Fresno County Department of Behavioral Health
Fiscal Year 2019/20

Quality Management, Assurance and Performance Improvement Work Plan for Mental Health Plan and Drug Medi-Cal Organized Delivery System

Approved by QIC FY2019-20
(Revised November 18, 2020)

Department of Behavioral Health
Mental Health/Substance Use Disorder
Technology & Quality Management Division
1925 E. Dakota Avenue
Fresno, CA 93726
(559) 600-9390
dbhqualityimprovement@fresnocountyca.gov

Fresno County Department of Behavioral Health
Quality Improvement Work Plan

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1. MISSION, VISION, AND VALUES

Vision: Health and well-being for our community

Mission Statement: DBH, in partnership with our diverse community, is dedicated to providing quality, culturally responsive, behavioral health services to promote wellness, recovery, and resiliency for individuals and families in our community.

The Fresno County Mental Health Plan and Drug Medi-Cal Organized Delivery System Services (MHP/DMC-ODS) are operated through the DBH and its network of contract providers, community partners, clients, family members, and stakeholders. Throughout this document, references to DBH include all providers that deliver Behavioral Health services. This includes county-operated programs, contracted organizational providers, and individual providers.

This Quality Management, Assurance, and Performance Work Plan integrates both the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) from here forward referred to as QIWP. The QIWP is committed to quality improvement throughout the system of care. The QIWP has developed a Quality Management Program in response to the State and Federal regulations outlined in the MHP and DMC-ODS separate contracts. This Quality Management (QM) Program and the Quality Improvement Committee are directly accountable to the Fresno County, Department of Behavioral Health, Mental Health Director, and Alcohol and Other Drug Administrator. The Quality Improvement Coordinator (QI Coordinator), within the Technology and Quality Management Division is tasked to oversee the activities and execution of the Quality Management Program.

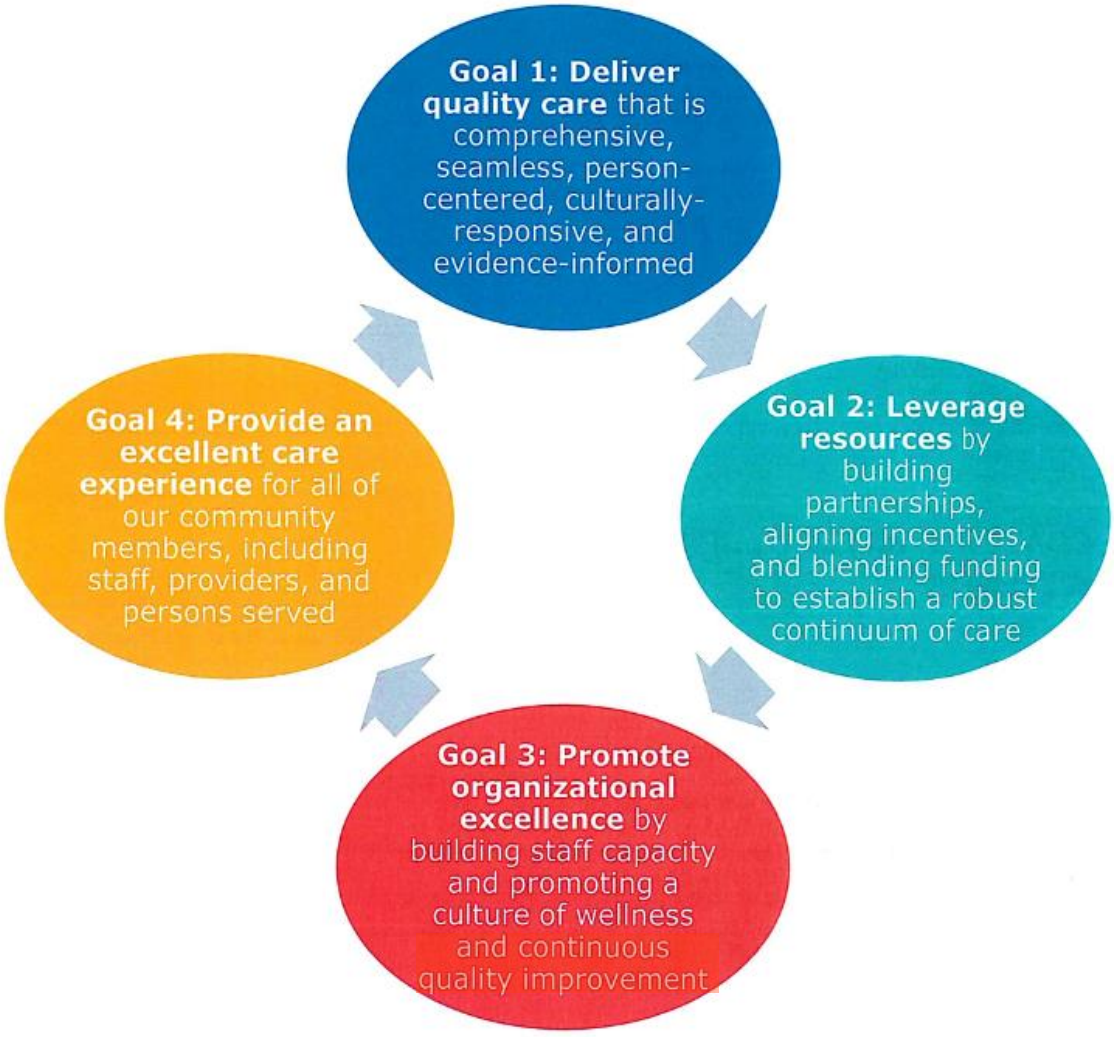
This Quality Management, Assurances, and Performance Improvement Work Plan (QI Work Plan) provides an overview of the QM Program and creates a foundation for continually improving both mental health and substance use disorder services. Performance indicators will identify trends and quality improvement action items, depending upon the availability of data.

The Drug Medi-Cal Organized Delivery System (DMC-ODS) was implemented on January 1, 2019. The QM program is working to identify objectives, and performance indicators, which will establish benchmarks, and standards, for managing this comprehensive new system of care. As a result, the DMC-ODS performance indicators are outlined in this document, and data is not available for a full fiscal year. The DMC-ODS program is strengthening the data for these indicators and will be available in the Fiscal Year (FY) 2020-21 Quality Improvement Work Plan.

2. STRATEGIC PLAN GOALS

The Fresno County Department of Behavioral Health (DBH) has developed a Strategic Plan for Calendar Years 2020 to 2030. Four key goals are outlined in the Strategic Plan, which provide a vision for creating and implementing the Quality Management Program. As shown below, the four Strategic Plan goals include: 1) Deliver quality care; 2) Leverage resources; 3) Promote organizational excellence; and 4) Provide an excellent care experience. Within the Quality Improvement Work Plan (QIWP), the Strategic Plan Goals will be referenced to provide integration and continuity between the Strategic Plan and the QI Work Plan.

