FY 18-19

FINAL QI WORK PLAN

Madera County

Behavioral Health Services

Quality Improvement Work Plan

July 1, 2018 – June 30, 2019

TABLE OF CONTENTS:

MADERA COUNTY BEHAVIORAL HEALTH SERVICES

QUALITY IMPROVEMENT WORK PLAN OVERVIEW JULY 2018 – JUNE 2019

The programs covered in this Quality Improvement Work Plan are provided through Madera County Behavioral Health Services in accordance to 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).

Quality Management (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.

Quality Management Work Plan (QMWP)

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;

- 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 a 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 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 is currently developing an Innovation proposals for FY 19-20, which is projected for implementation in late 2019 or early 2020.

The proposals will look at increasing access to mental health services. This collaborative project will include several organizations, including 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
Julie Morgan, LCSW	Behavioral Health Assistant Director
Anna “Missie” Rhinehart, LMFT	Managed Care Division Manager/ QMC Chair
Annette Presley, LCSW	Adult Services Division Manager
Art Galindo, LCSW	Children’s Services Division Manager
Melissa Nelson	Compliance Officer/Medical Records Supervisor
Eva Weikel	Managed Care Lead Analyst

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/UM committee collaborative JV 220 committee, medication monitoring committee, 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*

- *The BUZZ our staff newsletter*
- *Department Initiatives posted on Public Share (Intranet – PS) and the MCBHS website and Facebook*
- *Presentations to the Mental Health Board*

GOALS AND OBJECTIVES

The Quality Management Committee and other committees that deal with quality issues such as the QI/UM committee, 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 2018-19.

- 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, assessment tools, consumer and staff 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.

The 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.

To be completed at the end of the fiscal year.

Madera County Department of Behavioral Health
2018-2019 Quality Improvement Work Plan

SERVICE DELIVERY CAPACITY

Timeline: July 2018 – June 2019			(*) = new goal
Goal: Service Capacity will be analyzed to improve client services.			
Objective	**Indicator/Measurement**	**Responsible Entity**	**Planned Steps/Intervention**
1. Set up a process and identify a systems analyst to trend specific capacity related data: a) Total Medi-Cal Clients Served b) Type of Services c) # of Staff to Meet Demand	Semi-Annual Reports	Managed Care Designee QI Systems Analyst Kingsview Analyst	• EHR Client Service Reports will be ran • Reports will be ran to identify specific site information • Data trending process will be completed • Identify a baseline for each of the data components by site • Assess if changes need to be made to meet specific area service demand
***Goal: Ensure 100% of TAR denials receive a NOABD within 2 days from denial.**			
2. Ensure the NOABD process for denied TARs is established and kept current at all times.	Semi-Annual Report	Managed Care Designee Managed Care Analyst	• Maintain a denied TAR NOABD database current and accurate • Review database for any possible missing data or errors on a quarterly basis • Identify possible process breakdowns and determine a course of action to improve
***Goal: Implement Automated Phone System to meet DHCS requirements and improve client access.**			
3. Design a comprehensive automated phone system which provides clients with a way to contact the desired person or service as convenient and promptly as possible.	Implementation of Automated Phone System	Managed Care Designee Managed Care Analyst Service Manager	• Design a comprehensive narrative for client greeting and menu options • Set up option connections to assigned staff to assist for specific services • Inform clients and staff of said process before implementation • Train clerical staff as required

Analysis:

1. The MHP has established a quarterly reporting system which is presented during quarterly QM Committee Meeting. The assigned data analyst has been key in extracting and analyzing various data elements to provide the MHP with a clearer picture of our system. By trending said data and reporting it in a comprehensive manner the MHP is more in tune with changes or lack thereof within our overall system. As a result the MHP has moved closer to data based decision making. Quarterly data reports (demographics, services, and timeliness) have been presented to the QM Committee starting on 02/11/19.
   Some systematic changes made in the duration of this process were:
   - 01/11/19 - The addition of a "first accepted" field to our Medication Referral,
   - 02/01/19 - Transitioning our screening piece (first offered, first accepted entry) from front desk staff to a licensed clinician who can complete a pre-screening prior to scheduling, determine and complete a referral to managed care/other provider if needed.
   - 02/01/19 – Discontinue the use of our Initial Contact Form to capture first contact, first offered and first accepted data and transition this piece into Access to Services Journals which is another EHR function/component we were not previously using.
2. Since rolling out IN 18-010 (18-010E) we revamped our NOABD process to ensure timeliness and adherence to requirements across all MHP sites. The MHP has provided clear, consistent and concise direction to all staff to ensure the process is as clean and timely as possible, from understanding when to use each NOABD, how to complete it and which attachments to include with it. This process is ongoing as we better understand our agency needs and our effort to provide maximum clarity to staff and clients. In FY 18-19 there were a total of 41 denied TARs with 100% of denied TARs receiving a NOABD within 2 days from denial. This goal will not be part of FY 19/20 QIWP.
3. **This goal will not be part of FY 19/20 QIWP.** It was found that our current county wide phone system had the capability to meet all state requirements. There were a few changes made to the recorded greeting to ensure all required elements were present.

Goal for FY 19-20:

1. The data management piece is only in the first stages of development. Although much improvement has been made, there is much more to be done. We continue to work towards a more efficient way of capturing and extracting data to facilitate its interpretation and analysis. We are currently considering contracting with Tableau to facilitate some of this process.
2. The NOABD process will continue to be worked on and tracked. To make the collecting and tracking process more efficient we are considering creating a database, this will be worked on in the coming year.

BENEFICIARY/FAMILY SATISFACTION

Timeline: July 2018 – June 2019 (*) = new goal

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
Goal: Improve Client Satisfaction in Specified Areas.			
1. Analyze POQI results and improve: a) 95% of overall clients will be satisfied with BHS services b) 90% of responders will not have been arrested since starting services. c) 75% of responders will state they are better able to handle their daily life d) Increase number of Spanish language surveys collected	POQI Results	Managed Care Designee Managed Care Analyst	• Administer POQI twice a year in the Spring and Fall • Tracking and trend results from both • Analyze results • Design a roadmap to improve if established percentages are not met
Goal: Gather Client Satisfaction Surveys from Network Providers.			
2. POQI surveys will be sent to all Network Providers utilized by BHS in an effort to gage satisfaction data.	Annual POQI Results	Managed Care Designee Managed Care Analyst	• Send POQI forms to all our Network Providers who are actively providing services to our clients in the Spring • Collect POQIs from Network Providers separately from those administered by BHS • Analyze the same elements as those of BHS
Goal: Share POQI Results with Staff and BHB.			
3. POQI Results will be shared with staff and Behavioral Health Board (BHB) on an annual basis.	Annual Report Behavioral Health Board Minutes Email to Staff	Managed Care Designee Managed Care Analyst	• Send Email to staff after the fall POQI with reporting annual results • Present annual POQI report to BHB
Goal: Closely Monitor Grievance, Appeal, Fair Hearing & Change of Provider Forms.			
4. Complete follow through with all forms and keep up-to-date tracking logs for each. a) Track and trend data b) Review with QI Committee	Tracking Logs Acknowledgement Letters	Managed Care Designee Managed Care Analyst	• Review all logs for completion on a quarterly basis • Track and trend data annually • Present results to QI Committee annually • Establish goals for system improvement if necessary
Goal: Training on Difference between Grievance and Change of Provider Forms.			
5. Train Supervisors and Patient Rights Advocate on the difference between a grievance and a change of provider request form	Sign-in sheets Presentation	QI Coordinator	• Update training material as needed • Include how a complaint is also a grievance • This training should be annual

