FY 19-20

QUALITY IMPROVEMENT WORK PLAN

Madera County

Behavioral Health Services

Quality Improvement Work Plan

July 1, 2019 – June 30, 2020

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MADERA COUNTY BEHAVIORAL HEALTH SERVICES

QUALITY IMPROVEMENT WORK PLAN OVERVIEW JULY 2019 – JUNE 2020

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;

Children's Outpatient Services

- Serves the mental health needs of Madera county resident children and their families through a variety of services.
- Referrals are largely from parents, schools and other community organizations
- Services Provided with respect to Trauma Informed Practices
  - Comprehensive Clinical Assessment
  - Individual therapy
  - Individual Rehab
  - Group Rehab
  - Case Management
  - Collateral
  - Plan Development
  - Intensive Care Coordination
  - Intensive Home Based Services
  - Therapeutic Behavioral Services
  - Parent Orientation Groups
  - Parenting Classes

Lake Street

- Lake Street Center is a multi-disciplinary program comprised of Madera County Behavioral Health, Child Welfare Services and Madera County Public Health Department.
- Lake Street Center addresses the treatment needs of children, their families and care providers involved in the Child Welfare System.
- Services are provided are consistent with all aspects of the Continuum of Care Reform and Pathways to Well-Being (Formerly Katie A.)
- Services Provided with respect to Trauma Informed Practices
    - Comprehensive Clinical Assessment
    - Individual therapy
    - Individual Rehab
    - Group Rehab
    - Case Management
    - Collateral
    - Plan Development
    - Intensive Care Coordination
    - Intensive Home Based Services
    - Therapeutic Behavioral Services
    - Parenting Classes
    - Resource Parent Workshops

Health Beginnings/Infant Mental Health Program

- Specialized Mental Health services provided to families with children 0-5 years of age
- Focus on improving parent-child interaction and bonding as it pertains to related mental health impairments
- Services Provided with respect to Trauma Informed Practices
    - Comprehensive Clinical Assessment, specific 0-5 age group
        - Ages and Stages Questionnaires
        - Developmental Assessment
    - Individual therapy
    - Individual Rehab
    - Group Rehab
    - Case Management
    - Collateral

- Plan Development
- Intensive Care Coordination
- Intensive Home Based Services
- Therapeutic Behavioral Services
- Parent Orientation Groups
- Parenting Classes

Juvenile Justice Services

- Collaborative with Madera County Probation, Juvenile Division
- Serves families whose youth have been adjudged or at risk of being adjudged a ward of the Court
  - Includes youth involved with Court Day School, Correctional Academy and Juvenile Hall
- Pathways
  - Specialized treatment for those youth of been adjudicated for identified sexual offense

- Services Provided with respect to Trauma Informed Practices
  - Comprehensive Clinical Assessment
  - Individual therapy
  - Individual Rehab
  - Group Rehab
  - Case Management
  - Collateral
  - Plan Development
  - Intensive Care Coordination
  - Intensive Home Based Services
  - Therapeutic Behavioral Services
  - Parent Orientation Groups
  - Parenting Classes

Madera Access Point (MAP)

- The purpose of Madera Access Point (MAP) is to provide services to CalWORKS recipients who have identified Mental Health, Substance Use, or Domestic Violence Issues.
- The goal of the program is for participants to achieve:
  - Self-Sufficiency through decreased dependence on cash assistance (TANF)

- Personal growth
- Reduction in MH/SUD related impairments that are identified as barriers to employment

- Services Provided with respect to Trauma Informed Practices
  - Comprehensive Clinical Assessment
  - Individual therapy
  - Individual Rehab
  - Group Rehab
  - Case Management
  - Collateral
  - Plan Development
  - Mental Health First Aid Classes
  - Safe-Talk Classes
  - Total Health Plan

- **MENTAL HEALTH PLAN (MHP) OR MANAGED CARE**-- Provides the gate-keeping service for MCBHS. Staff provides a review for TARs from inpatient psychiatric hospitalizations, SARs for SB 785 services, as well as payment processing for all mental health related services and placements. It also handles site certifications and recertification, contracted provider credentialing, STRTP Presumptive Transfer related referrals and invoicing via CALMHSA portal, data analytics reporting for state and agency purposes, documentation reviews, Performance Improvement Projects, Cultural Competence Plan assessment, development and implementation, 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.

