ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES

# QUALITY IMPROVEMENT PROGRAM AND WORK PLAN

## Fiscal Year 2016/2017

*(July 1, 2016 – June 30, 2017)*

***Alameda County Behavioral Health Care Services 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 Quality Improvement Work Plan (QIWP) is the result of a stakeholder process, focus groups, Quality Improvement Council (QIC) priorities and, relevant initiatives from the current National Quality Initiatives for Health. We envision that the QI Strategy/Work Plan will be Alameda's guide for implementing the National Quality Strategy for Health care locally.

We understand that the National Strategy has three basic aims and six priorities that are the core overarching principles for Alameda's Quality Strategy and Work Plan. These Goals are:

- Better Care
- Healthy People/Healthy Communities
- Affordable Care
- Culturally and Linguistically Competent Care

Six Priorities:

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.

As envisioned, the MHP 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's 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 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.

The following Sections Describes the strategies, goals, objectives, interventions, activities and, the data and measures for evaluating the work plan's attainment of the goals and objectives identified herein.

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

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| **OBJECTIVE:** | **To evaluate whether there is Equal access to and utilization of SMHS for all beneficiaries, including those with limited English proficiency and underserved racial/ethnic populations** | |
| **BASELINE** | 1) Medi-Cal beneficiary penetration and utilization rates by race/ethnicity and preferred languages in FY2015/16.<br><br>2) Appendices: Table-1: Penetration and Utilization Rates by Race/Ethnicity, Age, Gender, and Preferred Languages. Geo-maps: Facility/Program location by Medi-Cal beneficiary population FY2015/16. | |
| **ACTION STEPS** | • Complete maps (with accompanying data tables), by MHSA region, describing the type and number of specialty mental health services within Alameda County (also broken out by age, preferred language, and race/ethnic group). Provided in FY2016/17<br>• Gap analysis and root cause analysis to determine differential access to and, utilization of SD/MC services.<br>• Executive/Leadership Team establishes penetration and utilization rate goals for FY2016/17.<br>• Executive Team, Network Office, SOC Directors, and other staff/CBO's design and implement initiatives to improve access and utilization rates in each region. | • |
| **MONITORING METHOD/ TIMEFRAME** | Publishing EMANIO 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. | |

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| **RESPONSIBLE PARTNERS** | *Executive Team, CBO Executives, SOC Directors; Network Office Director; QM Division;* | |

## SECTION I: MHP Capacity and Capacity Utilization

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

## SECTION II: Access and Timeliness

## Goal: Monitor the Timeliness of Mental Health Services for Non-Urgent and Urgent Conditions

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| **Objective 1:** | **To Reduce the average wait time from initial request for non-urgent and non-psychiatry service to the first scheduled clinical assessment appointment and first service after completion of assessment by 30% year-over-year.** |
| **BASELINE** | 1) FY2015/16 Performance Data from Emanio on the number of days from date of request to the referral to a provider, appointment, completion of assessment, and first service after the completion of the assessment and client plan..<br><br>2) Appendices. Table-2: Timeliness from date of service request to first service provided by race/ethnicity, gender, age, and preferred language dashboard reports. |
| **ACTION STEPS** | • Identify HEDIS/NCQA benchmarks for timeliness for outpatient/inpatient community behavioral health programs.<br><br>• Establish SMART performance benchmarks for timeliness to first offered appointment from referral/request for service, first actual service from referral/request for service, completed assessment from referral/request for service, and completed client plan from referral/request for service.<br><br>• Draft workflow map and/or schematic diagrams of the workflow and system documentation to expose the bottlenecks and inefficiencies<br><br>• Establish a PIP to improve the timeliness of service delivery through changes in workflow and documentation<br><br>• *Pilot site-specific improvement projects aimed at increasing timeliness at four regional programs* |
| **MONITORING METHOD/** | *(example) ACCESS Log of Initial Contacts; test calls; documentation of compliance to standard through mystery* |

