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

Fiscal Year 2021/2022

Quality Improvement Performance Plan (QIPP) Evaluation

Quality Improvement Performance Plan
Fiscal Year 2021/2022

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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.

San Bernardino County DBH SUDRS staff is committed to continued program development and compliance efforts as detailed in the San Bernardino County DBH-SUDRS Drug Medi-Cal Organized Delivery System (DMC-ODS) implementation plan. San Bernardino County DBH SUDRS and MHP strive to provide services based on the annual contract between DBH and the Department of Health Care Services (DHCS) and as detailed in the annual Quality Improvement Performance Plan (QIPP).

The DBH Quality Management Program includes both SUDRS and MHP and is accountable to the DBH Director. The goal of the Quality Management Program is to improve DBH's established treatment outcomes through structural and operational processes and activities that are consistent with current standards of practice. QM conducts performance monitoring activities throughout its operations. These monitoring activities include, but are not limited to the following:

- Improve the access and availability of services;
- Conduct utilization review;
- Improve quality of care, which may include assessing client satisfaction;
- Review provider appeals and resolution of grievances;
- Ensure continuity of care and coordination of care;
- Comply with regulatory and contractual requirements associated with quality management; and
- Improve client outcomes of the service delivery system.

DBH contracts with multiple providers who operate in various locations, offering an array of services in the community. DBH provides behavioral health through its clinics, contract agencies or Fee For Service providers for children, youth, adolescents, transitional age youth, adults and older adults in the San Bernardino County cities, high and low deserts as well as rural and frontier areas.

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.

The QIPP is the Quality Improvement Work Plan for DBH. The QIPP meets the contractual requirements of the SUD annual contract and Specialty Mental Health Services (SMHS) 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. This is attained in part by the formation of the San Bernardino County DBH Quality Management Action Committee (QMAC). Participation for QMAC includes SUD and Mental Health (MH) practitioners, providers, clients, family and community members who participate in program activities. The QIPP conducts performance monitoring activities throughout SUDRS and MHP operations. These monitoring activities are designed to improve access, quality of care, and outcomes of the service delivery system. The QIPP is organized in sections which relate to structure, implementation, and quantitatively measurable outcomes, and are used to assess performance, identify, and prioritize areas for improvement. The San Bernardino County DBH QIPP addresses the goals, objectives, and outcomes for key areas that have been identified. These include monitoring/improving the service capacity and delivery of services and monitoring the timeliness of services. The QIPP also identifies how San Bernardino County DBH SUDRS and MHP will maintain/improve beneficiary satisfaction, service delivery system and continuity of care and coordination.

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.

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 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 are need to be addressed systemwide. The 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.

Performance Indicators

Goal	Description	Rating M= Met PM= Partially Met NM= Not Met
Section 1: Timeliness		
A	Post-Hospitalization Appointments within Seven Calendar Days	PM
B	Meet or Exceed Timeliness Requirements • Initial Request Non-Urgent Non-Physician Appointment MH • Initial Request Psychiatric Appointment MH • Request or Need of Urgent Services MH	 PM M PM
C	Outpatient/Intensive Outpatient or Residential Treatment SUDRS	NM
D	Request or Need of Narcotic Treatment Program/Opioid Treatment Program SUDRS	NM
E	Specialized Report Process for Timeliness	NM
F	Education of Staff and Contract Agencies regarding Timeliness	PM
Section 2: MHP Service Delivery System for the Safety & Effectiveness of Medication Practices		
A	Physician Peer Reviews and Feedback	PM
B	New or Revised Practice Guideline Topic	M
C	Development of Psychopharmacology Consultation Team	PM
D	Annual Nursing Skills Training	NM
Section 3: Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)		
A	Inform Programs and Clinicians of Their Service Provision Patterns	M
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 Lines Answered 24/7	PM
B	After-Hours Message Directing Callers to MH Access Line or SUDRS BAL	PM
C	Both Access Lines Offer Prevalent Non-English Languages	PM
D	Test MH Calls to Ensure DBH Representatives Provide Information and Referrals	PM
E	MH Baselines and Call Trends Utilizing Software	PM
F	LDP Recommendation for Merger of Call Centers, MH and SUDRS	PM

