Stanislaus County Behavioral Health and Recovery Services
Annual Quality Management Work Plan
FY 2017-2018

INTRODUCTION

The scope of this work plan is the overarching Quality Management aspects of the Stanislaus County Behavioral Health and Recovery Services (BHRS) for the fiscal year (FY) ***2017-2018***. The work plan outlined in this document involves a Department-wide focus on quality initiatives. In addition, each system of care and division will develop an action plan that is more specific to the functions of the respective systems. BHRS is committed to providing high quality care and services to all its customers.

Our Mental Health Services Act (MHSA) programs are fully implemented. We continue our efforts to integrate the essential elements of MHSA into every facet of our organization. These elements are community collaboration, cultural competence, client/family-driven systems and services, wellness for recovery and resilience, and an integrated services experience. We believe our Quality Management Work Plan supports the ongoing transformation of our department.

Consumer and family member involvement in quality management process continues to be very important to our organization. Consumers and family members have participated in the various Quality Improvement Committee (QIC) meetings held during the year. This is expected to continue in the current fiscal year. It is also expected that consumers and family members will continue to participate in work groups and stakeholder meetings in which consumers and family members provide valuable feedback and assistance to the department.

This work plan is formatted as follows. The first section provides the system of care work plan with a summary of activities and outcomes for ***FY 2017-2018***. The last section introduces a new format and work plan goals/objectives for ***FY 2018-2019***.

Summary of Activities and Outcomes FY 2017-2018

Administrative and Fiscal Support Services Quality Improvement Council

This council has its focus on the fiscal and administrative support processes in the organization by managing and establishing process improvements for customer service, budget, position control, quality assurance and compliance, which includes the divisions of accounting and billing, purchasing, information systems and processes, contracts, human resources, quality services, medical records, utilization management, clerical/administrative staff and facilities.

- Customer Service Surveys within Fiscal and Administrative Services are conducted on a rotation basis via Survey Monkey. The surveys are designed to receive specific feedback in the area of customer satisfaction. Results are summarized and presented to the Admin QIC for recommendations based on what was learned and to identify process improvements. The department has standardized our survey process by establishing core questions that are asked in every survey for consistency and uniformity.

- For quality assurance, all staff has access to the presentation of what to do upon receipt of a subpoena, which includes who to directly contact and/or where to send for processing and the governmental mandates that are associated, including HIPAA regulations.

- The Release of Information training expanded to include an approach with the focus of technology being enhanced for the signature of this form, which included the purchase and disbursement of laptops (to key staff) with an electronic signature function for ease of access, customer service delivery, and timeliness for compliance. It also exposed the need for our contract providers to participate in trainings such as this for a more uniformed approach upon the completion of key processes.

- As a result of a survey conducted in February 2016, the Volunteer Services division provided a link to the County volunteer landing page for ease of access to those who are seeking to volunteer or utilize a volunteer. The landing page includes a list of all departments in the County, as well as contact information to the department's volunteer liaison, how the volunteer may be utilized within the department, and the application process. The BHRS Director of Volunteer Services identified strategies and processes in the areas of outreach via routine site visits, establishing program specific protocols, volunteer job descriptions, assignment agreements, time reporting, policy acknowledgements, and other related items, for efficiency and a shared understanding.

- The Probationary Review Committee continues to meet monthly to discuss employees who are on initial and now in addition, promotional probation. The committee invites Coordinators, Managers, and Sr. Leadership staff to the discussion. Strategies on how to accomplish successful employees are discussed, as well as re-direction needed in the area of corrective action, if necessary. It is a resource for the hiring authority to brainstorm with peers and have a clear understanding of the selection process for probationary personnel.

- The Hip Link Emergency Notification System was switched over to EverBridge. A monthly test of the notification process continues and has been initiated for actual emergencies. The Department has established a written protocol to include who should receive the information, training on how to respond to the information, and continued monitoring of the process.

- The standardization of payroll procedures has expanded into the Electronic Time Card (ETC) process known as "punch time", which is paperless. 80% of staff has been trained on this process with the timecard keyed by the employee and electronically sent to the approver (supervisor or delegated authority). This effort has been ongoing through the subsequent fiscal years, each year adding another element.

- Recruitment resources continue to be a work in progress, as the Chief Executive Office has implemented changes due to NEOGOV (online application system) upgrades and the reorganization of key management staff within their department. The BHRS Intranet continues to be a key component in linking recruitment resources.

Adult/Older Adult System of Care Quality Improvement Council

This QIC represents the Adult System of Care and Older Adult System of Care. The QIC strives to have consistent representation from all Adult/Older Adult County programs and contracted providers as well as consumer/community representatives.

Areas of Focus/ Key Processes	Focus of Improvement	Measurable Objective	QIC Activities	End of Year Summary of Activities/Outcomes
Access: Adult/Older Adult 1 and 2	Increase access data	Increase access in a timely for consumers; Meet 90% medical key indicator marker	Pull new data and explore options for continued support or new interventions as needed	In Progress/Partially Met. Indicators and Data were reviewed and worked on throughout the year. Current YTD (Quarters 1-3 or FY17/18) data indicates that 90% of adult clients and 93% of Older adult clients had a scheduled assessment within 10 business days, while 83% of Adult clients and 74% of Older adult Clients had a completed assessment within 10 business dates of initial contact call. This item will be carried over to the FY 2018/2019 QIC Work Plan.

