Madera County
Behavioral Health Services
Quality Improvement
Work Plan

July 1, 2016 - June 30, 2017

Table of Contents

QUALITY IMPROVEMENT WORK PLAN OVERVIEW JULY 2016 – JUNE 2017 3

MISSION STATEMENT 3

VISION STATEMENT 3

CORE VALUES 3

State Mandate for the QI Program 4

7th Street Center 7

- Mental Health Plan (MHP) or Managed Care 7
- Quality Management's (QM) 7

Chowchilla Recovery Center CRC) 7

Oakhurst Counseling Center (OCC) 7

Mental Health Services Act (MHSA) Services 8

Departmental Quality Committees 10

Goals and Objectives 12

Annual QI Work Plan Evaluation for All Programs and QI Activities. 16

Abbreviation Key 48

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

QUALITY IMPROVEMENT WORK PLAN OVERVIEW JULY 2016 – JUNE 2017

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, and 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 Fair mead. 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
Herbert Cruz, MD	Medical Director
Julie Morgan, LCSW	Assistant Behavioral Health Director
Debbie DiNoto, LMFT	Division Manager
Annette Presley, LCSW	Division Manager
Melissa Nelson	Compliance Officer/Medical Records Supervisor
Barney Oliver, LMFT	Mental Health Plan Clinician/QMC Coordinator
Anna “Missie” Rhinehart, LMFT	Supervising Mental Health Clinician
Mariam Agayan, LMFT	Supervising Mental Health Clinician
Larry Penner, LMFT	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
Glen Sutch, LMFT	Supervising Mental Health Clinician
Christina Lopez	Hope House Staff Representative
Dale Hudek	Client/Family Member representative
TBD	Network Provider
Eric Oxelson	Mental Health Board representative(s)
David Weikel, PsyD	Behavioral Health Program Supervisor
Felicia Ramirez Kristina Klemash	Community Service Liaisons

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 2016-17.

- 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 16/17, we are doing fewer program initiatives due to staff reductions. MCBHS lost almost 50% of its work-force 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.

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
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 where pay source coverage has been determined 3. Types of services clients are receiving broken down by zip	1. Information will be analyzed and reported to staff on a semi-annual basis	Request reports be run by Kingsview on Anasazi and be presented to MCBHS on a semi-annual basis	Division Manager or designee	Report developed by Kings View utilizing data on Anasazi	Due: 8/15/17 Completion: on-going	(see table below)

Demographics	Mental Health Clients Served					
FY 16-17	Medi-Cal		Non Medi-Cal		Total	
	#	%	#	%	#	%
Total Clients Served	3645	78.88	976	21.12	4621	100
	Gender:					
Female	2037	55.9	611	62.7	2648	57.3
Male	1606	44.1	364	37.3	1970	42.7
Unknown						
	Age:					
0-15	1195	32.5	115	12.2	1310	25.6
16-24	700	19.0	141	15.0	841	17.7
25-59	1559	42.4	480	51.0	2039	45.3
60+	226	6.1	205	21.8	431	11.4
	Race/Ethnicity:					
Asian -Other	10	0.32%	6	0.67%	16	0%
Black/African Am	180	5.68%	34	3.82%	214	5%
Chinese	1	0.03%	1	0.11%	2	0%
Eskimo/Alaskan Native	0	0.00%	2	0.22%	2	0%
Filipino	7	0.22%	1	0.11%	8	0%
Guamanian						0
Hawaiian Native	5	0.16%	1	0.11%	6	0%
Asian Indian	5	0.16%	1	0.11%	6	0%

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
code/residential area and demographics 4. Trending of data on a semi-annual basis						

Japanese	2	0.06%	1	0.11%	3	0%
Korean	1	0.03%	0	0.00%	1	0%
Laotian	1	0.03%	0	0.00%	1	0%
Native American	45	1.42%	14	1.57%	59	1%
Non-White-Other	1596	50.38%	416	46.74%	2012	50%
Other Pacific Islander	5	0.16%	1	0.11%	6	0%
Hmong	4	0.13%	1	0.11%	5	0%
Multiple	11	0.35%	6	0.67%	17	0%
Unknown	41	1.29%	12	1.35%	53	1%
Vietnamese	1	0.03%	0	0.00%	1	0%
	Residence:					
Madera	1723	71.6	1505	67.9	3228	69.2
Chowchilla	272	11.3	266.02	12.0	538	11.8
Oakhurst	100	4.2	99.64	4.5	200	4.4
Ahwahnee	13	0.5	11.28	0.5	24	0.5
Bass Lake	2	0.1	4.7	0.2	7	0.2
Coarsegold	87	3.6	78.96	3.6	166	3.6
North Fork	26	1.1	19.74	0.9	46	1.0
O'Neals	2	0.1	1.88	0.1	4	0.1
Raymond	5	0.2	6.58	0.3	12	0.3
Wishon	2	0.1	0	0.0	2	0.0
Fairmead	1	0.0	0	0.0	1	0.0
Other	172	7.2	221.84	10.0	394	9.0

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
						Client Services Report FY 2016-17 (see table below)

