Solano County
Health and Social Services Department
Behavioral Health Division
Solano Mental Health Plan
FY 2018 - 2019

Quality Assessment and Performance Improvement Plan

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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 12.25 FTE	.25 Mental Health Administrator 1.0 Mental Health Program Senior Manager 1.0 Mental Health Clinical Supervisor 6.0 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 2018-2019:

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 CFR 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 within expected parameters.

Quality Improvement team staffing was relatively stable during FY 2018-2019. 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 monthly basis, and progress and data are reported back to the Quality Improvement Committee once per quarter to inform committee membership and to 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**: System wide Cultural Competence Training **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 18-19, Access – Section D, VII. - Item E **Name of Data Report:** • Network Adequacy Certification Tool • Quality Improvement Training Tracking Sheets **Sub-committee/Staff Responsible:** • Quality Improvement **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 within the Solano Cultural Competency Plan. The CCC works with MHP Director/MH Administration and Quality Improvement to develop CC training opportunities for employees of both County and Contracted organizations. **FY 17-18 Baseline:** - 153 staff members trained **Goal:** Monitor Annual training and work toward 100% annual training compliance for: • Provider will include all direct service providers (including medical staff & peer support specialists that can bill for services) • Non-providers will include all staff that do not provide direct services (including management, clerical/support staff, board members, peer support specialists/volunteers that do not bill, etc.)	**Q1:** No Data Provided **Q2:** **Staff Category** / **Total Staff** / **% in Compliance** **County Provider** / **196** / **92%** **County Non-provider** / **60** / **94%** **Contracted Provider** / **Pending** / **Pending** **Contracted Non-provider** / **Pending** / **Pending** **Q3:** **Staff Category** / **Total Staff** / **% in Compliance** **County Provider** / **134** / **88%** **County Non-provider** / **41** / **91%** **Contracted Provider** / **Pending** / **Pending** **Contracted Non-provider** / **Pending** / **Pending** **Q4:** **Staff Category** / **Total Staff** / **% in Compliance** **County Provider** / **223** / **94%** **County Non-provider** / **82** / **96%** **Contracted Provider** / **Pending** / **Pending** **Contracted Non-provider** / **Pending** / **Pending**

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 18-19, Access – Section D, VII. - Items A-E **Name of Data Report:** • None **Sub-committee/Staff Responsible:** • Cultural Competence Committee **Previous FY Baseline Averages:** **FY 17-18 Quarterly Averages:** • CCC meetings per Quarter: 1 • CC Subcommittee meetings per Quarter: 2	

Quarter	Date of CCC Meeting	Date of report to QIC	Date CC Plan Updated	Date of Annual Report
1	9/11/2018	11/16/2018	9/11/2018	Pending approval by committee
2	12/7/2018	2/14/2019		
3	3/13/2019	5/9/2019		
4	6/13/2019	8/8/2019		

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: **Purpose for Monitoring:** **Name of Data Report:** • None **Sub-committee/Staff Responsible:** **Previous FY Baseline Averages:**	***Placeholder for CLAS QI Plans***

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 18-19, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3. **Name of Data Report:** Report 333 **Sub-committee/Staff Responsible:** Cultural Competence Coordinator **Previous FY Baseline Averages:** • Outreach Initiatives per Quarter: • HOLA calls per quarter: **FY 18-19 Quarterly Averages:** • Outreach Initiatives per Quarter: 6.5 • HOLA calls per quarter: 2	**Q1:**

Region	Community Agencies willing to Partner with HOLA	# of HOLA Calls received	#of HOLA referrals offered a SMHA assessment	# of HOLA Referrals who rec'd SMHS Assessment	# of HOLA referrals who rec'd a SMHS Tx Service
JUL	8	2	---	---	---
AUG	6	1	---	---	---
SEP	2	1	---	---	---

Q2:

OCT	1	7	---	---	---
NOV	0	7	---	---	---
DEC	0	2	---	---	---

Q3:

JAN	0	0	---	---	---
FEB	11	1	---	---	---
MAR	50	3	---	---	---

Q4:

APR	0	0	---	---	---
MAY	0	0	---	---	---
JUN	0	0	---	---	---

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 18-19, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3. **Name of Data Report:** Report 333 **Sub-committee/Staff Responsible:** Cultural Competence Coordinator **Previous FY Baseline Averages:** • Outreach Initiatives per Quarter: • Kaagapay calls per quarter: **FY 18-19 Quarterly Averages:** • Outreach Initiatives per Quarter: 7.3 • Kaagapay calls per quarter: 1.6	**Q1:** **Q2:** **Q3:** **Q4:**

Region	Community Agencies willing to Partner with Kaagapay	# of Kaagapay Calls received	#of Kaagapay referrals offered SMHA assessment	# of Kaagapay Referrals who rec'd a SMHA Assessment	# of Kaagapay referrals who rec'd a Tx Service
JUL	0	0	---	---	---
AUG	0	0	---	---	---
SEP	0	0	---	---	---
OCT	0	0	---	---	---
NOV	2	4	---	---	---
DEC	3	2	---	---	---
JAN	4	4	---	---	---
FEB	3	3	---	---	---
MAR	5	4	---	---	---
APR	33	1	---	---	---
MAY	36	0	---	---	---
JUN	2	1	---	---	---

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 Adult and Family community members to better support their understanding of their or their loved one's BH challenges and learn effective ways to cope and seek support. **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 18-19, Quality Improvement – Section C, I. – Items C & E **Name of Data Report:** Adult and Family Support Group sign-in sheets and Post Group Survey on quarterly basis (point in time data) **Sub-committee/Staff Responsible:** Wellness Recovery Unit/ Adult Peer (Consumer Affairs Liaison) and Family Liaison **Annual Goal Met:** ☐ **Met:** Item # ___ ☒ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-1:** Provide Adult and Family Support Groups facilitated by Peer Support Specialists or Family Liaison. **Baseline:** There were no FY 17-18 averages, b/c this is a new goal • **FY start capturing data Q3, FY 18-19**: Start administering the Quality of Life (QOL) survey at a point in time (second month) during each quarter to capture data. **Goal:** Increase the % of unduplicated participants in WR Peer Support Groups who respond positively to quarterly "Quality of Life Outcome Tool" survey items	

Quarter	# of total unique group members who participated	% of participants who "have learned tools/ways to support their or their loved one's behaviors/symptoms"	% of participants who feel supported by the group	% of participants who would return to the group
Q1	Data not collected			
Q2	Data not collected			
Q3 Starting data collection/ reporting:	Adult Group- 14 Family Group- 11	Adult Group- 85.7% Family Group- 82%	Adult Group- 85.7% Family Group- 82%	Adult Group- 100% Family Group- 91%
Q4	Adult Group- 23 Family Group- 36	Adult Group- 80% Family Group- 80%	Adult Group- 99% Family Group- 100%	Adult Group- 99% Family Group- 100%

II. Wellness and Recovery (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation

II. Wellness and Recovery:

- **DM-1:** Increase integration, collaboration and participation of youth, adults and family members with lived experience, including Peer Support Specialists, in SCBH advisory committees, workgroups, activities, and events to increase awareness and portray hope in our system of care.

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 18-19, Quality Improvement – Section C, III. – Items B &D

Name of Data Report: Sign-in Sheets, & Meeting Minutes. MHSA Sign in sheet edited to include collection of this data.

