QUALITY IMPROVEMENT PROGRAM
MENTAL HEALTH QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT (QAPI) WORK PLAN
FY 2020-2021

County of Santa Clara Behavioral Health Services Department
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COUNTY OF SANTA CLARA
Behavioral Health Services

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Introduction

In accordance with the California Department of Health Care Services (DHCS) requirements in California Code of Regulations Title 9, California Welfare and Institutions Code, as well as the MHP's performance contract with the California Department of Health Care Services (DHCS), the County of Santa Clara Behavioral Health Services Department (BHSD) has a Quality Improvement Team (QI) and an Annual Quality Improvement Work Plan.

The design of the QI Program and Annual Quality Improvement Work Plan are intended to drive the desired improvement in outcomes. Ideally, outline the organizational commitment to and capacity for QI projects and will help the County of Santa Clara BHSD use continuous quality improvement to achieve our mission:

> "To assist individuals in our community affected by mental illness and serious emotional disturbance to achieve their hopes, dreams, and quality of life goals. To accomplish this, services must be delivered in the least restrictive, non-stigmatizing, most accessible environment within a coordinated system of community and self-care, respectful of a person's family and loved ones, language, culture, ethnicity, gender and sexual identity."

The County of Santa Clara BHSD recognizes that QI starts with leadership and will not be successful without visible and explicit attention to quality by senior leaders. The BHSD continues to work hard to reach a desired future state where all employees understand the basics of QI, integrate its practice into daily operations, and are motivated to exceed the beneficiary's expectations of quality care, timeliness, and create an organizational culture of quality. Together we are designing an integrated care delivery model that focuses on ensuring and encompassing a seamless navigation and coordinated care for our beneficiaries, family members, mental health advocates, quality personnel, and our stakeholders.

Quality Improvement Program

CSC BHSD is committed to improving the quality of all its services, processes, and programs; thereby, the QI Team delineates the structures and methods used to monitor and evaluate these improvements. An array of teams and committees within and affiliated with the QI Team provide

structure for the quality management and oversight responsibilities of the organization. The QI Team in the CSC is a compilation of several specific departments, committees, and individuals:

- Executive Team, Behavioral Health Quality
- Improvement Committee (BHQIC)
- System of Care (SOC)
- Learning Partnership training (LP)
- Network Management
- Clinical Practice Guidelines Manual
- Quality Management Division

Collectively, these entities provide information and evaluation of current processes, identify areas for improvement, and assist with the department complying with state and federal mandates related to behavioral health services.

Executive Team:

The Executive Team (ET) has primary responsibility for the quality of service to beneficiaries. The ET is responsible for responding to recommendations from the QI Team and Behavioral Health Quality Improvement Committee (BHQIC) and identifying and initiating quality improvement projects. The ET consists of BHS Director, BHS Clinical Director, Assistant Deputy Directors, and QI Directors within multiple departments. These entities assure these projects promote this QI Program and Annual QI Work Plan.

BHQIC/System of Care (SOC) Committees:

The BHQIC and SOC Committees have senior and clinical leaders from the county, the community, and contracted agencies. They guide the ET in the development of each year's QI Work Plan and oversee the conduct of the work plan. Each committee meets six times a year and regularly reviews performance learning measures, workgroup progress, and generally inform and guide projects to achieve QI objectives.

Learning Partnership Training (LP):

LP is an invaluable resource offering training on various topics and principles that are an integral part of professional development at CSC. LP focuses on fundamental concepts for all county and stakeholder staff. These focus areas may include training specific to billing and documentation or clinical focus, such as evidence-based practices utilized in treatment programs. The overall goal of LP is to assure that training leads to skill development necessary to support the improvement of beneficiary's care throughout the system of care.

Network Management:

BHSD's network management team portrays an essential part, and its overarching functions is to ensure that network resources are effectively made available to beneficiaries. Furthermore, to assure contract agencies aptitude successful participation in the network of providers. Understanding the network's functions and operational baseline helps with problem-solving whenever QI objectives are challenging to achieve. These functions are proactively implemented through the use of contract monitoring but also reactively observed to ensure goals are achieved.

