Kern Behavioral Health and Recovery Services

Quality Improvement

Work Plan Evaluation

FY 2022 – 2023

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Mission Statement

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:**

   95% of Access Line initial request for services test calls will be logged correctly.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   Throughout the year, the Access Line supervisors provides 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:		
# of test call placed annually	**# of initial request test calls logged correctly**	**% of initial request test calls logged correctly**
38	38	**100%**

Break Down of Required Elements by Quarter					
Test Call Data FY 22/23	**Quarter 1 July - Sept**	**Quarter 2 Oct - Dec**	**Quarter 3 Jan - Mar**	**Quarter 4 April - June**	**FY 22/23 Averages**
Info about how to access SMHS is given	100%	100%	100%	100%	**100%**
Asked about services needed to treat urgent conditions	100%	100%	100%	100%	**100%**
Info given regarding Beneficiary Problem Resolution Information	100%	100%	100%	100%	**100%**
Recorded correct name in call log	100%	100%	100%	100%	**100%**
Recorded date in call log	100%	100%	100%	100%	**100%**
Initial disposition of request recorded	100%	100%	100%	100%	**100%**

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

   Results of test calls indicate that the continued education of Medi-Cal regulations is effective in meeting the 95% requirement

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #2 Access to After Hours

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

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

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   Service provider clinics have 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 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:		
# of service provider clinics	**# of service provider clinics available outside of typical hours**	**% of service provider clinics available outside of typical hours**
37	37	**100%**

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

   As a result of the monthly monitoring efforts and the efforts of the agencies to ensure after hours services, the system was able to meet the goal throughout the fiscal year.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

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.

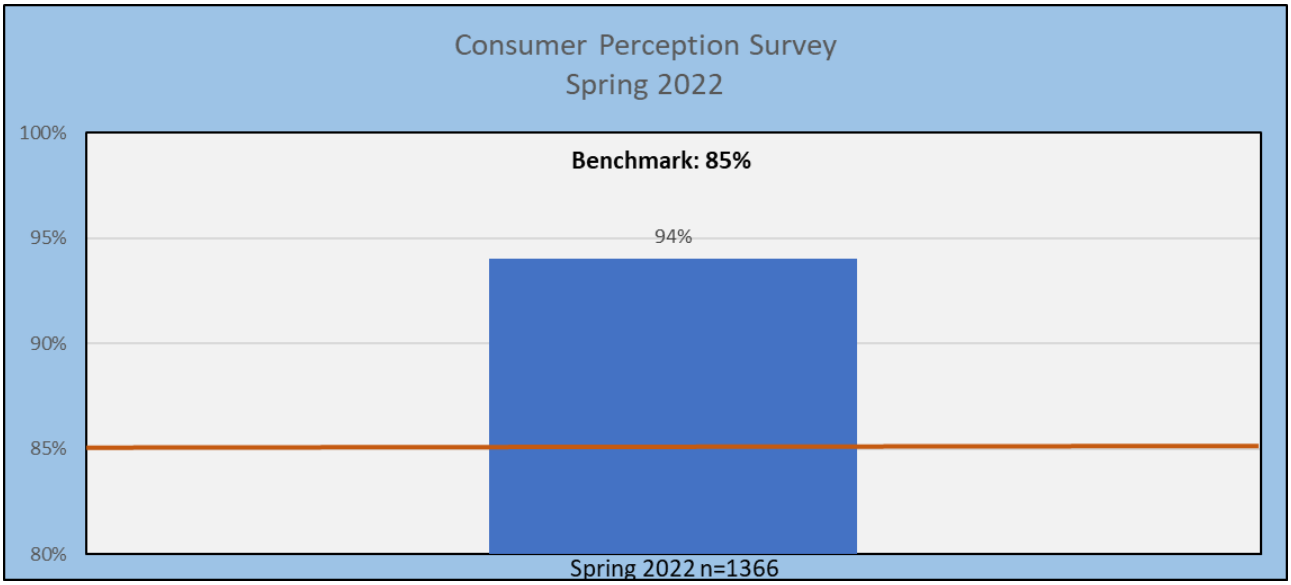
2. **2022/2023 The Goal Was:**

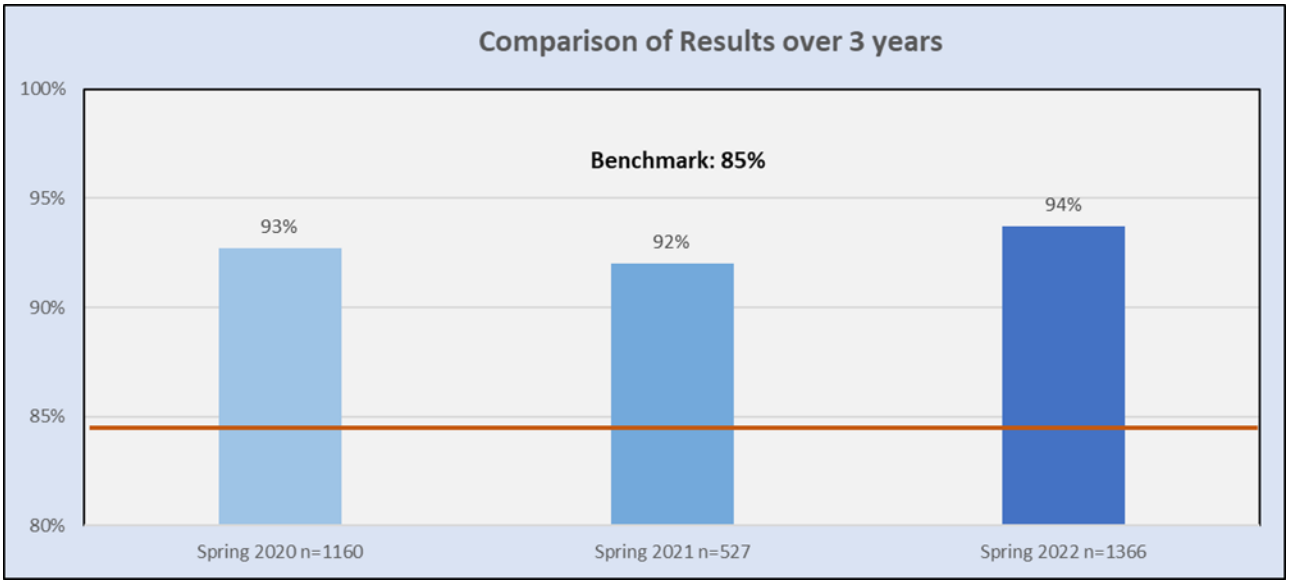
   ☒ MET ☐ NOT MET

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

   - The annual CPS was administered May 16-20, 2022. UCLA oversaw the survey process and delivered results to counties in mid-January 2023.
   - QID delivered results to MHP and contract providers in February 2023. QID prepared and delivered lobby posters to MHP and contract providers in February 2023. These lobby posters inform consumers of division-wide satisfaction results and that the CPS will next take place in Spring 2023.
   - QID presented survey results at the System Quality Improvement Committee (SQIC) meeting in April 2023. Results were also published on the KernBHRS.org website.
   - The Spring 2023 CPS took place May 15-19, 2023. UCLA will transmit data to Kern county in Fall 2023.

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





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

- MHP and contract providers achieved a cumulative satisfaction rating of 94% for the Spring 2022 reporting period.
- The KPIC committee utilizes CPS data to measure and monitor client satisfaction and other areas of consumer perception related to recovery principles, access to care, and progress in treatment.
- QID conducts an additional satisfaction survey monthly, the Local Recovery Survey (LRS), which provides 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

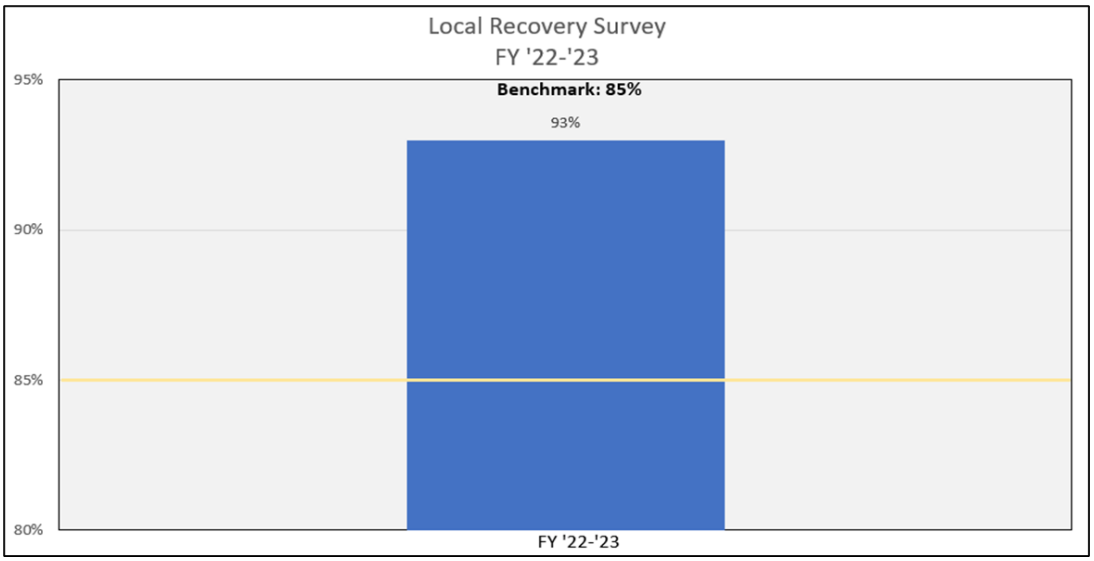
2. **2022/2023 The Goal Was:**

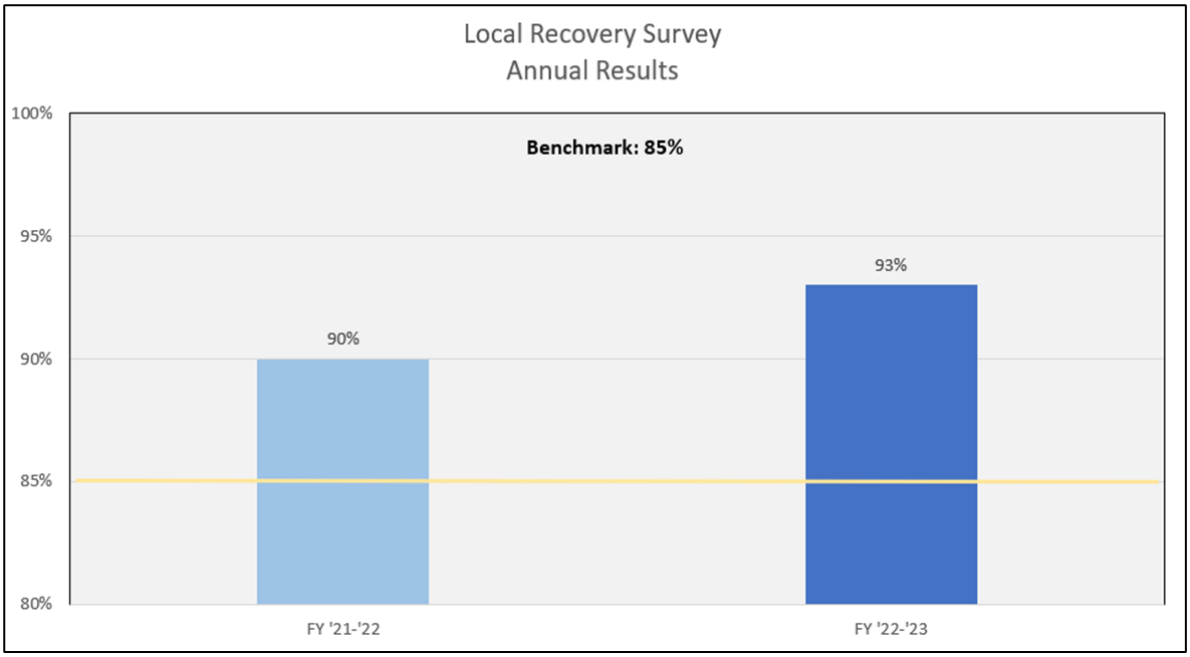
   ☒ MET ☐ NOT MET

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-eight individual teams were surveyed throughout the year, including 98 MHP teams and 30 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; staff attending training for reframing, which often involves recognizing a client's positive intentions and communicating an understanding that client is doing the best they can at the time; site-implemented weekly high risk review meetings to address high-risk clients and ensure they are receiving appropriate MH services; and the hiring of new staff and continued engagement in recruitment strategies. Also in the previous fiscal year, all service providers that did not meet the goal during the quarter did meet the goal the following quarter; therefore, all service providers surpassed the minimum satisfaction rating of 85%.
   - An annual report will be sent out to MHP and SUD supervisors and their administrators this month. The report 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:**





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

- MHP and SUD teams and contract providers achieved a cumulative satisfaction rating of 93% for FY 2022-2023.
- The KPIC committee utilizes LRS data to measure and monitor client satisfaction and other areas of consumer perception related to recovery principles, access to care, and progress in treatment.

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 KernBHRS staff and contract provider staff will complete the credentialing process.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   Continue to work diligently with KernBHRS HR, as well as with contracted providers, to ensure that credentialing is notified as soon as possible about the hiring of a new employee to get the credentialing process started.

