Final

April 30, 2019

FRESNO COUNTY,
DEPARTMENT OF BEHAVIORAL HEALTH

Quality Improvement Work Plan
EVALUATION *Fiscal Year 2017-2018*

Approved by QIC Chair on April 30, 2019

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Introduction

The Department of Behavioral Health (DBH) vision is the health and well-being for the community. It is a dedicated mission is supporting the wellness of individuals, families and communities in Fresno County who are affected by, or are at risk of, mental illness and/or substance use disorders through cultivation of strengths toward promoting recovery in the least restrictive environment. The Departments goal is to deliver quality care; maximizing resources while focusing on efficiency; provide excellent care experience to clients/families; and to promote a workforce well-being. This goal is embodied within the Departments five work plans. The Departments work plan is comprised of *Behavioral Health Integrated Access*, *Wellness, Recovery, and Resiliency Supports*, *Cultural/Community Defined Practices*, *Behavioral Health Clinical Care*, and *Infrastructure Supports*. In addition to the Departments work plan, the DBH has established the Guiding Principles of care delivery to define and guide a system that strives for excellence in the provision of behavioral health services where the values of wellness, resiliency, and recovery are central to the development of programs, services, and workforce. The principles provide the clinical framework that influences decision-making on all aspects of care delivery including program design and implementation, service delivery, training of the workforce, allocation of resources, and measurement of outcomes.

As mandated by the State Department of Health Care Services (DHCS), county Mental Health Plan (MHP) is to complete an evaluation of its annual Quality Improvement (QI) Work Plan. The FY 2017-18 Evaluation is overseen by the T&QM Division and Quality Improvement Committee (QIC) with input from various Department Divisions. The QIC is comprised of the DBH and its network of contract providers, community partners, clients, family members and stakeholders. The QIC, MHP staff are responsible for the planning, design and execution of the QI Work Plan. The MHP is committed to quality improvement spanning throughout the system of care. The MHP, QIC is directly accountable to the Fresno County Mental Health Director.

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 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 the QI Work Plan is to guide the QIC and its subcommittees to meet its goals. The QI Work Plan is reviewed frequently and evaluated annually and is made available to DBH staff, stakeholders, and can be found on the Fresno County DBH QI website.

The QIC shall adhere to the following steps to measure and initiate action within the MHP. Establish Goals, Objectives

- Measures progress of Objectives through pre-defined Performance Indicators
- Provides intervention in collaboration with stakeholders to improve or bring back to system level performance as needed
- Measures effectiveness of interventions
- Utilize Quality Improvement Tools

Definitions

Goal: Defined by Org Mission Statement, Vision, Values, Target Population

Objective: Defined as a general category of issue/values statements that are values interest to stakeholders. Objectives may encompass several Performance Indicators.

Performance Indicator(s):

a. **Indicator:** a quantifiable statement that can be used to evaluate key performance area or quality over time – Often expressed as an average or ratio
b. **Target:** objective or benchmark that can be adjusted as performance changes over time to reflect changes and improvement in the organization and/or environment.

Score:

Met (M) = 100% of the objective completed

Not Met (NM) = 0% completed

Partially Met (PM) = measure was monitored, reviewed, completed but did not reach standard goal and/or more than 0% of the objective has been met.

Resources:

- Fresno County, Mental Health Plan Exhibit A, # 22 Quality Management Program, CCR Title 9, 1810.440 MHP Quality Management Programs
- Beneficiary Problem Resolution Process Title 9 Division 1, Subchapter 5, Article 1, 1850.205
- Under/over utilization of services Code of Federal Regulations (CFR) 42, 438.240(b)(3)
- Cultural Competence & Linguistic Competence Title 9, California Code of Regulations (CCR) 1810.410
- Performance Improvement Projects (clinical/non clinical) 42 CFR; CCR 438.240 (b)(1) & (d)
- Access Standards to SMHS; CCR Title 9, Article 4, 1810.405(d)(f)
- External Quality Review Organization (EQRO) Calendar Year 2016

Results

The Fresno County Department of Behavioral Health believes that the most strategic path to ensure that our community members receive quality care is to provide a comprehensive behavioral health system of care.

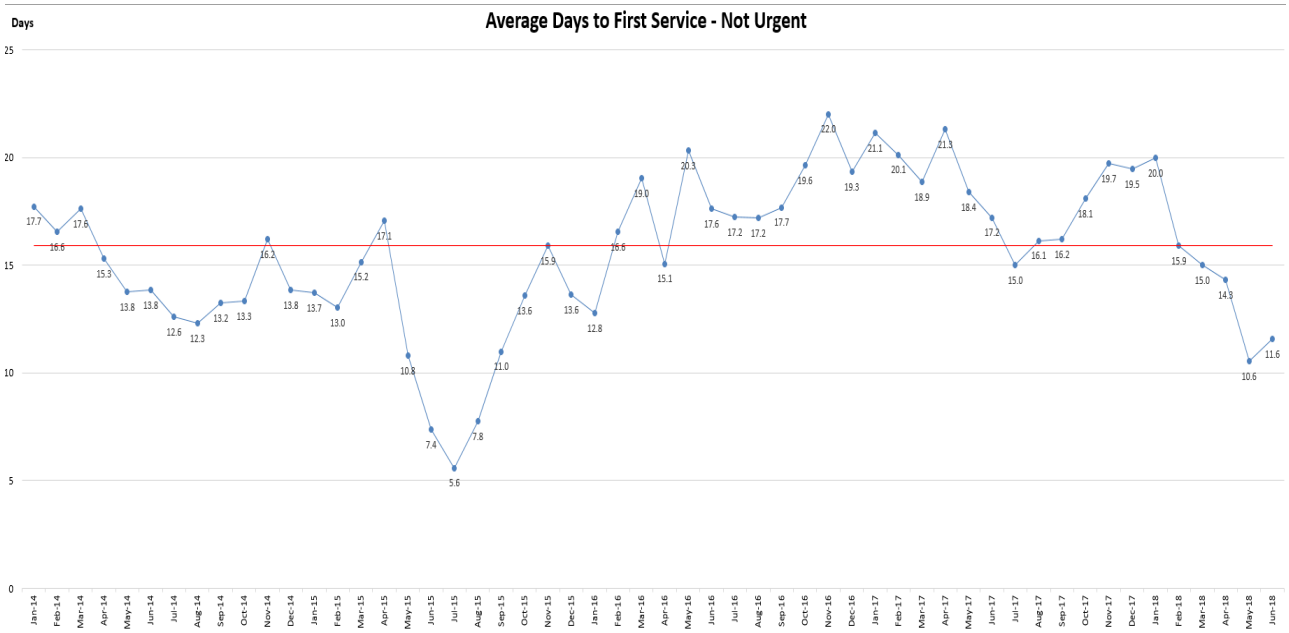
Goal # 1 TIMELINESS OF ACCESS TO CARE				
Objective	**Table/Chart**	**Standard Goal**	**Score**	**Status**
1. Beneficiaries accessing the Fresno County treatment facilities will be served in a timely manner	Chart A	30 days or less	See Chart	**PM**
2. Beneficiaries accessing the Fresno County psychiatric services will be served in a timely manner	Table B	30 days or less	See Chart	**PM**
3. Provide timely appointments for urgent conditions	Chart C	30 days or less	See Chart	**PM**
4. Track trend, access data to assure timely access to follow-up appointment after hospitalization	Chart D	Within 30 days after hospital	See Chart	**PM**
5. Track Trend for "No Show" rates	Chart E	Average < 20%	See Chart	**M**
6. Track Trend for "Client Cancellation" rates	Chart E	Average < 20%	See Chart	**M**
7. Track Trend for "Access Forms Completion" rates	Chart F	Less than 10% not completed	See Chart	**M**
8. Monitor and Track Trend for mandated monthly "Test Calls" for Fresno County Access Line (800) 654-3937	Chart G	Monitor Test Calls	See Chart	**M**
9. Track Trend for "penetration rates"	Chart H	5% Penetration Rate	See Chart	**M**
10. Develop and implement the "MSO Provider Connect Module"	Chart I	Provider List Availability	See Chart	**M**

Goal # 1 - Chart A

Objective 1: Beneficiaries accessing the Fresno County treatment facilities will be served in a timely manner.

Performance indicator: 85% of unduplicated clients served in FCDBH SD/MC facilities will be served within 30 days from first request (face-to-face clinical assessment).