Sub-committee/Staff Responsible:
Wellness Recovery Unit, MHSA, and other workgroup leads

Previous FY Baseline Averages:
- Average # of meetings/events per Quarter: Unknown
- Actual number of participants with lived experience per quarter: Unknown

FY 18-19 Quarterly Averages:
- Average # of Committees per Quarter: 2
- Total # of participants per quarter: 12

Quarter	Name of Activity	Number of persons with lived experience by demographics (youth, adult, family)	Total Peer and Family Involvement for the quarter
1	Recovery Month Event planning committee and event: 9/20/18	10	10
	Peer Specialist Team Meeting: July 16, August 17, Sept. 14	No data provided	
2	EQRO on site review: 10/23-10/24/18	4	19
	QIC Committee: 11/16/18	0	
	Peer Specialist Team Meetings October 12, November 16	15	
3	Peer Specialist Team Meeting: Jan. 11	7	7
4	Pending sign-in sheets	Pending sign-in sheets	---

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

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
III. Consumer Perception: • **AG-1:** Quarterly Service Verification Customer Service Survey **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 18-19, Quality Improvement – Section C, I. - Items E.1. and E.3. **Name of Data Report:** • Solano MHP Service Verification/Consumer Perception Surveys **Sub-committee/Staff Responsible:** Quality Improvement Survey Coordinator **Annual Goal Met:** ☒ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-1:** Solano MHP will review survey data from our semiannual Solano MHP Service Verification/Consumer survey to begin to look at survey results per program. Each program will be challenged set a program specific goal for improvement targeting baseline data from Consumer survey. Post intervention measurement will be compared with baseline data. **Baseline:** Baselines will be specific to the program's previous Service Verification/Consumer survey results. **Goal:** Solano MHP County and Contract programs will each identify an area of Consumer Satisfaction to improve, develop an intervention and goal to address the area of improvement, and demonstrate improvement from baseline to post intervention measure.	**Q1:** No Data Provided **Q2:** No Data Provided **Q3:**

Program	Identified Area of Focus	Baseline	Intervention	Post Intervention Result	Post Intervention Change
48151	Would you recommend our services to others?	83%	Reinstate the Service Verification table worked by front desk & OD staff in the lobby.	Pending	Pending
48966	Would you recommend our services to others?	72%	Check with clients monthly to assess their satisfaction w/ services to determine what needs to be done to improve satisfaction.	Pending	Pending
48961	Sexual Orientation/ Gender Identity	96%	Discuss this topic during staff meeting & provide staff w/ suggestions on ways in which to demonstrate increased sensitivity in this area.	Pending	Pending
48921	Sexual Orientation/ Gender Identity	95%	Put rainbow stickers on County cell phones & in vehicles.	Pending	Pending
48851	Sexual Orientation/ Gender Identity	88%	Discuss this topic during staff meeting & provide staff w/ suggestions on ways in which to demonstrate increased sensitivity in this area.	Pending	Pending

(See next page for Quarter 4 data)

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

Q:4

Program	Identified Area of Focus	Baseline	Intervention	Post Intervention Result	Post Intervention Change
48151	Would you recommend our services to others?	83%	Reinstate the Service Verification table worked by front desk & OD staff in the lobby.	71%	-12%
48966	Would you recommend our services to others?	72%	Check with clients monthly to assess their satisfaction w/ services to determine what needs to be done to improve satisfaction.	82%	10%
48961	Sexual Orientation/ Gender Identity	96%	Discuss this topic during staff meeting & provide staff w/ suggestions on ways in which to demonstrate increased sensitivity in this area.	98%	2%
48921	Sexual Orientation/ Gender Identity	95%	Put rainbow stickers on County cell phones & in vehicles.	95%	0%
48851	Sexual Orientation/ Gender Identity	88%	Discuss this topic during staff meeting & provide staff w/ suggestions on ways in which to demonstrate increased sensitivity in this area.	97%	9%

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

Quality Improvement Area of Data Monitoring

III. Beneficiary Protection:

- **DM-1:** Grievance, Appeal and Expedited Appeal

Purpose of Monitoring:

- DHCS Annual Review Protocols, FY 18-19, Quality Improvement - Section C, I. - Items C. & E.2., II. - Item B; Beneficiary Rights and Protections – Section F, I. - Item J.

Name of Data Report:

- ComplyTrack - Problem Resolution Log

Sub-committee/Staff Responsible:
Problem Resolution Coordinator

Previous FY Baseline Averages:

- Total # of Problem Resolution issues: 123
- # of issues requiring a system change: 1
- # Referred to Policy Committee: 1

FY 18-19 Quarterly Averages:

- Total # of Problem Resolution issues: 136
- # of issues requiring a system change: 2
- # of System Changes Initiated: 0
- # Referred to Policy Committee: 0
- # of Policies created or amended: 0

Results of Evaluation

Q1:

Month Received	Total quarterly # of Problem Resolution issues reported, primarily Grievances, Appeals, and NOABDs	# of issues Requiring a System Change	# of System Changes initiated	# Referred to Policy Committee	# of Policies created or amended b/c of identified Problem
July	10	0	0	0	0
Aug	17	0	0	0	0
Sept	7	0	0	0	0

Q2:

Oct	20	0	0	0	0
Nov	7	0	0	0	0
Dec	14	0	0	0	0

Q3:

Jan	8	0	0	0	0
Feb	13	0	0	0	0
Mar	10	0	0	0	0

Q4:

Apr	13	0	0	0	0
May	10	0	0	0	0
Jun	7	2	0	0	0

Quality Improvement Area of Data Monitoring	Results of Evaluation

III. Beneficiary Protection:

- **DM-2**: Tracking and trending of Beneficiary Grievances and Appeals to meet DHCS annual reporting standards

Purpose of Monitoring:

- DHCS Annual Review Protocols, FY 18-19, Quality Improvement - Section C, I. - Items C. & E.2., II. - Item B; Beneficiary Rights & Protections – Section F, I. - Items A,C,D, II. - Item 2.B.

Name of Data Report:

- ComplyTrack - Problem Resolution Log

Sub-committee/Staff Responsible:
Problem Resolution Coordinator

Previous FY Baseline Averages:

- Were all Problem Resolution processes logged and monitored: Yes
- Data Trends:

FY 18-19 Quarterly Averages:

- Were all Problem Resolution processes logged and monitored: Yes

Category	Process				Grievance Disposition		
	Grievance	Exempt Grievances	Appeal	Expedited Appeal	Grievances pending as of 6/30	Resolved	Referred
Appeals from NOABDs							
ACCESS	6	0			0	6	0
Quality of Care	52	0			1	49	2
Change of Provider	57	n/a			n/a	57	n/a
Confidentiality	0	n/a			n/a	0	n/a
Other	20	0			2	18	2
Total:							

Appeals Resulting from NOABD	Appeal Disposition			Expedited Appeal Disposition			NOABD/ NOA
	Appeals pending as of 6/30	Decision Upheld	Decision Over-turned	Expedited Appeals Pending as of 6/30	Decision Upheld	Decision Over- turned	Total Number of NOABD/NOAs Issued
Denial Notice (NOA-A)							64
Payment Denial Notice (NOA-C)							27
Delivery System Notice							61
Modification Notice							6
Termination Notice	0	1	0				541
Authorization Delay Notice							0
Timely Access Notice (NOA-E)							23
Financial Liability Notice							0
Grievance and Appeal Timely Resolution Notice							0
Total:	**0**	**1**	**0**				**722**

