Solano County
Health and Social Services Department
Behavioral Health Division
Solano Mental Health Plan
FY 2020 - 2021

Quality Assessment and Performance Improvement Plan Evaluation

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QUALITY ASSESSMENT AND PEFORMANCE IMPROVEMENT PROGRAM OVERVIEW

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

Quality Improvement Program

Staffing 12.25 FTE	.25 Mental Health Administrator 1.0 Mental Health Program Senior Manager 1.0 Mental Health Clinical Supervisor 6.0 Licensed Mental Health Clinicians 4.0 Clerical Support Staff

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

QAPI Program Areas of Focus for FY 2020 - 2021:

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:

- Diversity and Equity
- Wellness and Recovery
- Beneficiary Satisfaction and Protection
- Beneficiary Outcomes and System Utilization
- Service Timeliness and Access
- Performance Improvement Projects
- 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 has 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 2019-2020. 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 QAPI 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. Diversity and Equity (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
I. Diversity and Equity: • **AG-1**: System wide Diversity and Equity Training **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Item E **Name of Data Report:** • Quality Improvement Training Tracking Sheets • Training reports from Contracted Agencies **Sub-committee/Staff Responsible:** • Quality Improvement – QI Liaisons **Annual Goal Items Met:** ☒ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-1:** Solano County MHP Diversity and Equity Committee (DEC) endeavors to implement the goals and initiatives contained within the Solano Diversity and Equity Plan. The DEC works with MHP Director/MH Administration and Quality Improvement to develop Diversity and Equity training opportunities. **FY 19-20 Baseline:** • **Baseline: County Providers: 106** • **County Non-Provider: Pending** • **Contract Provider: 118** • **Contract Non-Provider:** Pending **Goal:** Monitor Annual training and work toward 100% annual training compliance for: • **Providers:** Include all direct service providers (including medical staff & peer support specialists that can bill for services) • **Non-providers**: will include all staff that do not provide direct services (including management, clerical/support staff, board members, peer support specialists/volunteers that do not bill, etc.)	**Q1:** **Staff Category** / **Total Staff Trained** / **% of Staff in Compliance w/ annual requirement** **County Provider** 110 74% **County Non-provider** 17 53% **Contracted Provider** 154 No Data Provided **Contracted Non-provider** 4 No Data Provided **Q2:** **Staff Category** / **Total Staff Trained** / **% of Staff in Compliance w/ annual requirement** **County Provider** 121 78% **County Non-provider** 21 42% **Contracted Provider** 84 51% **Contracted Non-provider** 4 80% **Q3:** **Staff Category** / **Total Staff Trained** / **% of Staff in Compliance w/ annual requirement** **County Provider** 286 91% **County Non-provider** 46 66% **Contracted Provider** 334 90% **Contracted Non-provider** 31 78% **Q4:** **Staff Category** / **Total Staff Trained** / **% of Staff in Compliance w/ annual requirement** **County Provider** 383 93% **County Non-provider** 83 82% **Contracted Provider** 422 92% **Contracted Non-provider** 70 88%

I. Diversity and Equity (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Diversity and Equity: • **DM-1: DEC Plan, Training Plan and Committee** **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Items A- C **Name of Data Report:** • None **Sub-committee/Staff Responsible:** • Diversity and Equity Committee **Previous FY Baseline Averages:** • CC Subcommittee meetings per Quarter: 1 **FY 20-21 Quarterly Averages:** • Diversity and Equity Subcommittee meetings per Quarter:	

Quarter	Date of DEC Meeting	Date of report to QIC	Date Diversity & Equity Plan Updated
1	7/21/20	11/12/20	December 2020
	8/18/20		
	9/15/20		
2	10/20/20	2/11/21	
	11/17/20		
	12/15/20		
3	1/12/21	5/13/21	
	2/9/21		
	3/9/21		
4	4/13/21	8/12/21	
	5/11/21		
	6/8/21		

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Diversity and Equity: • **DM-2: LGBTQ Visibility** QI Action Plan- Campaign to combat stigma for LGBTQ community and intersect for Latinex and Filipinex **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3. **Name of Data Report:** MHSA Report **Sub-committee/Staff Responsible:** MHSA Unit & Ethnic Services Coordinator	**Q1:**

Month	# of Latinex Posters Distributed	# 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	0	0	0	0	0
AUG	0	0	0	0	0
SEP	0	0	0	0	0
OCT	0	0	3	0	0
NOV	50	32	7	0	0
DEC	0	0	5	0	0
JAN	3	17	51	0	0
FEB	3	17	79	0	0
MAR	175	175	105	0	0
APR	0	0	75	0	0
MAY	107	0	14	0	0
JUN	162	140	20	0	0

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Diversity and Equity: • **DM-3:** ***Takin' CLAS to the Streets*** QI Action Plan-School Wellness Centers for K-12 and adult ed sites with a cultural lens **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3. **Name of Data Report:** MHSA Report **Sub-committee/Staff Responsible:** MHSA Unit & Ethnic Services Coordinator	**Q1:**

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	0	0	0	0
AUG	0	0	0	0	0	0
SEP	0	0	0	0	0	0
OCT	0	0	0	0	0	0
NOV	0	0	0	0	0	0
DEC	0	0	0	0	0	0
JAN	0	0	0	0	0	0
FEB	0	0	0	0	0	0
MAR	0	0	0	0	0	0
APR	0	0	0	0	0	0
MAY	0	0	0	0	0	0
JUN	0	0	0	0	0	0

*This project was implemented in many school sites, but since schools did not fully open in FY20-21 due to COVID pandemic, no data was taken. Plan to monitor in FY21-22.