DATA:



Results:

Fiscal Year (FY)	Monthly Average of Clients	Monthly Average Days to 1st Service	% within 30 days to 1st Service
FY 2014-15	596.75	13.22	60%
FY 2015-16	502.75	14.07	64%
FY 2016-17	486.86	18.86	40%
FY 2017-18	440.60	14.25	34%

Recommendation: Utilize a Performance Improvement Project with interventions to increase percentage of clients entering the MHP mental health system within 30-days

Goal # 1 - Table B

Objective 2: Beneficiaries accessing the Fresno County psychiatric services will be served in a timely manner.

Performance indicator: 100% of unduplicated clients served in FCDBH SD/MC facilities will be scheduled for a psychiatric appointment within 30 days from referral

DATA:

Results: Standard 30-days

Measure	All Services	Adult Services	Children Services
Average length of time from first request for service to first psychiatry appointment	27.14 days (mean) 24 days (median) 18.99 Std. Dev.	39 days (mean) 33 days (median) 16.50 Std. Dev.	11 days (mean) 12 days (median) 5.79 Std. Dev.
MHP standard or goal	30 days	30 days	30 days
Percent of appointments that meet this standard	53%	60%	45%
Range	0- 90 days	0-90 days	0-90 days

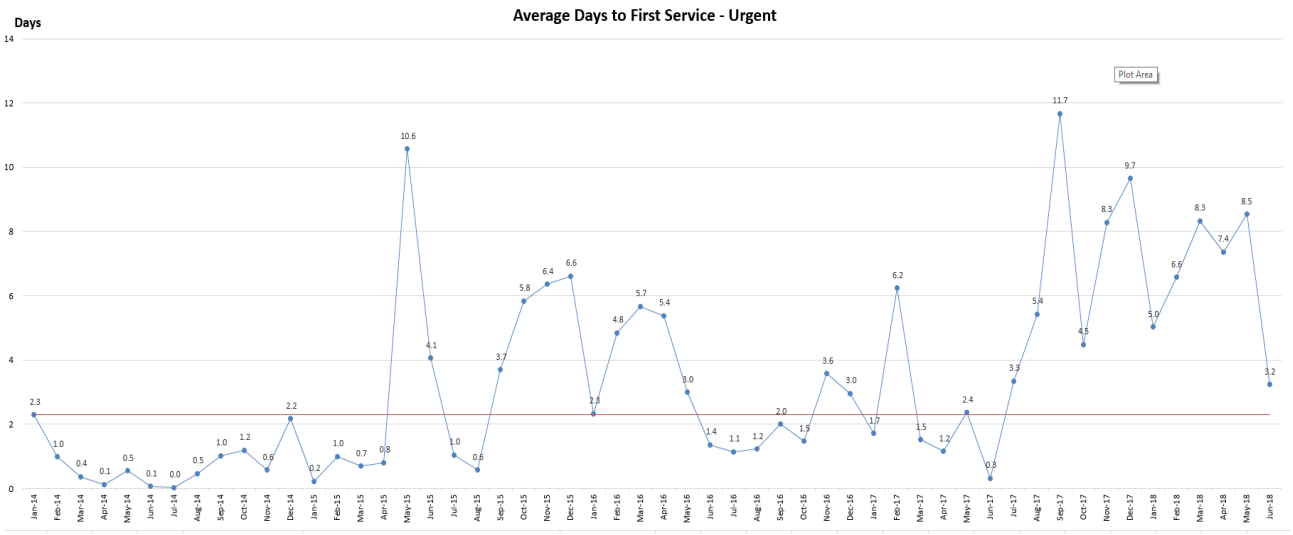
Recommendation: Monitor Adult referral services more closely for FY 2018-19.

Goal # 1 - Chart C

Objective 3: Provide timely appointments for urgent conditions

Performance indicator: 95% of unduplicated clients with urgent conditions will receive appointments within 3 days.

DATA:



Results:

Fiscal Year (FY)	Monthly Average of Clients	Monthly Average Days Urgent	% within 3 day Standard
FY 2014-15	596.75	1.90	91%
FY 2015-16	502.75	3.89	53%
FY 2016-17	486.86	2.23	22%
FY 2017-18	554.00	7.33	37%

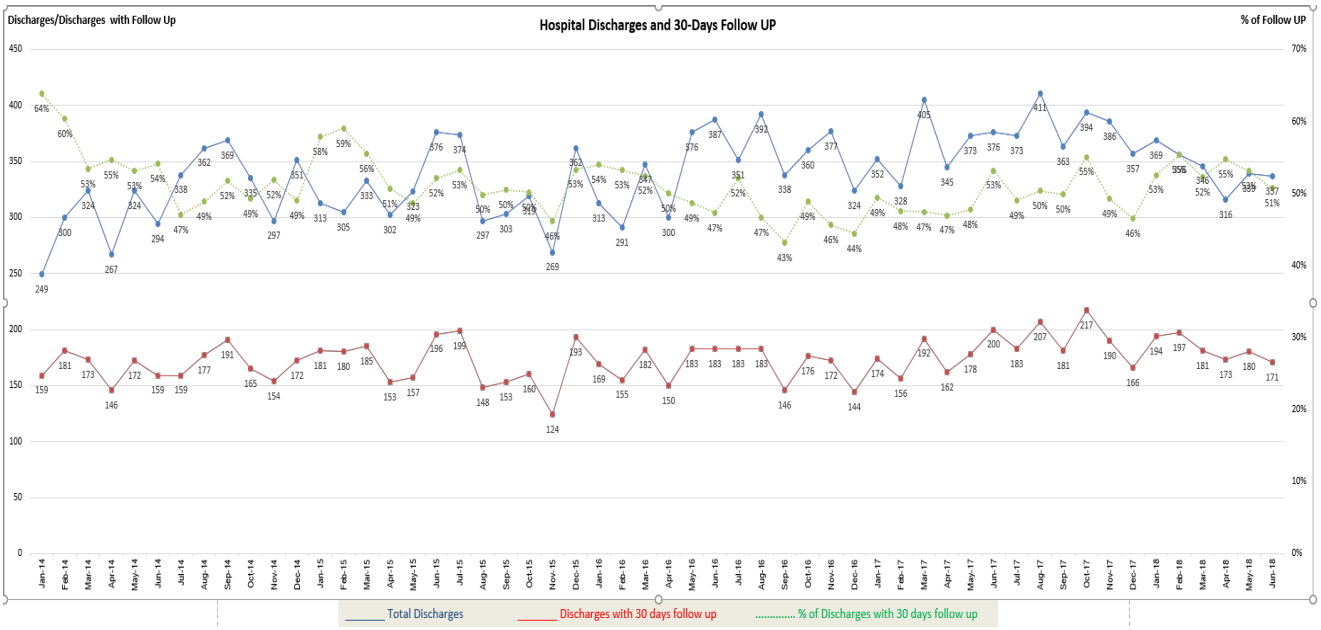
Recommendation: Focus on improving the % of clients receiving services within 3 days.

Goal # 1 - Chart D

Objective 4: Track trend, assess data to assure timely access to follow-up appointment after hospitalization

Performance indicator: More than 75% of clients, after hospitalization discharge, will receive a follow-up appointment within 30 Calendar days

DATA:



Results:

Fiscal Year (FY)	Monthly Average Census	30-day follow-up monthly average
FY 2014-15	334	51.8
FY 2015-16	328	50.7
FY 2016-17	360	47.8
FY 2017-18	362	51.50

Recommendation: Continuation of Clinical Performance Improvement Project FY 2018-19

Goal # 1 - Chart E

Objective 5 & 6: Track Trend for "No Show" and "Cancellation" rates

Performance indicator: MHP average no show rate for clinicians < 20%; average no show rate for psychiatrists < 20%

DATA:

Canceled/No Show Report
Children Division
Calendar Year 2018

Program	Total Services	Canceled	Canceled%	No Shows	No Shows%
2227-Children's Placement Team	7	-	0.00	0	0.00
2230-Youth Services Outpatient	14,058	1,598	11.37	2108	15.00
2240-Adolescent Day Treatment	603	189	31.34	12	1.99
2240P-Adolescent Day Treatment OP	28	-	0.00	0	0.00
2246-Outpatient Medical Staff Services	25,876	958	3.70	4076	15.75
2415-Violet Heintz Education Academy	6	2	33.33	2	33.33
4311-MHSA School Based Program Fresno CO	5,762	723	12.55	697	12.10
4312-MHSA Rural School Based	7,446	759	10.19	722	9.70
4313-Children MHSA ACT	46	3	6.52	0	0.00
4315-Youth Wellness Center	3,575	208	5.82	483	13.51
4316-Children's Outpatient Expansion	4,494	448	9.97	816	18.16
4325A-Airport Children's Behavioral Heal	858	97	11.31	95	11.07
Totals	**62,759**	**4,985**	**8%**	**9011**	**14%**

