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 informati**on 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.

- **QAPI Chairs Subcommittee**—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

Initiative 1: Improve timely access to services					
#	Goal	FY18/19 Measurable Objectives	Baseline	Baseline data sources/notes	Ongoing data sources, responsible parties, and review intervals
1a	Timely initial clinical assessments	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%)*	73%	Data derived from Timeliness App and EHR; reported in FY17/18 EQRO Self-Assessment Baseline does not include data from contract providers Baseline for initial access to psychiatry was measured from first contact rather than determination of necessity	Ongoing data sources: Timeliness App; EHR, reported into QAPI Data Collection Tool 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. Review interval: monthly
		At least 85% of adults will be offered an initial clinical assessment within 10 business days of first request/first contact	77%		
		At least 85% of children will be offered an initial clinical assessment within 10 business days of first request/first contact	58%		
		At least 85% of foster children will be offered an initial clinical assessment within 10 business days of first request/first contact	22%		
1b	Timely initial psychiatry appointments	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%)*	16%		
		At least 65% of adults will be offered an initial psychiatric appointment within 15 days of determination of necessity by BHS	17%		
		At least 65% of children will be offered an initial psychiatric appointment within 15 days of determination of necessity by BHS	0%		
		At least 65% of foster youth will be offered an initial psychiatric appointment within 15 days of determination of necessity by BHS	Unk		
1c	Timely crisis evaluations	At least 75% of all beneficiaries in crisis will receive a crisis intervention within 120 minutes of request	58%		
		At least 75% of adults in crisis will receive a crisis intervention within 120 minutes of request	50%		
		At least 98% of children in crisis will receive a crisis intervention within 120 minutes of request	95%		
		At least 98% of foster youth in crisis will receive a crisis intervention within 120 minutes of request	97%		
1d	Timely post-hospitalization followup	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%)*	87%		
		At least 95% of adults will receive a followup appointment within 7 calendar days of discharge from hospital	87%		
		At least 95% of children will receive a followup appointment within 7 calendar days of discharge from hospital	91%		
		At least 95% of foster youth will receive a followup appointment within 7 calendar days of discharge from hospital	44%		

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 SJCBHS 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

Initiative 2: Ensure access to care					
#	Goal	FY18/19 Measurable Objectives	Baseline	Baseline data sources/notes	Ongoing data sources, responsible parties, and review intervals
2a	Beneficiaries receive timely and accurate information	100% of test calls to 24/7 call line during business hours will receive timely and accurate information	100%	FY 17/18, Q4, 24/7 Test Call Report Form	Ongoing data sources: Test Call Report Form Responsible parties: QAPI Council Review interval: monthly
		100% of test calls to 24/7 call line after hours will receive timely and accurate information	75%		
		100% of relevant test calls to 24/7 call line during business hours will document use of interpreter or language line	100%		
		100% of relevant test calls to 24/7 call line after hours will document use of interpreter or language line	100%		
2b	Increase proportion of beneficiaries who receive initial clinical assessment	At least 77% of initial clinical assessments of all ages will be claimed	71%	Timeliness App; FY17/18 contacts Baseline does not include data from contract providers	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
		At least 77% of initial clinical assessments of adults will be claimed	70%		
		At least 77% of initial clinical assessments of children will be claimed	76%		
		At least 77% of initial clinical assessments of foster youth will be claimed	unk		
2c	Decrease non-psychiatry appointment no-show rates	Fewer than 15% of all ages non-psychiatry appointments will result in a client no-show *(CalEQRO, FY 16/17, statewide MHP average: 9%)*	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
		Fewer than 15% of adult non-psychiatry appointments will result in a client no-show *(CalEQRO, FY 16/17, statewide MHP average: 8%)*	unk		
		Fewer than 15% of child non-psychiatry appointments will result in a client no-show *(CalEQRO, FY 16/17, statewide MHP average: 12%)*	unk		
		Fewer than 15% of foster youth non-psychiatry appointments will result in a client no-show	unk		
2d	Decrease psychiatry appointment no-show rates	Fewer than 10% of all ages psychiatry appointments will result in a client no-show *(CalEQRO, FY 16/17, statewide MHP average: 10%)*	unk		
		Fewer than 10% of adult psychiatry appointments will result in a client no-show *(CalEQRO, FY 16/17, statewide MHP average: 14%)*	unk		
		Fewer than 10% of child psychiatry appointments will result in a client no-show *(CalEQRO, FY 16/17, statewide MHP average: 12%)*	unk		
		Fewer than 10% of foster youth psychiatry appointments will result in a client no-show	unk		
2e	Improve Latino/ Hispanic penetration rates	Latino/Hispanic penetration rates will be at least 2.67% (source for goal is average medium county penetration rate for CY 2017)	2.46%	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

