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

Fiscal Year 2023/2024

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:

- Improving 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, urban 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.

<u>QIPP EVALUATION</u>
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.

Performance Indicators

Goal	Description	Rating M= Met PM= Partially Met NM= Not Met
Section 1: Monitoring 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	NM
Section 2: Monitoring Service Delivery System for the Safety & Effectiveness of Medication Practices		
A	Conduct (5) Peer Reviews, including Feedback regarding Quality of Care	PM
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	M
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	Train 50% of physicians on the use of the VSee telehealth platform	PM
G	Continue annual nursing skills training	NM

Goal	Description	Rating M= Met PM= Partially Met NM= Not Met
Section 3: Monitoring Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS)		
A	Inform Programs and Clinicians of Their Service Provision Patterns	PM
Section 4: Monitoring 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	NM
C	Language Services Training to all new DBH Employees Goal: 100% new staff trained	M
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*	PM
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.	NM
Section 6: Conducting Performance Improvement Projects (PIPs)		
A	Increase participation and engagement from multiple Department stakeholders. Goal: *80% attendance* and participation from multiple stakeholders within all levels of the organization in PIP QMAC Committee, Idea Labs and PIP Implementation meetings.	PM
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*	PM
C	Increase summary totals of PIP validation for clinical and non-clinical PIPS. *Goal: Increase the overall rating by*	PM

Goal	Description	Rating M= Met PM= Partially Met NM= Not Met
	10% from the prior year.	
Section 7: Monitoring/ Improving 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 for network adequacy but also for under and overutilization of services. *Goal: Review quarterly for MHP and semiannually for SUDRS*	M
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: Monitoring / Improving Client Satisfaction		
A	Track and Access Client Grievances, Appeals, and State Fair Hearings	PM
B	Utilize MCPAR Data to establish baseline data, identify inaccurate reporting and identify training needs	PM
C	Issue One Consumer Satisfaction Survey	NM
Section 8A: Monitoring / Improving Service Delivery		
A	Evaluate Consumer Perception Survey Data for SUDRS and MH, identify trends to be addressed during QMAC.	M
B	Publish data for view of clients, community clinics, providers and staff.	NM
QIPP Section 9:Evaluating Assessment of Client Experience		
A	Baseline of Clients Engaged in the Recovery Process	M
Section 10: Reducing Emergency Department Hospitalization		
A	Reduce hospitalizations with ED Bridge Buprenorphine Medication Assisted Treatment Stabilization	M
Section 11: Consumer/Family Member Evaluation and Contributions		
A	Increase Participation of SUDRS Consumer and/or Family Members	PM
B	Identification, Discussion and Implementation of Quality Improvement Initiatives	M
Section 12: Improving Data Collection for Managed Care Plan (MCP) Referrals		
A	Establish an improved data collection process for analyzing metrics related to timeliness, engagement, and recurring referrals from same clients.	PM
B	Enhance quality improvement via a “close the loop” process geared towards bridging the gap with the Managed Care plans by January 1, 2025.	PM

Section 1: Monitoring Timeliness
(MHP and SUDRS)

<table>
<tr><th>Goal</th><th>Rating
M=Met
PM=Partially Met
NM=Not Met</th><th>Description</th><th>Progress Evaluation</th></tr>
<tr><td>A</td><td>Partially Met</td><td>Comply with new DHCS requirements of 80% compliance rate with the following Mental Health (MH) timeliness requirements:
Initial request for non-urgent appointments with a non-physician specialty mental health care provider within 10 business days of the request.
Initial psychiatric appointment within 15 business days of the initial request. Requests for urgent services are provided within 48 hours.</td><td>The Monitoring Timeliness subcommittee met monthly during fiscal year 2023/2024 to review timely access data.

The following table shows the MHP compliance with timeliness standards for the year.

FY 2023/24 Requests for SMHS Timeliness Results
<table><tr><th>MH Contact Reason</th><th>MH Results</th><th>Rating</th></tr><tr><td>Non-Urgent Non-psych 10 days</td><td>DBH & Contract
3,935 requests 63.89 % met
Contract only
1,865 requests 46.65% met
DBH only
2,070 requests, 79.42% met</td><td>Not met</td></tr><tr><td>Psych, non-urgent 15 days</td><td>DBH & Contract
123 requests 86.18% met
Contract only
0 requests % met
DBH only
123 requests, 86.18% met</td><td>Met</td></tr></table></td></tr>
</table>

Section 1: Monitoring Timeliness *(MHP and SUDRS)*					
Goal	**Rating** **M=Met** **PM=Partially Met** **NM=Not Met**	**Description**	**Progress Evaluation**		
			Urgent **48 hours**	**DBH & Contract** **4 requests 0% met** **Contract only** **0 requests % met** **DBH only** **4 requests, 0% met**	Not Met
			Timeliness compliance information is recorded using the Initial Contact Log in our electronic health record. The department is currently reviewing and revising work processes to ensure that accurate data is being captured. The current process for psychiatric requests involves providing a mental health assessment to determine medical necessity and the appropriate level of care. If the assessment indicates that a psychiatric appointment is needed, the clinician will refer the member to the next available psychiatry appointment. However, this referral information is not currently recorded in the electronic health record in a way that allows DBH to track the interval between the referral date and the date the member receives the service. As a result, the psychiatry appointment may not always occur within 15 days of the member's request.		

