QUALITY IMPROVEMENT WORK PLAN (QIWP)
FY 17-18

BEHAVIORAL HEALTH SERVICES

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MADERA COUNTY BEHAVIORAL HEALTH SERVICES

QUALITY IMPROVEMENT WORK PLAN OVERVIEW JULY 2017 – JUNE 2018

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 the 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 that were 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;

- 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 a review for TARS from hospitalizations, handles all SB 785 services, payment for placements, hospital contracts, provider certifications, documentation reviews, and in-house training, 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 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 indicated, 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 the 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 the FY, 17-18. 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	Behavioral Health Director
Herbert Cruz, MD	Medical Director
Julie Morgan, LCSW	Assistant Behavioral Health Director
Missie Rhinehart, LMFT	Division Manager/ QMC Chair/QMC Coordinator
Annette Presley, LCSW	Division Manager
Melissa Nelson	Compliance Officer/Medical Records Supervisor
Art Galindo, LCSW	Division Manager
Rosario Trujillo, ASW	MHP Mental Health Clinician/Cultural Competence Chair
Barney Oliver, LMFT	MHP Licensed Clinician, IQIC Chair/QMC Coordinator/Cultural Competence Co-Chair
Mariam Agayan, LMFT	Supervising Mental Health Clinician
Larry Penner, LMFT	Supervising Mental Health Clinician
Greg Gregson, LMFT	Supervising Mental Health Clinician
Julia Garcia, LCSW	Supervising Mental Health Clinician
Irene Blanco, LCSW	Supervising Mental Health Clinician
Glen Sutch, LMFT	Supervising Mental Health Clinician
Valerie De La Fuente	Registered Nurse, Nursing Supervisor
Eva Weikel	Administrative Analyst/QMC Coordinator
Pat Sai	Administrative/Reports & Data Analyst
Sarah Valenzuela	IT Support Liaison
Rick Farinelli	Mental Health Board representative(s)

David Weikel, PsyD, ASW	Behavioral Health Program Supervisor
Felicia Ramirez	Vocational Assistant
Kristina Klemash	Vocational Assistant

Other Department QI Activities/Committees
The Department has other standing committees where QI/UM activities occur. These include the Performance Improvement Project (PIP) committees, Cultural Competency Committee, QI/Supervisor meetings, Interagency Quality Improvement Committee (IQIC), etc. Other committees are created as necessary to examine and 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 2017-18.

- 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 <u>*key elements*</u>: 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 the mission or overall singular purpose or desired result?
- What are the inputs?
    - Resources dedicated to or consumed by the program, e.g., money, staff, time volunteers, equipment, supplies, etc.
    - What are the constraints on the program, e.g., laws regulations, funding requirements, etc?
    - SWOT—strengths and weaknesses, opportunities and threats
- Establish goals—SMARTER
    - Specific
    - Measurable
    - Acceptable
    - Realistic
    - Time frame
    - Extending—stretch the performer's capabilities
    - Rewards/recognition when goal/outcome is achieved

- Build in accountability (regularly review who's doing what and by when)
- Note deviations from the plan and re-plan accordingly
- Evaluate the planning process and plan

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

Evaluation

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

The evaluation summarizes the following;

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

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

The following are the annual QI work plan evaluation and activities for all MCBHS programs and services:

For FY 17/18, 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, caseworkers and administrative analysts 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 17-18

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 3. Types of services clients are receiving 4. Trending of data on a semi-annual basis	1. Information will be analyzed and reported to staff on a semi-annual basis	Request reports be 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: 09/2018 Status: continued monitoring with reports and/or other documentation as required	Reports will be ran on a quarterly basis and presented to Management. Please see table below for data.

Total Clients Served				
	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Clients Served	2188	2133	2109	1988
Gender				
Female	1223	1213	1160	1095
Male	964	919	948	892
Unknown	1	1	1	1
Age				
0-15	678	662	635	591
16-24	368	335	323	307
25-59	1004	980	1001	955
60+	164	168	158	153
City of Residence				
Ahwanhee	14	13	12	13
Bass Lake	3	3	5	4
Chowchilla	327	312	314	313
Coarsegold	89	83	89	85
Madera	1464	1444	1437	1331
North Fork	33	24	23	25
Oakhurst	136	132	132	136
O Neal	1	3	2	5
Raymond	5	9	14	12
Wishon	3	3	4	4
Ethnicities				
Cuban	0	1	1	1
Mexican	798	756	720	620
Not Hispanic	999	971	969	931
Other Hispanic	388	402	417	434
Puerto Rico	3	3	2	2