Adult Division
Calendar Year 2018

Program	Total Services	Canceled	Canceled%	No Shows	No Shows%
2086-REACH Team	17	3	17.65	4	23.53
2116-Employment Services Program (ESP	1,238	6	0.48	31	2.50
2175-Conservatorship	4,818	8	0.17	7	0.15
2191-Intensive Outpatient	4,393	333	7.58	487	11.09
2192-Psychiatry Clinic	530	3	0.57	2	0.38
2820-Clinical -Main Building	7,374	799	10.84	1241	16.83
2830-Transitional Age Youth Pgm	5,115	427	8.35	807	15.78
2841-Medium Intensity Treatment	3,752	23	0.61	44	1.17
2850-Dialectical Behavior Therapy	2	0	0.00	0	0.00
2880-Asian Pacific Islander	2,494	148	5.93	362	14.51
2890-Latino Mod E	1,867	122	6.53	472	25.28
4314-Perinatal Program	8,179	927	11.33	961	11.75
4421-Transitional Age Youth Expansion	1	0	0.00	0	0.00
4470-MHSA Tay Turning Point	9,550	385	4.03	375	3.93
4519-RISE	5,613	60	1.07	123	2.19
4525-AB 109 FSP	6,097	132	2.16	606	9.94
4531-Vista	25,851	359	1.39	1217	4.71
4532A-Airport Adult's Behavioral Health	568	52	9.15	83	14.61
4532B-West Fresno Behavioral Health Ser	490	81	16.53	69	14.08
4610-DBH MHSA Older Adult	3,140	203	6.46	256	8.15
4610P-Older Adult MH Team II	89	1	1.12	4	4.49
4622-Urgent Care/Wellness Center	6,641	226	3.40	784	11.81
4761M-PEI First Onset Metro	1,515	109	7.19	260	17.16
4762-MHSA PEI Crisis and Acute Care	411	1	0.24	6	1.46
4784-First Street Center OP AB109	2,396	189	7.89	736	30.72
Total	**102,141**	**4,597**	**4%**	**8937**	**9%**

Canceled/ No Show
Doctor Division
Calendar Year 2018

Program	Total Services	Canceled	31	No Shows	No Shows%
2920-Doctors-Asian Pacific Islander	619	-	0.00	4	0.65
2922-Doctors Main Building	37,200	1,566	4.21	9,304	25.01
Total	**37,819**	**1,566**	**4%**	**9,308**	**25%**

Results:

Children's, Adult, and Doctors Cancellation rates are meeting standards. For No Shows, Children's and Adult Divisions meet standard (20% rate) whereas the Doctors No Show rates are above standard, at 25% no show rate.

Recommendation:

Validate measures, confirm reliability of methodology utilized to capture data and verify staff data entry.

Goal # 1 - Chart F

Objective 7: Track Trend for "Access Forms Completion" rates

Performance indicator: Reduce the number of Access Forms not completed to less than 10%

DATA:

SUMMARY OF ACCESS FORMS NOT COMPLETED

	Average Number of Access Forms Not Completed by Fiscal Year (FY)		Total # of forms not completed
FY	**FY 2016-17**	**FY 2017-18**	**FY 2017-18**
Adults	3.5	1.92	23
Children's	1.5	.36	4
Total	**5**	**2.25**	**27**

Results:

Access Forms "Not Completed" is 2.25% and meets Department standards

Recommendation:

Continue to monitor and track Access Forms not completed via Dashboard. Item can be removed from QIWP for FY 2019-20 and continued to be monitored by subcommittee such as Data Group.

Goal # 1 - Chart G

Objective 8: Monitor and Track Trend for mandated monthly "Test Calls" for Fresno County Access Line (800) 654-3937

Performance indicator: MHP will monitor monthly test calls to ensure 100% compliance. MHP to perform at minimum seven test calls per month (84 calls per year). Of the seven Test Calls, three calls will be in threshold languages: Spanish and Hmong

DATA:

Does the 24/7 Statewide Toll-Free Access Line provide:		Number of test calls made	Number of test calls where requirements were met	Percentage of test calls where requirements were met
1 Language capability in all languages (NON-ENGLISH) spoken by beneficiaries of the County? NON-ENGLISH Language(s) Tested: Spanish and Hmong	B	19	18	94.74%
	A	16	16	100.00%
2 Information about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met? (e.g. directing the caller where they can obtain a clinical assessment, providing clinic locations and hours of operation, information about walk-in services, etc.)	B	85	84	98.82%
	A	87	85	97.70%
3 Information about services needed to treat a beneficiary's urgent condition? (e.g. crisis services)	B	85	80	94.12%
	A	87	85	97.70%
4 Information about how to use the beneficiary problem resolution and fair hearing process?	B	6	6	100.00%
	A	4	2	50.00%
Does the written log of the initial requests for specialty mental health services include:		**Number of test calls required to be logged**	**Number of test calls logged that met requirements**	**Percentage of test calls logged that met requirements**
5 Name of the beneficiary?	B	85	80	94.12%
	A	87	71	81.61%
6 Date of the request?	B	85	81	95.29%
	A	87	76	87.36%
7 Initial disposition of the request (e.g. caller provided with clinic hours/location, beneficiary scheduled for assessment with [Provider] at [Date/time], warm hand off to 24-hour Crisis Clinician, etc.)?	B	85	80	94.12%
	A	87	71	81.61%

Results:

CALENDAR YEAR 2018 SUMMARY OF ACCESS LINE TEST CALLS										
	176	162 of 176= 92%	158 of 176= 90%	162 of 176= 92%	158 of 176= 87%	153 of 176= 87%	163 of 176= 93%	167 of 176= 95%	32 of 176= 18%	31 of 32= 97%
CALENDAR YEAR 2017 SUMMARY OF ACCESS LINE TEST CALLS										
	164	157 of 164= 96%	149 of 164= 91%	157 of 164= 96%	150 of 164= 91%	155 of 164= 95%	159 of 164= 97%	161 of 164= 98%	39 of 164= 24%	38 of 39= 97%
CALENDAR YEAR 2016 SUMMARY OF ACCESS LINE TEST CALLS										
	87	78 of 87= 90%	75 of 87= 86%	71 of 87= 82 %	76 of 87= 87%	67 of 87= 77%	75 of 87= 86%	73 of 87= 84%	32 of 87= 37%	30 of 32= 94%
CALENDAR YEAR 2015 SUMMARY OF ACCESS LINE TEST CALLS										
	67	41 of 67 = 61%	40 of 67 = 60%	40 of 67= 60%	39 of 67= 58%	35 of 67 = 52%	56 of 67= 84%	47 of 65 = 72%	41 of 67 = 61%	32 of 41 = 78%

Recommendation:

Continue to perform monthly test calls (15) on a monthly basis with three of the test calls performed in the County's threshold languages (Spanish, Hmong). Monitor After Hours calls vs Business Hours calls and monitor new test call log. Set new standards for DBH Contract provider.

Goal # 1 - Chart H

Objective 9: Track Trend for "penetration" rates

Performance indicator: Increase service delivery capacity to 4% based on large County Penetration Rate

DATA:

Calendar Year	Medi-Cal Eligible (MMEF in Avatar)	Medi-Cal Eligible Served (Avatar)	Penetration
2011	371,447	11,470	3.09%
2012	376,116	12,232	3.25%
2013	391,053	13,398	3.43%
2014	465,804	17,828	3.83%
2015	524,304	20,130	3.84%
2016	551,170	20,970	3.80%
2017	552,372	21,650	3.92%
2018	**544,506**	**21,795**	**4.00%**

Results:

Calendar Year 2018 has met the Departments goals of 4%; State goal for large counties is 5%

Recommendation:

Track Penetration Rate by Region (Rural/Metro); Ethnicity; Income, Time and Distance to available services or preferred services. Set a new goal penetration rate at 5% and focus on implementing interventions to increase access to services.

Goal # 1 - Chart I

Objective 10: Develop a Maintenance Service Organization (MSO) for "Provider Connect" for beneficiaries.

Performance indicator: The Fresno County MHP will develop and implement an MSO.

