VENTURA COUNTY
BEHAVIORAL HEALTH
A Department of Ventura County Health Care Agency

Quality Assessment and Performance Improvement (QAPI)

FY 2022-2023 Evaluation

A Living Document

Updated November 2023

The Ventura County Behavioral Health (VCBH) Quality Program is focused on the successful implementation of the mission, goals, and commitment of the Behavioral Health Department. To learn more about VCBH, please follow this link: https://www.vcbh.org/en/about-us/about-vcbh

The purpose of the annual Quality Assessment and Performance Improvement (QAPI) Work Plan is to provide a working document for the monitoring, implementation, and documentation of efforts to improve both mental health and substance use service delivery. Some of the objectives in the FY 2021-22 QAPI are being carried forward into this year's (FY 2022-23) plan, and other goals and objectives are new based on identified areas for monitoring and improvement. For example, efforts pertaining to the assessment of the Employee Engagement survey are now systematically integrated into department planning and the work continues in terms of planned action steps to continuously engage employees, even though it's no longer reflected in the plan.

Quality Management (QM) Program

The VCBH Quality Management (QM) Program resides within the Administration Division and is overseen by the Administration Division Chief with support from the Compliance Senior Manager. QM is focused on the successful implementation of the Behavioral Health Department's stated mission, vision, and goals and is responsible for overseeing and reviewing the quality of behavioral health services provided to Medi-Cal beneficiaries and ensuring compliance with contract requirements and relevant County, Federal and State regulations. For more information about the Quality Management Program, please follow this link: Quality Management - Ventura County Behavioral Health (vcbh.org)

Quality Assurance (QA) – overall activities include ensuring and monitoring compliance with County, Federal and State regulations, Contract requirements, Department Policies and Procedures, and conducting Utilization Reviews, provider credentialing, and site certifications.
Quality Improvement **(QI)** – overall activities include coordination, planning, oversight, and communication of quality and process and performance improvement projects, analyses, and findings, as well as monitoring and evaluating Specialty **Mental Health Services** and **Substance Use Services.**
Medical Records Unit – responsible for the maintenance and storage of medical records in compliance with the Health Insurance Portability and Accountability Act, 42 CFR Part 2 confidentiality safeguards, and State record retention requirements. Activities include processing requests for release of protected health information and responding to subpoenas.
Training Unit –responsible for overseeing the Department's mandatory staff training as well as providing opportunities for professional development. Training staff ensure that requirements are met to offer continuing education units to staff and contribute to overall workforce development.
Pharmacist – responsible for monitoring the safety and effectiveness of medication practices through activities, including providing medication consultation to prescribers, conducting medication room inspections, facilitating the Medication Monitoring Workgroup, and serving as a liaison to county pharmacies.

Quality Management Action Committee (QMAC)

The purpose of the QMAC is to provide recommendations and oversight of Behavioral Health's QAPI and other quality management activities. QMAC representation includes MHP and SUS practitioners, providers, community members, consumers, and family members. The QMAC reviews, evaluates, and advises on results of QI/QM activities designed to improve the access, quality of care, and outcomes of the service delivery system.

The QMAC meets twice a year with sessions that include focused data review and guidance on process improvement efforts and quality of care areas of focus, such as, grievances, change of provider trends, access, satisfaction, and quality data. The QMAC will continue to meet twice a year for the remainder of FY 2022-23. Additionally, the QMAC-Special Interests Group (QMAC-SIG) was established in FY 2021-22 to facilitate smaller group sessions and gather specific feedback on key QI initiatives. The QMAC-SIG meets three times per year and will also continue for the remainder of FY 2022-23.

2022-2023 QAPI Goals and Objectives

The Quality Assessment and Performance Improvement (QAPI) Work Plan goals for FY 2022-23 provides the framework for monitoring, implementing, and documenting of efforts to improve VCBH service delivery across the continuum of care in both the Mental Health (MH) and Substance Use Services (SUS) divisions. Unless specifically noted, all goals and objectives outlined in this document will pertain to both MH and SUS divisions.

These goals, and accompanying objectives, are embedded at the operational program level and address overarching priorities related to improving access, timeliness, quality of care, health equity, and acuity levels. The specific QAPI goal focus areas for FY 2022-2023 are as follows:

- Access to Services
- Quality
- Enhance Data-Driven Decision Making
- Beneficiary Outcomes
- Behavioral Health Quality Improvement Plan (BHQIP)

Structure of the Plan

VCBH's QAPI work plan includes the following essential domains: Access and Timeliness of Services, Quality, Data-Driven Decision Making, and Beneficiary Outcomes. An additional domain dedicated to the implementation of California Advancing and Innovating Medi-Cal (CalAIM) - Behavioral Health Quality Improvement Plan (BHQIP) initiatives has also been included this year.

