San Joaquin County Behavioral Health Services

Quality Assessment and Performance Improvement (QAPI) Workplan

July 1, 2018 – June 30, 2022

Updated for Fiscal Year 2018/19
Executive Summary

Purpose and Intent
San Joaquin County Behavioral Health Services (SJCBHS) is committed to service excellence and continuous quality improvement. Toward this end, SJCBHS has developed and implemented a range of quality assessment & performance improvement activities to measure and improve the timeliness, access, quality and outcomes of its services.

Quality Improvement Principles
Quality Improvement is defined as a systematic approach to assessing services and improving them. SJCBHS’ approach to quality improvement is based on the following principles:

- **Recovery-oriented**: Services provided should promote and preserve wellness and expand choices to meet individually defined goals.
- **Employee Empowerment**: Effective quality improvement initiatives should involve people at all levels of the organization in improving quality.
- **Leadership Involvement**: Strong leadership, direction and support of quality improvement activities are essential to performance improvement. Involving organizational leadership assures that quality improvement initiatives are consistent with SJCBHS’ mission, vision, and values and compliment the organization’s Strategic Plan.
- **Data Driven Decision-Making**: Successful quality improvement processes should incorporate feedback loops, using data to develop practices and measure results.
- **Prevention over Correction**: Continuous quality improvement includes designing processes that achieve positive outcomes rather than fixing processes that do not produce desired results.

Continuous Quality Improvement Activities
SJCBHS has adopted the following continuous quality improvement activities:

- **Collecting and analyzing data** to measure against the goals, or prioritized areas of improvement that have been identified;
- **Identifying opportunities for improvement** and deciding which activities to pursue;
- Identifying relevant committees internal or external to **ensure appropriate exchange of information** with the Quality Assessment & Performance Improvement Council (QAPIC);
- **Obtaining input** from providers, beneficiaries, and family members in identifying barriers to delivery of clinical care and administrative services;
- **Designing and implementing interventions** for improving performance;
- **Measuring the effectiveness** of the interventions;
- **Incorporating successful interventions** into SJCBHS’ operations as appropriate; and
- Reviewing grievances, standard appeals, expedited appeals, fair hearings, expedited fair hearings and provider appeals for **customer satisfaction**.

**Quality Assessment and Performance Improvement Council and Subcommittees**

The QAPIC is a formal body that has responsibility for reviewing the quality of services provided by SJCBHS and its contracted providers. The QAPIC recommends policy decisions, reviews and evaluates the results of quality assessment & performance improvement activities including Performance Improvement Projects (PIPs), institutes needed actions, ensures follow-up of quality assessment & performance improvement processes, and documents its decisions and actions taken.

The QAPIC meets monthly and its membership includes members of SJCBHS’ Senior Management, Program Managers, staff, providers, consumers, and family members. The QAPIC reviews and analyzes the results of the activities of the QAPI Review Subcommittee and the QAPI Chairs Subcommittee and makes recommendations regarding any impediment to quality of care, quality outcomes, timeliness of care, and access to service. The roles of and responsibilities of these subcommittees of the Council are as follows:

- **QAPI Review Subcommittees**—The QAPI Review Subcommittees are responsible for reviewing client records to determine if services were provided following state and federal regulations, agency policy and procedures, cultural competency, community standards of practice, and appropriate utilization of fiscal resources.
The QAPI Chairs meeting, which occurs monthly, is comprised of program managers and supervisors. SJCBHS Contract Liaisons and SJCBHS contracted providers are invited to attend the meetings quarterly. The primary function of QAPI Chairs is to ensure SJCBHS meets or exceeds documentation standards. As such, QAPI Chairs reviews current documentation practices, trends and verifies both Medi-Cal regulations and SJCBHS policy and procedures are followed. Additionally, the committee makes policy recommendations and ensures test call procedures and assignments are reviewed.

Three subcommittees whose recommendations are reviewed by QAPIC are:

- **Grievance Committee**—The Grievance Committee is an established committee that meets on a quarterly basis to provide a thorough review of grievances, standard appeals, and expedited appeals received from SJCBHS consumers, and analyze data and trends.

- **Cultural Competency Committee**—The Cultural Competence Committee has representation from management staff, direct services staff, consumer, community members, and representatives of cultures from the community. The Cultural Competence Committee meets regularly to review BHS adherence to the BHS Cultural Competency Plan by reviewing goals and objectives and making appropriate recommendations to BHS Administration regarding management and service provision as it relates to cultural and linguistic services.