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
Sherrie DeGuzman	Compliance & Privacy Officer
Eva Weikel	Managed Care Supervising 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.

Timeline: July 2019 – June 2020			(*) = new goal
Goal: Expand data reporting piece to improve client services.			
Objective	**Indicator/Measurement**	**Responsible Entity**	**Planned Steps/Intervention**
1. Expand the data reporting piece to provide a wider and clearer understanding of our system. a. Retention rates b. Mapping	Quarterly Reports	Managed Care Designee QI Systems Analyst	• EHR Client Service Reports will be ran on a quarterly basis and presented at QMC. • Data trending process will be completed • Contract with Tableau to facilitate data analysis and report preparation process.
***Goal: Create database for NOABD tracking and trending.**			
2. Create a database for the tracking and trending of all the different types of NOABD.	Semi-Annual Report	Managed Care Designee Managed Care Analyst	• Create a database • Track and trend NOABD data • Present semi-annual report to QMC

Analysis:

1. The MHP was successful in establishing a quarterly data reporting schedule for tracking and trending purposes. The MHP's contract with Tableau was delayed due to County IT's configuration of our needed level of security in accordance with Privacy, Security and HIPAA laws. Prior to Tableau's contract being executed, the MHP decided to move to a new Electronic Health Record which comes with its own analytics capabilities thus the contract with Tableau was halted. However, the MHP became aware preparation of data analytical reports with use of Tableau is in the MHP's contract with Kings View. The MHP began working with Kings View analytics team to develop tailored reports to further understand how its internal processes flow.
2. The MHP was successful in the development of a database to track and trend all agency NOABDs. Below you can see the total NOABDs received by the MHP for FY19-20.

NOA Tracking Detail

Type of NOA	Total Of Client
Delivery System (NOA-A)	65
Denial of Payment for Services (NOA-B)	34
Failure to Provide Timely Access (NOA-E)	12
Notice of Appeal Resolution	2
Termination of Services	130

Goal for FY 20-21:

1. Expand data reports with the new Electronic Health Record by looking at the following components:
    a. Retention rates
    b. Mapping
    c. Language

