BEHAVIORAL
HEALTH&RECOVERY
SERVICES

Kern Behavioral Health and Recovery Services

Quality Improvement Work Plan
FY 2022 – 2023

Director Stacy Kuwahara, LMFT
PO Box 1000, Bakersfield, CA 93302
P: 661-868-6600 • F: 661-861-1020
www.KernBHRS.org • @KernBHRS on

KERN COUNTY CALIFORNIA

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Mission

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

Vision

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

Statement

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

KERN QUALITY ASSESSMENT AND IMPROVEMENT PROGRAM

Kern Behavioral Health and Recovery Services (KernBHRS) seeks to provide excellence in service through the provision of person-centered, consumer-driven, recovery-oriented, and inclusive behavioral health care services that are integrated with primary health care and seek to address each beneficiary's unique needs. It is our mission to assist individuals with issues of mental health and substance misuse to find solutions to the challenges they face so they may live full and healthy lives.

KernBHRS is committed to continued program development and compliance efforts as detailed in the KernBHRS Quality Assessment and Improvement Program (QAIP) description. The QAIP meets the contractual requirements of the Mental Health Plan contract with Department of Health Care Services (DHCS), as well as the Drug Medi-Cal Organized Delivery System Intergovernmental agreement with DHCS. It also includes areas of performance improvement as identified by the California External Quality Review Organization (CAEQRO). The QAIP includes all services furnished to beneficiaries.

The QAIP is accountable to the KernBHRS Director who is over the MHP and SUD service delivery plans. The KernBHRS Director is a licensed mental health professional that is under the authority of the Kern County Board of Supervisors. The development and oversight of the QAIP is managed by the Administrator of the KernBHRS Quality Improvement Division (QID).

REPORTING AND IMPROVING

A vital component of the QAIP is the annual implementation of the Quality Improvement (QI) Work Plan. The QI Work Plan is the first element within the quality improvement cycle. The QI Work Plan covers the current fiscal year and includes:

- Evidence of monitoring activities including but not limited to review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review.

- Evidence that QI activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary services.

- A description of completed and in-process QI activities including:
    - Monitoring and tracking of previously identified issues
    - Objectives, scope and planned QI activities for each year
    - Targeted areas of improvement or change in service delivery or program design
    - Monitoring of Key Performance Standards

- A description of mechanisms implemented to assess the accessibility of services within the service delivery area. This includes goals for responsiveness for the 24-hour toll-free telephones number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care.

- Evidence compliance with the requirements for cultural competence and linguistic competence. An annual update to the Cultural Compliance Plan is included as an appendix to the QI Work Plan.

The QI Work Plan is based on the fiscal year and contains goals, objectives, and the responsible party. The impact and effectiveness of the QAPI program is evaluated annually through our Annual Reporting/Work Plan evaluation process. This process helps to prioritize areas for improvement over the upcoming fiscal year. At the conclusion of the fiscal year, each goal and corresponding objectives are evaluated in a report template called KernBHRS Annual Report. The template guides the author through a series of questions designed to evaluate the implementation and outcomes of each specific goal established in the Work Plan. The Quality Improvement Committee evaluates the implementation of the QI Work Plan goals. Each QI Work Plan goal is rated as Met, Not Met, or Partially Met. Each individual Annual Report is compiled into a larger document called the KernBHRS Annual Report and Work Plan Evaluation then submitted to the members of the Quality Improvement Committee (QIC). The committee members review the reports and use the information to establish the QI Work Plan goals for the new fiscal year.

KernBHRS QIC meets Quarterly. During these meetings Quarterly updates are provided on each of the Work Plan goals. In addition to the Work Plan goal reports, the QIC receives reports on the timeliness of services for both the MHP and DMC-ODS, performance improvement projects, corporate compliance investigations and other areas of interest. The three subcommittees of the QIC meet more frequently allowing QIC members to take a deeper dive into the objectives of the Work Plan and identified performance measures.

KernBHRS utilizes a quality improvement cycle to ensure continuous improvement efforts. All QIC reports include relevant data that allows us to measure success toward a benchmark or standard. When the benchmark or standard is not met, improvement activities are identified and implemented. Kern BHRS QIC continues to monitor the data to identify the success of the new activity. This process is particularly evident in our Key Performance Indicator Committee, a subcommittee of the QIC, where specific identified standards are monitored closely.

Below is a list of the identified key performance indicators established by the QIC. This list continues to grow throughout the year as our ability to produce accurate data improves. Kern BHRS uses the Cerner electronic health record which greatly limits our reporting mechanisms. Kern BHRS has adopted these performance indicators as part of our Quality Assessment and Performance Improvement program to establish quantitative priorities for improvement.

