SAN BENITO COUNTY BEHAVIORAL HEALTH

MENTAL HEALTH & SUBSTANCE USE SERVICES

Quality Improvement Work Plan and Evaluation Report

ANNUAL WORK PLAN FOR FY 2023/2024
AND
EVALUATION REPORT FOR FY 2021/2022

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A. QUALITY IMPROVEMENT PROGRAM OVERVIEW

1. Quality Improvement Program Characteristics

San Benito County Behavioral Health (SBCBH) has implemented a Quality Improvement (QI) program in accordance with state regulation for evaluating the appropriateness and quality of mental health and substance use disorder services, including over-utilization and underutilization of services; timeliness standards; access; and effectiveness of clinical care.

It is the purpose of SBCBH to build a structure that ensures the overall quality of services. The QI program meets this objective through the following processes:

a. Identifying goals and prioritized areas for improvement;
b. Collecting and analyzing data to measure against the identified goals or areas of improvement;
c. Based on data and identified trends, designing and implementing interventions to improve performance;
d. Measuring the effectiveness of the interventions over time, through the analysis of system- and client-level data;
e. Incorporating successful interventions across the system, as appropriate; and
f. Ensuring ongoing training of staff to ensure quality of care, including training, support, and monitoring to implement CalAIM. Trainings may be offered in-person, or online through the SBCBH Relias system, CalMHSA website, or other sources.

The SBCBH QI program is designed to address quality improvement and quality management to ensure to all stakeholders that the processes for obtaining services are fair, efficient, and cost-effective; and that the system produces results consistent with the belief that people with mental health issues and substance use disorders may recover.

The QI program is crucial for upholding and monitoring the requirements of state and federal regulations regarding timeliness and quality of care; the Medi-Cal Mental Health Plan (MHP) contract with the California Department of Health Care Services (DHCS); the intergovernmental agreement for the delivery of services within the Drug Medi-Cal Organized Delivery System (DMC-ODS); and the contracts between SBCBH and DHCS for the delivery of Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block Grant (SABG) services.

The QI program is responsible for monitoring program effectiveness through the development and implementation of performance monitoring activities at all levels of the organization, including, but not limited to client and system access; timeliness; quality; assessment of clients; clinical outcomes; utilization and clinical records review; monitoring and resolution of client grievances and appeals; fair hearings; and provider appeals.

Executive management and program leadership is crucial to ensure that QI activities and findings are used to establish and maintain the overall quality of the service delivery system and organizational operations. As a result, the QI program is directly accountable to the SBCBH Director.

2. Quality Improvement Committee

Essential to the performance of the QI program is a complete information feedback loop wherein information flows across clinical, programmatic, and administrative channels.

SBCBH has established a quality committee that includes representation from SBCBH (licensed MH clinicians, licensed and/or certified SUD counselors, management, etc.); network providers; clients; family members; and stakeholders, to ensure the effective implementation of the QI Work Plan. This committee is detailed below.

a. The Quality Improvement Committee (QIC)/Compliance Committee meets every month.

1) QIC Membership

a) Designated members of the QIC include the SBCBH Assistant Director; QI Supervisors; Staff Analysts; and representatives from MH, SUD, Access Team, Crisis, Medication Support, and Administrative Services.

2) QIC Functions and Responsibilities

a) Implements the specific and detailed review and evaluation activities of the agency.
   1. Regularly collects, reviews, evaluates, analyzes data, and implements actions that frequently involve handling sensitive and confidential information.
   2. Provides oversight to QI activities, including the development and implementation of the required Performance Improvement Projects (PIPs).
   3. Reviews collected information, data, and trends relevant to standards of cultural and linguistic competency

b) Recommends policy decisions; reviews and evaluates the results of QI activities; and monitors the progress of the PIPs.
   1. Institutes needed actions and ensures follow-up of QI processes.
   2. Documents all activities through dated and signed minutes to reflect all QI decisions and actions made by the QIC.

c) Ensures that QI activities are completed as required; and utilizes a continuous feedback loop to evaluate ongoing quality improvement activities.
   3. Monitors previously-identified issues and related data; and tracks issues, interventions, and outcomes over time.
   4. Promotes client and family voice to improve wellness and recovery.
   5. Continuously conducts planning and initiates new activities for sustaining improvement.

