Contra Costa Behavioral Health

2018
Quality Improvement Plan

CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Contra Costa Behavioral Health Services' Quality Improvement and Quality Assurance (QI/QA) Unit monitors service delivery with the aim of improving the processes of providing care and better meeting the needs of beneficiaries. The Quality Management Coordinator oversees the Unit and chairs the Quality Improvement Committee (QIC). The Quality Improvement Committee comprised of Behavioral Health Management, QIQA staff, providers and beneficiaries, meets on a monthly basis and is informed by the Quality Improvement Plan. QIC activities include 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 opportunities to pursue; identifying relevant committees to ensure appropriate exchange of information with the QIC; 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 effectiveness of the interventions; incorporating successful interventions into the operations of behavioral health services; and reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review. The QIC also reviews timeliness of services, client satisfaction, penetration and retention rates, service accessibility, and other service trends. In addition, the QIC works in collaboration with the Ethnic Services and Behavioral Health Training manager to monitor and improve the quality of offered trainings and education for its workforce, inclusive of promoting greater cultural diversity, humility, and competency. As a result of the monitoring activities described above, the QIC recommends policy decisions, reviews and evaluates the results of quality improvement activities including performance improvement projects, institutes needed quality improvement actions, ensures follow-up of QI processes, and documents QIC meeting minutes regarding decisions and actions taken.

Guided by the above, the BHSD developed its 2018 Quality Improvement Plan. The contents of the Quality Improvement Plan were also informed by County efforts to better meet client needs and incorporate BHSD's Strategic Plan and annual feedback from our External Quality review team. This Quality Improvement - Plan provides a vehicle for BHSD management to: 1) meet quality improvement requirements specified in the Mental Health Plan contract with the State Department of Health Care Services (DHCS) for the expenditure of Medi-Cal (Medicaid) dollars; 2) meet quality improvement requirements specified under the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver; and 3) address and resolve quality issues raised in the monitoring of the CCMH and DMC-ODS Plans.[1] The QI Plan is evaluated annually to assess progress towards identified goals and actions. Activities are marked in brackets as being new, ongoing (continuing from the previous year), and/or completed in comparison to previous year's. The frequency which activities are conducted (e.g., annually, quarterly, etc.)is also included in brackets. The quality improvement activities are divided into the following sections:

[1] Activities related to both Mental Health and Substance Use Disorder services are shaded gray.

Service Capacity

Behavioral Health DHCS Contractual Element: Assess the capacity of service delivery for beneficiaries, including monitoring the number, type, and geographic distribution of services within the delivery system.

Goal 1: Monitor service delivery capacity	
Objectives	**Actions/Frequency**
1. 100% of enrollees determined to have access to Behavioral Health services based on time and distance standards.	1. Use geo-mapping software to plot client and service locations. [ongoing] [MHP- Quarterly; SUD- Annually]

Access to Care

Behavioral Health DHCS Contractual Elements: Assess the accessibility of services within service delivery area, including:

- *Timeliness of routine appointments;*
- *Timeliness of services for urgent conditions;*
- *Access to after-hours care; and*
- *Responsiveness of the 24 hour, toll free telephone number.*

Goal 2: Beneficiaries will have timely access to the services they need	
Objectives	**Actions**
1. At least 90% of individuals, on average, requesting routine care mental health services offered an initial assessment appointment within 10 business days. *(MHP Non-Clinical PIP)*	1. Report the percentage of new client appointment requests for which a routine clinician appointment is offered within 10 business days. [ongoing] [Quarterly] 2. Provide direct outreach calls to new clients in regions showing the greatest need. [NEW] 3. Train 100% of Community Support Workers (CSWs) in Motivational Interviewing techniques and develop an outreach script to guide conversations. [NEW]
2. 75% of clients who spoke with a County staff member via a reminder call, will attend their scheduled intake appointment at East region county-operated clinics.	1. Report the percentage of new clients who were successfully contacted who attend their intake appointment. [NEW] [Quarterly]
3. At least 80% of individuals, on average, requesting routine care mental health services offered psychiatry appointment within 15 business days.	1. Report the percentage of new consumer client appointment requests for which a routine psychiatry appointment is offered within 15 business days. [ongoing] [Quarterly]
4. 100% of urgent care mental health service requests are offered an appointment within 2 business days for all clients.	1. Report the percentage of urgent outpatient mental health appointments with clinicians that are offered within 2 business days of request. [ongoing] [Quarterly]
5. 90% of hospital discharges are followed by an outpatient mental health visit within 7 calendar days.	1. Report the percentage of all hospital discharges for which the consumer receives an outpatient mental health appointment within 7 calendar days. [ongoing] [Quarterly]