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Diversity and Equity: • **DM-4: *Culturally Responsive Supervision*** QI Action Plan- Implement Culturally Sensitive Supervision model by Dr. Kenneth Hardy **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Item D-E **Name of Data Report:** MHSA Report **Sub-committee/Staff Responsible:** MHSA Unit & Ethnic Services Coordinator	**Q1:**

Month	# of trainings provided for supervisors and/or managers	# 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	0	0	0	0	0	0
AUG	2	18	0	0	0	0
SEP	0	0	0	0	0	0
OCT	0	0	0	0	0	0
NOV	0	0	0	0	0	0
DEC	0	0	0	0	0	0
JAN	0	0	2	0	0	0
FEB	0	0	2	0	0	0
MAR	0	0	2	0	0	0
APR	0	0	2	0	0	0
MAY	0	0	2	0	2	131
JUN	0	0	0	0	0	0

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Diversity and Equity: • **DM-5:** ***Mental Health Education*** QI Action Plan-Provide trainings for faith centers; train-the-trainer models Mental Health First Aid (MHFA), ASIST, safeTALK, SCBH system of care. Trainings for youth thru faith centers. **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Item D-E **Name of Data Report:** MHSA Report **Sub-committee/Staff Responsible:** MHSA Unit & Ethnic Services Coordinator	**Q1:**

Month	# of Train the Trainer Sessions Provided for Faith Leaders/Reps	# of Train the Trainer Participants	% of Faith Leaders/Reps Who Endorse Increased Knowledge of MH	# of Trainings Provided by Faith Leaders/Reps	# of Training Participants	# of Trainings Provided for Youth in Faith Centers	# of Youth Training Participants
JUL	0	0	0	0	0	0	0
AUG	0	0	0	0	0	0	0
SEP	0	0	0	0	0	0	0
OCT	0	0	0	0	0	0	0
NOV	0	0	0	0	0	0	0
DEC	0	0	0	0	0	0	0
JAN	0	0	0	0	0	0	0
FEB	0	0	0	0	0	0	0
MAR	0	0	0	0	0	0	0
APR	0	0	0	0	0	0	0
MAY	0	0	0	0	0	0	0
JUN	0	0	0	0	0	0	0

*This project implementation was delayed in FY20-21 due to COVID pandemic and therefore no data was taken. Plan to implement and monitor in FY21-22.

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Diversity and Equity: • **DM-6: *Gap Finders*** QI Action Plan- Program/CBO self-eval of true implementation of CLAS standards **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Access – Section D, VII. - Item D-E **Name of Data Report:** N/A **Sub-committee/Staff Responsible:** Diversity and Equity Committee/Ethnic Services Coordinator	**Q1:** **Month** | **# of CBO partners who submitted Cultural Responsivity Plan** | **% of CBO Cultural Responsivity Plans that addressed at least 10 of the 15 CLAS standards** JUL | 0 | 0 AUG | 0 | 0 SEP | 1 | 0 OCT | 0 | 0 NOV | 2 | 0 DEC | 1 | 0 JAN | 2 | 0 FEB | 0 | 0 MAR | 0 | 0 APR | 0 | 0 MAY | 0 | 0 JUN | 0 | 0

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Diversity and Equity: **DM-7**: ***TRUE Care Promoter*** QI Action Plan-Phase I Roadmap resource guide **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3. **Name of Data Report:** N/A HR **Sub-committee/Staff Responsible:** Ethnic Services Coordinator	**Q1:**

Month	# of Paper Roadmaps Dist.	# of Paper Roadmaps Dist. To Community Partners	# of Hits to QR Code/Website	# of Access Referrals from Roadmaps
JUL	0	0	0	0
AUG	0	0	0	0
SEP	0	0	0	0
OCT	0	0	0	0
NOV	0	0	0	0
DEC	0	0	0	0
JAN	0	0	161	0
FEB	0	0	274	0
MAR	0	0	288	0
APR	0	0	255	0
MAY	750	6	189	0
JUN	2655	15	186	0

I. Diversity and Equity:

- **DM-8:** HOLA Community Information and Education Plans – Outreach re: cultural/linguistic services

Purpose for Monitoring:
DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, IV. - Item C; V. - Item A3.

Name of Data Report:
Report 333

Sub-committee/Staff Responsible:
HOLA Coordinator

Previous FY Baseline Averages:
- Outreach Initiatives per Quarter: 2.6
- HOLA calls per quarter:

FY 20-21 Quarterly Averages:
- Outreach Initiatives per Quarter: 6.75
- HOLA calls per quarter: 2.75

Q1:

Month	# of Community Education & Engagement Activities	# of Community Members Present	# of Access calls as a direct result of outreach team
JUL	1	11	4
AUG	0	0	1
SEP	4	91	2
OCT	1	8	0
NOV	1	45	1
DEC	1	21	1
JAN	9	0	0
FEB	10	0	0
MAR	0	0	0
APR	0	0	2
MAY	0	0	0
JUN	0	0	0

II. Wellness and Recovery (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
II. Wellness and Recovery: • **AG-1:** Provide Support Groups to Adult and Family community members to better support their understanding of their or their loved one's BH challenges and learn effective ways to cope and seek support. **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Quality Improvement – Section C, I. – Items C & E **Name of Data Report:** Adult and Family Support Group sign-in sheets and Post Group Survey on quarterly basis (point in time data) **Sub-committee/Staff Responsible:** Community Integration Manager, Recovery Resilience/Peer Liaison, and Family Liaison **Annual Goal Met:** ☒ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-1:** Provide Adult and Family Support Groups facilitated by Peer Support Specialists or Family Liaison. **Baseline:** Data was **Goal:** • **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	**Peer Support Group:** **Family Support Group:** * Responses to Quality of Life outcome tool were inconsistent to due COVID pandemic and groups being provided online.

