Kern Behavioral Health and Recovery Services

Quality Improvement
Work Plan Evaluation

FY 2024-2025

PO Box 1000, Bakersfield, CA 93302 | 661.868.6600 | www.kernbhrs.org

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MISSION VISION VALUES

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

Kern Behavioral Health and Recovery Services (KernBHRS) is committed to delivering high-quality, person-centered, and recovery-oriented behavioral health care that is inclusive, culturally responsive, and integrated with primary health services. Our approach prioritizes the unique needs, voices, and lived experiences of each beneficiary, with a focus on advancing service equity and reducing disparities across all populations we serve.

Our mission is to empower individuals facing mental health and substance use challenges by supporting their journey toward wellness, resilience, and full participation in community life. We recognize that true quality extends beyond compliance encompasses access, effectiveness, safety, equity, and client satisfaction.

KernBHRS continuously strengthens its programs through the Quality Assessment and Improvement Program (QAIP), which aligns with the requirements of the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) agreements with the Department of Health Care Services (DHCS). The Kern BHRS QAIP is a structured framework that encompasses quality improvement and evaluation activities designed to enhance the delivery of high-quality behavioral health services. The QAIP also integrates performance improvement priorities identified by the California External Quality Review Organization (CAEQRO).

Oversight of the QAIP is provided by the KernBHRS Director, a licensed mental health professional under the authority of the Kern County Board of Supervisors. Day-to-day development and implementation are led by the Administrator of the Quality Improvement Division (QID), ensuring that KernBHRS remains accountable, data-driven, and responsive to the evolving needs of our community.

Goal #1 Provider Appeals

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

   Define and develop fiscal dashboard that includes service delivery data and informs leadership in making decisions about operations.

2. **2024/2025 The Goal Was:**

   ☐ MET ☒ NOT MET

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

   After careful consideration, Executive leadership has elected not to pursue the goal. It may be revisited as priorities evolve.

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

   N/A

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

   N/A

6. **Recommendation for Current Goal:**

   ☒ Discontinue goal

Goal #2 Fiscal Dashboard

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

   Define and develop fiscal dashboard that includes service delivery data and informs leadership in making decisions about operations.

2. **2024/2025 The Goal Was:**

   ☐ MET ☒ NOT MET

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

   After careful consideration, Executive leadership has elected not to pursue the goal. It may be revisited as priorities evolve.

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

   N/A

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

   N/A

6. **Recommendation for Current Goal:**

   ☒ Discontinue goal

Goal #3 Psychiatric No Show

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

   Decrease the Psychiatric No-Show rate for Kern BHRS to below 18%.

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2. **2024/2025 The Goal Was:**

   ☐ **MET** ☒ **NOT MET**

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

   The department discussed the challenges at hand and identified 3 primary areas needing improvement:

   1. Need for implementation of Case management/dyad intervention with clients who no show to psychiatry appointments at each occurrence.
   2. Need for reporting on clients who are missing multiple psychiatric services due to no-shows.
   3. Implementation of case confreres with treatment team for chronic no showing clients, considering intensified services to assist in re-engagement.

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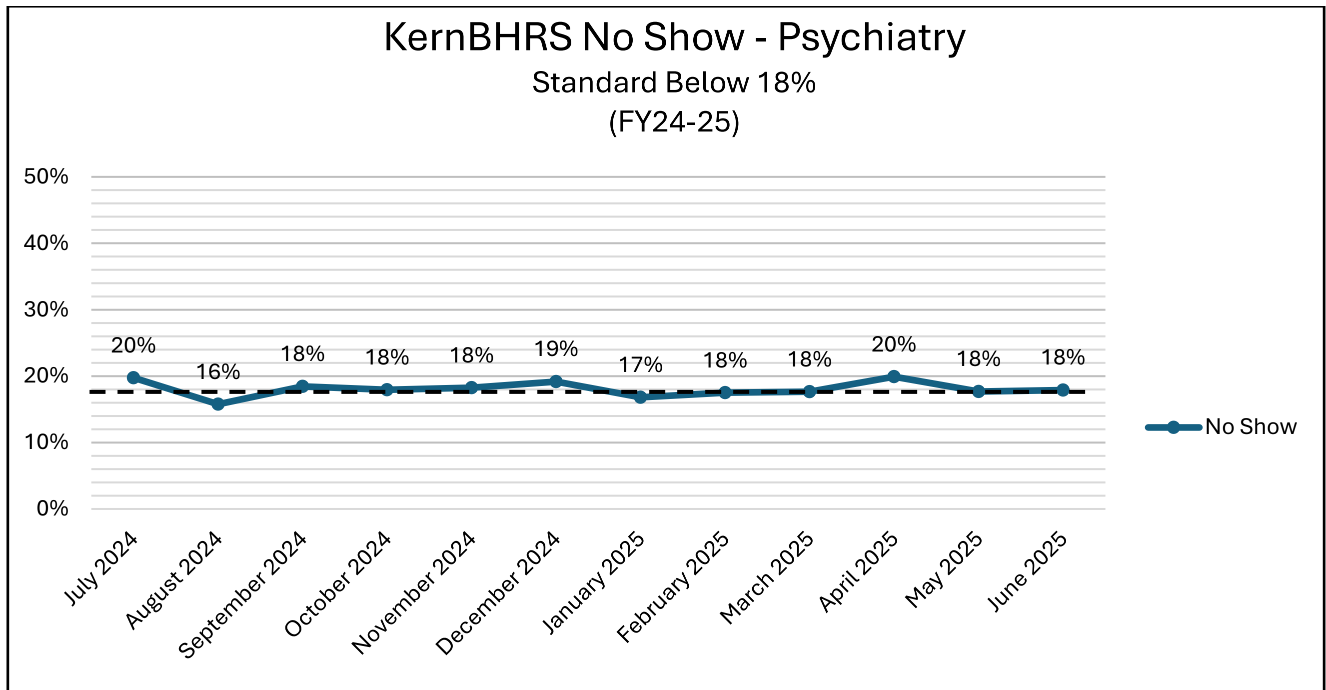
4. **Data Used to Measure the Outcome of this QI Goal:**



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

   With implementation of the call center, the department will streamline the process for no-showing clients to be connected with their Case Manager/Dyad for rapid intervention.

