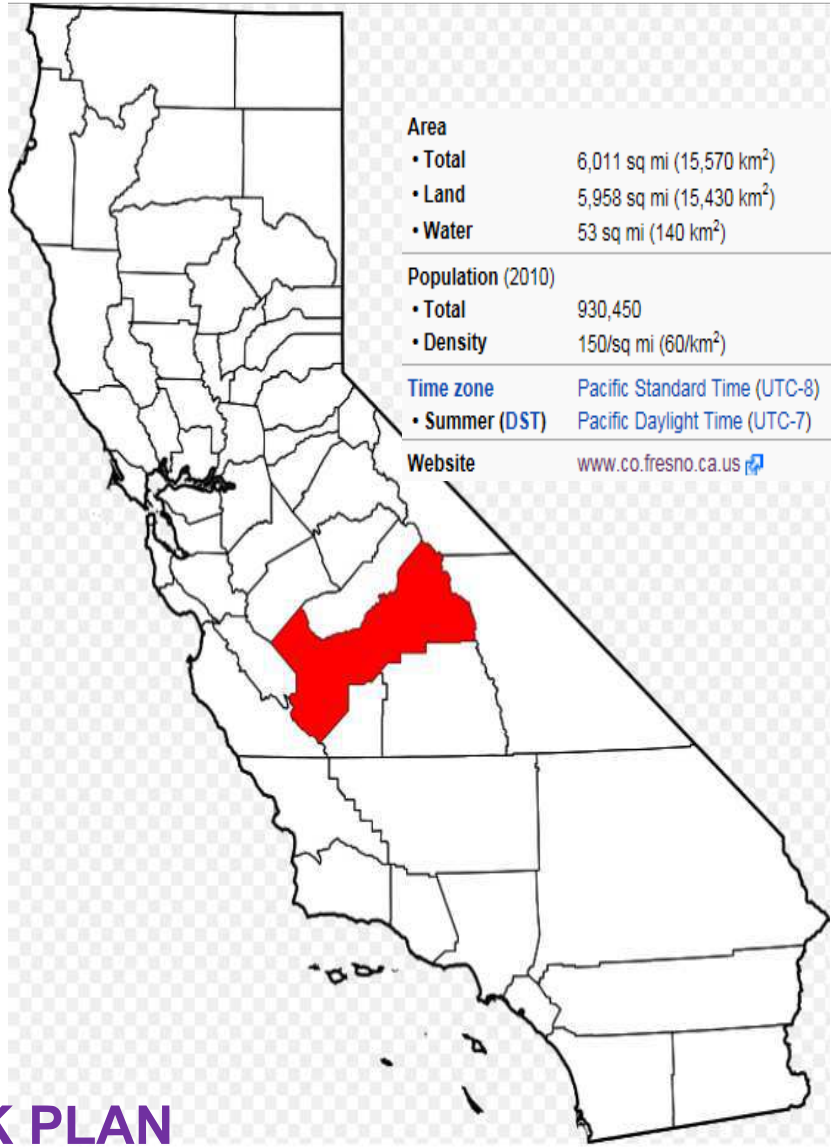


FRESNO COUNTY
MENTAL HEALTH PLAN
EVALUATION

QUALITY IMPROVEMENT WORK PLAN
FISCAL YEAR 2014-2015

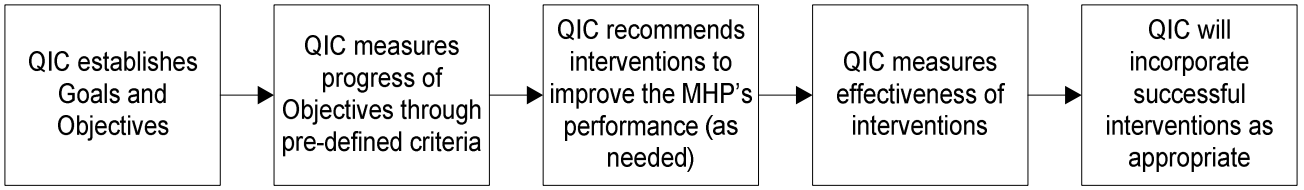
INTRODUCTION

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.

