

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 PERFORMANCE 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
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QUALITY ASSURANCE	QUALITY MANAGEMENT	QUALITY IMPROVEMENT
Site Certifications Clinical Records Review Problem Resolution/SIR Process Concurrent Review Process Staff Eligibility Verification Service Verification Service Authorization	Utilization Management Consumer Surveys Provider Satisfaction Surveys Service Capacity Analysis Network Adequacy Evidence-Based Practices Performance Outcomes	Training Coordination Continuing Education Core Competencies Communication via Mental Health Internet Site Communication via the Network of Care Performance Improvement Projects 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																																																															
<p>I. Cultural Competence:</p> <ul style="list-style-type: none"> • AG-1: System wide Cultural Competence Training <p>Purpose for Monitoring: DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Item E</p> <p>Name of Data Report:</p> <ul style="list-style-type: none"> • Network Adequacy Certification Tool • Quality Improvement Training Tracking Sheets <p>Sub-committee/Staff Responsible:</p> <ul style="list-style-type: none"> • Quality Improvement <p>Annual Goal Items Met:</p> <p><input type="checkbox"/> Met: Item # ____</p> <p><input checked="" type="checkbox"/> Partially Met: Item # ____</p> <p><input type="checkbox"/> Not Met: Item # ____</p>	<p>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.</p> <p>FY 18-19 Baseline:</p> <ul style="list-style-type: none"> • County Providers: 223 • County Non-Provider: 82 • Contract Provider: Pending • Contract Non-Provider: Pending <p>Goal: Monitor Annual training and work toward 100% annual training compliance for:</p> <ul style="list-style-type: none"> • 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.) 	<p>Q1:</p> <table border="1"> <thead> <tr> <th>Staff Category</th> <th>Total Staff</th> <th>% of Staff in Compliance with annual requirement</th> </tr> </thead> <tbody> <tr> <td>County Provider</td> <td>139</td> <td>90%</td> </tr> <tr> <td>County Non-provider</td> <td>49</td> <td>94%</td> </tr> <tr> <td>Contracted Provider</td> <td>97</td> <td>78%</td> </tr> <tr> <td>Contracted Non-provider</td> <td>0</td> <td>0%</td> </tr> </tbody> </table>	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%	<p>Q2:</p> <table border="1"> <thead> <tr> <th>Staff Category</th> <th>Total Staff</th> <th>% of Staff in Compliance with annual requirement</th> </tr> </thead> <tbody> <tr> <td>County Provider</td> <td>106</td> <td>44%</td> </tr> <tr> <td>County Non-provider</td> <td>1</td> <td>2%</td> </tr> <tr> <td>Contracted Provider</td> <td>118</td> <td>90%</td> </tr> <tr> <td>Contracted Non-provider</td> <td>0</td> <td>0%</td> </tr> </tbody> </table>	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%	<p>Q3:</p> <table border="1"> <thead> <tr> <th>Staff Category</th> <th>Total Staff</th> <th>% of Staff in Compliance with annual requirement</th> </tr> </thead> <tbody> <tr> <td>County Provider</td> <td>106</td> <td>44%</td> </tr> <tr> <td>County Non-provider</td> <td>1</td> <td>2%</td> </tr> <tr> <td>Contracted Provider</td> <td>118</td> <td>90%</td> </tr> <tr> <td>Contracted Non-provider</td> <td>0</td> <td>0%</td> </tr> </tbody> </table>	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%	<p>Q4:</p> <table border="1"> <thead> <tr> <th>Staff Category</th> <th>Total Staff</th> <th>% of Staff in Compliance with annual requirement</th> </tr> </thead> <tbody> <tr> <td>County Provider</td> <td>106</td> <td>44%</td> </tr> <tr> <td>County Non-provider</td> <td>1</td> <td>2%</td> </tr> <tr> <td>Contracted Provider</td> <td>118</td> <td>90%</td> </tr> <tr> <td>Contracted Non-provider</td> <td>0</td> <td>0%</td> </tr> </tbody> </table>	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%
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I. Cultural Competence (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation																													
<p>I. Cultural Competence:</p> <ul style="list-style-type: none"> DM-1: CC Plan, Training Plan and Committee <p>Purpose for Monitoring: DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Items A- C</p> <p>Name of Data Report:</p> <ul style="list-style-type: none"> None <p>Sub-committee/Staff Responsible:</p> <ul style="list-style-type: none"> Cultural Competence Committee <p>Previous FY Baseline Averages:</p> <p>FY 19-20 Quarterly Averages:</p> <ul style="list-style-type: none"> CCC meetings per Quarter: CC Subcommittee meetings per Quarter: 	<table border="1"> <thead> <tr> <th data-bbox="575 248 779 334">Quarter</th> <th data-bbox="779 248 1064 334">Date of CCC Meeting</th> <th data-bbox="1064 248 1262 334">Date of report to QIC</th> <th data-bbox="1262 248 1457 334">Date CC Plan Updated</th> <th data-bbox="1457 248 1673 334">Date of Annual Report</th> </tr> </thead> <tbody> <tr> <td data-bbox="575 334 779 386">1</td> <td data-bbox="779 334 1064 386">9/10/2019</td> <td data-bbox="1064 334 1262 386">11/14/2019</td> <td data-bbox="1262 334 1457 578" rowspan="4">7/31/2018</td> <td data-bbox="1457 334 1673 578" rowspan="4">1/24/2020</td> </tr> <tr> <td data-bbox="575 386 779 422">2</td> <td data-bbox="779 386 1064 422">2/18/2020</td> <td data-bbox="1064 386 1262 422">2/13/2019</td> </tr> <tr> <td data-bbox="575 422 779 474">3</td> <td data-bbox="779 422 1064 474">COVID RESTRICTIONS</td> <td data-bbox="1064 422 1262 474">5/14/2020</td> </tr> <tr> <td data-bbox="575 474 779 578" rowspan="2">4</td> <td data-bbox="779 474 1064 526">4/14/2020</td> <td data-bbox="1064 474 1262 526" rowspan="2">8/13/2020</td> </tr> <tr> <td data-bbox="779 526 1064 578">5/13/2020</td> </tr> <tr> <td data-bbox="575 578 779 630"></td> <td data-bbox="779 578 1064 630">6/23/2020</td> <td data-bbox="1064 578 1262 630"></td> <td data-bbox="1262 578 1457 630"></td> <td data-bbox="1457 578 1673 630"></td> </tr> </tbody> </table>					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	8/13/2020	5/13/2020		6/23/2020			
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Quality Improvement Area of Data Monitoring	Results of Evaluation						
<p>I. Cultural Competence:</p> <ul style="list-style-type: none"> DM-2: LGBTQ Visibility QI Action Plan- Campaign to combat stigma for LGBTQ community and intersect for Latinex and Filipinex <p>Purpose for Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3.</p> <p>Name of Data Report: MHSA Report</p> <p>Sub-committee/Staff Responsible: MHSA Unit & Ethnic Services Coordinator</p>	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						
<ul style="list-style-type: none"> 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						
<p>I. Cultural Competence:</p> <ul style="list-style-type: none"> DM-3: <i>Takin' CLAS to the Streets</i> QI Action Plan-School Wellness Centers for K-12 and adult ed sites with a cultural lens <p>Purpose for Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3.</p> <p>Name of Data Report: MHSA Report</p> <p>Sub-committee/Staff Responsible: MHSA Unit & Ethnic Services Coordinator</p>	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						
	<ul style="list-style-type: none"> 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						
<p>I. Cultural Competence:</p> <ul style="list-style-type: none"> DM-4: Culturally Responsive Supervision QI Action Plan- Implement Culturally Sensitive Supervision model by Dr. Kenneth Hardy <p>Purpose for Monitoring: DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Item D-E</p> <p>Name of Data Report: MHSA Report</p> <p>Sub-committee/Staff Responsible: MHSA Unit & Ethnic Services Coordinator</p>	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						
	<ul style="list-style-type: none"> 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							
<p>I. Cultural Competence:</p> <ul style="list-style-type: none"> 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. <p>Purpose for Monitoring: DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Item D-E</p> <p>Name of Data Report: MHSA Report</p> <p>Sub-committee/Staff Responsible: MHSA Unit & Ethnic Services Coordinator</p>	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							
	<ul style="list-style-type: none"> 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		
<p>I. Cultural Competence:</p> <ul style="list-style-type: none"> • DM-6: Gap Finders QI Action Plan- Program/CBO self-eval of true implementation of CLAS standards <p>Purpose for Monitoring: DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Item D-E</p> <p>Name of Data Report: N/A</p> <p>Sub-committee/Staff Responsible: Cultural Competency Committee/Ethnic Services Coordinator</p>	<p>Month</p>	<p># of CBO partners who submitted Cultural Responsivity Plan</p>	<p>% of CBO Cultural Responsivity Plans that addressed at least 10 of the 15 CLAS standards</p>
	JUL		
	AUG		
	SEP	1	
	OCT		
	NOV		
	DEC	10	
	JAN	2	
	FEB		
	MAR		
	APR		
	MAY		
	JUN		
	<ul style="list-style-type: none"> • 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					
<p>I. Cultural Competence:</p> <p>DM-7: TRUE Care Promoter QI Action Plan-Phase I Roadmap resource guide</p> <p>Purpose for Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3.</p> <p>Name of Data Report: N/A HR</p> <p>Sub-committee/Staff Responsible: Ethnic Services Coordinator</p>	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					
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Quality Improvement Area of Data Monitoring	Results of Evaluation																																																							