   Our IT department is looking into reporting options for no shows, controlling for individual clients receiving psychiatric services

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Department is working to take the above information to help identify clients needing case conferencing regarding no shows.

6. **Recommendation for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #4 Eliminate Bottlenecks in the Contracting Cycle

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

   Eliminate Bottlenecks in the Contracting Cycle to Improve Timeliness and Address Increases in Demand

2. **2024/2025 The Goal Was:**

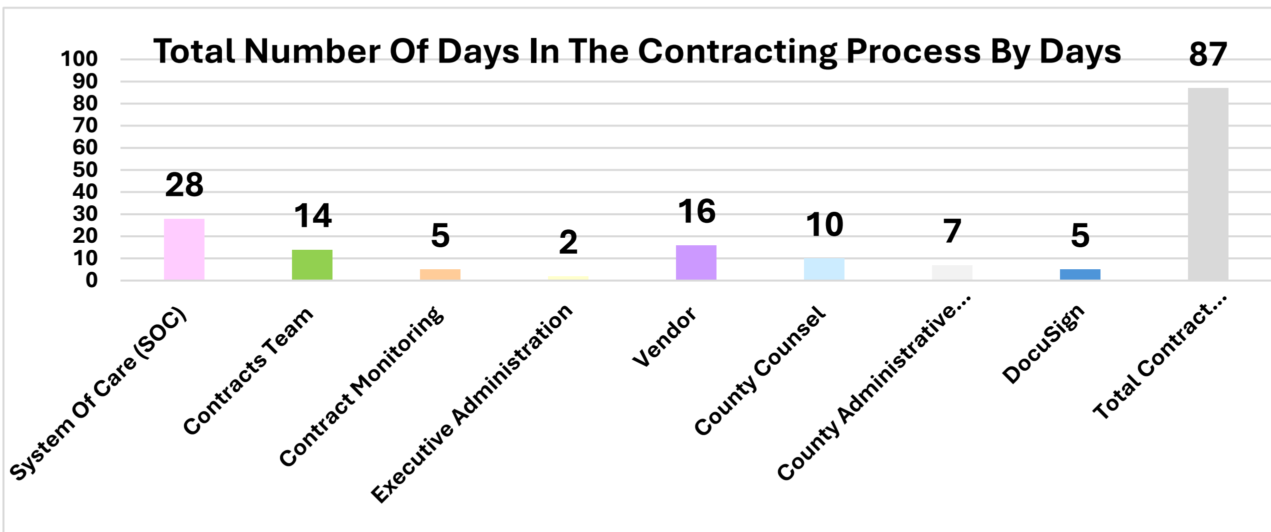
   ☐ **MET** ☒ **NOT MET**

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

   The Contract Processing Cycle was condensed from 10 steps to 6 steps to reduce processing times. Progress reports were sent to the system of care during the contract season.

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

   Data for FY 25-26



   Data for the previous fiscal year is unavailable.

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

   Challenges:
   Tracking outcomes quantitatively proved difficult, as the original goal did not include a clearly defined measurement. Additionally, the absence of prior-year data on key contracting dates limited the ability to assess progress with precision.

   Mitigations:
   Despite these limitations, proactive steps were taken to improve the efficiency of the contract processing cycle. Efforts were made to reduce the number of steps in the process to streamline workflows and minimize delays. In addition, progress reports were introduced to provide regular updates, identify bottlenecks, and help move contracts forward in a timelier and coordinated manner.

6. **Recommendation for Current Goal:**

☒ Change goal

Within 12 months, reduce the average contract processing cycle time by 25%, from the current 87 days to approximately 65 days. This will be achieved by implementing an initial kickoff meeting at the beginning of contract discussions with the System of Care (SOC), utilizing a progress report to track timelines and milestones, and identifying barriers throughout the process. The Contracts Team will proactively intervene to support the SOC in addressing these challenges, with the goal of reducing the number of days the SOC spends on tasks within the contract cycle.

Goal #5 Develop and Implement Plan for Community-Based SUD Infused Outreach

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

   Develop and Implement Plan for Community-Based SUD Infused Outreach to Assist Homeless Individuals in Engaging SUD Services and Support

2. **2024/2025 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   SUD case management staff continued to facilitate access to SUD services at five shelter locations including M St Navigation Center, Brundage Lane Navigation Center, Open Door Network, The Mission and Hope on Hart. Information was provided to shelter staff and residents, along with educational SUD groups. The Syringe Services Program run by the Prevention Team was connected with the Kern Linkage Mobile Clinic with Street Psychiatry in order to expand their reach and provide information on SUD treatment resources and harm reduction. The SSP participated in scheduled outreach events weekly in the last quarter of FY 24-25.

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

   N/A-

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

   Ongoing SUD presence was maintained at shelters in Bakersfield in order to increase outreach to the homeless population during FY 24-25. The addition of the SSP to outreach events increased the number of individuals informed about available SUD services and harm reduction supplies.

