Solano County
Health and Social Services Department
Behavioral Health Division
Solano Mental Health Plan
FY 2019 - 2020

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 2019-2020:

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 19-20, 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. **FY 18-19 Baseline:** • **County Providers:** 223 • **County Non-Provider:** 82 • **Contract Provider:** Pending • **Contract Non-Provider:** Pending **Goal:** Monitor Annual training and work toward 100% annual training compliance for: • **Providers:** 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:** **Staff Category** | **Total Staff** | **% of Staff in Compliance with annual requirement** **County Provider** | **139** | **90%** **County Non-provider** | **49** | **94%** **Contracted Provider** | **97** | **78%** **Contracted Non-provider** | **0** | **0%** **Q2:** **Staff Category** | **Total Staff** | **% of Staff in Compliance with annual requirement** **County Provider** | **106** | **44%** **County Non-provider** | **1** | **2%** **Contracted Provider** | **118** | **90%** **Contracted Non-provider** | **0** | **0%** **Q3:** **Staff Category** | **Total Staff** | **% of Staff in Compliance with annual requirement** **County Provider** | **106** | **44%** **County Non-provider** | **1** | **2%** **Contracted Provider** | **118** | **90%** **Contracted Non-provider** | **0** | **0%** **Q4:** **Staff Category** | **Total Staff** | **% of Staff in Compliance with annual requirement** **County Provider** | **106** | **44%** **County Non-provider** | **1** | **2%** **Contracted Provider** | **118** | **90%** **Contracted Non-provider** | **0** | **0%**

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 19-20, Access – Section D, VII. - Items A- C **Name of Data Report:** • None **Sub-committee/Staff Responsible:** • Cultural Competence Committee **Previous FY Baseline Averages:** **FY 19-20 Quarterly Averages:** • CCC meetings per Quarter: • CC Subcommittee meetings per Quarter:	

Quarter	Date of CCC Meeting	Date of report to QIC	Date CC Plan Updated	Date of Annual Report
1	9/10/2019	11/14/2019	7/31/2018	1/24/2020
2	2/18/2020	2/13/2019		
3	*COVID RESTRICTIONS*	5/14/2020		
4	4/14/2020 5/13/2020 6/23/2020	8/13/2020		

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: • **DM-2: LGBTQ Visibility** QI Action Plan- Campaign to combat stigma for LGBTQ community and intersect for Latinex and Filipinex **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3. **Name of Data Report:** MHSA Report **Sub-committee/Staff Responsible:** MHSA Unit & Ethnic Services Coordinator	

Month	# of Latinex Posters Distributed	# of tags/hits to QR code or website linked to Latinex posters	# of Filipinex Posters Distributed	# of tags/hits to QR code or website linked to Filipinex posters	# of Access calls because of posters	# of Access referrals from Solano Pride Center
JUL					**Pending New Question on Screening Tree**	
AUG						
SEP						
OCT						
NOV						
DEC						
JAN						
FEB						
MAR						
APR						
MAY						
JUN						

- **This project was still in an implementation stage during FY 19-20 and delayed due to statewide public health emergency**

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: • **DM-3: *Takin' CLAS to the Streets*** QI Action Plan-School Wellness Centers for K-12 and adult ed sites with a cultural lens **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3. **Name of Data Report:** MHSA Report **Sub-committee/Staff Responsible:** MHSA Unit & Ethnic Services Coordinator	

Month	# of K-12 School Wellness Centers/ Rooms Opened	# of students who accessed the wellness centers/ rooms	Demographics of K-12 students (Only if schools allow us to collect this data)	# of adult school Wellness Centers/ Rooms Opened	# of students who accessed the adult Wellness Centers	Demographics of adult ed students (Only if schools allow us to collect this data)
JUL				0	0	
AUG				0	0	
SEP	1	57		0	0	
OCT	3	33		0	0	
NOV	0	86		0	0	
DEC	0	80		1	40	
JAN		2		0		
FEB		17		0		
MAR		12		0		
APR						
MAY						
JUN						

- **This project was initiated during FY 19-20 and delayed due to statewide public health emergency**

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: • **DM-4: *Culturally Responsive Supervision*** QI Action Plan- Implement Culturally Sensitive Supervision model by Dr. Kenneth Hardy **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Item D-E **Name of Data Report:** MHSA Report **Sub-committee/Staff Responsible:** MHSA Unit & Ethnic Services Coordinator	

Month	# of trainings provided for supervisors and/or managers (County and CBO)	# of training participants for supervisor/ managers trainings	# of small group consultation groups held for supervisory staff	Will insert a data point to track from training survey tool	# of trainings provided for all staff	# of training participants for all staff trainings
JUL						
AUG						
SEP						
OCT						
NOV						
DEC						
JAN						
FEB	1	18			1	100
MAR						
APR						
MAY						
JUN						

- **This project was initiated during FY 19-20 and delayed due to statewide public health emergency**

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: • **DM-5:** ***Mental Health Education*** QI Action Plan-Provide trainings for faith centers; train-the-trainer models Mental Health First Aid (MHFA), ASIST, safeTALK, SCBH system of care. Trainings for youth thru faith centers. **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Item D-E **Name of Data Report:** MHSA Report **Sub-committee/Staff Responsible:** MHSA Unit & Ethnic Services Coordinator	

Month	# of train-the-trainer trainings provided for faith leads/ reps	# of training participants trained as a trainer	% of faith leads who endorse increased knowledge of MH (post training tool to be developed)	% of faith leads who endorse increased likelihood of referring to MH services	# of trainings faith leads provide & # of participants trained	# of trainings provided for youth in faith centers	# of training youth participants for trainings
JUL							
AUG							
SEP							
OCT							
NOV							
DEC							
JAN							
FEB							
MAR							
APR							
MAY							
JUN							

- **This project was still in an implementation stage during FY 19-20 and delayed due to statewide public health emergency**

<table>
<tr><th>Quality Improvement Area of Data Monitoring</th><th>Results of Evaluation</th></tr>
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I. Cultural Competence:

- **DM-6: *Gap Finders*** QI Action Plan- Program/CBO self-eval of true implementation of CLAS standards

Purpose for Monitoring:
DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Item D-E

Name of Data Report:
N/A

Sub-committee/Staff Responsible:
Cultural Competency Committee/Ethnic Services Coordinator