Initiative 3: Improve Quality of Service Delivery and Beneficiary Satisfaction					
#	Goal	FY18/19 Measurable Objectives	Baseline	Baseline data sources/ notes	Ongoing data sources, responsible parties, and review intervals
3a	Determination of medical necessity	At least 99% of case managed/therapy client records reviewed in subcommittee will demonstrate that medical necessity was determined	98.6%	QAPI Disallowance Summary Analysis, FY17/18. Includes all BHS and contractor providers. Does not include meds only clients yet	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
		At least 90% med-only client records reviewed in subcommittee will demonstrate that medical necessity was determined	Unk		
3b	Determination of level of care	At least 90% of all beneficiary records reviewed in subcommittee will demonstrate that services are provided at the appropriate level of care	n/a	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.	TBD
		At least 90% of adult records reviewed in subcommittee will demonstrate that services are provided at the appropriate level of care	n/a		
		At least 90% of child records reviewed in subcommittee will demonstrate that services are provided at the appropriate level of care	n/a		
3c	Increase service dosage	MHP will increase annual approved claims per beneficiary by at least 20%	$4397 per beneficiary	Baseline data derives from FY18-19 External Quality Review Report. Statewide and small county claims per client are significantly larger than San Joaquin's for all beneficiaries, Latinos, and foster care youth.	Ongoing data source: Monthly Subcommittee 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
		MHP will increase annual approved claim per Latino/Hispanic beneficiary by at least 20%	$3505 per beneficiary		
		MHP will increase annual approved claim per foster care beneficiary by at least 20%	$5219 per beneficiary		
3d	Increase beneficiary participation in QAPI, MHSA and Cultural Competency planning	Involve at least 5 new consumer and/or family member beneficiaries in QAPI, MHSA, and/or Cultural Competency activities	n/a	Roster of active advocates	Ongoing data source: Roster of active advocates, meeting sign-in sheets Responsible parties: Ethnic Services Mgr; MHSA coordinator QAPI Review Interval: monthly
		Ensure at least two consumer and/or family member beneficiaries are present at each QAPI Council, MHSA, and Cultural Competency Committee meeting	1 beneficiary at each meeting	Attendance sign in sheets	
3e	Beneficiary satisfaction with quality of care	Fewer than 58 Quality of Care Grievances will be received annually	67	FY 2017/18 Grievance Log - Quality of Care Category	Ongoing data source: Grievance Log, Quality of Care Category Responsible party: QAPI Grievance Coordinator Review interval: monthly
3f	Beneficiary satisfaction with provider	Develop an electronic Change of Provider Tracking System and benchmarks to demonstrate client satisfaction	unk	Review of FY16-17 Change of Provider Log. Review of FY1819 Q1 & Q2 to establish definitions and types for the three provider categories.	
3g	Overall beneficiary satisfaction	At least 85% of youth will report overall satisfaction with services	84.5%	2017 Consumer Perception Survey, n= 609	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 MHSA Coordinator and Cultural Competency Committee to inform program planning Review interval: annual
		At least 90% of family members of youth will report overall satisfaction with services	96.1%		
		At least 90% of adults will report overall satisfaction with services	90.8%		
		At least 90% of older adults will report overall satisfaction with services	93.3%		

FY 18/19 Strategic Actions

1. Determination of medical necessity and level of care:
    - Provide medical necessity and level of care training for direct service staff.
    - QAPI subcommittees and chairs will focus on level of care determination in addition to reviewing medical necessity for case managed and therapy clients.
    - 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:
    - Conduct an analysis of staffing to determine capacity.
    - Implement new FSP programs designed to increase engagement in intensive services.