- **Child and Adult Needs and Services Assessment Committee (Cansa)**—The Cansa Committee is an established committee that was developed to ensure SJCBHS was part of the statewide implementation of a standardized assessment tool that assessed the needs of children, youth, adult, older adult and families through a strength-based needs-driven approach.

**Annual Evaluation**

An evaluation of the effectiveness of quality assessment & performance improvement activities is completed annually and reviewed with the QAPIC. The evaluation summarizes progress associated with each of the QAPI Work Plan goals and objectives, and includes actions taken in response to outcomes. Based upon the evaluation, revisions may be made to subsequent QAPI Work Plans.
Quality Assessment & Performance Improvement Work Plan
This is a living document and may be changed as needed.

During FY 18/19, SJCBHS is committed to six quality assessment and performance improvement initiatives:
1. Improve timely access to service
2. Ensure access to care
3. Improve quality of service delivery and beneficiary satisfaction
4. Improve clinical outcomes
5. Enhance data-driven decision-making
6. Develop staff and enhance cultural competency

FY 18/19 measurable objectives are incremental and based on QAPI Council and SJCBHS Executive Leadership’s judgment of what is manageable and possible to achieve in one year. In each year of this four-year work plan, SJCBHS will review the previous year’s findings and adjust its measurable objectives accordingly. SJCBHS’ longer-term goal is to improve performance expectations every year in order to achieve the gold standard in service delivery.

SJCBHS’ overarching strategies guiding these initiatives involve:
1. Collaborating between divisions and disciplines to ensure quality services;
2. Coordinating with SJCBHS divisions and the Information Systems unit, to develop reliable reports that provide monthly data for each initiative’s measurable objectives;
3. Reviewing data reports monthly with QAPI Council to identify the greatest discrepancies between current findings and goals;
4. Developing real-time strategies to address areas of concern;
5. Implementing formal PIPs for areas of greatest need;
6. Revising goals annually or as needed to meet regulatory expectations and stakeholder expectations; and
7. Fostering staff participation in and commitment to quality assessment and performance improvement initiatives
### Initiative 1: Improve Timely Access to Services

<table>
<thead>
<tr>
<th>Initiative 1: Improve timely access to services</th>
<th>FY18/19 Measurable Objectives</th>
<th>Baseline</th>
<th>Baseline data sources/notes</th>
<th>Ongoing data sources, responsible parties, and review intervals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1a</strong> Timely initial clinical assessments</td>
<td>At least 85% of all beneficiaries will be offered an initial clinical assessment within 10 business days of first request/first contact (CalEQRO, FY 16/17, Statewide MHP average: 79%)</td>
<td>73%</td>
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<td>At least 85% of adults will be offered an initial clinical assessment within 10 business days of first request/first contact</td>
<td>77%</td>
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<td>At least 85% of children will be offered an initial clinical assessment within 10 business days of first request/first contact</td>
<td>58%</td>
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<td>At least 85% of foster children will be offered an initial clinical assessment within 10 business days of first request/first contact</td>
<td>22%</td>
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<tr>
<td><strong>1b</strong> Timely initial psychiatry appointments</td>
<td>At least 65% of all beneficiaries will be offered an initial psychiatric appointment within 15 days of determination of necessity by BHS (CalEQRO, FY 16/17, Statewide MHP average: 62%)</td>
<td>16%</td>
<td>Data derived from Timeliness App and EHR; reported in FY17/18 EQRO Self-Assessment</td>
<td>Ongoing data sources: Timeliness App; EHR, reported into QAPI Data Collection Tool</td>
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<tr>
<td></td>
<td>At least 65% of adults will be offered an initial psychiatric appointment within 15 days of determination of necessity by BHS</td>
<td>17%</td>
<td>Baseline does not include data from contract providers</td>
<td>Responsible parties: data entry overseen by Clinic Managers and analyzed by Timeliness PIP Team. Data monitored by QAPI Coordinator. Strategic planning recommendations by Timeliness PIP Team and Executive Leadership.</td>
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<tr>
<td></td>
<td>At least 65% of children will be offered an initial psychiatric appointment within 15 days of determination of necessity by BHS</td>
<td>0%</td>
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<tr>
<td></td>
<td>At least 65% of foster youth will be offered an initial psychiatric appointment within 15 days of determination of necessity by BHS</td>
<td>Unk</td>
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<td><strong>1c</strong> Timely crisis evaluations</td>
<td>At least 75% of all beneficiaries in crisis will receive a crisis intervention within 120 minutes of request</td>
<td>58%</td>
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<td>At least 75% of adults in crisis will receive a crisis intervention within 120 minutes of request</td>
<td>50%</td>
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<td>At least 98% of children in crisis will receive a crisis intervention within 120 minutes of request</td>
<td>95%</td>
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<td></td>
<td>At least 98% of foster youth in crisis will receive a crisis intervention within 120 minutes of request</td>
<td>97%</td>
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<td><strong>1d</strong> Timely post-hospitalization followup</td>
<td>At least 95% of all beneficiaries will receive a followup appointment within 7 calendar days of discharge from hospital (CalEQRO, FY 16/17, Statewide MHP average: 71%)</td>
<td>87%</td>
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<td></td>
<td>At least 95% of adults will receive a followup appointment within 7 calendar days of discharge from hospital</td>
<td>87%</td>
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<td>At least 95% of children will receive a followup appointment within 7 calendar days of discharge from hospital</td>
<td>91%</td>
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<td>At least 95% of foster youth will receive a followup appointment within 7 calendar days of discharge from hospital</td>
<td>44%</td>
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</table>
FY 18/19 Strategic Actions

