ALPINE COUNTY
BEHAVIORAL HEALTH SERVICES

Quality Improvement Work Plan & Evaluation Report

FY 2023/2024 Annual Work Plan and FY 2022/2023 Evaluation Report

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I. QUALITY IMPROVEMENT PROGRAM OVERVIEW

The mission of Alpine County Behavioral Health Services is to provide safe, ethical, and accessible services that inspire personal growth and development through strength-based behavioral health programs and supportive connections.

A. Quality Improvement Program Characteristics

Alpine County Behavioral Health Services (ACBHS) maintains a Quality Improvement (QI) program in accordance with state requirements for evaluating the appropriateness and quality of the mental health and substance use disorder system, including monitoring utilization of services; timeliness; access; and effectiveness of clinical care.

The goal of the ACBHS QI program is to build a structure that ensures the overall quality of services. This goal is accomplished by effective QI activities and data-driven decision making, and collaboration among staff, contract providers, clients, and their family members. Through data collection and analysis, significant trends are identified; and policy and system-level changes are implemented, when appropriate.

QI processes include:

1. Identifying goals and prioritized areas for improvement;
2. Collecting and analyzing data to measure against the identified goals or areas of improvement;
3. Based on data and identified trends, designing and implementing interventions to improve performance;
a. Measuring the effectiveness of the interventions over time, through the analysis of system- and client-level data;
4. Incorporating successful interventions across the system, as appropriate; and
5. Ensuring ongoing training of staff to ensure quality of care, including training, support, and monitoring to implement CalAIM and other statewide initiatives. Trainings may be offered in-person, or online through the ACBHS Relias system, CalMHSA website, or other sources.

The ACBHS QI program is designed to address quality improvement and quality management to ensure to all stakeholders that the processes for obtaining services are fair, efficient, and cost-effective; and that they produce results consistent with the belief that people with mental illness may recover.

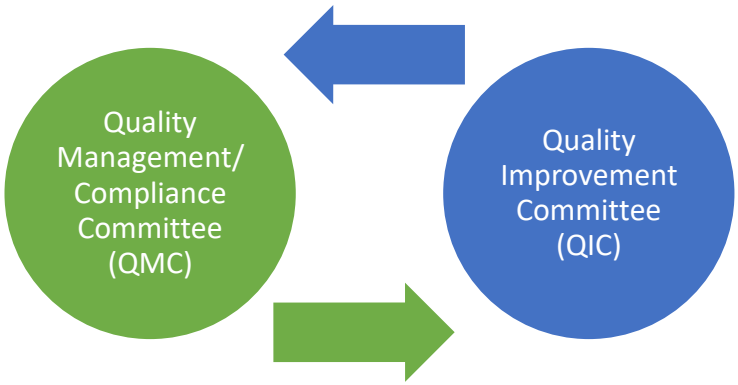
The QI program is responsible for monitoring ACBHS effectiveness through the implementation and maintenance of performance monitoring activities through all levels of the department, including but not limited to, client and system access; timeliness; quality; assessment of clients; clinical outcomes; utilization and clinical records review; monitoring and resolution of client grievances and appeals; state fair hearings; and provider appeals.

The QI program is crucial for upholding and monitoring the requirements of state and federal regulations regarding timeliness and quality of care; the Medi-Cal Mental Health Plan (MHP) contract with the California Department of Health Care Services (DHCS) for Specialty Mental Health Services (SMHS); the state plan contract with DHCS for the delivery of Drug Medi-Cal (DMC) services; and the contract between ACBHS and DHCS for the delivery of Substance Use Prevention and Treatment Block Grant (SUBG) services.

Executive management and program leadership is crucial to ensure that QI activities and findings are used to establish and maintain the overall quality of the service delivery system and organizational operations. As a result, the QI program is directly accountable to the ACBHS Director.

B. Quality Management Committees

Essential to the performance of the QI program is a complete information feedback loop wherein information flows across clinical, programmatic, and administrative channels. Two (2) committees comprise the QI program: 1) Quality Management/Compliance Committee (QMC) and 2) Quality Improvement Committee (QIC). These forums are responsible for the key functions of the ACBHS QI program. The specific functions of each committee are outlined below.



1. **Quality Management/Compliance Committee (QMC)**: The QMC is responsible for identifying and addressing process and policy changes, and ensuring compliance program adherence. This committee meets monthly and includes the Director of Health and Human Services (HHSA), Deputy Director of Behavioral Health Services, Compliance Officer, and Clinical Supervisor.