<p>I. Cultural Competence:</p> <ul style="list-style-type: none"> • DM-8: HOLA Community Information and Education Plans – Outreach re: cultural/linguistic services <p>Purpose for Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3.</p> <p>Name of Data Report: Report 333</p> <p>Sub-committee/Staff Responsible: Cultural Competence Coordinator</p> <p>Previous FY Baseline Averages:</p> <ul style="list-style-type: none"> • Outreach Initiatives per Quarter: • HOLA calls per quarter: <p>FY 19-20 Quarterly Averages:</p> <ul style="list-style-type: none"> • Outreach Initiatives per Quarter: ____ • HOLA calls per quarter: ____ 	<table border="1"> <thead> <tr> <th>Month</th> <th># of Community Education & Engagement Activities</th> <th># of Community Members Present</th> <th># of Access calls as a direct result of outreach team</th> </tr> </thead> <tbody> <tr><td>JUL</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>AUG</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>SEP</td><td>1</td><td>60</td><td>0</td></tr> <tr><td>OCT</td><td>3</td><td>223</td><td>0</td></tr> <tr><td>NOV</td><td>1</td><td>27</td><td>0</td></tr> <tr><td>DEC</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>JAN</td><td>1</td><td>30</td><td>0</td></tr> <tr><td>FEB</td><td>2</td><td>231</td><td>0</td></tr> <tr><td>MAR</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>APR</td><td></td><td></td><td></td></tr> <tr><td>MAY</td><td></td><td></td><td></td></tr> <tr><td>JUN</td><td></td><td></td><td></td></tr> </tbody> </table>	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						
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	JUN																																																							
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Quality Improvement Area of Data Monitoring	Results of Evaluation																																																							
<p>I. Cultural Competence:</p> <ul style="list-style-type: none"> • DM-9: Kaagapay Community Information and Education Plans – Outreach re: cultural/linguistic services <p>Purpose for Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3.</p> <p>Name of Data Report: Report 333</p> <p>Sub-committee/Staff Responsible: Cultural Competence Coordinator</p> <p>Previous FY Baseline Averages:</p> <ul style="list-style-type: none"> • Outreach Initiatives per Quarter: • Kaagapay calls per quarter: <p>FY 19-20 Quarterly Averages:</p> <ul style="list-style-type: none"> • Outreach Initiatives per Quarter: ____ • Kaagapay calls per quarter: ____ 	<table border="1" data-bbox="590 196 1587 797"> <thead> <tr> <th data-bbox="590 196 695 326">Month</th> <th data-bbox="695 196 1199 326"># of Community Education & Engagement Activities</th> <th data-bbox="1199 196 1373 326"># of Community Members Present</th> <th data-bbox="1373 196 1587 326"># of Access calls as a direct result of outreach team</th> </tr> </thead> <tbody> <tr><td>JUL</td><td>3</td><td>22</td><td>0</td></tr> <tr><td>AUG</td><td>6</td><td>8</td><td>0</td></tr> <tr><td>SEP</td><td>6</td><td>44</td><td>0</td></tr> <tr><td>OCT</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>NOV</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>DEC</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>JAN</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>FEB</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>MAR</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>APR</td><td></td><td></td><td></td></tr> <tr><td>MAY</td><td></td><td></td><td></td></tr> <tr><td>JUN</td><td></td><td></td><td></td></tr> </tbody> </table> <p data-bbox="590 867 1787 894">This initiative was interrupted due to staffing challenges impacted by the statewide public health emergency</p>				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			
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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																																																																
<p>II. Wellness and Recovery:</p> <ul style="list-style-type: none"> 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. <p>Purpose for Monitoring: DHCS Annual Review Protocols, FY 19-20, Quality Improvement – Section C, I. – Items C & E</p> <p>Name of Data Report: Adult and Family Support Group sign-in sheets and Post Group Survey on quarterly basis (point in time data)</p> <p>Sub-committee/Staff Responsible: Wellness Recovery Unit/ Adult Peer (Consumer Affairs Liaison) and Family Liaison</p> <p>Annual Goal Met: <input type="checkbox"/> Met: Item # ____ <input checked="" type="checkbox"/> Partially Met: Peer Support Group <input checked="" type="checkbox"/> Not Met: Family Support Group</p>	<p>AG-1: Provide Adult and Family Support Groups facilitated by Peer Support Specialists or Family Liaison.</p> <p>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:</p> <p>Goal:</p> <ol style="list-style-type: none"> Increase # of total unique group members who participate quarterly Increase the % of unduplicated participants in WR Peer Support Groups who respond positively to quarterly “Quality of Life Outcome Tool” survey items 	<p>Peer Support Group:</p> <table border="1" data-bbox="947 326 2007 716"> <thead> <tr> <th>Quarter</th> <th># of total unique group members who participated</th> <th>% of participants who “have learned tools/ways to support their or their loved one’s behaviors/symptoms”</th> <th>% of participants who feel supported by the group</th> <th>% of participants who would return to the group</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>7</td> <td>99%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Q2</td> <td>29</td> <td>89%</td> <td>99%</td> <td>99%</td> </tr> <tr> <td>Q3</td> <td>15</td> <td>95%</td> <td>95%</td> <td>100%</td> </tr> <tr> <td>Q4</td> <td>50</td> <td>COVID</td> <td>COVID</td> <td>COVID</td> </tr> <tr> <td>FY 18-19, Q4</td> <td>23</td> <td>80%</td> <td>99%</td> <td>100%</td> </tr> </tbody> </table> <p>Family Support Group:</p> <table border="1" data-bbox="947 862 2007 1252"> <thead> <tr> <th>Quarter</th> <th># of total unique group members who participated</th> <th>% of participants who “have learned tools/ways to support their or their loved one’s behaviors/symptoms”</th> <th>% of participants who feel supported by the group</th> <th>% of participants who would return to the group</th> </tr> </thead> <tbody> <tr> <td>Q1</td> <td>38</td> <td>42%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Q2</td> <td>31</td> <td>99%</td> <td>100%</td> <td>99%</td> </tr> <tr> <td>Q3</td> <td>5</td> <td>80%</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>Q4</td> <td>41</td> <td>COVID</td> <td>COVID</td> <td>COVID</td> </tr> <tr> <td>FY 18-19, Q4</td> <td>36</td> <td>80%</td> <td>100%</td> <td>100%</td> </tr> </tbody> </table>					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%	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%
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II. Wellness and Recovery (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation																							
<p>II. Wellness and Recovery:</p> <p>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.</p> <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Quality Improvement – Section C, III. – Items B &D</p> <p>Name of Data Report: Sign-in Sheets, & Meeting Minutes. MHSA Sign in sheet edited to include collection of this data.</p> <p>Sub-committee/Staff Responsible: Wellness Recovery Unit, MHSA, and other workgroup leads</p> <p>Previous FY Baseline Averages:</p> <ul style="list-style-type: none"> • Average # of meetings/events per Quarter: • Actual number of participants with lived experience per quarter: <p>FY 19-20 Quarterly Averages:</p> <ul style="list-style-type: none"> • Average # of Committees per Quarter: ____ • Total number of participants per quarter: ____ 	<table border="1"> <thead> <tr> <th data-bbox="573 277 747 367">Quarter</th> <th data-bbox="747 277 1234 367"># of Activities</th> <th data-bbox="1234 277 1633 367">Number of persons with lived experience by demographics (youth, adult, family)</th> <th data-bbox="1633 277 2018 367">Total Peer and Family Involvement for the quarter</th> </tr> </thead> <tbody> <tr> <td data-bbox="573 367 747 402">1</td> <td data-bbox="747 367 1234 402">84</td> <td data-bbox="1234 367 1633 402">193</td> <td data-bbox="1633 367 2018 402"></td> </tr> <tr> <td data-bbox="573 402 747 438">2</td> <td data-bbox="747 402 1234 438">81</td> <td data-bbox="1234 402 1633 438">323</td> <td data-bbox="1633 402 2018 438"></td> </tr> <tr> <td data-bbox="573 438 747 474">3</td> <td data-bbox="747 438 1234 474">87</td> <td data-bbox="1234 438 1633 474">209</td> <td data-bbox="1633 438 2018 474"></td> </tr> <tr> <td data-bbox="573 474 747 509">4</td> <td data-bbox="747 474 1234 509">0</td> <td data-bbox="1234 474 1633 509">0</td> <td data-bbox="1633 474 2018 509"></td> </tr> </tbody> </table>	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				
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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				
<p>III. Consumer Perception:</p> <ul style="list-style-type: none"> • AG-1: Quarterly Service Verification Customer Service Survey <p>Purpose of Monitoring:</p> <ul style="list-style-type: none"> • DHCS Annual Review Protocols, 19-20, Quality Improvement – Section C, I. - Items E.1. and E.3. <p>Name of Data Report:</p> <ul style="list-style-type: none"> • Solano MHP Service Verification/Consumer Perception Surveys <p>Sub-committee/Staff Responsible: Quality Improvement Survey Coordinator</p> <p>Annual Goal Met: <input checked="" type="checkbox"/> Met: Item # ____ <input type="checkbox"/> Partially Met: Item # ____ <input type="checkbox"/> Not Met: Item # ____</p>	<p>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.</p> <p>Baseline: Baselines will be specific to the program’s previous Service Verification/Consumer survey results.</p> <p>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.</p>	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/ bilingual 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.	