Client Services Report FY 2016-17

Service	Client Hours	Units	Contacts	Server Hours	Client Count (unduplicated) by Service	
Assessment	3,805.32	22,173.20	2125	3,805.32		1,921
Crisis Intervention	4,088.68	14,433.76	2746	4,088.68		1,050
Collateral	2,537.40	10,064.01	2796	2,537.40		594
Individual Therapy	17,895.75	113,181.04	15991	17,895.75		2,033
Group Therapy	1,194.50	3,841.03	726	278.74		119
Rehab Individual	2,555.32	9,493.04	1568	2,555.32		357
Rehab Group	1,983.17	7,026.54	1295	505.65		241
Plan Development	3,710.20	21,029.38	5372	3,710.20		2,202
Case Manage Broke-rage	15,049.42	68,378.34	15400	15,049.42		1,383
Intensive Care Co-ordination	575.08	1,954.45	387	575.08		31
Med Eval Initial	581.83	2,090.53	455	581.83		440

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						
						Med Eval On-going	2,792.93	9,955.43	5351	2,792.93		1,081
						Med Admin	206	796	412	206		46
						Med Management	1,650.15	6,474.60	3183	1,650.15		859
						Total	58,625.75	290,891.35	57807	56,232.47		4,060

Analysis—During FY 16-17, the Department, overall, saw more clients than the prior fiscal year. As in prior fiscal years, we saw more females than males. There were increases in the number of children 0-15 and 16-24, being served. Adults and Older Adults remained relatively the same. We tended to see an increase in youth through Katie A referrals from the Department of Social Services.

There was an increase in the number of Latino's seen in the department during the fiscal year. It appears that monolingual Spanish speakers were down this FY from the prior FY.

We also saw an increase in the number of people receiving services at the Madera clinic. The other rural clinics remained relatively the same as the prior FY. There was also an increase in the number of individuals not on Medi-Cal at the Madera clinic over the prior FY.

Services were also up for this FY in all categories other than group therapy. Medication services (initial) remained relatively the same as the prior FY, however there were more contacts and follow-up services than in FY 15-16. The medication management services also showed a marked increase over the FY. This is due to staff now billing for services, and additional nursing staff. There are several new rehabilitation groups that were started during the fiscal year. The figures show this data. We will expect to see an increase in the coming fiscal year in this category.

Goal for FY 17-18:

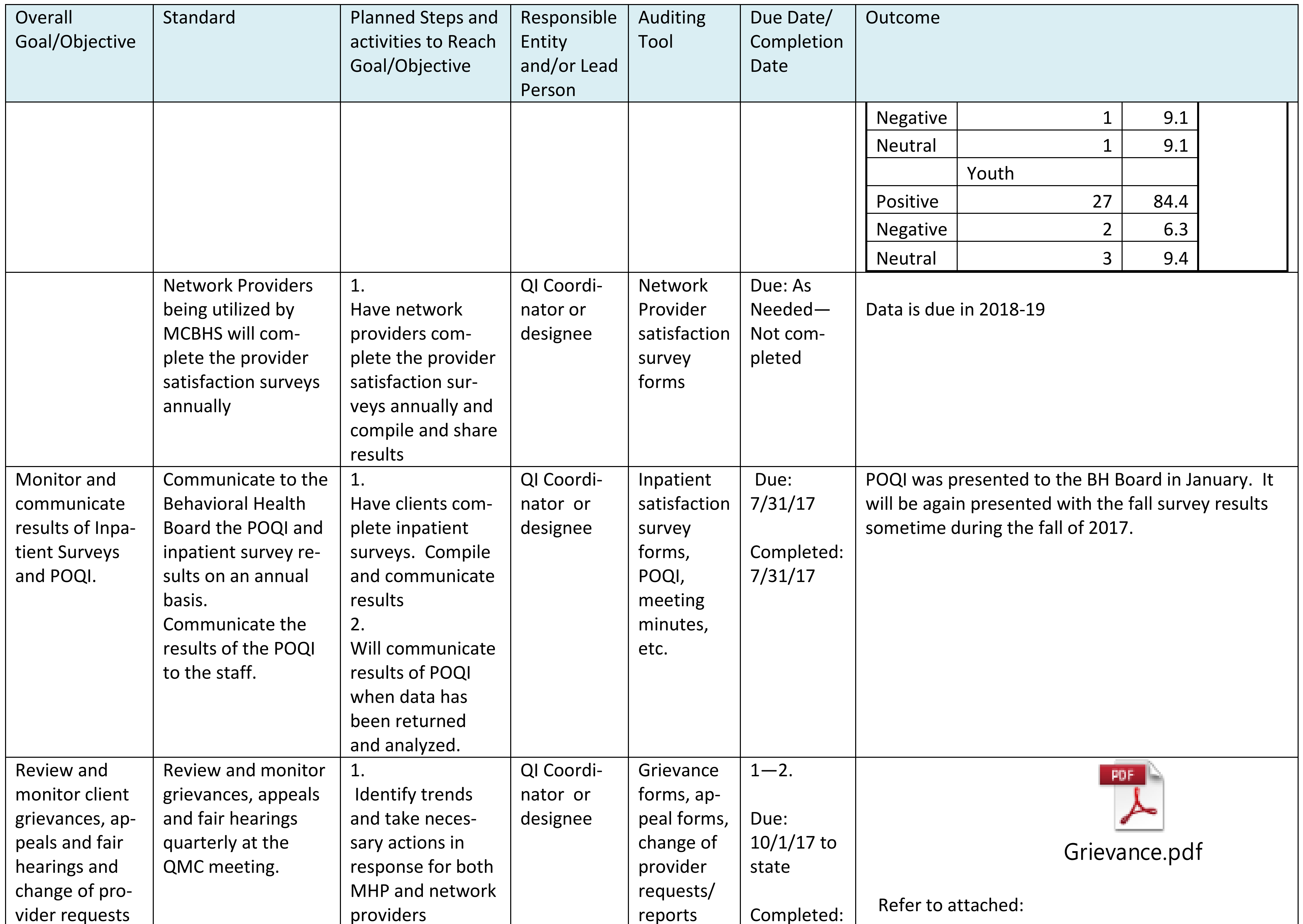
1. Continue to analyze data regarding where services are provided and the number of clients seen. Examine if additional staff is indicated.