Figure 1: Four-Legged Strategic Plan Goals



3. COUNTY PROFILE AND DEMOGRAPHICS*

County Profile

Founded in 1856, Fresno County is located near the center of California's San Joaquin Valley, which together with the Sacramento Valley to the north, from the Great Central Valley, create one of the distinct physical regions of the state. The Coast Range foothills, which form the county's western boundary, reach a height of over 4,000 feet near Coalinga while some peaks along the crest of the Sierra Nevada, the county's eastern boundary, exceed 14,000 feet. The Valley floor in between is fifty to sixty miles wide and has an elevation near the city of Fresno of about 325 feet. (Environment of Fresno County, Fresno County Planning Dept., 1975). According to the U.S. Census Bureau, the County has a total area of 6,011 square miles (15,570 km^2), of which 5,958 square miles (15,430 km^2) is land and 53 square miles (140 km^2) (0.9%) is water.

Figure 2: Geographical Location and Attributes of the County

Demographics

It is estimated that Fresno County is populated with 1,009,024 people (as of 2020). The population size with a total population growth of 8.44% from 2010 to 2020, an average household income of $82,302, total households of 310,343, and an average household size of 3.20.

Figure 3 utilizes the information from the 2020 Healthy Fresno County Data website to identify age, race/ethnicity, and gender of the general population. For the estimated 1,009,024 residents of Fresno County, it is estimated that 23.65% are children ages 0-14; 14.58% are Transition Age Youth (TAY) ages 15-24; 49.2% are adults ages 25-64; and 12.58% are ages 65 years and older. It is estimated that the majority of persons in Fresno County are Hispanic/ Latino (55.07%). Caucasian/White represent 27.54% of the population, Asian/Pacific Islander represent 10.17% of the population, African American/ Black represent 4.43% of the population, Alaskan Native/ Native American represent .56% of the population, and some other/not reported race represent 2.23% of the population. It is estimated that there are slightly more females (50.15%) than males (49.85%) in the County.

Figure 3
Fresno County Residents
By Gender, Age, and Race/Ethnicity
(Population Source: 2020 data from Health Fresno County Data website)

Fresno County Population 2017 CA Department of Finance American Community Survey Estimate		
Age Distribution	**Number**	**Percent**
0 - 14 years	238,680	23.65%
15 - 24 years	147,087	14.58%
25 - 64 years	496,330	49.2%
65+ years	126,927	12.58%
Total	**1,009,024**	**100.00%**
Race/Ethnicity Distribution	**Number**	**Percent**
African American/ Black	44,750	4.43%
Alaskan Native/ American Indian	5,624	0.56%
Asian/ Pacific Islander	102,620	10.17%
Caucasian/ White	277,854	27.54%
Hispanic/ Latino	555,660	55.07%
Other/Not Reported	22,516	2.23%
Total	**1,009,024**	**100.00%**
Gender Distribution	**Number**	**Percent**
Male	503,020	49.85%
Female	506,004	50.15%
Total	**1,009,024**	**100.00%**

Threshold Languages
The threshold languages for Fresno County are English, Spanish, and Hmong. It is estimated that about 42% of the population of Fresno County speaks a language other than English at home (2012 – 2016 American Community Survey).

Disparities
According to California Poverty by County, 2014 – 2016, the California statewide poverty rate was at 19.8%, and Fresno County was at 25.8%.

Substance Use Disorders
Integrated into the FY 2019-20 QIWP is the Substance Use Disorder Drug Med-Cal Organized Delivery System (DMC-ODS) which served 5,491 unique persons in Calendar Year (CY) 2019 and 639,165 billable services (report as of 12-2-19). During CY 2019, 874 (14.7%) utilized residential treatment programs; 2,241 (37.7%) utilized outpatient treatment programs; and 3,338 (56.2%) accessed outpatient SUD services. Fresno County, DBH will continue its effort to integrate mental health and substance use disorder program equally in current and future QIWP.

4. QUALITY MANAGEMENT AND ASSURANCES

The DBH provides excellence in services through the provision of person-driven, recovery-oriented, and culturally responsive behavioral health care services. DBH is committed to implementing a system of care model that integrates quality improvement through its planning, service delivery, and quality management system, utilizing a feedback loop that informs managers, staff, providers, clients, and family of quality of care across services. This ensures an integrated process that includes both program development and compliance activities as outlined in the QI Work Plan, to ensure the department meets contractual requirements of the Department of Health Care Services (DHCS) as well as the performance improvement activities required by the California External Quality Review Organization (EQRO).

The scope of the DBH QI Work Plan has also been expanded to include quality improvement activities that address the regulatory requirements associated with the Drug Medi-Cal/Organized Delivery System. Therefore, the QI Work Plan includes all services delivered to beneficiaries receiving mental health and substance use disorder services from DBH and contracted providers.

The Quality Management team and QI Coordinator will valid timely and reliable data to inform all stakeholders of the quality management system. As data is utilized to document timely access to services, service utilization, and system and client outcomes, improvements in data collection, analysis, and management reports will be refined and updated to support the QM program. The QI Coordinator will collaborate with the DBH Executive Team, Leadership Division Managers, contracted service providers, stakeholders, beneficiaries and family members, and state and local departments, such as State Department of Health Care Services (DHCS) and California External Quality Review Organization (EQRO) to ensure that the QM components meet all standards and requirements.

