FY 20-21

QUALITY IMPROVEMENT WORK PLAN

Madera County

Behavioral Health Services

Quality Improvement Work Plan

July 1, 2020 – June 30, 2021

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MADERA COUNTY BEHAVIORAL HEALTH SERVICES

QUALITY IMPROVEMENT WORK PLAN OVERVIEW JULY 2020 – JUNE 2021

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, Medication Monitoring Committee, Quality Monitoring Committee (QMM), 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*
- *Weekly WebEx Conference with Director*

GOALS AND OBJECTIVES

The Quality Management Committee and other committees that deal with quality issues such as the QMM 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 2020-21.

- 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 2020 – June 2021			(*) = 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 the new EHR system.	Ongoing/Quarterly Reports	Managed Care Designee QI Systems Analyst	• EHR Client Service Reports will be ran on an ongoing basis by supervisors and managers, and monthly reports will be presented at the Quarterly Monitoring Meeting (QMM). • Data trending process will be completed

Analysis:

1. The MHP moved to a new Electronic Health Record (EHR) – InSync Heathcare Solutions. The new EHR system rolled out on December 21, 2020 and has its own analytics capabilities. The MHP was successful in utilizing some of the report's functionality and were able to create tailored forms and reports for providers, supervisors, and managers to assist with improving delivery of client services. This functionality includes the custom creation of forms for staff use and custom reports for supervisors and managers to review staff caseload management and client services on an ongoing basis. These reports include but are not limited to the MHP – Service Report, SUP/MNGMT – Productivity Report and SUP/MNGMT – 30/60/90 Report.

   In addition, MHP needed additional reporting functionality that did not currently exist in the new EHR. The MHP met with InSync representatives during the week of June 7, 2021 thru June 11, 2021 to map and configure additional customization of report services such as reports for the Assessment of Timely Access, CSI Module mapping and billing functionalities. In addition, the MHP has a weekly EHR InSync Meeting consisting of Madera County Department of BHS staff and InSync representatives to review current and ongoing data reporting successes, issues, and needs. Data trending and reporting are also included in the monthly Quality Monitoring Meetings (QMM) as a regular agenda topic.

Goal for FY 21-22:

1. Expand data reports with the new EHR by looking at the following components:
   a. Retention rates
   b. Language
   c. Others
2. (New) Make use of the new EHR's Patient Portal to communicate with beneficiaries and streamline document exchange process and their preferred means of communication.

BENEFICIARY/FAMILY SATISFACTION

Timeline: July 2020 – June 2021			(*) = new goal
Goal: Improve Client Satisfaction in Specified Areas.			
Objective	**Indicator/Measurement**	**Responsible Entity**	**Planned Steps/Intervention**
1. Collect more POQI feedback from Spanish speakers to better understand the impact of our services. Goal: Increase total FY collection to 48 or more. a. POQI Results will show year over year comparisons.	POQI Results	Managed Care Designee Managed Care Analyst Ethnic Services Manager	• 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: Communication with Network Providers to Ensure Beneficiary Rights.			
2. The MHP will contact all Network Providers twice a year 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 twice a year • Create and maintain log of contacts made, disposition and compliance with objective. • Report results to QMC annually.
Goal: Audits of Reception Areas			
3. 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. The Performance Outcome Quality Improvement (POQI) objective was placed on Hold during the Covid19 pandemic office closure mandates. As a result, the surveys collected for FY19-20 and FY20-21 are significantly lower than the FY18-19 making the year-to-year comparison difficult.

   However, the MHP is committed to obtaining data that is reflective of the services we provide. After the pandemic restrictions were lifted, the MHP has restarted the POQI survey feedback again. The MHP provided walk-in clients with a Consumer Perception Survey during the week of June 21, 2021 – June 25th, 2021 in all its facilities. Future emphasis will be placed on collecting feedback from the monolingual Spanish speaking population to better understand the impact of our services to this beneficiary group.

   As of July 14, 2021 a total of 162 surveys were received.
   - Survey A: Youth Services Survey Spring 2021
   - Survey B: Youth Services Survey for Families Spring 2021
   - Survey C: Adult Survey Spring 2021
   - Survey D: Older Adult Survey 2021

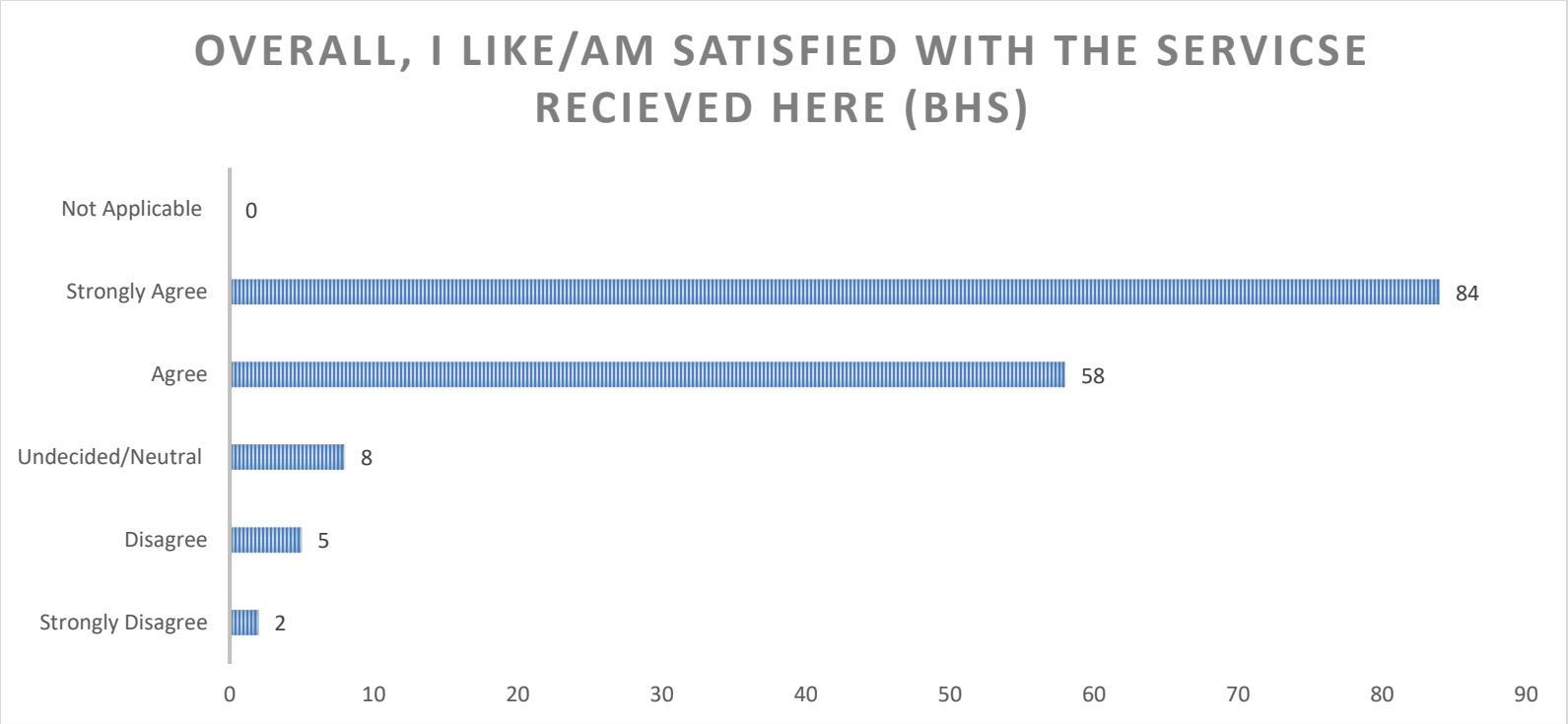
   Table 1.1 POQI Survey Total Count

	Total	Survey A	Survey B	Survey C	Survey D
POQI Survey Total Count	162	19	37	100	6

Table 1.2 Language Survey

	Total	Survey A	Survey B	Survey C	Survey D
English	146	18	30	92	6
Spanish	16	1	7	8	0
Grand Total	162	19	37	100	6

Table 1.3 Agency Satisfaction Survey Spring 2021



2. The MHP has a designated staff who contacts network providers on a semi-annual basis to ensure provider's current forms, notices and guides are up-to-date and made readily available to clients. The MHP has ensured updated forms are readily available and distributed in a timely manner to all providers. The MHP is keeping a record of the contacts made, dispositions and network

provider compliances. Total number of forms and/or brochures provided during FY20-21 is 912. Data reports are presented to the QMM committee annually.

3. Although a process was established, the goal was not completed since an unscheduled audit did not take place. All four reception areas received a scheduled visit on 10/21/2020 from two MHP staff members which included the Ethnic Services Manager to ensure compliance with the Cultural Competence section of the audit. A scoring method was created to set up an efficient system and produce an impartial evaluation of each individual office. Eight sections were created and given a point range.

   Sections and Rating Scales:

   I. Brochures - Informing Materials **[*possible points: 0 – 4]***
   II. Flyers - Informing Materials ***[possible points: 0 – 1]***
   III. Flyers - Anthem & CalViva Info Materials ***[possible points: 0 – 1]***
   IV. Accessibility - Safety & ADA Compliance ***[possible points: 0 – 1]***
   V. Accessibility - General Operation Procedures ***[possible points: 0 – 1]***
   VI. Accessibility - Provided upon request ***[possible points: 0 – 1]***
   VII. Accessibility - Language & Cultural Competence (Front Desk Only) ***[possible points: 0 – 1]***
   VIII. Other (if applicable) ***[possible points – n/a]***

   Section I is broken down based on form count, below is the established rating scale:

   - 90% - 100% updated forms (17-18 out of 18 current forms) = points 4 - Outstanding
   - 80% - 89% updated forms (15-16 out of 18 current forms) = points 3 - Exceeds Expectations
   - 70% - 79% updated forms (13-14 out of 18 current forms) = points 2 - Meets Expectations
   - 60% - 69% updated forms (11-12 out of 18 current forms) = points 1 - Below Expectations
   - 0 - 59% updated forms (10 or less out of 18 current forms) = points 0 - Poor

   Sections II – VIII are rated with a pass (1) or needs improvement (0) for a total possible score of 10 for the audit.

   Once all points were tallied every office received a final score and given any recommendations. A strong process was created but consistency in supervision is needed. Half of the offices did very well (100% & 90%) while the other two had an overall score of 50%. Below are the audit findings report received by each of the offices.

Table 1.4 Audits of Reception Area

	Oakhurst Counseling Center	Pine Recovery Center	Chowchilla Recovery Center	7th Street
Brochures - Informing Materials	0	4	0	4
Flyers - Informing Materials	1	1	1	1
Flyers - Anthem & CalViva Info Materials	1	1	1	1
Accessibility - Safety & ADA Compliance	1	1	1	1
Accessibility - General Operation Procedures	0	1	1	1
Accessibility - Provided upon request	1	1	1	1
Accessibility - Language & Cultural Competence (Front Desk Only)	1	1	0	0
Total Score out of 10 =	5	10	5	9
Percentage =	50.00%	100.00%	50.00%	90.00%

Goal for FY 21-22:

1. Continue efforts to gather feedback from Spanish speaking monolingual clients by partnering with the MHP's Ethnic Services Manager (ESM). Goal for FY 21-22 is to obtain 48 or more surveys from this population.
2. Goal will not be part of FY21/22 QIWP.
3. Two unscheduled audits will be set for the next fiscal year. Data will be provided by comparing the rate of change and overall improvement of reception areas.
4. (New) Have satisfaction surveys and suggestion boxes available in our lobbies for beneficiary feedback.

Timeline: July 2020 – June 2021 (*) = 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 66% 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: TAR Concurrent Review Process Analysis**			
2. Analyze data on existing concurrent review log to better understand the flow.	Concurrent Review Log	Managed Care Designee QI Coordinator Managed Care Analyst	• Become familiar with data on concurrent review log • Analyze data to better understand the process • Present results to QMC/QMM • Make changes if determined necessary to improve the process

Analysis

1. The MHP met this goal for the FY20-21. A total of 114 charts have been reviewed. Of the 114 charts, 82 charts met the state standards for documentation which is 71.93%. Moving forward this will be managed through an audit manager in our new Electronic Health Record (EHR). A process will be reviewed, established and if necessary, it may be added to future QIWPs.

2. The MHP has a designated analyst to run the Treatment Authorization Review (TAR) Concurrent report on a quarterly basis. The data reviewed on the TAR Concurrent process include but are not limited to the admitting facility, the number of clients authorized or denied, the type of authorizations approved, the expected length of client's inpatient stay, the average number of days authorized and the number of days from the date of admission to the date the notice of admission was received by the MHP. This report is presented to the Quality Monitoring Meeting on a quarterly basis and is a revolving agenda item.

   The MHP has an overall 96.04% authorized or approval rating for the treatment review process.

Concurrent Review
Log Data Report (FY

Goal for FY 21-22:

1. Goal will not be part of FY21/22 QIWP.
2. Goal will not be part of FY21/22 QIWP.
3. (New) Complete 10 Inter-Rater reliability chart reviews per year.

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

Timeline: July 2020 – June 2021 (*) = new goal

Goal: Monitor Medication Practices.

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
1. Promote safe medication prescribing practices and evaluate their effectiveness a) Medication consent will be present: goal 70% b) Drug & allergy history updated at least every 90 days: goal 74% c) Meds were prescribed in compliance with general screening criteria: goal 88% d) Had current lab work ordered at least annually or as appropriate for therapy prescribed: goal 68% e) Vitals were obtained quarterly: 74% f) Meds prescribed were appropriate for indication/diagnosis: 86% g) Med Eval/Progress Note included presence or absence of side effects: goal 87% h) Med Eval/Progress Note included the effectiveness of current therapy: 87% i) Med Eval/Progress Note included client compliance: 87% j) Had client evaluated at least every 90 days: 85%	Monthly medication monitoring meetings Client Charts	Managed Care Designee Contracted Pharmacist Med Monitoring Minutes	• Compile data • Analyze data from log. • Pharmacist will continue to check for medication consents and evaluate MD prescription • Information will be presented on an annual basis to med monitoring committee.

Analysis

1. The MHP restarted the safe medication practice log using the Survey Monkey collector. The MHP have been collecting and compiling data to ensure tracking and monitoring of the medication prescribing processes for FY20-21. The data is presented to the Medication Monitoring Committee annually. The Medication Monitoring Committee meets monthly to review and evaluate current medication prescribing practices to ensure effectiveness and timeliness of the process. FY20-21 data results are below. The agency has met 50% of its targeted goal.

   Table 2.1 Medication Practice

	Goal	FY %	Goal Met	Number of patients
a) Consent for the psychotropic medication prescribed & present inpatient record per BHS procedure.	70%	51%	No	69
b) Drug & allergy history (updated at least every 90 days) obtained from patient & present in record.	74%	75%	Yes	69
c) Medication prescribed in compliance with general screening criteria.	88%	84%	No	69
d) Current lab work ordered at least annually or as appropriate for therapy prescribed.	68%	62%	No	69
e) Current weight/vitals obtained at least quarterly.	74%	23%	No	69
f) Medications prescribed by Psychiatrist appropriate for indication/diagnosis.	86%	77%	No	69
g) Medication Evaluation/Progress Note by physician includes presence or absence of side effects.	87%	94%	Yes	69
h) Medication Evaluation/Progress Note by physician includes effectiveness of current therapy.	87%	96%	Yes	69
i) Medication Evaluation/Progress Note by physician includes patient compliance.	87%	96%	Yes	69
j) Patient evaluated at least every 90 days when prescribed by Psychiatrist.	85%	96%	Yes	69

Goal for FY 21-22:

1. Safe medication data collection and tracking processes will be transitioned into the new Electronic Health Record (EHR) - InSync Healthcare Solutions through the Dynamic Forms Reporting functionality. The MHP's focus will be on improving the FY percentage for item a) and item e) to no less than a 10% increase.
2. (New) Establish a process to allow for completion of medication monitoring from within the electronic health record.

CONTINUITY AND COORDINATION OF CARE WITH PHYSICAL HEALTH PROVIDERS

Timeline: July 2020 – June 2021			(*) = new goal
*Goal: Transition Credentialing Documentation to Electronic Fillable.			
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 by end of FY.	Credentialing Fillable Forms	Managed Care Designee Managed Care Analyst	• Adapt the credentialing packet(s) to electronically fillable forms. • Present to QMC/QMM • Add credentialing
*Goal: MCP Informational Material			
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. Goal to be met by end of FY.	Informational Material from MCPs	Managed Care Designee Managed Care Analyst	• Obtain most current informational material from MCPs • Incorporate material or assigned area for MCP material for client access.

Analysis

1. This goal was not met due to agency processes and policy shifts from Covid19 pandemic office closure mandates. In addition, the MHP has transitioned to a new Electronic Health Record (EHR) system and will begin working towards transitioning the credentialing paperwork processes to the new system by end of the next FY21-22.

2. On 10/21/2020, MHP staff visited each BHS office and added all MCP flyers and brochures to the reception areas for easy beneficiary accessibility. The MHP has designated staff to ensure MCP informational materials will continue to be readily available to Madera County Beneficiaries.

Goal for FY 21-22:

1. MHP will continue with proposal to transition credentialing paperwork into electronic fillable forms with new EHR by the end of FY21-22.
2. This goal was met and will be retired.
3. (New) Add bidirectional form to our EHR to facilitate its completion by staff as a referral form when beneficiaries don't meet our criteria.

Timeline: July 2020 – June 2021			(*) = 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 mini-mize their presence.

Analysis

1. The MHP did not have an opportunity to achieve this goal due to changing from the old Electronic Health Record (EHR) system, Anasazi, to the new EHR, InSync Healthcare Solutions. This 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 FY21-22 to better understand their reasons and impact on services/processes. In addition, the MHP is currently working with In-Sync representatives on obtaining additional customization of report services to ensure the new EHR reporting tool is adequately meeting MHP reporting needs. Outcomes of the finding will be presented to the QMM committee.

Goal for FY 21-22:

1. Continue to expand quarterly reports with the new EHR InSync System. The MHP will begin looking at outliers to better understand their causes. The MHP hopes to have a better understanding of the different reasons for outliers by end of FY21-22.
2. (New) Establish reporting process, compiling, and exporting of timeliness and service data.

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

Timeline: July 2020 – June 2021 (*) = new goal

*Goal: Clinical PIP – Reducing Psychiatric Re-Hospitalizations			
Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
1. Will re-hospitalization episodes for each of the 2 PIP categories decrease by 3% after implementation of Hospital Services Case Manager interventions by the end of PIP study?	Research TAR Log her data Data analysis reports	Managed Care Designee Managed Care Analyst	• Gather statistics from EHR • Analyze data • Use new PIP tool to present results
Goal: Non-Clinical PIP			
2. Will the implementation of TEARS decrease the percentage of client absenteeism for medication services by December 2020?	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 – Reducing Psychiatric Re-hospitalization episodes has a project period of two years. The Clinical PIP started on July 1, 2020 and will run through July 31, 2022. During the initial phase of conducting the performance improvement project, the MHP discovered that the third category, 14+ days or more inpatient hospital stay, did not provide relevant data to re-hospitalization rates and was removed. The two continuing categories: 1) one or more admission episodes within 30 days and 2) the number of clients with three or more admissions in six months are being tracked by the MHP monthly. Data reports are provided to the QMM committee for review on a quarterly basis. After the first re-measurement, the data analysis indicates a downward trend of the recidivism rate as compared to the baseline data from FY17-18 and FY18-19. At this rate, the MHP expects to meet its targeted goal of a 3% decrease from the baseline percentages. In addition, the MHP is working closely and meeting with EQRO to ensure the success of the Clinical PIP. Meetings with EQRO occurred on April 19, 2021 and June 16, 2021 to discuss and review the status of the current Clinical PIP and the documentation process. Recommendations, issues, and suggestions were deliberated and updated in the Clinical PIP document as appropriate.

Table 3.1 Clinical PIP

Madera MHP Baseline Data	1+ Admission Episodes in 30 Days	Percent	3+ or More Admissions in 6 Months	Percent
FY17-18	48	19.35%	15	8.82%
FY18-19	34	15.81%	12	7.79%
Average	41	17.58%	14	8.31%

Current MHP Re-hospitalization Rates	Cumulative FY 20-22	FY 20-21 Q1	FY 20-21 Q2	FY 20-21 Q3	FY 20-21 Q4
1+ Admission Episodes in 30 Days	26	7	10	5	2
Percentage %	11.16%				
3+ or More Admissions in 6 Months	9	6	2	1	0
Percentage %	4.92%				

2. The Non-Clinical PIP Text and/or Email Appointment Reminder System (TEARS) was placed on hold due to Covid19 pandemic office closure mandates during FY19-20 and FY20-21. As the agency adopted new contactless processes to provide services to our beneficiaries, the appointment reminder process became obsolete as beneficiaries were no longer seen in the office. With the office closure mandate being lifted in June of 2021, the MHP will meet to review the outcome of the Non-Clinical PIP and determine if the appointment reminder process will resume or be retired.

Goal for FY 21-22:

1. Continue to monitor, update and report status of Clinical PIP. Perform data analysis at each of the three Clinical PIP re-measurements to ensure PIP is successful. Provide data reports quarterly to QMM committee and adopt changes and recommendations from committee as appropriate.
2. Unable to complete due to Covid19 pandemic office closure mandates.
3. (New) Develop Non-Clinical PIP. Work with EQRO to ensure MHP is on track with the new Non-Clinical PIP. Involve all stakeholders in project development and implementation process from start to end.

Timeline: July 2020 – June 2021 (*) = new goal

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
***Goal: 24/7 Telephone Access Line**			
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. Goal is to maintain a consistent % from quarter to quarter and a FY % of at least 92%	Test call form and call database	QI Coordinator Managed Care Analyst	• Track and trend all test calls • Determine % of calls meeting requirements • Provide test call logging results as close to real-time as possible vs. on quarterly basis so staff can become familiar with the types of calls that should be logged • Stress the importance of logging calls • Report to QMC/QMM annually
Goal: Timeliness.			
1. Meet timeliness requirements as follows: a) Urgent appointment that do not require prior authorization (48 hours): Improve by 3% from 85% to 88% b) Urgent appointment that require prior authorization (96 hours): Improve by 2% from 80% to 82% c) Timely follow-up after hospitalization (7 working days): Improve by 3% from 42% to 45% d) Re-hospitalizations rate: Improve by 5% from 12% to 7% e) No-shows rate: Improve MD no-show rate by 3% from 19% to 16% and Improve Clinical no-show rate by 3% from 15% to 12%	EHR Reports Crisis log TAR log	QI Coordinator Managed Care Analyst	• Collect data • 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

Analysis

1. For the FY20-21, the MHP was unable to complete the Test Calls for the first quarter (from July 2020 thru December 2020) due to inadequate staffing and adopting alternative work schedules for staff during the Covid19 pandemic office closures. After adequate staffing were secured by December of 2020, test calls resumed for the last two quarters of FY20/21. Test calls were made as close to real-time as possible during business hours and after business hours. Performance results are reported annually to the QMM committee. From January 19, 2021 thru June 30, 2021, the MHP completed 61 test calls. Three performance measure categories were tracked:

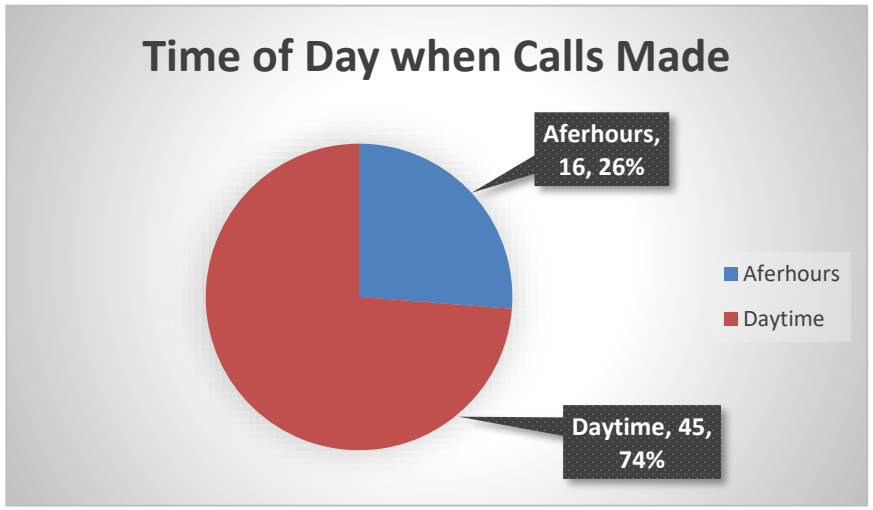
    - Was the person who took the call helpful and knowledgeable?
    - Did you receive the information you requested?
    - Were you satisfied with the efforts made to provide requested information in your language?

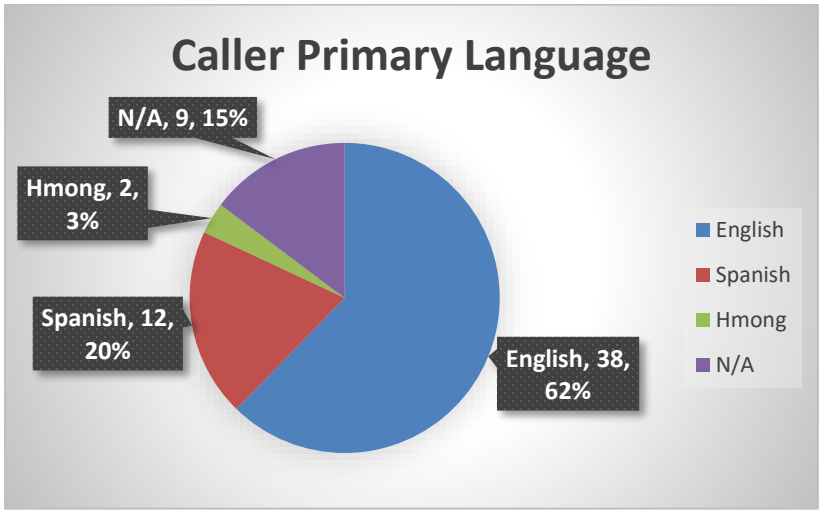
    Table 4.1 Performance Measures

	Yes	No	N/A or Blanks	Percentage
Was the Person who took the call helpful and knowledgeable?	46	7	8	87%
Did you receive the information you requested?	44	8	9	85%
Were you satisfied with the efforts made to provide requested information in your language?	41	7	13	85%

Note: Percentage does not include N/A or Blanks or null measures. These could be due to reasons such as no contact, dropped calls, not applicable, toll free number not working etc. during the time the call was placed.

Table 4.2 MHP Test Calls





2. The MHP needed additional reporting functionality that did not currently exist in the new EHR. The MHP met with InSync representatives during the week of June 7, 2021 thru June 11, 2021 to map and configure additional customization of report services including reports for the Assessment of Timely Access. In addition, the MHP has a weekly EHR InSync Meeting consisting of Madera County Department of BHS staff and InSync representatives to review current and ongoing data reporting successes, issues, and needs. During the last collaborative meeting with InSync representatives on July 13, 2021, the MHP was informed that functionality to extract Timeliness data reporting is not yet functional and has been added to future system updates. However, InSync representatives will attempt to generate back end analytic reports for the MHP's Timeliness reporting needs with an unknown date of completion. Data trending and reporting are also included in the monthly Quality Monitoring Meetings (QMM) as a regular agenda topic.

Goal for FY 21-22:

1. Goal to will not be part of FY21/22 QIWP.
2. Goal to be retired. Note: similar goal for FY21-22 is added to section Meaningful Clinical Issues/Other System Issues.
3. (New) Establish a process for the collection of crisis walk-ins and phone calls at our clinics by end of first fiscal quarter.

COMPLIANCE WITH REQUIREMENT FOR CULTURAL COMPETENCE AND LINGUISTIC COMPETENCE

Timeline: July 2020 – June 2021			(*) = new goal
*Goal: Cultural Competence Trainings.			
Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
1. Complete monthly educational/informative articles on cultural (competence) related topics in the agency wide newsletter, "The Buzz".	Agency The Buzz newsletter issues	Cultural Competency Coordinator	• Write and submit articles monthly
*Goal: Client Rights Postings and Literature Availability in Threshold Languages.			
2. Ensure clients feel supported in their language by having bilingual staff voluntarily wear an identifier displaying their bilingual language.	Badge Sample	Cultural Competency Coordinator	• Determine the type of badge and/or addition to badge would be most feasible. • Coordinate to purchase the badge and/or addition. • Distribute to bilingual staff for easy access.

Analysis

1. This goal was met and will not be part of FY21/22 QIWP. The Ethnic Services Manager (ESM) has been consistent in completing monthly news articles to keep staff engaged and abreast of culturally relevant topics. Each month a new topic is discussed and presented in the agency wide newsletter called The Buzz. The ESM has received positive feedback from staff who have expressed enjoyment or acquired knowledge from the different articles posted.

2. This goal was met and will not be part of FY21/22 QIWP . Bilingual identifiers have been given to all staff who have volunteered to wear them. These language identifiers are placed below the name badge. The identifier has been designed to be stacked and can accommodate multiple languages. Each language is a different color so stakeholders can begin to identify each color to a certain language. Originally 19 staff members volunteered for a language identifier. The languages currently being displayed are Punjabi, Hindi, Hmong, Spanish and Armenian. Since rolling out the language identifier, other staff have expressed interest and more have been dispersed.

Goal for FY 21-22:

1. This goal was met and will not be part of FY21/22 QIWP.

2. This goal was met and will not be part of FY21/22 QIWP.

3. (New) A calendar will be created to promote diversity, equity, and inclusion. It will also be used to get information out on different topics. Once COVID-19 restrictions are completely lifted, the calendar can also be used to plan activities.

4. (New) A Cultural Competence Committee independent from the Quality Management Meeting will be created to refine our approach in promoting cultural competence.

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