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)

<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>
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 # ___
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<td>
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.)
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<td>
Q1:
<table>
<tr><th>Staff Category</th><th>Total Staff</th><th>% in Compliance</th></tr>
<tr><td>County Provider</td><td></td><td></td></tr>
<tr><td>County Non-provider</td><td></td><td></td></tr>
<tr><td>Contracted Provider</td><td></td><td></td></tr>
<tr><td>Contracted Non-provider</td><td></td><td></td></tr>
</table>
Q2:

Q3:

Q4:
</td>
</tr>
</table>

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				
2				
3				
4				

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: ___ • HOLA calls per quarter: ___	**Q1:** **Q2:** **Q3:** **Q4:**

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

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: ___ • Kaagapay calls per quarter: ___	**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

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- Family Group-	Adult Group- Family Group-	Adult Group- Family Group-	Adult Group- Family Group-
Q4	Adult Group- Family Group-	Adult Group- Family Group-	Adult Group- Family Group-	Adult Group- Family Group-

Demographics of participants:
Graph pending Q3 data

Adult Group-
Family Group-

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:
- Actual number of participants with lived experience per quarter:

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

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 peers joined workgroup and event; 3 shared their personal recovery stories	13
	Peer Specialist Team Meeting: July 16, August 17, Sept. 14	(Gather data from WRU sign in sheets)	
2	EQRO on site review: 10/23-10/24/18	4 participants for both days of review (Excludes breakout groups)	19
	QIC Committee: 11/16/18	0	
	Peer Specialist Team Meetings October 12, November 16	10/12: 8, 11/16: 7= 15 (check sign in sheets)	
3	Peer Specialist Team Meeting: Jan. 11	1/11: 7;	

III. Beneficiary Satisfaction & Protection (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>
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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 # ___

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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.

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Q1:

Program	Identified Area of Focus	Baseline	Intervention	Post Intervention Measurement/ Change

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</table>

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 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: • # of issues requiring a system change: • # Referred to Policy Committee: **FY 18-19 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: ___	**Q1:** **Q2:** **Q3:** **Q4:**

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					
Aug					
Sept					
Q1 Total					

Oct					
Nov					
Dec					
Q2 Total					

Jan					
Feb					
Mar					
Q3 Total					

Apr					
May					
Jun					
Q4 Total					

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: • Data Trends:	

Category	Process				Grievance Disposition		
	Grievance	Exempt Grievances	Appeal	Expedited Appeal	Grievances pending as of 6/30	Resolved	Referred
Appeals from NOABDs							
ACCESS							
Quality of Care							
Change of Provider							
Confidentiality							
Other							
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)							
Payment Denial Notice (NOA-C)							
Delivery System Notice							
Modification Notice							
Termination Notice							
Authorization Delay Notice							
Timely Access Notice (NOA-E)							
Financial Liability Notice							
Grievance and Appeal Timely Resolution Notice							
Total:							

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: • % of Disposition letters sent within timeframes: **FY 18-19 Quarterly Averages:** • % of Acknowledgement letters sent within timeframes: • % of Disposition letters (NGR's and NAR's) sent within timeframes:	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Month Rec'd	Total # of Grievances, Appeals and Expedited Appeals Rec'd	Total # of Acknowl-edgement Letters sent	Total % that Comply	Total # of Dispo Letters sent	Total % that Comply	Total # and % of Providers who were notified of Disposition	
July							
Aug							
Sept							
Q1 Total							

Q2:

Oct							
Nov							
Dec							
Q2 Total							

Q3:

Jan							
Feb							
Mar							
Q3 Total							

Q4:

Apr							
May							
Jun							
Q4 Total							

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: • # of issues requiring a system change: • # Referred to Policy Committee: • # Referred for Adverse Outcome Mtg: **FY 18-19 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:** **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				
Aug				
Sept				
Q1 Total				

Oct				
Nov				
Dec				
Q2 Total				

Jan				
Feb				
Mar				
Q3 Total				

Apr				
May				
Jun				
Q4 Total				

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 # ____ ☐ **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:** **Q2:** **Q3:** **Q4:**

FSP Programs this Quarter (Adults)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospitalized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homelessness
VJO Adult FSP					
FACT/AB 109					
Caminar Adult FSP					
Caminar OA FSP					
Caminar HOME FSP					
Seneca TAY FSP					
Totals					

FSP Programs this Quarter (Youth)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospitalized > 1x	Total # incarcerated 1x	# of clients exp. 1x incidence of homelessness
FCTU Youth FSP					
FF Youth FSP					
VV Youth FSP					
VJO Youth FSP					
Totals					