Clinical Practice Guideline Manual:

Developed by the Practice Standards Work Group, the Clinical Practice Guidelines Manual integrates recovery-oriented and person-centered best practices with regulatory requirements. It helps to align clinical coaching/supervision and training activities, so they increasingly unite around the needs of beneficiaries – while supporting compliance, reimbursement, and productivity.

Quality Management Division:

The Quality Management Division will provide the staffing and infrastructure for a wide range of quality management activities, including utilization management and authorization, decision support and measurement, quality assurance and auditing, analytics and reporting, and research and evaluation. Quality Management staff will provide critical quality improvement support to both the ET and the BHQIC/SOC Committees.

Quality Management represents an amalgamation of existing infrastructure that is coming together through the Behavioral Health Integration initiative, which is underway. BHSD's Executive Team, along with the multi-agency Behavioral Health Quality Improvement Committee (BHQIC) and System of Care (SOC) Committees, have the shared responsibility to arrange improvement priorities with the agency vision and oversee their conduct to advance the organizations mission.

Quality Improvement Process

BHDS has adopted a continuous quality improvement model for producing improvement in essential service and clinical areas. This model encompasses a systematic series of activities, organization-wide, which focuses on improving the quality of identified key systems, services, and administrative functions. The overall objective of the quality improvement process is to ensure that quality is built, measured consistently, interpreted, and articulated into the performance of the BHDS functions. The objective is met through a commitment to quality from the administration, QI staff, beneficiaries, family members, and both contracted and county providers. The quality improvement process is incorporated systematically into all service areas of BHDS. It is applied when examining the care and services delivered by the BHDS network of providers, programs, and facilities.

Goals of Quality Improvement

1) Increase beneficiary satisfaction and quality of care
2) Increase efficiencies in administrative processes
3) Strengthen the beneficiary experience of care and key beneficiary protections
4) Reduced rates of hospitalization and 24-hour services, and use of emergency and urgent care services

Goals/Objectives/Baseline

I. Access To Care

Goal	Objectives	Baseline
1. **Provider Network Adequacy** **Santa Clara MHP will maintain and monitor a network of providers to provide adequate access to appropriate specialty mental health services.**	1. Santa Clara MHP will provide county programs and contracted agencies with the Network Adequacy Certification Tool (NACT) to track changes/additions to the provider network. This is currently manual and time-consuming process. 2. BHSD will update Provider Directory quarterly per DHCS requirement. 3. BHSD will work with county programs and contracted providers to be in compliance with network adequacy requirements. 4. BHSD will implement 274 Expansion Project to replace the NACT.	As of March 2021, Santa Clara County MHP has passed federal network certification requirements with an approved corrective action plan. BHSD will continue monitoring provider ratios and timeliness to access to meet beneficiary needs. Data Source(s): BHSD Network Adequacy Certification Tool, Provider Directory

<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>2. Provider Linguistic Capacity

Ensure services are provided in the client's preferred language by utilizing bilingual staff, qualified interpreters, and/or language line.</td>
<td>1. Ensure that preferred language is offered and-documented at each service indicating preferred language.

2. Ensure that when clients request a preferred language utilize qualified interpreters, language line or bilingual staff to provide service in preferred language. Document at each service if client declines preferred language service.</td>
<td>FY2020-21 Percent of Providers linguistic capacity:
<table>
<tr><th>Threshold Languages</th><th>% Of Providers</th></tr>
<tr><td>Chinese</td><td>3.7%</td></tr>
<tr><td>Farsi</td><td>0.6%</td></tr>
<tr><td>Spanish</td><td>33.2%</td></tr>
<tr><td>Tagalog</td><td>0.6%</td></tr>
<tr><td>Vietnamese</td><td>5.3%</td></tr>
<tr><td>Other Languages</td><td>2.8%</td></tr>
</table>
Formula: $(Provider\ by\ thershold\ language)\ /\ (Total\ providers)$