Name of Key Performance Indicator	Benchmark/Purpose	MHP or DMC-ODS
7 - Day Inpatient Discharge to Outpatient Appointment	All (100%) clients discharged from the hospital will receive a face-to-face outpatient mental health service within seven (7) calendar days.	MHP
Client Satisfaction Consumer Perception Survey	Achieve a cumulative minimum satisfaction rating of 85% or greater on the Consumer Perception Survey.	MHP
Client Satisfaction Treatment Perception Survey	Achieve a cumulative minimum satisfaction rating of 85% or greater on the Treatment Perception Survey.	DMC-ODS
Initial Request to First Kept Assessment	80% of routine mental-health assessments will be conducted within 14 calendar days (10 business days) of initial request for service.	MHP
Initial Request to First Offered Assessment	All (100%) routine mental-health assessments will be offered within 14 calendar days (10 business days) of initial request for service.	MHP
Inpatient Hospital Recidivism Rate	Less than or equal to 14%. This report tracks the number of clients who return to inpatient within 30 days of discharge.	MHP
No Show Rate - Other Clinicians	No-show rates for other clinical appointments (non-psychiatric) will not exceed 15%.	MHP
No Show Rate - Psychiatric Appointments	No-show rates for psychiatric appointments will not exceed 18%.	MHP
No Show/Cancellation Rate	No-show rates for outpatient appointments will not exceed 60%. No-show rates for NTP and Residential service appointments will not exceed 30%.	DMC-ODS
Penetration Rate	Penetration rates of 4.2 percent or higher in each service area.	MHP
Penetration Rate	The percentage of clients entering the DMC-ODS system stratified by: Age, Race & Gender.	DMC-ODS
Request for Psychiatric Service First Kept	All (100%) first psychiatric services must be scheduled within 21 days (15 business days) of initial request.	MHP
Request for Psychiatric Service First Offered	80% of first psychiatric services must be done within 21 calendars days (15 business days) of initial request.	MHP
Residential Discharge to Lower Level of Care	At least 85% of clients discharged from residential treatment will have a lower level follow up service within 7 days.	DMC-ODS

Residential Recidivism Rate	Less than or equal to 20%. This report tracks the number of clients who return to residential services within 30 days of discharge.	DMC-ODS
Timeliness of Initial Request to First Kept Assessment	80% routine SUD assessments will be conducted within 14 calendar days (10 business days) of initial request for service. NTP: 80% of SUD Assessments will be conducted within 5 days (3 business days). IV User: 80% of SUD Assessments will be conducted within 7 days (5 business days).	DMC-ODS
Timeliness of Initial Request to First Offered- Urgent Appointment	80% of initial requests for an urgent appointment will be scheduled within 48 hours of initial request.	DMC-ODS
Timeliness of Initial Request to First Offered Assessment	80% of routine SUD assessments will be conducted within 14 calendars days (10 business days) of initial request for service. NTP: 80% of SUD Assessments will be conducted within 5 days (3 business days) of initial request for service. IV User: 80% of SUD Assessments will be conducted within 7 days (5 business days) of initial request for service.	DMC-ODS
Timeliness of Services for Urgent Conditions	80% of urgent requests will receive an assessment within 48 hours of the initial request for service.	MHP
Withdrawal Management Recidivism Rate	Less than or equal to 2%. This report tracks the number of clients who return to withdrawal management within 30 days of discharge.	DMC-ODS

The list below is a list of regulatory compliance standards closely monitored through the Regulatory Compliance Committee. This list is not an exhaustive list of standards monitored throughout the system. Kern BHRS has a number of processes and structures in place for ensuring compliance with all laws and regulations including contract monitoring, site visits, quality monitoring and reviews, documentation reviews and utilization management activities.

TOPIC	COMPLIANCE STANDARD	Application
Change of Provider	100% of MHP change of Provider Requests are addressed.	MH
Corporate Compliance Training	100% of the staff will complete the Corporate Compliance training each year	MH, SUD
Documentation Compliance	95% of MHP documents within the electronic health record will be written according to all DHCS guidance and Clinical guidelines.	MH
Documentation Compliance	SUD teams will achieve a score of 85% or better on their trimester progress note reviews.	SUD
Documentation Timeliness	75% of “Routine Services”, will be documented in the EHR within 3 business days of the provided service	MH, SUD
Documentation Timeliness	100% of “Crisis Services” will be documented in the EHR within 24 hours of provided service	MH, SUD
Grievance and Appeals	98% of grievance and appeals will be processed according to DHCS policy.	MH, SUD
HIPAA Training	100% of staff will complete the annual HIPAA training each year	MH, SUD
Human Trafficking Training	100% of SUD staff will complete the human trafficking training annually	SUD
No Show Indicator	100% of the time when using scheduler, and a client does not show up for a scheduled appointment, staff will change the indicator to reflect “No Show.”	MH, SUD
NOABD	95% of all MH NOABDs will be provided to a beneficiary upon an adverse determination	MH
NOABD	90% of all SUD NOABDs will be provided to a beneficiary upon an adverse determination	SUD
Privacy and Security Training	100% of the staff will complete the Privacy and Security training each year.	MH, SUD
Privacy Breach Investigation	100% of all Potential Breaches will be reported to CCO within 24 hours of discovery of the event	MH, SUD
Records Request	100% of Client request for records will be processed within 15 days.	MH, SUD
Service Verification	95% of all mental health and substance use services captured in the electronic health record will be an honest and accurate account of a service.	MH, SUD
Title 22 Training	100% of SUD staff will complete the Title 22 training annually	SUD