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Month	# of CBO partners who submitted Cultural Responsivity Plan	% of CBO Cultural Responsivity Plans that addressed at least 10 of the 15 CLAS standards
JUL		
AUG		
SEP	1	
OCT		
NOV		
DEC	10	
JAN	2	
FEB		
MAR		
APR		
MAY		
JUN		

- **This project was initiated during FY 19-20 and delayed due to statewide public health emergency**

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Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: **DM-7**: ***TRUE Care Promoter*** QI Action Plan-Phase I Roadmap resource guide **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3. **Name of Data Report:** N/A HR **Sub-committee/Staff Responsible:** Ethnic Services Coordinator	

Month	# of paper roadmaps distributed via tabling events	# of hits on the web version of the Roadmap	# of paper roadmaps distributed to community partners (FRC, E&E, CBOs, libraries, etc.)	# of tags/hits to QR code or website linked to Roadmap	# of calls to Access as a result of Roadmap (only once new question added to screening tree)
JUL					
AUG					
SEP					
OCT					
NOV					
DEC					
JAN					
FEB					
MAR					
APR					
MAY					
JUN					

- **This project was still in an implementation stage during FY 19-20 and delayed due to statewide public health emergency**

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: • **DM-8:** HOLA Community Information and Education Plans – Outreach re: cultural/linguistic services **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, 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 19-20 Quarterly Averages:** • Outreach Initiatives per Quarter: ___ • HOLA calls per quarter: ___	

Month	# of Community Education & Engagement Activities	# of Community Members Present	# of Access calls as a direct result of outreach team
JUL	0	0	0
AUG	0	0	0
SEP	1	60	0
OCT	3	223	0
NOV	1	27	0
DEC	0	0	0
JAN	1	30	0
FEB	2	231	0
MAR	0	0	0
APR			
MAY			
JUN			

This initiative was interrupted due to statewide public health emergency

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: • **DM-9:** Kaagapay Community Information and Education Plans – Outreach re: cultural/linguistic services **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, 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 19-20 Quarterly Averages:** • Outreach Initiatives per Quarter: ___ • Kaagapay calls per quarter: ___	

Month	# of Community Education & Engagement Activities	# of Community Members Present	# of Access calls as a direct result of outreach team
JUL	3	22	0
AUG	6	8	0
SEP	6	44	0
OCT	0	0	0
NOV	0	0	0
DEC	0	0	0
JAN	0	0	0
FEB	0	0	0
MAR	0	0	0
APR			
MAY			
JUN			

This initiative was interrupted due to staffing challenges impacted by the statewide public health emergency

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 19-20, 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:** Peer Support Group ☒ **Not Met:** Family Support Group	**AG-1:** Provide Adult and Family Support Groups facilitated by Peer Support Specialists or Family Liaison. **Baseline:** Data was only collected in Q3 and Q4 of FY 18-19 work plan. See FY 18-19, Q4 data in adjoining tables for comparison: **Goal:** 1. **Increase # of total unique group members who participate quarterly** 2. Increase the % of unduplicated participants in WR Peer Support Groups who respond positively to quarterly "Quality of Life Outcome Tool" survey items	**Peer Support Group:** **Family Support Group:**

Peer Support Group:

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	7	99%	100%	100%
Q2	29	89%	99%	99%
Q3	15	95%	95%	100%
Q4	50	COVID	COVID	COVID
FY 18-19, Q4	23	80%	99%	100%

Family Support Group:

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	38	42%	100%	100%
Q2	31	99%	100%	99%
Q3	5	80%	100%	100%
Q4	41	COVID	COVID	COVID
FY 18-19, Q4	36	80%	100%	100%

II. Wellness and Recovery (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation

II. Wellness and Recovery:

3. **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 19-20, 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:
- Actual number of participants with lived experience per quarter:

FY 19-20 Quarterly Averages:
- Average # of Committees per Quarter: ___
- Total number of participants per quarter:___

Quarter	# of Activities	Number of persons with lived experience by demographics (youth, adult, family)	Total Peer and Family Involvement for the quarter
1	84	193	
2	81	323	
3	87	209	
4	0	0	

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, 19-20, 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: County Programs** **Q2: Contractor Programs** **Q3: County Programs**

Q1: County Programs

Program	Identified Area of Focus	Baseline (FY18-19: Q3)	Intervention	Post Intervention Change (FY19-20: Q1)
Fairfield Youth FSP	Would you recommend our services to others?	82%	Check with clients monthly to assess their satisfaction with services to determine what needs to be done to improve satisfaction.	72% (-10%)
Fairfield Youth	Sexual Orientation/ Gender Identity	98%	Discuss this topic during staff meeting & provide staff with suggestions on ways in which to demonstrate increased sensitivity in this area. Goal will be to have 100% yes responses.	97% (-1%)
Foster Care Treatment Unit	Sexual Orientation/ Gender Identity	95%	Put rainbow stickers on County cell phones & in vehicles.	100% (+5%)
Vacaville Youth	Sexual Orientation/ Gender Identity	97%	Discuss this topic during staff meetings & provide staff with suggestions on ways in which to demonstrate increased sensitivity in this area.	88% (-9%)
Fairfield ICC	Would you recommend our services to others?	71%	Reinstate the Service Verification table worked by front desk & OD staff in the lobby.	74% (+3%)

Q2: Contractor Programs

Program	Identified Area of Focus	Baseline (FY18-19: Q3)	Intervention	Post Intervention Change (FY19-20: Q1)
Uplift Family Services	Did the staff listen carefully to you?	94%	During a monthly collateral session with the youth & caregiver, the clinician will check in with them.	
Uplift Family Services	As a result of the services you're receiving, do you feel better?	76%	During a monthly collateral session with the youth & caregiver, the clinician will check in with them.	
Caminar FSP	Sexual Orientation/ Gender Identity	97%	In the next 30 days, staff will receive training from program director about "overcoming barriers" when delivering services.	
Caminar HOME	Sexual Orientation/ Gender Identity	83%	Staff will complete training on cultural competency & continue annually. Will bring CC training to Caminar ACT team monthly for next 6 months.	
A Better Way	Was an interpreter/ bi-lingual staff provided?	13%	Increase training for assessment of language needs w/ clinicians; new interpreter service provider has been contracted to increase access to translators w/ improved service & quality. Continue to hire bilingual staff.	