   The QMC meetings include at least the following activities:

   - Identify and develop plans to mitigate clinical issues, such as inappropriate or inadequate treatment
   - Identify clients with high utilization of services and develop plans or changes to mitigate
   - Use outcome data to inform program-planning decisions
   - Identify and address operations and workflow needs

- Identify and implement policy and process changes, including needed EHR enhancements
- Monitor staffing and capacity needs and issues
- Monitor the Compliance Program
- Address evidence of care that is not within quality, professional, or ethical standards
- Ensure that Medi-Cal services are billed appropriately and in compliance with all state and federal regulations

Refer to the *ACBHS Compliance Plan* for the additional roles and responsibilities of this Committee.

Information from this meeting is summarized and forwarded to the QIC to ensure consistency and quality of services, as well as confidentiality. As appropriate, action items and proposed changes are provided to the QIC for discussion and dissemination.

2. **Quality Improvement Committee (QIC):** The QIC is a broader committee responsible for general oversight of the quality improvement activities of ACBHS. The QIC is a forum for engaging staff, clients, and agency partners in the QI process, and to help inform planning and decision making.

   The QIC reviews and evaluates data; and implements actions that address identified issues and trends. The QIC recommends policy decisions; reviews and evaluates the results of QI activities; and monitors the progress of QI projects. The QMC brings relevant items to the QIC for discussion and action, as appropriate.

   a) QIC Meeting Frequency

      1) QIC meetings are held quarterly, for a total of four (4) meetings a year.

   b) QIC Membership

      1) Designated members of the QIC include the ACBHS Deputy Director; Alcohol and Drug Program Specialist; designated clinical staff; designated administrative staff; and selected community members, including clients and family members, as well as MHSA- and SUD-funded agencies. ACBHS contracts with several non-profit groups for outreach and engagement services. As a component of the contracts, these entities are expected to attend the quarterly meetings of the QIC.

      2) Due to the diverse membership of the QIC, information sharing will not breach client confidentiality regulations; as a result, information of a confidential or sensitive nature is provided to QIC members in summary form only.

c) QIC Functions and Responsibilities

1) Conducts specific and detailed review and evaluation activities of ACBHS.
    - Regularly reviews and analyzes data and implements actions to identify and address systems issues, including quality of care and clinical issues
    - Provides oversight to QI activities, including the development of the Performance Improvement Projects (PIPs).
    - Reviews collected information, data, and trends relevant to the standards of cultural and linguistic competency.

2) Recommends policy decisions; reviews and evaluates the results of QI activities; and monitors the progress of the PIPs.
    - Institutes needed actions and ensures follow-up of QI processes.
    - Documents all activities through dated and signed minutes to reflect all QI decisions and actions made by the QIC.

3) Ensures that QI activities are completed as required; and utilizes a continuous feedback loop to evaluate ongoing QI activities.
    - Monitors previously-identified issues and related data; and tracks issues and interventions over time.
    - Promotes client and family voice to improve wellness and recovery.
    - Continuously conducts planning and initiates new activities for sustaining improvement.

d) QIC Agenda

1) The QIC uses a standing meeting agenda to ensure that all required QI components are addressed at each QIC meeting.

2) The agenda includes at least the following:

    - Mental Health program updates
    - DMC/SUD program updates
    - Access Log and related data review
        - Business days for initial assessment and first service appointments; medication requests
        - Response for urgent/crisis conditions (during regular hours and after-hours)
        - Requests for cultural/linguistic services, including language assistance; and assess results
        - Access Line Test Calls (quarterly report)

