sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT WORK PLAN

FISCAL YEAR 2020 – 2021

ADOPTED ON: 3/1/2021

REVISED ON:

The Quality Improvement Plan is a required element of the Quality Management Program, as specified by DHCS contract, Exhibit A Attachment I (relevant sections: 22-25), and by CCR Title 9, Chapter 11, § 1810.440.

This Plan comports with PHAB Accreditation Standards Version 1.5.

TABLE OF CONTENTS

PURPOSE AND INTRODUCTION

EXECUTIVE SUMMARY

The Sonoma County Department of Health, Behavioral Health Division (DHS-BHD), Quality Assessment and Performance Improvement (QAPI) program serves as a unifying structure for all QAPI activities across all service delivery sections, ensuring and improving the quality of behavioral health services provided to beneficiaries. QAPI activities are designed to ensure that service delivery is consumer-focused, clinically appropriate, cost effective, data-driven, and culturally responsive. These values are achieved in collaboration with cross-sector stakeholders, including beneficiaries, their family members, community providers, DHS-BHD leadership and staff. QAPI Plan activities derive from a number of information sources about quality of care issues. These include State and Federal requirements, Department initiatives, consumer and family feedback, and community stakeholder input. This plan serves as the foundation for implementing and sustaining a model of quality across the Behavioral Health Division.

MISSION, VISION, AND VALUES

The mission of the Department of Health Services, Behavioral Health Division (DHS-BHD) is to promote recovery and wellness to Sonoma County residents.

DHS-BHD embraces a recovery philosophy that promotes the ability of a person with mental illness and/or a substance use disorder to live a meaningful life in a community of his or her choosing, while striving to achieve his or her full potential. The principles of a recovery-focused system include: *

- Self-Direction
- Individualized and Person-Centered Care
- Empowerment and Shared Decision-Making
- Holistic Approach that Encompasses Mind, Body, Spirit, and Community
- Strengths-Based
- Peer Support
- Focus on Respect, Responsibility, and Hope.

DHS-BHD fosters a collaborative approach by partnering with clients, family members, and the community to provide high quality, culturally responsive services.

Services are provided in all languages.

DHS-BHD provides mental health and substance use disorder services across the service spectrum, from prevention, early intervention and treatment, to aftercare and recovery. DHS-BHD provides these services directly or through partnerships with community based agencies.

DHS-BHD directly administers specialty mental health treatment services to Sonoma County residents whose mental health needs are determined to be medically necessary as defined by CCR Title 9 and W&I Code 5600.

DHS-BHD provides oversight, quality assurance, training, and site monitoring for contracted services.

*adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA)

DEFINITIONS AND ACRONYMS

INTRODUCTION

A common vocabularyis used agency-wide when communicatingabout quality and quality improvement. Key terms and frequently used acronyms are listed alphabeticallyin this section. For a complete Glossaryof Terms, see Appendix A.

DEFINITI ONS

ACCESS

Access is the potential for or actual entry of a populationinto the behavioral health system. Entry is dependent uponthe wants, resources, and needs that individuals bring to the care-seekingprocess. The ability to obtain wanted or needed services may be influenced by many factors, including travel, distance, waiting time, available financial resources, and availabilityof a regular source of care. Access also refers to the extent to which a behavioral health service is readily available to the community's individuals inneed. Accessibilityalso refers to the capacity of the organization to provide service in such a way as to reflect andhonor the social and cultural characteristics of the community and focuses on organizational efforts to reduce barriers to service utilization. (Turnock, BJ. *Public Health: What It Is and How It Works*. Jones and Bartlett. 2009).

ALI GNMENT

Alignment is the consistency of plans, processes, information, resource decisions, actions, results and analysisto support key organization-wide goals. (Baldrige National Quality Program, 2005).

BEST PRACTI CES

The best clinical or administrative practice or approach at the moment, given the situation, the consumer or community needs and desires, the evidence about what works for a particular situation and the resources available. Organizations often also use the term promising practices whichmay be defined as clinical or administrative practices for whichthere is considerable practice-based evidence or expert consensus which indicates promise in improving outcomes, but for which are not yet proven by strong scientific evidence. (National Public Health Performance Standards Program, *Acronyms, Glossary, and Reference Terms*, CDC, 2007. www.cdc.gov/nphpsp/PDF/Glossary.pdf).

CONTI NUOUS QUALITY I MPROVEMENT (CQI)

A systematic, division-wide approachfor achievingmeasurable improvements inthe efficiency, effectiveness, performance, accountability, andoutcomes of the processes or services provided. Applies use of a formal process (PDSA, etc.) to "dissect" a problem, discover a root cause, implement a solution, measure success/failures, and/or sustain gains.

EVI DENCE-BASED PRACTICE

Evidenced-based practice involves making decisions on the basis of the best available scientific evidence, using data and informationsystems systematically, applying program-planningframeworks, engaging the community in decisionmaking, conducting soundevaluation, and disseminating what is learned. (Brownson, Fielding and Maylahn. *Evidence-based Public Health: A Fundamental Concept for Public Health Practice.* Annual Review of Public Health).

OUTCOMES

Outcomes are measured by collecting andanalyzing clinical data over a period of time in order to determine the effectiveness of a treatment or service. Measuring outcome data enables an organizationto visualize areas of best care and identify areas for improvement.

PLAN, DO, STUDY, ACT (PDSA, ALSO KNOWN AS PLAN-DO-CHECK-ACT)

An iterative, four-stage, problem-solving model for improvinga process or carrying out change. PDSA stems from the scientific method (hypothesize, experiment, evaluate). A fundamental principle of PDSA is iteration. Once a hypothesis is supported or negated, executing the cycle again will extend what one has learned. (Embracing Quality in Local Public Health: Michigan's QI Guidebook, 2008)

QUALITY IMPROVEMENT (QI)

Quality Improvement in Behavioral Healthis the use of a deliberate and defined improvement process, such as Plan-Do-Study-Act, whichis focused on activities that are responsive to community needs and improving populationbehavioral health. It refers to a continuous andongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality inservices or processes whichachieve equity and improve the healthof the community. (Riley, Moran, Corso, Beitsch, Bialek, and Cofsky. *Defining Quality Improvement in Public Health.* Journal of Public Health Management and Practice. January/February 2010).

QUALITY IMPROVEMENT PLAN

A plan that identifies specific areas of current operational performance for improvement within the organization. These plans can andshouldcross-reference one another, soa quality improvement initiative that is inthe QI Planmay also be in the Strategic Plan. (PHAB Acronyms and Glossary of Terms, 2009)

QUALITY CULTURE

QI is fully embeddedinto the way the organization renders service, across all levels, departments, and programs. Leadershipandstaff are fully committed to quality, and results of QI efforts are communicated internallyandexternally. Even if leadership changes, the basics of QI are so ingrainedin staff that they seek out the root cause of problems. They do not assume that an intervention will be effective, but rather they establish and quantify progress toward measurable objectives. (Roadmap to a Culture of Quality Improvement, NACCHO, 2012)

STORYBOARD

Graphic representation of a QI team's quality improvement journey. (Scamarcia-Tews, Heany, Jones, VanDerMoere & Madamala, 2012)

TIMELINESS

Timeliness is a core monitoringdomain of Quality Improvement, referring to the wait times anddelays withina service deliverysystem. Quality Improvement processes include efforts to reduce wait times for both those who receive services and those who give care. Minimum timeliness standards are set in statute.

ADDI TI ONAL ACRONYMS

5150	Declared to be a danger to self and/or others
ACA	Affordable Care Act
ACL	All County Letter
ACT	Assertive Community Treatment (program run by Telecare)
ANSA	Adult Needs and Strengths Assessment
AODS	Alcohol and Other Drugs Services – now a part of the Behavioral Health Divisionandcalled SUDS
ARF	Adult Residential Facility
ART	Aggression Replacement Therapy
BHD	Behavioral Health Division(Sonoma County)
CADPAAC	County Alcohol and Drug Program Administrators' Association of California
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalEQRO	California External Quality Review Organization
CALMHB/C	California Associationof Local Mental Health Boards & Commissions - comprised of representatives from many MHBs in the State
CANS	Child, Adolescent Needs and Strengths (Assessment)
CAPE	Crisis Assessment, Prevention, and Education Team; goes intothe schools when called to intervene in student mental health matters
CAPSC	Community Action Partnership-Sonoma County
CARE	California Access to Recovery Effort
CBHDA	California Behavioral Health Directors Association
CBT	Cognitive Behavioral Therapy
CCAN	Corinne Camp Advocacy Network - Peers involved in mental healthadvocacy
CDSS	California Department of Social Services
CFM	Consumer and Family Member
CHD	California Human Development
CIP	Community Intervention Program
CIT	Crisis Intervention Training (4-day training for law enforcement, to help them identify and respondto mental health crisis situations)
CMHC	Community Mental Health Centers, Located in Petaluma, Guerneville, Sonoma, and Cloverdale (part of DHS-BHD)
CMHL	DHS-BHD's Community Mental Health Lecture series - open to the public - usuallytakes place monthly
CMS	Centers for Medicare and Medicaid Services
ConREP	Conditional Release Program
CPM	Core Practice Model
CPS	Child Protective Services
CPS (alt)	Consumer Perception Survey (alt)
CRU	Crisis Residential Unit (aka Progress Sonoma-temporary home for clients incrisis, run by Progress Foundation)
CSAC	California State Association of Counties
CSN	Community Support Network (contract Provider)
CSS	Community Services and Support (part of Mental Health Services Act-MHSA)
CSU	Crisis Stabilization Unit – open 24/7 for psychiatric crises – 2225 Challenger Way
CTRT	Collaborative Treatment and Recovery Team
CWS	Child Welfare Services
CY	Calendar Year
DAAC	Drug Abuse Alternatives Center
DBT	Dialectical Behavior Therapy
DHCS	(State) Department of Health Care Services
DHS	Department of Health Services (Sonoma County)
DPI	Department of Program Integrity
DSRIP	Delivery System Reform Incentive Payment
EBP	Evidence-Based Program or Practice
EHR	Electronic Health Record

EMR	Electronic Medical Record
EPSDT	Early Periodic Screening, Diagnosis & Treatment(Children's Full Scope Medi-Cal to age 21)
EQR	External Quality Review
EQRO	External Quality Review Organization(annual review of our programs by the State)
FACT	Forensic Assertive Community Treatment
FASST	Family Advocacy Stabilization, Support, and Treatment (kids 8-12)
FQHC	Federally Qualified Health Center
FY	Fiscal Year
FYT	Foster Youth Team
HCB	High Cost Beneficiary
HIE	Health Information Exchange
HIPAA	Health Insurance Portabilityand Accountability Act
HIS	Health Information System
HITECH	Health Information Technologyfor Economic and Clinical Health Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
HSD	Human Services Department
IA	Inter-Agency Agreement
ICC	Intensive Care Coordination
IHBS	Intensive Home-Based Services
IMDs	Institutes for Mental Disease (locked residentialfacilities for clients on Conservatorship)
INN	Innovation (part of MHSA)
IPU	Inpatient Psychiatric Unit
IRT	Integrated Recovery Team (for those with mental illness + substance use issues)
ISCA	Information Systems Capabilities Assessment
IT	Information Technology
JCAHO	Joint Commission on Accreditation of Healthcare Organizations - accredits hospitals & other organizations
LEA	Local Education Agency
LG	Los Guilicos-Juvenile Hall
LGBQQTI	Lesbian/Gay/Bisexual/Queer/Questioning/Transgender/Intersexed (also LGBT)
LOS	Length of Stay
LSU	Litigation Support Unit
M2M	Mild-to-Moderate
MADF	Main Adult Detention Facility (Jail)
MHB	Mental Health Board
MDT	Multi-Disciplinary Team
MHBG	Mental Health Block Grant
MHFA	Mental Health First Aid
MHP	Mental Health Plan
MHSA	Mental Health Services Act
MHSD	Mental Health Services Division (of DHCS)
MHSIP	Mental Health Statistics Improvement Project
MHST	Mental Health Screening Tool
MHWA	Mental Health Wellness Act
MOU	Memorandum of Understanding
MRT	Moral Reconation Therapy
MST	Mobile Support Team - gets called by law enforcement to scenes of mental health crises
NAMI	National Alliance on Mental Illness
NBSPP	North Bay Suicide Prevention Project
NOABD	Notice of Adverse Benefit Determination
NP	Nurse Practitioner
OAT	Older Adult Team
OSHPD	Office of Statewide Health Planning and Development
PA	Physician Assistant

PATH	Projects for Assistance in Transition from Homelessness
PC1370	Penal Code 1370 (Incompetent to Stand Trial, by virtue of mental illness)
PCP	Primary Care Provider (medical doctor)
PEI	Prevention and Early Intervention (part of Mental Health Services Act-MHSA)
PHI	Protected Health Information
PHP	Parker Hill Place – Progress Foundation's transitional residential program in Santa Rosa
PHP	Partnership Health Plan
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PM	Performance Measure
PPP	Triple P - Positive Parenting Program
PPSC	Petaluma People Services Center
QI/QA	Quality Improvement/Quality Assurance
QIS	Quality Improvement Steering (meeting)
QIC	Quality Improvement Committee (meeting)
QMP	Quality Management Policy (meeting)
RCC	Redwood Children's Center
RCFE	Residential Care Facility for the Elderly
RFP	Request For Proposals (released when new programs are planned and contractors are solicited)
RN	Registered Nurse
ROI	Release of Information
SAR	Service Authorization Request
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCBH	Sonoma County Behavioral Health
SCOE	Sonoma County Office of Education
SDMC	Short-Doyle Medi-Cal
SELPA	Special Education Local Plan Area
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SNF (Sniff)	Skilled Nursing Facility
SPMI	Serious Persistent Mental Illness
SOP	Safety Organized Practice
SUD	Substance Use Disorders
SUDS	Substance Use Disorders Services (formerly AODS)
SWITS	Sonoma Web Infrastructure for Treatment Services
TAY	Transition Age Youth (18-25)
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TSA	Timeliness Self-Assessment
VOMCH	Valley of the Moon Children's Home
WET	Workforce Education and Training (part of MHSA)
WRAP	Wellness Recovery Action Plan
Wraparound	Community-based intervention services that emphasize the strengths of the child and family
YFS	Youth and Family Services (Sonoma County Behavioral Health)
YSS	Youth Satisfaction Survey
YSS-F	Youth Satisfaction Survey-Family Version

DESCRIPTION OF QUALITY IN SONOMA COUNTY BEHAVIORAL HEALTH DIVISION

INTRODUCTION

This section provides a description of quality efforts in Sonoma County Behavioral Health, including culture, roles and responsibilities, processes, andlinkages of quality efforts to other agencydocuments.

DESCRIPTION OF QUALITY EFFORTS

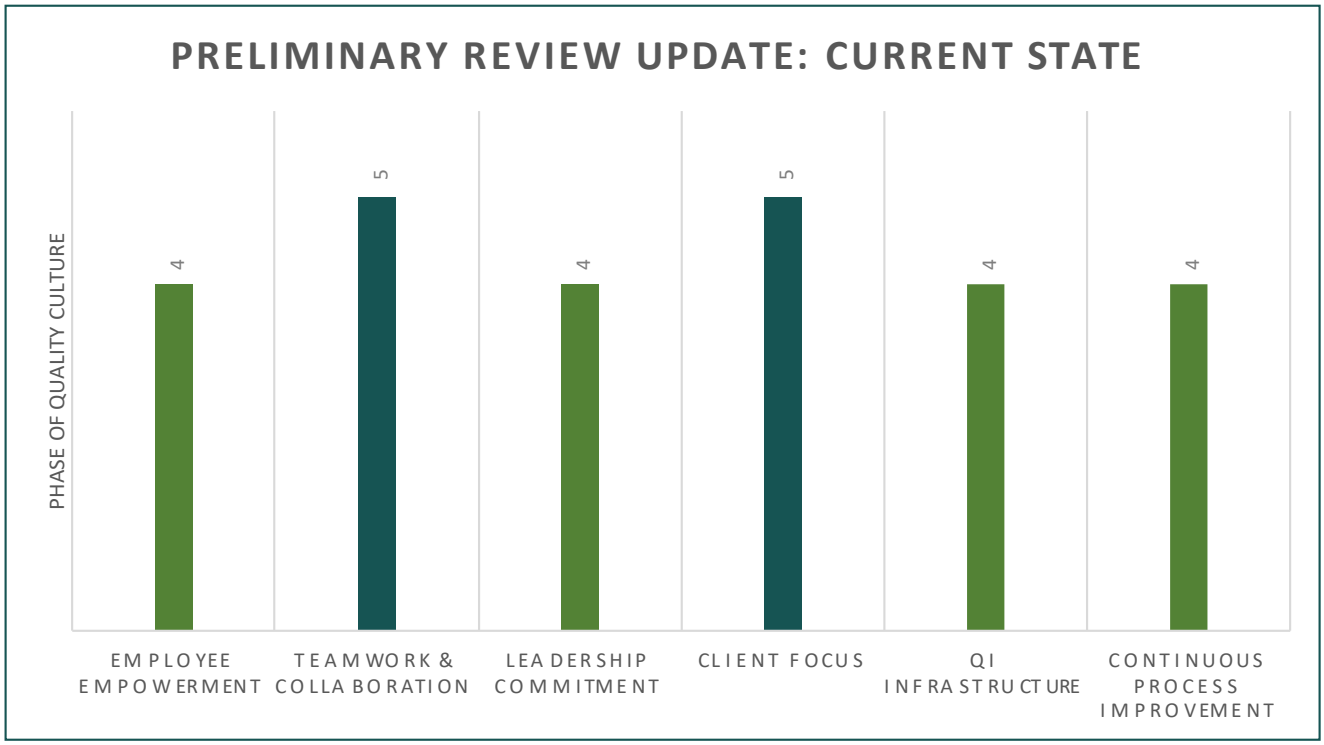
The current culture of quality within Sonoma County Behavioral Health is assessed overall at Phase Four: Formal QI Activities Implemented in Specific Areas. The desired state is Phase 5: Formal Agency-Wide QI. Goalsandstrategies are prioritized to support progress toward this desiredfuture state.

CULTURE OF QUALITY

In FY 19-20, formal assessment of the Culture of Qualitywas disrupted by the COVID pandemic; however, initial planning and questionselection was completed. In FY 20-21, Sonoma County Behavioral Health will complete this project and utilize the Organizational Culture of Quality Self-Assessment Tool Version 2.0 (QI SAT 2.0) to formallyassess the Division's current position onthe spectrum of quality culture and inform strategic planning of quality initiatives. The QI SAT 2.0 provides insight intoan organization's maturity acrosssix foundationalelements of quality culture.

- Employee Empowerment
- Teamwork & Collaboration
- Leadership Commitment
- Client Focus
- QI Infrastructure
- Continuous Process Improvement

And updated preliminary high-level review indicates the current state as follows:



Foundational Element	Phase of Quality Culture	Characteristics
Employee Empowerment	Phase 4: Formal QI Activities Implemented in Specific Areas	• Employees incertain areas have knowledge, skills, and abilities to complete formal QI projects • Basic and advancedlevel QI training/resources are available • Performance data are used by supervisors to evaluate program performance • Employees understandthe value of QI; some still view it as an added responsibility
Teamwork & Collaboration	Phase 5: Formal Agency-Wide QI	• Informal groups of employees from across the organization are commonly formed for problem solving • Formal QI project teams are formed throughout the organization • Several formalmethods for peer sharing and learning exist
Leadership	Phase 4: Formal QI Activities Implemented in Specific Areas	• Leaders in the Quality Unit hold staff accountable to QI initiatives • Executive leaders proactively seek out resources for QI and appropriately budget for staff time, training, etc. • Governing entities (DHCS, DHS) are informed about agency QI initiatives and goals
Client Focus	Phase 5: Formal Agency-Wide QI	• Employees are empowered to take corrective action to resolve client grievances • Client satisfactionperformance standards and measures are standard throughout the organization • Client satisfactiondata is actively used to improve performance • Clients andproviders are proactively engaged in decision-makingand improvement processes
QI Infrastructure	Phase 4: Formal QI Activities Implemented in Specific Areas	• A formallyestablished, cross-sectional QIC meets regularly to monitor, oversee, and lead implementationplanning for formal agency-wide QI efforts • Some parts of the organization have formal processes for data collection, analysis, and reporting against pre-defined objectives andstandards; but data is stored indisparate, unlinked systems • QI projects or improvement initiatives are often identified from existing performance data
Continuous Process Improvement	Phase 4: Formal QI Activities Implemented in Specific Areas	• A formal QI model is commonly used to improve processes in some parts of the agency • Staff are comfortable with using various basic QI tools (e.g. flowcharting, Cause-and-Effect Diagram, Brainstorming) • Performance data is being used insome areas of the organization but consistency and reliability issues exist • Formal QI projects are resultingin process improvements, however, successes are not always spread to other parts of the organization

Reference: *Roadmap to a Culture of QualityImprovement*, (NACCHO, 2012)

QUALITY OF CARE COMPONENTS

QI systems are evaluated globally alongthe following domains: Access to Care, Timeliness of Services, Quality of Care, and Beneficiary Outcomes.

