SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Quality Improvement Work Plan

Fiscal Year 2019-2020

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Quality Improvement Work Plan for
Objectives, Scope and Planned Activities for FY 2019-2020

Introduction

Quality Improvement and Continuous Quality Improvement are central tenants of how we work within the Santa Barbara County Department of Behavioral Wellness. It is a core business strategy and informs and influences all we do. This can be seen throughout the organizational structure of the department. Examples include the ongoing System Change efforts led directly by the Director, as well as the organization of the Office of Quality Care and Strategy Management (OQSM). The OQSM oversees the Quality Improvement Program and works to support continuous quality improvement throughout System Change efforts.

The Behavioral Wellness Quality Improvement (QI) Program is a Department of Health Care Services (DHCS) Mental Health Plan and Drug Medi-Cal Organized Delivery System requirement. The QI Program coordinates performance-monitoring activities throughout the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS), including:

- Service delivery capacity
- Accessibility of services
- Timeliness of services
- Beneficiary satisfaction
- Service delivery system monitoring and analysis
- Service coordination with physical healthcare and other agencies
- Monitoring provider appeals
- Tracking and resolution of beneficiary grievances, appeals, and fair hearings, as well as provider appeals
- Performance improvement projects
- Consumer and system outcomes
- Utilization management
- Credentialing

The QI Program also assesses beneficiary and provider satisfaction and conducts clinical records review. The Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) QI Program is consulted in the contracting process for hospitals, as well as individual, group and organizational providers. The MHP QI Program has access to, and reviews as necessary, relevant clinical records to the extent permitted by State and Federal laws.

The Santa Barbara County Quality Improvement Committee embodies in its charter, the process of continuous quality improvement. The mission statement reflects the focus of review of the quality of specialty mental health and DMC-ODS services provided to beneficiaries and service recipients throughout the overall Behavioral Wellness system of care and recovery, focusing on continuous quality improvement. A very substantial aspect of that mandate relates to reviewing and selecting performance indicators and using data to evaluate and improve the performance of the Santa Barbara County Behavioral Wellness System of Care and Recovery.

Quality Improvement Committee Program Description

The QIC promotes the quality improvement program and supports recognition of both individual and team accomplishments. Its members are responsible for helping create a quality improvement culture. In this culture, employees use quality improvement principles and tools in their day-to-day work, with extensive support and guidance from leadership. The QIC reports to the Core Leadership Team and other management and staff work teams. Its executive sponsors play a critical role in maintaining leadership support.

The Quality Improvement Committee is responsible for:

1. Recommending policy decisions
2. Initiating, coordinating, reviewing and evaluating the results of Quality Improvement (QI) activities
3. Reviewing and evaluating performance improvement projects (PIPs)
4. Institution of needed QI actions
5. Guiding system-wide selection and application of quality improvement methods
6. Ensuring follow-up of QI processes
7. Documenting Quality Improvement Committee (QIC) meetings regarding decisions and actions taken
8. Developing the annual Quality Improvement Work Plan as well as the evaluation of the Work Plan.
9. Facilitation of routine committee activity reports

The Quality Improvement Committee (QIC) meets monthly throughout the year. Meetings are facilitated by the Quality Care Program Manager, who is a licensed practitioner and oversees the Quality Care Management Division. The QIC assigns and receives reports from QI sub-Committees and coordinates with the work of the Compliance Committee, reviews and evaluates the results of QI activities, recommends actions to appropriate departmental staff/divisions and ensures follow-up evaluation of actions. When appropriate, the QIC may recommend policy proposals

for Santa Barbara County Mental Health Plan (SBCMHP) and Santa Barbara County Drug Medi-Cal Organized Delivery System (DMC-ODS) Executive Team consideration. On a quarterly basis, the QCM Manager presents the activities and recommendations of the QIC activities to the SBCMHP Executive Leadership Team. QIC decisions and actions are memorialized by dated minutes that are signed by the QCM Manager.

The QI Committee (QIC) is composed of:

- Chief Quality Care and Strategy Officer (OQSM team)
- Research and Evaluation Program Coordinator (OQSM team)
- Chief of Compliance
- SBCMHP Medical Director
- SBCMHP Division Chief for Clinical Operations
- Division Chief of Alcohol and Drug Programs
- Quality Care Management (QCM) Manager
- Utilization Review (UR) staff
- QCM psychiatrist
- SBCMHP Wellness Regional Program Managers
- Management staff of Community Based Organizations (CBO's)
- Division Chief Information Technology
- Consumers and Family Members
- Patient Rights Advocates
- Consumer Empowerment Manager
- Peer Support Employees

The following active departmental sub-committees aid in the overall continuous quality improvement process and meet on a regular basis. These subcommittees, although not under the umbrella of the QIC, provide input, recommendations and reports to the QIC.

