Madera County
Behavioral Health Services
Quality Improvement
Work Plan

July 1, 2014 - June 30, 2015

Contents

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

QUALITY IMPROVEMENT WORK PLAN OVERVIEW JULY 2014 – JUNE 2015

The programs covered in this Quality Improvement Work Plan include the programs provided through Madera County Behavioral Health Services and are based on our Mission Statement, Vision Statement, and our Core Values

MISSION STATEMENT

To promote the prevention of and recovery from mental illness and substance abuse for the individuals, families, and communities we serve by providing accessible, caring, and culturally competent services.

VISION STATEMENT

We envision a world where all persons with addictions and mental illness can achieve recovery and can live with dignity and respect as valued members of their families and communities.

CORE VALUES

We, the employees of Madera County Behavioral Health Services, value the:

- Promotion of mental health and recovery from mental illness disability.
- Integrity of individual and organizational actions.
- Dignity, worth, and diversity of all people.
- Importance of human relationships.
- Contribution of each employee, clients and families.

State Mandate for the QI Program

According to the State Department of Health Care Services, the Quality Management (QM) Program clearly defines the QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The QM Program shall be evaluated annually and updated as necessary per Title 9, CCR, Section 1810.440(a)(6) and Title 42, CFR, Section 438.240(e).

QM Program

The QM Program shall:

- Conduct performance monitoring activities throughout its operations.
- Activities shall include but not be limited to:
    - Client and system outcomes,
    - Utilization management,
    - Utilization review,
    - Provider appeals,
    - Credentialing and monitoring, and
    - Resolution of beneficiary grievances.
- Ensure continuity and coordination of care with physical health care providers.
- Coordinate with other human services agencies used by its beneficiaries.
- Assess the effectiveness of any MOU with a physical health care plan.
- Have mechanisms to detect both underutilization of services and overutilization of services, as required by Title 42, CCR, Section 438.240(b) (3).
- Implement mechanisms to assess beneficiary/family satisfaction. The Contractor shall assess beneficiary/family satisfaction by:
    - Surveying beneficiary/family satisfaction with the Contractor's services at least annually;
    - Evaluating beneficiary grievances, appeals and fair hearings at least annually; and
    - Evaluating requests to change persons providing services at least annually.
    - Inform providers of the results of beneficiary/family satisfaction activities.
- Implement mechanisms to monitor the safety and effectiveness of medication practices.
    - The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs.
    - Monitoring shall occur at least annually.
- Implement mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.
    - Monitor appropriate and timely intervention of occurrences that raise quality of care concerns.
    - Take appropriate follow-up action when such an occurrence is identified.
    - Results of the intervention shall be evaluated by the Contractor at least annually.

QM Work Plan

MCBHS shall have a QM Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. The QM Work Plan shall include:

- Evidence of the monitoring activities including, but not limited to:
    - Review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Title 9, CCR, Section 1810.440(a)(5) and Title 42, CFR, section 438.416;
    - Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;
- A description of completed and in-process QM activities, including performance improvement projects. The description shall include:
    - Monitoring efforts for previously identified issues, including tracking issues over time;
    - Objectives, scope, and planned QM activities for each year; and,
    - Targeted areas of improvement or change in service delivery or program design.

- A description of mechanisms Contractor has implemented to assess the accessibility of services within its service delivery area. This shall include:
    - Goals for responsiveness for the Contractor's 24-hour toll-free telephone number,
    - Timeliness for scheduling of routine appointments,
    - Timeliness of services for urgent conditions, and
    - Access to after-hours care.
- Evidence of compliance with the requirements for cultural competence and linguistic competence specified in Title 9, CCR, Section 1810.410.

Quality Improvement (QI) Program

The QI Program shall be accountable to the Behavioral Health Director as described in Title 9 CCR, Section 1810.440(a) (1). Operation of the QI program shall include substantial involvement by a licensed mental health staff person, as described in Title 9 CCR, Section 1810.440(a)(4). The QI Program shall include active participation by practitioners and providers, as well as consumers and family members in the planning, design and execution of the QI Program, as described in Title 9 CCR, Section 1810.440(a)(2)(A-C).

There shall be a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in Title 42, CFR, Section 438.240(b)(1) and (d). Each performance improvement project shall focus on a clinical area, as well as one non-clinical area.

QI Activities

QI activities shall include:

- Collecting and analyzing data to measure against the goals stated in the QI/QM annual work plan, which prioritize areas of improvement that have been identified;
- Identifying opportunities for improvement and deciding which opportunities to pursue;
- Identifying relevant committees internal or external to ensure appropriate exchange of information with the QI Committee;
- Obtaining input from providers, consumers 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 BHS Department operations as appropriate;
- Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Title 9, CCR, Section 1810.440(a) (5).

QI Program Committee (MCBHS Quality Management Committee)

The QI program shall monitor the service delivery system with the aim of improving the processes of providing care and better meeting the needs of its clients. The QI Program Committee shall;

- Review the quality of specialty mental health services provided to beneficiaries.
- Recommend policy decisions;
- Review and evaluate the results of QI activities, including;
    - Performance improvement projects;
    - Institute needed QI actions;
    - Ensure follow-up of QI processes; and
    - Document QI Committee meeting minutes regarding decisions and actions taken.

Quality Assurance (QA)

MCBHS shall set standards and implement processes that will support understanding of, and compliance with, documentation standards set forth in the State Department of Health Care Services contract and any standards set by MCBHS. QA activities may include monitoring performance so that the documentation of care provided will satisfy the requirements set forth in the State Department of Health Care Service's contract. The documentation standards for client care are minimum standards to support claims for the delivery of specialty mental health services. All standards shall be addressed in the client record.

Utilization Management (UM) Program

The Utilization Management Program shall:

- Be responsible for assuring that beneficiaries have appropriate access to specialty mental health services as required in Title 9, CCR, Section 1810.440(b) (1-3).
- Evaluate medical necessity, appropriateness and efficiency of services provided to Medi-Cal beneficiaries prospectively or retrospectively.
- Implement mechanisms to assess the capacity of service delivery for its beneficiaries. This includes monitoring the number, type, and geographic distribution of mental health services within the Department's delivery system.
- Implement mechanisms to assess the accessibility of services within its service delivery area. This shall include the assessment of responsiveness of the Contractor's 24 hour toll-free telephone number, timeliness of scheduling routine appointments, timeliness of services for urgent conditions, and access to after-hours care.
- Implement mechanisms to assure authorization decision standards are met. Authorization of services shall include all of the following:
    - Pursuant to Title 42, CFR, Section 438.210(b)(1), the Contractor and its subcontractors must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services.
    - Pursuant to Title 42, CFR, Section 438.210(b) (2), the Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate.
    - Pursuant to Title 42, CFR, Section 438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition or disease.
    - Decisions must be made within the timeframes outlined for service authorizations in Title 42, CFR Section 438.210(d), and notices of action related to such decisions must be provided within the timeframes set forth in Title 42, CFR, Section 438.404.(c).

Madera County Behavioral Health Services (MCBHS) Programs

This section of the Work Plan covers Madera County Behavioral Health Services (MCBHS) department programs and activities with the primary goal of providing the highest quality behavioral health services we can with the resources available.

Programs/Services within MCBHS include:

7th Street Center

The target population is Medi-Cal eligible Madera County adult/older adult residents that are severely mentally ill and seriously emotionally disturbed and children and youth that meet the diagnostic criteria as set forth by the State of California for Medi-Cal eligibility. Specific mental health and substance use programs housed at the 7th Street Center include:

- Family Treatment Center--offers services to 0-5 infants, toddlers, juvenile justice adolescents, adult women with bonding and attachment issues with their children, the severely and persistently mentally ill adults and the severely emotional disturbed (SED) children and adolescents.
- Services to foster children and youth--Serves youth and their caretakers (parents and foster parents). The center provides services to those foster youth between 6 and 18 years old that are on a CWS caseload, who are SED.
- Services to CalWORKs recipients (MAP)-- Includes adults that receive Temporary Assistance to Needy Families (TANF) and are referred by the Department of Social Services to address barriers they are experiencing in securing employment, e.g., mental health needs, Substance Use Disorders (SUD), and domestic violence issues.
- Mental Health Plan (MHP) or Managed Care--Provides the gate-keeping service for MCBHS. Staff provides review for TARS from hospitalizations, handles all SB 785 services, payment for placements, hospital contracts, provider certifications, documentation reviews, in-house training and CEU's, etc.
- Quality Management's (QM)--The purpose is to ensure that BHS provides high quality services and is a collaborative, accessible, responsive, efficient, and effective mental health system that is recovery oriented, culturally competent, client and family oriented and age appropriate. Provides QI reviews at the jail, juvenile hall and substance use providers.