<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-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 # ___</td>
<td>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.</td>
<td>Q1:
<table>
<tr><th>Month</th><th>Total # of Adult Inpatient Hospitalizations</th><th>Total # of Adult Discharges</th><th colspan="2">Total # of Adult Rehospitalizations within 30 days of discharge & % of total of discharges</th></tr>
<tr><td>Jul</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Aug</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Sep</td><td></td><td></td><td></td><td></td></tr>
<tr><td>TOTALS:</td><td></td><td></td><td></td><td></td></tr>
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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>
<tr><td>TOTALS:</td><td></td><td></td><td></td><td></td></tr>
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Q3:
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<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>
<tr><td>TOTALS:</td><td></td><td></td><td></td><td></td></tr>
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Q4:
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<tr><td>Apr</td><td></td><td></td><td></td><td></td></tr>
<tr><td>May</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Jun</td><td></td><td></td><td></td><td></td></tr>
<tr><td>TOTALS:</td><td></td><td></td><td></td><td></td></tr>
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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 # ___	**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				
Aug				
Sep				
TOTALS:				
Oct				
Nov				
Dec				
TOTALS:				
Jan				
Feb				
Mar				
TOTALS:				
Apr				
May				
June				
TOTALS:				

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:** ☐ **Partially Met:** See Note ☐ **Not Met:**	**AG-4:** MHP Staff will continue to provide support, outreach, and assistance to homeless mentally ill individuals who are brought to the attention of SCBH Services. The MHP hired two Homeless Outreach staff during FY 16-17: Mental Health Specialist and Mental Health Clinician. Services started in January 2017. These staff members go to homeless shelters, encampments, ride 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							
TAY ARCH							

Q2:

Adult ARCH							
TAY ARCH							

Q3:

Adult ARCH							
TAY ARCH							

Q4:

Adult ARCH							
TAY ARCH							

<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>
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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 # ___
☐ **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 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**

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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			

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 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 # ___

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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.**

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Q1:

County Program	Total # Clients experiencing co-occurring challenges	Total # of Clients with integrated treatment plans	Total # who showed Clinical Improvement through stage of change (this would be included in tx plan updates)
Vallejo Adult FSP	In process of identifying		
FACT			
Q1 TOTAL:			

Team	# staff received training	# staff attended workgroup or planning session

Q2:

Q3:

Q4:

</td>
</tr>
</table>

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

<table>
<tr><th>Quality Improvement Area of Data Monitoring</th><th>Results of Evaluation</th></tr>
<tr><td>

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:

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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				

Q2:

Q3:

Q4:

</td></tr>
</table>

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:** **Q2:** **Q3:** **Q4:**

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**

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 # ___ ☐ **Partially Met:** Item # ___ ☐ **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 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:**

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			
Urgent			
Total:			

Q2:

Routine			
Urgent			
Total:			

Q3:

Routine			
Urgent			
Total:			

Q4:

Routine			
Urgent			
Total:			

<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 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 # ___
☐ **Partially Met:** Item # ___
☐ **Not Met:** Item # ___

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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, VV, FF and VJO 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)

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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			
Urgent			
Total:			

Q2:

Routine			
Urgent			
Total:			

Q3:

Routine			
Urgent			
Total:			

Q4:

Routine			
Urgent			
Total:			

</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-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 # ___</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></td><td></td><td></td></tr>
<tr><td>Urgent</td><td></td><td></td><td></td></tr>
<tr><td>Total:</td><td></td><td></td><td></td></tr>
</table>
Q2:
<table>
<tr><td>Routine</td><td></td><td></td><td></td></tr>
<tr><td>Urgent</td><td></td><td></td><td></td></tr>
<tr><td>Total:</td><td></td><td></td><td></td></tr>
</table>
Q3:
<table>
<tr><td>Routine</td><td></td><td></td><td></td></tr>
<tr><td>Urgent</td><td></td><td></td><td></td></tr>
<tr><td>Total:</td><td></td><td></td><td></td></tr>
</table>
Q4:
<table>
<tr><td>Routine</td><td></td><td></td><td></td></tr>
<tr><td>Urgent</td><td></td><td></td><td></td></tr>
<tr><td>Total:</td><td></td><td></td><td></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-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 # ___
☐ Partially Met: Item # ___
☐ Not Met: Item # ___</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></td><td></td><td></td></tr>
<tr><td>Urgent</td><td></td><td></td><td></td></tr>
<tr><td>Total:</td><td></td><td></td><td></td></tr>
</table>
Q2:
<table>
<tr><td>Routine</td><td></td><td></td><td></td></tr>
<tr><td>Urgent</td><td></td><td></td><td></td></tr>
<tr><td>Total:</td><td></td><td></td><td></td></tr>
</table>
Q3:
<table>
<tr><td>Routine</td><td></td><td></td><td></td></tr>
<tr><td>Urgent</td><td></td><td></td><td></td></tr>
<tr><td>Total:</td><td></td><td></td><td></td></tr>
</table>
Q4:
<table>
<tr><td>Routine</td><td></td><td></td><td></td></tr>
<tr><td>Urgent</td><td></td><td></td><td></td></tr>
<tr><td>Total:</td><td></td><td></td><td></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>
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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 # ___
☐ **Partially Met:** Item # ___
☐ **Not Met:** Item # ___