Goal 2: Beneficiaries will have timely access to the services they need	
Objectives	**Actions**
6. Reduce 30-day hospital readmission rate for mental health clients to be below 10%.	1. Report annually 30-day hospital readmission rates for all clients by system of care and county-wide. [ongoing] [Annually]
7. Develop strategies to reduce avoidable hospitalization for adults with mental illness.	1. Launch Mobile Crisis Response Team (MCRT). [NEW]
	2. Respond to MCRT calls 7 days/week, 24 hours per day. [NEW]
8. Provide tele-psychiatry services in regions showing the greatest needs to reduce wait times for 1st psychiatry appointment	1. Provide pilot tele-psychiatry appointments at the East Adult specialty mental health clinic. [ongoing]
	2. Compare wait times for first psychiatry appointment at East Adult for the 6 months before tele-psychiatry started and 6 months after tele-psychiatry started. [NEW] [Quarterly]
	3. Resolve tele-psychiatry barriers. [NEW]
9. Develop a set of effective procedures that are activated upon the loss of psychiatry coverage, bringing on additional resources until a permanent solution can be developed [EQRO Recommendation].	1. Develop externally provided telemedicine resources coupled with locum tenens providers. [NEW]

Goal 3: Reduce appointment no-show rates	
Objectives	**Actions**
1. Improve appointment data collection on mental health appointments.	1. Establish appointment adherence reporting based on Cadence data. [NEW]
2. Implement TeleVox automated call reminder system across mental health clinic sites.	1. Start providing text message reminders for clients who opt in via the TeleVox automated call reminder system. [NEW]
3. With implementation of reminder calls, reduce rate of missed initial intake appointments (i.e. No Show, Canceled, and Left without Seen) at East region county-operated Mental Health clinics be at or below 25%.	1. Report quarterly the percentage of first scheduled appointments with the disposition of no show, canceled, and left without seen. [NEW] [Quarterly]

Goal 4: Improve the Behavioral Health Access Line triaging and referral processes into the behavioral health system of care	
Objectives	**Actions**
1. Access Line test call results made for both daytime and after-hours will have an 80% success rate.	1. On quarterly basis, conduct 10 tests calls, 6 (including 2 in Spanish) during business hours and 4 (including 2 in Spanish) after hours. [ongoing] [Quarterly]
	2. Evaluate the Access Line test call protocol. [ongoing] [Quarterly]

Beneficiary Satisfaction

Behavioral Health DHCS Contractual Elements: Assess beneficiary or family satisfaction at least annually by:

- *Surveying beneficiary/family satisfaction with services;*
- *Evaluating beneficiary grievances, appeals, and fair hearings;*
- *Evaluating requests to change persons providing services; and*
- *Informing providers of the results of beneficiary/family satisfaction activities.*

Goal 5: Evaluate client grievances, unusual occurrence notifications, and change of provider and appeal requests	
Objectives	**Actions**
1. Review and respond to 100% of grievances, and change of provider and appeal requests within the policy guidelines and state regulations to identify system improvement issues.	1. Collect and analyze behavioral health service grievances, unusual occurrence notifications, change of provider, appeals, and fair hearing requests to examine patterns that may inform the need for changes in policy or programming. [ongoing]
	2. Respond to 100% of grievances. [NEW]
	3. Present findings to the QIC on a quarterly basis to identify strategies to improve reporting and address issues. [ongoing] [Quarterly]
2. Review 100% of unusual occurrences to identify trends	1. Collect and analyze trends in unusual occurrences. [NEW] [Quarterly]
	2. Report on unusual occurrences quarterly to the QIC. [NEW] [Quarterly]