Performance Indicators

Section 6: Performance Improvement Projects (PIPs)		
A	Participation and Engagement from Multiple Department Stakeholders	M
B	Participation and Engagement from Clients	M
C	Improved Summary totals of PIP Validation for Clinical and Non-Clinical PIPS	PM
Section 7: Service Capacity		
A	Service Delivery System Monitoring	NM
B	Number of MHP Service Providers Meets Provider Ratios	PM
Section 8: Client Satisfaction		
A	Consumer Satisfaction Surveys to Establish Baseline Data	PM
B	Tracking and Accessing Client Grievances, Appeals, State Fair Hearings and ABGAR	PM
Section 8A: Improve Service Delivery combine		
A	Utilize Treatment Perception Survey data to assist with QI	NM
Section 9: Service Delivery System		
A	Baseline of Clients Engaged in the Recovery Process	NM
Section 10: Reducing Emergency Department Hospitalization		
A	Reduction of Hospitalization with ED Bridge Buprenorphine Medication Assisted Treatment Stabilization Visit	M
Section 11: Consumer/Family Member Evaluation and Contributions		
A	Increase Participation of SUDRS Consumer and/or Family Members	NM
B	Identification, Discussion and Implementation of Quality Improvement Initiatives	M
Section 12: Contract Agency Feedback and Contributions		
A	Continuation of SUDRS Contract Agency Meeting	M
B	Determination to Establish Contract Agency Meeting for MH	M

SECTION 1 WORK GROUP MONITORING TIMELINESS *(Source: NACT, EQRO, Title 28)*	MHP AND SUDRS
FY 21/22 Evaluation	During Fiscal Year 21/22, DBH struggled to develop a centralized process to receive hospital discharge summaries for various reasons, with the largest challenge being the lack of sufficient staffing. The goal to improve the post-hospital discharge appointments will continue. DBH will also continue to strategize what it can accomplish to develop a centralized process to receive the hospital discharge summaries. Due to challenges with establishing a plan, DBH will look to downsize the magnitude of the project and/or to do a pilot. Regarding continued compliance with the other MH timeliness requirements, DHCS considers 70% or greater to be meeting timeliness standards. Based on a review of the non-urgent non-physician appointments, DBH analyzed the data which showed the compliance rate for contract agencies overall were less than the minimum compliance rate while county clinics exceeded the DHCS requirement and achieved its goal of 80% in the quarter of January – March 2022 and the month of April 2022. However, when reviewing the compliance rate for the MHP, DBH is not meeting DHCS standards; therefore, the goal will continue. The compliance rate of psychiatric appointments within 15 business days of the request, DBH exceeded the compliance rate as it achieved an average of 88%. The goal will continue as it a requirement for the QIPP. The compliance rate for urgent services within 48 hours was vastly different for the contract agencies than the county clinics. In every month and quarter reviewed, the contract agencies greatly exceeded the DHCS compliance rate, while DBH did not comply with the timeliness standard and resulted in the overall MHP rate being less than the DHCS requirement. This goal will continue. For post-hospitalization appointments within seven (7) days of discharge, DBH was able to meet its goal of achieving 50% or greater for the age group of 0-17 as it achieved 52.9% within seven (7) days, 73.3% within 14 days and 85.3% follow up post discharge within 30 days. However, it was unable to meet its goals for the age groups of 18-20 and 21+. For 18-20, 30.5% of the clients received an appointment within seven (7) days of discharge, 36.1% within 14 days and 42.9% within 30 days. For the age group of 21+, DBH provided 25.7% of the clients services within seven (7) days of discharge, 33.5% within 14 days of discharge and 41.9% within 30 days of

	discharge. This goal will continue. SUDRS uses a number of evaluation methods to continually monitor, review and analyze data for outcomes related to timely access to care and learn of areas that need improvement. These methods consist of conducting quarterly quality assurance reviews, mystery shopper calls, and working with the DBH Research and Evaluation (R & E) division who obtain/analyze data from the DBH electronic health records (EHR). In addition, SUDRS collaborates with the DBH Mental Health Plan (MHP) and contract agencies on the Timeliness Sub-committee with the goal to analyze data outcomes aligned to timeliness to develop strategies for improvement. R & E plays an integral role in extracting and compiling the Initial Call Log (ICL) data from the EHR to discuss at the committee meetings. The Narcotic Treatment Program (NTP)/Opioid Treatment Program (OTP) contract agency staff attended the meeting, in January 2022, to discuss the lack of information located in the EHR on timeliness to services. The agencies report utilizing their own internal system to capture this data and expressed being unaware of the need to input into the DBH EHR system. Technical assistance (TA) was provided to agencies with the agencies notified DBH and IT will provide additional training and individualized TA provide additional training as needed. SUDRS continues to review data outcomes related to timeliness adherence in other levels of care including outpatient/intensive outpatient treatment (IOT) and residential treatment. SUDRS is finding challenges in meeting timely access to residential treatment for adults and adolescents. With a goal to increase bed capacity SUDRS initiated an open procurement process for agencies interested to submit a proposal to provide Residential/ Withdrawal Management. SUDRS will continue to focus on this goal to improve timeliness standards. While Contract and County administrative staff attended trainings on how to input information into the Initial Contact Log (ICL) and Scheduler outcomes show there, is a need for SUDRS and MHP to provide ongoing training and technical assistance to its treatment providers for all the DHCS timeliness requirements. In addition, review of the data outcomes for both Urgent and Non-Urgent show a category related to “unidentified providers”. The issue found is the Program/RU in the ICL, within the DBH EHR, is not a required field so if this is not marked data entered automatically defaults to an “unidentified provider’. To improve the outcome measures R & E

