ALPINE COUNTY
BEHAVIORAL HEALTH SERVICES

Quality Improvement Work Plan & Evaluation Report

FY 2025/2026 Annual Work Plan and FY 2024/2025 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. Designing and implementing interventions to improve performance, based on data and identified trends;
4. Measuring the effectiveness of the interventions over time, through the analysis of system- and client-level data;
5. Incorporating successful interventions across the system, as appropriate; and
6. 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.

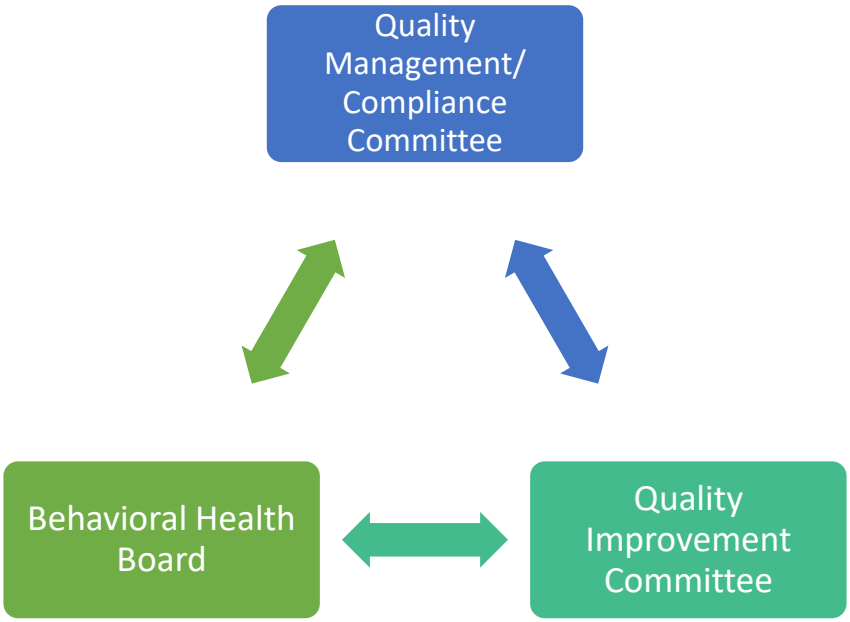
The QI program is responsible for monitoring ACBHS effectiveness through the implementation and maintenance of performance monitoring activities through all levels of the department, including but not limited to, client and system access; timeliness; quality; assessment of clients; clinical outcomes; 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) and Mental Health Block Grant (MHBG); the contract with DHCS for the delivery of State Plan 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 Deputy 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. Three (3) committees comprise the QI program: 1) Quality Management/Compliance Committee (QMC); 2) Quality Improvement Committee (QIC); and 3) Behavioral Health Board (BHB). 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 most recent *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 at least quarterly, for a total of four (4) meetings each 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.
    - Reviews collected information, data, and trends relevant to the standards of cultural and linguistic competency.

2) Recommends policy decisions, and reviews and evaluates the results of QI activities.
    - 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.
    - Shares data analysis and action items with other QI committees to ensure ongoing quality improvement across the system.

d) QIC Standing 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:

    a. Mental Health program updates
    b. DMC/SUD program updates
    c. Access Log and related data review
        1. Business days for initial assessment and first service appointments; medication requests
        2. Response for urgent/crisis conditions (during regular hours and after-hours)
        3. Requests for cultural/linguistic services, including language assistance; and assess results
        4. Access Line Test Calls (quarterly report)
    d. Review Clinical Team Meeting Assessments (CANS, PSC, etc.)
    e. Review chart review results and issues; required Corrective Action Plans (CAPs)
    f. Review Clinical Practices and Peer Consultation (DMC/SUD and Mental Health)
    g. Review data for client- and system-level performance outcome measures
    h. Review Inpatient / IMD / Residential programs: census, utilization, and length of stay
    i. Review processed Treatment Authorization Requests (TARs)
    j. Audit medication monitoring reviews documented by third-party prescriber (Mental Health)
    k. Review issued Notices of Adverse Benefit Determination (NOABDs)
    l. Review grievances or appeals (client or provider)
    m. Monitor Change of Provider Requests
    n. Review requests for or results of State Fair Hearings; requests for Aid Paid Pending
    o. Review results of audits and other reviews (Triennial; EQR; DMC/SUD; MHSA)
    p. Review results of Medi-Cal service delivery verification process
    q. Review compliance concerns; fraud/waste reports; patient's rights; and HIPAA/privacy issues
    r. Review provider concerns; contract denials; appeals; satisfaction surveys
    s. Review county and contract provider certification/recertification status; credentialing

t. Review QI Work Plan updates (annually)
u. Review SMHS Implementation Plan, as necessary (annually)
v. Discuss client participation in services, system planning, QIC, etc.
w. Assess client and family satisfaction surveys for access and cultural competence issues
x. Review new regulations and standards, including DHCS notices and publications
y. Other items for discussion
z. 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.)
aa. 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.