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| **TIMEFRAME** | *shoppers; Consumer Satisfaction Survey results.* |
| **RESPONSIBLE PARTNERS** | *ACCESS Children's and Adults Manager; ASOC and CSOC Data Analyst; QM Division; Provider Partners*<br>*Lead Partner:Deputy Director* |

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| **Objective 2:** | **To reduce the 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) FY2015/16 Performance Data from Emanio Dashboards on wait times to first available appointment from request for service, psychiatric assessment completed, and next service from date of completed psychiatric appointment. |
| **ACTION STEPS** | • Identify HEDIS/NCQA benchmarks for timeliness for outpatient/inpatient community behavioral health programs.<br>• Establish SMART performance benchmarks for timeliness to first offered appointment from referral/request for service, first actual service from referral/request for service, completed assessment from referral/request for service, and completed client plan from referral/request for service.<br>• Draft workflow map and/or schematic diagrams of the workflow and system documentation to expose the bottlenecks and inefficiencies<br>• Establish a PIP to improve the timeliness of service delivery through changes in workflow and documentation<br>• *Pilot site-specific improvement projects aimed at increasing timeliness at four regional programs*<br>• *Complete first data gathering/trending in the BHCS Performance Improvement Project addressing Adult System of Care.* |
| **MONITORING METHOD/** | EMANIO Dashboard, Implement brief assessment model with contractor (Pathways to Wellness a Contracted Provider/CBO). |

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| **TIMEFRAME** | Monthly reports from Emanio/Decision Support will be reviewed by Exec Committee of the PIP team. |
| **RESPONSIBLE PARTNERS** | *Pathways Director; Pathways Psychiatrist; QM Division,*<br>*Lead Partner: Medical Director* |

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| **Objective 3:** | **To Reduce the no show rates for non-urgent psychiatric appointments by 30 percent year-over-year.** |
| **BASELINE** | 1) FY2015/16 Performance Data from Emanio |
| **ACTION STEPS** | • Establish a workgroup to complete a descriptive study that of 'best practices' used by the set of MHP providers that currently use "no-show" statistics to increase access to psychiatrist and non-psychiatrist clinicians.<br>• Use results of the pilot to develop a toolkit that offers operational solutions for "how to" allow access to "no-show" slots by clients needing same-day services. Beta-test the toolkit with a sample of provider organizations representing the continuum of care by age and ethnic group.<br>• The QM Unit will work with the Information Systems Department, Decision Support and the Alameda County Council of Community Mental Health Agencies (ACCMHA) to build a prototype system that can be used to capture and report no show data. The MHP will implement a pilot to with a small sample of contract and county programs to test the feasibility of the data capture system.<br>• QM Workgroup will review results of the pilot and recommend a no-show policy and procedure for reducing no show rates to the QIC<br>• Develop interventions using best practices and data collected from beneficiaries .<br>• Implement interventions to impact and reduce no show rates. |
| **MONITORING METHOD/ TIMEFRAME** | Survey beneficiaries to determine factors and barriers to showing up for scheduled appointments. |

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| | Quarterly monitoring of pilot results. |
| **RESPONSIBLE PARTNERS** | *Quality Management; Network Office; Information Systems, ASOC, CSOC; Alameda County Council of Community Mental Health Agencies(ACCMHA)*<br>*Lead Partner: Deputy Director* |

*SECTION III: Crisis and Inpatient Service Capacity and Performance*

*GOAL: Reduce the inappropriate utilization of emergency, crisis, and inpatient services, including psychiatric hospital bed days, CSU/PES 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** |
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| **BASELINE** | 1) FY2015/16 Performance Data from Emanio 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.<br>• Develop a *process improvement project* with a cohort of hospitals and outpatient programs serving clients who experienced outpatient services *over* 7 days post-hospitalization.<br>• What circumstances impact a client's ability to "make it" to |