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

Performance Toward Goal:		
# of Kern BHRS and contract provider staff needing to be credentialed	**# of Kern BHRS and contract provider staff credentialed**	**% of staff completing credentialing process**
145	145	**100%**

Additional Data Break Down:

- 145 applications approved (100%)
  - 65 of these applications were for BHRS staff (57%)
  - 80 of these applications were for contract provider staff (43%)

- Staff Credentialed by type
  - 55 Associates (38%)
  - 12 Certified (8%)
  - 54 Licensed (37%)
  - 24 Registered (17%)

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

   Efficiencies in the credentialing process were maintained, preventing unnecessary delays in the ability for newly hired credentialed staff to provide services and document those services in the electronic health record.

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 performed within the mandated time frame.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   We continued to do daily checks & tracking of the Appeal Case Management System (ACMS) website.

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

Quarterly break down of State Fair Hearings				
Fiscal Year: 22-23	**Q1 July-Sep**	**Q2 Oct-Dec**	**Q3 Jan-Mar**	**Q4 Apr-Jun**
# State Fair Hearing Appeals Submissions	**0**	**0**	**0**	**0**
Result: MET/NOT MET	**MET**	**MET**	**MET**	**MET**

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

   No appeals have been submitted during the third quarter.

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 youth penetration rate to an overall monthly average of 50% or greater.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   - Worked with Department of Human Services (DHS) by providing monthly lists to facilitate updating of Medi-Cal aid codes for foster youth.
   - Continued collaboration with DHS to increase utilization of Child and Adolescent Needs and Strengths (CANS-IP) assessment tool to support decision making in Child and Family Team (CFT) meetings (including process to ensure sharing of CANS-IP between agencies through a dedicated CANS submission email).
   - Provided continued support to eleven STRTPs including monthly provider meetings and weekly visits to STRTPs to train and support providers.
   - Implemented and utilized evidenced-based model, Zero Suicide, to monitor all STRTPS.
   - Continued work with partner agencies through AB 2083 (Collaborative MOU) to create innovative models to address youth with complex needs.
   - Attended community wide stakeholder meeting to evaluate community needs and resources for Family First Prevention Services Act (FFPSA).
   - Continued cross system coordination of referrals by having Behavioral Health staff co-located at DHS sites and DHS staff co-located in Behavioral Health treatment teams. Foster Care Supervisor attends bi-monthly meetings with DHS to promote Behavioral Health referrals for children 0-5 years of age.
   - Met with ITS to explore methodology used on current foster care penetration rate report.
   - Implemented and monitored screening of Pathways to Well-Being services for all youth including ICC, IHBS and TFC at intake and every 6 months thereafter.
   - Implemented STRTP step-down meetings with DHS and Probation departments.

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

Year	Month	Actual MMEF Eligible Foster Kids	CAEQRO MMEF Eligible Foster Kids [1]	Unique Foster Kids Served	Total services	12 Month cumulative Unique Foster Kids Served	12 Month cumulative Penetration rate [2]	12 Month cumulative Total services	12 Month cumulative Total eligible months
2023	6	2,295	2,388	639	4,163	1,267	53.06%	57,718	28,654
2023	5	2,279	2,402	637	4,807	1,259	52.41%	58,702	28,829
2023	4	2,317	2,416	646	4,586	1,283	53.11%	59,055	28,990
2023	3	2,358	2,429	682	5,082	1,286	52.94%	59,420	29,151
2023	2	2,320	2,444	626	4,671	1,287	52.67%	58,983	29,322
2023	1	2,340	2,475	643	4,903	1,306	52.77%	58,707	29,698
2022	12	2,399	2,505	663	4,192	1,318	52.61%	58,402	30,061
2022	11	2,426	2,537	670	4,737	1,323	52.16%	57,919	30,438
2022	10	2,468	2,548	687	5,041	1,339	52.55%	57,560	30,576
2022	9	2,486	2,553	678	4,765	1,329	52.05%	56,860	30,641
2022	8	2,474	2,555	707	5,754	1,324	51.81%	55,967	30,665
2022	7	2,492	2,559	710	5,017	1,333	52.10%	54,758	30,703

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

The Foster Care Penetration Rate report for FY 22/23 shows that the penetration rate was met for all 12 months. The highest month reported was at 53.11% for April of 2023. Services have focused largely on providing support to youth with complex care needs and partnering with placement agencies to be proactive in their referrals. KernBHRS continues to identify areas that the Department of Human Services is under referring to, for example youth that are ages 0-5 years, and provides regular data and updates to help inform practices of identifying and referring early. Also, KernBHRS has met with DHS to provide information about the number of foster youth served that do not have the correct aid code. Some of these aid codes, including Social Security and CalWORKs, are not able to be updated and therefore are not reflected on penetration rate reports.

6. **Plan for Current Goal:**.

☒ Keep the goal with no change for the upcoming year

Goal #8 Grievance & Appeals / Problem Resolution

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

   98% of all resolved Grievance and Appeals will have been addressed within the prescribed timeframes

2. **2022/2023 The Goal Was:**

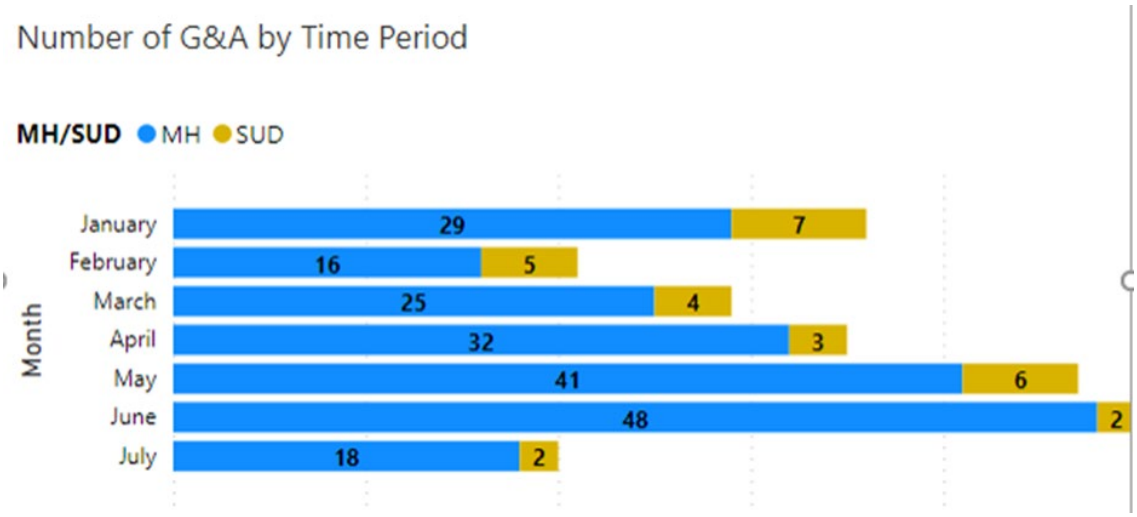
   ☒ MET ☐ NOT MET

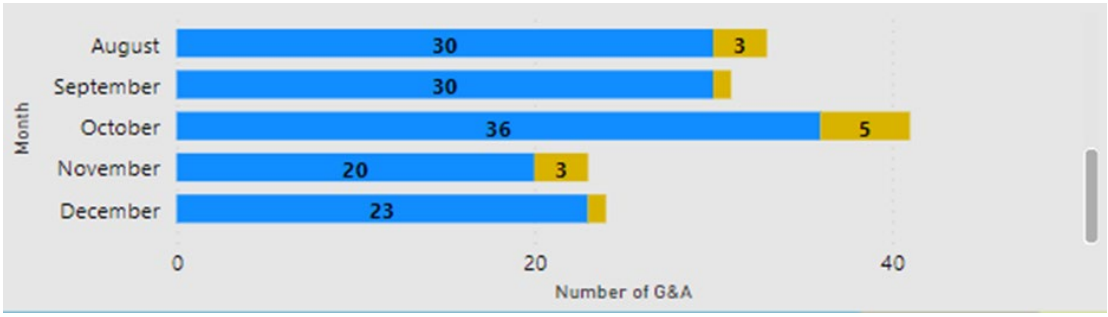
3. **Quality Improvement Activities / Actions Taken Over the Past Year:**

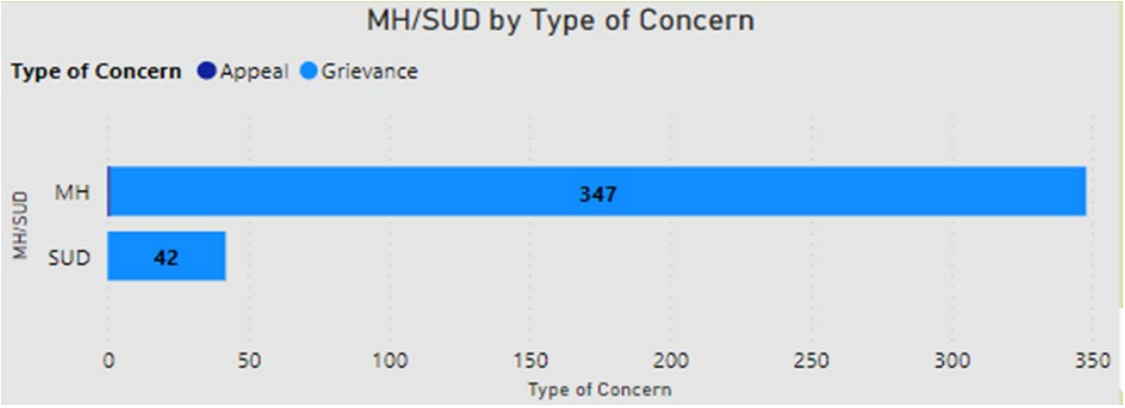
   - The goal for the PR office is to increase the number of grievances being submitted by the KernBHRS System of Care and Contracted Providers.
   - Each Grievance and Appeal will be submitted within the web application by the supervisor within one business day or via Grievance and Appeal Paper form from 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:		
# Grievances and Appeals for FY 22/23	**# Grievances and Appeals addressed within the prescribed timeframes**	**% Grievances and Appeals addressed within the prescribed timeframes**
780 total	778 total	**99.25%**







FY22/23 (Fiscal Year)

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

- For FY 22-23, data shows that there was a total of 389 grievances submitted and 1 Appeal.
- For Mental Health Division (MH), there are a total of 347 grievances submitted and 1 Appeal.
- For Substance Use Division (SUD), there were a total of 42 grievances submitted and 0 appeals.

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 prescriber will achieve a combined rating of 85% or higher on peer review medication monitoring evaluation.

2. **2022/2023 The Goal Was:**

   ☒ **MET** ☐ **NOT MET**

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

   During this year, we increased the number of charts reviewed per prescriber in order to obtain a better view of how prescribers were doing: 196 charts were reviewed during this reporting period, covering 40 prescribers.

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	Average Rating	CAPs issued
99%	100%	100%	94%	98%	100%	100%	96%	100%	94%	100%	100%	99%	98%	11

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

   Overall, all prescribers met or exceeded the departmental standard of 85% or higher in the reporting period with seven (7) of the thirteen (13) areas being 100% met at each review. For the specified areas that did not meet the 85% threshold, eleven (11) Corrective Action Plans (CAP) were issued requiring immediate review with clients of medication consents, as at least one (1) Medication Consent for these charts were not found during the review.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #10 Navigation Center Referrals

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

   50% of individuals living in the shelters and navigation centers will be referred into behavioral health services.

2. **2022/2023 The Goal Was:**

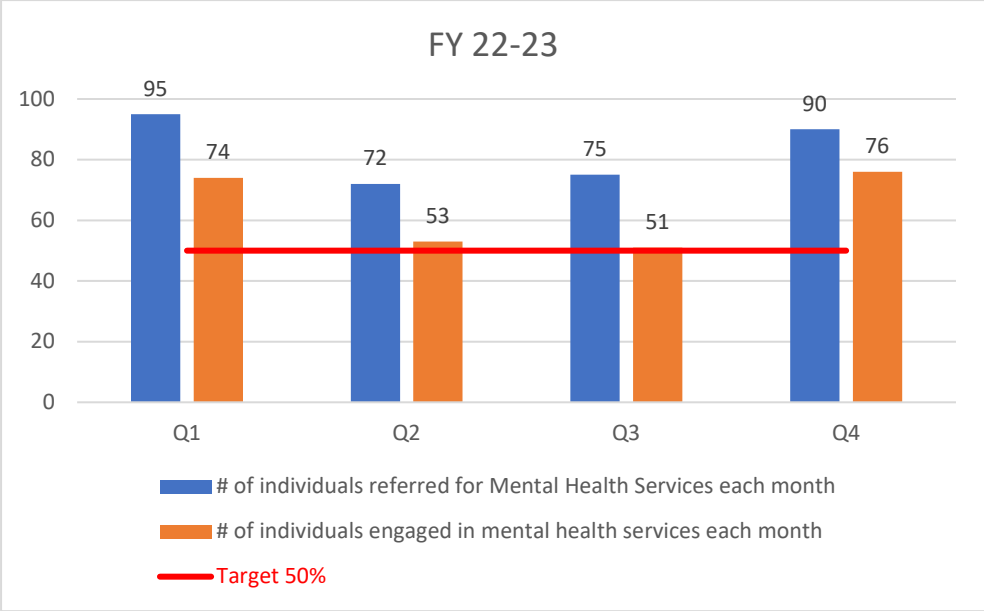
   ☒ MET ☐ NOT MET

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

   - Engage and refer individuals living in the shelters and navigation centers into behavioral health services by ensuring consistent staffing, coordination and collaboration with shelter staff and maintaining a consistent and engaged presence in the facilities.
   - Monthly Meetings with the Navigation Centers to work on referral and engagement services for individuals wanting to obtain treatment for the Mental Health and Substance Use Disorder Systems of Care.