The scope of each domain is outlined below and includes the following elements:

Goal: reflects VCBH's annual goals toward reaching the identified measurable activity/benchmark.

Objectives and Measurable Activities/Indicators: data-driven performance measures and outcomes to help identify strengths and barriers and establish benchmarks for assessment and improvement.

Responsible Party/Lead Assigned: establishment of leads or parties responsible for each measurable activity/benchmark identified/outlined.

Current Status: an indication of progress to date.

The creation and application of the goals and objectives is an iterative process that involves many leaders across VCBH, as well as stakeholder input.

Annual Evaluation

An evaluation of the effectiveness of quality assessment and performance improvement activities is completed at the conclusion of each fiscal year and is reviewed with stakeholders (e.g., QMAC). The evaluation summarizes progress associated with each of the QAPI Work Plan goals and objectives, and includes actions taken in response to outcomes. Based upon the evaluation, revisions may be made to subsequent QAPI Work Plans.

Initiative 1. Timely and Efficient Client Access to Services

The table below illustrates VCBH's efforts pertaining to Timely and Efficient Services to Clients, including monitoring of timeliness standards, and implementation of "No Wrong Door".

Objectives and Reporting Plan

Goal Focus Areas	FY 22-23 Objectives	FY 22-23 Measurement	FY22-23 Evaluation Updates
1a) No Wrong Door	1) Connect all consumers who request services at any outpatient service location to appropriate services for their needs. **Responsible Parties:** VCBH QM Team and VCBH Regional Managers	**Indicators:** • Documentation of access points, including the Care Coordination Team being the liaison for Beacon (front door requests) • Monitoring and analysis of Request for Services (RFS) Tracking Reports by location or program **Target:** Maintenance of monitoring efforts **Current Status:** A report on RFS by clinic location continues to be regularly reviewed by the MH Treatment Services Manager and DMC-ODS Plan Manager.	• With the new implementation of DHCS's screening tools, VCBH's A & O Division fields all initial phone requests for service requests and administers the screening tool for new clients requesting services and route them to the appropriate level of care and services. • A & O's Care Coordination team fields third party requests and administers/completes the screening tool on clients requesting services • The QI team also developed a reporting mechanism for the newly implemented DHCS screening tools. QI developed a monthly metric to report to our MCP partners regarding loop closure of persons sent to VCBH from MCPs who are now in VCBH's care. QI is continuing to develop reports for ongoing monitoring of the screening tools and is collaborating with VCBH's Care Coordination team to develop fields to be used for Care Coordination purposes directly onto the screening tools.

1b) Timeliness Standards	1) Maintain timeliness metrics that meet DHCS standards, and at least 10% improvement from the previous FY on metrics that do not yet meet DHCS standards. **Responsible Parties:** Quality Improvement team	**Indicators:** • reference 1st column in Table 1 for specific MH timeliness metrics and in Table 2 for specific SUS timeliness metrics • % of RFS offered an appointment **Target:** • For Mental Health Services, reference Table 1: DHCS Standard • For Substance Use Services, reference Table 2: DHCS Standard **Current status:** • For Mental Health Services, reference Table 1: % Meeting DHCS Standards • For Substance Use Services, reference Table 2: % Meeting DHCS Standards	**MH** • The data analysis methodology for first offered and first rendered service has been updated to reflect the CalAIM No Wrong Door policy. The new methodology now captures any service after the initial request, even if the service is before the assessment. • Please see Table 1 for updated FY22-23 Standards for Timely Access to Mental Health Services **SUS:** • For updated FY 22-23 timeliness outcomes for Substance Use Services, see Table 2 • Based on EQRO reviewer recommendation, the methodology for SUS timeliness was updated so that residential services were included in measurements of time to first service and % of 1st appointment no-shows
1c) 24/7 Access line: the 24-hour toll-free access lines will be responsive to all callers and will provide after-hours care for crisis and referrals	1) Maintain key access line metrics that meet VCBH standards, and at least 10% improvement from the previous FY on metrics that do not meet standards. **Responsible Parties:** QM, QI	**Indicators:** • Average call wait time • Average call duration • % calls dropped or abandoned **Target:** • Average call wait time: 30 seconds • Average call duration: under 10 minutes • % calls dropped or abandoned: less than 10%	• The Test Call team continues to review and report quarterly data to DHCS. Areas identified in the report as 'in need of improvement' are addressed by Access Line management and staff. • For MH calls from the Behavioral Health Access Line, average call answer time was 15 seconds during business hours and 11 seconds for after hours (5 pm – 8 am) for FY22-23. • Average call duration for FY22-23 during business hours was 3:47 seconds • On average 12.7% of the calls were abandoned during business hours