STRUCTURE AND ELEMENTS

The Quality Improvement Committee (QIC) reviews the quality of the service delivery system with the aim of improving the processes of providing care and better meeting the needs of its beneficiaries. The role of the QIC includes:

- Oversight and involvement in QI activities, including Performance Improvement Projects (PIPs)
- Recommends policy decisions
- Reviews and evaluates the results of QI activities
- Institutes needed QI actions
- Ensures follow-up of QI processes
- Documents decisions and actions taken through committee meeting minutes
- Monitoring Performance Standards

The QIC is also referred to as the Executive QIC because it has oversight over three subcommittees. The subcommittees include the System-wide Quality Improvement Committee, the Key Performance Indicator Committee, and the Regulatory Compliance Committee. The QIC subcommittees are a vital element to the oversight and evaluation of compliance efforts and performance outcomes. The vast content reviewed by the QIC limits its ability to track and improve efforts. The QIC subcommittees allow for better tracking and more meaningful change. The Executive QIC and its subcommittees are charged with the following activities:

- Collecting and analyzing data to measure against the goals or prioritized areas of improvement that have been identified
- Identifying opportunities for improvement and deciding which opportunities to pursue
- Identifying relevant committees internal and external to ensure appropriate exchange of information with the QIC
- Obtaining input from providers, beneficiaries, and family members in identifying barriers to delivery of clinical care and administrative services
- Designing and implementing interventions for improving performance
- Measuring effectiveness of the interventions

- Incorporating successful interventions into system operations
- Reviewing beneficiary grievance and appeals, expedited appeals, fair hearing, expedited fair hearing, provider appeals and clinical records review

The QIC and its subcommittees involve providers, beneficiaries, family members, community members and direct service staff in the planning, design, and execution of the QAPI. Having multiple QI subcommittees that feed information up to the Executive Committee allows us to effectively incorporate a variety of perspectives. Recruitment for the subcommittees is based on the targeted audience and described later in this document. It is important to note that the SQIC Committee (one of the three QIC subcommittees) in addition to having a variety of stakeholders as members of the committee, is an open meeting that any member of the community is welcome to attend. The meeting allots a time for public commentary.

The subcommittees make recommendations to the Executive QIC about opportunities for improvement and prioritize the workloads. The subcommittees participate in and delegate the collection of data and analysis of data to measure against goals and prioritized areas of improvements. They obtain information from beneficiaries, family members, in identifying barriers to delivery of clinical care and administrative services and recommend interventions for improving performance. Finally, the subcommittees also recommend policy decisions, review and report results of monitoring activities, report significant findings to the Executive QIC.

The Quality Improvement Division (QID) is responsible for much of the measuring, monitoring and reporting required by the QIC and the QI Work Plan. However, performance monitoring is conducted at a variety of levels throughout the system. All performance monitoring and improvement activities conducted by the QID are consistent with current standards of practice in the behavioral health industry. All monitoring activities are designed to improve the access, quality of care, and outcomes of the service delivery system. In addition, the QID monitors system compliance with all regulatory mandates and department standards. Monitoring activities include but are not limited to beneficiary and system outcomes and performance measurements, utilization management, utilization review, provider capacity and utilization monitoring, provider appeals, credentialing and monitoring, and monitoring of the problem resolution process. QID also performs service verification, medication monitoring, performance improvement projects, network adequacy monitoring, client/family perception surveys, documentation compliance reviews, and houses the Corporate Compliance and Privacy Officer. The QID leads system change using various improvement science methodologies such as Lean Six Sigma and PDSA.

The QIC has several other system committees that are tasked with the oversight of specific areas and/or system functions. These committees are not sub-committees of the QIC. However, they provided the QIC regular updates on their improvement activities.

These committees include:

- Length of Stay Committee
- Morbidity and Mortality Committee
- Internal Psychiatric Strategy meeting

- Cultural Competency Resource Committee
- Full-Service Partnership Committee

The Cultural Competence Plan works synchronously with our Quality Improvement Plan. The goal of the plan is to improve services for all diverse groups. In addition to the state and federal cultural competence requirements, we also integrate requirements specific to our funding, substance use delivery system, and mental health plan.

Performance Improvement Projects

A Performance Improvement Project is a process that involves setting goals, implementing systemic changes, measuring outcomes, and making subsequent appropriate improvements. There is a total of four PIPs, one Clinical and one Non-Clinical for both the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, as part of the Behavioral Health Quality Improvement Plan (BHQIP) issued by the Department of Health Care Services, KernBHRS has added 3 additional performance improvement projects. The current problem statement associated with each PIP is listed below.