	submitted a request to IT to add in more data with more fields being required to complete for enhanced outcomes, to be shared in the Timeliness Sub-Committee and in the SUDRS monthly meeting with providers. Regarding the education of DBH and Contract Agency staff, DBH was able to issue one web blast for the timeliness standards in the third quarter of FY 21/22. It was not able to post the second web blast timely for the fourth quarter, but is posting the following month to ensure it continues to educate staff on timeliness standards and to schedule publish dates for FY 22/23.

SECTION 2 WORK GROUP MONITORING THE SERVICE DELIVERY SYSTEM FOR THE SAFETY & EFFECTIVENESS OF MEDICATION PRACTICES *(Source: MHP & Annual Protocol)*	**MHP ONLY**
FY 21/22 Evaluation	Attempts were made to conduct five (5) peer chart reviews per year, per physician, and, subsequently, provide feedback to physicians on the quality of care provided. 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. However, due to the pandemic and initiation of the Electronic Health Records (EHR), this goal was not fully met. Nonetheless, a total of 86 peer reviews were completed. Although formal meetings of the Physician Peer Review Workgroup, Practice Guidelines Workgroup, and Pharmacy and Therapeutics Workgroup were suspended due to the pandemic, topics related to these workgroups efforts were made to discuss those items during the monthly Medical Services All Staff meetings. The goal of annually release or revising one new practice guideline was met, as the antidepressant prescribing practice guideline was updated during this fiscal year. Monthly presentations on psychopharmacology topic—as well as neuropsychiatric topics related to COVID-19—were consistently held to provide continuing education to Medical Service staff. In response to the COVID-19 pandemic, between February 2021 and December 2021, the division of Medical Services, in collaboration with the Office of Disaster and Safety, administered nearly 3,000 COVID-19 vaccines to approximately 2,220 members of the general public (many of whom were DBH patients), as well as approximately 700 San Bernardino County employees from multiple departments. A total of 41 individual vaccine clinics were held at various DBH locations throughout the county, as well as at contract provider locations. In addition, in order to enhance the ease and options available to DBH patients, DBH Medical Services worked to establish partnerships with many of our community pharmacies, to offer administration of injectable medications at the pharmacy, rather than at a DBH clinic. This option was especially helpful during the height of the COVID-19 pandemic during 2020-2021. Through these efforts, greater options were made available to a patient population often saddled with psychosocial hardships. San Bernardino County was recently

	awarded 2 National Association of County (NACo) 2022 Achievement Awards in recognition of the excellence of the above two efforts made in improving the quality of care to our beneficiaries.

SECTION 3 WORK GROUP MONITORING INTENSIVE CARE COORDINATION (ICC) AND INTENSIVE HOME-BASED SERVICES (IHBS) *(Source: MHP)*	MHP ONLY
FY 21/22 Evaluation	The workgroup reviewed the existing Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) provision of services and used a Plan-Do-Check-Act (PDCA) process to evaluate existing monitoring practices. With the implementation of myAvatar [a new billing system and Electronic Health Record (EHR)], DBH did not have access to accurate ICC and IHBS data during FY 20-21 due to difficulties tracking data, questions of data validity, and the absence of data points in the new system. In FY 21-22, DBH continued to work on resolving these issues through problem-solving data discrepancies, creating targeted business processes, developing new data structures, proprietary data tables, and processing methods. The workgroup determined four areas of focus and goals throughout FY 21-22: 1) Goal: Create a project to monitor ongoing access to ICC and IHBS. Through this monitoring develop program/agency expectations for services delivery of the ICC and IHBS. The San Bernardino MHP continues to work with programs to implement the Integrated Core Practice Model (ICPM). Each program is responsible for ensuring all ICPM elements are provided to any qualified youth; however, programs may emphasize elements slightly differently. For the Full Service Partnership (FSP) programs, the expectation is that 100% of foster youth meet eligibility for ICC. The challenge is to ensure that youth receiving services in the moderate level of service intensity programs are screened for ICC and IHBS. • Create an ICC/IHBS screening tool that is utilized in the intake process to ensure all children and youth that meet criteria are offered ICC and IHBS. Moreover, those eligible youth should receive ICC as needed. For Katie A. Subclass members this would be, minimally, every 90 days. This goal will continue. This new clinical tool will be created in the EHR; however, the workgroup is creating a supplemental algorithm based on Child Adolescent Needs and Strengths (CANS) scores to address this issue while the tool is being developed. This will ensure that youth with concurrent actionable scores (2/3s) on critical items be evaluated further considered for ICC. DBH also uses an existing CANS score, the Core Actionable Items Report

