alameda county
behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Integrated Mental Health & Substance Use Disorder

Quality Improvement Work Plan (QIWP)

Fiscal Year 2020-2021

Mission:

Alameda County Behavioral Health (ACBH)'s 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.

Vision:

We envision communities where all individuals and their families can successfully realize their potential and pursue their dreams, and where stigma and discrimination against those with mental health and/or alcohol and drug issues are remnants of the past.

Quality Improvement Work Plan (QIWP):

ACBH is committed to a culture of continues quality improvement (CQI), as described in this QIWP. Our primary CQI objectives, adapted from the National Quality Strategy for Improvement in Healthcare, are:

- **Better Care:** Improve the overall quality, by making health care more person-centered, reliable, accessible, and safe.
- **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.
- **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.
- **Culturally and Linguistically Responsive 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.

Through the QIWP, ACBH will:

- Implement quality improvement activities across the Department;
- Increase the capacity of ACBH's leadership and Quality Management staff 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.

As a living document, the QIWP is regularly reviewed, analyzed, and updated by ACBH's Quality Improvement team with input from the Quality Improvement Committee and other stakeholders.

Section I. Quality Improvement Monitoring Activities

ACBH Quality Improvement staff work closely with Quality Management staff and other stakeholders to monitor the following activities on a regular basis to ensure meaningful improvement in clinical care and beneficiary service:

Area Monitored	Data Reviewed	Partners	FY 2020-2021 Objectives
Performance Data	Timeliness, network adequacy, and other mandatory performance measures	Quality Improvement; Data Services/ Information Systems	ACBH will improve the capacity to measure timeliness outcomes, network adequacy, and other required performance measures. ACBH will set appropriate objectives based on benchmarks.
Utilization Data	Service modality, units of service, beneficiary demographics	Utilization Management; Quality Improvement; Data Services/Information Systems	ACBH will improve the utilization data reporting system for both MHP and DMC-ODS delivery systems.
Beneficiary Grievances	Annual Beneficiary Grievances and Appeals Report	Quality Assurance	ACBH will continue monitoring grievances and analyzing trends. ACBH will establish an automated tracking system for grievances.
Appeals & Expedited Appeals	Annual Beneficiary Grievances and Appeals Report	Quality Assurance	ACBH will continue monitoring appeals and analyzing trends.
Fair Hearings & Expedited Fair Hearings	Fair Hearings & Expedited Fair Hearings log	Utilization Management	ACBH will continue monitoring fair hearings and analyzing trends.

Area Monitored	Data Reviewed	Partners	FY 2020-2021 Objectives
Provider Appeals	Provider Appeals Log	Provider Relations; Quality Assurance; Network Office; Utilization Management	ACBH will continue monitoring provider problems and appeals and will create a system for tracking problems and appeals.
Clinical Records Review	Federal, State, and County Audit Reports (e.g. summary reports, claims sheets and recoupment) and utilization review findings (e.g. authorization determinations)	Quality Assurance; Utilization Management; Integrated Health Care Services	ACBH will evaluate appropriateness and quality of services rendered and improve coordination of care. Training and technical assistance will be available to providers to ensure understanding of documentation standards and to improve quality of documentation that reflects service and medical necessity.
Unusual Occurrences (UOs)	Unusual Occurrences log	Quality Assurance	ACBH will continue monitoring appeals and analyzing trends. ACBH will establish a quarterly workgroup to analyze UOs and recommend system changes. ACBH will create an automated system for tracking UOs.
Beneficiary Surveys	MH: Mental Health Statistics Improvement Plan Consumer Survey (MHSIP) (Consumer Perception Survey (CPS)) SUD: Treatment Perception Survey (TPS)	Quality Improvement; Office of Consumer Empowerment; Substance Use Disorder System of Care	ACBH will continue implementing and monitoring the results of the beneficiary surveys (biannual for mental health and annual for SUD) and analyzing trends based on demographics and services provided. ACBH will try to improve participation across all providers, program types, and demographics to ensure representative responses. ACBH will share survey results with providers.

