Solano County
Health and Social Services Department
Behavioral Health Division
Solano Mental Health Plan
FY 2017 - 2018

Quality Assessment and Performance Improvement Plan
EVALUATION

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QUALITY ASSESSMENT AND PEFORMANCE IMPROVEMENT PROGRAM OVERVIEW

Solano MHP's Quality Assessment and Performance Improvement program is responsible for providing support services to the Mental Health Plan (MHP) and its administration, programs, providers, consumers and family members, so that all members of the MHP, have an opportunity to develop, implement, coordinate, monitor and evaluate performance activities that throughout an annual period. Solano County's Health and Social Services Department, Behavioral Health Division, Quality Improvement team assists the MHP Director to facilitate the program.

Quality Improvement Program

Staffing 11.25 FTE	.25 Mental Health Administrator 1.0 Mental Health Program Senior Manager 1.0 Mental Health Clinical Supervisor 5.0 Licensed Mental Health Clinicians 4.0 Clerical Support Staff

QUALITY ASSURANCE	QUALITY MANAGEMENT	QUALITY IMPROVEMENT
Site Certifications	Utilization Management	Training Coordination
Clinical Records Review	Consumer Surveys	Continuing Education
Problem Resolution/SIR Process	Provider Satisfaction Surveys	Core Competencies
Concurrent Review Process	Service Capacity Analysis	Communication via Mental Health Internet Site
Staff Eligibility Verification	Network Adequacy	Communication via the Network of Care
Service Verification	Evidence-Based Practices	Performance Improvement Projects
Service Authorization	Performance Outcomes	Policies & Procedures

QAPI Program Areas of Focus for FY 2017-2018:

The Quality Assessment and Performance Improvement program will continue support and emphasize performance assessment via quantitative measures in order to identify areas of improvement within the MHP.

Quality Improvement continues to steer the MHP toward using system data to identify needs, and to develop Work Plan goals that help with system improvements that improve access, timeliness, outcomes and quality, and overall patient care. The QAPI plan is also developed with the focus and intention of ensuring that Solano MHP remains in compliance with Federal and California State regulations, most notably FCR Title 42, and CCR Title 9, as well as the parameters stipulated in Solano's MHP contract with California Department of Health Care Services. The following areas have been chosen and targeted by the MHP to include in this year's QAPI Work Plan:

- Cultural Competence
- Wellness and Recovery
- Beneficiary Satisfaction and Protection
- Beneficiary Outcomes and System Utilization
- Service Timeliness and Access
- Program Integrity
- Quality Improvement
- Network Adequacy

The QAPI Work Plan areas of focus are divided into "Active Goals" and "Data Monitoring" sections. Active Goals represent sectors of the system in which data indicated a need for system improvement. Data Monitoring sections include sectors of the system in which the data is not indicating a need for a specific QAPI goal, but that the MHP monitors on a regular basis to ensure the MHP operates with expected parameters.

Quality Improvement team staffing was relatively stable during FY 2017-2018. The QI team members act as liaisons to the MHP to monitor progress being made on QAPI goals on a quarterly basis. Contract Managers and Clinical Supervisors with a specialty role are encouraged to monitor data to look for areas of the system that could benefit from corrective action.

Solano MHP has taken on the practice of treating the Quality Improvement Work Plan as the "treatment plan" for the MHP, and therefore it guides the various Quality Improvement Committee (QIC) subcommittees during their monthly efforts. Progress is tracked on a quarterly basis, and progress and data are reported back to the Quality Improvement Committee once per quarter to inform committee membership and obtain any feedback and recommendations from the committee for consideration to improve current practices.

I. Cultural Competence (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
I. Cultural Competence: • **AG-1**: Pending **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #11, 12a-12c, &13a-13b **Name of Data Report:** • Pending **Sub-committee/Staff Responsible:** • Cultural Competence Committee **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-1:** Solano County MHP Cultural Competence Committee (CCC) endeavors to implement the goals and initiatives contained with the Solano Cultural Competency Plan. The committee accomplishes this by utilizing a diverse group of stakeholders, including county and contract providers, Consumer family members, and MH Consumers with lived experience. Committee members also help to improve the system by being involved in other county committees in order to ensure the CC Plan is being implemented. **FY 16-17 Baseline:** • Pending **Goal:** • The Cultural Competence Committee Chair will report on current activities every quarter.	**Q1:** The 2017-2018 Cultural Competence Plan Update included the addition of a Cultural Competence Training Plan. This new Training Plan organized the types of culturally responsive trainings available that could benefit staff. The Cultural Competence Committee was reorganized into a new format intended to increase member involvement and commitment. The new format will include the creation of several workgroups that will be responsible for addressing specific goals in the Plan Update. **Q2:** The Cultural Competence Committee has created three sub-committees; Outreach Sub-committee, Language Assistance Sub-committee, and Mission Sub-committee. The Outreach Sub-committee, comprised of outreach coordinators from across Health and Social Services, has been tasked with creating and implementing strategies focused on reducing barriers to effective outreach efforts and coordinating activities between divisions. The Language Assistance Sub-committee has been formed to specifically address the needs of clients and providers who benefit from language services. The Mission Sub-committee will be responsible for reviewing the Cultural Competence Committee's mission statement and vision. The work of all three sub-committees is included in the Cultural Competence Plan Update and their ongoing efforts will ensure that behavioral health services are culturally and linguistically appropriate. **Q3:** The Cultural Competence Committee meets on a quarterly basis and is open to the public. In addition, the various sub-committees meet on a monthly basis but are not open to the public. Those interested in being involved in one of the sub-committees are encouraged to contact Mara Leon, Ethnic Services Coordinator, to be added to the rosters. **Q4:** The Cultural Competence Plan Update for 2018-2019 is currently being drafted. The goals for the new year include a focus on health literacy and increasing community engagement, client retention, and improving workforce capacity. The Cultural Competence Committee meets on a quarterly basis and is open to the public. The Sub-committees continue to meet on a monthly basis and are by invite only. *The Innovations Project was implemented during 2017. This project involved work with the UC Davis Center for Health Disparities and focused on developing workplans to address cultural competency issues within Behavioral Health. QI Workplan goals related to the Innovations Project will be introduced in the FY 2018/2019 QAPI.

I. Cultural Competence (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: • **DM-1: CC Plan, Training Plan and Committee** **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #11, 12a-12c, &13a-13b **Name of Data Report:** • None **Sub-committee/Staff Responsible:** • Cultural Competence Committee **Previous FY Baseline Averages:** • CCC meetings per Quarter: 1 • Were all county staff offered annual CC training: Yes • Were all Contract staff offered annual CC training: Yes **FY 17-18 Quarterly Averages:** • CCC meetings per Quarter: 1 • Were all county staff offered annual CC training: Yes • Were all Contract staff offered annual CC training: Yes	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Date CC Plan Updated	Date CCC met this Quarter	Date of Annual Report	Date of report to QIC	CC Training Offered this Quarter (Y/N)?	What was the title of the training?	How many staff attended?
--	9/7/2017	--	2/8/2018	Yes	LGBT Sensitivity	337

Q2:

Date CC Plan Updated	Date CCC met this Quarter	Date of Annual Report	Date of report to QIC	CC Training Offered this Quarter (Y/N)?	What was the title of the training?	How many staff attended?
--	12/7/2017	--	2/8/2018	Yes	LGBT Sensitivity	94

Q3:

Date CC Plan Updated	Date CCC met this Quarter	Date of Annual Report	Date of report to QIC	CC Training Offered this Quarter (Y/N)?	What was the title of the training?	How many staff attended?
--	3/8/2018	--	5/10/2018	No	---	0

Q4:

Date CC Plan Updated	Date CCC met this Quarter	Date of Annual Report	Date of report to QIC	CC Training Offered this Quarter (Y/N)?	What was the title of the training?	How many staff attended?
--	6/12/2018	--	8/9/2018	No	---	0

Quality Improvement Area of Data Monitoring	Results of Evaluation

I. Cultural Competence:

- **DM-2:** HOLA Community Information and Education Plans – Outreach re: cultural/linguistic services

Purpose for Monitoring:
DHCS Annual Review Protocols, FY 17-18, Access - Section B, Item #7b, 8b, 12b

Name of Data Report:
TBD

Sub-committee/Staff Responsible:
Cultural Competence Coordinator

Previous FY Baseline Averages:

- Outreach Initiatives per Quarter: 6.75
- HOLA calls per quarter: 53.25

FY 17-18 Quarterly Averages:

- Outreach Initiatives per Quarter: 6.5
- HOLA calls per quarter: 34.25

Month	# of Community Partners	# of HOLA Calls received
Jul	1	22
Aug	2	19
Sep	5	23
Oct	3	12
Nov	3	17
Dec	4	9
Jan	2	10
Feb	3	12
Mar	3	13
Apr	-	-
May	-	-
Jun	-	-
Total:	26	137

*Decline in outreach initiatives appear to be due to lack of internship staff.

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: • **DM-3:** Kaagapay Community Information and Education Plans – Outreach re: cultural/linguistic services **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access - Section B, Item #7b, 8b, 12b **Name of Data Report:** TBD **Sub-committee/Staff Responsible:** Cultural Competence Coordinator **Previous FY Baseline Averages:** • Outreach Initiatives per Quarter: 14 • Kaagapay calls per quarter: 15 **FY 17-18 Quarterly Averages:** • Outreach Initiatives per Quarter: 9.5 • Kaagapay calls per quarter: 8	

Month	# of Community Partners	# of Kaagapay Calls received
Jul	5	5
Aug	6	4
Sep	3	4
Oct	2	5
Nov	4	2
Dec	2	2
Jan	5	3
Feb	6	4
Mar	5	2
Apr	-	-
May	-	-
Jun	-	-
Total:	38	32

*Decline in outreach initiatives appear to be due to lack of internship staff.

II. Wellness and Recovery (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
II. Wellness and Recovery: • **AG-1:** Provide Support Groups to Behavioral Health Family members to better support their understanding of BH challenges their loved one is going through and learn effective ways to interact with the BH loved one **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 17-18, Quality Improvement - Section I, Item # 1. **Name of Data Report:** Family Support Group sign-in sheets and Post Group Survey **Sub-committee/Staff Responsible:** Wellness Recovery Unit/Family Liaison **Annual Goal Met:** ☐ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-1:** Provide Family Support Groups facilitated by the Family Liaison and a community family member **Baseline:** There were no FY 16-17 averages, b/c this is a new goal • **FY 17-18 Q1 Baseline**: **Goal:** Increase the % of unduplicated participants in WR Peer Support Groups who respond to post group survey that they felt welcome, that they worked on something important to them, and that they believe life is improving b/c of the group (per Session Rating Scale).	

Month	# of total unique group members who participated	% that Felt Welcome in the Group	% that worked on something today that was important to him/her	% that believes that his/her life is improving b/c of the group
Jul	Survey Not Collected			
Aug				
Sep				
Oct				
Nov				
Dec				
Jan				
Feb				
Mar				
Apr				
May				
Jun				

*Multiple survey formats and scales were considered and tested, but no single survey was implemented.