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III. Beneficiary Satisfaction & Protection (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation																																																																					
<p>III. Beneficiary Protection:</p> <ul style="list-style-type: none"> DM-1: Grievance, Appeal and Expedited Appeal <p>Purpose of Monitoring:</p> <ul style="list-style-type: none"> 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. <p>Name of Data Report:</p> <ul style="list-style-type: none"> ComplyTrack - Problem Resolution Log <p>Sub-committee/Staff Responsible: Problem Resolution Coordinator</p> <p>Previous FY Baseline Averages:</p> <ul style="list-style-type: none"> Total # of Problem Resolution issues: # of issues requiring a system change: # Referred to Policy Committee: <p>FY 19-20 Quarterly Averages:</p> <ul style="list-style-type: none"> 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 	<p>Q1:</p> <table border="1" data-bbox="590 293 2045 849"> <thead> <tr> <th>Month Received</th> <th>Total quarterly # of Problem Resolution issues reported, primarily Grievances and Appeals</th> <th># of issues Requiring a System Change</th> <th># Referred to Policy Committee</th> <th># of Policies created or amended b/c of identified Problem</th> </tr> </thead> <tbody> <tr><td>JUL</td><td>8</td><td>0</td><td>0</td><td>1</td></tr> <tr><td>AUG</td><td>12</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>SEP</td><td>10</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>OCT</td><td>9</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>NOV</td><td>6</td><td>1</td><td>0</td><td>1</td></tr> <tr><td>DEC</td><td>12</td><td>1</td><td>0</td><td>0</td></tr> <tr><td>JAN</td><td>8</td><td>2</td><td>0</td><td>2</td></tr> <tr><td>FEB</td><td>11</td><td>1</td><td>0</td><td>1</td></tr> <tr><td>MAR</td><td>10</td><td>1</td><td>0</td><td>1</td></tr> <tr><td>APR</td><td>2*</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>MAY</td><td>5*</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>JUN</td><td>4*</td><td>0</td><td>0</td><td>0</td></tr> </tbody> </table> <ul style="list-style-type: none"> 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
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<p>III. Beneficiary Protection:</p> <ul style="list-style-type: none"> • DM-2: Tracking and trending of Beneficiary Grievances and Appeals to meet DHCS annual reporting standards <p>Purpose of Monitoring:</p> <ul style="list-style-type: none"> • 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. <p>Name of Data Report:</p> <ul style="list-style-type: none"> • ComplyTrack - Problem Resolution Log <p>Sub-committee/Staff Responsible: Problem Resolution Coordinator</p> <p>Previous FY Baseline Averages:</p> <ul style="list-style-type: none"> • Were all Problem Resolution processes logged and monitored: Yes • Data Trends: <p>FY 19-20 Quarterly Averages:</p> <ul style="list-style-type: none"> • Were all Problem Resolution processes logged and monitored: • Data Trends: 	<table border="1"> <thead> <tr> <th rowspan="2">Category</th> <th colspan="4">Process</th> <th colspan="3">Grievance Disposition</th> </tr> <tr> <th>Grievance</th> <th>Exempt Grievances</th> <th>Appeal</th> <th>Expedited Appeal</th> <th>Grievances pending as of 6/30</th> <th>Resolved</th> <th>Referred</th> </tr> </thead> <tbody> <tr> <td>Appeals from NOABDs</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>ACCESS</td> <td>3</td> <td>0</td> <td></td> <td></td> <td>0</td> <td>3</td> <td>0</td> </tr> <tr> <td>Quality of Care</td> <td>30</td> <td>0</td> <td></td> <td></td> <td>1</td> <td>29</td> <td>0</td> </tr> <tr> <td>Change of Provider</td> <td>42</td> <td>0</td> <td></td> <td></td> <td>0</td> <td>42</td> <td>0</td> </tr> <tr> <td>Confidentiality</td> <td>0</td> <td>0</td> <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>Other</td> <td>20</td> <td>0</td> <td></td> <td></td> <td>0</td> <td>20</td> <td>0</td> </tr> <tr> <td>Total:</td> <td>95</td> <td>0</td> <td></td> <td></td> <td>1</td> <td>94</td> <td>0</td> </tr> </tbody> </table>								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																						
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Quality Improvement Area of Data Monitoring	Results of Evaluation				
<p>III. Beneficiary Protection:</p> <ul style="list-style-type: none"> • DM-3: Tracking the compliance of sending the beneficiary an acknowledgement and Disposition letter. <p>Purpose of Monitoring:</p> <ul style="list-style-type: none"> • 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. <p>Name of Data Report:</p> <ul style="list-style-type: none"> • ComplyTrack - Problem Resolution Log <p>Sub-committee/Staff Responsible: Problem Resolution Coordinator</p> <p>Previous FY Baseline Averages:</p> <ul style="list-style-type: none"> • % of Acknowledgement letters sent within timeframes: • % of Disposition letters sent within timeframes: <p>FY 19-20 Quarterly Averages:</p> <ul style="list-style-type: none"> • % 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					
<p>III. Beneficiary Protection:</p> <ul style="list-style-type: none"> DM-4: Tracking and trending of Internal system improvement needs <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Quality Improvement - Section C, I. - Items C. & E.2., II. - Item B</p> <p>Frequency of Evaluation: Quarterly</p> <p>Name of Data Report:</p> <ul style="list-style-type: none"> Problem Resolution Log QIC Internal System Improvement Report <p>Sub-committee/Staff Responsible: Problem Resolution Coordinator</p> <p>Previous FY Baseline Averages: See FY 18-19 for:</p> <ul style="list-style-type: none"> Total # of Problem Resolution issues: # of issues requiring a system change: # Referred to Policy Committee: # Referred for Adverse Outcome Mtg: <p>FY 19-20 Quarterly Averages:</p> <ul style="list-style-type: none"> 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																																																																																																																																																																																																	
<p>IV. Outcomes & Utilization:</p> <p>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</p> <p>Authority: DHCS Annual Review Protocols, FY 19-20, Quality Improvement - Section C, I. - Items C. & D.</p> <p>Name of Data Report: Solano County MHSA Clinical Supervisor and Contract Manager</p> <p>Sub-committee/Staff Responsible: UM Committee & PIP FSP Work Groups</p> <p>Annual Goal Items Met: <input checked="" type="checkbox"/> Met: Item # 1-4 <input checked="" type="checkbox"/> Partially Met: Item # 5 <input type="checkbox"/> Not Met: Item # _____</p>	<p>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</p> <p>Baseline: FY 18-19 showed the following:</p> <ul style="list-style-type: none"> 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. <p>Goal: Solano MHP will:</p> <ol style="list-style-type: none"> 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 	<p>Q1:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9ead3;"> <th>FSP Programs this Quarter</th> <th># of Clients Served</th> <th>Total % of clients hosp. 1x</th> <th>% of clients hosp. > 1x</th> <th>Total % inc. 1x</th> <th>% of clients exp. 1x inc. of homelessness</th> <th>% Loss of Placement</th> </tr> </thead> <tbody> <tr><td>VJO Adult FSP</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>FACT/AB 109</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Caminar Adult FSP</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Caminar OA FSP</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Caminar HOME FSP</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>Seneca Tay</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>FCTU Youth FSP</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>County Regional Youth FSP (FF)</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> <tr style="background-color: #d9ead3;"><td>Totals</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table> <p>Q2:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9ead3;"> <th>FSP Programs this Quarter</th> <th># of Clients Served</th> <th>Total % of clients hosp. 1x</th> <th>% of clients hosp. > 1x</th> <th>Total % inc. 1x</th> <th>% of clients exp. 1x inc. of homelessness</th> <th>% Loss of Placement</th> </tr> </thead> <tbody> <tr><td>VJO Adult FSP</td><td>37</td><td></td><td></td><td></td><td></td><td></td></tr> <tr><td>FACT/AB 109</td><td>38</td><td>1%</td><td>3%</td><td>11%</td><td>3%</td><td></td></tr> <tr><td>Caminar Adult FSP</td><td>56</td><td>3%</td><td>5%</td><td>0%</td><td>2%</td><td></td></tr> <tr><td>Caminar HOME FSP</td><td>32</td><td>2%</td><td>6%</td><td>9%</td><td>3%</td><td></td></tr> <tr><td>Seneca Tay</td><td>24</td><td>1%</td><td>4%</td><td>17%</td><td>4%</td><td>0%</td></tr> <tr><td>FCTU Youth FSP</td><td>62</td><td>1%</td><td>2%</td><td>0%</td><td>2%</td><td>8%</td></tr> <tr><td>Fairfield Youth FSP</td><td>70</td><td>15%</td><td>21%</td><td>0%</td><td>3%</td><td>0%</td></tr> <tr style="background-color: #d9ead3;"><td>Totals</td><td>319</td><td>23%</td><td>7%</td><td>3%</td><td>2%</td><td>2%</td></tr> </tbody> </table> <p>Q3:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9ead3;"> <th>FSP Programs this Quarter</th> <th># of Clients Served</th> <th>Total % of clients hosp. 1x</th> <th>% of clients hosp. > 1x</th> <th>Total % inc. 1x</th> <th>% of clients exp. 1x inc. of homelessness</th> <th>% Loss of Placement</th> </tr> </thead> <tbody> <tr><td>VJO Adult FSP</td><td>59</td><td>8%</td><td>3%</td><td>5%</td><td>0%</td><td></td></tr> <tr><td>Caminar Adult FSP</td><td>63</td><td>5%</td><td>2%</td><td>0%</td><td>2%</td><td></td></tr> <tr><td>Caminar HOME FSP</td><td>45</td><td>7%</td><td>7%</td><td>11%</td><td>7%</td><td></td></tr> <tr><td>Seneca Tay</td><td>26</td><td>8%</td><td>4%</td><td>4%</td><td>0%</td><td>0%</td></tr> <tr><td>FCTU Youth FSP</td><td>52</td><td>0%</td><td>0%</td><td>0%</td><td>0%</td><td>10%</td></tr> <tr><td>Fairfield Youth FSP</td><td>76</td><td>5%</td><td>3%</td><td>3%</td><td>0%</td><td>7%</td></tr> <tr style="background-color: #d9ead3;"><td>Totals</td><td>321</td><td>5%</td><td>3%</td><td>3%</td><td>1%</td><td>6%</td></tr> </tbody> </table> <p>Q4:</p>					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							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%	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%