Race				
	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Asian -Other	9	10	12	10
Black/African American	101	91	96	83
Chinese	1	0	2	0
Filipino	2	2	3	3
Hawaiian Native	3	1	1	1
Asian Indian	1	2	1	2
Japanese	1	1	2	2
Korean	1	0	0	0
Native American	22	20	21	16
Non-White-Other	902	855	863	822
Other Pacific Islander	3	1	1	1
Hmong	1	0	0	0
Multiple	7	9	1	4
Unknown	14	14	9	13
Vietnamese	1	1	15	15
White	775	735	763	761
Contact by Service Type				
Assessment	529	539	587	441
Crisis Intervention	626	688	609	543
Collateral	590	497	644	662
Individual Therapy	3672	3186	3198	3086
Group Therapy	238	178	267	220
Rehab Individual	415	409	439	520
Rehab Group	531	560	472	489
Plan Development	978	927	979	902
Case Management/Brokerage	3802	3254	3662	3214
Intensive Care Coordination	16	21	2	6
Medication Evaluation Initial	108	95	108	91
Medication Eval Ongoing	1354	1292	1381	1417
Meds Admin (injection)	101	127	133	152
Medication Management	809	372	384	422

Analysis—
MCBHS was able to hire a number of new Administrative Analysts with 3 of them dedicated to the Managed Care Department. One of the analysts has been tasked with running and analyzing reports with assistance from our in-house Kingsview Analyst and other staff as needed. With direction from the Managed Care projects lead Analyst, an entire data collecting process is being mapped out for other to follow in the future. Quarterly data has been captured, analyzed and reported to management, as this will be our process.

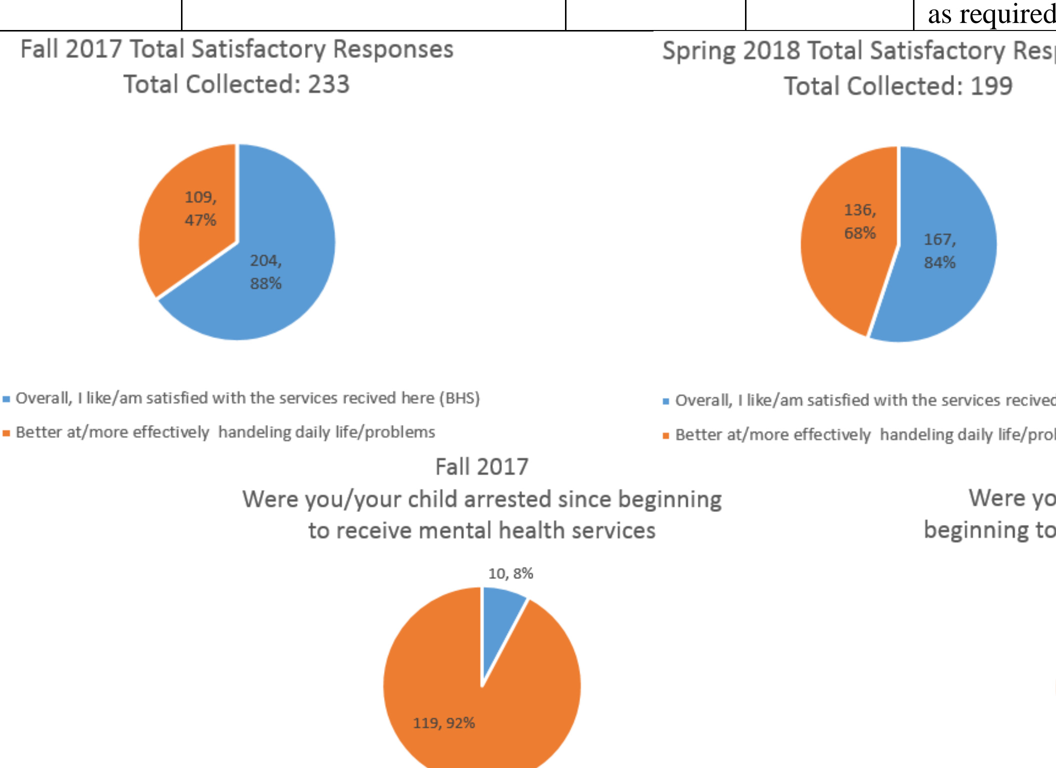
Goal for FY 18-19:

1. Continue to develop a clear and uniform process for capturing data from the system to ensure the most accurate data possible.
2. Monitor where services are provided and the number of clients seen.
3. Determine if additional staff are needed in accordance with adequacy standards.