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
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 2. 90% of responders will not have been arrested since starting services 3. 75% 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: 6/30/17 Completed: 7/31/17	

POQI 2016 Fall Responses			**Kudos**
Adult		**% Rate**	Shelly
Positive	17	70.8	Greg
Negative	5	20.8	John
Neutral	2	8.3	Maricela
	Older Adult		Dr. K
Positive	6	85.7	Judy
Negative	1	14.3	Emi
Neutral	0	0.0	
	Youth for Families		
Positive	18	72.0	
Negative	1	14.3	
Neutral	6	85.7	
	Youth		
Positive	12	54.5	
Negative	7	31.8	
Neutral	3	13.6	

POQI 2017 Spring Responses			**Kudos**
Adult		**% Rate**	Dr. K
Positive	21	75.0	Michael
Negative	4	14.3	Beth
Neutral	3	10.7	Valerie
	Older Adult		Shelly
Positive	1	100	Maria
Negative			
Neutral			
	Youth for Families		
Positive	9	81.8	



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
						Negative 1 9.1 Neutral 1 9.1 Youth Positive 27 84.4 Negative 2 6.3 Neutral 3 9.4
	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 or designee	Network Provider satisfaction survey forms	Due: As Needed—Not completed	Data is due in 2018-19
Monitor and communicate results of Inpatient Surveys and POQI.	Communicate to the Behavioral Health Board the POQI and inpatient survey 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: 7/31/17 Completed: 7/31/17	POQI was presented to the BH Board in January. It will be again presented with the fall survey results sometime during the fall of 2017.
Review and monitor client grievances, appeals and fair hearings and change of provider requests	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	QI Coordinator or designee	Grievance forms, appeal forms, change of provider requests/ reports	1—2. Due: 10/1/17 to state Completed:	PDF Grievance.pdf Refer to attached:

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		2. Review quarterly/annual report with QI Committee		with trends,	7/31/17	
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	7/31/17 Completed: January 2017	Supervisors were trained during their supervisor's meeting in January 2017. They relayed the information to the staff regarding the differences.

Analysis—Supervisors were trained on the differences between a change of provider request and a grievance. Staff started utilizing the mandated state forms for grievances and reporting those to the State. There were very few grievances given the number of clients served in the system.
POQI results continue to show the population served and their family members were pleased with the services provided and that the services have helped their particular situations.

Goals for FY 17—18: Continue to monitor grievances and appeals, POQI results, etc., for any changes noted from this FY's report. We will be attempting to get more surveys from individuals who have been hospitalized. We will also be sending out surveys to any network providers during FY 17—18.

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 ex-	Charts will be at 100% compliance with state	1. Review a minimum of three charts of clinical staff throughout the year	QI Coordinator or designee	1-3. Documentation review form Quarterly	1—3. Due: 7/31/17	<table><tr><td>Indicator and Percentage that Met Requirements</td><td>%</td></tr></table>

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	
ercised across the MHP	standards for documentation	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		compliance UR report 4. QMC minutes	Completed: On-going 4. Due: 7/31/17 (on-going) Completed: On-going	Signed Internal Authorization to Exchange Information in chart	91%
						Client asked whether he/she had an Advance Directive and information was provided	94%
						Diagnosis is consistent with presenting problems, history, MSE, and other assessment data, including AOD	93%
						Objectives specific, observable, measurable and are consistent with the diagnosis	98%
						Treatment Plan and proposed interventions are consistent with diagnosis and treatment goals, including AOD	97%
						BIOP notes appropriately completed	94%
						Medical necessity demonstrated by continued symptoms and impairments which impact daily social and community functioning	79%
						Interventions and relevant clinical decisions aimed at reducing the symptoms and impairments identified on Treatment Plan	67%
						Progress or lack of progress toward treatment goals, including SUD	87%
						Correspondence with PCP in effort to collaborate and co-	67%

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
						ordinate treatment
On-going/Annual Clinical Documentation training for all MHP provider staff and specifically in the following areas: • 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: 7/31/17 (on-going) Completed: (on-going)	Supervisory staff have been going over charts on a weekly basis with their staff and providing individualized training on chart documentation in areas where staff has been deficient. Department wide training is being developed and will be conducted on 08/16/2017. This training will be more comprehensive than just "documentation" training as it will include how to utilize the Cerner's Anasazi system for documentation. During the last quarter of the FY, supervisory staff indicated that staff was having difficulty writing treatment plans that reflected impairments and that there was also a difficulty in diagnosing impairments. As a result, a new PIP was developed to address those areas with staff. Please see clinical PIP.
Hospital charts of BHS clients will be reviewed retrospectively to determine appropriateness of	Review charts that are over 14 day stays, more than	1. BHS client's charts will be reviewed retrospectively. Those which are over 14 day stay, more than one	QI Coordinator or designee	TARS, Excel spreadsheet, etc. IQIC, QMC, minutes	1.—2. Due: quarterly Completed:	FY 16/17 • Clients <u>*Hospitalized More than 14 Days*</u> = 42 Episodes • Clients Had <u>*More Than One Admission Episode in 30 Days*</u> (Total Number of

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
admission, length of stay and recommendations for preventing further hospitalizations	one admission in 30 days, 3 or more admissions in 6 months; one day stays at the IQIC meeting quarterly	admission in 30 days, 3 or more admissions in 6 months; one day stays 2. Data will be reported to IQIC, management and QMC				Episodes = 52) • Clients Had *3 or More Admissions in 6 Months* = 23 Episodes • Clients had *1 Day Stay* = 3 Episodes
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: 7/31/17 Completed: On-going	No adverse incidents reported.

