ALAMEDA COUNTY

BEHAVIORAL HEALTH CARE SERVICES

MHS/SUDS Integrated Plan

QUALITY IMPROVEMENT PROGRAM AND WORK PLAN

FISCAL YEAR 2017/2018

(July 1, 2017 – June 30, 2018)

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 purpose of the Work Plan is to comply with the requirements of the Medicaid Managed Care Organization (MCO) Final Rule pursuant to CFR 42, Section 438 regarding the quality and performance mandates for Prepaid Inpatient Health Plans (PHIP), the Special Terms and Conditions (STC's) of the 1915(b) Medicaid Specialty Mental Health waiver (MHS), the Medicaid 1112 Drug Medi-Cal Organized Delivery System waiver , and the Medi-Cal Specialty Mental Health Services (MHP) and Drug Medi-Cal/Substance Abuse Prevention and Treatment grant contracts with State Department of Health Care Services (DHCS).

Specifically, Alameda Medi-Cal Mental Health Plan (MHP) and the Drug Medi-Cal service delivery system have established this integrated Alameda County Behavioral Health Services (BHCS) Annual Quality Improvement Work Plan (WP0 to improve the quality and outcomes of care for Medi-Cal beneficiaries by performing the following activities and initiatives throughout FY2017/18 and continuing in FY2018/19:

- ✓ Assess and evaluate the capacity and capacity utilization of the MHP service delivery system to ensure timely access to and utilization of mandated and optional MHS/DMC services for beneficiaries;
- ✓ Survey beneficiaries and families to evaluate their satisfaction with the MHS/DMC service

- ✓ Monitor and evaluate the safety and effectiveness of medication practices and intervene when issues of care are identified
- ✓ Collect and analyze data to measure against the goals, objectives, and prioritized areas of improvement that have been identified
- ✓ Conduct two Performance Improvement Projects (PIP's) to comply with the requirements of 42 CFR, 438.240 to improve quality of care, system performance and outcomes
- ✓ Identify and establish relevant committees internal and/or external to the MHP/DMCP to ensure transparency and ensure appropriate exchange of information across systems of care and the Quality Improvement Committee (QIC)
- ✓ Establish mechanisms and obtain input from staff, providers, beneficiaries, families, and stakeholders in identifying barriers to delivery of clinical care and administrative services
- ✓ Design and implement interventions to improve performance, quality and outcomes of care rendered
- ✓ Measure and report the effectiveness of interventions and initiatives
- ✓ Incorporate and imbed successful interventions and initiatives into the MHP/DMCP operations as appropriate
- ✓ Review and analyze beneficiary grievances, appeals, and expedited appeals, fair hearings, and expedited fair hearings, provider appeals, and clinical records review as required by CCR, Title-9, Section 1810.440(a)(5)

The following Sections describe the strategies, goals, objectives, interventions, activities and, the data and measures for evaluating the work plan's achievement of the goals and objectives identified herein. The QI Plan references mental health and substance use treatment services as Behavioral Health Care Services (BHCS).

Table of Contents: FY 17/18 QI Work plan Goals

SECTION	GOAL DOMAIN	PAGE NUMBER
I	BHCS Capacity and Capacity Utilization	5
II	Access and Timeliness	6
III	Crisis and Inpatient Service Capacity and Performance	9
IV	Beneficiary Experience and Satisfaction	13
V	Quality Improvement Program	15
VI	Provider Appeals and Problem Resolution Process	17
VII	Medi-Cal/ Drug Medi-Cal Documentation and Standards of Clinical Practice	18
VIII	Coordination of Care	19
IX	Specialty Mental Health Care Cost Reduction	20

SECTION I: BHCS Capacity and Capacity Utilization

Goal: Build and maintain the service delivery system capacity to comply with the Final Rule Network Adequacy and Parity requirements established by 42 CFR, Section 438 which ensures access by the diverse population of Alameda County beneficiaries.