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| | appointments.<br>• Improve discharge planning between inpatient and outpatient staff and providers through the active involvement of members with Utilization management committee.<br>• 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** | EMANIO Dashboard, Quarterly Report to QIC |
| **RESPONSIBLE PARTNERS** | *ASOC, CSOC, QM Division, MHP Medical Director, Critical Care Manager, Alameda County Council of Community Mental Health Agencies(ACCMHA), Partner Hospitals*<br>*Lead Partner: Deputy Director* |
| **Objective 2:** | **To Reduce 30 day readmission rates at acute psychiatric hospitals by utilizing intensive case-management.** |
| **BASELINE** | 1) FY2015/16 Performance Data from Emanio dashboards |
| **ACTION STEPS** | • *Complete "walk through" and identify connection between discharge planning processes and outpatient service engagement rates for clients discharged from John George Psychiatric Pavilion and Children's Hospital.*<br>• *Review experience of a sample of hospital patients with recidivism histories.*<br>• *Identify resources that might be developed to serve hospital discharges and promote stability and wellness.*<br>• *Complete analysis*<br>• *Evaluate options, including a peer-assisted "linkage program" for consumers discharged from hospitals to BHCS programs.* |
| **MONITORING METHOD/ TIMEFRAME** | EMANIO Dashboard, 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, BHCS Critical Care Manager; Children's Hospital Administrator, other Partner Hospitals, Quality Management Division, Medical Director*<br>*Lead Partner: Deputy Director* |

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| **Objective 3:** | To improve percentage of Client Follow-up within 24-hours for non-urgent after hour request for MHS |
| **BASELINE** | 1) FY2015/16 Performance Data from Emanio dashboards |
| **ACTION STEPS** | • Convene a workgroup to: identify and summarize procedures currently used by programs offering after hours care;<br>• Describe demographics and clinical profile for cohorts of clients receiving after hours care;<br>• Survey a sample of providers about their perceptions of the needs of their clients for after hours care needs and utilization.<br>• Develop a procedure and beta-test in a sample of providers. |
| **MONITORING METHOD/ TIMEFRAME** | Workgroup Report<br>Updated goal in QI Workplan |
| **RESPONSIBLE PARTNERS** | *JJPP; Sausal Creek; Seneca Center; ASOC and CSOC; QM Division; ACCMHA, Partner programs where QI Process Improvement Project is being implemented*<br>*Lead Partner: Deputy Director* |

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| **Objective 4:** | To Reduce the response time of the BHCS 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 MHP's 24-hour, toll free number through internal audits, phones calls and mystery shoppers.<br><br>Training for access staff on issues identified by a process improvement process.<br><br>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. |

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| **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<br>Lead Partner: ACCESS Manager |

## SECTION IV: Beneficiary Experience and Satisfaction

## Goal: Improve the overall client experience with services rendered and Client Satisfaction

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| **Objective 1:** | To conduct semi-annual beneficiary/Client Satisfaction Surveys with MHS in FY2016/17 measuring client experience and satisfaction. |
| **BASELINE** | 1) FY2014/15 MHSIP 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.<br>• QM staff will work with senior operational managers and |

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| | beneficiary/family leaders to develop the survey questions. This survey will give providers immediate feedback on a small and useful set of indicators.<br><br>• Results will be trended by provider and by continuum of care "sector" and reported back to the Goal's Workgroup. In areas where satisfaction is low, providers will be asked to complete process improvement studies to develop practices that impact satisfaction.<br><br>• 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;*<br>*Lead Partner:* Deputy Director |

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| **Objective 2:** | To Improve the client experience with the **Grievance and Appeal Process as documented by post service satisfaction survey's.** |
| **BASELINE** | 1) Upon request of the Mental Health Board, the MHP completed an analysis of the beneficiary grievance and appeal process.<br><br>2) MHP 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. |
| **ACTION STEPS** | ▪ Review and implement relevant results of the "Consumer Complaint and Grievance Process Review<br>▪ Make corrections to the log/database. Train the Mental Health Association Grievance Phone<br>▪ 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.<br>▪ Complete a manual that will explain this process and clearly define |