Chowchilla Recovery Center CRC)

Offers mental health substance use services to residents of Chowchilla and surrounding communities including Fairmead.

Oakhurst Counseling Center (OCC)

Provides a comprehensive, culturally and linguistically appropriate outpatient and community based specialty mental health, substance abuse services, wellness and recovery services to the mountain communities of Madera County. These services also include a peer directed wellness and recovery center.

Mental Health Services Act (MHSA) Services

These services represent a comprehensive effort to further the development of community-based mental health services and supports for the residents of Madera. The MHSA services address a broad continuum of mental health services ranging from prevention and early intervention to intensive outpatient services and provide infrastructure, technology and training elements that support the local mental health system.

The five components are:

Community Services and Supports which includes Full Service Partnerships (FSP's)

- **The Adult and Older Adult FSP** targets population is Madera County residents who are severely mentally ill (SMI) adults 25 or older with multiple hospitalizations, at risk of homelessness, at risk of residential treatment and LPS Conservatorship, and those reentering the community from residential placement or justice systems.
- **The Children and Transition Age Youth FSP** targets child and youth populations in Madera County who are seriously emotionally disturbed (SED) who need intensive services to remain in their home or in placement.

Workforce Education and Training's (WET)'s focus is to advance the knowledge and skills of BHS employees and encourage mental health clients, family members, and high school and college students to participate in training and college certificate programs to increase the number of people who pursue a career in public mental health.

Capital Facilities and Technology (Cap/Tech) funds provide money for infrastructure such as buildings to house MHSA programs or computer technology, such as electronic medical records for mental health programs.

Prevention and Early Intervention (PEI) programs are designed to promote mental health and prevent mental illnesses from becoming severe and disabling. Prevention services emphasize improving timely access to prevention services for underserved populations, and treatment services when people are experiencing early onset of serious mental illness (e.g. first break). These programs include the following components:

- Outreach to families, employers, primary care health care providers, and others to promote the mental health protective factors, reduce mental illness risk factors and, when indicate to recognize and treat the early signs of potentially severe and disabling mental illnesses.
- Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness, as defined in Welfare and Institutions Code (W and I) Section 5600.3, and for adults and seniors with severe mental illness, as defined in W and I Section 5600.3, as early in the onset of these conditions as practicable.
- Reduction of social stigma associated with either being diagnosed with a mental illness or seeking mental health services to reduce social isolation and increase social protective factors.
- Reduction in discrimination against people with mental illness, which can lead to traumatic experiences.

Innovation Services are to pilot new and untried services which focus on learning if the proposed services improve service delivery. Madera County has one Innovation Project this fiscal year. These services will be delivered by a nonprofit contractor. The purpose of the project is to learn how to develop a collaboration of organizations through the implementation of an inter-organizational project; an active learning approach. The project implemented is a Perinatal Mood and Anxiety Disorder prevention service that includes primary care, public health, social services and other services that promote mental health protective factors and manage mental illness risk factors.

Departmental Quality Committees

The ***Quality Management Committee (QMC)*** provides ongoing operational leadership of continuous quality improvement activities in the department. It meets quarterly and consists of the following individuals:

Name	Title/Department
Dennis Koch, MPA - Chair	Behavioral Health Director
Orlando Collado, MD	Medical Director
Debby Estes, LCSW	Assistant Behavioral Health Director
Debbie DiNoto, LMFT	Division Manager
Julie Morgan, LCSW	Division Manager
Sonja Bentley	Compliance Officer
Carol Powroznik	Patient's Rights Advocate
Lisa Bernal	Medical Records Supervisor
Larry Penner, LMFT	Supervising Mental Health Clinician
Annette Presley, LCSW	Supervising Mental Health Clinician
Art Galindo, LCSW	Supervising Mental Health Clinician
Greg Gregson, LMFT	Supervising Mental Health Clinician
Joe Torres, LCSW	Supervising Mental Health Clinician
Michelle Richardson, LMFT	Supervising Mental Health Clinician
Darrel Hamilton, MFTI	Supervising Program Manager
Christina Lopez	Hope House Staff Representative
Dale Hudek	Client/Family Member representative
Network Provider	Network Provider
Eric Oxelson	Mental Health Board representative(s)
David Weikel, PsyD	Behavioral Health Program Supervisor
Kristina Klemash Felicia Ramirez	Community Service Liaison

Other Department QI Activities/Committees

The Department has other standing committees where QI/UM activities occur. These include the Performance Improvement Project (PIP) committees, QI/Supervisor meetings, Interagency Quality Improvement Committee (IQIC), etc. Other committees are created as necessary to resolve quality improvement issues.

Department Communication of QI Activities

The Department supports QI activities through the planned coordination and communication of the results of measurement of QI initiatives. There are overall efforts to continually improve the quality of care provided.

Through planned and shared communication, the Mental Health Board, staff, clients and family members, stakeholders, etc., have knowledge of ongoing QI initiatives as a means of continually improving overall program performance.

This planned communication may take place through the following methods;

- *Posters and brochures displayed in common areas*
- *Recipients participating in QI Committee reporting back to recipient groups*
- *Sharing of the Department's annual QI Plan evaluation*
- *Emails*
- *Department Initiatives posted on Public Share (Intranet – PS) and the MCBHS website*
- *Presentations to the Mental Health Board*

Goals and Objectives

The Quality Management Committee and other committees that deal with quality issues such as the Supervisor meeting, program planning committees, etc., identify and define goals and specific objectives to be accomplished each year. Progress in meeting these goals and objectives is an important part of the annual evaluation of quality improvement activities.

The following are the ongoing long term goals for the Department's QI Program and the specific objectives for accomplishing these goals for FY 2014-15.

- To implement quantitative measurement to assess key processes or outcomes;
- To bring managers, clinicians, and staff together to review quantitative data and major clinical adverse occurrences and to identify problems;
- To carefully prioritize identified problems and set goals for their resolution;
- To achieve measurable improvement in the highest priority areas;
- To meet internal and external reporting requirements;
- To provide education and training to managers, clinicians, and staff.
- To develop or adopt necessary tools, such as practice guidelines, consumer surveys and quality indicators.

Performance Measurement

Performance Measurement is the process of regularly assessing the results produced by a program/service. It involves:

- Identifying processes, systems and outcomes that are integral to the performance of service delivery,
- Selecting indicators of these processes or outcomes,
- Analyzing information related to these indicators on a regular basis,
- Taking action as needed based on data analysis and the opportunities to improve performance as identified.

The ***purpose*** of measurement and assessment is to:

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
- Identify problems and opportunities to improve the performance of processes.
- Assess the outcome of the care provided.
- Assess whether a new or improved process meets performance expectations.

This involves the:

- Selection of a process or outcome to be measured
- Identification and/or development of performance indicators for the selected process or outcome to be measured.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.
- Assessment of performance with regard to these indicators at planned and regular intervals.
- Taking action to address performance discrepancies when indicators indicate that a process is not stable, not performing at an expected level or represents an opportunity for quality improvement.
- Reporting on findings, conclusions and actions taken as a result of performance assessment.

Selection of a Performance Indicator

A performance indicator is a quantifiable behavior change that, when measured, provides information about the performance of a program/services process, functions or outcomes. Selection of a Performance Indicator for each of the services within MCBHS is based on the following considerations:

- Relevance to the Department's mission.
- Clinical importance - whether it addresses a clinically important process that is:
    - high volume
    - problem prone
    - high risk
    - client satisfaction with services
    - cultural competency of services, etc.

The Performance Indicators Selected for the Department Program's Quality Improvement Plan. For purposes of this plan, an indicator(s) comprises the following *key elements*: name, goals, objectives, activities, responsible person, and data to be collected, the frequency of analysis or assessment, and preliminary ideas for improvement.

Evaluation is accomplished by comparing actual performance on an indicator with:

- *Describing the progress in achieving the Target*
    - *Activity toward achieving the target, number of people served,*
    - *What was done? Who participated? How many clients were involved?*
    - *What indicators (concrete, observable things) were looked at to see whether or not progress was being made toward the goal?*
    - *What was used to measure the desired result?*
    - *Describe how the desired result was measured and what indicators were used to measure*
- *Describing relevant evaluation data (results compared with standards, including statistics and qualitative information)*
    - *Any stories used to illustrate the statistics or qualitative information?*
- *Comparing results of the evaluation with the target. Results compared with standards?*
- *Exploring ideas for improvement or any next steps*

Once the performance of a selected process has been measured, assessed and analyzed, the information gathered by the above performance indicator(s) is used to identify a continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon program/service priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones.