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

Performance Toward Goal:		
# individuals living in the shelters and navigation centers referred to Kern BHRS	**# individuals living in the shelters and navigation centers referred to Kern BHRS that were engaged in services**	**% individuals living in the shelters and navigation centers referred to Kern BHRS that were engaged in services**
332	254	**77%**



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

   This goal was **met** for this reporting period and over the next year, we will continue and implement the following interventions:

   - Continued monthly meetings with shelter staff to discuss referral processes and engagement services.

- Coordinate with the System of Care and Contract Providers to encourage and monitor linkage into services upon leaving the shelters for continuity of care.
- Establish standardized procedures within the shelters for linkage into Mental Health and Substance Use Disorder Systems of Care.

6. **Plan for Current Goal:**

☒ Change goal- increase percentage to 70%
increase percentage to 70%

Goal #11 Outcomes Measurements – Penetration Rate

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

   Increase penetration rate of the Asian Pacific Islander population into MH treatment from 1.00% to 1.25% by implementing culturally sensitive outreach and engagement strategies.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   The fiscal year penetration rate for the Asian/Pacific Islander population into MH treatment was 1.34% for fiscal year 22-23. This means we were 0.09% above our goal.

   The department tried doing more focused outreach to Asian/Pacific Islander community groups; but in a way that was focused on meeting the community where they are. This resulted in three different teams participating in Outreach & Education activities for the Asian/Pacific Islander Community including:

   - Cultural Competence team coordination of the Southeast Asian Townhall where a department doctor provided information on mental health and wellness to Sikh youth and families
   - MHSA coordination of Cultural Competence team's participation in Bakersfield Sikh Women's Association Annual 5K and resource fair
   - Prevention Team participation in culturally responsive Outreach & Education at local Sikh Gurdwaras

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

   The data used to measure this was taken from two sources: The mental health penetration rate dashboard in PowerBI and the MHSA team Outreach & Education Tracker.

	MH PRR					
	H/L (2.85%)	EA/W (5.24%)	AA/B (5.75%)	API (1.75%)	AIAN (5.9%)	Other (3.25%)
July, 22	2.85%	5.83%	5.88%	1.32%	13.49%	1.73%
Aug, 22	2.83%	5.85%	5.96%	1.25%	13.77%	1.73%
Sept, 22	2.82%	5.85%	5.92%	1.26%	14.26%	1.69%
Oct, 22	2.86%	5.90%	5.95%	1.40%	13.33%	1.82%
Nov, 22	2.88%	5.86%	5.79%	1.31%	13.03%	1.92%
Dec, 22	2.88%	5.91%	5.83%	1.35%	11.74%	2.00%
Jan, 23	2.96%	5.97%	5.97%	1.34%	12.54%	2.09%
Feb, 23	2.98%	5.95%	5.91%	1.31%	13.04%	2.30%
Mar, 23	3.04%	5.96%	6.07%	1.39%	13.81%	2.42%
Apr, 23	3.01%	5.98%	5.91%	1.41%	13.00%	2.55%
May, 23	3.03%	5.98%	5.93%	1.39%	12.94%	2.77%
Jun, 23	2.74%	5.37%	5.27%	1.25%	12.21%	2.50%
Totals	2.91%	5.87%	5.87%	1.33%	13.10%	2.13%

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

   While the Asian/Pacific Islander community is very diverse, our department has concentrated its efforts on building connections to the local Sikh Punjabi population; in part because of their having the largest Asian/Pacific Islander population in our county, but also because there are many active Sikh-serving organizations with whom we managed to make contact during this increase in efforts to outreach to local Asian/Pacific Islander populations.

6. **Plan for Current Goal:**

   ☒ Change goal

The goal should be changed to 1.35%. This is using the methodology shared by Evalcorps who used a 1% growth model to project the client population growth over the next 10 years for the MHSA and Cultural Competence Reports.

Goal #12 Outreach Effort to the Homeless & Hard to Reach

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

   Community outreach efforts in each area of the 5 MH clinics (Taft, Lake Isabella, Arvin/Lamont, Delano, Bakersfield) will increase the number of initial referrals recorded in the Bakersfield and Community referral application by 10% over the identified baseline for each site.

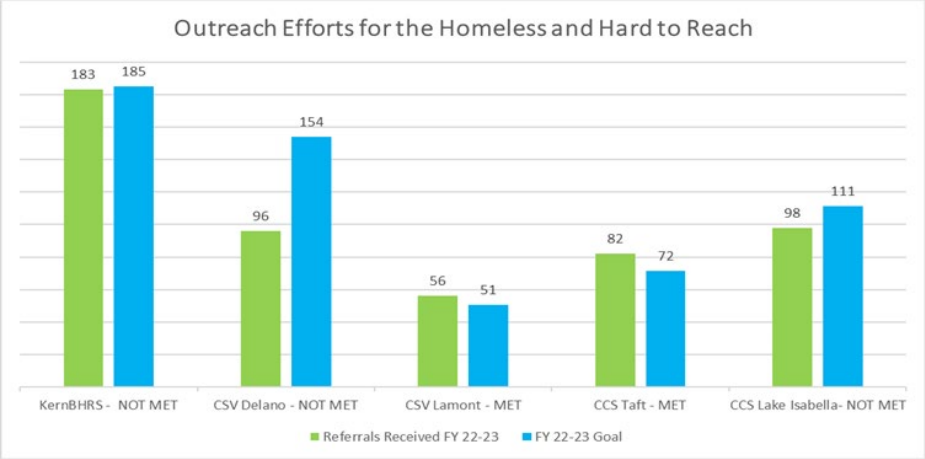
2. **2022/2023 The Goal Was:**

   ☒ MET ☒ NOT MET

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

   - Monitored web application entries for each Behavioral Health clinic to ensure consistent collection and update of referral data; contacted staff directly to determine and address in real time reasons for missing/incomplete data.
   - Provision of individualized training to teams experiencing turnover, struggling to understand the program, and/or needing general support to ensure accuracy in data collection and consistency in program operations.
   - Coordination of ROEM Team Job Shadowing for new outreach staff.
   - Replenished clinic marketing materials and engagement supplies for continued outreach and program education.
   - Discussed with clinic leaders the necessity of monitoring data and developing engagement supply management systems to ensure consistent outreach efforts are occurring.
   - Discussed with contractor leadership the challenges experienced pertaining to staff turnover and filling vacant outreach positions in outlying areas.

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



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

   1. Continued enhancements of web application allowed for accurate and comprehensive tracking of client referrals and outcomes.
   2. Coordination of training and job shadowing for new outreach staff increased program knowledge and goals, and enhanced skillsets, allowing for utilization of additional and improved engagement techniques, and thereby increasing the effectiveness of staff's interaction with referred clients.

3. Replenishment of marketing materials and purchase and dissemination of engagement supplies resulted in increased opportunities to educate and interact with individuals in the community and at events, thereby allowing for additional prospective client referrals.
4. Discussions regarding positions being recruited to fill outreach staff vacancies resulted in an analysis of the benefits of hiring peer-equivalent staff, due to the anticipated increased number of qualified applicants, versus recovery specialists.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #13 Peer Support

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

   80% of the current Peer Support Specialist Staff who are eligible for Medi-Cal certification under the Grandparenting process will achieve certification through CalMHSA by June 30, 2023.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   KernBHRS stopped tracking the number of Peer Support Specialist Staff who achieved certification through the CalMHSA Grandparenting process, because the Grandparenting process has ended and is no longer an opportunity for applicants.

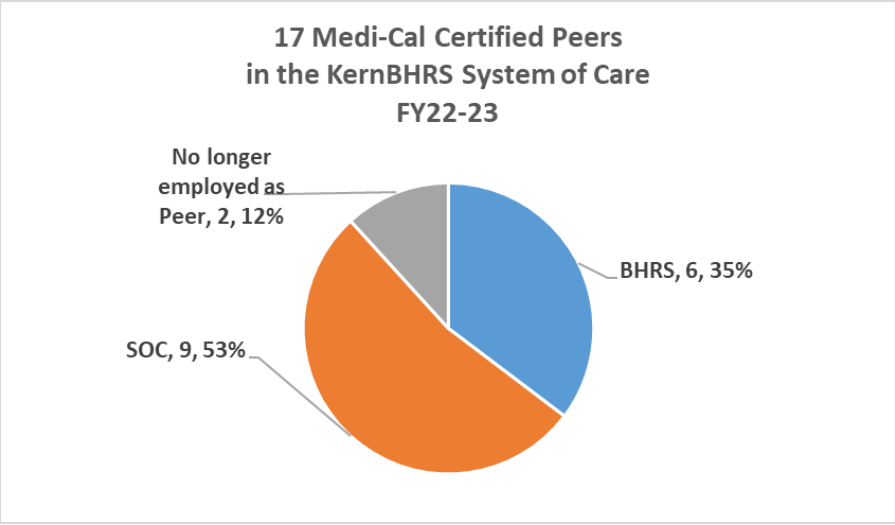
   KernBHRS stopped tracking the number of Peer Support Specialist Staff who applied for scholarships through CalMHSA. CalMHSA no longer requires applicants to have their names submitted to CalMHSA by County Behavioral Health for certification or for scholarships. Applicants are now able to apply directly to CalMHSA.

   KernBHRS has developed a process for credentialing Medi-Cal Certified Peer Support Staff prior to providing these staff with access to the electronic health record. Until these staff are credentialed, they are barred from accessing the EHR codes for documentation and billing of Medi-Call Peer Support Services. Credentialing is being completed for both KernBHRS Medi-Cal Certified Peer Support Staff and those of BHRS' System of Care contracted providers.

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

   For KernBHRS staff, 100% of seven (7) current Peer Support Specialist Staff who are eligible for Medi-Cal certification under the Grandparenting process will achieve certification through CalMHSA by June 30, 2023.

   Currently there are 17 Medi-Cal Certified Peer Support Specialist staff across the KernBHRS System of Care (i.e., both BHRS and contracted provider staff combined).



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

KernBHRS exceeded the goal of 80% of staff applying to CalMHSA using the Grandparenting Process, achieving Medi-Cal Peer Support certification. Beyond this goal, the KernBHRS System of Care also achieved Medi-Cal Peer Support certification through the Initial Certification process.

6. **Plan for Current Goal:**

☒ Change goal

100% of current KernBHRS Medi-Cal Certified Peer Support Specialist Staff will maintain their certification as required by CalMHSA.

Goal #14 Provider Appeals

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

   100% of Provider Appeals will be resolved in a timely manner.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

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

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

   Number of Appeals filed = 0

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

   KernBHRS Finance division continued to ensure that providers are aware of their right to appeal financial decisions and the process for filing the appeal. This information was communicated on a number of occasions. No appeals were filed in FY22-23.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #15 SUD Access Line/ Test Calls

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

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

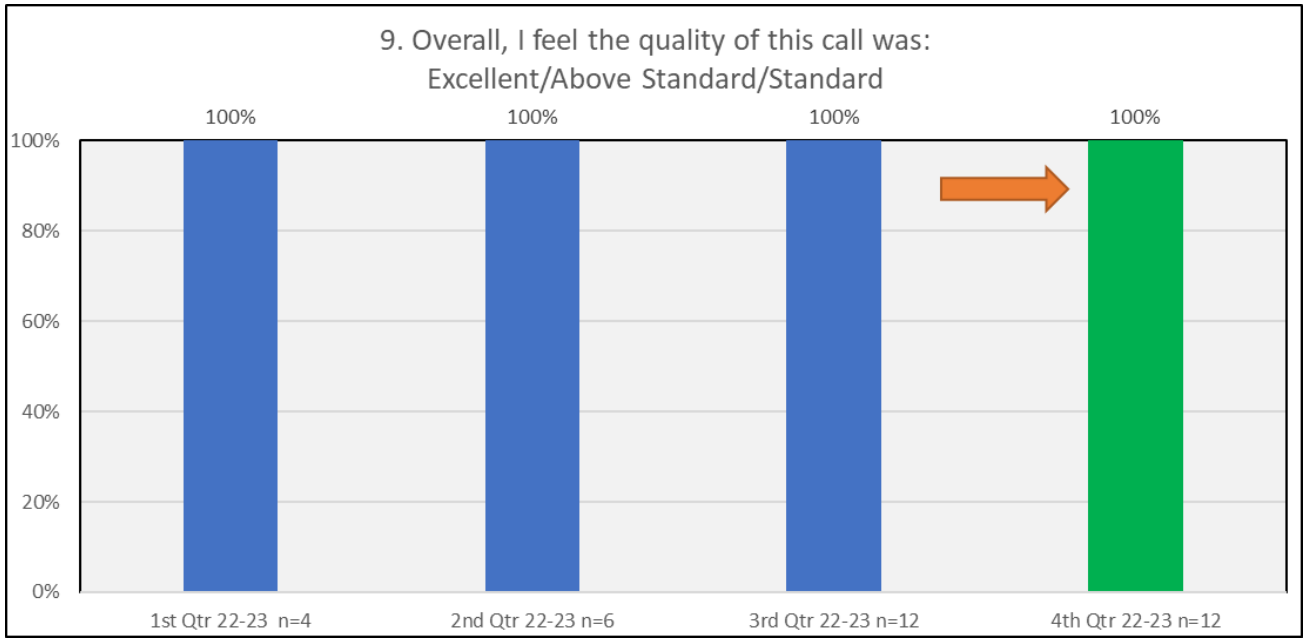
2. **2022/2023 The Goal Was:**

   ☒ 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 number of test calls per quarter increased from four to six to twelve in the last two quarters.
   - 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:**



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

   - Satisfaction scores for each quarter met the goal of standard or above 100% of the time.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #16 SUD Adult Satisfaction - TPS

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.