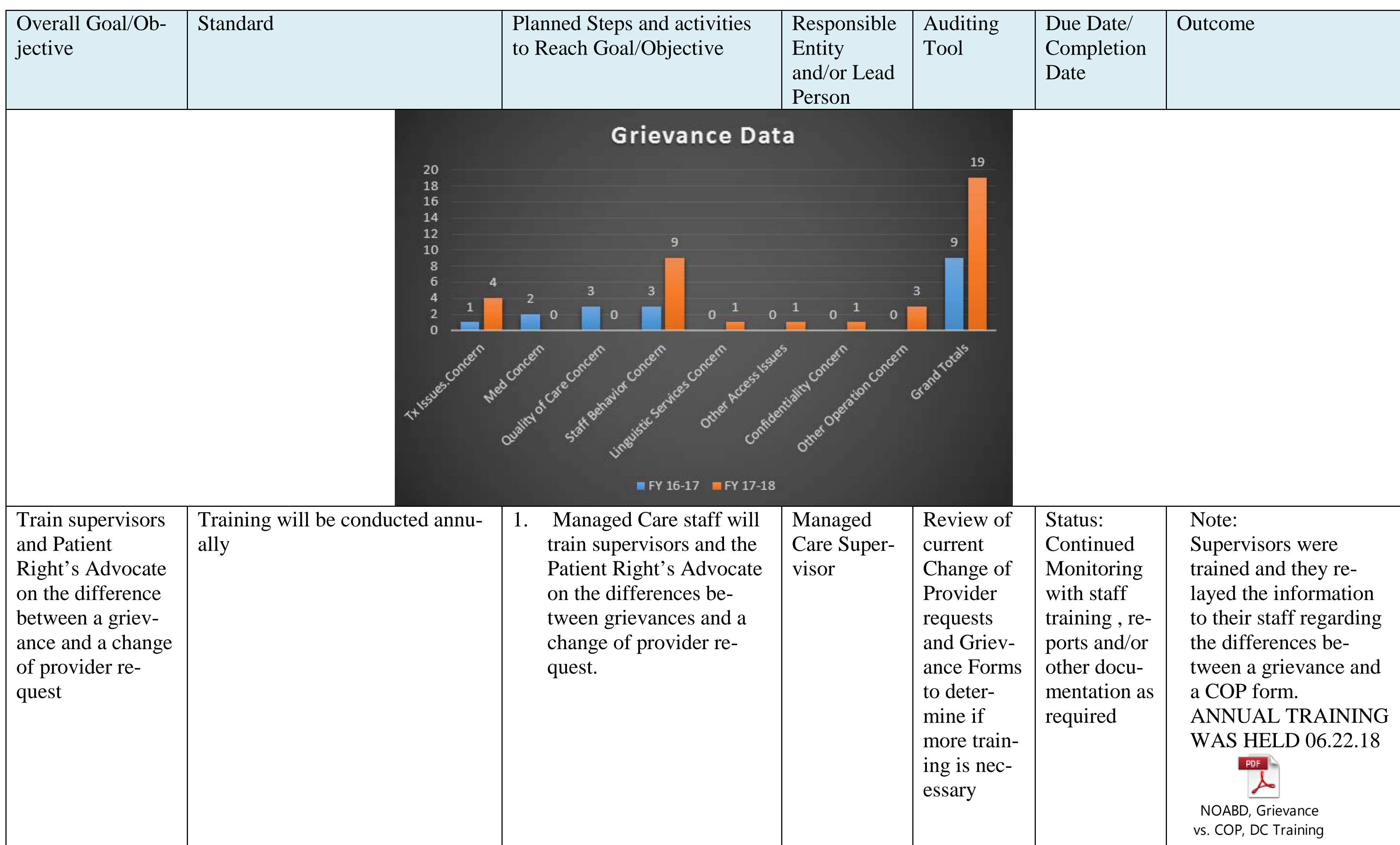
Beneficiary/Family Satisfaction

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 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 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: 7/30/18 Status: Continued monitoring with reports and/or other documents as required	FALL ‘17: 88%; SPRING ‘18: 84% FALL ‘17: YES 8% NO 92% SPRING ‘18: YES 12% NO 88% FALL ‘17: 47%; SPRING ‘18: 68%

POQI Comments	Fall 2017	%	Spring 2018	%
Adult				
Positive	33	67%	32	51%
Negative	3	6%	6	10%
Neutral	4	8%	2	3%
Older Adult				
Positive	2	4%	4	6%
Negative	0	0%	1	2%
Neutral	0	0%	2	3%
Youth for Families				
Positive	4	8%	5	8%
Negative	0	0%	0	0%
Neutral	0	0%	3	5%
Youth				
Positive	0	0%	8	13%
Negative	2	4%	0	0%
Neutral	1	2%	0	0%
Ttl Comments	**49**		**63**	
Overall Positve Ttl	39	80%	49	78%
Overall Negative Ttl	5	10%	7	11%
Overall Neutral Ttl	5	10%	7	11%



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
	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 Status: Continued Monitoring with reports and/or other documentation as required	We continue striving to meet this goal. An Analyst has been assigned as our Network Provider contact. She will contact all network providers with the goal of developing rapport. She will make sure network providers meet all requirements (BHS and State), as well as establish a tracking system.
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: 7/30/18 Status: Continued Monitoring with reports and other documentation as required	POQI results were reviewed by the Behavioral Health Board on 06/20/2018. PDF Behavioral Health Board Agenda.Minute
Review and monitor client grievances, appeals and fair hearings and change of provider requests for trends	Review and monitor grievances, appeals and fair hearings quarterly at the QMC meeting.	1. Identify trends and take necessary actions in response for both MHP and network providers 2. Review quarterly/annual report with QI Committee	QI Coordinator or designee	Grievance forms, appeal forms, change of provider requests/ reports with trends,	1—2. Due: As required per DCHS Continued monitoring with reports and/or other documentation as required	There were a total of 6 grievances and 97 change of provider forms filed in FY 17-18. All were followed up according to required timelines. QI Coordinator and/or designee reviews and monitors all grievances, appeals and change of provider forms to ensure compliance with requirements.