One of the models used at MCBHS is referred to as Plan-Do-Study-Act (PDSA) cycle.

- **Plan -** The first step involves identifying preliminary opportunities for improvement. At this point the focus is to analyze data to identify concerns and to determine anticipated outcomes. Ideas for improving processes are identified. This step requires the most time and effort. Affected staff or people served are identified, data compiled, and solutions proposed.
- **Do** - This step involves using the proposed solution, and if it proves successful, as determined through measuring and assessing, implementing the solution usually on a trial basis as a new part of the process.
- **Study** - At this stage, data is again collected to compare the results of the new process with those of the previous one.
- **Act** - This stage involves making the changes a routine part of the targeted activity. It also means "Acting" to involve others (other staff, program components or consumers) - those who will be affected by the changes, those whose cooperation is needed to implement the changes on a larger scale, and those who may benefit from what has been learned. Finally, this means documenting, reporting findings and following up.

This model has been used successfully for the Small County Emergency Relief Pool (SCERP) PIP.

Another model in use at MCBHS is the Logic Model. This model was mandated by the State Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) for the development, measurement and monitoring of the MHSA programs. The Logic Model in use by MCBHS was developed by the United Way. It consists of the following:

- What is the mission or overall singular purpose or desired result?
- What are the inputs?
    - Resources dedicated to or consumed by the program, e.g., money, staff, time volunteers, equipment, supplies, etc.
    - What are the constraints on the program, e.g., laws regulations, funding requirements, etc?
    - SWOT—strengths and weaknesses, opportunities and threats
- Establish goals—SMARTER
    - Specific
    - Measurable
    - Acceptable
    - Realistic

    - Time frame
    - Extending—stretch the performer's capabilities
    - Rewards/recognition when goal/outcome is achieved
- Build in accountability (regularly review who's doing what and by when)
- Note deviations from the plan and re-plan accordingly
- Evaluate the planning process and plan

This method was used with clients/family members and other stakeholders in the development of the Department's MHSA Prevention, Early Intervention Programs and the MHSA Innovation plan. Clients/family members and stakeholders were used for the setting of goals/objectives for the program.

Evaluation

An evaluation is completed at the end of each fiscal year. The annual evaluation is conducted by the MHP and kept on file, along with the Quality Improvement Plan. These documents will be reviewed by the Quality Management Committee and others as appropriate.

The evaluation summarizes the following:

- The goals and objectives of the programs/service's Quality Improvement Plan,
- The quality improvement activities conducted during the past year, including the targeted process, systems and outcomes,
- The performance indicators utilized,
- The findings of the measurement, data aggregation, assessment and analysis processes, and
- The quality improvement initiatives taken in response to the findings.
- The progress towards meeting the Department's Annual Initiatives/Objectives:
    - For each of the objectives, a brief summary of progress including progress in relation to the objective(s).
    - A brief summary of the findings for each of the indicators used during the year. These summaries include both the outcomes of the measurement process and the conclusions and actions taken in response to these outcomes.
    - A summary of the progress toward the Quality Initiative(s)?
- Recommendations: Based upon the evaluation, the actions deemed necessary to improve the effectiveness of the Department's/program services.

Annual QI Work Plan Evaluation for All Programs and QI Activities.

The following are the annual QI work plan evaluation and activities for all MCBHS programs and services. For FY 14/15, we are doing fewer program initiatives due to staff reductions. MCBHS lost almost 50% of its workforce since 2008 due to budgetary issues. MCBHS is beginning to hire as evidenced by several clinicians hired by various departments in the last fiscal year. We are still significantly under our 2008 level of staffing.

Madera County Behavioral Health
Annual Quality Management/Improvement Work Plan FY 14—15

Service Delivery Capacity

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/ or Lead Person	Auditing Tool	Due Completion Date:	Outcome
Obtain on a semi-annual basis reports from Anasazi regarding the following: 1. Location of clients receiving services by zip code/residential area 2. Demographics of clients receiving services 3. Types of services clients are receiving broken down by zip code/residential area and demographics 4. Trending of data on a semi-annual basis	1. Information will be analyzed and reported to staff on a semi-annual basis	Request reports be developed by Kingsview on Anasazi and be presented to MCBHS on a semi-annual basis	Division Manager (Debbie DiNoto) or designee (Ken?)	Report developed by Kings View utilizing data on Anasazi	Due: 8/15/15 Completion: **July 29, 2015**	

Demographic Information	Mental Health Clients Served					
	Medi-Cal		Non Medi-Cal		Total	
	#	%	#	%	#	%
Total Clients Served	**2596**	**73.17**	**952**	**26.83**	**3548**	**100.0**
Gender:						
Female	1417	54.58	501	52.63	1918	54.06
Male	1179	45.42	451	47.37	1630	45.94
Unknown	0	0.00	0	0.00	0	0.00
Age:						
0-15	664	25.58	315	33.09	979	27.59
16-24	454	17.49	223	23.42	677	19.08
25-59	1287	49.58	338	35.50	1625	45.80
60+	191	7.36	76	7.98	267	7.53
Race/Ethnicity:						
Caucasian	980	37.75	385	40.44	1365	38.47
Latino	1353	52.12	465	48.84	1818	51.24
African American	137	5.28	57	5.99	194	5.47
Asian/Pacific Islander	31	1.19	17	1.79	48	1.35
Native American	38	1.46	7	0.74	45	1.27
Multi/Other	43	1.66	16	1.68	59	1.66
Unknown	14	0.54	5	0.53	19	0.54
Language:						
English	2365	91.10	837	87.92	3202	90.25
Spanish	219	8.44	103	10.82	322	9.08
Other	12	0.46	12	1.26	24	0.68
Residence:						
Madera	1866	71.88	573	60.19	2439	68.74
Chowchilla	341	13.14	70	7.35	411	11.58
Oakhurst	136	5.24	39	4.10	175	4.93
Ahwahnee	30	1.16	4	0.42	34	0.96
Bass Lake	7	0.27	1	0.11	8	0.23
Coarsegold	117	4.51	52	5.46	169	4.76
North Fork	34	1.31	12	1.26	46	1.30
O'Neals	3	0.12	1	0.11	4	0.11
Raymond	12	0.46	2	0.21	14	0.39
Wishon	3	0.12	0	0.00	3	0.08

Client Services Report FY 2014-15				
Service	Client	Units	Contacts	Server Hours

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/ or Lead Person	Auditing Tool	Due Completion Date:	Outcome

	Hours			
Assessment	3,410.73	28,582.70	2,020	3,411.98
Crisis Intervention	4,426.70	16,312.31	2,349	4,426.70
Collateral	1,776.88	7,012.71	2,137	1,777.53
Individual Therapy	16,048.57	105,762.06	19245	16,065.08
Group Therapy	2,283.17	2,7728.63	1,607	555.73
Rehab Individual	1,636.98	6,194.88	796	1,636.98
Rehab Group	1176.75	2,952.08	735	314.75
Plan Development	2,756.47	28,212.16	4,498	2,758.22
Case Manage Brokerage	13,301.32	65,795.29	10,7040	13,303.45
Intensive Care Coordination	50.42	189.67	24	50.14
Med Eval Initial	635.6	2,308.39	735	635.6
Med Eval Ongoing	2,269.03	8,441.21	5,734	2,271.03
Med Admin	173.3	684.21	346	173.3
Med Management	138.42	547.28	306	138.75
Total	**50,084.34**	**300,723.58**	**51,272**	**47,519.52**

Analysis: There continues to be difficulty in obtaining statistical information from the computer system. After constant review/requests for data, it appears that we may not be utilizing some of the forms in Anasazi correctly. This warrants further study. After being told not to use the index card in Anasazi eight years ago, staff has been doing a new demographic form for each change in phone number, address, etc. With multiple demographic forms for one individual, it makes it impossible to obtain accurate data. It now appears that updating information on the index card automatically updates information on the demographic form. Therefore there would only be one demographic form. Data would be much easier to obtain. Over the next year, it is hoped that there will be a clean-up of the demographic forms so that data can be run on the system for a variety of reports. It is then hoped that a new template can be developed so supervisory staff can run their own reports on types of services, etc.