Peer Support Group:

Quarter	# of total unique group members who participated	% of participants who "have learned tools/ways to support their or their loved one's behaviors/symptoms"	% of participants who feel supported by the group	% of participants who would return to the group
Q1	29	100%	100%	100%
Q2	53	N/A	N/A	N/A
Q3	68	100%	100%	100%
Q4	66	N/A	N/A	N/A

Family Support Group:

Quarter	# of total unique group members who participated	% of participants who "have learned tools/ways to support their or their loved one's behaviors/symptoms"	% of participants who feel supported by the group	% of participants who would return to the group
Q1	25	83%	100%	100%
Q2	47	N/A	N/A	N/A
Q3	47	99%	100%	100%
Q4	47	100%	100%	100%

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

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
III. Consumer Perception: • **AG-1:** Quarterly Service Verification Customer Service Survey **Purpose of Monitoring:** • DHCS Annual Review Protocols, 19-20, Quality Improvement – Section C, I. - Items E.1. and E.3. **Name of Data Report:** • Solano MHP Service Verification/Consumer Perception Surveys **Sub-committee/Staff Responsible:** Quality Improvement Survey Coordinator **Annual Goal Met:** ☐ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-1:** Solano MHP will review survey data from our semiannual Solano MHP Service Verification/Consumer survey to begin to look at survey results per program. Each program will be challenged to set a program specific goal for improvement targeting baseline data from Consumer survey. Post intervention measurement will be compared with baseline data. **Baseline:** Baselines will be specific to the program's previous Service Verification/Consumer survey results. **Goal:** Solano MHP County and Contract programs will each identify an area of Consumer Satisfaction to improve, develop an intervention and goal to address the area of improvement, and demonstrate improvement from baseline to post intervention measure.	**Q1:** | Program | Identified Area of Focus | Baseline | Intervention | Post Intervention Change | |---|---|---|---|---| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | *Due to COVID Pandemic, Consumer Survey process was impacted and surveys given to beneficiaries and those completed were minimal. Program operations were also impacted by the pandemic & therefore program specific survey goals were not required by the MHP.

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

Quality Improvement Area of Data Monitoring	Results of Evaluation
III. Beneficiary Protection: • **DM-1:** Grievance, Appeal and Expedited Appeal **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 19-20, Quality Improvement - Section C, I. - Items C. & E.2., II. - Item B; Beneficiary Rights and Protections – Section F, I. - Item J. **Name of Data Report:** • ComplyTrack - Problem Resolution Log **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Previous FY Baseline Averages:** • Total # of Problem Resolution issues: 28.6 • # of issues requiring a system change: 2 • # of Policies created or amended: 2 **FY 20-21 Quarterly Averages:** • Total # of Problem Resolution issues: 23.3 • # of issues requiring a system change: 0 • # of System Changes Initiated: 0 • # Referred to Policy Committee: 0 • # of Policies created or amended: 0	**Q1:**

Month Received	Total # 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	9	0	0	0
AUG	6	0	0	0
SEP	11	0	0	0
OCT	6	0	0	0
NOV	7	0	0	0
DEC	5	0	0	0
JAN	7	0	0	0
FEB	11	0	0	0
MAR	8	0	0	0
APR	11	0	0	0
MAY	6	1	0	0
JUN	7	0	0	0

Quality Improvement Area of Data Monitoring	Results of Evaluation

III. Beneficiary Protection:

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

Purpose of Monitoring:

- DHCS Annual Review Protocols FY 19-20, Quality Improvement - Section C, I. - Items C. & E.2., II. - Item B; Beneficiary Rights & Protections – Section F, I. - Items A,C,D, II. - Item 2.B.

Name of Data Report:

- ComplyTrack - Problem Resolution Log

Sub-committee/Staff Responsible:
Problem Resolution Coordinator

Previous FY Baseline Averages:

- Were all Problem Resolution processes logged and monitored: Yes
- Data Trends: Significant increase in NOABDs and related appeals

FY 20-21 Quarterly Averages:

- Were all Problem Resolution processes logged and monitored: Yes
- Data Trends: More Appeals due to more NOABDs appropriately being delivered.

Category	Process				Grievance Disposition		
	Grievance	Exempt Grievances	Appeal	Expedited Appeal	Grievances pending as of 6/30	Resolved	Referred
Appeals from NOABDs			17	0			
ACCESS	2	0			0	2	0
Quality of Care	10	0			2	61	0
Change of Provider	53	0			1	61	0
Confidentiality	0	0			0	0	0
Other	0	0			0	0	0
Total:	**65**	**0**	**17**	**0**	**3**	**0**	**0**