Goal 6: Monitor client/family satisfaction	
Objectives	**Actions**
1. Survey means (4.0 or higher) and focus group themes indicate clients and/or their families are satisfied with their care.	1. Conduct a mental health client/family satisfaction survey to gather quantitative and qualitative data about satisfaction with services. [ongoing] [Bi-annually]
	2. Conduct focus groups with clients at each county-operated clinic annually to gather feedback about services. [ongoing] [Annually]
	3. Report satisfaction survey findings to clinics and contracted providers. [ongoing] [For MHP- Bi-annually; For SUD-Annually]
	4. Report findings from focus groups to clinics. [ongoing] [Annually]
	5. Conduct in-depth program and fiscal review of MHSA funded programs, including site visits and client interviews and surveys. [ongoing] [Every 3 years]

Cultural and Linguistic Competence

Behavioral Health DHCS Contractual Elements: Comply with the requirements for cultural and linguistic competence.

Goal 7: Provide all clients with welcoming, engaging, and culturally- and linguistically-appropriate client-centered care	
Objectives	**Actions**
1. All services are delivered in a culturally competent manner.	1. Update the cultural competence plan, incorporating DHCS cultural competency plan requirements. [ongoing] [Annually]
	2. Strengthen the Reducing Health Disparities Workgroup membership of behavioral health staff and contract providers. [NEW]
2. 100% of clients are served in their preferred language.	1. Monitor accessibility of Access Line and services to non-English speakers. [ongoing] [Quarterly]
3. 100% of staff complete a cultural competency training.	1. Track percentage of staff who complete cultural competency training. [ongoing] [Annually]
4. 80% of mental health clients/families report they agree staff are respectful and supportive of culture, values, beliefs, life ways and lifestyle.	1. Compare the number of clients/family members who agree or strongly agree that staff are respectful and supportive to the total number of respondents. [ongoing] [Bi-annually]
5. Implement efforts to create a more Welcoming Environment for clients and their families.	1. Revise Welcome Packet for new clients based on staff and client feedback. [NEW]
	2. Standardize Welcome Packet distribution. [ongoing]
	3. Convene staff orientations that include best practices in client- and family-centered care. [NEW] [Quarterly]
	4. Identify customer service trainings. [NEW]
	5. Establish clinic-based Welcoming Environments learning communities. [NEW]

Medication Practices

Behavioral Health DHCS Contractual Elements: Monitor safety and effectiveness of medication practices.

Goal 8: Promote safe and effective medication practices	
Objectives	**Actions**
1. Mental Health charts reviewed using the Medication Monitoring Tool will maintain an average compliance rate of at least 90%.	1. All (100%) of medical staff to have a sample of their charts reviewed once a year. [ongoing] [Annually]
	2. Conduct follow up with psychiatrists with the lowest compliance rates. [ongoing]
2. Identify behavioral health clients who are medication stable.	1. Develop reporting on clients prescribed psychotropic medications. [ongoing]
	2. Collaborate with treating psychiatrists and primary care doctors to review 100% of charts of clients who are stable on anti-depression medication for possible step-down. [NEW] [Annually]
3. Establish and ensure safe medication practices.	1. Establish Safe Prescription Standards for Benzodiazepines for the Behavioral Health Division. [NEW]
	2. Develop reporting on labs of clients receiving anti-psychotic medication. [ongoing]
	3. Review safe medication reports Quarterly. [NEW] [Quarterly]
	4. Convene safe medication workgroup. [NEW]
	5. Conduct follow-up with psychiatrists prescribing anti-psychotic medication as needed. [NEW]
	6. Train 75% of psychiatrists on safe prescribing procedures for benzodiazepines by December 31, 2018. [NEW]
4. Develop a Disaster Medication Plan.	1. Develop a plan to provide clients with medication replacement during a disaster. [NEW] [Annually]
	2. 100% of clinic staff know where they can refer clients to access medications in a disaster. [NEW] [Annually]
	3. Provide lead pharmacists at major pharmacies within service area with brochure explaining disaster medication replacement procedure. [NEW]
	4. Provide clients with a brochure explaining how they can get medication replacement in event of a disaster. [NEW]
	5. Create outgoing messages for clinic voicemail informing clients how to access medication replacement in event of a disaster. [NEW]

Goal 8: Promote safe and effective medication practices	
Objectives	**Actions**
	6. Develop TeleVox script and logic for message to be sent out in the event of a disaster to notify clients of the number they can contact to get medication replacement. [NEW]

Service Delivery and Clinical Issues

Behavioral Health DHCS Contractual Elements:

a. Address meaningful clinical issues affecting beneficiaries system-wide.

b. Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.