- **The Client and Family Member Advisory Committee/Peer Action Team**: Addresses issues related to consumer and family volunteer and employment opportunities within the Department of Behavioral Wellness and other means through which the role of consumers and their families may participate in leadership, as well as ongoing activities of the department. (Meets monthly)

- **Community Based Organization Collaborative Meeting**: Children and Adult Community Based Organization Provider Meeting: Discusses various system issues, service delivery issues, documentation, DHCS review and contract issues. (Meets monthly)

- **Crisis and Acute Care Daily Triage Team**: Monitors and evaluates the flow and care provided to consumers who are using high levels of services, particularly inpatient, SNF, IMD, crisis residential, and other residential care, in order to identify trends, improve efficiency and effectiveness of care and suggest improvements. (Meets daily)

- **Information Systems Steering Committee**: Monitors implementation as well as areas of possible improvement in the MHP's electronic medical records, billing, and related information technology systems. The committee includes representatives from QI, MIS, Fiscal, Programs, and CBO's. (Meets monthly)

- **MIS/Clinician's Gateway User Groups**: Discusses Share/Care and Clinician's Gateway User concerns, suggestions and updates. (Meets quarterly)

- **Community Treatment and Supports**: Weekly joint provider meeting to prioritize and triage transfer and placement of clients into appropriate programs of the system. (Meets Weekly in each region)

- **Clinical Leads**: Weekly meeting which includes management and supervisors from all aspects of the system to discuss clinical/operation issues and programs. Collective problem solving and program planning for the clinical operations of the overall system. (Meets Weekly)

- **Data Management Meeting:** Meets every other week and includes representatives from various parts of the department including the MIS/IT Division Chief, Data and Evaluation team members and Leadership representation. System data reports are reviewed and refined prior to public posting. Review on how data collection occurs within the system and prioritization of data related system changes.

- **Change Agents:** Change agents meet monthly and include staff representatives from throughout the system. This group develops new system change ideas and projects.

- **Grievance and Incident Report Committee:** Meets monthly and includes QCM staff as well as management and executive staff. Grievances and incident reports are reviewed and discussed for any follow up and quality improvement.

- **Clinical Documentation Subcommittee:** Meets monthly and includes management and QCM staff to discuss trends, identify areas of concern, and work towards quality improvement as it relates to documentation.

- **DMC-ODS Implementation Workgroup:** Meets every other week and includes representation from Compliance, QCM, ADP, IT, and Fiscal to plan for, implement, and improve processes related to DMC-ODS.

Evaluation of FY 18/19 Quality Improvement Committee Goals

For fiscal year 2018-2019, the Santa Barbara County QI Committee focused on four key areas. The Quality Improvement Committee tracked and trended data throughout the previous year and identified the four areas of priority for quality improvement activities. Each goal has an associated work group or committee that developed and implemented interventions designed to improve the specific function of the MHP and DMC-ODS.

Goal 1: Improve Access to Care			
Objective	**Indicator**	**Result/Status**	**Point Person**
Ensure all MH and SUD services are available in prevalent non-English languages	Provide information/training on use of Language Line During site visits QCM will monitor availability of language services	Occurring during site visits.	Yaneris QCM
Address disparities in referrals, diagnosis and treatment for youth of color in the juvenile justice system	Provide training for outpatient clinic based staff on implicit bias in clinical diagnosis	Training Dates: August 23 and September 5, June 3, June 25	Yaneris Jill Sharkey
Track and analyze data on Access line wait times	Reports	Auto reports created from MIS; Global Nav reports utilized. Reports generated and reviewed weekly.	QCM
Continue to train Access screener staff on SUD and MH procedures	Training dates	Formally trained on November 7th (as well as countless informal trainings). Completed 8-10 hours of online ASAM trainings. Crisis staff were trained Dec. 3rd and Dec. 7th. New Access staff trained upon hire and as needed.	John QCM
Finalize Access tools - ASAM Screening and Assessment	Finalize forms in EHR	ODS IT workgroup meeting: testing, refining and training on ADP Access.	ADP MIS/IT

Ensure Beneficiaries have access to information regarding safety resources for MH and SUD crises.	Monitor: information on overdose prevention and emergency services at clinics for beneficiaries to easily access. Include in CAP for providers to correct if this goal is not met during monitoring visit.	Monitoring at programmatic site visits.	QCM
Examine walk-in data and address as needed	Design Report Monitor	Added walk-in (n/%) to QIC access data report for review. Reported quarterly.	Jelena Shereen
Conduct routine test calls to 24/7 Access line (4 per month)	Documentation of test calls Monthly QIC tracking; Quarterly QIC reports	Occurring; scheduling, but ongoing challenges with completing scheduled calls.	QCM
Make modification as needed to EHR to monitor Access to SUD services	Changes made by MIS/IT/vendor to EHR	JIRA project management list; subcommittee prioritizes - ongoing.	Deana/JIRA subcommittee

