BEHAVIORAL HEALTH&RECOVERY SERVICES

Kern Behavioral Health and Recovery Services

Quality Improvement

Work Plan Evaluation

FY 2020 – 2021

KERN COUNTY

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FY 20-21 Work Plan Evaluation

BEHAVIORAL HEALTH&RECOVERY SERVICES

Our MISSION

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

Our VISION

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

Our VALUES

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.

INTRODCUTION TO
KERN BEHAVIORAL HEALTH AND RECOVERY SERVICES
WORK PLAN EVALUTION PROCESS

Exhibit A-Attachment 1-Appendix A, Part B of the MHP Contract with the State requires each MHP to have a written annual evaluation of the overall effectiveness of the QI/QM Program demonstrating how QI/QM activities contributed to meaningful improvement in clinical care and beneficiary service and describes completed and in-process QI/QM activities through monitoring of previously identified issues and tracking of issues over time, planning and initiation of activities for sustaining improvement, and establishing objectives, scope, and planned activities for the coming year in accordance with Title 42, Code of Federal Regulations (CFR), Section 438.240(a)(2), and shall meet the criteria identified in Title 42, CFR, Section 438.240(d).

At the completion of the fiscal year, the Quality Improvement Committee evaluates its effectiveness at achieving the goals and objects 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 goals is rates as "Met" or "Not Met."

The Quality Improvement Committee and subcommittees review the Annual Reports then sets the Work Plan Goals for the following fiscal year.

Goal #1 24/7 Toll-Free Number

1. Quality Improvement Goal:
   100% of calls will meet all 24/7 access line Medi-Cal regulations.

2. 2020/2021 The Goal Was:

   ☒ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   Over the last year, the QID team has continued to complete test calls to ensure that Access line calls are meeting Medi-Cal requirements. Feedback from test calls is reviewed with the team for improvement opportunities.

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

Silent Monitoring Data FY 20/21	Quarter 1 July - Sept	Quarter 2 Oct - Dec	Quarter 3 Jan - Mar	Quarter 4 April - June	FY 20/21 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%	93%	98.3%
Recorded date in call log	100%	100%	100%	100%	100%
Initial disposition of request recorded	100%	100%	100%	93%	98.3%

5. Summarize the Results of Actions Taken:
   Access line continues to meet this goal at 100%

6. Plan for Current Goal:
   ☒ Discontinue goal

GOAL #2 24/7 Toll-Free Number – Silent Monitoring

1. **Quality Improvement Goal:**
   Have 5% of all hotline calls monitored by silent monitoring.

2. **2020/2021 The Goal Was:**

   ☐ MET ☒ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   Hotline staff continue to be required to complete the peer review process through silent monitoring. This data is then collected and processed through Performance Outcomes Measures (POMs) reporting.

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

Silent Monitoring Data FY 20/21	Quarter 1 July - Sept	Quarter 2 Oct - Dec	Quarter 3 Jan - Mar	Quarter 4 April - June	FY 20/21 Averages
Total Hotline Calls	9,657	9,140	8,556	9,003	9,089
Calls Silently Monitored	252	261	154	441	277
Percentage of calls monitored	2.6%	2.9%	1.8%	4.9%	3%

5. **Summarize the Results of Actions Taken:**
   Hotline staff continue to struggle with meeting this goal. Ongoing conversations regarding the importance of this goal, as well as strategies for success are discussed with the Supervisor to find solutions to barriers prohibiting this goal from being met. However, barriers regarding staffing and call volume persist.

6. **Plan for Current Goal:**
   ☒ Discontinue goal

   Crisis Hotline staff will continue to complete silent monitoring forms for quality review, in vivo training, and as indicated in their EPR's.

GOAL #3 Change of Provider/Second Opinion Request

1. **Quality Improvement Goal:**
   100% of the Change of Provider/Second Opinion request shall come to a resolution between the client and provider.

2. **2020/2021 The Goal Was:**

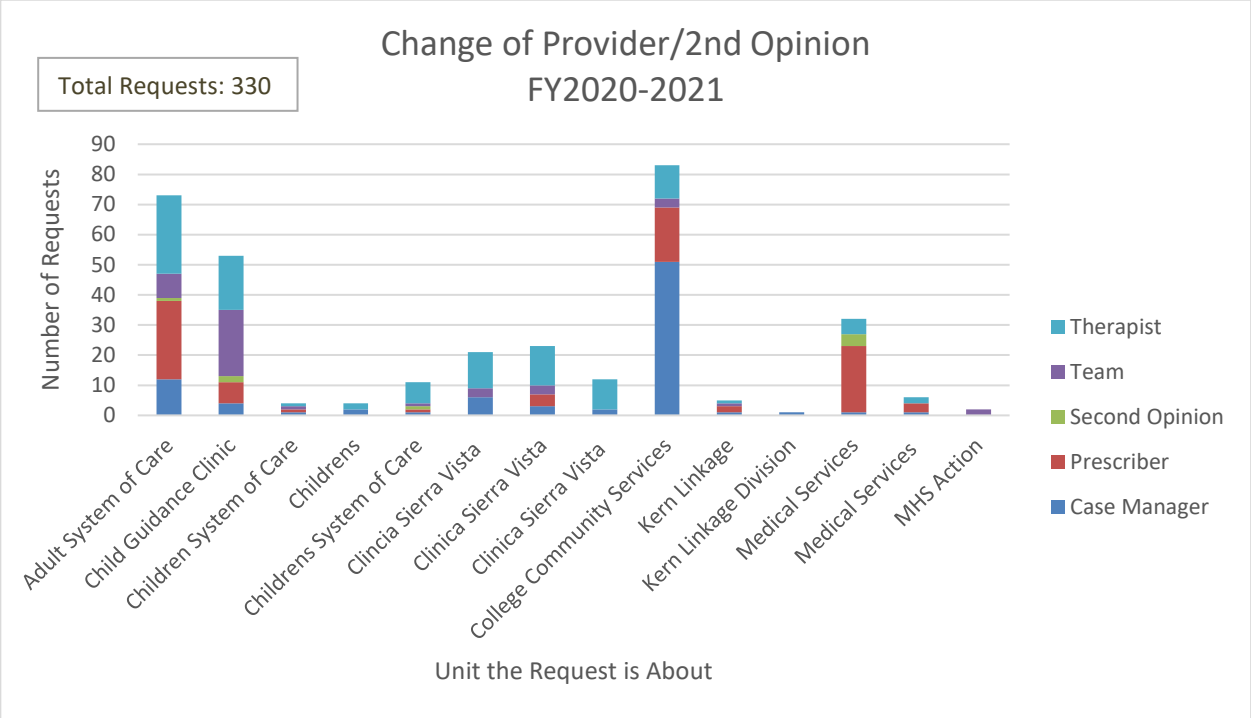
   ☐ MET ☒ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   Over the last fiscal year, the Quality Monitoring (QM) Team has:
   1. Launched the Change of Provider/Second Opinion (COP/2nd) app allowing supervisors to describe the request and the actions taken to resolve the client's request.
   2. Increased monitoring: reviewing each request when "No" resolution was identified to determine accuracy of the resolution
   3. Contacting supervisors to address any specific errors or concerns with the information entered
   4. Providing training information and reporting at QQID, RCC and QIC
   5. Supervisors having access to the reporting application within the COP/2nd App, and can now track and trend his/her team's data

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

Change of Provider/Second Opinion Requests FY20-21			
#Requests	#Resolved	%Compliance	Goal
330	317	96%	Not Met

Trend Data:



5. Summarize the Results of Actions Taken:

We learned the information being requested was not giving us the answers we thought we would get to make the determination that a resolution was developed 100% of the time.

To increase the accuracy of the reporting on COP/2nd requests, QM Team has worked with IT to make some changes to the required boxes, the titles of the different sections, and overall function in the COP/2nd App. These changes will take place July 2021.

To determine client satisfaction with the requests, Quality Monitoring Team developed an enhanced monitoring process that includes:

1. Weekly reviews of the COP/2nd requests entered in the app
    a. Evaluating any trends, i.e., multiple requests for the same reason, same staff, same team, etc.
    b. Contacting the client to rate satisfaction with the request resolution

6. Plan for Current Goal:

☒ Discontinue goal

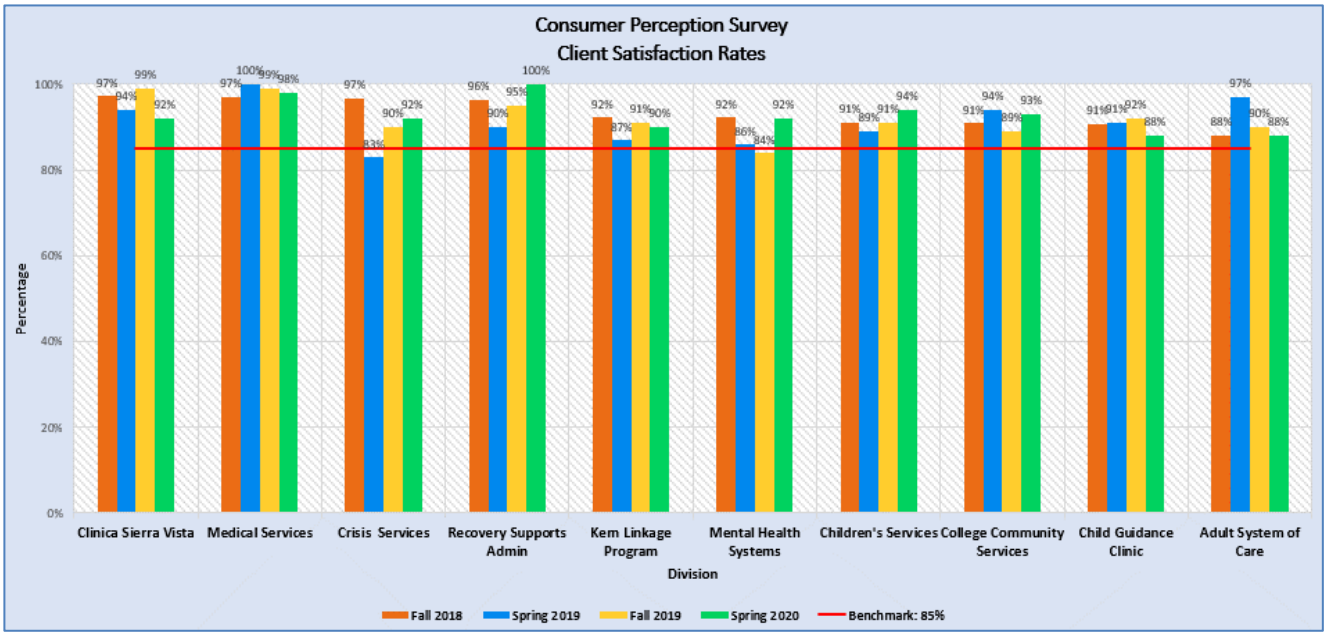
GOAL #4 Consumer and Family Satisfaction - CPS

1. **Quality Improvement Goal:**
   Each MHP service provider will each achieve a minimum satisfaction rating of 85% or greater on the bi-annual Consumer Perception Survey.

2. **2020/2021 The Goal Was:**
   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   QID analyzes the different elements of the CPS and gives each group the information they need to improve. This allows for improvement to be made based on; team, administration, cultural, and general overview. Further information was provided directly to the teams to allow clients to see the information. One significant change to this was that the staff were not talking directly to the clinical staff to complete the survey so there is less chance of survey bias.

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



5. **Summarize the Results of Actions Taken:**
   During FY20/21 the CPS was only administered one time per DHCS. During that survey all Kern BHRS and contract divisions met or exceeded the goal of 85%. The department moved to the online surveys and had staff call the clients. Results were presented to the Key Performance Improvement Committee and clients to review.

6. **Plan for Current Goal:**
   ☒ Change goal
   Change to aggregate goal due to low return rate and implementation of the Local Recovery Survey (LRS).New Goal: KernBHRS MH system of care will each achieve a minimum satisfaction rating of 85% or greater on the bi-annual Consumer Perception Survey

Goal #5 Credentialing

1. Quality Improvement Goal:
   100% of all applicable staff will complete the credentialing process.

2. 2020/2021 The Goal Was:

   ☒ MET ☐ NOT MET

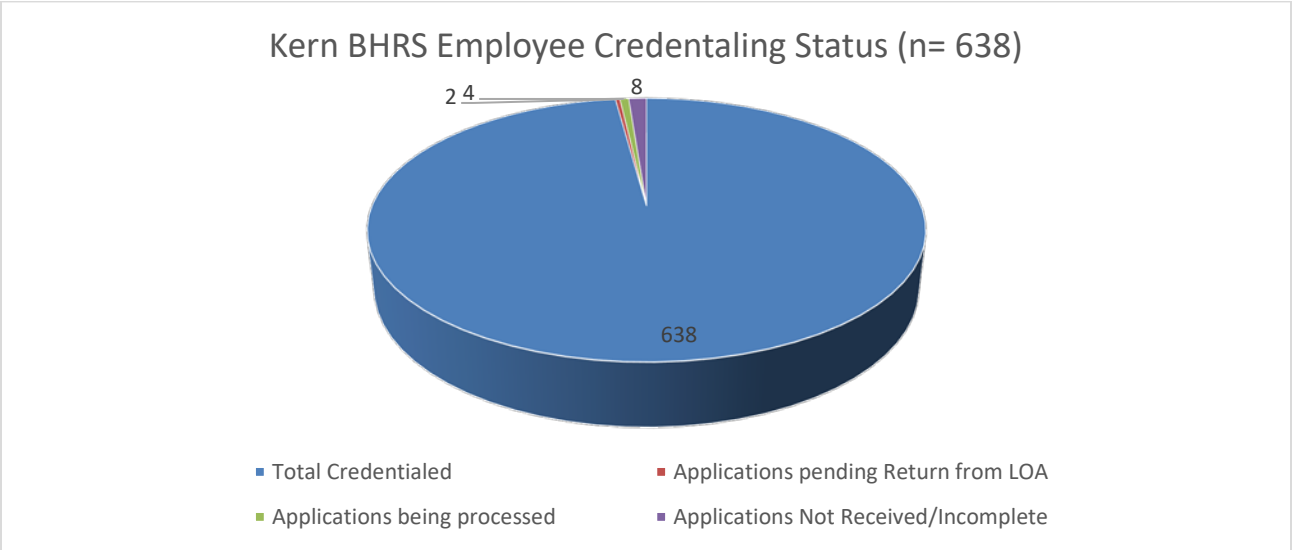
3. Quality Improvement Activities / Actions Taken Over the Past Year:
   1. Educated KernBHRS and contracted providers about Credentialing to ensure that all applicable staff were aware of the requirement to reduce confusion or resistance with staff completing the credentialing process.
   2. Credentialing of existing staff was completed by division and the process improvement by requesting feedback from staff on their experience completing the credentialing process.
   3. Implemented MD staff credentialing software system wide to increase efficiency and ensure that all applicable staff are credentialed
   4. Annual audits of contractors that complete their own credentialing efforts
   5. Require monthly staff roster reports from contractors where KernBHRS is completing credentialing to ensure new hires are appropriately credentialed.
   6. Review KernBHRS bi-weekly report to ensure all new hires/license changes are appropriately credentialed.
   7. KernBHRS Credentialing staff worked to reduce the amount of processing time it takes to complete an application by improving team communication, centralizing various tracking systems and developing written procedures to ensure consistent processes were being utilized by the entire team.