OBJECTIVE 1:	**Evaluate whether there is equal access to and utilization of BHCS for all beneficiaries, including those with limited English proficiency and members of underserved racial/ethnic populations.**
BASELINE	1) Medi-Cal and Drug Medi-Cal beneficiary penetration and utilization rates by race/ethnicity and preferred languages in FY2016/17. 2) Appendix: Table-1: Penetration and Utilization Rates by Race/Ethnicity. 3) Geo-maps: Facility/Program location by Medi-Cal beneficiary population FY2017/17.
ACTION STEPS	• Complete maps (with accompanying data tables), by MHSA region, describing the type and number of BHCS within Alameda County (also broken out by age, preferred language, and race/ethnic group). Provided in FY2016/17. • Gap analysis and root cause analysis to determine differential access to and, utilization of SD/MC and DMC / ODS services. • Executive/Leadership Team establishes penetration and utilization rate goals for FY2017/18. • 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 YELLOW FIN 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; AOD Administrator*

SECTION II: Access and Timeliness

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

OBJECTIVE 1:	**To ensure that 80% of the scheduled appointments for initial non-urgent and non-psychiatry appointments are scheduled within 15-days from the date of request by the beneficiary assessment appointment and first service after completion of assessment by 30% year-over-year.**
BASELINE	1) FY2016/17 Performance Data from Yellow Fin dashboard 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. 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. • 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. • Draft workflow map and/or schematic diagrams of the workflow and system documentation to expose the bottlenecks and inefficiencies. • Establish PIPs to improve timeliness of service delivery through changes in workflow and documentation. • Pilot site-specific improvement projects aimed at increasing timeliness at four regional programs.
MONITORING METHOD/ TIMEFRAME	(example) ACCESS Log of Initial Contacts; test calls; documentation of compliance to standard through mystery shoppers; Consumer Satisfaction Survey results.
RESPONSIBLE PARTNERS	*ACCESS Children's and Adults Manager; ASOC and CSOC Data Analyst; QM Division; Provider Partners*

OBJECTIVE 2:	**To reduce BHCS 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) FY2016/17 Performance Data from YELLOW FIN 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. • 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. • Draft workflow map and/or schematic diagrams of the workflow and system documentation to expose the bottlenecks and inefficiencies. • Establish PDSA's to improve the timeliness of service delivery through changes in workflow and documentation. • Pilot site-specific improvement projects aimed at increasing timeliness at four regional programs.
MONITORING METHOD/ TIMEFRAME	YELLOW FIN Dashboard, Implement brief assessment model with contractor (Pathways to Wellness a Contracted Provider/CBO). Monthly reports from YELLOW FIN/Decision Support will be reviewed by Exec Committee of the PIP team.
RESPONSIBLE PARTNERS	*Pathways Director; Pathways Psychiatrist; QM Division*

OBJECTIVE 3:	**To reduce the no show rates for non-urgent SUD appointments by 30 percent year-over-year.**
BASELINE	1) FY2017/18 Performance Data from YELLOW FIN.
ACTION STEPS	• Establish a workgroup to complete a descriptive study that of 'best practices' used by the set of BHCS providers that currently use "no-show" statistics to increase access to SUD treatment services. • Use results of the data collected from the Residential Call Center and Outpatient SUD treatment providers to determine the baseline for no-show rates. The baseline will distinguish age and ethnic groups. • The QM Unit will work with the Information Systems Department, Decision Support and the Alameda County of BHCS providers to build a prototype system that can be used to capture and report no-show data. The BHCS will implement a pilot with a small sample of contract and county programs to test the feasibility of the data capture system. • QM Workgroup will review results of the pilot and recommend a no-show policy and procedure for reducing no show rates to the QIC • Develop interventions using best practices and data collected from beneficiaries. • 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. Quarterly monitoring of pilot results.
RESPONSIBLE PARTNERS	*Quality Management; SUD Operations; Network Office; Information Systems; ASOC; CSOC; Alameda County Alcohol and Drug Provider Committee*

