BEHAVIORAL HEALTH&RECOVERY SERVICES

Kern Behavioral Health and Recovery Services

Quality Improvement
Work Plan
FY 2021 – 2022

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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.

KERN QUALITY ASSESSMENT AND IMPROVEMENT PROGRAM

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

KernBHRS is committed to continued program development and compliance efforts as detailed in the KernBHRS Quality Assessment and Improvement Program (QAIP) description. The QAIP meets the contractual requirements of the Mental Health Plan contract with Department of Health Care Services (DHCS), as well as additional areas of performance improvement as identified by the California External Quality Review Organization (CAEQRO). The scope of the QAIP has been expanded to include regulatory requirements associated with the Organized Delivery System waiver issued in the State of California. The QAIP includes all services furnished to beneficiaries.

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

REPORTING AND IMPROVING

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

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

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

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

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

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

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

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

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

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

Name of Key Performance Indicator	Benchmark/Purpose	MHP or DMC-ODS
Request for Psychiatric Service First Offered	All (100%) first psychiatric services must be done within 21 calendars days (15 business days) of initial request.	MHP
Request for Psychiatric Service First Kept	All (100%) first psychiatric services must be done within 21 days (15 business days) of initial request.	MHP
Initial Request to First Kept Assessment	70% of routine mental-health assessments will be conducted within 14 calendar days (10 business days) of initial request for service.	MHP
Initial Request to First Offered Assessment	All (100%) routine mental-health assessments will be offered within 14 calendar days (10 business days) of initial request for service	MHP
Timeliness of Services for Urgent/Emergent Conditions	All (100%) initial requests for urgent services will be followed by a face-to-face service within 48 hours (2 calendar days).	MHP and DMC-ODS
No Show Rate - Psychiatric Appointments	No-show rates for psychiatric appointments will not exceed 18 percent.	MHP
No Show Rate - Other Clinicians	No-show rates for other clinical appointments (no-psychiatric) will not exceed 15 percent	MHP
Inpatient Hospital Recidivism Rate	Less than or equal to fourteen percent (14%). This report tracks the number of clients who return to inpatient within 30 days of discharge.	MHP
Residential Recidivism Rate	Less than or equal to twenty (20%). This report tracks the number of clients who return to residential services within 30 days of discharge.	DMC-ODS
Withdrawal Management Recidivism Rate	Less thank or equal to two percent (2%). This report tracks the number of clients who return to withdrawal management within 30 days of discharge.	DMC-ODS
Penetration Rate	Penetration rates of 4.2 percent or higher in each service area.	MHP
Penetration Rate	Sandra: TBD. This report measures the percentage of clients entering the DMC-ODS system stratified by: Age, Race & Gender	DMC-ODS
7 - Day Inpatient Discharge to Outpatient Appointment	All (100%) clients discharged from the hospital will receive a face-to-face outpatient mental health service within seven (7) calendar days	MHP
Initial Request to First Kept Assessment	All (100%) routine SUD assessments will be conducted within 14 calendar days (10 business days) of initial request for service. Pregnant Clients: All (100%) of SUD Assessments will be conducted within 3 days. IV User: All (100%) of SUD Assessments will be conducted within 7 days.	DMC-ODS

Initial Request to First Kept Assessment	All (100%) routine SUD assessments will be conducted within 14 calendar days (10 business days) of initial request for service. Pregnant Clients: All (100%) of SUD Assessments will be conducted within 48 hours. NTP: All (100%) of SUD Assessments will be conducted within 3 days. IV User: All (100%) of SUD Assessments will be conducted within 7 days.	DMC-ODS
Consumer Perception Survey	MH subunits will maintain a minimum overall satisfaction rate of 85%	MHP
Treatment Perception Survey	SUD subunits will maintain a minimum overall satisfaction rate of 85%	DMC-ODS
Initial Request to 2nd Clinical Service	Standard: TBD. This report measures the number of days between a client's initial request for routine mental-health services to first clinical service and to second clinical service.	MHP
No Show/Cancellation Rate	No-show rates for outpatient appointments will not exceed 60 percent. No-show rates for NTP and Residential service appointments will not exceed 30 percent.	DMC-ODS
Residential Discharge to Lower Level of Care	At least 85% of clients discharged from residential treatment will have a lower level follow up service within	