Section II. Quality Improvement Projects

A. Performance Improvement Projects (PIPs)

1. Clinical PIP – Mental Health

AREA:	Quality of Care
OBJECTIVE:	Determine whether deploying a mobile team pairing a licensed behavioral health clinician with an emergency medical technician in response to 9-1-1 emergency calls to transport clients to appropriate alternative services can reduce psychiatric emergency services (PES) admissions and recidivism for adults over a thirty-month period.
INDICATOR(S) & BASELINE:	▪ Percent of CATT clients who end up on involuntary holds at PES: 82.2% ▪ Rate of readmission to PES within 7, 30, and 60 days: 7 days: 16.1%; 30 days: 34.6%; 60 days: 43.0% ▪ Percent of clients who connect to outpatient services within 7, 30, and 60 days after discharge from PES: 7 days: 20.1%; 30 days: 27.3%; 60 days: 29.0% ▪ Percent of EMS Mental Health Calls that result in 5150s: TBD *All baseline measures are based on FY 19-20 Psychiatric Emergency Services clients
ACTION STEPS:	▪ Deploy crisis transport teams to connect clients to appropriate alternative services ▪ Use Community Health Record to support care coordination ▪ Use Reddinet to determine services availability
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring Customized administrative data reports – monthly reporting
RESPONSIBLE PARTNERS:	Quality Improvement Committee; Office of the Medical Director – Crisis Unit; Adult and Older Adult System of Care; Contracted Providers (Bonita House); Emergency Medical Services; 9-1-1 dispatch; Alameda County Care Connect; Local Law Enforcement; External Evaluator (Public Consulting Group)

2. Non-Clinical PIP – Mental Health

<table>
<tr><td>AREA:</td><td>Access, Cultural Responsiveness</td></tr>
<tr><td>OBJECTIVE:</td><td>Determine whether providing a language assistance line for all providers for and all services will improve the penetration rates and outcomes for beneficiaries whose primary language is a non-English threshold language – especially for beneficiaries whose primary language is an Asian or Pacific Islander language – by 10%.</td></tr>
<tr><td>INDICATOR(S) & BASELINE:</td><td>▪ Penetration rates for non-English speakers: 2.8% overall, 2.4% outpatient
<table>
<tr><th>Language</th><th>Overall Penetration Rate</th><th>Outpatient Penetration Rate</th></tr>
<tr><td>Non-English</td><td>2.8%</td><td>2.4%</td></tr>
<tr><td>Cantonese</td><td>1.03%</td><td>0.90%</td></tr>
<tr><td>Mandarin</td><td>0.59%</td><td>0.54%</td></tr>
<tr><td>Vietnamese</td><td>1.19%</td><td>0.96%</td></tr>
<tr><td>Tagalog</td><td>1.29%</td><td>0.95%</td></tr>
<tr><td>Arabic</td><td>1.63%</td><td>1.30%</td></tr>
<tr><td>Farsi</td><td>4.61%</td><td>3.98%</td></tr>
</table>
*All data is from FY 18-19.</td></tr>
<tr><td>ACTION STEPS:</td><td>▪ Continue training providers on utilizing language line and telephonic interpreters
▪ Implement video language line
▪ Collect and analyze data regarding language line utilization, service utilization, and penetration rates
▪ Analyze results to determine lessons learned to be incorporated into ACBH system</td></tr>
<tr><td>MONITORING METHOD/ TIMEFRAME:</td><td>Yellowfin dashboards – continuous monitoring

Language line utilization reports – monthly monitoring</td></tr>
<tr><td>RESPONSIBLE PARTNERS:</td><td>Quality Improvement Committee; Quality Assurance; Office of Ethnic Services; Cultural Responsiveness Committee; Adult System of Care; Children’s System of Care; Contracted Providers</td></tr>
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3. Clinical PIP – Substance Use Disorder

AREA:	Quality of Care
OBJECTIVE:	Determine whether providing a recovery coach following withdrawal management will increase the number of clients connected to outpatient or residential SUD services following discharge by 20%
INDICATOR(S) & BASELINE:	▪ % of withdrawal management clients assessed for outpatient level of care connected to outpatient services within 30 days of discharge ▪ % of withdrawal management clients assessed for outpatient level of care engaged with outpatient services for 30 days following initial appointment ▪ % of withdrawal management clients assessed for outpatient level of care engaged with outpatient services for 60 days following initial appointment ▪ % of withdrawal management clients assessed for outpatient level of care who return to withdrawal management ▪ % of withdrawal management clients assessed for residential level of care connected to residential services within 30 days of discharge ▪ % of withdrawal management clients assessed for residential level of care engaged with residential services for 30 days following initial appointment ▪ % of withdrawal management clients assessed for residential level of care engaged with residential services for 60 days following initial appointment ▪ % of withdrawal management clients assessed for residential level of care who return to withdrawal management
ACTION STEPS:	▪ Assign recovery coach to withdrawal management clients to support transition to residential services, in addition to current outpatient services ▪ Collect and analyze data regarding client engagement and outcomes ▪ Analyze results to determine lessons learned to be incorporated into ACBH system
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring Yellowfin reports – monthly reporting
RESPONSIBLE PARTNERS:	Quality Improvement Committee; Substance Use Disorder System of Care; Quality Assurance; Data Services/ Information Systems; Contracted Providers

