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



**Fiscal Year 2022/2023**

**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 disorders 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.

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| **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 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.

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| **Performance Indicators** |

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| **Goal** | **Description** | **Rating**  M= Met  PM= Partially Met NM= Not Met |
| **Section 1: Timeliness** | | |
| A | Meet MH Timeliness Requirements of 80% compliance rate   * Initial Request Non-Urgent Non-Physician Appointment * Initial Request Psychiatric Appointment * Requests for Urgent Services | PM |
| B | Meet SUDRS Timeliness Requirements   * Outpatient/Intensive Outpatient Treatment or Residential Treatment Appointment * Narcotic Treatment Program/Opioid Treatment Program | PM |
| C | Monitor SUDRS Bed Capacity Procurement Process for Intensive Outpatient Treatment (IOT) and Residential Treatment | PM |
| D | Enhancement of Report Process between SUDRS and R&E | PM |
| E | Educate MH and SUDRS staff and contract agencies regarding   * Timeliness Requirements when Scheduling Initial Clients * Initial Contact Log Requirements | PM |
| F | Monitor Post-Hospitalization Appointments within Seven Calendar Days | PM |
| **Section 2: MHP Service Delivery System for the Safety & Effectiveness of Medication Practices** | | |
| A | Conduct (5) Peer Reviews, including Feedback regarding Quality of Care | M |
| B | Release or Revision of (1) Practice Guideline Topic | M |
| C | Use of Parameter 3.8 for Use of Psychotropic Medications in Children and Adolescents | M |
| D | Development of Psychopharmacology Consultation Team | NM |
| E | Utilize UpToDate, which is an electronic clinical resource tool to support and guide physicians, nursing staff and patients in collaborative clinical decision-making. | PM |
| F | Establish an annual nursing skills training*.* | M |
| **Section 3: Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS)** | | |
| A | Inform Programs and Clinicians of Their Service Provision Patterns | PM |
| **Section 4: Mental Health Needs in Specific Cultural and Ethnic Groups** | | |
| A | Maintain and Analyze the penetration Rate for Underserved Ethnic/Cultural Populations twice a year. | PM |
| B | Monitor DBH Providers completion of the required Cultural Competency Training Goal: 80% Staff completion | M |
| C | Language Services Training to all new DBH Employees Goal: 100% new staff trained | M |

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| **Section 5: Responsiveness of the 24/7 Toll Free Access Line and**  **Access to Services** | | |
| A | Ensure the SUDRS and MHP Access Lines Answered 24/7  *Goal 90% + compliance based test call data* | PM |
| B | After-Hours Message Directing Callers to MH Access Line or SUDRS BAL. *Goal: 90% compliance* | NM |
| C | Ensure SUDRS and MHP Access lines are provided in the prevalent non-English languages. Goal: Establish baseline data regarding the number of calls provided in threshold languages, and conduct test calls in the threshold languages with *90% compliance rate*. | PM |
| D | Conduct regular test calls for MHP to ensure clients are provided appropriate information and referrals. *Goals: Conduct 4 test calls per month for business hours and 3 test calls per month for after-hours calls. Compliance rate of 80%.* | PM |
| E | Utilize software to establish MHP baselines and identify call trends, including but not limited to, the following: call volume, peak call times, dropped calls, length of time for calls, language spoken or requested, and types of calls received. | PM |
| F | Review the Leadership Development Project (LDP) recommendation for merger of the Call Centers to determine what can/cannot be implemented, identify, and discuss action items. | N/A |
| **Section 6: Performance Improvement Projects (PIPs)** | | |
| A | Increase participation and engagement from multiple Department stakeholders to enhance the quality, input, data discovery and implementation of current and future PIPs. Goal: *80%* *attendance* and participation from multiple stakeholders within all levels of the organization in PIP QMAC Committee, Idea Labs and PIP Implementation meetings. | M |
| B | Increase participation and engagement from clients to ensure PIPs are representative and are driven by client needs. *Goal: Obtain relevant client feedback for each Performance Improvement Project* | M |
| C | Increase summary totals of PIP validation for clinical and non-clinical PIPS. *Goal: Increase the overall rating by 10% from the prior year.* | PM |
| **Section 7: Service Capacity** | | |
| A | Monitor the service delivery system on an ongoing basis and report findings of the type, number, and location of services for MHP and SUDRS in the QMAC. Review fornetwork adequacy but also for under and overutilization of services. *Goal: Review quarterly for MHP and semiannually for SUDRS* | NM |
| B | Review the number of service providers for MHP to ensure it meets the provider ratios required by DHCS. *Goal: Meet the minimum number of providers based on the current DHCS formula* | PM |
| **Section 8: Client Satisfaction** | | |
| A | Track and Access Client Grievances, Appeals, and State Fair Hearings | M |
| B | Utilize MCPAR Data to establish baseline data, identify inaccurate reporting and identify training needs | M |
| C | Issue One Consumer Satisfaction Survey | NM |
| **Section 8A: Improve Service Delivery combine** | | |
| A | Evaluate Assessment of SUDRS and MH client experiences | PM |
| B | Publish data for view of clients, community clinics, providers and staff. | PM |
| **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 | M |
| B | Visit recommendation in collaboration with ARMC | M |
| **Section 11: Consumer/Family Member Evaluation and Contributions** | | |
| A | Increase Participation of SUDRS Consumer and/or Family Members | M |
| B | Identification, Discussion and Implementation of Quality Improvement Initiatives | M |

