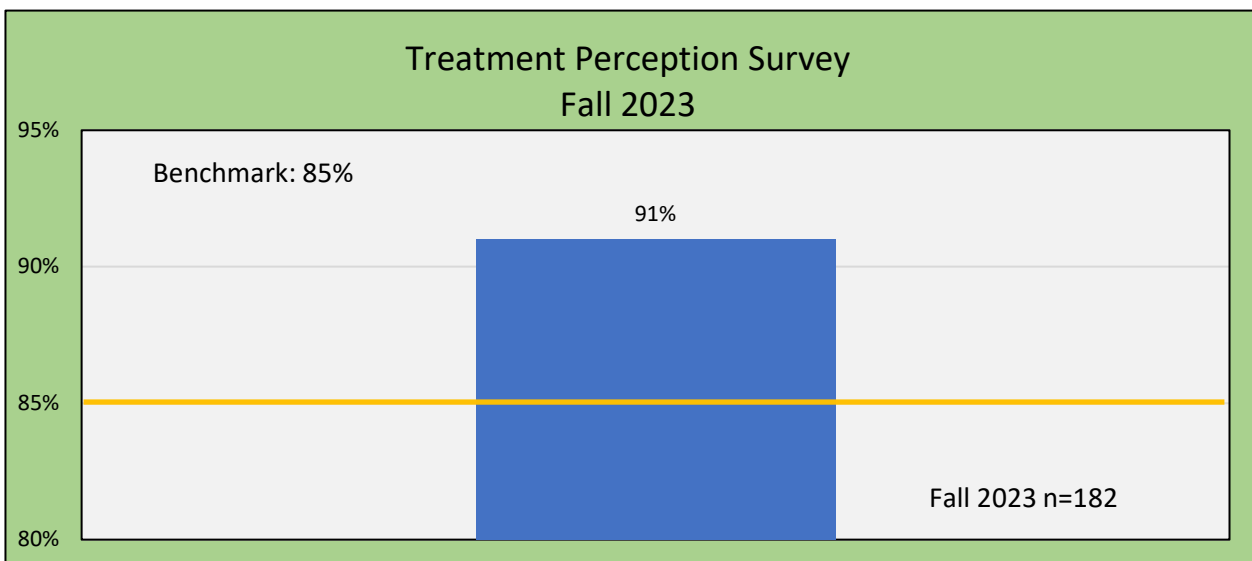
QID prepared and delivered lobby posters to SUD and contract providers in April 2024. These lobby posters inform consumers of division-wide satisfaction results and that the TPS will next take place in Fall 2024.