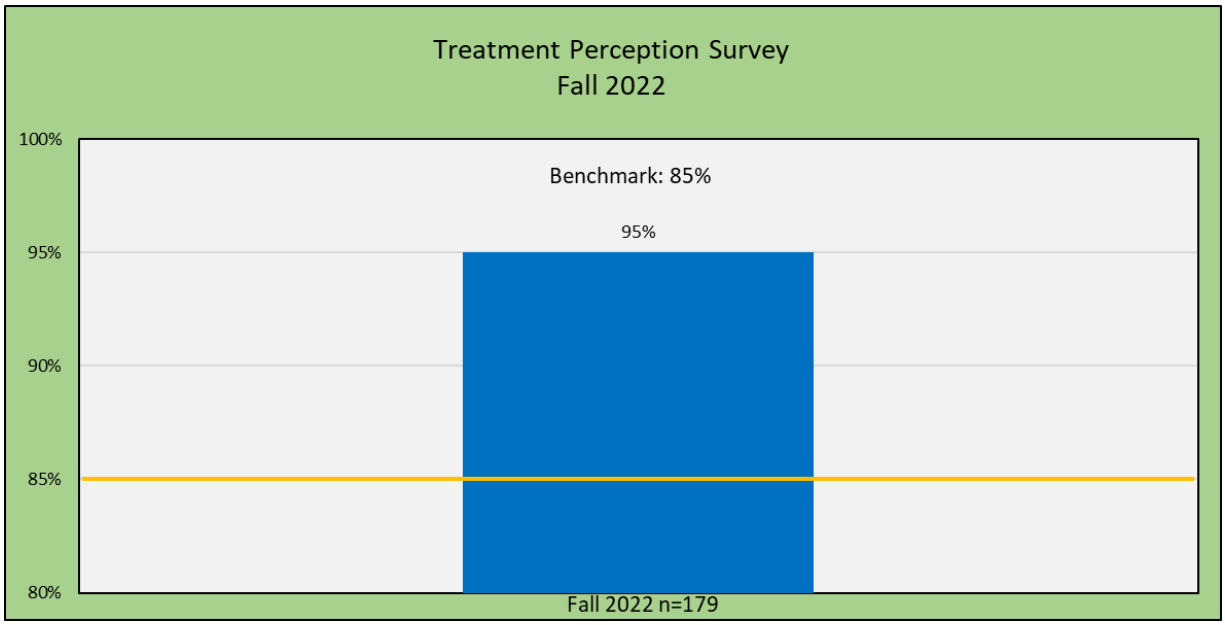
2. **2022/2023 The Goal Was:**

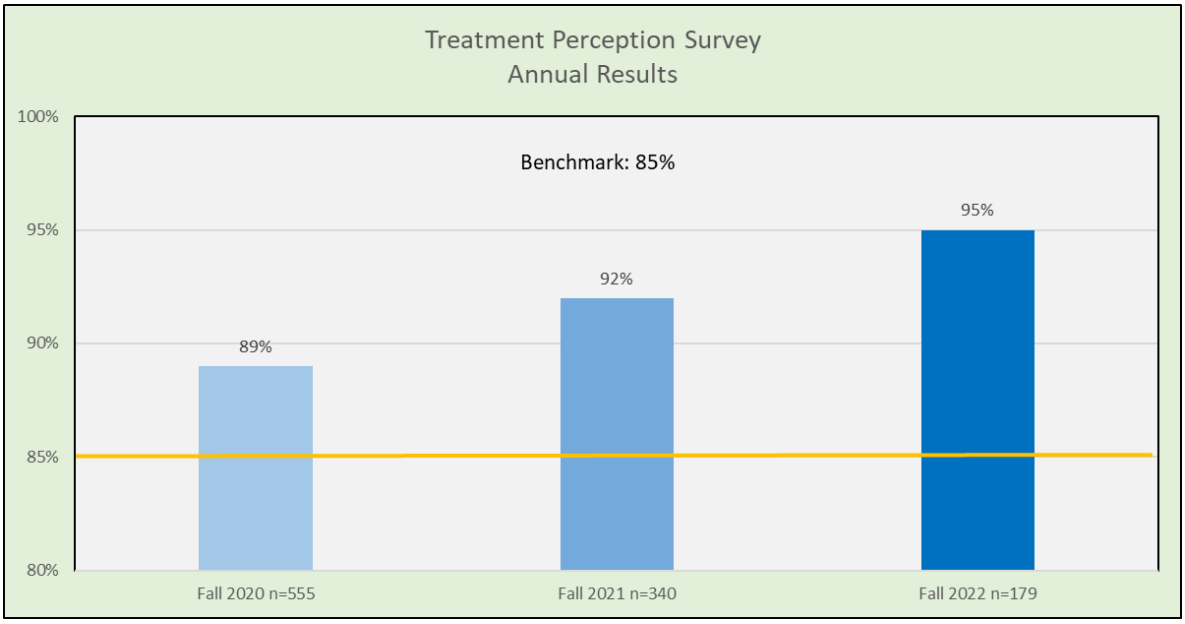
   ☒ MET ☐ NOT MET

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

   - The annual TPS was administered October 17-21, 2022. UCLA oversaw the survey process and delivered results to counties in March 2023.
   - QID delivered results to SUD and contract providers in April 2023.
   - QID prepared and delivered lobby posters to SUD and contract providers in April 2023. These lobby posters inform consumers of division-wide satisfaction results and that the TPS will next take place in Fall 2023.
   - QID presented survey results at the System Quality Improvement Committee (SQIC) meeting in April 2023. Results were also published on the KernBHRS.org website.

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





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

- SUD and contract providers achieved a cumulative satisfaction rating of 95% for the Fall 2022 reporting period.
- The KPIC committee utilizes TPS data to measure and monitor client satisfaction and other areas of consumer perception related to recovery principles, access to care, and progress in treatment.
- QID conducts an additional satisfaction survey monthly, the Local Recovery Survey (LRS), which provides 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 #17 SUD Audit Review - Training

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

   85% of all DMS-ODS agencies who received their annual quality review will meet staff training requirements as evaluation on the QID SUD monitoring goal.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   - Created a SUD trainings presentation
   - A Providers' Staff Training spreadsheet was created to track individual staff trainings and quantify individual staff training percentages
   - Allow time for providers' staff to complete trainings during the review
   - Had on going communication with providers to help them meet the goal

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

85% of all DMS-ODS agencies who received their annual quality review will meet staff training requirements as evaluation on the QID SUD monitoring goal.

Agencies Reviewed	Completion percentage			
	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
0	0			
3		100%		
4			100%	
2				100%

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

   We didn't conduct reviews during the 1st quarter. We used the 1st quarter to provide technical assistance and training. During the course of the reviews, we provided training reports from Relias to providers by each individual staff and we allowed time for the staff to complete the trainings while we were conducting the review. The reports provided valuable data to providers to identify issues and gaps. As a result of this, providers were able to meet the target goal.

6. **Plan for Current Goal:**

   ☒ Discontinue goal

   Because all the providers met the goal and now were able to provide timely training reports during the review, we will discontinue the goal.

Goal #18 SUD Outcome Measures – Access Line

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

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

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   Over the course of FY 22-23, staff from the Quality Improvement Division facilitated two No-Show Focus groups with provider staff as well as internal KernBHRS staff. These focus groups attempted to identify root causes for client no-shows and identify activities that could be helpful in increasing attendance.

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

	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	April 23	May 23	Jun 23	Average
Total referred	558	710	640	634	623	539	546	563	654	621	591	539	601.5
Total attended	237	267	250	254	239	206	233	194	248	227	223	194	231.0
Successful linkage	42.5%	37.6%	39.1%	40.1%	38.4%	38.2%	42.7%	34.5%	37.9%	36.6%	37.7%	36.0%	38.4%

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

   The SUD Access Line continued reminder calls prior to appointments, but were not able to consistently reach those that had upcoming appointments. When they did reach them and the original appointment had passed, appointments were rescheduled to assist clients to engage in treatment. As the no-show focus group report was integrated into bi-monthly meetings with providers, five of them were able to include interventions to increase client show rates to assessments.

   Some of these interventions included reminder calls by administrative staff ahead of the appointment, calls from therapists to those that were not present for their appointments in order to try to schedule them for a later time on the same day, walk-in assessment slots, double booking assessment times, offering to assist with transportation to the appointment.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #19 SUD Outcome Measures – MAT

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

   Continue referrals to MAT community providers with a minimum of 500 for Fiscal Year 22-23.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   SUD Administration continued to hold quarterly meetings with Clinica Sierra Vista (CSV) and Omni in order to discuss referral processes and updates. Omni did not participate in any meetings this fiscal year, but did reach out in May to continue the MOU with KernBHRS for another 3 years. CSV proposed a new referral form, and this helped in streamlining and tracking patients referred by the SUD Access Line. As MAT referrals were discussed with SUD Supervisors, one of the teams reported that Sober Living Environments were advising clients to stop MAT in order to reside at their homes. SUD Administrator worked with the Housing Team to provide education around the effectiveness of MAT and made recommendations to reduce negative feedback to residents.

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

	Jul - 22	Aug-22	Sep-22	Oct - 22	Nov-22	Dec-22	Jan - 23	Feb-23	Mar-23	Apr-23	May-23	Jun - 23	Total
Referred to CSV by KernBHRS	52	38	30	30	21	20	27	29	13	24	14	17	315
Referred to Omni by KernBHRS	3	4	1	3	0	1	0	0	0	6	3	2	23
Referred to CSV by Providers	1	3	4	2	6	14	4	5	5	8	6	2	60
Referred to Omni by Providers	0	1	0	0	1	4	1	1	0	0	0	0	8
Referred to Other by Providers	9	9	12	15	14	12	6	15	15	13	15	13	148
Totals	65	55	47	50	42	51	38	50	33	51	38	34	**554**

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

   Utilizing CSV's recommended referral improved process so that clients would be scheduled for appointments. Omni reached out at the end of the fiscal year and was willing to continue the MOU. They will be participating in quarterly meetings and provide updates so these can be shared with the DMC-ODS network. The MAT presentation to housing providers led many to be vocal about how they struggle to work with residents with an opioid use disorder, but this also allowed others to point out how clients respond well to treatment and are able to make progress in their recovery. These conversations will continue to reduce stigma of MAT within housing providers.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #20 SUD Outcome Measures – Penetration Rate

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

   Increase penetration rate of the Latino/Hispanic population into SUD treatment from .52% to .57% by implementing culturally sensitive outreach and engagement strategies.

2. **2022/2023 The Goal Was:**

   ☒ MET ☒ NOT MET

   The fiscal year penetration rate of the Hispanic/Latino population in SUD treatment was .43% for fiscal year 22-23. This means we were 0.14% below our goal.

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

   Of 147 logged Outreach and Education Events, 16 were specifically organized for a Hispanic-serving organization and/or in a Hispanic-predominant area of the county. Additionally, since Census estimates show that overall the county population is 56% Hispanic, there were an additional 47 events that were listed for the general public. This means that if we only counted these events, a total of about 43% of events were focused on this population. This does not acknowledge the intersectionality of the local Hispanic population, because events for other populations may also have touched the Hispanic population. The full list of additional populations of focus:

   - African American
   - Asian/Pacific Islander
   - Disability
   - Faith based
   - General
   - Hispanic
   - Homeless
   - LGBTQ+
   - Males
   - Native
   - Older Adults
   - Rural
   - Veterans
   - Victims of Domestic Violence
   - Youth

   In this time period, the Prevention Team also provide community presentations on substance use prevention and, along with the Drug Free Kern Coalition, developed a video series that focused on demystifying substance use myths and misinformation.

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

   The data used to measure this was taken from two sources: The substance use penetration rate dashboard in PowerBI and the MHSA team Outreach & Education tracker.