Quality Improvement Area of Data Monitoring	Results of Evaluation
III. Beneficiary Protection: • **DM-3**: Tracking the compliance of sending the beneficiary an acknowledgement and Disposition letter. **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 18-19, Quality Improvement - Section C, I. - Items C. & E.2., II. - Item B; Beneficiary Rights and Protections – Section F, I. - Item E.1-3, J., III. - Items B & C, IV. - Items A.3. & B.1. **Name of Data Report:** • ComplyTrack - Problem Resolution Log **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Previous FY Baseline Averages:** • % of Acknowledgement letters sent within timeframes: 99% • % of Disposition letters sent within timeframes: 100% **FY 18-19 Quarterly Averages:** • % of Acknowledgement letters sent within timeframes: 100% • % of Disposition letters (NGR's and NAR's) sent within timeframes: 100%	**Q1:** **Q2:** **Q3:** **Q4:**

Month Rec'd	Total # of Grievances, Appeals and Expedited Appeals Rec'd	% of Acknowledgement letters in compliance	% of Disposition letters in compliance	% of Provides notified of Disposition
July	10	100%	100%	100%
Aug	17	100%	100%	100%
Sept	7	100%	100%	100%
Oct	20	100%	100%	100%
Nov	7	100%	100%	100%
Dec	14	100%	100%	100%
Jan	8	100%	100%	100%
Feb	13	100%	100%	100%
Mar	10	100%	100%	100%
Apr	13	100%	100%	100%
May	10	100%	100%	100%
Jun	7	100%	100%	100%

Quality Improvement Area of Data Monitoring	Results of Evaluation
III. Beneficiary Protection: • **DM-4**: Tracking and trending of Internal system improvement needs **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 18-19, Quality Improvement - Section C, I. - Items C. & E.2., II. - Item B **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 Averages: See FY 17-18 for:** • Total # of Problem Resolution issues: 145 • # of issues requiring a system change: 3 • # Referred to Policy Committee: 0 • # Referred for Adverse Outcome Mtg: 9 **FY 18-19 Quarterly Averages:** • Total # of Problem Resolution issues: 177 • # of issues requiring a system change: 0 • # of System Changes Initiated: 0 • # Referred to Policy Committee: 0 • # of Policies created or amended: 0 • # Referred for Adverse Outcome Mtg: 12	**Q1:** **Q2:** **Q3:** **Q4:**

Month Received	Total quarterly # of Internally Identified System Needs, including quality of care issues	# of System Change Requests	# Referred to Policy Committee	# of Internally Identified System Needs Resulting in an Adverse Outcome Case Review
July	17	0	0	1
Aug	16	0	0	1
Sept	12	0	0	1
Oct	18	0	0	0
Nov	10	0	0	0
Dec	14	3	0	1
Jan	23	0	0	2
Feb	10	0	0	0
Mar	22	0	0	2
Apr	10	0	0	0
May	13	0	0	0
Jun	12	0	0	0

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: Expand Full Service Partnership to achieve goals per the ACT model that center on best practices around enrollment, discharge, interventions, Utilization and Outcomes

Authority:
DHCS Annual Review Protocols, FY 18-19, Quality Improvement - Section C, I. - Items C. & D.

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

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

Annual Goal Items Met:
☐ **Met:** Item # ____
☒ **Partially Met:** Item # 1 - 7
☐ **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 17-18 showed the following:

- 4.8% (38) adult FSP Programs clients (includes TAY) were hospitalized 1x and 1.8% (14) were hospitalized 2 or more times.
- 4.0% (21) Children/Youth FSP Programs clients were hospitalized 1x and 1% (3) were hospitalized 2 or more times.

Goal: Solano MHP will:

1. Decrease total FSP clients in inpatient hospitalizations by 5%
2. Decrease the percentage of t FSP clients hospitalized by 5%
3. Decrease total FSP clients incarcerated by 5%
4. Reduce # of FSP clients without stable housing.
5. Increase capacity to serve clients with co-occurring MH/SUD; track # clients with dual diagnosis
6. Establish eligibility and discharge criteria
7. Train teams in utilizing the ACT model to fidelity

Q1:

FSP Programs this Quarter	# of Clients Served	Total % of clients hosp. 1x	% of clients hosp. > 1x	Total % inc. 1x	% of clients exp. 1x inc. of homelessness	% Loss of Placement
VJO Adult FSP	46	4%	4%	0%	4%	
FACT/AB 109	60	5%	2%	8%	0%	
Caminar Adult FSP	34	0%	0%	0%	0%	
Caminar OA FSP	10	0%	0%	0%	0%	
Caminar HOME FSP	25	0%	0%	0%	8%	
Seneca Tay	32	13%	6%	3%	6%	0%
FCTU Youth FSP	63	2%	0%	2%	0%	5%
FF Youth FSP	37	5%	0%	0%	3%	0%
VV Youth FSP	10	10%	0%	0%	10%	0%
VJO Youth FSP	12	0%	0%	0%	0%	8%
Totals	329	4%	2%	2%	2%	1%

Q2:

FSP Programs this Quarter	# of Clients Served	Total % of clients hosp. 1x	% of clients hosp. > 1x	Total % inc. 1x	% of clients exp. 1x inc. of homelessness	% Loss of Placement
VJO Adult FSP	54	9%	7%	0%	13%	
FACT/AB 109	51	2%	0%	6%	0%	
Caminar Adult FSP	34	0%	0%	6%	3%	
Caminar OA FSP	9	0%	0%	0%	0%	
Caminar HOME FSP	24	4%	0%	4%	4%	
Seneca Tay	29	10%	0%	0%	7%	3%
FCTU Youth FSP	51	2%	0%	0%	0%	10%
FF Youth FSP	54	9%	7%	0%	13%	0%
VV Youth FSP	13	0%	0%	0%	0%	0%
VJO Youth FSP	12	8%	0%	0%	8%	0%
Totals	331	5%	2%	2%	6%	2%

Q3:

FSP Programs this Quarter	# of Clients Served	Total % of clients hosp. 1x	% of clients hosp. > 1x	Total % inc. 1x	% of clients exp. 1x inc. of homelessness	% Loss of Placement
VJO Adult FSP	54	9%	2%	0%	20%	
FACT/AB 109	57	5%	5%	18%	2%	
Caminar Adult FSP	47	15%	4%	2%	4%	
Caminar OA FSP	9	0%	0%	0%	0%	
Caminar HOME FSP	37	3%	0%	0%	0%	

Seneca Tay	36	3%	0%	3%	8%	0%
FCTU Youth FSP	58	0%	0%	0%	0%	9%
FF Youth FSP	56	5%	5%	0%	0%	0%
VV Youth FSP	11	9%	9%	0%	0%	0%
VJO Youth FSP	5	0%	0%	0%	0%	20%
Totals	370	6%	3%	3%	5%	2%

Q4:

FSP Programs this Quarter	# of Clients Served	Total % of clients hosp. 1x	% of clients hosp. > 1x	Total % inc. 1x	% of clients exp. 1x inc. of homelessness	% Loss of Placement
VJO Adult FSP	57	12%	4%	0%	7%	
FACT/AB 109	59	0%	3%	14%	0%	
Caminar Adult FSP	46	7%	2%	2%	7%	
Caminar HOME FSP	36	11%	6%	3%	14%	
Seneca Tay	34	3%	3%	0%	9%	0%
FCTU Youth FSP	53	0%	2%	0%	0%	19%
FF Youth FSP	70	7%	3%	0%	1%	1%
Totals	355	6%	3%	3%	5%	3%

Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
IV. Outcomes & Utilization: • **AG-2:** ADULT: CSU-Exodus, Bay Area Community Services, Hospital Liaison **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 18-19, Quality Improvement - Section C, I. - Items C. & D. **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 # 1 - 2	**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 17-18 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 FY17-18 baseline **Baseline:** Quarterly average of 159 average Adult inpatient hospitalizations in FY 17-18. • **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 11.2% readmission rate in FY17-18.	**Q1:** **Q2:** **Q3:** **Q4:**

Month	Total # of Adult Inpatient Hospitalizations	Total # of Adult Discharges	Total # of Adult Rehospitalizations within 30 days of discharge & % of total of discharges	
Jul	73	71	9	12.68%
Aug	64	64	16	25%
Sep	54	59	11	18.64%
TOTALS:	191	194	36	18.56%
Oct	77	76	10	13.16%
Nov	79	77	8	10.39%
Dec	88	78	6	11.26%
TOTALS:	244	231	7	11.26%
Jan	73	74	13	17.8%
Feb	71	65	11	15.5%
Mar	67	71	7	10.5%
TOTALS:	211	210	31	14.7%
Apr	62	73	9	12.33%
May	70	83	8	9.64%
Jun	68	76	10	13.16%
TOTALS:	200	232	27	11.64%

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 18-19, Quality Improvement - Section C, I. - Items C. & D. **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 # 1 - 2	**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 17-18 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 17-18 baseline average to under 25 Inpatient hospitalizations per quarter. **Baseline:** 26.5 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:** 16.0% average readmission rate in FY16-17	**Q1:** **Q2:** **Q3:** **Q4:**

Month	Total # of Child Inpatient Hospitalizations	Total # of Child Discharges	Total # of Child Rehospitalizations within 30 days of discharge & % of total of discharges	
Jul	8	11	3	27.3%
Aug	11	12	3	25%
Sep	10	10	2	20%
TOTALS:	29	32	8	20%
Oct	17	15	1	6.67%
Nov	21	23	3	11.04%
Dec	19	18	4	14.29%
TOTALS:	57	56	8	14.29%
Jan	16	16	0	0%
Feb	20	19	4	20%
Mar	17	17	5	29.4%
TOTALS:	53	53	9	17%
Apr	20	26	4	15.38
May	9	11	1	9.09
June	9	12	3	25
TOTALS:	38	49	8	16.33%

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. **Purpose of Monitoring** DHCS Annual Review Protocols, FY 18-19, Network Adequacy and Availability of Resources - Section A, IV. - Item C. **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:** Item # 2 ☒ **Partially Met:** Item # 1, 3 ☐ **Not Met:** Item # ___	**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 along 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:** Please see FY 17-18 Baselines **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	Total # of individuals contacted at least 1 X	Total # unduplicated individuals screened	Total # unduplicated individuals new to MHP linked to Access	Total # unduplicated individuals re-connected w/ existing Tx provider	Total # unduplicated individuals linked to Sub. Abuse	Total #unduplicated individuals linked to other basic needs (food, clothing, etc.)
Adult ARCH	28	169	100	39	24	1	162
TAY ARCH	4	6	6	3	2	0	7

Q2:

Adult ARCH	3	320	12	3	3	1	9
TAY ARCH	15	463	32	3			2

Q3:

Adult ARCH	62	15	7	3	2	0	9
TAY ARCH	418	16	17	5	3	0	4

Q4:

Adult ARCH	4	21	14	4	3	0	16
TAY ARCH	15	15	15	1	3	0	0

Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
IV. Outcomes & Utilization: • **AG-5**: Expand the use of Evidence-Based practices throughout the system of care **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 18-19, Quality Improvement - Section C, I. - Item G; VI. - Item A. **Name of Data Report:** No current report **Sub-committee/Staff Responsible:** • Quality Improvement • MHSA, Adult/Children's Bureau **Annual Goal Met:** ☒ **Met:** Item # 1, 3 ☒ **Partially Met:** Item # 2 ☐ **Not Met:** Item # ___	**AG-5:** Evidence based practices are shown to lead to improved outcomes and cost-effectiveness for the intended populations. Solano County has historically offered EBP trainings as needed however there has not been a mechanism to sustain and support teams/staff in coaching & cross-training; systematically tracking outcomes to show system improvements; or making policy and documentation changes to collect data. **Baseline:** During FY 17-18 • TF-CBT EBP was put on hold after Q1 of FY 17-18 **Goal: EBP goals include:** 1. **Increase baseline # of Clients treated with an EBP** 2. **80% of trained staff will attend trainings/coaching sessions** 3. **Develop mechanisms to track outcome data by EBP and program**	**Q1:** **Q2:** **Q3:** No Data Provided **Q4:**

Q1:

Program	# trainings/coaching sessions	# staff attended	# clients supported with this EBP
FACT Team: ACT model	**2**	**Session 1: 8/10= (80%) Session 2: 7/8 (88%)**	**43 (current caseload)**
TF-CBT	-	-	-
EMDR			
Peer Employment Training- Recovery Innovations	**80 hours- 10 day training**	**14**	**Used in WRU support groups currently**

Q2:

Program	# trainings/coaching sessions	# staff attended	# clients supported with this EBP
ACT model Training: 1/29-1/30/19	**2-days**	**All FSP staff (#)**	**FSP FACT Caminar**
EMDR			
Peer to Peer Support- March 2019			

Q4:

Program	# trainings/coaching sessions	# staff attended	# clients supported with this EBP
ACT	**3**	**50**	**142**
TF-CBT	**0**	**---**	**---**
EMDR	**2**	**16**	**23**
Peer Support	**0**	**22**	**27**
IPS Supported Employment	**1**	**---**	**---**

<table>
<tr><th>Goal Purpose and Monitoring</th><th>Goal/Objectives (Include standards, baselines, annual goal, etc.)</th><th>Results of Evaluation</th></tr>
<tr>
<td>
IV. Outcomes & Utilization:

• AG-6: Expand our system of care to become Co-Occurring Capable to serve and improve outcomes for individuals with multiple complex conditions such as serious Mental illness and substance use disorders.

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 18-19, Quality Improvement – Section C, I. – Item G, II. – Items C & D, VI. – Item A

Name of Data Report:
No current report

Sub-committee/Staff Responsible:
• Quality Improvement

Annual Goal Met:
☒ Met: Item # ___
☐ Partially Met: Item # ___
☐ Not Met: Item # ___
</td>
<td>
AG-6: Persons with co-occurring mental health and co-occurring substance use challenges need cross-trained staff to support their recovery, as well as systems and policies that support integrated services, billing and documentation.