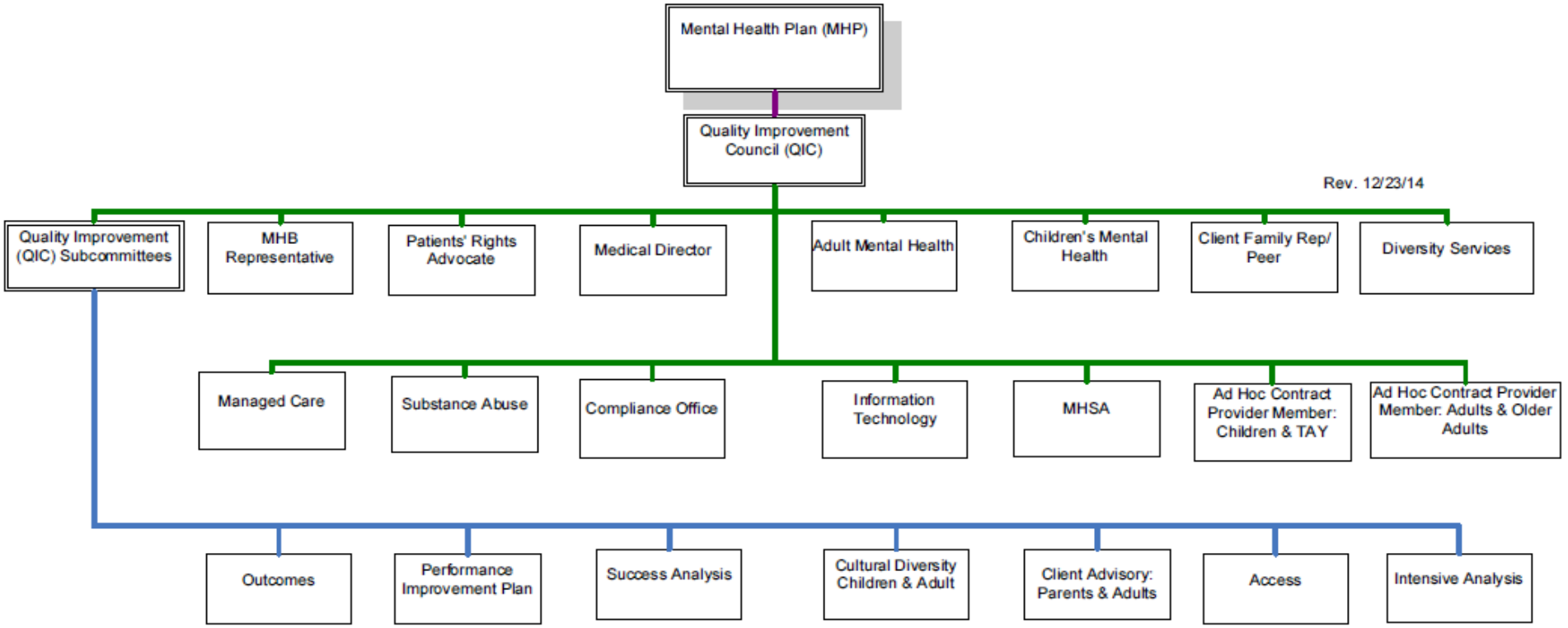
The Quality Improvement Committee (QIC) is responsible for the planning, design and execution of the Quality Improvement (QI) Work Plan. The QI Work Plan provides a roadmap to outline how the MHP is to review the quality of specialty mental health services under its umbrella. The goals and objectives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

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. 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:

1. Service Delivery Capacity
2. Client and System Outcomes
3. Utilization Management
4. Quality Assurance
5. Beneficiary Satisfaction
6. Service Accessibility
7. Safety and Effectiveness of Medication
8. Performance Improvement Projects
9. Coordination of Care With Primary Health Care
10. Staff Development
11. Overutilization and Underutilization of Services
12. Quality of Care Concerns

<table>
<tr><th>OBJECTIVE</th><th>PLANNED ACTIVITY</th><th>EVALUATION</th><th>RESPONSIBLE PARTIES</th></tr>
<tr><td colspan="4">1. Service Delivery Capacity: Increase service delivery capacity to the greatest extent possible given the current resources of the MHP.</td></tr>
<tr>
<td>Previously Identified Issue: Fresno County MHP's penetration rate is much lower than other large CA counties per EQRO supplied data below:

<table>
<tr><th>Period</th><th>Large Counties</th><th>Fresno MHP</th></tr>
<tr><td>CY 2008</td><td>6.63%</td><td>4.37%</td></tr>
<tr><td>CY 2009</td><td>6.25%</td><td>4.01%</td></tr>
<tr><td>CY 2010</td><td>5.92%</td><td>3.60%</td></tr>
<tr><td>CY 2011</td><td>5.76%</td><td>3.44%</td></tr>
<tr><td>CY 2012</td><td>5.77%</td><td>3.59%</td></tr>
</table>

Increase overall penetration rate of Medi-Cal beneficiaries to match a statewide-average for large counties in California (5.77% for CY 2012).</td>
<td>1. Maintain the internal "Penetration Rate" report to compare the number of Medi-Cal beneficiaries in the County against the number of unique Medi-Cal clients served. This report should be broken down into age groupings, ethnicity, geographical location and language.
2. Convert statewide average of the overall penetration rate to a static number.
3. Monitor each category (overall number of unique clients served, age, ethnicity, geographical location, language, type of service). Set goals for each category and report on progress towards goals to QIC on a quarterly basis.
4. Monitor impact of system of care redesign on penetration rates and the number served over time.
5. Report to QIC quarterly with progress on Penetration Rates</td>
<td><u>EVALUATION:</u>

GOAL:
Increase overall penetration rate of Medi-Cal beneficiaries to match statewide average for Large counties in California (4.99% for CY 2014).

DATA:

<table>
<tr><th>Period</th><th>Large Counties</th><th>Fresno MHP</th></tr>
<tr><td>CY 2008</td><td>6.63%</td><td>4.37%</td></tr>
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<tr><td>CY 2014</td><td>4.99%</td><td>3.83%</td></tr>
</table>

RESULT:
Goal: Partially Met – as based on the current methodology calculated by External Quality Review Organization (EQRO) for Calendar Year 2014. 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.</td>
<td>IT, Access Committee, Cultural Diversity Committee</td>
</tr>
</table>

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
2. CLIENT AND SYSTEM OUTCOMES: Create meaningful outcome tracking tools to measure clients' and the system's effectiveness in achieving progress			
Continue to test, select and implement outcome tools for the Department.	1. Take all data analyses (survey results, outcomes data) from MHP testing of the Outcomes Questionnaires (client-completed tool suite) and the Milestones of Recovery Scale (practitioner-completed tool) and compare with Recovery-360 to determine which tool to use. 2. Members of the outcomes committee to travel to Denver, Colorado to the site where the Recovery-360 suite is being used to determine its applicability with Fresno County. 3. Determine which outcomes tool to use. 4. Implement the outcome tools throughout the Department and begin to collect data from them.	*At the end of the fiscal year, client and system outcomes will be reported in a dashboard format for all staff to view.* ***Outcomes Questionnaires (OQ)*** ***PROS:*** *has three parts to cover all ages (YOQ and YOQ-SR (ages 0-17) and OQ (ages 18+), has established reliability and validity, has clinical cut offs, reliable change indexes and critical items If completed, can provide immediate feedback to clinical staff.* ***CONS:*** *has many questions and can be cumbersome for clients (45 questions) During the pilot, the tool was rated a 5.79 by practitioners (1-10, 10 being extremely useful), difficult to calculate the totals, during the pilot, a total of 344 client surveys completed, and of those, had 31 "matched pairs"* • *Above Clinical Cut Off - 64%* • *Under Clinical Cut Off - 36%* ***Milestones of Recovery (MORS)*** ***PROS:*** *can be completed by Case Managers, a tool itself is free, but the training has a cost through the creators of the tool, used by several counties, a tool has one question, so the clinical staff don't feel overwhelmed. During the pilot, a total of 2,449 MORS surveys completed on 846 unique clients during the testing*	IT, Outcomes Committee