1. All provider ap-	100% of	1.	QM Coordinator	Provider Ap-	Ongoing	Treatment Authorization Request (TAR) Appeals: 29

peals will be monitored for quality purposes	provider appeals will be analyzed for quali-ty pur-poses	Provider appeals will be re-viewed monthly.		peal forms	activity Due: 7/31/17 Completed: 7/31/17	Appeals for claims related to hospitali-zation stay (doctor rounds): 7

Analysis—Documentation reviews continue to go well. Supervisors have been working with staff weekly and have noticed that there are significant challenges with the staff documenting to impairment. As a result, our clinical PIP was developed for FY 2017-18, that will utilize the WHODAS 36 question scale to deter-mine impairment. Staff should be able to utilize the impairment ratings on the scale to write their treatment plans, etc., from it.
The last part of the FY, showed an increase in crisis visits and in hospitalizations. This was particularly true for youth. Data analyzed from this shows a 300 per-cent increase in 6 year olds coming into the emergency room stating they were a danger to themselves. This large increase started around the time that Netflix was showing the series Thirteen Reasons Why. When youth were questioned if they had watched the series, etc., they had indicated that they had or had heard about it.
Also youth, it appears may have been influenced by the political rhetoric and many Hispanic youth indicated that they were afraid they were going to be sent to Mexico or that their parents would be deported. Even though their parents assured them that they were citizens and had nothing to fear, the youth reported that they continued to be bullied at school, etc. and this had made them anxious.
We continue to get pushback from hospitals regarding late TARs. We have been told by the hospitals that Madera County is the only county in the state follow-ing the state regulations about late TARs. We have had one hospital refuse to take our clients and another threaten the same. This continues to make place-ments difficult given the few beds available for inpatient psychiatric services.
We are seeing a trend this year of longer hospital stays, however people placed in psychiatric facilities seem to have more acute symptoms than previously seen. We continue to get a number of individuals in crisis services from counties other than Madera that we then place in an inpatient facility. We continue to see an uptake in individuals who show up for crisis services who have not been open to the system before. We also continue to see an increase in the number of indi-viduals who are from other counties, moving to Madera, due to the cheaper housing costs.
There continues to be a large number of individuals seen for crisis services that have been abusing substances. We are looking at having a SUD counselor at the ER to speak with these individuals once they are medically clear.
We continue to partner with the school districts in training instructors and staff on Mental Health First Aid for Youth, ASIST training, SafeTALK training, etc., for suicide prevention. These classes are open to the community as well. All classes are free. Staff continues to outreach to the public through health fairs and other community events.

Goals for FY 17-18: Continue to work with facilities to get their documentation in, on time, for payment. We continue to look for alternative methods of having the TARs delivered other than through a mail service. Difficulty has been that the TAR has to have a “wet” signature, so having the documents placed in a “drop box” internet type of service has not been an option at this time. We will continue to explore this and other methods so that hospitals won’t be late with the appropriate paperwork.
Provide ASIST suicide prevention training to all classroom instructors for Madera Unified School District for grades 5—12.
Continue to examine having a SUD counselor at the ER for those individuals on a 5150 who have abused a substance.

Continue to provide suicide prevention trainings to the public for free. Continue to be at health fairs and community events promoting our classes, distributing literature, talking with individuals, etc.

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
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	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 requested for review monthly. Not less than 5 charts will be reviewed monthly. 5. Results will be discussed at the quarterly QMC meeting.	Director 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 minutes	Ongoing activity	The following was measured for FY 2016/17 charts were reviewed. 1. 75% had consents for the psychotropic medication prescribed & present inpatient record per BHS procedure. 2. 71% had drug and allergy history updated at least every 90 days 3. 92% had med(s) prescribed in compliance with general screening criteria 4. 73% had current lab work ordered at least annually or as appropriate for therapy prescribed 5. 89% had vitals obtained quarterly 6. 99% had medications prescribed by Psychiatrist were as appropriate for indication/diagnosis 7. 99% Medication Evaluation/Progress Note including presence or absence of side effects 8. 99% had Medication Evaluation/Progress Note including the effectiveness of current therapy 9. 98% had Medication Evaluation/Progress Note including client compliance 10. 92% had client evaluated at least every 90 days

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
	obtained at least quarterly. 90% 6. Medications prescribed by Psychiatrist 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.					

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%					
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 prescribe by the Department's physicians.	Anasazi committee will work with Kingsview to develop a 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	7/31/17 Completed: On-going	In Progress. New way of obtaining information and recording it was taught to the Division Manager on 8/3/17. This method will now be taught to MD/medical staff during FY 17-18. We will also be implementing a check box on the MD progress note to indicate if they have updated the allergy section.