Appeals Resulting from NOABD	Appeal Disposition			Expedited Appeal Disposition			NOABD/ NOA
	Appeals pending as of 6/30	Decision Upheld	Decision Overturned	Expedited Appeals Pending as of 6/30	Decision Upheld	Decision Overturned	Total # of NOABD Issued
Denial Notice (NOA-A)	0	0	0	0	0	0	88
Payment Denial Notice (NOA-C)	0	0	0	0	0	0	44
Delivery System Notice	0	0	0	0	0	0	42
Modification Notice	0	0	1	0	0	0	1
Termination Notice	4	0	14	0	0	0	859
Authorization Delay Notice	0	0	0	0	0	0	0
Timely Access Notice (NOA-E)	0	1	0	0	0	0	69
Financial Liability Notice	0	1	0	0	0	0	1
Grievance and Appeal Timely Resolution Notice	0	0	0	0	0	0	0
Total:	**4**	**2**	**15**	**0**	**0**	**0**	**1104**

Quality Improvement Area of Data Monitoring	Results of Evaluation
III. Beneficiary Protection: • **DM-3**: Tracking the compliance of sending the beneficiary an acknowledgement and Disposition letter. **Purpose of Monitoring:** • DHCS Annual Review Protocols FY 19-20, Quality Improvement - Section C, I. - Items C. & E.2., II. - Item B; Beneficiary Rights and Protections – Section F, I. - Item E.1-3, J., III. - Items B & C, IV. - Items A.3. & B.1. **Name of Data Report:** • ComplyTrack - Problem Resolution Log **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Previous FY Baseline Averages:** • % of Acknowledgement letters sent within timeframes: • % of Disposition letters sent within timeframes: **FY 20-21 Quarterly Averages:** • % of Acknowledgement letters sent within timeframes: 95% • % of Disposition letters (NGR's and NAR's) sent within timeframes: 100%	**Q1:**

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
JUL	9	100%	100%	100%
AUG	6	100%	100%	100%
SEP	11	100%	100%	100%
OCT	6	83%	100%	100%
NOV	7	100%	100%	100%
DEC	5	80%	100%	100%
JAN	7	100%	100%	100%
FEB	11	90%	100%	100%
MAR	8	100%	100%	100%
APR	11	100%	100%	100%
MAY	6	100%	100%	100%
JUN	7	100%	100%	100%

Quality Improvement Area of Data Monitoring	Results of Evaluation
III. Beneficiary Protection: • **DM-4**: Tracking and trending of Internal system improvement needs **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Quality Improvement - Section C, I. - Items C. & E.2., II. - Item B **Frequency of Evaluation:** Quarterly **Name of Data Report:** • Problem Resolution Log • QIC Internal System Improvement Report **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Previous FY Baseline Quarterly Averages: See FY 19-20 for:** • Total # of Problem Resolution issues: 39.5 • # of issues requiring a system change: 0 • # Referred to Policy Committee: 0 • # Referred for Adverse Outcome Mtg: 4.25 **FY 20-21 Quarterly Averages:** • Total # of Problem Resolution issues: 34.3 • # of issues requiring a system change: 0 • # of System Changes Initiated: 0 • # Referred to Policy Committee: 0 • # of Policies created or amended: 0 • # Referred for Adverse Outcome Mtg: 8	**Q1:** **Month** | **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** JUL | 19 | 0 | 0 | 1 AUG | 10 | 0 | 0 | 1 SEP | 11 | 0 | 0 | 0 OCT | 14 | 0 | 0 | 1 NOV | 4 | 0 | 0 | 2 DEC | 9 | 0 | 0 | 4 JAN | 10 | 0 | 0 | 6 FEB | 12 | 0 | 0 | 4 MAR | 14 | 0 | 0 | 5 APR | 10 | 1 | 0 | 3 MAY | 8 | 0 | 0 | 4 JUN | 8 | 1 | 0 | 3

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

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

IV. Outcomes & Utilization:

AG-1: Expand Full Service Partnership to achieve goals that center on best practices around enrollment, discharge, interventions, utilization and outcomes. Guiding EBP for adults is the ACT model; for TAY, it is the TIP model.

Authority:
DHCS Annual Review Protocols, FY 19-20, Quality Improvement - Section C, I. - Items C. & D.

Name of Data Report:
MHSA data form, TMACT fidelity document for adult programs.

Sub-committee/Staff Responsible:
Adult Specialty Services Manager and Children's FSP Manager

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

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

Baseline: See FY 19-20 showed the following:

- # of adult FSP Program clients (including TAY population) were hospitalized and # were hospitalized 2 or more times.
- # of Children/Youth FSP Program clients were hospitalized and # were hospitalized 2 or more times.

Goal: Solano MHP will:

1. Decrease percentage of FSP clients in inpatient hospitalizations to less than 5%
2. Decrease the percentage of FSP clients hospitalized 2 or more times to less that 3%
3. Decrease total FSP clients incarcerated by 5%
4. Reduce # of FSP clients without stable housing.
5. Increase capacity to serve clients with co-occurring MH/SUD; track # clients with dual diagnosis

Q1:

FSP Programs this Quarter	# of Clients Served	Total % of clients hosp. 1x	% of clients hosp. > 1x	Total % inc. 1x	% of clients exp. 1x inc. of homelessness	% Loss of Placement
Adult ACT Team FSP	88	11%	0%	7%	2%	N/A
Caminar Adult FSP	61	2%	0%	0%	0%	
Caminar HOME FSP	47	6%	4%	4%	2%	
Seneca Tay	26	0%	0%	8%	0%	8%
FCTU Youth FSP	42	2%	0%	0%	0%	17%
Fairfield Youth FSP	83	5%	0%	2%	1%	11%
Totals	347	5%	0%	4%	1%	11%

Q2:

FSP Programs this Quarter	# of Clients Served	Total % of clients hosp. 1x	% of clients hosp. > 1x	Total % inc. 1x	% of clients exp. 1x inc. of homelessness	% Loss of Placement
Adult ACT Team FSP	55	2%	0%	0%	9%	N/A
Caminar Adult FSP	60	8%	2%	0%	2%	
Caminar HOME FSP	46	2%	7%	4%	0%	
Seneca Tay	32	6%	0%	3%	0%	6%
FCTU Youth FSP	46	2%	0%	0%	0%	4%
Fairfield Youth FSP	102	6%	1%	1%	0%	2%
Totals	341	5%	1%	3%	2%	5%

Q3:

FSP Programs this Quarter	# of Clients Served	Total % of clients hosp. 1x	% of clients hosp. > 1x	Total % inc. 1x	% of clients exp. 1x inc. of homelessness	% Loss of Placement
Adult ACT Team FSP	54	6%	6%	2%	6%	N/A
Caminar Adult FSP	62	6%	5%	2%	0%	
Caminar HOME FSP	44	0%	2%	0%	0%	
Seneca Tay	33	9%	0%	0%	0%	12%
FCTU Youth FSP	39	3%	0%	0%	0%	23%
Fairfield Youth FSP	130	4%	3%	0%	0%	5%
Totals	362	4%	3%	0.5%	0.8%	6%

Q4:

FSP Programs this Quarter	# of Clients Served	Total % of clients hosp. 1x	% of clients hosp. > 1x	Total % inc. 1x	% of clients exp. 1x inc. of homelessness	% Loss of Placement
Adult ACT Team FSP	61	5%	0%	10%	7%	N/A
Caminar Adult FSP	69	4%	3%	1%	0%	
Caminar HOME FSP	41	2%	0%	2%	0%	
Seneca Tay	33	0%	3%	0%	3%	3%
FCTU Youth FSP	32	0%	0%	0%	0%	9%
Fairfield Youth FSP	143	1%	1%	1%	0%	1%
Totals	379	2%	1%	2%	1%	3%

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

• AG-2: ADULT: Adult Inpatient Hospitalizations

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 19-20, Quality Improvement - Section C, I. - Items C. & D.

Name of Data Report:
Quality and Utilization Review of CSU services

Sub-committee/Staff Responsible:
Acute Care Manager

Annual Goal Items Met:
☒ Met: Item # 1 & 2
☐ Partially Met: Item # ___
☐ Not Met: Item # ___</td>
<td>AG-2: The Hospital Liaison team and the Utilization Management Committee is charged with monitoring the effectiveness of the MHP's infrastructure to reduce inpatient stays and recidivism.
Baseline: FY 19-20 Averages
Goal: Maintain or improve the following hospital-related measures (based on Solano Adult Medi-Cal clients, excludes 0-17 y.o., private insurance, Kaiser Medi-Cal, or other county insurance):

• Measurement #1: Maintain a quarterly average of less than 240 total hospitalizations.
Baseline: Quarterly average of 251 average Adult inpatient hospitalizations in FY 19-20
• Measurement #2 Maintain a baseline average of 15% or less of clients re-hospitalized within 30 days of discharge from inpatient hospitalization.
Baseline: Quarterly average of 17% readmission rate in FY 19-20</td>
<td>Q1:
<table>
<tr><th>Month</th><th>Total # of Adult Inpatient Hospitalizations</th><th>Total # of Adult Discharges</th><th colspan="2">Total # of Adult Rehospitalizations within 30 days of discharge & % of total of discharges</th></tr>
<tr><td>Jul</td><td>56</td><td>37</td><td>6</td><td>11%</td></tr>
<tr><td>Aug</td><td>48</td><td>46</td><td>4</td><td>8%</td></tr>
<tr><td>Sep</td><td>54</td><td>45</td><td>10</td><td>19%</td></tr>
<tr><td>TOTALS:</td><td>158</td><td>128</td><td>20</td><td>13%</td></tr>
</table>
Q2:
<table>
<tr><td>Oct</td><td>51</td><td>32</td><td>1</td><td>1.96%</td></tr>
<tr><td>Nov</td><td>45</td><td>57</td><td>5</td><td>11.11%</td></tr>
<tr><td>Dec</td><td>58</td><td>64</td><td>7</td><td>12.07%</td></tr>
<tr><td>TOTALS:</td><td>154</td><td>153</td><td>13</td><td>8.44%</td></tr>
</table>
Q3:
<table>
<tr><td>Jan</td><td>61</td><td>57</td><td>11</td><td>21.15%</td></tr>
<tr><td>Feb</td><td>80</td><td>79</td><td>7</td><td>10%</td></tr>
<tr><td>Mar</td><td>86</td><td>89</td><td>14</td><td>19.18%</td></tr>
<tr><td>TOTALS:</td><td>227</td><td>225</td><td>32</td><td>16.78%</td></tr>
</table>
Q4:
<table>
<tr><td>Apr</td><td>75</td><td>45</td><td>12</td><td>19%</td></tr>
<tr><td>May</td><td>64</td><td>38</td><td>7</td><td>12%</td></tr>
<tr><td>Jun</td><td>85</td><td>42</td><td>4</td><td>6%</td></tr>
<tr><td>TOTALS:</td><td>224</td><td>125</td><td>23</td><td>12%</td></tr>
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Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
IV. Outcomes & Utilization: • **AG-3:** CHILD: Adult Inpatient Hospitalizations **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Quality Improvement - Section C, I. - Items C. & D. **Name of Data Report:** Quality and Utilization Review of CSU services **Sub-committee/Staff Responsible:** Acute Care Manager, Children's Manager **Annual Goal Items Met:** ☒ **Met:** Item # 2 ☒ **Partially Met:** Item # 1 ☐ **Not Met:** Item # ___	**AG-3:** The Utilization Management Committee is charged with monitoring the effectiveness of the MHP's infrastructure to reduce inpatient stays and recidivism. **Baseline:** FY 19-20 Averages **Goal:** Monitor data on hospitalization and re-hospitalization rates for Solano County Child clients age 0-17 (excluding private insurance, Kaiser Medi-Cal, and other county Medi-Cal clients): • **Measurement #1:** Maintain a quarterly average of less than 30 total hospitalizations. **Baseline:** 34 Child inpatient hospitalizations in FY 19-20 • **Measurement #2:** Improve quarterly average to 10% or less clients re-hospitalized within 30 days of discharge from inpatient hospitalization. **Baseline:** 9% average readmission rate in FY 19-20	**Q1:** **Q2:** **Q3:** **Q4:**