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		phase. Of the 846 unique clients, 561 (66.31%) had more than one MORS completed ("matched pairs"). During the pilot, the tool was rated a 6.17 by practitioners (1-10, 10 being extremely useful), research indicates that it is valid and reliable is already built into Avatar. ***CONS:*** *Since there is only one question, statistical analysis is limited, there are many aspects of the client's life that are not accounted for in the MORS, it will need to be paired with another tool, the level of care portion of this tool is not validated, nor is it heavily used and no version for youth or TAY available.* ***Recovery-360:*** *Members of the outcomes committee visited the Mental Health Center of Denver in October 2014 to review the tools. A suite of tools to measure Recovery from multiple perspectives, including the client, the practitioner, and an overall agency assessment. It also has a level of care component that correlates with services that are offered through the MHP. The Department is in a process of contract development to use the tools (18+).*	

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		EVALUATION: ***GOAL:*** • *At the end of the fiscal year, Client and system outcomes will be reported in a dashboard format for all staff to view* • *Client-completed outcomes tools will be implemented throughout the Department.* • *Functional variables will be implemented throughout the Department via AVATAR.* ***DATA:*** *See Supporting documentation and sample Outcomes for 2013. Outcomes Reports are submitted to the MHB at their regularly scheduled meetings.* ***RESULTS:*** *Goal: Partially Met. The Department continues to review and test Dashboard applications and seeks to integrate a dashboard as mandated by State DHCS, by September 2016. Reaching Recovery 360 Outcomes tools have been scheduled for installation in the Departments AVATAR system in January 2016. Forms available are: Recovery Needs Level; Recovery Marker Inventory; and the Consumer Recovery Measure. The Promoting Recovery in Organizations Survey (PROS) is not currently available at current moment.*	

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
3. UTILIZATION MANAGEMENT: Develop consistent methods of evaluating medical necessity and appropriateness of treatment authorizations.			
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.	1. Conduct consistency monitoring in October 2014 for the authorization of specialty mental health services for out of county providers and day treatment intensive with 100% consistency achieved. 2. Managed Care to make recommendations and changes when consistency monitoring is less than 100% or when a treatment authorization is not completed within the designated timeframe. 3. Managed Care to maintain the appropriate documentation to show the consistency percentage achieved and recommended actions.	The consistency monitoring will be at 100% each time it is completed. **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 7 items were discussed. Of the 7 items discussed; 1 item scored 91% consistency. All items identified were discussed and addressed. See Managed Care Minutes of Meeting dated October 7, 2014 **RESULTS:** Goal: Met	Managed Care

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
Continue to implement mechanisms to ensure 100% consistent application of review criteria for authorization decisions through consistency monitoring of authorizations for inpatient services.	1. Conduct consistency monitoring in October 2014 for Treatment Authorization Requests for Inpatient and Psychiatric Hospital Services with 100% consistency achieved. 2. Managed Care to make recommendations and changes when consistency monitoring is less than 100% or when a treatment authorization is not completed within the designated timeframe. 3. Managed Care to maintain the appropriate documentation to show the consistency percentage achieved and recommended actions.	The consistency monitoring will be at 100% each time it is completed. **EVALUATION:** **GOAL:** Continue to implement mechanisms to ensure 100% consistent application of review criteria for authorization decisions through consistency monitoring of Treatment Authorization Request services. **DATA:** Managed Care Utilization Review Specialists conducted consistency monitoring for TARS for Inpatient and Psychiatric Hospital Services. A total of 20 charts and 71 days were reviewed for consistent monitoring. 1 of the 20 charts (5%) reviewed had issues of timeliness and medical necessity. These items were discovered and addressed. See Managed Care Minutes of Meeting dated October 15, 2014 **RESULTS:** Goal: Met	Managed Care

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
4. QUALITY ASSURANCE: Establish an effective process for monitoring the medical necessity, documentation and appropriate utilization of behavioral health resources within the MHP			
Continue to conduct chart audits throughout the MHP to ensure medical necessity criteria are met, the documentation of services is appropriate and utilization of resources is monitored.	1. Utilization Review Specialists from Managed Care and the Compliance team will review charts regularly and report their findings to the Compliance Officer. 2. The Compliance Officer will report to QIC twice a year on the results of the chart audits. Additionally, the Compliance Officer will bring instances where practices are either inconsistent or could indicate poor quality to QIC. QIC to recommend training needs and MHP-wide standards when necessary. 3. Report to QIC March 2015 and August 2015.	The chart audits will be conducted regularly, and the results of the chart audits will be presented at the QIC meeting for recommendations on training needs and/or MHP-wide standards. **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. **METHOD:** For each contract provider and each County Doctor a randomized selection of medical records will undergo a Utilization Review: 10% of total cases seen in the review period or 10 cases whichever is less. **DATA:** Summary reports of chart audits were created in February 2015, and in August 2015. • February 2015 Report - Review period includes claims between January-June 2014 • August 2015 Report – Review period July-December 2014.	Managed Care, Compliance Officer