Goal 9: Standardize processes and cross-regional referrals	
Objectives	**Actions**
1. Strengthen internal and external referral process across systems of care.	1. Optimize referral workqueue in electronic health records. [ongoing]
	2. Re-train 100% of Program Managers on how to use referral process. [NEW]
	3. Update augmented Board and Care waitlists on a weekly basis to inform staff of housing referral options. [NEW] [Weekly]
	4. Initiate quarterly review process for consumers residing in enhanced/"super" Board and Care to track clients' progress and readiness to step-down into a lower level of care placement and open beds for clients with greater needs. [NEW] [Quarterly]

Goal 10: Increase use of evidence-based practices	
Objectives	**Actions**
1. Embed evidence-based trauma-informed practices in the delivery of care across behavioral health services.	1. Infuse our system with trauma informed practices (e.g., check-ins at staff meetings, gratitude and mindfulness practices, increased focus on learning about cultural humility, etc.). [ongoing]
	2. By December 2018, 80% of BHS staff will be trained in Trauma Informed Systems (TIS) 101. [NEW] [Monthly]
	3. Convene a Trauma-Informed Collaborative to provide ongoing input and direction, including developing policies and procedures. [ongoing]
2. Implement Trauma Focused Cognitive Behavioral Therapy (TF-CBT) in the Children's system of care.	1. Provide one initial TF-CBT training and booster training, along with 12 supervision calls, and monthly supervision group at clinics. Continue training opportunities and consultation on TF-CBT. [ongoing] [Annually]
	2. Monitor certification of 10 Staff/year in TF-CBT in the move from state to national certification. [ongoing] [Annually]
3. Implement Child-Parent Psychotherapy (CPP) in the Children's system of care.	1. Continue training and consultation on CPP. [NEW]
	2. Begin getting clinicians "rostered". [NEW]
	3. Develop an outcomes plan. [NEW]
4. Expand delivery of Seeking Safety.	1. Investigate the feasibility of expanding Seeking Safety to mental health clinics. [ongoing]

Goal 10: Increase use of evidence-based practices	
Objectives	**Actions**
5. Support use of Mindfulness by providers.	1. Develop mindfulness curriculum. [NEW]
6. Expand implementation of Dialectical Behavioral Therapy (DBT).	1. Provide a weekly DBT consultation group, introduction training every other year, quarterly training, and team lead training to maintain DBT fidelity and effectiveness and assure quality delivery of services. [ongoing] [Annually]
	2. At least 26 clinicians county-wide will participate in DBT. [NEW] [Annually]
	3. Implement DBT with at least 6 clinicians at Mt. Diablo School District. [NEW] [Annually]
	4. Hold ongoing groups in Spanish across all County regions. [NEW] [Annually]
	5. Investigate the feasibility of expanding DBT in the adult system of care. [ongoing]
7. Expand implementation of Family Based Therapy (FBT) for Eating Disorders in the Children's and Adult systems of care.	1. Provide consultation to support FBT fidelity and effectiveness and assure quality delivery of services. [NEW] [Annually]
	2. Certify at least 6 staff in FBT. [NEW] [Annually]
	3. Administer outcomes tools to youth and caregivers. [NEW]
	4. Use centralized outcomes database. [NEW]
8. Implement at least one evidence-based program across the adult system of care	1. Identify EBP Leads in the adult system of care. [NEW]
	2. Develop certification plan for CBSST and CBTp. [ongoing]
	3. Participate in consultation trainings. [ongoing] [Annually]
9. Build internal capacity to provide trainings and supervision on evidence-based practices.	1. Assess capacity for staff to become Train-the-Trainers on evidence-based programs. [ongoing]