			SUS: • Average call wait time: 3 minutes 7 seconds • Average call duration: 19 minutes 31 seconds • % calls dropped or abandoned: 57% • There were several changes to SUS Access Line operations starting in March 2022, including greater cross-training of SUS and MH call center staff, a revised RFS screening tool that collects more information in order save time during the full assessment, and agents who are trained to start an RFS immediately rather than transfer clients to a separate clinician. These changes led to increased flexibility among trained staff and less documentation duplication between the RFS and assessment. However, these changes, combined with consistently high demand for services, have impacted metrics such as call wait times and dropped call rate.
	2) Implement plans for conducting test calls for quality assurance monitoring of SUS calls to the access line; evaluate results from the first year of test calls and share findings with operational staff.	**Indicators:** • Complete and up-to-date records of all test-calls conducted since implementation • Evidence of completed call logs on SurveyMonkey • Summary of 1st year evaluation of test-call process • Percent (%) of completed calls/month	• 30 test calls to the SUS Access Line were made in FY 22-23, for a rate of 2.5 calls per month • Call data is monitored in Survey Monkey to ensure calls are made • A summary of the test calls data was created and will be shared with staff in the Access and Outreach Division

	Responsible Parties: QI, clinical operational leadership, Access Line operational staff	**Target:** • delivery of test call records, staff trainings, and 1st year evaluation report to operational staff. • 3 SUS calls/month	
		Current Status: first year of test call implementation is in process. Evaluation report is forthcoming after the FY concludes.	

Table 1: Standards for Timely Access to Mental Health Services (FY22-23 Updates)

Metric	DHCS Standard	% Meeting DHCS Standard		
		All Services	Adult Services	Children's Services
		FY22-23	FY22-23	FY2-23
1. Initial request to first offered routine appointment	10 business days	84%	84%	83%
2. Initial request to first rendered service	10 business days	82%	83%	81%
3. Time to First Offered Non-Urgent Psychiatry Appointment	15 business days	N/A	87%	49%
4. Time to First Rendered Psychiatry Service	15 business days	N/A	86%	40%
5. Service request for urgent appointment to actual face to face encounter	48 hours	67%	75%	55%
6. Follow-up services after psychiatric hospitalization	7 calendar days	90%	88%	97%

Table 2: Standards for Timely Access to Substance Use Services (FY22-23 Updates)

Metric	DHCS Standard	% Meeting DHCS Standard		
		All Services	Adult Services	Children's Services
		FY22-23	FY22-23	FY22-23
1. Initial request to first offered routine appointment (if tracked)	10 business days	89%	89%	93%
2. Initial request to first face to face routine visit/appointment	10 business days	79%	79%	74%
3. Initial routine MAT request to NTP appointment/contact	3 business days	95%	95%	N/A
4. Service request for urgent appointment to actual face to face encounter	48 hours	53%	52%	57%[1]
5. Follow-up services post-residential treatment discharge	7 calendar days	12%	12%	8%[2]

[1]Total of 7 urgent requests from youth clients

[2]Total of 12 residential discharges for youth clients

Initiative 2. Continuous Quality Improvement of Operations

The table below illustrates work toward continuous quality improvement efforts within VCBH, including in the areas of Care Coordination, Utilization of Services and Review of these Services, and the Credentialing and Licensing of Providers.

Objectives and Reporting Plan

Goal Focus Areas	FY 22-23 Objectives	FY 22-23 Measurement	FY22-23 Evaluation Updates
2a) Care Coordination	1) Implement and maintain all care coordination activities to ensure continuity of care for VCBH beneficiaries and to comply with state standards.	**Indicators:** • Documentation of collaboration with county partners (e.g., Gold Coast, Beacon), in the form of agendas, minutes, and emails to ensure quality in care for shared beneficiaries	• Established new workflows and relationships with MCPs (Gold Coast [Carelon, formerly Beacon] & Kaiser) to fulfill DHCS's reporting requirements pertaining to the mandated screening tools.