The purpose of a PIP is to assess and improve processes and outcomes of treatment provided by KernBHRS. PIPs are presented at the Quality Improvement Committee, and two of the QIC subcommittees, the Key Performance Indicator Committee and the System Quality Improvement Committee. The ultimate goal of a PIP is to benefit the clients we are serving.

A Performance Improvement Project (PIP) is a process that involves identifying a problem, setting goals to address the problem, implementing systemic changes, measuring outcomes, and making subsequent improvements to process and/or treatment provided by KernBHRS.

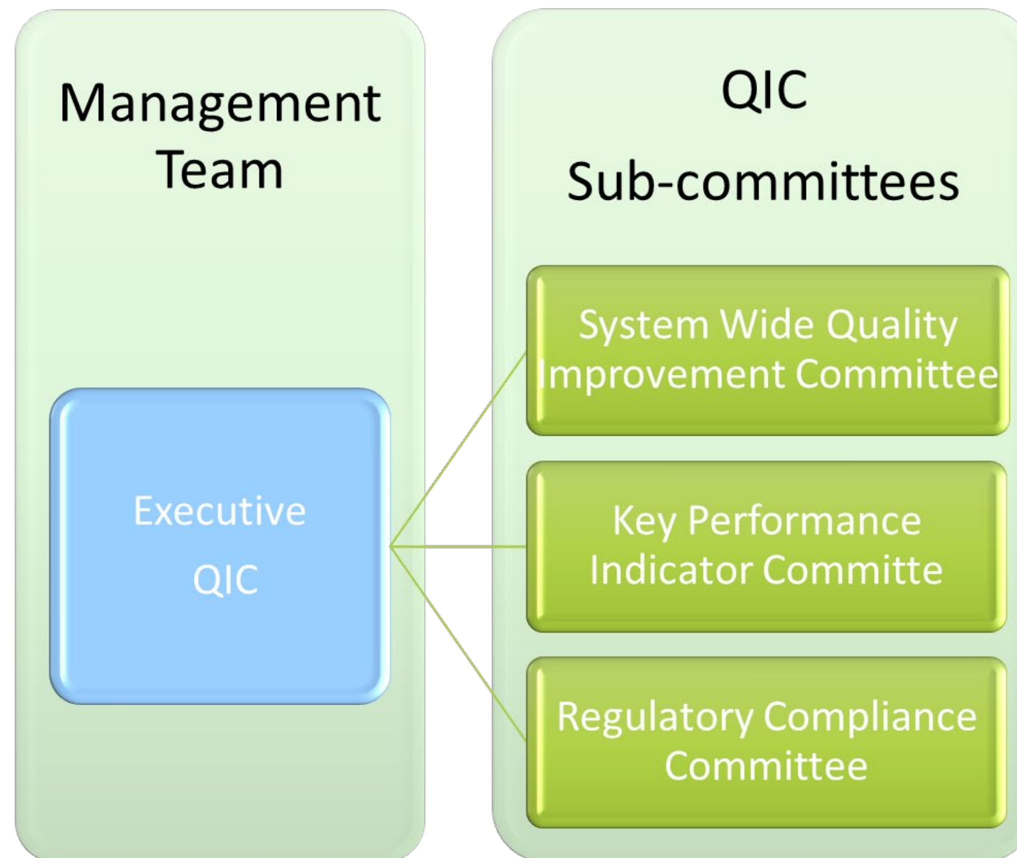
There is a total of four PIPs, one Clinical and one Non-Clinical for both the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, as part of the Behavioral Health Quality Improvement Plan (BHQIP) issued by the Department of Health Care Services (DHCS), KernBHRS has added 3 additional performance improvement projects.

The PIPs are presented regularly at the Quality Improvement Committee (QIC), and two of the QIC subcommittees, the Key Performance Indicator (KPI) Committee and the System Quality Improvement Committee (SQIC).

Each PIP and current Problem Statement is listed in the table below.