Results/Status:

MSO – Provider Connect 12/31/2018

DBH Managed Care and IT staff began meeting with Netsmart to plan implementation with MSO/PC in September of 2017 and completed the plan by the end of October 2017. Fresno County's IT program began setting up the data collection tables for funding sources, Benefit Plans, CPT/Revenue codes, group codes, authorizations and automatic authorizations.

In early November 2017, Provider data was added including, Fee Definitions, Approve/Pend/Deny Rules Data, MSO Dictionaries Data, User Roles Data, Assessments and Reporting Requirements. In addition, Envisioned Workflows and HIPAA transactions were added.

All MSO functions were added and pre-tested in January of 2018 and are pending final testing.

Netsmart has been unable to activate Provider Connect due to engineering problems and work is still being completed. All County required functions have been completed.

In January of 2019, Netsmart plans to activate Provider Connect and the MHP will begin testing and training for that module.

Once module is completed, the MHP will select a provider to test with and the MHP will perform concurrent claiming with both our current manual system/Avatar and our MSO/PC that downloads into Avatar (MHP electronic health record). Then MHP will roll out MSO/PC to our contracted providers.

Recommendation: Continue with the Development and Implementation of the MSO system for FY 2018-19.

Goal # 2 SAFETY & QUALITY OF CARE				
Objective	**Table/Chart**	**Standard Goal**	**Result**	**Score**
1. Develop a medication and monitoring tool	Table A	Develop Med Monitoring Tool	See Notes	**NM**
2. Develop a polypharmacy monitoring tool	Table A	Develop Med Monitoring Tool	See Notes	**NM**
3. Provide Timely Review of Outpatient Chart Audits to ensure Medical Necessity Criteria are met	Chart B	See Chart C		**M**
4. Intensive Analysis Monitoring	Data C	By Committee	By Committee	**M**
5. Intensive Analysis Monitoring	Data C	By Committee	By Committee	**M**

Goal # 2 - Chart A

Objective 1 & 2: Develop a medication & polypharmacy monitoring tool

Performance indicator: Develop a Medication & Polypharmacy Monitoring Tool. The Fresno County MHP Psychiatry Teams will ensure accurate dispensing, monitoring and documentation of Medication dispensed.

DATA:

	Average %	Median	Standard Deviation
Antipsychotic	46.52	45	10.42
Antianxiety	3.05	2.5	3.08
Antidepressant	20.21	19.5	10.03
Anticonvulsant	8.74	9	5.18
Antihistamine	4.74	4	4.08
Antiparkinsons	6.42	7	4.55
Sedative-Hypnotic	.93	0	2.08
Antihypertensive Adrenergic blockers	3.53	2	5.14
Other	5.82	3	8.82

Results: Need to confirm how to present raw data

Goal # 2 - Chart B

Objective 3: Provide Timely Review of Outpatient Chart Audits to ensure Medical Necessity Criteria are met

Performance indicator: The Fresno County MHP URS staff reviewing contracted provider charts. In-House Clinical Supervisor will review one client chart per month from each of their respective clinical staff.

DATA: Results/Recommendation: Compliance to continue to monitor Charts and report quarterly

QIC Report: Chart Audits
Presented: November 14, 2018

Chart Audit Results

This report includes Managed Care chart audit results for sampled claims/services within the noted review period

Review period: Jan - June 2017				Presented By: Elizabeth Vasquez, Compliance Officer		
INDIVIDUAL/GROUP PROVIDERS						
Chart Audits completed: 4/12/2017 - 8/29/2017	Total no. of records reviewed	Total no. of claims reviewed	Total no. of claims disallowed	Total dollars reviewed	Total dollars disallowed	Reasons for disallowance
	43	234	12	$32,374.32	$524.68	POC Issues
ORGANIZATIONAL PROVIDERS						
Chart Audits completed: 5/11/2017- 9/26/2017	Total no. of records reviewed	Total no. of claims reviewed	Total no. of claims disallowed	Total dollars reviewed	Total dollars disallowed	Reasons for disallowance
	84	1478	69	$214,839.82	$10,781.36	POC Issues, Incorr Dx or Time, Incorrect Service code, Not MH service, Doc does not support time spent, No Doc, Services out of Scope
MED TEAM COUNTY-OPERATED PROVIDERS						
Chart Audits completed: 9/14/2017- 11/17/2017	Total no. of records reviewed	Total no. of claims reviewed	Total no. of claims disallowed	Total dollars reviewed	Total dollars disallowed	Reasons for disallowance
	129	135	2	$43,099.05	$582.16	POC Issues

SUMMARY:

Provider Type	Total no. of providers reviewed	Total no. of records reviewed	Total no. of claims reviewed	Total no. of claims disallowed	Total dollars reviewed	Total dollars disallowed	Reasons for disallowance & MHP corrective actions	
Individual/ Group	9	43	234	12	$32,374.32	$524.68		
Organizational	11	84	1478	69	$214,839.82	$10,781.36	POC Issues, Incorrect service code, Not MH service, Not MH Service, Time spent not supported, No Doc., Service Out of Scope, No Med Consent	
Med Team County Programs	6	129	135	2	$43,099.05	$582.16		
Total	26	256	1847	83	$290,313.19	$11,888.20	Error Rate %	4.09%
Total for AUG 2017	24	304	1300	100	$275,712.11	$20,621.86	Error Rate	7.48%
Total for FEB 2017	37	286	3028	391	$484,340.49	$47,473.03	Error Rate	9.80%

QIC Report: Chart Audits
Presented: November 14, 2018

Chart Audit Results

This report includes Managed Care and Compliance chart audit results for sampled claims/services within the noted review period

Review period: July - Dec 2017				Presented By: Elizabeth Vasquez, Compliance Officer		
INDIVIDUAL/GROUP PROVIDERS						
Chart Audits completed: 3/15/2018 - 5/4/2018	Total no. of records reviewed	Total no. of claims reviewed	Total no. of claims disallowed	Total dollars reviewed	Total dollars disallowed	Reasons for disallowance
	29	212	18	$11,560.65	$655.50	No Doc, Incorrect Dx or time, Incorrect Service Code
ORGANIZATIONAL PROVIDERS						
Chart Audits completed: 1/25/2018- 3/22/2018	Total no. of records reviewed	Total no. of claims reviewed	Total no. of claims disallowed	Total dollars reviewed	Total dollars disallowed	Reasons for disallowance
	18	250	11	$30,799.55	$1,602.26	Incorrect Service code, Incorrect Dx or Time, Not MH service, Note not Individualized, No Doc, Duration issue
MED TEAM COUNTY-OPERATED PROVIDERS						
Chart Audits completed: 8/7/18	Total no. of records reviewed	Total no. of claims reviewed	Total no. of claims disallowed	Total dollars reviewed	Total dollars disallowed	Reasons for disallowance
	89	464	22	$36,353.25	$1,395.90	Provider not Credentialed

SUMMARY:

Provider Type	Total no. of providers reviewed	Total no. of records reviewed	Total no. of claims reviewed	Total no. of claims disallowed	Total dollars reviewed	Total dollars disallowed	Reasons for disallowance & MHP corrective actions	
Individual/ Group	9	29	212	18	$11,560.65	$655.50	No Doc, Incorrect Dx or time, Incorrect Service Code,	
Organizational	2	18	250	11	$30,799.55	$1,602.26	Incorrect Dx or Time, Not MH service, Note not	
Med Team County Programs	1	89	464	22	$36,353.25	$1,395.90	individualized, Duration issue, Provider not Credentialed	
Total	12	136	926	51	$78,713.45	$3,653.66	Error Rate %	4.64%
Total for FEB 2018	26	256	1847	83	$290,313.19	$11,888.20	Error Rate %	4.09%
Total for AUG 2017	24	304	1300	100	$275,712.11	$20,621.86	Error Rate %	7.48%

Goal # 2 - Data C

Objectives 4 & 5: Intensive Analysis Monitoring

FCMHP will review 100% of incident reports from all MHP providers. FCMHP will track and trend unusual occurrences/critical incidents.

Performance indicators: The Fresno County MHP will review 100% of incident reports collected from all MHP providers (Objective 4). The Fresno County MHP will track and trend incidents involving MHP clients (Objective 5).

DATA (Objective 4)**:**

- There were 123 incident reports collected from the MHP (outpatient SMHS).
- 100% of these had an initial review by the Intensive Analysis Chair and/or Committee member.

DATA (Objective 5)**:**

- There were 123 incident reports were tracked
- 100% of these were reviewed by the Intensive Analysis Chair and/or Committee member.