<table>
<tr><th>Quality Improvement Goal and Means to Accomplish it</th><th>Objectives (Include standards, baselines, annual goal, etc.)</th><th>Results of Evaluation</th></tr>
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II. Wellness and Recovery:

- **AG-2:** Provide Support Groups to Behavioral Health Family members to better support their understanding of BH challenges their loved one is going through and learn effective ways to interact with the BH loved one

Purpose for Monitoring:
DHCS Annual Review Protocols, FY 17-18, Quality Improvement - Section I, Item # 1.

Name of Data Report: Wellness Recovery Peer Support Group sign-in sheets and Post Group Survey

Sub-committee/Staff Responsible :
Wellness Recovery Unit/Consumer Affairs Liaison

Annual Goal Met :
☐ **Met:** Item # ___
☐ **Partially Met:** Item # ___
☐ **Not Met:** Item # ___

Goal added 1/31/2017

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AG-1 : Provide WR Peer Support Groups

Baseline: There were no FY 16-17 averages, b/c this is a new goal

- **FY 17-18 Q1 Baseline**::

Goal: Increase the % of unduplicated participants in WR Peer Support Groups who respond to post group survey that they felt welcome, that they worked on something important to them, and that they believe life is improving b/c of the group.

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Q1 :

<table>
<tr><th>Month</th><th># of total unique group members who participated</th><th>% that Felt Welcome in the Group</th><th>% that worked on something today that was important to him/her</th><th>% that believes that his/her life is improving b/c of the group</th></tr>
<tr><td>Jul</td><td colspan="4" rowspan="11">Survey Not Collected</td></tr>
<tr><td>Aug</td></tr>
<tr><td>Sep</td></tr>
<tr><td>Oct</td></tr>
<tr><td>Nov</td></tr>
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*Multiple survey formats and scales were considered and tested, but no single survey was implemented.

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II. Wellness and Recovery (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation
II. Wellness and Recovery: • **DM-1:** Maintain the pool of 20(+) Consumers/Family Members' Directory to contact to provide them with opportunities to participate in committees **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item #7 **Name of Data Report:** 2017-2018 WR QI Work Plan Goal Report, Sign-in Sheets, & Meeting Minutes **Sub-committee/Staff Responsible:** Wellness Recovery Unit **Previous FY Baseline Averages:** • Average # of Committees per Quarter: 8.5 • Average number of participants per quarter: *inconclusive (pending confirmed data)* **FY 17-18 Quarterly Averages:** • Average # of Committees per Quarter: 5.75 • Average number of participants per quarter: 21	**Q1:** *Due to staff departure, the MHP was unable to obtain final numbers for the fourth quarter.

Month	# of Committees with Consumer or Family Member participation	# of participants
Jul	0	0
Aug	2	7
Sep	2	8
Oct	3	8
Nov	3	7
Dec	3	16
Jan	3	12
Feb	4	15
Mar	3	11
Apr		
May		
Jun		

Quality Improvement Area of Data Monitoring	Results of Evaluation
II. Wellness and Recovery: Provide Wellness Recovery Action Plan (WRAP) Groups to support Behavioral Health Consumers to better understand their BH issues and personal strengths and support them in taking personal responsibility for their BH stability, wellness and recovery **Purpose of Monitoring:** To ensure that Consumers are becoming educated and empowered with in the MHP **Name of Data Report:** WRAP group sign-in sheets **Sub-committee/Staff Responsible:** Wellness Recovery Unit/Office of Consumer Affairs **Previous FY Baseline Averages:** • Total # of Wrap Groups Annually: *inconclusive (pending confirmed data)* • Average number of participants per quarter: 9.5 **FY 17-18 Quarterly Averages:** • Total # of Wrap Groups Annually: 16 • Average number of participants per quarter: 8.5	**C-1: Q1:** *Due to staff departure, the MHP was unable to obtain final numbers for the fourth quarter.

Month	# of WRAP Groups Offered	# of Participants
Jul	0	0
Aug	0	0
Sep	0	0
Oct	4	7
Nov	6	13
Dec	6	14
Jan	0	0
Feb	0	0
Mar	0	0
Apr		
May		
June		

III. Beneficiary Satisfaction & Protection (Active Goals - AG)

Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
III. Consumer Perception: • **AG-1:** Annual Surveying of Client/Family Satisfaction **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item #2a, 2d **Name of Data Report:** • State Consumer Perception Surveys; Follow up surveys **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Annual Goal Met:** ☐ **Met:** ☐ **Partially Met:** ☐ **Not Met:**	**AG-1:** Solano MHP participates in the annual California DHCS Consumer Perception Survey Process, in which surveys are distributed at service programs throughout the MHP over the period of one week (designated by the state). Quality Improvement obtains copies of the results and inputs the data into an MHP database. The Problem Resolution Coordinator is responsible for reviewing the results and making recommendations for service areas to target as areas to be addressed with improvement goals. **Baseline:** MHP participates in the Consumer Perception Survey at least annually and works to create related goals. **Goal: Problem Resolution Coordinator will ensure:** • **Measurement #1:** Pending	<table><tr><th>Q#</th><th colspan="2">List the most recent survey goal & outcome.</th></tr><tr><td rowspan="5"></td><td colspan="2">Q#:</td></tr><tr><td>Adult:</td><td rowspan="4"></td></tr><tr><td>Older Adult:</td></tr><tr><td>Youth:</td></tr><tr><td>Families:</td></tr></table> *Although the MHP did participate in the semi-annual DHCS Consumer Satisfaction Survey, MHP determined that the DHCS survey data is ineffective for determining areas of growth in a timely manner. The MHP has implemented a more focused survey, administered on a quarterly basis, which will be used to identify areas of improvement within programs related to consumer satisfaction.

III. Beneficiary Satisfaction & Protection (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation
III. Consumer Perception: • **DM-1:** Annual Surveying of Client/Family Satisfaction **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item #2a, 2d **Name of Data Report:** • State Consumer Perception Surveys **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Previous FY Baseline Averages:** • **Goal(s) for FY 16-17:** DHCS Consumer Perception Survey, Q #15: Staff told me about Side Effects • **Were results shared with Providers**: Yes **FY 17-18 Quarterly Averages:** • Goal(s) for FY 17-18: • Were results shared with Providers:	**DHCS Consumer Perception Survey** **Service Verification Survey** **ICC Customer Satisfaction Survey**

DHCS Consumer Perception Survey

Date range for most recent survey	Is the MHP working on a goal?	Date range for most recent survey results obtained	Were results shared with providers?
November 2017	No	May 2017	Yes
May 2018	No	November 2017	Yes

Service Verification Survey

Program	Total Surveys Logged	Satisfaction Rating
Adult	623	87%
Youth	955	91%
Total:	1578	90%

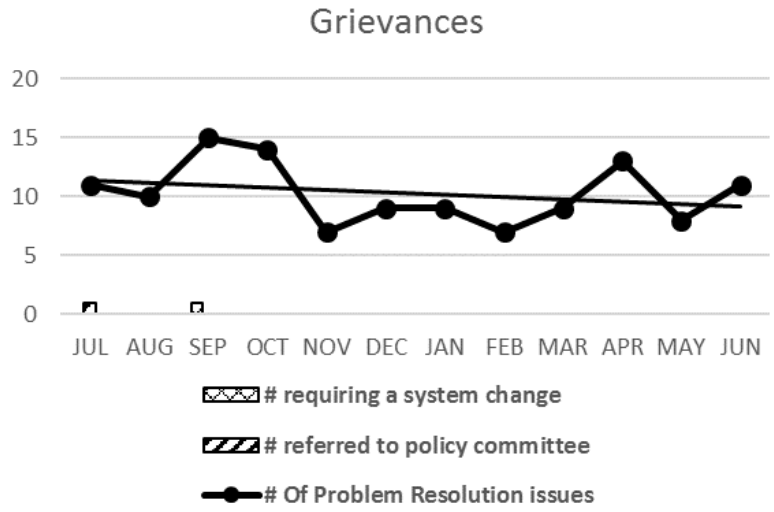
ICC Customer Satisfaction Survey

Rating Scale*	1	2	3	4	5	6	7	8	9	10
Total Surveys: 17	1					1			3.5	11.5

* 1 – least satisfied, 10 – most satisfied

Quality Improvement Area of Data Monitoring	Results of Evaluation
III. Beneficiary Protection: • **DM-2:** Grievance, Appeal and Expedited Appeal **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 17-18, Quality Improvement - Section I, Item # 2b, #5, and #6b; Beneficiary Protection – Section D, Item #2, #8a & 8b **Name of Data Report:** • Problem Resolution Log • QIC Problem Resolution Report **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Previous FY Baseline Totals:** • Total # of Problem Resolution issues: 117 • # of issues requiring a system change: 10 • # Referred to Policy Committee: 0 **FY 17-18 Totals:** • Total # of Problem Resolution issues: 123 • # of issues requiring a system change: 1 • # Referred to Policy Committee: 1 • # of Policies created or amended: 0	**Q1:**

Month Received	Total quarterly # of Problem Resolution issues reported, including quality of care issues	# of issues Requiring a System Change	# Referred to Policy Committee	# of Policies created or amended b/c of identified Problem
July	11	0	1	0
Aug	10	0	0	0
Sept	15	1	0	0
Oct	14	0	0	0
Nov	7	0	0	0
Dec	9	0	0	0
Jan	9	0	0	0
Feb	7	0	0	0
Mar	9	0	0	0
Apr	13	0	0	0
May	8	0	0	0
Jun	11	0	0	0
Total	**123**	**1**	**1**	**0**



Quality Improvement Area of Data Monitoring	Results of Evaluation
III. Beneficiary Protection: • **DM-3**: Tracking and trending of Beneficiary Grievances and Appeals to meet DHCS annual reporting standards **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 17-18, Quality Improvement - Section I, Item # 2b, #5, and #6b; Beneficiary Protection – Section D, Item #2a, 2b. **Name of Data Report:** • Problem Resolution Log • QIC Problem Resolution Report **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Previous FY Baseline Averages:** • Were all Problem Resolution processes logged and monitored: Yes • Data Trends: **FY 17-18 Quarterly Averages:** • Were all Problem Resolution processes logged and monitored: Yes • Data Trends:	**FY 2016/17** **FY 2017/18**

FY 2016/17

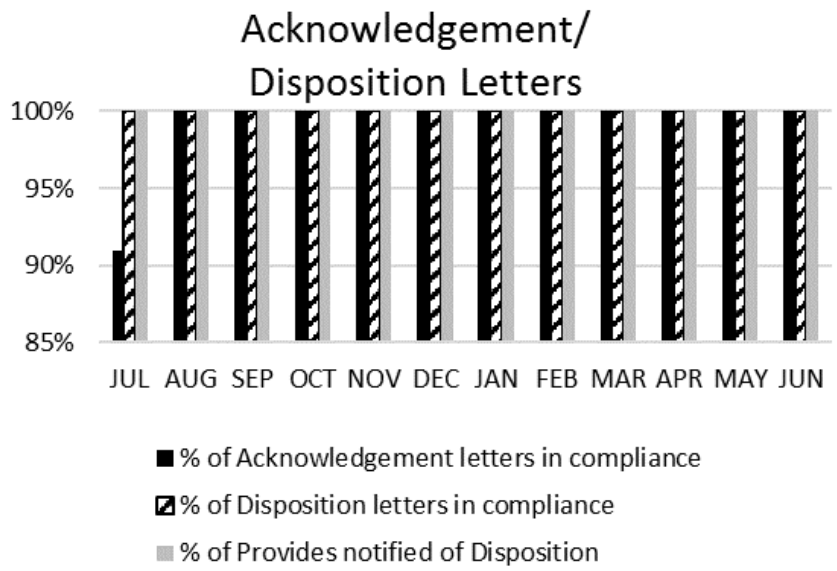
Category	Total	Process					Disposition		
		Grievance	Appeal	Exp. Appeal	State Fair Hearing	Exp. Fair Hearing	Ref. Out	Res.	Still Pending
ACCESS	1	1						1	
Denied Services	3	3						3	
Change of Provider	52	51						51	1
Quality of Care	42	40						40	2
Confidentiality	1						1		
Other	17	17						17	
Total:	**116**	**112**					**1**	**112**	**3**