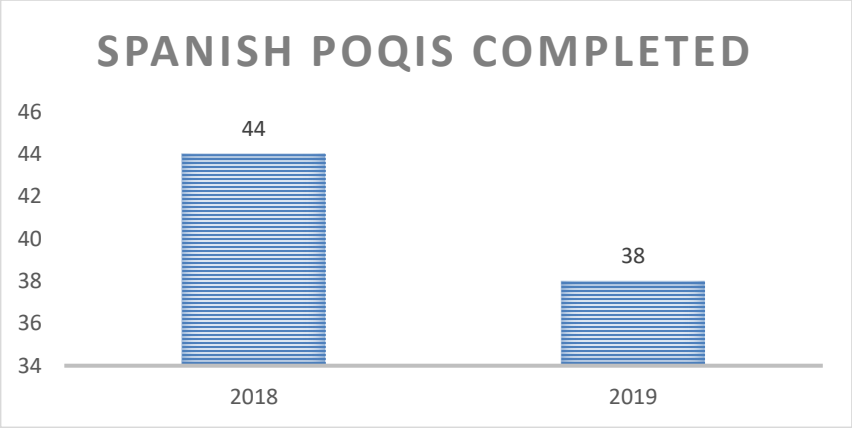
BENEFICIARY/FAMILY SATISFACTION

Timeline: July 2019 – June 2020 (*) = new goal

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
*Goal: Improve Client Satisfaction in Specified Areas.			
1. Collect more POQI feedback from Spanish speakers and the elderly to better understand the impact of our services.	POQI Results	Managed Care Designee Managed Care Analyst	• Continue administering POQI twice a year in the Spring and Fall • Tracking and trend results from both • Analyze results • Design steps to improve numbers to meet the objective.
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: Present Grievance, Appeal, Fair Hearing & Change of Provider Data Reports to QIC.			
3. The MHP will present data reports to QIC on an annual basis.	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: Communication with Network Providers to Ensure Beneficiary Rights.			
4. The MHP will contact all Network Providers on a quarterly basis to ensure all beneficiary rights literature is available to our clients.	Contact Logs to include Disposition and Compliance	QI Coordinator Managed Care Analyst	• Contact NP on a quarterly basis • Create and maintain log of contacts made, disposition and compliance with objective. • Report results to QMC annually.
*Goal: Audits of Reception Areas			
5. The MHP will complete 1 unscheduled audit of BHS' reception areas and 1 scheduled site certification check/audit.	Tracking log and forms system	QI Coordinator Managed Care Analyst	• Complete audits at all BHS reception areas • Complete forms • Prepare report • Present findings to QMC annually.

Analysis

1. Due to COVD-19 we were unable to compare more recent data than the one you see in the table below. The MHP is committed to obtaining data that is more reflective of the community we serve, efforts will continue to be made to gather feedback from Spanish speaking clients to better understand their needs.



2. The MHP sent out a total of 40 POQIs to contracted placement facilities as well as STRTPs to provide our clients the opportunity to provide feedback regarding their services. Unfortunately, at this time the MHP hasn't received any of them back. The MHP will continue this process.
3. The MHP was successful in meeting this goal by presenting grievance, appeal, fair hearing and change of provider data on several occasions through-out FY19-20. On 08.12.19 Change of Provider data was presented to the Quality Management Committee (QMC); on 10.14.19 Grievance/Change of Provider/Appeal became an agenda standing item for the QMC.
4. The MHP contacted providers on a bi-annual basis and although they reported clients do not make use of client rights forms, the MHP will ensure any updated forms are distributed to all providers in a timely manner regardless of use.
5. The MHP had an un-scheduled audit planned when the pandemic arose, and it was decided that the audit would be completed at a later date. Due to the continued modifications and safety requirements of the pandemic, the MHP has not been able to complete either an un-scheduled or scheduled audit of BHS' reception areas.

Goal for FY 20-21:

1. Continue efforts to gather feedback from Spanish speaking monolingual clients by partnering with the MHP's Ethnic Services Manager (ESM). Goal for FY 20-21 is to see an increase of 10 or more surveys of feedback collected.
2. The MHP will reach out to contracted providers twice a year to ensure our clients have access to client rights information and forms.
3. The MHP will complete reception audits, 1 unscheduled and 1 scheduled during FY 20-21 to ensure the most current informational material is available to beneficiaries.

SERVICE DELIVERY SYSTEM/CLINICAL ISSUES

Timeline: July 2019 – June 2020 (*) = 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. • Co-occurring diagnosis training piece added.
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.		• Continue to collaborate with partner agencies to provide family festivals where trauma informed education can be provided. • Incorporate trauma informed education as possible through our services.

Analysis

1. Chart review process was established to ensure chart reviews are completed on an ongoing basis. A total of 644 chart reviews were completed in FY 19-20. Of those 173 were compliant and an additional 185 became compliant after plan of correction (POC) was completed for a total of 358 charts in compliance for a grand total of (358/644 =) 56% compliance as per our chart review log. The MHP will revisit this process to increase completion of plan of correction process which can possibly be improved by closer and continuous follow-up.


Documentation Training PPT


Documentation Sign-In Sheets

2. Annual documentation training was completed on 07.25.19. Annual trainings will continue to ensure compliance with all documentation requirements.
3. In-Inpatient chart reviews are discussed monthly as part of the Quality Monitoring Meeting (QMM). Track and trend data is reported to Quality Management Committee (QMC) on a quarterly basis. As a result of this ongoing reporting, the MHP is planning to further address hospitalization rates through a clinical PIP.
4. All appeals to include hospital appeals are followed up on a timely manner to ensure quality of services. In FY 19-20 there were a total of 7 appeals all related to termination of benefits which were overturned thereafter.
5. All client rights processes to include grievances, change of provider requests, NOABDs are addressed in a timely manner with the MHP making contact with the client to resolve the issue. Data related to these processes is presented to the QMC at least biannually.
6. Trauma informed education events happened throughout the year. Education was provided to other community agencies as well as MHP providers with the most recent one happening at the end of the FY. Here are some of the trainings coordinated by Julia Garcia, LCSW.


Secondary Trauma


Secondary Training PPT


Trauma at the Table


Trauma Master Series


The Body Keeps Score

Goal for FY 20-21:

1. Expand on creating accountability for supervisor completion of Plan of Corrections (POC). All chart reviews for which corrections are noted upon review will be followed up on with supervisors to ensure a completed plan of correction is received by the MHP. The MHP will contact the supervisors if a POC is not received within a month from chart review. The MHP would like to see a total compliance percentage of 66% by next fiscal year.
2. The MHP will determine how to best analyze data from our existing TAR concurrent review log and report to QMC/QMM at least annually.

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

Timeline: July 2019 – June 2020 (*) = 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: Medical Conditions Data Report			
2. The MHP will work on educating itself about the medication conditions report, what type of information would be feasible to track and trend.	Monthly medication monitoring meetings EHR Reports	QI Coordinator Managed Care Analyst	• Determine the area of EHR used to gather the data • Determine which data would be more informational for tracking and trending • Present data to QMC and/or Medication Monitoring Committee semi-annually
Goal: Medication Management Group for Clients			
3. Provide an ongoing educational group for our clients regarding medication management	Documentation collected by Nursing Staff	Nursing Staff	• Pilot to begin 07.16.19

			• Provide ongoing groups to stress the importance of medication compliance.

Analysis

1. The safe medication practice log was discontinued last year due to discontinued use of Survey Monkey collector and was not revamped thus no report was available for EQRO last year. The MHP compiled the data to ensure tracking and monitoring continued once again in FY19/20, results are below.
   a. Medication consent will be present 100% of the time – 65% compliance
   b. Drug & allergy history updated at least every 90 days – 72% compliance
   c. Meds were prescribed in compliance with general screening criteria – 86% compliance
   d. Had current lab work ordered at least annually or as appropriate for therapy prescribed – 66% compliance
   e. Vitals were obtained quarterly – 72% compliance
   f. Meds prescribed were appropriate for indication/diagnosis – 84% compliance
   g. Med Eva/Progress Note included presence or absence of side effects – 85% compliance
   h. Med Eva/Progress Note included the effectiveness of current therapy – 85% compliance
   i. Med Eva/Progress Note included client compliance – 85% compliance
   j. Had client evaluated at least every 90 days – 83% compliance
2. The MHP did not address this goal this fiscal year and will put it on hold as it may be readily available for all staff in our new EHR.
3. The medication management group for clients was launched 07.16.19, however, there wasn't enough interest from our clients and was discontinued soon thereafter. There are no plans to attempt this approach again in the foreseeable future.

Goal for FY 20-21:

1. Safe Medication Data will be tracked an additional year for components a-j listed above, we hope to see a 1-2% improvement for each component and results will be presented to medication monitoring committee on quarterly basis.

CONTINUITY AND COORDINATION OF CARE WITH PHYSICAL HEALTH PROVIDERS

Timeline: July 2019 – June 2020			(*) = new goal
Goal: Appropriate Referrals will Be Made.			
1. Primary care will refer severely and persistently mentally ill (SMI) adults and seriously emotionally disturbed (SED) youth. a. Expand to PCPs	EHR Data Logs	Managed Care Designee Managed Care Analyst	• Determine how we can best communicate referral process and appropriateness to PCPs • Determine how to track inappropriate referrals and provide training if necessary
***Goal: Bidirectional Referral into EHR**			
2. Add bidirectional form to our EHR to facilitate its completion by staff as a referral form when beneficiaries don't meet our criteria.	EHR Reports	Managed Care Designee Managed Care Analyst	• Add bidirectional form to EHR • Run reports to ensure clients are being linked when they don't meet criteria for our services.

Analysis

1. As of this FY all referrals go through a screening process which allows the MHP to determine appropriateness of referral as opposed to assessing anyone who requested services. As you see in the attachment, a total of 340 referrals were made by health care providers, from those 61 were inappropriate referrals and 339 making appropriate referrals 82% of the time.

Health Care
Provider Referrals

2. The bidirectional form was added to the EHR in September of 2019, however, due to limitations in our system's ability to make the form in the EHR look or functions as that on paper, it was decided the MHP would move back to completing the hardcopy bidirectional instead of completing it in the EHR as of January 2020.

Goal for FY 20-21:

1. The MHP will begin working on transitioning the credentialing paperwork component from hard copies to electronic fillable forms and determine the feasibility of having this component on the agency website for easy access to all interested providers.
2. The MHP will begin working on adding informational material such as brochures, flyers from each MCP in our lobbies to better inform Madera County beneficiaries.

Timeline: July 2019 – June 2020			(*) = new goal
***Goal: Extract EHR Data Into A Meaningful Format.**			
Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
1. Continue to expand our quarterly reporting process. a. Begin looking into reasons for outliers	Data Reports EHR reports	Managed Care Designee Managed Care Analyst	• Continue to identify meaningful data reports • Identify outliers and work to understand why they look the way they do and determine what the best course of action is to minimize their presence.
Goal: Provide Mental Health Awareness.			
2. Continue providing Mental Health Awareness in the community a. Look to establish partnerships with schools throughout our service area.	Training Flyers, sign-in sheets, reports, tables	Outreach/PEI Supervisor	• Monitor data reports, track and trend as needed.
Goal: Develop an Internal Tracking System for Down Time and Connectivity Issues.			
3. Collaborate with County IT and KV as necessary to develop a meaningful tracking system for down time as well as connectivity issues a. Monitor ticket system to ensure issues are resolved in a timely manner.	Database or tool used for tracking	QI Coordinator Kingsview Analyst	• Seek feedback from County IT/KV to develop a similar internal process • Designate staff to monitor ticket response and resolution.

Analysis

1. The MHP did not have an opportunity to achieve this goal due to staffing changes and volume of duty redistribution. It is still a goal the MHP wants to reach and finds important to the integrity of data reports. The MHP will begin looking at outliers in FY 20-21 to better understand their reason and impact on services/processes.
2. Mental Health Awareness education continued during FY19-20 with a total of 106 outreach events through end of April with 46 of those taking place in


Outreach Log

community school grounds from head start to college level for a grand total attendance county of 13,524 students reached.
3. The agency worked with county IT to develop a ticket system to deal with any Anasazi related issues. All staff have the I.T. Helpdesk icon on their desktop which is to be used for any system issues for tracking and resolution tracking. The I.T. Helpdesk system is managed by our own internal staff,


I.T. Helpdesk

not County I.T.

Goal for FY 20-21:

1. Upon analysis of quarterly reports the MHP will begin looking at outliers to better understand their causes. The MHP will better understand the different reasons for outliers by next EQRO review. A report of reasons or information in general will be provided to the QMC and QMM once compiled.

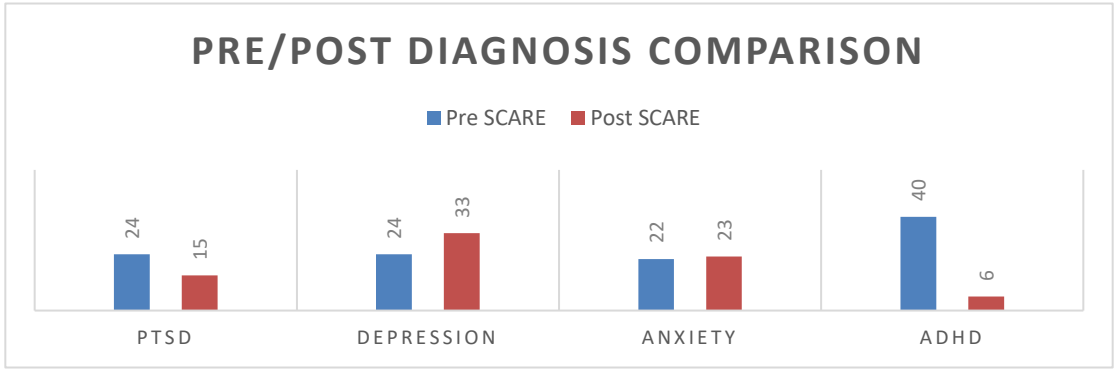
PERFORMANCE IMPROVEMENT PROJECTS (PIP) (WORK IN PROGRESS AND MAY CHANGE)

Timeline: July 2019 – June 2020 (*) = new goal

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
Goal: Develop Clinical PIP.			
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. The Clinical PIP became active on 04.15.19. Its evaluation was completed in June 2020, the findings showed that ADHD was most likely over diagnosed. The SCARE tool proved to be beneficial in the diagnosing process and improved the overall process by providing clinical staff with a tool to better pinpoint the most appropriate diagnosis between those with similar symptomology. As seen below, data showed an exceptional decrease of 85% in ADHD diagnosis post SCARE while the biggest increase was depression with an overall increase of 27%. In addition, PTSD saw a decrease of 37 % post SCARE with a slight increase in anxiety diagnosis. Although the PIP did not provide evidence to support the MHP's hypothesis quite the way it was expected, the MHP did learn that a diagnosis of ADHD was being overrepresented and that its decrease resulted in an increase in depression diagnosis and a decrease in PTSD.



2. The Non-Clinical PIP was extended through December 2020. The MHP began collecting authorizations from clients who wanted to opt into the text/email appointment reminder system (TEARS) in June of 2019. On 01.03.20 the pilot became active and on 01.29.20 TEARS went agency-wide, however, COVID-19 occurred and to adapt the agency changed who/how appointment were to be scheduled, the responsibility wen to each individual clinician which decentralized the process and TEARS had to be suspended. At this point the MHP has decided to scale this PIP back down to clients attending medication appointments only, TEARS will be reactivated as front desk staff have taken back that responsibility and are able to complete the process. A concern at the moment is the authorization form for new clients or ongoing clients who would like to opt in during COVID-19 as most are completing the intake process via phone making it impossible to obtain their signature on the TEARS authorization. For the moment the MHP is honoring verbal agreements.

Goal for FY 20-21:

1. The MHP has a new Clinical PIP running from FY20-22 related to decreasing psychiatric inpatient hospitalizations. The interventions started on 07.01.20. The MHP believes that a new process with additional interventions will result in a decrease number of re-hospitalizations. Please refer to *Clinical PIP – Reducing Psychiatric Re-Hospitalizations*.
2. The MHP will continue using text/email appointment reminders for medication services and will provide a complete analysis upon completion.

ACCESSIBILITY OF SERVICES

Timeline: July 2019 – June 2020			(*) = 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 business days. b) Determination of need of psychiatric services to first psychiatric appointment offered: 15 business days. c) Urgent appointment that do not require prior authorization: 48 hours d) Urgent appointment that require prior authorization: 96 hours e) Timely follow-up after hospitalization: 7 working days f) Re-hospitalizations: reduce to 5% g) 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 • Present to QMC quarterly
Goal: Crisis Calls.			
3. 95% of crisis call will be responded to within 1 hour.	EHR Reports Crisis log TAR log	QI Coordinator Managed Care Analyst	• Create Database • Track and trend data • Determine % of requirements met and/or not met • Identify improvement plan if necessary • Report to QMC quarterly

Analysis

1. The MHP has made changes to this process to include the creation of a database for data collection as well as modifying the process and providing education to the staff in charge of collecting the data. Our compliance rate ranges from quarter to quarter, this indicates reminders or closer tracking and communication with staff is necessary on an ongoing basis. Our current rate is 90.9% of test calls met MCBHS and state criteria.
2. Timeliness has been a big focus for the MHP in the last few years, we continue to make changes to our system to improve access to services.
   a. Initial contact to first appointment offered: 10 business days – 98% compliance
   b. Determination of need of psychiatric services to first psychiatric appointment offered: 15 business days – 98% compliance
   c. Urgent appointment that do not require prior authorization: 48 hours – 80% compliance
   d. Urgent appointment that require prior authorization: 96 hours – 97% compliance
   e. Timely follow-up after hospitalization: 7 working days – 42% compliance
   f. Re-hospitalizations: reduce to 5% - FY 18/19 was at 15% in FY19/20 we are at 12% for a total decrease of 3%
   g. No-shows: Goal setting was overlooked, however we had a slight improvement:
      MD No Shows: FY18-19 at 20% and FY19-20 at 19% for a 1% decrease
      Clinical No Shows: FY18-19 at 19% and FY19-20 at 15% for a 4% decrease
3. The MHP managed to meet the 95% goal for response to crisis calls within 1 hour with a 99.12% compliance rate for FY19-20.

Goal for FY 20-21:

1. The MHP will monitor the test call process by providing test call results to those in charge of logging them as close to real-time as possible. It is hoped the additional data will help stress the importance of logging calls into the “Call Log” database and for them to become familiar with the types of calls that should be logged. A report will be provided annually at QMM.

COMPLIANCE WITH REQUIREMENT FOR CULTURAL COMPETENCE AND LINGUISTIC COMPETENCE

Timeline: July 2019 – June 2020 (*) = new goal

Goal: Cultural Competence Trainings.			
Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
1. Complete a quarterly training on a cultural (competence) related topic thru Relias	Relias reports	Cultural Competency Coordinator QI Coordinator Managed Care Analyst	• Assign 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: Client Rights Postings and Literature Availability in Threshold Languages.			
2. 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.	Audit Documents/Reports/Logs	Cultural Competency Coordinator Managed Care Analyst	• Complete site audits • Document findings • Report to QMC annually.
*Goal: Complete an In-Person Client Culture Training.			
3. Coordinate to provide an all staff mandatory client culture training.	Flyer Sign-In Sheets	Cultural Competency Coordinator Managed Care Analyst	• Work with agency partners to coordinate a client culture training. • Collect sign-in sheets.

Analysis

1. Quarterly Trainings through Relias are proceeding as expected and the goal will be met. Quarterly cultural competence trainings were set to be rotated evenly with in person trainings so it will not become monotonous to staff. The schedule was set for Q1 & Q3 to be scheduled in Relias and for Q2 & Q4 to be given in person. A vote was taken at the Quality Monitoring Meeting to determine which culturally sensitive topics to cover. The two training topics that received the highest number of votes were: *How Culture Impacts Communication* and *Building a Multicultural Care Environment*. Due to COVD-19, an additional training will be added to replace the Q4 in-person training. From Relias reports, 88% of staff completed the Q1 trainings with 12% either in progress or have not yet started. The Q3 Relias training will be scheduled soon.
2. Completing audits to ensure language access/clients rights are visible in threshold languages, has been placed on hold and the goal will not be met. The audit was due to be completed in March, however that had to be canceled due to COVID-19. A stay in place order was given which lasted until the end of May. In June, staff began returning to the office and but towards the end of June, COVID-19 cases began rapidly rising so there have been no immediate talks about completing those audits.
3. Coordinating all staff client culture trainings had to be cancelled due to COVD-19, so this goal will not be met. Quarterly cultural competence trainings were set to be rotated evenly with in person trainings so it will not become monotonous to staff. The schedule was set for Q1 & Q3 to be scheduled in Relias and for Q2 & Q4 (Interpreter Training, Sikh Culture, senior population) to be given in person. The Q2 in person trainings were set for March and April (Interpreter Training and Sikh Culture Training) but that had to be cancelled due to the restrictions on large in person gatherings. Since there was a transition from staff working in an office, to working from home, no training took place in Q2. After careful consideration for staff/provider safety, all in person meetings will be cancelled and Q4 will be replaced with an online Relias course.

Goal for FY 20-21:

1. Complete monthly educational/informative articles on cultural (competence) related topics in the agency wide newsletter, “The Buzz”.
2. Ensure clients feel supported in their language by having bilingual staff voluntarily wear an identifier displaying their bilingual language.

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
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
QMM	Quality Monitoring Committee
S&D	Screening and Disposition
SED	Severely and Emotionally Disturbed
SCERP	Small County Emergency Relief Plan
SMI	Severely and Mentally Ill