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 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.	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	7/31/17 Completed: Ongoing, see administrative PIP	See PIP
Examine our consent for treatment forms to determine if they meet the state requirements. Have those forms reWYSIWYG'd into Anasazi	Written consent must be signed by the beneficiary agreeing to the administration of psychiatric medication 1. Reason for taking the medication 2. Reasonable alternative treatment available, if any 3. Type, range of frequency and amount, method (oral or injec-	1. Form will be developed between nursing staff, contracted pharmacist and Division Manager 2. Form, once approved by Medication Monitoring Committee will be given to Kingsview to be WYSIWYG'd into the chart 3. Form will be piloted after staff is trained on the form 4. Form will be implemented if there are not any issues in gathering data, etc.	Supervising Nurse, IT, Medication Monitoring Committee, Division Manager	State requirements	7/31/17 Completed: Not-completed, will be ongoing	Medication Consent forms were submitted to the State Medi-Cal oversight staff. There has been no response from the State that the forms meet their criteria. During Medi-Cal Policy meetings, we were informed that the State would not be providing feedback (other than during their reviews) on whether or not the forms meet criteria. We are waiting for new contract to determine if the forms developed meet State criteria before they are WYSIWYG'd into the Cerner electronic health record.

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
	tion) and duration of taking the medication 4. Probable side effects 5. Possible additional side effects that may occur if taking the medication longer than three months 6. Consent given may be withdrawn at any time by the beneficiary					

Analysis—there have been changes to the medical staffing throughout the year. Our Medical Director for over 20 years passed away during the FY. A new Medical Director was announced on June 1st of this year. Also we have reduced our telemedicine time for physicians in response to increased "in person" MD time. We also made a change and now have a nurse going to the rural sites several days a week. We hired a nurse practitioner who just completed his psychiatric nurse practitioner program and is working in the Madera clinic five days a week and one day a week in Oakhurst. We also increased the "in person" MD time for the Chowchilla clinic.
As per suggestion from EQRO, we changed our PIP (both administrative and clinical). We await EQRO's response and technical assistance on these.
We requested approval of our revised Medication Consent forms from State DHCS. We continue to await a response from them.
We have added a section to the MD progress note to complete re: asking for updated allergy information. That note format will be implemented during FY 17-18 and it is anticipated that this will no longer be an issue with documentation for the MD's.
We continue to scan in lab work documents as Cerner does not have an active lab module for the MD home page. It is not anticipated that this will be part of the MD home page for several more years.

Goals for FY 17-18:

1. Continue with monitoring the MD/Nurse Practitioner medical records by the independent pharmacist for compliance with the areas she believes best reflect quality care regarding prescription of medications and follow-up services.
2. WYSIWYG the new MD progress note into Anasazi.
3. Continue to work with the State regarding medication consent forms and have those WYSIWYG'd into the computer system.
4. Continue to work with EQRO regarding the administrative and clinical PIP.
5. Continue to have supervisory staff work with clinicians and case managers to coordinate with the client's PCP and document that in the medical record.

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
Continue to track referrals from primary care for behavioral health services	1. Be able to log in service requests and obtain data on referral and status	1. Develop data tracking mechanism in Survey Monkey regarding referrals, appointments offered, etc. , if necessary 2. Run reports from Anasazi regarding referrals from primary care	Division Manager	Anasazi and possible Survey Monkey form	7-31-17 Continue to track referrals.	We developed on our Call Log Assessment tool, a question as to whether the person being referred was referred by their PCP. We also have been capturing data from our FQHC, Rural Health Clinic and Adventist Health on referrals into the system.
Primary Care will send appropriate referrals for BHS services	Primary care will refer severely and persistently mentally ill (SMI) adult and seriously emotionally disturbed (SED) youth to MCBHS for services. All others will be referred back to the health care plans.	1. Determine if any primary care physicians need training on who is appropriate and who would not meet criteria for services. 2. Give primary care our brochures, and determination sheet re: SMI and SED population 3. Meet with physician if pattern emerges as to sending inappropriate referrals.	1. Division Manager	1. Data on which PCP sent client and result of assessment.	On-going	After working with Primary Care and refining the process, we are getting much more appropriate referrals to BHS. Our new Medical Director has met with the Medical Director of the local FQHC and future joint trainings are planned for FY 17—18.
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 Quarterly	Division Manager and staff continue to meet quarterly with representatives from Anthem Blue Cross and HealthNet/CalVIVA. Division Manager is also on HealthNet's community board

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
						representing mental health services. Board meets twice a year.

Analysis— The Division Manager and appropriate staff continues to meet with Anthem Blue Cross and CalVIVA Health quarterly. The Division Manager is part of the CalVIVA/HealthNet Board for persons with disabilities and other special populations. This Board meets once every six months. Also the Division Manager and a client/family member are going to be part of a local advisory group for special populations who have HealthNet Medi-Cal insurance.
We continue to work very closely with the Camarena Clinic for referrals for care. Our Medical Director met with Camarena Health's Medical Director and has offered his phone number for any consultations needed between BHS and their primary care providers. He has also offered to do training of the primary care staff on MH diagnosis, medications, etc.
As part of our Innovations Plan for next year, we will be working with Fresno State University's School of Nursing's nursing, nurse practitioner and psychiatric nurse practitioner programs for our clients to have physical examinations. The University will have their mobile van parked at our locations and physicals, health care education, etc., will be provided for free to our clients. We will be training them on the use of the ACES survey and the effects of trauma on responses to primary care issues.
During the FY 16—17, BHS also became a psychiatric placement rotation for Physician Assistant Students from A.T. Stills Medical School in Arizona. This is a partnership between the medical school, MCBHS and the Camarena Clinic. We will again be doing this for PA students this coming FY. Four of the five students decided to stay in Madera and provide services upon graduation. One of those four students will be practicing in mental health. This is a great boon to this HRSA designated physical and mental health practitioner shortage area. We are proud to have played a role in this.
BHS will also be accepting a family practice nurse practitioner student from Waldon University for her psychiatric rotation starting next FY.
BHS also accepted a psychiatric nursing student from Fresno State University in October, 2016. He did his rotation here and is now continuing to provide services while he obtains his Ph.D. in psychiatric nursing.
We continue to find that about 50% of the letters we sent to primary care physicians do not get a response. These letters inform the physician that their patient is receiving care here at MCBHS and that they are receiving medications prescribed by our medical staff. The letter includes the name of the medication(s) and dosage(s). We ask for a response back regarding any chronic health conditions and any medications being prescribed.
Also, about 50% of the referrals we receive from primary care state they want services. From that number, and additional 50% do not show up for their scheduled assessment appointment, even after confirming the appointment the day before. So from our data we see only about 25% of the primary care patients that are referred to our clinic. We will continue to work with primary care on improving those numbers.

