Drug Medi-Cal Organized Delivery System (DMC-ODS) and Mental Health Plan (MHP)

Fiscal Year 2020/2021

Quality Improvement Performance Plan (QIPP) Evaluation

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Background

The San Bernardino County Department of Behavioral Health (DBH) Substance Use Disorder and Recovery Services (SUDRS) and Mental Health Plan (MHP) understand the need to provide excellent services through the provision of client-centered, consumer-driven, recovery oriented, and culturally competent behavioral health care services that strives for integration with primary health care and seeks to address each client's unique needs. It is DBH's mission to assist individuals with issues of substance use disorders (SUD) and mental health to find solutions to challenges faced, so they may live full and healthy lives and function and thrive within their families and communities.

DBH and its contractors are committed to continued quality improvement, program development and compliance efforts as detailed in the San Bernardino County Mental Health Plan (MHP), Department of Health Care Services (DHCS) contracts for mental health and Drug Medi-Cal Organized Delivery System (DMC-ODS), as well as the annual Quality Improvement Performance Plan (QIPP).

The QIPP is the Quality Improvement Work Plan for DBH. The QIPP meets the contractual requirements of the Mental Health Plan Contract with DHCS as well as additional areas of performance improvement as identified by California External Quality Review Organization (CAEQRO), the Countywide Vision Statement and DBH Strategic Plan. The DBH Quality Management Program is accountable to the MHP Director and is evaluated annually and updated as necessary.

Purpose

The purpose of the QIPP is to organize and provide structure for Quality Management Program activities and outline DBH's plan in response to specific requirements with both its Implementation Plans, DMC-ODS and MHP.

Implementation of the QIPP is through department infrastructure which includes QMAC, subcommittees that function as work groups, focus groups, clients, peers and family advocates, DBH Management, as well as DBH and contract clinics.

The Quality Management Program conducts performance monitoring activities throughout the MHP's operations. These monitoring activities are designed to improve the access, quality of care, and outcomes of the service delivery system. The QIPP has been organized into sections which relate to structure, implementation, and quantitatively measurable outcomes used to assess performance and to identify and prioritize areas for improvement. Outlined throughout are the goals, objectives, and outcomes for key areas that have been identified by the Mental Health Plan and DMC-ODS. They include but are not limited to the following elements: access to service, timeliness of services and/or appointments, service delivery capacity, beneficiary satisfaction, technology infrastructure, clinical issues, previously identified issues, provider appeals, continuity of care, and integration with physical health care.

MHP practitioners, providers, administrative staff, consumers, and family members participate in Quality Management Program activities.

QIPP EVALUATION

The purpose of the QIPP Evaluation is to provide an annual evaluation of the effectiveness of the Quality Improvement (QI) activities in meeting the QI goals and the objectives detailed in the QIPP. The evaluation will examine if QI goals were met and if so, determine whether the goals should be revised or if another QI goal should be pursued. The decision will be that of QMAC and consideration will be given to QI goals that DBH is contractually required to review. Therefore, the QIPP allows for continuous improvement of existing goals as well as the opportunity to identify new goals that need to be addressed systemwide. This year's evaluation utilizes performance indicators (Met, Not Met, and Partially Met) that clearly identify the scoring. Part of the evaluation also includes an examination of the QI activities and whether they need to be revised, removed, or remain as written, which is dependent on the scoring of the QI goal. Continuation of a goal should not be viewed as negative as there is always room for improvement not only regarding the performance of DBH but in improving the process, access, or outcome for clients.