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
						
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	Status: Continued Monitoring with staff training , reports and/or other documentation as required	Note: Supervisors were trained and they relayed the information to their staff regarding the differences between a grievance and a COP form. ANNUAL TRAINING WAS HELD 06.22.18 NOABD, Grievance vs. COP, DC Training

Analysis—

POQI Surveys continue to be administered as indicated by Informational Notice. When it comes to Network Providers, due to lack of staff we were unable to meet this requirement this FY, however, since the hiring of Administrative Analysts we have assigned one of them as the Network Provider contact. This Analyst will make sure all requirements specific to Network Providers are met by making sure they receive any forms they are required to complete, track and follow-up as needed to ensure the process is complete from beginning to end. We will continue to work towards meeting our set "standards" for the POQI in the coming FY. The POQI results will continue to be share with the Behavioral Health Board as well as staff. QI Coordinator and/or designee will continue to track and trend grievances, appeals and change of provider forms.

Goals for FY 18—19:

1. Work towards meeting our POQI set "standards" noted above by possibly adding more staff who interact with clients to provide information about what the POQI in reception areas and ensuring bilingual services are available at all times to assist not only in explaining but also in reading it to the client if client does not read or has a visual impediment.
2. Share POQI results with the Behavioral Health Board as well as staff.
3. Continue to monitor grievances and appeals, POQI results 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 17—18 FY.
4. Ensure all staff are aware of the difference between a Grievance and a Change of Provider form thru an annual training.

Service Delivery System/Clinical Issues

<table>
<tr><th>Overall Goal/Objective</th><th>Standard</th><th>Planned Steps and activities to Reach Goal/Objective</th><th>Responsible Entity and/or Lead Person</th><th>Auditing Tool</th><th>Due Date/ Completion Date</th><th colspan="2">Outcome</th></tr>
<tr><td rowspan="11">Ensure regulatory and clinical standards of care for documentation are exercised across the MHP</td><td rowspan="11">Charts will be at 100% compliance with state standards for documentation</td><td rowspan="11">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</td><td rowspan="11">QI Coordinator or designee</td><td rowspan="11">1-3. Documentation review form Quarterly compliance UR report

4. QMC minutes</td><td rowspan="11">1—3. Due: 7/30/18

Status: Continued Monitoring with reports and/or documentation as required

4. Status: continued monitoring with reports and/or documentation as required

Status: continued monitoring</td><td>Indicator and Percentage that Met Requirements</td><td>%</td></tr>
<tr><td>Signed Internal Authorization to Exchange Information in chart</td><td>97%</td></tr>
<tr><td>Client asked whether he/she had an Advance Directive and information was provided</td><td>97%</td></tr>
<tr><td>Diagnosis is consistent with presenting problems, history, MSE, and other assessment data, including AOD</td><td>86%</td></tr>
<tr><td>Objectives specific, observable, measurable and are consistent with the diagnosis</td><td>75%</td></tr>
<tr><td>Treatment Plan and proposed interventions are consistent with diagnosis and treatment goals, including AOD</td><td>86%</td></tr>
<tr><td>BIOP notes appropriately completed</td><td>89%</td></tr>
<tr><td>Medical necessity demonstrated by continued symptoms and impairments which impact daily social and community functioning</td><td>86%</td></tr>
<tr><td>Interventions and relevant clinical decisions aimed at reducing the symptoms and impairments identified on Treatment Plan</td><td>94%</td></tr>
<tr><td>Progress or lack of progress toward treatment goals, including SUD</td><td>78%</td></tr>
<tr><td>Correspondence with PCP in effort to collaborate and coordinate treatment</td><td>40%</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
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: 7/31/18 Status: Continued monitoring with reports and/or documentation as required	Note: Clinical Supervisors continue to review charts on a weekly basis with their staff and provide individualized training on chart documentation in areas where staff has been deficient. During the last quarter of the previous 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. LAST TRAINING WAS HELD 08.16.17 Documentation Training 08.16.17
Hospital charts of BHS clients will be reviewed retrospectively to determine appropriateness of admission, length of stay and recommendations for preventing further hospitalizations	Review charts that are over 14 day stays, more than one admission in 30 days, 3 or more admissions in 6 months; one day stays at	1. BHS client's charts will be reviewed retrospectively. Those which are over 14 day stay, more than one admission in 30 days, 3 or more admissions in 6 months; one day stays 2. Data will be reported to IQIC, management, and QMC	QI Coordinator or designee	TARS, Excel spread-sheet, etc. IQIC, QMC, minutes	1. — 2. Due quarterly Status: Continued monitoring with reports and/or other documentation due as indicated	See table below for cumulative FY 17-18 data or see attached file for quarterly data breakdown. Hospital Data

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
	the IQIC meeting quarterly					

