ALAMEDA COUNTY

BEHAVIORAL HEALTH

MH / SUD Integrated

alameda county
behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

QUALITY IMPROVEMENT PROGRAM AND WORK PLAN

FISCAL YEAR 2018/2019
(July 1, 2018 – June 30, 2019)

Alameda County Behavioral Health Mission Statement:

Our mission is to maximize the recovery, resilience and wellness of all eligible Alameda County residents who are developing or experiencing serious mental health, alcohol or drug concerns.

Background

Purpose and Intent of Work Plan

The Alameda County Continuous Quality Improvement Work Plan (CQIWP) is Alameda County Behavioral Health (ACBH)'s outline for local implementation of the National Quality Strategy (NQS) for improvement in healthcare. The CQIWP integrates feedback from a county-wide stakeholder process, focus groups, Quality Improvement Council (QIC) priorities, along with key NQS concepts.

NQS's aims and priorities serve as the overarching principles for the CQIWP. The CQIWP's four objectives are:

1. **Better Care:** Improve the overall quality, by making health care more person-centered, reliable, accessible, and safe.
2. **Healthy People/Healthy Communities:** Improve the health of Alameda County residents by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
3. **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.
4. **Culturally and Linguistically Competent Care:** Ensure that services are effective, equitable, understandable, and respectful and responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

The CQIWP's six priorities are:

1. Making care safer by reducing the harm caused in the delivery of care.
2. Ensuring that each person and family are engaged as partners in their care.
3. Promoting effective communication and coordination of care.
4. Promoting the most effective prevention and treatment practices for leading causes of mortality.
5. Working with communities to promote wide use of best practices to enable healthy living.
6. Making quality care more affordable to individuals, families, employers, and governments by developing and spreading new health care delivery models.

ACBH will incorporate the current Federal and State Quality Improvement Strategies for Healthcare in the work plan. As referenced by the National Quality Strategy, Alameda's quality improvement goal is to build a consensus so that stakeholders can align their quality efforts for maximum results. This national framework will be utilized in Alameda County for developing quality measures and evaluating the impact of these quality strategies and initiatives on outcomes of care, consumer satisfaction, and cost of care annually.

Through the CQIWP, ACBH will:

- Implement quality improvement activities across the Department;
- Increase the capacity of the ACBH Director's Office to track key indicators addressing beneficiary outcomes, program development, and system change;
- Support decision-making based on performance improvement measures; and,
- Increase quality improvement capability in programs operating across the continuum of care.

Continuous Quality Improvement

Continuous Quality Improvement is a fundamental component of the CQIWP. As a living document, the CQIWP is regularly reviewed, analyzed, and updated by the ACBH Quality Improvement leadership team with input from the QIC and other Stakeholders.

ACBH strives to develop a culture of continuous quality improvement through teamwork, creative problem solving, evidence-based and best practices, diversity and inclusion, and performance management. The CQIWP tries to balance between immediate needs and long-term objectives. The CQIWP seeks the simplest approach that accomplishes the needs of the process and system.

In order to implement the CQIWP, the ACBH QI team will take the following steps:

1. Develop the process for QI leadership orientation and transition;
2. Assess what resources are needed;
3. Establish internal and external communication for all stakeholders; and,
4. Embrace flexibility to address any challenges or unexpected concerns.

The QI team will conduct quarterly meetings to review and discuss progress toward the specific goals and objectives listed in the CQIWP and will present annual reports to ACBH leadership and the QIC.

The QI team will also consider and implement Performance Improvement Projects as described in the following sections. These sections enumerate the strategies, goals, objectives, interventions, activities, and the data and measures for evaluating the CQIWP's attainment of the goals and objectives identified herein.

Staff Training Quality Management

The ACBH Training Officer, a member of the Quality Improvement Committee (QIC), convenes an annual meeting with the training sub-committee, ACBH staff and MH/SUD provider personnel, to determine training activities for the coming year. The Training Officer works with the MH/SUD Sub-Committee members and other content experts

to identify and engage qualified instructors and trainers for specific training subjects and activities that support the ACBH Mission and Vision.

QA activities include QA staff trainings that are based on the state county contract, state and federal regulations and county practice standards including but not limited to: the CQIP; process of monitoring and evaluating the safety and effectiveness of medications; clinical documentation standards; timeliness and access to services; evidence based practices and interventions; Clinicians Gateway (EHR); 42 CFR Part 2/Confidentiality & Privacy Practices (see training calendar for more details). QA staff are crossed trained in MH and SUD services requirements, regulations, standards and ACBH policy.