Goal for FY 15-16: Clean-up of data in Anasazi. Have standard reports written for upgraded Anasazi so supervisory staff can run them on the services their staff provide.

Beneficiary/Family Satisfaction

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
Maximize client response to mandated POQI for quality improvement purposes	1. POQI will be administered twice a year 2. 90% of responders will be satisfied with services 3 90% of responders will not have been arrested since starting services 4. 60% of responders will state they are better able to handle their daily life	1. Distribute survey at all outpatient sites 2. Utilize Community Support Specialists and client/family member volunteers to administer the survey 3. Results will be shared with stakeholders, clients, staff, etc.	QI Coordinator or designee	1—2. POQI key results 3. Meeting minutes, postings, etc.	1—3. Due: 6/30/15 Completed: **6/23/15**	**Oct POQI 2015 Survey results** • N = 168 • 97% English Speaking • 3% Spanish Speaking • 88% Staff Considerate to Cultural Background • Race/Ethnicity ○ 29% Mexican/Hispanic/Latino ○ 7% Native American ○ .05% Asian ○ 6% Black African American ○ .05% Nat Haw/ Other Pac ○ 43% White/Caucasian ○ 12% Other ○ 2% Unknown • 79% Adults Encouraged to Use Peer Support • 84% Were Not Arrested Since Starting Services • 94% Liked/Satisfied with Services • 47% Adults Initiated Service Willingly on Their Own • 78% Said they Got the Help They Needed • 77% - Said They Were Better Able to Handle Daily Life • 59% of Respondents were Women • 40% Male

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome

						May POQI 2015 Survey
						• N = 197
						• 94% English Speaking
						• 6% Spanish Speaking
						• 79% Staff Considerate to Cultural Background
						• Race/Ethnicity
						  ○ 40% Mexican/Hispanic/Latino
						  ○ 9% Native American
						  ○ 1% Asian
						  ○ 5% Black African American
						  ○ 1% Nat Haw/ Other Pac
						  ○ 60% White/Caucasian
						  ○ 25% Other
						  ○ 5% Unknown
						• 60% Adults Encouraged to Use Peer Support
						• 91% Were Not Arrested Since Starting Services
						• 88% Liked/Satisfied with Services
						• 29% Adults Initiated Service Willingly on Their Own
						• 85% Said they Got the Help They Needed
						• 63% - Said They Were Better Able to Handle Daily Life
						• 70% of Respondents were Women
						• 30% Male

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						• 83% of the narrative responses made positive comments about BHS service and staff Outcomes were distributed to all BHS staff, presented at the last QMC meeting and presented at the BHS Behavioral Health Board in July 2015
	Network Providers being utilized by MCBHS will complete the provider satisfaction surveys annually	1. Have network providers complete the provider satisfaction surveys annually and compile and share results	QI Coordinator (Michelle Richardson) or designee	Network Provider satisfaction survey forms	Due: As Needed—no network providers utilized this FY	No surveys have been completed.
Monitor and communicate results of Inpatient Surveys and POQI.	Communicate the POQI results to the Behavioral Health Board on an annual basis. Communicate the results of the POQI to the staff.	1. Have clients complete inpatient surveys. Compile and communicate results 2. Will communicate results of POQI when data has been returned and analyzed.	QI Coordinator or designee	Inpatient satisfaction survey forms, POQI, meeting minutes, etc.	Due: 6/30/15 Completed: **6/23/15**	18 Surveys Completed for 7 Hospitals: Madera Hospital, Saint Helena, Sierra Vista, Marie Green Heritage Oaks, Kaweah Delta and Community Behavioral Center. 1. 94% Received Information About Patients' Rights Services 2. 100% Received a Physicians Evaluation within 24 Hours 3. 100% Were Treated Respectfully by Staff and Physicians 4. 83% Felt Staff Was Available to Discuss Problems/Concerns

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						5. 39% Said They Were Given Information About MCBHS 6. 83% Said They Were Able to Communicate With Staff in Their Primary Language to Their Satisfaction 7. 71% Said They Were Able to Discuss Concerns About Services or Discharge Plans with MCBHS Representative 8. 72% Said They Felt Safe While in the Inpatient Unit 9. 60% Said They Were Satisfied With the Services They Received in the Inpatient Unit Three Complaints: 1. Wanted actual groups to process my emotions & needs. No groups & too much free time. (Heritage Oaks) 2. They should put males on one side and females on the other. Sometimes nurses were rude and meds were not given, and I was hit by a nurse. (St. Helena) 3. More water, larger glasses, clean bedroom floors, and more outside

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						time. I was under the impression that we would have daily counseling sessions. (Sierra Vista) This information was provided to upper management, the Behavioral Health Board, as per regulation, hospital liaisons and is reviewed during QMC meetings.
Review and monitor client grievances, appeals, fair hearings and change of provider requests for trends	Review and monitor grievances, appeals and fair hearings quarterly at the QMC meeting.	1. Identify trends and take necessary actions in response for both MHP and network providers 2. Review quarterly/annual report with QI Committee	QI Coordinator or designee	Grievance forms, appeal forms, change of provider requests/ reports with trends	1—2. Due: 6/30/15 Completed: **7/15/15**	FY 14-15: No expedited appeals/fair hearings **Total** 12 Grievances/Complaints/ Change of Provider Requests • 1 Appeal from Same Individual That Had 4 Grievances Last FY (**Denied**) • 2 Substance Use Related (**Referred to SUD** Services) • 1 Complaint about staff's written documentation in their chart. • 1 Complaint about Referral to VA since client had full benefits offered by the VA • 1 Complaint about being asked to discuss personal information in a therapy group • 3 complaints from the same person Re: 2 different staff members not returning the client's calls and being humiliated in group

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						• 1 Complaint about not being allowed to see a nurse on a walk-in basis (whenever parent wanted to) • 1 Complaint about a staff member talking angrily towards a client • 1 Compliant generally stating "very bad service"

Analysis: Responses on the POQI continue to be high regarding satisfaction with services. Statistics for both surveys combined show an overall 91% were satisfied with services. For both the May and October surveys, 88% had not been arrested since starting services and overall 70% were better able to handle their daily lives. We were two percentage points shy of meeting our goals for 90% of individuals taking the survey not being arrested after starting services. It is hoped with the new FSP criminal justice services, the implementation of a mental health court and other supportive services, these numbers will meet our criteria next year.

The complaints about services from the hospital were investigated and were unfounded. Staff/clients need to be educated re: differences between grievances and change of providers. Often if a person is unhappy with their therapist, they are told to complete a grievance form instead of a request for a change of provider. QI staff will provide this education to supervisors and other key staff during FY 15-16. All requests for changes of providers were granted.

Grievances, appeals, etc., continued to be reviewed at the QMC meetings.

Goals for FY 15/16:

- Train staff on differences between a grievance and a change of provider request.
- State will be issuing a form for counties to complete regarding reporting of grievances, change of provider requests, etc. Managed Care/QI will be implementing this form for reporting purposes.
- Work with staff and hospitals to obtain more surveys from clients placed in those facilities.
- Grievances, appeals, etc., will be reviewed at the QMC meetings.
- Continued training of staff on customer service practices

Service Delivery System/Clinical Issues

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome	
Ensure regulatory and clinical standards of care for documentation are exercised across the MHP	Charts will be at 100% compliance with state standards for documentation	1. Review a minimum of three charts of clinical staff throughout the year by the Supervisory Review Committee 2. Review a minimum of 6 system charts per year for inter-rater reliability 3. Track errors to determine if further training is necessary either individually or as staff 4. Report quarterly/annually in QMC meeting	QI Coordinator or designee	1-3. Documentation review form Quarterly compliance UR report 4. QMC minutes	1—3. Due: 6/30/15 Completed: Ongoing 4. Due: 6/30/15 Completed: **On-going**	Indicator and Percentage that Met Requirements	%
						Signed Internal Authorization to Exchange Information in chart	88%
						Client asked whether he/she had an Advance Directive and information was provided	92%
						Diagnosis is consistent with presenting problems, history, MSE, and other assessment data, including AOD	92%
						Objectives specific, observable, measurable and are consistent with the diagnosis	79%
						Treatment Plan and proposed interventions are consistent with diagnosis and treatment goals, including AOD	92%
						BIOP notes appropriately completed	96%
						Medical necessity demonstrated by continued symptoms and impairments which impact daily social and community functioning	96%
						Interventions and relevant clinical decisions aimed at reducing the symptoms and impairments identified on	96%