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.**
BASELINE	1) FY2016/17 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 <u>*within*</u> 7 days post discharge. • Develop a <u>*process improvement project*</u> with a cohort of hospitals, detoxification services, SUD residential, and outpatient programs serving clients who experienced outpatient services <u>*over*</u> 7 days post-hospitalization. • 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	YELLOW FIN Dashboard, Quarterly Report to QIC
RESPONSIBLE PARTNERS	*Adult and Children's System of Care Directors; John George Psychiatric Pavilion Administrator; Cherry Hill Detoxification Services; SUD Residential Helpline; BHCS Critical Care Manager; Children's Hospital Administrator; other Partner Hospitals; Quality Management Division; Medical Director*

OBJECTIVE 2:	**To reduce 30-day readmission rates at acute psychiatric hospitals by utilizing intensive case-management.**
BASELINE	1) FY2016/17 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. • Review experience of a sample of hospital patients 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 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*

OBJECTIVE 3:	**To improve percentage of Client Follow-up within 24-hours for non-urgent after hour requests for BHCS.**
BASELINE	1) FY2016/17 Performance Data from YELLOW FIN dashboards.
ACTION STEPS	• Convene a workgroup to: identify and summarize procedures currently used by programs offering after hours care. • Describe demographics and clinical profile for cohorts of clients receiving after hours care. • Survey a sample of providers about their perceptions of the needs of their clients for after-hour care needs and utilization. • Develop a procedure and beta-test in a sample of providers.
MONITORING METHOD/ TIMEFRAME	Workgroup Report Yellow Fin Dashboard Reports Monthly Meeting with providers delivering services Updated goal in QI Work Plan
RESPONSIBLE PARTNERS	*JJPP; Sausal Creek; Seneca Center; ASOC and CSOC; QM Division; ACCMHA; Partner programs where QI Process Improvement Projects are being implemented; SUD Residential Helpline*

OBJECTIVE 4:	**To reduce the response time of the BHCS ACCESS line via the 24-hour toll free number by 10 percent by the prior year.**
BASELINE	1) FY2016/17 Performance Data from Access log and Data Tracking database.
ACTION STEPS	• Measure the responsiveness of the BHCS'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. • Review/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. Monthly Meeting with providers Yellow Fin Dashboard Reports
RESPONSIBLE PARTNERS	*Quality Management; Quality Assurance; ACCESS Manager*

SECTION IV: 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 BHCS in FY2017/18 measuring client experience and satisfaction.**
BASELINE	1) FY2016/17 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. • QM staff will work with senior operational managers and beneficiary/family leaders to develop the survey questions. This survey will give providers immediate feedback on a small and useful set of indicators. • 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. • The Workgroup will use results to make recommendations to the QIC.
MONITORING METHOD/ TIMEFRAME	Monthly Meetings with providers Yellow Fin Monthly Dashboard Reports of Performance 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*

<table>
<tr><td>OBJECTIVE 2:</td><td>To improve the client experience with the Grievance and Appeal Process as documented by post-service satisfaction surveys.</td></tr>
<tr><td>BASELINE</td><td>1) Upon request of the Mental Health Board, the BHCS completed an analysis of the beneficiary grievance and appeal process.

2) BHCS 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</td></tr>
<tr><td>ACTION STEPS</td><td>• 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.
• Complete a manual that will explain this process and clearly define grievances and appeals.
• Update the Grievance Poster and Consumer materials including translations into all four 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.</td></tr>
<tr><td>MONITORING METHOD/ TIMEFRAME</td><td>Monthly Meeting with providers who have grievances
Quarterly reports to the QIC of Trends
Annual report of the client satisfaction survey.</td></tr>
<tr><td>RESPONSIBLE PARTNERS</td><td>Consumer Relations Team; Family Relations Manager; FERC; ACNMHC; PEERS; Patient Advocate; Family Partners; ASOC; CSOC; QM Division; Alameda County Alcohol and Drug Provider Committee</td></tr>
</table>

SECTION V: Quality Improvement Program

Goal: Improve the BHCS's Quality Improvement program infrastructure through reorganization of the staffing resources to enhance the accomplishment of the Final Rule and STC's requirements established for Quality.