	SUD PRR					
	H/L (.85%)	EA/W (2.35%)	AA/B (1.25%)	API (.17%)	AIAN (2.25%)	Other (1.25%)
July, 22	0.45%	1.63%	0.78%	0.25%	2.92%	0.15%
Aug, 22	0.44%	1.65%	0.77%	0.23%	3.29%	0.15%
Sept, 22	0.45%	1.64%	0.75%	0.22%	3.39%	0.15%
Oct, 22	0.44%	1.63%	0.80%	0.20%	3.38%	0.14%
Nov, 22	0.42%	1.56%	0.78%	0.18%	3.16%	0.13%
Dec, 22	0.40%	1.56%	0.77%	0.15%	2.76%	0.14%
Jan, 23	0.42%	1.59%	0.79%	0.19%	3.04%	0.15%
Feb, 23	0.42%	1.57%	0.83%	0.22%	2.72%	0.16%
Mar, 23	0.44%	1.63%	0.86%	0.22%	2.68%	0.16%
Apr, 23	0.45%	1.65%	0.88%	0.20%	2.87%	0.18%
May, 23	0.46%	1.68%	0.83%	0.19%	0.19%	0.18%
Jun, 23	0.43%	1.57%	0.76%	0.18%	0.18%	0.17%
Totals	0.44%	1.61%	0.80%	0.20%	2.55%	0.16%

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

Despite ongoing efforts to outreach to the Hispanic Community, there is an ongoing decrease in the penetration rate for this population. One of the actions we have undertaken as part of a statewide equity collaborative is to get input directly from the community on what we can do to increase the number of Hispanic individuals coming into services. This project was launched at the end of fiscal year 22-23 and will continue into 23-24 with the community defined projects of teaching Promotores (Community Health Workers) how to help community members navigate our system as well as joining in neighborhood level coffee talks and support groups so that we can build direct personal connections with the Hispanic population and destigmatize help-seeking.

6. **Plan for Current Goal:**

☒ Change goal

This goal should be changed to 0.43%. This is rounded up and using the methodology shared by Evalcorps who used a 1% growth model to project the client population growth over the next 10 years for the MHSA and Cultural Competence Reports. The actual value for a 1% increase would be 0.4343%, so we suggest rounding down to 0.43% which is exactly the same value as was able to be attained in FY 22-23.

Goal #21 SUD Points in Time Surveys

1 **Quality Improvement Work Plan Goal:**

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

2 **2022/2023 The Goal Was:**

☐ MET ☒ NOT MET

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

Over the course of FY22-23, SUD Administration refined the process for identifying groups of clients to survey at each provider. A number of staff were identified from various teams in order to administer surveys, but as time went on, less staff were available for this task, as they were focused on clinical service provision. Additional parameters were developed for administrative staff so that enough surveys could be completed per month to deliver a larger, more representative sample.

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

Point in Time	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Average # Surveys
Admission	48	28	24	21	23	31	23	25	35	19	34	37	29
During Treatment	11	17	11	14	9	12	7	2	15	14	23	17	12.6
Discharge	19	18	9	11	12	19	14	5	8	3	9	11	11.5
Follow up	23	18	11	20	21	21	23	4	8	13	22	18	16.8

Point in Time	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Average annual positive rating
Admission	93.8%	96.4%	96.9%	89.3%	96.7%	91.1%	91.3%	93%	91.4%	89.5%	92.6%	91.9%	92.85%
During Treatment	100%	90.2%	100%	76.2%	100%	88.9%	100%	100%	86.7%	97.6%	87.0%	86.3%	92.7%
Discharge	94.7%	83.3%	77.8%	77.3%	79.2%	63.2%	82.1%	100%	75%	33.3%	50.0%	86.4%	75.1%
Follow up	89.1%	94.4%	77.3%	90%	95.2%	76.2%	100%	87.5%	87.5%	88.5%	90.9%	97.2%	89.5%

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

As quarterly averages were calculated, these were brought to individual provider meetings held every two months for discussion. By the time these meetings occurred, provider leadership was aware of situations that were mentioned in survey comments. If they were not familiar with the situation, they would take the comments back to their staff in order to discuss opportunities for improvement. Some of these included better customer service by reception staff and recognition of staff who had be praised by name during surveys.

6 **Plan for Current Goal:**

☒ Change goal

Propose to change the goal to only focus on Discharge and Follow up points in time, as these have the lower percentages, and activities for improvement could help improve retention and continued communication with providers even if discharge is not favorable. New goal could read: "Client satisfaction ratings at Discharge and Follow up will obtain positive ratings at 85% or higher".

Goal# 22 UOR – MH Timeliness

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

   95% of UOR will be completed and signed by Contracted Administrator and KernBHRS administrator within the required timeframes.

2. **2022/2023 The Goal Was:**

   ☐ MET ☒ NOT MET

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

   - QID reviewed the timeliness of all UOR submitted for FY 22-23 to ensure these were submitted within the required timeframes by contracted and KernBHRS administrators.
   - QID sent weekly reminders to supervisors and administrators who had pending reports to remind them to approve their UORs.
   - QID reviewed the reports and changed the name of supervisors or administrators when these were entered in error to avoid any further delays.
   - The UOR App sent emails with a link to the supervisor or administrator who had a pending report after it had been pending for 14 days.
   - QID collaborated with administrators and supervisors who had UORs overdue to explore barriers to getting reports approved and assisted in getting them completed.

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

Annual Data	Total UORs	Submitted on Time	Submitted LATE	% Submitted on Time	Goal 95%
	1866	879	987	49.5%	Not Met

QTR	PROVIDER	TOTAL UORs	Submitted on Time	Submitted LATE	% Submitted on Time	Goal 95%
1st	KBHRS	182	138	44	78%	Not Met
	Contracted	259	139	120	46%	
2nd	KBHRS	170	92	78	54%	Not Met
	Contracted	240	125	115	52%	
3rd	KBHRS	173	101	72	58%	Not Met
	Contracted	390	115	275	30%	
4th	KBHRS	151	71	80	47%	Not Met
	Contracted	301	98	203	33%	

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

   - **1866** UORs reports were submitted and completed for FY22-23.
   - **987** Reports were completed outside the required timeframe with some still pending approval at the time of QIC report.
   - Of the 987 submitted late, 713 of them were submitted by our Contracted providers and 274 were submitted by KBHRS teams.
   - **64** UORs were still pending approval for this FY from supervisors or administrators as of 7/21/23.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #23 UOR – Outpatient MH

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

   95% of all MHP Outpatient UOR will be addressed in a clinically appropriate manner.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   - QID reviewed all MH UOR submitted in the fiscal year to ensure they were addressed in an appropriate manner and no additional actions steps were necessary to address the incidents or prevent any future incidents from happening.
   - QID sent recommendation letters to teams, supervisors, and administrators when policies or standards were not followed.
   - All UORs submitted due to deaths or suicide attempts were automatically routed to the chair of the M&M committee for a complete investigation/review.
   - All UORs submitted due to Confidentiality, PHI potential breaches or unethical conduct by the staff were routed to the corporate and compliance officer for further investigations.
   - QID collaborated with KernBHRS training department and identified appropriate trainings to be assigned to all direct staff of internal and contract providers to help them in learning skills on how to handle incidents related to aggression as these were identified to be the highest type of incidents submitted in the department.
   - The system addressed concerns identified in the UORs by providing direction, guidance, training and support during supervision and or team meetings.

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

UORs FY 22-23					
Qtr.	**KernBHRS**	**Contract Providers**	**Total Submitted**	**# Addressed Appropriately**	**Goal 95%**
1Q	182	259	441	441	100%
2Q	170	240	410	410	100%
3Q	170	388	558	558	100%
4Q	151	304	455	455	100%
Total FY	**673**	**1191**	**1864**	**1864**	**MET**

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

   - **1864** UORs were submitted all together for appropriateness in FY22-23.
   - **673** UORs were submitted by KBHRS teams.
   - **1191** UORs submitted by contract providers for FY22-23.
   - We continue to see increase in reports submitted. This year we had 1,864 which is 360 more reports than last years overall number of 1382. This is due to the number of reports submitted by our STRTP providers and easier access by our new providers.
   - STRTPs continue to have the highest incidents reports submitted.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal # 24 UOR – Outpatient SUD

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

   100% of all DMC-ODS UOR will be addressed in an appropriate manner.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   - QID reviewed all **108** UORs submitted for FY22-23 to ensure all incidents were being addressed appropriately and no additional actions steps were necessary to address the incident or to prevent future incidents from happening.
   - QID sent recommendation letters to teams, supervisors, and administrator when a protocol, or a policy was not followed or when there was an action step that the team could do to improve an incident. **Eight (8)** recommendations letters for Disclosure of PHI were sent this FY22-23.
   - All UORs submitted due to Confidentiality, PHI potential breaches or unethical conduct by the staff were routed to the corporate and compliance officer for further investigations.
   - All UORs submitted due to deaths or suicide attempts were automatically routed to the chair of the M&M committee for a complete investigation/review.
   - QID provided training to all SUD providers in Provider meeting and QQID to ensure they understood when UORs needed to be completed to help increase the reports submitted by our providers.
   - QID collaborated with KernBHRS training department and identified appropriate trainings to be assigned to all direct staff of internal and contract providers to help them in learning skills on how to handle incidents related to aggression as these were identified to be the highest type of incidents submitted in the department.
   - The system addressed concerns identified in the UORs by providing direction, guidance, training and support during supervision, and/or team meetings.

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

UORs Submitted FY 22-23					
Qtr.	**KBHRS Teams**	**Contracted Provider**	**TOTAL Submitted**	**Total # Addressed Appropriately**	**GOAL 95%**
1Q	16	12	28	28	100%
2Q	12	11	23	23	100%
3Q	16	15	31	31	100%
4Q	12	14	26	26	100%
ANNUAL	**56**	**52**	**108**	**108**	**MET**

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

   - **108 UORs** were submitted and reviewed for FY22-23.
   - **100%** of them were addressed appropriately.
   - **8** of them required a Disclosure of PHI which occurs when ambulance and/or EMTs were called.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #25 Utilization Management MHP

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

   95% of all reviewed MH assessments will have an appropriate determination on Medical Necessity documented.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   - QID provided monthly assessment training for new staff to ensure staff is aware of the access to care criteria and medical necessity for specialty mental health services. This training was recorded and made available virtually in Relias so staff could access it immediately and before clinicians started assessing and providing services to our clients.
   - QID provided follow up training to anyone who failed the exam after their initial Assessment Relias training to ensure they understood the determinations on medical necessity and recommendations after an evaluation.
   - Due to staff shortages, and other duties, QID was not able to complete the UM assessments reviews by an LPHA every quarter but sought out the help of clinicians in the department when possible and completed assessment reviews during documentation chart reviews.

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

Assessments Reviewed	Medical Necessity Determined Appropriately	Goal 95%
487	487	100%

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

   - All Teams were reviewed at least once during this year by the documentation compliance team.
   - A total of 487 Assessments were reviewed this fiscal year.
   - 100% of assessments documented appropriate determination of medical necessity for the clients.
   - QID will continue to provide consultation and training to clinicians needing it after their assessment training as identified in their testing results or as requested by staff or supervisor.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #26 Utilization Management SUD

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

   95% of all SUD ASAM Assessments reviewed will document appropriate medical necessity for services.

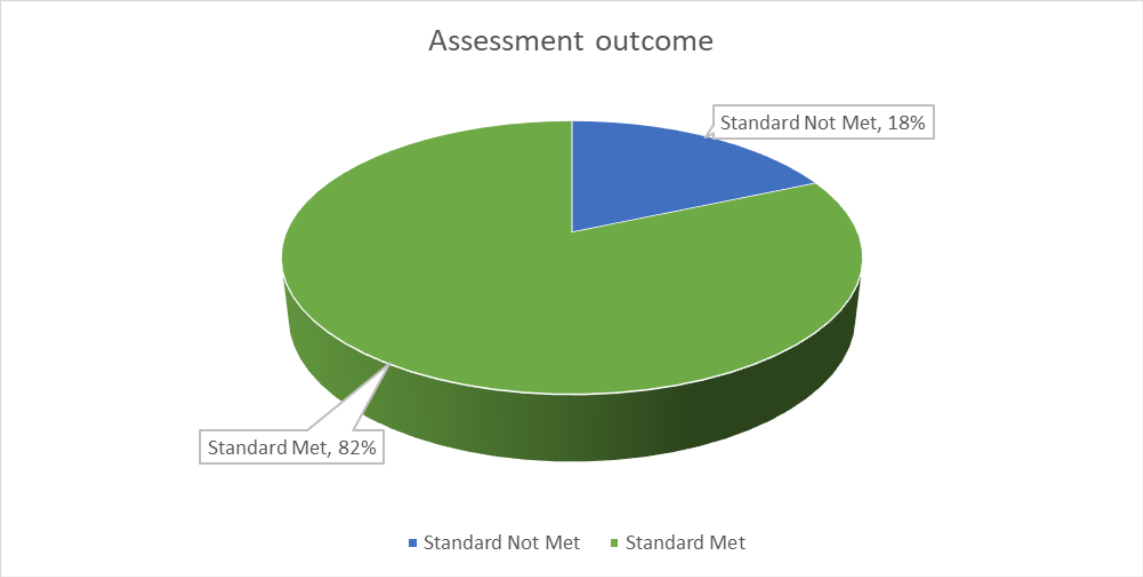
2. **2022/2023 The Goal Was:**

   ☐ MET ☒ NOT MET

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

   Over the past year, the SUD Access Line began reviewing assessments and reassessments completed by contracted providers and internal SUD teams, and an audit tool was created to mirror the mental health assessment audit tool. Based on the volume of assessments that were completed, the SUD Access line team adjusted their procedure to target 5% of assessments completed per quarter, which was a sustainable target.

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



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

   Providers were interested in seeing results of these reviews, as they allowed them to target specific training within their staff. Over the course of the year, when assessments were found not to document medical necessity appropriately, the reviewer contacted the assessor individually to provide feedback in real time. This allowed for adjustments to be made over time. Analyzing the data revealed that two providers accounted for the majority of the assessments that were not completed appropriately. This is partly due to the different modalities of treatment offered (outpatient vs. residential) and to therapist turnover in the rural areas. Over the course of FY22-23, 130 assessments were reviewed and 106 met the standard for medical necessity. The trend that was found for not meeting the standard was incongruency between ASAM risk severity level, severity of the diagnosis, and documentation of risk.