EQRO specifically defines the Quality of Care Components as follows:

- Organizational Commitment/Engagement: Quality management and performance improvement are organizational priorities
- Data Utilization: Data used to inform management and guide decisions
- Collaboration: Evidence of effective communication from MHP administration, and stakeholder input and involvement on system planning and implementation
- Service Spectrum: Evidence of a systematic clinical continuum of care
- Workforce Diversity: Evidence of beneficiary andfamilymember employment inkey roles throughout the system
- Peer-Programming: Beneficiary-run and/or beneficiary-driven programs exist to enhance wellness andrecovery
- Outcome-Orientation: Measures clinical and/or functional outcomes of beneficiaries served
- Responsiveness to Feedback: Utilizes information from Consumer Satisfaction Surveys

LINKS TO OTHER ORGANIZATIONAL PLANS

Sonoma County Behavioral Health QI Plan goals and activities align with and support the Sonoma County Department of Health Services (DHS) Strategic Plan in the followingways:

DHS Strategic Plan Goal 1: All residents andcommunity environments are healthy and safe	
DHS Objective and Strategy: Improve quality of life outcomes by advancing cross-sector partnerships, networks, collaboration, and community engagement to improve community and individual determinants of health	QI Plan Alignment: The Quality Improvement Committee is comprised of DHS-BHDLeadership, Staff, Community Providers, Clients, and Family Members of Clients; this cross-sector team collaborates to improve community and individual determinants of behavioralhealth
DHS Strategic Plan Goal 2: Individuals, families, and communities access high qualityandcoordinated services for health, recovery, well-being, and self-sufficiency	
DHS Objective and Strategy: Increase access to safety net services by strengthening coordinationof services with emphasis on high-need residents	QI Plan Alignment: The Access Timeliness Performance Improvement Project improves access to safety net services by streamlining the intake process andremoving delays to treatment
DHS Strategic Plan Goal 3: The Department of Health Services is a highachieving, high functioning organization	
DHS Objective and Strategy: Builda highlycompetent, effective, and engaged workforce by improving communicationandcollaboration	QI Plan Alignment: The QI Communication Planimproves communicationandcollaborationby informing staff performance metrics and client outcomes; regular program-level QI trainings provide a forum for technical assistance and team collaborationon best-practices

More informationon the DHS Strategic Plancan be foundat this link: https://healthstrategicplan.sonomacounty.ca.gov/

Cultural Responsiveness is critical to promoting equity, reducing health disparities andimprovingaccess to high-quality behavioral health services that are delivered in a manner whichis respectful of and responsive to the needs of diverse clients. Insupport of this value, the QI Plan aligns with the Cultural Competence Plan by monitoring client satisfaction survey results pertaining to cultural responsiveness of staff, whichthen inform improvement goals for the service system. The QI Team analyzes anddisseminates these results to Division Leadership, the Ethnic Services Manager, and Program Managers to assist in identifying disparities and developing strategies toward Cultural Responsiveness.

Lastly, the QI Plan aligns with the DHS Workforce Development Planby supporting improvements inthe following Core Competencies:

Core Competency	QI Plan Alignment
Planning and Evaluation	Establishes a systematic approach to set andevaluate priorities, goals, and timelines to ensure accomplishment of specific quality standards
Communications	Solicits input from internal and external stakeholders to inform and engage in strategies aimed at quality outcomes
Cultural Competence	Develops quality objectives, plans, andpolicies that are relevant to the culture and language of the community, clients, andfamilies
Collaboration	Works throughmulti-disciplinary committees inpartnershipwith community providers, consumers, and family members to accomplish shared goals and improve community behavioral health and wellbeing
Personal and Professional Accountability	Demonstrates anoutcomes orientation indevelopment and implementation of qualityinitiatives, plans, andpolicies
Organizational Awareness	Combines ethical practice and organizational knowledge to implement and manage policies and procedures of the Behavioral Health Division
Leadership and SystemsThinking	Identifies, analyzes, andleads efforts to address barriers that may affect deliveryof behavioral healthservices, programs, andpolicies
Understanding of the Disciplines	Applies best practices in the discipline of behavioral health in the monitoringandevaluation of service delivery, programs, plans, and policies

QUALITY IMPROVEMENT MANAGEMENT, ROLES, AND RESPONSIBILITIES

The QAPI Program brings together quality assurance andquality improvement activities to facilitate the development of a well-coordinated, accessible, affordable andaccountable system for delivering behavioral health care. The following sections outline the system governance and structural components of the QAPI program.

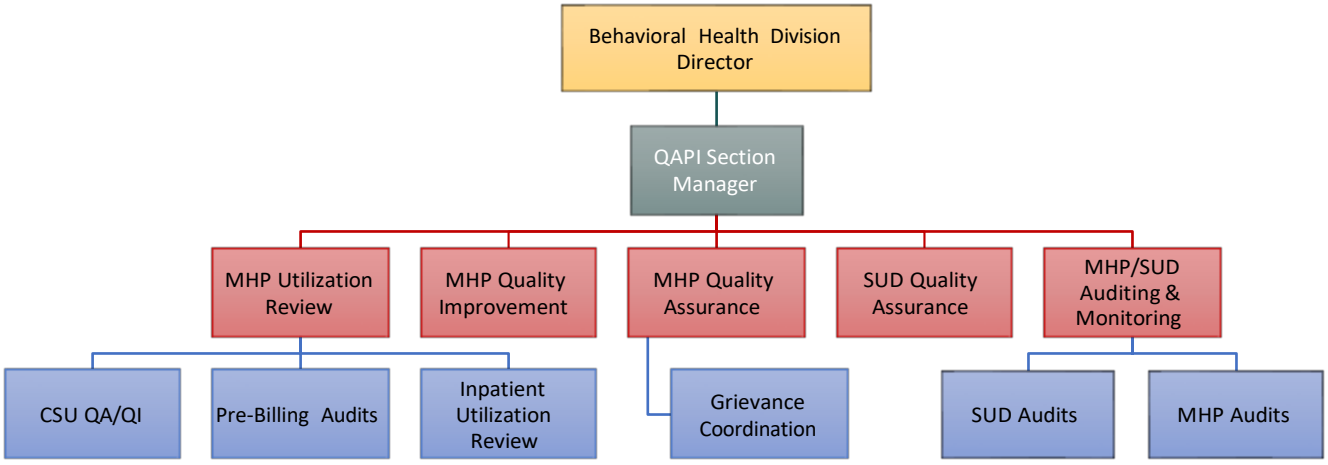
QAPI STANDARDS, STATUTES, AND REGULATIONS

The QAPI program is charged with ensuring regulatorycompliance with allstatutes andrequirements governing the operation and administrationof behavioral health services. These governing standards include, but are not limited to:

- Sonoma County Contracts and MOUs
- Mental Health Plan Contract Exhibits
- DHCS Information Notices and Letters
- California Business and Profession Code
- California Code of Regulations Titles 9, 15, 16, & 22
- California Health and Safety Code
- California Welfare and Institutions Code
- Center for Medicare and Medicaid Services/DHCS 1915(b) Waiver
- Code of Federal Regulations Titles 6, 28, 42, 45
- The Health Insurance Portability and Accountability Act (HIPAA)
- Social Security Act, Subpart A

QAPI PROGRAM STRUCTURE

The following chart depicts the organizational components of the QAPI program for boththe Mental Health Plan (MHP) and Substance Use Disorder Services (SUD).



Quality Assurance tasks include monitoring compliance with contractual, state, and federal regulations in day-to-day service delivery. Specifically:

- Ensuring MHP compliance with DHCS State Contract, Title 9 and 42 CFR Regulations
  - Network Adequacy and Availability of Services
  - Care Coordinationand Continuity of Care
  - Quality Assessment and Performance Improvement
  - Access and Information Requirements
  - Coverage and Authorization of Services
  - Beneficiary Rights and Protections
  - Program Integrity
- Preparing andfacilitating DHCS Triennial Reviews
- Managing MHP Policies and Procedures
- Tracking and distributing DHCS Information Notices
- Performing Medi-Cal Site Certifications
- Monitoring andtracking Beneficiary Protections
  - Grievances and Appeals
  - Change of Provider Requests
  - State Fair Hearings
  - Notices of Adverse Benefit Determination

Quality Improvement tasks include utilizing outcome data to work toward improvement of the service deliverysystem. Specifically:

- Monitoring system access, timeliness, quality, andoutcomes
- Providing program data analysisto inform system change
- Analyzing Consumer Perception Surveyresults to identifypotential needs
- Implementing centralized data tracking through the Electronic Health Record
- Designingandimplementing QAPI Plan goals and projects
- Developing andmonitoring Performance Improvement Projects
- Preparing andcoordinating EQRO
- Coordinating Network Adequacycertifications
- Updating the Provider Directory

Utilization Review tasks include training and reviewing programactivities to maximize effective service delivery. Specifically:

- Ensuring adherence to Medi-Cal and MediCare documentationstandards
    - Documentation Training
    - Technical Assistance
    - Chart Reviews
    - Claiming Accuracy
- Implementing the QAPI Training Plan
    - Facilitating New Employee Documentation Trainings
    - Providing Documentation updates in Division Meetings
    - Creating, updating, and maintaining documentationguides and handbooks
- Reviewing audit findings and providing support for implementing Corrective Action Plans
- Providing contract oversight andreview of affiliated community provider organizations
- Supervising QAPI activities within the Crisis Stabilization Unit
    - Seclusion and Restraint review
    - Staff ratios
    - Daily Census
    - Timely admissions and discharges
- Hospital Utilization Review
    - Reviewing and processing Treatment Authorization Requests (TAR) and Short-Doyles (SD)
    - Reviewing and processing TAR Appeals and SD Appeals
    - Coordinating with Hospital Liaison team regarding discharge medications for clients, as needed
    - Coordinating with hospitals' utilization review coordinators to ensure all needed documentation is submitted
    - Once implemented, using concurrent review process for authorizinghospital treatment.

Auditing and Monitoring tasks include reviewing andensuring documented compliance with contractual, state, and federal regulations. Specifically:

- Preparing, executing, andreporting MHP Program Audit Findings
- Preparing, executing, andreporting SUD Program Audit Findings
- Issuing Corrective Action Plans
- ManagingAudit Appeals
- Updating Audit Tools and Report Templates
- Conducting Pre-Billing Audits
- Reporting on non-Program Audit Findings
    - Pre-Billing Audits
    - Service Verification
    - Treatment Authorization Requests
    - Service Authorization Requests/Presumptive Transfers
    - Excluded Provider Screenings
    - Peer Review Medication Monitoring

QUALITY MANAGEMENT POLICY COMMITTEE (QMP)

The purpose of QMP is to provide the overall policy directionregarding quality of care issues relevant to the whole Division. While each committee communicates and informs all other committees, QMP gives overall direction to the other Committees to analyze, review and make recommendations regarding issues raised in the course of reviewing training, quality improvement or compliance activities.

QMP Membership:

- Section Managers
- Medical Director
- Quality Improvement Manager
- Quality Assurance Managers
- DHS Compliance Analyst
- Administrative Services Officer II

QMP Workgroups:

- Audits Program Workgroup
- Billing and Claiming Workgroup
- CANS/ANSA Steering Committee Workgroup
- Contract Review Workgroup
- Credentialing Workgroup
- DHCS Reviews
- Documentation Workgroup
- Forms Workgroup
- Information Notices Workgroup
- Medical Staff Meeting
- Medication Policy Workgroup
- Patients' Rights
- Policies
- Privacyand Security
- QIC
- QIS
- Sentinel Events Committee
- Training Committee

QUALITY IMPROVEMENT STEERING COMMITTEE (QIS)

The purpose of QIS is to ensure that quality improvement activities are effectively implemented throughout the Division. QIS functions as the central organizing body for the Division. QISreceives directionfrom and provides recommendations to QMP, gives guidance to and receives information and recommendations from QIC. QIS is responsible for reviewing and making recommendations regarding Consumer Satisfaction/Outcomes data and reviewinggeneral documentationand other qualityimprovement issues as the need arises.

QIS Membership:

- Health Program Managers
- Clinical Specialists
- Quality Improvement Manager
- Quality Assurance Managers
- Consumer Affairs Coordinator
- Consumer Manager
- Section Managers
- Medical Director
- Recorder
- Safety Coordinator
- Patients' Rights Advocate

QIS Standing Items:

- Managers' Checklist
- Peer Provider Update
- Sentinel Events
- QI
- QA/Documentation
- Change of Provider Requests and Grievances
- Pre-Billing Audits
- Training Committee Update
- Safety Committee Update
- Clerical Meeting

- ORNC Results
- Medical Staff Meeting Results
- Cultural Responsiveness Committee
- QIC Follow-up

QUALITY IMPROVEMENT COMMITTEE (QIC)

The purpose of QIC is to oversee and be involved in quality improvement activities including exploring policy issues, reviewing and evaluating results of QI activities, andinstituting needed QI actions. The areas of responsibility for the QIC are to monitor andreview consumer relations/outcomes, develop and review an annual QI work plan, review data and work planactivities, andmonitor performance improvement projects.

QIC Membership:

- DHS-BHD Senior Managers
- Behavioral Health Providers (including clinical practitioners and contractors)
- Mental Health and SUD Plan beneficiaries who have accessed specialty mental health services
- Other individuals with lived experience inmental health and substance use disorders
- Healthcare andsocial service providers
- Law enforcement representatives
- Family members and/or significant persons of beneficiaries who have accessed specialty mental health or substance use disorder services

QIC Standing Items:

- System Re-design
- QI Updates (QI Plan, PIPs, EQRO, Consumer Surveys)
- Fire Disaster Recovery
- Training
- MHSA
- Board & Care Subcommittee
- Housing Subcommittee
- CSU Subcommittee

QUALITY IMPROVEMENT PROCESS

The QAPI Program utilizes a variety of QI tools and resources to assess system performance issues and planquality interventions and projects. Refer to Appendix B for a full listing of QI tools that may assist with QAPI activities. The over-arching process utilized by the QAPI program is the Plan-Do-Study-Act (PSDA) Model for Quality Improvement.

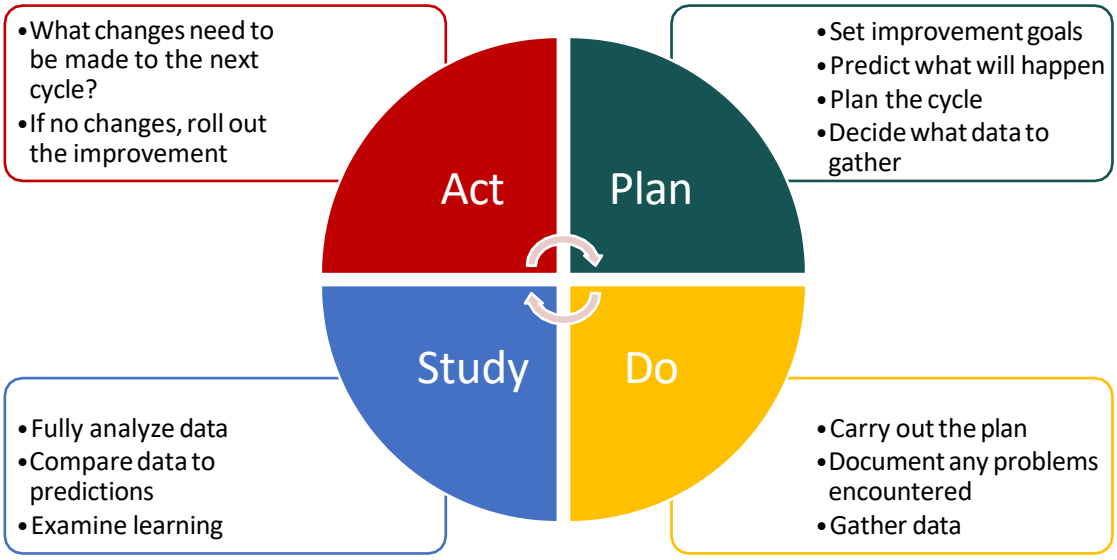
PLAN-DO-STUDY-ACT MODEL FOR QUALITY IMPROVEMENT

Plan: Investigate the current situation, fully understandthe nature of anyproblem to be solved, anddevelop potential solutions to the problem.

Do: Implement the action plan on a test basis.

Study: Compare data results of the new process with those of the previous one.

Act: Decide, basedupon the data, whether to adopt the new process, make slight changes to the process, or to abandon the process and start over. For decisions to adopt or adapt the improvement process, monitor the gains going forward. For decisions to abandon the process, determine a new course.



PERFORMANCE STANDARDS

The QAPI Program annuallyevaluates systemic trends inthe areas of Service Delivery Capacity, Service Accessibility Performance Metrics, and Beneficiary Satisfaction. Specific Performance Targets are outlined as follows.

SERVICE DELIVERY CAPACITY

Service system capacity is reviewed on fiveelements: Geographic Access and Service Distribution; Latinx Service Utilization; Staff Training and Development; Peer Provider Capacity; Language Capacity.

Element	Element Description
Geographic Analysis	The MHP tracks the number, service type, and geographic distribution of mental health services providedby DHS-BHD and contractors.
Latinx Service Utilization	The MHP tracks Latinx service utilization and seeks to increase the Latinx service penetration rate in order to match community Medi-Cal eligible demographics.
Staff Training and Development	DHS-BHD provides at least two mandatory staff development trainings annually on topics related to Cultural Responsiveness. Topics are selected from the top three issues identified in the FY 16-17 Staff Cultural Responsiveness Survey.
Peer Provider Capacity	DHS-BHD tracks andtrends the number of Peer Provider positions allocated throughout the service system.

