

Madera County
Behavioral Health Services
Quality Improvement
Work Plan

July 1, 2015 - June 30, 2016

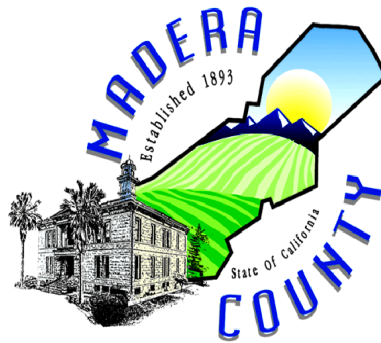


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MADERA COUNTY BEHAVIORAL HEALTH SERVICES

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 projects 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 prioritized 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 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, and 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 and substance use disorder services to residents of Chowchilla and surrounding communities including Fairmead. The FSP services offers supported independent living in Chowchilla.

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.

Pine Recovery Center (PRC)

Pine Recovery opened in September 2015. It houses the Full Service Partnership (FSP) services for Adult/Older Adult, Youth/TAY services along with the FSP services offered through a contract with SERI for individuals coming

from the Madera County Department of Corrections through the Mentally Ill Offender (MIOCR) grant. Supported Independent Living services are also offered through this Center in Madera.

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.
- **Supported Independent Living** services are also offered with housing units available in Chowchilla, Madera and in partnership with Turning Point, in Oakhurst.

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.
- **Peer services** are offered in Madera through Turning Point. **Hope House** is located next to the Pine Recovery Center. **The Mountain Wellness Center** is located in Oakhurst, next to the Oakhurst Counseling Center.

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 organization 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 Powroznic	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, LCSW	Supervising Mental Health Clinician
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
Felicia and Kristina	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.

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 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 15/16, 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 15—16**

Service Delivery Capacity

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/ Completion Date:	Outcome																																																																																																																																																
<p>Obtain on a semi-annual basis reports from Anasazi regarding the following;</p> <p>1. Location of clients receiving services by zip code/residential area</p> <p>2. Demographics of clients receiving services</p> <p>3. Types of services clients are receiving broken down by zip code/residential area and demographics</p> <p>4. Trending of data on a semi-annual basis</p>	<p>1. Information will be analyzed and reported to staff on a semi-annual basis</p>	<p>Request reports be developed by Kingsview on Anasazi and be presented to MCBHS on a semi-annual basis</p>	<p>Division Manager or designee</p>	<p>Report developed by Kings View utilizing data on Anasazi</p>	<p>Due: 8/15/16</p> <p>Completion:</p>	<table border="1"> <tr> <th rowspan="2">Demographics FY 15-16</th> <th colspan="4">Mental Health Clients Served</th> </tr> <tr> <th colspan="2">Medi-Cal</th> <th colspan="2">Non Medi-Cal</th> </tr> <tr> <td></td> <th>#</th> <th>%</th> <th>#</th> <th>%</th> </tr> <tr> <td>Total Clients Served</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="5">Gender:</td> </tr> <tr> <td>Female</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Male</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Unknown</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="5">Age:</td> </tr> <tr> <td>0-15</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>16-24</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>25-59</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>60+</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="5">Race/Ethnicity:</td> </tr> <tr> <td>Caucasian</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Latino</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>African American</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Asian/Pacific Islander</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Native American</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Multi/Other</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Unknown</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="5">Language:</td> </tr> <tr> <td>English</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Spanish</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Other</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="5">Residence:</td> </tr> <tr> <td>Madera</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Chowchilla</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Oakhurst</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Demographics FY 15-16	Mental Health Clients Served				Medi-Cal		Non Medi-Cal			#	%	#	%	Total Clients Served					Gender:					Female					Male					Unknown					Age:					0-15					16-24					25-59					60+					Race/Ethnicity:					Caucasian					Latino					African American					Asian/Pacific Islander					Native American					Multi/Other					Unknown					Language:					English					Spanish					Other					Residence:					Madera					Chowchilla					Oakhurst				
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Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/ Completion Date:	Outcome				
						Ahwahnee				
						Bass Lake				
						Coarsegold				
						North Fork				
						O'Neals				
						Raymond				
						Wishon				
						Client Services Report FY 2015-16				
						Service	Client Hours	Units	Con-tacts	Server Hours
						Assess-ment				
						Crisis Intervention				
						Collateral				
						Individu-al Thera-py				
						Group Therapy				
						Rehab Individu-al				
						Rehab Group				
						Plan Devel-opment				
						Case Manage Broke-				

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/ Completion Date:	Outcome					
						rage					
						Intensive Care Co-ordination					
						Med Eval Initial					
						Med Eval On-going					
						Med Admin					
						Med Management					
						Total					