6. **Plan for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #27 Timeliness for Routine Appointments

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

   80% of routine initial requests will receive an assessment within 10 business days of the request.

2. **2022/2023 The Goal Was:**

   ☒ MET ☐ NOT MET

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

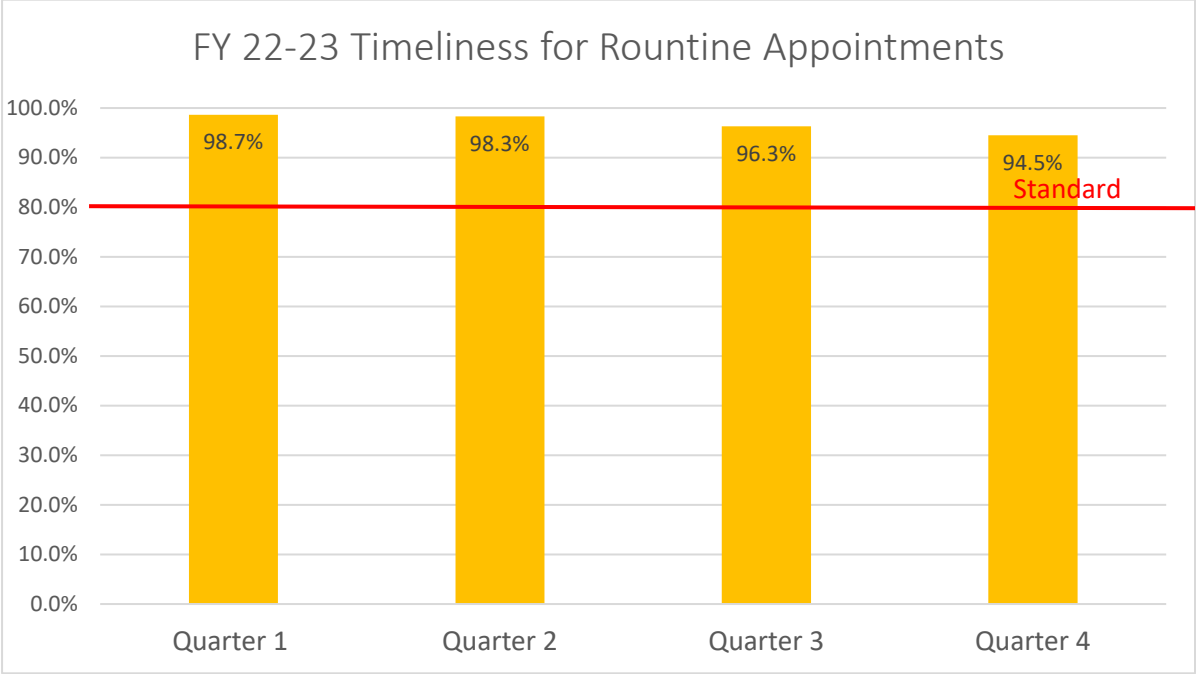
   Action steps taken by QID:

   - Facilitated a CSI Tracking Log workgroup, which included Crisis Services, CSOC, ASOC, CCS, CGC, CSV, and MHS Action, to identify process improvements for entering urgent appointment data and enhance training based on group feedback.
   - Routine discussions were held with each SOC to clarify when clients should receive urgent appointments as opposed to routine appointments.
   - Developed an updated training on the CSI Tracking Log and how to accurately enter required data.
   - Created a workgroup with Medical Services to review performance measures and interventions that affect other MH systems of care.

   Action steps taken by KernBHRS Treatment Teams and Contracted Providers:

   - Assessment Center has developed a process for connecting the clients with the provider,
   - including:
     - Using email communication
     - Warm hand off
     - Direct contact with the agency if medications/urgent appointments are needed.
   - Hired and trained new front desk staff for scheduling and to enter information in the CSI Tracking Log.
   - Made appointment reminders calls.
   - Offered clients transportation to appointments.
   - Standardized the availability of assessment and psychiatric evaluation appointments that are provided to the Assessment Center.
   - Medical Services provided training to scheduling staff to ensure accurate entry of scheduled appointments and no-shows in the CSI Tracking Log
   - Added/increased available appointments.
   - Added/increased walk-in appointments.

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



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

KernBHRS System of Care continues to be far above DHCS's 80% standard with the timeliness for routine appointments. This will continue to be a metric in monthly KPI reporting.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #28 Timeliness for Urgent Appointments

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

   80% of urgent requests will receive an assessment within 48 hours of the initial request.

2. **2022/2023 The Goal Was:**

   ☐ MET ☐ NOT MET

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

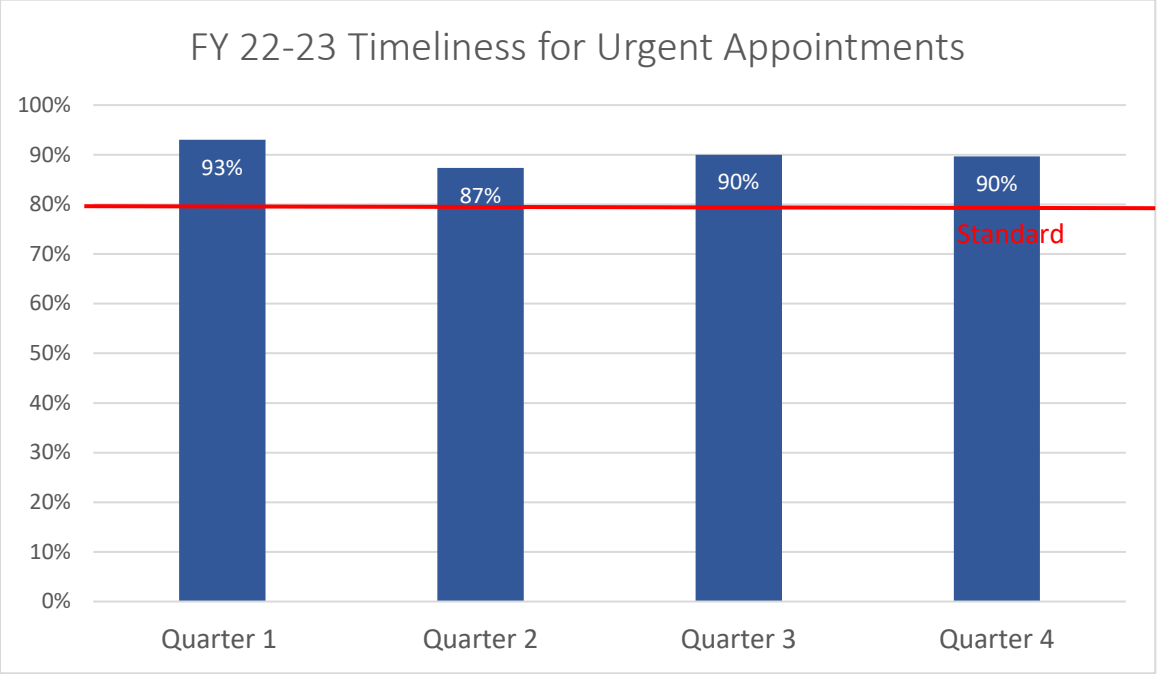
   Action steps taken by QID:

   - Facilitated a CSI Tracking Log workgroup, which included Crisis Services, CSOC, ASOC, CCS, CGC, CSV, and MHS Action, to identify process improvements for entering urgent appointment data and enhance training based on group feedback.
   - Follow-up discussions were held with each SOC to clarify when clients should receive urgent appointments as opposed to routine appointments.
   - Ensured that all SOCs received a copy of the memorandum provided by KernBHRS outlining criteria to identify urgent clients.
   - Routine discussions were held with each SOC to clarify when clients should receive urgent appointments as opposed to routine appointments.
   - Developed an updated training on the CSI Tracking Log and how to accurately enter required data.
   - Created a workgroup with Medical Services to review performance measures and interventions that affect other MH systems of care.

   Action steps taken by KernBHRS Treatment Teams and Contracted Providers:

   - Assessment Center has developed a process for connecting the clients with the provider,
   - including:
     - Using email communication
     - Warm hand off
     - Direct contact with the agency if medications/urgent appointments are needed.
   - Hired and trained new front desk staff for scheduling and to enter information in the CSI Tracking Log.
   - Made appointment reminders calls.
   - Offered clients transportation to appointments.
   - Standardized the availability of assessment and psychiatric evaluation appointments that are provided to the Assessment Center.
   - Medical Services provided training to scheduling staff to ensure accurate entry of scheduled appointments and no-shows in the CSI Tracking Log
   - Added/increased available appointments.
   - Added/increased walk-in appointments.

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



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

Although the aggregate data shows the system of care is far above the 80% standard established by DHCS, this is not a true representation of the systems of overall compliance with this standard. In the monthly KPI reporting, the number of team/sites that are reporting urgent request is very small and in the bi-monthly division KPIC meetings, QID discusses this with the teams and determines that there should be a more urgent request reported than is being entered in database. In this next year, QID will be bringing this forward to the divisions to set specific standards that are attainable and realistic for each of these teams, to provide a more specific data.

6. **Plan for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #29 Zero Suicide

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

   All internal and provider teams will screen clients using the CSSRS Screener at 65% or greater.

2. **2022/2023 The Goal Was:**

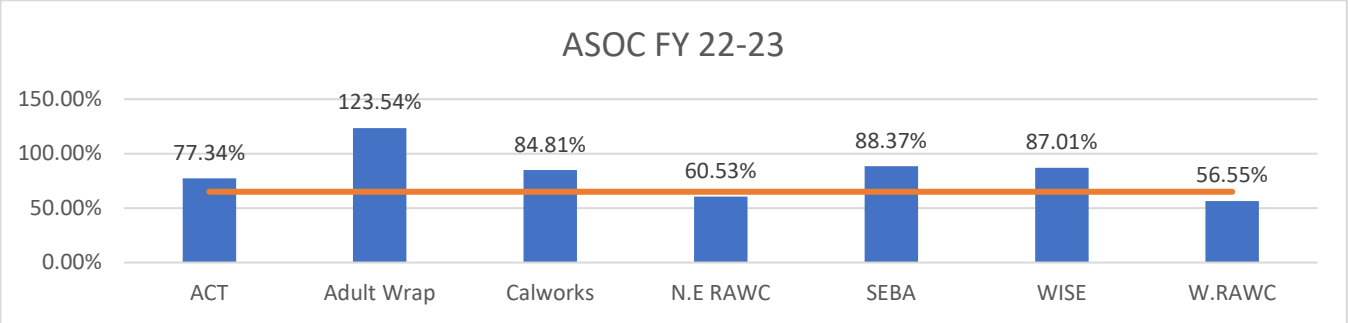
   ☒ MET ☒ NOT MET

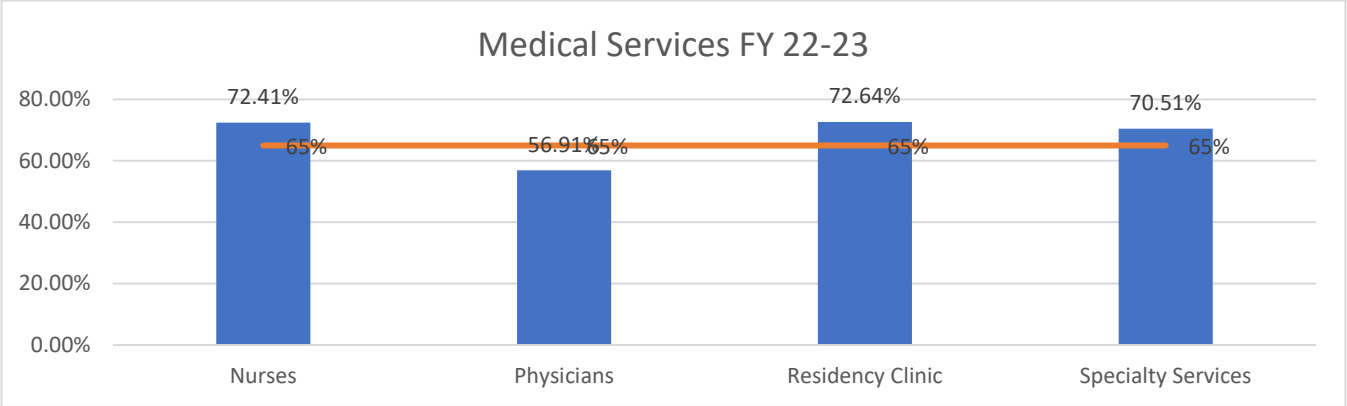
3. **Quality Improvement Activities / Actions Taken Over the Past Year:**

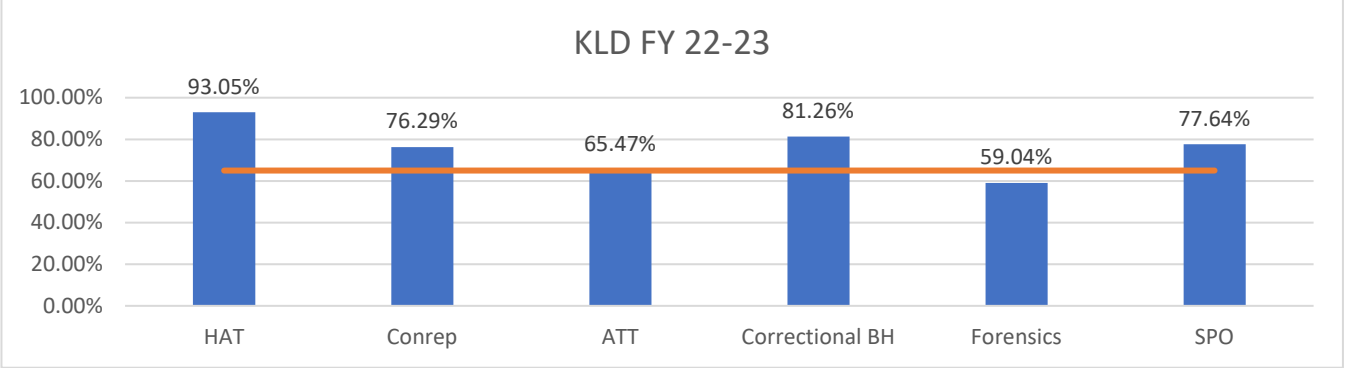
   - The Zero Suicide team compiled data regarding screening rates for all teams implementing the Zero Suicide protocol.
   - The data are shared with team supervisors and administrators via emails and discussed during monthly Getting to Zero Meeting.
   - Data are also placed on individual team's folders on SharePoint.

