FY 22-23

QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT WORK PLAN

Behavioral Health Services (BHS)
Connie Moreno-Peraza, LCSW, BHS Director
Eva H. García Weikel, Quality Division Manager
July 1, 2022 – June 30, 2023

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MADERA COUNTY BEHAVIORAL HEALTH SERVICES

QUALITY IMPROVEMENT WORK PLAN OVERVIEW

The programs covered in this Quality Assurance & Performance Improvement Work Plan (QAPI) are provided through Madera County Behavioral Health Services in accordance with 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.

QUALITY MANAGEMENT PROGRAM STATE MANDATE

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 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).

Departmental Quality Committees

The ***Quality Improvement Committee (QIC)*** provides ongoing operational leadership of continuous quality improvement activities in the department. It meets quarterly and consists of the following individuals:

Name	Title/Department
Connie Moreno-Peraza, LCSW	Director, Behavioral Health Services
Etisha Wilbon, LMFT	Assistant Director, Behavioral Health Services
Herbert Cruz, M.D.	Medical Director, Behavioral Health Services
Andrea Martinez, BBHS	Deputy Director of Operations, Behavioral Health Services
Art Galindo, LCSW	Children's System of Care Division Manager, Behavioral Health Services
Joaquin "Jake" Gonzalez, AMFT	Adult/FSP/Crisis System of Care Division Manager, Behavioral Health Services
Eva H. Weikel, MBA	Quality, Compliance, and Admin. Srvcs. Division Manager, Behavioral Health Services
Miravel Navarro, MA	Substance Use Disorder Division Manager, Behavioral Health Services
Kimberlee Hernandez	Administrative Analyst, Behavioral Health Services
Say Yang	Administrative Analyst, Behavioral Health Services
Lisa Bernal	Administrative Analyst, Behavioral Health Services
Michael McKinney	Peer Support, Behavioral Health Services
Claudia Camarena	Administrative Assistant, Behavioral Health Services
Shawn Jenkins	Chief Operating Officer, Westcare
Mary Ann Knoy	Director of Special Projects, Westcare
Michelle Allen	Director of Contract Compliance, Westcare

Terry Walker	Quality Assurance Assistant, Westcare
Edward Crossman, LMFT	Clinical Director, Westcare
Jana Todd, LCSW	Owner, JDT Consultants, Inc.
Andrea Evans	CEO, Valley Teen Ranch
Kim Gerhardt	Counselor, Valley Teen Ranch
Arlene Vargas	Director of Residential Programs, Promesa Behavioral Health

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 Improvement Committee (QIC), 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 agency's 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 Improvement Committee and other committees that deal with quality issues such as the QIC 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,
- Acting 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 regarding 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 because 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 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 summary of progress including progress in relation to the objective(s).
    - A 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.

SERVICE CAPACITY

Timeline: July 2022 – June 2023			(*) = new goal
Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
*Goal: Expand data reporting piece to improve client services			
1. Expand data reports in the following areas and prepare quarterly reports no later than the 3rd fiscal quarter. a. Retention Rates b. Language c. Penetration Rates	Quarterly Reports will be prepared for each of the goal elements starting no later than the 3rd fiscal quarter.	Managed Care Designee QI Systems Analyst	• EHR Insync Reports will be ran on a quarterly basis and presented at QIC. • Establish baseline data where appropriate. • Data trending process will be completed.
*Goal: Network Adequacy Efforts Will Continue			
2. Ensure network adequacy by: a. Continuing recruitment efforts for key direct service positions. b. At least 3 bilingual clinicians will be hired by 12/31/22.	Recruiting efforts will continue to ensure the network has an adequate number of providers.	Managed Care Designee QI Systems Analyst	• Share recruitment flyers. • Post vacancies on our county website • Post vacancies in HRSA website

Evaluation:

1. Goal partially met. Data report has been updated beginning with reporting period of FY22.23 Q1.

   This update has added the following:
   a. Gender Identity
   b. Primary Language

   A penetration report has also been prepared for reporting period of FY22.23 Q1 which breaks down penetration rates by gender, age, ethnicity, and primary language.