Baseline: FY 17-18

• New Goal: No data was collected on number of clients with co-occurring needs per team and where services are provided

Goal: Co-Occurring System goals include:

1. Track the # of clients with co-occurring engaged in and receiving treatment
2. Increase # of staff cross-trained within the mental health and substance use teams
3. Develop mechanisms to support integrated documentation of treatment, billing, ROIs, engagement through access, and follow through with outpatient providers as needed.
</td>
<td>
Q1: No Data Collected
Q2: No Data Collected
Q3: No Data Collected
Q4:
<table>
<tr><th>Total # Clients experiencing co-occurring challenges</th><th>Total # of Clients with integrated treatment plans</th><th>Total # who showed Clinical Improvement through stage of change (this would be included in tx plan updates)</th></tr>
<tr><td>2474</td><td>Pending</td><td>Pending</td></tr>
</table>
<table>
<tr><th>Activity</th><th># staff received training</th><th># of workgroup planning/meeting</th></tr>
<tr><td>Recovery Month Event</td><td>80</td><td>---</td></tr>
<tr><td>MH/SUD Integration</td><td>56</td><td>9</td></tr>
<tr><td>Inservice Trainings</td><td>51</td><td>8</td></tr>
<tr><td>Access/BHAT Integration</td><td>12</td><td>11</td></tr>
</table>
</td>
</tr>
</table>

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 18-19, Quality Improvement – Section C, I. - Item F **Name of Data Report:** Avatar Report # 339 **Sub-committee/Staff Responsible:** Clinical Quality Review Committee **Previous FY Baseline Averages:** • **FY 17-18 # of Youth on Psychotropic Medication:** • **FY 17-18 # of Youth on 4 or more Psychotropic Medications:** • **FY 17-18 # of Youth on Antipsychotic Medication:** • **FY 17-18 # of Youth on 2 or more Antipsychotic Medications:** **FY 18-19 Quarterly Averages:**	**Q1: No data collected**

	# of Youth on 1 or more Psychotropic Medication:	# of Youth on 4 or more Psychotropic Medications:	# of Youth on 1 or more Antipsychotic Medication:	# of Youth on 2 or more Antipsychotic Medications:
Foster Youth				
Non-Foster Youth				
Total				

Q2: No data collected

Q3: No data collected

Q4: No data collected

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 18-19, Network Adequacy and availability of Services – Section A, I. – Item D, V. - Item A2 **Name of Data Report:** • Avatar Report # 347 **Sub-committee/Staff Responsible:** • Utilization Management Committee membership • Cultural Competence Committee **Previous FY Baseline Averages:** • FY 17-18 African American Quarterly Average Served: 1613 • FY 17-18 Hispanic/Latino Quarterly Average Served: 1071 • FY 17-18 Filipino Quarterly Average Served: 216 • FY 17-18 LGBT Quarterly Average Served: 282 **FY 18-19 Quarterly Averages:**	**Q1:** No Data Collected

Date Range	Black/AA Clients	Black/AA Providers	Hispanic/ Latino Clients	Hispanic/ Latino Providers	Filipino Clients	Filipino Providers	LGBTQ Clients	LGBTQ Providers
North County Region								
Central County Region								
South County Region								
Out of County								
Unknown								
Quarter Total:								
Previous Quarter:								
FY 17-18 Q Ave (Baseline)	**1,613**	**N/A**	**1,071**	**N/A**	**216**	**N/A**	**282**	**N/A**

Q2: No Data Collected

Q3: No Data Collected

Q4: No Data Collected

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 18-19, Network Adequacy and Availability of Services – Section A, I. - Item F & H. **Name of Data Report:** Avatar Timeliness Report #333 **Sub-committee/Staff Responsible:** Access Supervisor **Annual Goal Items Met:** ☒ **Met:** Item # 1a, 1c, 2a-c ☐ **Partially Met:** Item # ___ ☒ **Not Met:** Item # 1b	**AG-1:** Solano MHP has made significant progress since FY 2015-16 to improve timeliness from point of access to the date of first-offered assessment appointment. **Baseline:** See FY 2017-18 average timeliness for Children's services **Goal:** 1. For Routine requests for service, County Children's programs will: a. Maintain goal of 80% resulting in an offered assessment within 10 business days (FY17-18 baseline: 74%) b. Maintain goal of an average of 10 business days or less from service request to actual assessment (FY17-18 baseline: 10.8) c. Achieve goal of an average of 25 business days or less from service request to tx service initiation (FY17-18 baseline: 23.57 days) 2. For Urgent requests for service, County Children's programs will: a. Achieve goal of 80% resulting in an offered assessment within 3 business days (FY17-18 baseline: 71%) b. Achieve goal of an average of 3 business days or less from service request to actual assessment (FY17-18 baseline: 4.12 days)	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

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	80%	10.44	25.25
Urgent	78%	2.8	13.60
Total:	78%	10.18	24.53

Q2:

Routine	73%	12.16	28.06
Urgent	100%	0.00	16.00
Total:	73%	12.08	27.89

Q3:

Routine	82%	11.58	29.03
Urgent	100%	4	13.75
Total:	83%	11.32	28.3

Q4:

Routine	76%	11.75	30.8
Urgent	100%	3	---
Total:	83%	11.7	30.8

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 18-19, Network Adequacy and Availability of Services – Section A, I. - Item F & H. **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 # 1a-c, 2a, 2c ☐ **Partially Met:** Item # ___ ☒ **Not Met:** Item # 2b	**AG-2:** Solano MHP made significant progress over the past few years to improve timeliness from point of access to the date of first-offered assessment appointment. **Baseline:** See FY 2017-18 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 (FY17-18 baseline for all Adults: 75%) b. Achieve goal of an average of 10 business days or less from service request to actual assessment (FY17-18 baseline for all adults:8.02 days) c. Achieve goal of an average of 20 business days or less from service request to tx service initiation (FY17-18 baseline for all adults: 18.35 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 (FY17-18 baseline for all adults: 78%) b. Achieve goal of an average of 3 business days or less from service request to actual assessment (FY17-18 baseline for all adults: 6.13 days) c. Achieve goal of an average of 15 business days or less from service request to service initiation (FY17-18 baseline for adults: 18.58 days)	**Q1:** **Q2:** **Q3:** **Q4:**

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	99%	7.18	14.68
Urgent	100%	9.17	17.25
Total:	99%	7.23	14.73

Q2:

Routine	96%	7.25	15.54
Urgent	100%	6.00	11.60
Total:	96%	7.21	15.45

Q3:

Routine	91%	7.57	16.4
Urgent	100%	3.3	10
Total:	92%	7.5	16.39

Q4:

Routine	99%	9.27	16.4
Urgent	100%	4.8	13
Total:	92%	9.16	16.3

<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-3: Retention: Service Request to First Offered Assessment Appointment

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 17-18, Access – Section C, I. - Item C, IV. – Item A

Name of Data Report:
Avatar Timeliness Report #333; MHP Access Referral form (under construction)

Sub-committee/Staff Responsible:
Access Supervisor

Annual Goal Items Met:
☐ Met: Item # ___
☐ Partially Met: Item # ___
☒ Not Met: Item # 1a-b, 2a-b</td>
<td>AG-3: Maintain or improve the following engagement & attrition measures for Children:
Baseline: See FY 2017-18 average engagement & attrition for Children’s services
Goal:
1. For Routine requests for service, County Adult programs will:
a. Maintain goal of 85% resulting in an Assessment
(FY17-18 baseline: 81%)
b. Achieve goal of 55% resulting in initiation of treatment
(FY17-18 baseline: 40%)
2. For Urgent requests for service, County Adult programs will:
a. Maintain goal of 95% resulting in an assessment
(FY17-18 baseline: 97%)
b. Achieve goal of 90% resulting in initiation of treatment
(FY17-18 baseline: 75%)</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>182</td><td>74%</td><td>40%</td></tr>
<tr><td>Urgent</td><td>5</td><td>96%</td><td>74%</td></tr>
<tr><td>Total:</td><td>187</td><td>75%</td><td>41%</td></tr>
</table>
Q2:
<table>
<tr><td>Routine</td><td>228</td><td>66%</td><td>30%</td></tr>
<tr><td>Urgent</td><td>2</td><td>50%</td><td>50%</td></tr>
<tr><td>Total:</td><td>230</td><td>66%</td><td>30%</td></tr>
</table>
Q3:
<table>
<tr><td>Routine</td><td>212</td><td>78%</td><td>39%</td></tr>
<tr><td>Urgent</td><td>6</td><td>100%</td><td>67%</td></tr>
<tr><td>Total:</td><td>230</td><td>80%</td><td>40%</td></tr>
</table>
Q4:
<table>
<tr><td>Routine</td><td>183</td><td>75%</td><td>36%</td></tr>
<tr><td>Urgent</td><td>1</td><td>100%</td><td>0%</td></tr>
<tr><td>Total:</td><td>184</td><td>75%</td><td>36%</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>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 C, I. - Item C, IV. – Item A