Goal 2: Improve <u>Timeliness</u> to Services			
Objective	**Indicator**	**Result/Status**	**Point Person**
Track timeliness of access across the MHP and ODS systems and utilize for system improvement.	Quarterly QIC reports	MH: being reported on a quarterly basis. ADP: began with Q3 (since ODS went live December 1)	Shereen
Develop reporting mechanisms to assess access and timeliness to SUD	1. Contact to assessment 2. Contact to 1st face to face 3. Contact to MAT 4. Contact to detox 5. Residential to follow up (w/in 7 days)	Began Q3 (most measures)	John Shereen MIS/IT
Track no show rates and utilize for system improvement		Tracking no show by adult/ child and separately for Dr's and clinicians. Reporting to QIC quarterly.	Shereen
Begin tracking timeliness separately for the adult and child systems of care; follow up as needed for CQI	QIC Quarterly reports	MIS/IT created new quarterly reports; data now reported to QIC by adult/child	Ana Shereen
Make modification as needed to EHR to track timeliness to SUD services	Changes made by MIS/IT/vendor to EHR	Two regular meetings to manage this – ODS IT subcommittee and JIRA prioritization.	Deana
Increase the timeliness of reviewed charts 1. within the Department 2. with CBO's	Monthly chart audit	QCM conducts monthly chart audit; reported at Clinical Documentation sub-committee.	Careena Lindsay

Goal 3: Improve Quality of Care Provided to Clients			
Objective	**Indicator**	**Result/Status**	**Point Person**
Ensure Beneficiaries have access to information regarding safety resources for MH and SUD crises.	Information on overdose prevention and emergency services at clinics for beneficiaries to easily access. Include in CAP/POC if this goal is not met during monitoring visit.	Monitoring at programmatic site visits.	Josh - SUD & Stephanie-MH
Discuss and strategize Suggestion Box or other ways to obtain and utilize client feedback in MH and SUD clinics/ programs		Ideas discussed at QIC (additional satisfaction surveys, comment box on website). Three new client satisfaction surveys: PHF, Children's Crisis and PolyPharmacy	QCM
Establish baseline and goals for SUD documentation –charts meeting documentation standards	QCM will conduct monthly chart review for approx. 5 % of charts, reported to ODS Work Group. Provide feedback and support to CBOs.	Began in Dec 2018; reporting at ODS Work Group	QCM
Site visits for all in-county contract providers to assure regulatory requirements are met for MH and SUD providers	Documentation of site visits	MH – Stephanie SUD admin – Stephanie SUD programmatic - Josh & Lindsay.	QCM
CPS/TPS: Based on the data, formulate system recommendations and monitor improvement activities	Demonstrations of data presentations at various committees; utilization of data/results by administrators for decision-making purposes	CPS presented to QIC, BeWell Commission, CFMAC, Lompoc Staff, SM Staff and CBO Collaborative. CPS data are included in annual report. TPS administration will begin next FY.	Shereen Leadership

Ensure that all MH and SUD grievances and appeals are logged and include name, date and nature of problem	Grievance documentation; 100% of grievances received will be logged and responded to appropriately	Documented; discussed at grievance committee meeting and QIC meeting.	QCM
Ensure that all SUD grievances are reported to the State quarterly and MH are reported annually	Grievance report	Confirmed by QCM – being reported.	QCM-Josh and Susan
Revise/Improve Health History Questionnaire		In process	Ana & Ole
Increase completion of PCP identification (to 90%)	Quarterly QIC reports	Reported to QIC; improving	Ana Careena
Utilize data from test calls for quality improvement of Access line	Test call information shared with managers/supervisors as indicated/appropriate	Test call #'s reported at QIC and content shared with supervisors, as needed.	QCM
Improve identification of individuals with co-occurring mental health and substance use disorders who are served by the MHP	Documentation of SUD in EHR	Ana regularly getting a report. QCM staff PDSA on diagnoses for clients in co-occurring treatment teams (paused since primary staff resigned – being reassigned).	Ana QCM
Maintain 90 % charts that have current assessments and treatment plans	% current (from MIS report)	Monitoring	Ana QCM
Increase the quality of reviewed charts (% in compliance) (Goal=90%)	QCM report (monthly audit)	Monitoring	Careena
Increase % of completed corrective action plans, following chart review feedback 1. within the Department 2. with CBO's (Goal=90%)	QCM report	Monitoring	Careena

Ensure the availability of a high quality documentation manual	Updated as needed; posted online	Currently under revision	QCM
Track progress on PIPs	Semi-Annual PIP reports to QIC	On agenda (Jan and June)	Shereen & Caitlin
Improve adherence to the team based care protocol and documentation of team based care planning	1. common diagnosis 2. work towards same Tx goals	Discussed/reported at QIC	Ana Careena
Make modification as needed to EHR to monitor quality of SUD services	Changes made by MIS/IT/vendor to EHR	JIRA (project management) prioritization committee meets to review and rank institutional priorities. Progress is being made; there is a long list of change requests.	Deana
Routine review of contracted providers to ensure qualifications to provide specialty mental health services	1. Organizational providers re-certification every three years 2. Individual Network Providers re-certification every two years 3. Organizational providers with medication rooms are reviewed quarterly	New Certs: 9 Re-Certs: 18 Network Provider Re-Certs: 3 Med room checks: 16	QCM – Stephanie