OBJECTIVE 1:	**To increase the number of Consumers, Providers, Family Members active in the planning, design and execution of QI Programs through active recruitment in QIC and sub-committees.**
BASELINE	1) FY2016/17 QIC Membership Roster
ACTION STEPS	• Increase ratio of Consumers, Providers and Family Members to BHCS Staff on the QIC. QM and BHCS Director will identify the new ratio of beneficiaries, family members and providers to BHCS staff. • 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. • 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*

OBJECTIVE 2:	**To increase the number of BHCS Professional and Support staff during FY16/17 by 26 FTEs.**
BASELINE	1) In FY 16/17, the QI function was staffed by of 1 FTE Senior Manager (Project Management, Research and Analytical tasks) and 1 FTE Administrative Assistant position 2) SUD functions across BHCS are staffed by three .20 and two .50 FTE, 1.0 AOD Administrator, and 1.0 Program Specialist
ACTION STEPS	• Hire a new Quality Improvement Coordinator. • Add 5 FTE to the Quality Improvement analytical team and the remainder to: Decision Support, Fiscal , I.S., Medical Director, Network Office, SUD Operations • Add 24 FTE to implement and sustain the BHCS DMC ODS Implementation Plan: 1- Management Analyst; 2-FSS I/II; 2-IS Specialist, 2-IS Technician II; .50-Admin Assist (Med Dir), 1-Physician III; 1-Sr. Program Spec, 1-Program Spec, 1-Sr. FSS, 1-FSS I/II, .50-Admin Assist; I-IS Analyst, 1-CRS Supervisor, 3-BH Clinician II, 1-Clinical Review Spec; 1-Sr. Program Manager, 4-Program Specialists • 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. • 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. • Provide annual reports of progress and deliverables at monthly QIC meetings.
MONITORING METHOD/ TIMEFRAME	Increase in FTEs and reorganization of the organizational chart to ensure reporting authority and responsibility.
RESPONSIBLE PARTNERS	*QM Division; Behavioral Health Director; AOD Administrator;* *Quality Management Director*

SECTION VI: 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 BHCS's authorization and other processes.**
BASELINE	1) FY2016/17 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. • 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 2018.
RESPONSIBLE PARTNERS	*Authorizations; Quality Management; ACCMHA; Provider Relations*

SECTION VII: Medi-Cal/ Drug Medi-Cal Documentation and Standards of Clinical Practice

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

OBJECTIVE 1:	**To conduct chart reviews/audits quarterly to reduce disallowance rates and loss revenues.**
BASELINE	1) FY2016/17 disallowance rates from quarterly QA audits and Mental Health Triennial Audits. 2) FY 2016/17 establish baseline from SUD System Of Care audits
ACTION STEPS	• Complete a review of chart documents for BHCS 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 improve audit results. • 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; Interim Quality Assurance Associate Administrator; Decision Support*

SECTION VIII: Coordination of Care

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

OBJECTIVE 1:	**To improve the coordination of care between the BHCS and physical healthcare agencies by establishing an MOU to formalize relationship, roles, and responsibilities.**
BASELINE	1) FY2016/17 Performance Data (Number of shared clients involved in joint case planning and conferencing) as evidenced by Yellow Fin dashboards
ACTION STEPS	• Identify best practices in data sharing procedures and EHR 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 BHCS. • Establish a data-sharing agreements with primary care • Through the WPC Pilot, 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). BHCSs 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. Yellow Fin Monthly Dashboard Reports Monthly Meeting with Collaborative Partners
RESPONSIBLE PARTNERS	*BHCS Training Officer; QM Division; Integration Workgroup;* *BHCS Behavioral Health Primary Care Manager*

SECTION IX: Specialty Mental Health Care Cost Reduction

Goal: Implement state-of-the-art monitoring mechanisms to detect underutilization and overutilization of services.