Goals for FY 17—18: Continue to work with CalVIVA Health and Anthem Blue Cross's case coordinators on difficult cases. Continue to train students (P.A., Nurse Practitioner and Psychiatric Nurse Practitioner) students on their mental health rotation. Continue to outreach to primary care physicians and work closely with our FQHC and other primary health care providers.

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
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 request for psychiatric services to first appointment offered and first appointment accepted.	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 16--17 Completed: On-going	A form was developed. Data requested but when analyzed, it was not the data that the MHP wanted or needed for tracking. We continue to work with Kingsview to refine the data collection process.
Increase Mental Health Awareness in the community	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.	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.	Ongoing Activity: Completed: On-going	Outreach FY 16-17 85 - Outreach Events • 2915 - Contacts Mental Health Community Training Certifications 81 – ASIST 76 – MHFA 33 - MHFA Spanish 36 – MHFA Youth 99 - safeTALK The Suicides Reported in Madera over the last 5 years are below. These numbers reflect the general population and those individuals from

				4. Reduction of the number of suicides in the county		neighboring counties who suicide in Madera County: FY 16/17 – 10 FY 15/16 – 8 FY 14/15 – 14 FY 13/14 – 36 FY 12/13 – 29 **Hope House (PEI services)– 492 - Unduplicated** Duplicated Count for Race Ethnicity • 3,231 - White • 843 - African America • 119 – Native American • 226 – Asian • 7 - Native Hawaiian and OPI • 12 - Two or More Races • 1 – Other • 6,079 - Hispanic/Latino • 4 - Non-Hispanic or Non-Latino **Mountain Wellness Center (PEI services)– 413 - Unduplicated** Duplicated Count for Race Ethnicity • 883 – White • 1 - Native American • 4 – Hispanic/Latino • 967 – Unknown/Decline to Answer • 1 – Non-Hispanic **CalWORKs - 42 (MHFA) - Unduplicated**

						Unduplicated • 14 - White • 28 – Hispanic/Latino **Mental Health Educator (Duplicated)** – 2915 - Outreach and 325 – Training Duplicated Count for Race Ethnicity • 245 – White • 11 - African American • 30 – Native American • 5 – Asian • 2 - Native Hawaiian/OPI • 7 – Two or More Races • 7 – Other Race • 933 – Hispanic/Latino • 21 – Non-Hispanic/Non-Latino **Community Health Worker (Duplicated) - 288** Duplicated Count for Race Ethnicity • 26 – White • 19 – African American • 9 - Native American • 1 – Asian • 232 – Hispanic/Latino • 1 - More Than One Ethnicity **Youth Empowerment Program – Unduplicated - 91**

						Duplicated Count for Race Ethnicity • 19 – White • 1 – Black • 6 – Native American • 11 – Asian • 82 – Hispanic • 1 - Non-Hispanic or Non-Latino • 1 - Other Non-Hispanic or Non-Latino Nurturing Parenting Program 11 participants
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 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.	7/31/17 Completed: On-going	Ongoing

Analysis—The MHP has requested staff be trained on writing reports from Anasazi so timeliness data can be captured. We now have a new liaison from Kingsview who continues to work hard to get the data requested. We look forward to continuing to work with Kingsview on refinement of the data for timeliness.

The MHP was just able to hire (FY 17-18) a data analyst that is currently updating several databases and queries for the MHP. We consider ourselves very lucky to have hired this individual and have him working on several reports and updates.

We continue to find that the way to penetrate the various ethnic populations of Madera County are through PEI services. We find that our community and its agencies, schools, etc., have embraced our MHFA, SafeTALK and other programs. Our parenting programs continue to be popular with the Latino community.

Goals for FY 17-18:

1. Continue to work with Kingsview on refining the data we need for completing the timeliness surveys.
2. Continue to work with Kingsview on developing and updating various data reports.