4. **Non-Clinical PIP – Substance Use Disorder**

AREA:	Access to Care
OBJECTIVE:	Does implementation of 1) improved procedures for processing individuals waiting for residential treatment services, 2) three-way calling protocol for intake appointments, and 3) a bed availability mobile application improve timeliness of access to residential treatment by 20% and improve bed utilization of residential treatment beds by 20%?
INDICATOR(S) & BASELINE (FY 18-19):	▪ % of residential treatment bed capacity utilized by clients: 52% (22,074/42,136) ▪ Average time from referral screening to first scheduled residential treatment services appointment: 9.09 days ▪ Average time from referral screening to first actual residential treatment services appointment: 16.43 days ▪ % of three-way calls between residential treatment provider and referral counselor, with intent to schedule a residential treatment services intake appointment for the beneficiary: N/A ▪ % of providers who update their bed availability at least once per day: N/A *All data is from FY 18-19.
ACTION STEPS:	▪ Modify interim services list procedures to expedite connection to programs ▪ Implement three-way call process post-screening for potential residential treatment client with residential treatment provider ▪ Implement bed availability mobile application ▪ Collect and analyze data regarding client engagement and outcomes ▪ Analyze results to determine lessons learned to be incorporated into ACBH system
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring Yellowfin reports – monthly reporting
RESPONSIBLE PARTNERS:	Quality Improvement Committee; Substance Use Disorder System of Care; Data Services/Information Systems; Contracted Providers

B. Quality Improvement Projects (QuIPs)

AREA 1:	Standards of Clinical Practice & Provider Capacity
OBJECTIVE:	Increase number of individuals trained and availability of trainings by implementing online training modules for Quality Assurance (QA) trainings by 10%.
INDICATOR & BASELINE:	▪ 738 individuals completed QA training (by topic) (FY 19-20) ▪ Number of individuals completing online QA training (by topic)
ACTION STEPS:	▪ Create online training modules for quality assurance including for clinical documentation ▪ Set up online training software ▪ Develop training material and content for key QA topics ▪ Produce trainings and publish online ▪ Develop tracking mechanism for completion of online trainings
MONITORING METHOD/ TIMEFRAME:	Customized report on trainings through tracking system – monthly
RESPONSIBLE PARTNERS:	Quality Assurance; Workforce Employment and Training; Information Systems; Contracted Providers

AREA 2:	Continuity and Coordination of Care
OBJECTIVE:	Improve transition of consumers between Transition Age Youth (TAY) providers and Adult and Older Adult System of Care providers by 10%.
INDICATOR & BASELINE:	▪ Number and percent of TAY consumers referred to adult system of care programs who receive Level 1 and FSP services: 95% (41/43) (FY 19-20) ▪ Number and percent of TAY consumers referred to adult system of care programs who receive Level 1 and FSP services that are still connected to adult services after six months: 87% (60/69) (FY 18-19) ▪ Number and percent of TAY consumers referred to adult system of care programs who receive Level 1 and FSP services that are still connected to adult services after twelve months: 77% (53/69) (FY 18-19) ▪ Average and median length of time between when clients are open to adult programs and when TAY provider closes services: 35.3 Average; 0 Median (FY 19-20)
ACTION STEPS:	▪ Develop outcome goals and accompanying reports to track outcomes ▪ Implement Transition Protocol for TAY to adult system of care

	▪ Send report of clients turning 25 within 6 months to TAY providers to ensure all appropriate clients are referred for transition
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboard – continuous monitoring
RESPONSIBLE PARTNERS:	Children and Young Adult System of Care; Adult and Older Adult System of Care; Quality Improvement Committee