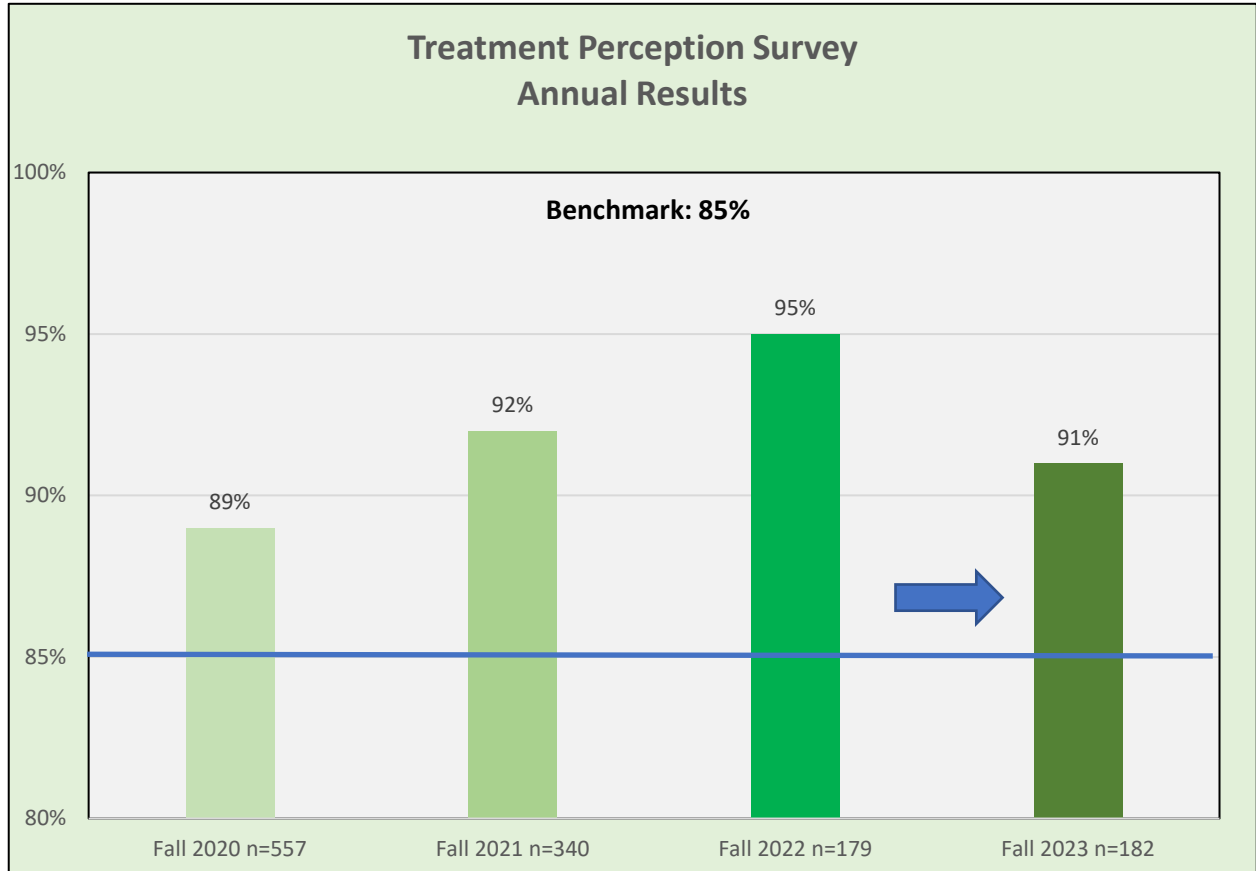
TPS results were also published on the KernBHRS.org website.

QID will present results at the System Quality Improvement Committee (SQIC) meeting in September 2024.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
166	182	91%





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

SUD and contract providers achieved a cumulative satisfaction rating of 91% for the Fall 2023 reporting period.

QID conducts an additional satisfaction survey monthly, the Local Recovery Survey (LRS), which provides feedback to the individual teams so they can make improvements as needed.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #14 DMC-ODS Assessment Follow Through

1. Quality Improvement Work Plan Goal:

At least 40% of individuals contacting the SUD treatment access line will attend assessment

2. 2023/2024 The Goal Was:

☒ MET ☐ NOT MET

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

Over the course of the year, SUD administration worked with the SUD Access Line supervisors to ensure that staff provided information on SUD services available in order to engage callers into taking next steps and connecting with their treatment provider. Ongoing reminder calls and reminder texts from the EHR provided additional reminders to clients in order to improve access. SUD providers were also encouraged to take walk in clients and begin engaging with those that were scheduled some time out in order to ensure engagement. Managing new electronic health record reports to ensure accurate data was challenging.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
2996	4626	64.8%

5. Summarize the Results of Actions Taken:

This percentage seems to have increased a significant amount from last year, although it is recognized that there are limitations in how the information is collected. Regardless of these challenges, SUD providers took advantage of suggested ways to increase their rosters by conducting reminder/engagement calls ahead of assessment appointments, providing separate first-time-service appointments in order to reduce wait times, and taking walk-in appointments at outpatient sites to take advantage of individuals' motivation to begin treatment.

6. Plan for Current Goal:

☒ Keep the goal with no change for the upcoming year

Goal #15 MAT Referrals

1. **Quality Improvement Work Plan Goal:**

Kern BHRS and network providers will make over 600 MAT referrals this fiscal year.

2. **2023/2024 The Goal Was:**

☐ MET ☒ NOT MET

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

Kern BHRS launched its first Outpatient MAT program, which was received with a high level of excitement systemwide. Presentations were offered to mental health teams, SUD providers, and community partners including hospitals in order to increase referrals. The MAT quarterly meeting continued, and CSV and Omni shared updates of their own programs that can treat substance use disorders in primary care.