In the summer of 2018, QA staff attended the SUD Clinical Documentation Standards Training that included at a minimum but not limited to: 1) ASAM LOC, ASAM Assessments & Re-Assessments, Medical Necessity, Intake/Assessment, Progress Notes, Treatment Plans, Case Services/Coordination, Discharge Plans and Recovery Support Services; 2) An overview of SUD Clinical Quality Review Team (CQRT) & ACBH expectations for Provider QA Activities; QI Work Plan, ACBH follow-up responsibility for DHCS PSPP and TA monitoring and utilization reviews; and the ACBH Annual Audit requirement.

Table of Contents: FY 16/17 QI Work plan Goals

SECTION I: ACBH Capacity and Capacity Utilization

Goal: Build and maintain a service delivery system (Network Adequacy) that is adequately accessible to the diverse population of Alameda County.

OBJECTIVE:	**To address lack of adequate access to and utilization of ACBH services for Medi-Cal beneficiaries for members of various racial/ethnic populations by geography.**
BASELINE	1) Asians and Pacific Islanders (API) have a very low penetration rate within Alameda County's ACBH System. 2) A disproportionate number of Adult African-American beneficiaries only receive services within crisis and criminal justice settings instead of community-based outpatient services. 3) Geo-maps: Facility/Program location by Medi-Cal beneficiary population FY2017/18.
ACTION STEPS	• Complete provider and beneficiary maps for mental health and substance use disorder services within Alameda County disaggregated by type of service, age, preferred language, and race/ethnic group. • Explore strategies to increase outpatient services for clients served in crisis and hospital settings. • Explore strategies for increasing outpatient services to mental health clients following release from incarceration. • Develop Performance Improvement Project to improve penetration rates for API beneficiaries. • Establish baselines for penetration rates within SUD services.
MONITORING METHOD/ TIMEFRAME	Publishing Yellowfin Dashboard on County and State DHCS website of Penetration and Retention Rates; Longitudinal data reports describing trends over time and analysis of barriers to access and utilization of SMHS; Semi-Annual review by QIC.
RESPONSIBLE PARTNERS	*Executive Team; CBO Executives; SOC Directors; Network Office Director; QM Division; SUD Administrator*

SECTION II: Access and Timeliness

Goal: Monitor the Timeliness of ACBH for Non-Urgent and Urgent Conditions

OBJECTIVE 1:	**To reduce the average wait time from initial request for non-urgent and non-psychiatry service to the first offered clinical assessment appointment and to the first service by 30% year-over-year.**
BASELINE	1) FY 2017/18 Performance Data from Yellowfin on the number of days from the date of initial service request to the date of the first offered appointment; from the date of the initial service request to the date of the first service. 2) Timeliness from the date of initial service request to the date of the first service, broken down by race/ethnicity, gender, age, and preferred language dashboard reports.
ACTION STEPS	• Develop and deploy tool to measure timeliness at all ACBH helplines, screening and referral entry points, and service-entry points.
MONITORING METHOD/ TIMEFRAME	(Example) Yellowfin dashboards monitoring time between the initial request for service and first service, ACCESS Log of Initial Contacts; test calls; and new tool to record first request for service and first offered appointment.
RESPONSIBLE PARTNERS	*ACCESS Children's and Adults Manager; ASOC, CSOC, QM Division; SUD, Information Systems, Provider Partners*

OBJECTIVE 2:	**Reduce ACBH beneficiaries' average wait time from initial request for service to the Non-Urgent Psychiatry Medication appointment and/or psychiatric assessment by 30% year-over-year.**
BASELINE	1) FY 2017/18 Performance Data from Yellowfin Dashboards on wait times to first available appointment from initial request for service, psychiatric assessment completed, and next service from date of completed psychiatric appointment.
ACTION STEPS	• Pilot site-specific improvement projects to increase timeliness.