3) QIC Agendas

a) The QIC uses three (3) standing meeting agendas (one for each month of each quarter) to ensure that all required QI components are addressed at each meeting. The agendas include at least the following:

1. Access Log review
    - Business days for initial assessment and first service appointments; meds requests
    - Response for urgent and crisis conditions (during regular hours and after-hours)
    - Requests for cultural/linguistic services, including language assistance; assess results
    - Access Line Test Calls (quarterly report)
2. Clinical Team Meeting Assessments (CANS, PSC, etc.)
3. Crisis/Inpatient/IMD/Residential program review; concurrent review: census; utilization; length of stay; and linkage to outpatient services
4. Processed Treatment Authorization Requests (TARs) for utilization and documentation compliance
5. Clinical Practices and Peer Consultation (DMC-ODS/SUD and Mental Health)
6. Chart review results for quality and appropriateness of client care; timeliness of services; and compliance with documentation standards (assessments, service plans, etc.)
    - Review UR decisions for quality, timeliness, and utilization management issues
    - Monitor UR Return for Review and Correction process through summary format
    - Review EQR process for quality assurance
    - Review clinical peer reviews
    - Follow up on any required Corrective Action Plans (CAPs)
7. Data for client- and system-level performance outcome measures
8. Medication monitoring/medication chart reviews (Mental Health)
9. Issued NOABDs, including timeliness & appropriateness; requests for second opinions
10. Grievances and appeals (client or provider), including change of provider requests
11. Requests for (or results of) state fair hearings, including Aid Paid Pending
12. Mental Health and DMC-ODS/SUD program updates
13. New regulations & standards, including DHCS notices & publications
14. Results from audits & other reviews (Triennial; EQR; SUD) & monitor CAP progress
15. Performance Improvement Projects (PIPs)
16. Compliance; fraud/waste; patient's rights; and HIPAA/privacy issues

17. County and contract provider certification/recertification status; credentialing
18. SMHS & DMC-ODS Implementation Plan Updates
19. Results of Medi-Cal service delivery verification process
20. Provider satisfaction surveys
21. Client and family satisfaction surveys
22. Client and family participation in services, system planning, QIC, etc.
23. Other items for discussion
24. Recommend identified program changes; assign new action items

4) QIC Meeting Sign-In Sheet

a) A Sign-In Sheet is collected at the beginning of each QIC meeting. A Confidentiality Statement is integrated into the QIC Sign-In Sheet to ensure the privacy of protected health information.

5) QIC Meeting Minutes

a) The QIC uses a meeting minute template that closely follows the agenda template, to ensure that all relevant and required components are addressed in each set of minutes. Meeting minutes are utilized to track action items and completion dates. Minutes are maintained by a designated QI Supervisor, and are available for required annual audits and triennial reviews.

3. Behavioral Health Board

The Behavioral Health Board (BHB) meets at least ten (10) months annually. The members of the BHB include appointed consumers; representative from the San Benito County Board of Supervisors; SBCBH Director; Program Managers for Children, Adults. and SUD; QI staff; and support staff.

The BHB receives information from the QIC, and provides feedback on access findings and policy change proposals. The comments from this forum are documented in the meeting minutes and reported back to the QIC to inform practices, and policy changes. A QIC member regularly presents information to the BHB to ensure that quality issues are discussed.

4. Quality Improvement Annual Work Plan Components

The annual SBCBH Quality Improvement Work Plan and Evaluation Report (referred to as the "QI Work Plan" or the "Plan" throughout this document) provides the blueprint for the quality management functions designed to improve client access, quality of care, cost-effectiveness, and outcomes. This Plan is evaluated and updated at least annually.

The SBCBH Annual QI Work Plan includes at least the following components:

a. An annual evaluation of the overall effectiveness of the QI Program, utilizing data to demonstrate that QI activities have contributed to meaningful improvement in clinical care and client services;
b. A determination of goals and objectives for the coming year;
c. Progress on previously-identified issues, including tracking issues over time through data analysis and program monitoring; and
d. An outline of activities and interventions for improving identified issues; and
e. Activities for sustaining improvement and quality of care.

Designated QI staff facilitates the implementation of the QI Work Plan and the QI activities. Sufficient time to engage in QI activities is allocated to these functions (e.g., conducting chart reviews, coordinating PIPs, facilitating the committee, monitoring activities).

The SBCBH QI Work Plan ensures the opportunity for input and active involvement of clients, family members, licensed and paraprofessional staff, providers, and other interested stakeholders in the QI Program. QIC members participate in the planning, design, and implementation of the QI Program, including policy setting and program planning. The QI Work Plan addresses quality assurance/improvement factors as related to the delivery of timely, effective, and culturally-responsive specialty mental health and substance use disorder services.