Section 1: Monitoring Timeliness
(MHP and SUDRS)

<table>
<tr><th>Goal</th><th>Rating
M=Met
PM=Partially Met
NM=Not Met</th><th>Description</th><th>Progress Evaluation</th></tr>
<tr><td></td><td></td><td></td><td>Although the overall timeliness standards were not met for Non-Urgent, Non-Psych and Urgent initial requests for services, we have made notable improvements in data entry and reporting of new member request for services with DBH owned and operated clinics. .</td></tr>
<tr><td>B</td><td>Partially Met</td><td>Meet Substance Use Disorders and Recovery Services (SUDRS) timeliness requirements:
Offers an outpatient/intensive outpatient treatment (IOT) or residential treatment appointment within ten (10) business days of request/identified need.
Offers Narcotic Treatment Program (NTP)/Opioid Treatment Program (OTP) within three (3) calendar days of request/identified need.</td><td>Most members were offered appointments within the specified timeliness standard; however, continued monitoring is required to ensure that all providers accurately report the date appointment is offered to ensure compliance with the required timeframe.
The data below represents SUDRS timeliness Report for the period :
<table><tr><th>Contact Reason</th><th>SUDRS Results</th><th>Rating</th></tr><tr><td>Non-Urgent Non-psych 10 days</td><td>DBH & Contracts 1,788 requests 72.93%</td><td>Met</td></tr><tr><td></td><td>Contract Only 318 requests 77.35% met</td><td>Met</td></tr><tr><td></td><td>DBH only 1,470 requests 71.97% met</td><td>Met</td></tr></table></td></tr>
</table>

Section 1: Monitoring Timeliness *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
C	Partially Met	Monitor bed capacity procurement process for agencies interested in providing IOT and residential treatment with the goal of meeting timely access.	SUDRS increased residential bed capacity by 12 , growing from 219 beds to 231 beds; and is currently expanding IOT services through the procurement process.. SUDRS is also working to implement a mobile clinic to offer services in remote locations.
D	Partially Met	Enhance report process between SUDRS and Research and Evaluation (R&E), including a specialized report to measure timeliness.	SUDRS and R&E worked together to streamline referrals for R&E PIPs related to SUDRS members and timeliness standards. Additional projects are underway to further improve the reporting matrix.
E	Partially Met	Educate MH and SUDRS staff and contract agencies of the following: •Timeliness requirements when scheduling initial clients with the goal to increase timeliness and •Initial contact log requirements with the goal of increasing the accuracy of the logs and increase the compliance rates.	During FY 23/24 quarterly mental health Timeliness standard reminders were sent to DBH, contract agencies and FFS providers. It was noted that Initial Contact Log (ICL) data entry improved in the months following the reminders. Quarterly reminders will continue to be sent in fiscal year 24/25. An ICL Information Notice, How to Guide and Cheat sheet were also distributed during the fiscal year. The committee anticipates increased ICL recording compliance with the use of the additional tools. Preliminary results show 53% improvement in ICL recording compliance. For SUDRS the ICL was created, and the ICL training was

Section 1: Monitoring Timeliness *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
			completed with DBH staff and CBO staff. SUDRS ICL enhancements are in the works.
F	Not Met	Continue to monitor post-hospitalization appointments within seven (7) calendar days of discharge. Strive for compliance rate of 50% or higher.	DBH is not currently meeting the 50% compliance rate with meeting post-hospitalization appointments within seven days. Key observations worth noting are as follows: • An appointment is given within the required 7 days when a hospital calls a DBH clinic to make a discharge appointment. If the member is a no-show to the appointment, a case manager will attempt contact, and another appointment is scheduled. • Though the clinics may not currently be documenting follow-up contact, steps are being taken to implement methods to do so. Presently, Access Unit has established a process for recording calls in myAvatar for members without an open chart in DBH/MH. Clinics and Programs would either adopt this method or develop a similar process to track current and potential members. Many discharges are for people experiencing homelessness for whom follow-up is very difficult since there is no address and frequently no working telephone number. If we are unable to reach the client , there is no further attempt.

Section 1: Monitoring Timeliness *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
			We will continue to monitor and strategize on ways to improve the follow-up appointment process.