MONITORING METHOD/ TIMEFRAME	Yellowfin Dashboards
RESPONSIBLE PARTNERS	*QM Division, ASOC, CSOC, Medical Director's Office*

OBJECTIVE 3:	**To provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met, with 100% accuracy, through the MHP statewide 24/7 toll free number.**
BASELINE	1) Results of FY 2017/18 DHCS Triennial Audit 2) FY 2017/18 Performance Data generated by monthly ACBH Test Calls to the 24/7 toll free number.
ACTION STEPS	• Train ACCESS and After-Hours staff on how to more effectively answer beneficiary questions on how to access SMHS services, including how to assess whether medical necessity is met. • Remind staff on an ongoing basis regarding the importance of documenting all calls coming into the 24/7 line, including caller/beneficiary name. • Review monthly test calls for accuracy and completeness of information given to beneficiaries. ACCESS program manager reviews all test calls, sends report to QA and follows up with ACCESS staff and after-hours supervisor with results of test calls.
MONITORING METHOD/ TIMEFRAME	ACBH test calls will be made monthly to the 24/7 toll free number both during and after business hours, and in languages other than English.
RESPONSIBLE PARTNERS	*QM, QA, ACCESS Manager, and After-Hours Supervisor and Executive Director.*

OBJECTIVE 4:	**To provide information to beneficiaries about how to access SUD services, including residential treatment, through the 24/7 toll free Substance Use Access and Referral Helpline.**

BASELINE	1) Results of FY 2017/18 Performance Data generated by monthly reports
ACTION STEPS	• Train SU Access and Referral Helpline staff on how to more effectively answer beneficiary questions on how to access SUD services, including how to improve screening using the ASAM Level of Care and referring to external resources (housing, mental health) • Remind staff on an ongoing basis regarding the importance of documenting all calls coming into the 24/7 line, including caller/beneficiary name. • Review quarterly test calls for accuracy and completeness of information given to beneficiaries, sends report to QA and follows up with Helpline staff regarding with results of test calls.
MONITORING METHOD/ TIMEFRAME	ACBH test calls will be made quarterly to the 24/7 toll free number both during and after business hours, and in languages other than English.
RESPONSIBLE PARTNERS	*QM, QA, SUD Administrator and Crisis Support (After-hours) Supervisor and SUD Senior Project Manager.*

SECTION III: Service Utilization in the Specialty Mental Health Care and Substance Use Disorder Continuums of Care

Goal: Develop and implement a utilization data reporting system for both SMHS and Specialty SUD services to detect overutilization, underutilization, and inefficient utilization of resources and help ACBH executive leaders make informed system of care decisions.

OBJECTIVE 1:	**The Utilization Management Program to establish utilization levels, patterns of care, utilization practice patterns, and utilization trends for both SMHS and specialty SUD services**
BASELINE	1) FY 2017/18 customized SMHS InSyst hospital services reports and Yellowfin dashboards to indicate service modality utilization, further broken down by provider/reporting unit. 2) FY 2017/18 UM High Risk Tracking Yellowfin dashboard, which contains all active and closed SMHS acute psychiatric hospital episodes for all hospital reporting units; UM clinical staff via concurrent hospital review identify high risk clients; make specific lower-level-of-care disposition and aftercare recommendations; log and track recommendations, outcomes, and a client's longitudinal treatment history. 3) FY 2017/18 customized InSyst specialty SUD services reports and Yellowfin dashboards to establish utilization benchmarks for specialty SUD services in the DMC-ODS.
ACTION STEPS	• UM to further collaborate with Information Systems (IS) and Data Services to develop and implement a more comprehensive SMHS utilization data reporting system, to include the non-hospital services and macro and micro-level movement of clients in the SMHS continuum of care. • UM to collaborate with IS and Data Services to develop a comprehensive specialty SUD services utilization data reporting system, inclusive of all service modalities.
MONITORING METHOD/ TIMEFRAME	Monthly, Quarterly, and Annual customized InSyst reports; Yellowfin Dashboards.

RESPONSIBLE PARTNERS	*Quality Management: Utilization Management, Information Systems, Data Services; ACBH Executive Leadership*