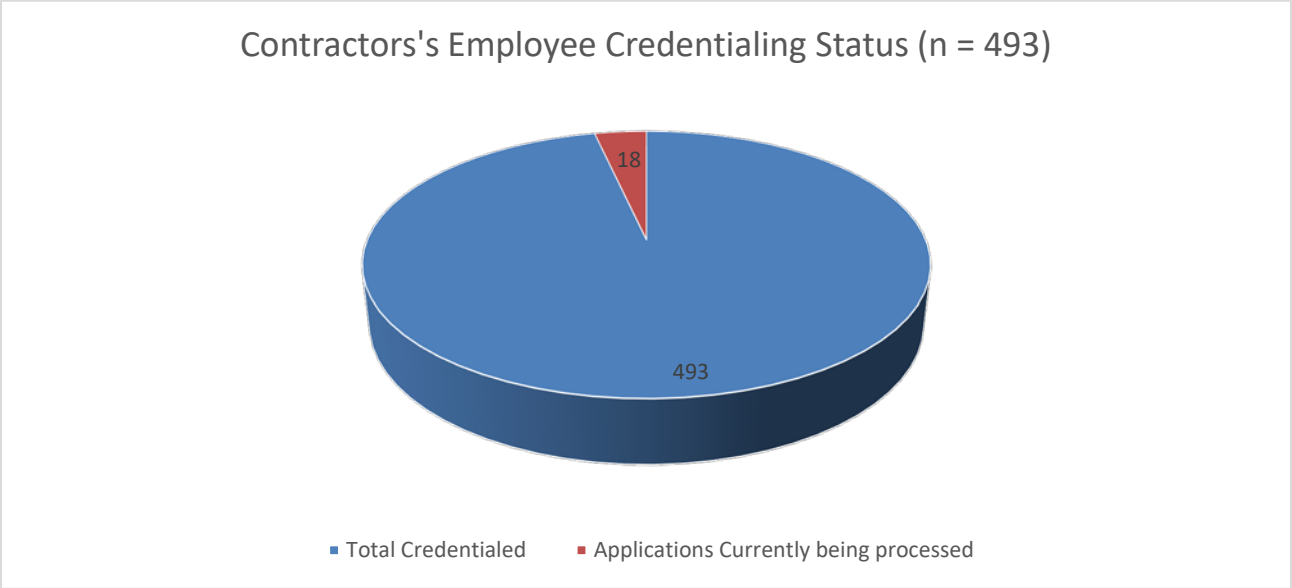
4. Data Used to Measure the Outcome of this QI Goal:

   Data Demonstrating Progress:
   1. Credentialing audit results for contractors (February 2020-March 2020)
   2. 336 personnel files reviewed; 256 files were non-compliant (76%)
   3. All plans of corrections have been completed from most recent credentialing audit.
   4. Credentialing audit for 2021 contractors are estimated to be completed in Summer 2021

   Processing time improvements for KernBHRS Staff
   1. Processing time 12/2019-6/2020 = 47 days
   2. Processing time 7/2020 to 9/30/20 = 19 days
   3. Processing time 10/1/20 to 12/31/2020 = 16 days
   4. Processing time 1/1/2021 to 3/31/2021 = 13 days
   5. Processing time 4/2021 to 6/2021 = 7.6 days

   Processing time for Contractor's Employees
   1. Processing time 12/2019-6/2020 = 40 days
   2. Processing time 7/2020 to 9/30/20 = 39 days
   3. Processing time 10/1/20 to 12/31/20 = 17.6 days
   4. Processing time 1/1/2021 to 3/31/2021 = 11.5 days
   5. Processing time 4/2021 to 6/2021 = 11.6 days





5. <u>Summarize the Results of Actions Taken:</u>

Over the course of the last year, 1,131 employees needed to be credentialed throughout the system of care. At this point, 1099 employees (both KernBHRS employees and contract provider employees) have been credentialed in accordance with the applicable IN. The credentialing team has worked diligently to streamline their credentialing process, thereby reducing the amount of time it was taking to complete the credentialing process. With the implementation of trainings, standardizing forms and processes and implementing a system wide credentialing software platform, our system has been able to ensure all required staff are appropriately credentialed in a timely manner.

6. <u>Plan for Current Goal:</u>

☒ Keep the goal with no change for the upcoming year

GOAL# 6 Documentation Review MH

1. Quality Improvement Goal:
   Improve documentation standards for compliance across all service teams to achieve 5% or less disallowance rates for 85% of the teams reviewed.

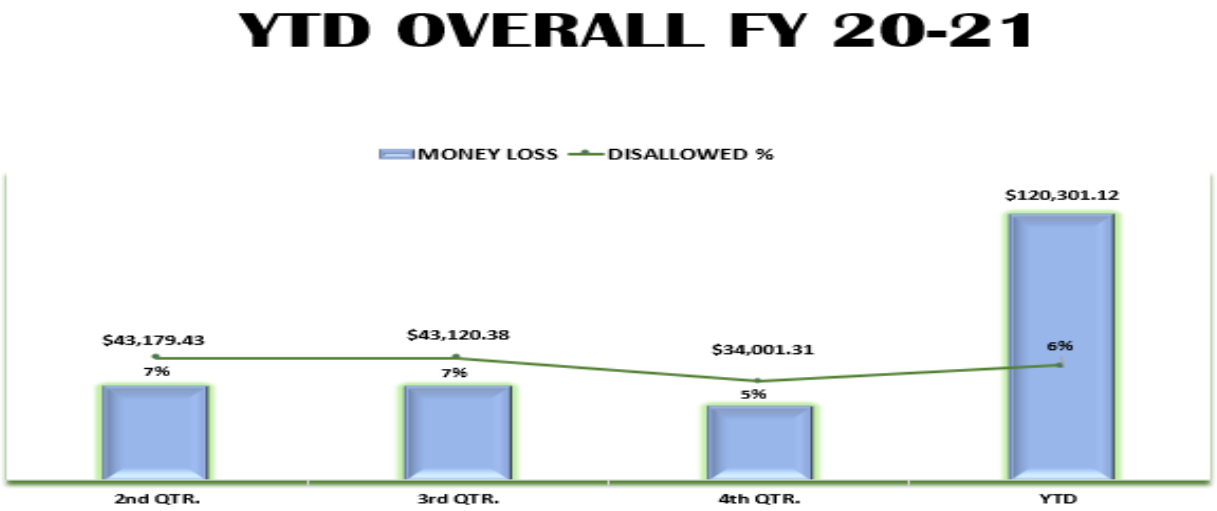
2. 2020/2021 The Goal Was:

   ☐ MET ☒ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   Documentation Compliance Team did:
   1. Quarterly Progress Note Reviews: QID completed reviews of 40 notes for all internal and contracted providers to ensure all notes follow DHCS and department standards.
   2. Feedback with Results: QID provided immediate feedback and training information in the results sent to the teams with their audits so the supervisor and staff understood why a note did not meet the requirements and what they needed to correct in future notes. Teams were also provided with tips and handouts to review in their team meetings.
   3. Documentation Training: QID provided specific team trainings when supervisors requested it to train the entire team on their audit results and trends found in their audits.
   4. Advance Writer's Workshop: Starting on March of 2021, this workshop was reinstated after being put on hold on March 2020 due to our State Health Crisis. Any staff who needs help documenting services can attend this monthly training. Staff who QID identifies as needing documentation support due to audit results was scheduled to attend the training. Some supervisors were also asked to attend when the trends were similar across the entire team.
   5. Plans of Corrections: QID prescribed plans of corrections for teams with disallowances higher than 15%, teams with disallowances of 30% and above also had a follow up audit and those with 40% and above had their billing suspended until their follow up audits were completed to ensure the training provided had helped with their documentation.
   6. Documentation Compliance Support: QID continued to provide support to our staff via our hotline. Answering over 640 calls in addition to multiple emails and calls made to team members.
   7. QQID Meetings: QID had quarter meetings with all team supervisors and contract providers to review audit results, trends noticed in the audits, tips to help their teams improve documentation and provide training on specific topics to increase compliance.
   8. QID New Employee Training: QID Documentation team updated its training materials to include a more interactive learning experience where staff is learning and applying the information by documenting a note during their initial training.
   9. Changes to Forms: QID simplified the note forms required to document services to make it easier for staff to capture their services following our documentation standards.

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

FY 20-21	1Q	2Q	3Q	4Q	Aggregated Totals
Total # Teams Audited	N/A	60	61	67	188
Total # PN Reviewed	N/A	2312	2432	2618	7362
% Disallowance Overall	N/A	7%	7%	5%	6%
% of Teams Meeting 5% or under	N/A	55%	57%	65%	59%
Goal: 85% of Teams having 5% or Less	N/A	Not Met	Not Met	Not Met	Not Met



5. Summarize the Results of Actions Taken:

1. QID's action and training has helped reduce the number of notes disallowed each quarter as well as the amount of revenue lost. The overall year disallowance for FY 19-20 was 10% while this FY the overall percentage is 6%. During FY 19-20 we had a qtr. with 14% disallowance, while in FY 20-21, the highest disallowance per qtr. was 7% with the lowest being 5%.
2. Plans of corrections and teams suspended also decreased during the year in comparison with previous years. FY 18-19 we had a total of 14 teams suspended on the first 3 Qtrs. In FY 19-20 we had 2 teams suspended, while in FY 20-21, we had 0 teams in the suspense category. During FY 19-20, we had a total of 43 plans of corrections prescribed with 7 teams being over 30% disallowance, but in FY 20-21 we only had 23 POCs and only 1 team over 40%.
3. Revenue lost during our quarter audits on FY20-21 was a total of $120,301.12 which was $54,391.85 less than FY 19-20 where we disallowed $174,692.97
4. In regard to our goal of 85% of the teams achieving 5% or less, we started FY20-21 with 55% of the teams in this category and ended the year with 65% of the team in 5% or less. A total of 21 out of 67 teams achieved 0% disallowance in the last qtr. of this FY.

6. Plan for Current Goal:

☒ Discontinue goal

This report is being moved to the Regulatory Compliance Committee (QIC Sub-committee) to increase discussion in improvement of goals.

GOAL#7 Documentation Review SUD

1. **Quality Improvement Goal:**
   All SUD teams will achieve at least 75% compliance in their quarterly progress note audits.

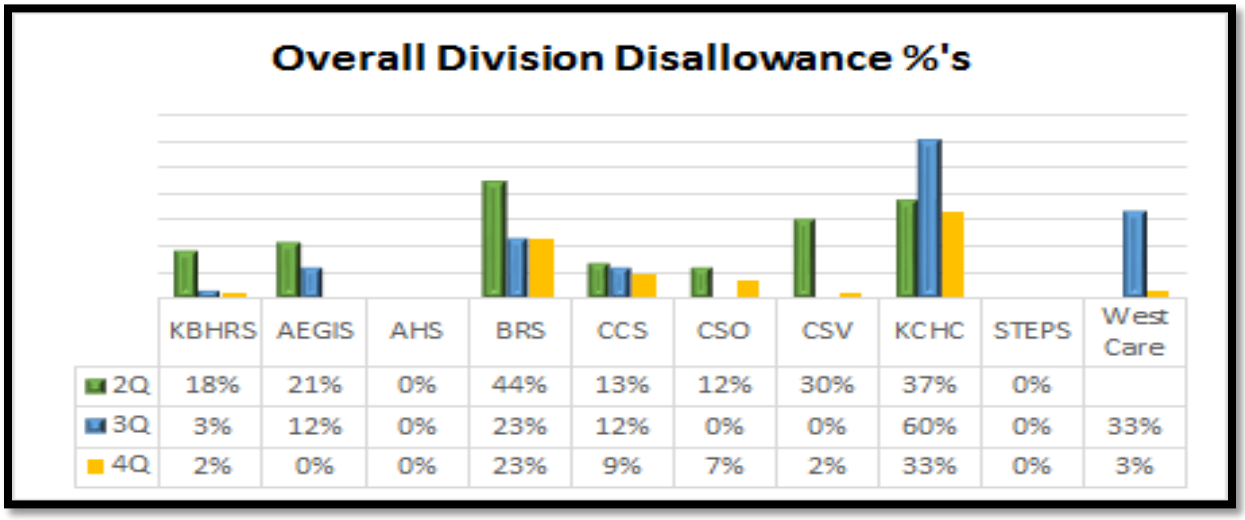
2. **2020/2021 The Goal Was:**

   ☐ MET ☒ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   Documentation Compliance Team did:
   1. Quarterly Progress Note Reviews: QID completed reviews of 30 notes for all internal and contracted providers to ensure all notes follow DHCS and department standards.
   2. Feedback with Results: QID provided feedback and detail information in the results sent to the teams with their audits so the supervisor and staff understood why a note did not meet the requirements and what they needed to correct in future notes. Teams were also provided with tips and handouts to review in their team meetings.
   3. Documentation Training: QID provided specific team trainings when supervisors requested it to train the entire team on their audit results and trends found in their audits.
   4. Documentation Compliance Support: QID continued to provide support to our staff via our hotline. Answering over 360 calls in addition to multiple emails and calls made to team members.
   5. QQID Meetings: QID had quarter meetings with all team supervisors and contract providers to review audit results, trends noticed in the audits, tips to help their teams improve documentation and provide training on specific topics to increase compliance.
   6. QID New Employee Training: QID Documentation team updated its training materials to include a more interactive learning experience where staff is actively engaged in the learning and must participate during practice or quiz time.
   7. Changes to Forms: QID with the collaboration of SUD administration launched a new process to document residential group notes to help teams ease the documentation of such services.

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

FY 20-21	1Q	2Q	3Q	4Q	Aggregated Totals
Total # Teams Audited	N/A	21	22	22	65
Total # PN Reviewed	N/A	630	651	660	1,941
% Disallowance Overall	N/A	22%	13%	9%	15%
Progress: % of Teams Meeting 25% or less	N/A	62%	77%	86%	75%
Goal: All SUD Teams having 25% or Less	N/A	Not Met	Not Met	Not Met	Not Met



	KBHRS	AEGIS	AHS	BRS	CCS	CSO	CSV	KCHC	STEPS	West Care
2Q	18%	21%	0%	44%	13%	12%	30%	37%	0%	
3Q	3%	12%	0%	23%	12%	0%	0%	60%	0%	33%
4Q	2%	0%	0%	23%	9%	7%	2%	33%	0%	3%

5. Summarize the Results of Actions Taken:

1. QID's action and trainings have helped reduce the number of notes disallowed each quarter. The overall year disallowance for FY 19-20 was 27% while this FY the overall percentage is 15%. During FY 19-20 the lowest percentage in qtr. Disallowances was 16% while in FY 20-21, the lowest disallowance per qtr. was 9%.
2. Revenue lost during our quarter audits on FY 20-21 also decreased. We started Qtr. 2 with a total of $18,001.18 disallowed but finished Qtr. 4 with $10,956.31
3. In regard to our goal of all teams achieving 75% compliance in their audits, we started FY20-21 with 62% of the teams in this category and ended the year with 86% of the teams achieving this goal. A total of 19 out of 22 teams achieved 75% compliance in the last qtr. of this FY.