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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																																																																																								
<p>IV. Outcomes & Utilization:</p> <ul style="list-style-type: none"> • AG-2: ADULT: CSU-Exodus, Bay Area Community Services, Hospital Liaison <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Quality Improvement - Section C, I. - Items C. & D.</p> <p>Name of Data Report: Quality and Utilization Review of CSU services</p> <p>Sub-committee/Staff Responsible: Utilization Management team</p> <p>Annual Goal Items Met: <input type="checkbox"/> Met: Item # ____ <input type="checkbox"/> Partially Met: Item # ____ <input checked="" type="checkbox"/> Not Met: Item # 1-2</p>	<p>AG-2: The Utilization Management Committee is charged with monitoring the effectiveness of the MHP's infrastructure to reduce inpatient stays and recidivism.</p> <p>Baseline: FY 18-19 Averages</p> <p>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):</p> <ul style="list-style-type: none"> • Measurement #1: Maintain FY 19-20 baseline <p>Baseline: Quarterly average of 212 average Adult inpatient hospitalizations in FY 18-19</p> <ul style="list-style-type: none"> • Measurement #2 Maintain a baseline average of 12% or less of clients re-hospitalized within 30 days of discharge from inpatient hospitalization. <p>Baseline: Quarterly average of 11.9% readmission rate in FY 18-19</p>	<p>Q1:</p> <table border="1" data-bbox="940 152 2047 386"> <thead> <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> </thead> <tbody> <tr> <td>Jul</td> <td>107</td> <td>87</td> <td>19</td> <td>18%</td> </tr> <tr> <td>Aug</td> <td>96</td> <td>77</td> <td>22</td> <td>23%</td> </tr> <tr> <td>Sep</td> <td>82</td> <td>69</td> <td>9</td> <td>11%</td> </tr> <tr> <td>TOTALS:</td> <td>285</td> <td>233</td> <td>50</td> <td>14%</td> </tr> </tbody> </table> <p>Q2:</p> <table border="1" data-bbox="940 415 2047 555"> <tbody> <tr> <td>Oct</td> <td>94</td> <td>104</td> <td>14</td> <td>14.74%</td> </tr> <tr> <td>Nov</td> <td>65</td> <td>59</td> <td>11</td> <td>16.92%</td> </tr> <tr> <td>Dec</td> <td>87</td> <td>91</td> <td>7</td> <td>8.05%</td> </tr> <tr> <td>TOTALS:</td> <td>247</td> <td>254</td> <td>32</td> <td>12.96%</td> </tr> </tbody> </table> <p>Q3:</p> <table border="1" data-bbox="940 584 2047 724"> <tbody> <tr> <td>Jan</td> <td>113</td> <td>107</td> <td>20</td> <td>17.70%</td> </tr> <tr> <td>Feb</td> <td>91</td> <td>89</td> <td>21</td> <td>23.08%</td> </tr> <tr> <td>Mar</td> <td>83</td> <td>87</td> <td>13</td> <td>15.66%</td> </tr> <tr> <td>TOTALS:</td> <td>287</td> <td>283</td> <td>54</td> <td>18.82%</td> </tr> </tbody> </table> <p>Q4:</p> <table border="1" data-bbox="940 753 2047 893"> <tbody> <tr> <td>Apr</td> <td>59</td> <td>55</td> <td>8</td> <td>13.56%</td> </tr> <tr> <td>May</td> <td>75</td> <td>69</td> <td>16</td> <td>21.33%</td> </tr> <tr> <td>Jun</td> <td>56</td> <td>65</td> <td>14</td> <td>25%</td> </tr> <tr> <td>TOTALS:</td> <td>190</td> <td>189</td> <td>38</td> <td>19.96%</td> </tr> </tbody> </table>				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%	Oct	94	104	14	14.74%	Nov	65	59	11	16.92%	Dec	87	91	7	8.05%	TOTALS:	247	254	32	12.96%	Jan	113	107	20	17.70%	Feb	91	89	21	23.08%	Mar	83	87	13	15.66%	TOTALS:	287	283	54	18.82%	Apr	59	55	8	13.56%	May	75	69	16	21.33%	Jun	56	65	14	25%	TOTALS:	190	189	38	19.96%
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<p>IV. Outcomes & Utilization:</p> <ul style="list-style-type: none"> • AG-3: CHILD: CSU-Exodus, Bay Area Community Services, Hospital Liaison <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Quality Improvement - Section C, I. - Items C. & D.</p> <p>Name of Data Report: Quality and Utilization Review of CSU services</p> <p>Sub-committee/Staff Responsible: Utilization Management team</p> <p>Annual Goal Items Met: <input checked="" type="checkbox"/> Met: Item # 1 <input type="checkbox"/> Partially Met: Item # ____ <input checked="" type="checkbox"/> Not Met: Item # 2</p>	<p>AG-3: The Utilization Management Committee is charged with monitoring the effectiveness of the MHP's infrastructure to reduce inpatient stays and recidivism.</p> <p>Baseline: FY 18-19 Averages</p> <p>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):</p> <ul style="list-style-type: none"> • 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 	<p>Q1:</p> <table border="1" data-bbox="932 191 2037 425"> <thead> <tr> <th>Month</th> <th>Total # of Child Inpatient Hospitalizations</th> <th>Total # of Child Discharges</th> <th colspan="2">Total # of Child Rehospitalizations within 30 days of discharge & % of total of discharges</th> </tr> </thead> <tbody> <tr> <td>Jul</td> <td>5</td> <td>8</td> <td>1</td> <td>20%</td> </tr> <tr> <td>Aug</td> <td>9</td> <td>6</td> <td>0</td> <td>0%</td> </tr> <tr> <td>Sep</td> <td>13</td> <td>8</td> <td>2</td> <td>15%</td> </tr> <tr> <td>TOTALS:</td> <td>27</td> <td>22</td> <td>3</td> <td>11%</td> </tr> </tbody> </table> <p>Q2:</p> <table border="1" data-bbox="932 457 2037 594"> <tbody> <tr> <td>Oct</td> <td>16</td> <td>16</td> <td>0</td> <td>0%</td> </tr> <tr> <td>Nov</td> <td>18</td> <td>20</td> <td>3</td> <td>16.67%</td> </tr> <tr> <td>Dec</td> <td>14</td> <td>15</td> <td>1</td> <td>7.14%</td> </tr> <tr> <td>TOTALS:</td> <td>48</td> <td>51</td> <td>4</td> <td>8.33%</td> </tr> </tbody> </table> <p>Q3:</p> <table border="1" data-bbox="932 626 2037 763"> <tbody> <tr> <td>Jan</td> <td>12</td> <td>10</td> <td>2</td> <td>16.67%</td> </tr> <tr> <td>Feb</td> <td>16</td> <td>17</td> <td>0</td> <td>0%</td> </tr> <tr> <td>Mar</td> <td>13</td> <td>15</td> <td>2</td> <td>15.38%</td> </tr> <tr> <td>TOTALS:</td> <td>41</td> <td>42</td> <td>4</td> <td>9.76%</td> </tr> </tbody> </table> <p>Q4:</p> <table border="1" data-bbox="932 795 2037 932"> <tbody> <tr> <td>Apr</td> <td>9</td> <td>7</td> <td>0</td> <td>0%</td> </tr> <tr> <td>May</td> <td>3</td> <td>6</td> <td>1</td> <td>33%</td> </tr> <tr> <td>June</td> <td>6</td> <td>4</td> <td>0</td> <td>0%</td> </tr> <tr> <td>TOTALS:</td> <td>18</td> <td>17</td> <td>1</td> <td>33%</td> </tr> </tbody> </table>					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%
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<p>IV. Outcomes & Utilization:</p> <ul style="list-style-type: none"> • AG-4: Expand the use of Evidence-Based practices throughout the system of care <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Quality Improvement - Section C, I. - Item G; VI. - Item A.</p> <p>Name of Data Report: No current report</p> <p>Sub-committee/Staff Responsible:</p> <ul style="list-style-type: none"> • Quality Improvement • MHSA, Adult/Children’s Bureau <p>Annual Goal Met:</p> <p><input type="checkbox"/> Met: Item # ____</p> <p><input type="checkbox"/> Partially Met: Item # ____</p> <p><input type="checkbox"/> Not Met: Item # ____</p>	<p>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.</p> <p>Baseline: During FY 18-19 Q4:</p> <p># of clients supported with this EBP:</p> <ul style="list-style-type: none"> • ACT Model: 142 • EMDR: 23 • Peer Support: 27 <p>Goal: EBP goals include:</p> <ol style="list-style-type: none"> 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 	<p>Q1:</p> <table border="1" data-bbox="947 224 2018 521"> <thead> <tr> <th data-bbox="947 224 1199 321">Program</th> <th data-bbox="1199 224 1446 321"># trainings/coaching sessions</th> <th data-bbox="1446 224 1740 321"># staff attended</th> <th data-bbox="1740 224 2018 321"># clients supported with this EBP</th> </tr> </thead> <tbody> <tr> <td data-bbox="947 321 1199 386">FACT Team: ACT model</td> <td data-bbox="1199 321 1446 386"></td> <td data-bbox="1446 321 1740 386"></td> <td data-bbox="1740 321 2018 386"></td> </tr> <tr> <td data-bbox="947 386 1199 418">EMDR</td> <td data-bbox="1199 386 1446 418"></td> <td data-bbox="1446 386 1740 418"></td> <td data-bbox="1740 386 2018 418"></td> </tr> <tr> <td data-bbox="947 418 1199 521">Peer Employment Training- Recovery Innovations</td> <td data-bbox="1199 418 1446 521"></td> <td data-bbox="1446 418 1740 521"></td> <td data-bbox="1740 418 2018 521"></td> </tr> </tbody> </table> <p style="text-align: center;">*This Goal was interrupted to COVID</p> <p>Q2:</p> <p>Q3:</p> <p>Q4:</p>				Program	# trainings/coaching sessions	# staff attended	# clients supported with this EBP	FACT Team: ACT model				EMDR				Peer Employment Training- Recovery Innovations			