SERVICE ACCESSIBILITY PERFORMANCE METRICS

The following constitute the standard performance metrics for an MHP:

- 24/7 Access Line Response
- Request to Offered Assessment
- Request to Attended Assessment
- Request to Offered Psychiatry
- Urgent requests
- Post-Hospital Services
- Re-Admission Rates
- No-Show Rates
- TBS Utilization Rate

Metric	Performance Standard
METRIC 1	95% of calls to the 24-hour toll free telephone number willbe answered by a live person to provide informationto beneficiaries about how to access specialty mental health services.
METRIC 2	100% of non-urgent after-hours callers requesting a service willreceive a call back the next business day.
METRIC 3	The average length of time from initial request for services to first offered assessment appointment will be 10 business days or less.
METRIC 4	70% of beneficiaries requesting a mental health assessment will be offered an initial assessment appointment within 10 business days from the date of the initial request for service.
METRIC 5	The average length of time from initial request for services to first kept appointment will be 10 business days or less.
METRIC 6	70% of beneficiaries scheduled for an initial mental health assessment will attend the assessment appointment within 10 business days from the date of the initial request for service.
METRIC 7	The average length of time from initial request to first offered psychiatry appointment will be 15 business days or less.
METRIC 8	70% of beneficiaries requesting psychiatryservices will be offered a psychiatry appointment within 15 business days from the date of the initial request for psychiatry.
METRIC 9	The average length of time from **urgent** service request to actual encounter willbe 48 hours or less.
METRIC 10	95% of the beneficiaries who are screened as needing an **urgent** mental health assessment willreceive services within48 hours.
METRIC 11	The average length of time between post-hospital inpatient discharge and follow-upappointment will be 7 calendar days or less.
METRIC 12	50% of follow-uppost-hospital appointments will be scheduled within 7 calendar days of inpatient discharge.
METRIC 13	The 30-daypsychiatric inpatient re-admission rate will be 10% or less.
METRIC 14	The no-show rate for initial assessment appointments will be less than 10%.
METRIC 15	The no-show rate for psychiatry services will be less than 10%.
METRIC 16	The no-show rate for outpatient clinical services other thanpsychiatry will be less than 10%.
METRIC 17	The MHP will provide Therapeutic Behavioral Services (TBS) at a minimum of a 4% utilization rate of all unique Medi-Cal beneficiaries under the age of 21.

BENEFI CI ARY SATI SFACTION

Beneficiary satisfaction is assessed by the consumer perception survey results and key performance metrics below.

Element	Element Description
Consumer Perception Survey	The MHP collects and submits completed Adult, Older Adult, Youth, and Family/Parents of Youth Consumer Perception Satisfaction Survey data during the review period to CIBHS; analyzes the results; and disseminate the results and analysis to DHS-BHD staff and providers.
Grievances	100% of client grievances will be decided upon and communicated backto the client within 90 days of receiving the grievance.
Appeals	100% of client/family outpatient appeals will be decided upon and communicated back to the client within 60 days of receivingthe appeal.
Fair Hearings	100% of client fair hearing results will be evaluated and if issues are identified, they will be addressed within 60 days of the fair hearing results.
Change of Provider	100% of client requests to change persons providing services will be evaluated and addressed within 30 days of the request.

QUALITY GOALS, OBJECTIVES, AND IMPLEMENTATION

INTRODUCTION

This section presents the overall goals and implementationplan for QI. Overall goals and objectives are determinedannuallyafter review of the prior year's QAPI Plan Evaluation, the findings of the Timeliness Self-Assessment Summary, and the results of the Consumer Perception Surveys. Goals are selected based upontheir potential to increase service capacity, improve system processes, or achieve treatment outcomes.

ACTION PLAN

The QAPI Action Planincludes seven essential domains: Access to Care, Timeliness of Services, Quality of Care, Beneficiary Outcomes, Foster Care, Information Systems, Structure and Operations.

ACCESS TO CARE

Network Adequacy: In FY 19-20, the DHS-BHD Division Management Team workeddiligently to maximize funding opportunities and streamline service system design in order to expandprovider networkcapacity andright-size caseloads. The Admin Program Support Unit recruited for and filled 97 positions for multiple levels of staffing inboth Mental Health services and Substance Use Disorder services. Of these recruitments, 40 staff positions were allocated for direct outpatient mental health services. As a result of these efforts, DHS-BHDmet the provider-beneficiary ratiostandards set forth by DHCS. To continue this forwardmomentum, DHS-BHD is focusing on streamlining the Beneficiary Request for Service/Continuity of Care (BRS/COC) process to increase access to care andminimize service disruptions during transitions of care. Details of this project are outlined below.

Goal	Objectives & Activities	Measure / Standard	Monitoring Timeframe	Responsible
DHS-BHD develops and maintains an adequate provider network to ensure provision of timely, appropriate, and quality care within the reasonable capacity of the service system	At the annual Network Adequacycertification, DHS-BHD will meet the provider-beneficiary ratiostandards identified by DHCS	Provider FTE Targets	Quarterly	Division Leadership Team (Recruitment & Structural Changes)
	• Prioritize staffing recruitments for direct service programs • Maximize contract site capacity through competitive procurement • Expand the student-intern and peer-provider pipeline programs • Enhance the Adult and Youth Access Teams • Right-size caseloads on Full Service Partnership Teams • Consolidate Provider Network data tracking into a centralized database	Adult Psychiatry: 4.06 FTE Youth Psychiatry: 2.64 FTE Adult Outpatient: 37.35 FTE Youth Outpatient: 68.39 FTE	Jul 1, 2020 Oct 1, 2020 Jan 15, 2021 Apr 1, 2021	QI Manager (Data Tracking/Monitoring)

Goal	Objectives & Activities	Measure / Standard	Monitoring Timeframe	Responsible
	By the end of FY 20-21, DHS-BHD will implement a streamlined BRS/COCprocess throughthe Electronic Health Record system	BRS/COC approval timeliness	Monthly	QA Manager (Process and Form Design)
	• Map the required data elements on the BRS/COC Form • Render and test the BRS/COC Form in AVATAR • Map the workflow from beneficiaryrequest through final approval • Develop a User's Manualto support process implementation in AVATAR • Conduct staff and management trainings on form use • Transition to fullyelectronic process	BRS/COC Form utilization rates in AVATAR	Reported at BHPA meeting	QI Manager (AVATAR Implementation)

Cultural Competence: Cultural Responsiveness is a core priority of the QAPI Program, which supports Division Leadership's continuing work to identify and implement strategies for ensuring access for underserved populations. A new Ethnic Services Manager (ESM) was selected in 2019 to oversee cultural responsiveness efforts in the Division. The ESM reconstituted the Cultural Responsiveness Committee (CRC) and updated the Cultural Competence Planto address identified disparities; however, the COVID-19 Pandemic significantly disrupted CRC meetings and activities. Despite these set-backs, the Latino/Hispanic penetrationrates improvedin FY 19-20 by 5%. Cultural competence is a key aspect of all DHS-BHD trainings, and expansionof knowledge and related skills inthis areas are an on-going target of trainings. To guide training topic selection, the 3-year Staff Cultural Responsiveness Survey will be conducted in FY 20-21. Lastly, analysisof Latinx service utilization revealed that for clients requesting services who are not offered an assessment, a muchhigher percentage of Latinx clients are deemed ineligible for the assessment due to not meeting medical necessity for specialty mental health services. DHS-BHDis initiating a Performance Improvement Project to examine Latinx Access Equity. Details of these projects are outlined below.

Goal	Objectives & Activities	Measure / Standard	Monitoring Timeframe	Responsible
DHS-BHD provides culturally responsive services, ensuring equal access for all cultures and demonstrating parity in mental health services for all cultures	Non-Clinical PIP: increase the percentage of Latino/Hispanic clients served to meet/exceed 42%	Percent MHP clients identified as Latino/Hispanic	Monthly	Ethnic Services Manager (Planning)
	• Engage PDSA process to analyze low penetrationrates • Conduct root-cause analysis into Access Barriers • Review screening tools with Cultural Responsiveness Committee to recommend updates • Implement Implicit Bias Training for Access Team staff • Improve data entry accuracy of CSI ethnicity data fields • Recruit/retainbilingual/bicultural staff for the Access Teams	Sonoma County Medi-Cal Population Statistics for Latino Ethnicity = 42%		QI Manager (Data Analytics)

Goal	Objectives & Activities	Measure / Standard	Monitoring Timeframe	Responsible
	During FY 20-21, provide at least two mandatory staff training opportunities on Cultural Competence topics, in which Training Evaluationscores surpassa minimum satisfaction threshold of 4.00	Staff training evaluation aggregate and item scores	Annually	Ethnic Services Manager (Planning and Facilitation)
	• Identify cultural responsiveness gaps from Consumer Perception Survey results • Conduce the 3-Year Staff Cultural Responsiveness Survey • Identify staff knowledge gaps from Cultural Responsiveness Staff Survey • Select and schedule applicable topics	Minimum threshold: 4.00 on Likert scale 1-5 Master Training Schedule Attendance Sheets		QI Manager (Data Analytics)
	During FY 20-21, schedule and facilitate 4 Cultural Responsiveness Committee Meetings	Cultural Responsiveness Committee Schedule	Quarterly	Ethnic Services Manager
	• Recruit andselect dedicated Ethnic Services Manager • Re-develop planning agenda for COVID-impacted services • Schedule meetings in virtual environment	Meeting Minutes Attendance Sheets	Jul-Sep, 2020 Oct-Dec, 2020 Jan-Mar, 2021 Apr-May, 2021	

TIMELINESS OF SERVICES

Access Timeliness: Review of timeliness data for FY 19-20 shows that performance on fulfilling requests for psychiatry with 15 business days has declined. Contributing to this result was the Kincade Fire in November, which resulted in County-wide evacuations for a significant portion of that month. In response to this trend, DHS-BHD is implementing structuralandprocess changes to the Adult Medication Clinic to improve timeliness.

Goal	Objectives & Activities	Measure / Standard	Monitoring Timeframe	Responsible
DHS-BHD ensures timely access to high quality, culturally sensitive services for individuals and their families	By the end of FY 20-21, the average lengthof time from initial request for psychiatry to first offeredpsychiatry appointment will be 15 business days or less.	Average business days from initial request to offered appointment	Monthly	Medication Clinic Leadership(System Implementation)
	• Review scheduling workflow andrevise for efficiency • Right-size prescriber caseloads • Develop and implement Prescriber Caseload report in AVATAR for monthly monitoring • Designate a point-person to case-manage Adult Med Clinic post-hospital referralsand Meds-Only clients.	DHCS target set at 15 days	Reported at BHPA meeting	QI Manager (Data Tracking/Monitoring)

Native American YouthConsumer Satisfaction: Analysisof the Consumer Perception Survey data for CY 2019 revealed significant concerns withinthe Native American Youthconsumer population. Overall, mean scores among Native American Youthshowed significant decline in 2019, with scores falling below the satisfaction threshold in all domains, except Perception of Social Connectedness and Perception of Cultural Sensitivity. In response to this feedback, the Cultural Responsiveness Committee is seeking to add Native American focused training to the Staff Development curriculum.

Goal	Objectives & Activities	Measure / Standard	Monitoring Timeframe	Responsible
DHS-BHD designs quality services that are informed by and responsive to consumer feedback	For Native American Consumer Perception surveys collected in FY 20-21, the satisfaction rate will exceed the 3.5 minimum satisfactionthreshold on all domains	Average domain scores for Native American Youth Consumer Perception Surveys	Annually	Cultural Responsiveness Committee (Planning and Implementation)
	• Invite Native American stakeholders to participate inthe Quality Improvement Committee and Cultural Responsiveness Committee • Provide staff development training focused on Native American clinical interventions andbest-practices	Minimum threshold: 3.5 on a Likert scale 1-5		QI Manager (Data Tracking/Monitoring)

Consistent Provider Practice: In aneffort to increase training resources for both new andexperienced staff, DHS-BHDhas established a formal process to orient and train new staff in Medical Necessity Criteria, Assessment, Client Planning, Risk Assessment, Clinical Documentation, and Recovery-Oriented Language. Additionally, the QAPI team has initiated a project to develop and publisha Provider Handbook for bothcounty staff and community providers. This handbookwill include direction andupdates on current policies and procedures, documentationguidelines, and best-practices.

Goal	Objectives & Activities	Measure / Standard	Monitoring Timeframe	Responsible
DHS-BHD seeks best-practice refinements in service delivery to provide consistent high-quality care	During FY 20-21, 100%of new staff will attend a Documentation NEO within 3 months of hire	Number of new staff trained within 3 months of hire	Annually	UR Manager
	• Develop NEO Curriculum and training materials • Establish notification pathway for tracking new-hires • Implement NEO training schedule	Training Attendance Tracker		
	By the end of FY 20-21, complete an initial draft of the DHS-BHD Provider Handbook	Working Draft	Annually Updated	QA Manager
	• Designate included content • Obtainstakeholder feedback • Finalize Handbookandpublish to website			QI and UR Support

BENEFICIARY OUTCOMES

High-Cost Beneficiaries(HCB): CY 2017 Performance Metrics indicate that the percentage of high-cost beneficiaries in Sonoma County is nearly double that of the State average. The QIC selected this outcome as the focus for a Clinical Performance Improvement Project. Analysisof CY 2018 data revealed that 11.2% of DHS-BHD consumers account for 53.4% of total service costs. Further analysis showed that 13.8% of adult consumers were generating 59.7% of adult service costs; whereas, 5.0% of youth consumers generated 26% of youth service costs. For Adult HCBs, this results in anaverage annual cost of $70,122.45 per consumer compared to adult non-HCBs at $7,579.61 per consumer. Giventhe higher proportion and greater cost impact of adult HCBs, this population was selected as the focus of study. Factor analysis of ANSA element scores revealed that the primarydistinguishing elements between HCBs and non-HCBs are functionallydrivenrather than symptom driven. In examining actionable ANSA score differences between the groups, two key factors were identified for targeted intervention:

Factor One ANSA Items: Community and Connection

- Recreation
- Social Connectedness
- Optimism
- Talents/Interests
- Spiritual/Religious
- Community Connection
- Natural Supports
- Resiliency
- Resourcefulness

Factor Two ANSA Items: Living with Psychosis

- Social
- Living Skills
- Self-Care
- Decision Making
- Involvement in Recovery
- Psychosis
- Impulse Control
- Other Self Harm

The Boston University Psychiatric Rehabilitation Approach (PRA) was selected as aninterventionmodel because it provides an evidence-based approach to functional skill building in psychiatric populations. Unfortunately, the COVIDpandemic disrupted group service interventions. The Clinical PIP is in re-development to adjust to a COVID impacted service system. A Strengths Model program willbe implemented instead, as outlinedbelow.

Goal	Objectives & Activities	Measure / Standard	Monitoring Timeframe	Responsible
DHS-BHD provides recovery-oriented services that promote the ability of consumers to live a meaningful life in a community of their choosing	By the end of FY 20-21, re-development of the Clinical PIP will be complete anda Strengths Model pilot program will commence at FY 21-22.	Completed Revisionof Implementation Plan	Monthly	QI Manager
	• Re-assess baseline data to add FY 19-20 results • Adapt curriculum to COVIDimpacted service system • Develop inclusion criteria for pilot program participation • Produce treatment manual • Develop training plan		Developed in QIC Committee	

Goal	Objectives & Activities	Measure / Standard	Monitoring Timeframe	Responsible
	By the end of FY 21-22, the average actionable items for Factors One and Two for Adult HCBs	ANSA Actionable Item Scores	Quarterly	Adult Services Program Leadership (Implementation)
	• Train a staff cohort of Strengths Model facilitators • Recruit andselect group participants • Implement Strengths Model pilot program • Administer Strengths Assessment to program participants • Create Personal Recovery Plan	Factor One: Community and Connection Factor Two: Living with Psychosis		QI Manager (Planning, Training, Data Trackingand Monitoring)
	By the end of FY 20-21, establisha peer-provider pipeline program with rotations at the Crisis Stabilization Unit to reduce Crisis Service utilization by 10%	Crisis Service utilization rates	Annually	QIC CSU subcommittee (Planning and Implementation)
	• Design peer-provider rotations through the CSU • Train a peer cohort of PRA facilitators • Customize the curriculum to fit a crisis setting • Deliver one-on-one PRA interventions to CSU clients	CSU Peer Pipeline Rotation Schedule Peer Pipeline Program Description Re-Hospitalization rates		QI Manager (Data Analytics)

FOSTER CARE

Data Monitoring and Reporting: A project commencedin FY 19-20 to consolidatefoster youth data capture andmonitoringcapacity into the EHR. This project was disrupted by the COVIDPandemic and willbe carried forward, as outlined below.

Goal	Objectives & Activities	Measure / Standard	Monitoring Timeframe	Responsible
DHS-BHD works collaboratively with FY&C to provide equal access to SMHS for minor and non-minor dependents in foster care	By the end of FY 20-21, consolidate SB 1291 Medication Monitoring metrics into the Electronic Health Record	AVATAR Medication Monitoring Reports	Annually	QI Manager (Data Mapping Research)
	• Identify and mapexisting data systems for tracking HEDIS measures • Consolidate into single data needs summary • Validate against HEDISstandards • Render applicable reports in the Electronic Health Record	HEDIS ADD HEDIS APC HEDIS APP HEDIS APM		AVATAR Change Governance Committee (Implementation)

INFORMATION SYSTEMS

Data System Consolidation: In FY 19-20, DHS-BHDcommenced a project to complete clinicalimplementation of the Electronic Health Record, utilizing consulting and project management resources from the vendor NetSmart. This project presents the opportunity to consolidate external data tracking into a single centralized location. As service data capture migrates, the need for expanded QAPI data reporting from the EHR increases. The COVIDPandemic delayed implementationon this project, so this goal is carried forward and expandedas follows.

Goal	Objectives & Activities	Measure / Standard	Monitoring Timeframe	Responsible
DHS-BHD utilizes centralized information systems to inform mental health planning and service delivery at community and individual levels	By end of FY 21-22, consolidate all external service data tracking systems into the Electronic Health Record, including all requisite reports	AVATAR Monitoring Reports	Annually	QI Manager (Data Mapping Research)
	• Locate and map allexternal tracking databases • Develop data reporting needs list • Design QAPI data reporting dashboard • Render reporting capacity in the Electronic Health Record • Train QAPI and Management staff on utilization and interpretation of the reports	Timeliness Tracking Database Inpatient Hospital Database CSU Database Referral Management Database		AVATAR Change Governance Committee (Implementation)
	By end of FY 20-21, implement prototype Audits and Monitoring database to expandcompliance tracking and trending capabilities	Audits and Monitoring Database	Annually	Audits and Monitoring Manager
	• Map existing Audits and Monitoring team tools • Design Audits and Monitoring Access database • Implement and test prototype • Import 3-year lookback of historical audit results data	Compliance Trend Reports		

STRUCTURE AND OPERATIONS

QAPI Program Process Improvements: During FY 19-20, the QAPI Team implemented Phase I of the QAPI Communication Plan, which includedincreased data reporting at all levels of the organization, and increase documentationtraining opportunities andtechnical assistance. Phase II has commenced in FY 20-21 andwill focus on website design and content, to increase public-facing data sharing andsupport. The COVID pandemic causeddelays in the formal system assessment process, sogoals in this area will be carried forwardinto FY 20-21. Additional focus will be given to completionof a formal quality systems riskassessment and mitigation plan to augment and support compliance activities.

Goal	Objectives & Activities	Measure / Standard	Monitoring Timeframe	Responsible
DHS-BHD seeks for continuous process improvement of service system structures and operations to maximize utilization of best-practices	During FY 20-21, conduct a formal assessment of organizational quality culture, utilizing the QI SAT 2.0 Tool	QI SAT 2.0 Tool	Annually	QI Manager
	• Review the QI SAT Tool in QIC and QIS • Select survey questions • Schedule survey window • Distribute survey to direct service staff andmanagers • Analyze results to establish baseline state • Review recommended strategies for each domain • Select and implement strategies in next QI Plan	Leadership Commitment QI Infrastructure Employee Empowerment Client Focus Teamwork & Collaboration Continuous Process Improvement	Results reported to Division	
	By end of FY 20-21, complete a formal quality risk assessment and mitigation plan	Behavioral Health Quality Risk Assessment	Annually	QI Manager
	• Identify key regulatory requirements • Conduct Compliance Risk Assessment • Designate lead monitors for top compliance risks • Conduct Control Assessment • Initiate Mitigation Plan	Inherent Risk Assessment Control Assessment Risk Assessment Matrix	Results Monitored in BHPA	
	By end of FY 20-21, complete andimplement a QAPI Communication Plan: Phase II	Communication Plan Phase II: QAPI website	Annually	QI Manager
	• Identify Quality Tools, Reports, and Content for QAPI website • Complete wireframe model of hierarchy of content • Establish navigation and design features • Launch QAPI website	Management Staff Community Providers Consumers Public	Review in QIC	

GOAL SUMMARY

The following table summarizes the QAPI goals for FY 20-21.