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| | grievances and appeals. Redesigning the letters to bring them into compliance.<br>▪ Develop a database with letter merge and reporting capability.<br>▪ Update the Grievance Poster and Consumer materials including translations into all four threshold languages.<br>▪ 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; Lead Partner: Deputy Director* |

## SECTION V: Medication Support Service Delivery

## Goal: Enhance the Monitoring for the Safety & Effectiveness of Medications

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| **Objective 1:** | To increase the number of prescriber charts and medication logs reviewed and reported using an electronic review tool to improve the quality of care and effectiveness of medication practices. |
| **BASELINE** | 1) FY 15/16 Pharmacy Performance Data |
| **ACTION STEPS** | • Pharmacy Unit will focus on a project that addresses safety and effectiveness of medication practices for adults and children within the mental health system.<br>• This quality improvement effort is called the *Medication Monitoring Project and Compliance with TAR for Foster Care Clients.*<br>• Table I, below, lists the adult and children's providers that |

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| | are included in this project. The protocol is to review 15% of each psychiatrist's charts during the course of a year. This review is completed in quarterly increments. Guidelines for psychotropic medication practices are applied to psychiatrist's documentation and prescribing practices.<br><br>**Adult System of Care**<br>• Level I Service Teams<br>• Santa Rita Jail<br>• Full Service Partnerships serving adults<br>• Wellness Centers<br><br>**Children's/TAY System of Care**<br>• Level I Adult Service Team providers who also provide services to children<br>• Child Guidance Clinic<br>• Full Service Partnerships serving children<br>• County Providers serving children |
| **MONITORING METHOD/ TIMEFRAME** | Twice yearly reports on physician peer review activities; quarterly reports on actions of the Medication Monitoring Committee with 90% compliance in chart reviews. |
| **RESPONSIBLE PARTNERS** | *Pharmacy Director, Medical Director, ASOC, CSOC*<br>*Lead Partner: Pharmacy Director* |

## SECTION VI: Quality Improvement Program

## Goal: To improve the MHP's Quality Improvement Program Infrastructure through the addition of a QI Coordinator and implementing best practices to guide QI processes.

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| **Objective 1:** | To Increase the Number of Consumers, Providers, Family Members Are Active In the Planning, Design and Execution of QI Program through active recruitment in QIC and sub-committees |

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| **BASELINE** | 1) FY20015/16 QIC MEMBERSHIP ROSTER |
| **ACTION STEPS** | • Increase ratio of Consumers, Providers and Fmaily Members to BHCS Staff on the QIC. QM Manager and BHCS Director will identify the new ratio of beneficiaries, family members and providers to BHCS staff.<br>• The QM Director and BHCS Director will consider the recommendation to use operational workgroups to implement Work plan Goals and circulate findings to the QIC.<br>• Workgroups will act as subcommittees of the QIC and consisting of providers, consumers, family members and BHCS 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<br>Lead Partner: QM Director |

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| **Objective 2:** | To increase the number of QI Professional and support staff during FY16/17 by 2 FTE |
| **BASELINE** | 1) In FY 15/16, the QI function was staffed by of 1 FTE Senior Manager (Project Management, Research and Analytical tasks) and 1 FTE Administrative Assistant position. |

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| **ACTION STEPS** | • Hire a new Quality Improvement Coordinator<br>• Add 1 FTE to the Quality Improvement analytical team<br>• Formalize linkage between the Quality Improvement Unit and three BHCS departments/functions that are integral to the Quality Improvement Program: Decision Support, Quality Assurance and Utilization Management.<br>▪ The Quality Improvement Unit and designated BHCS 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<br>▪ Provide annual reports of progress and deliverables at monthly QIC meetings. |
| **MONITORING METHOD/ TIMEFRAME** | Increase in FTE and Reorganization of the Organizational Chart to ensure reporting authority and responsibility. |
| **RESPONSIBLE PARTNERS** | QM Division; Behavioral Health Director<br>Lead Partner: Quality Management Director |