Results: 100% of incidents collected were reviewed and reported accordingly

Recommendation: Continue monitoring and reviewing 100% of collected incident reports. Although Confidentiality prevents QIC from reviewing raw data, it is recommended that the Intensive Analysis Committee monitor by demographics such as facility, program, gender, age etc…

Goal # 3 BENEFICIARY SATISFACTION				
Objective	**Table/Chart**	**Standard Goal**	**Result**	**Score**
1. Consumer Perception Survey	Data A	See Charts		**M**
2. To Provide Effective tracking of Grievances, Appeals, State Fair Hearings and Change of Provider requests	Chart B			**M**
3. Caller Satisfaction	Chart C			**M**

Goal # 3 - Data A

Objective 1: Consumer Perception Survey (formerly known as POQI)

Performance indicator: The Fresno County MHP QI team will analyze data and recommend to Leadership suggested improvements in process, procedures, and service delivery.

DATA/Results:

Consumer Perception Survey reports can be found at
https://www.co.fresno.ca.us/departments/behavioral-health/quality-improvement/reports-dashboard

Recommendation:

Continue to perform the Consumer Perception Survey for the month of November and May of each year and identify significant Performance Indicators from results of CPS such as Quality of Life portion of survey.

Goal # 3 - Chart B

Objective 2: To Provide Effective tracking of Grievances, Appeals, State Fair Hearings and Change of Provider requests

Performance indicator: The Fresno County MHP QI team will analyze data and recommend to Leadership suggested improvements in process, procedures, and service delivery.

DATA:

	FISCAL YEAR 2015-2016	FISCAL YEAR 2016-2017	FISCAL YEAR 2017-2018
CATEGORY	**Totals**	**Totals**	**Totals**
ACTIONS (Appeals on Actions)			
NOTICE OF ACTION - A			1
NOTICE OF ACTION - B			
NOTICE OF ACTION - C			
NOTICE OF ACTION - D			
NOTICE OF ACTION - E			
ALL OTHER ACTIONS			
TOTAL	**N/A**	**N/A**	**N/A**
ACCESS			
SERVICE NOT AVAILABLE			1
SERVICE NOT ACCESSIBLE			
TIMELINESS OF SERVICES			3
24/7 TOLL-FREE ACCESS LINE			
LINGUISTIC SERVICES			
OTHER ACCESS ISSUES			1
TOTAL	**0**	**0**	**5**
QUALITY OF CARE			
STAFF BEHAVIOR CONCERNS	24	24	19
TREATMENT ISSUES OR CONCERNS	9	12	8
MEDICATION CONCERN	7	4	6
CULTURAL APPROPRIATENESS			
OTHER QUALITY OF CARE ISSUES	1		2
TOTAL	**41**	**39**	**35**
CHANGE OF PROVIDER	**14**	**22**	***64**
CONFIDENTIALITY CONCERN	**4**	**1**	**2**
OTHER			
FINANCIAL	1	1	1
LOST PROPERTY	2	1	1
OPERATIONAL	3	2	2
PATIENTS' RIGHTS			
PEER BEHAVIORS		1	
PHYSICAL ENVIRONMENT			1
OTHER GRIEVANCE NOT LISTED ABOVE		4	1
TOTAL	**6**	**10**	**6**
GRAND TOTALS	**65**	**74**	**112**

***The Change of Provider totals for FY 17-18 reflect those in which clients reported grievance**

Results:

Grievances/Appeals are presented at the QIC with historical information included, along with trend analysis in the text of the report to the committee. Trends has been discussed in the committee with only one reported area for further examination, the increase in grievances over previous years.

This was the result of the corrective action plan from the Triennial Review of 2015, when it was noted by the State that our grand totals were low, compared to other large counties. Some discrepancy is relevant due to the fact that Fresno is large, with regard to physical dimensions, but smaller than most large counties when viewed by population.

Reports to the State noted that, "Our Change of Provider" requests have revolved around medication support services for two reasons. One is the continued discomfort that many of our Clients have with receiving services by way of telemedicine providers. Our Department is very aware of this discomfort and has taken steps to provide for our Clients by way of a recent contract with Central California Faculty Medical Group (CCFMG), which will enhance our ability to provide more in-person psychiatric services. The second reason for our increase in Change of Provider requests is in regard to our Department's stricter guidelines in prescribing and monitoring benzodiazepine medications. When a Client realizes they are being tapered down from a medication which has addictive qualities they will often put in a request to change to another provider in the hopes that they will find one who will prescribe them the medication they wish to have."

"We continue to improve the availability of in-house providers to our Clients which will help improve the interactive services needed for their psychiatric care and treatment. Our Department is also careful in maintaining the appropriate care for those persons who can easily have issues with addiction. All medications are monitored and state guidelines are followed in these areas."

It was furthered discussed during the QIC, as part of our corrective action after the Triennial Review, to audit all of our public common areas where forms are provided, to ensure that our in-house programs and our contracted network providers all have sufficient supplies of grievance forms and stamped return envelopes to meet the needs of those served. Increased volume of materials informing clients of the appropriate steps to file grievances and appeals.

Recommendation:

Analyze Grievances and Change of Providers separately. Design Performance Indicators and historical Run Chart to monitor trends. Determine why the increase in grievances from previous years.

Goal # 3 - Chart C

Objective 1: Caller Satisfaction 800 Access Line

Performance indicator:

1. Call Survey to capture, at minimum 40% participation level from sample size.
2. 70% of participants will be satisfied with, "*Operator understood me and gave me the information and direction on what to do*"
3. 70% of participants will be satisfied with their experience with the MHPs Access Line

DATA:

Total Maximum Participation Satisfication Score				Total									
410				Operator understood me and gave me the information and direction on what to do					Overall I am statisfied with my experience with the Access Line				
Participation Rate		Non-Participation Rate		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Total # of Calls	160	Total # of Calls	160	180	108	42	6	2	185	92	45	10	2
				338					334				
# of Participants	82	# of Non-Participants	78	% of Satisfication		82%			% of Satisfication		81%		
				Overall % of Satisfication									
% of Participant	51%	% of Non-Participant	49%	82%									

Legend	
Strongly Agree	100%
Agree	80%
Neutral	60%
Disagree	40%
Strongly Disagree	20%

Results:

1. Of the sample size used in the caller survey, there were 51% participation.
2. 82% of participants were satisfied when asked if the "*Operator understood me and gave me the information and direction on what to do*"
3. 81% of participants were satisfied with their experience in utilizing the MHPs Access Line

Recommendation:

Continue to utilize caller satisfaction survey on an annual basis.

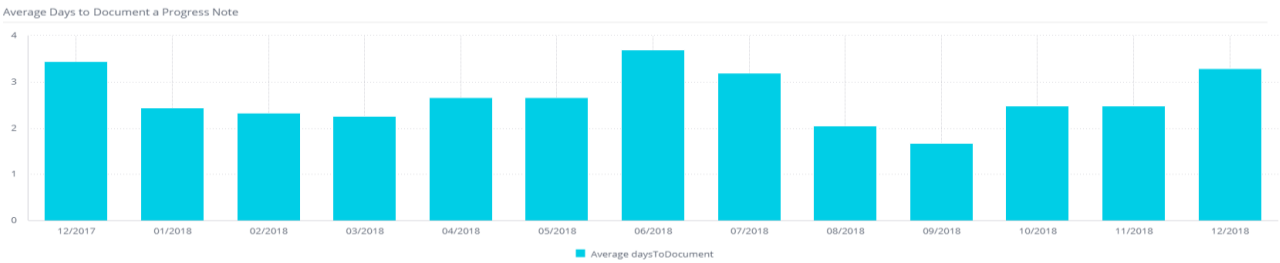
Goal # 4 QUALITY ASSURANCE				
Objective	**Table/Chart**	**Standard Goal**	**Result**	**Score**
1. Ensure Timeliness of Clinical Documentation within 5 business days	Chart A	5.00 days	See Chart	**M**
2. Ensure the timeliness of Treatment Authorization Request (TARs)	Data B	**PM**		
3. Certification and Re-Certification of Programs	Data C	100%	See Letter	**M**

Goal # 4 - Chart A

Objective 1: Ensure Timeliness of Clinical Documentation within 5 business days

Performance indicator: The Fresno County MHP will develop and implement policies and procedures to identify best practice and set standards for timely clinical documentation.