Analysis

1. POQI Analysis: most areas met with a slight decrease for item "c".
    a. From 95% in 2018 to 99.6% in 2019 = 4.6% increase
    b. From 90% in 2018 to 90.6% in 2019 = .6% increase
    c. From 75% in 2018 to 70.9% in 2019 = 4% decrease
    d. From 16 surveys in 2018 to 20 surveys in 2019 = 20% increase
2. The spring Client Satisfaction Survey (POQI) was mailed to 9 network providers. BHS received completed POQIs from only 1 provider facility.
3. **This goal will not be part of FY 19/20 QIWP, ongoing and established process.** POQI results will be shared with BHB via the 08.21.19 meeting.
4. Grievance, Appeal, Fair Hearing & Change of Provider logs are kept up to date at all times. A trending report was presented to QM committee on 02/11/19. When the new NOABDs were rolled out, the entire process was looked at, informal training took place to ensure all elements, to include the acknowledgement letter, was completed and provided to the client as per IN 18-010 and 18-010E.
5. **This goal will not be part of FY 19/20 QIWP, ongoing and established process.** Training was completed by Managed Care Division Manager on 05.22.19.

Goal for FY 19-20:

1. The MHP will continue to develop and expand the gathering of client satisfaction surveys from Network Providers to increase feedback from Spanish speaking clients and the elderly.
2. The MHP will collect provider satisfaction surveys from all Network Providers. Due to the low response from providers this year, we will continue to try to establish this process.
3. The grievance, appeal, fair hearing and change of provider piece has been completed, however, the data report to QI has not happened. In the coming FY we will tighten up that piece.
4. The MHP will ensure all Network Provider sites have BHS client rights informational brochures by contacting them on a quarterly basis and providing them a Brochure Request Form.
5. The MHP will complete 1 unscheduled audit of BHS' reception areas and 1 scheduled site certification check/audit.

Timeline: July 2018 – June 2019 (*) = new goal

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
Goal: Regulatory and Clinical Standards of Care for Documentation will be Exercised Across the MHP.			
1. Charts will be at 90% compliance with state standards for documentation.	Documentation Review Form Quarterly Compliance QI Report QI/UM Minutes QMC Minutes	Managed Care Designee QI Coordinator Managed Care Analyst	• Analyze data from collector. • A minimum of 3 charts for each clinical staff member will be reviewed annually by an external contract provider. • Results of the chart review are forwarded to clinical supervisors for corrections and staff training. • Clinical supervisors document the training provided regarding each chart review • Categorical errors are tracked to determine agency-wide need for training in specific • 6 charts per year will be reviewed for inter-rater reliability. • Report quarterly at QI/UM meeting. • Report annually at QMC meeting.
Goal: Complete Annual Documentation Training.			
2. Focus on: a) Specific, observable, measurable Tx plan objectives consistent with the diagnosis b) Chart progress (or lack of) towards treatment goals inclusive of SUD services.	Training Handouts Staff Sign In sheets QMC Minutes	Managed Care Designee QI Coordinator Managed Care Analyst	• Annual documentation training sponsored by DHCS will take place. • Additional documentation training will be provided during team meetings or individually at the discretions of Supervisors. • Annual documentation training will be updated as necessary.
Goal: Hospital Charts Will Be Reviewed & Recommendations Made to Decrease Re-hospitalization Rates.			
3. To decrease overall re-hospitalization rates with increased attention to: a) 1 day stays b) 14 day and over stays c) 2 or more admits in 30 days d) 3 or more admits in 6 months	Treatment Authorization Requests (TAR) TAR Log Database QMC Minutes	Managed Care Designee QI Coordinator Managed Care Analyst	• Maintain up-to-date TAR log • Track and Trend specified data • Report findings to QMC on a quarterly basis.
Goal: Monitor Appeal Hospital Charts for Quality Purposes.			
4. 100% of provider appeals related to hospitalizations and corresponding doctor rounds will be reviewed for quality	Provider Appeals	QM Coordinator	• Provider appeals will be reviewed retrospectively on a monthly basis. • Develop tracking system to trend data.