6. **Recommendation for Current Goal:**

   ☒ Change goal

Goal #6 Develop Best Practice Protocol to Complete Timely Warm Handoffs

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

   Develop Best Practice Protocol to Complete Timely Warm Handoffs While Implementing Path Services to Justice Involved Youth and Adults Needing Specialty Mental Health Services and Substance Abuse Services

2. **2024/2025 The Goal Was:**

   ☐ **MET** ☒ **NOT MET**

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

   Worked with KCSO, Probation, MCPs to complete implementation plan and Readiness Assessment. We currently are pending approval from the State to begin implementation with our local partners

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

   N/A

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

   Implementation Plan and Readiness Assessment pending State approval.

6. **Recommendation for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #7 DMC-ODS Client and Family Satisfaction Rate – TPS

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

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

2. **2024/2025 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   The SUD Division conducted point-in-time surveys throughout FY24-25, which include a selection of questions from the Treatment Perception Survey. Over the year, satisfaction rates remain at or above the standard, and when negative comments are gathered, they are brought to the contracted provider for resolution. SUD contractors are familiar with the Grievance process and are responsive to SUD Administrator when questions arise.

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

Performance Toward Goal:		
Numerator	**Denominator**	**Percentage**
150	161	**93%**

   This data reflects the number of TPS surveys collected during the annual survey period (third week of October), which is in line with ongoing Point-in-Time survey results.

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

   SUD providers have been able to maintain good service that leads to overall client satisfaction.

6. **Recommendation for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #8 DMC-ODS UM Review

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

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

2. **2024/2025 The Goal Was:**

   ☐ **MET** ☒ **NOT MET**

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

   ASAM assessments were audited monthly beginning in January 2025 by the SUD Access Line (the first quarter could not be reviewed due to staffing shortages and changes in supervisors). The ASAM report was completed in SmartCare monthly giving a total of all new ASAMs completed in that month. From that report, assessments were chosen at random to review, with a total of 5% of new assessments audited. Generally, this resulted in at least one audit per provider, with a total of 3 charts per quarter for each provider. Additionally, the Documentation Compliance team also completed their semester audits to determine if ASAMs showed the need for medical necessity. Documentation Compliance provided additional training materials regarding the ASAM criteria and ratings through audit results and QQID meetings to help assist providers in meeting this goal.

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

Performance Toward Goal:		
Numerator	**Denominator**	**Percentage**
64	78	**82%**

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

   Due to recent changes with the Access Line, the process was reestablished and assigned to an LPHA. LPHAs audited the assessments and saved outcome forms for each audit. Outcomes and trends were provided to SUD administrator at the end of each quarter highlighting strengths and areas of improvement to be reviewed with providers. Trends identified by the Access Line include: lack of justification for 3.1 LOC, discrepancies between risk rating and LOC rating, and lack of justification for assigning a different LOC than what was recommended. Administrator would provide trends to the providers individually at provider meetings. QID additionally completed regular ASAM audits and discussed trends and training materials to assist in areas that need improvement. Despite these audits and feedback provided, QID noted continued need for improvements in the areas of diagnostic clarity, risk rating justification, and vague documentation of the prescribed amount of treatment. QID reported they rarely get questions regarding ASAM training and that it is possible incorrect information is being passed down from senior staff to new staff during training.

6. **Recommendation for Current Goal:**

   ☒ Discontinue goal

Goal # 9 Establish RAWC Teams as Access Points

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

   Establish RAWC Teams as Access Points and Integrate MH SUD and Peers as Part of the RAWC Teams

2. **2024/2025 The Goal Was:**

   ☐ MET ☒ NOT MET

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

   Substance Use Disorder Specialists were added to all RAWC teams. The policy and job descriptions for certified peer support specialists were also drafted for department review. A new service map search bar has been developed for the KernBHRS public website and will be implemented by the end of August. This will assist community members in finding potential service locations once the Access and Assessment Center is no longer the centralized access point.

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

   N/A

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

   There was an increase in the number of clients receiving co-occurring treatment on the RAWC teams, forward motion to including more effective treatment approaches by developing the policies and procedures necessary to hire certified peers, and preparation for clients having better/more efficient access to geographic services providers.

6. **Recommendation for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal # 10 Coordinate Focused Training for Staff.

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

   Coordinate Focused Training for Staff to Enhance and Strengthen Their Crisis Intervention Skills

2. **2024/2025 The Goal Was:**

   ☐ MET ☒ NOT MET

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

   During this time frame, is what determined the focus of mandatory safety training would be field/home visits. The development, review, and implementation of this training became priority with the crisis intervention skills training becoming a follow-up to the field/home visit safety training.

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

   N/A

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

   Due to the increased number of Unusual Occurrence Reports related to employees being assaulted by clients, it was determined in order to provide a safe working environment for the employees, an expedited focus on the mandatory field/home visit safety training was necessary. Moving forward, the crisis intervention skills training will be the focus in addition to the field/home visit safety training being provided on an annual basis.

6. **Recommendation for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #11 Conduct Root Cause Analysis of Barriers Limiting SUD Treatment Referrals

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

   Conduct Root Cause Analysis of Barriers Limiting SUD Treatment Referrals from MH Youth and Adult Teams.

2. **2024/2025 The Goal Was:**

   ☒ **MET** ☐ **NOT MET**

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

   As part of a comprehensive root cause analysis aimed at understanding barriers limiting substance use treatment referrals from mental health treatment programs for adults and youth, a mixed-methods approach was used to explore systemic, provider-level, and client-related factors. Initial stakeholder interviews and program data reviews indicated inconsistencies in referral practices and a lack of standardized protocols. To further investigate, a survey was developed and implemented across multiple mental health and substance use treatment programs to collect quantitative and qualitative data directly from providers. The survey explored provider knowledge, attitudes, perceived role clarity, interagency communication, and structural barriers such as time constraints and resource availability.

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

   N/A

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

   The root cause analysis revealed several key barriers contributing to the low rate of referrals from mental health (MH) treatment programs to substance use disorder (SUD) services. Most notably, service delivery teams lacked a consistent and well-understood process for making referrals, and there were no formal guidelines in place to support or standardize referral practices.