FY 2017/18

Category	Total	Process					Disposition		
		Grievance	Appeal	Exp. Appeal	State Fair Hearing	Exp. Fair Hearing	Ref. Out	Res.	Still Pending
ACCESS	1	1						1	
Denied Services									
Change of Provider	57	57						57	
Quality of Care	50	50						48	2
Confidentiality	3	3					3		
Other	11	11						11	
Total:	**122**	**122**					**3**	**117**	**2**

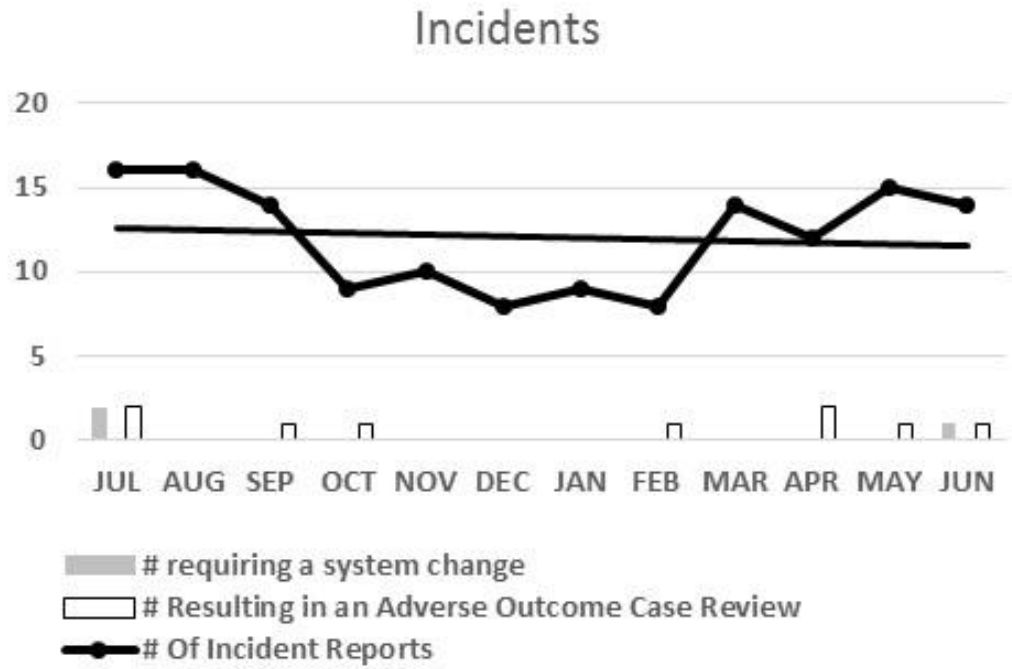
Quality Improvement Area of Data Monitoring	Results of Evaluation
III. Beneficiary Protection: • **DM-4**: Tracking the compliance of sending the beneficiary an acknowledgement and Disposition letter. **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 17-18, Quality Improvement - Section I, Item # 2b, #5, and #6b; Beneficiary Protection – Section D, Item #3, 4, 6 **Name of Data Report:** • Problem Resolution Log • QIC Problem Resolution Report **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Previous FY Baseline Averages:** • % of Acknowledgement letters sent within timeframes: 98.25% • % of Disposition letters sent within timeframes: 98% **FY 17-18 Quarterly Averages:** • % of Acknowledgement letters sent within timeframes: 99% • % of Disposition letters sent within timeframes: 100%	**Q1:**

Month Rec'd	% of Acknowledgement letters in compliance	% of Disposition letters in compliance	% of Provides Notified of Disposition
July	91%	100%	100%
Aug	100%	100%	100%
Sept	100%	100%	100%
July	100%	100%	100%
Aug	100%	100%	100%
Sept	100%	100%	100%
July	100%	100%	100%
Aug	100%	100%	100%
Sept	100%	100%	100%
July	100%	100%	100%
Aug	100%	100%	100%
Sept	100%	100%	100%



Quality Improvement Area of Data Monitoring	Results of Evaluation
III. Beneficiary Protection: • **DM-5**: Tracking and trending of Internal system improvement needs **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 17-18, Quality Improvement - Section I, Item # 1a; #5; 6b. **Frequency of Evaluation:** Quarterly **Name of Data Report:** • Problem Resolution Log • QIC Internal System Improvement Report **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Previous FY Baseline:** • Total # of Problem Resolution issues: 142 • # of issues requiring a system change: 12 • # Referred to Policy Committee: 1 • # Referred for Adverse Outcome Mtg: 7 **FY 17-18 Totals:** • Total # of Problem Resolution issues: 145 • # of issues requiring a system change: 3 • # Referred to Policy Committee: 0 • # Referred for Adverse Outcome Mtg: 9	**Q1:**

Month Received	# Of Incident Reports	# Requiring a system change	# Referred to Policy Committee	# Resulting in an Adverse Outcome Case Review
July	16	2	0	2
Aug	16	0	0	0
Sept	14	0	0	1
Oct	9	0	0	1
Nov	10	0	0	0
Dec	8	0	0	0
Jan	9	0	0	0
Feb	8	0	0	1
Mar	14	0	0	0
Apr	12	0	0	2
May	15	0	0	1
Jun	14	1	0	1
Totals	145	3	0	9



IV. Beneficiary Outcomes and System Utilization (Active Goals - AG)

Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation

IV. Outcomes & Utilization

- **AG-1:** Full Service Partnership Utilization and Outcomes

Authority:
DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item # 8a

Name of Data Report:
Solano County MHSA Clinical Supervisor and Contract Manager

Sub-committee/Staff Responsible:
UM Committee & FSP Work Groups

Annual Goal Items Met:
☒ **Met:** Item # 1-4
☐ **Partially Met:** Item # ____
☐ **Not Met:** Item #_____

AG-1: Full Service Partnerships are intended to do "whatever it takes" in terms of service provision to stabilize vulnerable, high risk clients, and to keep them from falling into highly restrictive, high cost services such as inpatient hospitalization, incarceration, etc. Due to difficulty recovering data from the statewide ITWS DCR system to measure success Solano MHP will explore the feasibility of having all FSP programs being able to use Avatar E.H.R to enter data that will link or upload to the DCR system

Baseline: FY 16-17 showed the following:

- 7% (24) adult FSP Programs clients were hospitalized 1x and 1% (5) were hospitalized 2 or more times.
- 3% (9) Children/Youth FSP Programs clients were hospitalized 1x and 1% (3) were hospitalized 2 or more times.
- Unduplicated counts for incarcerations and unstable housing was not available.

Goal: Solano MHP will:

1. Decrease total FSP clients in inpatient hospitalizations by 5%
2. Decrease the percentage of FSP clients hospitalized by 5%
3. Decrease total FSP clients incarcerated by 5%
4. Reduce # of FSP clients without stable housing.

Q1:

FSP Programs this Quarter (Adults)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospitalized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homelessness	# of clients with loss of placement
VJO Adult FSP	54	6% (3)	2	1	7	NA
FACT/AB 109	60	2%(1)	0	3	3	NA
Caminar Adult FSP	35	9% (3)	0	2	1	NA
Caminar OA FSP	13	0% (0)	0	0	0	NA
Caminar HOME FSP	29	3%(1)	0	0	1	NA
Seneca TAY FSP	15	0%(0)	0	0	3	0
FCTU Youth FSP	53	2%(1)	0	0	0	4
FF Youth FSP	56	4%(2)	0	1	1	2
VV Youth FSP	20	25%(5)	1	1	0	1
VJO Youth FSP	19	0%(0)	0	1	1	0
Totals	**354**	**6%**	**3**	**9**	**17**	**7**

Q2:

FSP Programs this Quarter (Adults)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospitalized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homelessness	# of clients with loss of placement
VJO Adult FSP	56	4	0	1	2	NA
FACT/AB 109	62	5	1	3	1	NA
Caminar Adult FSP	23	4	3	0	0	NA
Caminar OA FSP	11	2	1	0	0	NA
Caminar HOME FSP	23	0	0	0	3	NA
Seneca TAY FSP	17	1	0	0	1	0
FCTU Youth FSP	53	1	0	0	0	3
FF Youth FSP	41	1	0	2	1	4
VV Youth FSP	18	2	1	0	0	0
VJO Youth FSP	19	0	0	0	0	0
Totals	**323**	**6% (20)**	**0.6% (2)**	**1.5% (5)**	**2% (7)**	**2% (7)**

Q3:

FSP Programs this Quarter (Adults)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospitalized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homelessness	# of clients with loss of placement
VJO Adult FSP	53	6% (3)	4% (2)	0%	0%	NA
FACT/AB 109	69	1% (1)	0%	3% (2)	1% (1)	NA
Caminar Adult FSP	28	0%	0%	0%	0%	NA
Caminar OA FSP	11	0%	0%	0%	0%	NA
Caminar HOME FSP	24	0%	0%	0%	0%	NA

Seneca TAY FSP	17	6% (1)	0%	0%	6% (1)	0%
FCTU Youth FSP	59	2% (1)	0%	0%	0%	14% (8)
FF Youth FSP	39	5% (2)	3% (1)	0%	0%	3% (1)
VV Youth FSP	12	8% (1)	0%	0%	0%	0%
VJO Youth FSP	15	0%	0%	0%	0%	0%
Totals	**327**	**3%(9)**	**1%(3)**	**1%(2)**	**1%(2)**	**3%(9)**

Q4:

FSP Programs this Quarter (Adults)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospitalized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homelessness	# of clients with loss of placement
VJO Adult FSP	47	4	3	2	4	NA
FACT/AB 109	57	2	1	5	0	NA
Caminar Adult FSP	33	0	0	0	0	NA
Caminar OA FSP	10	0	0	0	0	NA
Caminar HOME FSP	24	0	0	0	0	NA
Seneca TAY FSP	22	3	1	0	5	0
FCTU Youth FSP	65	2	0	0	1	11
FF Youth FSP	35	3	0	0	1	2
VV Youth FSP	11	0	0	0	0	0
VJO Youth FSP	13	0	0	0	0	0
Totals	**317**	**4% (14)**	**1.5% (5)**	**2.2% (7)**	**3% (11)**	**4% (13)**

Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
IV. Outcomes & Utilization: • **AG-2:** ADULT: CSU, Bay Area Community Services, Hospital Liaison **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Quality Improvement Section I, Item #6c. **Name of Data Report:** Quality and Utilization Review of CSU services **Sub-committee/Staff Responsible:** Utilization Management team **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☒ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-2:** The Utilization Management Committee is charged with monitoring the effectiveness of the MHP's infrastructure to reduce inpatient stays and recidivism. **Baseline:** FY 16-17 Averages **Goal:** Maintain or improve the following hospital-related measures (based on Solano Adult Medi-Cal clients, excludes 0-17 y.o., private insurance, Kaiser Medi-Cal, or other county insurance): • **Measurement #1:** Maintain FY16-17 baseline **Baseline:** Quarterly average of 125 average Adult inpatient hospitalizations. • **Measurement #2** Establish a baseline average of 12% or less of clients re-hospitalized within 30 days of discharge from inpatient hospitalization. **Baseline:** Quarterly average of 12.4% readmission rate in FY16-17.	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Month	# of Adult Inpatient Hospitalizations	# of Adult Discharges	# of Adult Rehospitalizations within 30 days of discharge & % of total of discharges	
Jul	54	45	6	11.11%
Aug	66	60	1	1.52%
Sep	66	72	7	10.61%
TOTALS:	**186**	**177**	**14**	**7.53%**

Q2:

Month	# of Adult Inpatient Hospitalizations	# of Adult Discharges	# of Adult Rehospitalizations within 30 days of discharge & % of total of discharges	
Oct	59	54	5	9.25%
Nov	56	47	4	8.5%
Dec	56	56	7	12.5%
TOTALS:	**171**	**157**	**16**	**10.20%**

Q3:

Month	# of Adult Inpatient Hospitalizations	# of Adult Discharges	# of Adult Rehospitalizations within 30 days of discharge & % of total of discharges	
Jan	54	56	7	12.5%
Feb	44	44	9	20%
Mar	42	40	10	25%
TOTALS:	**140**	**140**	**26**	**18.5%**

Q4:

Month	# of Adult Inpatient Hospitalizations	# of Adult Discharges	# of Adult Rehospitalizations within 30 days of discharge & % of total of discharges	
Apr	37	37	4	10.8%
May	37	37	4	10.8%
Jun	65	48	7	14.6%
TOTALS:	**139**	**122**	**15**	**12.3%**

Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
IV. Outcomes & Utilization: • **AG-3:** CHILD: CSU-Exodus, Bay Area Community Services, Hospital Liaison **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Quality Improvement Section I, Item #6c. **Name of Data Report:** Quality and Utilization Review of CSU services **Sub-committee/Staff Responsible:** Utilization Management team **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☒ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-3:** The Utilization Management Committee is charged with monitoring the effectiveness of the MHP's infrastructure to reduce inpatient stays and recidivism. **Baseline:** FY 16-17 Averages **Goal:** Monitor data on hospitalization and re-hospitalization rates for Solano County Child clients age 0-17 (excluding private insurance, Kaiser Medi-Cal, and other county Medi-Cal clients): • **Measurement #1:** Improve FY 16-17 baseline average to under 18 Inpatient hospitalizations per quarter. **Baseline:** 18.5 Child inpatient hospitalizations in FY 16-17 • **Measurement #2:** Improve quarterly average to 15% or less clients re-hospitalized within 30 days of discharge from inpatient hospitalization. **Baseline:** 15.8% average readmission rate in FY16-17	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Month	# of Child Inpatient Hospitalizations	# of Child Discharges	# of Child Rehospitalizations within 30 days of discharge & % of total of discharges	
Jul	11	10	1	9.09%
Aug	8	8	3	37.5%
Sep	10	9	2	20%
TOTALS:	**29**	**27**	**6**	**20.69%**

Q2:

Month	# of Child Inpatient Hospitalizations	# of Child Discharges	# of Child Rehospitalizations within 30 days of discharge & % of total of discharges	
Oct	12	13	3	23.08%
Nov	11	7	2	28.57%
Dec	3	6	0	0%
TOTALS:	**26**	**26**	**5**	**19.23%**

Q3:

Month	# of Child Inpatient Hospitalizations	# of Child Discharges	# of Child Rehospitalizations within 30 days of discharge & % of total of discharges	
Jan	9	6	0	0
Feb	11	10	2	20%
Mar	8	8	3	37.5%
TOTALS:	**28**	**24**	**5**	**20.8%**

Q4:

Month	# of Child Inpatient Hospitalizations	# of Child Discharges	# of Child Rehospitalizations within 30 days of discharge & % of total of discharges	
Apr	8	9	1	11.1%
May	7	9	0	0.0%
Jun	8	4	0	0.0%
TOTALS:	**23**	**21**	**1**	**4.8%**

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
IV. Outcomes & Utilization: • **AG-4: Homeless Outreach Services (HOS) to SMI populations:** Provide outreach, engagement, and support to homeless mentally Ill adults toward acquiring benefits, resources, and services they need. **Name of Data Report:** WR Unit Homeless Outreach monthly reports and/or PATH Grant Quarterly Performance Outcome Reports **Sub-committee/Staff Responsible:** Wellness Recovery Unit/Homeless Outreach Specialist. **Annual Goal Met:** ☐ **Met:** ☒ **Partially Met:** See Note ☐ **Not Met:**	**AG-4:** MHP Staff will continue to provide support, outreach, and assistance to homeless mentally ill individuals who are brought to the attention of SCBH Services. The MHP hired two Homeless Outreach staff during FY 16-17: Mental Health Specialist and Mental Health Clinician. Services started in January 2017. These staff members go to homeless shelters, encampments, ride alongs with law enforcement, and in the community to identify mentally ill homeless individuals, and assist these individuals to access benefits and services needed. The Specialist focuses on the adult population and the Clinician is focused on the TAY population. **Baseline:** In the previous FY 16-17 a total of 111 adults were provided ARCH services and 86% of those were screened for MH/SA need and 59% were linked to other basic needs. FY 16-17 30 TAY individuals were provided ARCH Services and of those 100% were screened for MH/SA needs and 47% were linked to other basic needs. **Goal:** **1.** At least 85% of the individuals contacted will be screened for MH/SA needs. **2.** Of those screened, at least 50% of the individuals will be linked to Access or an existing MH provider. **3.** At least 50% of the individuals contacted will be linked to other basic need services.	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Program	# of Homeless Outreach Activities	# ind. contacted at least 1 X	# ind. screened	# ind. new to MHP linked to Access	# ind. re-connected w/ existing Tx provider	# ind. linked to Sub. Abuse	# ind. linked to other basic needs (food, clothing, etc.)
Adult ARCH	28	42	26	7	11	0	26
TAY ARCH	97	19	17	2	6	0	10

Q2:

Program	# of Homeless Outreach Activities	# ind. contacted at least 1 X	# ind. screened	# ind. new to MHP linked to Access	# ind. re-connected w/ existing Tx provider	# ind. linked to Sub. Abuse	# ind. linked to other basic needs (food, clothing, etc.)
Adult ARCH	11	50	16	10	4	0	31
TAY ARCH	72	19	15	0	4	0	14

Q3:

Program	# of Homeless Outreach Activities	# ind. contacted at least 1 X	# ind. screened	# ind. new to MHP linked to Access	# ind. re-connected w/ existing Tx provider	# ind. linked to Sub. Abuse	# ind. linked to other basic needs (food, clothing, etc.)
Adult ARCH	26	146	77	33	22	0	95
TAY ARCH	9	44	35	18	6	0	10

Q4:

Program	# of Homeless Outreach Activities	# ind. contacted at least 1 X	# ind. screened	# ind. new to MHP linked to Access	# ind. re-connected w/ existing Tx provider	# ind. linked to Sub. Abuse	# ind. linked to other basic needs (food, clothing, etc.)
Adult ARCH	9	31	31	11	6	1	24
TAY ARCH	5	17	31	9	2	0	8

Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
IV. Outcomes & Utilization: • **AG-5**: TF-CBT **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item #6c **Name of Data Report:** No current report **Sub-committee/Staff Responsible:** • Quality Improvement • MHSA **Annual Goal Met:** ☐ **Met:** Item # ___ ☒ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-5:** Trauma-Focused Cognitive Behavioral Therapy is an evidence-based practice that uses CBT techniques to help decrease PTSD symptoms, decrease negative attitudes about the traumatic event, decrease problem behaviors, improve parent-child relationships, improve parenting. Solano MHP has been committed to facilitating a TF-CBT training process since FY 2014-15 and implementing TF-CBT into outpatient treatment settings. **Baseline:** During FY 16-17: • Quarterly average # of clients served w/ TFCBT by county programs was 11. • 1.75 average # of county program clients completed the post assessment quarterly (range=0-3 per quarter) • 100% who completed the post assessment showed clinical improvement. ***Goal: TF-CBT goals include:** 1. **Increase baseline # of Clients treated with TF-CBT by 15%** 2. **50% of Clients will complete Post-Test** 3. **75% of clients measured will show clinical Improvement on the Post-Test**	**Q1:** **Q2:** **Q3:** **Q4:** *The ongoing monitoring of this evidence-based practice is pending, due to the end of the contract period with the certification vendor.

Q1:

County Program	Total # Clients treated with TF-CBT this Quarter	Total # of Clients to complete Post-Assessment	Total # who showed Clinical Improvement on the Post-Test
VV Youth	1	0	0
FF Youth	3	0	0
VJO Youth	2	0	0

Q2:

County Program	Total # Clients treated with TF-CBT this Quarter	Total # of Clients to complete Post-Assessment	Total # who showed Clinical Improvement on the Post-Test
VV Youth	Data Not Available		
FF Youth			
VJO Youth			

Q3:

County Program	Total # Clients treated with TF-CBT this Quarter	Total # of Clients to complete Post-Assessment	Total # who showed Clinical Improvement on the Post-Test
VV Youth	Data Not Available		
FF Youth			
VJO Youth			

Q4:

County Program	Total # Clients treated with TF-CBT this Quarter	Total # of Clients to complete Post-Assessment	Total # who showed Clinical Improvement on the Post-Test
VV Youth	Data Not Available		
FF Youth			
VJO Youth			

IV. Beneficiary Outcomes and System Utilization (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation
IV. Outcomes & Utilization: • **DM-1: Youth Medication Monitoring** **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item #3 **Name of Data Report:** Avatar Report # ___ **Sub-committee/Staff Responsible:** Quality Review Committee **Previous FY Baseline Averages:** • **FY 16-17 # of Youth on Psychotropic Medication:** • **FY 16-17 # of Youth on 4 or more Psychotropic Medications:** • **FY 16-17 # of Youth on Antipsychotic Medication:** • **FY 16-17 # of Youth on 2 or more Antipsychotic Medications:** **FY 17-18 Quarterly Averages:** **Annual Goal Met:** ☐ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☒ **Not Met:** Item # ___	**Q1:** | Month | # of Youth on Psychotropic Medication: | # of Youth on 4 or more Psychotropic Medications: | # of Youth on Antipsychotic Medication: | # of Youth on 2 or more Antipsychotic Medications: | | --- | --- | --- | --- | --- | | Jul | | | | | | Aug | | | | | | Sep | | | | | *Data was not fully available the MHP's electronic health record reporting mechanism. Avatar strategic plan for FY 2018-19 is to enhance medication monitoring report capabilities for youth clients, specifically for foster care youth.