			• Present data at QMC Meeting semi-annually.
Goal: Identify Occurrences of Poor Quality Care.			
5. Track all/any report of poor quality care and take appropriate and timely action to address the issues.	EQRO Reports Adverse Incident Reports Grievances Change of Provider Requests Cultural Competency Committee Recommendations POQI Surveys	Data Management QI Staff Clinical Supervisors BHS Staff QMC Committee	• Review adverse incidents within 3 working days of report • Report poor quality and/or cultural competence considerations at QMC meeting • Report data on a quarterly basis
*Goal: Broaden Trauma-Informed Services.			
6. Schedule community events and trainings to provide education about the impact of trauma experiences.	Database Information Community events and trainings sign-in sheets, flyers, presentation material, etc.		• Provide 2nd Family Festival in October • Provide 4-5 full day trauma community trainings • Show at least 4 documentaries about the impact of trauma (ex. Paper Tiger) • Develop ACES screener outcomes database from multiple populations/organizations

Analysis

1. The goal percentage was modified from 100% to a more reasonable compliance rate of 90%. In addition, the intervention process has been intensified, new process is outlined in the Intervention section above. The MHP tracks this data to determine any areas of needed training.
2. The Annual Documentation Training is scheduled for supervisors on 07/17/19 and follow up with staff training on 07/25/19.
3. Hospital charts are reviewed and discussed during the QI/UM meeting. Recommendations regarding treatment options to decrease re-hospitalization are discussed. A quarterly report of the various day stays is presented to QMC.
4. Appeal hospital charts are reviewed retrospectively by licensed clinician. A tracking system is kept updated by the MHP and trending data is presented to QMC on a quarterly basis.
5. The grievance process is used to track all grievances to include poor quality of care occurrences, as mentioned previously, a quarterly report is presented at QMC.
6. ACES training provided to MFT, PA Nursing Intern and a High School Intern as well as 12-15 First 5 staff members. The ACES form is also used by clinical staff, at their discretion to assess trauma. BHS participated in 2 family community festivals at school settings on weekend days with much success.

Goal for FY 19-20:

1. The MHP will continue to complete chart reviews to identify any deficiencies and/or areas where training may be beneficial.
2. Annual documentation training continues to be an important part of our process not only because of any changes within the MHP processes but also because it's important all staff is under the same understanding about all requirements. This year the training will include a co-occurring piece to train clinical staff how to identify the presence of a co-occurring diagnosis.
3. Hospital charts will continue to be reviewed during the QI/UM meeting. Trending hospitalization stay data reports will be provided to QI/UM in addition to QMC.
4. With concurrent review changing the way we process TARs, we will continue to monitor appeal hospital charts for quality purposes and timeliness. A tracking system has been in place and data reports are presented to QMC on a quarterly basis.
5. Occurrences of poor quality will continue to be addressed on a timely manner and tracked for trending purposes in an effort to identify any possible deficiencies in the process and ensure service delivery. Data reports will continue to be presented to QMC.
6. BHS will continue to collaborate with community partners in the planning of family festivals which are an opportunity for outreach, provide information about our services and about ACES.

MONITOR SAFETY AND EFFECTIVENESS OF MEDICATION PRACTICES (THESE MAY CHANGE OVER TIME)