Analysis—

Goal for FY 16-17:

Beneficiary/Family Satisfaction

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/Completion Date	Outcome
<p>Maximize client response to mandated POQI for quality improvement purposes</p>	<p>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. 75% of responders will state they are better able to handle their dai-</p>	<p>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.</p>	<p>QI Coordinator or designee</p>	<p>1—2. POQI key results 3. Meeting minutes, postings, etc.</p>	<p>1—3. Due: 6/30/16 Completed:</p>	<p>Oct POQI 2015 Survey results</p> <ul style="list-style-type: none"> • N = • % English Speaking • % Spanish Speaking • % Staff Considerate to Cultural Background • Race/Ethnicity <ul style="list-style-type: none"> ○ % Mexican/Hispanic/Latino ○ % Native American ○ % Asian ○ % Black African American ○ % Nat Haw/ Other Pac ○ % White/Caucasian ○ % Other ○ % Unknown • % Adults Encouraged to Use Peer Support • % Were Not Arrested Since Starting Services • % Liked/Satisfied with Services • % Adults Initiated Service Willingly on Their Own • % Said they Got the Help They Needed • % - Said They Were Better Able to Handle Daily Life • % of Respondents were Women • % Male • % of the narrative responses made positive comments about BHS service and staff

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/Completion Date	Outcome
	ly life					<p>May POQI 2016 Survey results</p> <ul style="list-style-type: none"> • N = • % English Speaking • % Spanish Speaking • % Staff Considerate to Cultural Background • Race/Ethnicity <ul style="list-style-type: none"> ○ % Mexican/Hispanic/Latino ○ % Native American ○ % Asian ○ % Black African American ○ % Nat Haw/ Other Pac ○ % White/Caucasian ○ % Other ○ % Unknown • % Adults Encouraged to Use Peer Support • % Were Not Arrested Since Starting Services • % Liked/Satisfied with Services • % Adults Initiated Service Willingly on Their Own • % Said they Got the Help They Needed • % - Said They Were Better Able to Handle Daily Life • % of Respondents were Women • % Male • % of the narrative responses made positive comments about BHS service and staff
	Network Providers being	1. Have network providers complete the provider satis-	QI Coordinator or designee	Network Provider satisfaction sur-	Due: As Needed—	

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/ Completion Date	Outcome
	utilized by MCBHS will complete the provider satisfaction surveys annually	faction surveys annually and compile and share results		vey forms		
Monitor and communicate results of Inpatient Surveys and POQI.	Communicate to the Behavioral Health Board the POQI results 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: 6/30/16 Completed:	
Review and monitor client grievances, appeals and fair hearings and change of provider requests	Review and monitor grievances,	1. Identify trends and take necessary actions in response for both MHP and network providers	QI Coordinator or designee	Grievance forms, appeal forms, change of provider re-	1—2. Due: 10/1/16 to state	

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/ Completion Date	Outcome
for trends	appeals and fair hearings quarterly at the QMC meeting.	2. Review quarterly/annual report with QI Committee		quests/ reports with trends,	Completed:	
Train supervisors and Patient Right's Advocate on the difference between a grievance and a change of provider request	Training will be conducted annually	1. Managed Care staff will train supervisors and the Patient Right's Advocate on the differences between grievances and a change of provider request.	Managed Care Supervisor	Review of current Change of Provider requests and Grievance Forms to determine if more training is necessary	6/30/16 Completed:	

Analysis—

Goals for FY 16—17:

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 Date/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 a 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: 6/30/16 Completed: 4. Due: 6/30/16 (on-going) Completed:	Indicator and Percentage that Met Requirements	%
						Signed Internal Authorization to Exchange Information in chart	%
						Client asked whether he/she had an Advance Directive and information was provided	%
						Diagnosis is consistent with presenting problems, history, MSE, and other assessment data, including AOD	%
						Objectives specific, observable, measurable and are consistent with the diagnosis	%
						Treatment Plan and proposed interventions are consistent with diagnosis and treatment goals, including AOD	%
						BIOP notes appropriately completed	%
						Medical necessity demonstrated by continued symptoms and impairments which impact daily social and community functioning	%
						Interventions and relevant clinical decisions aimed at reducing the symptoms and impairments identified on Treatment Plan	%
						Progress or lack of progress toward treatment goals, in-	%