DATA:



Average Days to Complete Progress Notes			
Month	**Overall DBH**	**Month**	**Overall DBH**
December 2017	3.44	July 2018	3.19
January 2018	2.44	August 2018	2.04
February 2018	2.33	September 2018	1.67
March 2018	2.26	October 2018	2.48
April 2018	2.66	November 2018	2.48
May 2018	2.67	December 2018	3.29
June 2018	3.70	**Total**	**2.67**

Results:

Overall, in the last 13 months, the MHP had an average of 2.67 days, a decrease from previous year measure of 3.92 days and below the MHP standard.

Recommendation:

Continue monitoring average days to complete Progress Notes.

Goal # 4 - Data B

Objective 2: Ensure the timeliness of Treatment Authorization Request (TARs)

Performance indicator: The Fresno County MHP will approve or deny TARs within 14 Calendar days, 90% within compliance.

DATA:

FINDINGS

DHCS inspected a sample of 100 TARs to verify compliance with regulatory requirements. The TAR sample review findings are detailed below:

PROTOCOL REQUIREMENT		# TARS IN COMPLIANCE	# TARs OOC	COMPLIANCE PERCENTAGE
C1c	Adverse decisions based on criteria for medical necessity or emergency admission approved by a physician (or psychologist, per regulations)	99	1	99%

These TARs did not include evidence that adverse decisions based on criteria for medical necessity or emergency admission were reviewed and approved by a physician (or by a psychologist, per regulations). Protocol question C1c is deemed in partial compliance.

PLAN OF CORRECTION

The MHP must submit a POC addressing the OOC findings for these requirements. The MHP is required to provide evidence to DHCS to substantiate its POC and to demonstrate that it complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services.

FRESNO'S RESPONSE:

Please note that the "Results Summary: System Review" reflects C1b as a protocol question out-of-compliance or partial compliance, however under "Findings", Protocol Requirement C1c is highlighted. This POC addresses C1c.

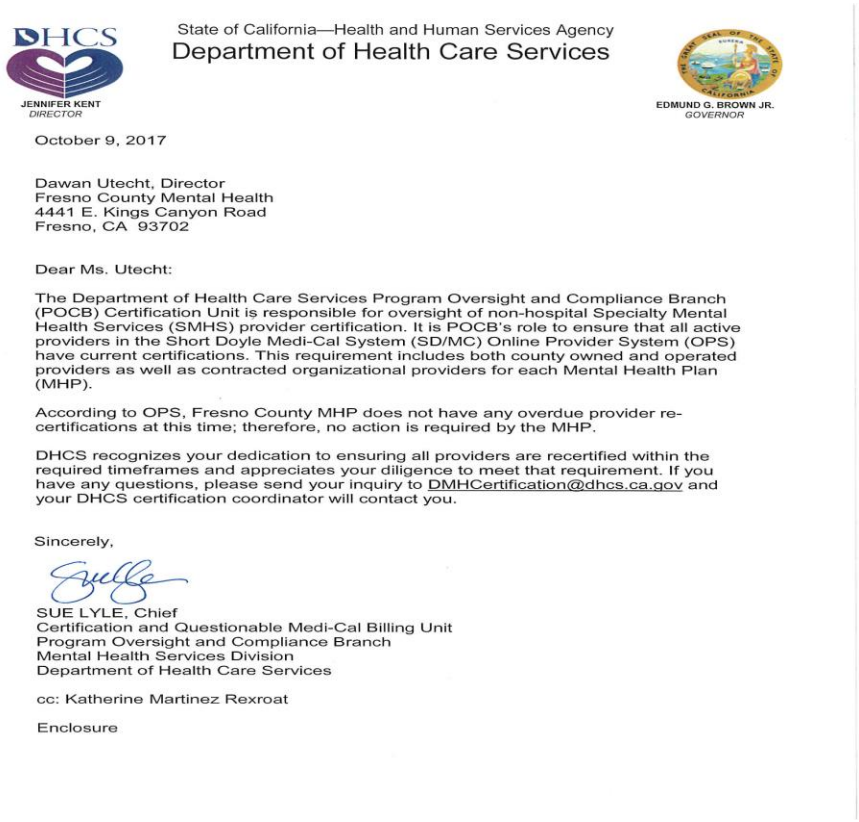
On May 15, 2018, Utilization Review Specialists were reminded of the need for a physician's review and signature for adverse decisions based on criteria for medical necessity, in this case, a non-included diagnosis code. See Attachment C for staff meeting minutes and sign-in sheet.

Goal # 4 - Data C

Objective 3: Certification and Re-Certification of Programs

Performance indicator: The Fresno County MHP will certify/re-certify DBH In-House Programs and Medi-Cal Contracted Providers, no later than 60 days after inception of program operations and re-certify programs every three (3) years after prior certification.

DATA:



DHCS

JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services

EDMUND G. BROWN JR.
GOVERNOR

October 9, 2017

Dawan Utecht, Director
Fresno County Mental Health
4441 E. Kings Canyon Road
Fresno, CA 93702

Dear Ms. Utecht:

The Department of Health Care Services Program Oversight and Compliance Branch (POCB) Certification Unit is responsible for oversight of non-hospital Specialty Mental Health Services (SMHS) provider certification. It is POCB's role to ensure that all active providers in the Short Doyle Medi-Cal System (SD/MC) Online Provider System (OPS) have current certifications. This requirement includes both county owned and operated providers as well as contracted organizational providers for each Mental Health Plan (MHP).

According to OPS, Fresno County MHP does not have any overdue provider re-certifications at this time; therefore, no action is required by the MHP.

DHCS recognizes your dedication to ensuring all providers are recertified within the required timeframes and appreciates your diligence to meet that requirement. If you have any questions, please send your inquiry to DMHCertification@dhcs.ca.gov and your DHCS certification coordinator will contact you.

Sincerely,

SUE LYLE, Chief
Certification and Questionable Medi-Cal Billing Unit
Program Oversight and Compliance Branch
Mental Health Services Division
Department of Health Care Services

cc: Katherine Martinez Rexroat

Enclosure

Results:

100% of programs requiring certification have been completed or renewed via DHCS

Recommendation:

Continue to monitor and maintain an up to date listing of programs requiring certification or re-certifications

Goal # 5 STAFF DEVELOPMENT & ENGAGEMENT				
Objective	**Table/Chart**	**Standard Goal**	**Result**	**Score**
1. The MHP will Distribute Staff Engagement Surveys Once Per Year	Chart A	See Chart		**M**
2. Conduct an Annual Cultural Competency Staff Survey	Data B	See Notes		**M**
3. Cultural Competency Plan				
4. Building Capacity for Core Competencies and Best Practices	Data C	See Chart C		**M**

Goal # 5 - Chart A

Objective 1: The MHP will Distribute Staff Engagement Surveys Annually to MHP staff and providers

Performance indicator: The MHP will collect and analyze responses of staff to identify areas for greater staff engagement and satisfaction, and implement policies and procedures to support greater staff engagement.

DATA:

Aggregate Scores by Organizations and Divisions

	2012	2013	2015	2017	2018
DBH Overall Scores	3.58	3.71	3.68	3.64	3.81
DBH scores by Division	**2012**	**2013**	**2015**	**2017**	**2018**
Administration			3.67	3.83	3.90
Adult Services			3.71	3.52	3.65
Business Office			3.78	3.81	4.22
Children Services			3.65	3.58	3.58
Clinical Support**					*
Contracts			3.39	3.91	4.01
Leadership**			NA	NA	*
Managed Care			3.91	3.98	4.18
Medical Team**					*
Technology & Quality Improvement			3.81	4.12	4.39
	2012	**2013**	**2015**	**2017**	**2018**
MH Contractor Overall Scores	NA	3.83	4.15	4.12	4.15
MH Contractors	**2012**	**2013**	**2015**	**2017**	**2018**
Exodus- PHF					*
MHS Inc.			*		4.18
Turning Point		3.91	4.13	4.01	4.10
Uplift		3.75	*	4.22	4.30
Westcare					4.04
	2012	**2013**	**2015**	**2017**	**2018**
SUD Contractor Overall Scores			3.94	3.82	3.88
SUD Contractors	**2012**	**2013**	**2015**	**2017**	**2018**
BAART			3.72	*	3.60
CAP				3.72	*
MHS, Inc.			4.10		*
Turning Point			3.75	3.92	4.00
Westcare			3.85		3.72
	2012	**2013**	**2015**	**2017**	**2018**
Overall Scores by year	3.58	3.77	3.92	3.79	3.90

Above the 66th percentile in the Gallup database

33rd to 66th percentile in the Gallup database

Below the 33rd percentile in the Gallup database

*** Due to confidentiality, programs with less than 4 participants will not be given a score**

** DBH Subgroup

Results: In 2018, Division Managers along with Clinical and non-clinical supervisors participated in the Gallup Employee Engagement workgroup (monthly All Supervisors Meeting). This workgroup provided for an understanding of the survey and help guide staff on the next steps required by their respective Divisions. Each Division was provided their survey results, the *Team Conversation, State of the Team Tool*, instructions on how to use the tool, *Resource Activity Guide & Question and Insights*. The direction from the Department is for each individual Division to select areas for improvement, provide interventions and measure to the Gallup Staff Engagement. Survey in 2019 to be provided in May/June of 2019.