Timeline: July 2018 – June 2019 (*) = new goal

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
Goal: Monitor Medication Practices.			
1. Promote safe medication prescribing practices and evaluate their effectiveness a) Medication consent will be present 100% of the time b) Drug & allergy history updated at least every 90 days c) Meds were prescribed in compliance with general screening criteria d) Had current lab work ordered at least annually or as appropriate for therapy prescribed e) Vitals were obtained quarterly f) Meds prescribed were appropriate for indication/diagnosis g) Med Eva/Progress Note included presence or absence of side effects h) Med Eva/Progress Note included the effectiveness of current therapy i) Med Eva/Progress Note included client compliance j) Had client evaluated at least every 90 days	Monthly medication monitoring meetings Client Charts	Managed Care Designee Contracted Pharmacist Med Monitoring Minutes	• Analyze data from Survey Monkey collector • Pharmacist will continue to check for medication consents and evaluate MD prescription • Information will be presented during monthly med monitoring meetings
Goal: Capture Allergy History from the EHR.			
2. Continue to work with Kingsview to create a mechanism for recording if an allergy and drug history was asked every 90 days	Monthly medication monitoring meetings EHR Reports	QI Coordinator Kingsview Analyst	• Determine the area of EHR used to gather the data • Determine the process for entering data • Train designated staff on the process • Run reports and analyze data
Goal: Establish a Medication Consent which meets all State Requirements.			
3. Decide on a medication consent to be used agency wide	Monthly medication monitoring meetings EHR	Managed Care Designee Contracted Pharmacist QIC Coordinator	• Determine the format for a medication consent

			• WYSIWYG it into the EHR to implement agency wide • Run reports and analyze data as needed

Analysis

1. Due to an issue around privacy with our Survey Monkey collector, we stopped data entry of safe medication prescribing. At this point, we are unable to provide compliance rates for this component.
2. Worked with kingsview to educate telemed and in-office doctors via a webinar how to enter vitals, allergies and medical conditions. The webinar has been accessible to all doctors since 08/27/18. A quick guide with screen shots named "Medical Condition Review Data" is also part of this training. The training shows doctors how to navigate the EHR and determines a process for entering data. It is now also possible to run medical conditions (which include allergies) reports from the EHR.
3. **This goal will not be part of FY 19/20 QIWP, established process.** A medication consent meeting all state requirements was added to the EHR, agency doctors began using it on 10/18/18. Data reports can now be ran directly from the medical record.

Goal for FY 19-20:

1. BHS will work on getting a tracking system in place for this safe medication prescribing and will be able to provide compliance rates.
2. The educational webinar will continue to be utilized for training of new doctors. The MHP will work to expand its quarterly data reports to include a medical conditions report.
3. Establish a medication management group facilitated by nursing staff to educate clients how to manage medication, side effects, the effects of not taking medication as prescribed, etc. The pilot phase is scheduled with a start date of 07/16/19.

CONTINUITY AND COORDINATION OF CARE WITH PHYSICAL HEALTH PROVIDERS

Timeline: July 2018 – June 2019 (*) = new goal

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
Goal: Track Primary Care Referrals.			
1. Develop data tracking tool for primary care referrals	EHR Data Logs	Managed Care Designee Managed Care Analyst	• Design a tracking tool with all desired elements to obtain data • Track and trend data • Report as required
Goal: Appropriate Referrals will Be Made.			
2. Primary care will refer severely and persistently mentally ill (SMI) adults and seriously emotionally disturbed (SED) youth	EHR Data Logs	Managed Care Designee Managed Care Analyst	• Share referral determination sheet to primary care to ensure appropriate referrals • Track inappropriate referrals and provide training if necessary
Goal: Monitor Effectiveness of Physical Health Care Plans.			
3. Meet with both Blue Cross and Health Net (CalVIVA) over contractual issues	Meeting Minutes	Managed Care Designee Managed Care Analyst	• Meet with representatives from Blue Cross and Health Net on a quarterly basis • Discuss any issues

Analysis

1. **This goal will not be part of FY 19/20 QIWP as this component has been established and in effect for a few years.** The tracking tool is kept updated as new referrals are received by the MHP.
2. The MHP's focus in coordinating appropriateness of referrals has been made with our local FQHC which has been successful and ongoing.
3. **This goal will not be part of FY 19/20 QIWP as this component has been established and in effect for a few years.** The MHP has quarterly ongoing meetings with Managed Care Plans and local FQHC at the table. We recently collaborated to launch a bidirectional referral form; BHS is now working with Kingsview to have this form added to our EHR.