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						Treatment Plan Progress or lack of progress toward treatment goals, including SUD 79% Correspondence with PCP in effort to collaborate and coordinate treatment 82%
On-going/Annual Clinical Documentation training for all MHP provider staff	Provide documentation training through weekly supervision and annually through training sponsored by DHCS	Update annual clinical documentation training and provide to all MHP staff	QI Coordinator or designee	Training Handouts Staff sign-in sheets QMC minutes	1—3. Due: 6/30/15 Completed: **On-going**	Last supervisor documentation training occurred on July 22, 2013. Each individual Supervisor trained staff in the areas of documentation that the chart reviews showed they were weakest in. This was done during weekly supervision. The next training will be on August 19th and 20th 2015
Hospital charts of BHS clients will be reviewed retrospectively to determine appropriateness of admission, length of stay and recommendations for preventing further hospitalizations	Review charts that are over 14 day stays, more than one admission in 30 days, 3 or more admissions in 6 months; one day stays at the IQIC meeting quarterly	1. BHS client's charts will be reviewed retrospectively. Those which are over 14 day stay, more than one admission in 30 days, 3 or more admissions in 6 months; one day stays 2. Data will be reported to IQIC,	QI Coordinator or designee	TARS, Excel spreadsheet, etc. IQIC, QMC, minutes	1.—2. Due: quarterly Completed: **7/15/15**	FY 14/15 – **Psych Hospitalization Episodes = 273** (Only includes Madera County residents. Staff hospitalized clients from outside Madera County but are placed on a 5150 in Madera County) • 29 (10.6%) Clients *Hospitalized More than 14 Days* • 20 (7%) Clients Had *More Than One Admission Episode in 30 Days* (Total Number of Episodes = 26 Episodes) ○ 14 (6%) adults ○ 6 (11%) children • 9 (3%) Clients Had *3 or More*

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
		management and QMC				*Admissions in 6 Months* • 17 (6.2%) Clients had 1 Day Stay
Identify potential occurrences of poor quality care and implement appropriate interventions	Review all adverse incidents, identifying issues including cultural competence considerations, requesting and reviewing plans of corrections at least annually. These will be reported at QMC at least quarterly	1. Adverse incidents will be reviewed within three working days of being reported. 2. Any identified issues re: poor quality of care will be analyzed and reported at the QMC meeting 3. Any cultural competence considerations will be brought up at the QMC meeting and a plan of correction will be determined.	Data management, QI staff, clinical supervisors, staff, QMC Committee, etc.	Computer system, EQRO reports, QI measures and reports, adverse incident reports, cultural competency committee recommendations, staff surveys, client/ family member surveys, provider surveys, stakeholder reports, etc.	Ongoing activity Due: 6/30/15 Completed: **7/24/15**	We did not have any reported adverse incidents. We did have a team formulated to review the service sites to determine if they were client/family member friendly, were culturally appropriate, etc. That report is included in the cultural competency plan.
1. All provider appeals will be monitored for quality purposes	100% of provider appeals will be analyzed for quality purposes	1. Provider appeals will be reviewed monthly.	QM Coordinator	Provider Appeal forms	Ongoing activity Due: 6/30/15 Completed: **7/01/15**	There were no provider appeals

Analysis: More training on documentation is necessary due to the large amount of new staff who have entered the workforce within the Department. Documentation training that combines training on how to use Anasazi and meet state standards for charting is necessary. Managed Care needs to be fully staffed so it can work on a template with Kingsview for this express purpose.

Documentation trends show the following: BHS staff has been consistent with completing Progress Notes with BIOP (behavior, intervention, objective and plan) by 96% according to the sample of charts reviewed. BHS staff are also meeting criteria (96%) indicating medical necessity being met.

BHS staff will need to show improvement (79%) within treatment plans and documentation indicating the objectives are specific, observable, measurable and consistent with the diagnosis. Additionally, the other area of improvement (79%) is charting, needs to reflect the progress or lack of progress toward treatment goals including SUD (substance use disorder).

Another issue this fiscal year was the signed Internal Authorization to Exchange Information in the chart. The percentage met for this FY was at 88%. As of July 2015, we now have the Internal Authorization to Exchange Information WSYWIG'd into the EHR.

Finally, we also found that 82% of charts reviewed had correspondence with PCP in efforts to collaborate and coordinate treatment with our consumers and their physical health providers. Some of our consumers receive behavioral services that have not included medications and that may be part of the reason some charts do not reflect that collaboration.

We have also started a new PIP to establish regular contact and interface with our consumers PCP's and our goal is to increase communication and collaboration between physical health and behavioral health clinics alike as well as have every person receiving services complete a physical health examination yearly.

There has been several new staff who have been providing crisis intervention services through our contract for weekends and after hours with West Care. We anticipate an increase in hospitalizations during a training phase for these staff until they get to know our clients, etc. This year there were 20 episodes of re-hospitalization within 30 days. One day stay rates remain the same as in previous years 17 in FY12/13, 16 in FY13/14 and 17 in FY 14/15. Most of these individuals were ones who had ingested illegal substances and were coming off of the substance when they were hospitalized. We have requested additional training regarding this for the contract staff.

Re-hospitalizations within 30 days averaged 7%. The national average for re-hospitalizations for persons with mental illness is about 12%. Madera County is below those figures; however, our goal is to get to less than 5%.

Goals for FY 15/16

- Improve on documentation through chart reviews and training
- Documentation training for staff in the following areas:
    - Writing treatment plan objectives that are specific, observable, measurable and consistent with the diagnosis
    - Charting that reflects the progress or lack of progress towards treatment goals including SUD services.
    - Documentation of collaboration with physical health care including client obtaining a yearly physical.
- Reduce readmissions to hospitalizations within the first 30 days of initial discharge to less than 5%.
    - Establish contact with client within 7 days of hospitalization
    - Give client a written discharge plan upon including an appointment with clinical staff upon exiting the hospital
    - Improve referrals and access for services for those with co-occurring disorders
    - Follow-up with peer services

Monitor Safety and Effectiveness of Medication Practices

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
1. Promote safe medication prescribing practices 2. Evaluate effectiveness of prescribing practices	1. Consent for the psychotropic medication prescribed & present inpatient record per BHS procedure. 100% 2. Drug & allergy history (updated at least every 90 days) obtained from patient & present in record. 100% 3. Med(s) prescribed in compliance with general screening criteria. 100% 4. Current lab work ordered at least annually or as appropriate for therapy prescribed. 100% 5. Current weight/vitals obtained at least quarterly. 90% 6. Medications prescribed by Psychiatrist	1. Monthly Medication monitoring at Medication Monitoring Committee by a random review of charts of clients receiving medication services by the contracted pharmacist. 2. Review prescribing practices and provide feedback to staff psychiatrists. 3. Use of practice guidelines approved by the Medication Monitoring Committee will be found in 95% of charts reviewed by the contracted pharmacist. 4. Random charts and charts	Director (Dennis Koch) or designee Contracted pharmacist	1—2. Quarterly report to QMC committee Pharmacist will evaluate MD prescription practices according to guidelines approved by the Medication Monitoring Committee and according to established practices. 3. Practice guidelines 4. Notes from contracted pharmacist 5. QMC and, Medication Monitoring minutes	Ongoing activity	There is a monthly Medication Monitoring Committee to review chart compliance. For FY 2014-15 the Medication Monitoring Committee met once a month. The MHP has a consulting Pharmacist that reviews prescribing practice and medication in the aforementioned meeting, which includes the treatment psychiatrist. The psychiatrist is required to sign off on the recommendations document. • 50 charts reviewed between 7/2014 – 5/2015 • 24 Females • 26 Males • Major DX Category Frequencies 2 – Major Depressive 5 – ADHD 1 – Asperger's 1 – Schizoaffective 15 – Bipolar 3 - Depressive NOS 10 – Major Depressive 2 – Mood NOS 5 – Schizoaffective

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
	appropriate for indication/ diagnosis. 100% 7. Medication Evaluation/Progress Note by physician includes presence or absence of side effects. 100% 8. Medication Evaluation/Progress Note by physician includes patient compliance. 100% 9. Patient evaluated at least every 90 days when prescribed medications by a Psychiatrist. 90%	requested for review monthly. Not less than 5 charts will be reviewed monthly. 5. Results will be discussed at the quarterly QMC and Medication Monitoring meeting.				6 – Schizophrenia 1 - Adjustment 2 - Psychotic NOS The following ratings show a 79% compliance rate with practice guidelines. Consent for the psychotropic medication prescribed & present inpatient record per BHS procedure. (90%) 45 – Yes 3 - N/A 1 - Unclear 1 - Blank Drug & allergy history (updated at least every 90 days) obtained from patient & present in record. (62%) 31 – Yes 15 – No 4 - Unclear Med(s) prescribed in compliance with general screening criteria. (98%) 49 – Yes 1 – Unclear Current lab work ordered at least annually or as appropriate for therapy prescribed. (60%) 30 – Yes

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						16 – No 1 - Unclear 3 - N/A Current weight/vitals obtained at least quarterly. (88%) 44 – Yes 6 - No Medications prescribed by Psychiatrist appropriate for indication/diagnosis. (86%) 43 – Yes 4 – No 2 – Unclear 1 - Blank Medication Evaluation/Progress Note by physician includes presence or absence of side effects. (100%--yea!) Yes - 50 Medication Evaluation/Progress Note by physician includes effectiveness of current therapy. (100%--yea!) Yes - 50 Medication Evaluation/Progress Note by physician includes patient compliance. (100%--yea!)