Section 2: Monitoring the Service Delivery System for the Safety & Effectiveness of Medication Practices (MHP Only)			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
A	**Partially Met**	Conduct five (5) peer reviews per fiscal year, per physician, and provide feedback to physicians on quality of care provided, which is consistent with the "Patient or Peer Feedback Module" that meets the requirements of an Improvement in Medical Practice (PIP) activity established by the American Board of Psychiatry and Neurology (https://abpn.org/maintain-certification/moc-activity-requirements/improvement-in-medical-practice-pip/patient-or-peer-feedback-module/).	In FY 23/24 MHP physicians conducted a total of 90 peer reviews which was an improvement from the 49 peer reviews conducted in FY 22/23. While the comparison records an improvement in the number of peer reviews completed, it did not fully meet the goal established in the QIPP. Due to a shortage of psychiatric physicians in our MHP system of care, DBH prioritized physician time for the delivery of care over peer reviews.
B	Met	Annually release or revise one (1) new practice guideline topic or Medical Services Practice Policy/Procedure related to medication or related practices.	ECT Policy and Procedure documents were developed by DBH-Medical Services division and published by DBH in 1/2024.
C	Met	Continue using Parameters 3.8 for Use of Psychotropic Medications in Children and Adolescents.	This is a parameter established by Los Angeles County Department of Mental Health and utilized by multiple other MHPs throughout the state. DBH-Medical Services Associate Medical Director R. Parikh, MD and DBH—Clinic Medical Director, R. Patel, MD—both child/adolescent psychiatrists—participate in meetings throughout the year where this parameter is discussed.
D	Met	Complete development of a Psychopharmacology Consultation Team for consultation by physicians regarding patients	The Psychopharmacology Consultation Team had its first meeting in the last quarter of calendar year 2023 and has had 2 meetings thus far in the first 6 months of 2024.

Section 2: Monitoring the Service Delivery System for the Safety & Effectiveness of Medication Practices (MHP Only)			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
		with complicated treatment issues.	
E	Partially Met	Purchase and utilize an electronic clinical resource tool(s) containing evidence-based information to support and guide physicians, nursing staff and patients in collaborative clinical decision-making and improving patient care.	In late 2023, at the direction of the DBH Director, this goal was reassigned from DBH-Medical Services division to the DBH-Workforce and Education Training [WET] division. Before it was re-assigned, two such electronic tools were identified ("Up-to-Date" and "Psychiatry Online") and either contracts or purchase orders obtained from respective vendors.
F	Partially Met	Train 50% of physicians on the use of the VSee telehealth platform to help improve access to care for patients. Assess barriers to both provider and patient use of this modality.	Ongoing encouragement was made by DBH Medical Services leadership over the 2023-24 fiscal year to physician staff to utilize VSee to increase patient access to services. However, a formal training on VSee was never actually conducted. We received feedback from several physicians on barriers to use of the VSee telehealth platform, including technical/glitches issues (which may be related to limited internet bandwidth available in many of our DBH directly-operated clinics). Furthermore, physicians reported that since they had never received formal training in VSee, they were not entirely comfortable with its features and use—since it was introduced in the middle of the COVID-19 pandemic.

Section 2: Monitoring the Service Delivery System for the Safety & Effectiveness of Medication Practices (MHP Only)			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
G	Not Met	Continue annual nursing skills training.	The annual nursing skills training was planned for May 2024. However, the location experienced a catastrophic flooding event, and so the training was cancelled.

Section 3: Monitoring Intensive Care Coordination (ICC) And Intensive Home-Based Services (IHBS) *(MHP ONLY)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
A	**Partially Met**	Utilize the QIPP ICC/IHBS data to inform programs and clinicians of their service provision patterns.	The workgroup reviewed the existing Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) provision of services and the related goals. In fiscal year 23/24, the ICC/IHBS workgroup focused on the following: 1.) Improve ongoing access to ICC and IHBS by implementing a screening tool used in the intake process to ensure all children and youth that meet criteria are offered ICC and IHBS. – Partially Met. To enhance ongoing access to Integrated Core Practice Model (ICPM) services, specifically ICC and IHBS. The San Bernardino Mental Health Plan (MHP) collaborates with various programs to implement the ICPM. While each program is responsible for ensuring all ICPM elements are provided to qualified youth, there may be slight variations in emphasis. For Full Service Partnership (FSP) programs, the expectation is that 100% of foster youth meet eligibility criteria for ICC. However, a challenge remains in ensuring that youth receiving services in moderate-level intensity programs are appropriately screened for ICC and IHBS. During fiscal year 2023-2024, the ICC/IHBS workgroup evaluated potential screening tools for incorporation into the existing DBH Netsmart Billing System (myAvatar). Unfortunately, implementing a new screening tool proved

Section 3: Monitoring Intensive Care Coordination (ICC) And Intensive Home-Based Services (IHBS) *(MHP ONLY)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
			complex, and the necessary resources were not readily available. Additionally, staff members with the required technological skills within DBH Children and Youth Collaborative Services (CYCS) left the department. As an alternative, the workgroup has adopted a reverse monitoring strategy by analyzing existing QIPP ICC/IHBS Monitoring reports and the Monthly Caseload (MCL) report and will continue to explore if qualified youth receiving services in moderate-level intensity programs are appropriately screened for ICC and IHBS. 2.) Monitor ongoing utilization rates, utilization management, and utilization review. - Met The 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

Section 3: Monitoring Intensive Care Coordination (ICC) And Intensive Home-Based Services (IHBS)
(MHP ONLY)

Goal	Rating M=Met PM=Partially Met NM=Not Met	Description	Progress Evaluation

manager and program specialists.