## **SECTION VII: Provider Appeals** and Problem Resolution Process

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

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| **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 MHP's authorization and other processes. |

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| **BASELINE** | 1) FY2015/16 Logs of Provider Complaints and Appeals in Network Office and QA. |
| **ACTION STEPS** | • Establish and publish provider problem resolution policy and procedure documenting the provider appeal process.<br>• Build the infrastructure for effectively resolving provider appeals, complaints, and grievances.<br>• Produce annual reports and submit reports to the QIC |
| **MONITORING METHOD/ TIMEFRAME** | Provider appeal log, provider appeal summaries and provider follow-up calls.<br><br>Completion date of January 2017 |
| **RESPONSIBLE PARTNERS** | *Authorizations; Quality Management; ACCMHA*<br>*Lead Partner: Provider Relations* |

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

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

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| **Objective 1:** | To Conduct chart reviews/audits quarterly to reduce disallowance rates and loss revenues. |
| **BASELINE** | 1) FY2014/15 disallowance rates from quarterly QA audits and DHCS Triennial Audits |
| **ACTION STEPS** | • Complete a full review of all chart documents for mental health services quarterly using a randomly selected number of medical charts. The annual target is 5% of all clinical charts.<br>• Complete draft revisions of core clinical forms within the fiscal year for inclusion into the EHR including progress notes, clinical/psychiatric assessments, and client plans.<br>• Produce audit reports, plans of correction, and technical assistance to improve audit results.<br>• Conduct trainings and technical assistance for providers to improve their knowledge and skills relevant to clinical documentation . |
| **MONITORING METHOD/ TIMEFRAME** | Audit Reports, Completed draft forms, committee findings, and minutes, Quality Management Systems Assessment Report. |
| **RESPONSIBLE PARTNERS** | *Quality Management;*<br>*Lead Partner:* Interim Quality Assurance Associate Administrator |

## SECTION IX: Coordination of Care

## Goal: Improve the Coordination of Care Between the MHP, Physical Healthcare Agencies, and SUD services

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| **Objective 1:** | To Improve the coordination of care between the MHP and Physical Healthcare agencies by establishing an MOU to formalize relationship, roles, and responsibilities. |
| **BASELINE** | 1) FY2014/15 Performance Data (Number of shared clients involved in joint case planning and conferencing) as evidenced by Emanio dashboards |
| **ACTION STEPS** | • Identify best practices in data sharing procedures and EHR systems used by current Behavioral Health/Primary Care collaboration projects.<br>• Consult with the CIBHS Care Coordination Collaborative.<br>• Develop a training plan and resources to implement a workshop series and collaborative focused on process improvement/ Coordination of Care.<br>• Participate in the whole person care pilot<br>• Improve the implementation and monitoring of current MOUs that Medi Cal managed care plans (MCPs) are currently required to sign with MHP<br>• Establish a data-sharing agreements with primary care<br>• Develop and establish consensus on joint outcome measures for shared members/beneficiaries, MCPs and county specialty mental health plans (MHPs) would be jointly responsible for improving health outcomes as measured by:<br>1) Reducing avoidable emergency room/PES visits |

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| | 2) Reducing acute hospital stays of joint clients/patients<br>3) Real-time Information sharing capacy for members who meet medical necessity criteria for Medi Cal Specialty Mental Health Services and primary care staff at Federally Quality Health Clinics. |
| **MONITORING METHOD/ TIMEFRAME** | MOU and data sharing activities annual reports. |
| **RESPONSIBLE PARTNERS** | *BHCS Training Officer; QM Division; IntegrationWorkgroup*<br>*Lead Partner: BHCS Behavioral Health Primary Care Manager* |

## SECTION X: Reduce the Costs of Specialty Mental Health Care

## Goal: Implement state-of-the-Art monitoring mechanisms to Detect Underutilization and Overutilization of Services to prevent potential waste and abuse.