(CAIR) Score, as an overall indicator for functioning. The workgroup is going to co-opt this score which will be used to prompt for ICC. The algorithm approach is helpful because it can be implemented within the Children's Programs within a couple months. The new algorithm will be developed in Objective Arts and sent to providers monthly and can be run by providers at any point in time.

2) Goal: Monitor ongoing utilization rates, utilization management, and utilization review.

- The existing ICC/IHBS Quality Improvement Performance Plan (QIPP) reports are used as an evaluation tool to communicate stratification levels of service intensity. The report details the number of youth within a given program who received ICC and IHBS. It also groups the frequency of ICC and IHBS as a count within a given period. The report further conveys the average number of days between services. The report is run on a quarterly frequency and findings are conveyed at agency and program meetings. This goal will continue.

3) Goal: Create a method of providing specific actionable items for programs (e.g., flagging youth with high needs who have a low service pattern of ICC or IHBS.)

- The existing Monthly Case Load (MCL) Report was evaluated by the workgroup. Based on program data review, the workgroup decided to add several new data points for monitoring utilization processes. The MCL provides a point-in-time review of the most recent CANS Core Actionable Needs score to assist in identifying youth with high needs along with the most recent ICC service date and the ICC service provider. In fiscal year 21/22, the workgroup developed a more functional business process to capture ICC Coordinator information using Objective Arts. ICC Coordinator information can now be extracted from Objective Arts and new data points have been added to the MCL report to assist staff in quickly identifying coordinators or highlighting when an ICC Coordinator is not identified for youth. Additional data points include the last IHBS service date and identifies the IHBS service provider. The MCL report will be run monthly and uploaded onto a HIPPA compliant

File Transfer Protocol site allowing providers to download their program reports monthly and review. This goal will continue.

4). Goal: Explore the relationship of the provision of ICC and IHBS to positive treatment outcomes.

- The Integrated Core Practice Model (ICPM) expanded the target population for ICC and IHBS beyond subclass members to all beneficiaries involved with two or more "child-service systems." The workgroup met and recognized the need for data related to outcomes to the provision of ICC and IHBS services. With this recognition a report mock-up was developed, and service and client status indices are being identified. New self-contained data tables that require data from several other sources are conjointly being created to be used to create the new Treatment Outcomes Report - ICC/IHBS (TORII). With this report, the workgroup will identify and analyze the manner in which ICC and IHBS relate to treatment progress and outcomes. The workgroup and report development project staff will continue to meet regularly to review findings and validate report development. This goal will continue.

SECTION 4 WORK GROUP MONITORING BEHAVIORAL HEALTH NEEDS IN SPECIFIC CULTURAL AND ETHNIC GROUPS	MHP and SUDRS
FY 21/22	Traditionally, the workgroup reviews an entire fiscal years' worth of data for the penetration rates. Therefore, the review typically occurs in July of each year. When determining the goals for FY 21/22, the review was conducted July 2021. The workgroup reviewed penetration rates for both mental health and substance use. 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 0.7% to 0.5%. 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 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). An analysis of Specialty Mental Health Services 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 DBH's Public Relations and Outreach program to identify issues/barriers in accessing services for these populations. The goals for this year's QIPP were partially met as penetration rates were only viewed once in the fiscal year and rates were not maintained. FY 21/22 penetration rates will be reviewed in the July 2022 meeting for all populations. For FY 21/22, 1,141 DBH staff (96.37%) completed Cultural Competency training. This goal was met. For FY 21/22, 100% (177) of DBH new employees received language services training during new employee orientation to ensure clients receive services in their preferred language when accessing and receiving services. This goal was met. From FY20-21 to FY21-22, the total number of language service appointments decreased slightly by 3.77%, from 7,154 to 6,894

appointments. The number of in-person appointments increased significantly (from 60 to 2,567), while the number of telephonic appointments decreased (from 7,058 to 4,198). This change from telephonic appointments to in-person appointments was likely due to the lift of many of the COVID-19 emergency restrictions for San Bernardino County, which allowed for more in-person appointments. *Please Note*: This data does not include services for the months of May and June 2022. This evaluation is being completed prior to the end of the FY and data for services is received after the end of the month when services are provided.