Goal 11: Effectively collect data and communicate data findings to staff and the community	
Objectives	**Actions**
1. Develop electronic reporting capacity to regularly examine quality, access, and timeliness of services through the Behavioral Health Electronic Health Record.	1. Develop a communication plan that includes contract providers in the planning and implementation of electronic interoperability of EHR data between disparate systems. [ongoing]
	2. Champions lead monthly Super User meetings. [ongoing] [Monthly]

Goal 11: Effectively collect data and communicate data findings to staff and the community	
Objectives	**Actions**
2. Continue to mature the deployment of EHR resources, including outcome tools to all parts of the system of care, especially contract organizational providers. [EQRO Recommendation]	1. Ensure contract providers have access to mental health history and medical data. [NEW]
3. Develop capacity to regularly examine quality, access, and timeliness data.	1. Prioritize data and reporting needs with Business Intelligence, ensuring that the data system captures individual and program level data. [ongoing] [Bi-monthly]
4. Monitor program performance to improve BHSD capacity and service delivery.	1. Develop goals and objectives related to the Division's 5-year strategic plan. [ongoing] [Quarterly]
	2. 75% of established goals will be achieved according to established timeframe. [NEW]
	3. Identify meaningful way to report themes and data across the Division. [NEW]
5. Identify actions to impact the percentage of high-cost beneficiaries [EQRO Recommendation]	1. Fully investigate and explore the population of high-cost beneficiaries. [NEW]
6. Begin administering levels of care and outcome measure(s) to assess client performance.	1. Identify Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC) data collection and reporting needs. [NEW]
	2. Update forms and policies to reflect administration of CANS and PSC for young adults, children and youth. [NEW]
	3. Develop and implement training plan for the CANS and PSC. [NEW]
	4. Identify and develop educational and communication materials. [NEW]
7. Pilot utilization of the PHQ-9 and GAD-7.	1. Administer the tools and collect data on 100 clients at the two pilot sites. [NEW]
8. Use Child and Adolescent Needs and Strengths (CANS) and Pediatric Symptom Checklist (PSC-35) outcome measures for children and young adults up to age 21.	1. Coordinate with Counties using the CANS to capture lessons learned and inform implementation planning. [ongoing]
	2. Form an Implementation Team to oversee infrastructure changes and training. [ongoing]
	3. Select a CANS tool and embed into clinical workflows. [NEW]
	4. Certify 100% of Mental Health clinical staff who provide services to children and youth (0-21) in the CANS by November 1, 2018.[NEW] [Semi-weekly up until September 31st]

Goal 12: Improve client and community communication, collaboration, and education	
Objectives	**Actions**
1. Include the Office of Consumer Empowerment (OCE) in all aspects of policies and practices. [EQRO Recommendation]	1. Include OCE representation in Executive Team meetings[NEW] 2. Include OCE staff in MRT Program. [NEW]
2. Plan, coordinate, and oversee the implementation of 12 different Wellness Recovery Action Plan (WRAP) groups across Contra Costa County.	1. Monitor implementation of WRAP across the County, to at least 12 different groups, including expanding to new populations (TAY, AODS, jails, residential men). [ongoing] 2. Hold two Level 2 WRAP facilitator trainings. [ongoing] 3. Train four CSW peer staff to become certified Level 3 Wrap trainers. 4. Convene a WRAP Sub-Committee that has at least 50% attendance for the 12 meetings/year. [NEW] 5. Administer Recovery Assessment Scale at pre and post WRAP group to collect program effectiveness data. [NEW]
3. Educate peers and family members through Service Provider Individualized Recovery Intensive Training (SPIRIT) program, a college-accredited three college course series, and achieve an 80% graduation rate	1. Implement curriculum emphasizing recovery, including facilitation, coordination of speakers and activities, and assessment of students' readiness to graduate. [ongoing] [Bi-annually] 2. Report percentage of enrolled students who graduate from SPIRIT. [NEW] [Bi-annually] 3. Increase recruitment of peers and family members of clients from 20% to 35%. [ongoing] [Bi-annually] 4. Update curriculum to meet goals of Peer Core Competencies and Standards. [ongoing] [Bi-annually] 5. Coordinate internship placements for 100% of Spirit participants. [ongoing] [Bi-Annually] 6. Support 60% of students and alumni in obtaining and maintaining paid and unpaid employment. [ongoing] [Bi-annually] 7. Hold10 alumni workshops/year on topics related to obtaining and retaining employment. [NEW] [Annually] 8. Input 100% of data for 2018 into vocational database to assist in tracking employment placement and outcomes. [NEW]
4. Convene the Committee for Social Inclusion to foster a community alliance and provide public education.	1. Facilitate 12 monthly meetings with an average of 20 participants/meeting, including educational presentations on 2 state and/or national campaign themes (e.g., suicide prevention week and Mental Health Awareness Month). [ongoing] [Annually]