Q3: County Programs

Program	Identified Area of Focus	Baseline (FY19-20: Q1)	Intervention	Post Intervention Change (FY19-20: Q3)

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

Fairfield Youth FSP	Did the staff listen carefully to you?	91%	Staff will practice "active listening".	94% (+3%)
Fairfield Youth	Did the staff explain things in a way that was easy to understand?	91%	Clerical, FSP & Outpatient staff will check in with clients at least once per month to inquire if clients have any questions about services received & referrals.	97% (+6%)
Vacaville Youth	Would you recommend our services to others?	69%	Create a suggestion box for the lobby & a sign for the back of the Front Desk door that requests clients/families contact the clinic supervisor with any concerns &/or questions.	75% (+6%)
Vallejo Youth	As a result of the services you're receiving, do you feel better?	68%	Asking clients/families at the conclusion of each service activity: "Was there anything more you would like to cover today? Was I able to hear your needs today?"	64% (-4%)
FACT	Would you recommend our services to others?	93%	Educate clients about ACT, purpose & services available including information about the team approach & working with various team members.	94% (+1%)
Fairfield ICC	Sexual Orientation/ Gender Identity	87%	Provide the Diversity & Social Justice training at the All Staff meeting.	100% (+13%)
Vacaville ICC	Would you recommend our services to others?	78%	We will be using the customer service surveys at every appointment encouraging clients to fill them out & place them in our drop box in our lobby.	94% (+1%)
Vallejo Adult FSP	Would you recommend our services to others?	94%	Customer service training at all levels.	88% (-6%)
Vallejo ICC	Would you recommend our services to others?	89%	Customer service training at all levels.	82% (-7%)

Q4: Contractor Programs

Program	Identified Area of Focus	Baseline (FY19-20: Q2)	Intervention	Post Intervention Change (FY19-20: Q4)
Uplift Family Services	Did the staff listen carefully to you?	94%	During a monthly collateral session with the youth & caregiver, the clinician will check in with them.	
Uplift Family Services	As a result of the services you're receiving, do you feel better?	76%	During a monthly collateral session with the youth & caregiver, the clinician will check in with them.	
Caminar FSP	Sexual Orientation/ Gender Identity	97%	In the next 30 days, staff will receive training from program director about "overcoming barriers" when delivering services.	
Caminar HOME	Sexual Orientation/ Gender Identity	83%	Staff will complete training on cultural competency & continue annually. Will bring CC training to Caminar ACT team monthly for next 6 months.	
A Better Way	Was an interpreter/ bi-lingual staff provided?	13%	Increase training for assessment of language needs w/ clinicians; new interpreter service provider has been contracted to increase access to translators w/ improved service & quality. Continue to hire bilingual staff.	

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

Quality Improvement Area of Data Monitoring	Results of Evaluation
III. Beneficiary Protection: • **DM-1:** Grievance, Appeal and Expedited Appeal **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 19-20, 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: • # of issues requiring a system change: • # Referred to Policy Committee: **FY 19-20 Quarterly Averages:** • Total # of Problem Resolution issues: 28.6 • # of issues requiring a system change: 2 • # of System Changes Initiated: ___ • # Referred to Policy Committee: 0 • # of Policies created or amended: 2	**Q1:** • **These numbers were low apparently due to statewide public health emergency; therefore, they were not considered in quarterly averages**

Month Received	Total quarterly # of Problem Resolution issues reported, primarily Grievances and Appeals	# of issues Requiring a System Change	# Referred to Policy Committee	# of Policies created or amended b/c of identified Problem
JUL	8	0	0	1
AUG	12	0	0	0
SEP	10	0	0	0
OCT	9	0	0	0
NOV	6	1	0	1
DEC	12	1	0	0
JAN	8	2	0	2
FEB	11	1	0	1
MAR	10	1	0	1
APR	2*	0	0	0
MAY	5*	0	0	0
JUN	4*	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 19-20, 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 19-20 Quarterly Averages:** • Were all Problem Resolution processes logged and monitored: • Data Trends:	

Category	Process				Grievance Disposition		
	Grievance	Exempt Grievances	Appeal	Expedited Appeal	Grievances pending as of 6/30	Resolved	Referred
Appeals from NOABDs							
ACCESS	3	0			0	3	0
Quality of Care	30	0			1	29	0
Change of Provider	42	0			0	42	0
Confidentiality	0	0			0	0	0
Other	20	0			0	20	0
Total:	**95**	**0**			**1**	**94**	**0**

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)	0	0	0	0	0	0	84
Payment Denial Notice (NOA-C)	0	0	0	0	0	0	74
Delivery System Notice	0	0	0	0	0	0	149
Modification Notice	0	0	0	0	0	0	4
Termination Notice	0	1	5	0	0	0	1092
Authorization Delay Notice	0	0	0	0	0	0	0
Timely Access Notice (NOA-E)	0	0	0	0	0	0	36
Financial Liability Notice	0	0	0	0	0	0	0
Grievance and Appeal Timely Resolution Notice	0	0	0	0	0	0	0
Total:	**0**	**1**	**5**	**0**	**0**	**0**	**1439**

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 19-20, 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: • % of Disposition letters sent within timeframes: **FY 19-20 Quarterly Averages:** • % of Acknowledgement letters sent within timeframes: • % of Disposition letters (NGR's and NAR's) sent within timeframes:	

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	8	100%	100%	100%
Aug	12	100%	100%	100%
Sept	10	100%	100%	100%
Oct	9	100%	100%	100%
Nov	6	50%	100%	50%
Dec	12	50%	100%	50%
Jan	8	75%	100%	100%
Feb	11	100%	100%	100%
Mar	10	100%	100%	100%
Apr	2	100%	100%	100%
May	5	100%	100%	100%
Jun	4	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 19-20, 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 18-19 for:** • Total # of Problem Resolution issues: • # of issues requiring a system change: • # Referred to Policy Committee: • # Referred for Adverse Outcome Mtg: **FY 19-20 Quarterly Averages:** • Total # of Problem Resolution issues: ___ • # of issues requiring a system change: ___ • # of System Changes Initiated: ___ • # Referred to Policy Committee: ___ • # of Policies created or amended: ___ • # Referred for Adverse Outcome Mtg: ___	**Q1:**