Name of Data Report:
Avatar Timeliness Report #333; MHP Access Referral form (under construction)

Sub-committee/Staff Responsible:
Access Supervisor

Annual Goal Items Met:
☒ Met: Item # 1b, 2a
☐ Partially Met: Item # ___
☒ Not Met: Item # 1a, 2b</td>
<td>AG-4: Maintain or improve the following engagement & attrition measures for Adults:
Baseline: See FY 2017-18 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
(FY17-18 baseline: 62%)
b. Achieve goal of 55% resulting in initiation of treatment
(FY17-18 baseline: 47%)
2. For Urgent requests for service, County Adult programs will:
a. Maintain goal of 85% resulting in an assessment
(FY17-18 baseline: 83%)
b. Achieve goal of 60% resulting in initiation of treatment
(FY17-18 baseline: 58%)</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>365</td><td>65%</td><td>50%</td></tr>
<tr><td>Urgent</td><td>7</td><td>85%</td><td>57%</td></tr>
<tr><td>Total:</td><td>372</td><td>66%</td><td>50%</td></tr>
</table>
Q2:
<table>
<tr><td>Routine</td><td>415</td><td>65%</td><td>51%</td></tr>
<tr><td>Urgent</td><td>8</td><td>100%</td><td>63%</td></tr>
<tr><td>Total:</td><td>423</td><td>65%</td><td>52%</td></tr>
</table>
Q3:
<table>
<tr><td>Routine</td><td>328</td><td>54%</td><td>41%</td></tr>
<tr><td>Urgent</td><td>5</td><td>60%</td><td>40%</td></tr>
<tr><td>Total:</td><td>333</td><td>60%</td><td>40%</td></tr>
</table>
Q4:
<table>
<tr><td>Routine</td><td>370</td><td>56%</td><td>41%</td></tr>
<tr><td>Urgent</td><td>5</td><td>100%</td><td>60%</td></tr>
<tr><td>Total:</td><td>375</td><td>57%</td><td>41%</td></tr>
</table></td>
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</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 18-19, Network Adequacy and Availability of Services – Section A, I - Item F1; Access and Information Requirements – Section D, VI. – Items B & C **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 # 1 ☒ **Partially Met:** Item # 2-4 ☐ **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 17-18 % that met standards **Goal:** During QI initiated test calls, the MHP will demonstrate in 75% Business and Afterhours calls: • **Measure #1:** Provide a Minimum of 4 test calls/month. • **Measure #2:** Testing for language capabilities (Spanish & Tagalog primarily) • **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	% of Test Calls that met standards in FY 2017-18
Languages Tested: Spanish	**B**	1	0	0%	66%
	A	3	2	67%	33%
Was Information given about how to access SMHS, including how to get an Ax.	**B**	2	1	50%	80%
	A	3	1	33%	25%
Info about how to treat a client's urgent condition	**B**	1	1	100%	100%
	A	1	1	100%	100%
Info about how to use the Problem Resolution/Fair Hearing process	**B**	1	1	100%	100%
	A	1	1	100%	0%
Logging Name of client, date of request, & initial disposition	**B**	3	2	67%	78.6%
	A	4	3	75%	21.4%

Q2:

	Bus or after hrs	# of Test Calls/ Quarter	# of Test Calls that meet Standards	% of Test Calls that meet Standards this Quarter	% of Test Calls that met standards in FY 2017-18
Languages Tested: Spanish	**B**	0	0	N/A	66%
	A	2	2	100%	33%
Was Information given about how to access SMHS, including how to get an Ax.	**B**	3	3	100%	80%
	A	6	5	83.3%	25%
Info about how to treat a client's urgent condition	**B**	1	1	100%	100%
	A	0	0	N/A	100%
Info about how to use the Problem Resolution/Fair Hearing process	**B**	0	0	N/A	100%
	A	0	0	N/A	0%
Logging Name of client, date of request, & initial disposition	**B**	4	3	75%	78.6%
	A	6	2	33.3%	21.4%

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

	Bus or after hrs	# of Test Calls/ Quarter	# of Test Calls that meet Standards	% of Test Calls that meet Standards this Quarter	% of Test Calls that met standards in FY 2017-18
Languages Tested: Spanish	**B**	3	3	100%	66%
	A	2	1	50%	33%
Was Information given about how to access SMHS, including how to get an Ax.	**B**	4	3	75%	80%
	A	3	3	100%	25%
Info about how to treat a client's urgent condition	**B**	1	1	100%	100%
	A	0	0	N/A	100%
Info about how to use the Problem Resolution/Fair Hearing process	**B**	1	1	100%	100%
	A	1	1	100%	0%
Logging Name of client, date of request, & initial disposition	**B**	6	6	100%	78.6%
	A	4	4	100%	21.4%

Q4:

	Bus or after hrs	# of Test Calls/ Quarter	# of Test Calls that meet Standards	% of Test Calls that meet Standards this Quarter	% of Test Calls that met standards in FY 2017-18
Languages Tested: Spanish	**B**	2	2	100%	66%
	A	3	2	66.67%	33%
Was Information given about how to access SMHS, including how to get an Ax.	**B**	5	5	100%	80%
	A	5	4	80%	25%
Info about how to treat a client's urgent condition	**B**	0	0	---	100%
	A	0	0	---	100%
Info about how to use the Problem Resolution/Fair Hearing process	**B**	0	0	---	100%
	A	1	1	100%	0%
Logging Name of client, date of request, & initial disposition	**B**	5	4	80%	78.6%
	A	5	1	20%	21.4%

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

Quality Improvement Area of Data Monitoring	Results of Evaluation

V. Access and Timeliness:

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

Purpose for Monitoring:
DHCS Annual Review Protocols, FY 18-19, Network Adequacy and Availability of Services – Section A, I - Item F1

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 17-18: **98.6%**
- Quarterly Average of % of Abandoned calls in FY 17-18: **1.4%**

FY 18-19 Quarterly Averages:

- Total calls received: 4026
- Average % of calls handled: 99%

Month/ Quarter	Calls Received	Calls Handled	% (Handled/ Received)
JUL	330	329	99%
AUG	387	387	100%
SEP	266	265	99%
OCT	323	321	99%
NOV	221	211	100%
DEC	269	268	99%
JAN	321	315	98%
FEB	284	272	96%
MAR	302	297	98%
APR	379	370	97%
*MAY	538	527	98%
*JUN	406	401	99%

***Mental Health Access and Substance Use Access (BHAT) merged.**

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. Program Integrity: • **AG-1: Service Verification County Programs** **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 18--19, Program Integrity – Section G, III. - Item A. **Name of Data Report:** QI-Compliance Service Verification Spreadsheet **Sub-committee/Staff Responsible:** • Compliance Committee • Quality Improvement unit **Annual Goal Items Met:** ☒ **Met:** Item # 1 ☐ **Partially Met:** Item # ___ ☐ **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 17-18 Baseline**: 100% • **Measurement #2:** 90-100% of services will be verified during the week of Service Verification. **FY 17-18 Baseline**: 92.7%	**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	% of services verified	Cost of unverified services	Were NOBE's submitted for all unverified services?
FF Youth FSP	99%	$138.24	Yes
FF Youth	98%	$1,411.74	Yes
FF Adult	88%	$9,967.76	Yes
VV Youth FSP	100%	---	N/A
VV Youth	100%	---	N/A
VV Adult	95%	$1,599.52	Yes
VJO Youth FSP	89%	$650.24	Yes
VJO Youth	100%	---	N/A
VJO Adult	92%	$6,374.58	Yes
VJO Adult FSP	95%	$1,324.99	Yes
FCTU	100%	---	N/A
FACT/AB 109	92%	$2,041.44	Yes