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| **SECTION 1 WORK GROUP**  **MONITORING TIMELINESS**  *(Source: NACT, EQRO, Title 28)* | | **MHP AND SUDRS** |
| **FY 22/23 Evaluation** | The evaluation of mental health timeliness standards for Fiscal Year (FY) 22/23 was reviewed and found to partially satisfy the DHCS criterion of 80% compliance rate.  The compliance rate for initial request for non-urgent appointments with a non-physician specialty mental health care provider within 10 business days of the request partially met the requirement. DBH county operated programs had a total of 1,684 calls of which 81.59% met the requirement. Contract provider programs had a total of 1,563 calls of which 57.65% met the requirement. DBH and Contract providers had an overall 70.6% compliance rate of calls that were able to offer an appointment within 10 business days for non-urgent, non-psych appointments.  This result was also found during the NACT review. Corrective actions taken include updating the initial contact log (ICL) form in our electronic health record MyAvatar, releasing, and updated online training for identified programs, and updating the reports to provide actionable information for programs use.  The chart below summarizes the requirements and results from the Initial Contact Log review for Fiscal Year 2022/2023.   |  |  |  | | --- | --- | --- | | **MH Contact Reason** | **MH Results** | **Rating** | | Non-urgent,  non-psych 10 business days | **ICL results for DBH & Contractors**  3,247 calls of which **70.6%**  **Contractors Only results**  1,563 calls of which **57.65%**  **DBH only results**  1,684 calls of which **81.59%**  Note: ICL and/or CSI 50% not captured | PM | | Initial psych,  non-urgent  15 business days | 333 calls, of which **82.28%** | M | | Urgent Requests 48 hours | 309 calls of which **94.82%** | M |   The goals for MH will continue for FY 23/24.  SUDRS continues to monitor and evaluate data related to timely access to assist in improving outcomes. DBH continues to conduct quarterly quality assurance reviews, mystery shopper calls, and other agency meetings to update contractors on current trends and related data.  Overall, the first service request to first offered appointment within 10 days for adults is 83%. This percentage falls within the DHCS standard of 80% compliance rate for the first offered appointment. For youth, the first request for service to first offered appointment is 35% compliance rate for FY 2022-23.  For Non-Urgent NTP/OTP first call to first appointment in 3 business days is 99% compliance rate. The number of calls observed for this population is 317 calls for the fiscal year. The range of days between the first call to first appointment for NTP provides is 0 to 71 days.  SUDRs has continued to monitor the IOT and residential procurement process. In FY 22-23, DBH added two new residential providers to increase bed availability, as well as Withdrawal Management beds at an existing contractor. DBH continues to monitor procurements for IOT and is in the process of possibly contracting with additional vendors to increase capacity and expand locations of service to a broader area of the county. Additionally, DBH has opened a county operated IOT clinic, and is currently in the process of opening another. These clinics will expand coverage for highly needed services to a wider area of the county’s hard to reach areas.  A final Timeliness Monitoring report for SUDRS has not been finalized. Several drafts for this report have been reviewed for implementation with needed changes still in process. Much of the timeliness efforts have been concentrated in developing an Initial Contact Log that will meet the data requirements for reporting. A provider training has been developed and training implementation is in process. As providers are trained to input data into the ICL, the close relationship between SUDRS and R&E makes it easier to create drafts of a timeliness report and make enhancements to the report as data collection improves.  DBH continued to invite SUD contract providers to attend the committee meetings to better understand timeliness standards and the role of the ICL for data entry at the program level. In FY 22-23 residential, perinatal, and outpatient contractors attended. This has allowed for all contract modalities to be represented in the work group, and continued input and strategy development from an outside perspective.  Training developed for providers to enter data into the Initial Contact Log has been uploaded onto the Relias training platform. SUDRS is currently in the process of contacting both DBH and Contract Providers to access the training and start inputting data if they are not already doing so. Currently approximately half of the providers are entering data into the ICL without training. The goal is that the halves that are inputting data will learn to input the data accurately therefore improving data quality more accurately. For those providers that are not inputting data, the goal is they will start the input process once trained. SUDRS works with providers on the ICL in our Substance Abuse Provider Network and Quality Improvement meetings as well as at the contract monitoring level to improve training and outcomes.  The Department of Behavioral Health (DBH) continues to monitor post-hospitalizations through the report outs at the monthly timeliness subcommittee meeting for QMAC. Timeliness to follow up is segmented to monitor by age groups and Child Welfare cases.  A committee was formed to address the low seven (7) day follow-up rate for adults (age 18+) which was initially led by Medical Services. Additional reports designed to bring actionable information were requested and design specifications developed. Staffing issues delayed the creation of the requested report(s) and changes in the leadership of the committee have stalled progress. | |