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

g) Continuous Feedback Loop

1) 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.

a. 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.

3. **Behavioral Health Board:** The Behavioral Health Board (BHB) is a state-mandated board convened to advocate and promote recovery for individuals with mental illness and substance use disorders. The BHB 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.

   As a small county, ACBHS is required to have a minimum of 5 BHB members. Membership must include at least one client and one family member of an individual who is receiving or has received BH services. Representatives from veterans' services, office of education, and other local agencies is encouraged. ACBHS strives to ensure a diverse BHB that reflects the county population and encourages a variety of voices, to the extent feasible in this very small, remote county.

   The BHB 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.

C. 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; facilitating the committees; conducting monitoring activities).

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.

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 draft QI Work Plan is reviewed and final approved by the QIC. It is then posted on the ACBHS website and is also available upon request. It is provided to DHCS as part of an annual review. The QI Work Plan is also available to state auditors upon request.

D. Accountability

The QIC is accountable to the BHS Deputy 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):

1. Client and service utilization data by type of service, age, gender, race, ethnicity, primary language, veterans, and LGBTQ2S+
2. Electronic Health Record (EHR) Reports
3. Access Logs (initial contact log; includes crisis calls)
4. Medication Request Logs
5. Test Call Logs
6. Client and family satisfaction surveys (state-directed)
7. Client Grievance/Appeal Logs; State Fair Hearing Logs
8. Change of Provider forms and Logs
9. QI Chart Review Checklists (and any corrective action plans [CAPs])
10. Medication Chart Review Checklists (and any CAPs)
11. Staff training logs, including Relias and trainings from other sources, such as in-person opportunities
12. Notice of Adverse Benefit Determination (NOABD) forms and logs
13. Second Opinion requests, resolutions, and outcomes
14. Concurrent Review / Inpatient Census Logs
15. Treatment Authorization Requests (TAR) and Inpatient Logs
16. Staff productivity reports
17. Compliance Logs
18. Policies and procedures
19. QMC and QIC meeting minutes

20. Internal MH and DMC/SUD monitoring activities (reported out by QMC)
21. EQR and Medi-Cal compliance review results (and any related CAPs)
22. 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.

    c. 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: Offer an initial non-crisis MH assessment appointment within ten (10) business days of a new request for services			
Objective	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	Offer an initial assessment appointment within 10 business days of request to at least 75% of clients who request services		
Data	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%
	Number and percent of new requests who met this standard in FY 2023-2024	19 of 22 clients	86.4%
	Number and percent of new requests who met this standard in FY 2024-2025	20 of 20 clients	100.0%
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 above the 75% goal across the past 4 fiscal years. There was a slight decrease from 98.4% in FY 2021-2022 to 95% in FY 2022-23 and another decrease to 86.4% in FY 2023-2024. The metric rose sharply last year, with 100% of new requests meeting the standard in FY 2024-2025.			
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 2025-2026. ACBHS will maintain and/or improve the percent of requests that are offered an initial assessment appointment within 10 business days.			
Planned Interventions to achieve Goal: • Continue training staff on scheduling new requests for services, with an emphasis on the 10-day standard. • Provide regular feedback to staff on the percent of requests that were offered within 10 business days (review A&I Log). • Review staff schedules and block assessment times to allow admin staff to schedule appointments within 10 business days. • Review and document data with management staff and quarterly with QIC to identify barriers to meeting the 10-day timeframe. • If necessary, develop a prompt or reminder regarding the 10-day rule on the A&I Log, and then train staff on the updated A&I Log.			

Data Source: Access and Information Log. **Frequency:** Annually.