Quality Improvement Area of Data Monitoring	Results of Evaluation
IV. Outcomes & Utilization: • **DM-2:** Regional Utilization and Service Penetration by cultural group **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Network Adequacy and Array of Services – Section A, Item #2b, 2c **Name of Data Report:** • Avatar Report # 347 **Sub-committee/Staff Responsible:** • Utilization Management Committee membership • Cultural Competence Committee **Previous FY Baseline Averages:** • FY 16-17 African American Quarterly Average Served: • FY 16-17 Hispanic/Latino Quarterly Average Served: • FY 16-17 Filipino Quarterly Average Served: • FY 16-17 LGBT Quarterly Average Served: **FY 17-18 Quarterly Averages:** **Annual Goal Met:** ☐ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	

Date Range	Black/AA	Hispanic/ Latino	Filipino	LGBTQ
North County Region	169	235	18	No data available
Central County Region	704	491	72	No data available
South County Region	642	308	115	No data available
Out of County	96	36	11	No data available
Unknown	2	1	0	No data available
Annual 17-18 Total:	1,613	1,071	216	282
FY 16-17 Annual (Baseline)	1558	922	204	Unknown

***LGBTQ – Data from Avatar 347 Report; Avatar report 337 does not yet have LGBTQ data to indicate county region**

V. Service Access and Timeliness (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
V. Access & Timeliness: • **AG-1: CHILD:** Service Request to First Offered Assessment Appointment **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #9 and #10 **Name of Data Report:** Avatar Timeliness Report #; MHP Access Referral form (under construction) **Sub-committee/Staff Responsible:** Access Supervisor **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☒ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-1:** Solano MHP made significant progress in FY 2015-16 to improve timeliness from point of access to the date of first-offered assessment appointment. **Baseline:** See FY 2016-17 average timeliness for Children's services **Goal:** 1. For Routine requests for service, County Children's programs will: a. Maintain goal of 90% resulting in an offered assessment within 10 business days (FY16-17 baseline: 82%) b. Maintain goal of an average of 10 business days or less from service request to actual assessment (FY16-17 baseline: 9.8 days) c. Achieve goal of an average of 30 business days or less from service request to service initiation (FY16-17 baseline: 32.4 days) 2. For Urgent requests for service, County Children's programs will: a. Achieve goal of 90% resulting in an offered assessment within 3 business days (FY16-17 baseline: 76%) b. Achieve goal of an average of 3 business days or less from service request to actual assessment (FY16-17 baseline: 4.2 days)	**Q1:** **Q2:** **Q3:** **Q4:** **Year Average:**

Request Type	Service Request to Offered Ax Appt (% w/in 10 bus days for Routine & 3 bus days for Urgent)	Average # of Business Days from Service Request to Actual Ax Appt	Average # of Business Days from Service Request to First Tx Service
Routine	64%	11.55	23.25
Urgent	50%	3.5	15
Total:	**77%**	**11.4**	**23.0**

Q2:

Routine	70%	8.85	21.63
Urgent	100%	3.25	7.67
Total:	**70%**	**8.64**	**21.63**

Q3:

Routine	76%	10.58	21.88
Urgent	50%	5.00	29.67
Total:	**75%**	**10.28**	**22.27**

Q4:

Routine	86.37%	12.19	27.51
Urgent	85.71%	4.71	28.00
Total:	**86.33%**	**11.76**	**27.56**

Year Average:

Routine	**74%**	**10.8**	**23.57**
Urgent	**71%**	**4.12**	**20.1**

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
V. Access & Timeliness: • **AG-2 Adult Services:** Service Request to First Offered Assessment Appointment **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #9 and #10 **Name of Data Report:** Avatar Timeliness Report #; MHP Access Referral form (under construction) **Sub-committee/Staff Responsible:** Access Supervisor **Annual Goal Items Met:** ☒ **Met:** Item # 1b, 1c, 2c ☒ **Partially Met:** Item # 1a, 2a, 2b ☐ **Not Met:** Item # ___	**AG-2:** Solano MHP made significant progress in FY 2015-16 to improve timeliness from point of access to the date of first-offered assessment appointment. **Baseline:** See FY 2016-17 average timeliness for Adult services **Goal:** 1. For Routine requests for service County Adult programs will: a. Achieve goal of 80% resulting in an offered assessment within 10 business days (FY16-17 baseline for all Adults: 84%) b. Achieve goal of an average of 10 business days or less from service request to actual assessment (FY16-17 baseline for all adults: 8.4 days) c. Achieve goal of an average of 30 business days or less from service request to service initiation (FY16-17 baseline for all adults: 26.5 days) 2. For Urgent requests for service, County Adult programs will: a. Maintain goal of 80% resulting in an offered assessment within 3 business days (FY16-17 baseline for all adults: 76%) b. Achieve goal of an average of 3 business days or less from service request to actual assessment (FY16-17 baseline for all adults: 5.4 days) c. Achieve goal of an average of 23 business days or less from service request to service initiation (FY16-17 baseline for all adults: 16.7 days)	**Q1:** **Q2:** **Q3:** **Q4:** **Year Average**

Request Type	Service Request to Offered Ax Appt (% w/in 10 bus days for Routine & 3 bus days for Urgent)	Average # of Business Days from Service Request to Actual Ax Appt	Average # of Business Days from Service Request to First Tx Service
Routine	71%	8.38	18.68
Urgent	56%	3.81	20.43
Total:	**71%**	**8.13**	**18.76**

Routine	68%	8.65	22.02
Urgent	89%	2.50	18.33
Total:	68%	8.41	21.87

Routine	64%	8.13	17.25
Urgent	82%	6.89	19.29
Total:	65%	8.08	17.33

Routine	95.44%	6.93	15.46
Urgent	85.71%	11.33	16.25
Total:	95.26%	7.05	15.48

Routine	**75%**	**8.02**	**18.35**
Urgent	**78%**	**6.13**	**18.58**

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
V. Access & Timeliness: • **AG-3: Retention:** Service Request to First Offered Assessment Appointment **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #9 and #10 **Name of Data Report:** Avatar Timeliness Report #; MHP Access Referral form (under construction) **Sub-committee/Staff Responsible:** Access Supervisor **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☒ **Partially Met:** Item # 2a, 2b ☒ **Not Met:** Item # 1a, 1b	**AG-3:** Maintain or improve the following engagement & attrition measures for Children: **Baseline:** See FY 2016-17 average engagement & attrition for Children's services **Goal:** 1. For Routine requests for service, County Youth programs will: a. Maintain goal of 95% resulting in an Assessment (FY16-17 baseline: 95%) b. Achieve goal of 75% resulting in initiation of treatment (FY16-17 baseline: 72%) 2. For Urgent requests for service, County Youth programs will: a. Maintain goal of 95% resulting in an assessment (FY16-17 baseline: 95%) b. Achieve goal of 75% resulting in initiation of treatment (FY16-17 baseline: 71%)	**Q1:** **Q2:** **Q3:** **Q4:** **Year Average**

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine	132	91%	51%
Urgent	2	100%	100%
Total:	**134**	**95.5%**	**75.5%**

Routine	141	71%	33%
Urgent	4	100%	75%
Total:	**145**	**72%**	**34%**

Routine	148	81%	39%
Urgent	8	88%	38%
Total:	**156**	**81%**	**38%**

Routine	138	81.16%	38.41%
Urgent	7	100%	85.71%
Total:	**145**	**82.07%**	**40.69%**

Routine	**139.75**	**81%**	**40%**
Urgent	**5.25**	**97%**	**75%**

<table>
<tr><th>Quality Improvement Goal and Means to Accomplish it</th><th>Objectives (Include standards, baselines, annual goal, etc.)</th><th>Results of Evaluation</th></tr>
<tr>
<td>V. Access & Timeliness:

• AG-4: Retention: Service Request to First Offered Assessment Appointment

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #9 and #10

Name of Data Report:
Avatar Timeliness Report #; MHP Access Referral form (under construction)

Sub-committee/Staff Responsible:
Access Supervisor

Annual Goal Items Met:
☒ Met: Item # 2a
☒ Partially Met:
Item # 1a, 2b
☒ Not Met: Item # 1b</td>
<td>AG-4: Maintain or improve the following engagement & attrition measures for Adult:
Baseline: See FY 2016-17 average engagement & attrition for Adult services
Goal:
1. For Routine requests for service, County Adult programs will:
a. Achieve goal of 65% resulting in an Assessment
(FY16-17 baseline: 59%)
b. Achieve goal of 55% resulting in initiation of treatment
(FY16-17 baseline: 46%)
2. For Urgent requests for service, County Adult programs will:
a. Maintain goal of 60% resulting in an assessment
(FY16-17 baseline: 55%)
b. Achieve goal of 55% resulting in initiation of treatment
(FY16-17 baseline: 46%)</td>
<td>Q1:
<table>
<tr><th>Request Type</th><th># of Service Requests</th><th>% Receiving an Assessment</th><th>% Who Initiated Treatment</th></tr>
<tr><td>Routine</td><td>298</td><td>65%</td><td>51%</td></tr>
<tr><td>Urgent</td><td>13</td><td>85%</td><td>50%</td></tr>
<tr><td>Total:</td><td>311</td><td>65%</td><td>51%</td></tr>
</table>
Q2:
<table>
<tr><td>Routine</td><td>331</td><td>60%</td><td>44%</td></tr>
<tr><td>Urgent</td><td>9</td><td>89%</td><td>67%</td></tr>
<tr><td>Total:</td><td>340</td><td>61%</td><td>44%</td></tr>
</table>
Q3:
<table>
<tr><td>Routine</td><td>335</td><td>64%</td><td>47%</td></tr>
<tr><td>Urgent</td><td>11</td><td>82%</td><td>64%</td></tr>
<tr><td>Total:</td><td>346</td><td>65%</td><td>48%</td></tr>
</table>
Q4:
<table>
<tr><td>Routine</td><td>373</td><td>58%</td><td>44%</td></tr>
<tr><td>Urgent</td><td>8</td><td>75%</td><td>50%</td></tr>
<tr><td>Total:</td><td>381</td><td>58%</td><td>44%</td></tr>
</table>
Year Average
<table>
<tr><td>Routine</td><td>334.25</td><td>62%</td><td>47%</td></tr>
<tr><td>Urgent</td><td>10.25</td><td>83%</td><td>58%</td></tr>
</table></td>
</tr>
</table>