- Review Clinical Team Meeting Assessments (CANS, PSC, etc.)
- Review chart review results and issues; required Corrective Action Plans (CAPs)
- Review Clinical Practices and Peer Consultation (DMC/SUD and Mental Health)
- Review data for client- and system-level performance outcome measures
- Review PIPs; progress; and related data
- Review Inpatient / IMD / Residential programs: census, utilization, and length of stay
- Review processed Treatment Authorization Requests (TARs)
- Audit medication monitoring reviews documented by third-party prescriber (Mental Health)
- Review issued Notices of Adverse Benefit Determination (NOABDs)
- Review grievances or appeals (client or provider)
    - Monitor Change of Provider Requests
- Review requests for or results of State Fair Hearings; requests for Aid Paid Pending
- Review results of audits and other reviews (Triennial; EQR; DMC/SUD; MHSA)
- Review results of Medi-Cal service delivery verification process
- Review compliance concerns; fraud/waste reports; patient's rights; and HIPAA/privacy issues
- Review provider concerns; contract denials; appeals; satisfaction surveys
- Review county and contract provider certification/recertification status; credentialing
- Review QI Work Plan updates (annually)
- Review SMHS Implementation Plan, as necessary (annually)
- Discuss client participation in services, system planning, QIC, etc.
- Assess client and family satisfaction surveys for access and cultural competence issues
- Review new regulations and standards, including DHCS notices and publications
- Other items for discussion
- Monitor QIC action items, recommended policy changes and system-level changes, and assignments from previous QIC meetings. *(To ensure a complete feedback loop, completed and incomplete action items are added to the Agenda for review at the next meeting.)*

- Recommend identified program changes; assign new action items

e) QIC Meeting Sign-In Sheet

1) A Sign-In Sheet is collected at the beginning of each QIC meeting. A Confidentiality Statement is integrated into the QIC sign-in sheet to ensure the privacy of protected health information.

f) QIC Meeting Minutes

1) The QIC uses a meeting minute template that closely follows the agenda template to ensure that all relevant and required components are addressed in each set of minutes.

- Meeting minutes are utilized to track action items and completion dates.
- Minutes are maintained by designated QI staff and are available for required annual audits and triennial reviews.

- The QIC assures that QI activities are completed and utilizes a continuous feedback loop to evaluate ongoing quality improvement activities. This loop helps to monitor previously-identified issues, and provides a mechanism to track issues over time. The QIC works in collaboration with the QMC to conduct activities for sustaining improvement.

- Note: ACBHS system changes are not required to be "approved" by the QIC. The QIC is a forum for engaging staff, clients, and agency partners in the QI process, and to help inform planning and decision making.

C. Mental Health Board

The Mental Health Board (MHB) is a state-mandated board convened to advocate and promote recovery for individuals with mental illness and substance use disorders. The MHB is a forum for identifying culturally-relevant needs; monitoring quality of care; monitoring cost-effective strategies; and making recommendations to the County Board of Supervisors.

Members of the MHB include appointed clients; representative from the Alpine County Board of Supervisors; ACBHS Deputy Director; and support staff. The MHB meets at least six (6) times each year.

The MHB receives information from the QIC and provides feedback on access findings and program change proposals. The comments from this forum are documented in the meeting minutes and reported back to the QMC to inform changes and implementation. A QMC/QIC member regularly presents information to the MHB to ensure that quality issues are discussed.

D. Annual Quality Improvement Work Plan Components

The annual ACBHS Quality Improvement Work Plan and Evaluation Report (referred to as the "QI Work Plan" or the "Plan" throughout this document) provides the blueprint for the quality management functions designed to improve client access and quality of care. The Plan is evaluated and updated annually.

The ACBHS Annual QI Work Plan includes at least the following components:

a. An annual evaluation of the overall effectiveness of the QI Program, utilizing data to demonstrate that QI activities have contributed to meaningful improvement in clinical care and client services;
b. A determination of objectives and goals for the coming year;
c. Progress on previously-identified issues, including tracking issues over time through data analysis;
d. An outline of activities and interventions for improving identified issues; and
e. Activities for sustaining improvement and quality of care.

Designated staff facilitates the implementation of the QI Work Plan and the QI activities. Sufficient time to engage in QI activities is allocated to these functions (e.g., conducting chart reviews; coordinating PIPs; facilitating the committees; conducting monitoring activities).

QI Work Plan review by the QIC ensures the opportunity for input and active involvement of clients, family members, licensed and paraprofessional staff, providers, and other interested stakeholders in the QI program. QIC members participate in the planning, design, and implementation of the QI program, including policy setting and program planning.

The ACBHS QI Work Plan addresses quality assurance/improvement factors, as related to the delivery of timely, effective, and culturally-competent SMHS and DMC/SUD services.

The QI Work Plan is posted on the ACBHS website and is also available upon request. It is provided to the External Quality Review Organization (EQRO) during its annual review of the ACBHS mental health system. The QI Work Plan is also available to state auditors during the Triennial Medi-Cal reviews.