FY2020-21 Percent of active clients Preferred Language:
<table>
<tr><th>Threshold Languages</th><th>% Active Clients</th></tr>
<tr><td>Chinese</td><td>0.4%</td></tr>
<tr><td>Farsi</td><td>0.4%</td></tr>
<tr><td>Spanish</td><td>14.8%</td></tr>
<tr><td>Tagalog</td><td>0.3%</td></tr>
<tr><td>Vietnamese</td><td>2.7%</td></tr>
<tr><td>Other Languages</td><td>8.0%</td></tr>
</table>
Formula: $(Client\ receiving\ preferred\ language\ services)\ /\ (Total\ active\ clients)$

Data Source(s): BHSD Network Adequacy Certification Tool, Unicare, Healthlink, and MyAvatar</td>
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<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>3. Cultural Competency of Service Providers

At least 80% of Santa Clara MHP providers will annually complete a cultural competency training.</td>
<td>1. Quarterly monitor completion of cultural competency training to ensure that all providers are meeting annual requirement. BHSD contract monitors and county program managers will inform providers their status throughout the year.

2. BHSD will increase cultural competency training opportunities for staff and contract providers from the previous year</td>
<td>Completion of Cultural Competency Training:

<table>
<tr><th>FY2020-21</th><th>Percent of Providers</th></tr>
<tr><td>Q1</td><td>80%</td></tr>
<tr><td>Q2</td><td>80%</td></tr>
<tr><td>Q3</td><td>80%</td></tr>
<tr><td>Q4</td><td>80%</td></tr>
</table>

Formula: $(\#\ of\ providers\ that\ completed\ the\ training)\ /\ (Total\ \#\ of\ SCC\ Providers)$

Data Source(s): BHSD Network Adequacy Certification Tool</td>
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<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
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<td>

4. Access to SMHS – 24/7 Phone Line

BHSD will conduct 18 test calls per quarter, during and after business hours, a minimum of 14 calls will be conducted in a language other than English. Test calls will be appropriately logged 96% of the time.

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1. Conduct 18 test calls per quarter using test call scripts/worksheets that capture all required elements.
2. Ensure at least 14 test calls per quarter are conducted in a language other than English to test capacity to link beneficiaries with an interpreter as needed.
3. Ensure that test calls are conducted both during and after business hours to assess Call Center services.
4. Review adherence to test call requirements on a quarterly basis (including appropriate logging of test calls) and provide feedback and training to Call Center staff.

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<u>24/7 Access line</u> –

An average of 10 test calls were conducted per quarter, 7 of which were conducted in a language other than English.

FY21	Total Test Calls placed	Total Non-English Calls	Total Test Calls Logged	Total Call Logging %
Goal	**18 calls/ quarter**	**14 calls/ quarter**		**96%**
Q1	7	7	2	29%
Q2	12	7	8	66%
Q3	12	9	7	58%
Q4	6	6	1	16%

Total Call Logging % Formula: $(Total\ \#\ calls\ logged)\ /\ (Total\ \#\ test\ calls\ placed)$

Total Non-English Calls Formula: $(Total\ \#\ test\ calls\ placed) - (Total\ \#\ test\ call\ placed\ in\ English)$

Call Center staff tracks calls manually on a tracking log.

Total test calls placed represent what is reported to the DHCS. It does not account for test calls made where there was no answer at the Call Center.

Data Source(s): Quarterly data for FY20-21 (based on 24/7 Test Call Quarterly Update Report Forms submitted to DHCS)