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						Yes – 50 Patient evaluated at least every 90 days when prescribed by Psychiatrist. (92%) 46 – Yes 4 – No

Analysis: MCBHS achieved between 90-100% on six out of 10 measures with three of those measures at 100%. Yearly we review these measures and increase the difficulty for the MD's to achieve. The two measures that need the most work are the ordering of labs and documentation of drug and allergy history. The lab section of the electronic health record is still not active. It is unclear from Cerner as to when it will become active. In the meantime, we are working with the insurance carriers regarding the ordering of labs. We are checking to see if our physicians can order labs under a different diagnosis then the client's primary care physician and still have the insurance company pay for them. We want our clients to get lab work completed but would like for their insurance to pay for the lab rather than the client out-of-pocket due to insurance restrictions. We are even exploring having a lab service come to the building once a week to draw lab work on our clients. This is part of our current proposed PIP and we will be working toward achieving the best way to get lab work completed and timely for our clients.

We will also examine if we can add a field to Anasazi and make it a mandatory one for the physician to complete re: asking about a drug and allergy history, etc., every time the client sees the physician. It is hoped this will improve through these efforts.

Goals for FY 15/16:

- Complete a work-around re: ordering of lab work until Cerner "turns on" the lab portion of the EHR.
- Continue to work with Kingsview to create a mechanism for recording if an allergy and drug history was asked every 90 days.
- Continue working with Genesight to administer genetic testing on clients who are not responding to their prescribed medications in an effort to determine the medication that can be best absorbed by their bodies.
- Examine our consent for treatment forms to determine if they meet the state requirements. Have those forms re-WYSIWYG'd into Anasazi.

Continuity and Coordination of Care with Physical Health Providers

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
Coordination of physical health care services with primary care physicians (see PIP)	1. Obtain a physical examination on 100% of clients who are prescribed psychotropic medications by our physicians 2. Obtain a medication reconciliation list from primary care and/or pharmacy for on 100% of clients who are prescribed psychotropic medications by our physicians.	1. Send to PCP's list of medications client is receiving 2. Ask for PCP to return list of physical health medications and chronic health conditions 3. Arrange consultation between the psychiatrist and primary care physician regarding clients who need close monitoring of medical conditions and medications. 4. Work with Anthem Blue Cross and Health Net for physical health information regarding clients	PIP Committee	Data collected for PIP	Ongoing Activity	1. Physical Health Examinations • Did not have way to capture data as of Feb 2014—0% data • 38% had physical health exams and labs listed in chart as of November 2014 2. As of 2/14, out of 172 medication only clients in the system; • 8% had shared medication lists As of 11/14, out of 176 medication only clients, 44.3% had shared medication lists
Monitor the effectiveness of physical health care	Meet quarterly	Meetings with both Anthem Blue Cross and Health Net (CalVIVA	Division Manager (Debbie	Meeting minutes	Ongoing Activity	Met quarterly

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
plans		Health) quarterly to go over issues regarding contract	DiNoto) or designee			

Analysis: MCBHS, Camarena Health, Family Health Services and Health Plans, have begun to exchange client data for the purpose of coordination of care and improved health status. In addition, as needed consultation between primary care was started. Will continue to try and engage the health plans to track service delivery and update MOUs.

Continue to meet with the health plans. We revised the MOU to meet current State requirements.

Goals for FY 15/16:

- Continue to meet quarterly with the managed care plans to work out any issues re: our MOU's
- Continue with PIP for coordination with primary care
- Will implement Physical Health Survey on all MCBHS clients receiving on-going services

Meaningful Clinical Issues/Other System Issues

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
1. Make Intake Packet fully electronic in the EHR 2. Create a way to track data to meet state and federal requirements: • Time from first client contact to Intake Assessment • Time from first contact to first therapy session • Time from first contact to first psychiatric appointment (when indicated)	Have all forms WYSIWYG'd onto the computer system. Create a way to track mandated timeliness requirements	1. Scanning documents into the electronic health record	1. Lead Clerical staff/Division Manager over Medical Records	1. List of new clients and review that all documents are electronic records or are scanned into the document	Completion: FY 14-15 Completed: **6/15**	Continue to not be able to obtain timeliness data/ information from our computer system. The Intake Packet was WYSIWYG'd into Anasazi in June 2015.
Peer Staff trained in Mental Health First Aid and CASRA for the provision of services to clients in the community	1. Have all peer staff trained in CASRA curriculum	1. Peer staff will take the MHFA and CASRA course provided through CIMH and Madera Community College 2. Peer staff will pass the MHFA and CASRA course.	1. Division Manager over the Peer Staff 2. Division Manager working with CIMH and Madera Community	1. Classroom records/school records that staff have passed the course	Completion FY 14-15 Completed: **7/15**	5 - Peer Staff Trained in Mental Health First Aid 5 – Peer Staff Completed CASRA Rehabilitation Courses for the three cohorts that have enrolled for the three school

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
			College			years which was offered and funded by MHSA.
Increase Mental Health Awareness in the community	1. Continue to provide Mental Health First Aid courses, ASIST and SafeTALK courses and parenting courses. Continue to attend farmer's markets, health fairs, etc.	1. Continue to train staff and the community/agencies in ASIST, SafeTALK, and Mental Health First Aid, provide community presentations, etc. 2. Work with the Suicide Prevention efforts through the Know the Signs campaign and through the Kingsview Suicide Prevention Hotline.	1. Supervisor over PEI services, Division Manager over PEI, Health Educator	1. Number of presentations, number of people attending presentations, trainings, etc. 2. Meeting minutes, agendas, etc. 3. County resolutions, attendance at suicide prevention community activities, etc. 4. Reduction of the number of suicides in the county 5. Increase in the number of people calling suicide prevention lines through advertisement of the telephone number at trainings, health fairs, etc.	Ongoing Activity: Completed: **9/14/15**	For FY 14-15; ASIST trainings • 5 classes • 65 people trained in ASIST Health Education • 4 classes offered • 7 individual sessions offered • 178 people received health education services Mental Health Education classes • 17 classes • 3 individual sessions • 21 outreach efforts • 1171 individuals total attendance Mental Health First Aid (Adult) • 72 classes

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						• 378 individuals trained Mental Health First Aid (Youth) • 7 classes • 117 individuals trained Parenting Classes • 18 classes • 92 people trained Promatores De Salud • 1 class • 8 individuals trained SafeTALK • 46 classes • 252 people trained Total 2790 people served • 14 Suicides (Madera County)– FY 14-15 which was down from FY 13-14 (22 suicides) and FY 12-13 (27)

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						• 215 people called the local suicide hotline between 1/1/14-12/31/14: 21% of the calls had suicidal content • The highest call volume by time was between 6pm and 10pm • The highest volume of calls are on Sunday, Wednesday and Saturday (in that order)
Reduce steps for Medi-Cal clients to get into system for outpatient services	1. Clients will be able to be seen for an initial assessment for services within 14 calendar days.	1. Re-examine how Medi-Cal clients get into the system and make modifications as necessary	1. Clinical Supervisor over crisis services 2. Division Manager over Crisis services	1. Review of records to determine if more Medi-Cal clients are getting into the system. 2. Satisfaction survey regarding client's experience obtaining services	Due: 6/30/15 Completed: **7/14/2015**	• Time frame for getting in for an assessment is between one day and two weeks.