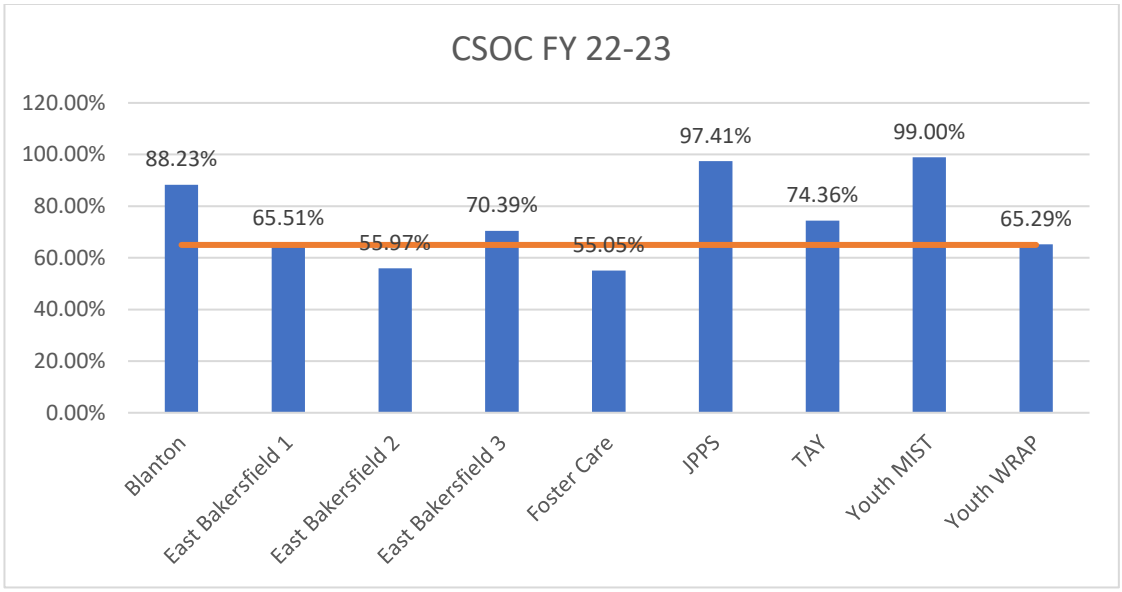
4. **Data Used to Measure the Outcome of this QI Goal:**

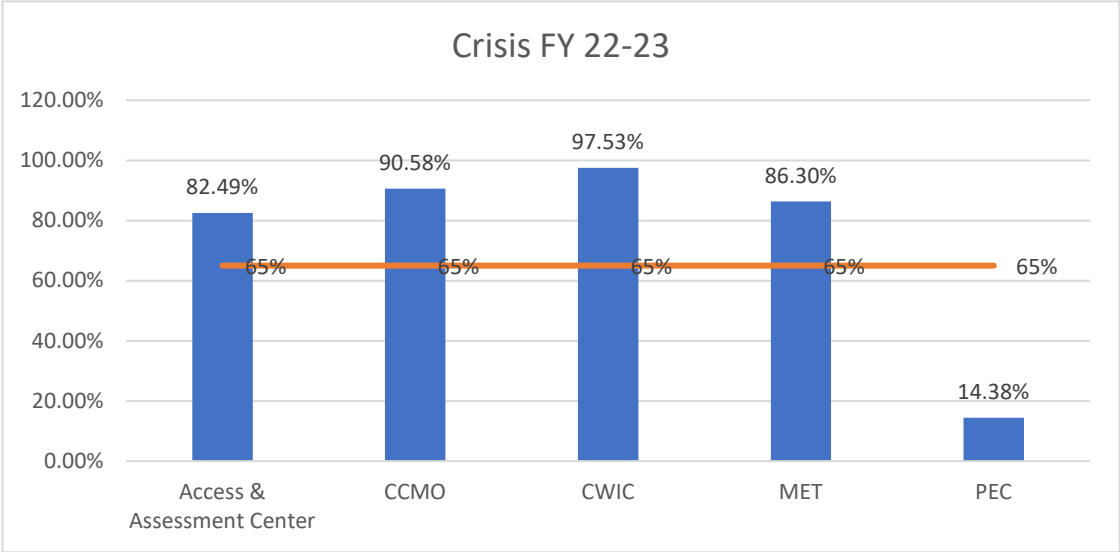
Mental Health Treatment Teams

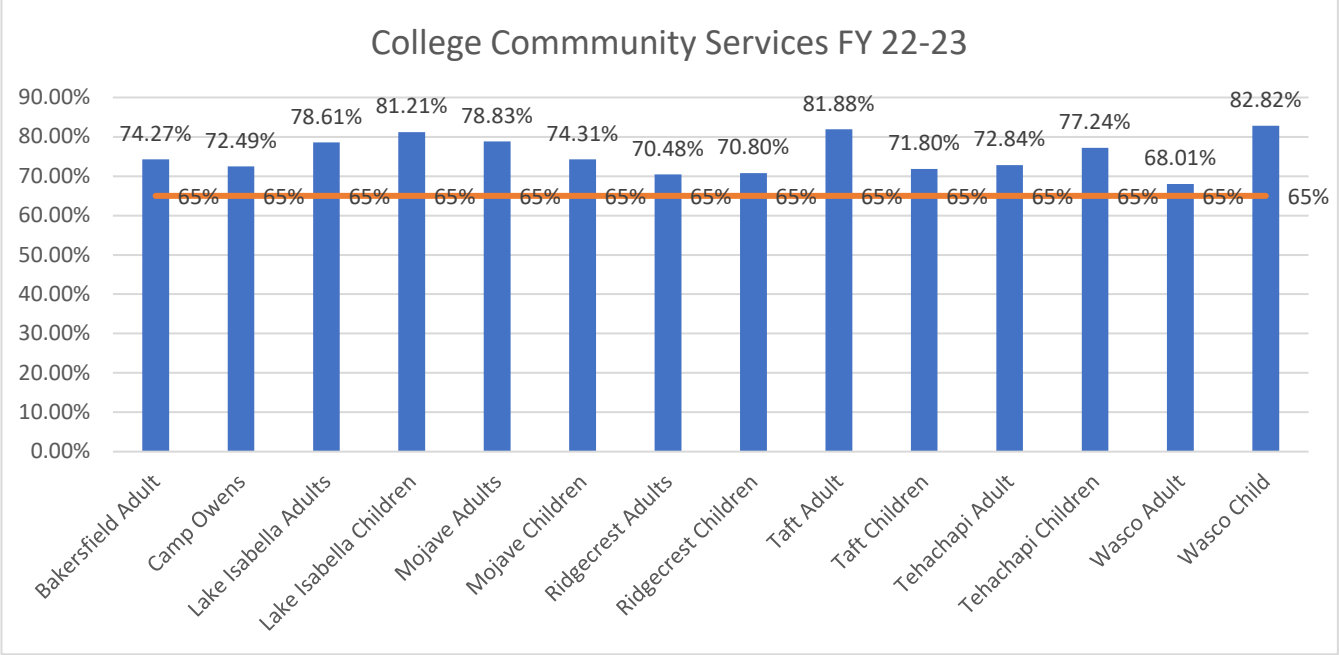


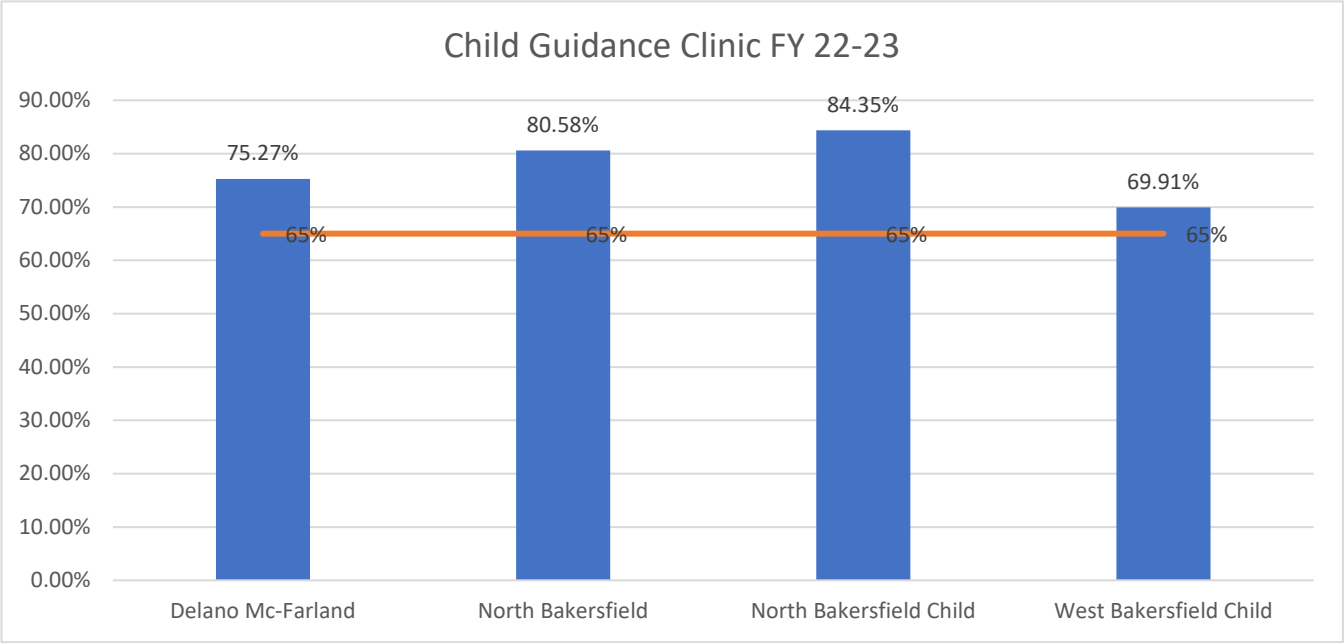


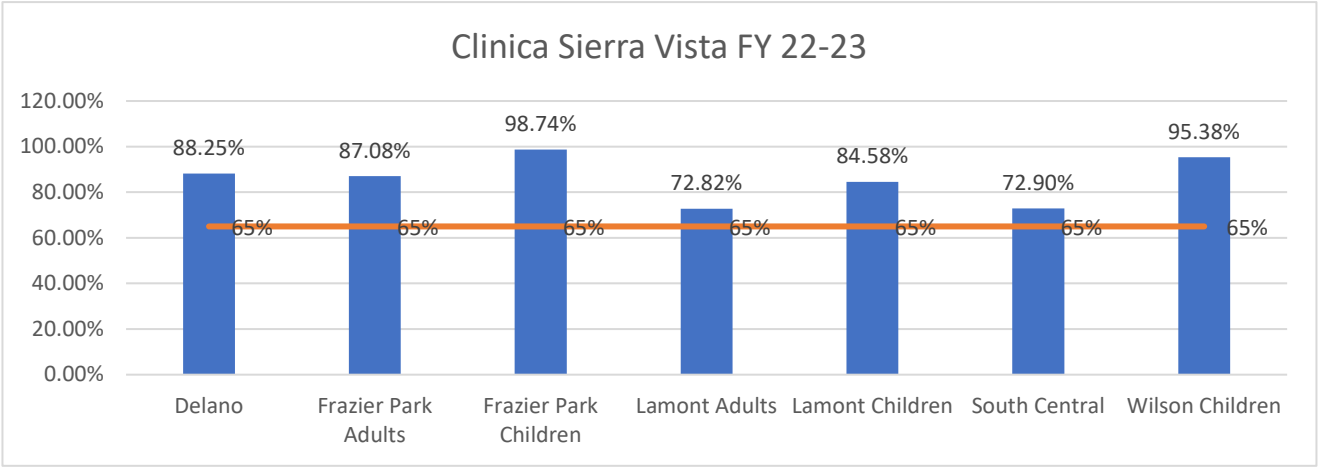



CSOC FY 22-23
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
88.23%
65.51%
55.97%
70.39%
55.05%
97.41%
74.36%
99.00%
65.29%
Blanton
East Bakersfield 1
East Bakersfield 2
East Bakersfield 3
Foster Care
JPPS
TAY
Youth MIST
Youth WRAP