Month	Total # of Child Inpatient Hospitalizations	Total # of Child Discharges	Total # of Child Rehospitalizations within 30 days of discharge & % of total of discharges	
Jul	7	7	0	0%
Aug	7	6	0	0%
Sep	12	13	0	0%
TOTALS:	26	26	0	0%
Oct	9	3	2	22%
Nov	10	15	2	20%
Dec	11	26	1	9.1%
TOTALS:	30	44	5	17.03%
Jan	18	18	2	11.11%
Feb	9	11	1	11.11%
Mar	8	6	0	0%
TOTALS:	35	35	3	7.41%
Apr	11	12	3	27%
May	21	21	1	5%
June	15	15	0	0%
TOTALS:	47	48	4	11%

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

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

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 19-20, Quality Improvement – Section C, I. – Item G, II. – Items C & D, VI. – Item A

Name of Data Report:
Avatar KPI Co-occurring Data, Avatar Treatment Plan Report (still to be created)

Sub-committee/Staff Responsible:
• Quality Improvement

Annual Goal Met:
☐ Met: Item # ___
☒ Partially Met: Item # 1-3
☐ Not Met: Item # ___
</td>
<td>
AG-6: Persons with co-occurring mental health and co-occurring substance use challenges need cross-trained staff to support their recovery, as well as systems and policies that support integrated services, billing and documentation.

Baseline: FY 18-19 Q4:

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

Goal: Co-Occurring System goals include:

1. Track the # of clients with co-occurring engaged in and receiving treatment
2. Increase # of staff cross-trained within the mental health and substance use teams
3. Develop mechanisms to support integrated documentation of treatment, billing, ROIs, engagement through access, and follow through with outpatient providers as needed.
</td>
<td>
Q1:

Q2:
<table>
<tr><th>County Program</th><th>Total # Clients experiencing co-occurring challenges</th><th>Total # of Clients with integrated treatment plans</th></tr>
<tr><td>Fairfield ICC</td><td>489</td><td></td></tr>
<tr><td>Vallejo ICC</td><td>314</td><td></td></tr>
<tr><td>Vacaville ICC</td><td>113</td><td></td></tr>
<tr><td>Caminar FSP</td><td>61</td><td></td></tr>
<tr><td>ACT Team</td><td>19</td><td></td></tr>
<tr><td>FTT</td><td>36</td><td></td></tr>
<tr><td>TOTAL:</td><td>1,032</td><td></td></tr>
</table>
Q3:

Q4:
</td>
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</table>

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

Quality Improvement Area of Data Monitoring	Results of Evaluation
IV. Outcomes & Utilization: • **DM-1: Youth Medication Monitoring** **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Quality Improvement – Section C, I. - Item F **Name of Data Report:** Avatar Report # 339C **Sub-committee/Staff Responsible:** Clinical Quality Review Committee, Medical Director or Designee **Previous FY Baseline Averages:** • **No averages from the previous year** **FY 20-21 Quarterly Averages:** • FY 20-21 # of Youth on 1 or more Antipsychotic medications: 27 • FY 20-21 # of Youth Age 12-17 on 4 or more Psychotropic medications: 5 • FY 20-21 # of Youth Age 6-11 on 3 or more Psychotropic medications: 4 • FY 20-21 # of Youth Age 0-5 on 2 or more Psychotropic medications: 0 • FY 20-21 # of Youth on 2 or more Antipsychotic Medications: 0	**Q1:** **Q2:** **Q3:** **Q4:**

	# of Youth on 1 or more Psychotropic Medication:	# of Youth Age 12-17 years on more than 3 Psychotropic Medications:	# of Youth Age 6-11 years on more than 2 Psychotropic Medications:	# of Youth Age 0-5 years on more than 1 Psychotropic Medications:	# of Youth on 2 or more Antipsychotic Medications:
Foster Youth	3	1	1	0	0
Non-Foster Youth	24	4	3	0	0
Total	27	5	4	0	0