   Staff reported limited knowledge about how to initiate referrals and uncertainty around the appropriate steps to take. Additionally, concerns about releasing client information—particularly in relation to confidentiality and consent—were identified as significant obstacles to effective communication between providers.

   The absence of clear communication channels between MH and SUD treatment teams further compounded these issues, leading to fragmented care and missed opportunities for coordinated treatment. These findings highlighted the need for structured referral protocols, clearer information-sharing practices, and stronger interagency collaboration.

6. **Recommendation for Current Goal:**

   ☒ Discontinue goal

Goal #12 Consumer and Family Satisfaction - CPS

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

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

2. **2024/2025 The Goal Was:**

   ☒ **MET** ☐ **NOT MET**

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

   The following actions were taken over the past year in each Division to help increase client overall satisfaction:

   1. Clinical Plan Services
      - Researched client complaints and directly contacted clients to assist in resolving their grievances
      - Involved the Care Coordination Unit to support prompt resolution of grievances. This collaboration has been successful in some cases, allowing clients to remain with their current clinic instead of needing to change providers.
      - Collaborated with Kern Health Systems to collaborate to develop new processes aimed at addressing the grievances they receive.
      - Clinic managers were asked to review grievances with the same rigor as morbidity and mortality cases, to gain deeper insights that can inform program changes and ultimately improve clinic satisfaction.
   2. Children's System of Care
      - Foster Care worked to increase engagement for resource parents/caregivers and involve them in treatment
      - TAY collaborated with agencies to streamline client care when engaged with multiple child serving agencies to bolster services
      - Youth Bridge immediate trauma informed crisis care for youth and families admitted to KM through the Reporting and Responding grant with public health
      - Through ICC Coordination CCR has been able to step down 54% of youth to RFA homes; 90% of youth who have been stepped down have not returned to the STRTP
   3. Crisis Services
      - PEC nurses have been working on their psychology preceptorship hours. We have 4 nurses who have completed their Psychiatric Nurse Practitioner program and a 5th starting in February. This has enhanced the understanding of therapeutic principles which compliments their medical care and a more cohesive approach has been observed when it comes to client centered care
      - We empower clients to use our grievance system to ensure they feel heard when there is a complaint.
      - The Crisis Walk-In Clinic has improved response times through staff hirings and provided additional trainings in more skill-based approaches to ensure that all customers are receiving the highest and best care at all hours of the day

- We have also placed more emphasis on increasing our connections and interactions with community partners allowing us to connect and educate customers on the resources out in the community
- CCMO has worked to foster an environment of collaboration with hospitals, outpatient teams and other community providers to model for clients how collaboration can benefit them
- We've also focused on personalizing each client's experience, meeting them where they are, and responding with professionalism
- We provide WRAP services for the clients, tailoring treatment to each individuals needs. Many times we are the first impression individuals have of the system of care and so we work hard to make each experience a good one, which will hopefully encourage continued participation in treatment.

4. Adult System of Care
   - Continued to evolve with improvements on system delivery, timeliness and access to care for individuals receiving Specialty Mental Health Services (SMHS) This year, timeliness for an initial assessment, first time service, aftercare and psychiatric appointments were closely monitored using the Mental Health Non-Psychiatric & Psychiatric Timeliness Record in our Electronic Healthcare Record SmartCare system. Monitoring the data through reports allows teams to identify offered appointment dates, rendered services dates and follow up appointment dates to ensure clients are receiving the needed treatment in a timely manner. More so, the data captured supports teams in identifying trends and corrections needed to meet the department and state standards.
5. Kern Linkage Division
   - Several steps were removed from the existing linkage procedure in coordination with Flood to streamline the client care process. Flood staff previously determined if a client could benefit from mental health services and scheduled an in-office assessment. To better support Flood and expedite client access to care, Flood can now call our on-call number to request a ROEM or MCSP staff member to provide an assessment in the field or at the client's earliest convenience.
   - A new weekly outreach date at Martin Luther King Park was added to boost community engagement and better support our SSP program.
   - We are in the process of certifying our division under DMC-ODS. This certification will allow our staff to conduct SUD assessments and screenings, making it easier for clients to access and link to SUD or MAT services. By reducing barriers to entry and enabling clients to work with familiar staff, we anticipate improved outcomes for individuals with co-occurring substance use and mental health disorders.
   - HAT team supervisor provides weekly Unit team meetings in which ice breakers and Intervention skills are reviewed and taught to the team. Modeling and practicing customer service, for staff to engage consumers with professionalism, kindness, genuine and empathetic support. HAT staff contribute to the team weekly intervention skills that they find useful with consumers. Discussions include but are not limited, to client care, communication styles, staff safety, best work practices, incorporating emotional

intelligence and social awareness (cognitive , emotional, social, and physical observations).

- A walk-in assessment process has been set up to make services easily accessible
- SPO has made significant efforts to coordinate with community, judicial partners to identify and assess individuals who better benefit from our behavioral health services rather than remaining in a cycle of incarceration and lack of support in the community. SPO has developed specific assessment strategies and applied evidence-based interventions to offer such support to our residents of Kern County.

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

Performance Toward Goal:		
Numerator	**Denominator**	**Percentage**
564	614	**92%**

This data reflects results from the Spring 2024 CPS survey collection period received in February 2025. The Spring 2025 collection period was May 19-23, 2025.