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

TOPIC	COMPLIANCE STANDARD	Application
Service Verification	95% of all mental health and substance use services captured in the electronic health record will be an honest and accurate account of a service.	MH, SUD
NOABD	95% of all MH NOABDs will be provided to a beneficiary upon an adverse determination	MH
NOABD	90% of all SUD NOABDs will be provided to a beneficiary upon an adverse determination	SUD
Documentation Compliance	95% of MHP documents within the electronic health record will be written according to all DHCS guidance and Clinical guidelines.	MH
Documentation Compliance	SUD teams will achieve a score of 85% or better on their trimester PN reviews.	SUD
Documentation Timeliness	85% of documents within the electronic health record will be written within 5 calendar days of the completion of the service.	MH, SUD
Change of Provider	100% of MHP change of Provider Requests are addressed.	MH
No Show Indicator	100% of the time when using scheduler, and a client does not show up for a scheduled appointment, staff will change the indicator to reflect "No Show."	MH, SUD

Records Request	100% of Client request for records will be processed within 15 days.	MH, SUD
HIPAA Training	100% of staff will complete the annual HIPAA training each year	MH, SUD
Corporate Compliance Training	100% of the staff will complete the Corporate Compliance training each year	MH, SUD
Privacy and Security Training	100% of the staff will complete the Privacy and Security training each year.	MH, SUD
Title 22 Training	100% of SUD staff will complete the Title 22 training annually	SUD
Human Trafficking Training	100% of staff will complete the human trafficking training annually	SUD
Privacy Breach Investigation	100% of all Potential Breaches will be reported to CCO within 24 hours	MH, SUD
Grievance and Appeals	100% of grievance and appeals will be processed according to DHCS policy.	MH, SUD

STRUCTURE AND ELEMENTS

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

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

The QIC is also referred to as the Executive QIC because it has oversight over three subcommittees. The subcommittees include the System-wide Quality Improvement Committee, the Key Performance Indicator Committee, and the Regulatory Compliance Committee. The Executive QIC and its subcommittees are charged with the following activities:

- Collecting and analyzing data to measure against the goals or prioritized areas of improvement that have been identified

- Identifying opportunities for improvement and deciding which opportunities to pursue
- Identifying relevant committees internal and external to ensure appropriate exchange of information with the QIC
- Obtaining input from providers, beneficiaries, and family members in identifying barriers to delivery of clinical care and administrative services
- Designing and implementing interventions for improving performance
- Measuring effectiveness of the interventions
- Incorporating successful interventions into system operations
- Reviewing beneficiary grievance and appeals, expedited appeals, fair hearing, expedited fair hearing, provider appeals and clinical records review

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

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

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

improvement science methodologies such as Lean Six Sigma and PDSA.

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

These committees include:

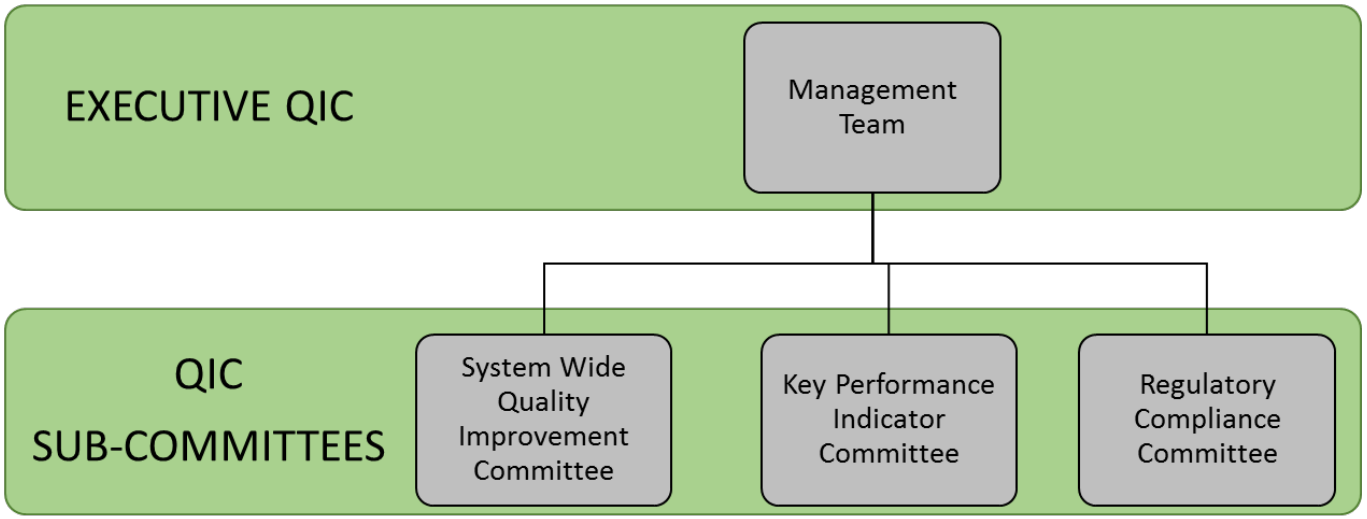
- Length of Stay Committee
- Morbidity and Mortality Committee
- Internal Psychiatric Strategy meeting
- Cultural Competency Resource Committee
- Full-Service Partnership meeting