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| **SECTION 2 WORK GROUP**  **MONITORING THE SERVICE DELIVERY SYSTEM FOR THE SAFETY & EFFECTIVENESS OF MEDICATION PRACTICES**  *(Source: MHP & Annual Protocol)* | | **MHP ONLY** |
| **FY 22/23 Evaluation** | The work group was tasked with ensuring mechanisms are in place to provide for the safety and effectiveness of medication practices and ensuring continuity and coordination of care exists between behavioral health and physical health providers.  The work group met most of their FY 2022/23 goals and made strides on two goals that were partially met.  Currently physicians are conducting monthly peer reviews using the approved peer review form. A total of 47 peer reviews were conducted for the MHP while 16 peer reviews were conducted for SUDRS. Thus 63 peer reviews were conducted for FY 22/23.    Revision of the Antidepressant Practice Guideline was completed and sent to Compliance for posting. Information was disseminated to DBH staff and contract providers via web blast and posted on the DBH website 06/30/2023.  All child and adolescent psychiatrists were/are given a copy of the Psychotropic Practice Parameters 3.8 and are currently in possession of the most recent version. In July 2023, the Associate Medical Director for Children’s services provided a copy to the attending physicians and thereafter provides a copy for the new trainees each academic year. The next distribution of the Psychotropic Practice Parameters is scheduled for August 2023.  Team members have been identified for the Psychopharmacology Consultation Team and the team is currently working on developing workflow and implementation. Due to several challenges including attrition of Medical Services staff who were working on QMAC Medical Services subcommittee and overall Medical Services psychiatrist shortage, having a stable and consistent team wasn’t established in FY 22/23. In the 23/24 FY, Medical Services will try to staff and setup a process for this consultation team. Eligible members will consist of DBH Psychiatrists and Psychiatric Nurse Practitioners.  An agreement for the use of the clinical resource tool, “UpToDate”, is currently with County Counsel and Risk Management for approval. The goal is to have the tool available for use in FY 23/24.  Medical Services successfully completed in-person Nursing Skills Training/Fair on 02/23/2023. | |
| **SECTION 3 WORK GROUP**  **MONITORING INTENSIVE CARE COORDINATION (ICC) AND INTENSIVE HOME-BASED SERVICES (IHBS)**  *(Source: MHP)* | | **MHP ONLY** |
| **FY 22/23 Evaluation** | The workgroup reviewed the existing Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) provision of services and the related goals. In FY 22/23, DBH continued to work on resolving these issues through problem-solving data discrepancies, creating targeted business processes, and refining new data structures, proprietary data tables, and processing methods.  The workgroup identified four goals in FY 22/23:   1. Goal: Improve 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.   Implement a screening tool for ICC and IHBS services 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, at least, every 90 days. The work group has identified a screening tool and is in the process of implementing the tool in the Children’s System of Care. This goal is partially met.   1. Goal: Monitor ongoing utilization rates, utilization management, and utilization review.   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 youths 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 utilization of ICC/IHBS is reviewed monthly at Workgroup meetings and provided at program and agency meetings. Providers who are not accessing data documents including the Monthly Caseload (MCL) Report are prompted by their Program Monitor (PS II).  DBH is also alerting Full-Service Partnership programs with Dependent and Probation youth who show in CWS/CMS the absence of or a delayed Child and Family Team meeting (outside of 90 days). The monthly email provides the name of the youth, the last CFTM date, and requests an accounting of the service or the barrier to providing the service.  Below is a summary of the FY 22-23 ICC and IHBS Report for the three (3) FSP programs with a comparison to FY 21-22 data (in parentheses):   |  |  |  |  | | --- | --- | --- | --- | | **FY 22-23 Program** | **Unduplicated Count Receiving EPSDT Service** | **Unduplicated Count Receiving ICC Service** | **Unduplicated Count Receiving IHBS Service** | | **ChRIS Program** | 434 (511) | 393 (452) | 115 (130) | | **SB 163 Wrap Program** | 720 (812) | 670 (689) | 266 (258) | | **Success First-Early Wrap** | 1291 (1408) | 954 (957) | 159 (183) |   The unduplicated count of youth receiving services in each program decreased this year. This is most likely attributed to staffing shortages reported throughout the system of care.  However, as a percentage of EPSDT services overall, more youth were receiving ICC and IHBS services in each program except for the 3% drop in IHBS services in Success First-Early Wrap. Continuing to provide utilization feedback and training related to ICC/IHBS services, the intent is to increase ICC to 95% in both high intensity programs of ChRIS and SB 163 Wraparound. Also increasing the percentage of IHBS to at least 40% in ChRIS and SB 163 Wraparound is a reasonable goal. This goal is partially met.   1. Goal: Monitor Identification of ICC Coordinators being designated in Objective Arts.   The existing Monthly Case Load (MCL) Report provides a point-in-time review of multiple data points. In FY 22/23, the workgroup continued to 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 is run monthly and uploaded onto a HIPAA compliant File Transfer Protocol site allowing providers to download their program reports monthly and review. Any missing identification is prompted for completion in Objective Arts. In addition, the names of youth with high service utilization but low ICC/IHBS are conveyed and problem-solved at agency meetings. This goal is partially met.   1. 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 of the provision of ICC and IHBS services. A report mock-up was developed, and service and client status indices were identified. New self-contained data tables that required data from several sources were created to generate a new Treatment Outcomes Report - ICC/IHBS (TORII). With this report, the workgroup will identify and analyze the way ICC and IHBS relate to treatment progress and outcomes. The report intended to explore this dynamic continues to be on hold due to staffing shortages. The workgroup and report development project staff will continue to meet regularly to review findings and validate report development. The design of this project may need to be explored because of the number of confounds involved. This goal is not met. | |