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

The results of the Consumer Perception Survey indicate a strong overall satisfaction rate, with 92% of the 614 respondents reporting that they were either satisfied or very satisfied with the services received. The highest-rated item was the statement, *"If I had other choices, I would still get services from this agency,"* which received a 95% positive response, reflecting a high level of loyalty and confidence in the agency's services. The lowest-scoring item was *"Staff were willing to see me as often as I felt was necessary,"* which, while still relatively positive, received an 88% satisfaction rate, suggesting an opportunity for improvement in perceived accessibility or responsiveness of staff. Overall, the survey results reflect a strong endorsement of the Behavioral Health System performance and consumer trust.

6. **Recommendation for Current Goal:**

☒ Keep the goal with no change for the upcoming year

Goal #13 In Preparation for BH Connect and BHT, Assess Readiness for EBT

1. **<u>Quality Improvement Work Plan Goal:</u>**

   In Preparation for BH Connect and BHT, Assess Readiness for EBT Implementation and Fidelity.

2. **<u>2024/2025 The Goal Was:</u>**

   ☒ MET ☐ NOT MET

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

   Monthly consultation meetings occurring where EBT implementation and fidelity have been assessed, action plan identified. This will be an ongoing process and currently are waiting for more final guidance from DHCS to continue strategic planning as well as information on COE's and fidelity monitoring.

4. **<u>Data Used to Measure the Outcome of this QI Goal:</u>**

   N/A

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

   Results are that there is an ongoing action/implementation plan created to address this area of focus.

6. **<u>Recommendation for Current Goal:</u>**

   ☒ Keep the goal with no change for the upcoming year

Goal #14 Publish a List of Each Divisions Flow Data Performance Indicators

1. **<u>Quality Improvement Work Plan Goal:</u>**

   Publish a List of Each Divisions Flow Data Performance Indicators and Description of How the Data is Monitored.

2. **<u>2024/2025 The Goal Was:</u>**

   ☒ MET ☐ NOT MET

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

   In an effort to collect each divisions flow data metrics, QID held meetings with each of the Administrators over clinical programs. A list was assembled and is currently in review. The additional flow data indicators will be published in the 2025/2026 Work Plan.

4. **<u>Data Used to Measure the Outcome of this QI Goal:</u>**

   N/A

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

   Flow data varies significantly across divisions. While some divisions utilize multiple indicators and have well-established, systematic processes for meaningful and actionable data review, others rely on a limited set of flow data indicators and employ informal review procedures.

   An analysis of the current flow data indicators and metrics reveals some overlap among divisions. To enhance consistency and effectiveness, the system could benefit from integrating these indicators into a standardized process framework, such as KPIC.

   Divisions with limited identified indicators are encouraged to collaborate with the Quality Improvement Department (QID) and IT to develop more robust metrics and reporting capabilities. The existing indicators restrict administrators' ability to fully understand and evaluate their system's performance.

6. **<u>Recommendation for Current Goal:</u>**

   ☒ Discontinue goal

Goal # 15 Fair Hearing

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

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

2. **2024/2025 The Goal Was:**

   ☒ MET ☐ NOT MET

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

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

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

Performance Toward Goal:		
Numerator	**Denominator**	**Percentage**
10	10	**100%**

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

   All 10 Fair Hearings were conducted with the 90-days by tracking each stage of the process.

6. **Recommendation for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #16 Identify Reports to Stratify by Race, Ethnicity, Gender

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

   Identify Reports to Stratify by Race, Ethnicity, Gender, in Order to Address Unintentional Institutional Biases

2. **2024/2025 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   To explore for potential institutional bias, a team of Quality Improvement Division (QID) analysts reviewed the current set of performance indicators used by the Mental Health Plan and the DMC-ODS plan, with the goal of stratifying key metrics by demographic variables such as age, race, ethnicity, and sex. The review confirmed that all performance indicators could be disaggregated by these variables. However, when analysts attempted to stratify data by race and ethnicity, they encountered limitations within the electronic health record (EHR), which grouped race and ethnicity into a single category. To address this, aggregated data was extracted, and federal guidelines were applied to separate race and ethnicity categories externally. Additionally, the EHR only includes three options for recording sex—male, female, and unknown—and does not capture gender, making it impossible to stratify data by gender identity. Despite these reporting limitations, all key performance indicators were successfully stratified by sex, age, race, and ethnicity.

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

   N/A

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

   All key performance indicators will continue to be stratified by demographic variables—including age, sex, race, and ethnicity—when reported to the respective Quality Improvement Committees. This stratification remains an integral part of the routine reporting process. Furthermore, appropriate actions will be promptly initiated whenever data reveals areas of concern or performance deficiencies.

6. **Recommendation for Current Goal:**

   ☒ Discontinue goal

Goal #17 Improve Collaborative Planning with Stakeholders

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

   Improve Collaborative Planning with Stakeholders Such as The Cultural Competency Resource Committee by Sharing Fiscal Data and Relevant Reports

2. **2024/2025 The Goal Was:**

   ☒ **MET** ☐ **NOT MET**

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

   Data has been shared with CCRC and this is an ongoing process that has been established

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

   N/A

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

   Fiscal data and relevant reports are shared at CCRC and MHSA stakeholders, this is an ongoing established process that no longer needs to be evaluated.

6. **Recommendation for Current Goal:**

   ☒ Discontinue goal

Goal #18 Put Out An RFI or An RFSQ for Culturally Specific Treatment Providers

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

   Put Out An RFI or An RFSQ for Culturally Specific Treatment Providers That is Based on Current Disparities.

2. **2024/2025 The Goal Was:**

   ☐ MET ☒ NOT MET

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

   Fiscal planning still in process and it has not yet been determined that the Department will put out a RFI to culturally specific treatment providers

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

   N/A

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

   Module 4 will be released soon by DHCS, more information on CDEP's will be included in this document. Continued strategic fiscal planning occurring

6. **Recommendation for Current Goal:**

   ☒ Change goal

Goal #19 24/7 Access Line

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

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

2. **2024/2025 The Goal Was:**

   ☒ **MET** ☐ **NOT MET**

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

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

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

Performance Toward Goal:		
Numerator	**Denominator**	**Percentage**
68	68	**100%**

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

   Results of test calls indicate that the continued education of Medi-Cal regulations is effective.