1. Timeliness PIP—continue to implement PIP strategies:
   a. Phase 1: clarify working definitions, eliminate screenings, conduct weekly data analysis and coordinate real-time strategies between clinics (completed).
   b. Phase 2: develop a 24/7 Call Center and Assessment Teams, and provide ongoing training to SJC BHS staff to ensure accurate data entry, provide Timeliness App access and training to contractors (by April 1, 2019).
   c. Phase 3: same-day assessment appointment options (see Timeliness PIP Report for further details).

2. Timeliness for foster care youth: Collaborate with County Counsel and San Joaquin County Human Services Agency to streamline referral and consent processes for youth in foster care and presumptive transfers.

3. Adequate staffing:
   a. Conduct staffing capacity analysis to ensure sufficient staffing availability for each discipline to meet timeliness goals.
   b. Ensure data submitted each quarter for the Network Adequacy Compliance Tool is accurate.

4. Review monthly data reports at QAPI Council to identify gaps and challenges.
   a. Identify barriers to reaching timeliness goals and develop future strategic actions.
## Initiative 2: Ensure Access to Care

<table>
<thead>
<tr>
<th>#</th>
<th>Goal</th>
<th>FY18/19 Measurable Objectives</th>
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<tbody>
<tr>
<td>2a</td>
<td>Beneficiaries receive timely and accurate information</td>
<td>100% of test calls to 24/7 call line during business hours will receive timely and accurate information 100% of test calls to 24/7 call line after hours will receive timely and accurate information 100% of relevant test calls to 24/7 call line during business hours will document use of interpreter or language line 100% of relevant test calls to 24/7 call line after hours will document use of interpreter or language line</td>
<td>100%</td>
<td>FY 17/18, Q4, 24/7 Test Call Report Form</td>
<td>Ongoing data sources: Test Call Report Form  Responsible parties: QAPI Council  Review interval: monthly</td>
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<tr>
<td>2b</td>
<td>Increase proportion of beneficiaries who receive initial clinical assessment</td>
<td>At least 77% of initial clinical assessments of all ages will be claimed  At least 77% of initial clinical assessments of adults will be claimed  At least 77% of initial clinical assessments of children will be claimed  At least 77% of initial clinical assessments of foster youth will be claimed</td>
<td>71% 70% 75%</td>
<td>Timeliness App; FY17/18 contacts Baseline does not include data from contract providers</td>
<td>Ongoing data sources: Timeliness App. Goal established in current Timeliness PIP (see PIP report)  Responsible parties: Data entry overseen by Clinic Managers and analyzed by PIP Timeliness Team and Evaluator. Data monitored by QAPI Council. Strategic planning recommendations by Timeliness PIP Team and Executive Leadership  Review interval: monthly</td>
</tr>
<tr>
<td>2c</td>
<td>Decrease non-psychiatry appointment no-show rates</td>
<td>Fewer than 15% of all ages non-psychiatry appointments will result in a client no-show (CalEQRO, FY 16/17, statewide MHP average: 9%)  Fewer than 15% of adult non-psychiatry appointments will result in a client no-show (CalEQRO, FY 16/17, statewide MHP average: 8%)  Fewer than 15% of child non-psychiatry appointments will result in a client no-show (CalEQRO, FY 16/17, statewide MHP average: 12%)  Fewer than 15% of foster youth non-psychiatry appointments will result in a client no-show</td>
<td>unk</td>
<td>Data source: Clinician’s Gateway and Sharecare; reported in No-show Report</td>
<td>Ongoing data source: Clinician’s Gateway and Sharecare; reported into QAPI Data Collection Tool  Responsible parties: Data entry overseen by Clinic Managers; IS runs report; data monitoring by QAPI Council; Medical Director reviews Psychiatry Reports; strategic planning recommendations by QAPI Council; Medical Director and other Executive Leadership  Review interval: monthly</td>
</tr>
<tr>
<td>2d</td>
<td>Decrease psychiatry appointment no-show rates</td>
<td>Fewer than 10% of all ages psychiatry appointments will result in a client no-show (CalEQRO, FY 16/17, statewide MHP average: 10%)  Fewer than 10% of adult psychiatry appointments will result in a client no-show (CalEQRO, FY 16/17, statewide MHP average: 14%)  Fewer than 10% of child psychiatry appointments will result in a client no-show (CalEQRO, FY 16/17, statewide MHP average: 12%)  Fewer than 10% of foster youth psychiatry appointments will result in a client no-show</td>
<td>unk</td>
<td>Data source: 2017/18 External Quality Review Report</td>
<td>Ongoing data source: MEDS Report; reported by IS  Responsible parties: IS runs report: MHSA Coordinator, Cultural Competency Committee, and executive leadership review findings and make strategic recommendations  Review interval: quarterly</td>
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</tbody>
</table>