In FY 21/22, 183 Spanish Bilingual staff received bilingual skills training. The titles of the training included the following:

- Metamorphosis: The Transformation of Spanish Speaking Clinical Providers Towards las Platicas, el Personalismo and el Empoderamiento Training
- Engagement, Treatment and Retention for Spanish Speaking Clients and their Families- Culturally and Linguistic Appropriate Services Training
- Genograma: Como una herramienta para la Evaluación, Establecer la Relación Terapéutica, e Intervención Training

In FY 21/22, 177 Staff received Language Services training at new employee orientation.

The DBH Bilingual Staff list is posted on the DBH Website and updated every six (6) months. In FY 21/22, DBH had over 200 certified bilingual staff employed. Over 90% of staff are certified in Spanish. Spanish is one of the county's threshold language.

In FY 21/22, DBH started translating informing materials into Vietnamese and Mandarin, the new threshold languages in FY 21/22. Some materials that are translated, include but are not limited to, the following:

- Services Guide
- Urgent Mental Health Care Flyer
- Screening Assessment and Referral Center Brochure
- Authorization to Release Protected Health Information (Vietnamese only)
- Consent for Outpatient Treatment (Vietnamese only)
  Advance Health Care Directive (Vietnamese only)

SECTION 5 WORK GROUP **MHP AND SUDRS**
MONITORING RESPONSIVENESS OF THE 24/7 TOLL FREE ACCESS LINE AND ACCESS TO SERVICES *(Source: DHCS contracts, Annual Protocol)*

FY 21/22 Evaluation

The Office of Equity and Inclusion (OEI) conducts test calls for the Mental Health Plan (MHP) and Substance Use Disorder and Recovery Services (SUDRS) access telephone lines. For MHP, OEI conducts live customer service calls during and after business hours and voicemail calls after hours for DBH clinics and its contract agencies in English and Spanish. For SUDRS, OEI conducts live test calls both during and after business hours. SUDRS conducts its own voicemail test calls and that data is not included.

In FY 21/22, OEI conducted a total of 124 test calls. The following table is a breakdown of the test calls:

Type of MHP Calls	English	Spanish	Mandarin	Total
Access Unit	56	15	1	72
CRT, CSU and CWIC Customer Service	13	4	0	17
Voicemail	23	12	0	35
Grand Total	92	31	1	124

In determining if the MH Access Unit was meeting requirements, a breakdown was completed regarding the test calls that met criteria. Of the 72 Access Unit calls, 34 met requirements resulting in 47.22% compliance rate. Of the 17 Customer Service test calls to the Crisis Residential Treatment (CRT), Crisis Stabilization Unit (CSU) and Crisis Walk-In Center (CWIC), 13 of the 17 calls met requirements resulting in a 76.47% compliance rate. Lastly, the purpose of the MHP voicemail calls is to confirm clinics and contract agencies have an appropriate voicemail for callers after business hours. For the test calls conducted for voicemails, 16 of the 35 calls met requirements, leaving the compliance rate of 45.71%.

The following table is a breakdown of the 72 calls made to the Access Unit:

Type of Call to Access Unit	English	Spanish	Mandarin	Total
Information	19	6	1	26
Urgent Condition	17	3	0	20
Grievance	20	6	0	26
Grand Total	56	15	1	72

For FY 21/22, OEI conducted Mystery Shopper calls to the SUDRS' Beneficiary Access Line (BAL) for three (3) DBH SUDRS clinics during normal business hours. OEI provided a report with

recommendations for improvement. Additionally, OEI placed two (2) calls to the BAL after normal business hours. A report was produced as well but there were no recommendations for the latter calls. A total of five (5) calls were made.