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<p>IV. Outcomes & Utilization:</p> <ul style="list-style-type: none"> • 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. <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Quality Improvement – Section C, I. – Item G, II. – Items C & D, VI. – Item A</p> <p>Name of Data Report: No current report</p> <p>Sub-committee/Staff Responsible:</p> <ul style="list-style-type: none"> • Quality Improvement <p>Annual Goal Met:</p> <p><input type="checkbox"/> Met: Item # ____</p> <p><input type="checkbox"/> Partially Met: Item # ____</p> <p><input type="checkbox"/> Not Met: Item # ____</p>	<p>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.</p> <p>Baseline: FY 18-19 Q4:</p> <ul style="list-style-type: none"> • Total # of Clients experiencing co-Occurring Challenges: 2474 <p>Goal: Co-Occurring System goals include:</p> <ol style="list-style-type: none"> 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. 	<p>Q1:</p> <table border="1" data-bbox="947 220 1982 485"> <thead> <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> </thead> <tbody> <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> </tbody> </table> <table border="1" data-bbox="947 518 1982 719"> <thead> <tr> <th>Team</th> <th># staff received training</th> <th># staff attended workgroup or planning session</th> </tr> </thead> <tbody> <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> </tbody> </table> <p>Q2:</p> <p>Q3:</p> <p>Q4:</p>				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				FACT				Q1 TOTAL:				Team	# staff received training	# staff attended workgroup or planning session												
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IV. Beneficiary Outcomes and System Utilization (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation																																	
<p>IV. Outcomes & Utilization:</p> <ul style="list-style-type: none"> • DM-1: Youth Medication Monitoring <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Quality Improvement – Section C, I. - Item F</p> <p>Name of Data Report: Avatar Report # 339C</p> <p>Sub-committee/Staff Responsible: Clinical Quality Review Committee</p> <p>Previous FY Baseline Averages:</p> <ul style="list-style-type: none"> • 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: <p>FY 19-20 Quarterly Averages:</p>	<p>Q1:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <thead> <tr style="background-color: #d9ead3;"> <th></th> <th># of Youth on 1 or more Psychotropic Medication:</th> <th># of Youth on 4 or more Psychotropic Medications:</th> <th># of Youth on 1 or more Antipsychotic Medication:</th> <th># of Youth on 2 or more Antipsychotic Medications:</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Foster Youth</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">Non-Foster Youth</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">Total</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #d9ead3;"> <th></th> <th># of Adults on 1 or more Psychotropic Medication:</th> <th># of Adults on 4 or more Psychotropic Medications:</th> <th># of Adults on 1 or more Antipsychotic Medication:</th> <th># of Adults on 2 or more Antipsychotic Medications:</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Foster Youth</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>Q2:</p> <p>Q3:</p> <p>Q4:</p> <p style="text-align: center; margin-top: 20px;">*Data report issues resulted in problems accessing this data.</p>					# 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				
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<p>IV. Outcomes & Utilization:</p> <ul style="list-style-type: none"> • DM-2: Regional Utilization and Service Penetration by cultural group <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and availability of Services – Section A, I. – Item D, V. - Item A2</p> <p>Name of Data Report:</p> <ul style="list-style-type: none"> • Avatar Report # 347 <p>Sub-committee/Staff Responsible:</p> <ul style="list-style-type: none"> • Utilization Management Committee membership • Cultural Competence Committee <p>Previous FY Baseline Averages:</p> <ul style="list-style-type: none"> • 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 <p>FY 19-20 Quarterly Averages:</p>	Q1:																																														
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	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
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Quality Improvement Area of Data Monitoring	Results of Evaluation																																			
<p>IV. Outcomes & Utilization:</p> <ul style="list-style-type: none"> 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. <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Resources - Section A, IV. - Item C.</p> <p>Name of Data Report: ARCH/MHSA Data</p> <p>Sub-committee/Staff Responsible: ARCH/Homeless Outreach Staff</p> <p>Previous FY Baseline Averages:</p> <ul style="list-style-type: none"> FY 18-19 <p>FY 19-20 Quarterly Averages:</p>	<p>Q1:</p> <table border="1" data-bbox="590 212 1900 513"> <thead> <tr> <th>Quarter</th> <th># of individuals screened</th> <th># of those screened offered an assessment</th> <th># of those screened reconnected with an existing MHP provider</th> <th># of Education & Engagement Activities</th> <th># of community members engaged</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>30</td> <td>8</td> <td>1</td> <td>2</td> <td>9</td> </tr> <tr> <td>2</td> <td>24</td> <td>12</td> <td>4</td> <td>0</td> <td>0</td> </tr> <tr> <td>3</td> <td>7</td> <td>2</td> <td>2</td> <td>0</td> <td>0</td> </tr> <tr> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>*COVID interrupted this process for Q4</p>						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					
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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																																																							
<p>V. Access & Timeliness:</p> <ul style="list-style-type: none"> • AG-1: CHILD: Service Request to First Offered Assessment Appointment <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, I. - Item F & H.</p> <p>Name of Data Report: Avatar Timeliness Report #333</p> <p>Sub-committee/Staff Responsible: Access Supervisor</p> <p>Annual Goal Items Met: <input checked="" type="checkbox"/> Met: Item # 1a & 2a <input checked="" type="checkbox"/> Partially Met: Item # 1b, 1c & 2b <input type="checkbox"/> Not Met: Item # ___</p>	<p>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.</p> <p>Baseline: See FY 2018-19 average timeliness for Children’s services</p> <p>Goal:</p> <ol style="list-style-type: none"> For Routine requests for service, County Children’s programs will: <ol style="list-style-type: none"> Maintain goal of 80% resulting in an offered assessment within 10 business days (FY 18-19 baseline: 76%) Maintain goal of an average of 10 business days or less from service request to actual assessment (FY 18-19 baseline: 11.48) 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) For Urgent requests for service, County Children’s programs will: <ol style="list-style-type: none"> Achieve goal of 80% resulting in an offered assessment within 3 business days (FY 18-19 baseline: 95%) Achieve goal of an average of 3 business days or less from service request to actual assessment (FY 18-19 baseline: 2.45 days) 	<p>Q1:</p> <table border="1" data-bbox="947 289 2053 524"> <thead> <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> </thead> <tbody> <tr> <td>Routine</td> <td>89%</td> <td>9</td> <td>25.4</td> </tr> <tr> <td>Urgent</td> <td>100%</td> <td>2</td> <td>18</td> </tr> <tr> <td>Total:</td> <td>89%</td> <td>9</td> <td>25.4</td> </tr> </tbody> </table> <p>Q2:</p> <table border="1" data-bbox="947 557 2053 659"> <tbody> <tr> <td>Routine</td> <td>81%</td> <td>9.93</td> <td>24.62</td> </tr> <tr> <td>Urgent</td> <td>50%</td> <td>4.5</td> <td>14.5</td> </tr> <tr> <td>Total:</td> <td>81%</td> <td>9.87</td> <td>12.37</td> </tr> </tbody> </table> <p>Q3:</p> <table border="1" data-bbox="947 691 2053 794"> <tbody> <tr> <td>Routine</td> <td>89%</td> <td>12.69</td> <td>29.24</td> </tr> <tr> <td>Urgent</td> <td>100%</td> <td>12.5</td> <td>38</td> </tr> <tr> <td>Total:</td> <td>89%</td> <td>12.69</td> <td>29.36</td> </tr> </tbody> </table> <p>Q4:</p> <table border="1" data-bbox="947 826 2053 928"> <tbody> <tr> <td>Routine</td> <td>98%</td> <td>8.45</td> <td>25.28</td> </tr> <tr> <td>Urgent</td> <td>66%</td> <td>3.6</td> <td>11</td> </tr> <tr> <td>Total:</td> <td>98%</td> <td>8.3</td> <td>24.84</td> </tr> </tbody> </table>				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	Routine	81%	9.93	24.62	Urgent	50%	4.5	14.5	Total:	81%	9.87	12.37	Routine	89%	12.69	29.24	Urgent	100%	12.5	38	Total:	89%	12.69	29.36	Routine	98%	8.45	25.28	Urgent	66%	3.6	11	Total:	98%	8.3	24.84