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		RESULTS: ***1) Medical Necessity*** Medical Necessity was documented in all but one of the 1,878 reviewed claims reported in February 2015. (Services between January and June 2014.) In the August 2015 report, Medical Necessity was properly documented in 98.3% of the reviewed claims. (Services between July and December 2014) Thirty-seven (37) claims of the 2,219 reviewed were disallowed for no documented medical necessity. ***2) Documentation of Services is appropriate*** • February 2015 Report indicated a 11.58% Error Rate. Errors/Reasons for Recoupment included: No Medication Consent, No Treatment Consent, Plan of Care issues, not a billable service, Service Duration issues, and no Medical Necessity. • August 2015 Report indicated a 12.16% Error Rate. Errors/Reasons for Recoupment include: No Medication Consent, No Medical Necessity, No Plan of Care, No Treatment Consent, Incorrect Service Code, and No Documentation.	

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		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 2015 Report included $256,100.15 worth in reviewed claims, of which $29,663.22 was disallowed. 11.58% Error Rate • The August 2015 Report included $303,194.62 worth in reviewed claims, of which $36,860.91 was disallowed. 12.16% Error Rate Goal: Not Met. Fresno County Mental Health Plan will attain less than 9% error rate in the next review period. Compliance Officer will discuss strategies for improved chart audit results in monthly compliance committee meetings. (Reports available upon request).	

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
5. BENEFICIARY SATISFACTION: Improved beneficiary satisfaction across the MHP.			
Previously Identified Issue: the Daily Report Card is not currently accessible to the MHP's community-based providers.	1. Research, test and select a new client satisfaction tool for the MHP. 2. Ensure the tool is accessible in the threshold languages. 3. Provide the survey MHP-wide, making sure to track for response rates. 4. Analyze the data and present to QIC. 5. Report to QIC February 2015 and August 2015.	At the end of the fiscal year, a new client satisfaction tool will be implemented, and the information from the survey will be used to guide quality improvement decisions. **EVALUATION:** **GOAL:** Improve the methodology of gathering beneficiary satisfaction to improve the number of clients who are surveyed, focusing especially on those not included in the Consumer Perception Survey (CPS) distribution. **DATA:** No Daily Report Card data was received from Community based organizations. Only one (1) Internal program was accounted for submitting Daily Report Cards: Supported Education Employment Services (113). Of the survey participants, 92% Agree/Strongly Agree that the program is welcoming; 89% Agree/Strongly Agree that the program "meet my cultural needs"; and 92% Agree/Strongly Agree that the program is designed to support wellness and recovery and fulfill goals I set for myself. **RESULTS:** Goal: Partially Met. The Daily Report Card Survey needs to expand for more	QI , QIC committee

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		internal and contracted services to capture input feedback from individuals not participating in the CPS survey.	
Assess beneficiary/family satisfaction by evaluating beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings and change of provider requests.	1. Record and resolve all grievances, appeals, change of provider requests and State Fair Hearings within regulatory standards. Maintain a log of each incident to be reported on to QIC on a quarterly basis. 2. Allow providers to resolve their own grievances, appeals and State Fair Hearings 3. Evaluate Grievances, Appeals, State Fair Hearings and Change of Provider requests. QIC to evaluate "MHP Action Items" that result from grievances, appeals, state fair hearings and change of provider requests. 4. QIC to track interventions to determine effectiveness in changing patterns of grievances, appeals, State Fair Hearings and Change of Provider Requests. *Report to QIC quarterly on Grievances, Appeals and State Fair Hearings (both data and themes)	**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: 25 Change of Provider: 6 State Fair Hearings: 1 **RESULTS:** Goal: Met,	Managed Care, QIC

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
Previously Identified Issue: Information from the State's POQI surveys has not been provided to the MHP in a timely fashion. Additionally, there are no standards set for response rates. These factors need to be addressed to improve the use and response rate of the tool. Goal: For the two POQI distributions of 2014, QI staff will data input the information into a spreadsheet (rather than waiting for the State to send the raw data). QI staff will then use SPSS to analyze the data by program and report information more quickly to the MHP by program.	1. The QI team will oversee the distribution of the POQI in November 2014 and May 2015. 2. Each survey will be data inputted into a spreadsheet by program. 3. QI staff will then analyze the data and present to QIC. Each program will also get a report on its POQI results. 4. Report to QIC in February and August 2015.	The MHP will have Consumer Perception Survey (CPS) (formerly referred to as POQI) data for the MHP and for each program. This information will be used in future years to see progress and improve services for clients. Recent updates: • 1,134 completed surveys administered during the November 17 - 21, 2014 period. • QI Team is performing the data entry locally by program number so that the data can be analyzed at a program level. **EVALUATION:** **GOAL:** **A)** The QI Team Analyzed November 2014 and May 2015 results and shared with MHP Providers and Department staff. **B)** The QI Team has established a baseline data (the number of completed CPS and/the number of CPS-eligible clients served during the survey week) **C)** The QI Team has completed the CPS results for Nov 2014 and May 2015 and has provided results in a timely fashion, prior to State results. The CPS results have been reported and compared to the baseline data from November 2014. **D)** CPS Data Report comparing November 2014 & May 2015	DBH Administration, all clinical/administrative staff of the MHP.