Goal 4: Measure Outcomes and Utilize Data for System Improvement			
Objective	**Indicator**	**Result/Status**	**Point Person**
Implement DHCS Consumer Perception Surveys (CPS) - share results.	Documentation – presentation of CPS results	CPS presented to QIC, BeWell Commission, CFMAC, Lompoc Staff, SM Staff and CBO Collaborative. CPS data are included in annual report.	Susan - admin Shereen - analysis
Maintain "high" (>=3.5) client and family member satisfaction with services - CPS	Analysis - CPS results	Maintained in FY 16/17	Shereen
Improve response rates and clinic participation - CPS	Analysis - CPS results	Participation has been improving	QCM
Plan for and implement SUD Adult client Treatment Perception Survey (TPS)	Survey administered	Not planned/scheduled until Fall 2019 (per schedule set by UCLA and the State)	John QCM
Implement and monitor results of CANS and PSC-35	CANS and PSC reports produced and discussed	New PSC reports were designed and are automatically sent to providers. New CANS reports under development	Ana Shereen
Track and analyze data on levels of care	1. ASAM 2. LOCRI	1. Developing scripts and datasets 2. Happening (Ana and mangers)	Ana Shereen Jelena and Robert
Conduct Network Provider and Recipient surveys to assess the value of services received through contracted providers	Demonstrated by agendas and minutes reflecting discussion and any recommendations/decisions made based on results	Results shared with QCM in April, 2019 – on July QIC agenda.	QCM

Develop reporting mechanisms to assess readmission to SUD Tx	1. Readmission to WM (w/in 30 days) 2. Readmission to Residential	Requested reports from MIS/IT; developing scripts and datasets.	John Shereen Jelena
Analyze and distribute ADP provider outcomes on a quarterly basis	Reports sent to providers and leadership	Analyzed and distributed quarterly Interrupted with ODS mid-quarter).	Shereen
Make modification as needed to EHR to monitor outcomes of SUD services	Changes made by MIS/IT/vendor to EHR	Many creations and modifications pre ODS implementation; modifications expected to continue as utilization reveals areas for improvement	Deana
Produce semi-annual and annual data reports that address access, timeliness, quality and outcomes	Posted to website	Semi-annual posted December 2018: finalizing FY 17/18 annual report	Shereen & Caitlin

Behavioral Wellness System Summary

Since the last QI Work Plan submission for FY 17-18, Behavioral Wellness has experienced significant changes as a result of many developments, including major Systems Change efforts as well as changes and enhancements in overall program operations.

Highlights of significant MHP and DMC-ODS changes over the past year:

1. Continued the response efforts to community disaster and trauma response to rebuilding and recovery following twin disasters as well as other evacuations and trauma events since. Maintained formation of Community Wellness Team (over 13 organizational providers, led by Behavioral Wellness) and FEMA funded HOPE 805 crisis counselors.
2. Implemented the Organized Delivery System with launch date of December 1. Call volume of Access calls, primarily due to substance use disorder authorizations, doubled in the month of December.
3. Depot Street ground breaking, adding 35 MHSA permanent housing beds.
4. Strengthening Families launched in South County in January of 2019, following the implementation of Strengthening Families programming in the North County.
5. The Assisted Outpatient Treatment (AOT) program remains active. During the first year of operation, 48 individuals were referred for services and 44% accepted voluntary services through engagement efforts.
6. Contract established with the Department of State Hospitals (DSH) for application of felony 1810 funds.
7. Developed license to establish and opened an inpatient pharmacy in September of 2018.
8. Pilot launched in the South County for the Co-Response of Behavioral Health and Sherriff with successful preliminary outcome data.
9. Crisis Services Hub opened in South County.
10. Integration and expansion of Outreach Teams in countywide community work. Expansion of homeless outreach teams in the North and West regions of the county. Through the HMIOT budget expansion, Behavioral Wellness has been enabled to purchase a mobile van with a shower hitch for portable showers in the field.
11. The Mental Health Office of Oversight and Accountability Committee (MHOAC) approval of expanded Innovation funding for the Resiliency Interventions for Sexual Exploitation (RISE) program.
12. Cyber Security training provided for all Behavioral Wellness staff.
13. Successful completion of a departmental Information Technology Security Risk Assessment.
14. Hired new departmental Human Resources Manager and renewed strategies enacted to focus on staff retention.
    a. Retained and utilized consultant for staff and team development who utilized the Gallup Strengths Finder methodology.
    b. Developed position for a departmental staffing recruitment lead, with this position currently in recruitment.
15. System wide Process Improvement Projects (PIPs) expanded to include Organized Delivery System (ODS) focus.
16. Memorandum of Understanding developed with the Department of Social Services to enable co-location of two Behavioral Wellness Mental Health Clinicians.
17. Signature pads provided for all contracted community based organizational (CBO) providers.