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	8	0	0	0
Aug	6	0	0	0
Sept	7	0	0	1
Oct	11	0	0	2
Nov	9	0	0	2
Dec	19	0	0	3
Jan	13	0	0	1
Feb	18	0	0	2
Mar	13	0	0	1
Apr	22	0	0	2
May	16	0	0	2
Jun	16	0	0	1

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 19-20, 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 # 1-4
☒ **Partially Met:** Item # 5
☐ **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 18-19 showed the following:

- 5.7% (50) of adult FSP Program clients (including TAY population) were hospitalized and 2.6% (23) were hospitalized 2 or more times.
- 3.6% (18) of Children/Youth FSP Program clients were hospitalized and 2.2% (11) 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 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

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						
FACT/AB 109						
Caminar Adult FSP						
Caminar OA FSP						
Caminar HOME FSP						
Seneca Tay						
FCTU Youth FSP						
County Regional Youth FSP (FF)						
Totals						

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	37					
FACT/AB 109	38	1%	3%	11%	3%	
Caminar Adult FSP	56	3%	5%	0%	2%	
Caminar HOME FSP	32	2%	6%	9%	3%	
Seneca Tay	24	1%	4%	17%	4%	0%
FCTU Youth FSP	62	1%	2%	0%	2%	8%
Fairfield Youth FSP	70	15%	21%	0%	3%	0%
Totals	319	23%	7%	3%	2%	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	59	8%	3%	5%	0%	
Caminar Adult FSP	63	5%	2%	0%	2%	
Caminar HOME FSP	45	7%	7%	11%	7%	
Seneca Tay	26	8%	4%	4%	0%	0%
FCTU Youth FSP	52	0%	0%	0%	0%	10%
Fairfield Youth FSP	76	5%	3%	3%	0%	7%
Totals	321	5%	3%	3%	1%	6%

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	68	4%	12%	6%	1%	
Caminar Adult FSP	65	3%	3%	2%	3%	
Caminar HOME FSP	45	7%	4%	4%	2%	
Seneca Tay	25					
FCTU Youth FSP	47	0%	0%	0%	2%	17%
Fairfield Youth FSP	76	4%	0%	0%	0%	5%
Totals	326	3%	4%	2%	2%	8%

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 19-20, 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 18-19 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 FY 19-20 baseline **Baseline:** Quarterly average of 212 average Adult inpatient hospitalizations in FY 18-19 • **Measurement #2** Maintain a baseline average of 12% or less of clients re-hospitalized within 30 days of discharge from inpatient hospitalization. **Baseline:** Quarterly average of 11.9% readmission rate in FY 18-19	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Month	Total # of Adult Inpatient Hospitalizations	Total # of Adult Discharges	Total # of Adult Rehospitalizations within 30 days of discharge & % of total of discharges	
Jul	107	87	19	18%
Aug	96	77	22	23%
Sep	82	69	9	11%
TOTALS:	285	233	50	14%

Q2:

Oct	94	104	14	14.74%
Nov	65	59	11	16.92%
Dec	87	91	7	8.05%
TOTALS:	247	254	32	12.96%

Q3:

Jan	113	107	20	17.70%
Feb	91	89	21	23.08%
Mar	83	87	13	15.66%
TOTALS:	287	283	54	18.82%

Q4:

Apr	59	55	8	13.56%
May	75	69	16	21.33%
Jun	56	65	14	25%
TOTALS:	190	189	38	19.96%

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 19-20, 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 # 1 ☐ **Partially Met:** Item # ___ ☒ **Not Met:** Item # 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 18-19 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 19-20 baseline average to under 40 Inpatient hospitalizations per quarter. **Baseline:** 44.3 Child inpatient hospitalizations in FY 18-19 • **Measurement #2:** Improve quarterly average to 15% or less clients re-hospitalized within 30 days of discharge from inpatient hospitalization. **Baseline:** 18.6% average readmission rate in FY 18-19	**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	5	8	1	20%
Aug	9	6	0	0%
Sep	13	8	2	15%
TOTALS:	27	22	3	11%
Oct	16	16	0	0%
Nov	18	20	3	16.67%
Dec	14	15	1	7.14%
TOTALS:	48	51	4	8.33%
Jan	12	10	2	16.67%
Feb	16	17	0	0%
Mar	13	15	2	15.38%
TOTALS:	41	42	4	9.76%
Apr	9	7	0	0%
May	3	6	1	33%
June	6	4	0	0%
TOTALS:	18	17	1	33%

<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-4**: Expand the use of Evidence-Based practices throughout the system of care

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 19-20, 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 # ___
☐ **Partially Met:** Item # ___
☐ **Not Met:** Item # ___

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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 18-19 Q4:

# of clients supported with this EBP:

- ACT Model: 142
- EMDR: 23
- Peer Support: 27

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**

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Q1:

Program	# trainings/coaching sessions	# staff attended	# clients supported with this EBP
FACT Team: ACT model			
EMDR			
Peer Employment Training- Recovery Innovations			

***This Goal was interrupted to COVID**

Q2:

Q3:

Q4:

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</table>

<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 19-20, 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 18-19 Q4:

• Total # of Clients experiencing co-Occurring Challenges: 2474

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:
<table>
<tr><th>County Program</th><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>Vallejo Adult FSP</td><td></td><td></td><td></td></tr>
<tr><td>FACT</td><td></td><td></td><td></td></tr>
<tr><td>Q1 TOTAL:</td><td></td><td></td><td></td></tr>
</table>
<table>
<tr><th>Team</th><th># staff received training</th><th># staff attended workgroup or planning session</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
</table>
Q2:

Q3:

Q4:
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</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 19-20, Quality Improvement – Section C, I. - Item F **Name of Data Report:** Avatar Report # 339C **Sub-committee/Staff Responsible:** Clinical Quality Review Committee **Previous FY Baseline Averages:** • **FY 18-19 # of Youth on Psychotropic Medication:** • **FY 18-19 # of Youth on 4 or more Psychotropic Medications:** • **FY 18-19 # of Youth on Antipsychotic Medication:** • **FY 18-19 # of Youth on 2 or more Antipsychotic Medications:** **FY 19-20 Quarterly Averages:**	**Q1:**

	# 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				

	# of Adults on 1 or more Psychotropic Medication:	# of Adults on 4 or more Psychotropic Medications:	# of Adults on 1 or more Antipsychotic Medication:	# of Adults on 2 or more Antipsychotic Medications:
Foster Youth				

Q2:

Q3:

Q4:

*Data report issues resulted in problems accessing this data.