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		presented to DBH staff and Participating Contractor providers. **DATA:** Both the Nov 2014 and May 2015 CPS surveys have been completed and evaluated. There was an increase (44%) in participation of CPS forms completed (from 1,134 to 1,630 completed surveys). The CPS results also identified the average length of stay with a majority of clients with more than one year of service. The Nov. 2014 percent of clients receiving services for more than one year was at 46%, while the percent in May 2015 was at 48% being served more than one year. Of the four target groups; Adult, Older Adult, Youth and Youth and Families, Adults made up the majority of the population surveyed at 53% (Nov 2014) and 63% (May 2015 respectively. **November 2014/May 2015:** • General Satisfaction 88%/87%; • Perception of Access 86%/83%; • Cultural Sensitivity 91%/86%; • Perception of Functioning 62%/66% respectively. **RESULTS:** Goal: Met	

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
6. SERVICE ACCESSIBILITY: Provide accessible, welcoming, culturally competent, recovery-oriented, integrated, respectful services that are based on the needs and strengths of the clients/families seeking services.			
Use 'Access Form' information to begin trending information on the wait times for initial requests for specialty mental health services. Monitor how the MHP is meeting its goals for timeliness of first services (30 calendar days for non-urgent requests and 3 calendar days for urgent requests). Provide feedback when the number of clients who receive a late service increases to a set period*. *QIC members to recommend the parameter in a few months once the QIC has enough data to make such recommendation.	1. Access committee to work with IT to track the data on wait times from initial requests for service. All data will be compared against the standards created by the MHP (30 calendar days for non-urgent requests and 3 calendar days for urgent requests) 2. Information to be tracked, trended and presented to QIC in conjunction with NOA-E data on a quarterly basis. 3. The Access Committee will work with leadership when the number of clients who receive a late service increases to a set period*. 4. Present data on wait times and NOA-E's on a quarterly basis	At the end of the fiscal year, the percentage of "on-time" services can be trended to see how well the MHP is doing meeting its service accessibility goals. **EVALUATION:** **GOAL:** At the end of the fiscal year, goals will be set for the timeliness of the responses for initial requests for service. **DATA:** In FY 2013-14; Access Committee and Departments ISDS were able to develop tracking tool to evaluate wait times. **RESULTS:** In FY 2014-15; there were a total of 7,184 requests for services. The overall average day for service is 11.36 days. Adult Urgent: 0.98 days Adult Non-Urgent: 6.31 days Child Urgent: 1.34 days Child Non-Urgent: 23.49 days NOA-E – Reports submitted and discussed at QIC meetings Goal: Met	Access Committee, IT

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
Increase accessibility of service requests by enabling beneficiaries to send requests for service through the Department of Behavioral Health's Website in all threshold languages.	1. Access committee to work with IT and clerical staff to translate (into Spanish and Hmong) link that beneficiaries can use to request for mental health services. 2. Make sure that the MHP is checking the website requests and tracking the follow through. 3. Present to QIC twice a year on the number of requests that have been received through this new method in each of the threshold languages.	At the end of the fiscal year, the website access should be fully functional (tested with feedback provided to the Department). Beneficiaries should be able to use the Department's website to access mental health requests in Spanish, English and Hmong (as of February 2015; Spanish and Hmong were added to the website). Recent updates: As of FY 2014-15 results were as follow: • 55 e-mails came to the Adult Inbox • 0 e-mails came to the Youth Inbox **EVALUATION:** **GOAL:** The website Contact page e-mail access is fully functional. Beneficiaries should be able to use the Department's website to access mental health requests in Spanish, English and Hmong. **DATA:** Visit Department website at: http://www.co.fresno.ca.us/DepartmentPage.aspx?id=54917 **RESULTS:** The Department of Behavioral developed a webpage via the County's Department website, contact page. The web link allows the user to contact the Department via e-mail. The Department will contact those individuals within two business days. Goal: Met	IT, Access Committee

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
Previously Identified Issue: From October 2012 to May 2013, the Access Line test callers only had their calls logged an average of 61% of the time. In addition, during the last Medi-Cal oversight review, only 1 of the 5 test calls "passed" the State's review. Monitor the 24-hour access line to ensure the accuracy and quality of the response.	1. Perform 5 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. 2. Check access log to ensure that the date of call, name, reason for call and disposition were recorded. 3. Make sure that all types of calls are tested, including requests for service, grievances, and literature requests. 4. Document findings and present to QIC and to the Access Committee on a quarterly basis. 5. QIC to make recommendations if deficiencies are noted. 6. Report to QIC on a quarterly basis	At the end of the fiscal year, 100% of all test calls will be performed without error. From January 2014 – December 2014, a total of 49 test calls were completed: • 46 test calls or 94% were logged. • 41 test calls or 84% were logged with accurate names. • 46 test calls or 94% were logged with accurate dates. • 41 test calls or 84% were logged with accurate phone numbers. • 42 test calls or 86% were logged with accurate call reasons. • 46 test calls or 94% were logged with "Assessed for Crisis". • 47 test calls or 96% were logged with "Appropriate Info given on how to access SMHS". • 39 test calls or 80% were logged with "Foreign Language". Of these 39 test calls, 39 or 100% were logged with "offered assistance to free language assistance services". **EVALUATION:** **GOAL:** At the end of the fiscal year, 100% of all test calls will be performed without error. **METHOD:** Perform 5 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.	Managed Care, Access Committee

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		DATA: In Calendar Year 2014; 49 test calls were completed randomly. Of the 49 calls; 94% of the calls were logged; 39% were foreign language calls (of the 39 foreign language calls, 49 were logged). 49 of the test calls were crisis oriented; of those 46 (94%) were assessed for crisis. **RESULTS:** Goal: Partially Met – At minimum 60 calls are to be completed for Calendar Year. State and County goals are set at 100% for each category.	
Reduce the wait time between inpatient hospitalization and first psychiatric appointment to 14 days	1. Create a report to track the duration between inpatient hospitalization and psychiatric service. 2. Once the report is created, the data will be trended through the Quality Improvement Analyst and provided to the Medical Director. 3. The Medical Director will present to QIC once a year on the progress toward getting clients in to a psychiatric service within 14 days an in inpatient service.	At the end of the fiscal year, a report will be created that can provide quick data to the Medical Director on the wait times for psychiatric services post-inpatient stay. A goal of 14 days wait time will be set. **EVALUATION:** **GOAL:** At the end of the fiscal year, a report will be created that can provide quick data to the Medical Director on the wait times for psychiatric services post-inpatient stay. A goal of 14 days wait time will be set. **METHOD:** The Department has created a reporting method, by age group, to track the length	Medical Director, Medical Staff, IT, QI