E. Accountability

The QIC and QMC are accountable to the HHSA Director. ACBHS contracts with Kings View for telepsychiatry outpatient care, and with hospitals in the region and state for inpatient services. As a component of the contracts, these entities are required to cooperate with the QI program and allow access to relevant clinical records to the extent permitted by state and federal regulations.

II. DATA SOURCES AND SYSTEM REVIEW PROCESS

A. Data Sources and Types

Data used for QI activities may include, but are not limited to, the following sources and types (as available):

- Client and service utilization data by type of service, age, gender, race, ethnicity, primary language, veterans, and LGBTQ
- Electronic Health Record (EHR) Reports
- Access Logs (initial contact log; includes crisis calls)
- Medication Request Logs
- Test Call Logs
- Client and family satisfaction surveys (state-directed)
- Client Grievance/Appeal Logs; State Fair Hearing Logs
- Change of Provider forms and Logs
- QI Chart Review Checklists (and any corrective action plans [CAPs])
- Medication Chart Review Checklists (and any CAPs)
- Staff training logs, including Relias and CalMHSA online trainings, and trainings from other sources, such as in-person opportunities
- Notice of Adverse Benefit Determination (NOABD) forms and logs
- Second Opinion requests, resolutions, and outcomes
- Concurrent Review / Inpatient Census Logs
- Treatment Authorization Requests (TAR) and Inpatient Logs
- Service Authorization Request (SAR) Logs
- PIP data
- Staff productivity reports
- Compliance Logs
- Policies and procedures
- QMC and QIC meeting minutes
- Internal MH and DMC/SUD monitoring activities (reported out by QMC)
- EQR and Medi-Cal compliance review results (and any related CAPs)
- Special reports from DHCS or other required studies

B. System Review Process and Resulting Interventions

1) Designated QI staff conduct ongoing analysis of system processes and data to review for issues and trends.

2) If there are areas of concern, the QMC discusses the issues.

    a. System policy and/or process changes may be implemented to address quality of services; compliance; timeliness; access; and effectiveness of clinical care.

3) Based on data and identified trends and issues, and as appropriate, proposed changes are discussed with the QIC and/or the MHB.

    a. Note: System changes are not required to be "approved" by the QIC. The QIC is a forum for engaging staff, clients, and agency partners in the QI process, and to help inform planning and decision making.

    b. Final program changes are approved by the QMC and/or HHSA Director prior to implementation.

4) Effectiveness of program and process changes are evaluated by the QMC and QIC.

    a. Data is reviewed and analyzed by the QMC and QIC to determine efficacy of new programs or processes.

    b. Input from the committees is documented in the meeting minutes, which include the activity, person responsible, and timeframe for completion. Each activity and the status for follow-up are discussed at the beginning of the next meeting.

III. DELEGATED ACTIVITIES STATEMENT

ACBHS does not delegate any ACBHS program review activities. Should delegation take place in the future, this Plan will be amended accordingly.

IV. QI EVALUATION REPORT AND ACTION PLAN – GOALS, DATA, AND INTERVENTIONS

Goal 1: Persons requesting non-crisis mental health services who are new to ACBHS are offered an initial assessment appointment within 10 business days of the request for services			
Objective	To monitor timeliness of new requests for routine outpatient mental health services to ensure accessibility		
Numerator	Total number of persons requesting mental health services who are new to ACBHS and were offered an initial assessment appointment within 10 business days in a given fiscal year		
Denominator	Total number of persons requesting mental health services who are new to ACBHS mental health services in a given fiscal year		
Performance Indicator/Target Goal	To offer an initial assessment appointment within 10 business days of request		
Data	Number and percent of new requests who met this standard in FY 2019-2020	58 of 60 clients	96.7%
	Number and percent of new requests who met this standard in FY 2020-2021	82 of 90 clients	91.1%
	Number and percent of new requests who met this standard in FY 2021-2022	60 of 61 clients	98.4%
	Number and percent of new requests who met this standard in FY 2022-2023	19 of 20 clients	95.0%
Evaluation			
Analysis: The percentage of persons requesting mental health services who are new to ACBHS and who were offered an assessment appointment within 10 days has remained high across the past 4 fiscal years. There was a decrease from 96.7% in FY 2019-2020 to 91.1% in FY 2020-2021 (which was likely due to challenges around COVID-19); a significant increase to 98.4% in FY 2021-2022; then a decrease to 95% in FY 2022-23, although the percentage still remains very high.			
Quality Improvement Action Plan: ACBHS has maintained the standard in this area; however, because timely access is a key component, ACBHS will continue to monitor this goal in FY 2023-2024. ACBHS will maintain and/or improve the percent of requests that are offered an initial assessment appointment within 10 business days.			
Planned Interventions to maintain Compliance: • Continue staff training on scheduling new requests for services, with an emphasis on the 10-day standard • Provide feedback to staff at monthly meetings on the percent of requests that were offered within 10 business days (review A&I Log) • Review staff schedules and block assessment times each week to allow admin staff to schedule appointments within 10 business days • Review and document data monthly with management staff and quarterly with QIC to identify barriers to meeting the 10-day timeframe • Develop prompt or reminder regarding the 10-day rule on the Access Log; train staff on the updated Access Log			