### Initiative 2: Ensure Access to Care

- **Baseline:** 100%
- **Baseline data sources/notes:** FY 17/18, Q4, 24/7 Test Call Report Form
- **Ongoing data sources, responsible parties, and review intervals:**
  - Test Call Report Form
  - QAPI Council
  - Monthly
- **Increase proportion of beneficiaries who receive initial clinical assessment:**
  - Baseline: 71%
  - Data sources: Timeliness App; FY17/18 contacts
  - Ongoing data sources: Timeliness App. Goal established in current Timeliness PIP (see PIP report)
  - Responsible parties: Data entry overseen by Clinic Managers and analyzed by PIP Timeliness Team and Evaluator. Data monitored by QAPI Council. Strategic planning recommendations by Timeliness PIP Team and Executive Leadership
  - Review interval: Monthly
- **Decrease non-psychiatry appointment no-show rates:**
  - Baseline: unk
  - Data source: Clinician’s Gateway and Sharecare; reported in No-show Report
  - Ongoing data source: Clinician’s Gateway and Sharecare; reported into QAPI Data Collection Tool
  - Responsible parties: Data entry overseen by Clinic Managers; IS runs report; data monitoring by QAPI Council; Medical Director reviews Psychiatry Reports; strategic planning recommendations by QAPI Council; Medical Director and other Executive Leadership
  - Review interval: Monthly
- **Decrease psychiatry appointment no-show rates:**
  - Baseline: unk
  - Data source: 2017/18 External Quality Review Report
  - Ongoing data source: MEDS Report; reported by IS
  - Responsible parties: IS runs report: MHSA Coordinator, Cultural Competency Committee, and executive leadership review findings and make strategic recommendations
  - Review interval: Quarterly
FY 18/19 Strategic Actions

1. 24/7 test calls:
   a. Identify and address logging errors.
   b. Provide after-hour staff training to ensure beneficiaries receive timely and accurate information.
   c. Survey after-hour callers to see if they are satisfied with Access services.

2. Continue to measure claimed initial clinical intake assessments during Timeliness PIP rollout—improved timeliness should result in an increase in the proportion of contacts who are linked to services.

3. No-shows:
   a. Establish taskforce to define no-show categories, and educate staff on utilizing categories in Electronic Health Record (EHR).
   b. Establish electronic data system to track and monitor no-show data for psychiatry and non-psychiatry appointments.