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		of time from initial contact to first psychiatric appointment. Results are based on Fiscal Year 2014-15. Fresno County Mental Health Plan (FCMHP) implemented a consistent method to track in March 2015. **DATA:** Average length of time form first request for service to first psychiatric appointment with a standard goal of 14 days: **RESULTS:** All services: 44.93 days Adult: 43.19 days Children: 48.38 days Goal: Not Met	
Previously Identified Issue: Clients and staff would like to maintain an up-to-date provider list with the goal of meeting the State standard and informing the MHP's providers, clients and potential clients of the types, number and location of available providers currently accepting new clients. Goal: Create an 'on demand' provider list in Avatar that will track the names, credentialing	1. Managed Care to work Credentialing Committee and the Access Committee to build an option in Avatar to track the needed information on each MHP provider. 2. IT to create an on-demand provider list based upon the information entered into Avatar on each provider. 3. Estimated Completion date: June 2015. 4. Report to QIC on progress in	**EVALUATION:** **GOAL:** By June 2015, the provider list will be an on-demand list that will meet the State standard and Inform MHP providers, clients and potential clients of the number, location, licensure, contact information, non-English languages spoken and cultural options available for providers currently accepting new clients.	Managed Care, Credentialing Committee, IT

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
dates, licensure, location, telephone number, non-English languages spoken and options for cultural/linguistic services.	April 2015.	**DATA:** An up to date Provider list has been updated but not developed into the Departments AVATAR system to allow staff to readily download upon request. **RESULTS:** Goal: Partially Met; provider list is currently available upon request. In addition, is being translated into threshold languages (Spanish and Hmong) Goal: Partially Met (in Process of development in FY 2014-15). As of October 2015 the Completion was presented at the DBH Billing Committee Meeting.	

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
7. SAFETY AND EFFECTIVENESS OF MEDICATION: Safely and effectively administer all medication prescribed by the MHP.			
Implement a medication monitoring system that includes compliance and quality metrics. Medication Monitoring will continue to work through Managed Care and report findings to the Medical Director.	1. The Medical Director to work with Managed Care Medication Monitoring to establish a review tool that has both compliance and quality metrics. 2. Medication Monitoring to continue throughout the year. 3. The Medical Director will present annually to QIC on the findings and actions created through the Medication Monitoring Process.	At the end of the fiscal year, the medication monitoring tool will include both quality and compliance measures to inform the medical director on the safety and effectiveness of the medication practices throughout the MHP. **EVALUATION:** **GOAL:** At the end of the fiscal year, the medication monitoring tool will include both quality and compliance measures to inform the medical director on the safety and effectiveness of the medication practices throughout the MHP. **DATA:** Two handout tools have been developed; Medication Monitoring Form and the Compliance Program Documentation Form **RESULTS:** In FY 2014-15 Medical Staff discussed medication monitoring: • Monitoring frequency for particular Safety concerns for Psychotropic Meds • Compliance of Medication monitoring • Policy and Procedures regarding; Side Effects; Disposal of Samples;	Medical Director, Managed Care, all medical providers

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		Opening Multiuse Vials and injectable; Medication/Injections; Disposal of Contaminated Sharps Goal: Partially Met, based on meeting minutes for FY 2014-15 and not presented at QIC meeting.	
Monitor polypharmacy for potential medication safety or effectiveness issues.	1. The Medical Director will regularly run a report to identify polypharmacy instances that could potentially raise safety or effectiveness concerns. 2. The Medical Director will continue to provide education and guidance on prescribing patterns. 3. The Medical Director will report to QIC 2x/year on the polypharmacy monitoring and subsequent actions.	The Medical Director will use the information monitoring tools to provide education and oversight to the psychiatric team on medication safety. **EVALUATION:** **GOAL:** The Medical Director will use the information from monitoring to provide education and oversight to the psychiatric team on medication safety. Dr. Chu, Medical Director stated that these items have been discussed at staff meetings but no evidence has been presented at QIC. **DATA:** Seeking supporting documentation Medical Staff Minutes. **RESULTS:** Goal: Partially Met, based on meeting minutes for FY 2014-15 and not presented at QIC meeting.	Medical Director, psychiatric staff.

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
8. PERFORMANCE IMPROVEMENT PROJECTS: Maintain two meaningful Performance Improvement Projects per year.			
Improve Access Line Test Call Results	Use data on the number of access line test calls that have been appropriately recorded, given the correct information and conducted in the language of preference to inform interventions to improve these baseline rates.	In September 2015; The PIP Team closed and out the Access line Test Call PIP and submitted to the EQRO. See PIP **EVALUATION:** **GOAL:** At the end of the fiscal year, the baseline data will be completed, the interventions will be started and the tracking of changes to the baseline data will be monitored. **DATA:** See supporting documentation for more detailed information of the Outline via Road Map. The goal is to achieve a 100% Increase. **Calls Logged** Pre Post Result Calls Logged 61.6% 74.3% Increase **Accuracy of Logged Caller information** Pre Post Result Caller Name 79.7% 71.4% Decrease Phone No. 87.5% 68.6% Decrease **Appropriate Handling of Calls** Pre Post Result Assessed for Crisis 94.9% 88.5% Decrease Access to SMHS 89.9% 82.9% Decrease Foreign Lang. 80.9% 68.6% Decrease	PIP Team