Below is a summary of the FY 23/24 Quarter 3 ICC and IHBS report.

Summary of Fiscal Year 23/24 Quarter 3 ICC and IHBS for the three Children's FSP programs.

FY 23-24 Quarter 3 Program	Unduplicated County Receiving EPSDT Service	Unduplicated Count Receiving ICC Service	Unduplicated Count Receiving IHBS Service
ChRIS Program	429	364 (84%	312 (72%)
SB 163 Wraparound Program	653	586 (90%)	568 (87%)
Success First-Early Wrap	985	644 (65%)	790* (80%)

*IHBS Services are only to be conducted in the context of ongoing ICC service provision. The workgroup will be reviewing if the noted data is a data entry error or if IHBS services are being inappropriately provided. Findings will be addressed at agency and program meetings.

Children and Youth Collaborative Services (CYCS) will continue to provide utilization feedback and training related to ICC/IHBS services with the intent to maintain ICC at 95% in both high intensity programs of ChRIS and SB 163 Wraparound and IHBS services above 40%.
3.) Monitor Identification of ICC Coordinators designated in

Section 3: Monitoring Intensive Care Coordination (ICC) And Intensive Home-Based Services (IHBS) *(MHP ONLY)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
			Objective Arts. - Met The existing Monthly Case Load (MCL) Report offers a snapshot of various data points, enabling agencies to review ICC/IHBS service provisions and take appropriate action with members. In the fiscal year 2022-2023, the workgroup developed a functional business process to capture ICC Coordinator Information using Objective Arts. Information about ICC Coordinators from Objective Arts is extracted and included in the MCL report, allowing agencies to verify the accuracy of the recorded details and identify any missing ICC Coordinator information. The MCL report is provided to agencies monthly, allowing for the facilitation to review youth with high service utilization but low ICC/IHBS engagement. The workgroup will continue to monitor the MCL report and utilize these reports during program meetings, agency discussions, and contract monitoring. 4.) Explore the relationship of the provision of ICC and IHBS to positive treatment outcomes. – Not Met In the fiscal year 2023-2024, the workgroup initiated the development of a new Treatment Outcomes Report (TORII) – ICC/IHBS (TORII). The purpose of this report was to examine how ICC and IHBS impact treatment progress and outcomes. However, the TORII development project was halted due to the

Section 3: Monitoring Intensive Care Coordination (ICC) And Intensive Home-Based Services (IHBS) *(MHP ONLY)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
			departure of staff with specialized technological development skills and insurmountable data challenges within the project. As a result, the TORII report is currently on hold. The workgroup now plans to launch a new pilot project that investigates the relationship between the hours of ICC services members receive and a member's CANS Core Actionable Items score and the impact on planned and unplanned discharges. This pilot project will utilize data from the Success First/Early Wrap program and will be tested to evaluate if the associated data provides usable outcome results.

Section 4: Monitoring Health Needs in Specific Cultural and Ethnic Groups *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
A	**Partially Met**	Maintain and analyze the penetration rates for underserved racial/ ethnic and cultural populations, twice a year.	Penetration rates were only reviewed once in the last year. For SUD there was an increase in members served from last fiscal year. ○ Penetration rates for Asian/Pacific Islander and Native American members decreased from the prior fiscal year. ○ Latino/Hispanic and Caucasian/White penetration rates stayed the same from the prior fiscal year. ○ African American/Black penetration rate increased from the prior fiscal year. For MHP there was an increase in members served from last fiscal year. ○ Penetration rates for Caucasian/White, Latino/Hispanic and Native American members decreased from the prior fiscal year. ○ African American/Black and Asian/Pacific Islander penetration rates stayed the same. • Data pulled by R&E 8/9/2023. Medi-Cal members only.
B	Not Met	Monitor required annual Cultural Competency training. Goal: 80%, staff completion.	The FY 2023-24 Cultural Competency training data (N-941) was pulled from WET Relias training systems and includes all active users during that period, as well as those that may have separated and are no longer with the department but were active during the reporting period. The FY 2023-24 Cultural Competency training data indicated that 941 staff trainings were completed from a total of 1231 staff. This resulted in a

Section 4: Monitoring Health Needs in Specific Cultural and Ethnic Groups *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
			percentage achievement of 76%.
C	Met	Provide language services training to all DBH new employees to ensure clients receive services in their preferred language when accessing and receiving services. Goal: 100%.	For FY 2023-24, 100% of DBH new employees (N=361) received language service training during new employee orientation to ensure members receive services in their preferred language when assessing and receiving services.