4. Latino/Hispanic penetration rate:
   a. Monitor success of MHSA Assessment and Respite Center Innovation project, which is focused on increasing racial and ethnic minorities’ access to services. Review demographic and consumer satisfaction data from MHSA Access and Respite Center project on a quarterly basis.
   b. Assign the Cultural Competency Committee to discuss and recommend strategies for effective outreach to and engagement with Latino/Hispanic communities.
   c. Explore opportunities to increase the number of mental health services available in Spanish.
### Initiative 3: Improve Quality of Service Delivery and Beneficiary Satisfaction

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</thead>
<tbody>
<tr>
<td>1a</td>
<td>Determination of medical necessity</td>
<td>At least 99% of case managed/therapy client records reviewed in subcommittee will demonstrate that medical necessity was determined</td>
<td>98.6%</td>
<td>QAPI Disallowance Summary Analysis, FY17/18. Includes all BHS and contractor providers. Does not include meds only clients to review process.</td>
<td>Ongoing data source: QAPI Disallowance Summary Analysis. Need to add meds only clients to review process. Responsible party: QAPI Subcommittee conducts chart review. QAPI creates summary analysis. Reviewed by QAPI Chairs who make strategic recommendations at QAPI Council. Review interval: monthly.</td>
</tr>
<tr>
<td>1b</td>
<td>Determination of level of care</td>
<td>At least 90% of all beneficiary records reviewed in subcommittee will demonstrate that services are provided at the appropriate level of care</td>
<td>n/a</td>
<td>Administration is in the process of developing protocols to ensure coordination of care based on level of need. Protocols will be developed by June 30, 2019.</td>
<td>TBD</td>
</tr>
<tr>
<td>1c</td>
<td>Increase service dosage</td>
<td>MHP will increase annual approved claims per beneficiary by at least 20%</td>
<td>$4397 per beneficiary</td>
<td>Baseline data derives from FY18-19 External Quality Review Report. Responsible parties: QAPI compiles report; Reviewed by QAPI chairs monthly and by contractors quarterly; Recommendations are presented to QAPI council and Executive Leadership for strategic planning. Review interval: monthly and quarterly for contractors.</td>
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<tr>
<td>2d</td>
<td>Increase beneficiary participation in QAPI, MHSAs and Cultural Competency planning</td>
<td>Involve at least 5 new consumer and/or family member beneficiaries in QAPI, MHSAs, and/or Cultural Competency activities</td>
<td>n/a</td>
<td>Roster of active advocates</td>
<td>Ongoing data source: Monthly Subcommittee Review Report. Responsible parties: Ethnic Services Mgr; MHSAs coordinator QAPI Review interval: monthly.</td>
</tr>
<tr>
<td>3e</td>
<td>Beneficiary satisfaction with quality of care</td>
<td>Fewer than 58 Quality of Care Grievances will be received annually</td>
<td>67</td>
<td>FY 2017/18 Grievance Log - Quality of Care Category</td>
<td>Ongoing data source: Grievance Log, Quality of Care Category.</td>
</tr>
<tr>
<td>3f</td>
<td>Beneficiary satisfaction with provider</td>
<td>Develop an electronic Change of Provider Tracking System and benchmarks to demonstrate client satisfaction</td>
<td>unk</td>
<td>Review of FY16-17 Change of Provider Log. Review of FY1819 Q1 &amp; Q2 to establish definitions and types for the three provider categories.</td>
<td>Responsible party: QAPI Grievance Coordinator Review interval: monthly.</td>
</tr>
<tr>
<td>3g</td>
<td>Overall beneficiary satisfaction</td>
<td>At least 85% of youth will report overall satisfaction with services</td>
<td>84.5%</td>
<td>2017 Consumer Perception Survey, n=609</td>
<td>Ongoing data source: Consumer Perceptions Surveys. Herein, surveys will be distributed annually. Responsible parties: QAPI responsible for collecting and compiling summary reports; data used by MHSAs Coordinator and Cultural Competency Committee to inform program planning. Review interval: annual.</td>
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</tbody>
</table>
FY 18/19 Strategic Actions

1. Determination of medical necessity and level of care:
   o Provide medical necessity and level of care training for direct service staff.
   o QAPI subcommittees and chairs will focus on level of care determination in addition to reviewing medical necessity for case managed and therapy clients.
   o Recruit medical staff to participate in monthly QAPI subcommittee reviews, and establish a process to review medication-only charts for level of care determination and medical necessity.

2. Increase service dosage:
   o Conduct an analysis of staffing to determine capacity.
   o Implement new FSP programs designed to increase engagement in intensive services.

3. Increase beneficiary participation:
   o Cultural Competency Committee, Ethnic Services Manager, and Consortium will recruit beneficiaries, family members, and other stakeholders to increase membership and participation in QAPI, MHSA, and Cultural Competency planning.

4. Beneficiary satisfaction:
   o Track, trend, and analyze types of concerns in grievances, appeals, expedited appeals, and state fair hearing actions.
   o Research strategies to prevent and decrease consumer grievances regarding quality of care.
   o Develop, prioritize, and implement staff trainings and beneficiary education to increase level of beneficiary satisfaction.
   o Analyze Consumer Perception Survey results to identify areas of concern and integrate or compare results of the SJCBHS-internal survey to guide improvement of services.