Goal 2: Ensure timely access to a Medication Assessment			
Objective	Ensure access to medication services through timely referrals to a new medication assessment		
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	At least 75% of 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 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%
	Number of clients who received an on-time med assessment in FY 2023-2024	1 of 1 client	100.0%
	Number of clients who received an on-time med assessment in FY 2024-2025	4 of 4 clients	100.0%
Evaluation			
Analysis: The percentage of mental health clients who were referred for a medication assessment and received a medication assessment service on time improved and then steadied across the past 4 years, with 100% of medication assessments delivered on time over the past 3 years.			
Quality Improvement Action Plan: ACBHS has maintained this goal. However, because timely access is a key component, ACBHS will continue to monitor this goal in FY 2025-2026. ACBHS will work closely with Kings View to maintain timely access to this level of care.			
Planned Interventions to achieve Goal: • 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: Access and Information Log and Credible data. **Frequency:** Annually.

Goal 3: Ensure that clients receive a scheduled MH treatment service within 10 business days of the completed 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	At least 75% of individuals will receive a scheduled MH appointment for a first treatment service appointment within 10 business days of the assessment		
Data	Number and percent of services that met this standard in FY 2021-2022	16 out of 17	94.1%
	Number and percent of services that met this standard in FY 2022-2023	3 out of 3	100.0%
	Number and percent of services that met this standard in FY 2023-2024	7 out of 12	58.3%
	Number and percent of services that met this standard in FY 2024-2025	10 out of 12	83.3%
Evaluation			
Analysis: The percentage of requests that met this goal increased from 94.1% in FY 2021-2022 to 100% in FY 2022-2023. In FY 2023-2024, the percentage decreased to 58.3% due to an increased number of declined first appointment dates and no-shows. In FY 2024-2025, this data exceeded the goal, with 83.3% of services meeting the standard. This improvement may be a result of fewer no-shows.			
Quality Improvement Action Plan: Although ACBHS exceeded its goal, ACBHS will continue to monitor this goal in FY 2025-2026. In the future, if this data drops again, ACBHS may consider changing the metric to measure "first appointment offered dates" rather than the dates of the actual first service. A change to the A&I Log or EHR may be required to capture the new data.			
Planned Interventions to achieve Goal: • Continue training staff 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. • Review A&I Log and/or EHR to implement any needed changes to track dates offered.			

Data Source: Access and Information Log and Credible data. **Frequency:** Annually.

Goal 4: Conduct medication monitoring activities on at least 10% of medication charts each year			
Objective	Assess the safety and effectiveness of ACBHS medication practices 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	Ensure that medication chart reviews are conducted on at least 10% of medication charts		
Data	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	0 charts	
	Number and percent of medication charts reviewed in FY 2023-2024	0 charts	
	Number and percent of medication charts reviewed in FY 2024-2025	0 charts	
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 in recent years. Future analysis will be conducted when a third-party prescriber has been identified.			
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 since FY 20021-2022. ACBHS will work with Kings View to identify a third-party prescriber to conduct future chart reviews.			
Planned Interventions to achieve Goal: • As needed, update scope of work with Kings View (telepsychiatry provider) for a third-party prescriber to review medication charts. • Third-party psychiatrist or pharmacist to complete medication monitoring at least quarterly. • Review medication monitoring results at QIC at least quarterly			

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

Goal 5: Reduce the number of Drug-Related Overdose Deaths of Alpine County Residents		
Objective	Reduce the number of drug-related overdose deaths of Alpine County residents	
Metric	Number of drug-related overdose deaths of Alpine County residents	
Performance Indicator/Target Goal	Reduce the number of drug-related overdose deaths of Alpine County residents	
Data	Number of drug-related overdose deaths in FY 2024-2025	4
Evaluation		
Analysis: Per the Alpine County Sheriff's Office, in FY 2024-2025, four (4) Alpine County residents died from a drug-related overdose.		
Quality Improvement Action Plan: This goal mirrors a statewide goal of the ACBHS BHSA Integrated Plan. Through BHSA and other available funding, ACBHS will conduct a variety of activities and interventions in an effort to reduce drug-related overdose deaths in FY 2025-2026. Monitoring will occur by tracking data from the Sheriff's Office.		
Planned Interventions to achieve Goal: • Targeted Naloxone distribution. • Outreach activities for linking individuals to SUD and MH services. • Enrolling high-risk individuals in the BHSA FSP program. • Increasing linkage of individuals to SUD services, including residential treatment. • Research potential to hire Peer Support/Prevention Specialist to direct and support these crucial activities.		

Data Source: Alpine County Sheriff's Office. **Frequency:** Annually.