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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

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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**				66%
	A				33%
Was Information given about how to access SMHS, including how to get an Ax.	**B**				80%
	A				25%
Info about how to treat a client's urgent condition	**B**				100%
	A				100%
Info about how to use the Problem Resolution/Fair Hearing process	**B**				100%
	A				0%
Logging Name of client, date of request, & initial disposition	**B**				78.6%
	A				21.4%

Q2:

Q3:

Q4:

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</table>

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 # of Problem Resolution	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Month/ Quarter	Calls Received	Calls Handled	% (Handled/ Received)	Calls Abandoned	% (Abandoned/ Received)
Jul					
Aug					
Sep					
Q1 Totals					

Q2:

Oct					
Nov					
Dec					
Q2 Total					

Q3:

Jan					
Feb					
Mar					
Q3 Totals					

Q4:

Apr					
May					
Jun					
Q4 Totals					

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 # ___ ☐ **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)***

County Program	Did all applicable programs participate in Service Verification?	Were 100% of services accounted for?	Was a NOBE submitted for all unverified services?
FF Youth FSP			
FF Youth			
FF Adult			
VV Youth FSP			
VV Youth			
VV Adult			
VJO Youth FSP			
VJO Youth			
VJO Adult			
VJO Adult FSP			
FCTU			
FACT/AB 109			

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

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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%)

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Q1: ***(Per MHP Policy, No Contract Agency SV required during Q1 and Q3)***

Q2:

Contract Program	Did all applicable programs participate in Service Verification?	Were 100% of services accounted for?	Was a NOBE submitted for all unverified services?
A Better Way			
Aldea			
Caminar			
Child Haven			
Psynergy			
Rio Vista CARE			
Seneca*			
Sierra School			
Uplift Family Services			

Q3: ***(Per MHP Policy, No Contract Agency SV required during Q1 and Q3)***

Q4:

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</table>

VI. Program Integrity (Data Monitoring - DM)

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

• DM-1: Compliance Committee

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 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></td><td></td><td></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></td><td></td><td></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></td><td></td><td></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>
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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>
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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>
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</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 # ___
☐ 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></td><td></td><td></td><td></td></tr>
</table>
Q2:

Q3:

Q4:
</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 # ___
☐ 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>---</td><td>---</td></tr><tr><td>Aug</td><td>---</td><td>---</td></tr><tr><td>Sep</td><td>---</td><td>---</td></tr></table>Q2:

Q3:

Q4:</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:** **Q2:** **Q3:** **Q4:**

Month	Doc Training offered?	Date Training Offered	Avatar Phase I training offered?	Date Training Offered	Avatar Phase II training offered?	Date Training Offered
Jul						
Aug						
Sep						
Oct						
Nov						
Dec						
Jan						
Feb						
Mar						
Apr						
May						
Jun						

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	Which 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			
Aug			
Sep			
Oct			
Nov			
Dec			
Jan			
Feb			
Mar			
Apr			
May			
Jun			

<table>
<tr><th>Quality Improvement Area of Data Monitoring</th><th>Results of Evaluation</th></tr>
<tr><td>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</td><td>Q1:
<table>
<tr><th>Month</th><th>How many providers initially showed up on one of the lists?</th><th>Was action taken to investigate provider's ability to work in the MHP?</th><th>How many providers were determined to be ineligible to practice?</th><th>Were 100% of County, Contract and Network Providers verified on the exclusion lists?</th></tr>
<tr><td>Jul</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Aug</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Sep</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>May</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Jun</td><td></td><td></td><td></td><td></td></tr>
</table></td></tr>
</table>

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		

Q2:

Q3:

Q4:

<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 colspan="2">Offered ICC Services # and %</th><th>Declined or AWOL</th><th colspan="2">Assigned an ICC Coordinator # and %</th><th colspan="2">CFT Meeting Held or Scheduled</th></tr>
<tr><td>SCMH</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Contract Agency</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>
Q2:

Q3:

Q4:</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:**

County Region	# of Providers in ea. Region	% of Providers in ea. 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.
N/A								
North								
Central								
South								