Area of Focus	Problem Statement
Mental Health Clinical: Cognitive Behavioral Therapy for Psychosis in Youth with Early Onset Psychosis	KernBHRS' Clinical PIP is designed to increase the recognition of psychotic symptoms in youth and ensure these beneficiaries are being linked with the appropriate services to address the psychosis.
Mental Health Non-Clinical: Homelessness-Increasing Access to Psychiatric Care	KernBHRS' Non-Clinical PIP is designed to address the high no show rates for psychiatric appointments in the Homeless Adult Team.
Substance Use Clinical: Dialectic Behavioral Health Skills Training	KernBHRS' Clinical PIP is designed to increase client retention in care, decrease client's risk and relapse.
Substance Use Non-Clinical: Increase Linkage to Lower Level of Care Following Residential Discharge	KernBHRS' Non-Clinical PIP is designed to address the low number of clients linked to lower levels of care following residential treatment discharge.
BHQIP FUA: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	There is a lack of real time data exchange between treatment providers (i.e., KernBHRS, EDs and MCPs) resulting in the inability to ensure clients with substance use disorder diagnosis who go to an ED receive the appropriate follow-up treatment after discharge.
BHQIP FUM: Follow-Up After Emergency Department Visit for Mental Illness	There is a lack of real time data exchange between treatment providers (i.e., KernBHRS, EDs and MCPs) resulting in the inability to ensure clients with mental health diagnosis or suicide attempt who go to an ED receive the appropriate follow-up treatment after discharge.
BHQIP POD: Pharmacotherapy for Opioid Use Disorder	Although Medications for Opioid Use Disorder (MOUD) is widely used to treat OUD and improve adverse health outcomes, despite its effectiveness in OUD treatment, many clients face barriers engaging in MOUD services.

KernBHRS QI Program



Executive QIC

PARTICIPANTS

A. Director
B. Deputy Directors
   i. Adult Clinical Services
   ii. Administrative Services
   iii. Specialty Clinical Services
C. System of Care Administrators:
   i. Adult System of Care
   ii. Children's System of Care
   iii. Kern Linkage
   iv. Crisis Services
   v. Recovery Support Services
   vi. Quality Improvement
   vii. Medical Services
   viii. Finance Manager
   ix. IT Manager
   x. Substance Use Disorder
   xi. Human Resources Manager
   xii. Corporate Compliance Officer
   xiii. Patient Right's Advocate
   xiv. Ethnic Services
   xv. Training Services
D. Members of the Quality Improvement Divisions

DATA REVIEWED

A. Subcommittee reports
B. Work Plan goal quarterly reports
C. Annual reports
D. Performance Improvement Projects
E. Quality Improvement Projects
F. Structure and process measure reports
G. Clinical Outcome reports
H. Evaluation of practice guidelines
I. Evidence Based fidelity monitoring
J. Negative outcomes through the Morbidity and Mortality and Unusual Occurrence reports
K. Safety related data

SCOPE / AREAS OF RESPONSIBILITY

A. Participate in and delegate the collection of data and analysis of data to measure against work plan goals and prioritized areas of improvements
B. Determine policy decisions
C. Monitor and evaluate results of PIP's
D. Institute needed quality improvement actions
E. Ensure follow up of quality improvement processes
F. Prioritize areas of improvement; identify opportunities for improvement
G. Ensure appropriate exchange of information
H. Oversee the design and implementation of interventions to improve performance
I. Ensure incorporation of successful interventions into operations
J. Develop and oversee the implementation of the Annual Work Plan
K. Conduct an annual evaluation of the Work Plan goals.
L. Conduct an annual evaluation of the QAPI program
M. Share relevant information with stakeholders and staff
N. Document minutes including any decisions and actions
O. Oversee Implementation of practice guidelines

System-Wide Quality Improvement Committee (SQIC)

PARTICIPANTS

A. Behavioral Health Board member(s) (CHAIR)
B. Direct service staff or designees from all clinical divisions
C. Ethnic Services Manager
D. QID staff person(s)
E. Representative from each contract provider
F. Consumer Family Learning Center (CFLC) representatives
G. Clients
H. Family Members
I. Community Stakeholders
J. Members of the public

DATA REVIEWED

A. Annual Recovery survey
B. 24/7 test call reports (Quarterly)
C. UOR reporting
D. Annual reports
E. Satisfaction Surveys
F. Lean Six Sigma projects
G. Outcome data analysis
H. Regulatory compliance efforts
I. Process and structure measures related to the implementation of the Cultural Competence Plan
J. Performance Improvement Projects
K. MHSA Implementation
L. Monthly Division updates
M. Progress toward Work Plan goals
N. Other areas as requested by the committee

SCOPE/AREAS OF RESPONSIBILITY

A. Provide feedback to guide system improvement
B. Make recommendations to Executive QIC
C. Progress toward Work Plan goals
D. Identify system improvement opportunities
E. Incorporate perspectives and feedback from direct service staff, clients, family members, stakeholders, and contract providers.
F. Hold open meetings advertised to the public.