CUMULATIVE FY 17-18

	Total Clients	%	Adults	Children	Foster Care
1 Day Stay	11	3%	11	0	0
Hospitalized >14 days	58	17%	54	4	3
>1 admission episodes in 30 days	53	15%	42	11	3
>3 or more admissions in 6 months	37	11%	33	4	3
	346				
Appeals					
Approved	11	3%	8	3	2
Denied	3	1%	1	2	2
DR Rounds Appeals					
Approved	10				
Denied	3				

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
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.	Due: 6/30/18 Status: Continued monitoring with reports and/or other documentation due as required	Nothing to report at this 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
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	Due: 7/30/18 Status: Continued monitoring with reports due as required	See table below for cumulative FY 17-18 data or see attached file for quarterly data breakdown. Hospitalization Data

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. We have not been able to meet our goal of 100% compliance but will continue to aim for that.
We saw pushback from hospitals regarding late TARs in FY 16/17, however, this is not as true for FY 17-18. We have been told by the hospitals that Madera County is the only county in the state following 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 placements difficult given the few beds available for inpatient psychiatric services. Appeals for psychiatric inpatient stays and doctor rounds continue to be reviewed and we continue to work with all providers for the best outcomes possible.
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 individuals 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 coordinating with SUD services to have a SUD counselor meet with these clients once they are medically clear.

Goals for FY 18-19:
1. Continue to work with facilities to get their documentation in, on time, for payment.
2. Continue to look for alternative methods of having the TARs delivered other than through a mail service. The 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.
3. Provide ASIST suicide prevention training to all classroom instructors for Madera Unified School District for grades 5—12.
4. Continue to coordinate with SUD services to have a SUD counselor meet with clients once they are medically cleared.

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 obtained at least quarterly. 90% 6. Medications prescribed by Psychiatrist appropriate for indication/diagnosis. 100%	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	Status: Continued monitoring with reports and/or other documentation as required	1. 76% had consents for the psychotropic medication prescribed & present inpatient record per BHS procedure. 2. 81% had drug and allergy history updated at least every 90 days 3. 100% had med(s) prescribed in compliance with general screening criteria 4. 94% had current lab work ordered at least annually or as appropriate for therapy prescribed 5. 83% had vitals obtained quarterly 6. 87% had medications prescribed by Psychiatrist were as appropriate for indication/diagnosis 7. 100% Medication Evaluation/Progress Note including presence or absence of side effects 8. 100% had Medication Evaluation/Progress Note including the effectiveness of current therapy 9. 100% had Medication Evaluation/Progress Note including client compliance 10. 98% 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
	7. Medication Evaluation/Progress Note by physician includes presence or absence of side effects. 100% 8. Medication Evaluation/Progress Note by physician includes patient compliance. 100% 9. Patient evaluated at least every 90 days when prescribed medications by a Psychiatrist. 90%					
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 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	7/30/18 Status: Continued monitoring with reports and/or other documentation as required	Allergies are currently entered into the medical progress note by doctors in the form of a narrative. In order to run data reports this information must be keyed into the medical conditions allergies EHR window, which is not happening consistently. The Anasazi committee met to set a clear process which will allow consistency of data entry and in turn the running of data reporting. In FY 18-19, Kingsview contractor will train doctors how to navigate and enter allergy information into the medical conditions section. Medical records will then be checking to make sure entries are being made consistently (every time a client

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
						see a doctor) and if it is not being entered, an error correction notice will be sent to the doctor.
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 an improved functioning score after having their medications changed. 3. Results will be documented in the EHR.	Supervising Nurse, Medical Director	HRQOL	7/30/18 Status: Continued monitoring with reports and/or other documentation as required (see administrative PIP)	This goal was discontinued as this is no longer the current PIP. We continue to collaborate with Genesight, however, the HRQOL nor any of the components to this specific PIP are being completed at this time. Please see PIP section for current PIP information. Please see PIP section for current PIPs.
Examine our consent for treatment forms to determine if they meet the state requirements. Have those forms re-WYSIWYG'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	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	Supervising Nurse, IT, Medication Monitoring Committee, Division Manager	State requirements	7/30/18 Status: continued monitoring with reports due as required	Note: Medication Consent forms were submitted to the State Medi-Cal oversight staff. There has been no response from the A medication consent which meets all state requirements has been created and will be presented at the Medication Monitoring meeting in July 2018. Once approved it will become part of our EHR and will allow for data to be pulled from it and analyzed. Med Monitoring Agenda 18 0815

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
	amount, method (oral or injection) 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	any issues in gathering data, etc.				

Analysis –

Our medical director is no longer on site and contracted for less hours. 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 four days a week, with one of those days dedicated to serving the Oakhurst community via telemed and one day a week providing in-person services 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 have been working with EQRO in their development.

A revised Medication Consent form has been developed in accordance with requirements outlined in Madera's MHP contract with the state, implementation is pending its approval.