AREA 3:	Performance Measurement and Management
OBJECTIVE:	Distribute or improve access to performance dashboards for all contracted providers
INDICATOR & BASELINE:	▪ Number of providers (agencies) with access to Yellowfin: 8 (7/1/20) ▪ Number of providers (individuals) with account-specific access to Yellowfin: 16 (7/1/20) ▪ Number of providers (agencies) that log into Yellowfin at least once a month: 6 (7/1/20) ▪ Number of providers (individuals) that log into Yellowfin at least once a month: 6 (7/1/20) ▪ Number of Yellowfin Hour attendees: ▪ Number of automated data broadcasts sent to contracted providers per month from ACBH Business Intelligence (BI) ▪ Number of individuals that receive automated data broadcasts per month from ACBH BI ▪ Number of agencies that receive automated broadcasts/data emails per month
ACTION STEPS:	▪ Create or improve Yellowfin dashboards that enable providers to review performance data for quality improvement, including hosting a public website with aggregate performance dashboards ▪ Improve process and publish guide for connecting providers to Yellowfin accounts for provider-specific/client-level data, in coordination with Information Systems Network Team and Privacy Officer ▪ Distribute access to providers – both entities and individuals – who are not yet on Yellowfin ▪ Provide regular trainings for providers to support and improve utilization of Yellowfin data ▪ Create a public-facing Power BI County Behavioral Health Dashboard
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboard – monthly reporting Report on number of public website dashboard views – monthly reporting
RESPONSIBLE PARTNERS:	Data Services/Information Systems; Information Systems/Systems Network; Contracted Providers; Quality Improvement Committee; Office of Privacy and Compliance

AREA 4:	Cultural Responsiveness
OBJECTIVE:	Improve collection and analysis of sexual orientation and gender identity and expression (SOGIE) data for mental health and substance use disorder consumers by 20%.
INDICATOR & BASELINE:	▪ Number of MH agencies collecting SOGIE data: 26 ▪ Number of SUD agencies collecting SOGIE data: 12 ▪ Number and percent of MH consumers with SOGIE data available: 4,553 and 17% ▪ Number and percent of SUD consumers with SOGIE data available: 2,166 and 31% *All data is from FY 19-20.
ACTION STEPS:	▪ Implement collection of SOGIE data during client registration through InSyst for MH providers ▪ Implement collection of SOGIE data during client registration through InSyst for SUD providers ▪ Create dashboard tracking number and percent of providers collecting SOGIE data ▪ Create dashboard tracking number and percent of clients with SOGIE data ▪ Add SOGIE data to SUD demographics dashboard/reports ▪ Add SOGIE data to MH demographics dashboards/reports ▪ Add SOGIE data to Cultural Responsiveness dashboards/reports
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboard – continuous monitoring
RESPONSIBLE PARTNERS:	Quality Assurance; Data Services/Information Systems; Office of Ethnic Services; Contracted Providers

AREA 5:	Quality of Care
OBJECTIVE:	Reduce the number of deaths of consumers in opioid treatment programs
INDICATOR & BASELINE:	▪ Number and percent of discharges to death for opioid treatment programs: 26 and 3% (26/935) (FY 19-20)
ACTION STEPS:	▪ Increase distribution of overdose reversal medication in opioid treatment programs ▪ Increase utilization of counseling/case management services in opioid treatment programs ▪ Create dashboard tracking number and percent of discharges to death for opioid treatment programs

MONITORING METHOD/ TIMEFRAME:	Yellowfin Reports – monthly monitoring
RESPONSIBLE PARTNERS:	Quality Assurance; Substance Use Disorder System of Care; Data Services/Information Systems; Contracted Providers

AREA 6:	Access to Care
OBJECTIVE:	Increase provision of telehealth by 15%
INDICATOR & BASELINE:	▪ Number hours of telehealth for MH clients: 12,742 (10,825 Medi-Cal) ▪ Number services of telehealth for MH clients: 10,078 (8,647 Medi-Cal) ▪ Number of agencies providing telehealth for MH clients: 54 (53 Medi-Cal) ▪ Number of reporting units providing telehealth for MH clients: 296 (291 Medi-Cal) ▪ Number of MH clients served by telehealth: 3,746 (3,122 Medi-Cal) ▪ Number hours of telehealth for SUD clients: 1,893 (1,601 Medi-Cal) ▪ Number services of telehealth for SUD clients: 2,305 (2,001 Medi-Cal) ▪ Number of agencies providing telehealth for SUD clients: 11 ▪ Number of reporting units providing telehealth for SUD clients: 30 (27 Medi-Cal) ▪ Number of SUD Medi-Cal clients served by telehealth: 228 *All data is from June 2020.
ACTION STEPS:	▪ Train providers on telehealth / providing remote services ▪ Improving documentation for telehealth ▪ Develop telehealth policy and procedure
MONITORING METHOD/ TIMEFRAME:	Yellowfin Dashboard – Continuous; Quarterly and annual review
RESPONSIBLE PARTNERS:	Office of the Medical Director; Quality Improvement Committee; Contracted Providers