Data Source: Access and Information Log; **Frequency:** Quarterly

Goal 2: Ensure timely access to a Medication Assessment			
Objective	To monitor timeliness of new referrals to a medication assessment through telepsychiatry to ensure access to medication services		
Numerator	Total number of persons referred to a telepsychiatrist who receive a medication assessment within 15 business days of the referral		
Denominator	Total number of persons referred for a medication assessment to telepsychiatry		
Performance Indicator/Target Goal	To ensure clients who need to be assessed for medications receive a medication assessment within 15 business days		
Data	Number of clients who received an on-time med assessment in FY 2019-2020	2 of 6 clients	33.3%
	Number of clients who received an on-time med assessment in FY 2020-2021	6 of 9 clients	66.7%
	Number of clients who received an on-time med assessment in FY 2021-2022	4 of 6 clients	66.7%
	Number of clients who received an on-time med assessment in FY 2022-2023	1 of 1 client	100.0%
Evaluation			
Analysis: The percentage of mental health clients who were referred for a medication assessment and received a medication assessment service has varied across the years. There are a small number of new clients who are referred for medication assessment each year; therefore, there is variability in the number of persons who receive a medication assessment through telepsychiatry. There are also a limited number of hours of telepsychiatry available to Alpine County, which limits the days that are available to schedule clients for an assessment.			
Quality Improvement Action Plan: ACBHS has increased the percentage over the last three (3) years; however, because timely access is a key component, ACBHS will continue to monitor this goal in FY 2023-2024. ACBHS will work closely with Kings View to increase the number of medication assessment appointments and to improve access to this level of care.			
Planned Interventions to maintain Compliance: • Ensure that the contract with Kings View has adequate access to a telepsychiatrist to schedule medication assessments within 15 business days • Provide feedback to Kings View about length of time to schedule a telepsychiatry assessment appointment • Offer transportation to clients to help them keep their medication assessment appointment as scheduled			

Data Source: Cerner; **Frequency:** Annually

Goal 3: Persons assessed for mental health services receive a first service within 10 business days of assessment			
Objective	Ensure that persons receive a first service within 10 business days of the assessment		
Numerator	Total number of persons assessed for outpatient mental health services who receive a first service within 10 business days of the assessment, in a given fiscal year		
Denominator	Total number of clients assessed for outpatient mental health services who received an assessment, in a fiscal year		
Performance Indicator/Target Goal	To receive an outpatient mental health service within 10 business days of the mental health assessment		
Data	Number and percent of services that met this standard in FY 2019-2020	15 out of 27	55.6% met goal
	Number and percent of services that met this standard in FY 2020-2021	16 out of 26	61.5% met goal
	Number and percent of services that met this standard in FY 2021-2022	16 out of 17	94.1% met goal
	Number and percent of services that met this standard in FY 2022-2023	3 out of 3	100.0% met goal
Evaluation			
Analysis: The percentage of requests that met this goal increased from 55.6% in 2019-2020 to 61.5% in FY 2020-2021; then significantly increased to 94.1% in FY 2021-2022 and to 100% in FY 2022-2023.			
Quality Improvement Action Plan: ACBHS has improved in this area; however, because timely access is a key component, ACBHS will continue to monitor this goal in FY 2023-2024. ACBHS will improve the percentage of services that meet this standard.			
Planned Interventions to maintain Compliance: • Continue staff training on scheduling and documenting services within the 10-day standard • Instruct Admin staff to call the client 24 to 48 hours before a scheduled service appointment, to remind the client of the appointment • Review timeliness data quarterly at QIC meetings to identify ongoing barriers; improve quality; and provide immediate support, training, and feedback • Provide feedback to staff at monthly staff meetings on the percent of persons who received a first service within 10 business days (review A&I Log)			