18. Development of departmental RENEW '22 (County of Santa Barbara Transformational Plan) initiatives. Presentations to all staff within Behavioral Wellness including over a dozen departmental teams and the Behavioral Wellness Commission on RENEW '22 and departmental initiatives.
19. Launched Incompetent to Stand Trial (IST) court calendar in October of 2018.
20. Expanded budget for contracts with community providers for expansion of 20 residential beds expected to open this year.
21. Non-emergency medical transportation agreements in place.
22. Children's Triage grant awarded in October of 2018. Two Mental Health Practitioners and two Parent Partners have been hired to provide assistance for families in crisis in hospital emergency rooms.
23. Support for the Lompoc Riverbed clean out effort and linkage to substance use disorder and mental health resources.

Current initiatives of the department include:

1. Expand Co-Response teams through contract with the Santa Barbara City Police Department
2. Approval attained for the launch of an Innovations funded Peer to Peer Chat and Digital Therapeutics (PPCDT) application, also referred to as the Tech Suite, which offers a free, voluntary and mobile web based network of trained peers available to chat 24/7 with individuals (or their family members/caregivers) experiencing symptoms of mental illness.
3. Active engagement in Stepping Up initiative aimed to reduce the number of persons with mental illness in jail settings.
4. Launch of pilot project with local hospitals to train and certify emergency room doctors to write 5150 detention holds.
5. Development of specialized Implicit Bias training designed for the Behavioral Health System. Training now offered for Behavioral Wellness staff.
6. Implement in-custody screening program for ADP services.

All of these efforts are consistent with the broad strategy of strengthening prevention, early intervention and outpatient programs to reduce the demand on our higher intensity and more expensive services. The goal is to be more balanced and increase capacity at all level of care with seamless and coordinated transitions. Behavioral Wellness aims to focus on being more welcoming, inclusive, transparent, accountable, responsive, recovery oriented, trauma informed, culturally competent, integrated, co-occurring and complexity competent.

FY 19/20 QI Work Plan Goals

Goal #1: Improve Continuity of Care

Intended Outcome:

- Broad array of providers available within the service continuum to allow for individualized services at varying levels of care
- Increase information sharing/communication between providers during patient transitions between levels of care within the system
- Within the MHP as well as the DMC-ODS, the appropriate level of care is provided after assessment is complete
- Cultural and Ethnic services needs are regularly assessed

Objectives:

- System wide cultural competency assessment completed annually
- Develop a policy to guide continuity of care practices
- Develop a resource document (guide/handbook) which outlines this practice in adherence with the related policy
- Improve coordination of transportation for children and/or families when a child is in residential placement outside of the county for mental health services, to assure continuity of services
- Use LOCRI, ASAM, and other defined tools to support decision making on most appropriate level of care for individual needs
- Utilize feedback from EQRO as a method to make improvements in continuity of care within the system
- Submit accurate and timely NACT reports to DHCS
- Monitor grievances, appeals, and state fair hearings for continuity of care concerns
- Explore CALOCUS implementation in children's system of care

Measurement:

- Complete cultural competence assessment in FY 19/20
- Creation and distribution of policy and resource document - continuity of care
- Documentation of efforts to improve coordination of transportation (agenda's, meeting minutes)
- Create new MIS reports, utilizing ASAM and LOCRI; regular distribution to supervisors and managers
- Documentation (agendas, minutes) of discussion of EQRO feedback for system utilization
- Confirmation of NACT report uploads
- Documentation (agendas, minutes) of discussion - beneficiary concerns (grievances, appeals, state fair hearings)
- Documentation (agendas, minutes) of discussion - CALOCUS

Key Work Groups:

- CFMAC/Peer Action Team
- Clinical Operations
- Community Treatment and Supports
- Community Based Organization Collaborative Meeting
- Data Meeting
- Grievance and Incident Report Committee
- Leadership

Goal #2: Increase Staff Support/Development & Improve Morale

Intended Outcomes:

- Increase staff retention
- Improve quality of care provided to beneficiaries
- Increase staff knowledge base and confidence

Objectives:

- Hire New Clinical Training Coordinator
- Provide RENEW '22 training/presentations to the Department
- Leverage RENEW '22 to invite creative thinking and project ideas among staff
- Pilot surveys such as the Lencioni Team Survey or Telecare's Ecosystem Survey to monitor as a tool to sustain staff morale
- Develop standard onboarding practice for new staff
- Make available ongoing training opportunities for staff development, team building and a positive work force
- Offer routine Supervisor Training Academy and other training on leadership development
- Utilize RENEW '22 data to evaluate project effectiveness and completions, and make all data available to system staff
- Use Relias to assign and track trainings
- Continue to offer routine trainings and make them accessible to all providers

Measurement:

- Clinical Training Coordinator Hired
- Evidence of RENEW '22 training/presentations provided

- Evidence of pilot surveys to assess and improve staff morale
- Evidence of documentation – standardized practice for onboarding staff
- Dates training made available - staff development, team building, culture/morale
- Evidence of data review and utilization – Strategic Plan/Renew 22 indicators for Revision, Re-Balance, Re-Design, Respond and Retain
- Evidence of utilization of Relias for offering, assigning and tracking training for staff and providers

Key Work Groups:

- Change Agents
- Clinical Leads
- Training Division

Goal #3: Improvement to Access and Timeliness

Intended Outcomes:

- Decrease wait times on Access Line
- Utilizing data collected through the Access Contact Sheet, strengthen the system to track timeliness of access across the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) and make recommendations for system improvement
- Regular monitoring of the Department's minimum standard for access to treatment including length of time between initial contact and first substance use disorder treatment and first Medication Assisted Treatment (MAT) appointment for those with opioid and alcohol disorders
- Either in person or telephonic translation will be made available at no charge for persons accessing or receiving services in the MHP or DMC-ODS, and written translation of client materials critical to obtaining services will be made available in English and Spanish
- Improve access to healthcare through increased completion of Health History Questionnaire and increased completion of the identification of client Primary Care Provider (located within the Health History Questionnaire and the Access template)

Objectives:

- Track timeliness of access across the MHP and ODS systems and utilize for system improvement.
- Develop reporting mechanisms to assess access and timeliness to SUD
- Regular review of NOABD forms to track timeliness
- Ensure all MH and SUD services are available in prevalent non-English languages
- Address disparities in referrals, diagnosis and treatment for youth of color
- Track and analyze data on Access line wait times
- Conduct routine test calls to 24/7 Access line (4 per month) and utilize data

- Develop systems to review and report timeliness of specialty mental health authorizations and residential SUD authorizations
- Increase completion of PCP identification
- Improve identification of individuals with co-occurring mental health and substance use disorders who are served by the MHP and DMC-ODS
- Monitor grievances, appeals, and state fair hearings for access and timeliness concerns
- Information on overdose prevention and emergency services at clinics for beneficiaries to easily access
- Track time from orientation group/initial assessment to next appointment to determine if initial assessment is leading directly to continuing care
- Implement RxNT Scheduler to enable tracking of compliance and changes in access and timeliness

Measurement:

- Evidence of data review and discussion – MHP and ODS timeliness data
- Evidence of review and discussion - NOABD data
- Evidence of availability - MH and SUD services in non-English languages
- Evidence of efforts to address RED/Implicit Bias
- Documentation (agendas, minutes) of discussion - Access Line (test calls, wait times)
- Documentation (agendas, minutes) of discussion - timeliness MHP and SUD authorizations
- Evidence of data review and discussion - PCP identification
- Evidence of data review and discussion - identification of co-occurring disorders
- Documentation (agendas, minutes) of discussion - beneficiary concerns (grievances, appeals, state fair hearings)
- Evidence of beneficiary access to information regarding overdose prevention and emergency services
- Evidence of data review and discussion - time from orientation group/initial assessment to next appointment
- Implementation of RxNT Scheduler

Key Work Groups:

- Clinical Leads
- CFMAC/Peer Action Team
- Clinical Documentation Subcommittee
- Clinical Operations
- Data Management Team
- Quality Improvement Committee
- Office of Quality Care and Strategy Management

- ODS Implementation Workgroup

Goal #4: Improve Access, Accuracy, and Sharing of Data

Intended Outcomes:

- Maintain a system of accountability to ensure accuracy and integrity of the data being reported
- Transparency of data with MHP and DMC-ODS system stakeholders, staff, and providers

Objectives:

- Research and Evaluation team to meet with managers and supervisors to discuss data reports for continuous quality improvement
- Make relevant data reports accessible to managers and staff so as to assure transparency and collective agreement on integrity of data
- Make relevant outcome data reports accessible to community based organization partners on a consistent basis
- Explore data exchange methods with community based organizational providers
- Share results of DHCS Consumer Perception Surveys (CPS)
- Maintain "high" (>=3.5) client and family member satisfaction with services – CPS
- Improve response rates and clinic participation - CPS
- Plan for and implement SUD adult client Treatment Perception Survey (TPS)
- Explore implementation of adolescent TPS
- Implement, monitor, and analyze results of CANS, PSC-35, and MORS
- Monitor ADP outcomes
- Track and analyze data on levels of care
- Conduct Network Provider and Recipient surveys to assess the value of services received through contracted providers
- Produce semi-annual and annual data reports that address access, timeliness, quality and outcomes which is available on the department website and accessible to all

Measurement:

- Documentation (agendas, minutes) of discussion - Research and Evaluation Manager and Managers/Supervisors, data for CQI
- Evidence of data availability to staff and providers
- Documentation (agendas, minutes) of discussion - data exchange with CBO providers
- Documentation (agendas, minutes) of presentations - Consumer Perception Surveys (CPS) results (satisfaction, response rates)
- Evidence of implementing the SUD adult client Treatment Perception Survey (TPS)

- Documentation (agendas, minutes) of discussion - possible implementation of adolescent TPS
- Evidence of analysis and utilization of outcome measures and reports - CANS, PSC-35, and MORS
- Evidence of analysis and utilization of ADP outcome data
- Evidence of analysis and utilization of data on levels of care
- Documentation (agendas, minutes) of discussion - results, Network Provider and Recipient surveys
- Semi-annual and Annual data reports available on the department website and accessible to all

Key Work Groups:

- CFMAC/Peer Action Team
- Clinical Operations
- Office of Quality Care and Strategy Management
- Collaborative Contract Provider Meetings
- Data Management Team
- Quality Improvement Committee
- ADP User Group Meetings

Addendum

Santa Barbara County Behavioral Health Care System

Last year, the Department of Behavioral Wellness Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) provided prevention, treatment, rehabilitation and support service to approximately 9,600 clients with mental illness and 4,453 clients with substance use disorders. Individuals needing assistance and wishing access mental health and/or substance use treatment services may call an Access Line at 888-868-1649, which is available to the community 24 hours a day, seven days a week. Services are provided throughout the system of care for Early Childhood Mental Health, Juvenile Justice Mental Health, children/adolescents and families, transition-age youth, and adults throughout the outpatient system, inpatient system and crisis services system. Services provided and teams assigned are based on the individualized level of need of the individuals being served.