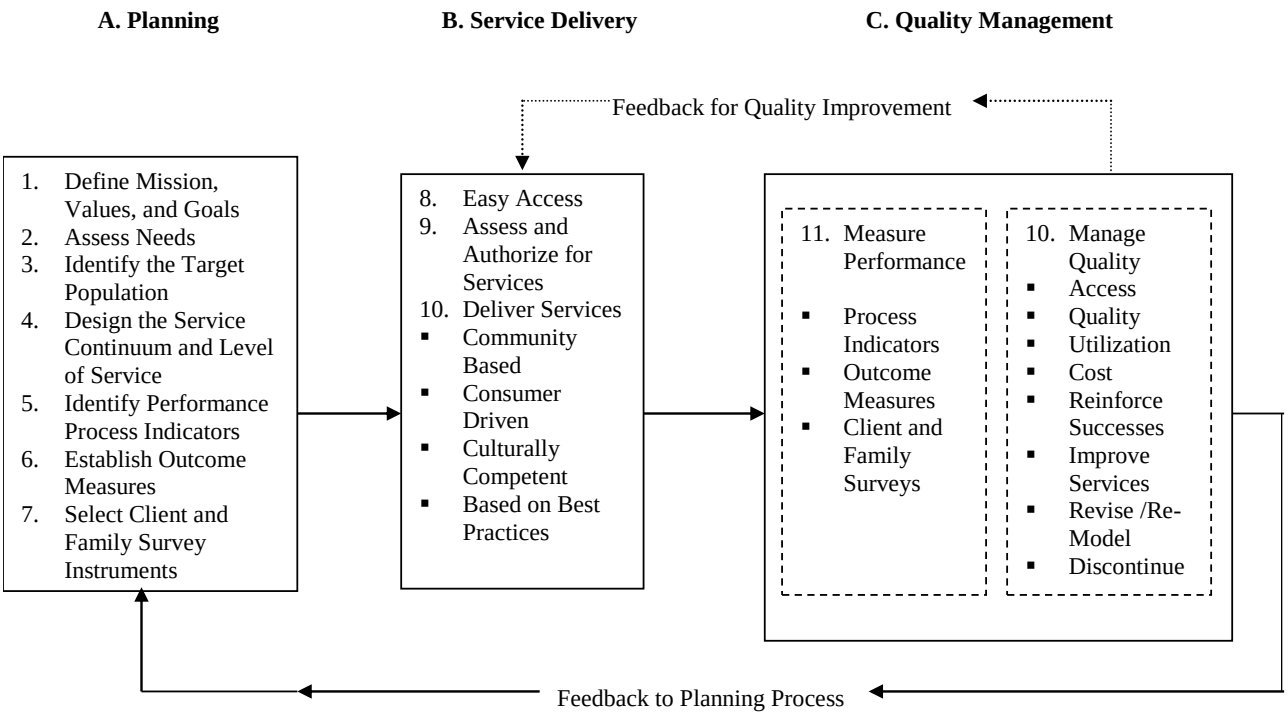
The Quality Management Team ensures that outcomes are consistent with current practices, and align with State, DHCS, and EQRO regulations. In addition, the Quality Management (QM)

Team will work collaboratively with divisions within DBH to provide oversight of timely access to services, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, compliance, and resolution of beneficiary grievances.

QM will work collaboratively with DBH's Medical Director to monitor the Department's Coordination of Care with physical health providers to provide services to persons with mild and moderate mental health conditions. This also helps to support managed care plans to utilize the expertise of DBH in providing mental health services.

The QM model shown in Figure 4 shows how all activities of DBH and its Leadership create a process for a continuum of feedback for improving access, quality, cost-effectiveness, and outcomes. DBH Leadership defines the mission, goals, target population, and performance indicators that accurately reflect the service delivery system. As data is collected in the QM system, it is used to inform managers, supervisors, and clients to develop strategies for improving service delivery, as well as to inform future planning to meet outcome goals.

Figure 4
Quality Management Model



The Quality Improvement Work Plan (QI Work Plan) incorporates both mental health and substance use disorder goals, objectives, performance indicator(s), QI activities, and reflects the Commission on Accreditation of Rehabilitation Facilities (CARF) standards in Annual Program Outcome Reports.

The QM Team ensures a QI Work Plan for current Fiscal Year (FY) and a Work Plan Evaluation that reflects the previous fiscal year and identifies the impact and effectiveness of its quality assessment and performance improvement program. The QIC and QI Work Plan ensures the development and delivery of all QI components outlined by DHCS. This includes but is not limited to evidence of monitoring QI activities, performance improvement projects (clinical and non-clinical) for both mental health and substance use disorder services, evidence of QM activities completed and in process, and a description of the methodology the QM Team has implemented to assess the timely accessibility of services and network adequacy within the service delivery system.

In addition, the QM Team ensures that substance use disorder providers utilize three (3) Evidence Based Practices, one of which is Motivational Interviewing.

QM ensures objectives and performance indicator(s) are developed through the following steps:

1. Identification of areas and/or problems to assess,
2. Identification of performance indicator(s),
3. Development of goals and objectives,
4. Selection of a methodology for evaluating each indicator, and
5. Setting a standard goal and timeframe.

When available, data is shown for three (3) fiscal years, to show trends in the data over time.

QM ensures activities and other ancillary items such as data, findings, and QI actions are available to DHCS, EQRO, and communicated to DBH staff, service providers, beneficiaries, family members, and other stakeholders.

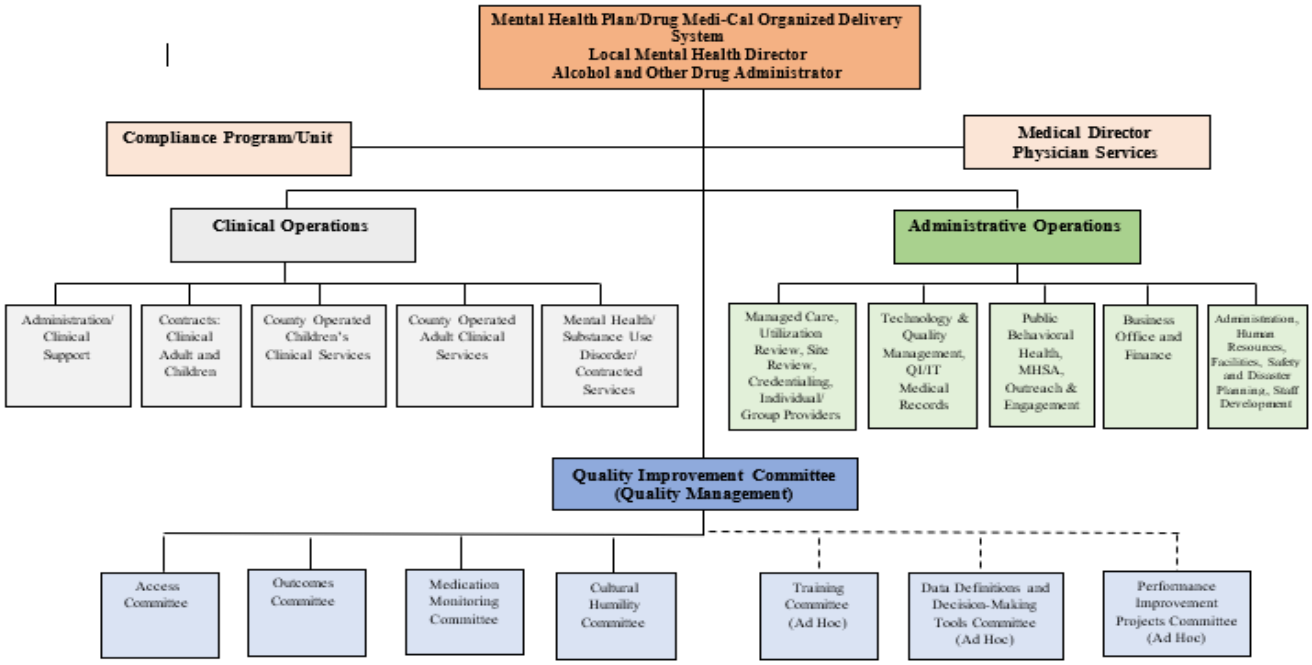
5. ORGANIZATION OF THE QUALITY IMPROVEMENT COMMITTEE

In addition to the QM Team, the QI Work Plan is comprised of the Quality Improvement Committee (QIC) and Sub-Committees, which are responsible for the assessment, improvement, and evaluation of the quality of behavioral health care rendered by the Fresno County DBH MHP/DMC-ODS.