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/Completion Date	Outcome
						cluding SUD Correspondence with PCP in effort to collaborate and coordinate treatment
On-going/Annual Clinical Documentation training for all MHP provider staff and specifically in the following areas: <ul style="list-style-type: none"> • Writing treatment plan objectives that are specific, observable, measurable and consistent with the diagnosis • Reflecting the progress or lack of progress towards treatment goals including SUD services. • Document collaboration with physical health care including client obtaining a physical yearly. 	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: 6/30/16 (on-going) Completed:	
Hospital charts of BHS clients will be	Review charts that	1. BHS client's charts will be	QI Coordinator or designee	TARS, Excel spread-	1.—2. Due: quarterly	FY 15/16 • Clients <i>Hospitalized More than 14</i>

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/Completion Date	Outcome
reviewed retrospectively to determine appropriateness of admission, length of stay and recommendations for preventing further hospitalizations	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	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, management and QMC		sheet, etc. IQIC, QMC, minutes	Completed:	<p><u>Days</u></p> <ul style="list-style-type: none"> • Clients Had <u>More Than One Admission Episode in 30 Days</u> (Total Number of Episodes =) • - Clients Had <u>3 or More Admissions in 6 Months</u> • Clients had <u>1 Day Stay</u>
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	<ol style="list-style-type: none"> 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: 6/30/16 Completed:	

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: 6/30/16 Completed:	
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Analysis—

- **Goals for FY 16-17:**

Monitor Safety and Effectiveness of Medication Practices (these may change over time)

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/Completion Date	Outcome
<p>1. Promote safe medication prescribing practices</p> <p>2. Evaluate effectiveness of prescribing practices</p>	<p>1. Consent for the psychotropic medication prescribed & present inpatient record per BHS procedure. 100%</p> <p>2. Drug & allergy history (updated at least every 90 days) obtained from patient & present in record. 100%</p> <p>3. Med(s) prescribed in compliance with general screening criteria. 100%</p> <p>4. Current lab work ordered at least annually or as appropriate for therapy prescribed. 100%</p> <p>5. Current weight/vitals</p>	<p>1. Monthly Medication monitoring at Medication Monitoring Committee by a random review of charts of clients receiving medication services by the contracted pharmacist.</p> <p>2. Review prescribing practices and provide feedback to staff psychiatrists.</p> <p>3. Use of practice guidelines approved by the Medication Monitoring Committee will be found in 95% of charts reviewed by the contracted pharmacist.</p> <p>4. Random charts and charts requested for review monthly. Not less than 5 charts will be reviewed monthly.</p> <p>5. Results will be discussed at the quarterly QMC meeting.</p>	<p>Director or designee</p> <p>Contracted pharmacist</p>	<p>1—2. Quarterly report to QMC committee</p> <p>Pharmacist will evaluate MD prescription practices according to guidelines approved by the Medication Monitoring Committee and according to established practices.</p> <p>3. Practice guidelines</p> <p>4. Notes from contracted pharmacist</p> <p>5. QMC minutes</p>	<p>Ongoing activity</p>	

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/Completion Date	Outcome
	<p>obtained at least quarterly. 90%</p> <p>6. Medications prescribed by Psychiatrist appropriate for indication/diagnosis. 100%</p> <p>7. Medication Evaluation/Progress Note by physician includes presence or absence of side effects. 100%</p> <p>8. Medication Evaluation/Progress Note by physician includes patient compliance. 100%</p> <p>9. Patient evaluated at least every 90 days when prescribed medications by a Psychiatrist.</p>					

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/Completion Date	Outcome
	90%					
Complete a work-around re: ordering of lab work until Cerner “turns on” the lab portion of the EHR	MD’s will be able to order lab work on line for clients	<ol style="list-style-type: none"> 1. Ken/Valerie will meet with Quest or other lab company to determine what can be used electronically to order lab work 2. Best system for ordering lab work on-line and recorded in the EHR will implemented 	IT staff and Supervising Nurse	Number of labs ordered through electronic means and documented in the EHR	6/30/16 Completed:	

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/Completion Date	Outcome
Continue to work with Kingsview to create a mechanism for recording if an allergy and drug history was asked every 90 days.	Allergies and drug histories will be documented every 90 days on 100% of charts whose clients receive medications prescribed by the Department's physicians.	Anasazi committee will work with Kingsview to develop a "tickler" section and method for counting the documentation of recording allergies and drug histories on clients receiving medications	Anasazi Committee, IT	Computerized count of number of allergy history and drug histories in each chart of clients being prescribed medications	6/30/16 Completed:	
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	Clients will state they have symptom reduction if their medications were changed due to lab results from Genesight.	<ol style="list-style-type: none"> 1. Nursing staff will administer HRQOL after changing medications due to lab results from Genesight. 2. Clients will show a better functioning score after having their medications changed. 3. Results will be documented in the EHR. 	Supervising Nurse, Medical Director	HRQOL	6/30/16 Completed:	
Examine our consent for treatment forms to determine if they meet the state requirements. Have those forms re-WYSIWYG'd into Anasazi	Unknown from the state at this time. Will have an audit by state later this FY.	<ol style="list-style-type: none"> 1. Review documentation with state when they come to audit. 2. Implement state suggestions (if any) onto existing forms. 	Supervising Nurse, IT, Medication Monitoring Committee	State requirements	6/30/16 Completed:	