Quality Improvement Area of Data Monitoring	Results of Evaluation
IV. Outcomes & Utilization: • **DM-2:** Regional Utilization and Service Penetration by cultural group **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and availability of Services – Section A, I. – Item D, V. - Item A2 **Name of Data Report:** • Avatar Report # 347 **Sub-committee/Staff Responsible:** • Utilization Management Committee membership or QI Manager **Previous FY Baseline Averages:** • FY **19-20** African American Quarterly Average Served: 1613 • FY **19-20** Hispanic/Latino Quarterly Average Served: 1071 • FY **19-20** Filipino Quarterly Average Served: 216 • FY **19-20** LGBT Quarterly Average Served: 282 **FY 20-21 Quarterly Averages:** • FY **20-21** African American Quarterly Average Served: 920 • FY **20-21** Hispanic/Latino Quarterly Average Served: 592 • FY **20-21** Filipino Quarterly Average Served: 147 • FY **20-21** LGBT Quarterly Average Served: 379	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Region	Black/AA Clients	Hispanic/ Latino Clients	Filipino Clients	LGBTQ Clients
North County	117	140	16	72
Central County	377	225	42	117
South County	369	187	78	89
Out of County	57	23	7	8
Unknown	3	2	0	0
Quarter Total:	923	577	143	286
Previous Quarter:				
FY 19-20 Q Ave (Baseline)	**1,613**	**1,071**	**216**	**282**

Q2:

Region	Black/AA Clients	Hispanic/ Latino Clients	Filipino Clients	LGBTQ Clients
North County	114	139	17	151
Central County	382	242	42	218
South County	339	179	73	158
Out of County	64	21	6	26
Unknown	2	1	1	0
Quarter Total:	901	582	139	553
Previous Quarter:	923	577	143	286
FY 19-20 Q Ave (Baseline)	**1,613**	**1,071**	**216**	**282**

Q3:

Region	Black/AA Clients	Hispanic/ Latino Clients	Filipino Clients	LGBTQ Clients
North County	120	141	15	65
Central County	379	253	47	132
South County	353	189	85	110
Out of County	64	24	8	19
Unknown	2	0	0	0
Quarter Total:	918	607	155	326
Previous Quarter:	901	582	139	553
FY 19-20 Q Ave (Baseline)	**1,613**	**1,071**	**216**	**282**

Q4:

Region	Black/AA Clients	Hispanic/ Latino Clients	Filipino Clients	LGBTQ Clients
North County	110	143	18	76
Central County	393	263	44	145

Quality Improvement Area of Data Monitoring	Results of Evaluation				
	South County	364	172	77	108
	Out of County	70	20	11	21
	Unknown	1	2	0	1
	Quarter Total:	938	600	150	351
	Previous Quarter:	918	607	155	326
	FY 19-20 Q Ave (Baseline)	**1,613**	**1,071**	**216**	**282**

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

IV. Outcomes & Utilization:

- **DM-3: Homeless Outreach Services (HOS) to SMI populations:** Provide outreach, engagement, and support to homeless mentally Ill adults toward acquiring benefits, resources, and services they need.

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Resources - Section A, IV. - Item C.

Name of Data Report:
ARCH/MHSA Data; Homeless Outreach data

Sub-committee/Staff Responsible:
ARCH/Homeless Outreach Staff, Community Integration manager-housing/homeless team

Previous FY Baseline Averages:
- FY 19-20

FY 20-21 Quarterly Averages:

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Q1: Unable to collect data.

Q2:

Month	Total Clients Referred for Services
October	**10**
November	**7**
December	**20**

Q3:

Month	Total Clients Referred for Services
January	**30**
February	**17**
March	**20**

Q4:

Month	Total Clients Referred
April	15
May	6
June	17

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</table>

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

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
V. Access & Timeliness: • **AG-1: CHILD:** Service Request to First Offered Assessment Appointment **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, I. - Item F & H. **Name of Data Report:** Avatar Assessment Timeliness Report #422 **Sub-committee/Staff Responsible:** Access Supervisor **Annual Goal Items Met:** ☒ **Met:** Item # 1a, 1b, 2a, 2b ☒ **Partially Met:** Item # 1c & 2c ☐ **Not Met:** Item # ___	**AG-1:** Solano MHP has made significant progress since FY 2015-16 to improve timeliness from point of access to the date of first-offered assessment appointment. **Baseline:** See FY 19-20 average timeliness for Children's services **Goal:** 1. For Routine requests for service, County Children's programs will: a. Maintain goal of 80% resulting in an offered assessment within 10 business days (FY 19-20 baseline: 89.5%) b. Maintain goal of an average of 10 business days or less from service request to actual assessment (FY 19-20 baseline: 10) c. Achieve goal of an average of 10 business days or less from Assessment Completion date to tx service initiation (See FY 19-20 baseline for time from service request to tx service initiation) 2. For Urgent requests for service, County Children's programs will: a. Achieve goal of 80% resulting in an offered assessment within 48 hours (FY 19-20 baseline: 79% based on 3 bus days) b. Achieve goal of an average of 48 hours or less from service request to actual assessment (FY 19-20 baseline: 5.65 days)	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Request Type	Service Request to Offered Ax Appt (% w/in 10 bus days for Routine & 48 hrs for Urgent)	Average # of Business Days from Service Request to Actual Ax Appt	Average # of Business Days from Service Request to First Tx Service
Routine	90%	10.21	24.19
Urgent	100%	2.00	23.00
Total:	95%	10.14	24.17

Q2:

Routine	84.3%	10.29	23.55
Urgent	100%	11	15
Total:	84.66%	10.3	23.44

Q3:

Routine	91%	9.7	18.7
Urgent	100%	3.85	14.6
Total:	92.3%	9.5	18.6

Q4:

Routine	94%	7.54	23.2
Urgent	100%	2	14.5
Total:	97%	7.47	23.03

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

V. Access & Timeliness:

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

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

Name of Data Report:
Avatar Assessment Timeliness Report #422

Sub-committee/Staff Responsible:
Access Supervisor

Annual Goal Items Met:
☒ **Met:** Item # 1b & 1c
☒ **Partially Met:** Item # 1a, 2a – 2c
☐ **Not Met:** Item # ___