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| **SECTION 4**  **BEHAVIORAL HEALTH NEEDS IN SPECIFIC CULTURAL AND ETHNIC GROUPS** | | **MHP AND SUDRS** |
| **FY 22/23 Evaluation** | The workgroup reviewed penetration rates for both mental health (MH) and substance use disorder (SUD) in Fiscal Year (FY) 22/23 for underserved racial, ethnic, and cultural populations once a year, thus partially meeting this goal. This goal may continue next FY.  The MH penetration rate dropped slightly from 3.3% in FY 21/22 to 3.2% in FY 22/23.  The SUD penetration rate stayed the same, at 0.5% in FY 21/22 and 0.5% in FY 22/23.  While there was a general increase in the total numbers of both MH and SUD beneficiaries served, the Latino and Native American populations had a decrease in MH penetration rates from 2.7% to 2.6% and 8.4% to 7.8%, and for SUD Asian and/or Pacific Islander and Native American from .2% to .1% and from 2.2% to 1.7% from the prior year penetration rates.  For FY 22/23, 83.9% of DBH staff (N= 945) completed their required annual Cultural Competency training. This goal was met.  For FY 22/23, 100% of DBH new employees (N= 287) received language services training during new employee orientation to ensure clients receive services in their preferred language when assessing and receiving services. This goal was met.  From FY 21/22 to FY 22/23, the total number of language service appointments increased by 15.5%, from 7,103 to 8,205 appointments.  The DBH bilingual staff list is posted on the DBH website every 6 months. In FY 22/23, DBH had 191 certified bilingual staff employed. Over 90% of bilingual staff are certified in Spanish. Spanish is the county’s primary non-English threshold language.  In FY 22/23, DBH continued to translate informing materials into all three (3) non-English threshold languages: Spanish, Mandarin, and Vietnamese. These materials included provider directories, beneficiary handbooks, grievance and second opinion postings, as well as audio recordings in English, Spanish, Mandarin, and Vietnamese. All are posted on the DBH website.  In FY 22/23, Section 4 workgroup members attended monthly meetings and participated in the workgroup activities of the Consumer Evaluation Council Quality Improvement Advisory Workgroup to address access and engagement issues.  Note: There may be a slight discrepancy in the penetration rates that were listed in the FY 2021/2022 evaluation due to the date that the penetration rate reports were pulled. | |