6. **Recommendation for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal # 20 Access to After Hours Service

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

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

2. **2024/2025 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   To enhance access to care, the Kern BHRS Plan mandated that service providers offer appointments beyond the traditional business hours of 8:00 AM to 5:00 PM. Providers employed various methods to assess service utilization needs and independently developed protocols to ensure availability during nontraditional hours.

   The Quality Improvement Department (QID) conducted monthly monitoring of after-hours services using the network adequacy timeliness application. Designated representatives at each provider location were required to submit monthly reports detailing the availability of after-hours services. In instances where a provider reported the absence of such services, QID forwarded the report to the system of care administrator responsible for managing the provider's contract. The administrator then collaborated with the provider to adjust scheduling and increase service availability outside standard business hours.

   A limited number of providers operate in specialized settings that do not permit after-hours services, such as the Dream Center, where hours are determined by the superintendent of schools. These exceptions contribute to a goal achievement rate below 100%, thereby justifying a target closer to 90%.

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

Performance Toward Goal:		
Numerator	**Denominator**	**Percentage**
73	80	**91.25%**

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

   Kern BHRS and its network service providers were able to offer services outside of traditional business hours the year. Although there were a few service delivery sites that were unable to offer services outside of 8:00 AM – 5:00 PM at their location service delivery staff ensured client needs were met. Results for each quarter included:

   Q1: 91.8% Q2: 90.63% Q3: 89.06%

   Results for each quarter maintained a consistent level throughout the year.

   Providers within the mental health plan had a slightly more difficult time than providers within the DMC-ODS. The slightly below score on quarter 3 was later attributed to a lack of reporting and not a lack of service availability.

6. **Recommendation for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal # 21 Credentialing

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

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

2. **2024/2025 The Goal Was:**

   ☒ **MET** ☐ **NOT MET**

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

   Credentialing staff continue to optimize the amount of process time it takes to complete an application by improving team communication, centralizing tracking systems and refining written procedures to ensure consistent process.

   The Credentialing team will continue to use the streamlined process already set in place to continue to optimize the amount of time it takes to complete a file.

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

Performance Toward Goal:		
Numerator	**Denominator**	**Percentage**
159	159	**100**

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

   100% of Credentialing Applications were Approved in FY24-25. 53% of staff credentialed were staff of System of Care contract providers (85 staff); 47%, were BHRS staff (74 staff).

6. **Recommendation for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal # 22 Medication Monitoring

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

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

2. **2024/2025 The Goal Was:**

   ☒ MET ☐ NOT MET

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

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

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

1--Drug/Allergy Hx	2a--Meds are appropriate for dx,	2b--Medication and medical condition	3--Consent forms	4--Dosage level	5--Med changes	6--Side effects noted	6a--AIMS completed	7--Tx improving/maintain	8--Lab tests ordered	9--Lab tests utilized	10--Follow up on abnormal labs	11--Re-evaluation every 90 days
95%	99%	99%	89%	98%	100%	97%	99%	100%	100%	100%	99%	100%

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

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

6. **Recommendation for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal #23 DMC-ODS Access Line

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

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

2. **2024/2025 The Goal Was:**

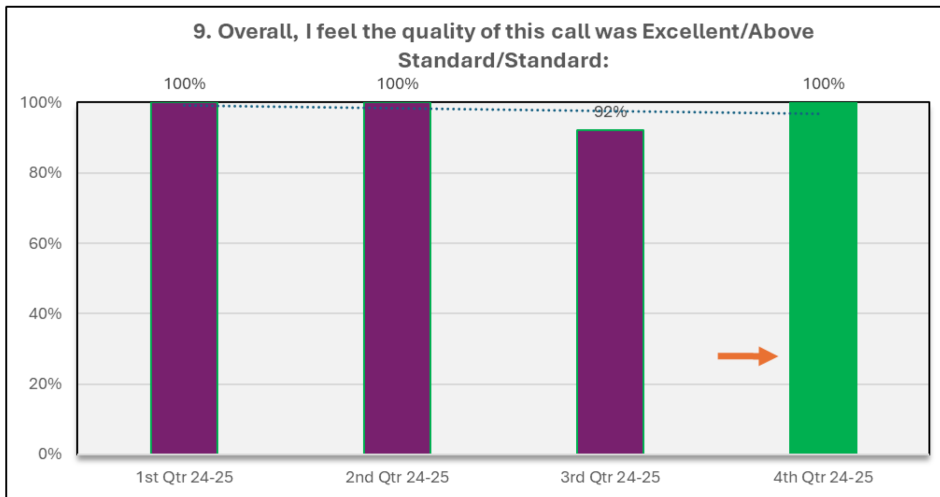
   ☒ **MET** ☐ **NOT MET**

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

   During FY 24/25 QID continued to conduct calls to the SUD Access Line at various times during the day, in both English and Spanish. Results of the calls are provided to team supervisors in order to give positive or negative feedback to individual staff and ensure calls are being answered as expected.

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

Performance Toward Goal:		
Numerator	**Denominator**	**Percentage**
43	44	**98%**



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

   Team supervisors have continued to emphasize to their staff the importance of providing great service to all callers, including during on-call times to support 24/7 coverage. Scores remained high throughout the year.