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

Total referrals for FY 23-24: 383

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

The Kern BHRS Outpatient MAT program has continued to do well as it gained a steady flow of referrals and a caseload of up to 37. There have been challenges with referrals as other programs have changed in the community (addition of Kern Medical's similar clinic, Bridge programs in hospitals referring to other resources). SUD providers have continued to refer individuals to community providers in addition to our internal program.

6. **Plan for Current Goal:**

☒ Change goal

Propose to track and increase referrals to internal MAT clinic in order to ensure sustainability in preparation for Justice Initiative

Goal #16 DMC-ODS Latino-Hispanic Penetration Rate

1. **Quality Improvement Work Plan Goal:**

Increase SUD penetration rate of the Latino/Hispanic population into SUD treatment from .33% to .43% by implementing culturally specific outreach and engagement strategies.

2. **2023/2024 The Goal Was:**

☐ MET ☒ NOT MET

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

Participated in Kern Health Equity Partnership (KHEP) to establish goals related to improving accessing care and health education/health literacy. Collaborated with Unidad Popular Benito Juarez and recruited staff to Cultural Competence Resource Committee (CCRC). Presentations at California State University, Bakersfield (CSUB) cultural clubs, including those that focus on Hispanic/Latinx culture, to recruit for the CCRC as well as inform of volunteer and career opportunities. Collaborated with H.E.A.R.T.S. Connection. Conducted outreach at: H.E.A.R.T.S. Connection Spanish support group, Dignity Health virtual and in-person Spanish support groups, Greenfield Family Resource Fair, Arvin High School Mental Health Awareness Fair, Foothill High School Mental Health Awareness Fair, More Than Sad: East & Del Oro High Schools, Community Health Fair GNC Family Clinic Delano, Rethink Your Drink at MLK Park, EL Dia del Niño at Beale Library, You Matter Mental Health Awareness Fair, Mental Health Awareness in Lost Hills, Grimmway Farms Employee Resource Fair, Tacos and Taxes East Bakersfield High School, Project Rebound Resource Fair, Wasco State Prison Wellness Fair, Heart for the Community Toy Giveaway, Hispanic Chamber of Commerce Día de los Muertos, Union Cemetery Día de los Muertos, Día de la Familia, Prevention Fair Greenfield Family Resource Center, Halloweentown MLK Park, Vista West High School Health Fair, Tierra del Sol High School Career Fair, Healthful Harvest Arvin Community Fair, Fall Festival Semitropic School, Fiestas Patrias at Mercado Latino, South High School Health and Wellness Fair.

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

Unable to measure goal due to new EHR

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

Participation in the Kern Health Equity Partnership has led to the development of framework for listening sessions and plans to conduct sessions in areas with a large Hispanic/Latinx community. Collaboration with Unidad Popular led to inclusion of their staff in the CCRC as well as involvement in KHEP. Presentations at CSUB led to students inquiring about employment and volunteer opportunities, as well as some attending the CCRC meetings. Collaboration with H.E.A.R.T.S. Connection has led to education sessions being regularly hosted at their support groups. Community outreach conducted has helped Hispanic/Latinx population be aware of substance use services available, and how to access care.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #17 DMC-ODS Point in Time Satisfaction Rates

1. Quality Improvement Work Plan Goal:

DMC-ODS Client satisfaction ratings at Discharge and Follow up will obtain positive ratings at 85% or higher.

2. 2023/2024 The Goal Was:

☒ MET ☐ NOT MET

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

Point in Time surveys continued throughout the fiscal year, although there were some challenges with obtaining reports from our new electronic health record and staff to conduct surveys. Options were explored to utilize volunteers to conduct surveys, and assistance was requested from IT in order to extract data needed to know which individuals to survey across the system.

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

Performance Toward Goal: Discharge		
Numerator	Denominator	Percentage
56	64	87.5%

Performance Toward Goal: Follow up		
Numerator	Denominator	Percentage
160	176	90.1%

5. Summarize the Results of Actions Taken:

Throughout the year, discussion about comments gathered in the surveys was most helpful to identify opportunities for discussion with individual providers during bi-monthly meetings. SUD providers were responsive to concerns brought about, and most were aware of incidents mentioned. This is indicative of close involvement with managers and treatment staff directly involved in client care.