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
V. Access & Timeliness: • **AG-5**: Access: Test Call Performance **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access – Section A, Item #9 and #10 **Name of Data Report:** Avatar Access Screen Tree form and QI Test Call Log **Sub-committee/Staff Responsible:** • Quality Improvement unit • Access Supervisor **Annual Goal Items Met:** ☒ **Met:** Item # 2, 3 ☒ **Partially Met:** Item # 1, 4 ☐ **Not Met:** Item # ___	**AG-5:** All calls to (800) 547-0495 MH Access unit are routed to a Care Manager, 24 hours/day, 7 days/week. Care Managers provide or arrange for Access services in any language spoken in Solano County. Additionally, calls should: • Provide information about how to access specialty MH services, including how to access an intake assessment. • Provide information about urgent services. • Provide information about how to access Problem Resolution and State Fair Hearing processes. **Baseline:** See FY 15-16 % that met standards **Goal:** During QI initiated test calls, the MHP will demonstrate in 75%-100% Business and Afterhours calls: • **Measure #1:** Provide a Minimum of 4 test calls/month. • **Measure #2:** Testing for language capabilities • **Measure #3:** Testing for appropriate information given (SMHS access, Urgent conditions, and Problem Resolution) • **Measure #4:** Logging all appropriate data	**Q1:** **Q2:** **Q3:**

Q1:

	Bus or after hrs	# of Test Calls/ Quarter	# of Test Calls that meet Standards	% of Test Calls that meet Standards this Quarter
Languages Tested: Spanish	**B**	0	0	n/a
	A	0	0	n/a
Was Information given about how to access SMHS, including how to get an Ax.	**B**	2	1	50%
	A	3	0	0%
Info about how to treat a client's urgent condition	**B**	1	1	100%
	A	1	1	100%
Info about how to use the Problem Resolution/Fair Hearing process	**B**	0	0	n/a
	A	0	0	n/a
Logging Name of client, date of request, & initial disposition	**B**	3	2	66%
	A	4	0	0%

Q2:

	Bus or after hrs	# of Test Calls/ Quarter	# of Test Calls that meet Standards	% of Test Calls that meet Standards this Quarter
Languages Tested: Spanish	**B**	0	0	n/a
	A	0	0	n/a
Was Information given about how to access SMHS, including how to get an Ax.	**B**	2	2	100%
	A	1	0	0%
Info about how to treat a client's urgent condition	**B**	0	n/a	n/a
	A	0	n/a	n/a
Info about how to use the Problem Resolution/Fair Hearing process	**B**	0	n/a	n/a
	A	0	n/a	n/a
Logging Name of client, date of request, & initial disposition	**B**	2	2	100%
	A	0	0	n/a

Q3:

	Bus or after hrs	# of Test Calls/ Quarter	# of Test Calls that meet Standards	% of Test Calls that meet Standards this Quarter
Languages Tested: Spanish	**B**	0	0	n/a
	A	0	0	n/a
Was Information given about how to access SMHS, including how to get an Ax.	**B**	2	2	100%
	A	3	1	33%
Info about how to treat a client's urgent condition	**B**	1	1	100%
	A	1	1	100%
Info about how to use the Problem Resolution/Fair Hearing process	**B**	0	0	n/a
	A	0	0	n/a
Logging Name of client, date of request, & initial disposition	**B**	3	2	66%
	A	4	2	50%

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation

Q4:	Bus or after hrs	# of Test Calls/ Quarter	# of Test Calls that meet Standards	% of Test Calls that meet Standards this Quarter
Languages Tested: Spanish	**B**	3	2	66%
	A	3	1	33%
Was Information given about how to access SMHS, including how to get an Ax.	**B**	4	3	75%
	A	5	2	40%
Info about how to treat a client's urgent condition	**B**	N/A	N/A	N/A
	A	N/A	N/A	N/A
Info about how to use the Problem Resolution/Fair Hearing process	**B**	2	2	100%
	A	1	0	0%
Logging Name of client, date of request, & initial disposition	**B**	6	5	83%
	A	6	1	16%

V. Service Access and Timeliness (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring

V. Access and Timeliness:

- **DM-1:** Access Calls Handled

Purpose for Monitoring:
DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #9

Name of Data Report:
CISCO-Contact Service Queue Activity Report (by CSQ)

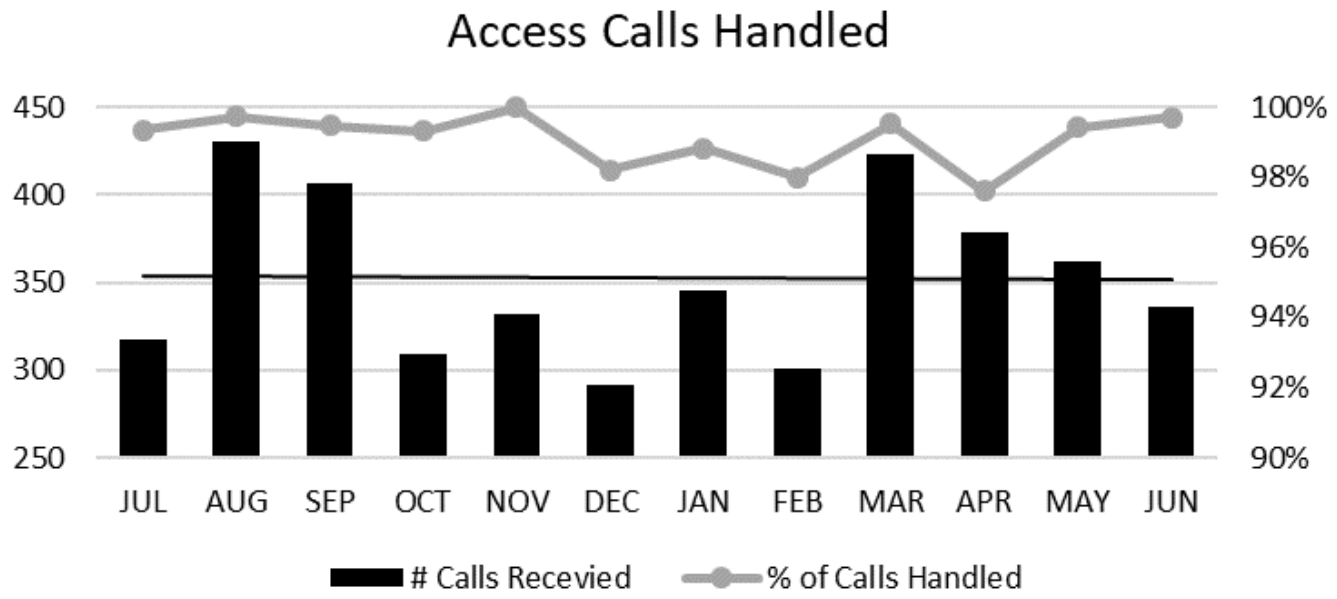
Sub-committee/Staff Responsible:
- Quality Improvement unit
- Access Supervisor

Previous FY Baseline Averages:
- Quarterly Average of % of Calls Handled "Live" during FY 16-17: **99.5%**
- Quarterly Average of % of Abandoned calls in FY 16-17: **.5%**

FY 17-18 Quarterly Averages:
- Quarterly Average of % of Calls Handled "Live" during FY 16-17: **98.6%**
  Quarterly Average of % of Abandoned calls in FY 16-17: **1.4%**

Results of Evaluation

Month/ Quarter	Calls Received	Calls Handled	% (Handled/ Received)
Jul	317	315	99.34%
Aug	430	429	99.75%
Sep	407	405	99.49%
Oct	309	303	99.32%
Nov	332	332	100%
Dec	292	275	98.21%
Jan	345	341	98.84%
Feb	301	295	98.00%
Mar	423	421	99.52%
Apr	379	370	97.62%
May	362	360	99.44%
Jun	336	335	99.70%



VI. Program Integrity (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
VI. Service Verification – • **AG-2: SV County Programs** **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Program Integrity – Section H, Item # 3a & 3b **Name of Data Report:** QI-Compliance Service Verification Spreadsheet **Sub-committee/Staff Responsible:** • Compliance Committee • Quality Improvement unit **Annual Goal Items Met:** ☒ **Met:** Item # 2 ☒ **Partially Met:** Item # 1 ☐ **Not Met:** Item # ___	**AG-1:** According to Program Integrity requirements of 42 CFR §455.1(a)(2) as set forth in the MHP Contract between the State of California and the County of Solano, there is a need to develop and implement a means to verify whether services were actually furnished to beneficiaries. **Baseline:** The MHP began implementing a service verification process during FY 2013-14. Expectation is that all programs will participate in Service Verification. **Goal:** The MHP will continue to implement a service verification model during Q1 and Q3, and endeavor to demonstrate 90-100% accountability for each service identified during the sampling period (services not verified will be repaid). • **Measurement #1:** 100% of all applicable County programs participate in the service verification process? **FY 16-17 Baseline**: 100% • **Measurement #2:** 90-100% of services will be verified during the week of Service Verification. **FY 16-17 Baseline**:	**Q1:** **Q2:** ***(Per MHP Policy, No County SV required during Q2 and Q4)*** **Q3:** **Q4:** ***(Per MHP Policy, No County SV required during Q2 and Q4)***

Q1:

County Program	Did all applicable programs participate in Service Verification?	Were 100% of services accounted for?	Were unaccounted services investigated?
FF Youth FSP	Yes	98%	Yes
FF Youth	Yes	100%	Yes
FF Adult	Yes	99%	Yes
VV Youth FSP	Yes	100%	Yes
VV Youth	Yes	100%	Yes
VV Adult	Yes	95%	Yes
VJO Youth FSP	Yes	100%	Yes
VJO Youth	Yes	100%	Yes
VJO Adult	Yes	98%	Yes
VJO Adult FSP	Yes	87%	Yes
FCTU	Yes	98%	Yes
FACT/AB 109	Yes	100%	Yes

Q3:

County Program	Did all applicable programs participate in Service Verification?	Were 100% of services accounted for?	Were unaccounted services investigated?
FF Youth FSP	Yes	89%	Yes
FF Youth	Yes	68%	Yes
FF Adult	Yes	71%	Yes
VV Youth FSP	Yes	100%	Yes
VV Youth	Yes	100%	Yes
VV Adult	Yes	100%	Yes
VJO Youth FSP	Yes	100%	Yes
VJO Youth	Yes	100%	Yes
VJO Adult	Yes	97%	Yes
VJO Adult FSP	Yes	88%	Yes
FCTU	Yes	100%	Yes
FACT/AB 109	Yes	100%	Yes

<table>
<tr><th>Quality Improvement Goal and Means to Accomplish it</th><th>Objectives (Include standards, baselines, annual goal, etc.)</th><th>Results of Evaluation</th></tr>
<tr>
<td>VI. Service Verification –

• AG-2: SV Contract Programs

Authority:
DHCS Annual Review Protocols, FY 17-18, Program Integrity – Section H, Item # 3a & 3b

Name of Data Report:
QI-Compliance Service Verification Spreadsheet

Sub-committee/Staff Responsible:
• Compliance Committee
• Quality Improvement unit

Annual Goal Items Met:
☒ Met: Item # 2
☒ Partially Met: Item # 1
☐ Not Met: Item # ___</td>
<td>AG-2: According to Program Integrity requirements of 42 CFR §455.1(a)(2) as set forth in the MHP Contract between the State of California and the County of Solano, there is a need to develop and implement a means to verify whether services were actually furnished to beneficiaries.
Baseline: The MHP began implementing a service verification process during FY 2013-14. Expectation is that all programs will participate in Service Verification.
Goal: The MHP will continue to implement a service verification model during Q2 and Q4, and endeavor to demonstrate 90-100% accountability for each service identified during the sampling period (services not verified will be repaid).