Performance Improvement Projects

A Performance Improvement Project is a process that involves setting goals, implementing systemic changes, measuring outcomes, and making subsequent appropriate improvements. There is a total of four PIPs, one Clinical and one Non-Clinical for both the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS).

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

KernBHRS QI Program



The Executive QIC

PARTICIPANTS

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

DATA REVIEWED

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

SCOPE / AREAS OF RESPONSIBILITY

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

System-Wide Quality Improvement Committee (SQIC)

PARTICIPANTS

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

SCOPE / AREAS OF RESPONSIBILITY

A. Provide feedback to guide system improvement
B. Make recommendations to Executive QIC
C. Identify system improvement opportunities
D. Incorporate perspectives and feedback from direct service staff, clients, family members, stakeholders, and contract providers.
E. Hold open meetings advertised to the public.
F. Fulfill applicable regulatory requirements such as those with the Brown Act

DATA REVIEWED

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

Key Performance Indicator Committee

PARTICIPANTS

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

SCOPE /AREA OF RESPONSIBILITY

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

DATA REVIEWED

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

Regulatory Compliance Committee

PARTICIPANTS

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

SCOPE / AREAS OF RESPONSIBILITY

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

DATA REVIEWED

A. Policy review related to Compliance, Privacy, and Information Security.
B. Current Compliance, Privacy and Information Security concerns that require prompt action.
C. Relevant updates to Compliance, Privacy, and Information Security regulations.
D. Sequestered chart audits
E. Service Verification completion
F. Trends reports related to Privacy breaches
G. APGAR

Quality Improvement Work Plan

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

Goal #1 Consumer and family Satisfaction- CPS: Each MHP service provider will each achieve a minimum satisfaction rating of 85% or greater on the bi-annual Consumer Perception Survey (CPS)	Responsible Party
Objectives: 1. Complete the CPS. 2. Create flyers for the overall satisfaction rate to post in clinics and online. 3. Complete the Plan Do Study Act model for any team that is out of compliance.	QID, DATA Supervisor

Goal #2 Consumer and family Satisfaction- LRS: Each MHP service provider will each achieve a minimum satisfaction rating of 85% or greater on the annual Local Recovery Survey (LRS)	Responsible Party
Objectives: 1. Complete the LRS 2. Create a Visualization in Power BI to add to KPIC reporting. 3. Begin “Interventions” for teams out of compliance	Children’s System of Care Administrator

Goal #3 Credentialing: 100% of all applicable staff will complete the credentialing process.	Responsible Party
Objectives: 1. Discontinue Cerner access to those providers that have not completed their credentialing application 2. Develop re-credentialing process so the system is established when current credentialed staff are due to be re-credentialed.	Contracts Administrator

Goal #4 Fair Hearings: 100% of State Fair Hearings will be performed within the mandated time frame.	Responsible Party
Objectives: 1. Check CDSS Appeals Case Management System website every day. 2. Fair hearing will be completed within the mandated time frames. 3. Improvement efforts will be reports through the QIC	QID, Administrative Coordinator

Goal #5 Foster Care Penetration Rates: Increase foster youth penetration rate to an overall monthly average of 50% or greater	Responsible Party
Objectives:	

1. Update foster youth Medi-Cal to include foster care aid codes. 2. Ensure staff availability to attend both open and unopened CFTMs. 3. Work 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.	Children's System of Care Administrator

Goal #6 <u>Grievance and Appeals/Problem Resolution:</u> 100% of Grievance and Appeals will be addressed within the prescribed timeframes	Responsible Party Patients' Rights Supervisor
Objectives: 1. PRA monitors all Grievances and Appeals that are submitted 2. The Grievance and Appeals application monitors status of all submissions for timeliness 3. Increase communication with Administrators regarding all trends and time frames.	