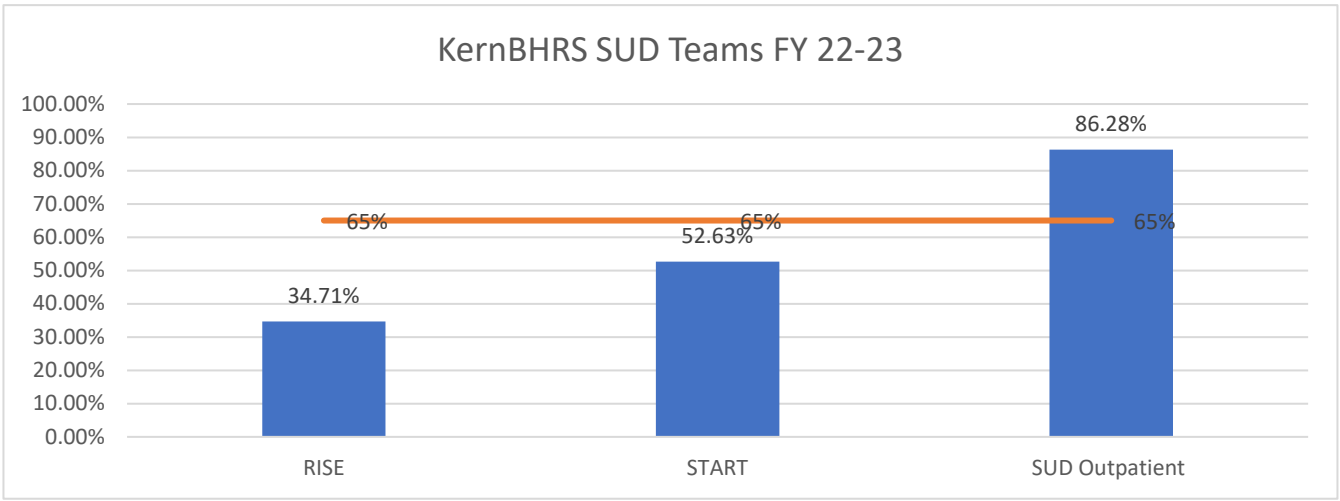

Crisis FY 22-23
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
82.49%
90.58%
97.53%
86.30%
14.38%
65%
Access & Assessment Center
CCMO
CWIC
MET
PEC

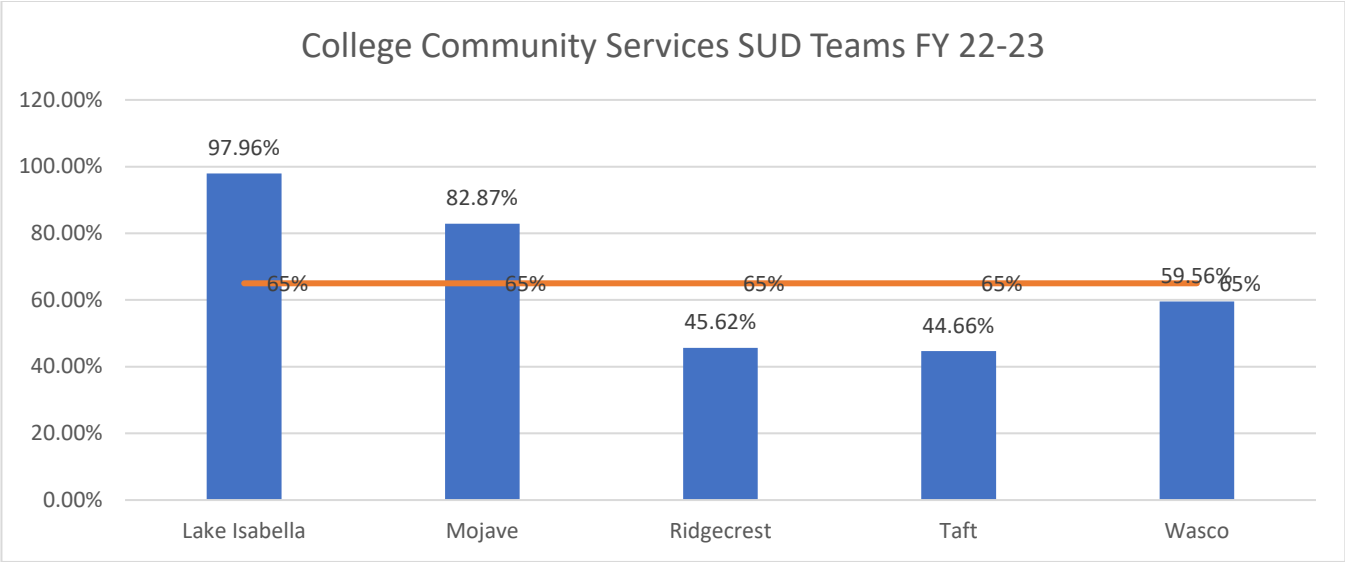

College Commmunity Services FY 22-23
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
74.27%
72.49%
78.61%
81.21%
78.83%
74.31%
70.48%
70.80%
81.88%
71.80%
72.84%
77.24%
68.01%
82.82%
65%
Bakersfield Adult
Camp Owens
Lake Isabella Adults
Lake Isabella Children
Mojave Adults
Mojave Children
Ridgecrest Adults
Ridgecrest Children
Taft Adult
Taft Children
Tehachapi Adult
Tehachapi Children
Wasco Adult
Wasco Child

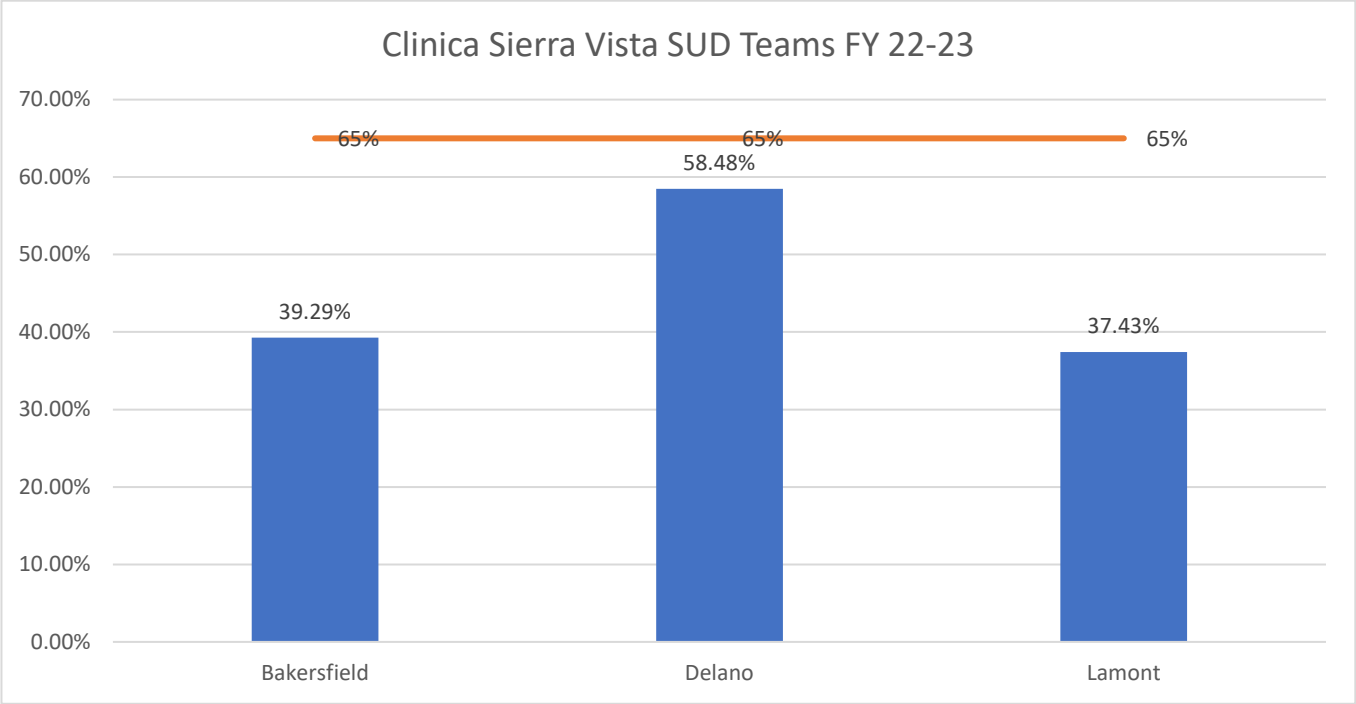


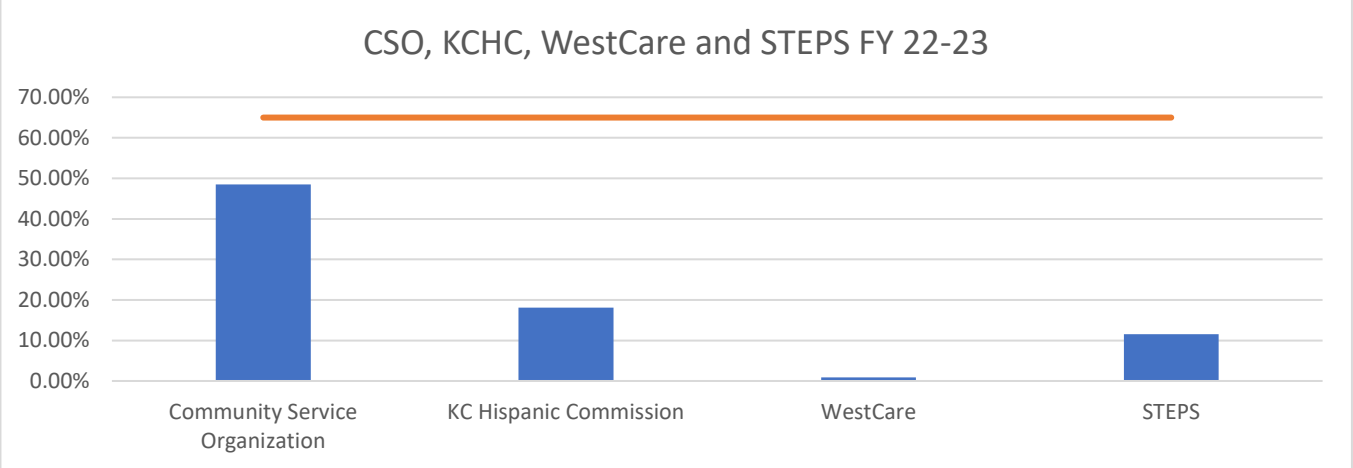


Substance Use Treatment Teams




College Community Services SUD Teams FY 22-23
120.00%
100.00%
80.00%
60.00%
40.00%
20.00%
0.00%
97.96%
82.87%
45.62%
44.66%
59.56%
65%
65%
65%
65%
65%
Lake Isabella
Mojave
Ridgecrest
Taft
Wasco


Clinica Sierra Vista SUD Teams FY 22-23
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
65%
65%
65%
39.29%
58.48%
37.43%
Bakersfield
Delano
Lamont


CSO, KCHC, WestCare and STEPS FY 22-23
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Community Service Organization
KC Hispanic Commission
WestCare
STEPS

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

- For FY 22-23, all mental health Provider/Contractor treatment teams (College Community Services, Clinica Sierra Vista, Child Guidance Clinic, Mental Health Systems) met the goal of 65% screening. Screening averages for providers teams are the following:
  - College Community Services: 74%
  - Child Guidance Clinic: 78%
  - Mental Health Systems: 98%
  - Clinica Sierra Vista: 86%
- All Adult System of Care (ASOC) teams met the goal except for NERAWC (61%) and WestWRAC (57%).
  - ASOC screening average for FY 22-23 is 83%
- All Medical Services teams met the goal, except for Physicians (57%).
  - Medical Services screening average is 68%.
- All Kern Linkage Division teams met the goal, except for Forensics (59%).
  - KLD screening average is 76%
- All Children System of Care teams met the goal, except for EB 2 (56%) and Foster Care (55%)
  - CSOC screening average is 75%
- All Crisis teams met the goal, except for the PEC (14%).
  - Crisis screening average is 74%

<u>Substance Use Treatment Teams</u>

- KernBHRS SUD treatment teams.
  - SUD Outpatient Treatment team met the goal; RISE (35%) and START (53%) did not
  - Average screening for KernBHRS SUD teams for FY 22-23 is 58%
- College Community Services SUD treatment teams:
  - CCS Lake Isabella and CCS Mojave met the goal; CCS Ridgecrest (46%), Taft (45%), and Wasco (60%) did not.
  - Average screening for CCS SUD teams is 66%
- Clinica Sierra Vista SUD treatment teams did not meet the goal.
  - Average screening for CSV SUD teams is 45%
- Community Service Organization did not meet the goal, with an average screening rate of 49%.
- Kern County Hispanic Commission did not meet the goal, with an average screening rate of 18%.
- WestCare did not meet the goal, with an average screening rate of 1%
- STEPS did not meet the goal, with average screening rate of 12%

6. **Plan for Current Goal:**

☒ Change goal

The goal needs to be changed for FY 23-24 because of SmartCare. FY 23-24 goal will be as follows: "At least one screening per month will be completed for each client on a team's caseload".