3. Increase beneficiary participation:
    - 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:
    - Track, trend, and analyze types of concerns in grievances, appeals, expedited appeals, and state fair hearing actions.
    - Research strategies to prevent and decrease consumer grievances regarding quality of care.
    - Develop, prioritize, and implement staff trainings and beneficiary education to increase level of beneficiary satisfaction.
    - 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

Initiative 4: Improve Clinical Outcomes					
#	Goal	FY18/19 Measurable Objectives	Baseline	Baseline data sources notes	Ongoing data sources, responsible parties, and review intervals
4a	Prevent PHF rehospitalizations	Fewer than 14% of all beneficiaries will be readmitted to any hospital within 30 days of discharge *(CalEQRO, FY 16/17, statewide MHP average: 14%)*	17%	Source: FY17/18 EQRO Self Assessment, data pulled from Sharecare	Ongoing data source: IS department runs monthly report Responsible Parties: QAPI Council reviews data and makes strategic recommendations to Executive Leadership Review intervals: monthly
		Fewer than 14% of adults will be readmitted to any hospital within 30 days of discharge *(CalEQRO, FY 16/17, statewide MHP average: 15%)*	18%		
		Fewer than 9% of children will be readmitted to any hospital within 30 days of discharge *(CalEQRO, FY 16/17, statewide MHP average: 9%)*	11%		
		Fewer than 9% of foster youth will be readmitted to any hospital within 30 days of discharge	22%		
4b	Divert hospitalizations through CSU	At least 50% of all beneficiaries admitted to the CSU will be diverted from hospital admissions (e.g., released to lower level of care)	46%	Jan-Nov 2018 average, manual data collection into Excel by CSU Manager	Ongoing data source: IS department will automate data collection and reporting Responsible parties: currently CSU Manager reports data; Reviewed by QAPI Council
		At least 50% of adults admitted to the CSU will be diverted from hospital admissions (e.g., released to lower level of care)	46%		
		At least 50% of children admitted to the CSU will be diverted from hospital admissions (e.g., released to lower level of care)	47%		
4c	Medication adherence	At least 85% of case managed adults will be medication adherent (scoring 0 or 1 on Medication Involvement CANSA item)	78%	Baseline from Oct 2017 - Mar 2018 CANSA re-assessments, reported in current Clinical PIP	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)
4d	Cultural Stress	At least 85% of all beneficiaries will have a 0 or 1 on their Cultural Stress item at most recent CANSA reassessment	TBD	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.	
		At least 85% of adults will have a 0 or 1 on their Cultural Stress item at most recent CANSA reassessment	TBD		
		At least 85% of children will have a 0 or 1 on their Cultural Stress item at most recent CANSA reassessment	TBD		
4e	Involvement in Recovery	At least 85% of all beneficiaries will have a 0 or 1 on their Involvement in Recovery item at most recent CANSA reassessment	TBD		
		At least 85% of adults will have a 0 or 1 on their Involvement in Revovery item at most recent CANSA reassessment	TBD		
		At least 85% of children will have a 0 or 1 on their Involvement in Recovery item at most recent CANSA reassessment	TBD		
4f	Risk Factors	At least 70% of all beneficiaries will show a reduction in risk factor scores between intake and most recent CANSA assessment	TBD		
		At least 70% of adults will show a reduction in risk factor scores between intake and most recent CANSA assessment	TBD		
		At least 70% of children will show a reduction in risk factor scores between intake and most recent CANSA assessment	TBD		

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

Initiative 5 : Enhance Data Driven Decision-making					
#	Goal	FY18/19 Measurable Objectives	Progress	Baseline data sources/ notes	Ongoing data source, responsible parties, and review intervals
5a	Complete and expand use of monthly Quality Performance Dashboards	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)*	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	Data sources for dashboards include: Clinicians Gateway, Sharecare, Timeliness App; Excel logs	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
5b	CANSA reports and algorithms	Produce client-level outcome report using CANSA data	Objective met December 2018	CANSA data	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
		Produce program-level outcome report using CANSA	Development in progress	CANSA data	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

FY 18/19 Strategic Actions

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

2. CANSA reports and algorithms:
    - The CANSA Committee will develop client-level and program-evaluation report templates.
    - The IS unit will produce automated reports.
    - 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

Initiative 6: Staff Development and Cultural Competence					
#	Goal	FY18/19 Measurable Objectives	Baseline	Baseline data sources/ notes	Ongoing data sources, responsible parties and review intervals
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; Learing 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 responisble 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 linguistinc and cultrual 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.