Data Source: Access and Information Log and Cerner data; **Frequency:** Annually

Goal 4: Conduct medication monitoring activities on at least 10% of medication charts each year			
Objective	To assess the safety and effectiveness of medication practices in ACBH to ensure quality of care		
Numerator	Number of medication charts reviewed in a given fiscal year		
Denominator	Total number of persons receiving medication services in a given fiscal year		
Performance Indicator/Target Goal	To increase the number of medication charts reviewed through medication monitoring to represent 10% the persons receiving medication services.		
Data	Number and percent of medication charts reviewed in FY 2019-2020	7 charts	37%
	Number and percent of medication charts reviewed in FY 2020-2021	11 charts	79%
	Number and percent of medication charts reviewed in FY 2021-2022	11 charts	61%
	Number and percent of medication charts reviewed in FY 2022-2023	TBD	TBD
Evaluation			
Analysis: The percent of medication charts reviewed was 59% in FY 2018-2019. This number decreased in FY 2019-2020 (37%); greatly increased to 79% in FY 2020-2021; and then decreased to 61% in FY 2021-2022. In FY 2022-2023, ACBHS lost the contract with the third-party prescriber who conducted the medication chart reviews. As a result, medication charts have not been reviewed for FY 2022-2023. Analysis of this information will be added once a third-party prescriber has been identified and the FY 2022-2023 charts have been reviewed.			
Quality Improvement Action Plan: In FY 2022-2023, ACBHS lost the contract with the third-party prescriber who conducted the medication chart reviews. As a result, medication charts have not been reviewed for FY 2022-2023. Analysis of this information will be added once a third-party prescriber has been identified and the FY 2022-2023 charts have been reviewed.			
Suggested Interventions: • Provide staff training on the importance of medication monitoring • Contract with a psychiatrist or pharmacist to complete medication monitoring at least quarterly • Review medication monitoring results at QIC at least quarterly			

Data Source: Cerner; **Frequency:** Annually

Goal 5: To increase staff productivity, including the percent of billable services, to improve access, quality, and cost-effectiveness of services	
Objective	To assess and monitor staff productivity to improve access, staff performance, effective service utilization, service capacity, and cost-effectiveness of services
Numerator	Number of services delivered by staff that were billable services in a given fiscal year
Denominator/Comparison	Number of services delivered by staff that were billable services in the previous fiscal year
Performance Indicator/Target Goal	To improve the number and percent of billable services delivered by staff each year by 10%
Data	Year 1 data to be added once a data source has been identified and the data has been reported.
Evaluation	
The evaluation, including planned interventions for improvement, will be added once a data source has been identified and data has been reported.	

Data Source: TBD. **Frequency:** TBD.

Goal 6: To provide guidance and training to county-operated and county-contracted providers on all new behavioral health policies, as outlined by DHCS in BHIN numbers 21-071, 21-073, 22-011, 22-013, 22-019, and 23-001 (CalAIM Standards)			
NOTE: This goal or methodology may be updated when additional guidance is received from DHCS and CalMHSA.			
Objective	To train, support, and monitor county and provider staff around the CalAIM standards for Specialty Mental Health Services (SMHS), including (as relevant to job function) medical necessity; access; coding; and documentation and service standards.		
Numerator	Number of CalAIM CalMHSA modules completed by county and provider staff		
Denominator/Comparison	Number of CalAIM CalMHSA modules available		
Performance Indicator/Target Goal	To complete at least 75% of available CalAIM modules		
Data	Number and percent of CalAIM modules completed (April 2022 - April 2024)	32 / 78	41.0%
Evaluation			
Analysis: Staff and community providers have completed less than half of the available CalAIM training modules CalAIM training is now a key component, and ACBHS will continue to monitor this goal in FY 2023-2024.			
Quality Improvement Action Plan: In this fiscal year, MCBH plans to increase the number of county and provider staff who complete CalAIM training(s).			
Suggested Interventions: • Continue to encourage staff and providers to train on CalAIM standards • Track training and follow up			

Data Source: CalMHSA Training Documentation Dashboard. **Frequency:** Annually.