Q2: ***(Per MHP Policy, No County SV required during Q2 and Q4)***

Q3:

County Program	% of services verified	Cost of unverified services	Were NOBE's submitted for all unverified services?
FF Youth FSP	99%	$138.24	Yes
FF Youth	98%	$1,411.74	Yes
FF Adult	88%	$9,967.76	Yes
VV Youth FSP	100%	---	N/A
VV Youth	100%	---	N/A
VV Adult	95%	$1,599.52	Yes
VJO Youth FSP	89%	$650.24	Yes
VJO Youth	100%	---	N/A
VJO Adult	92%	$6,374.58	Yes
VJO Adult FSP	95%	$1,324.99	Yes
FCTU	100%	---	N/A
FACT/AB 109	92%	$2,041.44	Yes

Q4: ***(Per MHP Policy, No County SV required during Q2 and Q4)***

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
VI. Program Integrity: • **AG-2: Service Verification Contract Programs** **Authority:** DHCS Annual Review Protocols, FY 18--19, Program Integrity – Section G, III. - Item A. **Name of Data Report:** QI-Compliance Service Verification Spreadsheet **Sub-committee/Staff Responsible:** • Compliance Committee • Quality Improvement unit **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**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 17-18 Baseline**: 77% • **Measurement #2:** 90-100% of services will be verified during the week of Service Verification. **FY 17-18 Baseline**: Data Pending for Q4 (Q2=80.3%)	**Q1:** ***(Per MHP Policy, No Contract Agency SV required during Q1 and Q3)*** **Q2: Pending final reports** **Q3:** ***(Per MHP Policy, No Contract Agency SV required during Q1 and Q3)*** **Q4: Pending final reports**

Q2: Pending final reports

Contract Program	% of services verified	Cost of unverified services	Were NOBE's submitted for all unverified services?
A Better Way	63%	1432.83	Yes
Aldea	95%	252.07	Yes
Aldea TVS	100%	---	NA
Aldea SOAR	50%	224.84	Yes
Caminar FSP	91%	625.22	Yes
Caminar Home	88%	894.4	Yes
Caminar OA	100%	---	NA
Caminar CCM	89%	757.46	Yes
Child Haven	63%	584.09	Yes
Child Haven	68%	753.44	Yes
Child Haven VJO 0-5	100%	---	NA
Child Haven VJO	89%	163.43	Yes
Psynergy Morgan Hill	83%	182.7	Yes
Psynergy Sacramento	91%	547.17	Yes
Seneca	100%	---	NA
Seneca	100%	---	NA
Seneca Wrap	100%	---	NA
Seneca TBS	100%	---	NA
Seneca EPSDT	100%	---	NA
Sierra School	100%	---	NA

Q4: Pending final reports

Contract Program	% of services verified	Cost of unverified services	Were NOBE's submitted for all unverified services?
Seneca	100%	---	NA
Seneca	100%	---	NA
Seneca Wrap	100%	---	NA
Seneca TBS	100%	---	NA
Seneca EPSDT	100%	---	NA
Aldea	95%	$747.64	Yes
Aldea TVS	100%	---	NA
Aldea SOAR	100%	---	NA

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

Child Haven	89%	$459.82	Yes
Child Haven	89%	$775.60	Yes
Child Haven – CARE	80%	$1,657.53	Yes
Child Haven VJO	100%	---	NA
Child Haven VJO - CARE	100%	---	NA

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 18--19, Program Integrity – Section G, I. - Item B3.

Name of Data Report:
Compliance Committee meeting minutes/Compliance Unit report

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>---</td><td>---</td><td>---</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>October</td><td>Yes</td><td>10/9/2018</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>January</td><td>Yes</td><td>1/23/2019</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>June</td><td>Yes</td><td>6/26/2019</td></tr>
</table></td></tr>
</table>

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

• DM-2: Compliance Training and Communication to the MHP

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 18--19, Program Integrity – Section G, III. - Item B4-6

Name of Data Report:
TBD

Sub-committee/Staff Responsible:
Compliance Committee meeting minutes/Compliance Unit report</td><td>Q1:
<table>
<tr><th>Month</th><th>Did Dept. Offer Compliance Training this month?</th><th>How many Behavioral Health staff completed the training?</th><th>Did Compliance Officer send out communication of compliance issues?</th><th>Dates and Topics of Communication</th></tr>
<tr><td>Oct</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Nov</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Dec</td><td></td><td></td><td></td><td></td></tr>
</table>
Q2:
<table>
<tr><td>Oct</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Nov</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Dec</td><td></td><td></td><td></td><td></td></tr>
</table>
Q3:
<table>
<tr><td>Jan</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Feb</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Mar</td><td></td><td></td><td></td><td></td></tr>
</table>
Q4:
<table>
<tr><td>Apr</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Mar</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Jun</td><td></td><td></td><td></td><td></td></tr>
</table>
*Pending data from Compliance Unit</td></tr>
</table>

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 18-19, Network Adequacy and Availability of Services – Section A, VI. - Item D5 & F.

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 # 1-2
☐ 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: See Quality Improvement annual UR Audits during FY 2017-18.
Goal: The following processes are in place for FY 2018-19 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 audit alert period.
• 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>% of programs that received a UR Audit Report within 60 days after the audit alert period?</th><th>% of all programs audited required a Corrective Action Plan (CAP)?</th><th>% of all programs reviewed this Quarter submitted an adequate Corrective Action Plan (CAP)?</th></tr>
<tr><td>Q1</td><td>3</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Q2</td><td>19</td><td>89%</td><td>100%</td><td>88%</td></tr>
<tr><td>Q3</td><td>16</td><td>100%</td><td>100%</td><td>91%</td></tr>
<tr><td>Q4</td><td>7</td><td>67%</td><td>100%</td><td>Pending</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: Treatment Plan Review timeliness and QI Communication with programs around pending concurrent review status

Authority:
DHCS Annual Review Protocols, FY 18-19, Network Adequacy and Availability of Services – Section A, VI. - Item D5 & F.