Adults/Older Adults Continuity of Care # 2	Increase timeliness and look at penetration rate of limited English speaking adults to OP TX after hospitalization	Collect current data re: timeliness/penetration from all sources of Dc for limited English speaking adults 80% Goal via medical key indicator	Attend collaborative and explore collect data re: Dc referrals from hospital. Collect data and look at barriers/ interventions. Utilize current data from PEI data base to explore Latino/Spanish consumer information	Goal met: Indicators and Data were reviewed and worked on throughout the year. Current YTD (Quarters 1-3 or FY17/18) data indicates that 83% of adult clients and all of the Older adult clients that are limited English Speaking considered High Risk received a billable service within 10 business day after hospital Discharge.
Psychiatric Medication referral form to speak to Access: Adults/Older Adults 4 and 5	Improve data collection to help track timeliness of access to medication appointments for consumers. Goal is to increase interventions/reduce barriers to psychiatric appointment referrals and timeliness of psychiatric services to consumers.	Psychiatric Medication referral form to be implemented in all ASOC programs Goal to increase overall to medical key indicator standard of 90% – Currently 49% overall meeting appts	Form to be implemented in all teams (after completion by forms committee) staff to be trained. Data pulled and analyzed.	Form and training completed 4/17; QIC was used as a means to identify concerns, gaps, and address issues. A retraining was completed on 2/18 and recommendations for adjustments were made by group. Changes to the form based on the QIC recommendations are in Progress. This item will be carried over to the FY 2018/2019 QIC Work Plan.
MDs/RNs to be using scheduler EHR data for collection in support of Medi-cal Key indicator 4 and 5	All MDs/RNs to be using scheduler in EHR to help track current N/S-rescheduling of clients with psychiatrist with data accurately	All MDs/RNs trained on scheduler	QIC pull and analyze current data to see increase in numbers, identify barriers to attending appts.	In Process; most Dr./RN trained and in scheduler Data collection and analysis to be ongoing. This item will be carried over to the FY 2018/2019 QIC Work Plan.

To promote more culturally competent environment for consumers needing services from BHRS	More LGBTQ friendly waiting rooms/ sites. Goal: overall to reduce any LGBTQ barriers to access and provide more open environments for LGBTQ clients.	All MH ASOC programs to have “Welcoming packets” and materials available for LGBTQ	Collaborate with Stanislaus LGBTQ Collaborative stickers, rainbow pages and materials to be available and distributed to all sited BHRS ASOC Mental Health.	Completed. All ASOC MH programs were trained on creating a Welcoming Environment for the LGBTQ community and were provided with “Welcoming Packets” and Materials.
Internal site chart reviews	Increased consistency and accuracy to MH charting with goal of overall compliance with the needs of Medi-cal and best practice for working with consumers	All BHRS ASOC programs to engage in monthly internal chart reviews of MH charts	New form for reviews to be implemented when completed New team process to be in place for those not currently engaging; supported by QIC staff and coordinators to be trained as needed.	Partially completed: Currently working on Standardized form and format for report out of data by teams. All adult teams currently auditing; Data analysis to follow.

LOCUS a) and b) and c)	a) ASOC all teams to be using LOCUS for focus on more consistency of levels, more consistency within teams and more structured Tx plans b) All staff trained and training schedule standardized and implemented to support staff c) Begin work on data added to Cerner and new assessments added to EHR. Review relevance of current reports and revise as needed. Work groups to be formed as needed to support the above work.	All BHRS ASOC staff to be utilizing LOCUS consistently as evidenced by data; Training to be provided from Deerfield for Train the Trainers. Staff to utilize current system until LOCUS in incorporated into the EHR.	Pull and analyze data after staff super users trained, staff trained, to ensure that LOCUS is being done in a timely manner and utilized to look at Levels and changes in consumer wellness. Goal: to help move clients through system fluidly as well as support the individual needs of the consumer in completing Tx goals Provide relevant reports for staff to best see and work on changes/needs of consumers in a meaningful way and support the system overall.	A)Monthly goal completed 4/17 - Montioring B) Complted. Ongoing for new staff. C) Work on reports, Cerner forms and staff consistently utilizing LOCUS as well as consistent training and support for all staff

Standardized Transfer policy to be in accordance with BHRS Departmental Policy	All ASOC programs will have a standardized policy re: how to transfer clients from program to program and up and down levels to ensure the most expedite process possible for consumers and staff and ensure appropriate continuity of care in transfer process	Review current transfer policy in process for department and how currently managed in sites individually.	QIC to discuss and offer feedback and specific needs for ASOC program to ensure all program needs are taken into account. Implement departmental Standardized Transfer policy in all ASOC teams.	This was completed in the Last Fiscal Year and the QIC continued to Monitor.
Clothes Closet policies to be in accordance with BHRS Departmental policy	All ASOC programs will have a standardized Clothes closet donation and handling policy for consistency and safety of staff and consumers	Gather data re: existing policies in ASOC and those with clothes closets and exam need of programs individually and collectively with other BHRS systems.	ASOC to add needs for system and implement plan for ASOC	Completed: ASOC Programs Will be in accordance with the BHRS Department Policy for Clothes Closets. Policy was developed on 11/6/2017

Children's System of Care (CSOC) Quality Improvement Council

The CSOC QIC enjoys broad representation from County programs and contracted providers as well as consumer/community representatives. The group selects projects for the year that have the potential to improve the quality of care and program effectiveness across the system.