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| **Objective 1:** | To establish and operate a utilization management program to reduce utilization of acute inpatient and sub-acute facilities |
| **BASELINE** | 1) FY2015/16 average annual costs per beneficiary served across inpatient and outpatient service modalities. |
| **ACTION STEPS** | • Implement the following strategies for reducing the total cost of acute and sub-acute services by implementing the following pilot projects:<br><br>1) Reducing the 30-day rehospitalization rates<br>2) Increasing the number post-hospital discharge appointments attended.<br>3) Reducing the number of clients in sub-acute facilities.<br>4) Increasing the number of FSP members and programs<br>5) Implementing Community Consevatorship Pilot Programs.<br>6) Increase Outpatient Planned Service Utilization Rates for frequent utilizers of crisis, emergency, and inpatient hospital services |
| **MONITORING METHOD/ TIMEFRAME** | Emanio Dashboards, Monthly, Quarterly, and Annual Reports |
| **RESPONSIBLE PARTNERS** | TBA<br>Lead partner: Quality Management Director |

## SECTION XI: LPS 5150 Program

## Goal: Evaluate and Monitor the utilization of 5150 holds to reduce the frequency of 5150 admissions to emergency departments, PES, acute hospitals and Psychiatric Health Facilities (PHF's)

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| **Objective 1:** | To reduce the number of "5150" commitments completed by Law enforcement through the expansion of the Crisis Intervention Training (CIT) training for law enforcement personnel and certification of facilities and providers authorized to write and break 5150 holds |
| **BASELINE** | • In the CAEQRO FY 14/15 MHP Report) identified as a potential are of quality improvement the role of community police in the current involuntary detention (5150) for 72-hour evaluation and treatment. Although the BHCS Crisis Response Program works closely with local police, the majority of 5150 police calls do not involve clinical support. When 5150 procedures place clinical decision making in the hands of non-clinicians, the results may include multiple iatrogenic effects, including long wait times for police response, counter-therapeutic interactions during crisis situations, disruption of community settings, and diversion of police officers from other needed duties. Providers report delays in police response to 5150 calls which may impact beneficiary outcomes.<br>• Total Number of 5150's written in FY2014/15<br>• Total Number of 5150's written by police in FY2014/15<br>• Total Number of 5150's broken by LPS facilities in FY2014/015 |
| **ACTION STEPS** | • Establish, staff, and operationalize a 5150 committee that is a sub-committee of the QIC that includes representatives from the CA hospital Association, ED, MCO, and the MHP.<br>• Train and designate/authorize clinical staff at ED and CBO's to write and break 5150 holds.<br>• Convene a BHCS workgroup to design a descriptive |

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| | analysis of 5150 current system, focusing on entry into involuntary treatment. Workgroup members will include people with experience as providers, beneficiaries and family members who have 'lived experience' with the 5150 process.<br><br>• Examine the system impact of current 5150 policies on the MHP and its consumers; compare with 5150 practices of similar large urban counties.<br><br>• Launch a pilot project in collaboration with a community hospital to utilize tele psychiatry to reduce 5150 demand and wait times at their Emergency Departments to improve quality and appropriateness of care.<br><br>• Update and revise MHP policies regarding entry to involuntary acute treatment, including offering involuntary detention training and privileges to an expanded cohort of licensed mental health professionals.<br><br>• Review current Policies& Procedures and current communication of P&Ps to providers and other stakeholders involved in the 5150 process.<br><br>• Review current efforts to improve 5150 process through education and training. |
| **MONITORING METHOD/ TIMEFRAME** | Monitoring of the frequency and type of 5150 using data from monthly reports of Patient Rights, DHCS, LPS facilities. Research will be completed by the QI Unit in collaboration with BHCS operations staff.<br><br>Results will be used to recommend improvements in current 5150 system to BHCS Executive Team. |
| **RESPONSIBLE PARTNERS** | *QM Division; Medical Director; Critical Care Coordinator; Crisis Response Program; Seneca Mobile Crisis;*<br>*Lead Partner:* |