The following is data regarding test calls for SUDRS:

FY 2021/2022 data for county and contract NTP/OTP SUDRS programs show:

25% of contract providers met standards for Urgent Calls
39.73% of county providers met standards for Urgent Calls
35.39% of unidentified providers met standards for Urgent Calls

FY 2021/2022 data for county and contract OP/IOT and residential SUDRS programs show:

23.08% of contract residential providers met standards for Non-Urgent Calls
66.56% of county and contract OP/IOT providers met standards for Non-Urgent Calls
40.00% of unidentified providers met standards for Non-Urgent Calls

During this QIPP period, SUDRS continued to establish preliminary baseline data related to threshold languages pulled from Finesse phone line, and myAVATAR (EHR). SUDRS has been able to establish reports which include: average monthly Spanish calls, dropped calls, and variances between English and this threshold language. These reports will be used as part of the QIPP work group to analyze and develop strategies to improve customer service. For this QIPP period, OEI/Mystery Shopper call to the SUDRS BAL was not in threshold language. This goal was not met, and will be kept. Additionally, staffing constraints did not allow the MHP to utilize the Call Center software to establish baselines for Mental Health calls to identify trends but will continue this goal.

Additionally, the BAL was Mystery Shopped by the state reviewer as part of an SABG/DMC-ODS review. As follow up, a staff training was provided which covered the following topics: call script, customer services, interpretive services, documentation, and call documentation. This activity will continue.

As part of this QIPP period, staff of both the ACCES and BAL line met with and received training in the area of FINESSE system reports. The following reports have been developed and will be utilized to improve upon call line services: average monthly call volume, wait

	times, abandoned calls, variance with language. These and other reports will be utilized to analyze consumer needs and staffing patterns to meet those needs moving forward. Additionally, staff are working to develop more advanced reports. In completing the evaluation for this section, several items were discovered, the goals as well as expectations need to be clarified. OEI is committed to increasing the number of test calls conducted each month for English and our threshold languages. It is also necessary for the units to discuss the test call requirements, specifically any tools, scoring rubrics, scripts, etc. Lastly, to continues all goals for this section with the aim of improving the Access Lines for clients or community members calling either the MHP or SUDRS. Call Center staff and leadership met with the LDP team to discuss nuances of merger. Discussion included: staffing patterns and shortages, types of calls between systems, after hour needs, 24/7 possibilities, training needs, level of LPHAs needed, and space availability. The recommendation from LDP was not to merge the Call Centers; however, we know that is a CalAIM goal at a later date so management for the MHP and SUDRS 24/7 lines will further examine the recommendation of LDP to review the challenges or barriers. Additionally, it will consult with other counties who have already merged their call centers as it appears LDP did not speak with other counties, even though it was recommended. This goal will continue.

SECTION 6 WORK GROUP CONDUCTING PERFORMANCE IMPROVEMENT PROJECTS (PIPs) TO IMPROVE CLIENT CARE *(Source: EQRO)*	MHP AND SUDRS
FY 21/22 Evaluation	For FY 21/22, the Department has continued to work towards the goals of a) increasing participation and engagement from multiple Department stakeholders, b) increasing participation and engagement from clients to ensure PIPs are representative and are driven by client needs and c) increasing summary totals of PIP validation for the clinical and non-clinical PIPS. To increase participation and engagement from multiple stakeholders, DBH has partnered with multiple stakeholders internally and externally, including beneficiaries, administrative staff, direct service providers, Office of Equity and Inclusion, Executive Staff, Program Managers, Clubhouses, Research and Evaluation, and Information Technology. These stakeholders attend PIP QMAC meetings, and biweekly planning and implementation meetings where they receive status updates for ongoing PIPs and provide input regarding PIP challenges and solutions. DBH recognizes the importance of having multiple Department stakeholders from all levels of the organization involved in the planning and successful implementation of PIPs. This goal was met and the Department will continue this goal into FY 22/23. To increase participation and engagement from clients, the Department has continued to engage representatives from the Consumer Evaluation Committee (CEC). Consumers are regular invitees to the PIP QMAC Subcommittee meetings and their input has influenced PIP planning and implementation. For example, beneficiaries provided input on their client visits and what they expect from their treatment professionals. In addition, they provided input on 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 into FY 22/23. To increase the summary totals of PIP validation, DBH is continuously reviewing PIP requirements against what is feasible within the Department. The PIP worksheet requirements (i.e., components of PIP aim statement, defining a target population) 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, and the feasibility of setting improvement targets and carrying out interventions. DBH has received favorable and constructive feedback regarding the active PIPs and will continue this goal as an ongoing effort towards quality improvement.

SECTION 7 WORK GROUP **MHP AND SUDRS**
MONITORING / IMPROVING SERVICE CAPACITY *(Source: MHP & Annual Protocol)*

FY 21/22 Evaluation

During this FY, DBH found it challenging to monitor the service delivery system on an ongoing basis by the type, number and location of services. While it completed timely access standards, it did not review time and distance standards due to staffing constraints. However, Research and Evaluation (R&E) will run time and distance once a year before submission of the annual NACT for both SUDRS and MHP. While this does not give either program ample time to address alternative access, it provides an indication if DBH is likely to receive a Corrective Action Plan (CAP) for time and distance and whether it will be required to complete the Alternative Access form. This goal will continue but may be modified to occur twice per year, occurring Dec and June. The goal was not met.