	Responsible Parties: • VCBH Executive Team, QM, and Contracts • Collaborative Partners and Administrators • A & O Division • Care Coordination team	• Evidence of collaboration with executive leadership, in the form of agendas, minutes, and emails • Documentation of Single Case Agreements with contract partners for shared clients **Target:** • At least biannual collaborative meetings with each contract partner to discuss contractual requirements, updates, and system-wide clinical issues. **Current Status:** VCBH continues to communicate and meet with contract partners on a regular basis.	• Direct data exchange efforts with GCHP is in progress. • The Care Coordination (CC) team, under the Access & Outreach Division, is taking the lead on fielding third-party requests for services directly. • The A & O Division addresses all incoming calls for requests for services and completes the initial DHCS screener via phone and directs clients to the appropriate programs and levels of care
2b) Detection of Over and Under Utilization of Services	1) Systematically identify and review over and under utilization of services and apply appropriate interventions as needed Responsible Parties: QM, UR team, QI	**Indicators:** • % random sample of documentation of clients who have had at least one billable service in the previous month, including documentation for all open episodes (this process may help identify over and under utilizers of services) • Documentation of quarterly review by UR staff to review a third of their assigned programs over the course of a month to ensure all programs have one review per quarter. • Review of Avatar reports by UR staff - Avatar produces reports that help to identify overutilization and underutilization. As such, action may be taken to address instances of	• The UR team systematically reviews a random 5% sample of persons in care to determine their utilization – this in turn will help detect and identify clients with overutilization and underutilization in comparison to their level of care assignment. • The UR team meets quarterly to review their assigned programs (1/3 each month) so that they review all programs each quarter • In July of 2023, VCBH transitioned to a new EHR system. As a result, new/updated UR reports will be developed for regular use and monitoring of clients by the UR team (including the identification and monitoring of over- and under-utilization of services.

		overutilization and underutilization, as appropriate.	
		Target: • Completion and presentation of annual summary report to QM staff by the end of the next FY • 25% target percentile for reviewing cost of care	
		Current Status: • Quality Improvement has been researching additional metrics and methods for monitoring over and underutilization of services, such as comparisons by client characteristics.	
	2) Monitor beneficiary medication safety **Responsible Parties:** QA, QM, UR	**Indicators:** • Documentation (e.g., meeting minutes, Outlook invitation) of monthly workgroup meetings to review items and actions pertaining to medication safety (including review of medication treatment agreements signed between clients and physicians as well as for Youth and Family clients) • Evidence (e.g., example reports of semi-annual and annual review with redacted client PHI) of regular and ongoing review of the "CURES" report as related to client narcotic medication prescribing. • Documentation/consent forms (e.g., 1 or 2 example consent forms with redacted client PHI) of medication safety reviews with clients (Nursing staff review medications with clients)	• QI in collaboration with Y & F Division leads, including Youth and Family's pharmacist have held regular meetings to help facilitate the tracking and monitoring of medications • Regular review of the 'CURES' report by the pharmacist and psychiatrist (examples provided with our submission) Include review by the Psychiatry Committee at VCMC and peer review if required • Ongoing clozapine review of timely lab draws for continuation of medication treatment • Utilization of informed consent between prescriber and client

		Target: • Provide documentation of regular monitoring and review of medication safety and administration	
		Current Status: monthly and quarterly review meetings in progress	
2c) Credentialing	1) Ensure that all providers are up to date with credentialing/licensing **Responsible Parties:** VCBH Contracts, QM, and Compliance Teams	**Indicators:** • Evidence of all providers with valid and current credentials, as indicated by monthly licensing report (QM) • Documented review (e.g., review notes) of all contractors with valid and current credentials (Contracts) • Ensure that provider lists provided to the general public/consumers are accurate and up to date • Create new application/software for consolidating all credentialing & licensing information in one database for ease of tracking and monitoring	• Working with personnel to create a data storage mechanism to store information on all active VCBH providers (in progress) and will be completed in the next fiscal year. • The Provider Directory was updated regularly once/month onto the VCBH website for both MH and SUS providers. • VCHRP reporting on all VCBH providers those who are certified and automated alerts – 60-day, 30-day, 15-day alerts – for CBOs (at initial contracting with providers are completed and annual audits) • Monthly sanction checks on all registered providers -staff enter all names; to ensure no restrictions on their license. Part of this process to ensure compliance –VCBH utilizes Compliance Line
		Target: • 100% compliance regarding provider credentials • Ensure all credentialing information for MH & DMS-ODS providers is compiled into one database	
		Current Status: Ongoing monitoring and tracking of provider credentialing and licensing is underway	

Initiative 3. Enhance Data-Driven Decision Making

The table below illustrates the goal focus areas and objectives for VCBH's Data-Driven Decision-Making initiative, including development of key outcomes and reporting pertaining to VCBH's 5-year strategic plan and the development of VCBH's Public Facing Dashboards.

Objectives and Reporting Plan

Goal Focus Areas	FY 22-23 Objectives	FY 22-23 Measurement	FY22-23 Evaluation Updates
3a) Key Outcomes Development and Ongoing Reporting to Support the VCBH Strategic Plan	1) Establish key indicators of key performance objectives within a multi-phase 5-year plan. **Responsible Parties:** QI, Special Projects Manager	**Indicators:** Complete submission of year-1 report of key objective metrics **Target:** Complete year-1 evaluation report by end of FY22-23 **Current Status:** Needs assessment and initial evaluation of baseline metrics completed; additional metrics and tracking processes are being scoped	• A report on key outcomes and metrics was developed by QI and reported to the Special Projects Manager and Executive Leadership in winter of FY22-23 as part of the strategic plan. • QI recently started to re-envision key performance indicators (KPIs) based on Division goals. QI will develop a regular report of KPIs biannually to HCA leadership • The Quality Division also re-worked the Quality Management Action Committee (QMAC) and established an overall Quality Improvement Committee (QIC) and subcommittees. All subcommittees contribute to the establishment of KPIs related to their own Divisions and goal areas.
3b) Public Facing Data Forums (Dashboards)	1) Complete initial development of Public Facing Data Dashboards for	**Indicators:** • Project status of the dashboards	• Refinement of dashboard elements has taken longer than expected. In

	Mental Health (MH) Services and research parallel efforts for SUS services. **Responsible Parties:** QI, HCA IT	• Evidence (e.g., meeting minutes) of stakeholder input on data dashboards for MH services • Evidence (e.g., meeting minutes, Outlook invitation) of review and approval by division leadership **Target:** • Implementation to live status by end of the FY • At least one round of stakeholder input received prior to live status • Final review and approval by division leadership **Current Status:** The first phase of dashboard development, namely the presentation of clients served demographics and services data, is nearly complete. After a joint discussion with Ventura County IT teams and website developers, the dashboard is on course to be accessible to the public by the end of September 2022.	preparation of the new EHR system and alignment with CalAIM efforts, several data elements on the dashboard had to be redesigned. • As of October 2023, the dashboard experience is ready to be published. Final pending items include design of the website landing page and instructional materials. • Ventura County IT, Idea Engineering (webmasters for the VCBH website), and VCBH QI are in close collaboration and anticipate the dashboard being published by the end of Calendar Year 2023. • In parallel with this final development effort, the dashboard experience has been shared with VCBH QIC, senior leadership, and community stakeholders for final feedback. • In 2024, development of the Substance Use Services data dashboard pages will begin.
	2) Continue discussions with MH data metrics team to develop a standard reporting package of tracked metrics. **Responsible Parties:** QI, HR Personnel, Special Projects Manager	**Indicators:** Reports of outcomes and other standardized metrics to present at the QMAC and other forums **Target:** Completion and presentation of key performance measures package **Current Status:** The methodology to analyze key metrics and performance measures is continually refined through discussions with stakeholders. Over the past year, the QI team has also	**MHP Updates:** • MH has established the QIC and QIC subcommittees and currently working to develop a standardized document of relevant KPIs for regular measurement. We also work with the QIC committees to disseminate information and results and present data via the data dashboard and to other committees including the BHAB

		consolidated data into a separate QI database to ensure alignment on all metrics reported.	and Latinos Disparities Reduction Committee (LDRC). • These metrics will be monitored at both the department leadership level and by various staff involved in the QIC process. Anticipate establishing these metrics in early CY 2024, though many of these metrics are already tracked and monitored for topic-specific work (e.g., access metrics tracked through access line test calls work). **SUS Updates:** • For Substance Use Services, a data briefing is shared at least annually with operational leadership which summarizes key metrics such as time to service, treatment retention, and transitions between levels of care. • In FY 22-23, automated timeliness reports were exported to SUS clinic administrators each month. These reports were also available on-demand to staff.
3c) Enhancing Cultural and Linguistic Competence & Efforts at VCBH	1) Conduct regular evaluation of Cultural Competency Plan (CCP) at least annually to ensure current needs and practices are adequately reflected in the plan. **Responsible Parties:** QI, Office of Health Equity and Cultural Diversity (OHECD) Manager	**Indicators:** • Completion of annual evaluation of CCP • Documentation (e.g., Outlook invitation for meeting) of meetings with OHECD Manager to collect and examine data tied to criterions outlined in the CCP (as related to direct services to the community – to	• In collaboration with the Office of Health Equity and Cultural Diversity (OHECD), QI developed a comprehensive survey to assess the cultural competency of VCBH providers. Survey data collection was completed in late fall/early winter of FY22-23 and the results were presented to the OHECD manager and the Behavioral Health Director in

		develop short- and long-term solutions to identified barriers) • Evidence of QI data reporting to OHECD Manager	March of 2023. (PowerPoint slides can be provided upon request) • In March of 2023, the OHECD manager left her position and in the interim continued work regarding Cultural Competency is being led by the OHECD and executive leadership
		Target: • completion and delivery of annual evaluation of CCP to OHECD by the end of the next FY • Examination of data and submission of reports to OHECD Manager	
		Current Status: CCP is in progress and will be finalized by December 2022	
	2) Ensure at least biannual collaboration with OHECD to identify performance metrics for assessing cultural competence of services and providers; subsequently, develop a system for monitoring and continuous quality improvement in response to gaps in service as indicated by performance metrics. **Responsible Parties:** QI, OHECD Manager	**Indicators:** • Evidence of meetings and collaboration with OHECD • Project status of efforts to develop, implement, and report on survey of provider knowledge of culturally and linguistically competent services • Summary of new metrics • Summary of identified areas of training needs • Documentation of OHECD Manager meetings with SUS Division Chief to outline plan for including SUS-specific metrics	• In collaboration with the Office of Health Equity and Cultural Diversity (OHECD), QI developed a comprehensive survey to assess the cultural competency of VCBH providers. Survey data collection was completed in late fall/early winter of FY22-23 and the results were presented to the OHECD manager and the Behavioral Health Director in March of 2023. (PowerPoint slides provided with this submission) • In March of 2023, the OHECD manager left her position and in the interim continued work regarding Cultural

		Target: • Completion and delivery of initial assessment/staff cultural competency survey to OHECD Manager within FY 2022-23 **Current Status:** Cultural Competence Staff survey and other items in progress	Competency is being led by the OHECD and executive leadership

Initiative 4. Optimal Beneficiary Outcomes

The table below illustrates goal focus areas pertaining to QI's and VCBH's role in collecting and monitoring outcome measures for VCBH beneficiaries.

Objectives and Reporting Plan

Goal Focus Areas	FY 22-23 Objectives	FY 22-23 Measurement	FY22-23 Evaluation Updates
4a) Effectively collect and report outcomes data to measure service effectiveness.	1) Monitor to ensure regular data collection and reporting. **Responsible Parties:** QI	**Indicators:** • Evidence of regularly monitoring and researching findings • Implementation of new CalAIM MH screening tool on the EHR **Target:** • At least 5 concrete examples of regular monitoring efforts **Current Status:** • Current SUS PIP reporting • Current MH PIP reporting • Monitoring discharge status for SUS • Bimonthly LOC reporting	• QI team regularly engages in ongoing reporting of data and metrics (e.g., reporting monthly to the BHAB) as well as successfully addressing numerous ad hoc requests internally and externally • In FY22-23, an annual outcomes report was developed focused on VCBH's full-service partners (FSP). This was the first annual FSP outcomes report included as part of the annual MHSA update • The QI team also developed a reporting mechanism for the newly implemented DHCS screening tools. QI developed a monthly metric to report to our MCP partners regarding loop

		• SUS biannual data update • Monthly access line	closure of persons sent to VCBH from MCPs who are now in VCBH's care. QI is continuing to develop reports for ongoing monitoring of the screening tools and is collaborating with VCBH's Care Coordination team to develop fields to be used for Care Coordination purposes directly onto the screening tools.
4b) Client perceptions data	1) Maintain client perception surveys administrations biannually (MH) or annually (SUS) as required by DHCS and utilize results for quality improvement efforts related to beneficiary satisfaction. **Responsible Parties:** QI	**Indicators:** • Response rates for client satisfaction surveys • Both item-level and domain-level consumer satisfaction scores • Efforts to expand reporting capabilities for client perceptions data (e.g., development of an 'on-demand' report for clinics) **Target:** • At least a 10% increase in annual response rate for each client perceptions survey • Automated reporting of client perceptions data will be live and available to clinical staff to monitor by the end of the FY **Current Status:** • TPS total completed survey responses for FY21-22: (SUS TPS N = 174; MH TPS N = 1,594 [adult]; • CPS total completed for CY 2021 N = 352 (adult & youth combined)	<u>MH Updates:</u> • The Youth & Family Division decided to end the administration of the Youth TPS as of spring 2023. • The Adult Division will continue to administer the Adult TPS (external to SmartCare) – administration of the adult TPS is currently pending but QI is collaborating with the Adult Division to develop a plan for the administration of the TPS. • The annual CPS in May of 2023 yielded the highest number of surveys received with more than a 40% response rate in the survey (for a total of N =1088 surveys returned/completed) • An annual report for the 2022 CPS has been developed and completed by the QI team and will be distributed to Executive Leadership (.ppt summary attached) • For the MH TPS – out of a total 467 surveys administered, 440 surveys were completed for a response rate of

		• Client perceptions surveys continue to be administered throughout the year • QI is currently working to finalize automated summary reporting of client perceptions data	94%; average scores for the 5 domains ranged between 4.21 (Outcomes) to 4.40 (Quality). [CY 2021 summary report attached] <u>SUS Updates:</u> • Results of the 2022 Treatment Perceptions Survey (TPS) were shared with VCBH management, line staff, and contracted providers. Findings were reported at both the division and clinic level. • Findings were uniformly high across items (*M* = 4.5 / 5.0), while comments indicated overall high satisfaction with services. • Total responses (*N* = 349) increased significantly from the 2021 TPS (*N* = 199). An increase of about 43% attributed to a more refined approach to the methodology of distributing the surveys. Once change implemented was that QI team members attended the last 10 minutes of client group session meetings to introduce and administer the survey and field any questions that clients had about the survey.
4c) Monitoring of medication management education	2) Create opportunities to educate beneficiaries on medication management.	**Indicators:** • Attestations from staff captured on Target Solutions of provider training to ensure pertinent information regarding treatment	• Informational memo sent to nursing staff regarding utilization of medication informational sheets to be provided to clients upon initiation of

	Responsible Parties: EHR, Pharmacist	medications are consistently conveyed to beneficiaries • % of beneficiaries who were provided with informational sheets on prescribed medications and their side effects • % of medication consent forms signed between the beneficiary and provider (this will serve as a proxy for providing education to beneficiaries – consent forms are signed when the provider educates the beneficiary on the medications and any expected side effects) • Evidence of updated policies pertaining to beneficiary medication management and services (PH-10; PH-73; AS-56; AS-58; CA-72)	medication and/or upon client's request • Steps are being taken to review current regulations pertaining to necessity of acquiring signed medications consents by client
		Target: • 100% of beneficiaries should have a signed consent form on record with their provider regarding their medication(s)	
		Current Status: Care manager module is live as of January 2022 and is actively monitored for beneficiary medication management	
4d) Grievances	1) Continue to expand implementation and monitoring of updated system for processing and responding to beneficiary grievances, per	**Indicators:** • Documentation (e.g., meeting minutes, meeting invites) of collaboration with QM to develop more systematic monitoring and	• There were a total of 83 MH grievances and 37 appeals within FY22-23. (19/37 appeals had a timely resolution) and 64/83 were resolved in a timely manner (within 90 days).

	QM 18 and utilize findings for continuous quality improvement. **Responsible Parties:** QM, UR, (QI)	reporting processes given the integration of collecting and reporting grievances (i.e., MCPAR) • Evidence (meeting minutes, Outlook invitation of quarterly meeting) of review of beneficiary grievances • Documentation of reports that demonstrate compliance and reviews of compliance	• There was only 1 grievance filed for SUS, with no appeals within FY22-23 • This is in line with compliance of VCBH policy QM 18
		Target: • At least annual evaluation of grievances and report to QM staff • 100% compliance with QM 18 • Integrated database for grievance process will be submitted by September 1, 2022.	
		Current Status: review of grievances will be completed upon conclusion of the current FY	

Initiative 5. Seamless Implementation of CalAIM / BHQIP

DHCS launched a major transformation of the behavioral health system known as California Advancing and Innovating Medi-Cal (CalAIM) on January 1, 2022. The three primary goals of CalAIM are:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes and drive delivery system transformation through value-based initiatives, modernization of systems and payment reform.

The table below highlights QI's role in supporting CalAIM-BHQIP's deliverables for FY 2022-23.

Objectives and Reporting Plan

Goal Focus Areas	FY 22-23 Objectives	FY 22-23 Measurement	FY22-23 Evaluation Updates
5a) Implement CalAIM/BHQIP initiatives within Ventura County Behavioral Health **Re: Data Exchange/Data Collection**	1) Demonstrate improved data exchange capabilities (Establish/Execute Option #1 of Data Exchange Initiative; in reference to milestone 3a in BHQIP). (**Timeframe** = Deliverables due by September 30, 2022[a] & March 1, 2023[b]) **Responsible Parties:** QI, EHR, VCBH CalAIM Leadership	**Indicators:** • Signed/Executed Data Sharing Agreement/Contract[a] • Submission of the data sharing transaction log of the data exchange between entities involved[b] (as stated in the updated MOU, including specific use cases) **Target:** • Provide evidence of a data sharing agreement (or written evidence of attempts to attain an agreement) **Current Status:** In progress	• On January 13, 2023, the Ventura County Health Care Agency signed the CalHHS Data Exchange Framework Single Data Sharing Agreement. VCBH is identified as a subordinate entity for which this agreement applies. • On August 2, 2023, VCBH and Gold Coast Health Plan fully executed the FY 2023-24 GCHP VCBH MOU for Specialty Mental Health and Substance Use Disorder Services • The submission of the data-sharing transaction log has been extended by DHCS to March 1, 2024.

	2) Leverage improved data exchange capabilities to improve quality and coordination of care via the data collection and implementation of three HEDIS measures (FUA, FUM, and POD) (milestone 3d). (**Timeframe** = Deliverables due September 30, 2022[a] & March 1, 2023[b]) **Responsible Parties:** QI, Operations, EHR	**Indicators:** • Generate Finder File and submit to DHCS • Receive retrospective data from DHCS and partner with CalMHSA to establish baseline performance rates on the 3 performance HEDIS (FUA, FUM, POD) measures[a] • Partner with CalMHSA to start development of the 3 performance improvement projects (PIPs) to leverage improved data exchange capabilities to achieve improved performance for FY 22/23 via the HEDIS measures (FUA, FUM, POD). • Documentation (e.g., Outlook invitations) of collaborative meetings with CalMHSA to report baseline performance rate (July 1, 2021 – June 30, 2022) for FUA, FUM, and POD. • Provide updated narratives to VCBH leadership on projects, challenges, lessons learned, and next steps related to quality improvement on the three HEDIS measures (FUA, FUM, POD) during the measurement period[b] **Target:** • Submit three quality improvement plans (PIPs) to DHCS outlining how to improve performance on FUA, FUM, and POD via leveraging data sharing/exchange during	• VCBH has successfully partnered with CalMHSA in an effort to accomplish the objectives outlined, including several meetings with CalMHSA's epidemiologist & other team members to develop the three BHQIP PIPs (FUA, FUM, POD). • The first set of PIPs was submitted to DHCS last September, 2022. • Through ongoing collaboration with CalMHSA, an update on the 3 PIPs will be submitted this fall (September 2023). • In addition, to submitting the three PIPs to DHCS, these PIPs were also summarized for VCBH leadership to review and will be submitted as part of our annual CalEQRO performance improvement measures.

		the measurement period of July 1, 2022 – June 30, 2023.[a] **Current Status:** In progress	
5b) Successfully Implement CalAIM Health Policy Changes by Providing Guidance & Training to County-operated and County-contracted Providers on All New Behavioral Health Policies	1) Update and implement a written quality improvement plan to demonstrate how VCBH will provide ongoing training, support, and monitoring to implement the CalAIM policies under milestone 2e. **Responsible Parties:** VCBH Training, EHR, VCBH CalAIM Leadership, QI	**Indicators:** • Number & percent of staff identified who require the various training modules (e.g., staff who will utilize the standardized screening tool) • Number & percent of attestations via Vector Solutions (as evidence of training of CalMHSA LMS Modules) as evidence of training completions • Number of staff attending CalMHSA Office Hours & other trainings • Number of training modules developed to educate and support staff on CalAIM Health Policy Changes **Target:** • QI to submit written evidence (reports) of tracked metrics of training and support of staff (as part of the quality improvement plan) **Current Status:** In progress	• Total staff identified during FY22-23: 1,038. • Total trainings completed: 87% completion rate = 13,237 completed of 15,232 assigned total trainings. • VCBH specific completions rate: 88%. (VCBH-CalMHSA tab) • CalMHSA trainings completions rate: 86%. (VCBH-CalMHSA tab) • Office Hours: 11 sessions, 102 attended by staff • Number of training modules developed by VCBH: 6 which included 3 documents and 10 videos. *(Excel file outlining and summarizing these numbers can be provided upon request)*

Additional Strategic Actions

QI's efforts in FY 2022-23 also include the following strategic objectives linked to the aforementioned initiatives:

- VCBH's ongoing evaluation of employee engagement has led to several other initiatives to research and improve the experience of department staff. First implemented in 2019, the VCBH Employee Engagement Survey was administered to gauge employee opinions and perspectives on various aspects of working at VCBH. It also brought about the formation of an Employee Engagement Advisory Committee. Moreover, a list of proposed action items was developed and presented to executive leadership, including the development of an Exit Survey of employee attitudes upon separation, which was implemented in FY 2022-23.
- Additional highlights of the CalAIM implementation for FY 2022-23 include the addition of a new DHCS Standardized Screening/Assessment Tool for Specialty Mental Health Services (SMHS), the implementation of which will be led by Operations and Clinical Staff and streamlined improvements to documentation processes and mapping of data fields led by the EHR team.
- In addition to regular monitoring of key timeliness metrics, current Performance Improvement Projects (PIPs) address time to service goals for both MH and SUS. The current SUS PIP initiated the implementation of reminder calls prior to assessment appointments, resulting in a 5% decrease in no-show rates to first appointments and thus faster time into treatment. The MH PIP created a reporting tool to allow for greater transparency of the assessment to clinic assignment process to eliminate lag times and enable clinic staff to engage with clients immediately after the completion of an assessment.