Goal for FY 19-20:

1. The MHP will work with PCPs to ensure referrals made to BHS are appropriate thru education and coordination.
2. Incorporate bidirectional referral into EHR so that data can be extracted from it.

Timeline: July 2018 – June 2019			(*) = new goal
Goal: Extract EHR Data Into A Meaningful Format.			
Objective	**Indicator/Measurement**	**Responsible Entity**	**Planned Steps/Intervention**
1. Establish a process for running reports on an ongoing basis to meet all MCBHS Managed Care and State requirements. a) Create templates for each report to establish consistent data	More accurate and consistent data EHR reports	Managed Care Designee Managed Care Analyst Kingsview Analyst	• Identify an effective process to create meaningful system data • Create guides to ensure data reliability and consistency from one reporting period to the next
Goal: Provide Mental Health Awareness.			
2. Continue providing Mental Health Awareness in the community	Training Flyers, sign-in sheets, reports, tables	Outreach/PEI Supervisor	• Monitor data reports, track and trend as needed.
Goal: Rewrite Anasazi Reports.			
3. Update all already existing templates to make it as simple as possible for supervisors to run their own reports	Report Templates	QI Coordinator Kingsview Analyst	• Identify which templates require updating • Collaborate with Kingsview Analyst to update the specific areas • Post updates to the already existing file in the share drive
***Goal: Develop an Internal Tracking System for Down Time and Connectivity Issues.**			
4. Collaborate with County IT and KV as necessary to develop a meaningful tracking system for down time as well as connectivity issues	Database or tool used for tracking	QI Coordinator Kingsview Analyst	• Seek feedback from County IT/KV to develop a similar internal process • Develop tracking tool

Analysis

1. **The templates portion of goal will not be part of FY 19/20 QIWP**, however the data report piece continues to be in development and will be an ongoing goal for FY 19/20. A quarterly process has been set for data reports which are presented to QMC for feedback, identify any trends of concern and or areas of improvement. In addition, templates have been created by MHP's data analyst which have preset specifications and can be easily loaded to run any quarterly report. The MHP has also established a reports log which specifies the path location of any data source in and outside of the EHR available to all MHP staff.
2. Mental Health Awareness in the community continues to thrive with a rough estimate of 102 outreach activities completed this FY throughout Madera County communities and 20+ Mental Health Trainings such as safeTALK, MHFA and ASIST. Additional Mental Health Trainings are provided to on an ongoing basis at BHS' main clinic and open to the public.
3. **This goal will not be part of FY 19/20 QIWP as it was determined this function is more in line with those duties assigned to our contractor Kings view.** This item has been on their to-do project list.
4. BHS has been working with County IT staff to make use of a ticket based tracking system. All system issues would go to a centralized email address as our current one (BHSAnasasisupport) but the new system would have a ticket component for tracking from receipt of reported issue to its completion and/or resolution. This item will remain on the QIWP as we anticipate its completion in FY 19/20.

Goal for FY 19-20:

1. Continue to identify data reports which may be important for decision making or to identify areas of improvement such as outliers. Find the most meaningful way to present the data to facilitate decision making.
2. Continue work in the community thru education and community events. Continue to establish partnerships with school districts from all Madera County communities.
3. Establish and launch the ticket based tracking system for system down time and connectivity issues.