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| **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 22/23 Evaluation** | In FY 2022/2023 the Office of Equity and Inclusion (OEI) conducted live customer service calls during and after business hours for both MH and SUDRS. These calls were conducted in both English and Spanish. They also conducted after-hours voicemail calls for mental health DBH clinics and their contract agencies. The voicemail test calls were conducted by SUDRS.  To achieve the 90% target goal rate of ensuring that the SUDRS BAL and MHP Access Unit lines are answered 24/7, the work group activities put forth the following:  The Access Call Center received at total of 11,936 calls during business hours for FY 22/23.  Out of these, the Call Center successfully answered 11,499 calls, achieving a compliance rate of 96.33%.  The current software system is unable to track the data for answered calls during the after-hours shift.  However, the MHP data indicates that for FY 22/23 the after-hours team received 5,204 calls during the after-hours shift (5:00pm – 7:30am). MHP met the goal.  OEI conducted three (3) after-hours SUDRS-BAL live calls for its clients, this constituted a 66% compliance rate for SUDRS. Consequently, staff were trained on after-hours call requirements, customer service, call scripts, form completions. A new voicemail was set up on all SUD clinic phones. The achieved goal fell short at 66% against the target goal of 90%, thus the test call goal for SUDRS is rated Not Met. This goal will continue.  The MHP will continue to monitor county and county contracted providers annually to ensure compliance with after-hours voicemail messages with a goal of 90% compliance. As part of the MHP activities for FY 22/23, OEI conducted 43 after-hours voicemail test calls. Twenty-three of these test calls adhered to the required standard; representing a 53.49% achievement against the target goal rate of 90% Action items would include standardizing the voicemail scripts and test calls passing requirements at all DBH clinics and contract providers sites. Additional action items would include maintaining an ongoing feedback loop with a view to improving the test call system. The test call goal for the MHP was not met.  In contrast, SUDRS conducted 30 voicemail calls. 23 voicemail calls met the required compliant standard, and the clients were successfully connected to the Access and SUDRS BAL. An achievement rate of 76.6% was recorded against the targeted goal rate of 90%. As part of the contract monitoring process established in FY 20/21, the program review team has contacted the applicable programs with the aim to assist each program with strategies geared toward meeting their target. Activities towards this goal will continue. The test call goal for the SUDRS was not met.  In determining the achievement of ensuring SUDRS and MHP Access lines are provided in the prevalent non-English languages. The goal is to establish a baseline data with reference to the number of test calls conducted and the number of calls provided in the threshold languages at a 90% compliance rate:  OEI completed 15 prevalent non-English test calls to the MHP Access line for the FY 22/23. Out of these, seven (7) calls failed to connect to the interpreter service. This result represents an achievement of 53.33%. Notably six (6) of the seven (7) failed calls occurred after-hours. The MHP goal rating was not met. This goal will continue.    In comparison, SUDRS continued to refine preliminary baseline data as it relates to the threshold languages pulled from the Finesse phone line, and myAVATAR, which is DBH’s electronic health record (EHR). SUDRS has been active in monitoring various reports, including average monthly Spanish calls, dropped calls, and variances between English and Spanish. These reports were used as part of the QIPP work group to analyze and develop strategies to improve customer service. As a result of this analysis the following measures have been implemented:   1. Data was created that incorporated a comprehensive list of the Spanish speaking staff in the monitoring queue with an aim to enhance the identification of available Spanish speaking staff. 2. Analysis of real time duties of staff that may cause them to leave the call queue.   Additionally, all non-Spanish speaking staff are assigned a lower-level attribute in CISCO Finesse. This means that if all Spanish speaking staff in SARC are on a call, an incoming call will be routed to another SARC staff member who can assist the client with interpretation or requested service. For this reporting period, only one (1) Spanish speaking OEI/Mystery Shopper call was conducted which met required guidelines. Although this goal for SUDRS was met, it will be continued.  The MHP and SUDRS data represented below highlight the activities of the work group for the FY22/23 goal in conducting regular test calls for MHP Access Line, while ensuring clients are provided appropriate information and referrals. The target is to conduct four (4) test calls per month for business hours and three (3) test calls per month for after-hours calls at a compliance rate of 80%.  OEI conducted a total of 74 Access Unit test calls for the MHP, 70 calls were answered, which indicates that 94.59% of the test calls were answered. Of the 55 answered calls provided, resulted in an 74.32% passing rate. The 80% compliance goal was not met. This goal may be continued next FY.  OEI conducted 21 English, and one (1) Spanish Mystery Shopper calls to the SUDRS-BAL line during the reporting period. Seven (7) of these calls involved requests for NARCAN. Each NARCAN request was addressed, and appropriate resources were provided. Furthermore, the clients were offered an option to either pick up free NARCAN from DBH office upon walk-in or from nearby local pharmacies, based on the client’s reported location.  Additionally, SUDRS implemented Finesse call line Quality Assurance reviews to monitor consumer calls, provide clinical guidance to staff, and improve customer care. This goal for SUDRS was met and will continue.  The MHP Call center software was used to analyze the data for the MHP Access Line. The Access Call Center received a total of 11,936 calls during business hours for the FY 22/23. However, the current software system could not track the data for answered calls during the after-hours shift. Analysis of the MHP data indicates that the after-hours team received 5,204 calls during the after-hours shift. The target goal for MHP was partially met.  The following information is an analysis of the MHP work group activities for the period:   1. The goal was to conduct four (4) Specialty Mental Health (SMHS) test calls per month, yet OEI conducted 48 SMHS test calls in total for FY 22/23. This amounts to a 70.83% compliance rate, as 34 out of 48 SMHS calls were completed, this goal will continue.    * Goal was two (2) English test calls; however, OEI exceeded the minimum by completing 28 English test calls.    * Goal was two (2) prevalent non-English language test calls, and six (6) non-English test calls were completed.    * The goal was two (2) test calls during the month conducted after-hours, yet seven (7) after-hours test calls for SMHS were completed. 2. The goal was to conduct one (1) urgent condition information test call per month, OEI accomplished 21 urgent condition test calls in total for FY 22/23. The 90% compliance goal was met as OEI exceeded the number of calls required for this category.    * Goal was to alternate between English and non-English. One month English, following month prevalent non-English language. Seventeen (17) English urgent condition test calls were completed, and four (4) non-English urgent test calls were completed. 3. The goal was to conduct two (2) beneficiary problem resolution test calls per month, and 24 total beneficiary problem resolution test calls were completed for FY 22/23. This amounts to a 79.17% compliance rate, as 19 of 24 total beneficiary calls were completed, this goal will continue.    * Goal was one (1) English test call, and 14 test calls were completed.    * Goal was one (1) prevalent non-English test call, and five (5) prevalent non-English test calls were completed.    * The goal was one (1) test call must be made after-hours and three (3) after-hours test calls were completed.   QM completed an updated call script for the MHP Access line to reflect the addition of the CalAIM screening tool referral process. Access unit business and after-hours staff received training at the time of implementation. These trainings are ongoing and will address changes that may arise.    The final goal for the MHP and SUDRS for the period was to Review the Leadership Development Project (LDP) recommendation for merger of the Call Centers to determine what can/cannot be implemented, identify, and discuss action items. The target goal was not accomplished for the review period as LDP did not recommend a merger but to review what needed to be done to merge the lines. Due to competing priorities, specifically continual CalAIM initiatives, the proposed initiative will no longer be pursued as a QIPP initiative. The merger of MH and SUD requirements will proceed with the proposed CalAIM timeline provided by DHCS. | |