6. Plan for Current Goal:

☒ Keep the goal with no change for the upcoming year

Goal #18 UOR-Outpatient MH

1. Quality Improvement Work Plan Goal:

Decrease the number of aggression/violence incidents reported through the UOR application by 10%

2. 2023/2024 The Goal Was:

☒ MET ☐ NOT MET

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

Identified that all KernBHRS divisions were being included in the count, and that not all of the UORs being counted included aggression and/or violence.

Adult System of Care team supervisors continued to discuss challenging scenarios with the administrator to identify different interventions/actions to be taken to potentially change the outcome of crises.

Team supervisors continued to remind staff of "strategic disengagement" to ensure safety.

The management team began discussing the department-wide need for crisis intervention training.

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

Performance Toward Goal:		
Baseline FY 22/23	4 th Quarter	Goal <
649	76	435

5. Summarize the Results of Actions Taken:

The actions taken in the Adult System of Care resulted in a significant decrease of UORs due to aggression/violence. Debriefing, problem solving, and alternative options were discussed and debriefed at the staff/team, supervisor, and administrator levels.

6. Plan for Current Goal:

☒ Change goal

The recommendation is to revise the goal. This would include measuring the potential decrease in UORs specifically including aggression and/or violence as a result of receiving crisis intervention training. It is also recommended that the divisions are measured separately in order to be able to identify areas that are doing well and areas that need additional support.

Goal #19 UOR Outpatient DMC-ODS

1. Quality Improvement Work Plan Goal:

Decrease the number of aggression/violence incidents reported through the UOR application by 10%

2. 2023/2024 The Goal Was:

☒ MET ☐ NOT MET

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

This item was discussed in the February SUD Treatment Provider meeting, and ongoing monitoring of UORs continued throughout the year. Two Relias courses were suggested to DMC-ODS providers to support their efforts to better prepare their staff to manage situations by de-escalating and utilizing clinical interventions

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

Performance Toward Goal:		
Numerator Baseline FY22/23	Denominator Total FY23/24	Goal ≤
22	13	19

5. Summarize the Results of Actions Taken:

The discussion during the SUD Treatment Provider meeting was engaging, as several providers discussed situations and how they were handled. These are indicative of providers' familiarity with managing challenging situations and their willingness to share their successes with one another.

6. Plan for Current Goal:

☒ Keep the goal with no change for the upcoming year

Goal #20 MHP UM Review

1. Quality Improvement Work Plan Goal:

95% of reviewed medical necessity determination on MH assessments will be consistent between assessor and reviewer

2. 2023/2024 The Goal Was:

☒ MET ☐ NOT MET

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

- QID completed chart reviews for MH providers which consisted in reviewing the MH assessments, information entered in all 7 domains, their problem lists, and diagnosis to determine if medical necessity was appropriately determined.
- QID provided feedback and support to teams and/or clinicians when the assessment documents were missing information, or the documentation was lacking evidence to support their findings.
- QID provided assessment training for new employees and providers that trained staff in properly completing assessments, documenting, completing problem lists, and determining medical necessity for all clients.
- In addition to ad hoc support and training, QID worked together with the training department to ensure new and current clinicians have additional accessibility to training via self-pace recorded trainings on Relias, which clinicians are able to complete as soon as they are hired or as requested by their supervisor.
- QID continued to explore the expansion of training efforts to make them more accessible to providers in remote areas.

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

Performance Toward Goal:			
Semester	Numerator	Denominator	Percentage
1	1215	1218	99.7%
2	605	607	99.6%
Annual	1820	1825	99.7%

5. Summarize the Results of Actions Taken:

- This Fiscal Year, we reviewed the teams 2 separate times (2 semesters); first semester 10 charts which means 10 assessments were reviewed. In the second semester, QID reviewed 10 charts (10 assessments) per team.
 - In the first semester, we reviewed a total of 1,218 assessments, of which 1215 assessments (99.7%) met medical necessity.
-

- In the second semester, we reviewed a total of 607 assessments, of which 605 assessments (99.6%) met medical necessity.
- Overall, for the FY 23-24, QID reviewed a total of 1,825 assessments, of which 1820 assessments (99.7%) met medical necessity.
- From the five (5) assessments marked as not meeting medical necessity: 1 was due to client being closed and reopen without a new assessment being completed; 1 was for a new client not having an assessment completed within a reasonable time; 1 was due to a client having a reassessment overdue; and 2 were due to two (2) clients remaining open after the clients "no showed" to their assessment appointments. All teams were given instructions on how to correct their deficiencies.