5. Present findings from Quality Performance Dashboards to community and staff at QAPI Council, QAPI Chairs Committee, and Sr. Managers meetings.
### Initiative 4: Improve Clinical Outcomes

<table>
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<tr>
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<th>Goal</th>
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<th>Baseline data sources notes</th>
<th>Ongoing data sources, responsible parties, and review intervals</th>
</tr>
</thead>
<tbody>
<tr>
<td>4a</td>
<td>Prevent PHF rehospitalizations</td>
<td>Fewer than 14% of all beneficiaries will be readmitted to any hospital within 30 days of discharge (CallEQRO, FY 16/17, statewide MHP average: 14%)</td>
<td>17%</td>
<td>Source: FY17/18 EQRO Self Assessment, data pulled from Sharcare</td>
<td>Ongoing data source: IS department runs monthly report Responsible Parties: QAPI Council reviews data and makes strategic recommendations to Executive Leadership Review intervals: monthly</td>
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<tr>
<td></td>
<td></td>
<td>Fewer than 14% of adults will be readmitted to any hospital within 30 days of discharge (CallEQRO, FY 16/17, statewide MHP average: 15%)</td>
<td>18%</td>
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<td></td>
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<td>Fewer than 9% of children will be readmitted to any hospital within 30 days of discharge (CallEQRO, FY 16/17, statewide MHP average: 9%)</td>
<td>11%</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>Fewer than 9% of foster youth will be readmitted to any hospital within 30 days of discharge</td>
<td>22%</td>
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<tr>
<td>4b</td>
<td>Divert hospitalizations through CSU</td>
<td>At least 50% of all beneficiaries admitted to the CSU will be diverted from hospital admissions (e.g., released to lower level of care)</td>
<td>46%</td>
<td>Jan–Nov 2018 average, manual data collection into Excel by CSU Manager</td>
<td>Ongoing data source: IS department will automate data collection and reporting Responsible parties: currently CSU Manager reports data; Reviewed by QAPI Council</td>
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<tr>
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<td>At least 50% of adults admitted to the CSU will be diverted from hospital admissions (e.g., released to lower level of care)</td>
<td>46%</td>
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<td>At least 50% of children admitted to the CSU will be diverted from hospital admissions (e.g., released to lower level of care)</td>
<td>47%</td>
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<tr>
<td>4c</td>
<td>Medication adherence</td>
<td>At least 85% of case managed adults will be medication adherent (scoring 0 or 1 on Medication Involvement CANSA item)</td>
<td>78%</td>
<td>Baseline from Oct 2017 - Mar 2018 CANSA re-assessments, reported in current Clinical PIP</td>
<td>Ongoing Data Source: IS Department submits CANSA report with Medication Involvement Data every 2 weeks to evaluator Responsible parties: Evaluator and Clinical PIP Team review data; Medication PIP Team and Executive Leadership develop interventions as needed to improve outcomes (see current Medication PIP for further details)</td>
</tr>
<tr>
<td>4d</td>
<td>Cultural Stress</td>
<td>At least 85% of all beneficiaries will have a 0 or 1 on their Cultural Stress item at most recent CANSA reassessment</td>
<td>TBD</td>
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<tr>
<td></td>
<td></td>
<td>At least 85% of adults will have a 0 or 1 on their Cultural Stress item at most recent CANSA reassessment</td>
<td>TBD</td>
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<tr>
<td></td>
<td></td>
<td>At least 85% of children will have a 0 or 1 on their Cultural Stress item at most recent CANSA reassessment</td>
<td>TBD</td>
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<tr>
<td>4e</td>
<td>Involvement in Recovery</td>
<td>At least 85% of all beneficiaries will have a 0 or 1 on their Involvement in Recovery item at most recent CANSA reassessment</td>
<td>TBD</td>
<td>CANSA Team and evaluator will complete reporting templates by the end of February 2019. IS Department will produce monthly reports. QAPI Council will review baseline data and revise measurable objectives, as appropriate prior to subsequent annual QAPI workplan.</td>
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<tr>
<td></td>
<td></td>
<td>At least 85% of adults will have a 0 or 1 on their Involvement in Recovery item at most recent CANSA reassessment</td>
<td>TBD</td>
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<td>At least 85% of children will have a 0 or 1 on their Involvement in Recovery item at most recent CANSA reassessment</td>
<td>TBD</td>
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<td>4f</td>
<td>Risk Factors</td>
<td>At least 70% of all beneficiaries will show a reduction in risk factor scores between intake and most recent CANSA assessment</td>
<td>TBD</td>
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<td>At least 70% of adults will show a reduction in risk factor scores between intake and most recent CANSA assessment</td>
<td>TBD</td>
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<td>At least 70% of children will show a reduction in risk factor scores between intake and most recent CANSA assessment</td>
<td>TBD</td>
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FY 18/19 Strategic Actions