For this section of the QIPP, Quality Management (QM) and R&E met on a quarterly basis to review the DHCS required provider ratios for the MHP. The units met four times, July 20, 2021, October 20, 2021, January 20, 2022 and April 20, 2022. Although information was not provided in April, information was provided in February 2022 so that was included. The following chart demonstrates the counts for the various provider types, what the DHCS provider number is and what provider county DBH actually had:

July 2021	**Provider Type**	**DHCS Ratio**	**DBH Ratio**
	Child Outpatient	651.28	907.09
	Adult Outpatient	304.2	369.49
	Child Psychiatrist	25.14	27.49
	Adult Psychiatrist	33.06	37.57
October 2021	**Provider Type**	**DHCS Ratio**	**DBH Ratio**
	Child Outpatient	651.28	875.16
	Adult Outpatient	304.2	358.48
	Child Psychiatrist	25.14	25.29
	Adult Psychiatrist	33.06	33.11
January 2022	**Provider Type**	**DHCS Ratio**	**DBH Ratio**
	Child Outpatient	651.28	845.98
	Adult Outpatient	304.2	358.20
	Child Psychiatrist	25.14	25.42
	Adult Psychiatrist	33.06	33.91
February 2022	**Provider Type**	**DHCS Ratio**	**DBH Ratio**
	Child Outpatient	651.28	796.49
	Adult Outpatient	304.2	356.67
	Child Psychiatrist	25.14	24.74
	Adult Psychiatrist	33.06	32.49

	Based on the ratios, DBH met the ratio requirements each quarter except the last quarter as it was short the required number of adult and child psychiatrists. However, the numbers for adult and child psychiatrists have since increased and DBH is once again meeting DHCS ratios. This goal will continue as it is useful for DBH to determine if it has a sufficient number of providers and whether we are meeting time and distance standards. This goal was partially met.

SECTION 8 WORK GROUP MONITORING / IMPROVING CLIENT SATISFACTION	MHP AND SUDRS

FY 21/22 Evaluation

There were two goals DBH had for monitoring and/or improving client satisfaction: development of consumer satisfaction surveys and implement to begin establishing baseline data, and tracking and accessing grievances, appeals and state fair hearings via the Annual Beneficiary Grievance and Appeals Report (ABGAR).

DBH developed a survey but has had difficulty in determining how to implement. The survey can be issued electronically however, the clinics do not have a central mailbox to issue emails to clients but DBH Quality Management can problem solve this issue if the clinics are willing to maintain an electronic mailbox. The alternative is to issue the surveys in paper form which works but requires other challenges to address. Due to competing priorities, this goal was only partially met but can continue so DBH can continue to work in order to establish a baseline.

QM tracks grievances, appeals and state hearings for both MHP and SUDRS, and has reported out data in the Quality Management Action Committee (QMAC) meetings. The following table is a breakdown of the grievances for FY21/22:

Grievance Types	MHP	SUDRS	Total
Quality of Care	76	10	86
Other	25	7	32
Access	17	6	23
Grand Total	118	23	141

The largest amount of grievances received were for the category of Quality of Care, with the following being a breakdown of the prevalent sub-categories:

- 50 for Staff Behavior, 44 being against the MHP and SUDRS only having six (6)
- 26 for Treatment Issues, 24 being filed against the MHP and only two (2) being filed against SUDRS

Although QM is tracking the information, it has been unable to utilize the data to establish baseline data, identify inaccurate reporting and identify training needs; therefore, the goal will continue.

For Goal 8A, DBH determined it would begin posting the Treatment Perception Surveys but has yet to determine where and what elements to post. It identified some trends but will complete an in-depth analysis in FY 22/23.

SECTION 9 WORK GROUP MONITORING / IMPROVING SERVICE DELIVERY SYSTEM	SUDRS ONLY
FY 21/22 Evaluation	SUDRS was successful on establishing baseline data points and tracking those statistics during FY 21/22. Data points included as follows: • Intake, • Assessment, and • Two (2) additional treatment services. Data was only tracked from July 2021 to April of 2022. During that time, the above goal was met on an average of 49%. To being the tracking of data, an Engagement tracking log was set up by R&E. For FY 22/23, SUDRS will be tracking the following data points to continue establishing engagement within the first 30 days of treatment: • Intake, • Assessment, • Problem List, and • One (1) additional Treatment Service. The target is to have increased client engagement into treatment and recovery services by 2% during that stated time frame. Additionally, SUDRS will complete the following activities for next FY for the QIPP: • Track identified baseline engagement data points and develop a process to report the identified statistical findings. • Share outcomes findings on a quarterly basis during the SUDRS Provider Quality Improvement Committee Workgroup Meetings. • On-going discussion of engagement activities and audit reviews during monthly coordinator meetings. • Incorporate treatment perception survey county report findings to improve client engagement within the first 30 days.