6. **Plan for Current Goal:**

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

Goal #21 DMC-ODS UM Review

1. Quality Improvement Work Plan Goal:

95% of reviewed medical necessity determination on ASAM assessments will be consistent between assessor and reviewer

2. 2023/2024 The Goal Was:

☐ MET ☒ NOT MET

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

The SUD Access Line therapists and supervisors provided technical assistance to providers submitting Treatment Modification forms throughout the year. This helped to improve the clinical justification of the content and make the process smoother. Assessments were reviewed starting on the third quarter due to staffing shortages and new electronic health record implementation, and some technical deficiencies were found. The review tool was adjusted in order to avoid technical form completion errors to cause a disagreement between assessor and reviewer. The review process was also standardized to include a second review when there is a discrepancy to confirm.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
55	87	63%

5. Summarize the Results of Actions Taken:

Assessments were not reviewed during Quarter 1 and Quarter 2 due to staffing shortages and our systems' focus on implementation of the new EHR. There were improvements on Treatment Modification forms, as some providers requested meetings to better understand what justification was needed to request a higher level of care. After some reviews were completed, it was found that technical errors were due to the EHR form itself, not the clinical decision of the assessor.

The EHR team reached out to CalMHSA to see if the form error can be corrected so the right Level of Care displays. Providers were given reports to point out areas of improvement

6. Plan for Current Goal:

☒ Keep the goal with no change for the upcoming year

Goal #22 Timeliness of Routine Appointments

1. Quality Improvement Work Plan Goal:

80% of routine initial request for outpatient services will receive a service within 10 business days of the request.

2. 2023/2024 The Goal Was:

☒ **MET** ☐ **NOT MET**

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

July 2023, the system of care transitioned to a new EHR that required the system to develop:

- New workflow and identify when/how to identify services to be included in timeliness process.
- A new process for entering information in the new tracking log.
- Workflow at the team level to ensure timeliness standards are being met.
- A new way of tracking data was developed as the timeliness information is currently not being entered/tracked through the new EHR.
- A new reporting to present at division and quarterly KPIC meetings

In November 2023, DHCS issued new timelines standards to align with the CalAIM Initiative and the system of care:

- Provided training and information about these changes at bi-monthly KPIC, QQID, Provider Meeting and any team meetings when invited.
- New tracking logs and workflow changes to ensure timeliness information is being collected accurately.
- Updated the monthly tracking logs and the monthly KPI reports with these new measures.
 - A new reporting format was developed that outlined
 - The standards
 - The methodology for the reports
 - The outcomes for each Division/Agency and Team within
 - Disparity reporting such as age, gender, language
 - This report is being sent to supervisors and administrators each month and reviewed in the bi-monthly KPIC meetings.

Per the information provided in the KPIC meetings the teams have been doing the following to address timeliness issues within the clinics:

- Text reminders (not through SmartCare)
 - Same Day/Walk-in appointments
 - Staff trainings: Roles and responsibilities for scheduling services, accuracy of entering into the record
 - Filling vacancies for therapist to increase appointment availability
-

May 2024, QID and EHR Support partnered on training and rollout of using the Timeliness Records within SmartCare to track timeliness of service delivery outlined by DHCS.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
10396	12070	86.1%

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

- The reporting for this measure has solely been reliant on the tracking log spreadsheets that each of the teams are required to submit to QID each month.
 - We continue to have trouble with this data, matching it with previous entries, entries that are inconsistent and those with missing information; therefore, we must throw out many lines of data from the tracking logs.
- June 2024 data is the first time using the data entered SmartCare.
 - There are data entry errors and duplication in the data submitted, but through the cleaning process the data used for this reporting is a reliable representation of the system of care timeliness of services.
- The system of care continues to be above the 80% standard for Timeliness of routine service.