• Measurement #1: 100% of all applicable Contract Agency programs participate in the service verification process?
FY 16-17 Baseline:
• Measurement #2: 90-100% of services will be verified during the week of Service Verification.
FY 16-17 Baseline:</td>
<td>Q1: (Per MHP Policy, No Contract Agency SV required during Q1 and Q3)

Q2:
<table>
<tr><th>Contract Program</th><th>Did all applicable programs participate in Service Verification?</th><th>Were 100% of services accounted for?</th><th>Were unaccounted services investigated?</th></tr>
<tr><td>A Better Way</td><td>Yes</td><td>79%</td><td>Yes</td></tr>
<tr><td>Aldea</td><td>Yes</td><td>89%</td><td>Yes</td></tr>
<tr><td>Caminar</td><td>Yes</td><td>78%</td><td>Yes</td></tr>
<tr><td>Child Haven</td><td>Yes</td><td>100%</td><td>Yes</td></tr>
<tr><td>Psynergy</td><td>Yes</td><td>100%</td><td>Yes</td></tr>
<tr><td>Rio Vista CARE</td><td>Yes</td><td>75%</td><td>Yes</td></tr>
<tr><td>Seneca*</td><td>Yes</td><td>34%</td><td>Yes</td></tr>
<tr><td>Sierra School</td><td>Yes</td><td>100%</td><td>Yes</td></tr>
<tr><td>Uplift Family Services</td><td>Yes</td><td>68%</td><td>Yes</td></tr>
</table>
Q3: (Per MHP Policy, No Contract Agency SV required during Q1 and Q3)

Q4:
<table>
<tr><th>Contract Program</th><th>Did all applicable programs participate in Service Verification?</th><th>Were 100% of services accounted for?</th><th>Were unaccounted services investigated?</th></tr>
<tr><td>A Better Way</td><td>Yes</td><td>88%</td><td>Yes</td></tr>
<tr><td>Aldea</td><td>Yes</td><td></td><td>Yes</td></tr>
<tr><td>Caminar</td><td></td><td></td><td></td></tr>
<tr><td>Child Haven</td><td>Yes</td><td></td><td>Yes</td></tr>
<tr><td>Psynergy</td><td></td><td></td><td></td></tr>
<tr><td>Rio Vista CARE</td><td>Yes</td><td></td><td></td></tr>
<tr><td>Seneca*</td><td></td><td></td><td></td></tr>
<tr><td>Sierra School</td><td></td><td></td><td></td></tr>
<tr><td>Uplift Family Services</td><td>Yes</td><td>80%</td><td>Yes</td></tr>
</table>
*Seneca completed Service Verification during the following quarter due to agency error.
**Some data still pending</td>
</tr>
</table>

VI. Program Integrity (Data Monitoring - DM)

<table>
<tr><th>Quality Improvement Area of Data Monitoring</th><th>Results of Evaluation</th></tr>
<tr><td>VI. Program Integrity

• DM-1: Compliance Committee

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 17-18, Program Integrity – Section H, Item # 2c

Name of Data Report:
Compliance Meeting Minutes

Sub-committee/Staff Responsible:
Compliance Committee</td><td>Q1:
<table>
<tr><th>Month</th><th>Compliance Meeting Held?</th><th>Date of Mtg(s) and General Issues Addressed</th></tr>
<tr><td>N/A</td><td>No</td><td>N/A – Meeting postponed to October</td></tr>
</table>
Q2:
<table>
<tr><th>Month</th><th>Compliance Meeting Held?</th><th>Date of Mtg(s) and General Issues Addressed</th></tr>
<tr><td>Oct.</td><td>Yes</td><td>10/25/18 – Transportation, Texting, ROI’s, Background Checks</td></tr>
</table>
Q3:
<table>
<tr><th>Month</th><th>Compliance Meeting Held?</th><th>Date of Mtg(s) and General Issues Addressed</th></tr>
<tr><td>Jan.</td><td>Yes</td><td>1/24/18 – Transportation, Texting, ROI’s, Background Checks</td></tr>
</table>
Q4:
<table>
<tr><th>Month</th><th>Compliance Meeting Held?</th><th>Date of Mtg(s) and General Issues Addressed</th></tr>
<tr><td>May</td><td>Yes</td><td>5/24/18 – Transportation, Texting, ROI’s, Background Checks</td></tr>
</table></td></tr>
</table>

Quality Improvement Area of Data Monitoring	Results of Evaluation
VI. Program Integrity – • **DM-2: Compliance Training and Communication to the MHP** **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Program Integrity – Section H, Item # 2e, 2f & 2g **Name of Data Report:** TBD **Sub-committee/Staff Responsible:** Compliance Committee meeting minutes/ spreadsheet	

Month	Did Dept. Offer Compliance Training this month?	How many Behavioral Health staff completed the training?	Did Compliance Officer send out communication of compliance issues?	# of Communications Sent to System
Oct	Yes	2	Yes	1
Nov	Yes	3	Yes	1
Dec	Yes	0	Yes	2
Oct	No	-	No	-
Nov	No	-	No	-
Dec	No	-	No	-
Jan	yes	1	yes	1
Feb	yes	1	yes	2
Mar	yes	4	yes	1
Apr	yes	1	yes	1
Mar	yes	2	yes	1
Jun	yes	2	yes	2

VII. Quality Improvement (Active Goals - AG)

<table>
<tr><th>Quality Improvement Goal and Means to Accomplish it</th><th>Objectives (Include standards, baselines, annual goal, etc.)</th><th>Results of Evaluation</th></tr>
<tr>
<td>
VII. Quality Improvement:

• AG-1: Annual Utilization Review Audits - Timeliness and Appropriate Resolution of Annual Utilization Review Audit Findings

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 17-18, Provider Relations – Section G, Item # 1

Name of Data Report:
UR Audit Tracking Log (to be created)

Sub-committee/Staff Responsible:
QI Audit Supervisor and team

Annual Goal Items Met:
☐ Met: Item # ___
☒ Partially Met: Item # ___
☐ Not Met: Item # ___
</td>
<td>
AG-1: Solano County MHP Quality Improvement (QI) unit conducts Annual Utilization Review Audits of all County and Contracted Organizational Providers who bill Medi-Cal services, to ensure all such providers utilized by Solano MHP are in compliance with the documentation standards requirements, per CCR Title 9.
Baseline: Quality Improvement engaged in annual UR Audits during FY 2015-16. This is a new area of tracking and monitoring.
Goal: The following processes are in place for FY 2017-18 to monitor Provider compliance with CCR Title 9 documentation standards requirements:

• Measurement #1: At least 90% of UR Audit Reports will be submitted within 60 days after the review.
• Measurement #2: At least 90% of reviewed programs requiring a CAP will submit one that meets QI standards, within prescribed timelines.
</td>
<td>
Q1:
<table>
<tr><th>Q #</th><th># Programs Audited this Quarter</th><th>What % of all County/Contract programs reviewed this Quarter received a UR Audit Report within 60 days after the review?</th><th>What % of all County/Contract programs audited exceeded the 10% fiscal disallowance rate, triggering a Plan of Correction?</th><th>What % of all County/Contract programs reviewed this Quarter submitted a Corrective Action Plan (CAP) that adequately addressed areas of documentation noncompliance?</th></tr>
<tr><td>Q1</td><td>2</td><td>0%</td><td>100%</td><td>50%</td></tr>
<tr><td>Q2</td><td>9</td><td>0%</td><td>100%</td><td>Pending</td></tr>
<tr><td>Q3</td><td>7</td><td>0%</td><td>100%</td><td>Pending</td></tr>
<tr><td>Q4</td><td>16</td><td>NA (Technical)</td><td>NA (Technical)</td><td>NA (Technical)</td></tr>
</table>
</td>
</tr>
</table>

<table>
<tr><th>Quality Improvement Goal and Means to Accomplish it</th><th>Objectives (Include standards, baselines, annual goal, etc.)</th><th>Results of Evaluation</th></tr>
<tr>
<td>VII. Quality Improvement:

• AG-2: Annual Utilization Review Audits - QI Inter-rater Reliability for Concurrent Review and Annual Utilization Review Audits

Authority:
DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item #6d

Name of Data Report:
Concurrent Review Database and UR Audit Tracking Log (to be created)

Sub-committee/Staff Responsible:
QI Audit Supervisor and team

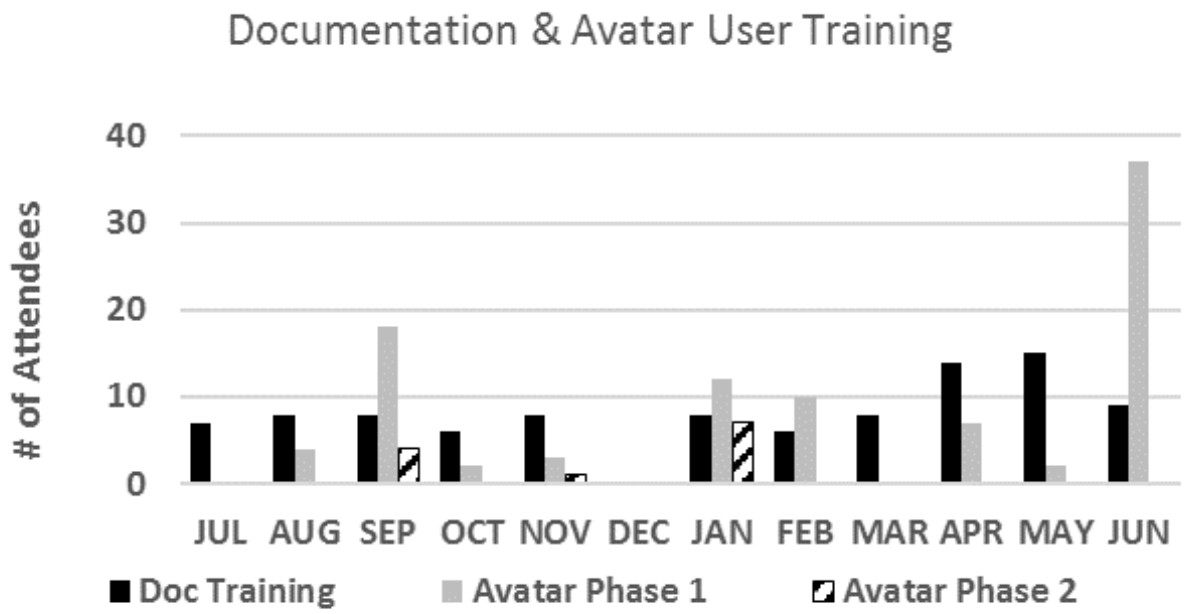
Annual Goal Items Met:
☐ Met: Item # ___
☐ Partially Met: Item # ___
☐ Not Met: Item # ___</td>
<td>AG-2: Solano County MHP Quality Improvement (QI) unit conducts ongoing Concurrent Review of assessments and treatment plans for all County and Contracted Organizational Providers as well as Annual Utilization Review Audits of all providers who bill Medi-Cal services. Solano MHP is committed to having an ongoing monitoring process that is in compliance with the documentation standards requirements, per CCR Title 9.
Baseline: Quality Improvement engaged in annual UR Audits during FY 2016-17. This is a new area of tracking and monitoring.
Goal: The following processes are in place for FY 2017-18 to monitor Provider compliance with CCR Title 9 documentation standards requirements:

• Measurement #1: Is the percentage of returned Concurrent Review cases within one standard deviation amongst the QI Clinical reviewers?
• Measurement #2: Did the results of each UR Audit Warm-Up Review yield less than 5% variation in responses among the reviewers present?
• Measurement #3: 90% of Service Authorization requests reviewed by QI Liaisons will be responded to within 10 business days?</td>
<td>Q1:
<table>
<tr><th>Month</th><th>Is the % of returned Concurrent Review cases within 1 std/dev amongst the QI reviewers?</th><th>Did the UR Audit Warm-Up Review yield <5% response variation amongst participating reviewers?</th><th>Are 90% of Service Authorization requests reviewed by QI Liaisons responded to within 10 business days?</th></tr>
<tr><td>Jul</td><td>Exercise Not Completed</td><td>---</td><td>---</td></tr>
<tr><td>Aug</td><td>Exercise Not Completed</td><td>---</td><td>---</td></tr>
<tr><td>Sep</td><td>100%</td><td>Not Yet Implemented</td><td>No</td></tr>
<tr><td>Oct</td><td>---</td><td>---</td><td>---</td></tr>
<tr><td>Nov</td><td>---</td><td>---</td><td>---</td></tr>
<tr><td>Dec</td><td>---</td><td>---</td><td>---</td></tr>
<tr><td>Jan</td><td>---</td><td>---</td><td>---</td></tr>
<tr><td>Feb</td><td>---</td><td>---</td><td>---</td></tr>
<tr><td>Mar</td><td>---</td><td>---</td><td>---</td></tr>
<tr><td>Apr</td><td>---</td><td>---</td><td>---</td></tr>
<tr><td>May</td><td>---</td><td>---</td><td>---</td></tr>
<tr><td>Jun</td><td>---</td><td>---</td><td>---</td></tr>
</table>
*Some data still pending</td>
</tr>
</table>

VII. Quality Improvement (Data Monitoring - DM)

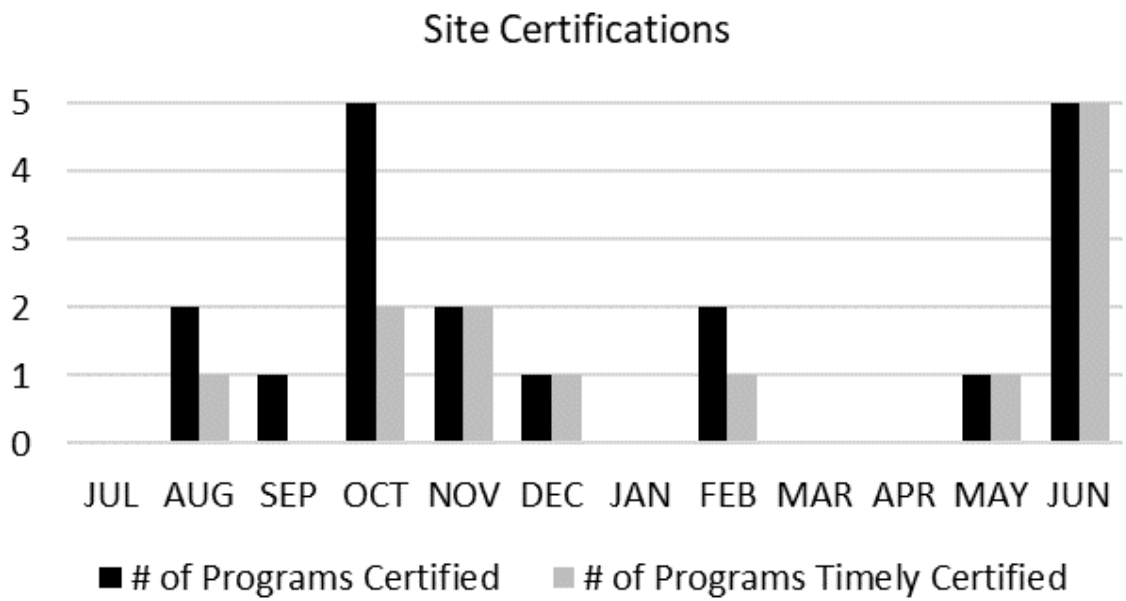
Quality Improvement Area of Data Monitoring	Results of Evaluation
VII. Quality Improvement: • **DM-1:** Documentation Training and Avatar User Training **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Section G, Item #1 **Name of Data Report:** TBD **Sub-committee/Staff Responsible:** QI Training Lead and team	**Q1:**

Month	Documentation Training Attendance	Avatar Phase I Attendance	Avatar Phase II Attendance
Jul	7	0	0
Aug	8	4	0
Sep	8	18	4
Oct	6	2	0
Nov	8	3	1
Dec	0	0	0
Jan	8	12	7
Feb	6	10	0
Mar	8	0	0
Apr	14	7	0
May	15	2	0
Jun	9	37	0



Quality Improvement Area of Data Monitoring	Results of Evaluation
VII. Quality Improvement: • **DM-2:** Site Certifications **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Provider Relations – Section G, Item # 3a **Name of Data Report:** Monthly Site Certification Tracking Report **Sub-committee/Staff Responsible:** QI Site Certification Lead and team	**Q1:**

Month	# of Programs Certified	# of Programs Certified in a Timely Manner
Jul	0	0
Aug	2	1
Sep	1	0
Oct	5	2
Nov	2	2
Dec	1	1
Jan	0	0
Feb	2	1
Mar	0	0
Apr	0	0
May	1	1
Jun	5	5



Quality Improvement Area of Data Monitoring	Results of Evaluation
VII. Quality Improvement: • **DM-3:** Medi-Cal Provider Eligibility and Verification **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Program Integrity – Section H, Item # 5 **Name of Data Report:** Provider Eligibility and Verification Tracking Report **Sub-committee/Staff Responsible:** QI Provider Eligibility Verification Lead	**Q1:** **Month** / **% of Providers Verified** **Jul** 100% **Aug** 100% **Sep** 0 **Oct** 100% **Nov** 100% **Dec** 0 **Jan** 100% **Feb** 100% **Mar** 100% **Apr** 100% **May** 100% **Jun** 100%

VIII. Network Adequacy (Data Monitoring - DM)

VIII. Network Adequacy:

- **DM-1**: Pathways to Well-Being (Katie A. Subclass)

Authority:
DHCS Annual Review Protocols, FY 17-18, Section A Item #5a-d

Frequency of Evaluation:
Quarterly

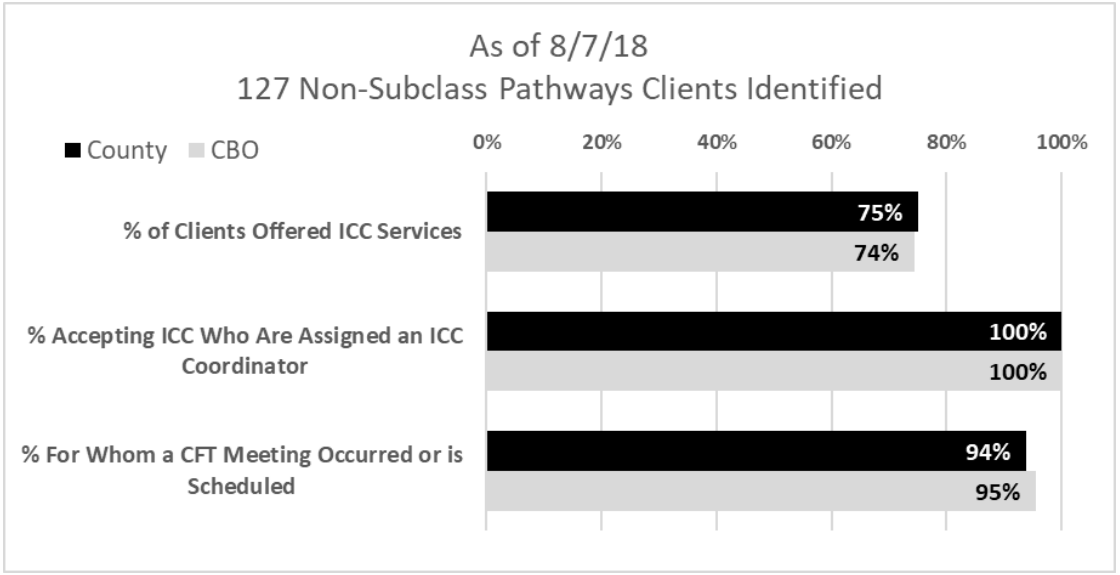
Name of Data Report:
Katie A. Database maintained by Foster Children's Treatment Unit; Foster Care Tx Unit Referral Log:

Sub-committee/Staff Responsible:
- Katie A. Implementation Team

# Refer'd to MHP	# Assessed & Refer'd for Services		# ID'd as Katie A. Subclass		Received CFT Mtg	Declined Services	AWOL	Awaiting Response
	MHP	MCP						
			In County	94	86	6	0	2
			Out of County	7	7	0	0	0

Program Name	ICC Clients	IHBS Clients
Seneca	35	
FCTU	31	
SC Children's FSP	10	

*Some data still pending.

Quality Improvement Area of Data Monitoring	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
VIII: Network Adequacy: • **DM-2**: Pathways to Well-Being (non-Subclass) **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Section A Item #5a-5d **Name of Data Report:** Pathways Database maintained by CCR Team **Sub-committee/Staff Responsible:** • CCR Coordinator	Services that were previously available only to children/youth who met Katie A. Subclass eligibility, including ICC and IHBS, are now available to any child/youth who meets medical necessity criteria for these services (Pathways). This includes children/youth who have more intensive MH needs or who are in or at risk of placement in residential or hospital settings, but could be effectively served in the home or community. **Baseline:** SCMH began identifying non-Subclass Pathways-eligible children/youth in June 2017. **Goal:** For FY 2017-18, monitor the identification of Pathways children/youth & the provision of services. **Measure 1: For Internal SCMH clients:** A. 100% of Pathways clients will be offered ICC services B. 100% of Pathways clients will be assigned an ICC Coordinator, excluding youth who are AWOL or decline ICC services. C. A CFT meeting will be held or scheduled for 100% of Pathways clients who accept ICC services **Measure 2: For Contract Agency Clients:** A. Pathways clients will be offered ICC services (25% by Quarter 3; 50% by Quarter 4) B. Pathways clients will be assigned an ICC Coordinator, excluding youth who are AWOL or decline ICC services (25% by Quarter 3; 50% by Quarter 4) C. A CFT meeting will be held or scheduled for Pathways clients who accept ICC services (25% by Quarter 3; 50% by Quarter 4)	

Goal Purpose and Monitoring	Results of Evaluation
VIII: Network Adequacy: • **DM-3**: Provider Network Data **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 16-17, Network Adequacy and Array of Services – Section A, Item #3a-3e **Name of Data Report:** Solano County Mental Health (MH) Managed Care Tracking; CALWIN Medi-Cal Eligible crystal report **Sub-committee/Staff Responsible:** Managed Care/Provider Relations