Key Performance Indicator Committee

PARTICIPANTS

A. Director
B. Deputy Director of Clinical Care
C. System of Care Administrators and appropriate staff persons
   i. ASOC Administrator
   ii. SUD Administrator
   iii. Contract System Administrator
   iv. Children's Administrator
   v. KLD Administrator
   vi. Medical Services Administrator
   vii. Crisis Services Administrator
   viii. QID Administrator
   ix. Ethnic Services Manager
   x. QID Data Analytics staff
   xi. Clinical Program Supervisors

DATA REVIEWED

A. Flow data review of all clinical service team monthly data reports
B. Network Adequacy Certification Data
C. Service Utilization Reports
D. Penetration Rate Flex Analyses
E. Timeliness Report
F. Client Perception Survey (State)
G. Client Perception Survey (Local)
H. FSP Quarterly Summary Reports

SCOPE/AREA OF RESPONSIBILITY

A. Key Performance Indicators
B. Network Adequacy
C. Performance Improvement Projects
D. Culturally appropriate services review
E. Access to Services
F. Provider Relations
G. Service Utilization
H. Service Capacity
I. Penetration
J. Client Perception
K. Timeliness of Services
L. Review effectiveness of service measures
M. Ensure validity and reliability of measures
N. Clinical Outcomes
O. Data Governance

Regulatory Compliance Committee

PARTICIPANTS

A. Privacy/ Compliance Officer (CHAIR) and staff
B. Information Security Officer (also the IT Manager)
C. QID Administrator and designated staff
D. Clinical Administrators
E. HR representative
F. Patient's Rights Supervisor
G. Appointed Supervisors

DATA REVIEWED

A. Policy review related to Compliance, Privacy, and Information Security.
B. Current Compliance, Privacy and Information Security concerns that require prompt action.
C. Relevant updates to Compliance, Privacy, and Information Security regulations.
D. Sequestered chart audits
E. Service Verification completion
F. Trends reports related to Privacy breaches
G. MCPAR submission
H. MH Site Certifications
I. Change of Providers
J. Exclusions
K. Grievance and Appeal Trends and Updates

SCOPE/AREAS OF RESPONSIBILITY

A. Regulatory compliance monitoring results
B. Service verification
C. Compliance investigations
D. Security breaches
E. HIPPA violations
F. Relevant trainings
G. Program Integrity
H. Risk Management
I. Exclusions Reporting
J. Confidentiality/Privacy
K. Staff Education and Training
L. Credentialing
M. Quality Monitoring Results
N. Documentation Compliance Reviews
O. Timeliness of documentation compliance reviews
P. Information Notice implementation efforts
Q. Beneficiary Protection reports

Quality Improvement Work Plan

For each of the following QI/QM Work Plan areas of concern, data or information will be collected, analyzed, and used to measure against goals and objectives so opportunities for improvement can be identified. Interventions will be designed and implemented to improve performance. Effectiveness of the interventions will be measured, and results will be used to validate or modify practices as appropriate.

Goal #1 24/7 Hotline Test Calls: 95% of Access Line initial request for services test calls will be logged correctly.	Responsible Party
Objectives 1. Supervisor will review 100% of the call log weekly. 2. Provide monthly feedback to Administrator with test call log results. 3. Test call logs will be completed within the mandated time frames.	QID, DATA Supervisor

Goal #2 Access to After Hours: 90% of service providers will have service available outside of typical service hours (8-5, Mon-Fri).	Responsible Party
Objectives: 1. Develop mechanism to track service availability hours 2. Report results of assessed service availability hours to QIC/RCC 3. Partner with service providers to make improvements when there is a lack of service availability.	QID Administrator

Goal #3 Consumer & Family Satisfaction - CPS: The Mental Health Plan and its contract providers will achieve a cumulative minimum satisfaction rating of 85% or greater on the Consumer Perception Survey	Responsible Party
Objective: 1. Complete the CPS 2. Create flyers for the overall satisfaction rate to post in clinics AND online. 3. Complete the PDSA model for any team that is out of compliance. 4. Have overall results posted on public website	QID, Quality Monitoring Supervisor

Goal #4 Consumer & Family Satisfaction - LRS: 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	Responsible Party
Objective: 1. Provide additional training to staff to learn techniques and interventions to assist clients and parents who may be more challenging 2. Hire additional staff to decrease workload of front desk employees 3. During team meetings discuss importance of positive intentions and unconditional regard. 4. Have overall results posted on public website.	QID, Quality Monitoring Supervisor

Goal #5 <u>Credentialing</u>: 100% of KernBHRS staff and contract provider staff will complete the credentialing process.	Responsible Party
Objective: 1. Restrict Cerner access for staff that have not completed the credentialing or re-credentialing process 2. Begin re-credentialing internal and contracted staff as required based on their original credentialing approval date.	Contracts Administrator

Goal #6 <u>Fair Hearing</u>: 100% of State Fair Hearings will be performed within the mandated time frame.	Responsible Party
Objective: 1. Check CDSS Appeals Case Management System website every day. 2. Fair hearing will be completed within the mandated time frames. 3. Improvement efforts will be reports through the QIC	QID, Administrative Coordinator

Goal #7 <u>Foster Care Penetration Rates</u>: Increase foster youth penetration rate to an overall monthly average of 50% or greater.	Responsible Party
Objective: 1. Work with DHS to ensure that they update Medi-Cal aid codes for youth. 2. Work with DHS to support efforts to provide alternative placement options for youth with complex needs.	Children's System of Care Administrator