OBJECTIVE 2:	**To reduce utilization of SMHS acute hospital and sub-acute services and establish baseline utilization of specialty SUD residential services.**
BASELINE	1) FY2017/18 average annual costs per client served in the SMHS and SUD services delivery systems, further broken down by service modalities. 2) FY 2017/18 customized InSyst reports and Yellowfin dashboards to indicate service modality utilization, further broken down by provider/reporting unit. 3) FY 2017/18 UM High Risk Tracking Yellowfin dashboard, which contains all active and closed SMHS acute psychiatric hospital episodes for all hospital reporting units; UM clinical staff via concurrent hospital review identify high risk clients; make specific lower-level-of-care disposition and aftercare recommendations; log and track recommendations, outcomes, and a client's longitudinal treatment history.
ACTION STEPS	• Implement a pilot project using the following strategies: 1) Reducing the 30-day re-hospitalization rates. 2) Increasing the number of post-hospital discharge appointments attended. 3) Reducing the number of clients in sub-acute facilities. 4) Increasing the number of FSP members and programs. 5) Increasing the number of Assisted Outpatient Treatment (AOT) members and programs. 6) Increasing the number of community conservatorship pilot members. 7) Increasing outpatient planned service utilization rates for frequent utilizers of crisis, emergency, and inpatient hospital services. • Establish written and publicized definitions of service modalities, to include medical necessity criteria, and process by which to access and move within the SMHS and DMC-ODS continuums of care.

MONITORING METHOD/TIMEFRAME	Monthly, Quarterly, and Annual customized Insyst reports; Yellowfin Dashboards.
RESPONSIBLE PARTNERS	*Quality Management: Utilization Management, Information Systems, Decision Support; Executive and SOC Directors, AOD Administrator*

SECTION IV: Crisis and Inpatient Service Capacity and Performance

Goal: Reduce the inappropriate utilization of emergency, crisis, and inpatient services, including psychiatric hospital bed days, crisis stabilization unit/psychiatric emergency services intakes/admissions, and crisis residential bed days.

OBJECTIVE 1:	**To increase the rate of completed appointments scheduled within 7-day and 30-days post-hospital discharge appointments.**
BASELINE	1) FY2017/18 Performance Data from Yellowfin on the appointment show/no-show rate within 7-days post-hospital discharge and 30-days post-hospital discharge.
ACTION STEPS	• Review data describing hospitals and outpatient programs where metric was met for a cohort of clients. Talk with hospital/program staff to identify business processes that contributed to outpatient services being received *within* 7 days post discharge. • Explore what circumstances might impact a client's ability to "make it" to appointments. • Improve discharge planning between inpatient and outpatient staff and providers through the active involvement of members with utilization management committee. • Establish desk procedures during the date of discharge for a warm hand-off of clients with repeated hospital admissions during a 30-day period.
MONITORING METHOD/ TIMEFRAME	Yellowfin Dashboard
RESPONSIBLE PARTNERS	*Adult and Children's System of Care Directors; Partner Hospital Administrators/Utilization Review Directors; ACBH Critical Care Managers; Cherry Hill Detoxification Services; SUD Residential Helpline; Quality Management Division; Medical Director*

OBJECTIVE 2:	**To reduce 30-day readmission rates at acute psychiatric hospitals by utilizing intensive case-management.**
BASELINE	1) FY 2017/18 UM High Risk Tracking Yellowfin dashboard, which contains all active and closed acute psychiatric hospital episodes for all hospital reporting units; UM clinical staff via concurrent hospital review identify high risk clients; make specific lower-level-of-care disposition and aftercare recommendations; log and track recommendations, outcomes, and a client's longitudinal treatment history. 2) FY 2017/18 Performance Data from Yellowfin dashboards.
ACTION STEPS	• Review FY 2017/18 identified high risk clients via UM High Risk Tracking Yellowfin dashboard to determine effectiveness (i.e. statistically significant reduction in 30-day readmission rates) of UM client-specific disposition and aftercare recommendations. • Complete "walk through" and identify connection between discharge planning processes and outpatient service engagement rates for clients discharged from Partner Acute Psychiatric Hospitals and Psychiatric Health Facilities. • Review experience of a sample of hospital clients with recidivism histories. • Identify resources that might be developed to serve hospital discharges and promote stability and wellness. • Complete analysis. • Evaluate options, including a peer-assisted "linkage program" for consumers discharged from hospitals to ACBH programs.
MONITORING METHOD/ TIMEFRAME	Yellowfin dashboards; interviews with clients and hospital personnel and "destination" outpatient programs.
RESPONSIBLE PARTNERS	*Adult and Children's System of Care Directors; John George Psychiatric Pavilion Administrator; ACBH Critical Care Manager; Children's Hospital Administrator; other Partner Hospitals; Quality Management Division; Medical Director*