6. Plan for Current Goal:

☒ Discontinue goal

This report is being moved to the Regulatory Compliance Committee (QIC Sub-committee) to increase discussion in improvement of goals.

GOAL# 8 Fair Hearings

1. Quality Improvement Goal:
   100% of State Fair Hearings will be performed within the mandated time frame.

2. 2020/2021 The Goal Was:

   ☒ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   KernBHRS now has 2 users that check the Appeals Case Management System (ACMS). This is the DHCS supported system for communicating to counties when an appeal has been filed and a Fair Hearing is initiated. By having multiple users, we can make sure the website is checked daily. We have implemented a forms document that is submitted every day the website is checked to track the daily check-ins. We had 1 State Fair Hearing Appeal and with DHCS siding with KernBHRS.

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

FY20-21 State Fair Hearings	Q1 July-Sep	Q2 Oct-Dec	Q3 Jan-Mar	Q4 Apr-Jun
# State Fair Hearing Appeals Submissions	0	0	0	1
% Completed on Time	100%	100%	100%	100%
Result: MET/ NOT MET	MET	MET	MET	MET

5. Summarize the Results of Actions Taken:
   As a result of daily checks of the ACMS system, QID identified one appeal that initiated a State Fair Hearing. QID partnered with Rebecca Badget from the Adult System of Care to represent KernBHRS in the State Fair Hearing. We also had PRA reach out to the client to ensure the client felt confident and comfortable with the proceedings. Rebecca and QID were present during the State Fair Hearing to answer all questions from Judge? The determination ended in KernBHRS favor.

6. Plan for Current Goal:
   ☒ Keep the goal with no change for the upcoming year

GOAL# 9 Foster Care Penetration Rates

1. Quality Improvement Goal:
   Increase foster youth penetration rate to an overall monthly average of 50% or greater.

2. 2020/2021 The Goal Was:

   ☒ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   Since July 2020, the 50% FC Penetration Rate goal has continuously been met and exceeded due to the actions listed below:
   1. Working with DHS to increase the utilization of CANS in CFT meetings, including new process to ensure sharing of CANS between agencies through a dedicated CANS submission email
   2. Request to DHS to update Behavioral Health screening form to consider behavioral health support that is needed by family as youth transitions
   3. Family Urgent Response System (FURS) implementation
   4. Availability to attend both open and unopened CFTMs
   5. Ongoing meetings with Probation and DHS to coordinate support for transitioning STRTPS
   6. Prioritizing completion of STRTP assessments to expedite youth's release from Juvenile Hall
   7. As a result of state pilot, shared goal of engaging family/long-term placements in CFTMs and family therapy
   8. Foster youth with non-foster care aid codes continue to be reviewed. For of FY 20/21, records for 513 Medi-Cal youth served have been updated to include a foster care aid code
   9. Continued support of transitioning STRTPs; five (5) STRTPs have received their mental health approvals as of 6/30/2021
   10. Continued work with partner agencies to implement AB 2083 (Collaborative MOU)
   11. Continue availability to attend both open and unopened CFTM
   12. Continue to accelerate STRTP assessments to expedite youth's release from Juvenile Hall

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

						12 Month cumulative			
Year	Month	Actual MMEF Eligible Foster Kids	CAEQRO MMEF Eligible Foster Kids [1]	Unique Foster Kids Served	Total services	Unique Foster Kids Served	Penetration rate [2]	Total services	Total eligible months
2021	6	2,444	2,387	602	3,953	1,235	51.73%	51,458	28,649
2021	5	2,466	2,377	626	4,422	1,265	53.21%	51,597	28,528
2021	4	2,408	2,362	641	5,154	1,262	53.44%	51,678	28,338
2021	3	2,411	2,348	624	4,649	1,254	53.42%	51,311	28,171
2021	2	2,422	2,335	657	4,633	1,246	53.36%	50,322	28,019
2021	1	2,397	2,323	648	4,728	1,244	53.55%	49,051	27,879
2020	12	2,395	2,313	614	3,543	1,246	53.88%	47,963	27,752
2020	11	2,348	2,299	624	3,490	1,242	54.02%	47,048	27,592
2020	10	2,347	2,288	649	4,495	1,238	54.10%	46,470	27,461
2020	9	2,341	2,277	633	3,943	1,222	53.66%	45,837	27,328
2020	8	2,338	2,268	651	4,153	1,208	53.27%	45,186	27,213
2020	7	2,332	2,257	648	4,295	1,206	53.43%	44,466	27,087

5. Summarize the Results of Actions Taken:

The Foster Care Penetration Rate report for FY 20/21 shows that the penetration rate was met for all 12 months. The highest month reported was at 54.1% for October of 2020. Continued coordination with DHS, Probation, and BH geographic providers has allowed the screening and assessment of more foster youth with high level needs to be referred and treated as needed. Interagency case planning and monthly review of penetration rates provides real time information and allows for treatment planning as needed. Identifying incorrect aid codes and updating through collaboration with DHS has also improved our process for increasing the penetration rate for foster youth accessing behavioral health services.

6. Plan for Current Goal:

☒ Keep the goal with no change for the upcoming year

GOAL#10 Grievance and Appeals/Problem Resolution

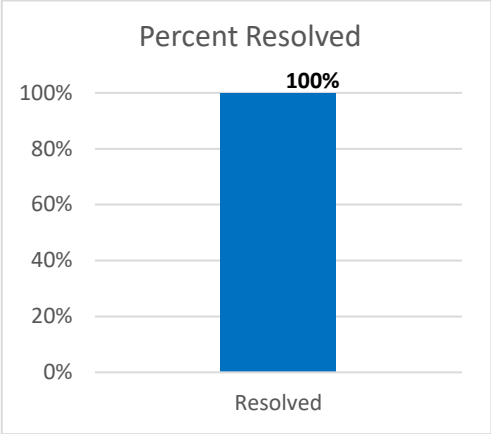
1. Quality Improvement Goal:
   100% of grievance and Appeals will be addressed within the prescribed timeframes.

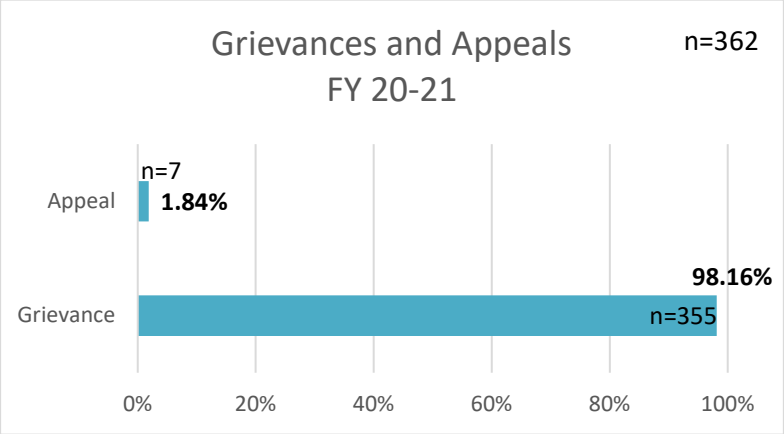
2. 2020/2021 The Goal Was:

   ☒ MET ☐ NOT MET

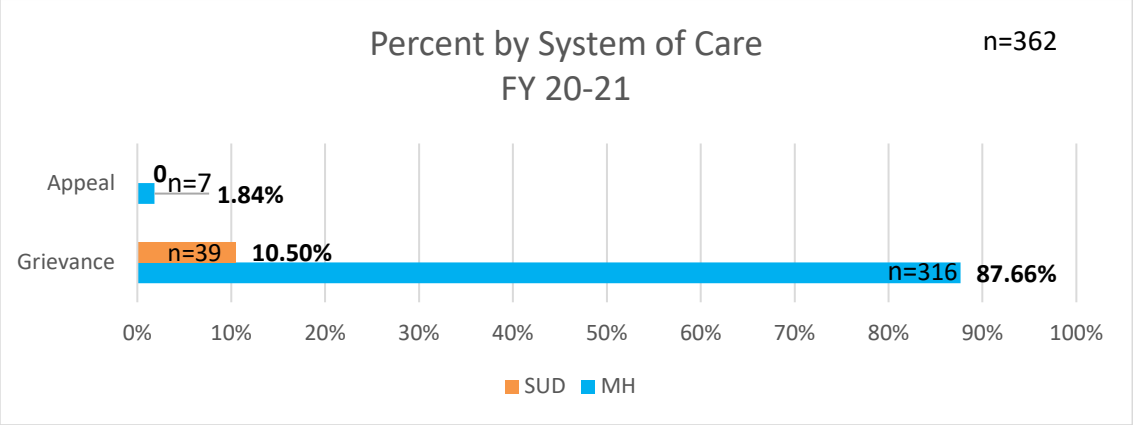
3. Quality Improvement Activities / Actions Taken Over the Past Year:
   Through the Grievance and Appeal web database, The Patients' Rights Office was able to review and resolve all incoming grievances and appeals within the state mandated timeframes. Each grievance and appeal were independently monitored by staff and electronically monitored by the web database to ensure they were resolved and meeting our goal of 100% within the appropriate timeframes.

4. Data Used to Measure the Outcome of this QI Goal:
   In review of the Grievance and Appeal web database, for FY 20-21, data shows 362 total grievances with 7 being appeals. The Patients' Rights Office resolved 100% of the grievances and appeals within the state mandated timeframes. The Grievance and Appeal database has proven to be a success for monitoring timeliness.





The table below displays the total grievances and appeals by System of Care:



5. Summarize the Results of Actions Taken:

For FY 20-21, The Patients' Rights Office provided grievance and appeal trainings to KernBHRS staff and contract providers which resulted in a positive response. The goal was to ensure staff were able to maneuver the Grievance and Appeal web database with ease and understand importance of reporting and/or resolving grievances and appeals promptly. Evidenced by the data, effective trainings, and providers responding quickly to all grievances and appeals.

6. Plan for Current Goal:

☒ Continue goal

GOAL# 11 Medication Monitoring

1. Quality Improvement Goal:
   Each prescriber will achieve a combined rating of 80% or higher on peer review medication monitoring evaluation.

2. 2020/2021 The Goal Was:
   ☐ MET ☒ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   QID's, Quality Monitoring (QM) Team developed and implemented a medication monitoring process for the NTP's and was able to complete one review of American Health Systems and has begun the first review for Aegis to be completed in July 2021.
   The QM Team has begun working with the contractors, including the NTPs, to develop a more efficient medication monitoring and reporting process. Plans are to implement this in the first quarter of FY21-22.

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

Medication Monitoring FY 20-21			
Agency	#Prescribers Reviewed	#Under 80%	Overall % of Compliance
KernBHRS (MH)	26	2	91%
College Community (MH)	1	0	0%
Child Guidance Clinic (MH)	4	2	50%
Clinica Sierra Vista (MH)	3	2	33%
American Health Systems (SUD)	1	1	100%

5. Summarize the Results of Actions Taken:
   KernBHRS internal providers were reviewed anywhere from 1-4 times each. The data for internal providers shows that the EHR system is lacking in the ability to report on certain areas in an efficient manner. We have since revised the forms to meet this need. Overall compliance for internal providers has improved over the last year.
   Contractors were only reviewed a few times and there is not enough data to draw statistical conclusions. QID has worked with the contractors to facilitate a more effective review process for these providers.

6. Plan for Current Goal:
   ☒ Discontinue Goal

GOAL# 12 Notice of Adverse Benefit Determination (NOABDs) MH

1. Quality Improvement Goal:
   95% of all types of NOABDS sent by the MHP will be issued correctly according to state mandates.

2. 2020/2021 The Goal Was:

   ☐ MET ☒ NOT MET

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

In the last Fiscal Year, the Quality Monitoring (QM) team has substantially honed the accuracy of reporting on the NOABDs and have discovered that issuance across the system of care has not been as accurate as previously reported.

1. 7 of the 9 NOABDs that are issued within the System of Care:
   a. Delivery System Notice
   b. Termination Notice
   c. Denial/Modification Notice
   d. Timely Access Notice
   e. Payment Denial Notice
   f. Grievance and Appeal Timely Resolution Notice

The Quality Monitoring (QM) Team developed and provided:

1. Enhanced reporting to Administrators and Supervisors, that included:
   a. Lists of NOABDs that should have been issued, but none were created within the NOABD app
   b. Lists of NOABDs that were created within the NOABD app, but there was no evidence as to why the NOABD was issued, i.e., a Delivery System Notice in the NOABD app with no corresponding Assessment to support the issuance this NOABD.
   c. Errors, i.e., duplicates, typos, wrong information entered, etc.
2. Quarterly reporting at the QIC sub-committee RCC
3. Discussions with administrators and supervisors at the division supervisor meetings

To increase accuracy, the QM Team has provided a lot of training this past FY, with a focus on NOABD issuance by Outpatient Teams: Delivery System, Termination, and Timely Access Notices. Because these are the most notices sent out within the system of care, we wanted to focus on getting our system into compliance with these first before moving on to the problems with the other notices, which are minimal. The training activities included:

1. Hosting live Team's trainings mandatory for all Therapist and Supervisors on clinical teams the weeks of November 30th to December 18th.
2. Creating and distributing one-page quick guides addressing the areas from each quarter's reports
3. Presenting information regarding the proper issuance of NOABDs at the quarterly QQID meetings
4. Meeting with team supervisors for Q&A
5. Working with Training Services to create a training in Relias that will be required for all new licensed staff and supervisors, but available for all

In the last quarter, the QM Team has developed a Corrective Action Plan (CAP) that will be implemented in the first quarter of FY21-22. To prepare the teams for CAP process the QM Team:

1. Announced the CAP process at last quarter's RCC meeting
2. Attended the division supervisor's meetings for almost all the MH division
3. Administrators schedule meeting with the QM Team to review the data and the CAP

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

NOABD Issuance FY20-21			
Type of NOABD	#Required	#Issued	%Compliance
Delivery System (Issued at Initial Assessment)	1245	693	56%
Termination (Issued at Annual Reassessment)	251	20	8%
Denial/Modification	0	162	0%
Timely Access	1401	678	48%
Payment Denial	140	94	67%
Grievance & Appeals Timely Resolution	0	0	100%

5. Summarize the Results of Actions Taken:

Even with all the enhanced monitoring, reporting, and training provided over the last fiscal year we continue to be out of compliance with the work plan goal.

1. This next fiscal year will be implementing Quarterly CAPs for those teams who are responsible for issuing the 3 notices (Delivery System, Termination and Timely Access) to clients seeking outpatient mental health treatment.
2. All NOABD monitoring will be reported on at RCC, a sub-committee of QIC, which in turn will report to QIC.
3. Working with IT to develop an app that will allow the supervisors to monitor the accuracy of the issuance of the NOABDs by his/her team. And address errors in a more timely manner, than waiting until the quarterly reporting to find out about the problems.