Analysis—

Goals for FY 16-17:

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 Date/Completion Date	Outcome
Coordination of physical health care services with primary care physicians (see PIP)	<p>1. Obtain a physical examination on 100% of clients who are prescribed psychotropic medications by our physicians</p> <p>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.</p>	<p>1. Send to PCP's list of medications client is receiving</p> <p>2. Ask for PCP to return list of physical health medications and chronic health conditions</p> <p>3. Arrange consultation between the psychiatrist and primary care physician regarding clients who need close monitoring of medical conditions and medications.</p> <p>4. Work with Anthem Blue Cross and Health Net for physical health information regarding clients</p>	PIP Committee	Data collected for PIP	Ongoing Activity	
Monitor the effectiveness of physical health care plans	Meet quarterly	Meetings with both Anthem Blue Cross and Health Net (CalVIVA Health) quarterly to go over issues regarding contract	Division Manager or designee	Meeting minutes	Ongoing Activity	

Analysis—

Goals for FY 16—17:

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 Date/Completion Date	Outcome
<p>1. Create a way to track data to meet state and federal requirements:</p> <ul style="list-style-type: none"> • 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) 	<p>Have all forms WYSIWYG'd onto the computer system.</p> <p>Create a way to track mandated timeliness requirements</p>	<p>1. Scanning documents into the electronic health record</p>	<p>1. Lead Clerical staff/Division Manager over Medical Records</p>	<p>1. List of new clients and review that all documents are electronic records or are scanned into the document</p>	<p>Completion: FY 15-16</p> <p>Completed:</p>	
<p>Increase Mental Health Awareness in the community</p>	<p>Continue to provide Mental Health First Aid courses, ASIST and SafeTALK courses and parenting courses. Continue to attend farmer's markets, health fairs, etc.</p>	<p>1. Continue to train staff and the community/agencies in ASIST, SafeTALK, and Mental Health First Aid, provide community presentations, etc.</p> <p>2. Work with the Suicide Prevention efforts through the Know the Signs campaign and through the Kingsview Suicide Prevention Hotline.</p>	<p>1. Supervisor over PEI services, Division Manager over PEI, Health Educator</p>	<p>1. Number of presentations, number of people attending presentations, trainings, etc.</p> <p>2. Meeting minutes, agendas, etc.</p> <p>3. County resolutions, attendance at suicide prevention community activities, etc.</p> <p>4.</p>	<p>Ongoing Activity:</p> <p>Completed:</p>	

				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.		
Continue to reduce and/or monitor steps for Medi-Cal clients to get into system for outpatient services	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: 6/30/16 Completed:	
Rewrite Anasazi reports for upgraded system so supervisors can run their own reports on caseloads, clients seen, etc.	Caseload reports, etc., will be run quarterly	Kingsview/Ken will rewrite standard reports so they can be run on upgraded Anasazi system	IT, Kingsview, Anasazi Committee	Current list of reports that cannot be run on upgraded system.	6/30/16 Completed:	

Analysis— FY 15-16

Goals for FY 16-17:

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 Date/Completion Date	Outcome
Increase the number of clients who receive physicals from their PCP	50% of clients will get a physical by their PCP annually. 30% of those 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.	Coordinate care between client, clinical staff and primary care physician/CalVIVA Health/Anthem Blue Cross to obtain a physical health examination for clients annually	PIP Committee	1. Data tool developed by CIMH 2. Data collection in Anasazi	Due: 6/30/16 Completed:	
Increase the amount of physical health information received by MCBHS from PCPs	We will obtain the results of 50% of the annual physical exams performed by the PCP	Coordinate care between client, clinical staff and primary care physician/CalVIVA Health/Anthem Blue Cross to obtain a physical health examination records and lab work for clients	PIP Committee	Data tool developed by CIMH, Anasazi reports	Due: 6/30/16 Completed:	
Improve health status by increasing knowledge and providing intervention strategies, e.g., diet information, exercise information/classes, for those clients who have <ul style="list-style-type: none"> high blood pressure and/or 	1. 50% of clients <ul style="list-style-type: none"> with a BMI over 30 and/or high blood pressure, and/or diabetes, and/or who smoke after being referred to the health educator for health education, will have an in-	1. Client will have a warm hand off from case manager to Health Educator 2. Health Educator will provide classes, individual sessions with those individuals who have a BMI over 30 and/or high blood pressure and/or diabetes,	PIP Committee. Health Educators	Data tool developed by CIMH, Health Educator's statistics, HRQOL, questionnaires, etc.	1—3. Due: 6/30/16 Completed:	