OBJECTIVE 3:	**Reduce the response time of the ACBH ACCESS line via the 24-hour toll free number by 30 percent by the prior year.**
BASELINE	1) FY2015/16 Performance Data from Access log and Data Tracking database.
ACTION STEPS	• Measure the responsiveness of the ACBH's 24-hour, toll free number through internal audits, phones calls and mystery shoppers. • Training for access staff on issues identified by a process improvement process. • Change 24/7 policy to ensure ACCESS and the 24/7 vendor ask the name of each caller who uses the 24/7 line and can document that the caller was contacted.
MONITORING METHOD/ TIMEFRAME	Test calls will be made during the FY at specified intervals throughout the day with test callers presenting a myriad of problems varying in complexity, scope and required response. Call details and success of callers in being advised on access to services.
RESPONSIBLE PARTNERS	*Quality Management; Quality Assurance; ACCESS Manager*

SECTION V: Coordination of Care

Goal: Improve the coordination of care between the ACBH, physical healthcare agencies, and SUD services.

OBJECTIVE 1:	**To improve the coordination of care between the ACBH and physical healthcare agencies by establishing an MOU to formalize relationship, roles, and responsibilities.**
BASELINE	1) FY2017/18 Performance Data (Number of shared clients involved in joint case planning and conferencing) as evidenced by Yellowfin dashboards
ACTION STEPS	• Identify best practices in data sharing procedures and electronic health record systems used by current Behavioral Health/Primary Care collaboration projects. • Develop a training plan and resources to implement a workshop series and collaborative focused on process improvement/ coordination of care. • Participate in the whole person care pilot • Improve the implementation and monitoring of current MOUs that Medi-Cal / Drug Medi-Cal managed care plans (MCPs) are currently required to sign with ACBH. • Establish a data-sharing agreements with primary care • Develop and establish consensus on joint outcome measures for shared members/beneficiaries, MCPs, county specialty mental health plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS). ACBH would be jointly responsible for improving health outcomes as measured by: 1) Reducing avoidable emergency room/PES visits 2) Reducing acute hospital stays of joint clients/patients 3) Real-time Information sharing capacity for members who meet medical necessity criteria for Medi-Cal Specialty Mental Health Services and DMC-ODS Services and primary care staff at Federally Quality Health Clinics.
MONITORING METHOD/ TIMEFRAME	MOU and data sharing activities annual reports.
RESPONSIBLE PARTNERS	*ACBH Training Officer; QM Division; Integration Workgroup; ACBH Behavioral Health Primary Care Manager*

OBJECTIVE 2:	**To improve access to physical healthcare for clients receiving ongoing ACBH services by adding physical healthcare on site and improving coordination of physical healthcare services.**
BASELINE	2) FY2017/18 ACBH case managed clients receiving primary care.
ACTION STEPS	• Explore adding primary care to behavioral health sites by expanding the PATH Clinic Model • Explore adding nurse care coordinators to behavioral health teams • Develop reporting for managing primary care coordination for SUD clients.
MONITORING METHOD/ TIMEFRAME	Yellowfin Dashboards
RESPONSIBLE PARTNERS	*Office of the Medical Director; QM Division; ASOC; CSOC;* SUD Director

SECTION VI: Beneficiary Experience and Satisfaction

Goal: Improve the overall client experience with services rendered and client satisfaction.

OBJECTIVE 1:	**To conduct semi-annual beneficiary/Client Satisfaction Surveys with ACBH in FY2016/17 measuring client experience and satisfaction.**
BASELINE	1) FY2014/15 MHSIP Survey Results 2) FY2017/2018 SUD Survey Results
ACTION STEPS	• Develop a beneficiary/family satisfaction survey designed for use across our continuum-of-care, and provides timely and usable results back to providers and administration. The survey will be beta tested in a sample of providers located across the continuum of care. • Develop reports of satisfaction data for analysis and interventions. • The Workgroup will use results to make recommendations to the QIC.
MONITORING METHOD/ TIMEFRAME	Establishment of survey timelines and reporting survey results to stakeholders annually.
RESPONSIBLE PARTNERS	*Consumer Relations Team; Family Relations Manager; FERC; ACNMHC; PEERS; Family Partners; Patient Advocate; ASOC; CSOC; QM Division; Alameda County Alcohol and Drug Provider Committee*

OBJECTIVE 2:	**To improve the client experience with the Grievance and Appeal Process as documented by post-service satisfaction surveys.**
BASELINE	1) Upon request of the Mental Health Board, the ACBH completed an analysis of the beneficiary grievance and appeal process. 2) ACBH policies regarding expedited appeals are unevenly implemented; appeal resolution documentation did not consistently meet contractual requirements; information about state fair hearings was not consistently communicated to clients.