6. Plan for Current Goal:

☒ Discontinue goal

Continue the language of this goal. However, to better utilize this information to improve the system, we recommend moving this report to the QIC sub-committee RCC.

GOAL# 13 Notice of Adverse Beneficiary Determination (NOABDs) SUD

1. Quality Improvement Goal:
   95% of all NOABDS sent by the SUD System will be issued correctly according to state mandates.

2. 2020/2021 The Goal Was:

   ☐ MET ☒ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   1. An NOABD training was created and is now provided to all SUD staff as a part of their annually required DMC-ODS training
   2. A *NOABD Frequently Asked Questions* document was developed and is revised as needed to clarify NOABD requirements, including the process for sending notices, and to address the commonly asked questions by for staff issuing notices (the document was e-mailed to all providers, is posted on the QID SUD SharePoint page, and is given to staff who attend the DMC-ODS annual training. Staff are notified via email when updates are made)
   3. The SUD NOABD app has been updated to allow staff to sign NOABDs using their computer mouse, via touchscreen, or a signature pad to accommodate those with limited printing capacity due to working from home or working remotely.
   4. QID SUD has scheduled individualized training for providers to address staff difficulties understanding NOABDs and to provide supportive guidance.
   5. QID SUD has worked with the Quality Management team to identify and monitor Grievance Resolution Notices to ensure they are being sent in compliance with applicable regulations.
   6. QID SUD and SUD Administration issued letters of non-compliance to three providers, making them aware of compliance concerns with appropriately sending NOABDs to beneficiaries.
   7. QID SUD worked with SUD Administration and the KernBHRS Gateway Team to transition the responsibility of sending Modification Notices from treatment providers to the Gateway Team. It was determined that based on the nature and requirements of Modification Notices, it is most appropriate for the Gateway Team to issue these notices; effective 12/01/2020.
   8. QID SUD released a monthly newsletter to all SUD contracted providers and county operated SUD teams providing them with reminders and information on properly issuing NOABDs.
   9. QID SUD has worked with the KernBHRS IT team to make the SUD NOABD forms easier/faster to complete for staff and the changes were introduced during the 4th quarter.
   10. Providers/teams were contacted individually at the close of each quarter with information regarding their compliance with this requirement with tips and suggestions for improvement.
   11. QID SUD worked with the KernBHRS IT team to build a report within the NOABD app to enhance monitoring and provide real time information about notices that have been issued appropriately.

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

FY	NOABDs Required	NOABDs Completed	Compliance %
2020 – 2021	2,341	1,234	53%

5. Summarize the Results of Actions Taken:

Quality Improvement activities performed during FY 20-21 enhanced the ability to monitor SUD NOABDs more effectively and to provide clarification of requirements/expectations to those responsible for issuing notices. The following activities have had a meaningful impact on the rate of compliance for issuing these notices when appropriate by approximately 40%:

1. Targeted training and written guidance for teams/providers received positive feedback in helping staff to understand the importance and proper issuance of SUD NOABDs. SUD staff were trained on the correct issuance of NOABDs during annually required training with increased the level of engagement and understanding from staff directly responsible for issuing the notices.
2. Specific feedback after each quarter was provided to all SUD teams/providers and helped them address with their staff areas that need improvement, this action resulted in improvements each following quarter.
3. Technological improvements, making SUD NOABD forms easier and faster to complete, helped to ensure that each notice contains all required elements. This alleviated documentation time spent by staff generating notices.

In FY 21-22 review of SUD NOABD compliance will occur at the Regulatory Compliance Committee meetings (a subcommittee of the Quality Improvement Committee) where compliance can be reviewed by team/agency and specific action steps for improvement can be developed.

6. Plan for Current Goal:

☒ Discontinue goal

This report is being moved to the Regulatory Compliance Committee (QIC Sub-committee) to increase discussion in improvement of goals.

GOAL# 14 Outreach Efforts to the Homeless and Hard to Reach - AOT

1. Quality Improvement Goal:
   In an effort to ensure system access to the hard-to-reach individuals, the AOT team will increase linkage of individuals to adult outpatient teams by 15%.

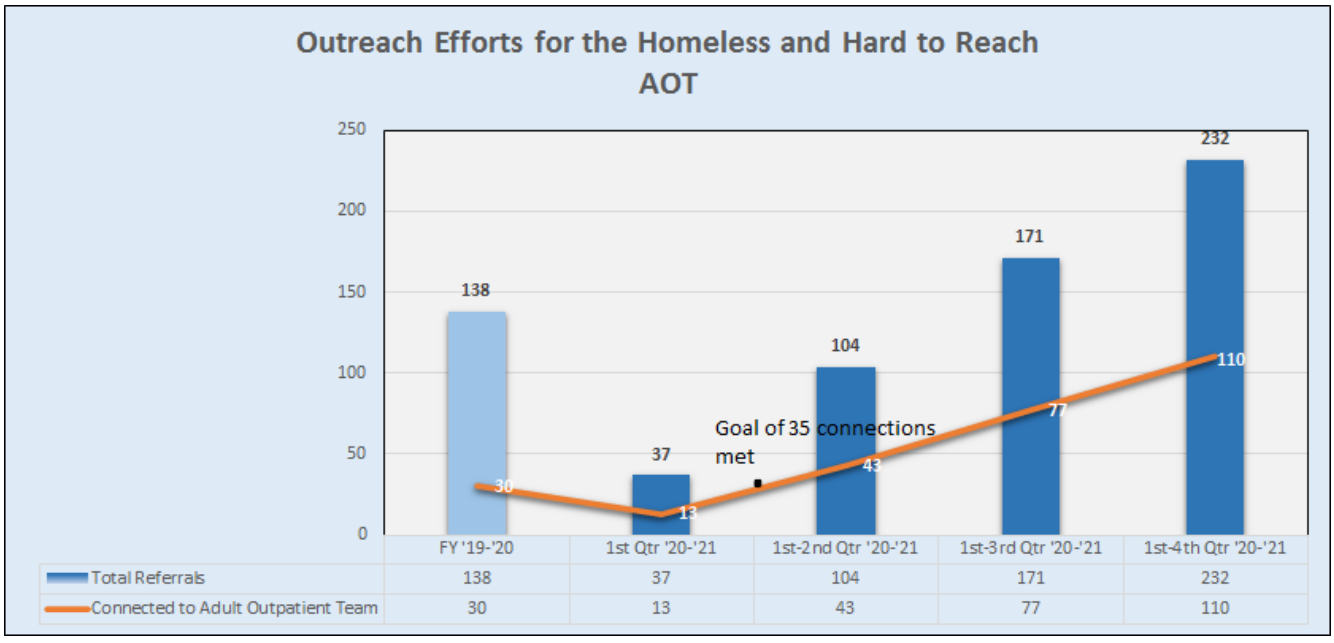
2. 2020/2021 The Goal Was:

   ☒ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   Continued to increase outreach in the community by providing trainings on the AOT program. Trainings included:
   1. KC Probation
   2. Behavioral Health Board
   3. Contract providers (Clinica Sierra Vista, Child Guidance, College Community Services)
   4. Crestwood PHF
   5. CBH
   6. HAT
   7. SEBA
   8. CWiC
   9. Provider Meeting
   10. CIT
   11. Mental health Collaborative of Kern County
   12. Manteca City Council

   Have worked with Crisis Services and Conservator's Office to ensure that AOT is an option for hospitalized clients who are not engaging in services. An AOT referral is done in conjunction with a T-con referral to ensure client is appropriately linked.

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



5. Summarize the Results of Actions Taken:

The total number of referrals connected to adult outpatient teams in FY 19-20 was 30. The workplan goal for FY 20-21 was to increase linkage to adult outpatient teams by 15%, which would be 35 individuals. This goal was met in the second quarter. For the entire year, out of 232 referrals, 110 individuals were connected to adult outpatient teams.

6. Plan for Current Goal:

☒ Change goal

In an effort to ensure system access to the hard-to-reach individuals, the AOT team will increase the number of petitions submitted to the courts by 15%.

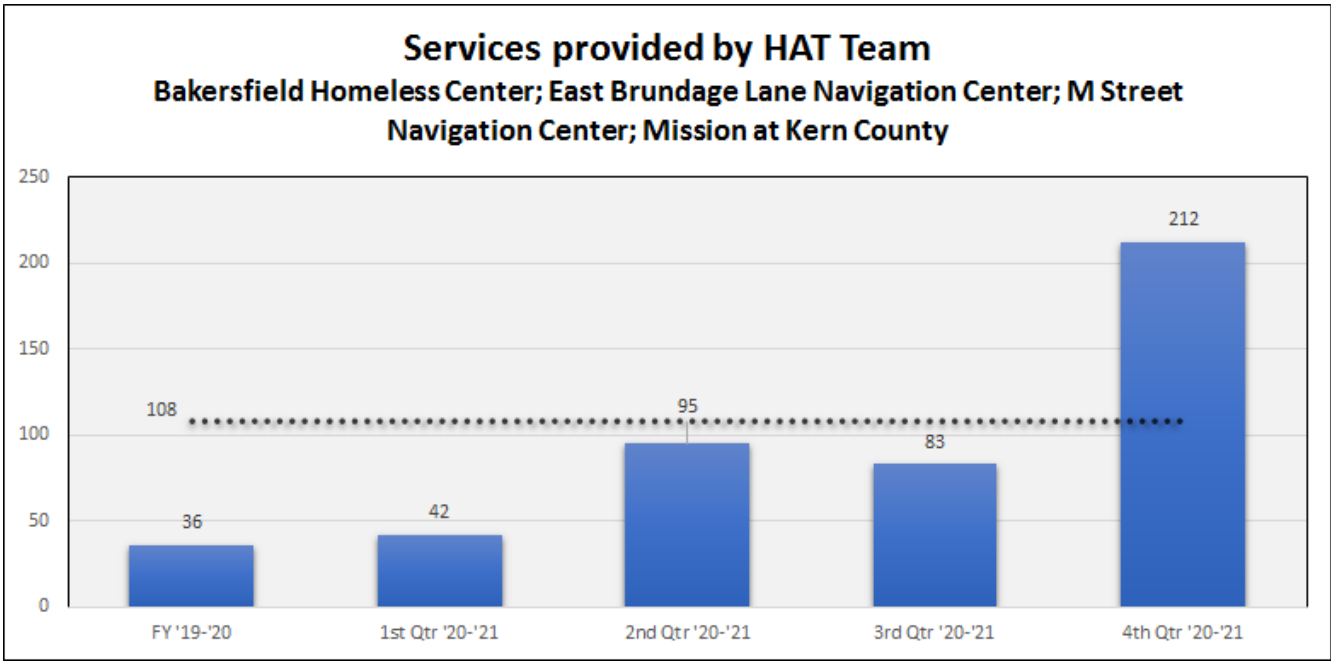
GOAL# 15 Outreach Efforts to the Homeless and Hard to Reach - HAT

1. Quality Improvement Goal:
   Establish a baseline for tracking the number of services the HAT team provides at the four local shelters.

2. 2020/2021 The Goal Was:
   ☒ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   1. Established a process for staff to code services provided in the shelters to enable accurate data to be collected.
   2. Created a staffing schedule to ensure regular staff presence at shelters.
   3. Started group services at shelters.
   4. New supervisor had meetings with shelter managers to strategize ways to increase client contact.

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



5. Summarize the Results of Actions Taken:
   Reason for jump in contacts between Q3 and Q4 is due to shelters opening up after covid restrictions and increased staffing on site. Moving forward, there will be the same level of staffing (or more) at the shelters as in Q4.

6. Plan for Current Goal:
   ☒ Discontinue goal

GOAL# 16 Outreach Efforts to the Homeless and Hard to Reach - REACH

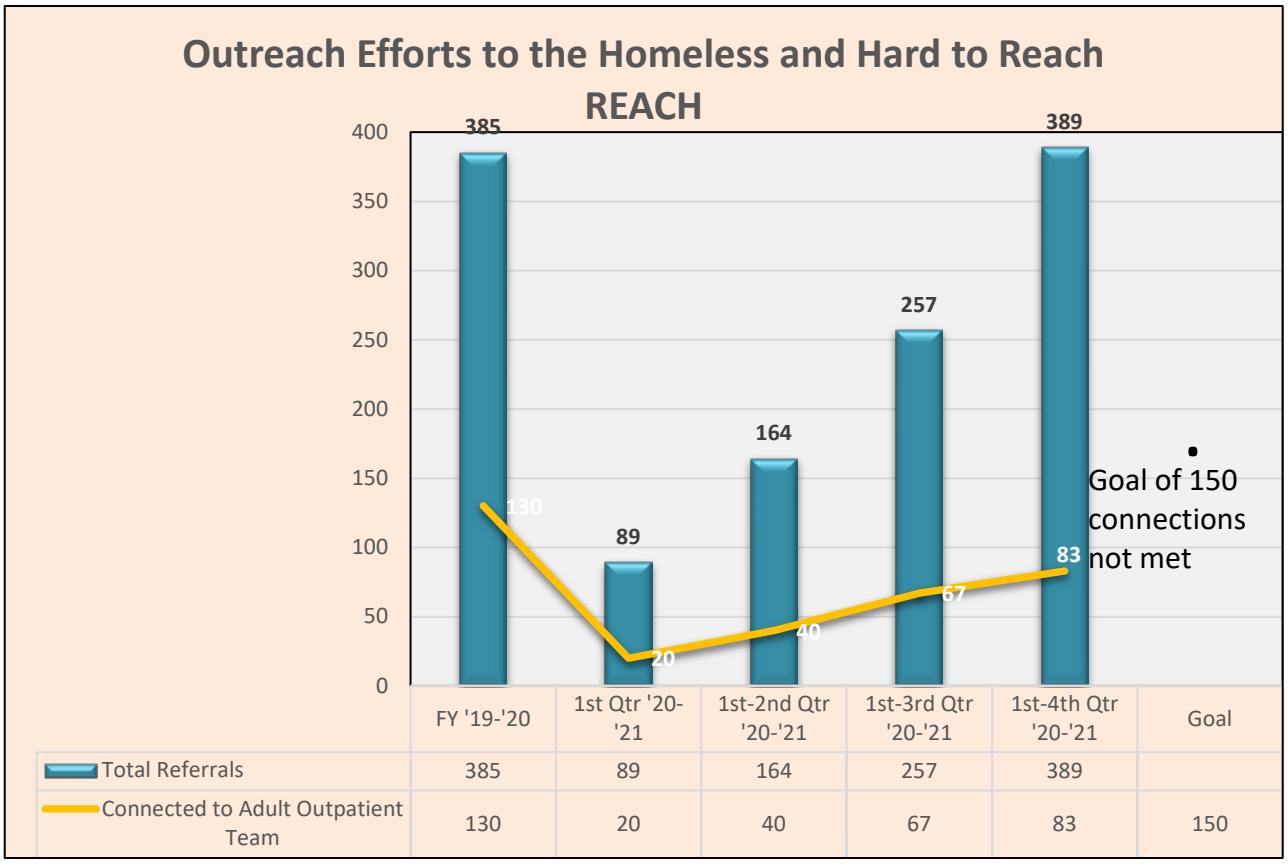
1. Quality Improvement Goal:
   In an effort to ensure system access to the hard to reach individuals The REACH team will increase linkage of individuals to adult outpatient teams by 15%

2. 2020/2021 The Goal Was:

   ☐ MET ☒ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   1. Reestablished the outreach meeting in February 2021
   2. Worked to standardize REACH program to create consistency in services provided and data collected.
   3. Created the outreach web app to ensure better data collection and reporting.
   4. Worked with PIO's office to create information cards and flyers for each outreach clinic. Next step will be to promote outreach program through Kern BHRS's social media platforms.
   5. Ensured all outreach staff have an outreach hotline number for their clinic (different than the main office number) to ensure referrals are addressed timely and appropriately.
   6. Rebranded outreach program to differentiate between the outreach and reengagement programs. New names are Bakersfield Referral Team and Community Referral Network.
   7. Educated inpatient facilities, Conservator's office, and system of care about REACH referral option while client is hospitalized.
   8. Closely monitored vacancies for the contract providers because we recognize this has negatively impacted our ability to provide outreach to our communities.
   9. Worked with contract providers to identify appropriate staff working outreach in the community.