We have added a section to the MD progress note to complete re asking for updated allergy information. That note format has been 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 18-19:

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. Continue to work with EQRO regarding the administrative and clinical PIP.
3. 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	7-30-18 Status: continued monitoring with reports due as required	We developed the Initial Contact form to include 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. A Survey Monkey collector was implemented and all data kept on excel spread sheet has been transferred into collector tool to be analyzed.
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.	Division Manager	Data on which PCP sent client and result of assessment.	Status: continued monitoring with reports and/or other documentation as required	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 will be scheduled if/as needed. FY 17-18 From a total of 105 Referrals 70 accepted services: 37 were assessed 33 were no shows 3 had wrong numbers 10 did not call back 9 were already open to BHS 7 declined services 5 had private insurance
Monitor the effectiveness of physical health care plans	Meet quarterly	Meetings with both Anthem Blue Cross and Health Net (CalVIVA	Division Manager or designee	Meeting minutes	Status: Continued monitoring with reports	Division Manager and staff continue to meet quarterly with representatives from An-

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
		Health) quarterly to go over issues regarding contract			and/or other documentation as required	them Blue Cross and Health-Net/CalVIVA. Board meets twice a year. 09.21.17 Health Plans Mtng 12.07.17 Health Plans Mtng 05.31.18 Health Plans Mtng

Analysis—

As part of our Innovations Plan, we continue to collaborate with Fresno State University's School of Nursing's, psychiatric and nurse practitioner programs to facilitate physical examinations for our clients. The University will have their mobile van parked at our locations to provide physicals, health care education, etc., for free to our clients. We will be training the nursing staff on the use of the ACES trauma tool and the effects of trauma on responses to primary care issues.

We have again done this for PA students this FY 17-18. 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 important as Madera County is HRSA designated as a physical and mental health practitioner shortage area. We're eager to continue this effort for the beneficiaries of this county.

BHS will also be accepting a family practice nurse practitioner student from Waldon University for her psychiatric rotation starting next FY 17-18.

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.

According to our data, 66% (up from 50%) of the referrals we receive from primary care state they want services. From that number, 47% (down from 50%) do not show up for their scheduled assessment appointment, even after confirming the appointment the day before. This means we see about 53% (up from 25%) of the primary care patients that are referred to our clinic. We will continue to update this data and work with primary care on improving the numbers.

Goals for FY 18—19:

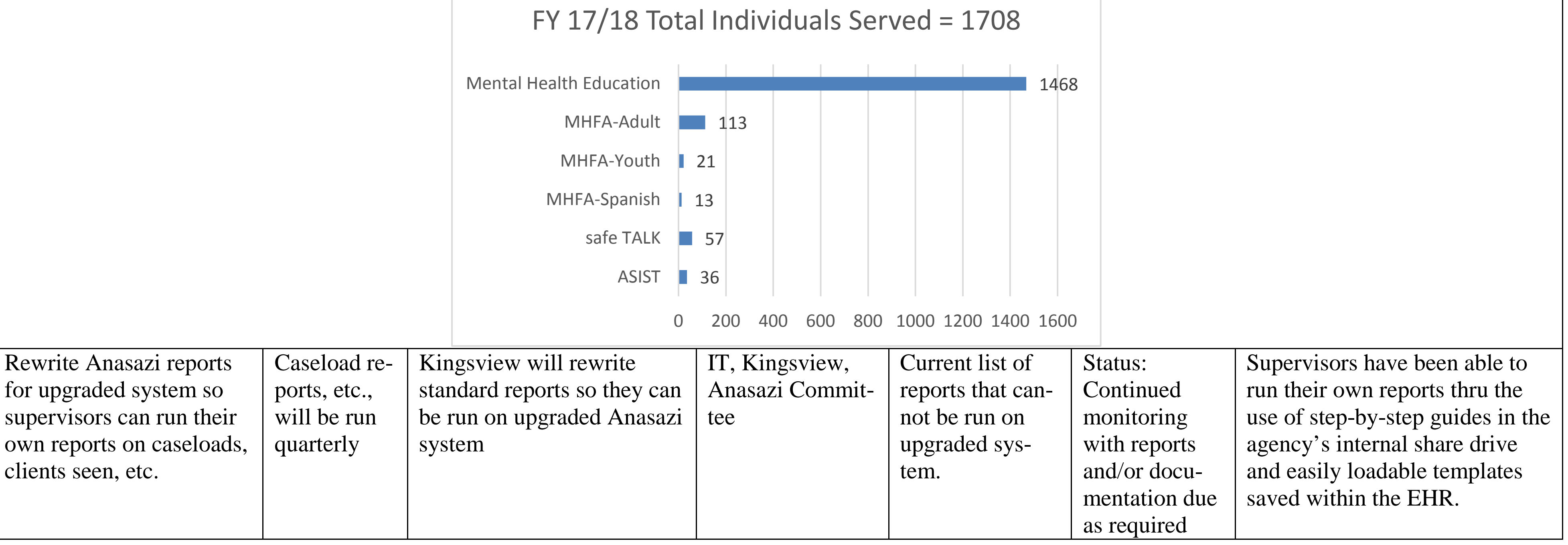
1. Continue to work with CalVIVA Health and Anthem Blue Cross's case coordinators on difficult cases.
2. Continue to train students (P.A, Nurse Practitioner, and Psychiatric Nurse Practitioner) students on their mental health rotation.
3. Continue to outreach to primary care physicians and work closely 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	Due: 7/2018 Status: Continued monitoring with reports and/or other documentation due as required	The Initial Contact form was implemented into the EHR to pull the data necessary to meet this goal, however, it was only able to capture those clients who were "admitted" (already open to services) in our system. This meant that any client calling to request services was not being captured at all. In order to capture clients prior to being admitted (date of first contact), a "registered" service assignment was keyed in addition to the Initial Contact form, this then made it possible for us to use the Initial Contact form to pull the client's timeliness information. Clerical staff then went back and keyed a "registered" service assignment for any client with an Initial Contact form entered in FY 17-18 so that we could pull data for the entire FY. This process continues to be in development and is updated as problems are identified and resolved. Our Kingsview Analyst is currently working on a training for all clerical staff involved to ensure the quality of data being entered is accurate as possible. Please see accessibility of services section for all data.