Areas of Focus/ Key Processes	Focus of Improvement	Measurable Objective	QIC Activities	Monitoring Frequency	End of Year Summary of Activities/ Outcomes
Access (CSF, Easy Access) Accessibility of Initial Assessment	Increase accuracy and consistency of data gathered to measure client access to services by adding collection of data related to **canceled** assessment appointments to the data that is being gathered for QIC FY 16-17 regarding assessments.	CSOC and contract agency programs will continue to track 100% of the assessments completed in programs to monitor no shows and timeliness of those assessments. This fiscal year, CSOC and contract agency programs will add tracking of 100% of **canceled** assessment appointments on a monthly basis.	Programs will continue to run assessment reports monthly to bring to QIC. This fiscal year the reports will include codes related to **canceled** assessment appointments. Assessment data will be discussed during the monthly QIC meeting to identify trends found during the tracking of the data. Strategies will be discussed to address the observed trends, and no shows and cancellations in	Monthly Monthly Monthly	Programs continued to run the assessment reports each month, and began running the cancelled codes (3/4) when they ran the monthly no show assessment reports. This was not consistent across programs. The data was discussed in the QIC meeting for programs that ran the data, but no specific trends were observed or identified. Cancellation numbers appeared to be low. No shows continued to be reviewed in the QIC meeting monthly. We lost time when we had the malware attack, and the SQL Server reports were not immediately available

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			specific programs.		when we recovered. Once available, we ran these reports monthly, including demographics related to no shows. There were no specific trends observed in the demographics. For the Fiscal Year, 31.4% of clients had at least one no show for a service in the year, and the no show rate in all programs combined for the year was 9.82% of services. The range of no shows for services was 8.92% to 11.32% across the months- fairly consistent. Through the QIC, an informal goal that was determined was to work toward a 10% or less no show rate in programs. Our programs were evenly split on meeting that standard, with 5 under 10% and 5 over 10% when looking at all services combined. Each month programs have much more detail than this in the reports that are run. They

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					are able to see the breakdown of no shows by service type, race/ethnicity, gender, age, geographic region, etc., and are supported in QIC in discussing strategies to address no shows. See no show spreadsheet for further details or program specific SQL Server reports.
	Improve the timeliness of assessments.	Increase timeliness of initial assessments to 75% in programs that are identified as being less than this rate. (Timeliness is defined as within 10 business days of the request for services).	Identify CSOC trends regarding wait time for assessment. Identify barriers to access, specific to programs, in order to identify possible interventions. Review at each CSOC and contract agency program of completed assessments. Review 15%, or no more than 5 charts, to evaluate	Monthly Monthly Monthly	In reviewing the monthly timeliness data what became apparent was that particular programs were consistently having greater challenges with access and timeliness of assessment than others. Time was carved out in QIC for some of these programs to present information after researching the barriers to access in their programs. SED was one of these programs, that continuously experienced challenges with timely assessment- For the

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			timeliness of assessment for any that were not within 10 business days. Determine reason why and report at QIC to begin to identify barriers to access and develop strategies to address. Report out on the results of any implemented strategies.	Monthly	FY, 56/125 assessments were timely (44.8%); 17/125 were waived (13.6%) and 52/125 assessments were not timely (41.6%). In researching this, one barrier appears to be documentation of the appointments. In one month, the program examined 18 late assessments and was able to determine that only 9 of those were actually late, and the other 9 were errors in documentation and/or data entry in the tracking by the staff. This information was taken back to the staff meeting to be discussed with the team to implement changes in tracking. Another program, CHS (a contractor), had 160/459 assessments completed timely (34.9%); 23/459 (5%) waived timely assessment; and 276/459 (60.1%) were not completed timely. From the QIC discussions, this

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					agency moved into Learning Conversations at the agency, researched the issues, and developed strategies that they are implementing this coming fiscal year. We will continue to track this in QIC to see if these strategies impact access for beneficiaries. After almost 2 years of QIC data/discussion, with continued concerns regarding timeliness, CSOC administration decided to develop a Children's Mobile Assessment Team (CMAT). The data for this team will be monitored in QIC and in the clinical PIP this coming fiscal year.
	Identify barriers to timeliness of psychiatry appointments for children and youth	Collect program specific data regarding psychiatry services, including no shows, cancellations, availability of	Run report on all no shows and cancellations for psychiatry services in CSOC and contract	Monthly	The SQL Server reports were used to run the no shows for psychiatry services by each program or agency. These showed a

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	in CSOC.	appointments, to determine barriers to timeliness. Identify at least one barrier in each program that is not meeting the timeliness standard of 10 business days (use Medi-Cal Key Indicator standard).	agency programs and report at QIC meetings. Review availability of psychiatry appointments and report at QIC. Discuss trends and strategies to implement to address barriers.	Monthly Monthly Monthly	range of no shows for this service for the fiscal year from 12.68% to 19.5% across the months. There was more variation in the no show percentages than the overall service no shows. One program fluctuated from 11-34% across months in the psychiatry services that were no shows. The Full Service Partnership had fewer no shows, including 3 months with no clients no showing for services. Child Welfare BH tended to have a lower no show rate, which could be attributed to greater oversight by the social worker and available transportation. As a CSOC, we had some barriers this fiscal year in that we had one of our longstanding Child Psychiatrists retire at the same time as our Medical Director. This meant our remaining Child Psychiatrist stepped in as the interim

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					Medical Director and stepped out of some of his direct clinics. We had to hire temporary doctors to assist and brought back a Nurse Practitioner to our system to support our clients. This has made it more challenging to look at available appointments as clinic schedules have changed this year and has likely contributed to our timeliness. We also noticed that when youth are inpatient that some clinics have not cancelled the psychiatry appointment, leading to no shows and loss of a valuable appointment time. We continue to discuss these things. With implementation of the Psychiatry and Medication Services Referral (PMSR) form in July, we hope to be able to gather and analyze more specific timeliness data for psychiatry moving forward into this next fiscal year.