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



	FY '19-'20	1st Qtr '20-'21	1st-2nd Qtr '20-'21	1st-3rd Qtr '20-'21	1st-4th Qtr '20-'21	Goal
Total Referrals	385	89	164	257	389	
Connected to Adult Outpatient Team	130	20	40	67	83	150

5. Summarize the Results of Actions Taken:

The total number of referrals connected to adult outpatient teams in FY 19-20 was 385 with 130 individuals connected to adult outpatient teams. The workplan goal for FY 20-21 was to increase linkage to adult outpatient teams by 15%, which would be 150 individuals. This goal was not met as there were only 83 individuals connected out of 389 referrals.

6. Plan for Current Goal:

☒ Change goal

In an effort to ensure system access to the hard-to-reach individuals the Bakersfield Referral Team and the Community Referral Network will increase linkage of individuals to Specialty MH outpatient teams and Community MH providers by 15%

GOAL# 17 Outreach Efforts to the Homeless and Hard to Reach - TAY

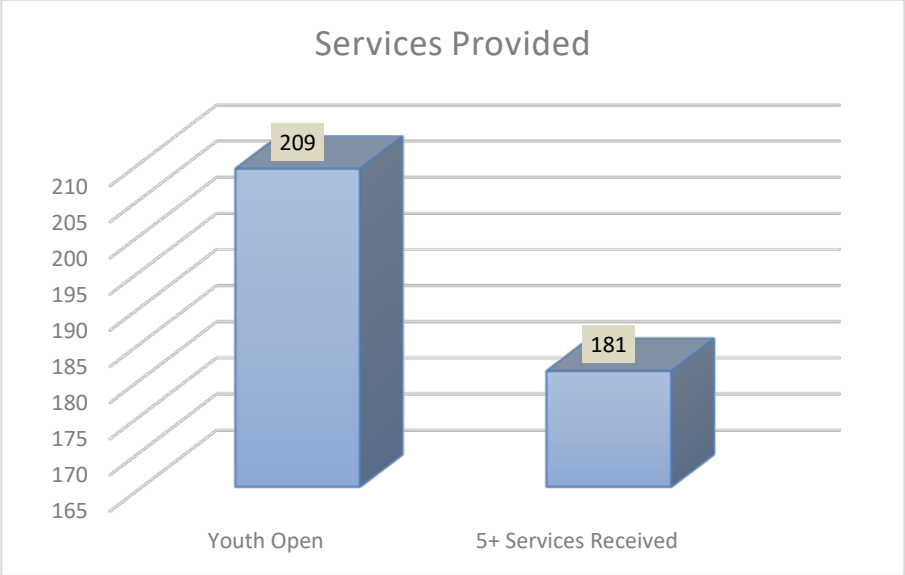
1. Quality Improvement Goal:
   At least 70% of transitional age youth will demonstrate treatment engagement by participating in 5 or more specialty mental health services.

2. 2020/2021 The Goal Was:

   ☒ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   1. Met with clients face to face in their homes and Dream Center.
   2. Assisted clients with community-based services including transportation for linkage to community resources.
   3. Implementation of Zero Suicide model. Education to clients and collaborative partners regarding importance of increased contact to engage the client in SMHS to maintain safety. Collaborative partners with incentives (e.g. housing, financial support) required or encouraged these clients to participate in intensive SMHS.
   4. OSA is sending clients text messages the previous business day for appointment reminders.
   5. Reminding clients of all their scheduled appointments for the week during scheduled contacts to increase kept appointments.
   6. Completed authorization to release confidential information with emergency contacts (e.g. family, partners, friends) to relay messages to contact TAY team and/or inquire about the client's whereabouts.
   7. Provision of services to youth at their preferred locations (home, park near home, work), while practicing safe social distancing, to increase likelihood of kept appointments and engaged youth.
   8. Collaboration with Dream Center and partnering with them to link clients back to TAY when they visit Dream Center.
   9. Increased collaboration with community partners to hold team meetings to discuss the benefits of participation in TAY services and consequences in some cases for nonparticipation (e.g. losing funding eligibility for extended foster care or transitional housing program).
   10. Utilized TIP model to increase engagement in services which includes meeting with youth at times most convenient for them and allowing them to set the menu of services.
   11. Several homeless and hard to reach youth did not have working phones or addresses which made contact difficult. The team has worked to assist the youth with acquiring government subsidized phones. Also, the team has worked to complete home or field visits.
   12. Linkage to TAY Dual Recovery Program at Third Tradition Sober Living Environment for support with addressing substance use needs, maintaining temporary placement while planning for permanent placement, and increased contact with clients while participating in TAY Dual Recovery Program.
   13. Worked to identify specific strategies to address needs due to COVID-19 which include: More face-to-face contacts significantly increased number of contacts and length of sessions; TAY staff have gone out to visit clients outside of Dream Center while practicing COVID-19 safety precautions; used runner (TAY RSA) to visit clients at home to reengage them in services; and utilized both in person and tele-health to maintain contact.

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



Between 7/1/2020-6/30/2021 there were a total of 209 youth participating in Transition Age Youth (TAY) services. Out of those youth, retention for behavioral health services reached 87% (181 of the 209 TAY received 5 or more SMH visits during the Fiscal Year 20/21).

5. Summarize the Results of Actions Taken:

The TAY team exceeded the goal of retaining 70% of the transition age youth hard to reach and homeless population, with 87% participating in at least five SMHS during FY 20/21. To obtain these outcomes over this past year the TAY team has focused interventions in the below areas:

1. Provided intensive services to at risk youth including at least three SMHS weekly and frequent home visits when phone contact was not possible proved helpful in achieving the goal by increasing the probability of making contact and providing SMHS. The team has started implementation of zero suicide model which has highlighted the importance of engagement in intensive services to clients and contributed to increased SMHS.
2. The team's use of the Transition to Independence Process (TIP) Model unique engagement strategies was helpful in achieving the goal by providing specialized high-quality care to at risk youth for example using a non-judgmental approach, respecting personal choice, engaging youth in activities of their interest, and meeting them at their preferred locations, date, and times.
3. Utilized intensive care coordination assisted the team with meeting this goal by involving community partners and natural supports to engage youth in services including reviewing benefits and consequences with clients about their level of participation in SMHS.
4. The team provided SMHS by safely visiting homes or Dream Center which increased access to clients that are difficult to engage by meeting in their preferred locations.

6. Plan for Current Goal:

☒ Discontinue goal

GOAL #18 Outreach Efforts to the Homeless and Hard to Reach - VSOP

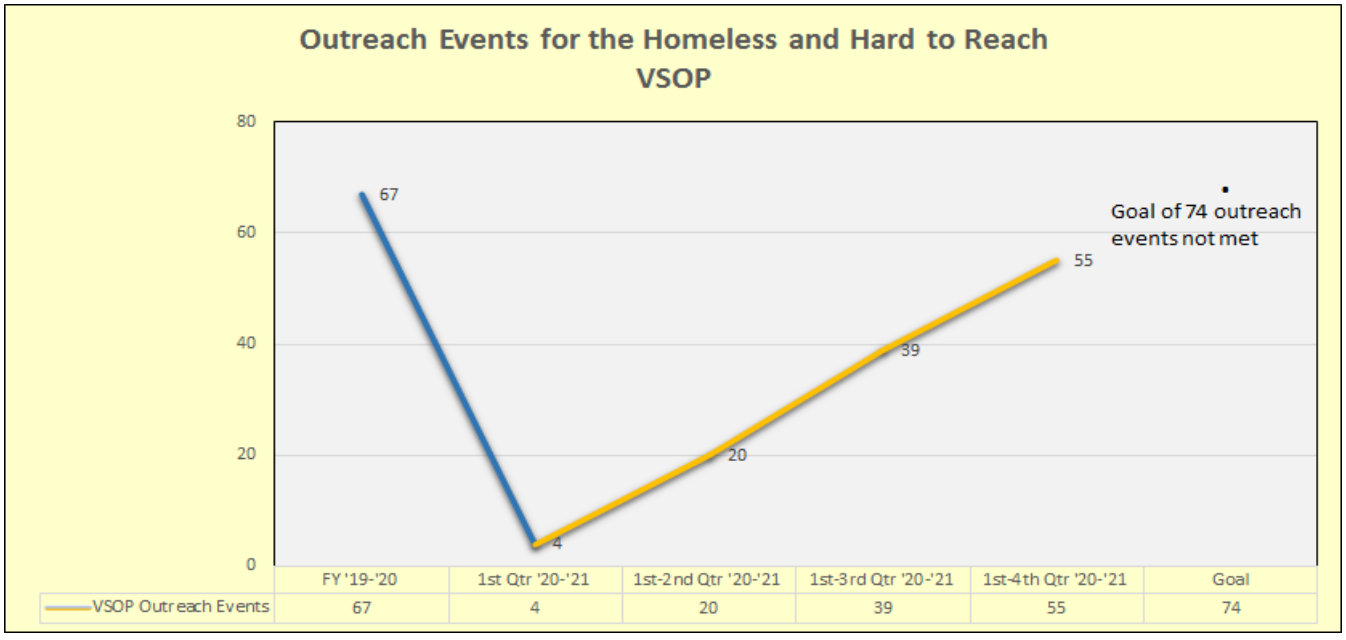
1. Quality Improvement Goal:
   In an effort to ensure system access to the hard to reach individuals The VSOP team will increase outreach efforts by 10%

2. 2020/2021 The Goal Was:

   ☐ MET ☒ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   Due to the pandemic, the traditional outreach events were modified to virtual events, which took time to coordinate in the various VSOP communities (Bakersfield, Lake Isabella, and Tehachapi). During our monthly VSOP meetings, the group problem-solved and discussed ways to provide information about the program to the community. The teams identified new resources including the faith-based community, medical offices, and homeless shelters by sharing our flyers with information about the program. Once more virtual meetings became available, the teams attended those meetings and presented information on the program. Outreach events included:
   1. Monthly Kern Valley Professional Forum meetings (Virtual and in person)
   2. Kern Valley Collaborative meetings (Virtual and in person)
   3. Commission on Aging meetings (Virtual and in person)
   4. Oildale Community Collaborative meetings (Virtual and in person)
   5. KCSOS Virtual Resource Fair (Virtual)
   6. Home Safe MDT meeting (a new collaboration between Flood, the Housing Authority, and AASD) (Virtual)
   7. Chamber of Commerce luncheon (in person)
   8. Networking with Adventist Health in Tehachapi in person)
   9. Aging and Adult Services meetings (Virtual)

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



5. Summarize the Results of Actions Taken:
We did not reach our goal of 74 outreach events during the fiscal year. We had 55 outreach events for the three VSOP sites, which was short by 19 events. As a result of the COVIS-19 pandemic during the past year, the teams were not able to attend the same amount of in-person outreach events, visit various senior housing facilities/units, or meet with health care providers, which has resulted in a significant decrease as compared to past years.

6. Plan for Current Goal:
☒ Discontinue goal

GOAL# 19 Provider Appeals

1. Quality Improvement Goal:
   100% of Provider Appeals will be resolved in a timely manner

2. 2020/2021 The Goal Was:
   ☒ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   Updated appeals policy and developed tracking reports and templates.
   Providers are notified of the appeals process found in the agreement.

4. Data Used to Measure the Outcome of this QI Goal:
   Number of Appeals = 0

5. Summarize the Results of Actions Taken:
   KernBHRS Finance division ensured 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.

6. Plan for Current Goal:
   ☒ Keep the goal with no change for the upcoming year

GOAL# 20 Psychiatric Consultations

1. Quality Improvement Goal:
   Medical Staff will perform 115 no cost consultations during fiscal year 20/21.

2. 2020/2021 The Goal Was:
   ☒ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   The department continues to see that the curbside consult mechanism for increasing consultations has been effective, COVID-19 and remote work orders has impacted this in new ways. We maintained our virtual presence in primary care clinics within the community to ensure continued no cost consultative support. The format of face-to-face / physical presence or co-location has been the key to increased consultations, and we saw a decline in this due to remote work. Beginning in June 2020 the Psychiatric provider for Adult Curbside Consults was changed, we anticipate an increase in Curbside Adult consults for FY 2020-2021.

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

Consults FY 2020-2021													
Consultation Type	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	Totals
E-consult Adult	0	0	0	0	0	0	0	0	0	0	0	0	0
E-consult Child	0	0	0	0	0	0	0	0	0	0	0	0	0
Curbside Adult	0	0	0	0	0	0	0	3	0	0	0	0	0
Curbside Child	8	6	11	6	14	5	7	12	18	16	8	11	122
												Sum	122

5. Summarize the Results of Actions Taken:
   We discovered that the Psychiatrist consulting for Curbside Adult continued to decline during the year. We brought forth reminders at the provider and executive levels for the co-located clinics. Despite this we did not see a notable increase in utilization. We asked for feedback and were told that the needs of the primary care providers were being met. The department will re- visit the flyer advertising for these services and will promote this no cost service through the Managed Care Plans.

6. Plan for Current Goal:
   ☒ Discontinue goal

GOAL# 21 QI when Negative Clinical Outcome: Mortality and Morbidity (M&M) Summary

1. Quality Improvement Goal:
   The M&M Committee will review 100% of adverse events.

2. 2020/2021 The Goal Was:

   ☒ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   1. The M & M committee saw an overall increase in unusual occurrence reports related to deaths or serious suicide attempts over the last year. Despite this increase, the committee continued to review 100% of all events reported.