1. Improve clinical outcomes:
   a. Produce monthly quality performance dashboards through the Information Systems unit so that programs can make data-driven decisions that lead to better consumer outcomes.
   b. Choose two evidence-based practices that improve clinical outcomes, and develop staff trainings on these methods.
   c. Provide ongoing training about measuring outcomes to clinic managers and program-level staff; require all programs to have at least one outcome measure that they monitor regularly.

2. Medication adherence:
   a. Continue to track data on medication adherence and monitor implementation of Medication PIP interventions during Medication PIP team meetings.
   b. Medication PIP team members will present progress on Medication PIP during staff meetings to increase buy-in.

3. Child and Adult Needs and Strengths Assessment (CANSA):
   a. Establish outcome baselines on Culture Stress, Involvement in Recovery, and Risk Factors by reviewing prior CANSA scores.
   b. Provide ongoing staff training on CANSA Tool to ensure scoring objectivity.
### Initiative 5: Enhance Data-Driven Decision-Making

<table>
<thead>
<tr>
<th>#</th>
<th>Goal</th>
<th>FY18/19 Measurable Objectives</th>
<th>Progress</th>
<th>Baseline data sources/ notes</th>
<th>Ongoing data source, responsible parties, and review intervals</th>
</tr>
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<tbody>
<tr>
<td>5a</td>
<td>Complete and expand use of monthly Quality Performance Dashboards</td>
<td>Complete at least 3 departmental monthly Quality Performance Dashboards by July 1 2019 (e.g., 24 hour service; adult/older adult; CYS) Complete at least 2 additional (5 total) departmental monthly Quality Performance Dashboards by July 1 2020</td>
<td>As of Dec 31, 2018, three dashboard templates are completed; IS is in the process of developing automation; Administration and Evaluator are reviewing for data validity</td>
<td>Data sources for dashboards include: Clinicians Gateway, Sharecare, Timeliness App; Excel logs</td>
<td>Ongoing data sources: In addition to existing data collection systems, IS developing customized data collection apps to replace excel logs. Responsible parties: Clinic Managers ensure reliable data entry. Evaluator and Administration develops relevant measures; IS Department automates data collection: Evaluator validates data and produces dashboards manually if needed. Review intervals: Dashboards reflect monthly data; Dashboard Team meets weekly to build dashboards</td>
</tr>
<tr>
<td>5b</td>
<td>CANSA reports and algorithms</td>
<td>Produce client-level outcome report using CANSA data</td>
<td>Objective met December 2018</td>
<td>CANSA data</td>
<td>Ongoing data source: CANSA data entered into Clinician’s Gateway. Automated client-level CANSA report accessed by case managers and used in treatment planning with consumers. Responsible parties: CANSA Committee and IS Department is responsible for ensuring the reliability of reports. Review interval: Case Managers can access reports as needed for tx planning</td>
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<td>Produce program-level outcome report using CANSA</td>
<td>Development in progress</td>
<td>CANSA data</td>
<td>Ongoing data source: CANSA. Responsible parties: Evaluator and CANSA Committee develop report templates and IS Dept produce prototype by March 1, 2019. Review Interval: monthly CANSA Committee meetings and followup meetings with IS dept to develop standardized monthly reports</td>
</tr>
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</table>
FY 18/19 Strategic Actions

1. Quality performance dashboards:
   o Under the direction of Behavioral Health Director, program evaluator and administrative staff will coordinate with deputy directors to establish measures and benchmarks.
   o The dashboard workgroup will develop reporting templates and coordinate with the IS unit to transition from manual data collection to automated processes.
   o The evaluator will review standardized reports to assess data validity and reliability.

2. CANSA reports and algorithms:
   o The CANSA Committee will develop client-level and program-evaluation report templates.
   o The IS unit will produce automated reports.
   o The CANSA Committee will train staff to use reports for treatment planning and assessing program outcomes. The CANSA Committee will develop algorithms that can be used during assessments to influence decisions regarding which level of care beneficiaries should be referred.