AREA 7:	Quality of Care
OBJECTIVE:	Increase frequency of follow-up appointments for next Level of Care (LOC) in accordance with individualized substance use treatment plans
INDICATOR & BASELINE:	▪ Average days until first clinical appointment in next Level of Care (LOC) after discharge from another LOC ▪ % of clients who receive at least 1 clinical appointment in next LOC within 7 days after discharge from another LOC ▪ % of clients who receive at least 1 clinical appointment in next LOC within 14 days after discharge from another LOC ▪ % of clients who receive at least 1 clinical appointment in next LOC within 30 days after discharge from another LOC *Baseline data FY 19-20
ACTION STEPS:	▪ Establish three-way call procedure between client, referring provider, and new provider (in next level of care) ▪ 1 to 5 days ***before*** planned discharge, residential treatment providers will engage Centerpoint's Care Navigator to facilitate client connection to step-down treatment at outpatient services, intensive outpatient services and/or recovery support services
MONITORING METHOD/ TIMEFRAME:	Yellowfin Dashboard – Continuous; Quarterly and annual review
RESPONSIBLE PARTNERS:	Substance Use Disorder Continuum of Care; Contracted Providers

Section III. Network Adequacy, Timeliness, and Accessibility

AREA 1:	Timeliness for Scheduling Routine Mental Health Appointments
OBJECTIVE:	Reduce the average wait time from initial request for non-urgent mental health services to the first offered clinical assessment appointment and to the first service by 10% for psychiatric services.
INDICATOR & BASELINE:	▪ Number of days from the date of initial request to the date of first offered appointment for psychiatry ▪ Number of days from the date of initial routine appointment service request to the date of first routine service for psychiatry Note: Baseline data not available due to incomplete data
ACTION STEPS:	▪ Develop and implement tool to measure timeliness at all ACBH helplines, screening and referral entry points, and service-entry points for psychiatry ▪ Increase provider compliance with timeliness submissions to improve data availability ▪ Develop monitoring tools and reports to monitor compliance with Timeliness Policy for psychiatry ▪ Identify barriers to timely service for psychiatry ▪ Identify and implement pilot to reduce wait time for psychiatry
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring ACCESS Log of Initial Contacts – monthly reports New tool to record first request for service and first offered appointment – monthly reports
RESPONSIBLE PARTNERS:	ACCESS, Data Services/Information Systems, Quality Management; Office of the Medical Director; Child and Young Adult System of Care; Adult and Older Adult System of Care; Substance Use Disorder System of Care

AREA 2:	Timeliness for Services for Urgent Mental Health Conditions
OBJECTIVE:	Reduce the average wait time from initial request for urgent mental health services to the first offered clinical assessment appointment and to the first service by 10% for psychiatric services.
INDICATOR & BASELINE:	▪ Number of days from the date of initial urgent service request to the date of first offered appointment for psychiatry ▪ Number of days from the date of initial urgent service request to the date of first service for psychiatry

	Note: Baseline data not available due to incomplete data
ACTION STEPS:	▪ Develop and implement tool to measure timeliness at all ACBH helplines, screening and referral entry points, and service-entry points for psychiatry ▪ Increase provider compliance with timeliness submissions to improve data availability ▪ Develop monitoring tools and reports to monitor compliance with Timeliness Policy
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring ACCESS Log of Initial Contacts – monthly reports New tool to record first request for service and first offered appointment – monthly reports
RESPONSIBLE PARTNERS:	ACCESS; Data Services/Information Systems; Quality Management; Children and Young Adult System of Care; Adult and Older Adult System of Care; Substance Use Disorder System of Care