Goal #7 <u>Outreach Efforts to the Homeless and Hard to Reach – AOT:</u> In an effort to ensure system access to hard-to-reach individuals, the AOT team will increase the numbers of petitions submitted to the courts by 15%.	Responsible Party Adult System of Care Administrator
Objectives: 1. AOT supervisor will reach out to assigned team supervisors if clients are willing to participate in voluntary outpatient services, but Cerner doesn't reflect regular engagement attempts. 2. AOT team will coordinate with Access & Assessment to expedite assessments for clients who are not yet connected to an outpatient team. 3. AOT staff will coordinate tandem visits with outpatient teams when possible.	

Goal #8 <u>Outreach Efforts to the Homeless and Hard to Reach:</u> 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%.	Responsible Party Adult System of Care & Contracts Administrator
Objectives: 1. Ensure training and shadowing of outreach staff to allow consistency and standardization in programs. 2. Test calls will be made on a quarterly basis to ensure community members are receiving appropriate responses to requests for assistance. 3. Review outreach data on a monthly basis to ensure contacts are being captured appropriately.	

Goal #9 <u>Provider Appeals</u>: 100% of Provider Appeals will be resolved in a timely manner	Responsible Party Contracts Administrator
Objectives: 1. Appeals will be addressed within the proper time frames. 2. Financial monitoring records will reflect provider appeal decisions.	

Goal #10 <u>SUD Access Line/Test Calls:</u> 95% of all access test calls will be given a customer service rating of standard or above	Responsible Party Substance Use Disorder Administrator & QID DATA Supervisor
Objectives: 1. Continue to do Quarterly Test Calls. 2. Will report findings to SUD Administrator and Gateway Supervisor. 3. Work with Gateway Supervisor each quarter to see what improvements were made.	

Goal #11 <u>SUD Adult Satisfaction TPS:</u> The Substance Use Division and its contract providers will achieve a cumulative minimum satisfaction rating of 85% or greater on the Treatment Perception Survey.	Responsible Party Substance Use Disorder Administrator & QID DATA Supervisor
Objectives: 1. Complete the TPS 2. Create flyers for the overall satisfaction rate to post in clinics and online. 3. Complete the Plan Do Study Act model for any team that is out of compliance.	

Goal #12 <u>SUD Annual Reviews – Training:</u> 90% of all DMC-ODS agencies who received their annual quality review will meet staff training requirements as evaluated on the QID SUD monitoring tool	Responsible Party QID, SUD Supervisor
Objectives: 1. Conduct an annual quality review for every SUD team/provider 2. Evaluate compliance of training requirements for all staff 3. Issue a Corrective Action Plan for any team/provider that does not meet the compliance standard and follow-up until satisfactory progress is made	

Goal #13 <u>SUD Outcome Measures - Access Line:</u> At least 30% of individuals contacting the SUD treatment access line through Gateway will attend assessment.	Responsible Party Substance Use Disorder Administrator
Objectives: 1. Increase ability to offer same-day assessments via Gateway therapist and Mini Assessment Center. 2. Continue Gateway reminder calls for assessment. 3. Obtain verbal consent from clients to share their information with providers so they can contact incoming clients.	

Goal #14 <u>SUD Outcome Measures MAT:</u> 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.	Responsible Party Substance Use Disorder Administrator
Objectives: 1. Continue MAT Quarterly meetings with Omni and CSV to discuss referrals. 2. Offer MAT training to SUD line staff in order to increase familiarity with MAT and increase referrals to community providers.	

Goal #15 <u>SUD Outcomes Measures - Penetration Rate</u>: Increase penetration rate of the Latino/Hispanic population into SUD treatment team .52% to .85% by implementing culturally sensitive outreach and engagement strategies	Responsible Party Department Supports Administrator
Objectives: 1. Complete the Hispanic Heritage Month Event on 9.24.2021. 2. Distribute the KernBHRS Menu of Outreach & Education Interventions Strategies to internal teams and community partners. 3. Formalize Hispanic/LatinX Subcommittee monthly meetings.	