The QI Work Plan is posted on the SBCBH website, and is also available upon request. It is provided to the External Quality Review Organization (EQRO) during its annual review of the SBCBH system for both the MHP and DMC-ODS programs. The QI Work Plan is also available to auditors during the triennial Medi-Cal compliance reviews.

5. Accountability

The QI program and the QIC are accountable to the SBCBH Director. The QI program coordinates performance monitoring activities throughout the program and includes client and system level outcomes; implementation and review of the utilization review process; credentialing of licensed staff; monitoring and resolution of beneficiary grievances, fair hearings, and provider appeals; periodically assessing consumer, youth, and family satisfaction; and reviewing clinical records.

SBCBH contracts with network providers of MH and DMC-ODS services, as well as psychiatric inpatient hospitals. As a component of the contracts, these entities are required to cooperate with the SBCBH QI Program, including following QI standards, as well as regularly monitoring

services. In addition, contract providers must allow SBCBH access to relevant clinical and fiscal records to the extent permitted or required by state and federal regulations.

B. DATA COLLECTION – SOURCES AND ANALYSIS

1. Data Collection Sources: QI Work Plan data sources include, but not are limited to, the following (as available):

    a. Client and service utilization data by type of service, age, gender, race, ethnicity, primary language, veterans, and LGBTQ+
    b. Electronic Health Record (EHR) Reports
    c. Access Log
    d. Client and family satisfaction surveys (internal and state-directed)
    e. Client Grievance/Appeal Log; State Fair Hearing Log
    f. Change of Provider forms and Log
    g. Medication Chart Review forms and Logs
    h. Staff training logs
    i. Notice of Adverse Benefit Determination (NOABD) forms and logs
    j. Second Opinion requests, resolutions, and outcomes
    k. Concurrent Review / Inpatient Census Logs
    l. Treatment Authorization Requests (TAR) Logs
    m. Service Authorization Request (SAR) Logs
    n. Staff productivity reports
    o. QI Chart Review Checklists and any corrective action plans (CAPs)
    p. Compliance Log
    q. Policies and procedures
    r. QIC minutes
    s. Internal MH and DMC-ODS monitoring activities
    t. EQR and Medi-Cal compliance review results
    u. Special reports from DHCS or other required studies

2. Data Analysis and Interventions

    a. Designated QI staff perform preliminary analysis of data to review for accuracy and completion.

        1) If there are areas of concern, the QIC discusses the information. Clinical staff may be asked to implement CAPs, as needed.
        2) Policy changes may also be implemented, if required.
        3) Subsequent review is performed by the QIC.

    b. Proposed policy and/or system changes to programs and/or interventions are discussed with individual staff; QIC members (including clients and family members); Behavioral Health Board members; and SBCBH management.

1) Program changes must have the approval of the SBCBH Director prior to implementation.

c. Effectiveness of program changes are evaluated by the QIC.

1) Input from the committees is documented in the meeting minutes, which include the activity, person responsible, and timeframe for completion.

2) Each activity and the status for follow-up are discussed at the next meeting.

C. DELEGATED ACTIVITIES STATEMENT

SBCBH does not delegate any review activities. Should delegation take place in the future, this Plan will be amended accordingly.

D. QI EVALUATION REPORT – GOALS, DATA, AND INTERVENTIONS

<table>
<tr><th colspan="4">Goal 1: To ensure timely access to routine outpatient services, persons requesting non-crisis mental health services who are new to SBCBH are offered an initial assessment appointment within 10 business days of the request for services</th></tr>
<tr><td>Objective</td><td colspan="3">To monitor timeliness of new requests for routine outpatient mental health services to ensure accessibility</td></tr>
<tr><td>Numerator</td><td colspan="3">Total number of persons requesting mental health services who are new to SBCBH and were offered an initial assessment appointment within 10 business days in a given fiscal year</td></tr>
<tr><td>Denominator</td><td colspan="3">Total number of persons requesting mental health services who are new to SBCBH mental health services in a given fiscal year</td></tr>
<tr><td>Performance Indicator/Target Goal</td><td colspan="3">To offer an initial assessment appointment within 10 business days of request</td></tr>
<tr><td rowspan="4">Data</td><td>Number and percent of new requests that met this standard in FY 2018-2019</td><td>472 / 539 clients</td><td>87.6%</td></tr>
<tr><td>Number and percent of new requests that met this standard in FY 2019-2020</td><td>438 / 473 clients</td><td>92.6%</td></tr>
<tr><td>Number and percent of new requests that met this standard in FY 2020-2021*</td><td>257 / 287 clients</td><td>89.5%</td></tr>
<tr><td>Number and percent of new requests that met this standard in FY 2021-2022*</td><td>275 / 330 clients</td><td>83.3%</td></tr>
<tr><th colspan="4">Evaluation</th></tr>
<tr><td colspan="4">Analysis: The percentage of persons requesting mental health services who are new to SBCBH and who were offered an assessment appointment within 10 business days has remained relatively steady since FY 2018-2019. In FY 2020-2021 and FY 2021-2022, the data was analyzed using a more consistent source (see *NOTE below). SBCBH continues to meet the standard in this area; however, because timely access is a key component, SBCBH will continue to monitor this goal in FY 2023-2024.</td></tr>
<tr><td colspan="4">Quality Improvement Action Plan: In FY 2023-2024, SBCBH will maintain or improve the percentage of requests that are offered an initial assessment appointment within 10 business days.</td></tr>
<tr><td colspan="4">Suggested Interventions:
• Continue to utilize the Screening Tool to ensure that eligible clients receive assessment appointments and/or are referred to appropriate LOC within 10 business days.
• Conduct staff training on scheduling new requests for services, with an emphasis on the 10-day standard.
• Review data weekly with management staff and monthly with QIC to identify barriers to meeting the 10-day timeframe; document review.
• Review assessment staff schedules and block assessment times each week to allow admin staff to schedule assessment appointments within 10 business days.</td></tr>
</table>