Goal	Objectives
DHS-BHD develops and maintains an adequate provider network to ensure provisionof timely, appropriate, and quality care within the reasonable capacity of the service system	At the annual Network Adequacycertification, DHS-BHD will meet the provider-beneficiary ratio standards identifiedby DHCS

Goal	Objectives
	By the end of FY 20-21, DHS-BHD will implement a streamlined BRS/COCprocess throughthe Electronic Health Recordsystem
DHS-BHD provides culturally responsive services, ensuring equal access for all cultures and demonstrating parity in mental health services for all cultures	Non-Clinical PIP: increase the percentage of Latino/Hispanic clients served to meet/exceed 42% During FY 20-21, provide at least two mandatory staff training opportunities on Cultural Competence topics, inwhich Training Evaluationscores surpassa minimum satisfaction threshold of 4.00 During FY 20-21, schedule and facilitate 4 Cultural Responsiveness Committee Meetings
DHS-BHD ensures timely access to high quality, culturally sensitive services for individuals and their families	By the end of FY 20-21, the average length of time from initial request for psychiatry to first offered psychiatryappointment will be 15 business days or less
DHS-BHD designs quality services that are informed by and responsive to consumer feedback	For Native American Consumer Perception surveys collected in FY 20-21, the satisfaction rate will exceed the 3.5 minimum satisfaction threshold on all domains
DHS-BHD seeks best-practice refinements in service delivery to provide consistent high-quality care	During FY 20-21, 100%of new staff will attend a Documentation NEO within 3 months of hire By the end of FY 20-21, complete an initial draft of the DHS-BHD Provider Handbook
DHS-BHD provides recovery-oriented services that promote the ability of consumers to live a meaningful life in a community of their choosing	By the end of FY 20-21, re-development of the Clinical PIP willbe complete and a Strengths Model pilot program will commence at FY 21-22. By the end of FY 21-22, the average actionable items for Factors One and Two for Adult HCBs By the end of FY 20-21, establisha peer-provider pipeline program with rotations at the Crisis Stabilization Unit to reduce Crisis Service utilization by 10%
DHS-BHD works collaboratively with Child Welfare Systems to provide equal access to specialty mental health services for minor and non-minor dependents in foster care	By the end of FY 20-21, consolidate SB 1291 Medication Monitoring metrics into the Electronic Health Record
DHS-BHD utilizes centralized information systems to inform mental health planning and service delivery at community and individual levels	By end of FY 21-22, consolidate all external service data tracking systems into the Electronic Health Record, including all requisite reports By end of FY 20-21, implement prototype Audits and Monitoring database to expand compliance tracking and trending capabilities
DHS-BHD seeks for continuous process improvement of service system structures and operations to maximize utilization of best-practices	During FY 20-21, conduct a formal assessment of organizational quality culture, utilizing the QI SAT 2.0 Tool By end of FY 20-21, complete a formal quality risk assessment andmitigationplan By end of FY 20-21, complete andimplement a QAPI Communication Plan: Phase II

PERFORMANCE IMPROVEMENT PROJECTS

INTRODUCTION

This section describes the process for QI project identification, prioritization, and selection of team members. Information about current and past projects may be obtained from QIC or the QI Manager.

PROJECT SELECTION

The QAPI Program conducts at least two performance improvement projects (PIPs) annually: a clinical PIP and a non-clinical PIP. Projects are driven by consumer and system need, data, and related research.

PROJECT NOMINATION

Potential QI projects are identified by staff members, managers, consumers, contractors, peers, and family members. The QAPI Program has developed a Quality Improvement Project Nomination Form available to aforementioned groups for submitting project ideas directly to the QI Manager and QIC for consideration. Individuals may also informally suggest changes to supervisors, managers, or the QAPI section manager.

SELECTION REVIEW PROCESS

All submitted Project Nomination Forms are reviewed and recorded for possible implementation. Additionally, upon receipt of the annual EQRO report, the QI manager and QI specialist conduct a detailed review of the findings. The report in its entirety is shared at the next monthly QIC meeting to initiate project brainstorming sessions. Discussion includes a focus on last year's performance improvement projects and implications. The QIC examines opportunities for improvement and considers direct recommendations by the EQRO to inform project selection.

Factors considered for topic selection include:

- QIC committee member interest
- Leadership team priorities
- Alignment with the strategic plan and mission
- Consumer survey results
- Staff survey results/suggestions
- Program outcome evaluations
- Audit or compliance issues
- Number of consumers impacted
- Financial consequences
- Availability of resources
- Timeliness
- Access to services

Selected projects are documented in the QIC minutes and put forth for prioritization discussion.

PROJECT PRIORITIZATION

QIC focuses on prioritizing projects that have the widest consumer and community reach, impact individuals with greatest need, and are data driven with clear outcome indicators. Prioritized projects are submitted to QMP for high level review and approval to ensure alignment with agency strategic plan and mission.

PROJECT TEAM MEMBERSHIP SELECTION

Team members are selected in QIC under the leadership of the QI manager. Subject matter expertise, diversity of representation, and availability are primary factors in membership selection. The objective is to obtain cross-sectional representation in terms of the scope of the project and related problem areas. Teams typically consist of five to seven members that meet as needed and report progress back to QIC monthly.

SPECIALIZED STAFFING AND RESOURCE NEEDS

Special project needs are identified by QIC members or project team members on subcommittee. These needs include but are not limited to the following:

- Specialized training requirements
- Custom dataset specifications
- Data analysissoftware capabilities
- Subject matter expertise

FINAL SELECTION AND APPROVAL

Once projects have been identified, priorities assessed, system needs evaluated, and team members selected, a formal recommendation is presented to QMP for review. QMP either approves, revises, or rejects the project proposal.

CURRENT PROJECTS

Current QI Projects are outlined as follows. A list of past QI Projects in included in Appendix C.

ENHANCING COMMUNITY CONNECTION AND LIVING SKILLS TO REDUCE HIGH COST SERVICE UTILIZATION (CLINICAL PIP)

Out of all adult consumers in DHS-BHD, 13.8%account for 59.7% of all adult service costs. These individuals are high cost beneficiaries (HCBs) that have an average annual service cost of $70,122.45 per consumer. DHS-BHD had planned to use the Boston University Psychiatric Rehabilitation Approach in groups and individual sessions to empower consumers with social, connection, andrecoveryskills whichwill enable them to utilize community resources andnatural supports rather than crisis services. However, the COVID-19 Pandemic suspended group treatment formats. As a result, this PIP is being re-designed to implement the Strengths Model Approach, an evidence-based practice which has demonstrated effectiveness with high-needs populations, andis more adaptable to the constraints of COVIDprecautions. Initialdesign will target consumers in Full Service Partnership (FSP) programs with plans to expandto the Outpatient Teams, Crisis Stabilization Unit (CSU), and residential treatment programs if promising results are obtained.

IMPROVING LATINX EQUITY WITHIN THE BEHAVIORAL HEALTH ACCESS PROCESS (NON-CLINICAL)

Analysis of Latinx service utilization revealed that for clients requesting services who are not offered an assessment, a much higher percentage of Latinx clients are deemed ineligible for the assessment due to not meeting medical necessity for specialty mental health services. Data analysis also revealed that Latinx clients were much less likely to decline services or drop out due to non-contact when compared to non-Latinx clients. These findings suggest a systemic barrier to Access for Latinx identified clients, and DHS-BHD has commenceda root-cause analysis to explore the nature of this equity barrier. System changes andinterventions will be targeted to the identified causes. This PIP is currentlyin the Development and Planning Phase, with the goal to complete the PIP design by the end of FY 20-21, and commence interventions at the onset of FY 21-22.

TRAINING

INTRODUCTION

Training is a vital element of QAPI efforts to empower staff in the utilization of quality improvement tools and techniques to effectivelyachieve the agency's mission. This sectionoutlines the QAPI Training Plan components.

TRAINING AND SUPPORT

QI training includes new employee orientations, focused technical assistance targeted to specific teams or staffing levels, division wide staff development, andcommunity provider support. Trainings related to appropriate clinical documentation are provided by the Utilization Review Manager. Trainings related to electronic health records are providedby the Quality Improvement Clinical Specialist. Staffdevelopment and other specific quality improvement trainings are provided by the Quality Improvement Manager.

NEW EMPLOYEE ORIENTATION

Avatar and DCAR Training: Training for how to use both of these electronic healthrecords (EHRs)is provided by the Quality Improvement Clinical Specialist. All new DHS-BHDstaff members withjobs falling under clerical, clinical, medical, and supervisory roles receive training on how to interface with Avatar. All new DHS-BHD staff with clinical roles and those needing read onlyaccess in other roles receive training on how to interface with DCAR. A training covering Avatar, DCAR, or both is scheduled within the first two weeks of employment. Staff are required to complete trainingbefore being granted loginaccess to both EHR systems. All staffcompleting clinical assessments of anykind must complete a CANS or ANSA certification on the PRAED foundation website. https://www.schoox.com/login.php

New Employee Documentation Trainings: These trainings are offered every 1-3 months based on staffing needs. They are required for new Sonoma County employees (Senior Client Support Specialists, Clinicians/Clinician Interns, Clinical Specialists, and Program Managers) who willbe billing Medi-Cal, and for existing employees transferring from non-Medi-Cal to Medi-Cal programs. Sessions are alsoopen to existing employees who have been identifiedas needing additional training. Course content covers:

- Medical Necessity
- Assessments (non-ANSA/CANS portion)
- Procedure Codes
- Progress Notes
    - Format & Content
    - Non-Billable Services
    - Claiming for Services
- Client Plans
- MAA codes
- Post-Psychiatric Hospitalization Visit, Suicide Risk Assessment, Violence Risk Assessment
- Recovery-Oriented and Respectful Language

Individual trainings are provided to psychiatric nurses andpsychiatric providers that cover those areas relevant to the documentation they are expected to complete.

Trainings are provided by the Utilization Review Manager and Utilization Review Clinical Specialist

FOCUSED TRAINI NGS

Individual Program Trainings: Individualized trainings are provided either uponrequest, or inresponse to an identified deficit as part of a corrective action plan. The content of these trainings is created on a case by case basis depending on identified deficits. Trainings are provided by Utilization Review Manager. Topics have included:

- Client Plangoals andinterventions
- Procedure codes
- Progress Note content and format
- Streamlining documentation time
- IHBS & ICC codes
- CSU Denial of Rights documentation

Clinical Specialist Monthly Meetings: In order to increase expertise in clinical documentation, comfort inmonitoring, and standardization of documentationsupervision, clinical specialists supervising clinical staff are required to attend monthly trainings with the Utilization Review Manager.

Nursing Staff Monthly Meetings: The Utilization Review Manager acts as a documentationliaison and attends monthly nursing staff meetings to answer anydocumentationquestions.

Medical Staff Monthly Meetings: The Utilization Review Manager acts as a documentation liaison andattends monthly meetings with licensed prescribers to answer anydocumentationquestions.

BEHAVI ORAL HEALTH DIVISION TRAININGS

Documentation Minute: Commonly occurring documentation problems that are pervasive across DHS-BHD teams are addressed at monthly divisionmeetings. These are brief 10-15 minute trainings provided by the Utilization Review Manager to all staffin attendance at the Division-wide staff meeting.

Staff Development Trainings: Division-wide staff development trainings are provided to inform staffof significant policy revisions and procedural changes resulting from regulatory updates. These trainings are facilitated by QAPI Managers.

COMMUNI TY PROVIDER TRAI NINGS

Documentation Trainings: Contractor trainings for community based organizations (CBOs) are typically provided every 2 months on an as needed basis and uponrequest. Topics have included:

- Procedure codes
- Progress Note content and format
- Client Plangoals andinterventions

Additionally, contractors are provided with aninstructional manual to assist with documentation. These trainings are providedby the Utilization Review Manager.

LEADERSHIP TRAININGS

Quality Improvement Committee Trainings: The QI Manager facilitates intermediate andadvanced QI trainings for the QIC on QI processes, QI Tools, and PIPs. These trainings are held quarterly.

Mental Health Board(MHB) Trainings: The MHB hosts anannual QI-themed training focusedon specific elements of Trauma-Informed Care. The QI Manager assists inproviding this training material.

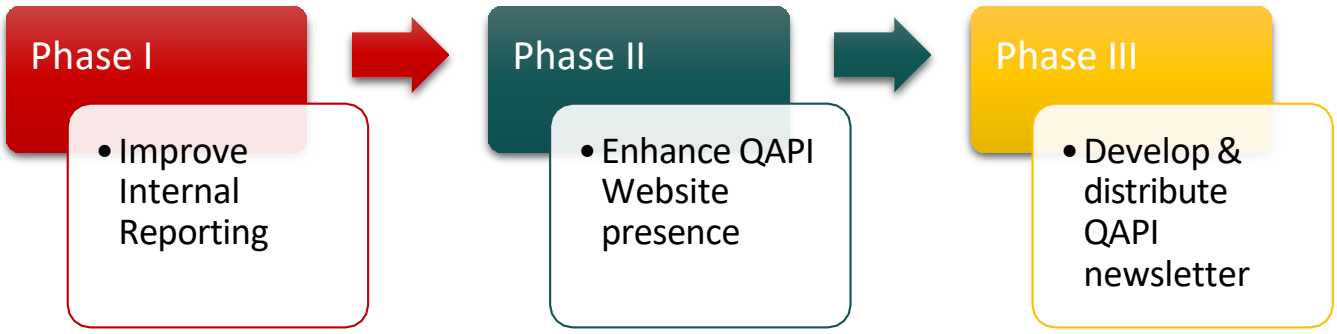
COMMUNICATION

INTRODUCTION

In order to support quality as a usual-way-of-business, quality-related news is communicated on a regular basis using a variety of methods to staff, consumers, community providers, the Mental Health Board, and the general public. This section describes how quality initiatives are shared.

COMMUNI CATION PLAN

The QAPI Sectionhas designed a Quality Sharing Communication Plan, to be implemented in three phases.



PHASE I: IMPROVE INTERNAL REPORTING

During FY 19-20, the QAPI Team implemented Phase I of the Quality Sharing Communication Plan, whichincluded increased data reporting at alllevels of the organization, andincrease documentation training opportunities andtechnical assistance. This phase commenced with the identification of quality initiatives in the categories of leadership, training, projects, outcomes, andpolicies.

Quality Category	Quality Initiatives	Lead	Communication Method
Leadership	• System Efficiency Re-design • Continuum of Care • Capacity Expansion • Productivity Maximization	DMT/QAPI	Division Staff Meeting
Training	• Documentation Training • New Employee Orientations	UR Manager/WET	Documentation Minute
Projects	• Performance Improvement Projects • Consumer Perception Survey Results	QIC	Division Staff Meeting
Outcomes	• Contract Performance Goals • Team Clinical Outcome Trends	QI/Contracts Unit	Contractor Meeting
Policies	• Network Adequacy • NOABDs • Continuity of Care • Concurrent Review	QA Manager	Staff Development Trainings

PHASE II: ENHANCE QAPI WEBSITE PRESENCE

The QAPI Website Workgrouphas been convened to implement Phase II of the Quality Sharing Communication Plan. This workgroup is taskedwith the following:

- Identify Quality Tools, Reports, and Content for the QAPI website
- Gather stakeholder input from QIC
- Complete the wireframe model of hierarchy of content
- Establish navigation and design features
- Launch the QAPI website

PHASE III: QAPI NEWSLETTER

In FY 21-22, a sub-committee of QIC will convene to establish content parameters, target audiences, anddistribution methods for the QAPI newsletter.

QUALITY SHARING

QAPI updates and activities are communicated at multiple levels of the organization, and include topics such as leadership initiatives, trainingopportunities, project proposals, treatment outcomes, and policyupdates.

ALL EMPLOYEES

- In the Division All-Staff Meetings:
  - Presentations of QI projects completed, withreport of experiences andresults
  - Recognitionandacknowledgment of team contributions
  - Project storyboards
  - EQRO results
- On the shared electronic drive:
  - All QIC and QIS meeting documents (agendas, summaries, data tools, storyboards) are stored and available for review
- By all-staff email distribution:
  - Results andanalysis of Consumer Perception Surveys, distributed annually
  - Results andanalysis of Staff Perception Surveys, distributed as completed

COMMUNITY PROVIDERS

- By email distribution list:
  - QIC system data analyses andresults summaries
  - Peer Center events and activities

MENTAL HEALTH BOARD

- Through the MHB Liaisonto QIC:
  - Updates on QAPI Planactivities
  - Results andanalysis of Consumer Perception Surveys
  - Results of EQRO

PUBLIC

- On the DHS-BHD website:
  - The annual QAPI Plan and the prior year Plan Evaluation results
  - The Network Provider Directory

MONITORING AND EVALUATION

INTRODUCTION

This section describes the monitoring and evaluation for the QI Plan, associated goals, and Behavioral Health System compliance. A QI Monitoring Activity Timelineis included in Appendix D. The System Auditing and Monitoring schedule is included in Appendix E.

QI METRICS/PERFORMANCE MEASURES

The QAPI program tracks and monitors a variety of metrics and performance measures to assess system quality.

PERFORMANCE MEASURES

At the annual EQRO review, DHS-BHDis validated on the following eight mandatory Performance Measures as defined by DHCS:

- Total beneficiaries served by each county MHP
- Penetration rates in each county MHP
- Total costs per beneficiary servedby eachcounty MHP
- High-Cost Beneficiaries (HCBs) incurring $30,000 or higher in approvedclaims during a calendar year (CY)
- Count of Therapeutic Behavioral Services (TBS) beneficiaries served compared to the 4 percent Emily Q Benchmark(not included in MHP reports; this information is included in the Annual Statewide Report submitted to DHCS)
- Total psychiatric inpatient hospital episodes, costs, and average length of stay (LOS)
- Psychiatric inpatient hospital 7-day and 30-dayrehospitalization rates
- Post-psychiatric inpatient hospital 7-day and 30-day SMHS follow-up service rates

In addition, the EQRO review examines the following SB 1291 Performance Measures (Chapter 844; Statutes of 2016):[1]

- The number of Medi-Cal eligible minor and nonminor dependents
- Types of mental health services provided to children, including preventionandtreatment services; these types of services may include, but are not limited to, screenings, assessments, home-based mental health services, outpatient services, daytreatment services or inpatient services, psychiatric hospitalizations, crisis interventions, case management, and psychotropic medication support services
- Performance data for Medi-Cal eligible minor and nonminor dependents in Foster Care (FC)
- Utilization data for Medi-Cal eligible minor and nonminor dependents in FC
- Medication monitoring consistent with the childwelfare psychotropic medication measures developed by the State Department of Social Services and any Healthcare Effectiveness Data and Information Set (HEDIS) measures related to psychotropic medications, including, but not limited to, the following:

[1] Public Information Links to SB 1291 Specific Data Requirements:
1. EPSDT POS Data Dashboards:
http://www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx
2. Psychotropic Medication and HEDIS Measures:
http://cssr.berkeley.edu/ucb_childwelfare/ReportDefault.aspx includes:
- 5A (1&2) Use of Psychotropic Medications
- 5C Use of Multiple Concurrent Psychotropic Medications
- 5D Ongoing Metabolic Monitoring for Children on Antipsychotic Medications New Measure

http://www.dhcs.ca.gov/dataandstats/Pages/Quality-of-Care-Measures-in-Foster-Care.aspx

- Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication(HEDIS ADD)
- Use of Multiple Concurrent Antipsychotics in Childrenand Adolescents (HEDIS APC)
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP)
- Metabolic Monitoring for Childrenand Adolescents on Antipsychotics (HEDIS APM)

- Access to, andtimeliness of, mental health services, as describedin Sections 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of Title 28 of the California Code of Regulations and consistent with Section 438.206 of Title 42 of the Code of Federal Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC
- Quality of mental health services available to Medi-Cal eligible minor andnonminor dependents in FC
- Translation and interpretation services, consistent with Section 438.10(c)(4) and (5) of Title 42 of the Code of Federal Regulations and Section 1810.410 of Title 9 of the California Code of Regulations, available to Medi-Cal eligible minor and nonminor dependents in FC

QI OUTCOME METRICS

Measures of Efficiency

Outcome	Description of Associated Measure
Time saved	Time to complete a specific process or deliver a specific service
Reduced number of steps	Number of steps to complete a specific process or delivery of a specific service
Revenue generatedfrom billable service	Revenue generated by changing the implementation of a billable process or service
Costs saved	Cost to complete a specific process or deliver a specific service
Costs avoided	Cost avoided because of changes in a specific process or delivery of a specific service

Measures of Effectiveness

Outcome	Description of Associated Measure
Increased client or staff satisfaction	Percentage of clients or staff who report being satisfied or extremely satisfied with a specific service or process
Increased reach to a target population	Percentage of target populationthat has been offered, received, or completed a specific behavioral health service or program
Dissemination of information, products, or evidence-based practices	Percentage of individuals or behavioral health partner organizations reached through dissemination of information, products, or evidence-based practices
Quality enhancement of services or programs	Descriptionof issue or improvement opportunity and its resolutionfor a specific service or program
Quality enhancement of data systems	Descriptionof issue or improvement opportunity and its resolutionfor a specific data or health information system
Organizational design improvements	Descriptionof improvements to organizational operations, business processes, or service/program delivery resulting from specific organization design efforts
Increased preventive behaviors	Percentage of preventive or behavioral health-promoting behavior or early indicators of preventive behaviors in a target population
Decreased incidence or prevalence of risk behaviors	Percentage of individuals with risk behaviors in the target population

QI PLAN MONITORING

In January of each year, the QIC reviews the recommendations indicated inthe EQRO final report to identify areas for further data review and analysis. The results of these analyses initiate brainstorming sessions on potential improvement ideas.