Analysis: FY 14/15
BHS established paperless charts for all new (first time admissions)

MCBHS continues to work on creating a way of tracking required service access times from first client contact with BHS to accessing the following services: assessment, therapy, and medication. BHS has implemented a medication practice where not all potential clients are referred to medication services automatically. When indicated some clients receive talk therapy first, to see if this level of intervention can help clients manage their symptoms, without medication.

For FY 14-15 the time for Medi-Cal clients to enter the system was reduced from a month to same day/week at our main clinic in the city of Madera. This was done through a series of paper tracking logs and comparing them to information in our EHR Anasazi/Cerner, and meetings with key staff.

DSS has requested an appointment be given in a two week time frame in order for their social worker to make transportation arrangements to get the child to the assessment. We were able to give same week appointments but it was not enough time for the parent/foster parent/social worker to bring the child in for the appointment. We are now scheduling these appointments within a two week time period. This has reduced the no-show rate for Katie A assessments.

Currently at our Madera, Chowchilla and Oakhurst clinics, assessments can take place within a two week period of time and often on the same day. The goal is to find a way to formally track this information, using our EHR. Outcomes were distributed to all BHS staff, Presented at the last QMC meeting and presented at the BHS Behavioral Health Board in July 2015.

We continue to provide Mental Health First Aid, SafeTALK, ASIST and parenting training courses in the community. Reviews of these programs shows a positive response and a continued increase in demand. Staff is to be commended for the outreach in the community that was provided this year. This is done in addition to their other duties. The majority of individuals attending these classes/events are of Latino descent. It is an excellent way to provide outreach. This will continue next FY in our QI plan.

The CASRA training course at the community college did not receive MHSA dollars to continue for this school year. However, the college was so pleased with the course, it has been incorporated into its on-going curriculum. Course is full for the fall 2015 semester.

Goals for FY 15/16:

- Continue with community outreach through providing Mental Health First Aid, ASIST, SafeTALK and parenting training courses
- Have our peer staff take the on-line Promotores de Salud course and provide services in the community (Promotores services and Mental Health First Aid trainings).

Performance Improvement Projects (work in progress and may change)

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
Increase the number of clients who receive physicals from their PCP	70% of Medi-Cal Meds Only clients will get a physical by their PCP annually. 30% of those Meds Only clients receiving health education/monitoring with a BMI over 30 and/or high blood pressure will show a reduction in weight and/or blood pressure.		PIP Committee	Data tool developed by CIMH	Due: 6/30/15 Completed: **Not Completed**	During FY BHS's EHR Cerner, did not have the capacity to generate this type of data. We are WYSIWYG'ing it into the computer and hope to have this data for FY 15-16. Currently we are counting this data by hand. Physical Health Examinations • Did not have way to capture data as of Feb 2014—0% data • 38% had physical health exams and labs listed in chart as of November 2014 BMI/Blood Pressure information—have been un able to obtain. BMI/Blood Pressure information—have been un able to obtain due to lack of canned reports and IT staff.

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
Increase the amount of physical health information received by MCBHS from PCPs	We will obtain the results of 80% of the annual physical exams performed by the PCP		PIP Committee	Data tool developed by CIMH, Anasazi reports	Due: 6/30/15 Completed: **7/24/15**	We are currently keeping this data by hand since Anasazi cannot collect the data. We have established protocols between Camarena Health who automatically sends us the lab work and physical health information when they make a referral. Family Health Services clinic sends us the information when we send them the list of clients who they provide primary care services. For FY 14-15, we received 90 referrals from primary care. 30 were assessed for services. 35 refused services. 25Kris had no disposition. Some were already receiving services. Since January 2014—March 2015, MCBHS has; • 176 requests for lab information

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						from primary care • 85 (48%) have responded with information • 12 pharmacy requests for medication reconciliation • 7 pharmacies have responded with information
Improve health status by increasing knowledge and providing intervention strategies, e.g., diet information, exercise information/classes, for those clients who have high blood pressure and/or a BMI over 30. Conditions to be measured by pre/post test	1. 50% of clients with a BMI over 30 and/or high blood pressure, after being referred to the health educator for health education, will have an increase in knowledge of their health issues (measured through a questionnaire). 2. 30% of clients receiving health education/monitoring with a BMI over 30 and/or high blood pressure will show a reduction in weight and/or blood pressure.	1.	PIP Committee	Data tool developed by CIMH, Health Educator's statistics	1—2. Due: 6/30/15 Completed: **6/30/15**	For FY 2014-15 Mental Health – Health Education Coordinator provided 25 general health education services to 165 individuals.

Analysis: We continue to have difficulty obtaining data from the EHR and have to count the data by hand each month as we get a caseload count. In the past year, when the local FQHC makes a referral to MCBHS for services, they include a copy of the physical, any lab work, medication reconciliation and any other pertinent data. We are also able to obtain the same information from the local rural

health clinic. This is a major accomplishment in obtaining physical health records including labs. We continue to outreach to clients/primary care patients who have been referred by primary care. We are calling them to come in for an assessment (something in the past we would not do). We also continue to work with primary care re: appropriate referrals. Some of the physicians are referring their patients to us for methadone maintenance. We then in turn have to refer them elsewhere. We developed a brochure for primary care to give to their patients when they make a referral as well as developing a guide for physicians as to the types of clients we see. CalVIVA Health has these documents that they are looking at utilizing for their primary care physicians.

Goals for FY 15/16:

- **Continue with strengthening the linkage between primary care and behavioral health through;**
  - **Exchange of records including lab work**
  - **MCBHS will be administering the physical health questionnaire on every client within the first 60 days of treatment and again annually**
  - **MCBHS will be mandating a physical health examination on every client annually.**
  - **See PIP Roadmap 2015-2018 for additional goals/information**

Accessibility of Services

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
Test responsiveness of the 24/7 access to services telephone line (toll free and local lines)	100% of monthly test calls will pass MCBHS and state criteria	Test 800 and local number after hours for 247 responsiveness in English and in Spanish	QI Coordinator or designee	Test call form and overnight log of calls from contractor	Due: 6/30/15 Completed: **7/24/15**	There were five test calls that were made for 2014--15. The response time ranged from 1 – 2 rings. Four of the five calls were logged. The call times ranged from 3 min. – 5 min. Four of the five callers were briefly put on hold, one of which was Spanish speaking. This was addressed with the contractor and resolved.
Monitor length of time from initial contact to first appointment. Have this information available on Anasazi	14 days	Review logs to determine average length of time from first request for service to first clinical assessment.	QI Coordinator or designee	Form requesting initial medication services, Anasazi data	Due: 6/30/15 Completed: **7/24/15**	This data was unavailable for FY 2014-15 due to BHS' EHR not being set up to produce this type of information. The means for gathering this information from the EHR will be established in FY 15-16, so should be available at the end of that fiscal year.
Monitor length of time from initial contact to first psychiatry appointment. Have this information available on Anasazi.	14 days for new patients. 1 day for clients in crisis.	Average length of time from first request for psychiatric appointment/assessment	QI Coordinator or designee	Anasazi data	Due: 6/30/15 Completed: **7/24/15**	This data was unavailable for FY 2014-15 due to BHS' EHR not being set up to produce this type of information. The

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						means for gathering this information from the EHR was established in FY 15-16, so should be available at the end of that fiscal year.
Track and trend access data for timely appointments for urgent conditions. Have this information available on Anasazi.	24 hours	Average length of time for response to an urgent condition –24 hours	QI Coordinator or designee	Anasazi data	Due: 6/30/15 Completed: **Not completed**	The MCBHS definition of urgent conditions is someone that needs to be seen quickly on an unscheduled basis but who is not in a psychiatric crisis that warrants a 5150 evaluation. BHS does not have the capacity to track this type of data at this time. It should be noted that the State does not have a definition of an urgent condition and is working to develop one.
Track and trend access data to assure timely access to follow-up services after hospitalization for those clients who are residents of Madera County with Medi-Cal and are not placed in an out of county facility. Have this	10 working days	Average length of time for a follow-up contact after hospital discharge	QI Coordinator or designee	Anasazi data SAMHSA PIP Log	Due: 6/30/15 Completed: **7/24/15**	Able to confirm 8 people were contacted within 7 days of discharge from a hospital and 6 people were not followed up within this timeframe from July 2014. The nurse that was tracking this