Goal 12: Improve client and community communication, collaboration, and education	
Objectives	**Actions**
	2. Conduct community outreach, including updating stigma brochures, hosting regional meetings, and tabling at community events. [NEW] [Annually]
5. Implement the Wellness and Recovery Education for Acceptance, Choice and Hope (WREACH) program.	1. Facilitate 10 monthly sub-committee meetings. [ongoing] [Annually]
	2. Educate on the "Tell Your Story" curriculum by holding 6 workshops. [ongoing] [Annually]
	3. Participate in Crisis Intervention Trainings (CIT) 2 times per year. [ongoing] [Bi-annually]
	4. Revisit use of a survey to measure impact of the client panel at CIT. [NEW]
6. Expand the implementation of PhotoVoice program to 8 community-based organizations.	1. Facilitate 10 monthly sub-committee meetings. [ongoing] [Annually]
	2. Hold 10 PhotoVoice exhibitions in the community to reduce stigma. [ongoing] [Annually]
	3. Coordinate implementation of PhotoVoice across the County, including with new populations (e.g., Housing, FSP, Wellness and Recovery Centers). [ongoing]
	4. Standardize facilitator training curriculum. [NEW]
	5. Provide facilitator training to 4 community-based organization staff. [ongoing] [Annually]
7. Assist clients/family members develop increased skills and capacity for getting to and from mental health services via the Overcoming Transportation Barriers project.	1. Compile and develop resources and workshops to share transportation information with 200 stakeholders, comprised of staff and consumers clients and their families. [ongoing] [Annually]
	2. Review and revise as necessary transportation policy(ies) and standardize practices across clinics. [ongoing]
	3. Liaise between Health Services County, service providers, and transit authorities, as well as act as the County representative in community forums related to transportation. [ongoing]
	4. Attend at least one transportation meeting per month, and share information among stakeholders. [NEW] [Monthly]
	5. Facilitate 4 Transportation Sub-committee meetings per year. [ongoing] [Annually]
	6. Hold transportation trainings. [ongoing]
8. Hold Educate Equip Support (EES) program.	1. Hold at least two groups with parents/ caregivers, including Spanish language groups. [ongoing] [Annually]

Goal 12: Improve client and community communication, collaboration, and education	
Objectives	**Actions**
9. Provide Mental Health First Aid (MHFA) to the community.	1. Convene strategic planning committee to plan implementation. [ongoing]
	2. Provide community trainings. [NEW]

Goal 13: Maintain effective and consistent utilization review practices	
Objectives	**Actions**
1. Improve communication with those who interface with or are part of the UR Team.	1. Hold regularly scheduled UR meetings on authorization, Level 1, and centralized reviews. [ongoing]
	2. Conduct documentation training monthly and by request at County operated clinics and community-based organizations. [ongoing] [Monthly]
	3. Attend County and community-based organization meetings to announce and communicate UR regulatory changes. [ongoing]
	4. Conduct monthly "UR Hurdles" teleconference to provide updates and respond to questions from CBOs and County service providers. [NEW] [Monthly]
	5. Send mass mailers and emails to all providers, and County owned and operated clinics on UR changes. [ongoing]
	6. Decrease disallowances by 5% . [NEW] [Quarterly]
	7. Decrease the percentage of focused reviews by 10%. [NEW] [Annually]
	8. Decrease the percentage of centralized reviews by 10%. [NEW] [Annually]
	9. Increase percentage of charts reviewed from 5% to 10%. [NEW] [Quarterly]
2. Train 100% of staff on HIPAA and Behavioral Health.	1. Track percentage of staff who complete HIPAA training. [ongoing] [Annually]

Continuity and Coordination of Care

Behavioral Health DHCS Contractual Elements: Work to ensure continuity and coordination of care with physical health care providers. Coordinate with other human services agencies used by beneficiaries.