3. SJCBHS staff and managers will utilize monthly dashboards and CANSA reports to identify emerging trends in quality of care and outcomes.

4. Establish a workgroup to create a glossary of SJCBHS terms to ensure consistent QAPI terminology across system of care.
### Initiative 6: Develop Staff and Enhance Cultural Competency

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<tr>
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<th>Goal</th>
<th>FY18/19 Measurable Objectives</th>
<th>Baseline</th>
<th>Baseline data sources/ notes</th>
<th>Ongoing data sources, responsible parties and review intervals</th>
</tr>
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</table>
| 6a | Train all staff in cultural competency                              | 100% of staff and contractors will receive online Cultural Competency Training within 12 months of employment | >98%     | PeopleSoft HR log; Leaning and Development Training Summary report (Baseline measured Dec 31, 2018) | Ongoing data source: same as baseline  
Responsible parties: Training Coordinator tracks completion of training; Clinic mgrs ensure staff are trained  
Review intervals: monthly |
| 6b | Increase staff towards achieving Network adequacy standards          | Increase ratio of adult psychiatrists to adult beneficiaries to eventually meet 1:263 standard | 1:433    | Network adequacy tool and HR employee records                                                                                                       | Ongoing data source: same as baseline  
Responsible Parties: IS department provide data for reports; QAPI reviews data; Executive Leadership responsible for strategic planning |
|    |                                                                      | Increase ratio of child psychiatrists to child beneficiaries to eventually meet 1:230 standard | 1:704    |                                                                                               |                                                                                         |
|    |                                                                      | Increase ratio of adult non-psychiatric positions to adult beneficiaries to eventually meet 1:50 standard | 1:65     |                                                                                               |                                                                                         |
|    |                                                                      | Increase ratio of child non-psychiatric positions to child beneficiaries to eventually meet 1:31 standard | 1:65     |                                                                                               |                                                                                         |
| 6c | Increase linguistic and cultural diversity among staff              | Increase proportion of Latino/Hispanic staff to reflect proportion of Latino/Hispanic beneficiaries (Current proportion of beneficiaries who are Latino is 46%) | 25%      | 2018 State Evaluation/ Workforce Education and Training Workforce Needs Assessment: HR Staffing Reports; In-House Staff/Ethnicity Database | Ongoing data source: same as baseline  
Responsible parties: MHSA coordinator, Cultural Competency Committee and Ethnic Services manager review data and make recommendations to Executive Leadership |
|    |                                                                      | Increase ratio above baseline of Cambodian speaking staff to Cambodian speaking beneficiaries | 1:98     |                                                                                               |                                                                                         |
|    |                                                                      | Increase ratio above baseline of Vietnamese speaking staff to Vietnamese speaking beneficiaries | 0:193    |                                                                                               |                                                                                         |
|    |                                                                      | Increase ratio above baseline of Laotian speaking staff to Laotian speaking beneficiaries | 0:89     |                                                                                               |                                                                                         |
| 6d | Staff are trained in proper documentation                           | Fewer than 1% of services will be disallowed due to documentation errors                       | 1.66%    | QAPI Disallowance Summary Analysis, FY17/88. Includes all BHS and contractor providers. Does not include meds only clients | Responsible Party: QAPI subcommittee conducts chart review; QAPI creates summary analysis: Reviewed by QAPI chairs who make strategic recommendations at QAPI council. Documentation trainings coordinated by Training Committee  
Review interval: monthly |
FY 18/19 Strategic Actions

1. Staff training in cultural competency and proper documentation:
   a. Create a SJCBHS Training Academy to provide clinical training and practical skills across the system of care.
   b. Hire SJCBHS Training Coordinator.
   c. Improve and expand cultural competency curriculum.
   d. Use findings from QAPI subcommittee reviews to improve and expand Medi-Cal documentation training.
   e. Develop new medical necessity and level-of-care trainings.
   f. Develop a standardized evaluation survey for training participants.

2. Increase cultural and linguistic diversity of staff:
   a. Cultural Competency Committee to research and develop strategies to increase recruitment of culturally and linguistically diverse staff and improve beneficiary-to-staffing ratios.
   b. Collaborate with San Joaquin County Human Resources Division on recruitment efforts to attract and retain a diverse SJCBHS workforce.

3. Network adequacy:
   a. Conduct staffing capacity analysis to ensure sufficient staffing availability and disciplines to meet timeliness goals.
   b. Ensure data submitted each quarter for the Network Adequacy Compliance Tool is accurate.