In addition to the Quality Improvement Committee, the QIC Subcommittees include, but are not limited to:

A. Access Committee
B. Outcomes Committee
C. Cultural Humility Committee
D. Training Committee
E. Data Definition and Decision-Making Tools Committee
F. Performance Improvement Projects Committee
G. Medication Monitoring

Figure 5
Quality Improvement Organizational Chart



6. QUALITY IMPROVEMENT COMMITTEE

The QIC is responsible for the planning, design and execution of the QI Work Plan. The QI Work Plan provides a roadmap to outline how the MHP/DMC-ODS will review the quality of specialty behavioral health services under its umbrella. The objectives of this QI Work Plan are to guide the QIC and its subcommittees to meet the identified goals. Furthermore, the QIC will develop and approve a Charter for the purpose of focusing and staying on track to fulfill QIC responsibilities. The QI Work Plan is available to stakeholders (including persons served) and evaluated annually.

The structure of the QIC is designed to include participation from DBH staff, service providers, beneficiaries and family members/legal representatives of anyone that has accessed services from the MHP/DMC-ODS. In addition, the QI Work Plan incorporates input and suggested feedback from EQRO and DHCS Medi-Cal Audit Review. The QIC is committed to honest dialogue; therefore, DBH ensures that all individuals participating in the QIC will not be subject to discrimination or any other penalty in their other relationships with DBH as a result of their role(s) in representing themselves and their constituencies.

The QI Work Plan activities are derived from several sources of information including but not limited to beneficiary and family feedback, DBH, State and Federal requirements, and input from providers. The meaningful use of reliable data is one of the only objective methods of measuring quality improvement. As such, the QIC works closely with appropriate Information Technology staff members to develop a data structure that continually improves the quality, validity, and reliability of data.

7. QIC SUBCOMMITTEES

Committee	**Quality Improvement Committee**
Composition	Director; Deputy Directors; Adult/Children Clinical, Managed Care, QI/IT, Contracts, Medical Records Division Managers; Contracted Services Providers; QI Coordinator; T&QM Division Staff; DBH Peer Support; Beneficiaries, Clients, and Family Members
Meeting Frequency	2nd Wednesday of each month
Responsibilities	1. Serve as the oversight body for Quality Management. 2. Responsible for the planning, design and execution of the QI Work Plan providing a roadmap to outline how the MHP/DMC-ODS is to review, assess, and evaluate the quality of specialty behavioral health services under its umbrella, and ensure its subcommittees meet their goals. 3. Develop a QIC Charter 4. Provide a forum to receive feedback regarding the quality of services provided to clients and family members. 5. Review system data collection activities, grievance and complaint procedures, and client outcomes, satisfaction and other surveys. 6. Provide input in development of an annual work plan to evaluate system objectives and activities and to address potential areas relating to QM functions. 7. Oversee the collection and analysis of data such as data/reports related to client's clinical outcomes, satisfaction, service access, service capacity, grievances, 800 Toll Free Access Line, monthly Test Calls, clinical guidelines, standards, policies and procedures. 8. As the need arises, recommend/designate the responsible party or workgroup or ad hoc committee to execute the planned improvements with specific parameters and timelines for reporting the results of its work. 9. Ensure that the identified improvement opportunities are planned, implemented and evaluated. 10. Monitor and evaluate the annual work plan's effectiveness. 11. Assure that QI activities include measures and processes that assess the cultural competence of System of Care services and activities.

Subcommittee	**Access Committee**
Composition	Adult and Children Clinical Services Division Managers relevant to care access points; Contracted Services Division Manager; QI Coordinator; QI Staff Members; Technology Staff Member; Contracted Program Directors; Contracted Access Line Program Manager. Chair is a Designated Member from Quality Improvement Team.
Meeting Frequency	Held Quarterly, 2nd Tuesday of the month
Responsibilities	1. Serve as the oversight body for access to care. 2. Ensure that beneficiaries have access to specialty mental health and substance use treatment services. 3. Review, discuss, identify issues/concerns and provide recommendation to leadership for program improvement, allowing for access to care to be efficient and effective. Items include reviewing PPGs, state regulations tracking/monitoring the 1-800 Access Line, timeliness of services, review/develop necessary reports for program effectiveness and interpreting and translation services. 4. To identity opportunities to improve access to care and ensure that, the identified improvement opportunities are planned, implemented and evaluated.

Subcommittee	**Outcomes Committee**
Composition	Director; Clinical Deputy Director; Adult/Children Clinical, Managed Care, QI/IT, Contracts, Medical Records Division Managers; QI Coordinator/designee; Clinical Support Team; Information Technology. Chair is the T&QM QI Coordinator or a Designee.
Meeting Frequency	Held every other month; 1st Monday of the month
Responsibilities	1. Serve as the oversight body for performance outcome measures. 2. Provide a forum to receive guidance and feedback from DBH leadership for making/recommending strategic decisions on the performance outcome measures, protocol and implementation. 3. Assess and recommend guidelines related to access, quality, cost-effectiveness, efficiency, and satisfaction with services to identify quality improvement opportunities. 4. Monitor the annual performance outcome measurement reporting. 5. Ensure that the identified improvement opportunities are planned, implemented and evaluated.

Subcommittee	**Cultural Humility Committee**
Composition	Cultural Humility Coordinator, DBH providers, DBH Managers and Staff, Cultural Stakeholders, Office of Education. Chair is the Cultural Humility Coordinator and/or Ethnic Services Manager.
Meeting Frequency	1st Thursday of each month
Responsibilities	1. Develop, implement, and update the Culturally Responsive Plan annually; 2. Distribute and report on the annual self-assessment results and provide insights for recommendations to enhance services; 3. Update on Cultural Humility protocols and actions approved by DBH leadership; 4. Update on insights of disparities, if any, and recommendations to leadership for review and approval; 5. Ensure DBH providers implement Cultural Humility action steps 6. Report to QIC in the areas of Cultural Humility as relevant.