Performance Improvement Projects (work in progress and may change)

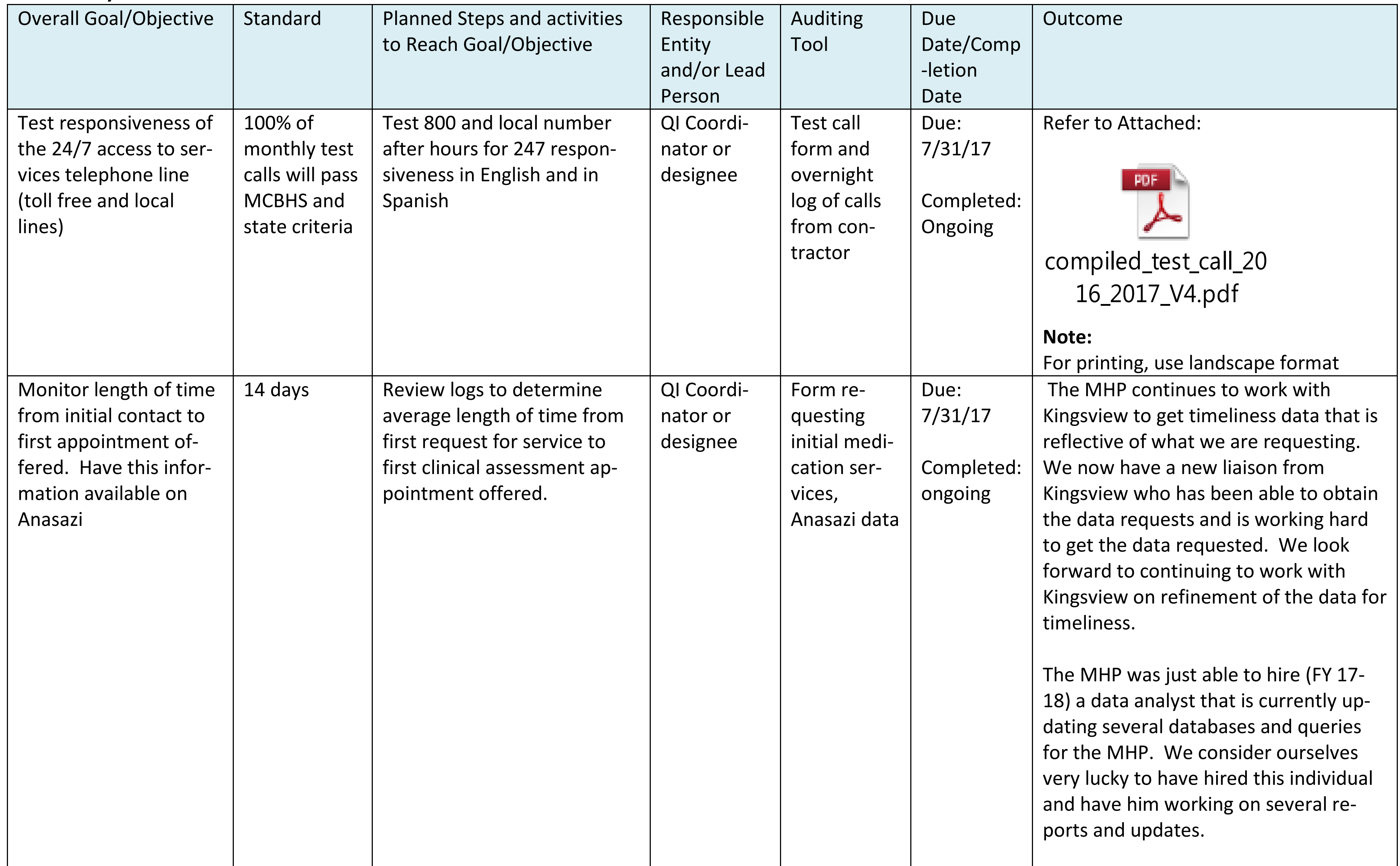
Overall Goal/Objective	Standard	Planned Steps and activities to Reach Goal/Objective	Responsible Entity and/or Lead Person	Auditing Tool	Due Date/Completion Date	Outcome
Clinical - Using the Mini and the WHODAS will assist in the development of more appropriate treatment plans. This will improve accuracy of diagnosis of impairments. Students and new clinicians will be utilized to build a better understanding within the community of professionals.	One Clinical PIP Per Year	Piloting standardized assessment instruments to improve diagnostic accuracy, treatment planning, and treatment. The MINI Interview is a standardized instrument to determine type of mental health disorder and the World Health Organizations Disability Scale can be used for impairments related to mental illness. These instruments will be piloted in our intake assessment team. The goal and objective is to see if these can have diagnostic precision and reduce the amount of time for an assessment to be completed.	Madera County Behavioral Health Managed Care	We will measure hour long it takes to complete and assessment before and after using the instruments and look for more precise diagnosing (e.g. fewer NOS diagnosis).	In conceptual stage	Clinicians will be charting not only to symptoms but also to impairment on the treatment plan. Progress notes will reflect the improvement in recovering from impairments that affect client's daily lives.
Admin. - Using genetic testing will provide the ability to identify medications that work with individual patient's metabolisms and help to reduce side effects.	One AdminPIP Per Year	The Genesite will be used for clients that have low medication adherence. A group of clients that have low adherence will be chosen for the pilot. It will be split into one group that uses Genesite and one that	Madera County Behavioral Health Managed Care and nursing staff	Auditing tool will be the tool contract Pharmacist's review tool	In conceptual stage	Nursing log will show fewer adverse reactions for those individuals who were Genesighted than those who were not.

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
		does not use the, to determine if the made any difference in rate of compliance.				

Analysis— New PIPs are in the process of being developed.

Goals for FY 17-18: Have PIPs out of the concept stage and in the active stage.