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II. Timeliness

Goal	Objectives	Baseline
5. Timely Access to Services **BHSD will monitor quarterly, the MHP's ability to meet statewide timeliness standards and achieve compliance with all standards (a-d) for adult, children/youth and foster youth beneficiaries.** Formula: **Measure (a) total # of days calculated from referral date to first offered assessment appointment date** **Measure (b) total # of days calculate from screening date to completed assessment date** **Measure (c) total # of days calculated from completed assessment to psychiatry appointment date** **Measure (d) total # of hours/minutes for service request for urgent appointment to actual encounter**	1. Monitor timeliness between initial request and first appointment for adults, children/youth and foster youth using the following standards: a. Initial request to first offered assessment appointment – 10 business days b. Screening to completed assessment – 10 business days c. Initial request (completed assessment) to psychiatry appointment – 15 business days d. Service request for urgent appointment to actual encounter – 48 hrs. (no prior authorization required) / 96 hours (prior authorization required)	FY21 the timeliness standards were met for all criterions and categories, except for completed assessment to psychiatry appointment (criteria c) which continued to increase for all categories. FY22, BHSD will begin tracking request to psychiatry and first offered in more detail. Timeliness to first offered appointment and completed assessment had a slight increase for all groups but met the 10-day standards for both criterions. Our timeliness for urgent appointments showed improvement for adults (decreased by 4 minutes) and Children/Youth (decreased by 2 minutes). Foster Youth showed an increase of 16 minutes. **FY21 Average wait times (calendar days)** **Measure** / **Goals** / **Adults** / **Children/ Youth** / **Foster Youth** a) Initial request to first offered assessment appointment — 10 Business days — 7.6 days — 6.5 days — 5.3 days b) Screening to completed assessment — 10 Business days — 9.6 days — 8.7 days — 6.5 days c) Completed assessment to psychiatry appointment — 15 Business days — 25 days — 31 days — 31 days d) Service request for urgent appointment to actual encounter — 2880 min (48 hrs.) (no prior authorization required) / 5760 (96 hours) (prior authorization required) — 13 minutes — 17 minutes — 30 minutes Data Source(s): Unicare, Healthlink, and MyAvatar

<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
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<td>

6. Post-psychiatric Hospitalization Follow-Up

Provide post-psychiatric hospitalization follow-up appointment within 7 days of discharge.

Reduce the number of beneficiaries receiving inpatient hospital services who are readmitted within 30 days to 9%.

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1. Monitor:

   a. Post-psychiatric hospitalization follow-up – 7 days after discharge

   b. Psychiatric inpatient readmission rates within 30 days – ≤9%

2. Partner with both divisions (Family and Children's Services and Adult/Older Adult Services) to identify challenges related to the 30-day recidivism rate and implement strategies to address issues.

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FY21	1a. Follow-up appt Post-psychiatric hospitalization	1b. Post-Psychiatric hospitalization readmission within 30 days
Adults	7.9 days	8.5%
Children/Youth	4.2 days	10.4%
Foster Youth	5.0 days	17.9%

Psychiatric hospitalization readmission rates within 30 days reflected improvement from FY20 for Adult, who are meeting the goal. Children/Youth have shown a decrease in readmission rates, however, are still above the goal of 9% or lower. Foster youth showed an increase in readmission rates (28% increase, at a 4.4 difference).

Formula 1a:
$Total\ of\ days\ from\ discharge\ to\ follow-up\ appt\ Post-psychiatric\ hopspitalization$

Formula 1b: $Total\ \#\ readmission\ within\ 30\ days \Big/ Total\ of\ post-psychiatric\ hospitalization\ readmission$

Data Source(s): Healthlink and MyAvatar

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<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>7. Client Engagement with SMHS – No Show Rates

Achieve less than or equal to 10% no-show rates to psychiatry and non-psychiatry scheduled SMHS appointments for adults, children/youth and foster youth.</td>
<td>1. Monitor no-show rates to scheduled SMHS appointments and achieve rates of 10% or less

a. No Show appointment rates – psychiatry appointments – ≤10%

b. No show appointment rates – non-psychiatry SMHS appointments – ≤10%</td>
<td>Average no-show rates met 10% goal for both items.