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<p>V. Access & Timeliness:</p> <ul style="list-style-type: none"> • AG-2: Vallejo OP and Vacaville OP Adult Services: Service Request to First Offered Assessment Appointment <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, I. - Item F & H.</p> <p>Name of Data Report: Avatar Timeliness Report #; MHP Access Referral form (under construction)</p> <p>Sub-committee/Staff Responsible: Access Supervisor</p> <p>Annual Goal Items Met: <input checked="" type="checkbox"/> Met: Item # 1a, 1b & 2a <input checked="" type="checkbox"/> Partially Met: Item # 1c & 2b <input type="checkbox"/> Not Met: Item # ___</p>	<p>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:</p> <ol style="list-style-type: none"> 1. For Routine requests for service, VV, FF and VJO County Adult programs will: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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) 	<p>Q1:</p> <table border="1" data-bbox="947 188 2053 423"> <thead> <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> </thead> <tbody> <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> </tbody> </table> <p>Q2:</p> <table border="1" data-bbox="947 456 2053 558"> <tbody> <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> </tbody> </table> <p>Q3:</p> <table border="1" data-bbox="947 591 2053 693"> <tbody> <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> </tbody> </table> <p>Q4:</p> <table border="1" data-bbox="947 725 2053 828"> <tbody> <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> </tbody> </table>				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	99%	7.04	19.5	Urgent	100%	6.6	15	Total:	99%	7.04	19.5	Routine	100%	6.13	16.16	Urgent	100%	8.2	16.67	Total:	100%	6.18	16.18	Routine	99%	6.86	16.97	Urgent	100%	4.75	17	Total:	99%	6.82	16.97	Routine	98%	6.1	13.3	Urgent	100%	1.8	3.6	Total:	98%	6	13.3
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<p>V. Access & Timeliness:</p> <ul style="list-style-type: none"> • AG-4: ADULT SERVICES Retention: Service Request to First Offered Assessment Appointment <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, I. - Item A & D</p> <p>Name of Data Report: Avatar Timeliness Report #333; MHP Access Referral form (under construction)</p> <p>Sub-committee/Staff Responsible: Access Supervisor</p> <p>Annual Goal Items Met: <input type="checkbox"/> Met: Item # ____ <input checked="" type="checkbox"/> Partially Met: Item # 1a & 2a <input checked="" type="checkbox"/> Not Met: Item # 1b & 2b</p>	<p>AG-4: Maintain or improve the following engagement & attrition measures for Adults: Baseline: See FY 2018-19 average engagement & attrition for Adult services Goal:</p> <ol style="list-style-type: none"> 1. For Routine requests for service, County Adult programs will: <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> 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%) 	<p>Q1:</p> <table border="1" data-bbox="947 188 2051 358"> <thead> <tr> <th>Request Type</th> <th># of Service Requests</th> <th>% Receiving an Assessment</th> <th>% Who Initiated Treatment</th> </tr> </thead> <tbody> <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> </tbody> </table> <p>Q2:</p> <table border="1" data-bbox="947 423 2051 526"> <tbody> <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> </tbody> </table> <p>Q3:</p> <table border="1" data-bbox="947 591 2051 693"> <tbody> <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> </tbody> </table> <p>Q4:</p> <table border="1" data-bbox="947 758 2051 860"> <tbody> <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> </tbody> </table>				Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment	Routine	409	50.9%	35.7%	Urgent	4	75%	50%	Total:	413	51.1%	35.8%	Routine	347	57%	32%	Urgent	6	83%	50%	Total:	353	58%	32%	Routine	381	59%	41%	Urgent	4	100%	75%	Total:	385	59%	42%	Routine	292	70.5%	51.03%	Urgent	5	100%	60%	Total:	297	71%	51.18%
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<p>V. Access & Timeliness:</p> <ul style="list-style-type: none"> • AG-5: Access: Test Call Performance <p>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</p> <p>Name of Data Report: Avatar Access Screen Tree form and QI Test Call Log</p> <p>Sub-committee/Staff Responsible:</p> <ul style="list-style-type: none"> • Quality Improvement unit • Access Supervisor <p>Annual Goal Items Met:</p> <p><input checked="" type="checkbox"/> Met: Item # 1, 2 & 4</p> <p><input checked="" type="checkbox"/> Partially Met: Item # 3</p> <p><input type="checkbox"/> Not Met: Item # ____</p>	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>Baseline: See FY 18-19% that met standards</p> <p>Goal: During QI initiated test calls, the MHP will demonstrate in 75% Business and Afterhours calls:</p> <ul style="list-style-type: none"> • 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 	<p>Q1:</p> <table border="1" data-bbox="947 228 2053 688"> <thead> <tr> <th></th> <th>Bus or after hrs</th> <th># of Test Calls/Quarter</th> <th># of Test Calls that meet Standards</th> <th>% of Test Calls that meet Standards this Quarter</th> <th>% of Test Calls that met standards in FY 2018-19</th> </tr> </thead> <tbody> <tr> <td rowspan="2">Languages Tested: Spanish & Tagalog</td> <td>B</td> <td>2</td> <td>2</td> <td>100%</td> <td>67%</td> </tr> <tr> <td>A</td> <td>3</td> <td>1</td> <td>33%</td> <td>71%</td> </tr> <tr> <td rowspan="2">Was Information given about how to access SMHS, including how to get an Ax.</td> <td>B</td> <td>3</td> <td>3</td> <td>100%</td> <td>81%</td> </tr> <tr> <td>A</td> <td>5</td> <td>1</td> <td>20%</td> <td>74%</td> </tr> <tr> <td rowspan="2">Info about how to treat a client's urgent condition</td> <td>B</td> <td>2</td> <td>2</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>A</td> <td>0</td> <td>n/a</td> <td>n/a</td> <td>100%</td> </tr> <tr> <td rowspan="2">Info about how to use the Problem Resolution/Fair Hearing process</td> <td>B</td> <td>1</td> <td>1</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>A</td> <td>1</td> <td>1</td> <td>100%</td> <td>100%</td> </tr> <tr> <td rowspan="2">Logging Name of client, date of request, & initial disposition</td> <td>B</td> <td>5</td> <td>5</td> <td>100%</td> <td>81%</td> </tr> <tr> <td>A</td> <td>5</td> <td>1</td> <td>20%</td> <td>57%</td> </tr> </tbody> </table> <p>Q2:</p> <table border="1" data-bbox="947 764 2053 1224"> <thead> <tr> <th></th> <th>Bus or after hrs</th> <th># of Test Calls/Quarter</th> <th># of Test Calls that meet Standards</th> <th>% of Test Calls that meet Standards this Quarter</th> <th>% of Test Calls that met standards in FY 2018-19</th> </tr> </thead> <tbody> <tr> <td rowspan="2">Languages Tested: Spanish, Creole & Tagalog</td> <td>B</td> <td>3</td> <td>3</td> <td>100%</td> <td>67%</td> </tr> <tr> <td>A</td> <td>2</td> <td>0</td> <td>0%</td> <td>71%</td> </tr> <tr> <td rowspan="2">Was Information given about how to access SMHS, including how to get an Ax.</td> <td>B</td> <td>4</td> <td>4</td> <td>100%</td> <td>81%</td> </tr> <tr> <td>A</td> <td>3</td> <td>2</td> <td>67%</td> <td>74%</td> </tr> <tr> <td rowspan="2">Info about how to treat a client's urgent condition</td> <td>B</td> <td>2</td> <td>2</td> <td>100%</td> <td>100%</td> </tr> <tr> <td>A</td> <td>0</td> <td>---</td> <td>---</td> <td>100%</td> </tr> <tr> <td rowspan="2">Info about how to use the Problem Resolution/Fair Hearing process</td> <td>B</td> <td>0</td> <td>---</td> <td>---</td> <td>100%</td> </tr> <tr> <td>A</td> <td>2</td> <td>1</td> <td>50%</td> <td>100%</td> </tr> <tr> <td rowspan="2">Logging Name of client, date of request, & initial disposition</td> <td>B</td> <td>6</td> <td>6</td> <td>100%</td> <td>81%</td> </tr> <tr> <td>A</td> <td>5</td> <td>4</td> <td>80%</td> <td>57%</td> </tr> </tbody> </table> <p>Q3:</p>							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.	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			A	2	0	0%	100%
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			A	5	2	40%	57%
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			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%
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			A	2	1	50%	100%
		Logging Name of client, date of request, & initial disposition	B	6	5	83%	81%
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V. Service Access and Timeliness (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation																																																							
<p>V. Access and Timeliness:</p> <ul style="list-style-type: none"> • DM-1: Access Calls Handled <p>Purpose for Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, I - Item F1</p> <p>Name of Data Report: CISCO-Contact Service Queue Activity Report (by CSQ)</p> <p>Sub-committee/Staff Responsible:</p> <ul style="list-style-type: none"> • Quality Improvement unit • Access Supervisor <p>Previous FY Baseline Averages:</p> <ul style="list-style-type: none"> • 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% <p>FY 19-20 Quarterly Averages:</p> <ul style="list-style-type: none"> • Total # of Problem Resolution 	<p>Q1:</p> <table border="1" data-bbox="575 310 1255 813"> <thead> <tr> <th>Month/ Quarter</th> <th>Calls Received</th> <th>Calls Handled</th> <th>% (Handled/ Received)</th> </tr> </thead> <tbody> <tr><td>JUL</td><td>378</td><td>354</td><td>94%</td></tr> <tr><td>AUG</td><td>452</td><td>447</td><td>99%</td></tr> <tr><td>SEP</td><td>471</td><td>469</td><td>100%</td></tr> <tr><td>OCT</td><td>482</td><td>480</td><td>99%</td></tr> <tr><td>NOV</td><td>339</td><td>333</td><td>98%</td></tr> <tr><td>DEC</td><td>421</td><td>419</td><td>99%</td></tr> <tr><td>JAN</td><td>469</td><td>473</td><td>99%</td></tr> <tr><td>FEB</td><td>435</td><td>435</td><td>100%</td></tr> <tr><td>MAR</td><td>403</td><td>405</td><td>99%</td></tr> <tr><td>APR</td><td>339</td><td>329</td><td>97%</td></tr> <tr><td>MAY</td><td>376</td><td>373</td><td>99%</td></tr> <tr><td>JUN</td><td>440</td><td>437</td><td>99%</td></tr> </tbody> </table>				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%