Section 5: Monitoring Responsiveness of the 24/7 Toll Free Access Line and Access to Services *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
A	**Partially Met**	Ensure the SUDRS and MHP Access lines are answered 24/7. Goal: 90% + compliance based on test call data.	Active monitoring and test calls confirm that SUDRS SARC Line met the goal. Active monitoring and test calls confirm that MHP Access Line is meeting the goal for business hours. Test call data indicates MHP Access Line after hours is partially meeting goal. Access Unit worked with Innovation and Technology Department (ITD) throughout the reporting period to further assess and problem-solve technological issues that were occurring in the transfer of the Access Line from business hours coverage to the Afterhours team. Additionally, training and guidance was provided to business hours and Afterhours staff to ensure that all calls are answered.
B	Partially Met	Ensure providers have after-hours message on voicemail directing clients to the MHP Access Line or the SUDRS BAL. Goal: 90% compliance	DBH staff and clinics have the appropriate message. DBH will continue to work with new providers and complete test calls. DBH will establish a procedure to provide feedback to clinics that do not meet established voicemail requirements.

Section 5: Monitoring Responsiveness of the 24/7 Toll Free Access Line and Access to Services *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
C	Partially Met	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.	Baseline data regarding the number of calls provided in threshold languages established through Language Services Interpreter Log data. Completed OEI training for the use of language services. DBH will continue to complete test calls in threshold languages/request for screenings in threshold languages in addition to ASL test calls. Staff ensure to utilize the "Language Services Guide" approve sentences when managing a call in a threshold language the staff is not fluent in.
D	Partially Met	Conduct regular test calls for MHP Access Line 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%.	Regular test calls are being completed. MHP will continue to work with OEI to verify the monthly goal is being met for the next fiscal year.
E	Partially Met	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.	SARC and Access Line supervisors utilize Cisco Finesse to monitor call trends. System was updated within this reporting timeframe. Updated Holiday standby staffing based on trends. Continued monitoring of trends is needed.

Section 5: Monitoring Responsiveness of the 24/7 Toll Free Access Line and Access to Services *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
F	Not Met	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.	SUDRS is limited by 42 CFR, however, we will continue to review project for potential implementation.

Section 6: Conducting Performance Improvement Projects (PIPs) To Improve Client Care
(MHP & SUDRS)

Goal	Rating M=Met PM=Partially Met NM=Not Met	Description	Progress Evaluation
A	**Partially Met**	Increase participation and engagement from multiple internal and external stakeholders to enhance the quality 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.	Research & Evaluation (R&E) facilitated various Performance Improvement Projects (PIPs) / Healthcare Effectiveness Data and Information Set (HEDIS) measures meetings that included both internal and external stakeholders. While several diverse stakeholders participated consistently, not everyone could always attend. For fiscal year 2023/24 the following number of meetings were held for each PIP with the average attendance rate for the meetings: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA): Four (4) meetings held with a 54% average attendance rate. Follow-Up After Emergency Department Visit for Mental Illness (FUM): Five (5) meetings held with a 48% average attendance rate. Pharmacotherapy for Opioid Use Disorder (POD): Three (3) meetings held with a 45% average attendance rate.
B	Partially Met	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.	For the POD PIP, feedback from members was solicited via a survey aimed at evaluating and improving members' social determinants of health (SDOH). For the FUM/FUA PIPs, feedback was solicited by consulting the Consumer Evaluation Committee (CEC) members during the

Section 6: Conducting Performance Improvement Projects (PIPs) To Improve Client Care
(MHP & SUDRS)

Goal	Rating M=Met PM=Partially Met NM=Not Met	Description	Progress Evaluation
			PIP QMAC Subcommittee during the planning phases. For the MH Clinical PIP, member feedback was obtained in previous PIP years via PIP survey and CEC input.
C	Partially Met	Increase summary totals of PIP validation for the clinical and non-clinical PIPS. Goal: Increase the overall rating by 10% from the prior year.	While targets for Key Performance Indicators (KPIs) of the FUA/FUM/POD PIPs were not all met, the following successes occurred and will contribute to ongoing improvements for these efforts. 1. Data-sharing agreement between MCPs and DBH leveraged to facilitate data exchange. 2. Monthly meetings with MCPs, DBH staff, and Compliance Unit to identify information needed. Additionally, discussions to resolve identified issues with data exchange occurred. 3. Established protocol for pharmacy data exchange with MCPs & ensured data quality care coordination occurs at intake. 4. Obtained consistent ED data from MCPs. 5. Implemented processes to review data to identify utilization patterns and high-risk populations for follow-up care needs. 6. Gathered input from ED staff/administration on current processes and factors that may impede member follow-through. 7. Assigned ED Navigators to monitor and follow-up on referrals. Clarified workflow and monitored care coordination efforts for ECM and ECM-eligible members.