PERFORMANCE IMPROVEMENT PROJECTS (PIP) (WORK IN PROGRESS AND MAY CHANGE)

Timeline: July 2018 – June 2019			(*) = new goal
Goal: Develop Clinical PIP.			
Objective	**Indicator/Measurement**	**Responsible Entity**	**Planned Steps/Intervention**
1. Are symptoms related to traumatic exposure (PTSD) being masked by ADHD, Anxiety and/or Depression symptoms?	Research EHR data Data analysis reports	Managed Care Designee Managed Care Analyst	• Gather statistics from EHR • Analyze data • Use the PIP tool to present results
Goal: Develop Administrative PIP.			
2. Will the implementation of TEARS decrease the percentage of client absenteeism for mental health services within six (6) months after implementation?	Research EHR data Data analysis reports	Managed Care Designee Managed Care Analyst	• Gather statistics from EHR • Analyze data • Use the PIP tool to present results

Analysis

1. Clinical PIP became active on 04.15.19 at which time clinical staff began using the SCARED tool with all new youth clients ages 8-18. We are actively working to add the SCARED tool to our EHR as an assessment allowing us to extract data directly from it for analysis, staff started making use of it on 07.01.19. We are currently looking at all collected data from 04.15.19-06.30.19 to ensure the process is moving forward accordingly.
   Findings thus far: 38 SCARED forms collected for a total of 29 unduplicated clients
   SCORING
   - 17 of the 38 clients had a total score of 25 or higher on first measure possibly indicating to an anxiety disorder
   - 2 clients had a score of 2 on the second measure possibly indicating a panic disorder or significant somatic symptom
   - 0 clients had a score of 9 on the third measure possibly indicating generalized anxiety disorder
   - 6 clients had a score of 5 on the fourth measure possibly indicating separation anxiety
   - 2 clients had a score of 8 on the fifth measure possibly indicating phobia disorder
   - 3 clients had a score of 3 on the sixth measure possibly indicating significant school avoidance

2. Non-Clinical PIP became active 06.18.19. It was rolled out to clients seen by one specific telemed doctor. Involved staff was informed of the process to ensure its flow and completion. Due to the closeness to EQRO from date of activation data analysis is not currently available, however, to date, all scheduled clients who have attended their scheduled appointments has agreed to text appointment reminders by signing an authorization form.

Goal for FY 19-20:

1. Analyze data collected on an ongoing basis, expand PIP to all clinical staff providing services to youth as soon as any possible issues in the pilot group are worked out. Identify whether our PIP hypothesis is true or not.
2. Continue to coordinate with front desk and medical records supervisor and kingsview contractor to implement all components of this very involved PIP. Lear how to use Teletask software and expand it to all clinics once the process is stable and all the details are figured out.

ACCESSIBILITY OF SERVICES

Timeline: July 2018 – June 2019			(*) = new goal
Goal: 24/7 Telephone Access Line.			
Objective	**Indicator/Measurement**	**Responsible Entity**	**Planned Steps/Intervention**
1. 90% of monthly test calls will pass MCBHS and state criteria. a) The 800 and the local numbers will be tested	Test call form and log of calls	QI Coordinator Managed Care Analyst	• Track and trend all test calls • Determine % of calls meeting requirements
Goal: Timeliness.			
2. Meet timeliness requirements as follows: a) Initial contact to first appointment offered: 10 days b) Initial contact to psychiatric appointment offered: 2 business weeks. c) Timely appointment for urgent conditions:72 hours d) Timely follow-up after hospitalization: 7 working days e) Re-hospitalizations: reduce to 5% f) No-shows: %	EHR Reports Crisis log TAR log	QI Coordinator Managed Care Analyst	• Run reports from EHR • Track and trend data • Determine % of requirements met and/or not met • Identify improvement plan if necessary
Goal: Crisis Calls.			
3. 100% of crisis call will be responded to within 1 hour.	EHR Reports Crisis log TAR log	QI Coordinator Managed Care Analyst	• Run reports from EHR • Track and trend data • Determine % of requirements met and/or not met • Identify improvement plan if necessary • Report to QMC quarterly