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

	Events Reported	M&M Committee Reviewed	Pending Review	M&M Admin Review	# events reported but Adverse Event Summary not received
FY 20-21 Q1	32	23	9	N/A	3
FY 20-21 Q2	33	15	14	N/A	4
FY 20-21 Q3	63	6	29	28	5
FY 20-21 Q4	59	0	34	25	11

5. Summarize the Results of Actions Taken:
   1. The M & M Committee shifted all meetings from in person to virtual to ensure continued reviews were occurring throughout the pandemic. When the committee was unable to meet in the early months of the pandemic, 100% of the cases were reviewed by the M & M committee chair.
   2. Committee reviews began to included committee members meeting with the treatment providers when they were reviewing cases to obtain a more complete clinical picture above what could be obtained from the EHR. This also served to remind teams about the M & M process and how vital it is for them to complete the adverse event summaries so these events could be reviewed by the committee.

6. Plan for Current Goal:
   ☒ Discontinue goal

GOAL# 22 Site Certification

1. Quality Improvement Goal:
   Ensure that all county owned/operated and contracted organizational providers providing Specialty Mental Health Services are certified and recertified per title 9 regulations.

2. 2020/2021 The Goal Was:
   ☒ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   Since the beginning of the COVID PHE in March 2020, all the certifications were done under the flexibilities issued by the State. These flexibilities allowed for certification paperwork to be submitted without a fire clearance and evidence of an onsite review. Once the PHE is lifted, we will have 6 months to obtain all updated fire clearances and to complete all onsite reviews.
   Quality Monitoring (QM) Team submitted a software project request to IT to design a web application for all site certification data/information to be stored and readily accessible. This will enhance our team's ability to efficiently track and monitor compliance of all certification requirements

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

FY20-21 Certifications/Recertifications
These were all completed under COVID-19 PHE Flexibilities. The onsite reviews will be conducted, and fire clearances gathered and submitted within 180 days of the PHE being officially lifted

Type of Certification	#Required	#Completed
New Certification	6	6
Triennial Recertification	10	10
Recertifications (adding suites, activating Provider Number)	2	2
TOTAL	18	18

5. Summarize the Results of Actions Taken:
   The QM Team has developed an implementation plan to complete all certifications once the flexibility is lifted to ensure that all these site certifications are completed within the 6-month timeframe.

6. Plan for Current Goal:
   ☒ Discontinue goal
   To better utilize this information to improve the system, we are moving this report to the QIC sub-committee Regulatory Compliance Committee .

GOAL# 23 SUD Access Line Test Calls

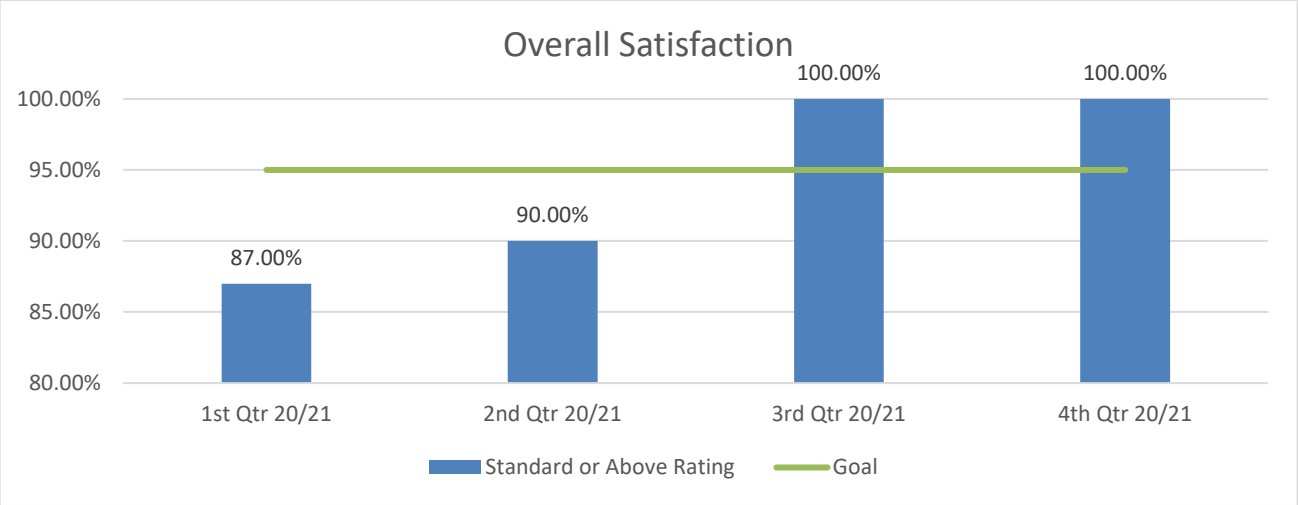
1. Quality Improvement Goal:
   95% of all access test calls will be given a customer service rating of standard or above.

2. 2020/2021 The Goal Was:

   ☐ MET ☒ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   The SUD Supervisor of the GATEWAY Team met with staff and provided additional trainings to improve areas that were contributing to the "Overall Satisfaction" rating not meeting the goal.
   The SUD and QID administrator added a question specifically asking overall satisfaction in Quarter 3. Quarter 1 and 2 were measured by the average of 5 satisfaction type questions.

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



5. Summarize the Results of Actions Taken:
   The SUD Access Line Test calls are completed by QID staff on a quarterly basis. The results are submitted to the SUD Administrator and GATEWAY Supervisor. The results of the satisfaction survey show that the SUD Supervisors increased focus and training of staff, continually improved client satisfaction. The change in what is being measured allowed for a true overall satisfaction rating.

6. Plan for Current Goal:
   ☒ Keep the goal with no change for the upcoming year

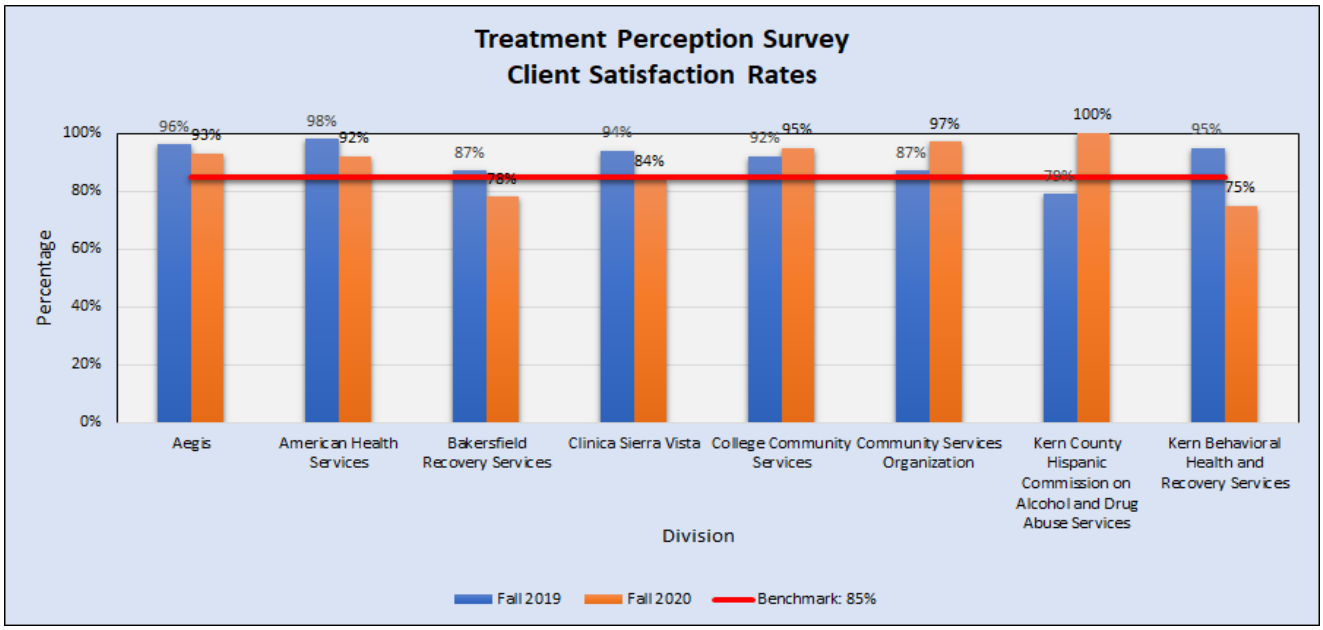
GOAL # 24 SUD Adult Satisfaction TPS

1. Quality Improvement Goal:
   Each SUD Adolescent and Adult service provider will each achieve a minimum satisfaction rating of 85% or greater on the Treatment Perception Survey.

2. 2020/2021 The Goal Was:
   ☐ MET ☒ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   The Substance Use Division Administrator added additional Point in Time Surveys on a regular basis to get more frequent feedback on satisfaction.

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



5. Summarize the Results of Actions Taken:
   The Quality Improvement Committee reviews the Treatment Perception Survey (TPS) on an annual basis. In FY 20/21 the survey was completed by phone. In addition to adding more frequent surveys, the SUD Administrator is communicating results to the providers that have lower compliance rates. Overall, the low number of surveys obtained significantly lowered many of the Providers Satisfaction Rates. The providers were directed to work with staff to be more welcoming, which had the greatest impact on the satisfaction survey.

6. Plan for Current Goal:
   ☒ Change goal
   This goal should be changed to, "The Substance Use Division and it's contract providers will achieve a cumulative minimum satisfaction rating of 85% or greater on the Treatment Perception Survey." This change will be more reflective of the overall satisfaction of the system that is not gathered in the "SUD Point in Time Surveys." The Point in Time Surveys are also reported in the Annual Workplan.

GOAL# 25 SUD Outcome Measures – Access Line

1. **Quality Improvement Goal:**
   At least 30% of individuals contacting the SUD treatment access line through Gateway will attend assessment.

2. **2020/2021 The Goal Was:**
   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   Beginning in October 2020, the RISE and START case management teams began conducting assessments for clients to facilitate access into treatment, as there are very high rates of no-shows to appointments across the provider network. These assessments are conducted for clients for which the case management teams already have some level of engagement, and it was anticipated this would increase the likelihood of successful linkages. A review of the START team's data revealed that very few cases were being successfully linked to their assigned SUD provider, so the supervisor began emphasizing providing support for this initial appointment as a higher priority.
   Reminder calls from Gateway continued in attempts to increase successful linkages. Other potential solutions considered were transportation support on the day of the appointment or connecting to case management staff that may be available at the time of the reminder call. Gateway staff link to available CM staff when available at the time of the call; however, transportation support was not implemented by the Gateway team due to staffing concerns. Case management staff provide ongoing support and transportation to clients, which is expected to increase in July 2021 once staff return to site full time. Additionally, on 5/18/21, Gateway began providing reminder texts to clients on to increase attendance to assessment appointments.

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

	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 20	Mar 21	April 21	May 21	Jun 21	Average
Total referred	656	664	745	706	660	728	611	712	826	841	754	772	8675
Total attended	211	247	284	288	251	218	192	200	283	293	275	289	3031
Successful linkage	32.16%	37.20%	38.12%	40.79%	38.03%	29.95%	31.42%	28.09%	34.26%	34.84%	36.47%	37.44%	34.94%

5. **Summarize the Results of Actions Taken:**
   When the Mini Assessment Center (MAC) began in October there was over a 2% increase in successful linkages for the month of October 2020. Successful linkages appear to have decreased around the holiday period. In March 2021, with more case management support, percentages of successful linkages began to increase and remained steady through the remainder of the year. Any impact from text reminders will begin to be evaluated 2 months from implementation date. From July 2020 to June 2021 34.94% of clients were successfully linked to treatment, exceeding the goal of 30% by 4.94%. The SUD division will continue to explore ways to increase attendance to assessment appointments and will increase the goal for next year to 40%.

6. Plan for Current Goal:

☒ Change goal

Goal to increase to 40% to improve attendance to assessment appointments as number of successful linkages have started to increase with more case management services.

GOAL# 26 SUD Outcome Measures – Length of Stay

1. Quality Improvement Goal:

   In fiscal year 20/21 the average length of stay for Intensive Outpatient will be greater than or equal to 40 days.

2. 2020/2021 The Goal Was:

   ☒ MET ☐ NOT MET

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

   SUD Administration obtained input from 2.1 IOT providers to inquire about challenges with providing intensive outpatient services and thoughts on reasons for wide variation in length of stay from month to month. Caseload reviews indicated that most individuals referred to this level of care are also deemed to need residential treatment, which may interrupt the treatment episode. If an individual is informed that a residential bed is now available, he or she will be linked and leave the 2.1 level of care suddenly. Residential bed capacity and utilization was monitored in relation to this level of care and length of stay. Feedback to 2.1 providers was on engagement and individualization of treatment plans to assist clients in meeting shorter term goals while they await a residential bed.

   SUD Administration continued to monitor the above information monthly. The Compliance Documentation team resumed chart audits in October of 2020 and provided feedback to providers about individualizing treatment plan objectives to accommodate clients' needs. Additional residential beds were expected to affect length of stay in 2.1 Intensive Outpatient, and additional feedback was given to providers to ensure that their clinical staff assess appropriately for this level of service.

   As pointed out in the recent SUD EQRO review, utilization is low, and a recommendation was made to examine housing support options for clients in 2.1 level of care services. One recent addition in 2.1 services includes adolescent services in Ridgecrest and Delano, so as clients come into this new level of care, their length of stay has been monitored as well.

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

Intensive Outpatient	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Average
Length of Stay (days)	40.6	149	73.9	139.3	85.3	78.7	89.8	57	74.4	30.6	28.6	57.4	72.7

5. Summarize the Results of Actions Taken:

   The Documentation Compliance Team indicated no major trends or concerns seen in this level of care, during reviews in Quarter 1 of 20-21. As observed in the data above, the length of stay continued to vary widely from one month to the next based on a limited number of discharges. With ongoing monthly monitoring, the overall length of stay continued to vary from month to month throughout the remainder of the fiscal year, but on average, it has remained longer than it was in July of 2020. Progress continues to be made in retaining clients in this level of service.

   With the increase of residential bed availability and additional adolescent services in Ridgecrest and Delano, there has not been a trend of an increase in length of stay.

6. Plan for Current Goal:

   ☒ Discontinue goal

   Will discontinue goal as it has been consistently met over the last two years and will continue to encourage providers to utilize it and work toward 90 days in the outpatient level of care.