Recommendation: Continue with the Gallup Employee Engagement Survey for Calendar Year 2019 and follow up with Divisions.

Goal # 5 - Data B

Objective 2 & 3 : Develop a Cultural Humility Responsive Work Plan

Performance indicator: Establish a Cultural Humility Responsive Work Plan

DATA:

The Department of Health Care Services (DCHS) triennial audit found that the Department of Behavioral Health's Mental Health Plan (MHP) was out of compliance in areas of cultural competency and recommended the following plan of corrections:

1. **(Section B – Access - Section B13a1/Section B13a2)** Demonstration that the MHP provides annual cultural competence training necessary to ensure the provision of culturally competent services. Specifically, the MHP must develop a plan for, and provide evidence of implementation of, cultural competency training for administrative and management staff as well as persons providing SMHS employed by or contracting with the MHP. The MHP must develop a process to ensure interpreters are train and monitor for language competency.

2. **(Section I – Quality Improvement – Section I6F)** Demonstration that the QAPI work plan provide evidence of compliance with the requirements for cultural competence and linguistic competence.

3. **(Section J – Mental Health Services Act - Section J4b3)** Demonstration that the MHP has percentages of diverse cultural, racial/ethnic and linguistic groups represented among direct service providers, as compared to the percentage of the total population needing services and the total population being served.

In accordance to DCHS's recommendations, DBH has implemented the following:

- Establishing Policy Procedure Guideline (PPG) 151 – Culturally and Linguistically Appropriate Services Policy. The policy identifies the 8-hour annual cultural competency training requirement for county staff and contracted direct services providers. The policy also requires certified bilingual county staff and contracted interpreters to complete training in areas related to interpretation services and best practices for target language usage, in addition to demonstrating language competence every fiscal year. DBH anticipated finalizing the PPG by September 28, 2018; however, it remains in draft form. Attached is a copy of the PPG, which is currently being reviewed by the Fresno County Department of Human Resources – Labor Relations unit. Upon completion of their review, it will be finalized.

- Cultural Humility Committee (CHC) reports to the Quality Improvement Committee (QIC) every other month. In addition to providing a status on committee goals, the CHC provides an update on cultural and linguistic competency requirements.

- Secured Relias Learning Management System (LMS) as an online training and tracking mechanism. All county staff were uploaded into the system in September 2018. Persons contracted to provide SMHS will be uploaded in September 2019. Trainings in the area of cultural competency are available through the LMS, and may be applied toward the 8-hr annual requirement.

- Opened the two-day Health Equity & Multicultural Diversity Training (HEMCDT) to all persons contracted the provide SMHS, in addition to County staff.

- Collecting of diverse cultural, racial/ethnic and linguistic groups from both County staff and direct service providers. DBH Administration's Division obtains information regarding County staff from Fresno County Department of Human Resources. In addition, DBH Contracted Services Division updated the Staffing Report that contracted programs are required to submit to DBH monthly. The report now requests gender, ethnicity, and language of staff. The information will be evaluated annually in comparison to the total population needing services and the total population being served.

Results: The Cultural Humility Committee (formerly known as Cultural Diversity Committee) developed and implemented a new Cultural Humility Response Plan for Department of Behavioral Health and submitted its new response plan to the State on December 3, 2018. Cultural Response Plan can be viewed at https://www.co.fresno.ca.us/home/showdocument?id=31866

Recommendation:

Continue to submit to the State, Department of Health Care Services (DHCS) and implement a new Cultural Humility Response Plan.

Goal # 5 - Data C

Objective 4: Building Capacity for Core Competencies and Best Practices

Performance indicator: The MHP will provide a number of coordinated training opportunities to build core competencies for clinical staff of the MHP and those who provide direct services, as well as provide training for best practices in a number of areas for all MHP staff. Identify the number of staff who receive core competencies and compare to clinical staff who did not receive training opportunities to build core competencies.

DATA: Evidence-Based Practice (EBP) Training and Implementation:

- Eye Movement Desensitization and Reprocessing (EMDR): 28 trained in the EMDR HAP Foundations and completed the required 10 post-training consultation hours. (November 2016/April 2017.
- Early Childhood Mental Health: 45 DBH staff and staff from contracted providers attended 11 foundations training sessions beginning in June 2016, with follow-up Reflective Practice (RP) session over the course of 10 months through April 2017. This training is the foundations training to be followed up with Child-Parent Psycho Therapy.
- Child-Parent Psychotherapy (CPP) EBP. 42 attendees have received the first of three CPP foundations training with 2 more foundations trainings in the series along with 18 months of RP sessions.
- Dialectical Behavior Therapy (DBT)—As part of the Department's DBT implementation, an existing DBT case consultation team has existed in DBH Adult Services Division. In early 2017, we planned an expansion of the DBT EBP by bringing formal DBT training for both DBH, including the Children's Services Division as well as our contracted providers of the mental health plan (MHP). In September 2017, we contracted with Behavioral Tech, Inc. to provide DBT foundations training, which consists of two weeks of training with the first week of training occurring in September 2017 and the second week occurring in March 2018. Implementation activities include weekly 2-hour sessions for each of the 9 DBT case consultation teams in the MHP, along with 8 hours of booster training conference calls for each case consultation team scheduled to take place between weeks one and two of the foundations training.
- Motivational Interviewing (MI)—80 individuals have been trained in the EBP in August 2017. Planning for MI began in early 2017. MI training plans include training an additional 40 persons in November 2017, along with training up to another 40 who are considered senior clinical staff in January 2018 in support of implementation goals. This January 2018 will include MI coaching from mentors and clinical supervisors, as well as other leaders with Clinical Operations.
- Health Equities and Multicultural Diversity Training (HEMCDT)—this training will include all staff, including non-clinical staff, in understanding cultural and linguistic barriers to accessing services, along with an introduction into the concept of implicit bias and other access barrier features.
- Nonviolent Crisis Intervention (NCI) —The Department has a number of certified NCI trainers in-house. Trainers are certified through the Crisis Prevention Institute (CPI). The Department provides monthly NCI training with the goal of training and certifying all DBH staff in NCI techniques, which include an awareness of the crisis development model and appropriate staff responses to challenges behaviors that help de-escalate crisis development.
- U. C. Davis, Center for Human Services- Supervisory Effectiveness Series (SES) training—although planned extensively in FY 2016-17, in October 2017 the first of two cohorts of Department supervisory staff began training in a twelve part training in supervisory skill development. Cohort 2 will begin in early 2018 with the same SES training.

- U.C. Davis, Center for Human Services—Lead Now (LN) training—as part of the U. C. Davis Center planning, the Department included LN as the leadership training in October 2017. Similar to the SES training, LN training will have two cohorts, but with a 6-part 12 day training designed to meet the specific needs of the public behavioral health department. This training is designed for leaders and emerging leaders within the Department.
- Cognitive Behavioral Therapy for Psychosis (CBTp) is an EBP planned since late 2016, but is being implemented in March 2018. The Department will include two weeks of CBTp with week 1 for Department staff, including peer support, case managers, clinicians and clinical supervisors/mentors. Week 2 of the CBTp will include County contracted provider staff.

Method of Data Collection & Influencing Factors: For Evidence-based Practices, data will be in the form of reports for the numbers of trained individuals, certifications, training and supervision milestones reached, number of practitioners of the modality in the public mental health system. For best practices, data will be collected in reports for the number of individuals trained. Data collection will differ according to the type of training. EBPs include fidelity tools that can be tracked both in real time and longitudinally. Many of the fidelity tools can be or already are incorporated within the AVATAR EHR system and so tracking usage and extrapolating outcomes would be a function of analyzing that data. Non-clinical EBPs and other training data can be captured in real time by the number of individuals who have received the training, as well as longitudinally in terms of the effects on staff morale, client survey data and reductions in cultural and linguistic barriers. ***Influencing Factors*:** Each training may have specific criteria to measure/certify and recertify individuals trained. Most EBPs have fidelity tools that track usage and outcomes. Some EBPs do not include fidelity tools (MI, HEMCDT, NCI) and so outcomes measurement can include number of individuals trained and case notes entered to include any use of the EBP in practice or through client surveys.