Section 6: Conducting Performance Improvement Projects (PIPs) To Improve Client Care
(MHP & SUDRS)

Goal	Rating M=Met PM=Partially Met NM=Not Met	Description	Progress Evaluation
			8. Set up clinical workflow for SUD provider alerts for all FUA members (including ED Bridge members). 9. Created data-sharing workflow to deliver daily ED data from Molina MCP to the Plan. 10. Worked with a county hospital, MCPs, Compliance, &County Counsel regarding HIPAA privacy and security concerns. 11. Developed referral process & tracking system with hospital EDs via data exchange with MCPs. 12. Participating in DHCS' Collaborative workgroup with IEHP. *Plan follow-up service within (a) 7 days & (b) 30 days. A new PIP relating to the attitudes staff have toward monitoring metabolic syndromes was added late in fiscal year 2023/24. The outcomes cannot be determined due to the PIP being in the preliminary phase.

Section 7: Monitoring / Improving Service Capacity Meeting
(MHP and SUDRS)

<table>
<tr><th>Goal</th><th>Rating
M=Met
PM=Partially Met
NM=Not Met</th><th>Description</th><th>Progress Evaluation</th></tr>
<tr><td>A</td><td>Met</td><td>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 for network adequacy but also for under and overutilization of services. Goal: Review quarterly for MHP and semiannually for SUDRS.</td><td>SUDRS now monitors monthly through 274 Provider Network Data Reporting, as well as the annual Certification of Network Adequacy Data and Documentation Submission.
<table>
<tr><th>Age Group</th><th>Outpatient Treatment Clinic</th><th>Intensive Outpatient Clinic</th><th>Residential</th><th>Opioid Treatment Program</th><th>Total</th></tr>
<tr><td>0-17</td><td>123</td><td>0</td><td>37</td><td>0</td><td>160</td></tr>
<tr><td>18+</td><td>2607</td><td>279</td><td>837</td><td>1468</td><td>5161</td></tr>
<tr><td>Total</td><td>2730</td><td>279</td><td>874</td><td>1468</td><td>5351</td></tr>
</table>
Expected Number of Medi-Cal members served Fiscal Year 2024/2025 (next certification year)
<table>
<tr><th>Age Group</th><th>Outpatient Treatment Clinic</th><th>Intensive Outpatient Clinic</th><th>Residential</th><th>Opioid Treatment Program</th><th>Total</th></tr>
<tr><td>0-17</td><td>140</td><td>0</td><td>31</td><td>0</td><td>171</td></tr>
<tr><td>18+</td><td>2965</td><td>293</td><td>746</td><td>1465</td><td>5469</td></tr>
<tr><td>Total</td><td>3105</td><td>293</td><td>777</td><td>1465</td><td>5640</td></tr>
</table>
Network Adequacy for mental health services were consistently reviewed throughout the fiscal year. The department did not meet the Adult Outpatient and Adult and Child Psychiatry ratios, This shortfall was due to the challenges the department faced in meeting the needed FTEs required by DHCS. Additionally, the ratio calculation revision done between 2023 and 2024, impacted our compliance with these standards and the steady</td></tr>
</table>

<table>
<tr><th colspan="4">Section 7: Monitoring / Improving Service Capacity Meeting
(MHP and SUDRS)</th></tr>
<tr><th>Goal</th><th>Rating
M=Met
PM=Partially Met
NM=Not Met</th><th>Description</th><th>Progress Evaluation</th></tr>
<tr><td></td><td></td><td></td><td>increase in the number of Medi-Cal members to be served, as determined by DHCS outpaced the required FTEs count of the department to meet their needs. While Medical Services and the Mental Health Executive team have continued to meet and strategize on ways to address the needs of members, the department has not yet matched the pace of the growing demand for providers.</td></tr>
<tr><td>B</td><td>Partially Met</td><td>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.</td><td>As of August 2024, the MH ratio was below the new DHCS FTE rates for the Adult Outpatient, Child Psychiatry, and Adult Psychiatry provider types.
<table>
<tr><th>Provider Type</th><th>DBH FTE</th><th>DHCS FTE 2024</th><th>Difference between DBH and DHCS FTE</th></tr>
<tr><td>Child Outpatient</td><td>766.58</td><td>691.67</td><td>74.91</td></tr>
<tr><td>Adult Outpatient</td><td>381.37</td><td>414.72</td><td>-33.35</td></tr>
<tr><td>Child Psychiatry</td><td>27.03</td><td>34.27</td><td>-7.24</td></tr>
<tr><td>Adult Psychiatry</td><td>49.26</td><td>51.68</td><td>-2.42</td></tr>
</table>
The following factors were identified as contributing to this</td></tr>
</table>

Section 7: Monitoring / Improving Service Capacity Meeting *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
			shortfall: • Increasing number of Medi-Cal eligible members in our County. • Graduation rates for Psychiatrist are not meeting the demand for annual increases for Psychiatrists needed. • Overall high demand and competition for SMH outpatient providers across all healthcare and educational systems. The department will continue to monitor service capacity and strategize ways to meet member's needs.