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 # 1-2
☐ 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 2017-18.
Goal: The following processes are in place for FY 2018-19 to monitor Provider compliance with CCR Title 9 documentation standards requirements:

• Measurement #1: 90% of requests for Treatment Plan review will be initially reviewed within 10 business days of receipt.
• Measurement #2: 100% of monthly concurrent review status reports are provided to programs.</td>
<td>Q1:
<table><tr><th>Month</th><th>% of Treatment Plans reviewed for quality within 10 business days of receipt</th><th>% of programs receiving monthly concurrent review status report</th></tr><tr><td>Jul</td><td>86%</td><td>38%</td></tr><tr><td>Aug</td><td>72%</td><td>23%</td></tr><tr><td>Sep</td><td>49%</td><td>0%</td></tr><tr><td>Oct</td><td>51%</td><td>41%</td></tr><tr><td>Nov</td><td>46%</td><td>72%</td></tr><tr><td>Dec</td><td>49%</td><td>79%</td></tr><tr><td>Jan</td><td>58%</td><td>79%</td></tr><tr><td>Feb</td><td>67%</td><td>77%</td></tr><tr><td>Mar</td><td>67%</td><td>97%</td></tr><tr><td>Apr</td><td>64%</td><td>92%</td></tr><tr><td>May</td><td>78%</td><td>95%</td></tr><tr><td>Jun</td><td>70%</td><td>82%</td></tr></table></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 18-19, Network Adequacy and Availability of Services - Section A, VI - Item F. **Name of Data Report:** QI Excel Monitoring Spreadsheet **Sub-committee/Staff Responsible:** QI Training Lead and team	**Q1:**

Month	Doc Training offered?	# of Attendees	Avatar Phase I training offered?	# of Attendees	Avatar Phase II training offered?	# of Attendees
Jul	Yes	5	Yes	5	No	0
Aug	Yes	7	Yes	11	Yes	3
Sep	Yes	17	Yes	2	No	0

Q2:

Oct	Yes	10	Yes	2	No	0
Nov	Yes	10	Yes	15	No	0
Dec	Yes	4	Yes	7	No	0

Q3:

Jan	Yes	2	Yes	2	No	0
Feb	Yes	22	Yes	1	Yes	2
Mar	Yes	3	No	0	No	0

Q4:

Apr	Yes	5	No	0	No	0
May	Yes	10	Yes	13	Yes	5
Jun	Yes	13	Yes	6	No	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 18-19, Network Adequacy and Availability of Services - Section A, VI - Item E. **Name of Data Report:** Monthly Site Certification Tracking Report **Sub-committee/Staff Responsible:** QI Site Certification Lead and team	**Q1:** **Q2:** **Q3:** **Q4:**

Month	# of Programs were Certified this Month?	Was the MHP's tracking report reviewed to ensure no Solano MHP programs were missed?	Were 100% of Site Certifications due this month facilitated in a timely manner?
Jul	1	Yes	Yes
Aug	1	Yes	Yes
Sep	0	Yes	Yes
Oct	0	Yes	Yes
Nov	0	Yes	Yes
Dec	3	Yes	No
Jan	3	Yes	No
Feb	1	Yes	Yes
Mar	1	Yes	Yes
Apr	0	Yes	Yes
May	2	Yes	Yes
Jun	0	Yes	Yes

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 18-19, Program Integrity - Section G, V - Item A. **Name of Data Report:** Provider Eligibility and Verification Tracking Report **Sub-committee/Staff Responsible:** QI Provider Eligibility Verification Lead	**Q1:** **Q2:** **Q3:** **Q4:** *Complete data pending from Compliance Unit

Month	How many providers initially showed up on one of the lists?	Was action taken to investigate provider's ability to work in the MHP?	How many providers were determined to be ineligible to practice?	Were 100% of County, Contract and Network Providers verified on the exclusion lists?
Jul			0	Yes
Aug			0	Yes
Sep			0	Yes
Oct			0	Yes
Nov			0	Yes
Dec			0	Yes
Jan			0	Yes
Feb			0	Yes
Mar			0	Yes
Apr			0	Yes
May			0	Yes
Jun			0	Yes

VIII. Network Adequacy (Data Monitoring - DM)

VIII. Network Adequacy:

- **DM-1**: Pathways to Well-Being

Authority:
DHCS Annual Review Protocols, FY 18-19, Network Adequacy and Availability of Services - Section A, III. - Item A-E.

Frequency of Evaluation:
Quarterly

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

Sub-committee/Staff Responsible:

- Pathways/Katie A. Implementation Team

Q1:

# 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					
			Out of County					

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

*Pending data

Q2:
*Pending data

Q3:
*Pending data

Q4:
*Pending data

<table>
<tr><th>Quality Improvement Area of Data Monitoring</th><th>Objectives (Include standards, baselines, annual goal, etc.)</th><th>Results of Evaluation</th></tr>
<tr>
<td>VIII: Network Adequacy:

• DM-2: Pathways to Well-Being (non-Subclass)

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 18-19, Network Adequacy and Availability of Services - Section A, III. - Item A-E.

Name of Data Report:
Pathways Database maintained by CCR Team

Sub-committee/Staff Responsible:
• CCR Coordinator</td>
<td>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)</td>
<td>Q1:
<table>
<tr><th></th><th># of Pathways Clients Identified</th><th>%Offered ICC Services</th><th>%Assigned an ICC Coordinator</th><th>%CFT Meeting Held or Scheduled</th></tr>
<tr><td>SCMH</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Contract Agency</td><td></td><td></td><td></td><td></td></tr>
</table>
*Pending Data Collection Mechanism
Q2:
<table>
<tr><th></th><th># of Pathways Clients Identified</th><th>%Offered ICC Services</th><th>%Assigned an ICC Coordinator</th><th>%CFT Meeting Held or Scheduled</th></tr>
<tr><td>SCMH</td><td>75</td><td>99%</td><td>100%</td><td>100%</td></tr>
<tr><td>Contract Agency</td><td>35</td><td>97%</td><td>100%</td><td>95%</td></tr>
</table>
Q3:
<table>
<tr><th></th><th># of Pathways Clients Identified</th><th>%Offered ICC Services</th><th>%Assigned an ICC Coordinator</th><th>%CFT Meeting Held or Scheduled</th></tr>
<tr><td>SCMH</td><td>75</td><td>100%</td><td>100%</td><td>100%</td></tr>
<tr><td>Contract Agency</td><td>35</td><td>100%</td><td>100%</td><td>100%</td></tr>
</table>
Q4:
<table>
<tr><th></th><th># of Pathways Clients Identified</th><th>%Offered ICC Services</th><th>%Assigned an ICC Coordinator</th><th>%CFT Meeting Held or Scheduled</th></tr>
<tr><td>SCMH</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Contract Agency</td><td></td><td></td><td></td><td></td></tr>
</table>
*Pending Data Report</td>
</tr>
</table>

Goal Purpose and Monitoring	Results of Evaluation
VIII: Network Adequacy: • **DM-3**: Provider Network Data **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 18-19, Network Adequacy and Availability of Services - Section A, I. - Item D. **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	**Q1:** **Q2:** **Q3:** **Q4:** *Pending complete data from Managed Care team

Q1:

County Region	# of Clients Served During the Quarter	# of Beacon Referral	# of Bilingual Provider	# trained to use Interp.	# 3 mons w/o taking a referral	# of Providers w/in 10 mins. of Pub Trans.	# of Providers w/ access for the physically disabled
N/A	64	51	5	23	9	23	18

Q2:

County Region	# of Clients Served During the Quarter	# of Beacon Referral	# of Bilingual Provider	# trained to use Interp.	# 3 mons w/o taking a referral	# of Providers w/in 10 mins. of Pub Trans.	# of Providers w/ access for the physically disabled
N/A	63	58	6	24		24	17

Q3:

County Region	# of Clients Served During the Quarter	# of Beacon Referral	# of Bilingual Provider	# trained to use Interp.	# 3 mons w/o taking a referral	# of Providers w/in 10 mins. of Pub Trans.	# of Providers w/ access for the physically disabled
N/A	56	56	5	24	11	24	18

Q4:

County Region	# of Clients Served During the Quarter	# of Beacon Referral	# of Bilingual Provider	# trained to use Interp.	# 3 mons w/o taking a referral	# of Providers w/in 10 mins. of Pub Trans.	# of Providers w/ access for the physically disabled
N/A		57					

*Pending complete data from Managed Care team