Data Sources: Cerner. **Frequency:** Quarterly.

**NOTE: The analysis methodology changed with the FY 2020-2021 and FY 2021-2022 data. Data is now pulled from the Cerner CSI Assessment Report for requests with a mental health subunit only (blank subunits were not included). Previous years' data was pulled from a different report, so the number of requests included were higher in prior years' data. Future years' data analysis will utilize the methodology used in FY 2020-2021 and FY 2021-2022.*

<table>
<tr><th colspan="3">Goal 2: Increase the number of outpatient mental health services received by Transition Age Youth (TAY)</th></tr>
<tr><td>Objective</td><td colspan="2">To offer TAY engaging outpatient mental health services to increase TAY utilization of services and SBCBH service delivery capacity</td></tr>
<tr><td>Numerator</td><td colspan="2">Total number of outpatient mental health services delivered to TAY in a given fiscal year</td></tr>
<tr><td>Denominator</td><td colspan="2">Total number of TAY clients served in a given fiscal year</td></tr>
<tr><td>Performance Indicator/Target Goal</td><td colspan="2">To maintain or increase the number of outpatient mental health services received by TAY to at least 15 mental health services per TAY client each year</td></tr>
<tr><td rowspan="4">Data</td><td>Average number of outpatient mental health services received by TAY clients in FY 2018-2019</td><td>11 services</td></tr>
<tr><td>Average number of outpatient mental health services received by TAY clients in FY 2019-2020</td><td>13 services</td></tr>
<tr><td>Average number of outpatient mental health services received by TAY clients in FY 2020-2021</td><td>15 services</td></tr>
<tr><td>Average number of outpatient mental health services received by TAY clients in FY 2021-2022</td><td>12 services</td></tr>
<tr><th colspan="3">Evaluation</th></tr>
<tr><td colspan="3">Analysis: The average number of outpatient mental health services received by TAY consistently increased from FY 2018-2019 to FY 2020-2021. In FY 2021-2022, this decreased to 12 services received by TAY. This population is at high risk; as a result, SBCBH will continue to monitor this goal in FY 2023-2024 and aim to increase to 15 services per TAY.</td></tr>
<tr><td colspan="3">Quality Improvement Action Plan: In FY 2023-2024, SBCBH will increase the number of outpatient mental health services received by TAY to 15 or more mental health services per TAY client per year.</td></tr>
<tr><td colspan="3">Suggested Interventions:
• Continue contracts with providers that specialize in Children and Family Services.
• Continue to train staff on designing services that help engage TAY in services and eliminating barriers.
• Conduct TAY focus groups at least quarterly to generate ideas for TAY activities
• Identify and deliver TAY engaging activities.
• Identify TAY activities for TAY and families to create positive experiences (e.g., bowling; evening hiking; picnics; Karaoke).
• Develop paid Peer Mentor positions (0.5 FTEs) to deliver TAY and create engaging TAY activities that are youth focused.</td></tr>
</table>

Data Source: Cerner. **Frequency:** Annually.