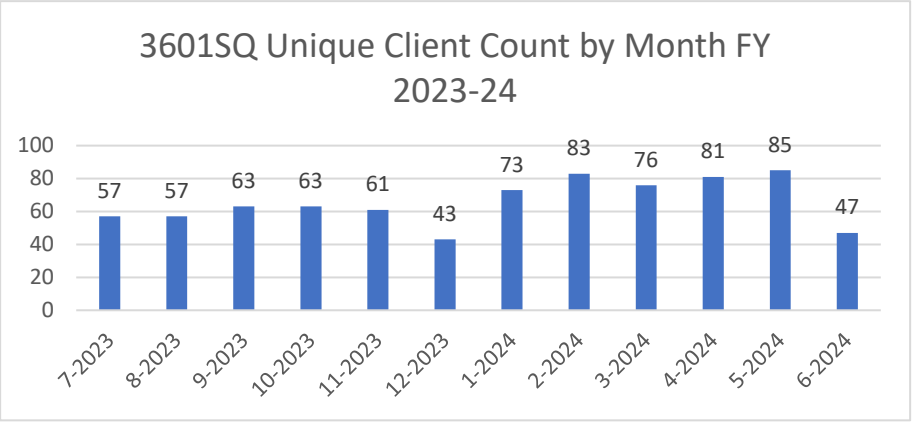
Section 8: Monitoring/Improving Client Satisfaction *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
A	**Partially Met**	Continue tracking and assessing client grievances, appeals, and state hearings quarterly to identify any trends.	Access Unit tracks all member grievances, appeals, and state hearings. Access Unit has begun assessing data and identifying trends. Trends are now being reported to the subcommittee. For fiscal year 2023-2024, quality of care, customer service and case management needs were identified as the most frequent concerns identified through grievances.
B	Partially Met	Complete annual Managed Care Program Annual Report (MCPAR). Goal: Utilize data to establish baseline data, identify inaccurate reporting and identify training needs.	MCPAR establishes baseline data and DBH will continue to identify inaccurate reporting and training needs. .
C	Not Met	Develop consumer satisfaction survey(s) targets grievance trends. Implement surveys to begin establishing baseline data. Goal: Issue at least one survey during FY 22/23.	Consumer Satisfaction Survey has not been issued during FY 22/23.

Section 8A: Monitoring / Improving Service Delivery *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
A	**Met**	Utilize existing Consumer Perception Survey data to assist with continued quality improvement in service delivery. Goal: Identify trends from the Consumer Perception Survey to be addressed during QMAC.	Consumer Perception Survey data was presented during QMAC.
B	Not Met	Publish data for view of clients, community clinics, providers, and staff.	Research and Evaluation is working with Public Relations and Outreach to publish data.

Section 9: Evaluating Assessment Of Client Experiences
(SUDRS Only)

<table>
<tr><th>Goal</th><th>Rating
M=Met
PM=Partially Met
NM=Not Met</th><th>Description</th><th>Progress Evaluation</th></tr>
<tr><td>A</td><td>Met</td><td>Establish a baseline of clients who are engaged in the recovery process.</td><td>Below is the engagement data for FY 2023-24 by quarter. Engagement is defined as 3 services withing 34 days of initiation. Treatment engagement remains at or above 85% for the first 3 quarters of FY 2023-24. Data for the 4th quarter is not complete.
<table>
<tr><th colspan="4">Engagement Measure defined as 3 services within 34 days from initiation</th></tr>
<tr><td>Fiscal Year</td><td>Percent Engaged</td><td>Percent Not Engaged</td><td></td></tr>
<tr><td>FY 2023-24 Q1</td><td>87%</td><td>13%</td><td>19 outpatient providers excluding NTP</td></tr>
<tr><td>FY 2023-24 Q2</td><td>85%</td><td>15%</td><td>20 outpatient providers excluding NTP</td></tr>
<tr><td>FY 2023-24 Q3</td><td>86%</td><td>14%</td><td>16 outpatient providers excluding NTP</td></tr>
<tr><td>FY 2023-24 Q4</td><td>76%</td><td>24%</td><td>Run 7/1/24. Not all data is in.</td></tr>
</table>
.</td></tr>
</table>

Section 10: Reducing Emergency Department Hospitalization
(SUDRS Only)