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| **SECTION 6 WORK GROUP**  **CONDUCTING PERFORMANCE IMPROVEMENT PROJECTS (PIPs) TO IMPROVE CLIENT CARE**  *(Source: EQRO)* | | **MHP AND SUDRS** |
| **FY 22/23 Evaluation** | The department continues to strategize and implement performance improvement projects in accordance with EQRO and Center for Medicare and Medicaid Services (CMS) requirements.  Considering California Advancing and Innovating Medi-Cal (CalAIM) requirements, San Bernadino County Department of Behavioral Health (DBH) has opted into the BHQIP 3d deliverables (which includes FUM, FUA and POD performance improvement projects). DBH is actively engaged in efforts to increase data exchange capabilities, and care coordination to address complex client needs. This has resulted in obtaining client input through surveys and through semi-structured discussions with the consumer evaluation committee. This goal was met.  Furthermore, with increased participation and engagement there have been active solution-oriented collaborative efforts with multiple stakeholders within the department, the hospitals, and the managed care plans. Consequently, data analysis has been developed, and reports that aim to drive decision-making are presented. This goal was met.  The department is currently brainstorming for solutions and strategies to overcome the technological, staffing and resource barriers so that the appropriate workflow is set up to successfully accommodate data exchange and care coordination for eligible populations. This goal is partially met. | |

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| **SECTION 7 WORK GROUP**  **MONITORING/ IMPROVING SERVICE CAPACITY**  *(Source: MHP & Annual Protocol)* | | **MHP AND SUDRS** | |
| **FY 22/23 Evaluation** | DBH had difficulty establishing a consistent review and reporting process for monitoring under and overutilization of services. During the fiscal year, the department had audits/reviews, NACT submission, and a NACT CAP, where the service utilization data was reviewed. The goal of reviewing the data quarterly for MHP was not met and was partially met for SUDRS.  In FY 22/23 San Bernardino County had 4.55% of Medi-Cal beneficiaries between the ages of 12-17 that would need SUDRS treatment services and 10% of those are anticipated to seek treatment. DBH expected 510 youth 12-17 years old to seek SUDRS services this fiscal year.  The 18+ adult population had 9.23% expected to need treatment and 10% of those are anticipated to seek treatment. DBH expected 5,802 18+ year olds to see treatment this fiscal year.  Based on FY 22/23 MH NACT data, DBH has the capacity to serve 5,115 adults and 156 youth at any one time. Comparing the State’s expected beneficiaries to DBH’s capacity to serve, it does not have the capacity to treat the Medi-Cal beneficiaries that are expected to seek treatment.  The actual service utilization for SUDRS services is illustrated in the table below. SUDRS showed utilization improvements over last year but are still a little short on expected utilization in all areas except Adult Residential services.   |  |  |  |  | | --- | --- | --- | --- | | FY 2022/23 |  | Expected Utilization | Actual Beneficiaries Served | | New\_Age\_Group | Modality | Count of PATID | Count Distinct of PATID | | 0 to 17 | 1\_OP | 155 | 141 | | 0 to 17 | 2\_IOT | 1 | 0 | | 0 to 17 | 3\_Res | 36 | 26 | | 0 to 17 | 4\_NTP | 1 | 0 | | 18+ | 1\_OP | 2,817 | 2,758 | | 18+ | 2\_IOT | 353 | 310 | | **18+** | **3\_Res** | **934** | **998** | | 18+ | 4\_NTP | 1,560 | 1,535 | | **Total** |  | **5,857** | **5,768** | | | |
| **SECTION 8 WORK GROUP**  **MONITORING/ IMPROVING CLIENT SATISFACTION** | | | **MHP AND SUDRS** |
| **FY 22/23 Evaluation** | The work group activities for QIPP FY 22/23 goals include tracking and assessing client grievances, appeals, state hearings, completion of the Managed Care Program Annual Report (MCPAR) and development of a consumer satisfaction survey report. The reported data below highlights the goals achieved.   * Continued tracking and assessing client grievances appeals, and state hearings – Met. * Completed Managed Care Program Annual Report – Met * Developed consumer satisfaction survey with one survey done FY 22/23 – Not met.   The MHP reports out on quarterly grievances, appeals, and state hearings. All grievances are received and processed by QM. The BHP reported a combined total of 155 grievances, 2 appeals, and 1 state hearing for both MH and SUDRS for FY 22/23.   |  |  |  |  | | --- | --- | --- | --- | | **Grievance Types** | **MHP** | **SUDRS** | **TOTAL** | | Quality of Care | 105 | 14 | 119 | | Access | 15 | 1 | 16 | | Confidentiality Concern | 1 | 0 | 1 | | Other | 15 | 4 | 19 | | **Grand Total** | **136** | **19** | **155** |  |  |  |  |  | | --- | --- | --- | --- | | **Appeal Types** | **MHP** | **SUDRS** | **TOTAL** | | Reduction, Suspension, or Termination of Previously Authorized Service | 0 | 2 | 2 | | **Grand Total** | **0** | **2** | **2** |   During QMAC a report is given regarding the identified trends and evaluated for further training needs. This report utilizes data collected for the state-mandated annual Managed Care Program Annual Report (MCPAR). Based on the MCPAR data that will be submitted for FY 22/23, DBH showed changes from the prior fiscal year for MH grievances:   * 31.03% increase in Quality-of-Care grievances * 14.29% increase in Customer Service grievances * 1.47% increase in all Other Type of grievances * 7.94% increase in Grand Total of grievances received. * 100% decrease in MH related NOABDs received   For FY 22/23, SUD showed changes from the prior fiscal year for SUDRS related grievances:   * 33.33% increase in Quality-of-Care grievances * 0% increase in Customer Service grievances * 66.67% decrease in Payment/Billing related grievances * 53.33% decrease in all Other Type of grievances * 20.83% decrease in Grand Total of grievances received. * 100% decrease in SUDRS related NOABDs received.   The workgroup discussed the feasibility of utilizing the emoji client survey created in Consumer Evaluation Committee (CEC) to collect data to address overall client satisfaction. The workgroup drilled down the overarching grievance categories into smaller subcategories, to help guide the creation of potential survey questions that could be added to the existing survey. The goal of issuing one survey for FY 22/23 was not met and will continue for FY 23/24. | | |