<table>
<tr><th>FY 2020-21</th><th>Psychiatry</th><th>Other SMHS</th></tr>
<tr><td>Adults</td><td>5.57%</td><td>2.85%</td></tr>
<tr><td>Children/Youth</td><td>0.48%</td><td>4.55%</td></tr>
<tr><td>Foster Youth</td><td>0.00%</td><td>2.95%</td></tr>
</table>
Formula:
$Total\ \#\ of\ no-shows / Total\ \#\ of\ schedule\ SMHS-Psychiatry\ appointment\ for\ each\ category$

Data Source(s): Unicare, Healthlink, and MyAvatar</td>
</tr>
</table>

III. Beneficiary Progress/Outcomes

<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>

8. Utilization Review – Clinical Record Review

Improve quality of clinical documentation as evidenced by < 5% disallowance rates for all programs reviewed during FY21-22

Improve baseline compliance for goals and interventions in treatment plans to >90%

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1. BHSD QA Department will conduct annual Clinical Record Reviews for all contracted and county operated outpatient programs that were designated to be audited.
2. BHSD QA Department will conduct an Exit Interview with the QA manager or designee of the agency or clinic to address any disallowance or compliance trends discovered through the clinical record review.
3. BHSD QA Department will complete further mentoring as needed with agencies that have a disallowance rate above 10%.
4. BHSD QA Department will provide a Clinical Documentation Training every month highlighting Title IX documentation standards and disallowance trends observed in the audits. The monthly Clinical Documentation Trainings that are available include either instructor-led or web-based, if not both being available within each month.
5. BHSD QA Department will continue to update the online training, which will be available to all county and contracted providers through a comprehensive online chart documentation training module. Successful completion of this training will be tracked via the online certificated issued from the Learning Partnership Division.
6. BHSD QA Department will collaborate with Clinical Standards to provide guidance to QA directors and managers from contacted and county agencies and clinics.

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<table>
<tr><th>Measure</th><th>Goal</th><th>Outcome FY 2020-21</th></tr>
<tr><td>Disallowance rate</td><td>< 5%</td><td rowspan="3">Due to COVID and Shelter-in-Place, audits were delayed. Final data not available at this time as audits & appeals are still in progress.</td></tr>
<tr><td>Compliance for Goals</td><td>>90%</td></tr>
<tr><td>Compliance for Interventions</td><td>>90%</td></tr>
</table>

Formula: $(Total\ \#\ of\ disallowance\ charts)\ /\ (Total\ \#\ of\ audited\ charts)$

Formula: $(Total\ \#\ of\ goal\ meeting\ compliance)\ /\ (Total\ \#\ of\ goals\ in\ audited\ tx\ plan)$

Formula: $Total\ \#\ of\ intervention\ meeting\ compliance\ /\ Total\ \#\ of\ interventions\ in\ aduited\ tx\ plan$

Total programs reviewed during FY20/21 = 28 TOTAL
(17 CBO'S + 11 COUNTY CLINICS)

Please Note: FY 20/21 audits not completed due to COVID-19 crisis response and various QA and QI Staff being deployed as Disaster Service Workers (DSWs). Audits/utilization reviews for this FY 20/21 commenced late (in February 2021) due to the COVID-19 response efforts and are still in progress.

Data Source: QA Collaborative Charter

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<table>
<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>

9. Utilization Management – Monitor Safe and Effective Medication Practices

Ensure appropriate medication therapy for our clients have a current, signed medication consent form on file, including all required supporting documentation (and any required JV-220 forms), 70% of the time.

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1. Mental Health Psychiatric Pharmacist quarterly conducts medication monitoring reviews to monitor completion of medication consent forms and other supporting documentation.

2. Identify patients that received medication management services and randomly select
   a. 3 charts from each contract agency or 1.25%, whichever is greater
   b. 3 charts per providers from County

3. Medical Director or designee will support corrective action findings defined in the summary report by the Pharmacist and report to Senior Management annually. Pharmacist will re-audit incomplete charts in approximately 3 months from the time of initial assessment.

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Medication Monitoring Chart Review

FY20-21	# Charts Reviewed	% Completed Consent Form	% of Charts Require Re-audit
Q1	310	86%	50%
Q2	332	92%	50%
Q3	322	92%	50%
Q4	325	94%	50%

Formula: $(Total\ \#\ of\ completed\ consent)\ /\ (Total\ \#\ of\ consent\ forms)$

Formula: $(Total\ \#\ of\ charts\ requiring\ re-audit)\ /\ (Total\ \#\ of\ charts)$

FY21 there has been an increase on meeting standards of completed consent forms. Each quarter the percent of incomplete charts remained the same through the fiscal year.