Goal #8 <u>Grievance & Appeals/Problem Resolution</u>: 98% of all resolved Grievance and Appeals will have been addressed within the prescribed timeframes.	Responsible Party
Objective: 1. Review 100% of submitted Grievances and Appeals to ensure that they are processed within the prescribed timeframes. 2. Provide reminders to Contract Providers and SOC supervisors at specified increments (30 days, 14 days, 7 days) on unresolved Grievances to promote timely processing. 3. Provide monthly feedback to supervisors and administrators when grievances and appeals are not completed in prescribed timeframes. 4. Offer ongoing and accessible Grievance and Appeal training for Contract Providers and SOC teams to ensure system wide knowledge of the Grievance and Appeal process	Patients' Rights Supervisor

Goal #9 <u>Medication Monitoring</u>: Each prescriber will achieve a combined rating of 85% or higher on peer review medication monitoring evaluation.	Responsible Party
Objective: 1. Complete monthly reviews of prescribers (internal and contracted) utilizing the Medication Monitoring tool. 2. Provide individual and group feedback based on quarterly/ monthly findings. 3. Identify system-wide improvements to support improved medication services to clients. 4. Contractors that have elected to complete their own reviews internally will submit them to QID for processing.	Medical Services Administrator

Goal #10 Navigation Center Referrals: 50% of individuals living in the shelters and navigations centers will be referred into behavioral health services.	Responsible Party Kern Linkage Administrator
Objective: 1. Engage individuals living in shelters and navigation centers into behavioral health services. 2. Collaborate with shelter staff to receive and exchange referrals 3. Maintain a consistent and engaged presence in shelters and navigations centers.	

Goal #11 Outcomes Measurement – Penetration Rate: 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.	Responsible Party Department Supports Administrator
Objective: 1. Participate in at least 3 outreach and education activities and utilize culturally responsive interventions/strategies. 2. Identify and target at least 3 API communities in Kern County to share materials and resources on BH services. 3. Assign 1 training to all staff that infuses culturally responsive outreach and care (Be Sensitive, Be Brave training).	

Goal #12 Outreach Effort to the Homeless & Hard to Reach: 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.	Responsible Party Adult System of Care & Contracts Administrators
Objective: 1. Provide the clinics with the baseline metrics and identify barriers/challenges that may impact the ability to achieve goal. 2. Monitor logged outreach events to ensure staff are engaging and educating the community on the program. 3. Explore opportunities for increased training and shadowing for new/current staff to strengthen engagement strategies/skills.	

Goal #13 Peer Support: 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.	Responsible Party Recovery Supports Administrator
Objective: 1. Provide current eligible Peer Support Specialist Staff and their supervisors, with information about the Grandparenting process for certification. 2. Submit a list to CalMHSA of the current staff eligible for certification under the Grandparenting process. 3. Submit a list to CA DHCS of current staff eligible for stipends to cover the cost of training and certification. 4. Establish a peer workgroup to study for the certification test. 5. Track and report successful CA Medi-Cal Peer Support Specialist certifications achieved by current eligible staff.	

Goal #14 Provider Appeals: 100% of Provider Appeals will be resolved in a timely manner.	Responsible Party
Objective: 1. Appeals will be addresses within the proper time frames. 2. Financial monitoring records will reflect provider appeal decisions.	Senior Administrative & Fiscal Services Officer

Goal #15 SUD Access Line/Test Calls: 95% of all access test calls will be given a customer service rating of standard or above.	Responsible Party
Objective: 1. QID will continue to do Quarterly Test Calls. 2. QID will report findings to Ana and Greg. 3. QID will work with Greg each quarter to see what improvements were made.	QID, Quality Monitoring Supervisor & SUD Administrator

Goal #16 SUD Adult Satisfaction - TPS: the Substance Use Division and its contract providers will achieve a cumulative minimum satisfaction rating of 85% or greater on the Treatment Perception Survey.	Responsible Party
Objective: 1. Complete the TPS 2. Create flyers for the overall satisfaction rate to post in clinics AND online. 3. Complete the PDSA model for any team that is out of compliance. 4. Have overall results posted on public website.	QID, Quality Monitoring Supervisor & SUD Administrator

Goal #17 SUD Audit Review - Training: 85% of all DMC-ODS agencies who received their annual quality review will meet staff training requirements as evaluation on the QID SUD monitoring tool.	Responsible Party
Objective: 1. SUD QID will work with the training division to set up providers' staff training reports. 2. SUD QID will run providers' training reports and follow up with providers before their annual review. 3. SUD QID will provide technical assistance to providers	QID, DATA Supervisor

Goal #18 SUD Outcome Measures – Access Line: At least 30% of individuals contacting the SUD treatment access line through Gateway will attend assessment.	Responsible Party
Objective: 1. Explore reasons for ongoing no-shows at outpatient providers via a focus group. 2. Track progress of various providers switching to offering walk-in assessments. 3. Assign Gateway staff to have "caseloads" in order to provide better engagement and follow up to increase show rate to assessment.	SUD Administrator

Goal #19 SUD Outcome Measures - MAT: Continue referrals to MAT community providers with a minimum of 500 for Fiscal Year 22-23.	Responsible Party SUD Administrator
Objective: 1. Renew MOUs with CSV and Omni in order to have ongoing relationship with community providers. 2. Meet with Health Plans to increase provider engagement and send referrals to MAT providers.	