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VI. Program Integrity (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation																																																																																																			
<p>VI. Program Integrity:</p> <ul style="list-style-type: none"> AG-1: Service Verification County Programs <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Program Integrity – Section G, III. - Item A.</p> <p>Name of Data Report: QI-Compliance Service Verification Spreadsheet</p> <p>Sub-committee/Staff Responsible:</p> <ul style="list-style-type: none"> Compliance Committee Quality Improvement unit <p>Annual Goal Items Met:</p> <p><input checked="" type="checkbox"/> Met: Item # 1</p> <p><input type="checkbox"/> Partially Met: Item # ____</p> <p><input type="checkbox"/> Not Met: Item # ____</p>	<p>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.</p> <p>Baseline: The MHP began implementing a service verification process during FY 2013-14. Expectation is that all programs will participate in Service Verification.</p> <p>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).</p> <ul style="list-style-type: none"> 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. 	<p>Q1:</p> <table border="1" data-bbox="947 285 2032 719"> <thead> <tr> <th>County Program</th> <th>% of services verified</th> <th>Cost of unverified services</th> <th>Were NOBE's submitted for all unverified services?</th> </tr> </thead> <tbody> <tr><td>FCTU</td><td>100%</td><td>\$ -</td><td>NA</td></tr> <tr><td>Vacaville Youth</td><td>100%</td><td>\$ -</td><td>NA</td></tr> <tr><td>Vallejo Youth</td><td>100%</td><td>\$ -</td><td>NA</td></tr> <tr><td>Fairfield Youth</td><td>96%</td><td>\$ 1,306.26</td><td>Yes</td></tr> <tr><td>Fairfield Youth FSP</td><td>100%</td><td>\$ -</td><td>NA</td></tr> <tr><td>Vallejo ICC</td><td>90%</td><td>\$ 6,449.01</td><td>Yes</td></tr> <tr><td>Vacaville ICC</td><td>100%</td><td>\$ -</td><td>NA</td></tr> <tr><td>Vallejo Adult FSP</td><td>88%</td><td>\$ 1,856.18</td><td>Yes</td></tr> <tr><td>Fairfield ICC</td><td>84%</td><td>\$ 7,718.58</td><td>Yes</td></tr> <tr><td>FACT</td><td>76%</td><td>\$ 1,547.40</td><td>Yes</td></tr> <tr><td>ICS</td><td>71%</td><td>\$ 2,003.50</td><td>Yes</td></tr> </tbody> </table> <p>Q2: (Per MHP Policy, No County SV required during Q2 and Q4)</p> <p>Q3:</p> <table border="1" data-bbox="947 849 2032 1282"> <thead> <tr> <th>County Program</th> <th>% of services verified</th> <th>Cost of unverified services</th> <th>Were NOBE's submitted for all unverified services?</th> </tr> </thead> <tbody> <tr><td>Vallejo ICC</td><td>85%</td><td>\$7,672.51</td><td>Yes</td></tr> <tr><td>ACT Team</td><td>57%</td><td>\$2,012.78</td><td>Yes</td></tr> <tr><td>Fairfield ICC</td><td>94%</td><td>\$2,369.25</td><td>Yes</td></tr> <tr><td>Vallejo Youth</td><td>100%</td><td>\$ -</td><td>NA</td></tr> <tr><td>Vacaville Youth</td><td>100%</td><td>\$ -</td><td>NA</td></tr> <tr><td>Vacaville ICC</td><td>100%</td><td>\$ -</td><td>NA</td></tr> <tr><td>FCTU</td><td>100%</td><td>\$ -</td><td>NA</td></tr> <tr><td>Fairfield Youth</td><td>100%</td><td>\$ -</td><td>NA</td></tr> <tr><td>Fairfield Youth FSP</td><td>74%</td><td>\$7,806.94</td><td>Yes</td></tr> <tr><td>FACT</td><td>100%</td><td>\$ -</td><td>NA</td></tr> <tr><td>ICS</td><td>77%</td><td>\$1,987.74</td><td>Yes</td></tr> </tbody> </table> <p>Q4: (Per MHP Policy, No County SV required during Q2 and Q4)</p>				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	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
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VI. Program Integrity (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation																																									
<p>VI. Program Integrity:</p> <ul style="list-style-type: none"> DM-1: Compliance Committee <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Program Integrity – Section G, I. - Item B3.</p> <p>Name of Data Report: Compliance Committee meeting minutes/Compliance Unit report</p> <p>Sub-committee/Staff Responsible: Compliance Committee</p>	<p>Q1:</p> <table border="1" data-bbox="583 318 1717 826"> <thead> <tr> <th data-bbox="583 318 732 383">Month</th> <th data-bbox="732 318 995 383">Compliance Meeting Held?</th> <th data-bbox="995 318 1717 383">Date of Mtg(s) and General Issues Addressed</th> </tr> </thead> <tbody> <tr> <td data-bbox="583 383 732 418">JUL</td> <td data-bbox="732 383 995 418">Yes</td> <td data-bbox="995 383 1717 418">7/24/2019 – Minor transportation, cell phone policy & ROI's</td> </tr> <tr> <td data-bbox="583 418 732 454">AUG</td> <td data-bbox="732 418 995 454"></td> <td data-bbox="995 418 1717 454"></td> </tr> <tr> <td data-bbox="583 454 732 490">SEP</td> <td data-bbox="732 454 995 490"></td> <td data-bbox="995 454 1717 490"></td> </tr> <tr> <td data-bbox="583 490 732 526">OCT</td> <td data-bbox="732 490 995 526">Yes</td> <td data-bbox="995 490 1717 526">10/23/2019 – Minor transportation, cell phone policy & ROI's</td> </tr> <tr> <td data-bbox="583 526 732 561">NOV</td> <td data-bbox="732 526 995 561"></td> <td data-bbox="995 526 1717 561"></td> </tr> <tr> <td data-bbox="583 561 732 597">DEC</td> <td data-bbox="732 561 995 597"></td> <td data-bbox="995 561 1717 597"></td> </tr> <tr> <td data-bbox="583 597 732 633">JAN</td> <td data-bbox="732 597 995 633"></td> <td data-bbox="995 597 1717 633"></td> </tr> <tr> <td data-bbox="583 633 732 669">FEB</td> <td data-bbox="732 633 995 669"></td> <td data-bbox="995 633 1717 669"></td> </tr> <tr> <td data-bbox="583 669 732 704">MAR</td> <td data-bbox="732 669 995 704"></td> <td data-bbox="995 669 1717 704"></td> </tr> <tr> <td data-bbox="583 704 732 740">APR</td> <td data-bbox="732 704 995 740"></td> <td data-bbox="995 704 1717 740"></td> </tr> <tr> <td data-bbox="583 740 732 776">MAY</td> <td data-bbox="732 740 995 776"></td> <td data-bbox="995 740 1717 776"></td> </tr> <tr> <td data-bbox="583 776 732 812">JUNE</td> <td data-bbox="732 776 995 812"></td> <td data-bbox="995 776 1717 812"></td> </tr> </tbody> </table> <p data-bbox="680 829 1161 857">*COVID interrupted Q4 Compliance meeting</p>			Month	Compliance Meeting Held?	Date of Mtg(s) and General Issues Addressed	JUL	Yes	7/24/2019 – Minor transportation, cell phone policy & ROI's	AUG			SEP			OCT	Yes	10/23/2019 – Minor transportation, cell phone policy & ROI's	NOV			DEC			JAN			FEB			MAR			APR			MAY			JUNE		
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	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																																			
<p>VII. Quality Improvement:</p> <ul style="list-style-type: none"> • AG-1: Annual Utilization Review Audits - Timeliness and Appropriate Resolution of Annual Utilization Review Audit Findings <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, VI. – Item D10, D12 & F.</p> <p>Name of Data Report: UR Audit Tracking Log (to be created)</p> <p>Sub-committee/Staff Responsible: QI Audit Supervisor and team</p> <p>Annual Goal Items Met: <input type="checkbox"/> Met: Item # ____ <input type="checkbox"/> Partially Met: Item # ____ <input checked="" type="checkbox"/> Not Met: Item # 1-2</p>	<p>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.</p> <p>Baseline: See Quality Improvement annual UR Audits during FY 2018-19.</p> <p>Goal: The following processes are in place for FY 2019-20 to monitor Provider compliance with CCR Title 9 documentation standards requirements:</p> <ul style="list-style-type: none"> • 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. 	<table border="1"> <thead> <tr> <th data-bbox="947 321 1016 483">Q #</th> <th data-bbox="1016 321 1157 483"># Programs Audited</th> <th data-bbox="1157 321 1383 483">% of programs that received UR Audit Report w/in 60 days of audit alert period?</th> <th data-bbox="1383 321 1604 483">% of programs requiring a Corrective Action Plan (CAP)?</th> <th data-bbox="1604 321 1850 483">% of programs that submitted a CAP w/in 60 days of UR Audit Report</th> <th data-bbox="1850 321 2053 483">% of programs that submitted an adequate CAP?</th> </tr> </thead> <tbody> <tr> <td data-bbox="947 483 1016 516">Q1</td> <td data-bbox="1016 483 1157 516">4</td> <td data-bbox="1157 483 1383 516">75%</td> <td data-bbox="1383 483 1604 516">100%</td> <td data-bbox="1604 483 1850 516">100%</td> <td data-bbox="1850 483 2053 516">100%</td> </tr> <tr> <td data-bbox="947 516 1016 548">Q2</td> <td data-bbox="1016 516 1157 548">14</td> <td data-bbox="1157 516 1383 548">21%</td> <td data-bbox="1383 516 1604 548">100%</td> <td data-bbox="1604 516 1850 548">64%</td> <td data-bbox="1850 516 2053 548">71%</td> </tr> <tr> <td data-bbox="947 548 1016 581">Q3</td> <td data-bbox="1016 548 1157 581">10</td> <td data-bbox="1157 548 1383 581">10%</td> <td data-bbox="1383 548 1604 581">100%</td> <td data-bbox="1604 548 1850 581">60%</td> <td data-bbox="1850 548 2053 581"></td> </tr> <tr> <td data-bbox="947 581 1016 613">Q4</td> <td data-bbox="1016 581 1157 613">10</td> <td data-bbox="1157 581 1383 613">22%</td> <td data-bbox="1383 581 1604 613">100%</td> <td data-bbox="1604 581 1850 613">100%</td> <td data-bbox="1850 581 2053 613">100%</td> </tr> </tbody> </table>						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%
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?																																