Subcommittee	**Training Committee**
Composition	Training Coordinator, Stakeholders. Chair is the Training Coordinator.
Meeting Frequency	At least quarterly
Responsibilities	The Training Committee is being renewed for FY2018-19; Committee will include community agencies that are partners and allies in the areas of workforce development, education and training. In addition, the Committee currently has members from the Regional Workforce Investment Board, Fresno State (various departments), State Center Community College District (several departments), Fresno Pacific University (several departments), Contracted Service providers, Behavioral Health Board Members, DBH representatives, and Peer Support Staff/Family Members. The goal is to develop working projects to advance capacity building and target training and education to help achieve those and other goals, including reducing barriers to services, and building capacity within the existing workforce regarding core competencies.

Subcommittee	**Data Definition and Decision Support Tools Committee**
Composition	Jeff Elliot, Epidemiologist, Technology and Quality Management, Sr. Staff Analyst, QI Clinicians, Consultant
Meeting Frequency	Monthly
Responsibilities	1. Review ongoing draft data 2. Analyze data for accuracy and consistency with service delivery 3. Identify areas to improve quality of the data 4. Standardize data definitions and methodology 5. Review data with managers to ensure accuracy of data reporting

Subcommittee	**Performance Improvement Projects (PIPs) Committee**
Composition	Karin Kalk, CIBHS, Consultant/Lead Francisco Escobedo, Sr. Staff Analyst Associated organizations, Division, staff and clients
Meeting Frequency	Monthly, as needed basis
Responsibilities	1. Provide Lead Project Management of PIPs 2. Provide technical support to monitor and track PIPs status 3. Mental Health PIPs Clinical/Non-Clinical 4. Substance Use Disorder PIPs Treatment/Non-Treatment

Subcommittee	**Medication Monitoring Committee**
Composition	Department of Behavioral Health Representatives: Psychiatrists, Nurses, T&QM (IT/QI), Compliance, and Pharmacist
Meeting Frequency	Monthly
Responsibilities	1. Update DBH Medication PPG 2. Develop and Implement Medication Monitoring Tool(s) for reviewing medication prescribing and documentation practices 3. Review and analyze State Information Notices 4. SB 1291 – Foster Care, Implement Review Process 5. Review chart audits findings to identify trends in meeting Medi-Cal documentation standards 6. Review and monitor trends in audit findings

8. QUALITY MANAGEMENT, ASSURANCE, AND PERFORMANCE IMPROVEMENT WORK PLAN GOALS – ACCESS TO MENTAL HEALTH AND SUBSTANCE USE DISORDERS SERVICES

Goal 1: Access to Mental Health Outpatient Care – First Offered Assessment Appointment

- ***Objective:*** Persons who are new to DBH will be offered an assessment appointment within 10 business days of first request for a mental health treatment service
- ***Numerator:*** Total number of persons requesting non-urgent mental health services who are new to DBH and were offered an initial assessment appointment within 10 business days in a given fiscal year
- ***Denominator:*** Total number of persons requesting non-urgent mental health services who are new to DBH services in a given fiscal year
- ***Performance Indicator/Target Goal:*** A minimum of 70% of individuals will be offered an assessment appointment within 10 business days of request
    - **Data Source:** Avatar – Sisense Access
    - **Frequency:** Quarterly
    - **Responsible Div./Program:** T&QM, QI/IT
    - **Reference:** MHSUDS IN 18-011; CCR Title 28, 1300.67.2.2

Goal 2: Access to Mental Health Outpatient Care – First Completed Assessment Appointment

- ***Objective:*** Individuals will be seen for an assessment within 10 business days of first request for a non-urgent mental health service
- ***Numerator:*** Total number of individuals requesting a non-urgent mental health services who are new to DBH and were seen for an assessment within 10 business days in a given fiscal year
- ***Denominator:*** Total number of individuals requesting non-urgent services who are new to DBH services in a given fiscal year
- ***Performance Indicator/Target Goal*:** A minimum of 70% of individuals will be seen for an assessment within 10 business days of request
    - **Data Source:** Avatar – Sisense Access
    - **Frequency:** Quarterly
    - **Responsible Div./Program:** T&QM, QI/IT
    - **Reference:** MHSUDS IN 18-011

Goal 3: Access to Mental Health Outpatient Care – First Treatment Service Appointment following a Completed Assessment

- ***Objective:*** Individuals will receive a scheduled MH appointment for a first treatment service appointment within 10 business days of the completed assessment.
- ***Numerator:*** Number of individuals who received a scheduled MH appointment for a first treatment service appointment within 10 business days of the date the assessment is completed
- ***Denominator:*** Number of individuals who received a scheduled assessment and are eligible to received planned outpatient MH services

- ***Performance Indicator/Target Goal*:** At least 70% of individuals will receive a scheduled MH appointment for a first treatment service appointment within 10 business days of the assessment
    - **Data Source:** Avatar – Sisense Access
    - **Frequency:** Quarterly
    - **Responsible Div./Program:** T&QM, QI/IT
    - **Reference:** MHSUDS IN 18-011; CCR Title 28, 1300.67.2.2

Goal 4: Access to Mental Health Outpatient Care – Psychiatric Medication Assessment

- ***Objective:*** Mental Health clients will receive a psychiatric medication assessment within 15 business days of first referral/request
- ***Numerator:*** Number of mental health clients referred for a psychiatric medication assessment who receive a psychiatric assessment within 15 business
- ***Denominator:*** Number of mental health clients making a first referral/request for a psychiatric medication assessment appointment
- ***Performance Indicator/Target Goal*:** A minimum of 70% of mental health clients who need to be assessed for medications will receive a psychiatric medication assessment within 15 business days of referral/request
    - **Data Source:** Avatar – Sisense Access
    - **Frequency:** Quarterly
    - **Responsible Div./Program:** T&QM, QI/IT
    - **Reference:** MHSUDS IN 18-011; CCR Title 28, 1300.67.2.2

Goal 5: Access to Mental Health Outpatient Care – Urgent Conditions

- ***Objective:*** Individuals with an urgent condition will receive a mental health service within 2 calendar days of referral/request
- ***Numerator:*** Number of individuals with a mental health urgent condition who receive a mental health service within 2 calendar days of request
- ***Denominator:*** Number of individuals a mental health urgent condition
- ***Performance Indicator/Target Goal*:** At least 95% of individuals with a mental health urgent condition will receive a mental health service within 2 calendar days of request
    - **Data Source:** Avatar – Sisense Access
    - **Frequency:** Quarterly
    - **Responsible Div./Program:** T&QM, QI/IT
    - **Reference:** MHSUDS IN 18-011; CCR Title 28, 1300.67.2.2; CCR, Title 9, 1810.405