Goal 3: Ensure timely access to a Medication Assessment			
Objective	To monitor timeliness of new referrals to a medication assessment through psychiatry (including telepsychiatry) to ensure access to medication services		
Numerator	Total number of persons referred for a medication assessment who receive a psychiatry (including telepsychiatry) medication assessment service within 15 business days.		
Denominator	Total number of persons referred for a medication assessment to psychiatry (including telepsychiatry).		
Performance Indicator/Target Goal	To ensure clients who need to be assessed for medications receive a medication assessment within 15 business days		
Data	Number of clients who received a medication assessment within 15 business days in FY 2018-2019	311 / 454 clients	68.5%
	Number of clients who received a medication assessment within 15 business days in FY 2019-2020	274 / 431 clients	63.6%
	Number of clients who received a medication assessment within 15 business days in FY 2020-2021*	58 / 63 clients	92.1%
	Number of clients who received a medication assessment within 15 business days in FY 2021-2022*	53 / 56 clients	94.6%

Evaluation

Analysis: The percentage of mental health clients who received a medication assessment slightly decreased from 68.5% in FY 2018-2019 to 63.6% in FY 2019-2020. The percentage then significantly increased to 92.1% in FY 2020-2021 and increased again to 94.6% in FY 2021-2022. In FY 2020-2021 and FY 2021-2022, the data was analyzed using a more consistent source (see *NOTE below), which may account for the increase. SBCBH will continue to monitor this goal in FY 2023-2024 and work to maintain access.

Quality Improvement Action Plan: SBCBH will work closely with the SBCBH psychiatrists and Kings View to maintain timely access to medication assessments. In FY 2023-2024, SBCBH plans to maintain timely access to this level of care.

Suggested Interventions:

- Ensure that psychiatrists understand the 15-day standard for scheduling medication assessments.
- Provide feedback to psychiatrists about length of time to schedule a psychiatric medication assessment appointment and the number of clients waiting for a psychiatry appointment over 15 business days.
- Offer transportation for clients to help them keep their medication assessment appointment, as scheduled.
- Research options for tracking the client's first treatment appointment, in order to better identify what type of treatment the client receives at their initial treatment appointment.

Data Source: Cerner. **Frequency:** Annually.

**NOTE: The analysis methodology changed with the FY 2020-2021 and FY 2021-2022 data. Data is now pulled from the Cerner CSI Assessment Report for medication subunits. Previous years' data was pulled from a different report, so the number of requests included were much higher in prior years' data. Future years' data analysis will utilize the methodology used in FY 2020-2021 and FY 2021-2022.*

<table>
<tr><th colspan="4">Goal 4: Increase access to Substance Use Disorder (SUD) services for Spanish-speaking clients</th></tr>
<tr><td>Objective</td><td colspan="3">To increase the number and percent of clients who are Spanish speaking and receive SUD services</td></tr>
<tr><td>Numerator</td><td colspan="3">Number of SUD clients served in a given fiscal year who have Spanish as their preferred language</td></tr>
<tr><td>Denominator</td><td colspan="3">Total number of all SUD clients served in a given fiscal year</td></tr>
<tr><td>Performance Indicator/Target Goal</td><td colspan="3">To maintain the percent of Spanish speaking SUD clients at 10%</td></tr>
<tr><td rowspan="4">Data</td><td>Number of SUD clients with Spanish as their preferred language in FY 2018-2019</td><td>23 / 274 clients</td><td>8.4%</td></tr>
<tr><td>Number of SUD clients with Spanish as their preferred language in FY 2019-2020</td><td>21 / 265 clients</td><td>7.9%</td></tr>
<tr><td>Number of SUD clients with Spanish as their preferred language in FY 2020-2021</td><td>33 / 305 clients</td><td>10.8%</td></tr>
<tr><td>Number of SUD clients with Spanish as their preferred language in FY 2021-2022</td><td>24 / 267 clients</td><td>9.0%</td></tr>
<tr><th colspan="4">Evaluation</th></tr>
<tr><td colspan="4">Analysis: The percent of SUD clients who are Spanish speaking decreased from 8.4% in FY 2018-2019 to 7.9 % in FY 2019-2020; the percent then increased to 10.8% in FY 2020-2021; then decreased to 9% in FY 2021-2022. SBCBH will continue to monitor this goal in FY 2023-2024 and work to maintain access.</td></tr>
<tr><td colspan="4">Quality Improvement Action Plan: In FY 2023-2024, SBCBH plans to increase the percent of Spanish-speaking persons to 10% of all SUD clients.</td></tr>
<tr><td colspan="4">Suggested Interventions:
Hire additional bilingual SUD counselors.
Develop a brochure in Spanish that describes the SUD services that are available in Spanish and introduces the Spanish speaking staff.
Expand the number of SUD groups that are offered in Spanish: offer more Spanish groups in the evening and weekends.
Conduct Spanish-speaking focus groups at least twice a year to generate ideas for engaging this population in SUD services, and for offering services that are culturally responsive to the Latino population.
Conduct addition outreach to this population, such as presentations about available SUD services to the migrant community.
Add Parent University presentations in Spanish for Spanish-speaking parents.</td></tr>
</table>

Data Source: Cerner. **Frequency:** Quarterly.