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Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation																																																							
<p>VII. Quality Improvement:</p> <ul style="list-style-type: none"> AG-2: Treatment Plan Review timeliness and QI Communication with programs around pending concurrent review status <p>Authority: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, VI. - Item D10, D12 & F.</p> <p>Name of Data Report: Concurrent Review Database and UR Audit Tracking Log (to be created)</p> <p>Sub-committee/Staff Responsible: QI Audit Supervisor and team</p> <p>Annual Goal Items Met: <input type="checkbox"/> Met: Item # ____ <input type="checkbox"/> Partially Met: Item # ____ <input checked="" type="checkbox"/> Not Met: Item # 1-2</p>	<p>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.</p> <p>Baseline: Quality Improvement engaged in annual UR Audits during FY 2018-19.</p> <p>Goal: The following processes are in place for FY 2019-20 to monitor Provider compliance with CCR Title 9 documentation standards requirements:</p> <ul style="list-style-type: none"> 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. 	<p>Q1:</p> <table border="1" data-bbox="947 196 1776 805"> <thead> <tr> <th data-bbox="947 196 1066 358">Month</th> <th data-bbox="1066 196 1289 358">% of Treatment Plans reviewed for quality within 10 business days of receipt</th> <th data-bbox="1289 196 1535 358"># of Treatment Plans received for Quality Review</th> <th data-bbox="1535 196 1776 358">% of programs receiving monthly concurrent review status report</th> </tr> </thead> <tbody> <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> </tbody> </table>				Month	% of Treatment Plans reviewed for quality within 10 business days of receipt	# of Treatment Plans received for Quality Review	% of programs receiving monthly concurrent review status report	JUL	84%	438	87%	AUG	75%	336	85%	SEP	61%	383	44%	OCT	40%	422	46%	NOV	31%	357	0%	DEC	49%	422	0%	JAN	42%	473	8%	FEB	40%	336	0%	MAR	31%	337	0%	APR	26%	312	0%	MAY	29%	307	0%	JUNE	Quality Review process was changed effective June 1, 2020		
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VII. Quality Improvement (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation																																																							
<p>VII. Quality Improvement:</p> <ul style="list-style-type: none"> • DM-1: Documentation Training and Avatar User Training <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, VI - Item F.</p> <p>Name of Data Report: QI Excel Monitoring Spreadsheet</p> <p>Sub-committee/Staff Responsible: QI Training Lead and team</p>	<p>Q1:</p> <table border="1" data-bbox="583 331 1249 834"> <thead> <tr> <th data-bbox="583 331 688 428">Month</th> <th data-bbox="688 331 892 428">Doc Training # of Attendees</th> <th data-bbox="892 331 1073 428">Avatar Phase I # of Attendees</th> <th data-bbox="1073 331 1249 428">Avatar Phase II # of Attendees</th> </tr> </thead> <tbody> <tr> <td>Jul</td> <td>11</td> <td>9</td> <td>3</td> </tr> <tr> <td>Aug</td> <td>6</td> <td>10</td> <td>0</td> </tr> <tr> <td>Sep</td> <td>9</td> <td>6</td> <td>0</td> </tr> <tr> <td>Oct</td> <td>3</td> <td>4</td> <td>0</td> </tr> <tr> <td>Nov</td> <td>8</td> <td>4</td> <td>0</td> </tr> <tr> <td>Dec</td> <td>6</td> <td>4</td> <td>3</td> </tr> <tr> <td>Jan</td> <td>7</td> <td>0</td> <td>0</td> </tr> <tr> <td>Feb</td> <td>9</td> <td>1</td> <td>1</td> </tr> <tr> <td>Mar</td> <td>5</td> <td>12</td> <td>3</td> </tr> <tr> <td>Apr</td> <td>0</td> <td>6</td> <td>0</td> </tr> <tr> <td>May</td> <td>6</td> <td>0</td> <td>0</td> </tr> <tr> <td>Jun</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>				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
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Nov	8	4	0																																																					
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Quality Improvement Area of Data Monitoring	Results of Evaluation																																																							
<p>VII. Quality Improvement:</p> <ul style="list-style-type: none"> • DM-2: Site Certifications <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, VI - Item E.</p> <p>Name of Data Report: Monthly Site Certification Tracking Report</p> <p>Sub-committee/Staff Responsible: QI Site Certification Lead and team</p>	<p>Q1:</p> <table border="1" data-bbox="600 191 1646 756"> <thead> <tr> <th data-bbox="600 191 743 323">Month</th> <th data-bbox="743 191 1031 323"># Programs Certified this Month?</th> <th data-bbox="1031 191 1325 323">Was the MHP's tracking report reviewed to ensure no Solano MHP programs were missed?</th> <th data-bbox="1325 191 1646 323">% of Site Certifications completed in a timely manner?</th> </tr> </thead> <tbody> <tr><td data-bbox="600 323 743 358">Jul</td><td data-bbox="743 323 1031 358">2</td><td data-bbox="1031 323 1325 358">Yes</td><td data-bbox="1325 323 1646 358">100%</td></tr> <tr><td data-bbox="600 358 743 394">Aug</td><td data-bbox="743 358 1031 394">2</td><td data-bbox="1031 358 1325 394">Yes</td><td data-bbox="1325 358 1646 394">100%</td></tr> <tr><td data-bbox="600 394 743 430">Sep</td><td data-bbox="743 394 1031 430">2</td><td data-bbox="1031 394 1325 430">Yes</td><td data-bbox="1325 394 1646 430">100%</td></tr> <tr><td data-bbox="600 430 743 466">Oct</td><td data-bbox="743 430 1031 466">2</td><td data-bbox="1031 430 1325 466">Yes</td><td data-bbox="1325 430 1646 466">100%</td></tr> <tr><td data-bbox="600 466 743 501">Nov</td><td data-bbox="743 466 1031 501">0</td><td data-bbox="1031 466 1325 501">Yes</td><td data-bbox="1325 466 1646 501">NA</td></tr> <tr><td data-bbox="600 501 743 537">Dec</td><td data-bbox="743 501 1031 537">1</td><td data-bbox="1031 501 1325 537">Yes</td><td data-bbox="1325 501 1646 537">100%</td></tr> <tr><td data-bbox="600 537 743 573">Jan</td><td data-bbox="743 537 1031 573">0</td><td data-bbox="1031 537 1325 573">Yes</td><td data-bbox="1325 537 1646 573">NA</td></tr> <tr><td data-bbox="600 573 743 609">Feb</td><td data-bbox="743 573 1031 609">0</td><td data-bbox="1031 573 1325 609">Yes</td><td data-bbox="1325 573 1646 609">NA</td></tr> <tr><td data-bbox="600 609 743 644">Mar</td><td data-bbox="743 609 1031 644">2</td><td data-bbox="1031 609 1325 644">Yes</td><td data-bbox="1325 609 1646 644">100%</td></tr> <tr><td data-bbox="600 644 743 680">Apr</td><td data-bbox="743 644 1031 680"></td><td data-bbox="1031 644 1325 680"></td><td data-bbox="1325 644 1646 680"></td></tr> <tr><td data-bbox="600 680 743 716">May</td><td data-bbox="743 680 1031 716"></td><td data-bbox="1031 680 1325 716"></td><td data-bbox="1325 680 1646 716"></td></tr> <tr><td data-bbox="600 716 743 751">Jun</td><td data-bbox="743 716 1031 751"></td><td data-bbox="1031 716 1325 751"></td><td data-bbox="1325 716 1646 751"></td></tr> </tbody> </table> <p data-bbox="695 760 1121 789">*COVID interrupted schedule during Q4</p>				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			
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Quality Improvement Area of Data Monitoring	Results of Evaluation																																																																					
<p>VII. Quality Improvement:</p> <ul style="list-style-type: none"> • DM-3: Medi-Cal Provider Eligibility and Verification <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Program Integrity - Section G, V - Item A.</p> <p>Name of Data Report: Provider Eligibility and Verification Tracking Report</p> <p>Sub-committee/Staff Responsible: QI Provider Eligibility Verification Lead</p>	<p>Q1:</p> <table border="1" data-bbox="598 188 1661 756"> <thead> <tr> <th data-bbox="598 188 709 354">Month</th> <th data-bbox="709 188 919 354">How many providers initially showed up on one of the lists?</th> <th data-bbox="919 188 1192 354">Was action taken to investigate provider's ability to work in the MHP?</th> <th data-bbox="1192 188 1396 354">How many providers were determined to be ineligible to practice?</th> <th data-bbox="1396 188 1661 354">Were 100% of County, Contract and Network Providers verified on the exclusion lists?</th> </tr> </thead> <tbody> <tr><td data-bbox="598 354 709 386">Jul</td><td data-bbox="709 354 919 386"></td><td data-bbox="919 354 1192 386"></td><td data-bbox="1192 354 1396 386">0%</td><td data-bbox="1396 354 1661 386">Yes</td></tr> <tr><td data-bbox="598 386 709 418">Aug</td><td data-bbox="709 386 919 418"></td><td data-bbox="919 386 1192 418"></td><td data-bbox="1192 386 1396 418">0%</td><td data-bbox="1396 386 1661 418">Yes</td></tr> <tr><td data-bbox="598 418 709 451">Sep</td><td data-bbox="709 418 919 451"></td><td data-bbox="919 418 1192 451"></td><td data-bbox="1192 418 1396 451">0%</td><td data-bbox="1396 418 1661 451">Yes</td></tr> <tr><td data-bbox="598 451 709 483">Oct</td><td data-bbox="709 451 919 483"></td><td data-bbox="919 451 1192 483"></td><td data-bbox="1192 451 1396 483">0%</td><td data-bbox="1396 451 1661 483">Yes</td></tr> <tr><td data-bbox="598 483 709 516">Nov</td><td data-bbox="709 483 919 516"></td><td data-bbox="919 483 1192 516"></td><td data-bbox="1192 483 1396 516">0%</td><td data-bbox="1396 483 1661 516">Yes</td></tr> <tr><td data-bbox="598 516 709 548">Dec</td><td data-bbox="709 516 919 548"></td><td data-bbox="919 516 1192 548"></td><td data-bbox="1192 516 1396 548">0%</td><td data-bbox="1396 516 1661 548">Yes</td></tr> <tr><td data-bbox="598 548 709 581">Jan</td><td data-bbox="709 548 919 581"></td><td data-bbox="919 548 1192 581"></td><td data-bbox="1192 548 1396 581">0%</td><td data-bbox="1396 548 1661 581">Yes</td></tr> <tr><td data-bbox="598 581 709 613">Feb</td><td data-bbox="709 581 919 613"></td><td data-bbox="919 581 1192 613"></td><td data-bbox="1192 581 1396 613">0%</td><td data-bbox="1396 581 1661 613">Yes</td></tr> <tr><td data-bbox="598 613 709 646">Mar</td><td data-bbox="709 613 919 646"></td><td data-bbox="919 613 1192 646"></td><td data-bbox="1192 613 1396 646">0%</td><td data-bbox="1396 613 1661 646">Yes</td></tr> <tr><td data-bbox="598 646 709 678">Apr</td><td data-bbox="709 646 919 678"></td><td data-bbox="919 646 1192 678"></td><td data-bbox="1192 646 1396 678">0%</td><td data-bbox="1396 646 1661 678">Yes</td></tr> <tr><td data-bbox="598 678 709 711">May</td><td data-bbox="709 678 919 711"></td><td data-bbox="919 678 1192 711"></td><td data-bbox="1192 678 1396 711">0%</td><td data-bbox="1396 678 1661 711">Yes</td></tr> <tr><td data-bbox="598 711 709 756">Jun</td><td data-bbox="709 711 919 756"></td><td data-bbox="919 711 1192 756"></td><td data-bbox="1192 711 1396 756">0%</td><td data-bbox="1396 711 1661 756">Yes</td></tr> </tbody> </table>					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
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VIII. Network Adequacy (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation								
<p>VIII: Network Adequacy:</p> <ul style="list-style-type: none"> DM-1: Pathways to Well-Being (Subclass) <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, III. - Item A-E.</p> <p>Name of Data Report: Pathways Database maintained by CCR Team</p> <p>Sub-committee/Staff Responsible:</p> <ul style="list-style-type: none"> 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
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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										
<p>VIII: Network Adequacy:</p> <ul style="list-style-type: none"> • DM-3: Provider Network Data <p>Purpose of Monitoring: DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, I. - Item D.</p> <p>Name of Data Report: Solano County Mental Health (MH) Managed Care Tracking; CALWIN Medi-Cal Eligible crystal report</p> <p>Sub-committee/Staff Responsible: Managed Care/Provider Relations</p>			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