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/Completion Date	Outcome
<ul style="list-style-type: none"> • a BMI over 30 and/or • diabetes and/or smoke. 	<p>crease in knowledge of their health issues (measured through a questionnaire).</p> <p>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.</p> <p>3. 30% of clients receiving health education/monitoring with diabetes and/or who smoke will show an increase in health status as measured by lab work, HRQOL, questionnaires, etc.</p>	<p>and/or who smoke.</p> <p>3. Conditions to be measured by pre/post test and physical health monitoring.</p>				
<p>Staff will utilize physical health questionnaires in Anasazi to obtain physical health information and to help coordinate care with primary care</p>	<p>Staff will complete a physical health questionnaire on each new client within the first 60 days of service and annually</p>	<ol style="list-style-type: none"> 1. Staff will be trained on how to complete Health Questionnaires, 2. Staff will complete Health Questionnaires for clients within the first 60 days of services and annually 	<p>Clinical Supervisors/PIP Committee</p>	<p>Anasazi/Clinical Record</p>	<p>Due: 6/30/16</p> <p>Completed:</p>	

Analysis—

Goals for FY 16-17:

Accessibility of Services

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/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: 6/30/16 Completed:	
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: 6/30/16 Completed:	
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: 6/30/16 Completed:	
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: 6/30/16 Completed:	
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	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: 6/30/16 Completed:	

Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/Completion Date	Outcome
county facility. Have this information available on Anasazi						

<p>Track and trend data regarding hospitalizations. Have this information available on Anasazi.</p> <p>Track and trend data re: rehospitalizations. Have this information be available on Anasazi</p>	<p>Less than 5% rehospitalizations within 30 days of initial hospitalization</p>	<p>Reduce readmissions to hospitalizations within the first 30 days of initial discharge to less than 5%.</p> <ul style="list-style-type: none"> 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 	<p>QI Coordinator or designee, Hospital Coordination Team</p>	<p>SAMHSA Log, Anasazi data</p>	<p>Due: 6/30/16</p> <p>Completed:</p>	<p>Total Psych Hospitalization Episodes = (only includes clients that we are responsible for)</p> <ul style="list-style-type: none"> Unique Clients Hospitalized – Hospitalization Episodes More Than 14 day <ul style="list-style-type: none"> Unique Clients The months with the highest rates of over 14 day stays were – Clients had more than 1 admission episode in 30 day <ul style="list-style-type: none"> Total Episodes - Clients had 3 or more admissions in 6 months – Clients had 1 day stays
<p>Track and trend data regarding no shows/cancellations. Have this information available on Anasazi</p>	<p>All staff will utilize scheduler in Anasazi by the end of FY 14-15.</p>	<p>Percentage of appointments that met standards Standards to be explored during FY 15—16</p> <p>The main challenge with tracking “No Shows” is that</p>	<p>QI Coordinator or designee</p>	<p>Anasazi data</p>	<p>Due: 6/30/16</p> <p>Completed:</p>	

		not all staff used the Scheduler function in Anasazi to code the type of appointment. Therefore, are we can get is a sample.				
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: 6/30/16 Completed:	
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 or designee	Data submitted by crisis staff	Due: 6/30/16 Completed:	

Analysis—

Goals for 16-17:

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 Date/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 Coordinator/QMC Committee	1. Anasazi Reports 2. EQRO reports on penetration rates	FY 15—16 Completed:	
Client/Family Member Sensitivity Training	Client/family member sensitivity training will be conducted yearly.	Provide annual training for staff regarding client/family member culture	Cultural Competency Coordinator/Training Coordinator	Training sign-in sheets, flyer	Due: 6/30/16 Completed:	
Client/Family Member staff will be trained in Promotores De Salud and other training as appropriate Clients/Family Members will provide outreach to members of their community	Training will be conducted annually Clients/Family members will provide outreach services on a quarterly basis	Training will be conducted annually through the online course by Dept of Health and Human Services Clients/Family members will provide outreach at local health fairs, community events, swap meets, in their neighborhoods, etc.	Training Coordinator	Print out of those completing the course through Dept of Health and Human Services Count of outreach services provided.	Due: 6/30/16	

Analysis—

Goals for FY 16-17:

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		