In July of each year, the QI manager commences anevaluationof the previous fiscal year QI Plan and activities. This is conducted throughdata analysisof plan goal metrics andfacilitated discussion at QIC. Evaluation will address:

- Progress towardand/or achievement of goals as outlined in the Goals, Objectives and Implementation section
- Effectiveness of goal interventions
- Effectiveness of the QI Plan inoverseeingquality projects and integration within the agency
- Clarity of the QI Plan and its associated documents
- Satisfaction survey results
- Lessons learned

A report of this evaluationandsubsequent actions will be usedin conjunction with a review of the QI Plan itself to revise the QI Plan.

QI PROJECT MONITORING

QI Project Teams will provide project progress reports to the QIC once per quarter. The QI Manager will develop and submit project storyboards at the conclusionof the project. Withinone month of a project's finalization, all team members will be surveyed to determine QI process learning, perceived contribution to the project, value of the project experience and ultimate outcome, lessons learned, andsuggestions for overall agency QI efforts.

BEHAVIORAL HEALTH SYSTEM RISK ASSESSMENT

The QAPI Unit has engaged ina Behavioral Health System Risk Assessment process inorder to buildan integrity culture, mitigate top compliance risks, and improve issue response.

Project Objectives:

- Demonstrate capability to proactively identify, assess, and mitigate risk
- Support existing strategic and budget planningprocesses
- Establish foundation for Quality Monitoring program that best meets regulatory objectives

Project Challenges:

- Changing behavioralhealth regulatoryenvironment (e.g., CalAIMInitiative, COVID Waiver)
- Project resources andsupport
- Clinical system complexity

Key Principles of Project:

- Simplicity and transparency
- Inclusion
- Utility

CORE PROCESSES

ASSESSMENT METHODOLOGY

The Key Components of the Behavioral Health Risk Assessment will be assessed on the following scale:

Rating	Oversight/Governance	Control Description	Repeatability
Optimized	Leadershipoversight is pro-active	Controls in place; regular risk-based testing	Strategies to make processes more efficient
Managed	Leadershipoversight is active	Controls in place; adhoc testing	Reevaluationandupdatingof methods
Defined	Leadershipoversight is continuous	Controls in place to cover requirements; no testing	Uniform processes and repeatable
Repeatable	Leadershipoversight is sporadic	Some but not all controls in place; some controls outdated	Highly dependent on actions and know-how of people close to the issue
Initial	No Leadership oversight	No institutional controls	Ad hoc

PROJECT DEVELOPMENT: DESIRED END-STATE

The Behavioral Health System Risk Assessment Project targets objectives in eight key component areas:

- Leadership Engagement
- Regulatory Inventory
- Risk Assessment & Planning
- Policies
- Training
- Audits & Monitoring
- Issue Response
- Remediation

Key Component	Essential Elements	Optimized State
Leadership Engagement	• Governance • Integrity • Leadership expectations	• A governance process ensuring ongoing ownership and reporting, which links Clinical Programs, the Behavioral Health Division, and the Health Services Department • DHS-BHD leaders take responsibility for ensuring integrity in programs and units • DHS-BHD leaders understand their legal andpolicy obligations, and take responsibility for owning their compliance risks
Regulatory Inventory	• Subject matter experts • Material requirements • Early warning of change	• Identification of subject matter experts for all material requirements • Identification of all material legal andregulatory requirements • Formalized process for identifying new requirements due to regulatory or operational changes
Risk Assessment & Planning	• Risk assessment • Monitoring planning • Updating	• Standardized riskassessment of material behavioral health requirements • Developed monitoring plans to ensure ownershipand proactive mitigation planning for all top risks • Risk assessment and monitoring plans updated annually to reflect change andthe effectiveness of prior planning efforts
Policies	• Capture legal requirements • Communication • Approval and inventory	• Policies exist around allkey requirements, and policies accuratelyreflect requirements • Policy requirements clearly and effectivelycommunicated to all relevant personnel • Streamlined structure to review, approve, and update policies • Inventory of all policies
Training	• Delivery andgovernance • Tracking	• Training deliverysystem and governance process to ensure training content reflects requirements, trainingis delivered to appropriate personnel, training is effective, and training load is streamlined • Process for tracking assignment and completionof all training
Auditing & Monitoring	• Standards • Plan	• Auditing and monitoring standards to measure effectiveness of controls in meeting requirements • Plan for comprehensive, risk-based auditingandmonitoring to ensure prioritized testing of controls around requirements
Issue Response	• Appropriate response • Reporting	• Processes to ensure appropriate response to compliance issues (internal andexternal) to enable accurate, timely, andfair resolutions • Channels to ensure reporting to senior leaders on compliance issues to support accountability and necessary corrective actions
Remediation	• Corrective actions • Reporting	• Standardized corrective action reports • Tracking and reporting on implementation and effectiveness of corrective actions

INHERENT RISK ASSESSMENT

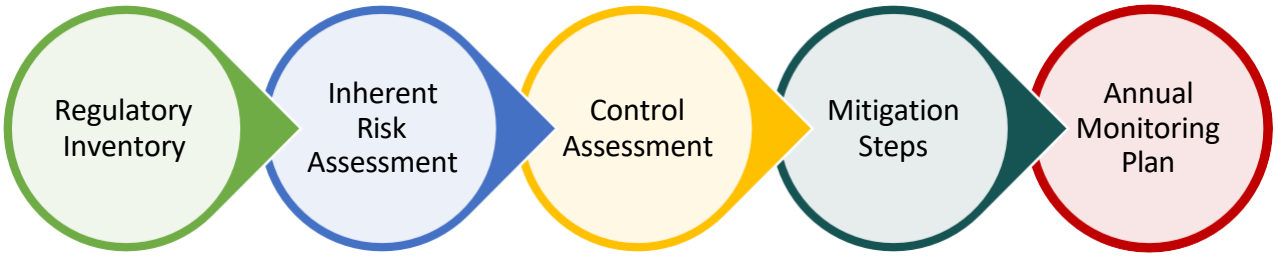
The Inherent Risk Assessment is anassessment of the severity of risk areas without mitigation. Severity of risk is scored as a product of Impact and Likelihood. The Impact Ratingconsiders four key areas: Financial, Reputational, Clinical, and Regulatory. The Likelihood Rating considers the frequency of the riskevent occurring without existing controls in place. The combinedscore sets the base-line risk for eachfocus area of the mitigationplan.

CONTROL ASSESSMENT

The control assessment measures the effectiveness of efforts to mitigate identified risk areas. Mitigation efforts are considered along the followingdimensions: Policy Requirements; Program Controls and Operational Consistency; Monitoring and Reporting. The resulting Control Score is applied to the Inherent Risk to determine Residual Risks inneed of further mitigation.

MONITORING PLAN OUTPUT

The end goal of the Behavioral Health Risk Assessment Project is to producea Risk Monitoring Plan, updated annually, which establishes a risk monitoring framework, defines risk mitigationactivities, andoutlines issue response processes. The steps for completion of this project are outlined below:



AUDITS AND MONITORING REVIEWS

The Audits and Monitoring Team (AMT) conducts detailed internal and contract-site audits to review and document compliance with contractual, state, and federal regulations. The FY 20-21 Audits and Monitoring schedule is included in Appendix E of this Plan.

AMT has commenced a project to implement a database tool that will expand compliance tracking and trending capabilities. This project beganby mapping existingAMT tools, whichinformed the design and rendering of the Audits & Monitoring Database. Implementationandtesting of the prototype database is expected by the end of the fiscal year.

LIST OF APPENDICES

APPENDIX A: GLOSSARY OF TERMS

A

Access

Access is the potential for or actual entry of a populationinto the health system. Entry is dependent upon the wants, resources, andneeds that individuals bring to the care-seeking process. The ability to obtainwanted or needed services may be influenced by many factors, including travel, distance, waitingtime, available financial resources, andavailability of a regular source of care. Access also refers to the extent to which a public health service is readily available to the community's individuals in need. Accessibility alsorefers to the capacity of the agencyto provide service insucha way as to reflect and honor the social andcultural characteristics of the community andfocuses on agency efforts to reduce barriers to service utilization.

Accreditation

Accreditationfor public health departments is definedas:

1. The development andacceptance of a set of national public healthdepartment accreditation standards;
2. The development andacceptance of a standardized process to measure health department performance against those standards;
3. The periodic issuance of recognitionfor health departments that meet a specified set of nationalaccreditation standards; and
4. The periodic review, refining, andupdating of the national public health department accreditation standards and the process for measuring andawarding accreditation recognition.

Advisory Board

Advisory boards of health report to a health officer and city, county, or township commissioners or trustees (the title varies). Advisory boards make recommendations and offer guidance on programs, policies, and budgets for public health and behavioral health operations. These recommendations are acted upon by those havingthe legal authority to govern.

After Action Report (AAR)

An After Action Report (AAR) is a narrative report that provides a description and analysis of performance during an emergency operationor exercise, identifying issues that need to be addressed, as well as recommendations for corrective actions. The Homeland Security Exercise and Evaluation Program (HSEEP) lists the following four sections as the required contents for the body of an AAR:

- Section 1: Exercise Overview (includes identifyinginformation, such as the exercise name, date, duration);
- Section 2: Exercise Design Summary(includes the overarching exercise purpose andgoals; capabilities, activities, and tasks identified for demonstration; exercise objectives; summary of designed initiating event(s)/ key scenario events; and planned simulations);
- Section 3: Analysis of Capabilities; and
- Section 4: Conclusion.

Alignment

Alignment is the consistency of plans, processes, information, resource decisions, actions, results and analysisto support key organization-wide goals.

All Hazards Plan

An all hazards planis anaction planfor the jurisdictiondeveloped to mitigate, respond to, andrecover from a natural disaster, terrorist event, or other emergencythat threatens people, property, business, or the community. The plan identifies persons, equipment, and resources for activation in anemergencyandincludes steps to coordinate andguide the response and recoveryefforts of the jurisdiction.

Appointing Authority

The appointing authority is the person with the power to hire the director of the health department.

Assessment

Assessment is defined as:

1. Collecting, analyzing, andusing data to educate and mobilize communities, develop priorities, garner resources, and plan actions to improve public/behavioral health.
2. One of the three core functions of public health, involving the systematic collectionandanalysis of data in order to provide a basis for decision-making. This mayinclude collecting statistics on community health status, health needs, community assets and/or other public health issues. The process of regularly and systematically collecting, assembling, analyzing, and makingavailable informationon the healthneeds of the community, including statistics on healthstatus, communityhealth needs, andepidemiologic andother studies of health problems.

Assurance

As one of the core functions of public health, assurance refers to the process of determining that "services necessary to achieve agreed upon goals are provided, either by encouraging actions by other entities (public or private sector), by requiring suchaction throughregulation, or by providing services directly." (Institute of Medicine, *The Future of Public Health.* Washington, DC: National Academy Press; 1988).

At-Risk Populations

Certain factors will increase a person's risk of negative outcomes on health, safety, and well-being; they may experience significant barriers, andtherefore need help maintaining medical care, food, andshelter. Factors that increase the risk of harm, for example, duringa natural disaster include:

- Economic disadvantage (e.g., having too little money to stockpile supplies, or to stay home from work for even a short time);
- Absence of a support network (e.g., some children; homeless; travelers; andthe socially, culturally, or geographically isolated);
- Requiring additional support to be independent in dailyactivities because of a physical, mental, or developmental disability; substance abuse or dependence; visionor hearing impairment; or certain other medical or physical conditions; or,
- Difficulty reading, speaking, or understanding English.

These factors are typical of at-riskpopulation characteristics.

Audit

An audit is a formal examination of anorganization's or individual's accounts or financial situation.

B

Benchmarks

Benchmarks are points of reference or a standardagainst whichmeasurements can be compared. In the context of indicators andbehavioral health, a benchmark is an accurate data point, which is usedas a reference for future comparisons (similar to a baseline). Sometimes it also refers to "best practices" ina particular field. Communities compare themselves against these standards. Manygroups use benchmark as a synonym for indicator or target.

Best Practices

The best clinical or administrative practice or approach at the moment, given the situation, the consumer or community needs and desires, the evidence about what works for a particular situation and the resources available. Organizations often also use the term "promising practices" which maybe defined as clinical or administrative practices for which there is considerable practice-based evidence or expert consensus which indicates promise in improving outcomes, but for which are not yet proven by strong scientific evidence.

C

Capacity

Capacity consists of the resources andrelationships necessary to carry out the core functions and essential services of behavioral health; these include humanresources, information resources, fiscal and physical resources, and appropriate relationships among the system components.

Cluster Evaluation/Analysis

A cluster evaluation or analysis is a set of statistical methods used to groupvariables or observations into strongly inter-related subgroups. In epidemiology, it may be used to analyze a closelygrouped series of events or cases of disease or other health-related phenomenon with well-defineddistribution patterns inrelation to time or place or both.

Coalition

A coalition is an organized groupof people in a community working towarda common goal. The coalition canhave individual, group, institutional, community, and/or public policy goals.

Collaboration

Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationshipincludes a commitment to mutual relationships andgoals; a jointly developed structure and shared responsibility; mutual authorityandaccountability for success; andsharingof resources and rewards.

Collaborative Leadership

Collaborative leadershipis a type of leadershipthat engages others by designingconstructive processes for working together, convenes appropriate stakeholders, andfacilitates andsustains their interaction. In collaborative leadership, leaders promote andsafeguardthe collaborative process throughshared leadership, rather thantakingunilateral action. Collaborative leaders perform their workin coalitions, alliances and partnerships.

Communication

Communication is defined as a process by whichinformationis exchanged between individuals through a common system of symbols, signs, or behavior.

Communications Strategies

Communications strategies are statements or plans that describe a situation, audience, behavioral change objectives, strategic approach, key message points, media of communication, management and evaluation. Health departments may develop communications strategies to address a variety of situation for health communications, emergency response, or health education.

Community

Community is a groupof people who have commoncharacteristics; communities canbe defined by location, race, ethnicity, age, occupation, interest in particular problems or outcomes, or other similar commonbonds. Ideally, there would be available assets and resources, as well as collective discussion, decision-making andaction.

Competencies

Core competencies are fundamental knowledge, abilities, or expertise associated in a specific subject area or skill set.

Compliance

Compliance is defined as conformity in fulfilling official requirements.

Consultation

Consultation is a process, act or conference throughwhichadvice is given, information is shared, and views are exchanged.

Continuing

For the purposes of Quality Improvement, continuing is defined as activities that have existed for some time, are currently in existence, andwill remainin thefuture.

Core Competencies for Integrated Behavioral Health and Primary Care

Core Behavioral Health competencies encompass the individual skillsdesirable for the deliveryof Integrated Behavioral Health Services. They transcend the boundaries of the specific disciplines within Behavioral Healthandhelpto unifythe profession. The competencies are dividedintothe following nine domains: Interpersonal Communication, Collaboration& Teamwork, Screening & Assessment, Care Planning& Care Coordination, Intervention, Cultural Competence & Adaptation, Systems Oriented Practice, Practice Based Learning & Quality Improvement, and Informatics.

Cultural Competence

Cultural competence is a set of skills that result in an individual understanding and appreciating culturaldifferences and similarities within, among, and between groups andindividuals. This competence requires that the draw on the community-based values, traditions, and customs to work withknowledgeable persons of and from the community developing targeted interventions and communications.

Current

For the purposes of Quality Improvement, current is defined as occurring within the previous 24 months.

Customer/Client

Customer/client is the person or groupthat receives or consumes services andhas the ability to choose among different products or services.

Customer/Client Satisfaction

Customer or client satisfaction is the degree of satisfaction provided by a person or group receiving a service, as defined by that person or group.

D

Determinants of Health

Factors whichinfluence the health status of an individual and/or a population are called determinants of health. They may be categorized in several groups such as the genetic or biological causes and predispositionof disease, mortality, or disability; the behavioral aspects of disease andillness (choices, lifestyle, etc.); the cultural, political, economic, and social aspects of disease and illness; the environmental aspects of disease and illness; the policy aspects of disease andillness; and the individual andresponse to all of the above

Diverse Workforce

A diverse workforce results when agencies recruit and retain aninclusive workforce -- one that looks like the population it serves -- and when individual differences are respected, appreciated, andvalued, diversity becomes an organizational strength that contributes to achieving results. Diversity offers a variety of views, approaches, and actions for anagency to use in strategic planning, problem solving, and decisionmaking. It also enables anagency to better serve the publicby reflecting the customers and communities it serves.

E

Evidence-based Practice

Evidenced-based practice involves making decisions on the basis of the best available scientific evidence, using data and information systems systematically, applying program-planningframeworks, engaging the community in decisionmaking, conducting soundevaluation, and disseminating what is learned.

G

Governing Entity

A governing entity is the individual, board, council, commission or other body with legal authority over the behavioral health functions of a jurisdiction of local government; or region, or district or reservation as established by state, territorial, or tribal constitution or statute, or by local charter, bylaw, or ordinance as authorized by state, territorial, tribal, constitution or statute.

H

Health

Health is a dynamic state of complete physical, mental, spiritualandsocial well-being andnot merely the absence of disease or infirmity.

Health Care Provider

A health care provider is a person, agency, department, unit, subcontractor, or other entity that delivers a health-related service, whether for payment or as an employee of a governmental or other entity. Examples include hospitals, clinics, free clinics, community health centers, private practitioners, the localhealth department, etc.

Health Care Service

A health care service is a business entity that provides inpatient or outpatient testing or treatment of humandisease or dysfunction; dispensing of drugs or medical devices for treating human disease or dysfunction; or provision of procedures performed on a personfor diagnosing or treatinga disease.

Health Communication

Health communication is informing, influencing, and motivatingindividual, institutional, and public audiences about important health or public health issues. Health communication includes disease prevention, health promotion, health care policy, and the business of health care, as well as enhancement of the quality of life and health of individuals within a community. Healthcommunicationdeals with how informationis perceived, combined, andusedto make decisions.

Health Disparities

Health disparities refer to differences in populationhealthstatus that are avoidable andcan bechanged. These differences canresult from environmental, social and/or economic conditions, as well as public policy. These and other factors adverselyaffect population health.