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 19-20, 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 18-19 African American Quarterly Average Served: 1613 • FY 18-19 Hispanic/Latino Quarterly Average Served: 1071 • FY 18-19 Filipino Quarterly Average Served: 216 • FY 18-19 LGBT Quarterly Average Served: 282 **FY 19-20 Quarterly Averages:**	**Q1:** **Q2:** **Q3:**

Q1:

Region	Black/AA Clients	Hispanic/ Latino Clients	Filipino Clients	LGBTQ Clients
North County Region	109	146	14	130
Central County Region	367	256	41	148
South County Region	396	219	74	159
Out of County	52	20	7	25
Unknown	0	0	0	0
Quarter Total:	924	641	136	462
Previous Quarter:				
FY 19-20 Q Ave (Baseline)	**1,613**	**1,071**	**216**	**282**

Q2:

Region	Black/AA Clients	Hispanic/ Latino Clients	Filipino Clients	LGBTQ Clients
North County Region	106	133	15	132
Central County Region	334	228	39	151
South County Region	376	203	71	159
Out of County	51	19	6	23
Unknown	0	0	0	0
Quarter Total:	867	583	131	465
Previous Quarter:	924	641	136	462
FY 19-20 Q Ave (Baseline)	**1,613**	**1,071**	**216**	**282**

Q3:

Region	Black/AA Clients	Hispanic/ Latino Clients	Filipino Clients	LGBTQ Clients
North County Region	118	152	14	64
Central County Region	331	219	35	76
South County Region	399	204	75	80
Out of County	61	20	9	15
Unknown	1	0	0	0
Quarter Total:	910	595	133	235
Previous Quarter:	867	583	131	465

Quality Improvement Area of Data Monitoring	Results of Evaluation

FY 19-20 Q Ave (Baseline)	1,613	1,071	216	282

Q4:

Region	Black/AA Clients	Hispanic/ Latino Clients	Filipino Clients	LGBTQ Clients
North County Region	126	147	11	66
Central County Region	397	239	44	102
South County Region	409	193	74	78
Out of County	59	21	7	14
Unknown	1	1	0	1
Quarter Total:	992	601	136	261
Previous Quarter:	910	595	133	235
FY 19-20 Q Ave (Baseline)	1,613	1,071	216	282

Quality Improvement Area of Data Monitoring	Results of Evaluation
IV. Outcomes & Utilization: • **DM-3: 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 19-20, Network Adequacy and Availability of Resources - Section A, IV. - Item C. **Name of Data Report:** ARCH/MHSA Data **Sub-committee/Staff Responsible:** ARCH/Homeless Outreach Staff **Previous FY Baseline Averages:** • FY 18-19 **FY 19-20 Quarterly Averages:**	**Q1:** *COVID interrupted this process for Q4

Quarter	# of individuals screened	# of those screened offered an assessment	# of those screened reconnected with an existing MHP provider	# of Education & Engagement Activities	# of community members engaged
1	30	8	1	2	9
2	24	12	4	0	0
3	7	2	2	0	0
4					

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 19-20, 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 & 2a ☒ **Partially Met:** Item # 1b, 1c & 2b ☐ **Not Met:** Item # ___	**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 2018-19 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 (FY 18-19 baseline: 76%) b. Maintain goal of an average of 10 business days or less from service request to actual assessment (FY 18-19 baseline: 11.48) c. Achieve goal of an average of 10 business days or less from Assessment Completion date to tx service initiation (FY 18-19 baseline for time from service request to tx service initiation: 28.29 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 (FY 18-19 baseline: 95%) b. Achieve goal of an average of 3 business days or less from service request to actual assessment (FY 18-19 baseline: 2.45 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 Assessment Completion Date to First Tx Service
Routine	89%	9	25.4
Urgent	100%	2	18
Total:	89%	9	25.4

Q2:

Routine	81%	9.93	24.62
Urgent	50%	4.5	14.5
Total:	81%	9.87	12.37

Q3:

Routine	89%	12.69	29.24
Urgent	100%	12.5	38
Total:	89%	12.69	29.36

Q4:

Routine	98%	8.45	25.28
Urgent	66%	3.6	11
Total:	98%	8.3	24.84

<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-2: Vallejo OP and Vacaville OP Adult Services: Service Request to First Offered Assessment Appointment

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 19-20, 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, 1b & 2a
☒ Partially Met: Item # 1c & 2b
☐ Not Met: Item # ___</td>
<td>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 2018-19 average timeliness for Adult services
Goal:
1. For Routine requests for service, VV, FF and VJO County Adult programs will:
a. Achieve goal of 80% resulting in an offered assessment within 10 business days
(FY18-19 baseline for all Adults: 96%)
b. Achieve goal of an average of 10 business days or less from service request to actual assessment
(FY18-19 baseline for all adults: 7.82 days)
c. Achieve goal of an average of 10 business days or less from Assessment Completion date to tx service initiation
(FY 18-19 baseline for time from service request to tx service initiation: 15.75 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
(FY18-19 baseline for all adults: 100%)
b. Achieve goal of an average of 3 business days or less from service request to actual assessment
(FY18-19 baseline for all adults: 5.82 days)</td>
<td>Q1:
<table>
<tr><th>Request Type</th><th>Service Request to Offered Ax Appt
(% w/in 10 bus days for Routine & 3 bus days for Urgent)</th><th>Average # of Business Days from Service Request to Actual Ax Appt</th><th>Average # of Business Days from Assessment Completion Date to First Tx Service</th></tr>
<tr><td>Routine</td><td>99%</td><td>7.04</td><td>19.5</td></tr>
<tr><td>Urgent</td><td>100%</td><td>6.6</td><td>15</td></tr>
<tr><td>Total:</td><td>99%</td><td>7.04</td><td>19.5</td></tr>
</table>
Q2:
<table>
<tr><td>Routine</td><td>100%</td><td>6.13</td><td>16.16</td></tr>
<tr><td>Urgent</td><td>100%</td><td>8.2</td><td>16.67</td></tr>
<tr><td>Total:</td><td>100%</td><td>6.18</td><td>16.18</td></tr>
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Q3:
<table>
<tr><td>Routine</td><td>99%</td><td>6.86</td><td>16.97</td></tr>
<tr><td>Urgent</td><td>100%</td><td>4.75</td><td>17</td></tr>
<tr><td>Total:</td><td>99%</td><td>6.82</td><td>16.97</td></tr>
</table>
Q4:
<table>
<tr><td>Routine</td><td>98%</td><td>6.1</td><td>13.3</td></tr>
<tr><td>Urgent</td><td>100%</td><td>1.8</td><td>3.6</td></tr>
<tr><td>Total:</td><td>98%</td><td>6</td><td>13.3</td></tr>
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<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: CHILDREN's SERVICES Retention: Service Request to First Offered Assessment Appointment