   Both reports have been presented to QIC in December 2022.

   A retention rate report is still in the works.

2. Goal met. Since July 2022, MCDBHS was able to hire a total of 4 bilingual clinicians. Efforts continue to be made to recruit and create interest in MCBHS' vacancies, some of these strategies involve incentives for specific positions labeled as hard to fill and for positions in rural clinics. Some hard to fill positions have also moved to open and ongoing recruitments and the internal bilingual pay process has been streamlined to provide that additional incentive pay as soon as possible.

Goal for FY 23-24:

1. Evaluate beneficiary access and utilization of MCDBHS to include:
   a. Prepare beneficiary penetration and utilization rates by Hispanic/not Hispanic ethnicity and primary language in FY23.24.

BENEFICIARY/FAMILY SATISFACTION

Timeline: July 2022 – June 2023 (*) = new goal

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
*Goal: QIC Brochure			
1. Develop a Quality Improvement Committee (QIC) brochure to create client and family member interest by 01/01/2023.	Develop a brochure to inform clients and family members of the committee's purpose and create interest. At least 1 client or family member will be recruited as part of the QIC in FY22.23.	Managed Care Designee Managed Care Analyst	• Create brochure. • Post brochure in agency lobbies • Share brochure with partner agencies
*Goal: Client Survey			
2. Finalize a brief client survey to make available in our lobbies and on County website to gather ongoing feedback regarding our services from the community we serve to determine areas of improvement by 01/01/2023.	Develop and launch survey. At least 10 surveys will be collected by the MHP in FY22.23.	QI Coordinator Managed Care Analyst	• Develop and launch survey. • Collect survey data. • Present to QIC bi-annually. • Make system changes as necessary

Evaluation:

1. Goal not met yet. Although the brochure for the Quality Improvement Committee has been established, approved, and is available at all MCDBHS sites, we have yet to recruit a client or family member to serve on the Quality Improvement Committee. Recruitment of a client or family member will be an ongoing effort.
2. Goal was met. Quality Improvement survey was developed and approved by Quality Improvement Committee in December 2022. Surveys are available at all MCDBHS sites. Quality Improvement survey also contains a QR code for ease of accessibility, both, the brochure, and survey link are available on the County's website. MCDBHS received a total of 15 English surveys and 1 Spanish survey.

Goal for FY 23-24:

1. Conduct semi-annual beneficiary/client satisfaction surveys to measure client experience and satisfaction in FY23.24 to:
    a. Establish baseline.
    b. Identify and present solutions to barriers to treatment.

Timeline: July 2022 – June 2023 (*) = new goal

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
*Goal: Chart Review Process			
Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
1. Establish the outpatient chart review process by 03/31/23.	A minimum of three randomly selected charts per clinician per year will be reviewed and a plan of correction will be completed as per policy with a minimum of 80% compliance.	Managed Care Designee QI Coordinator Clinical Division Manager	• Launch chart review process in alignment with CalAIM requirements. • Clinical staff will meet once a month to discuss chart review findings and corrective actions necessary.
*Goal: Review of Patient Rights Requests			
2. Review and respond to grievances, change of provider, appeals, fair hearings and related expediated requests within the policy guidelines and state regulation.	100% of grievance, change of provider, appeals, and expediated requests will receive timely response as shown by corresponding logs.	Managed Care Designee QI Coordinator	• Respond to all beneficiary requests in a timely manner. • Prepare data reports on a quarterly basis for QIC. • Identify system improvement issues

Evaluation:

1. Goal not met yet. The outpatient chart review process re-launch on 03/27/23, however, it was paused again to rework the overall process.

2. Goal was not met. MCDBHS will continue to focus on 100% timely response for grievances, change of providers, appeals and expediated request.

Goal for FY 23-24:

1. Peer reviews will occur on a monthly basis beginning with soft launch in October 2023 and hard launch in January 2024.
   a. Peer reviews will focus on quality and will follow a rotating schedule to ensure 3 charts per clinician are reviewed per FY.
2. Chart reviews will be completed on an annual basis in June 2024 as follows:
   a. Review 5 adult and 5 youth charts

MONITOR SAFETY AND EFFECTIVENESS OF MEDICATION PRACTICES

Timeline: July 2022 – June 2023			(*) = new goal
Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
*Goal: Medication Monitoring Process			
1. Medication monitoring process will be electronic as part of our EHR by 03/31/23.	100% of med monitoring forms will be completed within the EHR and placed in a folder with limited permissions in the document manager side of our EHR.	Managed Care Designee QI Coordinator Contracted Pharmacist	• Create a dynamic form in the EHR to meet medication monitoring needs. • Pharmacist and providers will complete the form electronically. • Create dynamic report to export data from dynamic form. • Report data to Medication Monitoring Committee at least bi-annually

Evaluation:

1. Goal was met. The Medication Monitoring form was established, approved, and added to our EHR with full implementation. It allows pharmacists and providers to complete medication monitoring using the EHR system. Benefits include centralization of information, added reporting capabilities, and electronic signature.

Goal for FY 23-24:

1. Begin use of EHR Medication Monitoring form to produce data reports for monthly medication monitoring committee meeting and to ensure compliance and monitoring of the various requirements.

CONTINUITY AND COORDINATION OF CARE WITH PHYSICAL HEALTH PROVIDERS

Timeline: July 2022 – June 2023			(*) = new goal
Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
*Goal: Collaborate with Managed Care Plans			
1. Meet with managed care plans on a quarterly basis and begin discussions about data-sharing to align with BHQIP.	Establish data-sharing agreements with MCPs by 09/30/22. Produce a data-sharing transaction log displaying activity to and from MCP and BHS by 03/01/23	Managed Care Designee Managed Care Analyst MCPs	• Discuss data-sharing agreement with MCPs during quarterly meetings. • Work with EHR vendor as needed. • Create data-sharing transaction log

Evaluation:

1. Goal not met yet. MCDBHS has met quarterly with MCP partners on 08/19/22, 11/18/22 and 02/17/23 and MOUs have been updated to include the data sharing component. Additional meetings to coordinate, discuss and complete troubleshoot activities related to data sharing BHQIP requirements. On 02/22/23 MCDBHS met with Anthem to discuss the data of sharing after SFTP was established, then on 03/01/23 MCDBHS met with CalViva to ensure the SFTP was set up and test files were transferred successfully. File transfer with Anthem have already taken place and file transfer is with CalViva continue to be coordinated.

Goal for FY 23-24:

1. Coordinate and complete file transfers with CalViva.
2. Begin the process of determine how to utilize transferred data for system improvement initiatives.

Timeline: July 2022 – June 2023			(*) = new goal
Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
*Goal: CalAIM compliant MH Assessment			
1. Launch new CalAIM compliant MH assessment form by 07/01/23.	100% of MH assessments will be completed using the new CalAIM compliant assessment form.	Managed Care Designee Managed Care Analyst Clinical Division Manager	• Work with EHR vendor to ensure new assessment form is CalAIM compliant. • Work with providers to resolve any issues during its use
*Goal: Group Calculation in EHR			
2. Work with EHR vendor to ensure the system calculations in the background calculated claim duration when groups are facilitated by one and by two providers by 01/01/23.	The EHR will be able to calculate group service duration 100% accurately by the end of the second FY quarter.	Managed Care Designee Managed Care Analyst	• Work with EHR vendor to ensure group calculations in the background are accurate and consistent. • Work with EHR to better understand how these calculations can be exported from the system
*Goal: Alert Mechanism for Annual Reviews			
3. Work with EHR vendor to ensure a tracking and alert mechanism for annual Clinical/Treatment Plan reviews is in place by 01/01/23.	Tracking and alert mechanisms are accurate in accordance with initial intake dates. Tracking and alert mechanism reports will show at least 80% compliance with timely treatment plan review completion	Managed Care Designee Clinical Division Manager	• Work with EHR vendor as needed to put in place a tracking and alert mechanism for treatment plan reviews. • Create a guide for running report. • Train staff on how to run report

Evaluation:

1. Goal Met. MCDBHS developed its CalAIM compliant assessment form which was launched on 08/01/2022. The initial launching did yield areas in which required our EHR vendor to make some formatting corrections however all required domains/elements were in place as per requirements for both the ACCESS Criteria and Medical Necessity.

2. Goal Met. The EHR fiscal department has indicated and reassured MCDBHS that the duration for services is applied correctly per the group formula for claiming purposes even if not calculated accurately when a report is run for services provided and duration. Providers were trained how to manually enter the duration per client as per group formula at time of completing the group progress notes to produce a more accurate report.

3. Goal Met. After working with our EHR vendor it became evident the system doesn't allow for this function as it relates to alerting providers when an annual review is coming due. Our clinical MCDBHS lead determined an already existing module, review date tracker, would serve our agency much in the same way. The Review Date Tracker module workflow allows the Supervisors, at time of assigning the case, to enter the Annual Review Date along with name of assigned provider. Both the Name of Provider and next review date can be produced through its own built-in report. These reports are reviewed during scheduled team meetings to ensure timely completion of Annual MH Clinical Reviews.

Goal for FY 23-24:

1. With the planned implementation phase of the new EHR in January 2024, the following alerts will be established:
    a. ICC/IHBS Screenings
    b. Child and Family Team Meetings
    c. 6-month SUD treatment justification
    d. CANS/PSC-35
2. Ensure continued compliance with CalAIM clinical requirements during and after implementation of new EHR.
    a. Determine need for new/revision of workflows
    b. Train staff on new forms/processes

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

Timeline: July 2022 – June 2023 (*) = new goal

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
*Goal: Clinical PIP – Criss Mobile Unit Implementation			
1. Establish a Madera County Department of Behavioral Health (MCDBH) Crisis Care Mobile Unit.	1. Steady increased trend in dispatch of crisis mobile teams into the community from quarter to quarter (undetermined, new service) 2. Inpatient Admission stay log will show a decrease in admissions. 3. Contacts by crisis team at emergency room will decrease as per data collected.	Managed Care Designee Managed Care Analyst QI Coordinator Crisis Division Manager	• Build infrastructure to include staffing, equipment, vehicles, materials, etc. • Establish a process for dispatch and service data collection. • Complete outreach activities to promote new service, create information material. • Provide Crisis Services (contacts) out in the field within County boundaries at any time of the day or night.
*Goal: Non-Clinical PIP – Centralized Appointment Scheduling Process			
2. Improve the process clients follow to schedule and/or reschedule, cancel or any other change to appointments in general.	1. Number of scheduled ongoing individual therapy appointments (not post assessment) for already established clients within 30 days from prior individual therapy. 2. Number of post assessment plan development or individual therapy scheduled appointments within 30 days from date of initial assessment.	Managed Care Designee Managed Care Analyst	• Gather statistics from EHR. • Analyze data. • Use the PIP tool to present results

Evaluation:

1. In Progress. Crisis Mobile Unit met soft launch date of 09/01/22 and hard launch of 10/01/22, it is actively providing services to the County with marketing and outreach services ongoing.

2. In Progress. Indicators will continue to be monitored on a monthly basis to determine impact of PIP on system as it pertains to streamlining of process.

Goal for FY 23-24:

1. Continue to monitor and track services provided by the Crisis Mobile Unit and efforts made to ensure timely access to services.
2. Continue to monitor and track process and implement improvement measures as needed. Consideration will be given to the expansion of the centralized scheduling system to include all services if the PIP proves successful.

Timeline: July 2022 – June 2023 (*) = new goal

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
*Goal: Access to Services			
1. Beneficiaries will have timely access to services.	Clients requesting non-urgent mental health services are offered an initial assessment appointment within 10 business days 95% of the time. Clients requesting initial non-urgent mental health services are offered psychiatry appointments within 15 business days 95% of the time.	QI Coordinator Managed Care Designee Front Desk Staff	• Communicate and educate agency staff on new process. • Create collection and tracking tools. • Prepare and present reports to QIC quarterly.
*Goal: Access Line Improvement and Training			
2. Improve Access Line triaging and referral process starting in 07/01/2022	A minimum of 2 calls will be made in each Hmong and Spanish for a total of 4 calls per month. A minimum of 8 calls per month will be made during business hours. A minimum of 8 calls per month will be made during after-hours. Train front desk staff on a quarterly basis on the type of information they must be able to provide to callers to include but not limited to, how to access SMHS, how to file a grievance, change of provider, where to locate informational material. First training to take place no later than 10/31/2022.	QI Coordinator Managed Care Designee Test Callers Front Desk Staff	• Clarify responsibility of test callers • Monitor test call completion. • Train front desk staff • Monitor data

Evaluation:

1. Goal met. Training meetings took place at the beginning of May 2022 to guide staff on the components and the use of the new module. Access to Services module had a soft-launch date of 05/16/22 and was rolled out to all clinics for use and data entry on 06/01/22. Through this module we've been able to monitor our timeliness data and adjust within our system as needed if appointments are offered too close to the 10-day/15-day mark to ensure we comply with timely access requirements. Since launching we have remained between 95% and 100%.

2. Goal was not met. Due to staff changes this goal was not fully met, however, Access Line Improvement Training was implemented on 10/2022 to help provide better understanding of this process and how it impacts access to information and services. MCDBHS will continue to improve to meet test call goals of bilingual calls.

Goal for FY 23-24:

1. Access Line Training will be provided to front desk staff as follows:
    a. Upon hire, front desk staff will be trained on access line information to ensure they understand how to guide our clients.
    b. Staff will complete an access line refresher training bi-annually.

COMPLIANCE WITH REQUIREMENT FOR CULTURAL COMPETENCE AND LINGUISTIC COMPETENCE

Timeline: July 2022 – June 2023 (*) = new goal

Objective	Indicator/Measurement	Responsible Entity	Planned Steps/Intervention
*Goal: Cultural Competence Calendar			
1. Establish a cultural competence calendar no later than 10/31/22 and continue cultural relevant monthly communications.	Cultural Competence calendar will inform staff of all major culturally related events/holidays	Cultural Competency Coordinator Cultural Competence Designee	• Monthly calendar with culturally relevant events and information
*Goal: Cultural Competence Committee			
2. Establish a cultural competence committee	Cultural Competence reporting will begin to the committee, agendas and minutes will reflect ongoing efforts no later than 01/01/23	Cultural Competency Coordinator Cultural Competence Designee	• Partner with community members and other County leaders to establish committee. • Determine committee logistics. • Set up committee values and expectations.
*Goal: Interpreter Training			
3. Interpreter training will be provided	Staff who are qualified to provide interpreter services will receive interpreter training no later than 06/31/23	Cultural Competency Coordinator Cultural Competence Designee	• Identify staff who are qualified to interpret. • Schedule training • Monitor completion

Evaluation:

1. Goal was met. MCDBHS established a cultural competence Calendar in October 2022 which is available for viewing on our webpage www.maderacounty.com/government/behavioral-health-services and also available for viewing at all our MCDBHS clinic sites.

2. Goal was met. MCDBHS established its Cultural Competence Advisory Board Committee, with its first meeting convening on 12/08/22. The committee consists of multiagency partners as well as Behavioral Health Board Members, direct service providers rom various disciples. Although the committee is in its infancy, the input brought forth by the various parties is invaluable for our agency and how we in turn provide services to the community we serve.

3. Goal was met. The interpreter training is ongoing, those who interpret for doctors complete the training within the first 3 months of employment while they shadow and train.

Goal for FY 23-24:

1. Develop successful outreach and engagement strategies to increase the penetration rate of Latinx/Hispanic client and find better methods of outreach to engage the Spanish speaking population.
2. Develop a training plan which aligns with Cultural Competence Plan goals in an effort to increase Latinx/Hispanic penetration rates.