GOAL# 27 SUD Outcome Measures – Penetration Rate

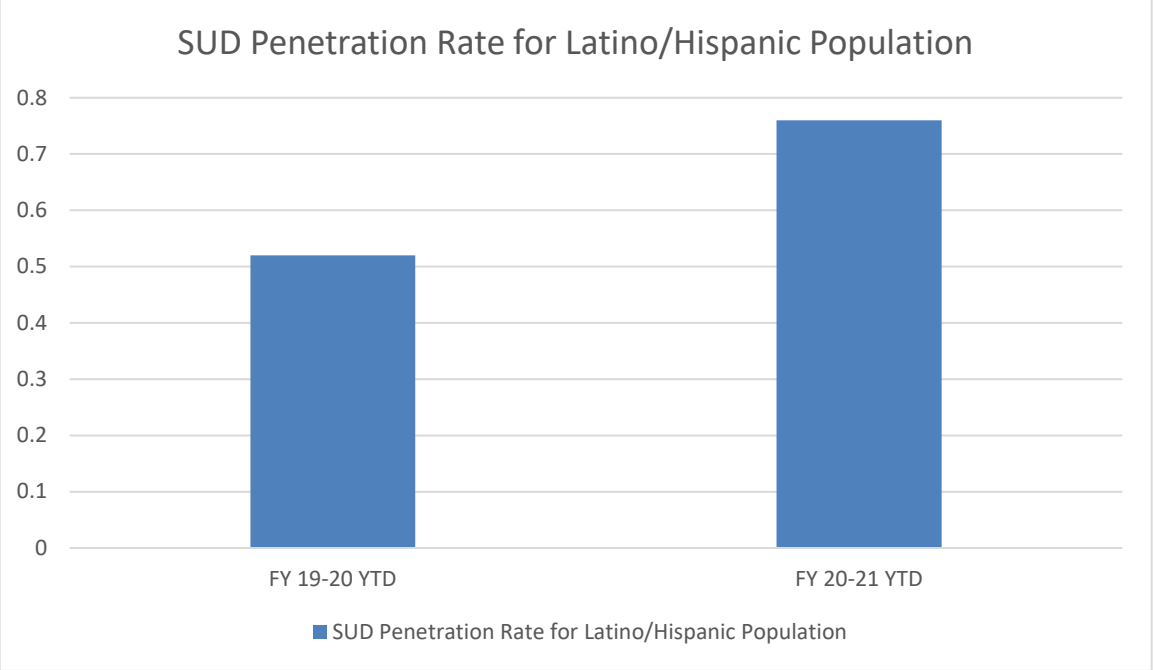
1. Quality Improvement Goal:
   Increase penetration rate of the Latino/Hispanic population into SUD treatment from .52% to .57% by implementing culturally sensitive outreach and engagement strategies.

2. 2020/2021 The Goal Was:
   ☒ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   1. Developed Workgroup Meeting Monthly (CCRC, QID, SUD, MHSA/O&E & PIO).
   2. CCRC attended SUD KPIC to review data and identify improvement strategies.
   3. Strengthened Community Partnerships.
   4. Enhanced O&E & Public Materials/Social Media/Radio/TV activities and enhancements.
   5. Distributed English & Spanish materials in targeted areas where Latino/Hispanic population resides.
   6. Distributed SUD Access & Gateway materials/cards in Mental Health & SUD Events throughout the year.
   7. Increased cross-agency sharing of information on access, resources, and events.
   8. Participated in Mental Health Awareness Month in various community events in May.
   9. Provided 1000 Crisis Hotline and Gateway cards to community partners such as Delano Police Dept.
   10. Reviewed access points and added Referral Question: “How did you learn about us?” on Point in Time contacts.
   11. Created O&E listing of events, dates, etc. throughout the year to maximize opportunities to share information.
   12. Recruited and partnered with Cultural Competence Resource Committee members from Central Valley Promotoras, Vision Y Compromiso, Kern County Latino Task Force.
   13. Partnered with community agencies to provide education and outreach to Latino/Hispanic community.
   14. Created “Intervention Recipe” list, outlining action activities on outreach, access, and penetration of Latino/Hispanic community.

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

SUD - Penetration Rate Report: Goal Met- From .52 % to .76 %.



5. Summarize the Results of Actions Taken:

The actions taken this year to meet our goal focused on strengthening collaborative work between different divisions in our system of care and with community partners. We see that in the internal department workgroup that met monthly and created our "Intervention Recipe" list, reviewed our penetration rate data, and recruited community partners to our Cultural Competence Resource Committee. The Promotoras and Vision y Compromiso held a Spanish-language mental health townhall where we presented on our upcoming public outreach events and basics of how to access our system of care. For the next fiscal year, we strive to increase our SUD Penetration rate for the Latino/Hispanic population from .76% to .85% because that will put us on par with the other large California counties' goal. We aim to do this by increasing community partnerships who represent the diversity within the Latino/Hispanic population, including indigenous communities with roots in Latin America and through enhanced O&E that takes into account the various countries of origin for Latinos/Hispanics as well as generational and linguistic differences.

6. Plan for Current Goal:

☒ Change goal

Change penetration rate goal from .52 % to .85% for the year (Large County percentage)

GOAL# 28 SUD Outcome Measures MAT

1. Quality Improvement Goal:
   Track and trend the number of referrals to MAT programs from the SUD Access line and DMC-ODS network to obtain a baseline for utilization of this new service.

2. 2020/2021 The Goal Was:
   ☐ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   SUD Administration scheduled a quarterly meeting with both Clinica Sierra Vista and Omni Family Health to discuss MAT programs at their respective sites, update one another on the number or providers available to treat opioid use disorders in primary care, and to clarify referral processes and information. Although the data was difficult to gather by CSV and Omni, both expressed that additional data points would be helpful to share (number of new patients per month, number of encounters, total number of referrals from the SUD Access line and referrals from DMC-ODS network providers). Additional requests were made for data, but this has been challenging to obtain due to limited responses and attendance from participants during meetings.

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

July 2020-March 2021	Referred to Clinica Sierra Vista	Referred to Omni
KernBHRS	29	18
SUD Providers	47	6
Total	76	24

July-Dec 2020	Total receiving MAT services	Total referred to KernBHRS
Clinica Sierra Vista	---	---
Omni	65	9

   The total number of people referred to MAT programs from the KernBHRS SUD Access line was 76 and the total referred from contracted providers was 24, for a grand total of 100. Although this is small number, it demonstrates that staff and providers are aware of this new resource in our community.

5. Summarize the Results of Actions Taken:
   Although relationships between KernBHRS, CSV and Omni remain collaborative, it has become difficult to obtain a result on whether individuals referred for these services actually engage or continue in treatment. It has also been difficult to gage whether the individuals that are receiving these medications in primary care are in need of additional treatment, or are obtaining support from the medical staff (Omni), or the behavioral health staff onsite (mild to moderate BH Services at CSV). Despite these challenges, the quarterly gathering will continue in order to maintain lines of communication open and continue efforts to reduce stigma of treating of opioid use disorder in various settings.

6. Plan for Current Goal:
   ☒ Change goal
   A baseline was obtained for Fiscal Year 20-21, and SUD Administration will continue to monitor with the following change: “Increase the number of referrals to community-based MAT providers by 5% (from 100 to at least 105) for FY 21-22”

Goal# 29 SUD Points in Time Surveys

1. **Quality Improvement 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. **2020/2021 The Goal Was:**

   ☐ MET ☒ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   In order to obtain a more representative sample from surveys, it was requested from providers that they inform our peer when someone was nearing discharge so a survey could be completed, and Recovery Services could be offered. This process was presented during the September SUD provider meeting. The peer staff is now tasked with sending reminder emails in order to prompt providers to share this information. This helped to increase the number of surveys collected, and better comments from all providers were gathered.

   The PIT survey results were discussed with individual providers during newly created Bi-Monthly check in meetings with SUD Administration. This process began in January of 2021, and providers have appreciated receiving the data. It will be important to continue to address specific comments with providers, as some are specific and can lead to discussion among staff to continue to improve quality of care.

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

	7/20	8/20	9/20	10/20	11/20	12/20	1/21	2/21	3/21	4/21	5/21	Overall rating
Admission	81.3%	93.8%	89.4%	83.9%	93.2%	100%	96%	89.3%	86.1%	83.6%	89.4%	89.64%
During Treatment	81.8%	89.8%	86.5%	86.5%	100%	95.8%	92.6%	97.1%	86.3%	77.8%	100%	90.38%
Discharge	---	---	50%	100%	87.5%	100%	77.3%	54.2%	83.3%	64.3%	83.3%	78%
Follow-up	100%	87.5%	86.7%	80%	75%	100%	78.6%	81.8%	85.7%	100%	75%	86%

5. **Summarize the Results of Actions Taken:**
   As more surveys are collected, a more representative sample of all providers has been obtained. Most clients seem to be satisfied with their treatment episode, share positive feelings about their connection with staff and being able to make positive changes in their life. The only area that did not meet the goal of 85% positive rating was the Discharge point in time. This could be because the sample was still too small, or because clients left treatment realizing that they did not get all that they needed or things did not end as expected. This goal will continue to be monitored in order to capture a larger sample and discuss more with providers what could be improved while clients are in treatment so that they report higher satisfaction by the time they are nearing discharge.

6. **Plan for Current Goal:**
   ☒ Keep the goal with no change for the upcoming year

GOAL# 30 TBS Utilization

1 **Quality Improvement Goal:**

Continue to meet state standard of 4% to provide Therapeutic Behavioral Services (TBS) to full scope EPSDT youth in order to decrease hospitalizations, placement changes, incarcerations, and crisis services.

2 **2020/2021 The Goal Was:**

☐ MET ☐ NOT MET

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

1. Continue contract standard of 4% of M/C beneficiaries to receive TBS
2. Contract monitoring follow up with clinics to ensure standards are met
3. Ongoing review of TBS rate in monthly Provider's meeting
4. Review of high-risk youth in SMART, as well as, discharging from hospital for appropriateness of service
5. Notice sent including BH Info Notice #20-009 from DHCS that includes direction on the continued provision of TBS during COVID-19 pandemic
6. College Community Services is working to develop internal monitoring processes
7. KernBHRS, East Bakersfield Outpatient, added TBS as a standing agenda item at team meetings to identify new assessments needed and review of data showing progress toward goals

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

Total Unique Clients Served		7416
Unique TBS Clients Served	Total number of clients that received services billed as TBS	352
TBS Equivalent Cases**	Clients that received services as part of the teams approved by Special Master	153
% of Clients Receiving TBS Services	Unique TBS clients + TBS Equivalent cases/Total Unique Clients Served	6.80%

**TBS Equivalent Cases – In April 2009, the Federal Court approved the Emily Q. v. Bonta Exit Plan and authorized the evaluation by the Special Master of a TBS-equivalent services. KernBHRS has two Youth Wraparound teams that were approved by the Special Master and those cases are counted toward the total number of TBS clients served.

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

The outcomes of our interventions demonstrate that TBS utilization rates have continued to rise and meet the standard for FY 20/21. KernBHRS TBS penetration rate for unique youth served, including equivalency services, was at 6.8% and continues to indicate that TBS has become well integrated into the service delivery system. Close monitoring of provider contracts with plans of correction being requested when needed and review of high-risk youth continue to assist with improvement of the TBS utilization rate in Kern.

6 **Plan for Current Goal:**

☒ Discontinue goal

This goal has been consistently met over the last few years and continues to be monitored by our CSOC providers and through contract monitoring.

GOAL# 31 Unusual Occurrence Reports - Inpatient

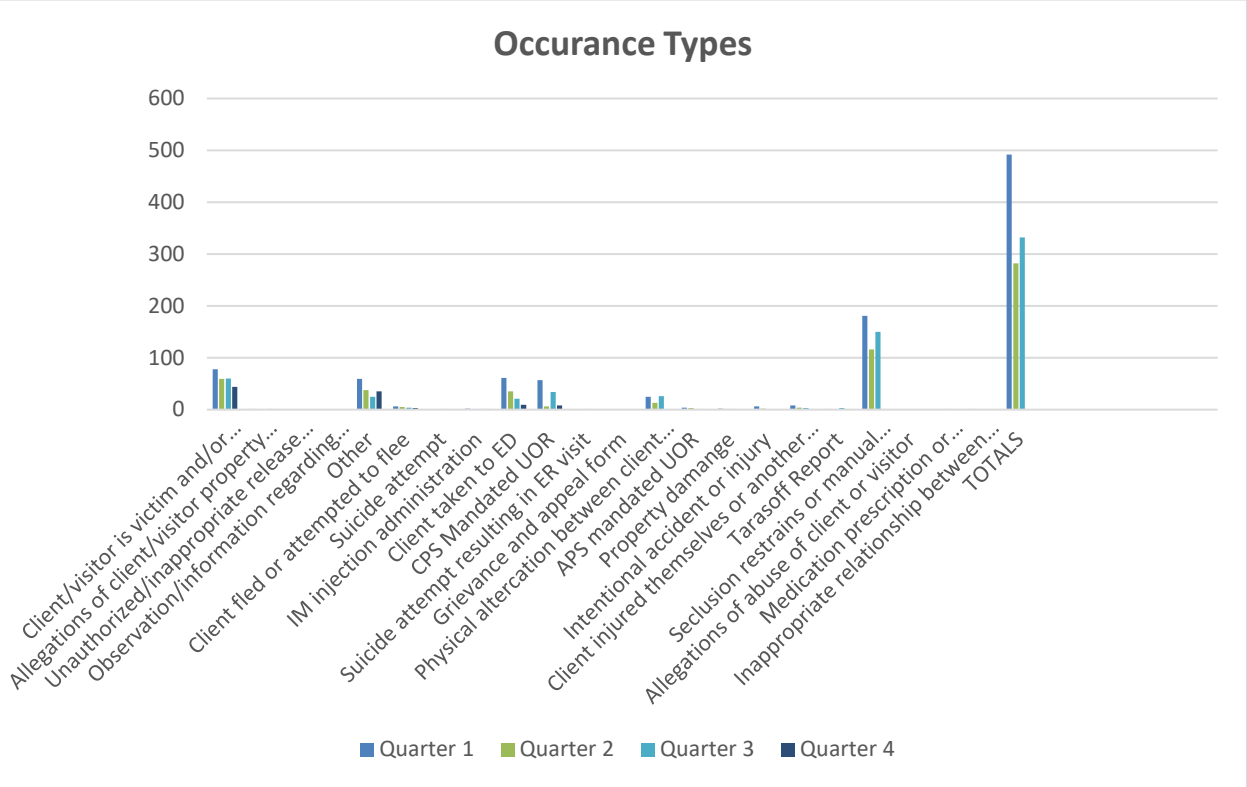
1. **Quality Improvement Goal:**
   100% of all Inpatient UOR will be address in an appropriate manner.

2. **2020/2021 The Goal Was:**
   ☒ MET ☐ NOT MET

3. **Quality Improvement Activities / Actions Taken Over the Past Year:**
   Crisis Services staff (support and Inpatient Supervisor) continue to monitor and track UOR's received from inpatient facilities. Any anomalies or egregious events are forwarded to the Crisis Services Administrator for additional review to determine if further action is required.