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		Access Achieved Pre Post Result Linked to services 49.2% 34.5% Decrease **RESULTS:** Goal: Met; as the CAEQRO Outline via Road Map has been completed.	
Participate in the Care Coordination Collaborative through CiBHS	Form a team and participate in the Care Coordination Collaborative and the ongoing learning collaborative.	**EVALUATION:** **GOAL:** This team will continue to work with CiMH throughout the year if the application is accepted. **DATA:** The Department was accepted and participated in the Care Coordination Collaboration. The QI team to continue to work with CiBHS throughout the year and until the collaborative was completed on January 24, 2015. The Clinical PIP was closed out **RESULTS:** Goal: Met, participated in the Care Coordination Collaborative	Care Coordination Collaborative Team
Levels of Care (Clinical)	Form a new team to participate in identifying appropriate program placement based on the beneficiaries needs	Team will conclude appropriateness of the new PIP, as to whether or not it meets the criteria of a Clinical PIP. The Team Concluded that the Levels of Care PIP did not meet Criteria and the PIP Team will pursue a new clinical PIP.	PIP Team

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
9. COORDINATION OF CARE WITH PRIMARY HEALTH CARE: Coordinate services with primary health care to improve the overall health of the clients.			
Allocate and monitor a Mental Health Clinician at a Primary Care Clinic (the Ambulatory Care Clinic in Fresno, CA) to help improve coordination with physical healthcare.	1. Allocate a mental health clinician at the Ambulatory Care Clinic in Fresno. 2. Monitor the activities of the clinician and present biannually to QIC on how the clinical services are utilized in that setting. QIC to make recommendations to the services as needed.	At the end of the fiscal year, the clinician will be placed and stable at the primary care clinic, and information on the impact of the position on primary care coordination will be available. **EVALUATION:** **GOAL:** Improve coordination between Primary Care and DBH Mental Health **METHOD:** Primary Care Integration program is overseen by Contract provider Dr. Hersevoort, CSUF since September 2013. **DATA:** A total of 4,107 unique people were seen in Calendar Year 2014. 1,272 of encounters received a full 30-45 minute encounter; 2,835 were given a 15-30 minute consultation. A majority of persons consulted were from Internal Medicine (46%) and Family Practice (33%). Calendar Year, January through December 2014; a total of 19,806 PHQ-9 were completed. A majority of PHQ-9 were completed at Family Practice (39%) and Women's Health facilities (32%) respectively. **RESULTS:** Goal: Met	Primary Care Clinician, Adult DM

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES

10. STAFF DEVELOPMENT: Provide ongoing support and training to enhance staff engagement and professional development.

Previously Identified Issue: When compared to other providers, DMH staff rated their satisfaction significantly lower (verified through independent sample t-test) on the following items (per February 2013 survey):

Item:	DBH Avg.	Other Agencies Avg.
I have the materials and equipment to do my work right	3.46	3.95
In the last 7 days, I have received recognition or praise for doing good work	3.43	3.64
The mission/ purpose of my company makes me feel my job is important	3.78	4.16
In the last 6 months, someone has talked to me about my progress	3.64	3.99

1. Solicit participation from MHP organizational providers in the Staff Satisfaction Survey in April 2015.
2. Use Gallup survey to distribute survey to staff.
3. QI to analyze results of survey and distribute to all agencies that participated.
4. Follow up actions to the survey will be documented.
5. Report to QIC the results of the survey in May 2015.

The Department of Behavioral Health will participate in the annual staff satisfaction survey, and the results will be provided to the leadership team. If other agencies participate in the survey, those results will also be provided to staff.

EVALUATION:

GOAL:
The Department of Behavioral Health will participate in the annual staff satisfaction survey, and the results will be provided to the leadership team. If other agencies participate in the survey, those results will also be provided to staff.

METHOD:
The use of Gallup Survey was utilized by the Department to reflect the previous year's Gallup survey

DATA:
Of the 600 surveys released, a total of 544 surveys were received of which 315 (90%) were DBH Staff; and 229 (92%) were other agency participants. Other Agencies included mental health providers (125) and Substance Use Disorders (104).

Chart below identifies results for CY 2015; Behavioral Health (DBH); Contractor Mental Health (MH); Substance Use Disorders (SUD)

QI, all staff

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES

Items previously measured	DBH Avg. CY 2015	Contractor MH Avg. CY 2015	Contractor SUD Avg. CY 2015
I have the materials and equipment to do my work right	3.70	4.36	4.17
In the last 7 days, I have received recognition or praise for doing good work	3.20	3.88	3.59
The mission/ purpose of my company makes me feel my job is important	3.77	4.53	4.28
In the last 6 months, someone has talked to me about my progress	3.53	4.07	3.75

RESULTS:
Goal: Met

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
11. Overutilization and Underutilization of Services: Create methods to detect underutilization of services.			
Track clients whom had been discharged from inpatient hospitals and do not have outpatient follow-up visits.	1. Create an "underutilization" report that shows the number of clients who received an inpatient hospitalization with no outpatient follow up. 2. Analyze the report to determine patterns in diagnostic categories, age, ethnicity, language to determine what patterns exist and where the MHP is underserving its clients. This should be reported to QIC on a quarterly basis. 3. Work with the cultural diversity committee to identify areas/training needs to reduce underutilization of services. 4. Track the impact of the interventions on the underutilization report. 5. Report on the underutilization report annually to QIC.	At the end of the fiscal year, patterns of underutilization will be tracked, committees will work together to recommend one or two interventions to reduce these patterns to leadership for consideration. This report can be used to track interventions but is ineffective as a tool to identify clients who need timely follow up due to several factors. Currently, there is not an efficient way of being notified when our clients are hospitalized or discharged. The report will be processed 30-60 days in arrears Recent update: In December 2014, a notification system/alert tool has been implemented and will be rolled out in February 2015 for practitioners to do timely follow-up in order for this monitoring goal to become attainable. **EVALUATION:** **GOAL:** At the end of the fiscal year, patterns of underutilization will be tracked, and the cultural diversity committee will have implemented one intervention to reduce these patterns. **METHOD:** Continuation of the Over/Under Utilization report. Report identifies	Cultural Diversity Committee, Access Committee, IT