Goal 6: Access to Care – Follow-Up after Hospitalization

- ***Objective:*** Individuals will receive a mental health follow-up service within 7 business days after release from a psychiatric hospital/PHF
- ***Numerator:*** Number of individuals who receive a mental health follow-up service within 7 business days of release from a psychiatric hospital/PHF
- ***Denominator:*** Number of individuals released from a psychiatric hospital/PHF

- ***Performance Indicator/Target Goal*:** A minimum of 70% of individuals will receive a mental health follow-up service within 7 business days of release from a psychiatric hospital/PHF
    - **Data Source:** Inpatient Hospitalization Services
    - **Frequency:** Quarterly
    - **Responsible Div./Program:** T&QM, QI/IT
    - **Reference:** 42 CFR Section 438.208

Goal 7: Access to Care – No Show Rate

- ***Objective:*** Individuals will keep their scheduled appointment
- ***Numerator:*** Number of scheduled appointments that resulted in a No Show
- ***Denominator:*** Number of scheduled appointments
- ***Performance Indicator/Target Goal*:** Less than 10% of scheduled appointments result in individuals not showing up for their appointment
    - **Data Source:** Avatar – Sisense Access
    - **Frequency:** Quarterly
    - **Responsible Div./Program:** T&QM, QI/IT
    - **Reference:** DBH Standard

Goal 8: Access to Care – 24/7 Toll-Free Access Line

- ***Objective:*** Individuals calling the Toll-Free Access line will talk with a live person, in their primary language, in a manner that meets the state criteria
- ***Numerator:*** Number of Mental Health test calls during Business Hours (B) and After Hours (A) that meet the state standard
- ***Denominator:*** Number of Mental Health test calls during Business Hours (B) and After Hours (A).
- ***Performance Indicator/Target Goal*:** 100% of test calls meet the state standard. There are 15 Mental Health test calls conducted each month, with 12 in English, two (2) calls conducted in Spanish, and 1 call conducted in Hmong
    - **Data Source:** County Monthly Test Call Data
    - **Frequency:** 15 Test Calls per month, Quarterly to QIC
    - **Responsible Div./Program:** T&QM, QI Team
    - **Reference:** MHSUDS IN 18-011; CCR, Title 9, Sections 1810.405 and 1810.410

Goal 9: Access to Care – Penetration Rates (Mental Health, Eligible Beneficiaries Only)

- ***Objective:*** To increase the number of persons who access mental health services in a manner that reflects the demographic populations in Fresno County
- ***Numerator:*** Number of persons who received a specialty mental health service in the fiscal year by age, race, ethnicity, and gender, and sexual identity
- ***Denominator:*** Total Medi-Cal Eligible population by age, race, ethnicity, and gender, and sexual identity
- ***Performance Indicator/Target Goal*:** The penetration rate will increase by 3% for each demographic population from the previous fiscal year

- **Data Source:** AVATAR Data
- **Frequency:** Quarterly
- **Responsible Div./Program:** T&QM, QI/IT
- **Reference:** DHCS Standard – Large County 5%

Goal 10: Access to Care – SUD Treatment Access Reports

- ***Objective:*** Client Access Forms are completed at admission/re-admission and are documented in the Access Log
- ***Numerator:*** The number of new requests for SUD services that are recorded in the Access Log
- ***Denominator:*** The number of new requests for services
- ***Performance Indicator/Target Goal*:** At any given time, 90% of Access Reports are completed
    - **Data Source:** Avatar Access
    - **Frequency:** Quarterly
    - **Responsible Div./Program:** T&QM, QI/IT
    - **Reference:** DHCS Standard

Goal 11: Access to SUD Outpatient Care – First Offered SUD Assessment Appointment Services

- ***Objective:*** Individuals who are new to SUD services will be offered an appointment for an outpatient drug free assessment service within 10 business days of first request
- ***Numerator:*** Total number of individuals who are new to SUD services and requesting a non-urgent SUD outpatient service and were offered an appointment within 10 business days in a given fiscal year
- ***Denominator:*** Total number of individuals who are new to SUD services and requesting a non-urgent SUD outpatient service in a given fiscal year
- ***Performance Indicator/Target Goal*:** A minimum of 70% of individuals will be offered an assessment appointment for drug free outpatient services within 10 business days of request.
    - **Data Source:** Avatar Access
    - **Frequency:** Quarterly
    - **Responsible Div./Program:** T&QM, QI/IT
    - **Reference:** MHSUDS IN 18-011

Goal 12: Access to Care – NTP Methadone Services

- ***Objective:*** Individuals will receive Narcotic Treatment Program (NTP) - Methadone services within 3 business days of referral
- ***Numerator:*** Number of individuals that receive NTP Methadone services within 3 business days of referral
- ***Denominator:*** Number of individuals referred to NTP Methadone services
- ***Performance Indicator/Target Goal*:** At least 70% of individuals referred will receive NTP Methadone services within 3 business days of referral
    - **Data Source:** TBD

- **Frequency:** Quarterly
- **Responsible Div./Program:** T&QM, QI/IT; SUD Contract Providers
- **Reference:** TBD

Goal 13: Access to Care – Additional MAT Services

- ***Objective:*** Individuals will be offered an additional Medication Assisted Treatment (MAT) appointment within 15 business days of referral
- ***Numerator:*** Number of individuals that are offered a MAT appointment within 15 business days of first referral
- ***Denominator:*** Number of individuals referred for a MAT appointment
- ***Performance Indicator/Target Goal*:** At least 70% of individuals referred will receive a MAT appointment within 15 business days of referral
  - **Data Source:** TBD
  - **Frequency:** Quarterly
  - **Responsible Div./Program:** T&QM, QI/IT; SUD Contract Providers
  - **Reference:** TBD

Goal 14: Access to Care – SUD Residential Treatment Authorization

- ***Objective:*** Treatment authorization requests for a SUD residential treatment program (ASAM Level 3.1 – 3.5) will be authorized within 24 hours of request for residential services
- ***Numerator:*** Number of treatment authorization requests with an ASAM score of 3.1 – 3.5 that are authorized for SUD residential treatment within 24 hours of request for residential services
- ***Denominator:*** Number of treatment authorization requests with an ASAM score of 3.1 – 3.5 for residential treatment services
- ***Performance Indicator/Target Goal*:** At least 70% of treatment authorization requests with an ASAM score of 3.1 – 3.5 are authorized for SUD residential treatment program within 24 hours
  - **Data Source:** Beacon Health Options – Data Report
  - **Frequency:** Quarterly
  - **Responsible Div./Program:** Managed Care; Beacon Health Options; SUD Contract Providers
  - **Reference:** TBD