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| **SECTION 8A**  **CLIENT EXPERIENCES** | | **MHP AND SUDRS** |
| **FY 22/23 Evaluation** | The MHP annually conducts the Consumer Perception Surveys (CPS) in the spring month i.e., May/June. A reason for this is to allow for the participation of school groups in the surveys. The survey questions are rated from 1 to 5, with a rating of 5 being the most satisfactory outcome and 1 a dissatisfaction rating. Scores above 3.5 are “in agreement” however the State target is rated at 4.3.  The most recent survey was conducted in the spring of 2023 and was sent out to the University of California Los Angeles UCLA for analysis. The result of the analysis is due by January 2024.  The CPS for the FY22/23 period which was conducted in the spring of 2022 was not presented in the QMAC meeting., however it was presented to the clubhouses during the Consumer Evaluation Council CEC meeting. In the CEC meeting, the potential locations to post the summarized version of the survey information were discussed, the conclusions on this would be finalized with DBH Public Relations Office PRO. There is also a need to include a review of the Community Policy Advisory Committee CPAC Survey results in the upcoming QMAC meeting agenda.  Below is an analysis of the County (MH) vis a vis the State CPS results: (*This survey was conducted in May 2022*)  **The CPS Age Groups covered were**   * Adult (ages 18-59) * Older Adults (ages 60+) * Youth (ages 13-17 and transitional-age youth who still receive services in child systems) * Family (Parent/Caregiver of youth)   **The survey domains categories covered for each age group are:**   * **Adult & Older Adult**   General Satisfaction  Perception of Access   * Perception of Quality & Appropriateness * Perception of Participation in Treatment Planning * Perception of Outcome of Services * Perception of Functioning * Perception of Social Connectedness * **Youth & Youth Families** * General Satisfaction * Perception of Access * Perception of Cultural Sensitivity * Perception of Participation in Treatment Planning * Perception of Outcome of Services * Perception of Functioning * Perception of Social Connectedness  |  |  |  | | --- | --- | --- | | **Adult and Older Adult 2022 CPS Results** | | | | **Domain** | **County** | **State** | | General Satisfaction | 4.48 | 4.42 | | Perception of Access | 4.40 | 4.30 | | Perception of Quality and Appropriateness | 4.37 | 4.30 | | Perception of Participation in Treatment Planning | 4.29 | 4.30 | | Perception of Outcome of Services | 3.29 | 4.30 | | Perception of Functioning | 3.94 | 4.00 | | Perception of Functioning | 3.92 | 3.94 | | Perception of Social Connectedness | 3.88 | 4.00 |  |  |  |  | | --- | --- | --- | | **Youth and Family 2022 CPS Results** | | | | **Domain** | **County** | **State** | | General Satisfaction | 4.33 | 4.30 | | Perception of Access | 4.34 | 4.33 | | Perception of Cultural Sensitivity | 4.50 | 4.47 | | Perception of Participation in Treatment Planning | 4.27 | 4.21 | | Perception of Outcome of Services | 3.90 | 3.86 | | Perception of Functioning | 3.94 | 3.89 | | Perception of Social Connectedness | 4.3 | 4.2 |   This goal is rated **Not Met** for the MHP and will be continued.  SUDRS conducts the Treatment Perception Survey (TPS) annually in October to track and trend client satisfaction ratings in relation to Access to Care, Quality of Care and General Service Satisfaction. The results of the survey are forwarded to UCLA for thorough analysis. Over the past four (4) years, the client satisfaction rating has been on an upward trend.  The survey for 2023 will be conducted in October 2023, and the results of the data analysis are anticipated by January 2024.  A comparison of the most recent Treatment Perceptions Survey (TPS) data for the County that was conducted in 2022 and the Statewide TPS data from the same year revealed no discernible distinction in the average scores across the five domains; with both the County and Statewide data showing the same average scores in the 5 domains i.e., Access (4.3), Quality (4.5), Care Coordination (4.3), Outcome (4.4), and General Satisfaction (4.5).  A closer assessment of specific items, however, shows some variance. The County achieved higher scores in three out of the four domains items.  The data provided below represents the difference for each item category.   |  |  |  |  | | --- | --- | --- | --- | | Domain | Item | SB County | Statewide | | Access | 01. Convenient Location | 4.2 | 4.3 | | Quality | 04. Staff Gave Me Enough Time | 4.5 | 4.4 | | Quality | 07. Cultural Sensitivity | 4.5 | 4.4 | | Care Coordination | 08. Work With Physical Health Providers | 4.4 | 4.3 |   These results are shared in various meetings such as the QMAC, Substance Abuse Provider Network (SAPN), and Provider Quality Improvement Committee.  The data has not yet been published for clients, community clinics, providers, and staff.  This goal is rated **Partially Met** and will continue as the results were evaluated and shared but not published. | |