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. 4.Reduction of the number of suicides in the county	Due: 07/2018 Status: Continued monitoring with reports and/or other documentation due as required	A new community fair event was coordinated by BHS' outreach unit resulting in a huge success. This even was in collaboration with many County agencies, each providing information to the public regarding their respective services. In addition, food, games, wellness activities and music were provided to make it a well-rounded family friendly event. Please see table below for stats.

FY 15/16		**FY 16/17**		**FY 17/18**	
Total Individuals Served = 425		**Total Individuals Served = 381**		**Total Individuals Served = 1708**	
safeTALK	131	ASIST	81	ASIST	36
Mental health/suicide-Teen Valley	27	MHFA-Youth	36	safe TALK	57
ASIST	35	MHFA-Spanish	33	MHFA-Spanish	13
MHFA	46	safe TALK	99	MHFA-Youth	21
Mental Health- 5150	69	MHFA	56	MHFA-Adult	113
Mental Health- 5151	26	MHFA	56	Mental Health Education	1468
Mental health/suicide	11	MHFA-Adult	20		
Mental Health Education	60				
Youth Mental Health	20				



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.	Status: Continued monitoring with reports and/or documentation due as required	Supervisors have been able to run their own reports thru the use of step-by-step guides in the agency's internal share drive and easily loadable templates saved within the EHR.

Analysis— previous data may have been modified or omitted

With the implementation of the Initial Contact Form in addition to the "registered" assignment we believe we have found the beginning of a good process to gather, track and capture timeliness data. This process continues to change as problems are identified and training continues to happen to ensure data entry uniformity. 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. It's important to note that Supervisors have been able to run their own reports for years with the use of templates, however, some of the templates require updates to be made. Kingsview Analyst is always available to not only supervisors but all staff whose job requires running reports to provide training and guidance to capture the information they need. In addition, the Managed Care unit has a dedicated Analyst who runs reports and analyzes data to present it in an easy to follow format.

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 (as evidenced by). Our parenting programs continue to be popular with the Latino community. 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 18-19:

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.
3. Continue to train Managed Care Analyst on how our EHR works, where data is pulled from, how to run reports to meet different requirements.
4. Develop standardized specifications for running all Managed Care reports to serve as a manual for report running, data gathering and report templates.
5. Continue to provide suicide prevention training to the public for free. Continue to be at health fairs and community events promoting our classes, distributing literature, talking with individuals, etc.
6. Collaborate with County IT and KV as necessary to develop a meaningful tracking system for down time as well as connectivity issues

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 – BHS will conduct a PIP to find out if symptoms related to traumatic exposure (PTSD) are being masked by ADHD, Anxiety and/or Depression symptoms to find out if BHS is under representing PTSD diagnosis in youth.	One Clinical PIP Per Year	Gather baseline statistics to identify the problem and find supporting documentation regarding problem. Administer the SCARED trauma tool to track possible trauma factors on intervals. If data captured from SCARED trauma tool proves current client diagnosis needs to be revised, identify, train and identify a plan to improve process.	Managed Care Analyst	SCARED brief assessment tool, Anasazi Report Data	Due: 7/2018 Status: Identify a measuring tool.	BHS continues to work with EQRO during the development of this PIP.
Admin. – BHS will investigate if the implementation of text appointment reminders will decrease the percentage of client absenteeism for mental health services within six (6) months after implementation.	One Admin-PIP Per Year	Roll out survey to gage client and staff interest is text appointment reminders. Gather baseline absenteeism rates. Develop a HIPAA compliant authorization and a process policy and procedure for texting of appointment reminders. Identify the tool/service to use to complete text reminders and roll it out to sample group to work out any possible "bugs" before rolling out agency wide.	Managed Care Analyst	Anasazi Report Data	Due: 6/2018 Status: finalize the authorization form and P&P. Identify a tool or service.	BHS continues to work with EQRO during the development of this PIP.

Analysis—
Clinical PIP – we are moving forward with narrowing down our report specs, as well as the trauma measuring tool we will use to complete this PIP.
Admin PIP – we are in the process of developing an authorization for to allow for text/email appointment reminders as well as finalizing the policy and procedure for said process. Compliance officer is actively working on both the authorization and the policy and procedure to ensure all HIPAA/Privacy requirements are met prior to rolling out this service to our clients.