	3) Integrate SUD Grievance and/or Appeals Process into MH policy and procedures.
ACTION STEPS	• Review and implement relevant results of the Consumer Complaint and Grievance Process Review**.** • Make corrections to the log/database. • Train line worker to correctly identify and categorize calls and to use the corrected Excel database. Correct all forms and letters to include the information on State Fair Hearings and to meet all pertinent regulations. • Update the ACBH Beneficiary and Family Grievance and Appeal policy and procedure to clearly define grievances and appeals and the process to file grievances and appeals; make this policy and procedure accessible to the public. • Update the Grievance Poster and Consumer materials including translations into all threshold languages. • Bring the Consumer Grievance Phone Line 'in house' to be directly supervised by the Quality Assurance Office and staffed by a licensed LPHA with background in mental health consumer services.
MONITORING METHOD/ TIMEFRAME	Annual report of the client satisfaction survey.
RESPONSIBLE PARTNERS	*Consumer Relations Team; Family Relations Manager; FERC; ACNMHC; PEERS; Patient Advocate; Family Partners; ASOC; CSOC; QM Division; Alameda County Alcohol and Drug Provider Committee*

SECTION VII: Provider Appeals and Problem Resolution Process

Goal: Improve provider relations to reduce provider complaints and appeals year over year.

OBJECTIVE 1:	**To establish a formal provider problem resolution process pursuant to Title-9 as an effective means of identifying, resolving and preventing the recurrence of provider problems with the ACBH's authorization and other processes.**
BASELINE	1) FY 2017/18 Logs of Provider Complaints and Appeals kept by QA. 2) FY 2017/18 Logs of Provider 1st and 2nd Level Appeals for SMHS hospital service reimbursement denials kept by UM.
ACTION STEPS	• Establish and publish provider problem resolution and appeal policy and procedure for both SMHS and SUD services. • Build the infrastructure for effectively resolving provider appeals, complaints, and grievances. • Produce annual reports and submit reports to the QIC.
MONITORING METHOD/ TIMEFRAME	Provider appeal log, provider appeal summaries and provider follow-up calls. Completion date of January 2019.
RESPONSIBLE PARTNERS	*Quality Management Division: UM and QA; ACCMHA; Provider Relations*

SECTION VIII: SMHS and Drug Medi-Cal Documentation and Standards of Clinical Practice

Goal: Improve clinical documentation practices and understanding to reduce audit disallowances and denied services.

OBJECTIVE 1:	**To conduct chart reviews/audits quarterly to reduce disallowance rates and loss revenues.**
BASELINE	1) FY 2017/18 disallowance rates from quarterly QA audits. 2) FY 2016/17 DHCS Triennial System-wide audit. 3) FY 2017/18 DHCS Short-Doyle/ Medi-Cal (SD/MC) Hospital (aka John George Psychiatric Hospital) audit. 4) FY 2017/18 establish baseline from SUD System Of Care audits
ACTION STEPS	• Complete a review of chart documents for ACBH quarterly using a randomly selected number of medical charts. The annual target is 5% of mental health clinical charts and selected SUD charts. • Complete draft revisions of core mental health clinical forms within the fiscal year for inclusion into the EHR including progress notes, clinical/psychiatric assessments, and client plans. • Complete draft revisions of core SUD clinical forms within the second fiscal year for inclusion into the EHR including progress notes, clinical/LPHA assessments, and client plans. • Produce audit reports, plans of correction, and technical assistance to providers to improve audit results. • Conduct trainings and technical assistance for providers to improve their knowledge and skills relevant to documenting medical necessity and Medi-Cal documentation timeliness standards and required elements. • Utilization Management clinical staff to engage in regular and consistent clinical case review and at a minimum yearly inter-rater reliability studies for both SMHS and SUD services, as mechanisms to ensure consistent application of review criteria for authorization decisions.