Goal 15: Access to Care – SUD Residential Treatment Admission

- ***Objective:*** Treatment authorization requests for a SUD residential treatment program (ASAM Level 3.1 – 3.5) will be admitted within 3 calendar days of request
- ***Numerator:*** Number of treatment authorization requests for SUD residential treatment with an ASAM score of 3.1 – 3.5 that are admitted for SUD residential treatment within 3 calendar days
- ***Denominator:*** Number of treatment authorization requests for SUD residential treatment with an ASAM score of 3.1 – 3.5

- ***Performance Indicator/Target Goal*:** At least xx% of requests for SUD residential treatment with an ASAM score of 3.1 or higher that are admitted to a SUD residential treatment program within 3 calendar days
    - **Data Source:** Beacon Health Options – Data Report
    - **Frequency:** Quarterly
    - **Responsible Div./Program:** Managed Care; Beacon Health Options; SUD Contract Providers
    - **Reference:** TBD

Goal 16: Access to Care – 24/7 Toll-Free Access Line

- ***Objective:*** Individuals calling the SUD Toll-Free Access to Care line will talk with a live person, in their primary language, in a manner that meets the state criteria
- ***Numerator:*** Number of test calls to the SUD Toll-Free Access to Care line that meet the state standard
- ***Denominator:*** Number of test calls to the SUD Toll-Free Access to Care line
- ***Performance Indicator/Target Goal*:** 100% of test calls meet the state standard. There are 7 test calls conducted each month with 1 call conducted in Spanish and 1 call conducted in Hmong
    - **Data Source:** Monthly Test Calls
    - **Frequency:** 7 Test Calls per month, Quarterly to QIC
    - **Responsible Div./Program:** T&QM, QI Team
    - **Reference:** DMC-ODS Intergovernmental Agreement

9. QUALITY MANAGEMENT, ASSURANCE, AND PERFORMANCE IMPROVEMENT WORK PLAN GOALS: OTHER PERFORMANCE INDICATORS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES (*Note that the following sections will be developed in the next fiscal years. Information will be displayed in tables similar to the above section, as data becomes available)*

A. Compliance – Safety and Quality of Care; Beneficiary Rights

1) Chart/Electronic Health Record (EHR) Service Documentation: The goal for this indicator is that staff will complete clinical documentation within 5 business days. The Managed Care/Compliance/QI/ ITSDS teams will collaborate to review the Progress Notes Report and Expired Treatment Plan Report pulled from Avatar/EHR and report the results to QIC on an annual basis. DBH will continue to develop and implement policies and procedures to identify best practices and set standards for timely clinical documentation. The quality goal for documentation is that it occurs on the same date as the service delivered. The maximum is 5 days after the service. Data will be measured for quality (same day documentation) and the goal for late billing (5 days).

2) Grievances and Appeals/ Problem Resolution: DBH will evaluate appeals, expedited appeals, and change of provider requests within the established DHCS timeframe standards (to be developed). The goal for this indicator is that 100% of all Change of Provider requests will be processed for approval or denial. In addition, 100% of all grievances will be processed and logged for further investigation. This indicator will be monitored by Managed Care staff using data from the Annual Beneficiary Grievance/Appeal Report (ABGAR), and reported to the QIC on an annual basis.

3) Notice of Adverse Benefit Determination (NOABD): DBH will ensure that 100% of all NOABD's sent to beneficiaries are logged and that the results are reported to the QIC on a quarterly basis. The QIC will evaluate the NOABD data to identify trends and make recommendations to implement system improvements. For example, the QIC will review trends in the types of NOABDs sent to beneficiaries and evaluate need for change in practices to reduce the need for NOABDs (e.g. timeliness of services; change of providers; timeliness of resolving a grievance).

4) Adverse Critical Incidents/ Unusual Occurrence Reports: General Areas of Concern; Trends: 100% of adverse critical incidents/ unusual occurrence reports are reviewed by the Intensive Analysis Committee. All data trends relating to critical incidents/unusual occurrences will be summarized at a high level and reported to the QIC on a quarterly basis. Adverse incidents data will be analyzed annually to identify trends that require additional intervention.
DBH will continue to work with providers and administrators to ensure compliance with required critical incidents/unusual occurrences reporting and

address the quality of reporting by providing further training to staff, including the provision of reference and training material annually. In addition, the QIC will review trends and identify patterns to identify clinically, administratively, and culturally relevant strategies to reduce adverse events.

5) Full-Service Partnership (FSP) Data: On an annual basis, DBH will develop a Full-Service Partnership Report to be submitted to QIC and Leadership for approval and distributed to FSP contract provider along with their respective data for monitoring and evaluation purposes. Each annual report will be posted on the Department's web page for stakeholders. FSP reports will not be limited to Data Collection Reports (DCR) required via the State Database. FSP reports will include demographics and DCR data such as *Homelessness, Legal Involvement, Hospitalization* (physical/Psychiatric) and *community benefit diversion.*

B. Surveys

1) Persons with Lived Experience Satisfaction Survey: *To be developed*

2) Treatment Perception Survey for SUD: DBH is required on an annual basis to distribute and analyze the Treatment Perception survey for Substance Use Disorder population. The purpose of the survey is to measure and evaluate the client's experience in SUD programs as it relates to *Access, Quality, Care Coordination, Therapeutic Alliance,* and *General Satisfaction.* The Department will distribute survey semi-annually during the months of May and October of each fiscal year.

3) Consumer Perception Survey for MH: On a semi-annual basis, DBH will distribute the Consumer Perception Survey (CPS) and Family Satisfaction Survey to obtain feedback from clients and family members regarding the quality of services delivered by the MHP. The goal for this indicator is to increase survey participation rate by 3%, as compared to previous fiscal year. The QI team will analyze data and make recommendations for improvements in process, procedures, and service delivery. DBH will continue to investigate alternative methods of survey distribution to encourage client/family participation.

4) Caller Satisfaction Survey: DBH operates a toll-free, linguistically competent Access Line twenty-four hours a day, seven days a week to provide beneficiaries with information and access to mental health and substance use disorder services. Annually (in May or June), DBH conducts a Caller Satisfaction Survey to assess the quality of Access Line services. The goal for this indicator is that 70% of caller survey participants are satisfied with Access Line services. The QI Team/ISDS will analyze the data and report it to QIC on an annual basis. DBH will continue to investigate alternative methods of survey distribution to encourage stakeholder participation.