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, I. - Item A & D

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 # 2a
☒ Partially Met: Item # 1a & 1b
☒ Not Met: Item # 1c & 2b</td>
<td>AG-3: Maintain or improve the following engagement & attrition measures for Children:
Baseline: See FY 2018-19 average engagement & attrition for Children's services
Goal:
1. For Routine requests for service, County Children's programs will:
a. Maintain goal of 80% resulting in an Assessment
(FY 18-19 baseline: 73%)
b. Achieve goal of 55% resulting in initiation of treatment
(FY 18-19 baseline: 36%)
2. For Urgent requests for service, County Children's programs will:
a. Maintain goal of 95% resulting in an assessment
(FY 18-19 baseline: 93%)
b. Achieve goal of 90% resulting in initiation of treatment
(FY 18-19 baseline: 64%)</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>191</td><td>86%</td><td>43.9%</td></tr>
<tr><td>Urgent</td><td>2</td><td>100%</td><td>50%</td></tr>
<tr><td>Total:</td><td>193</td><td>86%</td><td>44%</td></tr>
</table>
Q2:
<table>
<tr><td>Routine</td><td>240</td><td>75%</td><td>33%</td></tr>
<tr><td>Urgent</td><td>2</td><td>100%</td><td>100%</td></tr>
<tr><td>Total:</td><td>242</td><td>75%</td><td>33%</td></tr>
</table>
Q3:
<table>
<tr><td>Routine</td><td>195</td><td>85%</td><td>38%</td></tr>
<tr><td>Urgent</td><td>3</td><td>67%</td><td>33%</td></tr>
<tr><td>Total:</td><td>198</td><td>85%</td><td>38%</td></tr>
</table>
Q4:
<table>
<tr><td>Routine</td><td>121</td><td>86.78%</td><td>52.9%</td></tr>
<tr><td>Urgent</td><td>3</td><td>100%</td><td>66.6%</td></tr>
<tr><td>Total:</td><td>124</td><td>87.1%</td><td>53.2%</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: ADULT SERVICES
Retention: Service Request to First Offered Assessment Appointment

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, I. - Item A & D

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 # 1a & 2a
☒ Not Met: Item # 1b & 2b</td>
<td>AG-4: Maintain or improve the following engagement & attrition measures for Adults:
Baseline: See FY 2018-19 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
(FY 18-19 baseline: 6%)
b. Achieve goal of 55% resulting in initiation of treatment
(FY 18-19 baseline: 46%)
2. For Urgent requests for service, County Adult programs will:
a. Maintain goal of 85% resulting in an assessment
(FY 18-19 baseline: 88%)
b. Achieve goal of 60% resulting in initiation of treatment
(FY 18-19 baseline: 56%)</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>409</td><td>50.9%</td><td>35.7%</td></tr>
<tr><td>Urgent</td><td>4</td><td>75%</td><td>50%</td></tr>
<tr><td>Total:</td><td>413</td><td>51.1%</td><td>35.8%</td></tr>
</table>
Q2:
<table>
<tr><td>Routine</td><td>347</td><td>57%</td><td>32%</td></tr>
<tr><td>Urgent</td><td>6</td><td>83%</td><td>50%</td></tr>
<tr><td>Total:</td><td>353</td><td>58%</td><td>32%</td></tr>
</table>
Q3:
<table>
<tr><td>Routine</td><td>381</td><td>59%</td><td>41%</td></tr>
<tr><td>Urgent</td><td>4</td><td>100%</td><td>75%</td></tr>
<tr><td>Total:</td><td>385</td><td>59%</td><td>42%</td></tr>
</table>
Q4:
<table>
<tr><td>Routine</td><td>292</td><td>70.5%</td><td>51.03%</td></tr>
<tr><td>Urgent</td><td>5</td><td>100%</td><td>60%</td></tr>
<tr><td>Total:</td><td>297</td><td>71%</td><td>51.18%</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 19-20, 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, 2 & 4 ☒ **Partially Met:** Item # 3 ☐ **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 18-19% 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 2018-19
Languages Tested: Spanish & Tagalog	B	2	2	100%	67%
	A	3	1	33%	71%
Was Information given about how to access SMHS, including how to get an Ax.	B	3	3	100%	81%
	A	5	1	20%	74%
Info about how to treat a client's urgent condition	B	2	2	100%	100%
	A	0	n/a	n/a	100%
Info about how to use the Problem Resolution/Fair Hearing process	B	1	1	100%	100%
	A	1	1	100%	100%
Logging Name of client, date of request, & initial disposition	B	5	5	100%	81%
	A	5	1	20%	57%

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 2018-19
Languages Tested: Spanish, Creole & Tagalog	B	3	3	100%	67%
	A	2	0	0%	71%
Was Information given about how to access SMHS, including how to get an Ax.	B	4	4	100%	81%
	A	3	2	67%	74%
Info about how to treat a client's urgent condition	B	2	2	100%	100%
	A	0	---	---	100%
Info about how to use the Problem Resolution/Fair Hearing process	B	0	---	---	100%
	A	2	1	50%	100%
Logging Name of client, date of request, & initial disposition	B	6	6	100%	81%
	A	5	4	80%	57%

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 2018-19
Languages Tested: Spanish & Tagalog	B	3	3	100%	67%
	A	3	0	0%	71%
Was Information given about how to access SMHS, including how to get an Ax.	B	5	5	100%	81%
	A	3	0	0%	74%
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	2	0	0%	100%
Logging Name of client, date of request, & initial disposition	B	5	5	100%	81%
	A	5	2	40%	57%