MONITORING METHOD/ TIMEFRAME	Audit Reports, completed draft forms, committee findings, and minutes, plan of corrections, Quality Management Systems Assessment Report.
RESPONSIBLE PARTNERS	*Quality Management: Quality Assurance; Utilization Management.*

SECTION IX: Quality Improvement Program

Goal: Improve the ACBH's Quality Improvement program infrastructure through the addition of a QI Coordinator and implementation of best practices to guide QI processes.

OBJECTIVE 1:	**Maintain the number of Consumers, Providers, and Family Members active in the planning, design and execution of QI Programs through active recruitment in QIC and sub-committees.**
BASELINE	1) FY2017/18 QIC Membership Roster
ACTION STEPS	• The QM Director and ACBH Director will consider the recommendation to use operational workgroups to implement Work plan Goals and circulate findings to the QIC. • Workgroups will act as subcommittees of the QIC and consisting of providers, consumers, family members and ACBH Staff.
MONITORING METHOD/ TIMEFRAME	The number of diverse stakeholders that are members of the QIC and/or sub-committees reported annually to the QIC.
RESPONSIBLE PARTNERS	*QM Division; QIC Partners; Behavioral Health Director*

OBJECTIVE 2:	**To increase the number of ACBH Professional and Support staff during FY17/18 by 14 FTEs in the key areas of Quality Improvement and SUD SOC.**
BASELINE	1) In FY 17/18, the QI function was staffed by of 3.5 FTE. 2) SUD functions across ACBH are staffed by three .2 and two .5 FTE, 1.0 AOD Administrator, and 1.0 Program Specialist
ACTION STEPS	• Hire a Division Director for Quality Improvement. • Hire a Division Director for Utilization Management.

	• Add 3 FTE to the Quality Improvement Performance Management Team. • Add 3 FTE to the Quality Improvement Project Team • Add 6 FTE to implement and sustain the ACBH DMC ODS Implementation Plan. • Formalize linkage between the Quality Improvement Unit and three ACBH departments/functions that are integral to the Quality Improvement Program: Data Services, Quality Assurance, and Utilization Management. • The Quality Improvement Unit and designated ACBH staff from Quality Assurance, Decision Support, and Utilization Management will work together to manage the QI Work plan reporting cycle, work with QI Workgroups and track the implementation of mechanisms that monitor and assess quality improvement. • Provide annual reports of progress and deliverables at monthly QIC meetings.
MONITORING METHOD/ TIMEFRAME	Increase in FTEs and restructuring the organizational chart to ensure reporting authority and responsibility.
RESPONSIBLE PARTNERS	*QM Division; Behavioral Health Director; AOD Administrator; Quality Management Director*

Appendix

Penetration and Utilization Rates by Race/Ethnicity

All Clients – Mental Health Service Utilization

Ethnicity/Race (all age groups)	County Population (2010 Totals)	Total Clients Served	Penetration Rate
African American	185,440	9,184	5.0%
Asian/PI	407,185	2,410	0.6%
Caucasian	517,696	5,883	1.1%
Latino	341,125	6,499	1.9%
Native American	4,265	164	3.8%
Other/Unknown	57,294	6,045	10.6%
Total	**1,513,005**	**30,185**	**2.0%**

All Clients – Substance Use Disorder Service Utilization

Ethnicity/Race (all age groups)	County Population (2010 Totals)	Total Clients Served	Penetration Rate
African American	185,440	2,605	1.4%
Asian/PI	407,185	325	0.08%
Caucasian	517,696	2,256	0.44%
Latino	341,125	882	0.26%
Native American	4,265	75	1.76%
Other/Unknown	57,294	1,613	2.82%
Total	**1,513,005**	**7,756**	**0.51%**

Mental Health Services: Medi-Cal Penetration Rates by Ethnicity

Race/Ethnicity	Beneficiaries	Served	Penetration Rate
African-American	95,168	7,566	8.0%
Asian & Pacific Islander	122,884	1,904	1.6%
Caucasian	66,216	4154	6.3%
Latino	154,177	6,255	4.1%
Native American	1,449	124	8.6%
Other/Unknown	95,027	4,462	4.7%

Substance Use Disorder Services: Medi-Cal Penetration Rates by Ethnicity

Race/Ethnicity	Beneficiaries	Served	Penetration Rate
African-American	93,876	2,049	2.18%
Asian & Pacific Islander	116,850	181	0.15%
Caucasian	64,746	4154	6.42%
Latino	126,410	860	0.68%
Native American	1,435	37	2.58%
Other/Unknown	92,228	1,02	1.11%