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		clients, who were in their last day of inpatient hospitalization, and did not have an outpatient appointment within 30-days. **DATA:** Of the 1,720 clients identified during reporting period, January 1, 2014 through December 31, 2014, 528 or 31% were identified as Underutilizing the system. **RESULTS:** Goal: Met – Cultural Diversity continues to develop and implement intervention policies to improve underutilization. In March 2015, DBH launched a notification tool, via AVATAR, to notify program and direct staff for client follow up	

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
12. Quality of Care Concerns: Address and intervene on issues that potentially raise quality of care concerns.			
Continue to maintain the Intensive Analysis Committee to monitor, track and evaluate all deaths or serious client safety incidents that occur while in the care of 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 2 times per year on findings and make necessary recommendations. 3. The Medical Director will present twice a year to QIC in February and August 2015.	The Intensive Analysis will have met with staff and provided feedback to the MHP on issues that have raised potential quality of care concerns. **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 2014-15 the Intensive Analysis Committee did not meet as a group to discuss specific items. A new committee has been revisited in December 2015, facilitated by the newly hired Quality Improvement Coordinator. **RESULTS:** Goal: Not Met, no evidence was presented to Quality Improvement Committee for review and input.	Intensive Analysis Committee
Previously Identified Issue: The Intensive Analysis Committee had identified the need for a quantitative method to analyze timeliness of progress notes throughout the Department (excluding note to charts and non-billable services).	1. QI to work with IT to pull data average documentation time of progress notes (for billable services only). 2. QI to work with Leadership on a method of reporting and comparing timeliness of documentation.	At the end of the fiscal year, Leadership will have a consistent report (every other month) that will show the timeliness of progress notes department-wide. Since January 2014, a bi-monthly timeliness report has been shared with all Clinical Supervisors; the timeliness of progress notes has since improved.	All DBH Staff, Leadership, QI

<table>
<tr><th>OBJECTIVE</th><th>PLANNED ACTIVITY</th><th>EVALUATION</th><th>RESPONSIBLE PARTIES</th></tr>
<tr><td></td><td>3. QI to prepare reports on timeliness every other month to the Leadership and Clinical Supervisors.</td><td>

EVALUATION:

GOAL:
At the end of the fiscal year, Leadership will have a consistent report (every other month) that will show the timeliness of progress notes department-wide.

In Fiscal Year 2014-15 results showed a decrease for both the CCAIR Unit (13%) and Department (23%) respectively.

CCAIR is a 24x7 youth crisis intervention unit. The CCAIR Unit was dissolved as of June 2015 and no longer tracked.

DATA:
Average Days to complete Progress Notes.

<table>
<tr><th>Month</th><th>CCAIR</th><th>All Others</th></tr>
<tr><td>July 2014</td><td>1.68</td><td>4.24</td></tr>
<tr><td>Aug 2014</td><td>0.45</td><td>3.53</td></tr>
<tr><td>Sept 2014</td><td>0.44</td><td>3.48</td></tr>
<tr><td>Oct 2014</td><td>4.06</td><td>4.84</td></tr>
<tr><td>Nov 2014</td><td>3.29</td><td>4.53</td></tr>
<tr><td>Dec 2014</td><td>0.44</td><td>3.75</td></tr>
<tr><td>Jan 2015</td><td>3.04</td><td>3.75</td></tr>
<tr><td>Feb 2015</td><td>3.82</td><td>3.32</td></tr>
<tr><td>Mar 2015</td><td>3.23</td><td>3.57</td></tr>
<tr><td>April 2015</td><td>3.74</td><td>4.25</td></tr>
<tr><td>May 2015</td><td>1.46</td><td>4.10</td></tr>
<tr><td>June 2015</td><td>0</td><td>3.27</td></tr>
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OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		RESULTS: Goal: Met; the Department completed a quantifiable outcome which allows for Timeliness of Progress Notes. Information is shared with Program Clinical Supervisors.	
Utilize the Success Committee to review instances of clinical excellence and client success stories.	1. Success committee to meet at least biannually to review instances of clinical excellence from within the MHP. 2. Success committee to report biannually to QIC on trends and opportunities for clinical growth. 3. Report to QIC April 2015 and October 2015	At the end of the fiscal year, the Success Analysis Committee will have met twice and made at least one recommendation to QIC. **EVALUATION:** **GOAL:** Continue to utilize the Success Committee to review instances of clinical excellence and client success stories. **DATA:** Although the Success Committee has not met in 2014-15, the Committee has provided additional support in the way of promoting client success stories. In previous FY 2014-15, the County had seven local clients/staff selected as part of the Prop 63 Story, a book presented to Senate President Pro Tem Darrell Steinberg. Client success stories have been captured in a variety of formats and continue to be presented at the beginning of regularly scheduled Mental Health Board Advisory Committee meetings. In the January 2016 Department monthly Newsletter a client's poem was shared for others as the Department continues to utilize client art	Success Analysis Committee

OBJECTIVE	PLANNED ACTIVITY	EVALUATION	RESPONSIBLE PARTIES
		work through other forms of documentation and facility decorative items. **RESULTS:** Goal: Partially Met, although the Committee didn't identify a staff member for clinical excellence it did however utilize its efforts to identify and promote client success stories.	