Goal #20 SUD Outcome Measures -Penetration Rate: Increase penetration rate of the Latino/Hispanic population into SUD treatment from .52% to .57% by implementing culturally sensitive outreach and engagement strategies.	Responsible Party Department Supports Administrator
Objective: 1. Participate in at least 3 outreach and education activities and utilize culturally responsive interventions/strategies. 2. Identify and target at least 3 Latino/Hispanic communities in Kern County to share materials and resources on BH services. 3. Assign 1 training to all staff that infuses culturally responsive outreach and care (Be Sensitive, Be Brave training).	

Goal #21 SUD Points in Time Survey: 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.	Responsible Party SUD Administrator
Objective: 1. Continue to administer surveys monthly, with the exception of the month when the Treatment Perception Surveys will be collected. 2. Review results and comments with internally and with SUD providers to identify problems and solutions to increase satisfaction.	

Goal #22 UOR – MH Timeliness: 95% of UORs will be completed and signed by Contracted Administrator and KernBHRS administrator within the required timeframes.	Responsible Party QID, Documentation Compliance Supervisor
Objective: 1. Review 100% of all MH outpatient UORs submitted incidents to ensure all reports are approved within required timeframes for all internal and contracted providers. 2. Provide feedback and recommendation to the supervisors and administrators of the teams who are not meeting the standards. 3. QID will work with supervisors and administrators to reduce the length of time it is taking some to approve their reports to ensure these are approved within the required timeframes.	

Goal #23 <u>UOR – Outpatient MH</u>: 95% of all MHP Outpatient UORs will be addressed in a clinically appropriate manner.	Responsible Party
Objective: 1. Review 100% of all outpatient MH UORs submitted to ensure all incidents reported are being clinically addressed by the providers to prevent any future incidents. 2. Provide feedback and recommendations to the supervisors and administrators if any areas of concern or improvement are noted during UORs reviews. 3. QID will work with teams to reduce the use of “other” in the “type of incident” and entering incorrect types when submitting reports.	QID, Documentation Compliance Supervisor

Goal #24 <u>UOR – Outpatient SUD</u>: 100% of all DMC-ODS UORs will be addressed in an appropriate manner.	Responsible Party
Objective: 1. Review 100% of all outpatient SUD UORs submitted to ensure all incidents reported are being clinically addressed by the providers to prevent any future incidents. 2. Provide feedback and recommendations to the supervisors and administrators if any areas of concern or improvement are noted during UORs reviews. 3. QID will track and report to management any areas of improvement.	QID, Documentation Compliance Supervisor

Goal #25 <u>Utilization Management MHP</u>: 95% of all reviewed MH Assessments reviewed will document appropriate medical necessity for services.	Responsible Party
Objective: 1. Review MH assessments to ensure appropriate determination of medical necessity, level of care and recommendation of treatment is documented. 2. Provide feedback and recommendations to supervisors and SOC of any trends and areas of improvements noted during the reviews. 3. Ensure access to assessment training to all new LPHAs and any other clinicians to ensure everyone is evaluating clients similarly across all teams and providers.	QID, Documentation Compliance Supervisor

Goal #26 <u>Utilization Management SUD</u>: 95% of all SUD ASAM Assessments reviewed will document appropriate medical necessity for services.	Responsible Party
Objective: 1. Continue quarterly assessment review by Gateway therapists and review during SUD/QID meetings. 2. Share results with providers and QID Documentation compliance in order to offer additional training if needed.	SUD Administrator

Goal #27 Timeliness for Routine Appointments: 80% of routine initial requests will receive an assessment within 10 business days of the request.	Responsible Party QID, DATA Supervisor
Objective: 1. Regularly review performance data through the Key Performance Indicator Committee. 2. Identify providers that fall below the standard for more than three months. 3. When providers have been identified, implement performance improvement activity to correct problem.	

Goal #28 Timeliness for Urgent Appointments: 80% of urgent requests will receive an assessment within 48 hours of the initial request.	Responsible Party QID, DATA Supervisor
Objective: 1. Regularly review performance data through the Key Performance Indicator Committee. 2. Identify providers that fall below the standard for more than three months. 3. When providers have been identified, implement performance improvement activity to correct problem.	

Goal #29 Zero Suicide: All internal and provider teams will screen clients using the CSSRS Screener at 65% or greater.	Responsible Party Medical Services Administrator
Objective: 1. Run monthly department-wide data to identify progress towards goal. 2. Provide individual team feedback based on data. 3. Train and provide support to teams that are not meeting the 65% or greater goal.	