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/Comp-letion 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: 7/31/17 Completed: Ongoing	Refer to Attached: compiled_test_call_2016_2017_V4.pdf **Note:** For printing, use landscape format
Monitor length of time from initial contact to first appointment offered. 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 appointment offered.	QI Coordinator or designee	Form requesting initial medication services, Anasazi data	Due: 7/31/17 Completed: ongoing	The MHP continues to work with Kingsview to get timeliness data that is reflective of what we are requesting. We now have a new liaison from Kingsview who has been able to obtain the data requests and is working hard to get the data requested. We look forward to continuing to work with Kingsview on refinement of the data for timeliness. The MHP was just able to hire (FY 17-18) a data analyst that is currently updating several databases and queries for the MHP. We consider ourselves very lucky to have hired this individual and have him working on several reports and updates.

Monitor length of time from initial request for psychiatric services to first appointment offered and first appointment accepted.	3 business weeks for new patients.	Average length of time from first request for psychiatric appointment/assessment to first appointment offered	QI Coordinator or designee	Anasazi data	Due: 7/31/17 Completed: ongoing	The MHP continues to work with Kingsview to get timeliness data that is reflective of the data we are requesting. We now have a new liaison from Kingsview who is working hard to get the data requested. We look forward to continuing to work with Kingsview on refinement of the data for timeliness. The MHP was just able to hire (FY 17-18) a data analyst that is currently updating several databases and queries for the MHP. We consider ourselves very lucky to have hired this individual and have him working on several reports and updates.
Track and trend access data for timely appointments for urgent conditions. Have this information available on Anasazi.	72 hours	Average length of time for response to an urgent condition –72 hours	QI Coordinator or designee	Anasazi data	Due: 7/31/17 Completed: ongoing	We established an “urgent condition” code for staff to use when responding to clients who are defined as “urgent.” We now can track that data and will continue to track that data for a timely response.
Track and trend access data to on Anasazi to assure timely access to follow-up services after hospitalization for those clients who are residents of Madera County with Medi-Cal and are placed in an out of county facility. Have this information available on Anasazi	Within 10 working days post hospitalization	Average length of time for a follow-up contact after hospitalization.	QI Coordinator or designee	Anasazi data	Due: 7/31/17 Completed: ongoing	The standard is met for 97% of our hospitalized clients.

Track and trend data regarding hospitalizations. Have this information available on Anasazi.
 	
Track and trend data re: re-hospitalizations. Have this information be available on Anasazi
	Less than 5% re-hospitalizations within 30 days of initial hospitalization	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
			QI Coordinator or designee, Hospital Coordination Team	MHP hospitalization log, SAMHSA Log, Anasazi data	Due: 7/31/17
					
					Completed: Ongoing
						Total Psych Hospitalization Episodes =
						(only includes clients that we are responsible for)
						
						• 222 Unique Clients Hospitalized
						• – Hospitalization Episodes More Than 14 days
						  o 42 Unique Clients
						  o The months with the highest rates of over 14 day stays were February and April 2017 with 7 admits each
						• 52– Clients had more than 1 admission episode in 30 days
						
						• 23- Clients had 3 or more admissions in 6 months
						
						• 3– Clients had 1 day stays

Track and trend data regarding no shows/cancellations. Have this information available on Anasazi	All staff will continue to utilize scheduler in Anasazi	Percentage of appointments that met standards Standards to be explored/established during FY 16—17	QI Coordinator or designee	Anasazi data	Due: 7/31/17 Completed: Ongoing	We were able to get data re: no shows. For FY 16-17, the rate of our no-shows were for the following services Individual Therapy—16.3% • Youth—16.3% • Adult—16.3% Group Therapy • Youth--27% • Adults—21% Medication Evaluations Initial • Youth—3% • Adult—28% Medication Services—16.1% • Youth—15.1% • Adults—16.5%

						Staff cancellation rates are unavaila-ble at this time.
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 Coordina-tor or de-signee	Data submit-ted by crisis staff	Due: 7/31/17 Completed: Ongoing	87%
Respond to crisis calls from the jail within 8 hours. Have this in-formation available on Anasazi.	100% of crisis calls from the jail will be re-sponded to within 8 hours.	Percentage of crisis calls that met standards	QI Coordina-tor or de-signee	Data submit-ted by crisis staff	Due: 7/31/17 Completed: Ongoing	100%

Analysis— Due to the recent availability of this particular data set, meaningful analysis is not available at this time, though there appears to be a slight uptick in no-show and cancellations based on data from the previous fiscal year. There has been informal discussion about how and where to intervene (i.e., mailing ap-pointment reminder post cards), but no definitive action has been taken to date pending further analysis of this new information.

Goals for 17-18: The obvious goals are to continue to track and trend this data with analysis targeted at further illustrating/reducing no shows and cancellation trends. As of this date, data on staff cancellations is unavailable.

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
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: 7/31/17 Completed: Ongoing	Due to other trainings and the number of them, this distinct training was not completed during this FY but elements were incorporated into other trainings. We now have contracted with Relias Learning and this will be a mandated training through this company for all staff.

Analysis—Due to the number of trainings staff attended for completion of evidenced-based practices, we incorporated client/family sensitivity training into those evidenced based practices. The MHP has now contracted with Relias Learning and will now have staff obtain specific client/family member training through this service.

Goals for FY 17-18:

1. Staff will attend client/family member training through Relias Learning.
2. New Cultural Competency Coordinators have been appointed for the Department. They will be working on the CLAS standards for the Department and updating the Cultural Competency Plan.
3. Cultural Competency training will be obtained through Relias Learning and other trainers as appropriate.
4. The Cultural Competency Committee will be looking at the buildings of MCBHS to see if they comply with the latest information about trauma-based/trauma-informed information on how furniture should be placed, creating a welcoming atmosphere, etc.

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		