AREA 3:	Timeliness for Scheduling Routine Substance Use Disorder Treatment Services (SUD) Appointments
OBJECTIVE:	Reduce the average wait time from initial request for non-urgent SUD services to the first offered clinical assessment appointment and to the first service by 10% for both outpatient and NTP.
INDICATOR & BASELINE:	▪ Number of days from the date of initial request to the date of first offered appointment ▪ Number of days from the date of initial routine appointment service request to the date of first routine service Note: Baseline data not available due to incomplete data
ACTION STEPS:	▪ Develop and implement tool to measure timeliness at all ACBH helplines, screening and referral entry points, and service-entry points ▪ Develop monitoring tools and reports to monitor compliance with Timeliness Policy ▪ Increase provider compliance with timely access reporting ▪ Follow up with and provide technical assistance or providers who do not meet the timely access standard ▪ Identify barriers to timely service ▪ Identify and implement pilot to reduce wait time ▪ Present data quarterly at Timely Access QIC meetings

MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring
RESPONSIBLE PARTNERS:	Substance Use Disorder System of Care; Data Services/Information Systems; Quality Assurance; Quality Improvement Committee

AREA 4:	Timeliness for Services for Urgent Substance Use Disorder Treatment Services
OBJECTIVE:	Develop baseline metrics for access to urgent outpatient and NTP SUD appointments
INDICATOR & BASELINE:	▪ Number of days from the date of initial urgent service request to the date of first offered appointment ▪ Number of days from the date of initial urgent service request to the date of first service Note: Baseline data not available due to incomplete data
ACTION STEPS:	▪ Develop and implement tool to measure timeliness at all ACBH helplines, screening and referral entry points, and service-entry points ▪ Increase provider compliance with timely access reporting
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring
RESPONSIBLE PARTNERS:	Substance Use Disorder System of Care; Data Services/Information Systems; Quality Assurance; Quality Improvement Committee

AREA 5:	Responsiveness for 24 Hour Toll-Free Number / Access to After Hours Care – Mental Health
OBJECTIVE:	Reduce the response time for the 24-hour toll-free number by 30%, including after hours.
INDICATOR & BASELINE:	▪ Test call response time for the ACCESS number (during business hours and in languages other than English) ▪ Test call response time for the ACCESS number (after business hours and in languages other than English) Baseline not available
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, provide

	information to beneficiaries about services available to treat a beneficiary's urgent condition, and provide information to beneficiaries about how to use the beneficiary problem resolution and fair hearing processes ▪ Review and revise ACCESS Protocol as necessary; provide to staff ▪ Remind staff on ongoing basis regarding the importance of documenting all initial requests made by telephone (including 24/7 line) through a written log that includes the name of the beneficiary, the date of the request, and the initial disposition of the request ▪ Access Division Director will track all missing, insufficient, incorrect, or out of compliance items on each clinician's test calls, and supervisors will provide monthly feedback to staff and discuss any necessary improvements that are to be made ▪ Review monthly test calls for accuracy and completeness of information given to beneficiaries. ACCESS Division Director 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:	Test call reports – quarterly basis
RESPONSIBLE PARTNERS:	ACCESS; Quality Management

AREA 6:	Responsiveness for 24 Hour Toll-Free Number / Access to After Hours Care – Substance Use
OBJECTIVE:	Reduce the response time for the 24-hour toll-free number by 30%, including after hours.
INDICATOR & BASELINE:	▪ Test call response time for the Crisis Support Services after-hours call center (after business hours and in languages other than English) ▪ Test call response time for the SUD helpline (during business hours and in languages other than English) Baseline not available
ACTION STEPS:	▪ Train After-Hours staff on how to more effectively answer beneficiary questions on how to access SUD services ▪ Remind staff on ongoing basis regarding the importance of documenting all calls coming into the 24/7 line, including caller/beneficiary name ▪ Conduct and review monthly test calls for accuracy and completeness of information given to beneficiaries. Provide results and feedback to CenterPoint and Crisis Support Services for quality improvement

	▪ Provide regular training and feedback from test calls for SUD Helpline counselors in staff meetings and individual supervision ▪ Train SUD Helpline staff with monthly American Society of Addiction Medicine (ASAM) case consultation to improve Level of Care screening and referral
MONITORING METHOD/ TIMEFRAME:	Test call reports – quarterly basis
RESPONSIBLE PARTNERS:	Substance Use Disorder System of Care; Contracted Providers; Crisis Support Services; Quality Management

Section IV. Cultural & Linguistic Competence

Improving cultural and linguistic competence is a critical component of ACBH's Quality Assessment and Performance Improvement efforts. The following objectives were developed in coordination with the Office of Ethnic Services, based on ACBH's Cultural Competence Plan.