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Continuity of Care (CSF: Easy Access, Behavioral Health Promotion, Prevention & Recovery) Assessing for Co-occurring Issues	Support the development of resources and expertise for staff and teams in children's programs so they can intervene and treat children with mental health and SUD co-occurring issues.	75% of Child/Adolescent beneficiaries who remain open at least 60 days to a children's program and the CRAFFT screening indicates need for further assessment will receive assessment through the T-ASI or CHAT within 60 days of opening to the program.	Monitor completion of T-ASI: Process CRAFFT report in the EHR for each program each month, of the youth 12yr or older, to determine of those assessed, who needed a T-ASI completed. Review charts monthly to verify completion of the T-ASI.	Monthly	We have seen slow improvement in T-ASI completion over the past few years, which is why we continue to monitor this in QIC. Years back the completion rate for the T-ASI frequently ran in the 30 percentiles. Now, that is about the rate the staff fail to complete. They complete more than half of them timely and several of the cases close prior to the T-ASI being due. We are in the process of reconciling the data from last fiscal year, as there were some minor errors in program data that was submitted in QIC. Once that is corrected, the percentages will be updated and reportable. Overall, there has been improvement and we have remained consistent as a department in offering the T-ASI training quarterly that was started out of the

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					CSOC QIC. There has been some discussion in the QIC about the T-ASI tool not being as user friendly or useful as staff would like, but resources in CSOC have not been dedicated yet to exploring other options. As the DMC ODS waiver is implemented in the department this may lead to other discussions related to youth with co-occurring concerns that could shape practices in CSOC.
Efficient and Accountable Program Operation (CSF: Ethical Behavior and Regulatory Compliance)	Support the development of a consistent standard for the CSOC and contract agencies for internal program chart reviews to increase compliance with documentation standards and regulatory compliance.	Create a standardized discharge checklist that can be utilized at all programs when closing services for a client to ensure quality control and regulatory compliance.	Lead Administrative Clerks across CSOC will review existing discharge checklists and merge these into a standardized list that is consistent across programs, (with the exception of specific additions needed for specialized	Quarterly	The clerks in the CSOC programs developed a standardized discharge checklist that can be used by all programs. This is a living document as changes are made to our practices. Many programs are already using this document. Contractors have their own, but follow the same minimum adequate

Areas of Focus/ Key Processes	Focus of Improvement	Measurable Objective	QIC Activities	Monitoring Frequency	End of Year Summary of Activities/ Outcomes
			programs). They will review the standardized list at QIC for approval. Implement use of the standardized checklist at CSOC and Contract programs (If contract programs have an existing checklist that contains the agreed upon elements no change would be necessary) and ensure staff are trained on use of the checklist.	By end of FY	standard regarding content. Staff at the Child Welfare BH team developed their own due to the needs at that program. That checklist is in the process of being cross-checked with the standardized one created by the other clerks. This item will be removed from the workplan this coming year as programs are using the checklist.

Managed Care Quality Improvement Council

The Managed Care QIC's major responsibility is quality of care and quality of service under the Medi-Cal Managed Care Plan. These responsibilities include, but are not limited to, access, complaint and grievance processes, utilization management, and compliance with clinical standards. Consumer involvement is a key quality process each year.

- Consumers/family members participated in 12 out of 12 meetings held during FY 16/17
- 82% of adult beneficiaries report overall satisfaction with providers (MCKI beneficiary satisfaction 1)
- 85% of older adult beneficiaries report overall satisfaction with providers (MCKI beneficiary satisfaction 1)
- 92% of monolingual Spanish speaking adult beneficiaries report overall satisfaction (MCKI beneficiary satisfaction 2)
- 93% of monolingual Spanish speaking older adult beneficiaries report overall satisfaction (MCKI beneficiary satisfaction 2)
- 83% of forensic adult beneficiaries report overall satisfaction with providers (MCKI beneficiary satisfaction 1)
- 83% of children/youth/parent report overall satisfaction with providers (MCKI beneficiary satisfaction 1)
- 87% of monolingual Spanish speaking children/youth/parent report overall satisfaction (MCKI beneficiary satisfaction 2)
- Access – 90% of adult beneficiaries had a scheduled assessment within 10 business days of initial contact call (MCKI Access 1)
- Access – 92% of older adult beneficiaries had a scheduled assessment within 10 business days of initial contact call (MCKI Access 1)
- Access – 95% of forensic adult beneficiaries had a scheduled assessment within 10 business days of initial contact call (MCKI Access 1)
- Access – 56% of children/adolescent beneficiaries had a scheduled assessment within 10 business days of initial contact call (MCKI Access 1)
- Peer review results – 88% of beneficiaries participated in outpatient treatment planning evidenced by signature on Client Care Plan (MCKI Access 5)
- 100% of provider appeals and consumer grievances/appeals were processed according to Medi-Cal regulation (MCKI provider appeals 1 and beneficiary satisfaction 1-2)
- Coordination of care with Managed Care Plans – Transitioned to Quarterly Meetings with Health Plan of San Joaquin and Health Net to monitor care coordination, individual case review, referral concerns, and other topics.

Substance Use Disorders (SUD) Services Quality Improvement Council

This Quality Improvement Council (QIC) monitors the activities of the Stanislaus Recovery Center (SRC), Genesis Program and all outpatient SUD services. SRC is a full service adult treatment program, which includes detox, Outpatient Drug Free (ODF) and Intensive Outpatient Treatment (IOT) for SUD issues as well as a program component for clients with co-occurring SUD and mental health disorders. Genesis is the Department's methadone treatment program. A contracted program for perinatal women also participates in this QIC as do representatives from other adult programs providing outpatient SUD services.