BHSD will continue to monitor and track performance to meet goal standards of completion of consent forms and other required supporting documentation

Data Source: Quality Improvement Medication Monitoring Chart Review Summary Reports

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<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
<tr>
<td>10. Outcomes- Successful Discharges

Increase the number of beneficiaries who successfully discharge to 70% for Adults and 75% for Family and Children.</td>
<td>1. Successful discharges are beneficiaries who have discharged from the system after achieving their goal or making substantial progress towards their treatment goals.

a. Adult and Older Adult (A/OA) with MORS

b. Adult and Older Adult (A/OA) without MORS

c. Family and Children (F&C) status at discharge</td>
<td>Outcomes are currently measured by successful discharges for both divisions.

The percentage of successful discharges is increasing in both the A/OA and F&C SOCs. However, the percentage of A/OA with MORS beneficiaries who discharge successfully is far lower than we would like so we will continue to focus efforts towards improving this measure.

<table>
<tr><th rowspan="2">FY21</th><th colspan="3">Category</th></tr>
<tr><th>A/OA with MORS</th><th>A/OA without MORS</th><th>Family & Children</th></tr>
<tr><td>Q1</td><td>8.8%</td><td>52.3%</td><td>73.0%</td></tr>
<tr><td>Q2</td><td>11.7%</td><td>60.5%</td><td>72.5%</td></tr>
<tr><td>Q3</td><td>8.2%</td><td>48.1%</td><td>61.3%</td></tr>
<tr><td>Q4</td><td>7.1%</td><td>32.5%</td><td>66.8%</td></tr>
</table>
Formula: $(Total\ \#\ of\ successful\ disharge)\ /\ (Total\ \#\ of\ discharge\ (Category))$

Data source: Unicare, Healthlink, and MyAvatar</td>
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<tr><th>Goal</th><th>Objectives</th><th>Baseline</th></tr>
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<td>

11. Beneficiary/Family Satisfaction – California Department of Health Care Services Consumer Perception Survey Completion (CPS)

Ensure that 50% of CPS surveys are returned for analysis. Report results back to the programs, twice yearly and support programs in selecting improvement goals.

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1. Data will be collected utilizing CPS surveys (Youth and Family, Adult, and Older Adult) during the reporting week per DHCS schedule.

2. Report results to county staff, contractors, and clients 2x annually as the surveys occur.

3. Continue analysis of survey data to evaluate improvement goals on access, quality, cultural, and outcome.

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Client participation rate during CPS Survey data collection period

<table>
<tr><th>Target Group</th><th>June 2020
% Returned</th></tr>
<tr><td>Adult/ Older Adult</td><td>42%</td></tr>
<tr><td>Youth and Family</td><td>58%</td></tr>
</table>

Formula: $(Total\ \#\ Returned\ surveys\ by\ target\ group)\ /\ (Total\ \#\ of\ Expected\ surveys\ by\ target\ group\ )$

Overall response results:

The majority of the scores for this survey period were rated “good.”

Yellow=Excellent, Green=Good, and Blue=Satisfactory

<table>
<tr><th>June 2020 CPS Results</th><th>Youth & Family</th><th>Adult</th><th>Older Adult</th></tr>
<tr><td>Satisfaction with service access</td><td>4.44</td><td>4.33</td><td>4.23</td></tr>
<tr><td>Satisfaction with treatment planning</td><td>4.35</td><td>4.35</td><td>4.42</td></tr>
<tr><td>Satisfaction with services provided</td><td>4.43</td><td>4.40</td><td>4.41</td></tr>
<tr><td>Satisfaction with cultural sensitivity and appropriateness of service</td><td>4.56</td><td>4.33</td><td>4.41</td></tr>
<tr><td>Satisfaction with treatment outcomes</td><td>4.01</td><td>3.97</td><td>4.00</td></tr>
</table>

Results and data from the June 2021 survey period (June 21, 2021 – June 25, 2021) have not yet been received from DHCS.

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