AREA 1:	Access & Cultural Responsiveness
OBJECTIVE:	Increase the penetration rates by 50% for Asian and Pacific Islander (API) Medi-Cal beneficiaries.
INDICATOR & BASELINE:	Penetration rate for API beneficiaries: 1.63% Overall, 1.44% Outpatient (FY 19-20)
ACTION STEPS:	▪ Develop and implement a clinical Performance Improvement Project ▪ Develop and implement a non-clinical Performance Improvement Project
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboard – monthly
RESPONSIBLE PARTNERS:	Quality Improvement Committee – Asian & Pacific Islander Performance Improvement Project Workgroup; Office of Ethnic Services; Cultural Responsiveness Committee; Adult and Older Adult System of Care; Child and Young Adult System of Care; Mental Health Services Act; Contracted Providers

AREA 2:	Access & Linguistic Responsiveness
OBJECTIVE:	Increase the penetration rates by 25% for Medi-Cal beneficiaries whose primary language is a non-English threshold language, especially Asian and Pacific Islander languages. (See PIP – II.A.2.)
INDICATOR & BASELINE:	▪ Penetration rates for non-English speakers: 2.8% overall, 2.4% outpatient (FY 18-19)

Language	Overall Penetration Rate	Outpatient Penetration Rate
Non-English	2.8%	2.4%
Cantonese	1.03%	0.90%
Mandarin	0.59%	0.54%
Vietnamese	1.19%	0.96%

		Tagalog	1.29%	0.95%
		Arabic	1.63%	1.30%
		Farsi	4.61%	3.98%
ACTION STEPS:	▪ Implement a non-clinical Performance Improvement Project (See Section II.A.2. "Non-Clinical PIP – Mental Health)			
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboards – continuous monitoring Language line utilization reports – monthly reporting			
RESPONSIBLE PARTNERS:	Quality Improvement Committee; Quality Assurance; Office of Ethnic Services; Cultural Responsiveness Committee; Contracted Providers			

Section V. Consumer and Family Member Initiatives

Consumer and Family Member stakeholder participation is central to quality improvement efforts. In addition to the projects identified above, the following objectives were developed in coordination with the Quality Improvement Committee Consumer Workgroup and Family Member Workgroup, as well as the Office of Consumer Empowerment and the Office of Family Empowerment.

AREA 1:	Access to Care
OBJECTIVE:	Improve referrals that open to mental health services by 10%
INDICATOR & BASELINE:	Percent of referrals made by ACCESS that result in an open episode: 45% (FY 19-20)
ACTION STEPS:	▪ Develop reports to monitor and manage ACCESS referrals ▪ Share reports with Child and Adult System of Care leads
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboard – monthly
RESPONSIBLE PARTNERS:	Quality Improvement Committee – Consumer Workgroup; ACCESS; Child & Young Adult System of Care; Adult and Older Adult System of Care

AREA 2:	Beneficiary Outcomes
OBJECTIVE:	Connect homeless consumers with family members to reduce homelessness by improving the average and median hours per year of family collateral by 10%
INDICATOR & BASELINE:	▪ Average and median number of hours received per year of family collateral services for homeless clients: 1.61 average hours, 1.47 median hours (FY 19-20) ▪ Number / percent of homeless clients that receive family collateral services: 76 / 3.55% (FY 19-20) ▪ Average and median number of hours received per year of family non-collateral services for homeless clients: 1.18 average hours, 0.78 median hours (FY 19-20) ▪ Number / percent of homeless clients that receive family non-collateral services: 2,065 / 96.45% (FY 19-20)
ACTION STEPS:	▪ Match consumer data with HMIS data to identify who is homeless

	▪ Develop reports for system of care leads that measure the amount of family collateral for homeless consumers.
MONITORING METHOD/ TIMEFRAME:	Yellowfin dashboard – monthly
RESPONSIBLE PARTNERS:	Quality Improvement Committee – Consumer Workgroup; Quality Improvement Committee – Family Workgroup); Office of Consumer Empowerment; Office of Family Empowerment; Adult and Older Adult System of Care; Contracted Providers