Analysis

1. The 24/7 telephone access line data used to be keyed into a SurveyMonkey collector, however, due to some privacy issues related to our contract the MHP decided to move this piece into an internal database at the end of February 2018. After submitting last quarter's report to the State, the MHP identified some inaccuracies with our reported data. This led the MHP to create a log that has more specific information that can help us report with more accuracy. The MHP is also making additional test calls due to the low number of calls logged by our reception staff and their concern that our database was not accurately storing entries. These additional calls are from the MHP to all our reception sites explicitly requesting they log the call so that the database can be tested for accuracy. Those calls are being tracked in a separate log which is then compared to the call log database front desk staff at all of our facilities key into.
2. Reports for all timeliness requirements are ran on a quarterly basis and presented to QMC. Data is tracked and trended to include a % of how the goal is met or not met.
    a. Cumulative (Q1-Q3) initial contact to first appointment offered within 10 days: compliance rate of 90%
    b. Cumulative (Q1-Q3) initial contact to psychiatric appointment offered within 15 days: compliance rate of 76%
    c. Cumulative (Q1-Q3) timely appointment for urgent condition: compliance rate of 92%
    d. Cumulative (Q1-Q3) timely follow-up after hospitalization within 7 days: compliance rate of 49%
    e. Cumulative (Q1-Q3) re-hospitalization within 30 days: rate of 15% from 19% last FY with a total decrease of 4%, shy 1% from our goal of 5% reduction.
    f. Cumulative (QI-Q#) no show rate: for psychiatry of 20% and 18% for clinical services.
3. 98% of all crisis calls were responded to within the hour by one of BHS' crisis workers.

Goal for FY 19-20:

1. Continue to provide direction, clarification and education around the logging of test calls and aim for logging of all test calls.
2. Continue to produce quarterly timeliness reports, track and trend data to find areas of improvement which will benefit our staff and clients by encouraging informed systemic changes.
3. Crisis data will continue to be tracked. The MHP will be implementing a database to collect the data in an effort to standardize and facilitate its analysis.

COMPLIANCE WITH REQUIREMENT FOR CULTURAL COMPETENCE AND LINGUISTIC COMPETENCE

Timeline: July 2018 – June 2019 (*) = new goal

Goal: Cultural Competence Trainings.			
Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
1. Work on obtaining enough Relias licenses for all BHS staff and use this means to complete mandatory cultural competence related trainings. Some trainings may continue to be provided in person.	Training Flyers Training Sign-in sheets Relias reports	Cultural Competency Coordinator QI Coordinator	• Rework Relias contract to give access to all BHS staff • Structure a mandatory training schedule to include but not limited to: Cultural Diversity, Interpreter Training and Multicultural aspects • Run reports using Relias software to track course completion
*Goal: Develop a Process to Determine Reading Level of Informational Literature for Linguistic Competence.			
2. Ensure all information literature provided to clients meets the State required reading level	Clinic lobbies P&Ps Brochures	Cultural Competency Coordinator	• Develop a process to determine reading level • Create P&P outlining process • Make sure all brochures meet said requirement

Analysis

1. **This goal was met and will not be part of FY 19/20 QIWP.** BHS was able to add an additional 40 Relias licenses by amending its contract effective 08/07/18. This allowed all BHS staff to have access to the program for completion of trainings and/or professional growth.
2. **This goal was met and will not be part of FY 19/20 QIWP.** A process to determine reading level of informational literature for linguistic competence was completed and established on 08/24/18. Policy & Procedure MHP 13.00 Language Interpretation, Informing Material Translation and Distribution was distributed to all staff to ensure awareness of the process.

Goal for FY 19-20:

1. Complete a cultural compliance training on a quarterly basis thru Relias.
2. During reception area audits (scheduled and unscheduled) the MHP will ensure all language access and client rights posters are visible to clients and that all brochures in both threshold languages are readily available to clients.
3. Complete a Client Culture Training for all staff which covers client personal experience with services.

ABBREVIATION KEY

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