Recommendation: EBPs require on-going implementation that will include team specialization, cross-training and up/down coaching.

Goal # 6 TRANSPARANCY				
Objective	**Table/Chart**	**Standard Goal**	**Result**	**Score**
1. Dashboard as Required by 1915b Waiver Special Terms & Conditions	Data A	Develop Dashboards	Completed	**M**
2. Develop User-Friendly, Informative, Easy to Navigate Department of Behavioral Health Website	Data B	Develop Website	Completed	**M**
3. Develop and Integrate a Substance Use Disorders, DMC-ODS waiver	Data C	Develop DMC-ODS Waiver	Completed	**M**

Goal # 6 - Data A

Objective 1: Dashboard as Required by 1915b Waiver Special Terms & Conditions

Performance indicator: To provide readily available program Outcomes data to beneficiaries, members of the community, MHP staff, and the State via Department website

DATA:

Results: Outcomes accessible via the Fresno County, MHP at http://www.co.fresno.ca.us/departments/behavioral-health/quality-improvement Annual outcomes can be located at https://www.co.fresno.ca.us/departments/behavioral-health/outcomes

Recommendation: Continue MHP transparency and provide readily available and accessible data to stakeholders.

Goal # 6 - Data B

Objective 2: Develop User-Friendly, Informative, easy to Navigate Department of Behavioral Health Website

Performance indicator: Make readily available current program access information and program outcomes information for all programs on the DBH website

DATA:

Results: Outcomes accessible via the Fresno County, MHP at http://www.co.fresno.ca.us/home

Recommendation: Continue MHP transparency via the MHP website and remove from FY 2019-20 QIWP.

Goal # 6 - Data C

Objective 3: Develop integrated DMC-ODS Waiver

Performance indicator: Integrate a DMC-ODS Waiver approved by the State for substance use services

DATA:

Results: DMC – ODS waiver can be access at https://www.co.fresno.ca.us/departments/behavioral-health/substance-use-disorder-services

Recommendation: Integrate DMC-ODS Waiver into the MHPs FY 2019-20 QIWP.

Goal # 7 PERFORMANCE IMPROVEMENT PROJECTS				
Objective	**Table/Chart**	**Standard Goal**	**Result**	**Score**
1. Clinical Performance Improvement Project	Chart A	Provide Intervention	**67.50%**	**M**
2. Non-Clinical Performance Improvement Project	Chart B	Provide Intervention	**71.88%**	**M**

Goal # 7 - Chart A

Objective 1: Clinical Performance Improvement Project

Performance Improvement Title: Improving Care Coordination and Timeliness of Post Hospitalization Follow-Up.

DATA: EQRO DATA

MHP of the results produced one year after the second intervention was implemented. MHP considers it an accomplished improvement effort. With a continued daily collaborations between FCDBH-CMH and CYPHF teams, a 7-day post discharge assessment and a short tem treatment until linked with a clinical team, the second intervention effort reflected in a reduction of the 30-day readmission rate by 5.19%.

FCDBH-CMH also noticed improvement with unlinked youths and families beyond the data. The communication and collaboration between FCDBH-CMH and CYPHF also improved and has been going smoothly. With the current follow up set up, these unlinked youths also know who to reach out to in case of future crisis arise. FCDBH-CMH noticed the difference in coordinating the discharge as a Case Manager found that many of discharged youths are now linked to care so a Case Manager just needs to confirm with assigned therapist.

By incorporating a dedicated medical staff to support the post PHF discharge medication support (available on Mondays, Wednesdays, Thursdays, and Fridays), anticipates this effort will further reduce the 30-day readmission rate.

Results: EQRO Score 67.50%

Recommendation: Continue Performance Improvement Project.

Goal # 7 - Chart B

Objective 2: Non-Clinical Performance Improvement Project

Performance Improvement Title: Children's Mental Health Outpatient Intake Re-Design

DATA: MHP PIP Data

Results: EQRO Score 71.88%

The Performance Improvement Team utilized continuous quality improvement and statistical analysis techniques to analyze interventions and performance measures. The process included researching past trends and existing data to determine whether there was an issue with timely services within the Children's Mental Health (CMH) Outpatient Division. In addition to available data, the Performance Improvement Project Team developed a Process Map (Flow Chart) to understand the process of a Beneficiary entering the CMH Outpatient system. The Team also worked on a Driver Diagram to identify the issue, primary drivers, and conceptual design to improve the "In-Take" process to serve our target population. The interventions identified in this Performance Improvement Project derived from input received from stakeholders during the development of the driver diagram.

Performance indicators utilized correspond to interventions for quality improvement. Performance indicators were re-evaluated again during the data analysis to ensure measurements correspond to interventions, target population, data is valid & methodology is reliable and predict trends over time and tested frequently (monthly/quarterly). Data analysis sought trends and patterns and identified the Mean, Medium, Standard Deviation, and Goal based on target population and retesting.

Results of performance indicator No. 1 identified a significant reduction, *average days*, from initial request for mental health services to first assessment (from 23.52 days to 16.53 days). Although it identifies a 30% reduction in average days the program did not meet the State standard of 14 calendar days. Performance Indicator No. 2 provided its challenges as the Performance Improvement Team was unable to develop a mechanism to measure the first appointment kept after initial assessment. The Technology & Quality Management Division is seeking alternative ways to measure beneficiary engagement. Performance indicator No. 3 No Show/Cancellation identified a reduction, from 28% to 26% comparing calendar year 2017 vs 2018. Performance indicator No. 4 identified the number of beneficiaries receiving assessments within 14 calendar days. Not much of a significant change occurred between calendar year 2017 vs 2018. In calendar year 2017, 32.5% of the target population received services within 14 calendar days versus 33.4% in calendar year 2018.

Although there was success in providing some interventions such as Triage services to target population within the intake process, overall the PIP Team recommends the continuation of quality improvement of the intake process. Recommendations include but not limited to seeking alternative interventions such as *staff flexible hours* to meet the client needs, *contract/expand* existing mental health treatment services to serve children and youth (see non-clinical PIP FY 2018-19 mental health services in schools). In addition, the team recommends the development of a mechanism to measure client engagement and involve more consumer/family during the stakeholder process. Lastly, the team has identified beneficiaries who received services after 60 days from initial request and/or no assessments during both reporting periods (calendar year 2017 and 2018).

Division Managers within the Fresno County, Department of Behavioral Health are assigned as leads for each Performance Improvement Project and are designated to sign off on the Performance Improvement Project with further action(s). For the FY 2017-18 Non-Clinical Performance Improvement Project, Lesby Flores, Division Manager, Non-Clinical PIP Lead and accepts the following action(s).

Overall Findings & Recommendations

79.3% MET (23)
13.8% PARTIALLY MET (4)
6.9% NOT MET (2)

Recommendation

1. Incorporate Quality Management as part of QI Work Plan
2. Define Goal/Objective/Performance Indicator/Target in future QIWP
3. CARF Format – Define Domains in future QIWP and How it relates to Department and EQRO Values
4. Incorporate QI Tools
    a. Run Chart by Month, Quarter, Fiscal Year/Calendar Year
    b. Flow Chart for all Access Entry Points
    c. Fish Diagram (Cause & Effect)
    d. Driver Diagram
    e. Plan, Do, Study, Act (Test Interventions)
    f. Use performance indicators
5. Scheduled QIC Calendar for reporting QIWP reports, presentations and Client/Staff surveys (Staggered to avoid overlap)
6. Incorporate QIC members to participate in the Development of Work Plan and Evaluation Formatting
7. Performance Improvement Projects – utilize QI Tools
8. Develop Matrix for performance indicators based on Departments "Value Driven" Charter; Timeliness, Match Clients to appropriate services, and Client Engagement.
9. Incorporate Substance Use Disorders (SUD) Implementation Waiver and Measurable Outcomes, if available, into QI Work Plan
10. Develop SUD performance indicators based on EQRO and State Mandates
11. Develop and implement Access Line Database that incorporates mental Health, Substance Use Disorders, Family Advocate, MAAP Points and all other specification accordingly, capturing pertinent data for reporting.
12. Provide for immediate QIC Action for items not meeting set goals
13. Provide Evaluation measures within the QIWP and QI Action
14. Sign off by QIC Chair

Fresno County, Quality Improvement Work Plan Evaluation Approved by QIC Chair on: **April 2019**
Date