OBJECTIVE 1:	**To establish and operate a utilization management program to reduce utilization of acute inpatient and sub-acute facilities.**
BASELINE	1) FY2016/17 average annual costs per beneficiary served across inpatient and outpatient service modalities.
ACTION STEPS	• Implement a pilot project using the following strategies for reducing the total cost of acute and sub-acute services: 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) Implementing community conservatorship pilot programs. 6) Increasing outpatient planned service utilization rates for frequent utilizers of crisis, emergency, and inpatient hospital services.
MONITORING METHOD/ TIMEFRAME	Yellow Fin Dashboards, Monthly, Quarterly, and Annual Reports
RESPONSIBLE PARTNERS	Providers, CBO's, and JGP Administrator *Lead partner: Quality Management Director*

Appendix

Table-1: MHS Penetration and Utilization Rates by Race/Ethnicity
FY 2016-17 Capacity/Capacity Utilization

All Clients Served: FY2016/2017

Ethnicity/Race (all age groups)	County Population (2010 Totals)	Total Clients Served	Penetration Rate
African American	185,440	9,282	5.05%
Asian/PI	407,185	2,433	.06%
Caucasian	517,696	5,951	1.5%
Latino	341,125	6,230	1.8%
Native American	4,265	167	3.9%
Other/Unknown	57,294	6,116	10.7%
Total	**1,513,005**	**30,179**	**2.0%**

Medi-Cal Beneficiaries Served: FY2016/2017

Ethnicity/Race (all age groups)	Medi-Cal Eligibles	Beneficiaries Served	Penetration Rate
African American	94,615	7,576	8.01%
Asian/PI	117,410	1,887	1.60%
Caucasian	65,834	4,152	6.31%
Latino	126,193	6,000	4.75%
Native American	1,462	124	8.5%
Other	92,013	4,361	4.74%
Total	**497,527**	**24,100**	**4.84%**

Table-2: Penetration and Utilization Rates FY 2015-16 with projections through FY 2019/20

Estimated* Adult Medi-Cal Beneficiaries (18+ years) Needing and Accessing Substance Use Treatment					
	Total Medi-Cal Beneficiaries (18+)	Estimated Substance Use Prevalence**	Estimated Beneficiaries Needing SUD Treatment	Estimated Penetration Rate	Estimated Medi-Cal Beneficiaries Accessing SUD Treatment
FY 15-16	308,488	9.20%	28,381	18.61%	5,281
FY 16-17	311,573	9.20%	28,665	18.61%	5,335
FY 17-18	314,689	9.20%	28,951	20.61%	5,967
FY 18-19	317,835	9.20%	29,241	20.61%	6,027
FY 19-20	321,014	9.20%	29,533	20.61%	6,087

* For FY 16-17 – FY 19-20, assumes 1% population growth between 2015-2020, per CA DOT Alameda County Economic Forecast

** Based on 200% FPL rate for adults in Alameda County, California Behavioral Health Prevalence Estimates, Estimates of Need for Behavioral Health Services Alameda County – Alcohol or Drug Diagnosis All Ages, pg. 49

Table-3: Estimated* Youth Medi-Cal Beneficiaries (12-17 years) Needing and Accessing Substance Use Treatment

	Total Medi-Cal Beneficiaries (12-17)	Estimated Substance Use Prevalence	Estimated Beneficiaries Needing SUD Treatment	Estimated Penetration Rate	Estimated Medi-Cal Beneficiaries Accessing SUD Treatment
FY 15-16	49,338	7.35%	3,626	4.27%	155
FY 16-17	49,831	7.35%	3,663	4.27%	156
FY 17-18	50,330	7.35%	3,699	6.27%	232
FY 18-19	50,833	7.35%	3,736	6.27%	234
FY 19-20	51,341	7.35%	3,774	6.27%	237

* For FY 16-17 – FY 19-20, assumes 1% population growth between 2015-2020, per CA DOT Alameda County Economic Forecast

** Based on 200% FPL rate for youth 12-17 in Alameda County, California Behavioral Health Prevalence Estimates, Estimates of Need for Behavioral Health Services Alameda County – Alcohol or Drug Diagnosis All Ages, pg. 48