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
information available on Anasazi						went on leave after this and the information was not entered into the log that was tracking this. We will be working with staff and the contractor to make sure these forms are completed in a timely manner.
Track and trend data regarding hospitalizations. Have this information available on Anasazi	Standard to be determined	Interventions to be determined…	QI Coordinator or designee, Hospital Coordination Team	SAMHSA Log, Anasazi data	Due: 6/30/15 Completed: **7/14/15**	**FY 14-15 Psych Hospitalization Episodes = 273** (only includes clients that we are responsible for) 208 (out of 273) Unique Clients Hospitalized (76%) 3 Episodes deferred and pending. Not added to count. 29 (out of 273) Hospitalization Episodes More Than 14 day (11%) 27 Unique Clients The months with the highest rates of over 14 day stays were July (7) and November (7)

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						20 (out of 273) Clients had more than 1 admission episode in 30 day (7%) 26 Total Episodes 9 (out of 273) Clients had 3 or more admissions in 6 months (3%) 17 (out of 273) Clients had 1 day stays (6%)
Track and trend data regarding no shows/cancellations. Have this information available on Anasazi	All staff will utilize scheduler in Anasazi by the end of FY 14/15.	Percentage of appointments that met standards to be explored during FY 15/16 The main challenge with tracking "No Shows" is that not all staff used the Scheduler function in Anasazi to code the type of appointment. Therefore, all we can get is a sample.	QI Coordinator or designee	Anasazi data	Due: 6/30/15 Completed: **Not completed**	There was no method to consistently track "No Shows" because this had not been set up in the Cerner EHR that BHS uses. However, during FY 14-15, MCBHS made it mandatory for all staff to utilize scheduler. We anticipate being able to obtain this information in the future.
Respond to crisis calls within one hour. Have this information available on Anasazi	100% of crisis calls will be responded to within one hour	Percentage of crisis calls that met standards	QI Coordinator or designee	Data submitted by crisis staff	Due: 6/30/15 Completed: **7/24/15**	The number of calls in FY 14-15 that were responded to within 1 hour were 2830, which is 86% of 3202 total calls received by

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						the crisis line. Out of 3202 calls, there were 6 calls that did not have a response time noted in the crisis log.
Respond to crisis calls from the jail within 8 hours. Have this information available on Anasazi.	100% of crisis calls from the jail will be responded to within 8 hours.	Percentage of crisis calls that met standards	QI Coordinator (Larry Penner) or designee	Data submitted by crisis staff	Due: 6/30/15 Completed: **7/24/15**	There was only 1 out of 161 calls that took more than 8 hours to respond to at the jail or juvenile hall. The average response time was 1 hour and 7 minutes.

Analysis: During the fiscal year, through our test calls, we discovered a problem with the contractor for the after-hours line. They were not able to get an interpreter quickly. We worked with the contractor to resolve this problem and on subsequent calls this has not been an issue. We also discovered that staff were not entering data on the crisis log re: time in and time out. Again, we are working with staff and the contractor to resolve the issue.

There continues to be issues regarding not obtaining data and reports from Anasazi and Kingsview. This will again be addressed in FY 15-16. We are also looking at other Anasazi counties to determine how they obtain this data and will see if we can utilize their reporting format to obtain the data requested.

Goals: Continue to work with Anasazi and Kingsview to develop reports to obtain requested data.

Compliance with Requirement for Cultural Competence and Linguistic Competence

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
Improve penetration rates to Latino, Native American and the LGBTQIA populations	To be determined after consultation with consultants and training	1. Implement suggestions/ recommendations of prior consultants	1. Cultural Competency Committee	1. Anasazi Reports 2. EQRO reports on penetration rates	FY 14/15 Completed: **7/24/15**	The consultants did not have any suggestions for us. They stated we were doing things in the community to attract the Latino population and that our outreach services, etc., were very good. They also complimented us on the staff awareness and on how the buildings looked re: cultural competency. There were three cultural competency trainings during FY14-15 offered through MCBHS. Staff attended cultural competency training sponsored through various organizations. The first training titled Ethnic and Organizational Culture Conflict: This training used a polarity model to show how different elements of ethnic culture vary depending on national cultures. In addition, it introduced the idea of organizational culture and the fact that behavioral health services are founded on the culture of the USA and contrasted the culture of the USA with Mexico's culture. The training ended with running through an activity that allowed people to

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due/ Completion Date	Outcome
						understand how cultural conflict happens when people are behaving differently because they are acting on different unspoken cultural assumptions. Administrative support staff was sent to training on how to work with an interpreter. From this training, a training program was developed for staff on how to work with an interpreter, how to answer the phones in a culturally appropriate manner and key phrases in Spanish as well as how to provide good customer service. The trainings were very well received.
Client/Family Member Sensitivity Training	Client/family member sensitivity training will be conducted yearly.	Provide annual training for staff regarding client/family member culture	Coordinator Cultural Competency Coordinator	Training sign-in sheets, flyer	Due: 6/30/15 Completed: **7/24/15**	The client/family member training had to do with transitioning out of the culture of dependency of public mental health services, how people resists this transition, and how to help people work through the transition challenges and move beyond public mental health services.

Analysis: Goal Setting Rationale

Guided by the national culturally and Linguistically Appropriate Services (CLAS) standards, MCBHS will follow standards one, eleven and twelve.

- Standard 1 - Service organizations will be responsive to diverse cultural health beliefs and practices

- Standard 11 - Behavioral health organizations will collect and maintain accurate and reliable data to evaluate how responsive they are to meeting diverse cultural needs of their target populations.
- Standard 12 - Behavioral health organizations will leverage community assets to better engage and serve culturally diverse populations.

The culture that county behavioral health systems in California are based on is the culture of the USA. The culture of the USA assumes that people that need help will:

- Know what they need
- Seek help from strangers
- Discuss very personal issue strangers
- Access services by themselves and
- Make the decision to initiate services without consulting family

Other cultures would be more comfortable:

- Being educated about problems
- Use a trusted friend or community leader to broker access to services
- Get to know service providers on a more informal level before starting services
- Access services accomplice by family and close confidants
- Consulting with their kin network to decide to access services

It is difficult to meet the needs of cultures that have not acclimated to USA culture. However, MCBHS will use its prevention services to bridge to cultural gaps through educated people regarding mental illness and addictive disorders. Initial data shows the preventions services have a higher rate of serving Latinos than traditional outpatient services. In addition, they more flexible and able to be a cultural bridge between traditional clinical services and community members.

The first step will be to further refine the race/ethnicity and access data and evaluate how the prevention services can be leveraged as a conduit into treatment services when treatment is indicated. In addition, further develop the satisfaction serves the prevention service do during their training and outreach to improve the quality of services. Part of the data tracking that has not been developed well is referral to treatment when the prevention staff strongly suspects a person needs treatment services.

Goals for FY 15/16:

- CLAS Standard #11
    - Develop and train staff on a standardized method for classifying race/ethnicity of clients and community contacts.
- CLAS Standard #9
    - Restructure the QMC planning process to better integrate cultural competence planning throughout the system of care.
      * See Attachment 1 for rationale for goal setting.
- Provide at least 4 cultural competence trainings requiring mandated attendance of relevant workforce members.
- Utilize peer staff who have been trained in Promotores de Salud, parenting classes, Whole Health workshop, CASRA curriculum, Mental Health First Aid, etc., to provide outreach and education to members of the community.

Abbreviation Key

BHS	Behavioral Health Services	PDSA	Plan – Do – Study – Act
CIMH	California Institute of Mental Health	PIP	Performance Improvement Project
CCC	Cultural Competency Committee	POQI	Performance Outcome Quality Improvement
CRC	Chowchilla Recovery Center	PS	Public Share
CSL	Community Service Liaison		
DMH	Department of Mental Health	QCM	Quality Control Management
FSP	Full Service Partner	QI	Quality Improvement
FTC	Family Treatment Center	QIC-CR	Quality Improvement Committee Chart Review
IQIC	Interagency Quality Improvement Committee	QM	Quality Management
IT	Information Technology	QMC	Quality Management Committee
LSC	Lake Street Center	S&D	Screening and Disposition
MCC	Madera Counseling Center	SED	Severely and Emotionally Disturbed
Med Rec	Medical Records	SCERP	Small County Emergency Relief Plan
MHFA	Mental Health First Aid	SMI	Severely and Mentally Ill
MHP	Mental Health Plan	SURF	Supervisors' Utilization Review Form
MMC	Medication Monitoring Committee	WET	Workforce Education and Training
OCC	Oakhurst Counseling Center		