Goal #16 <u>SUD Points in Time Surveys</u>: Client satisfaction with various points in time (Admission, During Treatment, at Discharge, and a Follow up) during SUD treatment will obtain positive ratings at a rate of 85% or higher.	Responsible Party Substance Use Disorder Administrator
Objectives: 1. Reassign survey duties to administrative staff to increase number of surveys collected. 2. Review PIT Survey results with providers during bi-monthly meetings to discuss barriers and solutions	

Goal #17 <u>Unusual Occurrence Reports – Outpatient MH</u>: 100% of all MHP Outpatient UOR will be addressed in an appropriate manner.	Responsible Party QID, Documentation Supervisor
Objectives: 1. Review 100% of all MH UOR submitted to ensure all incidents are addressed appropriately. 2. Provide feedback and recommendation to the supervisors and administrators if any areas of concern or improvement are noted during UOR reviews. 3. QID will work with teams to reduce the use of “other” in the “type of incident” and entering incorrect types when submitting reports.	

Goal #18 <u>Unusual Occurrence Reports - Outpatient SUD:</u> 100% of all SUD Outpatient UOR will be addressed in an appropriate manner.	Responsible Party QID, SUD Supervisor
Objectives: 1. Review all SUD UORs on a weekly basis 2. Ensure the UORs are processed in a timely manner and send reminders for and follow-up on any delayed reports 3. Provide and track feedback to providers based on report content and quality of care concerns	

Goal #19 <u>Utilization Management MHP</u>: 95% of all reviewed MH assessments will have an appropriate determination on Medical Necessity documented.	Responsible Party QID, Documentation Compliance Supervisor
Objectives: 1. Review MH assessments to ensure Medical Necessity is documented appropriately 2. Provide feedback to supervisors and SOC of any trends and areas of improvements noted during the reviews.	

3. Provide monthly assessment training to all new LPHA and any older clinicians who may need a refresher to ensure everyone is evaluating clients similarly across all teams and providers.	

Goal #20 <u>Utilization Management SUD</u>: 95% of all SUD ASAM Assessments reviewed will document appropriate medical necessity for services	Responsible Party Substance Use Disorder Administrator
Objectives: 1. Review new process with Gateway supervisor to ensure appropriate sampling from providers. 2. Evaluate results of reviews and identify trends and problem areas. 3. Discuss findings at individual bi-monthly provider meetings.	

PERFORMANCE IMPROVEMENT PROJECTS (PIP): Non-Clinical		
2021-2022	**2021-2022**	**Person Responsible**
Mental Health (MHP): Homelessness – Increasing Access to Care **Problem:** KernBHRS' Non-Clinical PIP is designed to address the high no show rates for psychiatric appointments in the Homeless Adult Team. **Goal:** Providing clients with centralized bus routes will increase access to and improve no show rates to psychiatric appointments. **DMC-ODS: Increase linkage to Lower Level of Care Following Residential Discharges** **Problem:** KernBHRS' Non-Clinical PIP is designed to address the low number of clients linked to lower levels of care following residential treatment discharge. **Goal:** Increase client continuum of care for better client outcomes.	**MHP:** This Performance Improvement Project started in 2021 **DMC-ODS:** This Performance Improvement Project started in 2021	QID, DATA Team Supervisor
PERFORMANCE IMPROVEMENT PROJECTS (PIP): Clinical		
2021-2022	**2021-2022**	**Person Responsible**
Mental Health (MHP): Eye Movement Desensitization and Reprocessing (EMDR) **Problem:** KernBHRS' Clinical PIP is designed to address the low engagement in EMDR Trauma therapy following initial implementation. **Goal:** Increase attendance to sessions thereby improving trauma outcomes. **DMC-ODS: Seeking Safety Implementation** **Problem:** KernBHRS' Clinical PIP is designed to increase client retention in care **Goal:** Increase client engagement and retention in treatment, as evidenced by decreased drop-out rates, increased Length of Stay, and increased Successful Cal-OMS Discharges.	**MHP:** This Performance Improvement Project started in 2020 **DMC-ODS:** This Performance Improvement Project started in 2020	QID, Outcomes Supervisor