Areas of Focus/ Key Processes	Focus of Improvement	Measurable Objective	QIC Activities	Monitoring Frequency	End of Year Summary of Activities/ Outcomes
Access	Evaluate program specific data regarding number of days from initial referral/contact to completed assessment	Number of days from initial referral/contact to completed assessment.	Evaluating current intake processes through use of simulated walk-through form	Monthly	Programs completed simulated walk-through form and the QIC continues to evaluate current intake processes. Area will be carried on to next work plan for continued evaluation and improvement.
Access	Evaluate program specific data regarding number of days from completed assessment to first service.	Number of days from assessment to first service.	Evaluating current intake processes through use of simulated walk-through form	Monthly	Programs completed simulated walk-through form and the QIC continues to evaluate current intake processes. Area will be carried on to the 18/19 work plan for continued evaluation and improvement.
Regulatory Compliance	In effort to meet regulatory requirements, the QIC will	SUD Medi-Cal Key Indicators will be	SUD Medi-Cal Key Indicators will be	Monthly	QIC began working towards identifying SUD Medi-Cal Key

Areas of Focus/ Key Processes	Focus of Improvement	Measurable Objective	QIC Activities	Monitoring Frequency	End of Year Summary of Activities/ Outcomes
	develop SUD Medi-Cal Key Indicators to identify/monitor the following: Timeliness of first initial contact to face-to-face appointment Frequency of follow-up appointments in accordance with individualized treatment plans Timeliness of services of the first dose of NTP services Access to after-hours care Responsiveness of the beneficiary access line Strategies to reduce avoidable hospitalizations Coordination of physical and mental health services with waiver services at the provider level Assessment of the beneficiaries' experiences, including complaints, grievances and appeals Telephone access line and services in the prevalent non-English languages.	developed in order to stay in compliance with state-required elements	developed and submitted for approval by QIC and SLT		Indicators. Area will be carried on to the 18/19 work plan for further development of the SUD Medi-Cal Key Indicators.

OUTCOMES FOR FY 2017-2018

DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Customer Satisfaction	Customer Service	Adult, older adult, forensics, and children/youth/parent beneficiaries will be satisfied with the services they receive as evidenced by meeting or exceeding our customer satisfaction results for **FY 2016-2017** *Medi-Cal key indicators: Beneficiary Satisfaction	We did not meet our goal of **90%** external beneficiary satisfaction in all categories. However, we did stay the same for CSOC and had an increase in satisfaction for the Older Adult SOC from last FY. This year Forensics was separated from Adult SOC. **FY16/17** **FY17/18** Adult: 84% 82% - Older Adult: 84% 85% + Forensics ----- 83% Child/Family: 83% 83% =

DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Penetration	Easy Access to Services	Our overall penetration/prevalence rates will maintain or increase from **FY 2016-2017**. *Service Utilization Based on Prevalence Report	The methodology for calculating penetration is based on the expected prevalence (need) in our community of **5.75**% of population divided by the number of unduplicated clients served. The following are results: **FY16/17** **FY17/18** African-American: 59% 59% = SEA/PI: 26% 28% + Native American: 18% 19% + White American: 19% 18% - Other: 48% 48% = Hispanic Origin Hispanic: 28% 28% = Not Hispanic/Latino: 29% 29% =

DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Geographic Access	Easy Access to Services	Services will be accessible to all county residents regardless of geographic location as evidenced by penetration rates. The Westside will increase by **1%** over **FY 2016-2017** results. *Service Utilization Based on Prevalence Report	**FY16/17** **FY17/18** Ceres 29% 27% - Eastside 27% 28% + Modesto 40% 39% - Turlock 28% 27% - Westside 23% 28% +

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<tr><th>DESCRIPTION</th><th>KEY PROCESS</th><th>ACTIVITIES</th><th>STATUS</th></tr>
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<td>Client Retention</td>
<td>Behavioral Health Promotion, Prevention, Treatment & Recovery</td>
<td>We will provide services in a culturally competent way as evidenced by such measures as the retention rate, which is the percentage, by ethnicity, of clients who receive three (3) or more visits within six (6) months after opening episode.

*Mental Health Client Retention by Ethnicity Report</td>
<td>Overall retention rates remained the same from 70% in FY16-17 to 70% in FY 17-18.

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<tr><th></th><th><u>FY16/17</u></th><th><u>FY17/18</u></th><th></th></tr>
<tr><td>African American</td><td>68%</td><td>69%</td><td>+</td></tr>
<tr><td>Southeast Asian/PI</td><td>73%</td><td>73%</td><td>=</td></tr>
<tr><td>Hispanic</td><td>72%</td><td>73%</td><td>+</td></tr>
<tr><td>Native American</td><td>65%</td><td>69%</td><td>+</td></tr>
<tr><td>White American</td><td>72%</td><td>71%</td><td>-</td></tr>
<tr><td>Other</td><td>48%</td><td>45%</td><td>-</td></tr>
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DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Quality Care	Behavioral Health Promotion, Prevention, Treatment & Recovery	The LOCUS software has been implemented for all Adult System of Care programs.	The LOCUS form was successfully incorporated in the Adult Comprehensive Assessment as a TAB within the Adult Assessment and as a standalone form in our Electronic Health Record (EHR). Both the LOCUS form within the Adult Assessment TAB and the Standalone form have the LOCUS Tool Link embedded within. A LOCUS Reports Database was also developed to assist programs and staff to monitor clients' progress and level of care need on an ongoing basis. Reports were developed so data could be analyzed based on consumer, subunit, unit, and program. Several coordinators and managers were initially trained in the use of the reports database and we are currently working on the development of the general department LOCUS Reports Training based on their initial feedback and suggestions. This formal LOCUS Reports Training is scheduled to take place on September 18, 2018 and will be provided to the Coordinators/Managers for all programs that serve clients 18 years of age or older, LOCUS Super-users, LOCUS Trainers, and any staff who is interested in becoming a LOCUS Reports Super-user. Once this training is provided, the attendees will then train the rest of the staff at their programs on the use and interpretation of the available LOCUS reports.

DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Recovery Principles	Behavioral Health Promotion, Prevention, Treatment & Recovery	To promote recovery and resiliency concepts in the Children's System of Care (CSOC), the Child and Adolescent Needs and Strengths (CANS) has been selected for use throughout the SOC.	The CANS oversight committee continues to meet and discuss reporting, training, and database reports. Areas of focus for the committee also include a CANS peer review, and the implementation of a 0-5 CANS. An additional Child Welfare Workgroup was established for discussion s related to the use of joint BHRS and CW CANS. Finally, due to the DHCS requirement, the committee is also working on CANS implementation for the young adult population

DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Cultural & Ethnic Diversity	Human Resource Development	We will maintain the current measure of cultural and ethnic diversity of our staff as related to our threshold language, which is Spanish. This will be evidenced by measures that identify the rate to which our staff reflect the general Hispanic population and the rate to which our staff reflect our Spanish-speaking population. **FY 2017-2018** we had 623 total staff. ***Ethnicity and Language Report**	Overall staffing of **623** increased from the previous year of **617**. The diversity of our work force seems to have stabilized and continues to be generally reflective of our community. The percentage of Hispanic staff and Spanish-speaking staff are shown below by work function.

	FY16/17	FY17/18	
Overall Hispanic Staff by Function:	31.6%	31.6%	=
Admin/Managers:	29.6%	29.6%	+
Direct Services:	30.4%	30.4%	+
Support Services:	36.3%	36.3%	+

	FY16/17	FY17/18	
Overall Spanish Speaking Staff:	22.2%	24.2%	+
Admin/Manager:	16.1%	20%	+
Direct Services:	21.8%	21.4%	-
Support Services:	25.5%	31.1%	+

DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Cultural & Ethnic Diversity	Human Resource Development	To improve BHRS staff awareness of individual bias and beliefs, sensitivity to behavioral health clients and other diverse populations including LGBTQ and Southeast Asian culture, and the impact of social economic status, the department provided multiple cultural competency training this fiscal year: 1) A Brief Introduction to the Assyrian Culture and Providing Culturally Appropriate Services (3 hr) 2) Advanced Skills and Techniques in Addressing Self Harm (6 hrs) 3) LGBTQ 101 Training (3 hr training) 4) Principles and Practices of Culturally and Linguistically Appropriate Services (6 hrs) *this training was offered a total of 3 times this fiscal year 5) Trauma Informed Care in Connection with Southeast Asian Communities (6 hrs) 6) Understanding and Addressing Self Harm (4 hrs) *BHRS Courses Report	Attendance: **BHRS Staff** **Partner Staff** **1)** 22 0 **2)** 25 0 **3)** 7 9 **4)** 48 11 **5)** 31 0 **6)** 27 0

DESCRIPTION	KEY PROCESS	ACTIVITIES	STATUS
Staff Satisfaction	Human Resource Development	Senior Leadership will convene all-staff meetings at least twice a year to provide information and support to staff.	We will have an all-staff meeting in September 2018. Staff is routinely updated by email messages, monthly Leadership meetings and semi-annual all-staff meetings.
Compliance	Ethical Behavior and Regulatory Compliance	The Mental Health Plan will have satisfactory outcomes on State audit processes as evidenced by chart audit results below the **5%** disallowance threshold.	Our next Triennial review will be January 2020.

WORK PLAN GOALS/OBJECTIVES – FY 2018-2019

1: MONITORING THE SERVICE CAPACITY AND SERVICE DISTRIBUTION OF THE MHP (*Source: MHP*)	
• **Conducts performance monitoring activities that evaluate beneficiary and system outcomes and indicators of wellbeing.** • **Describes and provides information regarding the current type, number and geographic distribution of Mental Health Services in the system.** • **Evaluates and monitors the capacity of the MHP.** • **Makes program recommendations based on capacity indicators.** • **Participates in the county planning process which identifies expanded service populations.** • **Monitors the number of Medi-Cal beneficiaries receiving services and works with Performance Measurements to distribute information to Program Managers and the Quality Management Team (QMT).**	
Objective 1	To describe the current type, number, and geographic distribution of Mental Health Services in the MHP System of Care to ensure appropriate allocation of MHP resources in providing adequate behavioral health access to all beneficiaries.
Goal 1	To identify service provision to Children, Youth, and Adult Medi-Cal/Uninsured beneficiaries by types of services and service locations by geographic regions. To track service provision against service demand and ensure resources are appropriately allocated to provide for access.
Responsible Partners	SOC QICs; Performance Measurements
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include data dashboards and geographic maps.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined

2: MONITORING TIMELY ACCESS FOR ROUTINE AND URGENT SERVICE NEEDS (*Source: MHP*)	
• **Conducts and coordinates performance monitoring activities to test timeliness and access to services within the MHP.** • **Tests the ability of the appointment system through the mechanisms of test calls and internal audits of contact logs.** • **Reports findings and suggested solutions for systems issues which negatively impact access.** • **Tests and evaluates the ability of the system to respond to calls to 24/7 Toll Free Phone Number.** • **Reviews timeliness to service for all appointment types within the system including routine appointments and services for urgent conditions.**	
Objective 2	To conduct performance monitoring activities that gauge the system's effectiveness at providing timely access to routine specialty mental health appointments.
Goal 2	To ensure that all beneficiaries requesting a comprehensive assessment are offered an appointment within 10 business days.
Responsible Partners	Quality Services; Access Line team; SOC QICs; Performance Measurements
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include test calls, internal audit of contact logs, and medi-cal key indicators.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined
Goal 2.1	To ensure beneficiaries discharging from psychiatric hospitalization are given an outpatient medication appointment within 7 calendar days of discharge.
Responsible Partners	SOC QICs; Performance Measurements; Hospital Rate Committee
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include hospitalization reports, medi-cal key indicators, and SSRS reports.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined

Objective 2B	To conduct performance monitoring activities that gauge the system's effectiveness at providing timely access to services for urgent conditions.
Goal 2B	To ensure that all requests for urgent mental health services are responded to within 48 hours for services that do not require an authorization and within 96 hours for services that do require an authorization.
Responsible Partners	SOC QICs; Performance Measurements
Evaluation Methods/Tool(s)	Mechanism for monitoring services and activities is the medi-cal key indicators.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined

Objective 2C	To ensure that beneficiaries are provided with information on how to access specialty mental health services after business hours, including weekends and holidays.
Goal 2C	To confirm that all MHP providers have after-hours telephone message systems that provides information in English and Threshold language(s) on how to access emergency and routine mental health services for BHRS.
Responsible Partners	Quality Services; SOC QICs
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include ongoing after-hours test calls and documentation of compliance to standards outlined in the After – Hours Policy and SSRS reports.
FY 2017/2018 Evaluation	In progress
Recommendations	To be determined
Objective 2D	To provide a Toll-Free Telephone Line that operates 24/7 and meets all required elements of the MHP contract.
Goal 2D	To ensure that the 24/7 Telephone Line provides information, in beneficiary's language of choice, on how to access specialty mental health services, beneficiary resolution process and responds to urgent conditions.

Responsible Partners	Quality Services; Access Line Team; Ethnic Services Manager
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include monthly test calls made throughout various times of the day and night with test callers following a script and presenting a myriad of problems varying in complexity, scope and requiring a response. Call details are logged, and the success of test calls is determined by the callers' ability to be directed to the appropriate services.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined

3: MONITORING BENEFICIARY SATISFACTION (*Source: MHP*)	
• **Conducts and evaluates findings from satisfaction surveys.** • **Identifies areas of improvement as identified by beneficiary feedback and provides long term and short-term solution planning.** • **Conducts and evaluates findings from grievances/appeals/State Fair Hearings.**	
Objective 3	To conduct performance monitoring activities using mechanisms that assess beneficiary satisfaction with behavioral health services provided as an indicator of beneficiary and system outcomes.
Goal 3	To ensure beneficiaries are receiving excellence in behavioral healthcare services as indicated by satisfaction surveys. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.
Responsible Partners	Quality Services; SOC QICs; Performance Measurements
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include Consumer Perception Survey (youth, families of youth, adult, and older adult versions), dashboards, survey results reports.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined

Objective 3A	To conduct performance monitoring activities using mechanisms that assess the number of grievances (and their resolution), appeals and requests for State Fair Hearings. To analyze the nature of the causes for concern as an indicator of beneficiary and system outcomes.
Goal 3A	To ensure that beneficiary grievances, appeals, and requests for State Fair Hearings are being resolved expeditiously and appropriately within the MHP. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.
Responsible Partners	Quality Services; Patients' Rights
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include monthly reports on grievances, appeals and requests/outcomes for State Fair Hearings.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined

4: MONITORING THE SERVICE DELIVERY SYSTEM FOR MEANINGFUL CLINICAL & ETHICAL ISSUES (*Source: MHP*)	
• **Monitors, anticipates and evaluates clinical aspects and implications of departmental policies, procedures, and actions.** • **Reviews clinical issues, quality of care, utilization and utilization management issues that surface because of chart review and program review.** • **Considers the ethical implications of departmental and staff activities.** • **Prepares reports of findings and recommendations for submission to the Quality Management Team (QMT).**	
Objective 4	To conduct performance monitoring activities of the safety and effectiveness of the service delivery system related to clinical and ethical issues in the Inpatient system of care.
Goal 4	To identify and address issues affecting quality of care through the review of findings from incident reports, Patients' Rights investigations, inpatient authorization review, and applicable root cause analysis proceedings. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.
Responsible Partners	SOC QICs, Medical Director, Compliance Officer, Quality Services, Patients' Rights Advocate

Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include meeting minutes, QMT meeting minutes, applicable reports/dashboards, chart and on-site monitoring report summaries.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined
Objective 4A	To conduct performance monitoring activities of the mechanisms responsible for the safety and effectiveness in the Outpatient system of care.
Goal 4A	To identify and address issues which may affect the quality of care provided to beneficiaries, underutilization of services, overutilization of services and utilization management. To implement corrective measures as appropriate. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting consumer needs.
Responsible Partners	Medical Director, Quality Services, Compliance Officer, Utilization Management, and SOC Program Managers
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include meeting minutes, QMT meeting minutes, chart and on-site monitoring report summaries.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined

5: MONITORING THE MHP SERVICE DELIVERY SYSTEM FOR THE SAFETY & EFFECTIVENESS OF MEDICATION PRACTICES (*Source: MHP*)	
• **Under the supervision of a person licensed to prescribe or dispense prescription drugs, evaluates and monitors the safety and effectiveness of medication practices.** • **Reviews cases involving medication issues and tracks medication issues over time.** • **Recommends and institutes needed actions involving medication procedures and policies.** • **Conducts Peer Reviews regarding medication practices.**	
Objective 5	To conduct performance monitoring activities of the mechanisms responsible for the safety and effectiveness of medication practices**.**
Goal 5	To obtain information regarding the safety and effectiveness of medication practices. To continue to use this information to identify and prioritize areas for improving the processes of providing care and better meeting consumer needs.
Responsible Partners	Medical Director, MD/RN Team; Quality Services
Evaluation Methods/Tool(s)	Mechanisms to monitor the safety and effectiveness of medication practices include quarterly chart review summaries and reports under the supervision of a person licensed to prescribe or dispense prescription drugs.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined

6: MONITORING COORDINATION OF CARE BETWEEN THE MHP AND PHYSICAL HEALTHCARE AGENCIES (*Source: MHP*)	
• **Manages the continuity and coordination of care between physical health care agencies and the MHP across the department.** • **Develops department-wide processes to link physical health care into ongoing operating procedures.** • **Assesses the effectiveness and facilitates the improvement of MOU's with physical health care plans.**	
Objective 6	To conduct performance monitoring activities of the mechanisms responsible for enhancing continuity and increasing the coordination of care between the MHP and Physical Healthcare agencies/providers as an indicator of beneficiary and system outcomes.
Goal 6	Update MOU's with physical health plans to create a mechanism for exchange of information between BHRS & primary care with regards to individual client care. To enhance any additional continuity and coordination of care activities. To assess effectiveness of MOU with physical health care providers and revise as appropriate to improve the processes of providing care and better meeting consumer needs.
Responsible Partners	Medical Director; Privacy Officer; Quality Services
Evaluation Methods/Tool(s)	The completed draft of Health Plan of San Joaquin and Health Net MOUs, updated Coordination of Care policy, data reports, training sign in sheets, Coordination of Care protocol.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined

7: MONITORING PROVIDER APPEALS (*Source: MHP*)	
• **Reviews provider appeals submitted to the utilization management.** • **Evaluates the provider appeals process for efficiency and effectiveness.** • **Makes recommendations based on group findings and review of provider appeals that ensures equity and fairness in due process.**	
Objective 7	To conduct performance monitoring activities which review provider appeals and concerns on an ongoing basis as an indicator of the effectiveness of the provider appeal resolution process.
Goal 7	To provide an effective means of identifying, resolving and preventing the recurrence of provider concerns/appeals with the MHP's authorization and other processes. To continue to use this information to identify and prioritize areas for improving the processes of providing care.
Responsible Partners	Quality Services; Utilization Management; Managed Care QIC
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include Provider appeal log and provider appeal summaries.
FY 2017/2018 Evaluation	In progress
Recommendations	To be determined

8: MONITORING MENTAL HEALTH NEEDS IN SPECIFIC CULTURAL GROUPS	
• **Assumes responsibility for ensuring trainings designed to enhance cultural competence are being offered.** • **Conducts outreach activities to unserved, underserved, inappropriately served, and minority populations.** • **Monitors the implementation of cultural competence plan goals.** • **Participates as necessary in other committee activities.**	
Objective 8	To conduct performance monitoring activities of the mechanisms used to identify access barriers among specified ethnic/cultural groups that are currently unserved, underserved or inappropriately served.
Goal 8	To evaluate the effectiveness of current outreach activities in engaging diverse cultural groups into mental health treatment. To review and monitor the provision of cultural competency trainings to providers. To continue using this information to identify and prioritize areas for improving the processes of providing care and better meeting beneficiary needs.
Responsible Partners	Ethnics Services Manager, Quality Services Manager; Performance Measurements; Cultural Competency Social Equality Justice Committee (CCESJC)
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include training reports, CCESJC meeting minutes, and dashboard/reports.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined

9: PERFORMANCE IMPROVEMENT PROJECTS (PIP)	
• **Facilitates clinical and administrative PIP activities.** • **Uses data as a foundation for the PIP Implementation and Submission Tool.** • **Evaluates progress on PIP stages and reviews final reports.** • **Shares information about PIP activities with QMT that may be used in policy making.**	
Objective 9	To maintain two (**2**) active Performance Improvement Projects (PIPs); one (**1**) clinical and one (**1**) administrative, per fiscal year.
Goal 9	To complete the appropriate steps in the CAEQRO PIP Validation Tool for each PIP.
Responsible Partners	SOC QICs; PIP chairs; Quality Services
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include CAEQRO PIP summary reports and Implementation and Submission Tool.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined

10: MONITORING AND PROGRESS TOWARD COORDINATING CO-OCURRING SERVICES	
• **Evaluates current clinical practice and plans for coordination of care for Co-Occurring services.** • **Makes recommendations about clinical practices, standard policies, procedures, service delivery and coordination of care.** • **Reviews clinical chart documents for use and appropriateness in facilitating treatment for Co- Occurring clients and makes recommendations on useful modifications.**	
Objective 10	To conduct performance monitoring activities of the mechanisms used to evaluate the service delivery system for coordination of referrals, interventions and discharge planning.
Goal 10	To evaluate the level of coordination occurring between behavioral health and substance use treatment. To make recommendations as to what steps should be taken to better integrate care.
Responsible Partners	SOC Managers; Chief, SUD Services; Quality Services
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include provider meeting minutes, monthly reports to QMT, and review of appropriate and timely referrals.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined

11: MONITORING QUALITY IMPROVEMENT AND DOCUMENTATION REVIEW	
• **Reviews new regulations which may affect documentation issues** • **Works to build standardized procedures for new legislation when implemented in MHP.** • **Serves as a review body for audit results which go to appeal after the first plan of correction.**	
Objective 11	To conduct performance monitoring activities using mechanisms that assess if all chart documentation and audit review findings are in congruence with State and Federal regulations as an indicator of adherence credentialing and monitoring standards.
Goal 11	To review all current chart documents for ease of use and to ensure appropriateness to Title 9, Medi-Cal, Managed Care and Federal requirements; make revisions based on new legislation and State guidance as needed. To enhance department quality management practices, infrastructure and QM plan fidelity. To continue to use this information to identify and prioritize areas for improving the process of providing care and better meeting consumer needs.
Responsible Partners	Quality Services; Utilization Management; SOC managers
Evaluation Methods/Tool(s)	Mechanisms for monitoring services and activities include chart audits (peer review), treatment plan authorization review, and disallowance reports and/or suspended services for outpatient services and denied days for inpatient services, reports, and dashboards.
FY 2018/2019 Evaluation	In progress
Recommendations	To be determined