Goal	Rating M=Met PM=Partially Met NM=Not Met	Description	Progress Evaluation
A	**Met**	Reduce hospitalization by utilizing the Emergency Department Bridge Buprenorphine Medication Assisted Treatment Stabilization	In working to reduce hospitalization utilizing the Emergency Department Bridge Buprenorphine Medicated Assisted Treatment Stabilization, San Bernardino County DBH SUDRS continued to serve as a partner to local hospitals participating in California Bridge. The Inland Empire Opioid Crisis Coalition (IEOCC) Access workgroup held monthly meetings with community stakeholders including substance use navigators from the local hospital emergency departments. Meeting minutes and agendas were collected during the period. The report below represents the Emergency Department's (ED) Bridge Linkages for the period FY 2023-2024.  3601SQ

Section 10: Reducing Emergency Department Hospitalization
(SUDRS Only)

Goal	Rating M=Met PM=Partially Met NM=Not Met	Description	Progress Evaluation

Program code	Year	Month	Month Year	Service Count	Unique Client Count by Month
3601SQ	2023	7	7-2023	69	57
3601SQ	2023	8	8-2023	73	57
3601SQ	2023	9	9-2023	77	63
3601SQ	2023	10	10-2023	83	63
3601SQ	2023	11	11-2023	75	61
3601SQ	2023	12	12-2023	59	43
3601SQ	2024	1	1-2024	113	73
3601SQ	2024	2	2-2024	127	83
3601SQ	2024	3	3-2024	115	76
3601SQ	2024	4	4-2024	142	81
3601SQ	2024	5	5-2024	137	85
3601SQ	2024	6	6-2024	55	47
				1125	

Outcomes: Medication Assisted Treatment (MAT) demand remained strong at the Rialto Behavioral Addiction & Treatment Services (RBATS) clinic during FY 23/24, with a general trend suggesting an increase in services resulting from local hospital emergency department referrals.

Section 11: Consumer and Family Member Evaluation and Contributions *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
A	**Partially Met**	Increase SUDRS consumer and/or family member participation	While there has been participation from Consumer Evaluation Council members and Peer and Family Advocate staff who have co-occurring or SUDRS experience, we have yet to obtain meaningful participation from SUDRS consumers actively utilizing the system.
B	Met	Request consumers and family members identify, discuss, and implement quality improvement initiatives that can be made to the San Bernardino County Department of Behavioral Health system of care.	A variety of topics have been introduced by both DBH and the work group consumers for discussion, advisement and implementation feedback. These topics include Test call scripts, evaluation and feedback Consumer Satisfaction Survey delivery and collection methods Language Services, and impact of the passage of Proposition 1 impacts etc.

Section 12: Improving Data Collection For Managed Care Plans (MCP) Referrals
(MHP and SUDRS)

<table>
<tr><th>Goal</th><th>Rating
M=Met
PM=Partially Met
NM=Not Met</th><th>Description</th><th>Progress Evaluation</th></tr>
<tr><td>A</td><td>Partially Met</td><td>Establish an improved data collection process for analyzing metrics related to timeliness, engagement, and recurring referrals from same clients.</td><td>Goal is in process.
Successes:
1. Revised the incoming referral tracking log to include recurring referral data entry.
2. Revised the monthly referral report to include recurring referral data/information.
3. The timeliness component/formula has not been added.
The data below represents a summary of the SMHS monthly report :
<table>
<tr><th>Category</th><th>SMHS Referrals</th><th>Transition of Care Tools</th><th>Totals</th></tr>
<tr><td>Total of SMHS Referrals and Transition of Care Tools</td><td>3</td><td>22</td><td>25</td></tr>
<tr><td>Kaiser</td><td>3</td><td>18</td><td>21</td></tr>
<tr><td>IEHP</td><td>0</td><td>4</td><td>4</td></tr>
<tr><td>Molina</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Processed by SUDRS</td><td>3</td><td>0</td><td>3</td></tr>
<tr><td>Sent to SUDRS only</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Had previous referrals within the past 12</td><td>2</td><td>0</td><td>2</td></tr>
</table></td></tr>
</table>

Section 12: Improving Data Collection For Managed Care Plans (MCP) Referrals *(MHP and SUDRS)*			
Goal	**Rating** M=Met PM=Partially Met NM=Not Met	**Description**	**Progress Evaluation**
			months | | | | Challenges: 1. . Identifying staffing and required resources for increased data processing and metrics analysis. 2. Learning/understanding platforms available to attain data. .
B	Partially Met	Enhance quality improvement via a “close the loop” process geared towards bridging the gap with the Managed Care plans by January 1, 2025.	Goal is in process. Successes: 1. Internally developing and piloting a “close the loop” tracking log and the research for such data in order to enter into this log. 2. Currently, “close the loop” information is provided to the MCP on an ad hoc basis. 3. The timeliness component/formula has not been added to this log. Challenges: 1. Learning/understanding platforms available to attain data.

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.