Goals for FY 18-19:

1. Work and plan effectively with the guidance of EQRO so we can head in the direction to make both the Clinical and Non-Clinical PIPs active PIPs.

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: 6/30/18 Status: continued monitoring with reports and/or other documentation due as required	Data is Attached: Call LOG FY17-18 Q1.pdf Call LOG FY 17-18 Q2 Call LOG FY 17-18 Q3 Contractor Data Trends FY 17-18
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: 6/30/18 Status: continued monitoring with repots and/or other documentation due as required	For all services: Average: 13 days (mean), with a median of 10 days for a total percent of 63% meeting the MHPs standard of 14 days. Please see “Self-Assessment of Timely Access” report for detail data and category breakdown.
Monitor length of time from initial request for psychiatric services to first psychiatric appointment.	3 business weeks for new patients.	Average length of time from first request for psychiatric appointment/assessment to first appointment	QI Coordinator or designee	Anasazi data	Due: 6/30/18 Status: Continued monitoring with reports and/or other documentation due as required	For all services: Average: 27 days (mean), with a median of 19 days for a total percent of 39% meeting the MHP’s standard of 21 days. Please see “Self-Assessment of Timely Access” report for detail data and category breakdown.
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: 6/30/18 Status: continued monitoring with reports and/or other documentation due as required	For all services: Average: 15.47 minutes with 99% meeting the MHP’s standard of 72 hours/4320 minutes. Please see “Self-Assessment of Timely Access” report for detail data and category breakdown.

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
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 placed in an out of county facility. Have this information available on Anasazi	Within 7 days post hospitalization	Average length of time for a follow-up contact after hospitalization	QI Coordinator or designee	Anasazi data	Due: 6/30/2018 Status: continued monitoring with reports and/or other documentation due as required	For all services: Total # of Hospital admissions: 315 Average: 5 days (mean), with a median of 3 days for a total percent of 65% meeting the MHP's follow-up standard of 7 days. Please see "Self-Assessment of Timely Access" report for detail data and category breakdown.
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: 6/30/18 Status: continued monitoring with reports and/other documentation due as required	For all services: Total # of Hospital admissions: 315 with 61 or 19% being readmitted within 30 days. Please see "Self-Assessment of Timely Access" report for detail data and category breakdown.
Track and trend data regarding no shows. 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 : 6/30/18 Status: continued monitoring with reports and/or other	For all services: Average No-Shows for Psychiatrists: 18% Average No-Shows for Clinicians: 18% Both are higher than the MHP's standard of 10%.

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
					documentation due as required	Please see “Self-Assessment of Timely Access” report for detail data and category breakdown.
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: 06/31/18 Status: continued monitoring with reports and other documentation due as required	The overall number of calls went down by 8.4% in FY 17-18. Response timeliness: Went up 4% for calls from jail & for all other calls went down 2% Please see attachments for all the details. PDF Crisis Calls Data Trends
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: 7/31/18 Status: continued monitoring with reports and/or documentation due as required	

Analysis—
We are hoping to provide this information for the first time thanks to a few changes to our system, implementation of Initial Contact form, and system knowledge from our Kingsview Analyst as well as our Managed Care Analyst assigned to data gathering and analyzing. This process is just beginning, changes and adjustments to this process will take place as we identify better ways of capturing data, running reports and identifying problem areas. In the process of running reports and analyzing data we have already identified a few areas where our numbers don’t seem quite right, we are investigating what the cause of the issue is.

Goals for FY 18-19:

1. Continue to monitor and evaluate the availability of data.
2. Continue to improve all processes in place to allow for more complete data availability.
3. Continue to work on developing a roadmap for report running by creating templates and guides to ensure data reliability.
4. Use track and trend data to identify areas of improvement to move closer to meeting set standards

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: 7/31/18 Status: Continued monitoring with reports and/or other documentation due as required	Due to the number of trainings this past FY, this specific training was not completed as scheduled but elements were incorporated into other trainings. For FY, 17-18, we have contracted with Relias Learning and this will be a mandated professional development training through this company for all staff. Relias was implemented in FY 17-18, however, it was not made available across the agency. In FY 18-19 we are working on implementing Relias Learning across the agency which will facilitate training availability and completion. Relias Email

Analysis—
A yearly Office Etiquette Training was facilitated on 03.09.18 to all clerical staff. This training touches on cultural and linguistic aspects to be mindful of while working in an office setting and dealing with the public. An Interpreter training was facilitated on 03.23.18 to all BHS staff who are qualified and trained to interpret for our Psychiatrists, in person or via telemedicine sessions. In addition, a cultural competence online training was completed by all staff on 05.31.18.

Goals for FY 18-19:

1. Staff will complete all required trainings through Relias Learning such as cultural competence, interpreter training, etc. Relias software will also serve as a tracking system to ensure all staff complete all assigned training in a timely manner.
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. 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

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