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 2018-19
Languages Tested: Spanish, Lithuanian & Russian	B	3	3	100%	67%
	A	3	2	67%	71%
Was Information given about how to access SMHS, including how to get an Ax.	B	6	5	83%	81%
	A	4	2	50%	74%
Info about how to treat a client's urgent condition	B	0	n/a	n/a	100%
	A	0	n/a	n/a	100%
Info about how to use the Problem Resolution/Fair Hearing process	B	0	n/a	n/a	100%
	A	2	1	50%	100%
Logging Name of client, date of request, & initial disposition	B	6	5	83%	81%
	A	4	3	75%	57%

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 19-20, 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 18-19: **98.4%** • Quarterly Average of % of Abandoned calls in FY 18-19: **1.6%** **FY** 19-20 **Quarterly Averages:** • Total # of Problem Resolution	**Q1:** **Month/ Quarter** / **Calls Received** / **Calls Handled** / **% (Handled/ Received)** JUL 378 354 94% AUG 452 447 99% SEP 471 469 100% OCT 482 480 99% NOV 339 333 98% DEC 421 419 99% JAN 469 473 99% FEB 435 435 100% MAR 403 405 99% APR 339 329 97% MAY 376 373 99% JUN 440 437 99%

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 19-20, 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? • **Measurement #2:** 90-100% of services will be verified during the week of Service Verification.	**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?
FCTU	100%	$ -	NA
Vacaville Youth	100%	$ -	NA
Vallejo Youth	100%	$ -	NA
Fairfield Youth	96%	$ 1,306.26	Yes
Fairfield Youth FSP	100%	$ -	NA
Vallejo ICC	90%	$ 6,449.01	Yes
Vacaville ICC	100%	$ -	NA
Vallejo Adult FSP	88%	$ 1,856.18	Yes
Fairfield ICC	84%	$ 7,718.58	Yes
FACT	76%	$ 1,547.40	Yes
ICS	71%	$ 2,003.50	Yes

Q3:

County Program	% of services verified	Cost of unverified services	Were NOBE's submitted for all unverified services?
Vallejo ICC	85%	$7,672.51	Yes
ACT Team	57%	$2,012.78	Yes
Fairfield ICC	94%	$2,369.25	Yes
Vallejo Youth	100%	$ -	NA
Vacaville Youth	100%	$ -	NA
Vacaville ICC	100%	$ -	NA
FCTU	100%	$ -	NA
Fairfield Youth	100%	$ -	NA
Fairfield Youth FSP	74%	$7,806.94	Yes
FACT	100%	$ -	NA
ICS	77%	$1,987.74	Yes

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 19-20, 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 # 1-2 ☐ **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? • **Measurement #2:** 90-100% of services will be verified during the week of Service Verification.	**Q1:** ***(Per MHP Policy, No Contract Agency SV required during Q1 and Q3)*** **Q2:** **Q3:** ***(Per MHP Policy, No Contract Agency SV required during Q1 and Q3)*** **Q4:**

Q2:

Contract Program	% of services verified	Cost of unverified services	Were NOBE's submitted for all unverified services?
A Better Way	100%	$ -	NA
A Better Way	71%	$ 4,111.50	Yes
Aldea Counseling	99%	$ 176.00	Yes
Aldea SOAR	100%	$ -	NA
BACS Rosewood	100%	$ -	NA
Caminar CCM	89%	$ 3,291.25	Yes
Caminar FSP	91%	$ 2,342.83	Yes
Caminar Homeless	94%	$ 578.40	Yes
Child Haven	86%	$ 1,128.60	Yes
Child Haven EPSDT	100%	$ -	NA
Child Haven Vallejo	100%	$ -	NA
Child Haven Vallejo EPSDT	100%	$ -	NA
Psynergy	100%	$ -	NA
Seneca EPSDT	94%	$ 761.94	Yes
Seneca Family Support	85%	$ 865.98	Yes
Seneca TAY	98%	$ 336.60	Yes
Seneca TBS	100%	$ -	NA
Seneca WRAP	100%	$ -	NA
Sierra School	100%	$ -	NA
Uplift Family Services	91%	$ 3,078.10	Yes

Q4:

Contract Program	% of services verified	Cost of unverified services	Were NOBE's submitted for all unverified services?
A Better Way	No in-person services due to Covid-19 restrictions.		
Aldea	No in-person services due to Covid-19 restrictions.		
BACS Rosewood	100%	$ -	NA
Caminar CCM	89%	$ 683.26	Yes
Caminar FSP	100%	$ -	NA
Caminar Homeless	100%	$ -	NA
Child Haven	No in-person services due to Covid-19 restrictions.		
Psynergy	100%	$ -	NA
Seneca	No in-person services due to Covid-19 restrictions.		
Sierra School	No in-person services due to Covid-19 restrictions.		
Uplift Family Services	No in-person services due to Covid-19 restrictions.		

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 19-20, 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>JUL</td><td>Yes</td><td>7/24/2019 – Minor transportation, cell phone policy & ROI’s</td></tr>
<tr><td>AUG</td><td></td><td></td></tr>
<tr><td>SEP</td><td></td><td></td></tr>
<tr><td>OCT</td><td>Yes</td><td>10/23/2019 – Minor transportation, cell phone policy & ROI’s</td></tr>
<tr><td>NOV</td><td></td><td></td></tr>
<tr><td>DEC</td><td></td><td></td></tr>
<tr><td>JAN</td><td></td><td></td></tr>
<tr><td>FEB</td><td></td><td></td></tr>
<tr><td>MAR</td><td></td><td></td></tr>
<tr><td>APR</td><td></td><td></td></tr>
<tr><td>MAY</td><td></td><td></td></tr>
<tr><td>JUNE</td><td></td><td></td></tr>
</table>
*COVID interrupted Q4 Compliance meeting</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 19-20, Program Integrity – Section G, III. - Item B4-6 **Name of Data Report:** TBD **Sub-committee/Staff Responsible:** Compliance Committee meeting minutes/Compliance Unit report	**Q1:** **Month** / **# of BH staff participants** / **# of Communications** JUL: 0 / 1 AUG: 3 / 0 SEP: 0 / 1 OCT: 1 / 0 NOV: 3 / 0 DEC: 0 / 0 JAN: 2 / 0 FEB: 1 / 0 MAR: 0 / 2 APR: 0 / 4 MAY: 0 / 3 JUNE: 0 / 4

VII. Quality Improvement (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
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 19-20, Network Adequacy and Availability of Services – Section A, VI. – Item D10, D12 & 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 # ___ ☒ **Not Met:** Item # 1-2	**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 2018-19. **Goal:** The following processes are in place for FY 2019-20 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.	