Health Education

Health educationconsists of any planned combination of learning experiences designed to predispose, enable, and reinforce voluntary behavior conducive to healthin individuals, groups or communities. An educational process by which the public health system conveys informationto the community regarding community health status, health care needs, positive health behaviors and health care policy issues.

Health Information

Health information is information regarding medical, clinical or health-related subjects that individuals mayuse to make appropriate healthdecisions.

Health Information Exchange (HIE)

A health information exchange is a system to facilitate electronic access to patient-level health informationacross organizations withina region, community, or health care system. A health information exchange allows clinical informationto be shared among disparate health care informationsystems while maintainthe meaning of the informationbeing exchanged, using nationally recognized standards.

Health Needs

Health needs inbehavioral health are those demands required by a population or community to improve their behavioral health status.

Health Promotion

Health promotion is a set of intervention strategies that seek to eliminate or reduce exposures to harmful factors by modifying humanbehaviors. This process enables individuals and communities to control and improve their own health.

Health promotion approaches provide opportunities for people to identify problems, developsolutions, andwork in partnerships that build on existing skills and strengths. Health promotion consists of plannedcombinations of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities. Health promotionactivities are any combinationof educationandorganizational, economic, and environmental supports aimed at the stimulation of healthy behavior in individuals, groups, or communities.

Health Status

The degree to which a person or defined group can fulfill usuallyexpected roles andfunctions physically, mentally, emotionally, andsocially.

I

Information Systems

An information system is a combination of hardware, software, infrastructure, andtrained personnel organized to facilitate planning, control, coordination, anddecision-making inan organization.

Infrastructure

Infrastructure denotes the systems, competencies, relationships, andresources that enable performance of behavioral health's corefunctions and essential services in every community. Categories include human, organizational, informational, andfiscal resources.

Internal Audit

Internal auditing is anindependent, objective assurance andconsulting activity designedto add value and improve an organization's operations. It helps anorganization accomplishits objectives by bringing a systematic, disciplined approach to evaluate andimprove the effectiveness of risk management, control, andgovernance processes.

L

Laws

Laws are the legal powers andduties of the state to assure the conditions for people to be healthy, andthe limitations on the power of the state to constrain the autonomy, privacy, liberty, proprietary, or other legally protected interests of individuals for the protection and promotion of community health.

M

Mandated Behavioral Health Services

Mandated behavioral healthservices are required by statute, rule/regulation, ordinance or other similar legally binding process.

O

Operations

Operations refers to the performance of a practical work or of something involving the practical applicationof principles or processes.

P

Partnership

A partnershipis a relationship among individuals and groups that is characterized by mutual cooperationand responsibilities.

Policy/Policy Development

Policy is a definite course or method of actionselected from among alternatives and in light of givenconditions to guide and determine present and future decisions or a high-level overall plan embracing the general goalsandacceptable procedures especially of a governmental entity. Policy development is the means by whichproblem identification, technical knowledge of possible solutions, and societal values converge to set a course of action. As such, policy development is an outgrowth of the assessment and monitoring activities describedwith respect to all other essential behavioral health services. Policy development is a process that enables informed decisions to be made concerning issues related to the public's behavioral health.

Population Health

Populationhealthis a cohesive, integrated and comprehensive approachto healthconsidering the distribution of health outcomes withina population, the healthdeterminants that influence the distribution of care, and the policies and interventions that impact andare impacted by the determinants.

Practice-based Evidence

For Tribal healthdepartments, practice-based evidence is the incorporation of evidence grounded in culturalvalues, beliefs, and traditionalpractices.

Prevention

Primary prevention consists of strategies that seek to prevent the occurrence of disease or injury, generally through reducing exposure or riskfactor levels. These strategies canreduce or eliminate causative risk factors (risk reduction). Secondary prevention consists of strategies that seek to identify and control disease processes in their early stages before signs and symptoms develop(screening and treatment). Tertiary preventionconsists of strategies that prevent disability by restoring individuals to their optimal level of functioning after a disease or injury is established.

Primary Care

Primary care is basic or general healthcare focused on the point at whicha patient ideallyfirst seeks assistance from the health care system.

Primary Data

Primary data are data observed or collected from original sources, ranging from more scientifically rigorous approaches such as randomizedcontrolledtrialsto less rigorous approaches such as case studies.

Procedure/Protocol

A procedure or protocol is a written description of the way inwhich a particular action or set of actions should be accomplished.

Programs, Processes, and Interventions

Programs, processes, andinterventions are the terms used to describe functions or services or activities carriedout through the dailywork of behavioralhealth departments.

Public Health System

The public health system is the constellationof governmental andnongovernmental organizations that contribute to the performance of essential public healthservices for a defined community or population.

Q

Quality Improvement (QI)

Quality improvement in behavioral health is the use of a deliberate anddefined improvement process, such as Plan-Do-Check-Act, whichis focusedon activities that are responsive to community needs andimproving population health. It refers to a continuous and ongoing effort to achieve measurable improvements inthe efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality inservices or processes whichachieve equity and improve the behavioral health of the community.

R

Regulation

A regulationis a rule or order issued by anexecutive authority or regulatory agencyof government and having the force of law.

Reliable

Reliable is defined as giving the same result on successive trials.

Research

Research is a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalized knowledge.

Risk Assessment

Risk assessment is a process used to formallyassess the potential harm due to a hazardtaking intoaccount factors such as likelihood, timing, and durationof exposure.

S

Secondary Data

Secondary data are those data which have been collected in the past, collected by other parties, or result from combining data or information from existing sources.

Strategic Plan

A strategic plan results from a deliberate decision-making process and defines where anorganization is going. The plan sets the directionfor the organization and, through a commonunderstanding of the mission, vision, goals, and objectives, provides a template for all employees and stakeholders to make decisions that move the organizationforward.

T

Technical Assistance (TA)

Technical assistance is anarrayof supports including advice, recommendations, information, demonstrations, and materials provided to assist the workforce or organizations in improvingbehavioral health services.

Training

Training for the behavioral healthworkforce includes the provisionof information througha variety of formal, regular, plannedmeans for the purpose of supporting the behavioral healthworkforce inmaintaining the skills, competencies, and knowledge needed to successfully perform their duties.

Trend Analysis

Trend analysis is a studydesignwhichfocuses on overall patterns of change inan indicator over time, comparing one time period with another time period for that indicator. Trend analysis is not used to determine causation; rather associations can be drawn. Trendanalysis is commonly used inprogram evaluation, for policy analysis, andfor etiologic analysis.

V

Valid

Validis well-grounded or justifiable; being at once relevant and meaningful.

Values

Values describe how work is done and what beliefs are heldin commonas a basis for that work. They are fundamental principles that organizations stand for.

Vision

Vision is a compelling and inspiring image of a desiredandpossible future that a community seeks to achieve. A vision statement expresses goals that are worth striving for andappeals to ideals and values that are shared among stakeholders.

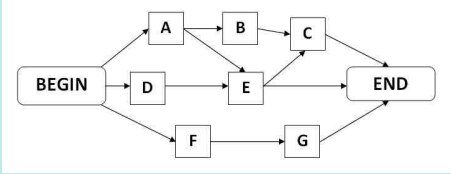
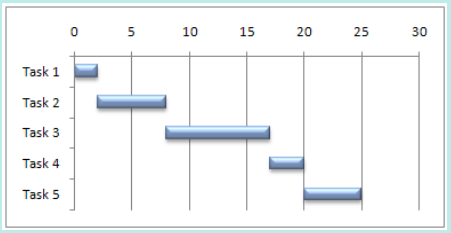
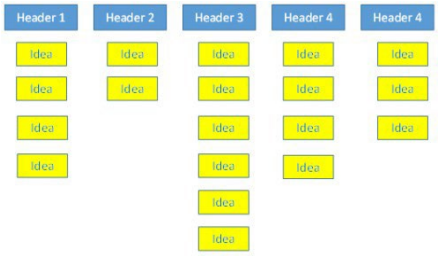
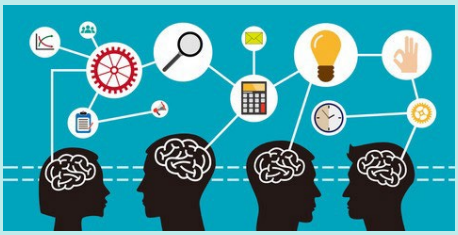
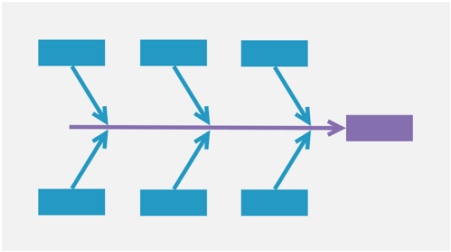
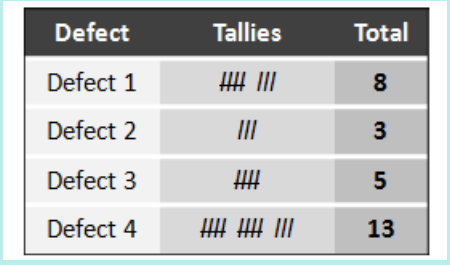
W

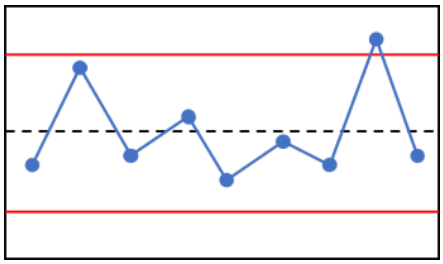
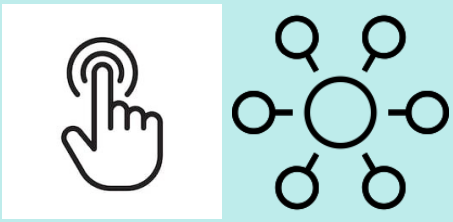
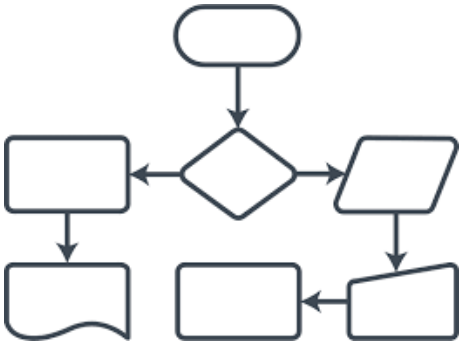
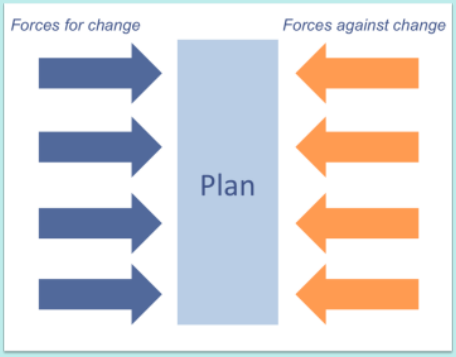
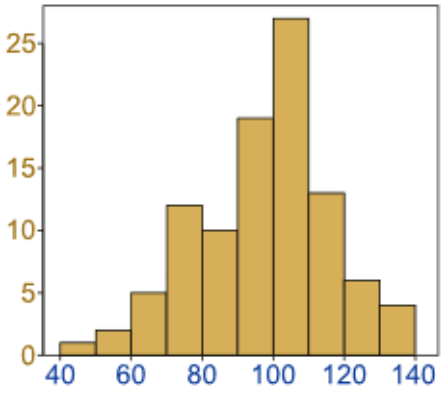
Wellness

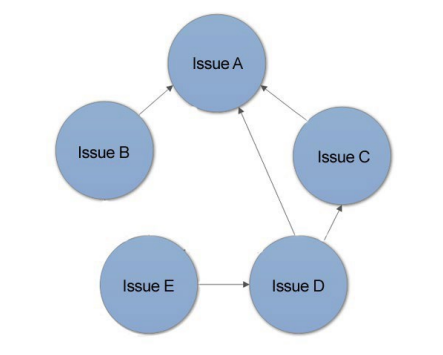
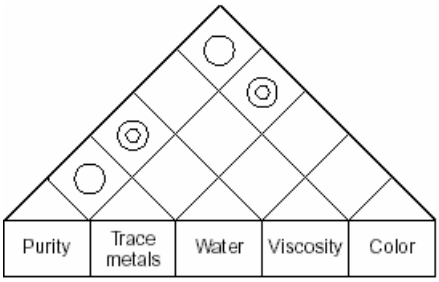
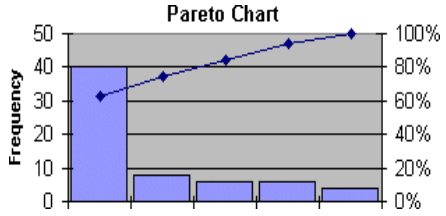
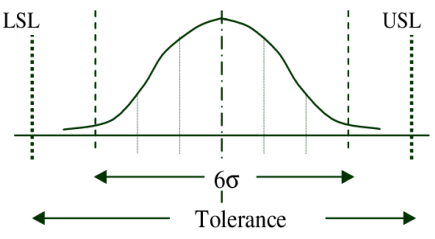
Wellness is the quality or state of being in good health especially as anactively sought goal.

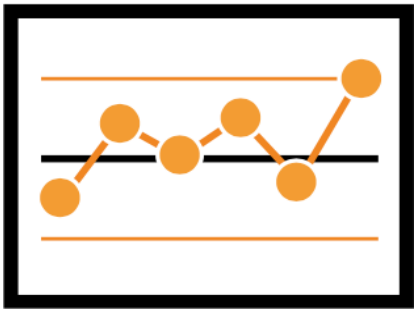
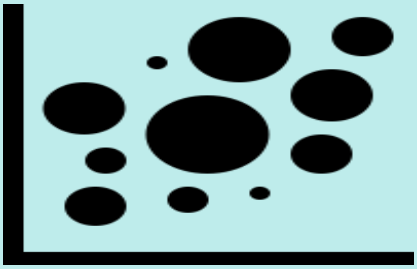
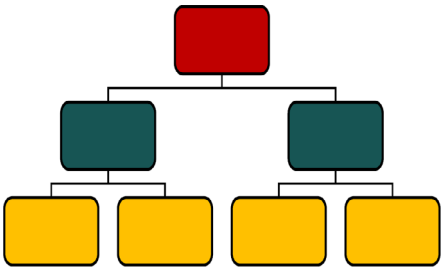
APPENDIX B: QI TOOL KIT

The following table lists helpful QI tools andresources.

QI Tool	What the Tool Does	Example
Activity Network Diagram / Gantt Chart	Used to: Schedule sequential andsimultaneous tasks • Gives team members the chance to show what their piece of the plan requires and helps team members see why they are critical to the success of the project • Helps team focus its attention andscare resources on critical tasks	 
Affinity Diagram	Used to: Gather and groupideas • Encourages team members creativity by breaking down communication barriers • Encourages ownership of results and helps overcome "team paralysis" due to an array of options anda lack of consensus	
Brainstorming	Used to: Create bigger and better ideas • Encourages open thinking andgets all team members involved and enthusiastic • Allows team members to build oneachother's creativity while staying focused on the task at hand	
Cause and Effect / Fishbone Diagram	Used to: Find and cure causes, not symptoms • Enables a team to focus on the content of the problem, not the problem's historyor differing personal issues of team members • Creates a snapshot of the collective knowledge and consensus of a team arounda problem • Focuses the team on causes, not symptoms	
Check Sheet	Used to: Count and accumulate data • Creates easy-to-understand data; makes patterns inthe data become more obvious • Builds a clearer picture of "the facts", as opposed to opinions of each team member, through observation	

QI Tool	What the Tool Does	Example
Control Charts	Used to: Recognize sources of variation • Serves as a tool for detecting and monitoring process variation; provides a commonlanguage for discussing process performance • Helps improvea process to perform with higher quality, lower cost, and higher effective capacity	
Data Points	Used to: Turn data into information • Determines what type of data you have • Determines what type of data is needed	
Flowchart	Used to: Illustrate a picture of the process • Allows the team to come to agreement on the steps of the process; canserve as a training aid • Shows unexpected complexity and problem areas; also shows where simplification and standardizationmay be possible • Helps the team compare andcontrast the actual versus the ideal flowof a process to help identify improvement opportunities	
Force Field Analysis	Used to: Identify positives and negatives of change • Presents the "positives" and "negatives" of a situation so they are easilycompared • Forces people to thinktogether about all aspects of making the desired change as a permanent one	
Histogram	Used to: Identify process centering, spread, and shape • Displays large amounts of data by showing the frequency of occurrences • Provides useful information for predicting future performance • Helps indicate there has been a change inthe process • Illustrates quicklythe underlying distributionof the data	

QI Tool	What the Tool Does	Example
Interrelationship Digraph	Used to: Look for drivers and outcomes • Encourages team members to think inmultiple directions rather than linearly • Explores the cause and effect relationships among all issues • Allows a team to identify root causes even when credible data doesn't exist	
Matrix Diagram	Used to: Find relationships • Makes patterns of responsibilities visible and clear so that there is even distribution of tasks • Helps a team come to consensus on small decisions, enhancing the quality andsupport for the final decision	
Nominal Group Technique	Used to: Rank for consensus • Allows every team member to rank issues without being pressuredby others • Makes a team's consensus visible • Puts quiet team members on an equal footing with more dominant members	**Example:** / **Option A** / **Option B** / **Option C** Henry: 2, 1, 3 Ian: 2, 3, 1 Emily: 1, 3, 2 Mercedes: 1, 2, 3 **Total:** 6, 9, 9
Pareto Chart	Used to: Focus on key problems • Helps team focus onthose causes that will have the greatest impact if solved • Progress is measured ina highlyvisible format that provides incentive to push on for more improvement	
Prioritization Matrices	Used to: Weigh your options • Forces a team to focus on the best thing(s) to do and not everything they coulddo • Increases the chance of follow-through because consensus is sought at each step in the process (from criteria to conclusions)	**Cost** / **A** / **B** / **C** / **Total** **A**: 1/5, 1/10, 0.3 **B**: 5, 1, 6 **C**: 10, 1, 11
Process Capability	Used to: Measure conformance to customer requirements • Helps a team answer the question"Is the process capable?" • Helps to determine ifthere has been a change in the process	

QI Tool	What the Tool Does	Example
Radar Chart	Used to: Rate organizational performance • Makes concentrations of strengths and weaknesses visible • Clearly defines full performance in each category • Captures the different perceptions of all the team members about organizational performance	
Run Chart	Used to: Track trends • Monitors the performance of one or more processes over time to detect trends, shifts, or cycles • Allows a team to comparea performance measure before and after implementation of a solution to measure its impact	
Scatter Diagram	Used to: Measure relationships between variables • Supplies the data to conform a hypothesis that two variables are related • Provides a follow-up to a Cause & Effect Diagram to find out if there is more than just a consensus connection between causes andthe effect	
Tree Diagram	Used to: Map the tasks for implementation • Allows all participants (and reviewers outside the team) to check all of the logical links and completeness at every level of plandetail • Reveals the real level of complexity involved in the achievement of any goal, making potentially overwhelming projects manageable, as well as uncovering unknown complexity	

APPENDIX C: SUMMARY OF PAST QI PROJECTS

Grievance Reporting PIP: QIC selected the Grievance Reporting process for a Performance Improvement Project. The incidence of grievances was very low, and rather than assume this was evidence of exceptional performance, QICsought to examine ifthere were issues in access to and awareness of the grievance process within the client community. A survey was developed to measure awareness of the grievance process. The consumer advocacy groups took on the project of administering the survey within their own communities, resulting in a high response rate. The resulting data showed that awareness of the process was low. The consumer advocacy groups then took on the education task of increasing awareness.

Post-Hospital PIP: QICtargeted post-hospital visits for a Performance Improvement Project. The goal was to provide a post-hospital visit by County staff within 7 days of release from anacute hospitalization. Initial data collection showedthe average to be between 12-15 days post-hospital. Staffingconstraints were identified as possible barriers to success. The post-hospital responsibilitywas expanded from Access Team to also include the Community Intervention Team and the Child-Adolescent Education and Prevention Team. With this shared responsibilityandexpanded capacity, the numbers improved significantly.