6. **Recommendation for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal # 24 Develop and Enhance Data Exchange Initiative

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

   Develop and Enhance Data Exchange Initiative with Partner Agencies and MCP's

2. **2024/2025 The Goal Was:**

   ☒ **MET** ☐ **NOT MET**

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

   Worked with Medical Services Administrator to initiate comprehensive review and redefinition of MOUs with all three managed care providers to align with state requirements. Negotiated terms and executed MOU with Kern Health Systems. We continue to work on negotiations with Anthem and Kaiser.

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

   N/A

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

   We have established regular weekly meetings with KHS to work directly on data exchange initiatives. We have developed and implemented bidirectional data exchange including: Enrollment files, Coordination files which are inclusive of ECM/CSS data, Health Conditions and Lab data. Implemented daily data exchanges for Follow up after Mental Health Discharges and Follow up after ED visits for Alcohol/Drug abuse metrics. Currently we are working on a technical specifications for all active prescriptions file exchange to enhance medication coordination and we are expanding our scope to include SUD data exchanges and working with the SUD system of care to define those specifications.

6. **Recommendation for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

Goal # 25 Execute MOU's for All Major Partnerships

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

   Execute MOU's for All Major Partnerships - KM - KHS - Kaiser – Anthem

2. **2024/2025 The Goal Was:**

   ☐ **MET** ☒ **NOT MET**

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

   We have executed 2 of the three MOUs. Kaiser remains and language in question is between Kaiser Legal, BHRS legal and both IT parties.

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

   N/A

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

   Mou Execution steps are being taken appropriately and timely. Items in dispute related to Data Exchange and Legal concerns with MOU language from Kaiser

6. **Recommendation for Current Goal:**

   ☒ Change goal

Goal # 26 Completion and Organization of New Website and Rebranding

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

   Completion and Organization of New Website and Rebranding

2. **2024/2025 The Goal Was:**

   ☐ **MET** ☒ **NOT MET**

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

   The PIO team and the facilities team collaborated to update exterior and interior signage at all of our locations. The KernBHRS public website has been overhauled and completed with our new web provider Granicus. Finally, the PIO Team has started the process of going to each location to double check that all of our teams are providing clients with the appropriate rebranded information.

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

   N/A

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

   There are still two outstanding sites that need updated signage that needs to be completed. That would be 34th Street and SEBA. The signage has already been approved, it just needs to be installed by Vital Signs, our contract provider. Additionally, the process of a complete overhaul of the website has been completed. Lastly, we are still in the process of going to each location and collaborating with our teams to make sure the most up-to-date information is being provided to our clients. This includes what hangs in the lobbies and what we are presenting them.

6. **Recommendation for Current Goal:**

   ☒ Change goal

   Ensure information our clients receive is accurate, up-to-date, on brand.

Goal # 27 Initiate Design Meetings to Build an HR Information Management System

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

   Initiate Design Meetings to Build an HR Information Management System to Support all Aspects of HR Processes and Workflow.

2. **2024/2025 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   Established Bi-weekly meetings between Human Resources and IT to ensure collaborative planning and specification development.
   Conducted needs assessment to define core system functionality requirements
   Developed specifications for the HRIS platform that will streamline HR workflows.

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

Performance Toward Goal:		
Numerator	**Denominator**	**Percentage**
System specifications defined	Employee information Onboarding/Offboarding Processes Licenses/Certifications Asset Tracking Reporting	**100%**

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

   Key Deliverables have been met as HR in collaboration with IT technical support and software development defined the specifications and various workflows needed to meet the needs of the department. We have exceeded the goal as system development and testing is near completion.

6. **Recommendation for Current Goal:**

   ☒ Discontinue goal

Goal # 28 Support Mission, Vision, and Values of Department

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

   Support Mission, Vision, and Values of Department by Ensuring Strong Social Media Presence - Including Recruitment, Events, Education, Outreach Marketing