SECTION 10 WORK GROUP REDUCING EMERGENCY DEPARTMENT HOSPITALIZATION	SUDRS ONLY
FY 21/22 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), and increased the collaboration as it also includes St. Bernardine's Hospital, St. Mary's Hospital Victorville, and Pomona Valley Medical Center. 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 developed and implemented a process for new ED Bridge clients referred to county operated clinics through a secured file transfer protocol (FTP) to facilitate the efficient and secure transmission of ED visit medical records at the time of the referral. This has been piloted through the collaborative partnership between ARMC and DBH. Workgroup members have worked with ED Bridge collaborative partners to support emerging protocols from ARMC using mirtazapine for managing drug cravings in stimulant use disorder methamphetamine type. DBH medical services has been contacted by St. Bernardine's ED Bridge substance use navigator to explore a new protocol providing ED based access to Long Acting Injectable Naltrexone for alcohol use disorder followed by linkage to ongoing MAT and behavioral interventions. Furthermore, DBH medical services maintains a current directory of participating ED Bridge Substance Use Navigators to facilitate ongoing function of the Bridge program despite changes in staffing. This goal will continue.

SECTION 11 WORK GROUP CONSUMER/FAMILY MEMBER EVALUATION AND CONTRIBUTIONS	MHP AND SUDRS
FY 21/22 Evaluation	As stated in the FY 20/21 evaluation, the MHP created this section specifically for client and family member input. The QMAC CEC and Family Member Subcommittee meets on a monthly basis and aims to achieve the goals of the QIPP. Increasing SUDRS consumer and family member participation is an ongoing goal. SUDRS leadership staff attend this meeting and are working on engaging stakeholders to represent SUDRS clients and family members. Consumers and family members who attend actively discuss and identify quality improvement initiatives during the monthly meetings. The workgroup reviewed the Quality Improvement Performance Plan for FY 21/22 over several meetings and provided feedback. The workgroup also guided the development of a one-page Behavioral Health 24-hour Hotline Flyer to distribute and post at Clubhouses and clinics. As a result of the monthly discussions, and at the request of workgroup members, the Office of Equity and Inclusion (OEI) developed a Sexual Orientation and Gender Identity (SOGI) training that is being delivered to Clubhouse and TAY (Transitional Age Youth) staff. Future trainings will be geared towards consumers and family members who support DBH in assisting peers with completing surveys that involve the collection of demographic data.

SECTION 12 WORK GROUP CONTRACT AGENCY FEEDBACK AND CONTRIBUTIONS	MHP and SUDRS
OBJECTIVE 12	SUDRS invites county and contract providers to two (2) meetings, the Substance Abuse Provider Network (SAPN) held quarterly and the Provider Quality Improvement (QI) meeting. The Provider QI meeting was taking place bi-monthly however with the needs around the implementation of CalAIM this is now a monthly meeting. The goals of each workgroup are to enhance partnerships, provide updates on required State/County information, discuss barriers and needs, provide data outcomes related to services for discussion, and provide trainings and technical assistance (TA). While SUDRS facilitates the SAPN meeting additional divisions in the DBH (Fiscal, IT, Compliance) have set times allotted to share vital information to assist the providers. The meeting includes an open forum portion where partners discuss concerns, ask questions and provide updates on their agencies. The Provider QI workgroup has the same general format with other DBH divisions in attendance, however the facilitators are two (2) agency managers voted in as Chair and Co-Chair. The Chair and Co-Chair participate with the preparation of the agenda items and speak as a collective voice, after conferring with the other agencies, on areas where all agencies need to provide input/feedback. The meetings are beneficial and will continue with the ongoing goal to work together to enhance quality improvement related to service delivery. Unfortunately, with scheduling challenges, QM was unable to attend a SUDRS monthly Provider Quality Improvement (QI) meeting but it has been in communication with its contract agencies who see the benefit and request QM move forward with such a meeting. The goals were met so this objective may not continue next fiscal year.

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. Continuation of a combined QIPP is practical and efficient. 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.

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.