Goal 14: Promote prevention and early intervention	
Objectives	**Actions**
1. Better integrate PEI programs with mental health treatment programs.	1. Three annual MHSA community forums will be held and focused on different underserved populations. [NEW] [Annually]
2. Strengthen and integrate suicide prevention efforts.	1. Suicide Prevention (SP) Committee will update Strategic Plan and organize training opportunities. [NEW] [Annually]
	2. SP Pilot clinician will support three adult BH clinics countywide. [NEW]
	3. The three behavioral health adult clinics and three youth clinics will receive Each Mind Matters resources and toolkits for September. [NEW]
	4. Present correlational data to Suicide Prevention Committee on the relationship between suicide and alcohol use. [NEW]
3. Begin implementing First Episode Psychosis (FEP) program at First Hope	1. Move into new location. [NEW]
	2. Hire 10 new staff by December 31, 2018. [NEW]

Goal 15: Integrate behavioral health services with other County systems	
Objectives	**Actions**
1. Serve 10-20 adult mental health clients with chronic health conditions per region through the Coaching to Wellness program	1. Screen, enroll, and provide individual, group, and community linkages services to participants on an ongoing basis. [ongoing]
	2. Hire project staff. [ongoing]
	3. Begin billing for Medi-Cal services. [NEW]
2. Provide with high fidelity Functional Family Therapy as part of the Mentally Ill Offender Crime Reduction Grant under the Contra Costa County Probation Department and achieve 19% youth improvement on the OQ and 28% parent improvement on the OQ.	1. Collect data on treatment adherence. [ongoing]
	2. Administer the Youth Outcomes Questionnaire Therapeutic Alliance (YOQ TA) and YOQ-Self-Report (SR) TA to measure therapeutic alliance and youth symptoms and social behavior difficulties. [ongoing]
	3. Determine percentage change for youth on the Outcome Questionnaire (OQ) from baseline. [ongoing]
	4. Determine the percentage change for parents on the Outcome Questionnaire (OQ)

Goal 15: Integrate behavioral health services with other County systems	
Objectives	**Actions**
	from baseline. [ongoing]
3. Expand trainings on recovery-oriented integrated care.	1. Develop behavioral health orientation that includes content on integrated care and client-centered services. [NEW]
4. Coordinate Drug Medi-Cal Waiver services with primary care and mental health services.	1. Conduct outreach and training to primary care on referrals and coordination of care. [ongoing]
	2. Conduct outreach to all 6 mental health clinics. [NEW]
	3. Designate staff at Access Line to address calls from primary care. [ongoing]
	4. Update substance use disorder services forms to include primary care information. [ongoing]
	5. Screen 100% of mental health clients on substance use and make appropriate referrals. [ongoing]
	6. Start Drug Medi-Cal certification process at specialty mental health clinics. [ongoing]
	7. Hire 1 FTE substance abuse provider to be embedded at a specialty mental health clinic in the East region. [NEW]
	8. For dual-diagnosed clients not engaged in treatment, hold voluntary groups when they come in for financial support. [ongoing]
	9. Access Line open portal for primary care to make referrals. [NEW] [Quarterly]

Goal 16: Improve services to youth in foster care	
Objectives	**Actions**
1. Monitor the use of Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS).	1. Staff complete Child and Family Team Meeting Action Plan and Progress Summary. [ongoing]
2. Identify outcome measure(s) to assess client performance.	1. Review the Child and Adolescent Needs and Strengths as an outcomes tool. [ongoing]
	2. Begin use of an outcomes tool by October 1, 2018. [NEW]