5) Staff Employment Engagement Survey: DBH conducts a Staff Employment Engagement Survey on an annual basis for DBH staff and contracted providers. DBH QI/ITSDS will collect and analyze staff survey responses to identify areas for improving staff engagement and satisfaction, as well as opportunities to implement policies and procedures that will support greater staff engagement (T&QM is not provided the raw data). The Employee Engagement Survey process is facilitated by Technology and Quality Management Division. Although, Gallup, Inc. is the sole proprietor of the Employee Engagement Q12 Survey, data is provided to the County. Gallup, Inc. collaborates with T&QM to develop, implement and coordinate the survey. Analysis does not include programs or organizations with less than four staff persons participating. Results will be reported to the QIC on an annual basis.

6) Cultural Humility Survey: Annually, a Cultural Humility Survey is distributed to DBH staff, organizational providers, and volunteers to provide information that will identify system strengths and opportunities for training to strengthen system-wide cultural humility and the delivery of culturally responsive services. DBH also conducts a Cultural Humility Survey for clients and caregivers/families to obtain feedback on services. Demographic information collected from each respondent will include race, ethnicity, age, gender, sexual identity, veteran status, and lived experience with behavioral health to assess the cultural diversity of DBH Administration/Clerical, Management and Direct Service/Clinical/Case Management staff and volunteers, as well as the clients that they serve. Results will be reported to the QIC on an annual basis.

7) Focus Group Survey (SUD Access Line, MHSA, Behavioral Health): Focus groups conducted by Fresno County DBH and shared at QIC meetings and/or its subcommittees will be identified in this section.

C. Quality Assurance

1) Medication Monitoring: DBH is refining a Medication Monitoring Tool and Polypharmacy Monitoring Tool in FY 2019/20. The Medication Monitoring Tool will be used to review a minimum of 30 charts each month. The DBH Psychiatry Team will ensure the accurate dispensing, monitoring, and documentation of medication dispensed to beneficiaries. Results will be reported to the QIC on a quarterly basis. A separate review of psychiatric medications for children in placement will be conducted annually to meet DHCS requirements.

2) Documentation Standards Reviews: DBH Utilization Review Specialist (URS) staff will monitor county and contracted provider charts for accuracy and completion. The goal for this indicator is that 100% of sample size charts are reviewed in a timely manner. DBH conducts random chart pulls during their annual audit. DBH analyzes trends to calculate the error rate, where the violations occurred, and if they are recoupable. In the case of a violation, DBH develops and issues a Corrective Action Plan (CAP) that the provider completes and implements. Each CAP is sent to DBH fiscal team for review. If the

violation(s) continue, Managed Care URS staff will go out to the site, as needed, until the issue is resolved. This may include reviewing additional charts, meeting with program leadership, and providing further training to staff. DBH may review 100% of charts, if necessary. Results of these activities will be reported to the QIC on a quarterly basis. The Compliance team conducts ongoing monitoring to ensure clinical documentation is in compliance with State and Federal regulations. Compliance will review, monitor and work to ensure the following: Documentation is accurately coded and reflects the services provided, documentation is being completed correctly and in a timely manner, services provided meet medical necessity criteria, and incentives for unnecessary billing do not exist.

3) Site Certification and Re-Certification: DBH will ensure that 100% of providers requiring certification/re-certification will be completed no later than 60 days after inception of program operations. In addition, re-certification of programs will be completed every three years after previous certification. Results will be reported to the QIC on an annual basis.

D. Effectiveness of Services (Client Outcomes and Performance Indicators)

1) Clinical Outcome Measurement – Ongoing Measurement System: DBH will select and implement evidence-based outcome measures to analyze client and program outcomes. Data will be collected as required by the indicators and methodology selected. DBH may require standard measures for all programs and may require specific measures based on the target population and/or clinical design of specific services. DBH will provide training to build core competencies in outcome measurements for mental health and SUD clinical staff who provide direct services to clients. The Staff Development team will track the number of trainings provided, and the number of staff attending each training. Data will be reported to the QIC on an annual basis.

    a. Child and Adolescent Needs and Strengths (CANS)
    b. Pediatric Symptom Checklist (PCS-35)
    c. Reaching Recovery
    d. Evidence-Based Practices with specific data collection procedures
    e. Others as identified

E. Performance Improvement Projects (PIPs)

DBH will plan, design, implement, and evaluate PIPs for mental health and SUD services as mandated by DHCS and monitored by EQRO. The Department will have four (4) active Performance Improvement Projects each fiscal year. Two (2) PIPs will be designated as clinical/treatment and two (2) will be designated for non-clinical/non-treatment. The PIPs for FY 2019-20 are currently seeking improvement in the following areas:

- Clinical (MH) – TBD; in exploratory process (data review)

- Non-Clinical (MH) – Children's MH Outpatient Services, Intake Process, same day services
- Treatment (SUD) – Outpatient Level of Care, client engagement and retention services
- Non-Treatment (SUD) – Access Line, system and operational redesign

F. Culturally Responsive Plan

In compliance with California Code Regulations, Title 9 Section 1810.410, DBH will develop and annually update a Culturally Responsive Plan (CRP) that outlines DBH's ongoing commitment to providing culturally and linguistically appropriate services. The CRP provides a vision and a blueprint for DBH to continually strengthening services across the next several years. The Cultural Humility Committee (CHC) is the identified committee that will guide the CRP goals and objectives, and continually review and analyze data to better understand our current service delivery system and the impact of the CRP as new strategies are implemented. Results will be reported to the QIC on an annual basis.

G. HIPAA/Privacy Violations

1) Breaches, Near Misses, Areas of Risk: The goal for this indicator is to reduce the number of HIPAA breaches to zero (0). T&QM/Compliance Division will monitor this indicator to ensure consistent compliance with all privacy standards as required by the Health Insurance Portability and Accountability Act (HIPAA) for all providers. QI Activities for this indicator include providing comprehensive HIPAA privacy and security training to all DBH staff and collaborating with contract providers to ensure that their staff are provided with adequate training and resources to adhere to privacy and security standards.

H. Voice of Persons served

The purpose of this section is to identify issues/concerns or items to be discussed at QIC meetings that impact clients and their families. This will allow time for clients and families to share their own experiences in various forms, such as verbal, written, and/or art. A representative(s) from client groups will be encouraged to bring information and feedback to the QIC to discuss strategies that promote health, wellness, and recovery.

I. Staff Development and Engagement

1) Staff Development/Capacity Building:

2) Staff Training (Develop Trainings: Cultural Humility; Interpreter, EBP, etc.): DBH documents all trainings offered to staff and/or service providers. Results are reported to the QIC on a quarterly basis.