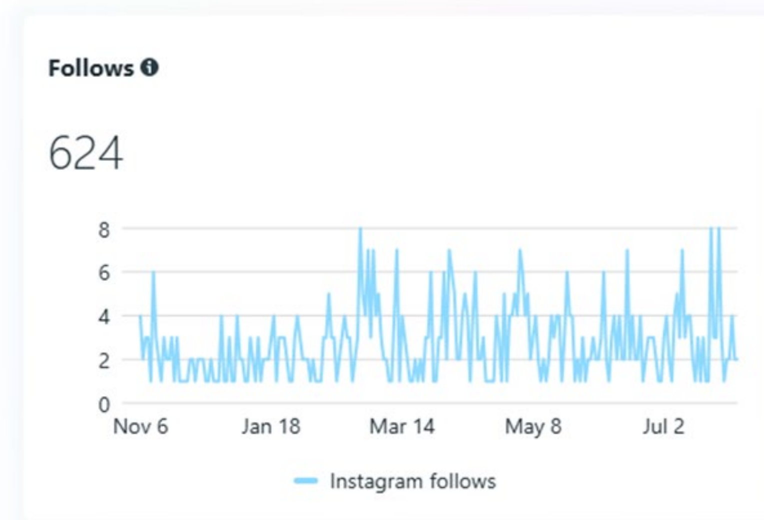
2. **2024/2025 The Goal Was:**

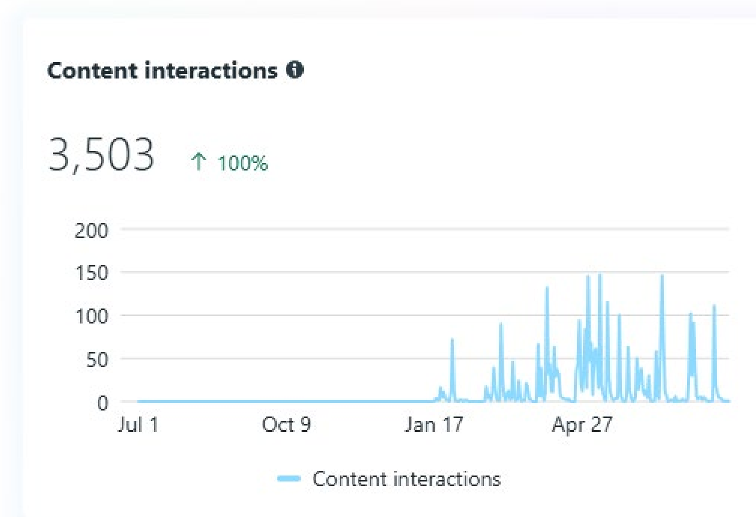
   ☒ **MET** ☐ **NOT MET**

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

   The PIO team used analytical data and creativity to represent KernBHRS in the best way possible on our social media platforms. This included looking at other similar accounts in the behavioral health field and other Kern County departments. Our team blended recent trends and what was working well on our sites, to maximize our exposure and helping get people the information they need.

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





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

The growth of our social media presence has been substantial over the last fiscal year. One area of concern is that our Facebook account has been suspended for reasons out of our control.

Moving forward, we will need to either get access to the current account or start over, which would take a long time to rebuild. However, it is not impossible.

6. **Recommendation for Current Goal:**

☒ Discontinue goal

While important, this goal could/should continue on in perpetuity at least for the PIO team. I think there are some other areas we could focus on that are new as we transition more to a plan, rather than a provider in the future.

Goal # 29 Increase Recruitment of Clinical and Administrative Positions

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

   Increase Recruitment of Clinical and Administrative Positions

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2. **2024/2025 The Goal Was:**

   ☒ **MET** ☐ **NOT MET**

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

   The department continues reach prospective candidates in Kern County and the outlining communities by building relationships with local vocation schools, community colleges, and universities. Recruitment efforts are made through advertising on various platforms such as Linkedin, email social media blast through KernBHRS Public Information Officer, outreach to educational organizations, job flyers, job fairs, and National Healthcare Service Corps job postings. KernBHRS Human Resources continues to collaborate with Kern County Human Resources to post job bulletin on the County Website and Linkedin. For hard-to-fill positions, County HR will work with Employer's Training Resources to post on Job Corner, Channel 17 news. Kern County HR continues to host their annual County Job Fair for all County Departments to attend. Our BH Workforce Development Coordinator continues to collaborate with our contract providers to host the KernBHRS Career Expo both in the Fall in the Spring to continue to maintain our relationship with the workforce.

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

   As of August 2025, KernBHRS has 1044 permanent positions with 162 vacancies. The department's current vacancy percentage rate is as follows:

   - 15 percent vacancy rate (Includes all vacancies)
   - 4 percent vacancy rate (Excludes vacancies on hold and vacancies that have not been requested by supervisor)

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

   KernBHRS Human Resources' goal is to always maintain a vacancy rate below 10 percent. Our Human Resources team has been keeping the vacancy rates well under the 10 percent threshold with those vacancies that are approved to be filled.

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6. **Recommendation for Current Goal:**

   ☒ Keep the goal with no change for the upcoming year

   It is important that this remains a goal as it is a NACT requirement to maintain our vacancy rate at 10 percent or lower. It is important to continue to recruit for all positions as the department moves forward with Proposition 1 changes.

Goal # 30 Improve Onboarding Process for Medical Staff (Psychiatry, NP's, RN's, LVN's)

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

   Improve Onboarding Process for Medical Staff (Psychiatry, NP's, RN's, LVN's) Ensuring Onboarding at Least 2 Weeks Prior to Start Date.

2. **2024/2025 The Goal Was:**

   ☒ MET ☐ NOT MET

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

   KernBHRS initially has a meeting with medical services and contracts to discuss the onboarding process for medical staff. During the meeting each team got full understanding of what is needed in order for Human Resources to complete the onboarding process in a timely manner. This included the timely execution of each contract and continuous communication with the Medical Services. Onboarding for BH Nurses and Vocational Nurses has improved and there have been no delays in onboarding.

   Medical Services continues to notify KernBHRS immediately when a psychiatrist – Contract Employee is onboarding to move forward with the process as quickly as possible. KernBHRS also maintains flexibility to coordinate with Psychiatrist's schedules.

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

   N/A

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

   For the 2024-25 year, we did not have any issues onboarding psychiatrists or nurses. All were onboarded on specified dates and received all their computer equipment the morning of onboarding. Our HR team worked with Medical Services to get everyone in to pre-screen in a timely manner. For psychiatrist coming from out-of-town electronic onboarding packets were provided to get their information in the system by ITs deadline. If there were any delays we would immediately notify IT so that they were prepared to build someone into the system before the onboarding date.

6. **Recommendation for Current Goal:**

   ☒ Change goal

   We have streamlined the onboarding process for nurses and psychiatrist contract employees. The area that Human Resources would like to improve is the onboarding process for the yearly Psych-Interns and Psychiatrist-Contract employees transitioning from KM. A few delays occurred that inconvenienced the staff and want to assure that everyone has a good experience before and after onboarding.

Goal # 31 Maintain Adequate Staffing Throughout the Crisis Division

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

   Goal # 31 Maintain Adequate Staffing Throughout the Crisis Division by Maintaining a 10% Or Less Vacancy Rate

2. **2024/2025 The Goal Was:**

   ☐ MET ☒ NOT MET

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

   Quarters 1-3 were impacted due to hiring holds/shifts related to Prop 1. However, Q4 saw a decrease in the vacancy rate as the Department began to fill positions.

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

Performance Toward Goal:		
Numerator	**Denominator**	**Percentage**
25.8	163	**15.8%**

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

   As the Department continues to fill vacant positions, the overall vacancy rate is expected to decrease.

6. **Recommendation for Current Goal:**

   ☒ Change goal