Goal 5: To conduct medication monitoring activities on at least 10% of medication charts each year			
Objective	To assess the safety and effectiveness of medication practices in SBCBH to ensure quality of care		
Numerator	Number of medication charts reviewed in a given fiscal year		
Denominator	Total number of persons receiving medication services in a given fiscal year		
Performance Indicator/Target Goal	To maintain the number of medication charts reviewed through medication monitoring to represent at least 10% of the persons receiving medication services		
Data	Number and percent of medication charts reviewed in FY 2018-2019	57 charts out of 595 medication clients	9.6%
	Number and percent of medication charts reviewed in FY 2019-2020	48 charts out of 594 medication clients	8.1%
	Number and percent of medication charts reviewed in FY 2020-2021	71 charts out of 624 medication clients	11.4%
	Number and percent of medication charts reviewed in FY 2021-2022	67 charts out of 616 medication clients	11%

Evaluation

Analysis: The percentage of medication charts being reviewed was 9.6% in FY 2018-2019. This number decreased to 8.1% in FY 2019-2020, then increased to 11.4% in FY 2020-2021. Although this number slightly dropped again to 11% in FY 2021-2022, SBCBH maintained its goal of reviewing at least 10% medication charts. Medication monitoring is a key component; as a result, SBCBH will continue to monitor this goal in FY 2023-2024.

Quality Improvement Action Plan: In FY 2023-2024, SBCBH plans to maintain the number of medication charts reviewed through medication monitoring activities, reviewing at least 10% of all medication charts to ensure quality of care.

Suggested Interventions:

- Continue to contract with a third-party prescriber (psychiatrist or pharmacist) to complete medication monitoring activities at least quarterly.
- Train staff and third-party reviewer on the importance of medication monitoring activities, including target goals.
- Review medication monitoring results at QIC at least quarterly; provide feedback to third-party reviewer if goals are not met.
- Review contractor budget and revise third-party review schedule as needed and allowed to meet the goal of reviewing 10% of charts.

Data Source: Cerner. **Frequency:** Annually.

Goal 6: Resolve, and respond in writing to, 100% of all filed grievances, within 60 calendar days			
Objective	To evaluate client grievances, appeals, and requests for state fair hearings, to ensure access and quality of care		
Numerator	Number of grievances that were resolved, and client and provider notified in writing, within 60 calendar days of receipt in a given fiscal year		
Denominator	Total number of grievances in a given fiscal year		
Performance Indicator/Target Goal	100% of filed grievances are resolved, and client and provider notified in writing, within 60 calendar days of receipt		
Data	Number of grievances and percent that met standard in FY 2018-2019	5 / 5 grievances	100%
	Number of grievances and percent that met standard in FY 2019-2020	18 / 18 grievances	100%
	Number of grievances and percent that met standard in FY 2020-2021	10 / 11 grievances	90.9%
	Number of grievances and percent that met standard in FY 2021-2022	15 / 15 grievances	100%
Evaluation			
Analysis: The number of grievances increased from 5 to 18 in FY 2019-2020, with 100% resolved within 60 calendar days. In FY 2020-2021, 10 of the 11 grievances were resolved in 60 calendar days (90.9%). In FY 2021-2022, all 15 of the grievances were resolved in 60 calendar days (100%). SBCBH continues to excel in this area; and, because this component is key to quality care, SBCBH will continue to monitor this goal in FY 2023-2024.			
Quality Improvement Action Plan: In FY 2023-2024, SBCBH will resolve 100% of filed grievances, and notify the client and provider in writing, within 60 calendar days of receipt.			
Suggested Interventions: • Continue to train staff on grievances, appeals, and state fair hearings and how to document and resolve each event. • Review grievances, appeals, and state fair hearings during QIC to evaluate services; review any trends in grievances; and develop strategies for improving services.			

Data Source: Grievance and Appeal Log. **Frequency:** Quarterly.

<table>
<tr><th colspan="4">Goal 7: To deliver services that are culturally sensitive to each client’s cultural/ethnic background and in their preferred language</th></tr>
<tr><td>Objective</td><td colspan="3">To ensure staff deliver services that are culturally and linguistically sensitive to help improve access and quality of care</td></tr>
<tr><td>Numerator</td><td colspan="3">Number of client and family respondents who agreed to the survey question: “Staff were sensitive to my cultural/ethnic background” in a given fiscal year</td></tr>
<tr><td>Denominator</td><td colspan="3">Total number of client and family respondents</td></tr>
<tr><td>Performance Indicator/Target Goal</td><td colspan="3">To increase and/or sustain the number and percent of clients and family members that report to the survey question: “Staff were sensitive to my cultural/ethnic background”</td></tr>
<tr><td rowspan="4">Data</td><td>Number and percent of clients and family members reporting that staff met this measure in FY 2018-2019</td><td>84 / 117</td><td>71.8%</td></tr>
<tr><td>Number and percent of clients and family members reporting that staff met this measure in FY 2019-2020</td><td>80 / 102</td><td>78.4%</td></tr>
<tr><td>Number and percent of clients and family members reporting that staff met this measure in FY 2020-2021*</td><td>8 / 9</td><td>88.9%</td></tr>
<tr><td>Number and percent of clients and family members reporting that staff met this measure in FY 2021-2022**</td><td>41 / 50</td><td>82.0%</td></tr>
<tr><th colspan="4">Evaluation</th></tr>
<tr><td colspan="4">Analysis: The percentage of survey respondents who reported staff sensitivity to their cultural/ethnic background increased each year from FY 2018-2019 to FY 2020-2021. In FY 2021-2022, this percentage decreased to 82%. This component is key to quality care, so SBCBH will continue to monitor this goal in FY 2023-2024.</td></tr>
<tr><td colspan="4">Quality Improvement Action Plan: In FY 2023-2024, SBCBH will increase and/or sustain the number and percent of clients and family members that report to the survey question: “Staff were sensitive to my cultural/ethnic background.”</td></tr>
<tr><td colspan="4">Suggested Interventions:
• Continue to train all staff on cultural humility, improve services, and create more culturally responsive services.
• Continue to train all staff on areas for providing culturally-relevant services to the Hispanic community.
• Regularly assess and report to the QIC the number of staff who are Hispanic and speak Spanish.
• Identify other cultures and languages that are underrepresented, including the LGBTQ community; assess and report regularly.
• Continue to support the strategies for hiring individuals to strengthen the diversity of staff.</td></tr>
</table>

Data Source: Completed POQI surveys. **Frequency:** Twice each year, totaled annually.

**NOTE: In FY 2020-2021, one (1) of the two (2) survey distributions was not conducted due to the public health restrictions. Also, most of the surveys were collected electronically by UCLA, but the responses were not sent to SBCBH. As a result, the number of completed surveys is much smaller in FY 2020-2021. **NOTE: Only Spring 2022 is available.*

Goal 8: To increase staff productivity, including the percent of billable services, to improve access, quality, and cost-effectiveness of services			
Objective	To assess and monitor staff productivity to improve access, staff performance, effective service utilization, service capacity, and cost-effectiveness of services		
Numerator	Number of services delivered by staff that were billable services in a given fiscal year		
Denominator/Comparison	Number of services delivered by staff that were billable services in the previous fiscal year		
Performance Indicator/Target Goal	To improve the number and percent of billable services delivered by staff each year by 10%.		
Data	Percent of services delivered by staff that were billable services in FY 2018-2019	32%	6.7% increase over previous year
	Percent of services delivered by staff that were billable services in FY 2019-2020	30%	6.3% decrease over previous year
	Percent of services delivered by staff that were billable services in FY 2020-2021	31%	3.3% increase over previous year
	Percent of services delivered by staff that were billable services in FY 2021-2022*	34%*	9.2% increase over previous year*

Evaluation

Analysis: The percentage of services delivered by staff that are billable decreased from 32% in FY 2018-2019 to 30% in FY 2019-2020. This then increased to 31% in FY 2020-2021 and increased again to 34% in FY 2021-2022. Improving staff productivity continues to be a challenge; as a result, SBCBH will continue to address this goal in FY 2023-2024.

Quality Improvement Action Plan: SBCBH will work closely with management and staff to identify and mitigate the reasons for the lack of improvement in this area. SBCBH will also work to improve consistent data collection for this metric. In FY 2023-2024, SBCBH plans to increase the percent of billable services delivered by staff.

Suggested Interventions:

- Assign dedicated staff to consistently track the metric and improve data collection.
- Train staff on documentation of services and identify opportunities to maximize the number of billable services.
- Review productivity on a quarterly basis at QIC, identifying any issues with compliance, as appropriate.
- Provide feedback to managers and staff on productivity and celebrate successes.
- Identify staff who have higher productivity and have them mentor other staff to help document billable hours.

Data Source: Billed Services Benefits Deducted report. **Frequency:** Monthly

**FY 2021-2022 data includes only July 2021, due to staffing reassignments and the data not being tracked consistently. Productivity will be more consistently tracked in the next fiscal year.*

<table>
<tr><td colspan="4">Goal 9: To provide guidance and training to county-operated and county-contracted providers on all new behavioral health policies, as outlined by DHCS in BHIN numbers 21-071, 21-073, 22-011, 22-013, 22-019, and 23-001 (CalAIM Standards)</td></tr>
<tr><td colspan="4">NOTE: This goal or methodology may be updated when additional guidance is received from DHCS and CalMHSA.</td></tr>
<tr><td>Objective</td><td colspan="3">To train, support, and monitor county and provider staff around the CalAIM standards for Specialty Mental Health Services (SMHS) and DMC-ODS services, including (as relevant to job function) medical necessity; access; coding; and documentation and service standards.</td></tr>
<tr><td>Numerator</td><td colspan="3">Number of county and provider staff who completed CalAIM CalMHSA training(s)</td></tr>
<tr><td>Denominator/Comparison</td><td colspan="3">Number of county and provider staff who were eligible to attend CalAIM CalMHSA training(s)</td></tr>
<tr><td>Performance Indicator/Target Goal</td><td colspan="3">To improve the number and percent of county and provider staff who complete CalAIM training(s).</td></tr>
<tr><td>Data</td><td>Percent of county and provider staff who completed CalAIM training(s) in May 2022 – August 2023</td><td>60 / 69</td><td>87.0%</td></tr>
<tr><td colspan="4">Evaluation</td></tr>
<tr><td colspan="4">Analysis: The percentage of county and provider staff who started and completed CalAIM training(s) in May 2022 – August 2023 was 87%. CalAIM training is now a key component, and SBCBH will continue to monitor this goal in FY 2023-2024.</td></tr>
<tr><td colspan="4">Quality Improvement Action Plan: In FY 2023-2024, SBCBH plans to increase the number of county and provider staff who complete CalAIM training(s).</td></tr>
<tr><td colspan="4">Suggested Interventions:
• Continue training staff and providers on CalAIM standards.
• Track training and follow up</td></tr>
</table>

Data Source: CalMHSA Training Documentation Dashboard. **Frequency:** Monthly.

Goal 10: Timeliness of services of the first dose of NTP services	
Objective	To monitor timeliness of first dose of NTP services to ensure access to medication-assisted treatment
Numerator	Number of NTP clients who have their first dose within 3 business days
Denominator/Comparison	Total number of clients referred to NTP provider
Performance Indicator/Target Goal	TBD
Data	**NOTE: SBCBH is developing the methodology for collecting and analyzing this data. Data will be included in the next QI Work Plan Annual Update.**
Evaluation	
Analysis: TBD	
Quality Improvement Action Plan: TBD	
Suggested Interventions: • TBD	

Data Source: TBD. **Frequency:** TBD.

Goal 11: Access to after-hours care (DMC-ODS)			
Objective	To ensure that DMC-ODS member information and requests for authorized services based upon an urgent or emergent need are available seven days a week, 24 hours a day **NOTE: SBCBH is developing the methodology for collecting and analyzing this data. Data will be included in the next QI Work Plan Annual Update.**		
Numerator	TBD		
Denominator/Comparison	TBD		
Performance Indicator/Target Goal	TBD		
Data	TBD		
Evaluation			
Analysis: TBD			
Quality Improvement Action Plan: TBD			
Suggested Interventions: • TBD			

Data Source: TBD. **Frequency:** TBD.

Goal 12: Coordination of physical and mental health services with DMC-ODS services at the provider level	
Objective	To monitor the coordination of physical health care services with DMC-ODS services
Numerator	Number of new SUD clients with physical examinations completed within 12 months
Denominator/Comparison	Number of new SUD clients admitted (new admissions)
Performance Indicator/Target Goal	To ensure that all SUD clients have a physical examination within 12 months of admission
Data	**NOTE: SBCBH is developing the methodology for collecting and analyzing this data. Data will be included in the next QI Work Plan Annual Update.**
Evaluation	
Analysis: TBD	
Quality Improvement Action Plan: TBD	
Suggested Interventions: • TBD	

Data Source: TBD. **Frequency:** TBD.