MHP

Outpatient Services

The regional County-operated children's and adult outpatient clinics serve adults with serious and persistent mental illness, children with serious emotional disturbances who require long-term medication services, care coordination, case management and transition-age youth. Children and adults are also served through the provider network or contracted agencies. Aside from crisis services, access to services is provided regionally to ensure linkage to care in each individual client location. Screening and referral is provided by centralized Access screeners.

The SBCMHP maintains contracts with 10 individual in–county network providers and approximately 20 out-of-county providers. The MHP also uses contracted CBO's as organizational network providers. In addition, the MHP has contracts with CBO's for Crisis and longer term Residential Programs, Assertive Community Treatment Programs, Supported Housing Programs, Alcohol and Drug prevention and treatment programs, Recovery Learning Centers, Children's Wraparound, Therapeutic Behavioral Services, Intensive In-Home Services and Prevention and Early Intervention programs. For individual needs that cannot be met within the community setting, the MHP contracts with IMD's for adult care and contracts with out-of-county CBO's and residential programs as needed for children's care.

Inpatient Services

Adult consumers are served either through the 16-bed County-operated Psychiatric Health Facility (PHF) or through other contracted hospitals as needed. When all beds at the PHF or existing contracted hospitals are full, the MHP seeks the nearest bed available to the community in other contracted hospitals.

Children who need inpatient services are served through one of our contracted hospitals, usually Aurora Vista Del Mar. In addition, to the extent that financial resources allow, the SBCMHP may contract with any hospital that has a bed available to provide inpatient services for either adults or children if such a contract is needed.

Crisis Services

Santa Barbara County Mental Health Plan has modified the previous system of care to improve urgent/emergent and routine access to care. Mobile Crisis Response teams are located in Santa Barbara, Santa Maria and Lompoc and available throughout the county.
The Mobile Crisis program is responsible for 24/7 crisis response. This ensures that the response to all mental health crisis calls (to Crisis Services, Access, and 911), as well as mental health visits to Emergency Rooms are made by the Department of Behavioral Wellness clinical staff. This ensures both assessment of needs and connection to appropriate services. In addition to crisis needs, the mobile crisis teams respond to urgent needs, helping-connect individuals with necessary supports and provide support during their time of crisis.

South County Crisis Services based in Santa Barbara. Crisis Services is staffed by a multi-disciplinary team of licensed professionals, including a psychiatrist, nurse, LCSWs, and MFTs, as well as unlicensed paraprofessional staff. Of the 20 FTE staff at Crisis Services South, 7 FTE staff members are bilingual. The Santa Barbara site is open from 8:00 a.m. to 6:00 p.m. Monday through Friday. Field-based services are provided to homeless individuals by designated homeless outreach staff from 8:00 a.m. to 7:00 p.m. Access and Mobile Crisis services are available 24 hours per day/7 days per week/365 days per year. A key role of the Crisis Services program is to provide services to individuals in psychiatric crisis, as well as to be the triage point for persons new to our system that are being discharged from psychiatric inpatient facilities.

North County Crisis Services based in Santa Maria is staffed by a multi-disciplinary team of licensed professionals including a psychiatrist, nurse, and MFTs, as well as unlicensed paraprofessional staff who provide interventions for clients in crisis. Of the 18 staff members, 8 are bilingual. North County Crisis Services is open 8:00 a.m. to 5:00 p.m. Monday through Friday, serving the same purpose as South County Crisis Services. Access and Mobile Crisis services are available 24 hours per day/7 days per week/365 days per year.

West County Crisis Services staff is physically located at the Lompoc County-operated adult outpatient clinic seven days a week during regular business hours. During all after business hour periods, the Santa Maria and Lompoc staff share crisis response duties due to lower demand, with response provided to crises in Santa Maria, Lompoc and the neighboring Santa Ynez Valley.

Crisis Residential Services: The MHP contracts for provision of Crisis Residential programs located in both Santa Barbara and Santa Maria regions of the county. Both programs are designed in location to be near other mental health services (the South County Crisis Services program is located on the campus immediately below the PHF and in close proximity to the Crisis Stabilization Unit). The programs both provide short-term 24/7 support and crisis stabilization services to consumers experiencing acute symptoms requiring more than outpatient care but less than acute hospitalization. These are voluntary programs and are supported by licensed and peer staff in both program.