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

UOR's Received	1st QTR	2nd QTR	3rd QTR	4th QTR	YTD
	496	282	333	352	1,492



UOR Type By Facility – Q1/Q2/Q3					
	BBHH	Crestwood	Good Samaritan	Kern Medical	Total
Client/visitor is victim and/or perpetrator of assault	40/38/41/14	10/6/8/4	2/1/3/6	26/14/8/19	78/59/58/43
Allegations of client/visitor property loss	0/0/0/0	0/0/0/0	1/0/0/1	0/0/0/0	1/0/0/1
Unauthorized/inappropriate release of PHI	0/0/0/0	0/0/0/0	0/0/0/0	0/0/0/0	0/0/0/0
Observation/information regarding questionable or inappropriate staff behavior related to client/visitor care	0/0/0/0	0/0/0/0	0/0/0/0	0/0/0/0	0/0/0/0
Other	19/16/5/13	11/7/7/7	9/0/4/4	20/7/9/11	50/30/25/35
Client fled or attempted to flee	3/0/1/1	1/1/1/1	1/0/2/0	1/1/0/1	6/2/4/3
Suicide attempt	0/0/0/0	0/0/0/0	0/0/0/0	0/0/1/0	0/0/1/0
IM injection administration	1/0/0/0	1/0/1/1	0/0/0/0	0/0/0/0	2/0/1/1
Client taken to ED	58/32/21/7	3/2/1/1	0/0/0/0	0/0/1/1	61/34/23/9
CPS Mandated UOR	57/6/34/8	0/0/0/0	0/0/0/0	0/0/0/0	57/6/24/8
Grievance and appeal form	0/0/0/0	0/0/0/0	0/0/0/0	0/0/0/0	0/0/0/0
Physical altercation between client and peer	25/12/18/34	0/1/5/0	2/0/0/0	2/0/3/0	29/13/26/34
APS mandated UOR	4/3/1/0	0/0/0/0	0/0/0/0	0/0/0/0	4/3/1/0
Property damage	2/1/0/0	0/0/1/0	0/0/0/1	0/0/0/0	2/1/1/1
Intentional accident or injury	3/1/0/0	2/0/0/1	0/0/0/0	0/1/0/0	5/2/1/1
Client injured themselves or another person	2/3/3/1	0/0/0/0	3/0/0/5	3/1/1/0	7/4/4/6
Tarasoff Report	0/0/1/0	0/0/0/0	1/0/1/0	0/0/1/0	1/0/3/0
Seclusion restrains or manual containment	158/100/95/118	2/2/2/0	0/0/3/9	21/14/49/54	181/116/149/181
Allegations of abuse of client or visitor	0/0/0/0	0/0/0/0	0/0/0/0	0/0/0/0	0/0/0/0
Medication prescription or administration errors	0/0/0/0	0/0/0/0	0/0/0/0	0/0/1/0	0/0/1/0
Inappropriate relationship between patients	1/0/0/7	0/0/0/0	0/0/0/0	0/0/0/0	1/0/0/7

5. Summarize the Results of Actions Taken:

As a result of the Crisis Services Division's tracking and review efforts, all UOR's were recorded and reviewed.

6. Plan for Current Goal:

☒ Discontinue goal

GOAL# 32 Unusual Occurrence Reports - Outpatient MH

1. Quality Improvement Goal:
   100% of all MHP Outpatient UOR will be address in an appropriate manner.

2. 2020/2021 The Goal Was:

   ☐ MET ☒ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   1. QID reviewed all UOR submitted during the FY to ensure all incidents were being addressed appropriately and no additional actions steps were necessary to address incident or prevent future incidents from happening.
   2. QID sent recommendations letters to team and administrators when something in the UOR was not addressed appropriately, or when a team forgot to complete any required protocols.
   3. QID sent a total of 45 Recommendations this FY asking supervisor to please follow policy 10.1.25 Disclosure of PHI (41), complete certain forms after a patient is deceased (2), complete UOR promptly (1) and one for promptness of service (1).
   4. QID met with training services to discuss possibility of specific trainings for all staff to assist them in serving a client who may present with aggressive/threating behaviors as this was one of the highest types of UORs seen during this FY.
   5. To improve the timeliness of the reports, QID work with IT to create an automated biweekly email sent to staff when a report is over 14 days old. QID also sends a weekly reminder to supervisors and administrators who have pending reports to remind them to approve them.
   6. QID also worked with IT to create a feature that allows administrators to send feedback to supervisors if the team needs to complete additional actions to address the incident.
   7. QID also met with contracted providers to not only provide training on the app and completing the forms but also to explore barriers in those teams completing the forms in the app as certain providers had minimal to no reports submitted in the previous FY.
   8. QID contacted specific supervisors who had multiple pending forms to expedite completion of the forms and explore possible barriers or discuss ways to ensure reports are submitted timely.

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

UORs FY 20-21					
QTR	KernBHRS	Contract Providers	Total Submitted	Total # Addressed Appropriately	GOAL 100%
1Q	196	101	297	273	92%
2Q	179	141	320	286	89%
3Q	231	152	383	366	96%
4Q	216	188	404	390	97%
Annual Total	**822**	**582**	**1,404**	**1390**	**99%**

Reasons for goal not met for each quarter are not due to teams addressing incidents inappropriately but rather due to timeliness as the reports were not completed on time and action steps or steps taken by the team were not able to be reviewed at time of QIC reports.

5. Summarize the Results of Actions Taken:
    1. QID found teams are responding correctly to the incidents; only 1 of the reports had an area of improvement. The team and administrator were informed of the actions needed to improve the service provided to the client.
    2. After our meeting with one of our contracted providers, we saw an increase in reports submitted by teams from the provider.
    3. Our training department has started to bring crisis and de-escalation trainings for all outpatient providers.

6. Plan for Current Goal:

    ☒ Change goal

    Due to timeliness issues with completion of reports each quarter, and the need to monitor that the teams addressed those incidents in a timely manner, QID recommends making changes to the goal to include that these reports are completed within 14 days from incident. The new recommended goal is: 100% of all MHP Outpatient UORs will be addressed in an appropriate manner and will be completed and submitted to QID within 14 days from incident.

GOAL# 33 Unusual Occurrence Reports – SUD

1. Quality Improvement Goal:
   100% of all SUD Outpatient UOR will be addressed in an appropriate manner.

2. 2020/2021 The Goal Was:

   ☐ MET ☒ NOT MET

12 Quality Improvement Activities / Actions Taken Over the Past Year:

1. QID SUD monitored 100% of UORs in the app at least biweekly to ensure they were completed in a timely manner, were processed appropriately and correctly, and were reviewed and signed by the responsible parties.
2. QID SUD provided recommendations and feedback for improvement (e.g., reminders were sent when reports had pending signatures or needed further action such as the submission of M&M Reports when required).
   a. One example of follow-up included an incident where client protected health information (PHI) from a lab was mistakenly sent to the wrong service providers. Our KernBHRS Privacy Officer followed up with the lab and DHCS, who concluded there was no breach of PHI. No quality-of-care recommendations were needed in this case.
3. QID SUD provided targeted training to contract providers and internal SUD Teams to clarify requirements and ensure that all UORs are appropriately submitted.
4. QID SUD implemented a quarterly tracking sheet to record trends, timeliness, final status/resolution, and recommendations offered for UOR improvement.

How did we use the available information/data to make things better?

The weekly UOR reviews provided valuable information about the most common UORs being submitted, including how appropriately and timely they were processed, reviewed, and signed. With this information QID SUD:

1. Identified and selected the top three (3) common UORs (Deaths, Suicide, and Abuse/Neglect) to track and report on trending occurrences to providers, KernBHRS Teams, and Administrative staff in a position to respond to these occurrences (e.g., consider appropriate quality of care actions, changes in policy or contract language, or offer special training or technical assistance).
2. Used the UOR App data to check and remind about missing signatures, appropriate reporting, and follow up requirements or suggestions (e.g., reporting deaths to M&M Committee, mandated reporting, reporting to DHCS, reporting to KernBHRS Privacy Officer).
3. Initiated quality improvement activities (i.e., targeted training and follow-up actions) during the year to enhance provider's understanding of UOR submission procedures and requirements, to ensure compliance, and to avoid repeating same reporting missteps.
4. Potential quality of care issues were identified and discussed with the appropriate internal Teams and contract providers to encourage the timely resolution of any deficiencies in the UOR process.

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

FY 2020-21	Total FY	Inappropriate	% Appropriate	Goal Met
	119	8 incomplete	93%	No

1. The number of UORs spiked significantly during the 2nd quarter due to the following:
   a. Four programs just started reporting UORs in the 2nd quarter
   b. One contract provider reported 8 UORs from one incident involving the misrouting of PHI by a lab. KernBHRS Privacy Officer and DHCS were notified, and it was determined there was no breech.
2. Annual aggregate data shows the following top three (3) most frequently reported types of UORs:
   a. Deaths other than Suicide: 23 (19%)
   b. Suicide – Deaths/Attempts/Threats: 21 (18%)
   c. Abuse/Neglect incidents: 19 (16%)
3. Other findings noted:
   a. The Gateway Team experienced a high rate of UORs, which often involved suicide threats/attempts, and other crisis related situations during individual's initial contact with the Team, including the Access Line.
   b. Contract providers experienced 18 of the 23 total reported Deaths/other than Suicide.

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5. Summarize the Results of Actions Taken:

KernBHRS SUD maintained a 93% rate in UORs being appropriately processed and addressed, which can be attributed to the following:

1. Weekly ongoing careful review of all UORs by QID SUD, including follow-up with providers to make them aware of procedural, timeliness, and appropriateness issues that affected compliance.
2. Presentations by QID SUD on UOR process at QQID quarterly meetings, and other provider meetings resulted in greater awareness of UOR reporting requirements.
3. Offered and conducted UOR training to selected providers to address procedural and appropriateness issues.

How will we use the data/information in the future? (based on what we have learned)

1. To track any growing concerns and continue to examine all UOR data for significant patterns that can be resolved through special response and actions to improve client quality of care.
2. Share/distribute UOR information with Teams and providers and solicit feedback on ways to improve reporting and assess for potential impact on clients. Use the QID SUD Newsletter, initiate direct communication with individual providers, and attend Waiver Meetings, Monitoring Meetings, Provider's Meetings, and QQID Meetings to brief providers on UOR issues.
3. Continue to offer targeted training to Teams and contract providers based on UOR findings (i.e., significant issues/trends in process and quality of care issues).
4. For big issues identified through the ongoing UOR review process, bring the concern to Administration to consider training or any needed changes in policy or resources, in response to the concern in areas such as suicide prevention, and crisis intervention, M&M reviews, or mandated reporting.

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6. Plan for Current Goal:

☒ Keep the goal with no change for the upcoming year

GOAL# 34 Utilization Management MHP

1. Quality Improvement Goal:
   95% of all reviewed MH assessments will have an appropriate determination on Medical Necessity documented.

2. 2020/2021 The Goal Was:

   ☒ MET ☐ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   1. Authorization for services is done by all clinicians in the teams by completing initial assessments or annual reassessments. QID's LPHA reviews a sample of 10 assessments/reassessments from all MH internal and contract providers/teams to ensure staff is assessing medical necessity for services appropriately for each client. QID LPHA also reviews to ensure the recommended treatment or referrals when someone does not meet criteria for services are appropriate based on the client's presenting issues.
   2. These audits are completed quarterly, however due to Covid restrictions and staffing patterns, QID was only able to do 2 LPHA quarter reviews this fiscal year. QID LPHA reviewed a total of 982 evaluations and found that only 1 client did not have the appropriate determination.
   3. QID also completes chart audits in which we review assessments and specifically have a question inquiring if the assessment documents medical necessity. During our chart audits for this FY, we reviewed an additional 468 assessments in which we found that only 1 assessment did not justify medical necessity.
   4. QID presented findings of the LPHA reviews during our quarterly QQID and QIC meetings to inform the system of trends or areas of improvement within their assessment including documentation of medical necessity. QID also contacted specific supervisors and administrators when errors or areas that required immediate attention were identified.
   5. QID provided monthly assessment training for all new LPHAs to ensure they are aware of the criteria necessary to meet medical necessity, and when to refer someone out to the community. During the assessment training, staff is trained not only on medical necessity but also trained on the different level services and recommendations based on the level of care to ensure all patients receive the appropriate treatment
   6. Teams were also given feedback in the qtr. chart audit reviews of errors in charts, including when a chart does not meet medical necessity and were asked to make corrections.

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

FY20-21	Division	Teams	Reviewed	Appropriate MN	No Appropriate MN	Goal 95%
2Q	10	47	468	467	1	Met
3Q	10	51	478	477	1	Met
4Q	10	53	504	504	0	Met
Annual Total			1450	1448	2	Met

5. Summarize the Results of Actions Taken:
    1. Due to having a QID LPHA Clinician this year, QID was able to do a clinical review of assessments rather than just reporting on chart reviews completed by our QID team.
    2. The number of reviews completed by the LPHA increased from last year's 134 assessments to 982 this FY with a total of 1450 assessments reviewed by all QID staff.
    3. 2 assessments reviewed by QID were noted as not meeting medical necessity. One of them was open less then 60 days and the evaluation had not been completed. The second one presented as needing Substance Abuse treatment and team was contacted to evaluate client appropriately and transition to provider as needed.

6. Plan for Current Goal:

    ☒ Change goal

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

GOAL# 35 Utilization Management SUD

1. Quality Improvement Goal:
   95% of all SUD ASAM Assessments reviewed will document appropriate medical necessity for services.

2. 2020/2021 The Goal Was:

   ☐ MET ☒ NOT MET

3. Quality Improvement Activities / Actions Taken Over the Past Year:
   1. QID held meetings with SUD administrator to create and implement a Utilization Management Review process for SUD services. SUD Administrator identified the SUD Gateway Team as the appropriate team to complete these reviews as they are also the authorization unit for SUD services.
   2. QID held meetings with Gateway supervisor and LPHA to discuss the details of the reviews and assisted in providing examples of MH UM review process and templates of tools utilized in these reviews.
   3. Gateway developed 2 separate tools to audit assessments and reassessments which will be utilized by the Gateway LPHA during their reviews. These tools look for presenting issues, ratings in all 6 Dimensions, justification for those ratings, diagnostic criteria, treatment recommendations and adequate level of care determination. Gateway is planning to audit 10% of all assessments completed by each of the SUD internal and contracted provider teams on a quarterly basis and adjust the samples if needed.
   4. Gateway's review process also includes immediate feedback to providers when an error or area of concern is identified in addition to providing training or consultation with the provider to ensure they are evaluating client's medical necessity for services appropriately. Gateway will also include a quarter report which will be reviewed with all providers in either the provider meetings, during QQID meetings or in both.
   5. Due to State Crisis and emergency priorities, Gateway was not able to launch this review on FY 20-21, however this process is scheduled to start on 8/1/2021.
   6. QID has continued to perform other documentation reviews during our quarter audits which include reviewing charts and looking specifically for documentation on medical necessity and recommendations in treatment which are not reported in this dataset.

4. Data Used to Measure the Outcome of this QI Goal:
   No Data to report

5. Summarize the Results of Actions Taken:
   1. Actions taken so far have been in the developing of tools and processes. Once the process is implemented on august 2021, QID will be able to see if actions taken to improve the system are having a positive outcome.
   2. QID has continued to provide monthly assessment training to all new SUD staff or for any LPHA needing a refresher course focusing not only on the completion of the form but also in the clinical evaluation and determination of client's treatment and level of service needed.

3. QID continues to give feedback and tips to the teams with their quarterly audit results and has provided team trainings to review these results which often includes training on our assessment forms, medical necessity criteria, and treatment recommendations based on diagnosis and dimensions ratings.

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6. Plan for Current Goal:

☒ Change goal

The language of the goal should remain the same, however this review is assigned to Gateway; It is recommended that this report is monitored/produced by SUD administration.