Consumer Satisfaction Survey: The consumer advocacygroups proposed a project to QIC to create their own consumer satisfactionsurvey with questions selected by client input only. This survey was conducted inadditionto the State mandated consumer satisfaction survey. The consumer groups met with several focus groups in the client community to draft the survey. Then the advocacy groups administered the survey in multiple client settings andcommunity venues. Response rate was very high(40%, compared to the typical 15%-20%). The results of the survey were presented to QIC, which spawned several subsequent projects.

Crisis Call Brochure: QIC spear-head the development of the 911 Crisis Call Brochure currently posted to the Sonoma County Behavioral Healthwebsite. They collaborated closely with law-enforcement and 911 Dispatchto complete this project. The resulting product remains in active use.

Jail Mental Health (the use of Safety Cells): Reports came to QICregarding dehumanizing conditions inthe use of safety cells (clients stripped naked andplaced in coldconcrete cells). Client Satisfaction Survey data confirmedthis concernin the client community. QIC approached the Sherriff's Department Corrections Officers to collaborate on this issue. The Main Adult Detention Facility offered to allow QIC members to tour the mental health modules of the jail and examine the safety cells. Officers suggested increasingthe use of anti-suicide blankets to afford more warmth and dignity to clients/inmates without putting them at riskfor self-harm. Law-enforcement was verysupportive of the project.

Family Packet for PES: Familyadvocacygroups reported data regarding family member frustrationwith confidentiality restrictions in emergency situations. Familymembers felt they had urgent andvaluable information to give to Psychiatric Emergency Services (PES) staff; however, PES staff were primarily taskedwith addressing the emergent need of the client in crisisandstruggled to deal with the family incrisis simultaneously. The Family Services Coordinator headed a project to create a Family Packet for PES to be given to families while their loved one was being assessed. The packet contained a means by which to communicate important information to PES staff, as well as resources, education, and support materials suited to the family perspective. The project was done incollaboration with PES staff, vetted through QIC, and distributed inthe PES lobby.

Board and Care Subcommittee: Reports came to QICregarding substandard conditions at local Boardand Care homes as well as Room and Boardplacements. Data from client satisfaction surveys indicated widespreaddissatisfaction with quality of services at this level of care. Members of QICresearched possible solutions implemented inother Counties. The coalition model was selected as a preliminarycourse anda subcommittee was formedbetween members of QICand representatives from successful Boardand Care homes. This groupdeveloped a survey for Boardand Care operators to

assess areas for improvement and desired support from the County and community. The data from this survey was analyzed and a coalition formed inviting Board and Care operators to receive supports andimprove quality.

Seclusion and Restraint Subcommittee: Data on the frequency of seclusion and restraint is alreadytrackedwith the goal of reducing the use of this procedure. A subcommittee was formed between members of QIC and staff/managers from the Crisis Stabilization Unit. This group worked to revise the existingpolicy on seclusion and restraint and transform the document into a Trauma-Informed Care approach. The subcommittee also revisedforms and aligned them with the new trauma-informed policy. Once the revisions were complete, a training program was implemented to affect a cultural shift toward this evidence-basedpractice.

Client Belongings Subcommittee: One of the issues raised in the consumer satisfaction surveys was the loss of belongings when transferring from one placement to another. A subcommittee was formed to research andaddress the issue. Several forms were considered to address the legalities of personal property and storage. The Wellness and Advocacy Center secured funding/contract to utilize part of its facility as a storage system for client belongings.

CSU Satisfaction Survey: The CSU Client Satisfaction Survey was developed by a subcommittee of QIC and CSU staff. CSU staff implemented the followingprocess:

- A survey is given to eachclient just prior to discharge from CSU
- Completionof the survey is voluntary andanonymous
- There is a check box if the client would like a peer support staff to call to assist with completing the form
- The client puts the survey into a locked drop box inthe CSU lobbyuponleaving CSU

An aggregated report is generated quarterly, andshared with QIC, CSU staff, and QIP. Program improvement activities are developed based on the feedback received.

Enhancing Mental Health Outcomes to Reduce Jail Recidivism: QIC members spent time during several meetings to focus on the topic: holes in the continuum of care for adult services. Members identified the need to look at jail recidivism, as our data shows anaverage of 42 days between jail episodes. QIC members expressed concern that consumers who are released from jailare experiencing difficulty connecting with MH services. They suggested a jail navigator who couldhelp connect consumers withservices upon release. The discussion resulted in the development of a new Clinical PIP: EnhancingMental Health Outcomes to Reduce Recidivism. The PIP was implemented initially on the adult teams, and was subsequently revisedto focus on the FACT team. A DBT programdesigned for forensic populations was implemented on this team. ANSA scores for the study group improvedby 27.87% compared to baseline of 8.75% (significant at p<.01). Average jail days annually reduced from 166.5 days to 19.4 days.

Redesigning Service Entry Process to Improve Timeliness: Based on data from FY 18-19 and first quarter FY19-20, only half of DHS-BHD consumers met the standard of receiving aninitial assessment appointment offer withinten business days of service request. DHS-BHD re-designed the process to access services by creatingspecific system changes to increase capacity, increase efficiency, and provide a more trauma-informed systems approach. Interventions were targeted to streamline the access team assessment, scheduling, anddata management processes to reduce wait times for assessment appointments.

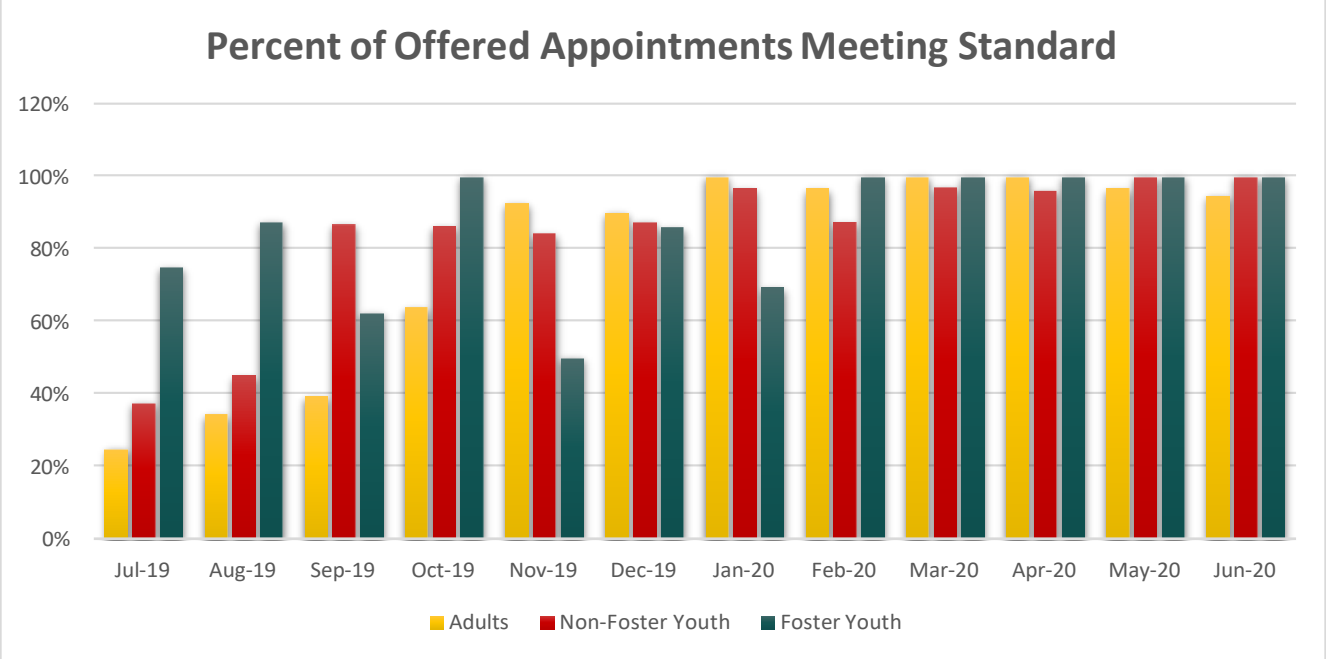
The following interventions were included inthe re-design:

- Fully staffing the Access Team
- Transferring Access Team caseloads to service teams
- Routing youth service requests directly to Youth Access instead of Adult Access
- Replacing the CANS and ANSA screening tools witha shorter Beacon Screening
- Shifting all screening duties to the OPTUM contract

- Providing trauma informed assessment training to all Access Team staff
- Consolidating data tracking into the Electronic Health Record
- Offering next business day walk-in appointments to all adult consumers

It was anticipated that these changes would increase timely access to services, reduce adverse outcomes, and reduce costs in the system of care by preventing crises exacerbated by delays in service delivery. The following charts depict the monthly percentage of offered assessment appointments meeting the 10 business day standard.

Month of Request	All Beneficiaries	Adults	Youth	Foster Youth
July 2019	33.33%	25.00%	53.57%	75.00%
August 2019	40.38%	34.21%	57.14%	87.50%
September 2019	58.33%	39.13%	81.58%	62.50%
October 2019	75.86%	63.64%	88.37%	100.00%
November 2019	86.42%	92.59%	74.07%	50.00%
December 2019	88.75%	89.80%	87.10%	85.71%
January 2020	94.85%	100.00%	88.10%	69.23%
February 2020	94.06%	96.49%	90.91%	100.00%
March 2020	98.97%	100.00%	97.62%	100.00%
April 2020	98.53%	100.00%	97.30%	100.00%
May 2020	97.40%	96.49%	100.00%	100.00%
June 2020	96.67%	94.44%	100.00%	100.00%
Overall Percentage	***78.78%***	***74.52%***	***85.40%***	***85.59%***



By January of 2020, the monthly average of offered assessment appointments which met the 10 business day standard increased to 94% and remained at this level or better for the remainder of the year.

APPENDIX D: QI ACTIVITY TIMELINE

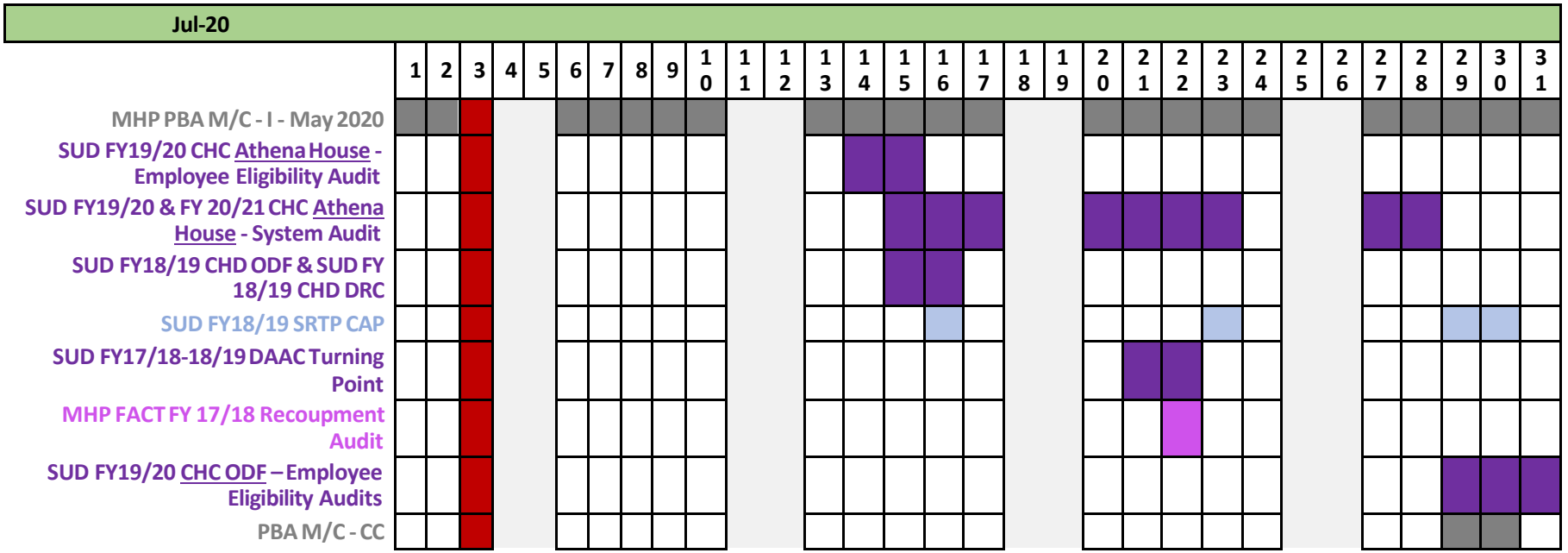
The following table summarizes QI indicators andreport monitoring timelines.

Report	System	Indicators	Reviewers	Interval
Caseload Report	AVATAR	• Identify clients in Hospital/IMDs: Determine D/C Plan • Identify clients who have not received service in last 90 days: Does client continue to meet medical necessity? • Identify clients who have not had a face-to-face by a psychiatrist in over 90 days: Does client continue to meet medical necessity? • Review trends in number of contacts with each client: Are we providing the appropriate level of treatment? Should client be referred to Beacon?	Program Managers	Weekly
Service Detail Report	AVATAR	• Review activity rates (claimable and not claimable)	Program Managers	Weekly
Client Plan Due Dates Report	AVATAR	• Ensure client plans are up to date • Ensure client planreflects reimbursable mental health interventions • Check authorized services for contractors • Ensure client planis signed by clinician	Program Managers	Weekly
Progress Notes in Late Status	AVATAR	• Ensure progress notes are entered intimely fashion • Manage staff schedule to allow for charting time	Program Managers	Weekly
Progress Note Viewer	AVATAR	Sample monitoring of one chart per clinician to ensure progress note: • Reflects mental health services on client plan • Establishes medical necessity • Has a claimableintervention • Service code matches the intervention • Signed by clinician	Program Managers	Monthly
PFI Due Dates	AVATAR	• Identify clients with expiration dates in next 30 days: update financial information	Program Managers	Weekly
Days Since Last Diagnosis	AVATAR	• Identify any clients missing diagnoses: Update diagnoses form	Program Managers	Weekly
CSI Report	AVATAR	• Identify clients missing CSI information: assign to staffto correct	Program Managers	Weekly
Timeliness Data Report	Database	• Review timeliness percentages for Adult and Youth systems • Monitor NOABDs	QI Manager	Monthly
System Performance Summary	AVATAR	• Dashboardreport summarizing service system performance by team/program • Reviewed in QIS to track improvements/changes	QI Manager	Monthly
Quarterly Test Call Summary	Database	• Conduct test calls • Submit report to State	QI Team	Quarterly
Pre-Billing Audits	AVATAR	• Review for billing corrections	QA Audits Specialist	Monthly
Sentinel Events Reports	Database	• Trend for types of events • Follow-up action items	QI Manager	Bi-weekly

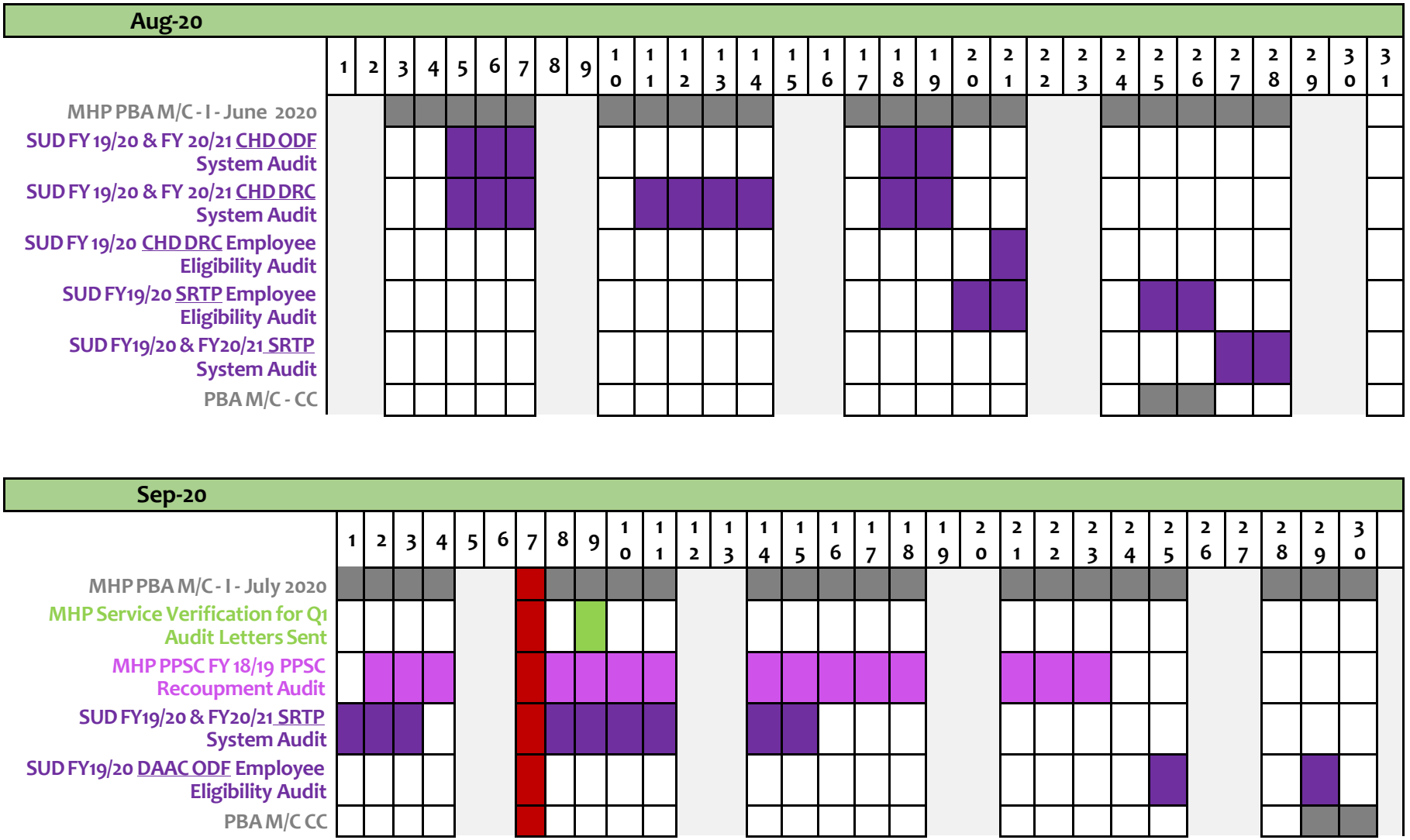
APPENDIX E: AUDITS & MONITORING REVIEW SCHEDULE

Legend:

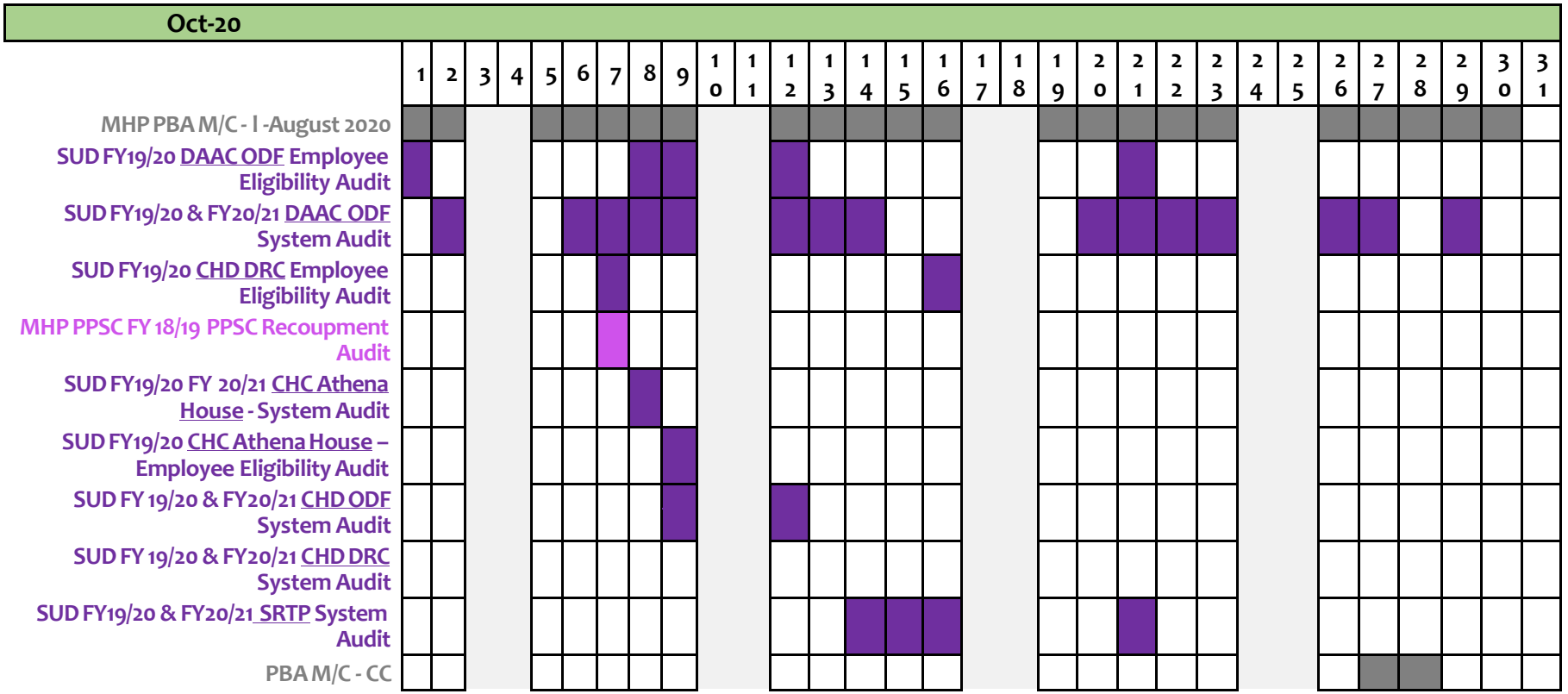
- MPH Pre-Billing Audit Medi-Cal Internal & Medicare Precriber (PBA M/C - I)
- MPH Pre-Billing Audit Medi-Cal Continuity of Care(PBA M/C CC)
- Holidays
- Special Audits (SA)
- Periodic Audits (PA)
- Substance Use Disorders Annual Program Audit (SUD)
- Mental Health Plan -Documentation Audit (MHP)
- MHP - Plan of Correction(POC)
- Corrective Action Plan (CAP)
- Monitoring Review (MR)
- Three Month Follow-up (3M)

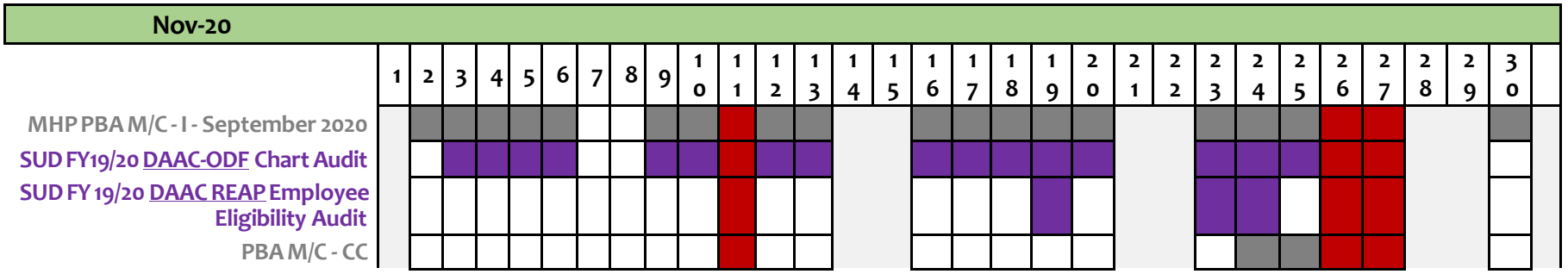


sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

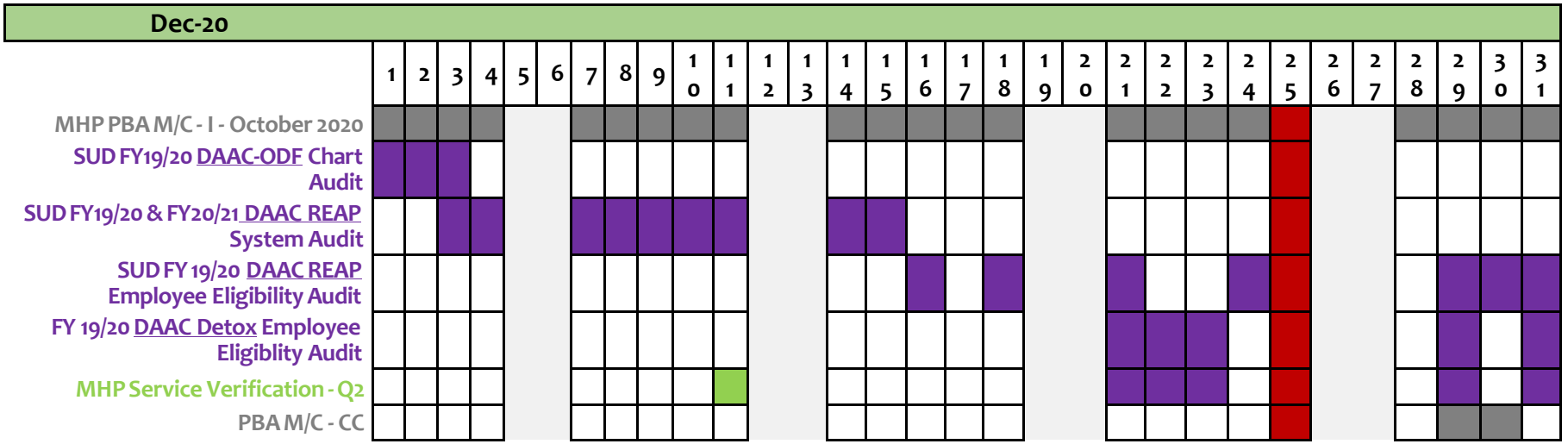


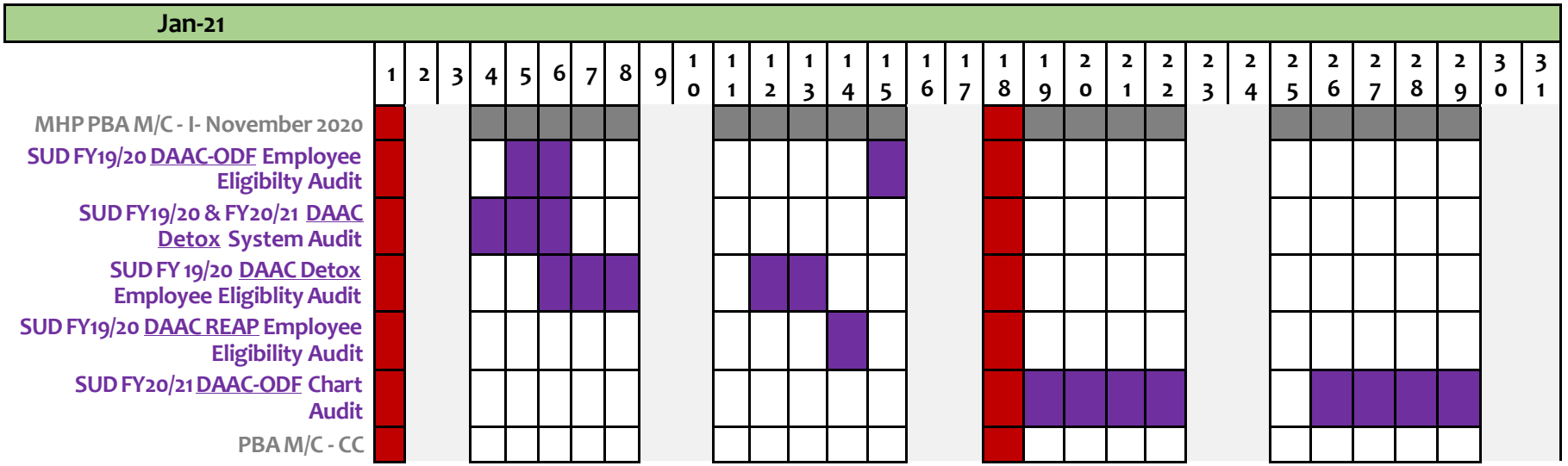
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION





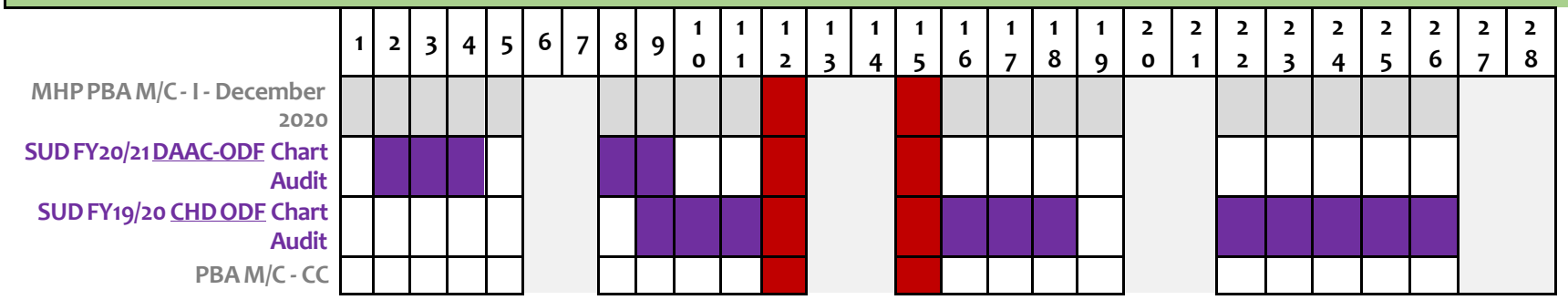
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION



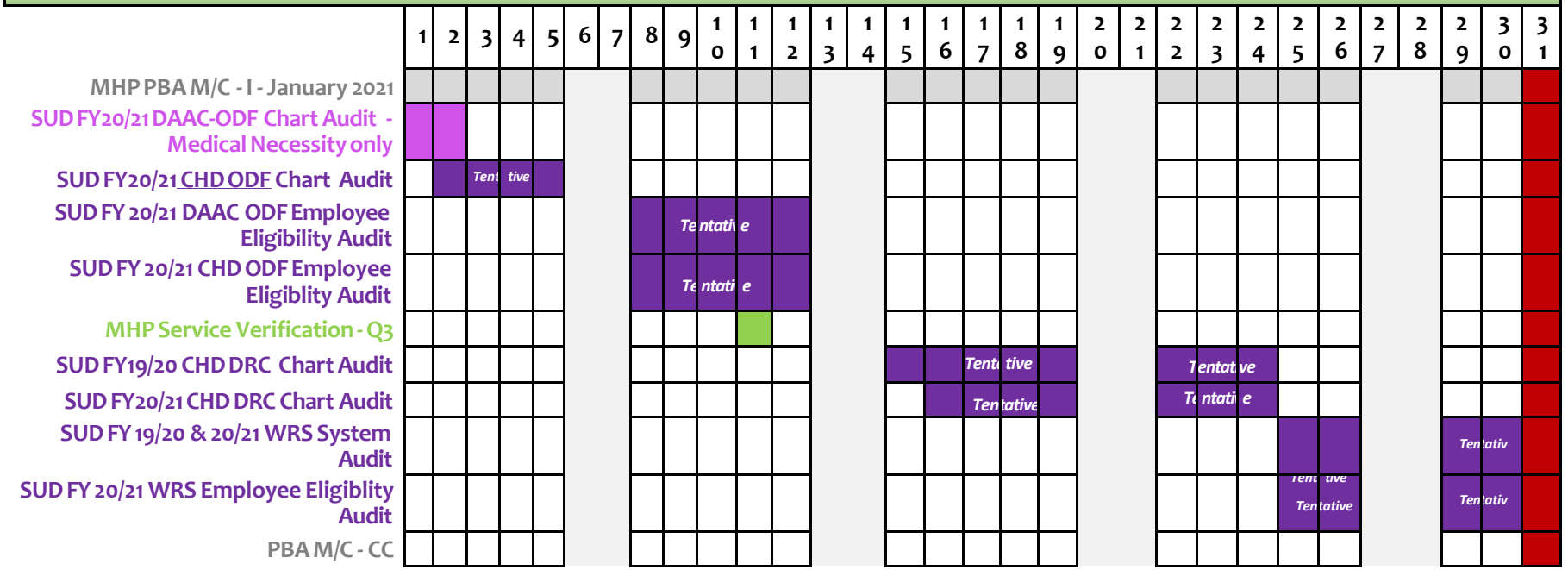


sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

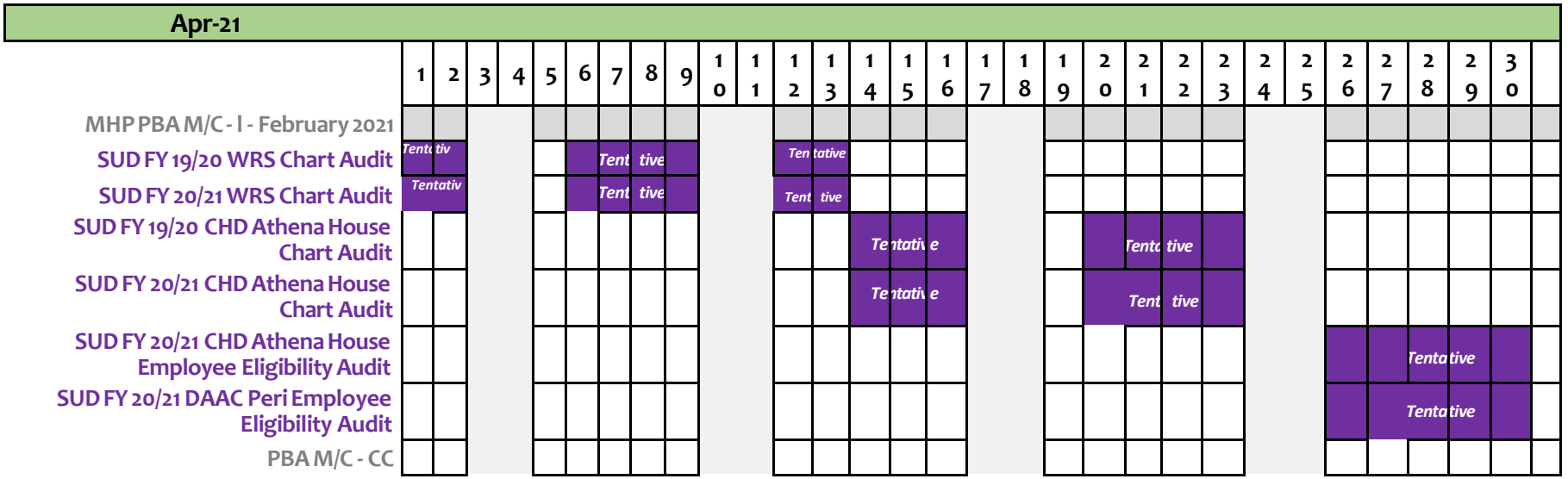
Feb-21

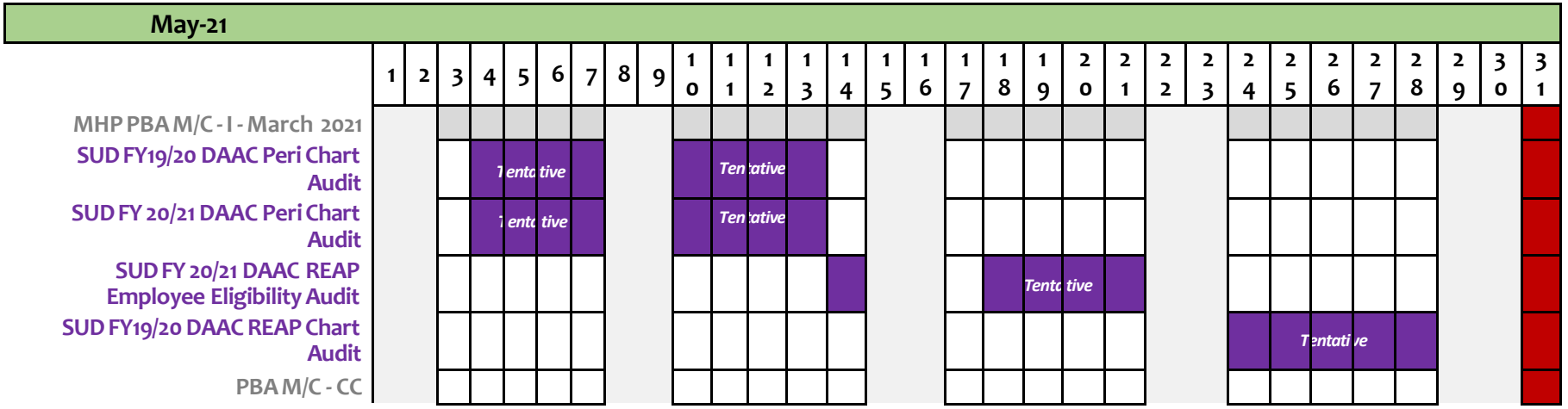


Mar-21

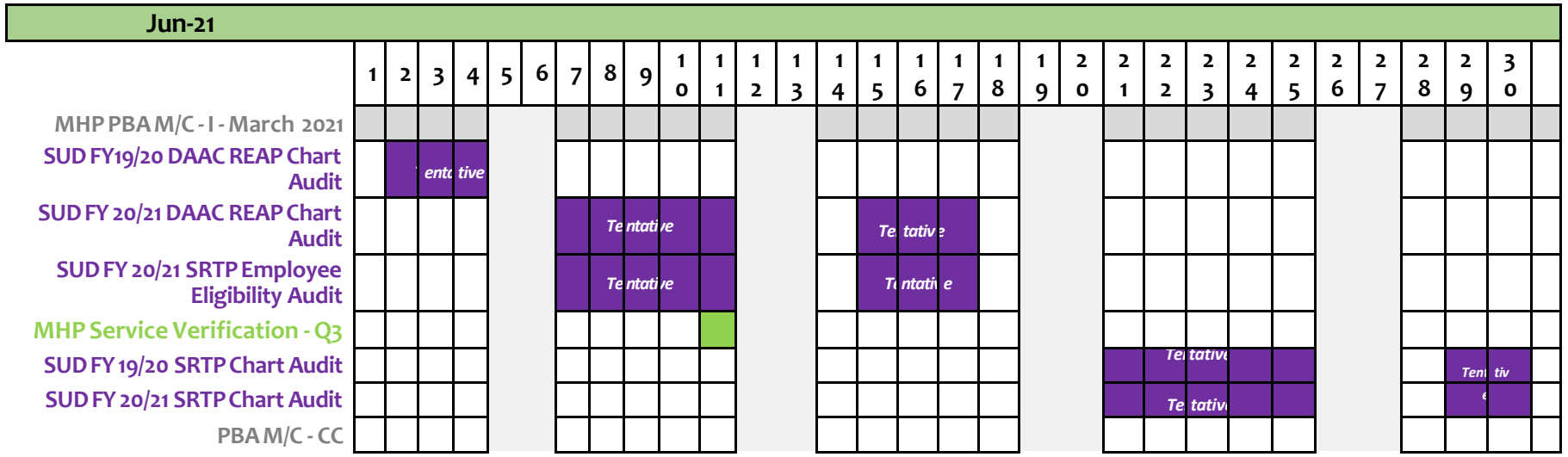


sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION





sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION



sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION