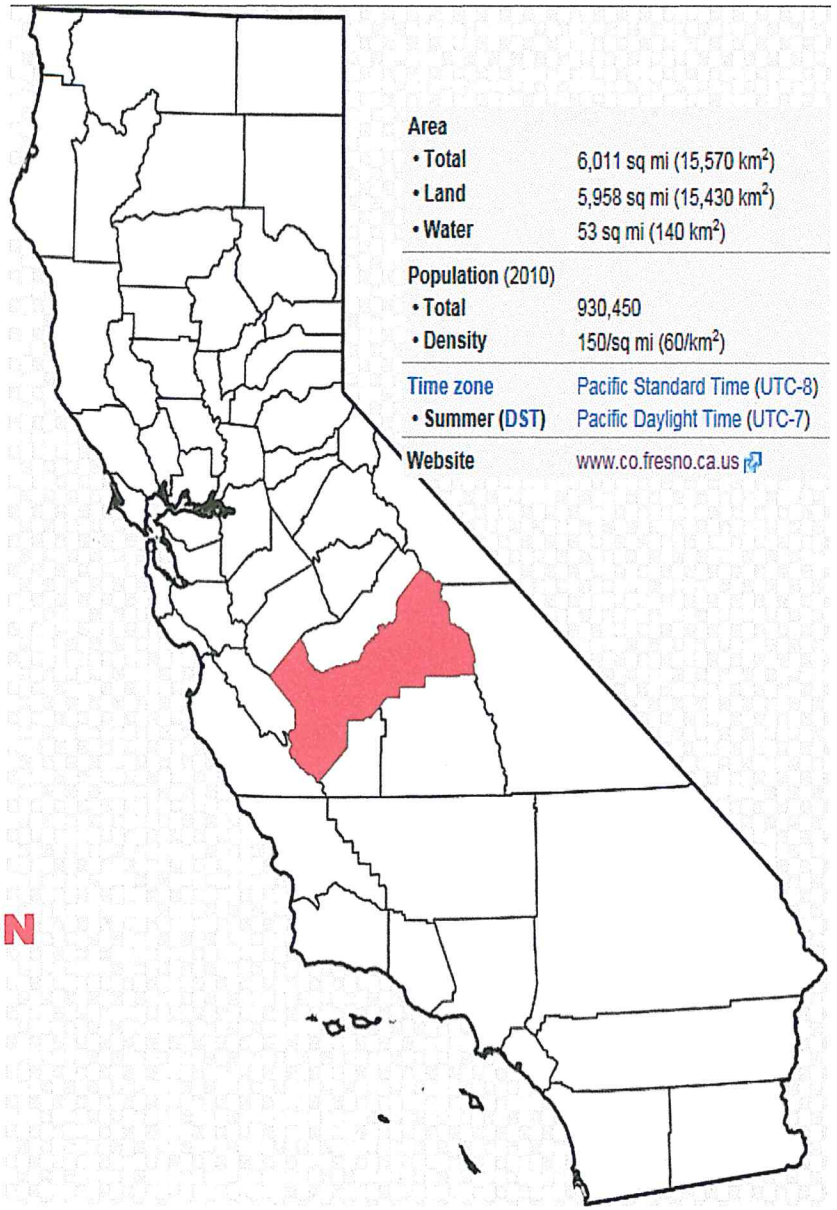


FRESNO COUNTY
MENTAL HEALTH PLAN EVALUATION
QUALITY IMPROVEMENT WORK PLAN
FISCAL YEAR 2015-16

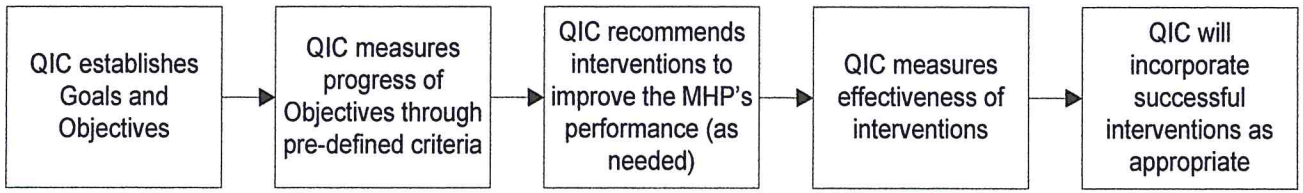
INTRODUCTION

The Fresno County Mental Health Plan (MHP) is operated through the Department of Behavioral Health and its network of contract providers, community partners, clients, family members and stakeholders. The MHP has a commitment toward quality improvement that spans throughout the system of care. The MHP has developed a Quality Management Program in response to the state and federal regulations outlined in the MHP contract. This Quality Management Program is directly accountable to the Mental Health Director. The Quality Improvement Coordinator is tasked to oversee the activities and execution of the Quality Management Program.

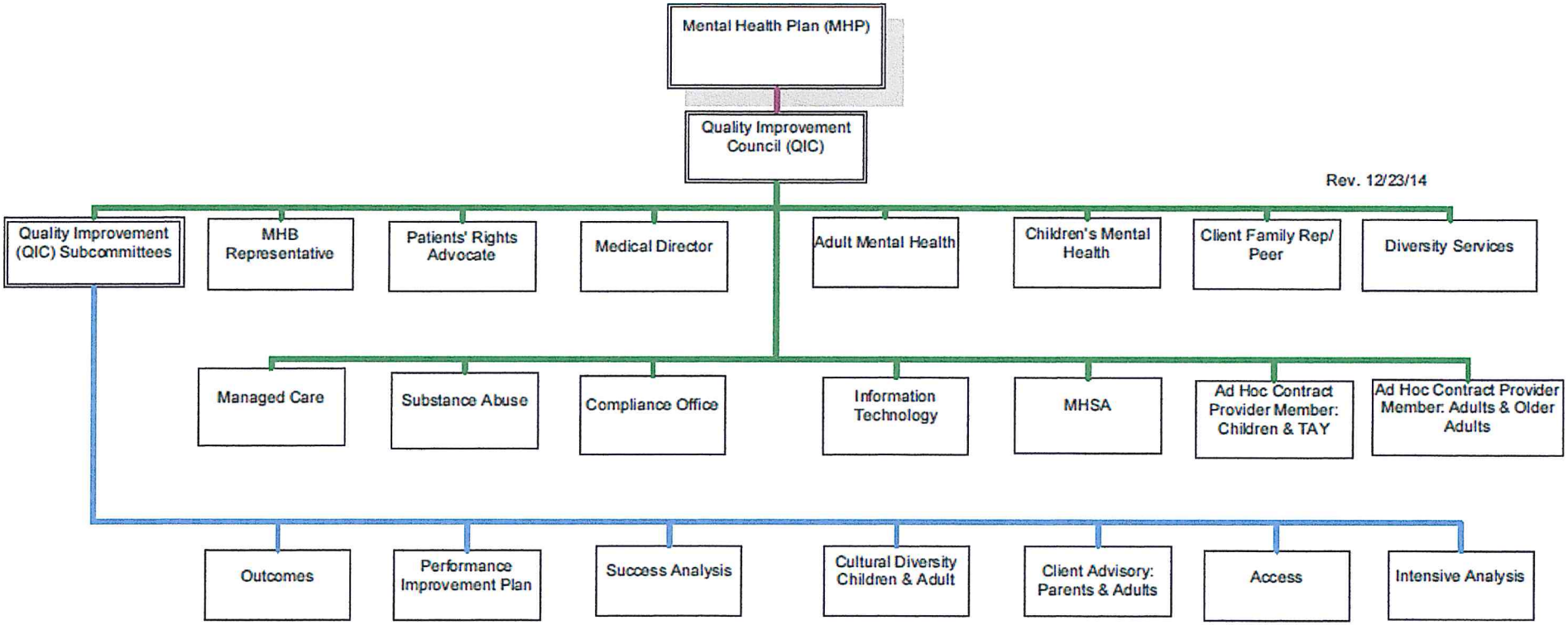
The Quality Improvement Committee (QIC) is responsible for the planning, design and execution of the Quality Improvement (QI) Work Plan. The QI Work Plan provides a roadmap to outline how the MHP is to review the quality of specialty mental health services under its umbrella. The goals and objectives of this QI Work Plan are to guide the QIC and its subcommittees to meet its goals. The QI Work Plan will be reviewed annually and made available to Department of Behavioral Health.

The structure of the QIC is designed to include participation from the Department of Behavioral Health, providers, clients and family members/legal representatives of anyone that has accessed services from the MHP. In addition, the QI Work Plan incorporates input and suggested feedback from External Quality Review Organization (EQRO) and most recently the State Department of Health Care Services (DHCS) Medi-Cal Audit. The QIC is committed to honest dialogue; therefore, the MHP ensures that all individuals participating in the QIC will not be subject to discrimination or any other penalty in their other relationships with the MHP as a result of their roles in representing themselves and their constituencies. The QI Work Plan activities derive from a number of sources of information about quality of care and service issues which include client and family feedback, Department, and State and Federal requirements and initiatives.

The QIC is adhered to the following steps to measure and initiate action within the MHP. Since data are one of the only objective methods of measuring quality improvement, the QIC works closely with Information Technology team to develop a data feedback structure on a timely basis.



Quality Improvement Work Plan Components



QI Work Plan includes:

A. **Access To Care:** *Improve Timeliness of Services, On Demand Provider List, Access Line, Service Delivery Capacity, and Treatment Authorization,*
B. **Safety and Quality of Care Concern:** *Hospitalization Discharge and Hospital Re-Admission, and Intensive Analysis Committee,*
C. **Client Satisfaction:** *Client Satisfaction Survey and Evaluation of Beneficiary Grievances/Appeals/Expedited Appeals,*
D. **Quality Assurance:** *Client Chart Audits and timeliness of Progress Notes,*
E. **Staff Engagement and Development:** *Staff Engagement Survey and Workforce Education and Training,*
F. **Transparency:** *Publication and Department Website, and*
G. **Performance and Improvement Projects (PIP's):** *Non-Clinical and Clinical Performance Improvement Projects*

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
A. QIWP Target Area: Access to care				
1	**Improve Timeliness of Service/Care**	Regularly evaluate trends, conduct trend analysis, and present at QIC quarterly	**Request for services and follow up timeliness:** -1st Service/Assessment Within 30 days: -Number of Urgent conditions -Number of Referrals to 1st Psych. (Med) Appt. -1st Service/Assessment Within 30 days:	**EVALUATION:** **GOAL:** Monitor and improve timeliness of services where needed. Areas of improvement will be based on data. **DATA:** For Calendar year 2016; the average time from 1st request (written, phone, or walk-in) to 1st service Assessment was 13.44 days. This is inclusive of Non-Urgent and Urgent request. For the Adult population (18 years and older) Non Urgent request had an average of 7.11 days; for Urgent request the average days was 1.84 days. For the Children and Youth population (less than 18 years of age) Non-Urgent request had an average of 24.33 days; for Urgent request the average days was 9.84 days. The Department also measured request to 1st Psychiatric appointment; measuring from 1st referral from clinical staff to 1st Psychiatric appointment. In Calendar Year 2016, there were a total of 2,412 referrals for Psychiatric appointments (children/Youth 985; Adult 1,427). The Overall average from Referral to 1st Psychiatric Appoint is 28.80 days in 2015. Children/Youth was 41.38 days; and Adults 20.11 days respectively. **RESULTS:** Goal: Met; based on continuous monitoring of Timeliness of Services within the County's standard of 30 days from 1st request to 1st clinical assessment for both adult and children. In addition for timeliness of Urgent conditions within the County standard within 3 days for both Adults and Children. For services related to Psychiatric appointment, the County did not meet its standards set at 30 days from referral to 1st psychiatric appointment. Methodology was changed between 2015 and 2016 as a result, only CY2016 data is represented in this report.

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
2	**State Required Certification** CCR Title 9, section 1810.435(d)(e) requires MHPs to certify and recertify Medi-Cal providers within established timeframes	On demand provider list The provider list in Avatar will track names, credentialing dates, licensure, location, telephone number, non-English languages spoken and options for cultural/linguistic services, and other relevant specialties Implement a tracking, alert, and collaboration method	On demand provider list report available in Avatar and posted at the DBH's website Make the current providers list available for staff and public accessible through DBH's website Monitor timeliness of certification and re-certification. Determine overdue re-certification. Report the overdue re-certification at QIC	**EVALUATION:** **GOAL:** To ensure that all required Medi-Cal Treatment Organizational Providers and County Operated In-House Programs are Medi-Cal certified. **DATA:** In FY 2015-16, the County identified a total of 51 organizational providers requiring Medi-Certification. Of the 51 requiring certification there were Zero (0) Overdue providers; and zero (0) Out of Compliance, making it 100% in Compliance. In the development of the tracking certification, the Department includes tracking Foster Care providers. These providers do not require re-certification as other organizational providers. As of May 2016; the Department identified six (6) Foster Care providers that do not require Re-Certification. **RESULTS:** Goal: Met, see supporting Documentation, letter from Department of Health Care Services identification of all Organizational Providers being update with their respective Certification and Re-Certification.

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
3	State Required DHCS also recommended that test calls are incorporated in the QIWP.	Monitor the 24-hour Access Line via monthly Test Calls Perform minimum of 7 test calls per month (84 calls per year) during and after business hours, in these three threshold languages (2 Hmong, 3 Spanish, 2 English) and other types of test calls such as: requests for service, grievances, literature requests, and recording of those not leaving a full name. Validate the written Access log to ensure that the date of call, name, and disposition of the call were recorded. Access Line Database (all calls should be logged) https://www.fcmhpaccessline.com	Ensure the accuracy and quality of the responses at 100% through monthly test calls	**EVALUATION:** **GOAL:** At the end of the fiscal year, 100% of all test calls will be performed without error. Perform 7 test calls a month. The test calls need to be in the three threshold languages and be performed during and after business hours. Maintain log of test calls made. **DATA:** In Calendar Year 2015; 67 test calls were completed randomly. Of the 67 calls; 61% of the calls were logged; 61% were foreign language calls (of the 41 foreign language calls, 32 were logged as appropriate calls). 56 of the test calls were crisis oriented; of those 56 (84%) were assessed for crisis. From January 2015 – December 2015, a total of 67 test calls were completed: • 41 test calls or 61% were logged. • 40 test calls or 60% were logged with accurate names. • 40 test calls or 60% were logged with accurate dates. • 39 test calls or 58% were logged with accurate phone numbers. • 35 test calls or 52% were logged with accurate call reasons. • 56 test calls or 84% were logged with "Assessed for Crisis". • 47 test calls or 72% were logged with "Appropriate Info given on how to access SMHS". • 41 test calls or 61% were logged with "Foreign Language". Of these 41 test calls, 32 or 78% were logged with "offered assistance to free language assistance services". **RESULTS:** Goal: Partially Met – At minimum 60 calls are to be completed for Calendar Year, County attained goal of Test Calls with 67 completed test calls. State and County goals are set at 100% for each category. There was a decline of calls logged from previous Calendar Year and the County is pursuing other avenues for improving the Access Line Operations.

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
4	**Service delivery capacity** MC Oversight 1915(b) Waiver EQRO	Review an internal Penetration Rate report to monitor overall MHP's penetration. Monitor each category (overall number of unique clients served, age, ethnicity, geographical location, language, type of service). Monitor the effects of system of care redesign and programmatic changes on penetration rates and the number served over time. Report to QIC and CDC quarterly with progress on Penetration Rates. Review PR through simultaneous comparison of age, ethnicity and geography to uncover gaps and report on change over time.	Monitor the Service delivery capacity through Penetration Rate of clients served ISDS – report Subject Matter Experts (SMEs) from CDC, QI , Epidemiologist for the criteria CY Large Fresno 2008 6.63% 4.37% 2009 6.25% 4.01% 2010 5.92% 3.60% 2011 5.76% 3.44% 2012 5.77% 3.59% 2013 5.44% 3.74% 2014 4.99% 3.83% Source: Department figures for 2015 EQRO figures for calendar years 2008 to 2014.	**EVALUATION:** **GOAL:** Increase overall penetration rate of Medi-Cal beneficiaries to match statewide average for Large counties in California (_____% for CY 2015). **DATA:** **RESULT:** Goal: Partially Met – as based on the current methodology calculated by External Quality Review Organization (EQRO) for Calendar Year 2015. Although the County has not reached its goal, the trend is showing an increase since CY 2011 while also narrowing the gap in penetration rate. Penetration Rates, quarterly reports were presented at QIC and Access Committee meetings and upon request at Cultural Diversity Committee meetings.

Period	Large Counties	Fresno MHP
CY 2008	6.63%	4.37%
CY 2009	6.25%	4.01%
CY 2010	5.92%	3.60%
CY 2011	5.76%	3.44%
CY 2012	5.77%	3.59%
CY 2013	5.44%	3.74%
CY 2014	4.99%	3.83%
CY 2015		3.84%

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
5	MC Oversight: evidence of MHP reviewing Utilization Management activities TAR: Title 9, Section 1820.220 requires the MHP to approve or deny a Treatment Authorization Request (TAR) within 14 calendar days.	Review of a treatment authorization for day treatment and out of county services Conduct consistency monitoring for the authorization of specialty mental health services out of county providers and day treatment intensive with 100% consistency achieved. Make recommendations and changes when consistency monitoring is less than 100% or when a treatment authorization is not completed within the designated timeframe. Maintain the appropriate documentation to show the consistency percentage achieved and recommended actions. Report finding's at the QIC semi-annually	Continue to implement mechanisms to ensure 100% consistent application of review criteria for authorization decisions through consistency monitoring of authorizations for day treatment and out of county services. Number of inpatient TAR Adjudicated within 14 days	**EVALUATION:** **GOAL:** Continue to implement mechanisms to ensure 100% consistent application of review criteria for authorization decisions through consistency monitoring of authorizations for Authorization Unit Out of County/Day Treatment consistency. **DATA:** Managed Care Utilization Review Specialists conducted consistency monitoring for Out of County Day Treatment. A total of 12 items were discussed. Of the 12 items discussed, there were no discrepancies in claims. All items identified were discussed and addressed. See Managed Care Minutes of Meeting dated January 30, 2017. **RESULTS:** Goal: Met

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
	B. QIWP Target Area: Safety and Quality of Care Concern			
6	1915(b) Waiver Monitor the post discharge follow up and hospital readmission within 30 days	Monitor the post discharge follow up and hospital readmission rates Clinical Operations – clinical intervention and oversight	Number of 1st post-hospital discharge appointments -1st Service/Assessment Within 30 days: Review the post-discharge follow up within 30 days, readmissions within 30 days. Regularly evaluate trends, conduct trend analysis, and communicate with Clinical Operations. Make reports available at QIC quarterly	**EVALUATION:** **GOAL:** Track the number of hospitalization follow-up appointments and identify those served within 30 days, as noted for the County Standard **DATA:** In Calendar Year 2016, there were a total of 4,063 hospital admissions (Adult: 3,490; Children: 573). Of those clients a total of 2550 had follow-up appointments (Adult: 2148; Children: 402). For 2016, of the total 2,550 clients with follow up appointments, 48% had a follow-up appointment within 30 days from hospital discharge. Adults had 46% follow-up appointments from time of hospital discharge within 30 days; and Children had a higher percent at 59% within 30 days post hospital discharge. **RESULTS:** Goal: Met. The Department will look further into setting a percentage standard within 30 days. Methodology was changed between 2015 and 2016 as a result, only CY2016 data is represented this report.
7	**Previous Measurable Outcome removed (Medication Monitoring & Polypharmacy:** **Not Measured in 2015-16**			

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
8	Intensive Analysis Committee: Monitor, track and evaluate all deaths or serious client safety incidents that occur while in the care of the Department	1. Continue to conduct intensive analyses to evaluate all deaths or serious client safety incidents that occur while in the care of the Department. 2. The Intensive Analysis Chair will report twice per year on findings and make necessary recommendations. 3. The Medical Director to present twice a year to QIC 2015-16	The Committee will meet with staff and provide feedback to the MHP on issues that have raised potential quality of care concerns The Committee to submit reports to the QIC semi-annually	**EVALUATION:** **GOAL:** The Intensive Analysis will have met with staff and provided feedback to the MHP on issues that have raised potential quality of care concerns. **DATA:** In FY 2015-16 the Intensive Analysis Committee met as a group to discuss specific items and revisit Incident reports and Unusual Occurrences (December 17, 2015). Committee meeting was facilitated by Licensed, Quality Improvement Coordinator. **RESULTS:** Goal: Met, although actual incidences and unusual circumstances were not presented to the Quality Improvement Committee for review and input, the committee did receive an update/status report. **Incident Reports:** 31 incidents were reported, of those incidents, 3 deaths were reported. Incidents by program: Central Stars PHF 10 Exodus CSU 8 Exodus PHF 6 Fresno Impact 1 Kings View BH 2 Kings View Blue Sky W 1 TP First Street Ctr 1 TP Selma 1 TPCC VISTA 1 **Unusual Occurrences** 51 unusual occurrences were reported, of which five are remain to be followed up by the State DHCS. These facilities are at the four licensed MHRC and PHFs within Fresno County.

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
	C. QIWP Target Area: Client Satisfaction			
9	Client satisfaction through the Consumer Perception Survey (formerly POQI)	Distribution of the POQI in November and May. Input surveyed data in the database by program, and analyze the data for improvement. Make analysis available to Access Committee, Cultural Diversity Committee, QIC, MHP, contractors, and public.	Compare CPS Survey by Calendar Year 2015 to 2016	**EVALUATION:** **GOAL:** Write a report comparing the May 2015 to May 2016; November 2015 to November 2016. **DATA:** **Findings from the 2015 vs 2016 surveys:** o Consumers' assessment of care was positive in many areas. o At the domain levels ratings were generally positive however individual item responses within the domains varied. o Six of the eight domain ratings were more negative in 2016 than in 2015. o 2% Increase of respondents from 2015 (3,379) to 2016 (3,675). o Survey participants who identified themselves as Mexican, Hispanic, or Latino origin were the largest ethnic group at 52% (2015) and 54% (2016) respectively. o Of the four (4) survey groups (Adult, Older Adult, Youth, and Youth Families), Adults make up the majority of the population surveyed at 61% (2015) and 54% (2016) respectively. **Comparison Results of 2015 & 2016** **2015** overall results, respondents rated *General Satisfaction* 89%, *Perception of Access* 86%, *Perception of Quality and Appropriateness* 88%, *Perception of Treatment Participation* 86%, and *Cultural Sensitivity* 93% but items related to *Perception of Outcomes Services* 70%, and *Perception of Functioning* 71% and *Perception of Social Connectedness* 79% were rated much less positively. **2016** overall results, respondents rated *General Satisfaction* 88%, *Perception of Access* 86%, *Perception of Quality and Appropriateness* 90%, *Perception of Treatment Participation* 85%, and Cultural Sensitivity 92% but items related to, *Perception of Outcomes Services* 70% and *Perception of Functioning* 71%, and *Perception of Social Connectedness* 79% were rated much less positively.

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
				Odds Ratio for Hispanics: When controlling for race and gender, Hispanic Adults and Older Adults tend to have significantly lower odds of answering that they "Agree" or "Strongly Agree" on the survey. Through use of logistic regression, Hispanics routinely had odds ratios significantly below 1.00. These results suggest that further research should be used to determine the veracity of these findings, as well as determine further course of action. Missing from this analysis is Socioeconomic Status, a useful tool in determining association. **RESULTS:** Goal: Met See Consumer Perception Survey for full report.

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
10	**Evaluate beneficiary grievances, appeals, expedited appeals process and timeliness** MC Oversight MC Protocol: 4a, 4b, 4c, 5a. CA. Code Regs., tit. 9, § 1810.440(a)(5).	Tracking of the grievances, appeals, State Fair Hearings and Change of Provider requests	Continue to record and resolve all grievances, appeals, Change of Provider requests and State Fair Hearings. Monitor the wait time and follow up time. PRA to report to DBH Director on a monthly basis. Make analysis/finding available to Access Committee, QIC, MHP, contractors, and public.	**EVALUATION:** The tracking of the grievances, appeals, State Fair Hearings and Change of Provider requests will be used as a feedback loop to provide more enhanced quality of care for the consumers of the MHP. **GOAL:** Assess beneficiary/family satisfaction by evaluating beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings and change of provider requests. **METHOD:** Managed Care's Utilization Review Specialist provided quarterly reports on Grievances, Change of Provider requests, Appeals, and State Fair Hearings. Reports were submitted to the QIC staff and meetings. **DATA:** Grievances: 71 Change of Provider: 65 State Fair Hearings: 1 **RESULTS:** Goal: Met

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
	D. QIWP Target Area: Quality Assurance			
11	**Compliance Chart Audits**	Continue to conduct outpatient chart audits throughout the MHP to ensure medical necessity criteria are met and documentation of services is appropriate Make the findings available to the Compliance Office regularly. Compliance Office makes the summarized findings available to QIC semi-annually. QIC to recommend training needs and MHP-wide standards when necessary	Findings of reviewed charts	**EVALUATION:** **GOAL:** Conduct chart audits throughout the MHP to ensure the following is met; 1) Medical Necessity, 2) Documentation of Services is appropriate, 3) Utilization of Resources is monitored. **DATA:** Summary reports of chart audits were created in February 2016, and in August 2016. • February 2016 Report - Review period includes claims between January-June 2015 • August 2016 Report – Review period includes claims between July-December 2015. **RESULTS:** 1) Medical Necessity Medical Necessity was not documented in 19 of the 1913 reviewed claims reported in February 2016. (Services between January and June 2015.) In the August 2016 report, Medical Necessity was properly documented in 94.5% of the reviewed claims. (Services between July and December 2015) Fifty-two (52) claims of the 957 reviewed were disallowed for no documented medical necessity. 2) Documentation of Services is appropriate • February 2016 Report indicated a 5.31% Error Rate. Errors/Reasons for Recoupment included: Plan of Care issues, not a billable service, Service Duration issues, and no Medical Necessity.

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
				• August 2016 Report indicated an 8.05% Error Rate. Errors/Reasons for Recoupment include: No Medical Necessity, No Plan of Care, Incorrect Service Code, and No Documentation. 3) Utilization of Resources is monitored FCMHP works to achieve cost-effective use of mental health care resources that assures clinical appropriateness and quality of care. Through the Utilization Review process Managed Care staff determines if clinical documentation is present to support proper Medi-Cal claims billing. • The February 2016 Report included $279,444.11 worth in reviewed claims, of which $14,839.27 was disallowed. 5.31% Error Rate • The August 2016 Report included $86,429.63 worth in reviewed claims, of which $6,961.55 was disallowed. 8.05% Error Rate **Goal: Met** Fresno County Mental Health Plan set a goal to attain a less than 9% error rate in this review period. This goal was met. Compliance Officer will continue to discuss strategies for improved chart audit results in monthly compliance committee meetings. The Mental Health Plan will attain a less than 6% error rate in the next period.

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
12	**Timeliness of clinical documentation**	Prepare reports on timeliness every month, and analyze the trend. Make a report available to QIC and Leadership on a quarterly basis and to Clinical Supervisors monthly.	Findings of Progress Notes timeliness monitoring	**EVALUATION:** **GOAL:** Monitor and report monthly results to Clinical Supervisors and QIC members. Goal to have all progress notes completed by three days. **DATA:** In the first six months of the fiscal year (July 2015-December 2015), the Department experienced a significant increase of 19%; while the last six months of the fiscal year (January 2016-June 2016) experienced a 28% decrease.

Month	Department
July - 15	3.42
August - 15	3.89
September-15	3.16
October – 15*	4.84
November – 15*	5.49
December - 15	4.09

Month	Department
January-16	4.97
February-16	3.45
March-16	4.13
April-16	3.30
May-16	3.70
June-16	3.56

*Note: Issues during transitioning period from DSM-5 to ICD-10

RESULTS:
Goal: Met

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
	E. QIWP Target Area: Staff Engagement and Development			
13	DBH Work Plan: Infrastructure and Support	Administer the Staff Engagement Survey and provide feedback to promote ongoing staff support, training and engagement as indicated Solicit participation from MHP and organizational providers in the Staff Engagement Survey. Use Gallop survey. Work with Gallop to analyze results of survey and distribute to all agencies that participated. Make survey results available to QIC and employees.	Analyze Staff Engagement Survey	**EVALUATION:** **GOAL: Measure Staff Engagement** **DATA: Not Available in Process January 2017** **GOAL: Not Met**

	Jul-12	Feb-13	Oct-15	Dec-16
Overall Satisfaction	NA	NA	3.58	In Process
Q1	3.88	3.98	4.03	
Q2	3.32	3.46	3.70	
Q3	3.65	3.81	3.75	
Q4	3.28	3.43	3.20	
Q5	4.00	4.13	4.01	
Q6	3.63	3.76	3.79	
Q7	3.47	3.55	3.51	
Q8	3.68	3.78	3.77	
Q9	3.66	3.81	3.90	
Q10	3.19	3.36	3.03	
Q11	3.46	3.64	3.53	
Q12	3.68	3.84	3.92	
Participants	300	255	325	

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
14	Continue to address the training needs of clinical and other staff through an ongoing training plan that is informed through both operational needs and building capacity for core competencies	1. Increase Workface Education and Training staff participation 2. Identify Department and Staff needs	The Number of Staff trained and number of trainings in 2015	**EVALUATION:** **GOAL:** Continue to address the training needs of clinical and other staff through an ongoing training plan that is informed through both operational needs and building capacity for core competencies. **DATA:** The following trainings and numbers trained reflect FY 2015-16 • Nonviolent Crisis Intervention training for 247 staff in the Department, with the goal of certifying the remaining Department staff within 2017; • Mental Health First Aid Training for 445 individuals comprised of County staff and members of the community; • Early Childhood Mental Health Training for 30 Mental Health Clinicians within the public mental health system, with 10 months of reflective practice supervision; • EMDR training (Part 1 and Part 2) with ten hours of EMDR consultation partially completed by end of 2016 with the remaining requirements to be completed by May, 2017; • The Department has committed to DBT training and consultation hours and is in the process of developing an agreement with Behavioral Tech to implement the training to build new DBT teams; • WRAP facilitator training has been scheduled for March, 2017, with the goal of recertifying 18 existing facilitators; • WRAP Advanced Level Facilitator training is in the process of being scheduled; • WISE Recovery 101 training is ongoing, with a commitment from the Department to develop additional Recovery 101 Level 1 Facilitators. **RESULTS:** Goal: Met. The Workforce Advisory Committee is in the process of implementing a Workforce Needs Assessment.

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
	F. QIWP Target Area: Transparency			
15	Create transparency through publication on the Department's Website 1915(b) Waiver EQRO DBH Work Plan: Infrastructure and Support	Participate in the DBH-IT sub-committee to collaborate on content Individual areas publish the information once available Make status available to QIC	New Department-Websites up/Go-Live July 2016	**EVALUATION:** **GOAL:** Update Website accordingly and participate in the IT Committee to provide input and feedback as to the development and implementation of the new County website. **DATA:** The IT Committee held its first meeting on September 11, 2015, followed by a meeting on October 9, 2015; since then the IT Committee has scheduled monthly meetings with staff representative to each Division within the Department. Meetings are facilitated by the IT, Sr. System and Procedures Analyst. The Department website has been updated and modified to include Department reports along with mandated State and EQRO reports for public viewing. The Department is currently working on State Mandated Dashboard. The new Department website continues to go through the Request for Proposal County process, until then the Department continues to update and refresh the website to make it accessible and user friendly for client. One of the features added during this reporting period is the electronic Mailbox for consumers who prefer to write in Spanish and Hmong. Fresno County, Department of Behavioral Health website: http://www.co.fresno.ca.us/Departments.aspx?id=120 **RESULTS:** Goal: Met Department Website is a live document and is continuously updated for staff, consumers, and their families and Community and Faith Based Organizations.

DEPARTMENT OF BEHAVIORAL HEALTH QUALITY IMPROVEMENT WORK PLAN (QIWP) FY2015-2016

#	Goal/Objective:	Proposed Interventions:	Indicator/Measure:	Evaluation
G. QIWP Target Area: Performance Improvement Project (PIP)				
16	**Conduct one Non-Clinical PIP and one Clinical PIP** State Required MHP Contract with DCHS	Review improvement needed in areas of MHP operations. Select areas of improvement for PIP for Clinical and Non-Clinical. Report status update Quarterly to QIC and other committees. Use the PIP Template provided by EQRO. Make status available to QIC	**Non-Clinical PIP:** • Grievances, Process and Division Integration **Clinical PIP** Hospital Discharge Follow-up Timeliness-Children's Mental Health	**EVALUATION:** **GOAL:** For FY 2015-16; maintain two Performance Improvement Projects (PIP) designed to assess and improve process, and outcomes of care that is designed, conducted and reported in a methodologically sound manner. At minimum, one PIP will be a non-Clinical and the other a clinical PIP **DATA:** Fresno County, Department of Behavioral Health elected to perform two PIPs: **Clinical PIP** – Reduce wait times for post hospitalization follow-up **Non Clinical PIP** – Consumer grievance process assessment and improvement. **RESULTS:** Goal: No Met Both PIPs were not rated for validation due to being determined to not be a PIP at time of EQRO Evaluation.