Q #	# Programs Audited	% of programs that received UR Audit Report w/in 60 days of audit alert period?	% of programs requiring a Corrective Action Plan (CAP)?	% of programs that submitted a CAP w/in 60 days of UR Audit Report	% of programs that submitted an adequate CAP?
Q1	4	75%	100%	100%	100%
Q2	14	21%	100%	64%	71%
Q3	10	10%	100%	60%	
Q4	10	22%	100%	100%	100%

<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 19-20, Network Adequacy and Availability of Services – Section A, VI. - Item D10, D12 & 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 # ___
☒ Not Met: Item # 1-2</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 2018-19.
Goal: The following processes are in place for FY 2019-20 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 Treatment Plans received for Quality Reveiw</th><th>% of programs receiving monthly concurrent review status report</th></tr>
<tr><td>JUL</td><td>84%</td><td>438</td><td>87%</td></tr>
<tr><td>AUG</td><td>75%</td><td>336</td><td>85%</td></tr>
<tr><td>SEP</td><td>61%</td><td>383</td><td>44%</td></tr>
<tr><td>OCT</td><td>40%</td><td>422</td><td>46%</td></tr>
<tr><td>NOV</td><td>31%</td><td>357</td><td>0%</td></tr>
<tr><td>DEC</td><td>49%</td><td>422</td><td>0%</td></tr>
<tr><td>JAN</td><td>42%</td><td>473</td><td>8%</td></tr>
<tr><td>FEB</td><td>40%</td><td>336</td><td>0%</td></tr>
<tr><td>MAR</td><td>31%</td><td>337</td><td>0%</td></tr>
<tr><td>APR</td><td>26%</td><td>312</td><td>0%</td></tr>
<tr><td>MAY</td><td>29%</td><td>307</td><td>0%</td></tr>
<tr><td>JUNE</td><td colspan="3">Quality Review process was changed effective June 1, 2020</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 19-20, 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 # of Attendees	Avatar Phase I # of Attendees	Avatar Phase II # of Attendees
Jul	11	9	3
Aug	6	10	0
Sep	9	6	0
Oct	3	4	0
Nov	8	4	0
Dec	6	4	3
Jan	7	0	0
Feb	9	1	1
Mar	5	12	3
Apr	0	6	0
May	6	0	0
Jun	0	0	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 19-20, 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:**

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

*COVID interrupted schedule during Q4

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 19-20, 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:**

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)

Quality Improvement Area of Data Monitoring	Results of Evaluation
VIII: Network Adequacy: • **DM-1**: Pathways to Well-Being (Subclass) **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, 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:** • Pathways/Katie A. Implementation Team	**Q1:**

	# of Pathways Clients Identified	# of Clients Offered ICC Services	% of Clients Offered ICC Services	Declined or AWOL	Accepted	# Assigned an ICC Coord	% Accepting ICC Who Are Assigned an ICC Coordinator	# For Whom a CFTM Occurred or is Scheduled
County								
CBO								

Q2:

	# of Pathways Clients Identified	# of Clients Offered ICC Services	% of Clients Offered ICC Services	Declined or AWOL	Accepted	# Assigned an ICC Coord	% Accepting ICC Who Are Assigned an ICC Coordinator	# For Whom a CFTM Occurred or is Scheduled
County	87	73	84%	9	64	64	100%	64
CBO	62	58	94	16	42	42	100	42

Q3:

	# of Pathways Clients Identified	# of Clients Offered ICC Services	% of Clients Offered ICC Services	Declined or AWOL	Accepted	# Assigned an ICC Coord	% Accepting ICC Who Are Assigned an ICC Coordinator	# For Whom a CFTM Occurred or is Scheduled
County	82	79	96	13	66	66	100	66
CBO	62	58	94	16	42	42	100	42

Q4:

	# of Pathways Clients Identified	# of Clients Offered ICC Services	% of Clients Offered ICC Services	Declined or AWOL	Accepted	# Assigned an ICC Coord	% Accepting ICC Who Are Assigned an ICC Coordinator	# For Whom a CFTM Occurred or is Scheduled
County	76	68	89%	11	57	57	100%	57
CBO	51	45	88%	13	32	32	100%	32

Quality Improvement Area of Data Monitoring	Results of Evaluation

VIII: Network Adequacy:

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

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 19-20, 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:

- Pathways/Katie A. Implementation Team

Q1:

# Referred to MHP	# Assessed & Referred for Services	# of Pathways Clients Identified	# of Clients Who Received/ Scheduled a CFT Meeting	# of Clients Who Declined Services	# of Clients AWOL	# of Clients Awaiting Response

Q2:

# Referred to MHP	# Assessed & Referred for Services	# of Pathways Clients Identified	# of Clients Who Received/ Scheduled a CFT Meeting	# of Clients Who Declined Services	# of Clients AWOL	# of Clients Awaiting Response
		127	118	5	0	4

Q3:

# Referred to MHP	# Assessed & Referred for Services	# of Pathways Clients Identified	# of Clients Who Received/ Scheduled a CFT Meeting	# of Clients Who Declined Services	# of Clients AWOL	# of Clients Awaiting Response

Q4:

# Referred to MHP	# Assessed & Referred for Services	# of Pathways Clients Identified	# of Clients Who Received/ Scheduled a CFT Meeting	# of Clients Who Declined Services	# of Clients AWOL	# of Clients Awaiting Response
		117	103	5	0	9

Goal Purpose and Monitoring	Results of Evaluation
VIII: Network Adequacy: • **DM-3**: Provider Network Data **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, 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	

	Clients Served	Total Network Providers	Billing for Services	Not Billing for Services	Not Billing or Accepting New Clients (3+ months)	Bilingual Providers	Trained to Use Interpreter	Near Public Transportation	Access for the Physically Disabled	Beacon Referrals
Q 1	9	28	16	12	12	5	28	25	17	85
Q 2	13	27	15	12	13	5	27	23	16	64
Q 3	10	27	11	16	16	5	27	23	16	73
Q 4	7	25	10	15	18	5	25	23	16	41