6. **Plan for Current Goal:**

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

Goal #23 Timeliness of Urgent Appointments

1. **Quality Improvement Work Plan Goal:**

80% of urgent request will receive a service within 48 hours of the initial request for urgent service.

2. **2023/2024 The Goal Was:**

☒ MET ☐ NOT MET

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

July 2023, the system of care transitioned to a new EHR that required the system to develop:

- New workflow and identify when/how to identify services to be included in timeliness process.
- A new process for entering information in the new tracking log.
- Workflow at the team level to ensure timeliness standards are being met.
- A new way of tracking data was developed as the timeliness information is currently not being entered/tracked through the new EHR.
- A new reporting to present at division and quarterly KPIC meetings

Assist with developing ways to identify when a request is an “urgent” request and ensuring that these are being recorded in the tracking log accurately.

In November 2023, DHCS issued new timelines standards to align with the CalAIM Initiative and the system of care:

- Provided training and information about these changes at bi-monthly KPIC, QQID, Provider Meeting and any team meetings when invited.
- New tracking logs and workflow changes to ensure timeliness information is being collected accurately.
- Updated the monthly tracking logs and the monthly KPI reports with these new measures.
 - A new reporting format was developed that outlined
 - The standards
 - The methodology for the reports
 - The outcomes for each Division/Agency and Team within
 - Disparity reporting such as age, gender, language
 - This report is being sent to supervisors and administrators each month and reviewed in the bi-monthly KPIC meetings.

Per the information provided in the KPIC meetings the teams have been doing the following to address timeliness issues within the clinics:

- Reviewing the Urgent Memo
-

- Creating process to triage Urgent requests
- Text reminders (not through SmartCare)
- Same Day/Walk-in appointments
- Staff trainings: Roles and responsibilities for scheduling services, accuracy of entering into the record
- Filling vacancies for therapist to increase appointment availability

May 2024, QID and EHR Support partnered on training and rollout of using the Timeliness Records within SmartCare to track timeliness of service delivery outlined by DHCS.

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

Performance Toward Goal:		
Numerator	Denominator	Percentage
1186	1475	80.4%

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

- The reporting for this measure has solely been reliant on the tracking log spreadsheets that each of the teams are required to submit to QID each month.
 - We continue to have trouble with this data, matching it with previous entries, entries that are inconsistent and those with missing information; therefore, we must throw out many lines of data from the tracking logs.
 - The following contributes to the low performance rates:
 - The number of reported urgent appointment requests continues to be low for the system of care.
 - Many teams are reporting zero urgent requests in the tracking log.
 - June 2024 data is the first time using the data entered SmartCare.
 - There are data entry errors and duplication in the data submitted, but through the cleaning process the data used for this reporting is a reliable representation of the system of care timeliness of services.
 - Even with this change, we still see very few Urgent services being reported in the Timeliness Records in the EHR.
 - The system of care continues to be above the 80% standard for Timeliness of routine service.
-

6. **Plan for Current Goal:**

- ☒ Keep the goal with no change for the upcoming year
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Goal #24 Zero Suicide

1. **Quality Improvement Work Plan Goal:**

At least one screening per month will be completed for each client on a team's caseload

2. **2023/2024 The Goal Was:**

☐ MET ☒ NOT MET

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

Due to EHR changes, we have been unable to pull accurate and necessary data in order to determine if department has met this goal.

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

Once developed, screening and service data will be to measure the outcome of this goal. The application will track each client within a team and when the client was last screened within a month

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

Department is currently working with our IT department to develop reporting on these items. The application is still being developed as of this writing. The Zero Suicide team informed IT developer of several errors in data collection that need to be corrected before the application can be used to measure the quality improvement goal above.

6. **Plan for Current Goal:**

☒ Discontinue goal

☒ Change goal

Even though IT reported that the issue with the application will be corrected by the end of August 2024, we have determined that in order to provide IT with more time, we will need to change our goal for the next quarter. Our next goal will be, "100% of clients opened to the PATHH will have a Safety Plan created"