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| **SECTION 9 WORK GROUP**  **MONITORING / IMPROVING SERVICE DELIVERY SYSTEM** | | **SUDRS ONLY** |
| **FY 22/23 Evaluation** | .  The FY 2022/2023 goal for the workgroup was to establish a baseline of clients who are engaged in the recovery process.  This goal was **partially met.**  The group defined engagement as the client participating in and receiving services for an intake/assessment, treatment plan, and one (1) additional service within 30 days of admission. Note: This definition of engagement only applies to the Outpatient Drug Free (ODF) providers. Engagement definitions for residential and narcotic treatment programs will be different and still need to be defined.  The following information illustrates the aggregate baseline engagement data for FY 2022-2023 for ODF providers.  .     |  |  |  |  | | --- | --- | --- | --- | | Engagement Measure defined as 3 services within 34 days from initiation | | | | | Fiscal Year | Percent Engaged | Percent Not Engaged | Total | | FY 2020-21 | 83.80% | 16.20% | 2453 | | FY 2021-22 | 83.60% | 16.40% | 2537 | | FY 2022-23 | 87.20% | 12.80% | 2462 | | FY 2023-24 July, August Only | 76.20% | 23.80% | 829 | | FY 2023-24 first quarter data may be incomplete. Run date 9-19-2023  Includes data from 21 outpatient clinics excluding NTP providers. | | | |   DBH’s Research and Evaluation team can separate each engagement data by their individual provider. This would assist each clinic in achieving their improvement goals.  The following goals will be included for FY 2023/2024 Evaluation and work group activities.   * DBH’s Research and Evaluation will continue the development of a report to tracks 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. * Engagement data can be presented in the aggregate form to large audiences of treatment providers and can be narrowed down for single clinics to review for creating improvement opportunities. | |

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| **SECTION 10 WORK GROUP**  **REDUCING EMERGENCY DEPARTMENT HOSPITALIZATION** | | **SUDRS ONLY** |
| **FY 22/23 Evaluation** | SUDRS worked to reduce Emergency Department (ED) Hospitalization by continuing to participate in ED Bridge referrals and collaborate with participating entities. This goal was met.  The following actions were taken during FY 22/23 to help reduce Hospitalizations:   * Implemented a physician coverage plan to reduce emergency room visits for medication refills. * Same day medication refills with SUDRS Physicians are available at DBH clinics Mariposa, Rialto, Barstow, and Phoenix. * Opened an ED Bridge program at Fontana-Kaiser. * An informal directory was drafted to facilitate communication and referrals between DBH, and the ED Bridge programs at the following hospitals: St Mary’s Medical Center, Loma Linda Medical Center, St Bernadine’s Medical Center, Kaiser Fontana, San Bernardino Community Hospital, and Pomona Valley Hospital. * Additionally, SUDRS staff attended training courses held by the California Bridge Program to remain current on best practices. * Equipment has been purchased and procedures written in support of DBH operated ambulatory withdrawal management services to directly provide services to clients in need, rather than refer for emergent withdrawal management in the Emergency Department. It is expected to go live in FY 24/25.   ARMC ED Bridge leadership continued to meet regularly with DBH medical leadership through regularly scheduled Inland Empire Opioid Crisis Coalition (IEOCC) Committee meetings and gained access to OD Mapping software. These efforts will provide insights into local trends in high-risk substance use, which will facilitate coordination of community harm reduction resources. Program outcomes and process improvement opportunities were discussed. As institutional relationships matured, direct provider to provider contact occurred on an as needed basis. This goal was met. | |

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| **SECTION 11 WORK GROUP**  **CONSUMER/FAMILY MEMBER EVALUATION AND CONTRIBUTIONS** | | **MHP AND SUDRS** |
| **FY 22/23 Evaluation** | The FY2022-2023 work group for Consumer and Family Member Evaluation and Contribution was tasked with increasing Substance Use Disorder and Recovery Services (SUDRS) consumer and family member participation and soliciting feedback on quality improvement initiatives for the Department.  The Consumer and Family Member Evaluation and Contributionwork groupmet the goals for the period.  The following summarizes the actions and accomplishments of the workgroup.   1. To assist with increasing SUDRS participation, the workgroup added a co-chair with SUDRS lived experience.  * The deliverables included a demographic analysis of lived experience within the work group.  1. Organized monthly meetings which achieved the highlighted outcomes:  * Client satisfaction survey for future implementation was completed. Deliverable: Survey * Finalized the recruitment flyer for additional workgroup members. Deliverable: Flyer * Advised on crisis support for public meetings. Deliverable: Action plan for meetings including messages posted in chat. * Developed recommendations for program design and evaluation surrounding creating welcoming and supportive service delivery environments. Deliverable: Memo   The CEC continues to be a valuable resource for the department to incorporate consumer input on quality improvement initiatives. Plans are to continue this workgroup and continue to encourage diverse consumer engagement. | |

# **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.