Crisis Stabilization Unit: Located in the South County in Santa Barbara. The CSU offer short-term, rapid stabilization for individuals experiencing psychiatric emergencies. The program serves as an integral component within the overall crisis services system. Brief evaluation, linkage and referral to follow-up care are available. This unit is open 24/7 and offers safe, nurturing short-term, voluntary emergency treatment as an option for individuals experiencing a mental health emergency. Services available up to 23 hours.

Children's Crisis Services: Urgent and crisis needs for children are provided through the Safe Alternatives for Treating Youth (SAFTY) program. In addition, through grant funding, a, new Children's Crisis Triage team has recently been developed. Casa Pacifica, a contracted

organizational provider, operates the SAFTY program. This program works with children and families throughout Santa Barbara County on a short-term, intensive basis to help alleviate crisis situations and provide families with tools to prevent future crises. This program operates on a 24/7 basis, and the staff are authorized by the County to write 5585 petitions with consultation from County staff.

In addition to 24/7 response, SAFTY provides expedited referrals to County-operated Adult and Children's Outpatient Clinics as well as short-term, in-home crisis resolution services.

DMC-ODS

Primary Prevention Services and Early Intervention Services (Level 0.5) include education, environmental prevention, and early intervention services targeted to prevent individuals from abusing substances and to limit access to alcohol and other drugs (AOD) in the community. Primary prevention services include the Strengthening Families Program which is a family skills training program that can significantly improve parenting skills and family relationships, and result in reduced substance abuse and delinquency risk factors.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

Outpatient Services (Level 1.0) and Intensive Outpatient Services (Level 2.1) for substance use disorders consist primarily of counseling and education about addiction-related problems. Outpatient services include intake, assessment, treatment planning, individual counseling, group counseling, family therapy, collateral services, member education, medication services, crisis intervention services, discharge planning, case management, and recovery services.

Opioid Treatment Program (OTP) services are provided in licensed narcotic treatment program facilities providing medication-assisted treatment for Narcotic (Heroin, Vicodin, OxyContin) abuse and dependence. Individuals in OTP attend treatment services daily including taking prescribed doses of methadone and or other medications (including buprenorphine, disulfiram, and naloxone) and attending counseling sessions. OTP's can last from 21 days for detoxification services for to up to years, depending on client need.

Medication Assisted Treatment (MAT) services for substance use disorders are available outside of Opioid Treatment Programs through the use of prescription medications, in combination with counseling and behavioral therapies. MAT services includes the order, prescribing, and monitoring of medications for SUD, particularly to address opioid and alcohol dependence.

Withdrawal Management Services (Level 3.2) are residential detoxification services to safely withdraw from alcohol and other drugs. Withdrawal Management services include intake and assessment, observation (to evaluate health status and response to any prescribed medication), medication services, and discharge planning. Most Withdrawal Management services last from five to seven days.

Residential Treatment (Level 3.1 and 3.5) for substance use disorders is a non-institutional, 24 hour non-medical, short-term residential program that provides rehabilitation services to members with a substance use disorder diagnosis. Residential services require prior authorization

by the county plan and are not to exceed two in a one-year period. Residential services can be for a maximum of 90 days for adults and 30 days for youth.

Youth and Family Treatment Centers provide treatment to youth who have begun using drugs and alcohol, and their families; in the community and through school based counseling services. The focus is youth between the ages of 13 and 17, and these youth centers provide age appropriate developmental services and offer family involvement and case management services

Perinatal Services serve pregnant/post-partum women and women with children who are in need of substance abuse services. Perinatal services include Outpatient Services, Intensive Outpatient Services, and Residential Services. These services are enhanced to address the unique needs of women.

Glossary of Terms

ADP – Alcohol and Drug Program

ASAM – American Society of Addiction Medicine

CALOCUS – Child and Adolescent Level of Care Utilization System

CAP – Corrective Action Plan

CBO – Community Based Organizational Provider

CFMAC – Consumer and Family Member Advisory Committee

CPS – Consumer Perception Survey

CQI – Continuous Quality Improvement

DHCS – Department of Health Care Services

DMC-ODS – Drug Medi-Cal Organized Delivery System

EHR – Electronic Health Record

EQRO – External Quality Review Organization

FTE – Full Time Equivalent (staff)

IMD – Institute for Mental Disease

LOCRI – Level of Care and Recovery Inventory

MAT – Medicated Assisted Treatment

MH – Mental Health

MHP – Mental Health Plan

MIS/IT – Management Information Systems/Information Technology

NACT – Network Adequacy Certification Tool

NOABD – Notice of Adverse Benefit Determination

OQSM - Office of Quality and Strategy Management

PDSA – Plan-Do-Study-Act

PHF – Psychiatric Health Facility

PIP – Project Improvement Plan

POC – Plan of Correction

QCM – Quality Care Management

QI – Quality Improvement

QIC – Quality Improvement Committee

SBCMHP – Santa Barbara County Mental Health Plan

SNF – Skilled Nursing Facility

SUD – Substance Use Disorder

TPS – Treatment Perception Survey

UR – Utilization Review