Goal	Description	Rating M= Met PM= Partially Met NM= Not Met
Section 1: Timeliness		
A	Initial Request Non-Urgent Non-Physician Appointment MH	M
B	Initial Request Initial Psychiatry Appointment MH	M
C	Post-Hospitalization Follow-up MH	NM
D	Requests or Need of Urgent Services MH	M
E	Outpatient/Intensive Outpatient or Residential Treatment SUDRS	M
F	Narcotic Treatment Program/Opioid Treatment Program SUDRS	M
Section 2: MHP Service Delivery System for the Safety & Effectiveness of Medication Practices		
A	Conduct Physician Peer Reviews	PM
B	Release New Practice Guideline Topic	M
Section 3: Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)		
A	Inform Programs and Clinicians of Their Service Provision Patterns	NM
Section 4: Mental Health Needs in Specific Cultural and Ethnic Groups		
A	Penetration Rate for Underserved Ethnic/Cultural Populations	PM
B	MHP Providers Complete Required Cultural Competency Training	M
C	Language Services Training to all new DBH Employees	M
Section 5: Responsiveness of the 24/7 Toll Free Access Line and Access to Services		
A	Access to After-Hours Care Available 24/7	M
B	Review and Update Resources Guides	M
C	Test Calls Properly Logged	M
D	Test Calls During After-Hours	NM
E	MHP Access Line and SUDRS BAL Offer Prevalent Non-English Languages	PM
F	MHP Test Calls Verify Speak with a Representative	PM
Section 6: Performance Improvement Projects (PIPs)		
A	Participation and Engagement from Multiple Department Stakeholders	M
B	Participation and Engagement from Consumers	M
C	Improved Summary totals of PIP Validation for Clinical and Non-Clinical PIPS	PM
Section 7: Service Capacity		
A	Service Delivery System Monitoring	PM
B	Number of MHP Service Providers Meets Provider Ratios	PM

Performance Indicators

Section 8: Client Satisfaction		
A	Up-to-Date Postings of Grievance Procedures	M
B	Tracking and Accessing Client Grievances, Appeals and State Fair Hearings	PM
C	Updated NOABD, Grievances, Appeals and State Hearing Procedures for SUDRS	M
Section 8A: Improve Service Delivery		
A	Utilize Treatment Perception Survey data to assist with QI	M
Section 9: Service Delivery System		
A	Baseline of Clients Engaged in the Recovery Process	PM
Section 10: Reducing Emergency Department Hospitalization		
A	Reduction of Hospitalization with ED Bridge Buprenorphine Medication Assisted Treatment Stabilization Visit	M

Evaluation

SECTION 1 WORK GROUP MONITORING TIMELINESS *(Source: NACT, EQRO, Title 28)*	MHP AND SUDRS
FY 20/21 EVALUATION	DBH continues to meet DHCS timely access requirements and was advised in 2020 that it was meeting timely access with 90% compliance rate. This indicates DBH exceeded its goal of 85% compliance. However, DBH would like to continue this goal because these are mandated time and distance standards. Regarding psychiatry appointments, DBH data shows an 87% compliance rate which is 2% higher compared to the prior QIPP. Requests for and the need for urgent services within 48 hours was evaluated and a review of the data showed 99.16% of the clients received services for urgent conditions in less than 24 hours. Although DBH's current EHR cannot calculate the exact number of hours less than 24 hours, it showed 99.22% of the clients with an urgent condition were provided a service within 48 hours. A deeper dive of the data by populations: adults, youth, foster youth were not much different: • Adults: 99.12% were seen in less than 24 hours and 99.18% were rendered a service within 48 hours; • Youth: 99.55% were seen in less than 24 hours and 99.68% were provided a service within 48 hours; and • Foster Youth: 99.44% were seen in less than 24 hours and 99.44% were provided a service within 24 hours. Although this goal was met, DBH will continue this goal as it is a requirement for DHCS regarding timely access. DBH continues to be challenged in meeting timely follow-up for post psychiatric hospitalizations. The goal is seven (7) calendar days upon discharge for a follow-up outpatient appointment to occur. A cumulative follow-up shows DBH can only meet the goal of seven (7) calendar days for 28.3% of the clients. The data slightly changes when examined by populations but none of the populations meet the goal: • 25% of adults receive services within seven (7) calendar days; • 48% of youth receive services within seven (7) calendar days; and • 64% of foster youth receive services within seven (7) calendar days. This goal must continue as DBH is not meeting DHCS standards. Additionally, DBH created a workgroup called Fee For Service (FFS) Hospital Discharge to Outpatient Clinics with the charge to develop a plan to increase its compliance rate. QMAC determined this would be a top concentration of Section 1 of the QIPP.

	SUDRS has implemented timeliness data requirements into the DBH electronic health record where data can now be captured. DBH continues to review timeliness data, identify areas of improvement, data entry errors and offer technical assistance to impacted Opioid Treatment Programs (OTPs). When the electronic health record for DBH was implemented, OTPs had identified data entry challenges with the system and were unable to entry services initially. OTPs brought this challenge to DBH and the DBH Information Technology (IT) staff collaborated with OTPs to address data entry challenges. This was part of the quality improvement process for electronic health record implementation. OTPs can now enter timeliness data into the system, however, this is still an area that needs improvement. OTPs data entry numbers are low in total number of entries; this shows a need for training with data entry staff in the OTPs. For example, for FY 20/21, there were a total of forty (40) entries for urgent calls. Of these 40 calls, only 8 calls met timeliness standards. All other calls either did not meet standards, showed a negative day difference or no offered appointment day was found. Although SUDRS has implemented timeliness data collection and reporting requirements, there are still areas for improvement. This goal will continue on in order to improve timeliness reporting, where DBH will be reviewing data, identifying data entry errors, correcting and providing technical assistance to data entry staff in the next fiscal year. FY 20/21 data for county and contract outpatient SUDRS programs show: • 58.3% of all contract outpatient providers met timeliness standards for non-urgent calls. • 79% of all county outpatient providers met timeliness standards for non-urgent calls. Additionally, beginning August 3, 2020, DBH began its QMAC Consumer Evaluation Committee (CEC) where clients and family members have a forum to discuss quality improvement needs. The goal was to review each topic of the QIPP to confirm their agreement or disagreement and to identify other topics QMAC can pursue to improve quality of the services. Timeliness was not a main area of concern for the QMAC CEC but they agreed with the goals of this section. For Substance Use Disorder and Recovery Services, consulting with its contract agencies has been an ongoing effort accomplished with a monthly meeting. For this fiscal year, timeliness was a consistent topic, specifically reviewing each agency is meeting timeliness and reviewing the cumulative data for each modality and age group to ensure compliance.

SECTION 2 WORK GROUP MONITORING THE SERVICE DELIVERY SYSTEM FOR THE SAFETY & EFFECTIVENESS OF MEDICATION PRACTICES *(Source: MHP & Annual Protocol)*	MHP ONLY
FY 20/21 EVALUATION	Attempts were made to conduct *ten (10) peer reviews* per year, per physician, and provide feedback to physicians on quality of care provided. However, due to the pandemic and initiation of the Electronic Health Records (EHR), not all clinics could meet this goal. A total of 99 peer reviews were completed. Annually release or revise *one (1) new practice guideline* topic based upon feedback from workgroup activities. The Practice Guidelines Workgroup did not meet during the pandemic. However, some physicians from the workgroup were able to review and revise the medication formulary for indigent patients. Physician Peer Review Workgroup did not meet during the pandemic. However, peer reviews were completed and monitored for quality of care on a monthly basis to ensure doctors were providing quality of care that met the standards in the community. Reviews were conducted in real-time and feedback was provided at the time of reviews. Practice guideline workgroup did not meet during the pandemic. Pharmacy and Therapeutics workgroup was able to revise the medication formulary for indigent clients and plan future training topics for physician and nursing staff. Continuing Medical Education provided monthly presentations on psychopharmacology topics as wells neuropsychiatric topics related to COVID-19. As part of our electronic health record launch, a report was created to analyze scheduled appointments vs documentation. Essentially, if an appointment was scheduled, was there documentation created against the scheduled appointment. This report was run for all physicians and the results communicated to them electronically. They then reviewed the list of any scheduled appointments that were not closed out and either closed them out or reported on why they could not be closed out. The QMAC CEC brought to light a few issues with medications, specifically the need for physicians to spend more time on side effects with the clients. While it was stated, the physicians do review side effects of the medication, depending on the state of mind of the client, the information may/may not be retained. As a result of this issue, the DBH Medical Director was invited to the next month's QMAC CEC to hear the issue. In the meeting, the Medical Director advised she would communicate the issue but also reminded clients' of their right to advocate for themselves by asking questions if more information is needed, if they have questions, inquire about why that medication was prescribed, etc.

SECTION 3 WORK GROUP MONITORING INTENSIVE CARE COORDINATION (ICC) AND INTENSIVE HOME BASED SERVICES (IHBS) *(Source: MHP)*	MHP ONLY
FY 20/21 EVALUATION	Historically, Children and Youth Collaborative Services (CYCS) has used the information gathered in the QIPP report to provide feedback to contract providers on their service delivery. CYCS conveyed data on Intensive Care Coordination (ICC) services and Intensive Home Based Services (IHBS) provided to Subclass and Non-Subclass members. The contract providers used this data to ensure that youth were receiving entitled specialty mental health services and adjusted their programs, accordingly. Unfortunately, with the implementation of myAvatar, a new billing system and Electronic Health Record (EHR), accurate ICC and IHBS data and the identification of Subclass and Non-Sub-Class Members was not available during FY 20-21. While it was anticipated that myAvatar would modernize the information processes of DBH, these benefits have not been actualized at this point. In fact, it has resulted in difficulties tracking data because of data entry errors, questions of data validity, and the absence of data points in the new system. These data tracking issues continue to be addressed at the highest administrative levels and the invaluable process of utilizing data feedback loops to calibrate activities was temporarily put on hold. As a result, DBH was not able to modify the quarterly Special Report for Outcomes, Utilization, and Treatment (SPROUT) which includes the percentage of clients who receive ICC and IHBS at stratified levels of intensity, as planned. DBH plans to make modifications to the SPROUT report FY 21/22 instead. DBH will potentially look to modify the goal next FY.

SECTION 4 WORK GROUP MONITORING BEHAVIORAL HEALTH NEEDS IN SPECIFIC CULTURAL AND ETHNIC GROUPS	MHP AND SUDRS
FY 20/21 EVALUATION	The workgroup reviewed penetration rates for both mental health and substance use in November of 2020 for FY 18/19 and 19/20 and in July of 2021 for FY 19/20 and 20/21. Overall, the number of Medi-Cal beneficiaries increased from FY 19/20 to 20/21, 69,424 new beneficiaries. The penetration rate dropped from 4.6% in FY 19/20 to 3.6% in FY 20/21 for mental health. For substance use, the penetration rate dropped from .7% to .5%. Penetrations rates were not maintained from FY 19/20 to 20/21, less beneficiaries were served in FY 20/21 despite the increase of beneficiaries overall in mental health and substance use. Important to note that while numbers of mental health beneficiaries served decreased the total number of clients overall served increased from 42,243 in FY 19/20 to 43,782 in FY 20/21 (1,539 clients without Medi-Cal). This goal will continue as it was partially met. For FY 19/20, 1,035 out of the 1,158 total DBH staff (89.38%) completed Cultural Competency training. This number improved in FY 20/21, where 1,186 out of the 1,268 total DBH staff (93.53%) completed their Cultural Competency training. This goal was met and will continue. 100% of DBH new employees received language services training to ensure clients receive services in their preferred language when accessing and receiving services. This goal was met and will continue. An analysis of Specialty Mental Health Penetration Rates, specifically for Asian, Pacific Islander and Latino populations was conducted and presented to the group in July of 2021. There was an overall beneficiary increase in FY 20/21 compared to FY 19/20 for both Mental Health and SUD services. Penetration rates in mental health dropped for both groups. Penetration rates for both groups dropped in substance use as well. The workgroup will continue to monitor the penetration rates and work with programs to identify issues/barriers in accessing services for these populations. In FY 19/20, DBH provided 6,725 contracted language service appointments (4,526 in-person, 2,111 telephonic, 44 video, 18 written, and 26 unspecified) to clients in 19 non-English languages. In FY 20/21, DBH provided 7,154 contracted language service appointments (60 in-person, 7,058 telephonic, 21 video, and 15 written) to clients in 14 non-English languages. From FY 19/20 to FY20/21, the total number of language service appointments increased by 6.38%, from 6,725 to 7,154. The number of in-person appointments decreased (4,526 to 60) while the number of telephonic appointments increased (2,111 to 7,058) this was due to the decrease of in-person appointments for safety reason due to the COVID-19 Pandemic.

In July of 2020, the workgroup recommended that Sexual Orientation and Gender Identity (SOGI) data be collected in the department's new electronic health record. SOGI data will be pulled and reviewed for future fiscal years.

In January of 2021, the workgroup reviewed MHSA Outreach and Engagement Data for FY 19/20 no follow up items emerged.

During FY 20/21, Public Relations and Outreach (PRO) had a difficult time collecting participant demographic data due to everything being virtual because of the COVID-19 Pandemic. In FY 20/21 PRO reported that DBH's online presence increased: 69.4% Increase in video views via Facebook, 97.7% increase in Twitter engagement, 118% increase in YouTube impressions, and 46.9% increase in Instagram followers.

In FY 20/21, 66 Spanish Bilingual staff received bilingual skills training.

In FY 20/21, 102 Staff received Language Services Training.

DBH Bilingual Staff list is posted on the DBH Website every 6 months. In FY 20/21 DBH had over 200 certified bilingual staff employed. Over 90% of staff are certified in Spanish. Spanish is the county's threshold language. Bilingual staff account for 16% of the department's workforce.

The QMAC CEC had identified a few issues within the area of cultural competence. The issues include the following:

- Providers using the preferred pronouns as indicated by client
- Interpreter requests for deaf or hard of hearing clients

As a result of this identification from the QMAC CEC, OEI is planning to develop a guide for staff use as well as trainings.

Cultural competence was yet another ongoing topic for the SUDRS contract agency meeting discussed for FY 20/21.

SECTION 5 WORK GROUP MONITORING RESPONSIVENESS OF THE 24/7 TOLL FREE ACCESS LINE AND ACCESS TO SERVICES *(Source: DHCS contracts, Annual Protocol)*	MHP AND SUDRS
FY 20/21 EVALUATION	Office of Equity and Inclusion (OEI) completed test calls for the last fiscal year for MHP. Per Test Call Report data, this goal was achieved as 92% of Test Calls were successfully answered. In the review of this goal, it was determined the wording implied that actual care was available as opposed to access to care. Since the Access Lines do not actually provide any care, if this goal would be continued, then it is recommended to state access to care was available 24/7. This goal was met and may be continued next FY. Access Unit Call Center continues to update resource guides at least monthly and as needed; therefore, it met this goal. QM determined there is no need for this goal to continue as a quality improvement initiative. With the addition of Call Center Software in 2020, the compliance rate for Test Calls (and calls in general) being logged correctly has significantly increased and error rates are minimal due to the addition of electronic tracking and fewer opportunities for human error. With the addition of electronic logging, QM determined this goal was met and does not need to continue to pursue this quality improvement goal. In FY 20/21, 23 voicemail test calls were made and 14 of them connected clients to the Access Line, resulting in a 61% passing rate. The 90% compliance rate was not met; therefore, the goal will continue. In FY 20/21, SUDRS conducted 28 voicemail calls and 10 connected clients to the Access and SUDRS BAL. As part of QIPP improvements for this reporting period, After-Hours/Mystery Shopper call follow up has been incorporated into the contract monitoring process. This process allowed for coordinators to work with providers and bring 10 into compliance. This resulted in an overall 77% passing rate. Goal will continue. OEI conducted 16 calls in non-English languages to the MHP Access Line in FY 20/21. For Spanish calls, 75% were provided services in Spanish, a threshold language. This goal was partially met and will continue next FY. During this QIPP period SUDRS was able to establish preliminary baseline data related to threshold languages pulled from SARC Access database, Finesse phone line, and myAVATAR (EHR). For this QIPP period, OEI/Mystery Shopper calls were not made to the SUDRS BAL, but to county SUD clinics and contract providers. This goal was not met and will be kept. OEI conducted 48 Access Unit test calls and 26 Customer Service calls in FY 20/21. Of the test calls conducted, 53 out of the 74 provided the appropriate information, resulting in a 71.62% passing rate. The 75% compliance goal was not met. This goal will continue.

Regarding other activities completed for this section, QM completed an Urgent Call script for the MHP Access line. Trainings continue to be ongoing for both MHP and SUDRS staff and after-hours staff for both lines. Training is ongoing to address changes, new staff, etc.

OEI conducted 23 after hour voice mail messaging test calls. Eight (8) out of the twenty-three (23) voicemail test calls provided the required information, resulting in a 34.78% passing rate. This activity will continue and will be considered as changing to a goal for QIPP for FY 21/22.

OEI conducted Mystery Shopper calls to the SUDRS line and selected SUD County/Contract Providers twice a year and provided reports with recommendations for improvement. In total, 7 calls were made. This activity was met and will continue.

For the test calls it stated it would conduct, OEI typically exceeded or met the number of calls with only a few exceptions. The following information is regarding calls conducted in languages indicated:

- Goal was to conduct four (4) resource/referral test calls per month but OEI actually conducted 48 test calls in English and Spanish.
    - Goal was two (2) Spanish test calls during business hours and OEI completed 16 Spanish test calls during business hours.
    - Goal was one (1) Vietnamese test calls after-hours. Due to lack of resources, zero (0) Vietnamese test calls were conducted after-hours.
    - Goal was one (1) Spanish test calls after-hours and three (3) Spanish after-hours test calls were completed.
- Goal was to conduct four (4) customer service test calls per month, yet OEI accomplished 26 customer service test calls in English and Spanish.
    - Goal was two (2) Spanish test calls during business hours and six (6) Spanish test calls were conducted during business hours.
    - Goal was one (1) Vietnamese test calls after-hours. Due to lack of resources, zero (0) Vietnamese test calls were completed after-hours.
    - Goal was one (1) Spanish test calls after-hours and two (2) Spanish test calls were completed after hours.
- Goal was to conduct two (2) grievance test calls bi-monthly (Access calls), and 15 Total Grievance test calls were completed in English and Spanish.
    - Goal was one (1) Spanish test call during business hours (bi-monthly) and ten (10) Spanish Grievance test calls were completed.
    - Goal was one (1) Spanish test call after hours (bi-monthly) but zero (0) Spanish after hours calls were completed.

SECTION 6 WORK GROUP CONDUCTING PERFORMANCE IMPROVEMENT PROJECTS (PIPs) TO IMPROVE CLIENT CARE *(Source: EQRO)*	MHP AND SUDRS
FY 20/21 EVALUATION	Regarding the goal of increasing participation and engagement from the Department, DBH has partnered with multiple stakeholders internally and externally, including beneficiaries, administrative staff, direct service providers, Cultural Competency, Executive Staff, Program Managers, Clubhouses, Research and Evaluation, Information Technology, as well as the National Council for Mental Wellbeing. These stakeholders have continued to attend PIP QMAC, planning and implementation meetings where they provide input regarding PIP challenges and solutions. DBH will continue this goal to emphasize the importance of having multiple stakeholders involved in the planning and successful implementation of PIPs. Regarding representation from beneficiaries, the Department has continued to engage representatives from the Consumer Evaluation Committee (CEC). Consumers are regular invitees to the PIP Subcommittee meetings and their input has influenced PIP planning and implementation. For example, beneficiaries provided their personal experience with antipsychotic medications, which has sensitized the Department around monitoring cardiometabolic risk factors. Beneficiaries also reviewed and provided input on sample scripts regarding the Youth Screening, Brief Intervention and Referral to Treatment evidence-based practice, which tries to engage adolescents in a motivational dialogue regarding preventing and treating substance use. This goal was met but will also continue as DBH strongly believes beneficiaries and consumers need to be included throughout all phases of PIPs. DBH has pursued a new goal to increase the summary totals of PIP validation for the clinical and non-clinical PIPs. The way in which this goal has been met, is by continuously reviewing PIP requirements. The PIP worksheet requirements (i.e., components of PIP aim statement) are regularly presented in PIP QMAC meetings as a means of providing a common understanding for the Department around PIP mandates. In addition, DBH is holding discussions around how PIP metrics can be operationalized and monitored. DBH will continue this goal as an ongoing effort towards quality improvement.

SECTION 7 WORK GROUP MONITORING / IMPROVING SERVICE CAPACITY *(Source: MHP & Annual Protocol)*	MHP AND SUDRS
FY 20/21 EVALUATION	During FY 20/21, the MHP and SUDRS, reviewed the array of services offered, the age groups served and the geographic distribution of services to determine if time and distance services would be met. For the MHP, it determined the array of services offered were in line with the services listed on the MHP NACT, as well as the ages served. Additionally, DBH determined it was compliant with time and distance standards by its calculations. For SUDRS, it was determined that DBH did not provide the following services due to lack of need from clients: • Outpatient substance use disorder services provided by DMC certified outpatient and intensive outpatient facilities. • Opioid use disorder services provided by DMC certified Opioid Treatment Program (OTP) facilities. • Residential substance use disorder services provided by DMC certified, state licensed, and American Society of Addiction Medicine (ASAM) designated residential facilities. Additionally, SUDRS is unable to obtain the following provider type: • Opioid Treatment Program (OTP) for age group 0-17 Based on socioeconomic factors and availability, the substance choice for minors in San Bernardino County is marijuana and alcohol; therefore, while there is no usage or current need, SUDRS understands the requirement to have the services available. To meet this requirement and maintain fiscal prudence, DBH determined the following solutions to meet the need, should it arise: • Short-term solution: San Bernardino County (SBC) has trained X-waivered physicians to provide MAT services to youth in-person or through telehealth. • Short-term solution: A Single Case Agreement is in development for Out of Network providers. Due to the county procurement process, an agreement is anticipated to be available December 2021. • Long-term solution: Contract or utilize an MOU with Out of Network (OON) providers for youth Opioid Treatment Program (OTP) services. The MHP monitored provider ratios for three (3) of the four (4) quarters: September 24, 2020; November 5, 2020; and June 23, 2021. MHP reviewed the provider ratios and determined the following at the meetings: Sept 24, 2020: The number of providers was not recorded but it was determined in the meeting that DBH was meeting the provider ratios. It was also determined a discussion was needed with Medical Services regarding the number of child psychiatrists being very close to not being compliant. Medical Services advised Quality Management of recruitment efforts for child psychiatrists and pending job offers.

November 5, 2020:

Service Category	DHCS Ratio Standard	MHP Number
Adult Outpatient SMHS	304.20	385.4
Child Outpatient SMHS	651.28	914.5
Adult Psychiatry	33.06	45.2
Child Psychiatry	25.14	25.32

June 23, 2021:

Service Category	DHCS Ratio Standard	MHP Number
Adult Outpatient SMHS	304.20	366.49
Child Outpatient SMHS	651.28	909.55
Adult Psychiatry	33.06	38.79
Child Psychiatry	25.14	25.67

Although the meetings occurred, the reports were not presented to the QMAC regularly, which will be corrected for the current fiscal year. DBH determined that it partially met the goals of this objective and will continue the goals for FY 21/22.

SECTION 8 WORK GROUP MONITORING / IMPROVING CLIENT SATISFACTION	MHP AND SUDRS
FY 20/21 EVALUATION	Regarding the posting of grievance procedures to make them easily accessible and visible, although DBH clinics never closed, in person services were limited as most of the services were provided via telehealth or telephone. In late 2020, DBH identified the decrease of in person services made it more cumbersome for clients to obtain documents that at normally found in the clinic lobbies, such as grievances. While the option to request a form has always been available, based on consult with consumers through the QMAC CEC, QM determined some clients may not be aware of other avenues to obtain forms like the grievance forms. In 2021, DBH remedied this by creating a flyer to be disseminated to clients reiterating the ability to file a grievance (or second opinion and change of provider) via phone through the 24-Hour Access Line. As a result, 14,000 flyers were mailed out to all MHP and SUDRS clients and the flyer was posted on DBH's website for those who prefer electronic means of communication. Similarly, SUDRS ensured all updated NOABD, Grievances, Appeals and State Hearing Procedures were updated in its Quality Assurance Review materials that program monitors use when evaluating a SUDRS program/clinic. Additionally, SUDRS has ensured the materials were update in the handbook given to clients and extended the update to the staff to make them aware. Therefore, DBH determined both goals were met and will not be continued. All grievances are received and processed by QM. During QMAC a report is given regarding the identified trends and evaluated for further training needs. In reviewing the ABGAR completed and submitted for FY 20/21, DBH showed changes from the prior fiscal year: • 55% decrease in Quality of Care grievances • 40% decrease in Other Type of grievances • 50% decrease in Grand Total of grievances received • 59% decrease in NOABDs received Due to a trend regarding a decrease in the number of grievances received, QM identified a training was necessary to remind everyone of the requirement to report grievances as QM is the repository for all grievances. Additionally, it was identified of the need to train regarding issuance of an NOABD. Training is scheduled to be conducted November 2021 for the following topics: • Continuity of Care • NOABDs • Change of Provider Requests • Second Opinion Requests The goal regarding tracking and assessing grievances will be continued and may consider adding in NOABDs.

OBJECTIVE 8A **FY 20/21 EVALUATION**	SUDRS utilized the Treatment Perception Survey data to inform quality improvement efforts. For example: SUDRS holds a meeting with contract providers regarding survey findings where countywide data is discussed. There are also opportunities to discuss how the results can inform program improvement efforts. Survey findings are also provided individually to each agency so they are able to utilize their own survey results within their agency. The MHP added supplemental questions to the Treatment Perception Survey to inquire about service delivery methods during the pandemic and post-pandemic and the clients' preferences for the service delivery method. DBH will be utilizing that data as well as the traditional question on the Treatment Perception Survey.

SECTION 9 WORK GROUP MONITORING / IMPROVING SERVICE DELIVERY SYSTEM	SUDRS ONLY
FY 20/21 EVALUATION	Work Group developed processes to conduct quarterly reviews on client health records to ensure providers are fully engaged within the 30 day timeline required by DHCS. A client is considered fully engaged when an Intake, Assessment, Diagnosis Treatment Plan and two (2) additional services are provided and documented. If they do not show up for scheduled appointments, the providers are required to document missed steps taken to engage clients in continued services. • Work Group recommends ongoing quarterly reviews with providers and continue to work with DBH's Research and Evaluation to develop a report to track the percentage of new intakes that meet the above definition of engagement and the percentage of new intakes that do not meet the above definition of engagement in order to establish baseline data. Based on the information compiled from quarterly reviews and reports provided by R&E technical assistance will be provided to identified programs to help improve engagement timelines. In addition, trainings may be developed to improve engagement throughout the system of care.

SECTION 10 WORK GROUP REDUCING EMERGENCY DEPARTMENT HOSPITALIZATION	SUDRS ONLY
FY 20/21 EVALUATION	DBH Medical Services staff continue to collaborate with partners for the purposes of the Emergency Department (ED) Bridge services with San Bernardino County Arrowhead Regional Medical Center (ARMC). Workgroup members meet with collaborative partners to review program outcomes and process improvement opportunities through partner organizations such as the Inland Empire Opioid Crisis Coalition. Workgroup members have developed a referral tracking system, however DBH will continue the goal in order to develop and implement a more efficient registration process for new ED Bridge clients referred to county operated clinics through a secured file transfer protocol (FTP). Workgroup members will also be working with ED Bridge collaborative partners to support emerging protocols from ARMC using mirtazapine for managing drug cravings in stimulant use disorder methamphetamine type. This goal will continue.

Conclusion

Fiscal Year 20/21 was the first year DBH combined the Mental Health Plan and Substance Use Disorder and Recovery Services QIPP. Combining the QIPP is a natural progression since DMC-ODS has a lot of mutual Quality Management mandates from what MHP has. Collaboration of many goals provided a more robust view of DBH and was beneficial for both DBH and the clients participating on QMAC or the QMAC CEC. There are some goals that remain solely for one aspect of the system of care. For ease, all sections of the QIPP are clearly identified as being applicable to MH, SUDRS or both. Additionally, if a goal is specific to one aspect of the system, then that system name is clearly mentioned in the applicable goal. The evaluation identifies goals that will continue, end or possibly will be modified.

Overall DBH determined that it would create two new sections of the QIPP for FY 21/22:

- QMAC CEC for client and family member input and
- Contract agency input for both SUDRS, which is already existing and MH, which will review for participation and input from contract agencies.

While both groups have the opportunity to contribute at the QMAC, it was determined that establishing a separate meeting or work group was beneficial for the participants as their voices were heard in the dedicated meeting instead of competing for their voice to be heard in the larger QMAC meeting.

DBH is committed to continuous quality improvement with the goal for the improvement efforts to benefit the clients and if applicable, DBH staff in the performance of their duties in directly or indirectly serving the client.