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AG-2: Solano MHP made significant progress over the past few years to improve timeliness from point of access to the date of first-offered assessment appointment.
Baseline: See FY 19-20 average timeliness for Adult services
Goal:

1. For Routine requests for service, VV, FF and VJO County Adult programs will:
   a. Achieve goal of 90% resulting in an offered assessment within 10 business days (FY 19-20 baseline for all Adults: 99%)
   b. Achieve goal of an average of 10 business days or less from service request to actual assessment (FY 19-20 baseline for all adults: 6.5 days)
   c. Achieve goal of an average of 10 business days or less from Assessment Completion date to tx service initiation (See FY 19-20 baseline for time from service request to tx service initiation)
2. For Urgent requests for service, County Adult programs will:
   a. Maintain goal of 95% resulting in an offered assessment within 48 hours (FY 19-20 baseline for all adults: 99%)
   b. Achieve goal of an average of 48 hours or less from service request to actual assessment (See FY 19-20 baseline for all adults)

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Q1:

Request Type	Service Request to Offered Ax Appt (% w/in 10 bus days for Routine & 48 hrs for Urgent)	Average # of Business Days from Service Request to Actual Ax Appt	Average # of Business Days from Service Request Date to First Tx Service
Routine	87%	8.98	21.05
Urgent	100%	2	9.85
Total:	87%	8.72	20.54

Q2:

Routine	87.3%	7.79	15.51
Urgent	100%	3.5	12.75
Total:	87.87%	7.59	15.4

Q3:

Routine	78.6%	9.7	18.7
Urgent	100%	3.85	14.6
Total:	79.4%	9.5	18.6

Q4:

Routine	82%	7.81	24.1
Urgent	93%	2.15	14
Total:	87.5%	7.58	23.3

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Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
V. Access & Timeliness: • **AG-3: CHILDREN's SERVICES Retention:** Service Request to First Offered Assessment Appointment **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, I. - Item A & D **Name of Data Report:** Avatar Timeliness Report # 422 **Sub-committee/Staff Responsible:** Access Supervisor **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☒ **Partially Met:** Item # 1a – 2b ☐ **Not Met:** Item # ___	**AG-3:** Maintain or improve the following engagement & attrition measures for Children: **Baseline:** See FY 19-20 average engagement & attrition for Children's services **Goal:** 1. For Routine requests for service, County Children's programs will: a. Maintain goal of 80% resulting in an Assessment (FY 19-20 baseline: 83.2%) b. Achieve goal of 55% resulting in initiation of treatment (FY 19-20 baseline: 42%) 2. For Urgent requests for service, County Children's programs will: a. Maintain goal of 90% resulting in an assessment (FY 19-20 baseline: 91.75%) b. Achieve goal of 70% resulting in initiation of treatment (FY 19-20 baseline: 62.4%)	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Request Type	# of Service Requests	% did not accept Ax offer dates	% did not show for Ax	% show to Ax, but did not complete Ax	% received Ax	% declined Tx	% did not meet medical necessity	% Received Tx
Routine	155	0%	18.06%	0.65%	75.48%	3.23%	6.45%	38.06%
Urgent	1	0%	0%	0%	100%	0%	0%	100%
Total:	156	0%	17.95%	0.64%	75.64%	3.21%	6.41%	38.46%

Q2:

Request Type	# of Service Requests	% did not accept Ax offer dates	% did not show for Ax	% show to Ax, but did not complete Ax	% received Ax	% declined Tx	% did not meet medical necessity	% Received Tx
Routine	160	0%	8.75%	1.88%	76.88%	1.25%	2.5%	50%
Urgent	3	0%	33.3%	0%	66.67%	0%	0%	33.33%
Total:	163	0%	9.2%	1.84%	76.69%	2.45%	2.45%	49.69%

Q3:

Request Type	# of Service Requests	% did not accept Ax offer dates	% did not show for Ax	% show to Ax, but did not complete Ax	% received Ax	% declined Tx	% did not meet medical necessity	% Received Tx
Routine	227	0.88%	18.06%	0.44%	81.94%	2.2%	2.2%	48.9%
Urgent	7	0%	0%	0%	100%	0%	0%	57.14%
Total:	234	0.85%	17.52%	0.45%	82.48%	2.14%	2.14%	49.15%

Q4:

Request Type	# of Service Requests	% did not accept Ax offer dates	% did not show for Ax	% show to Ax, but did not complete Ax	% received Ax	% declined Tx	% did not meet medical necessity	% Received Tx
Routine	184	0.00%	19.57%	0.54%	80.43%	4.35%	8.70%	45.11%
Urgent	3	0.00%	33.33%	0.00%	66.67%	0.00%	0.00%	66.67%
Total:	187	0.00%	19.79%	0.54%	80.21%	4.28%	8.56%	45.45%

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
V. Access & Timeliness: • **AG-4: ADULT SERVICES Retention:** Service Request to First Offered Assessment Appointment **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, I. - Item A & D **Name of Data Report:** Avatar Timeliness Report #422 **Sub-committee/Staff Responsible:** Access Supervisor **Annual Goal Items Met:** ☒ **Met:** Item # 1a ☒ **Partially Met:** Item # 1b, 2a – 2b ☐ **Not Met:** Item # ___	**AG-4:** Maintain or improve the following engagement & attrition measures for Adults: **Baseline:** See FY 19-20 average engagement & attrition for Adult services **Goal:** 1. For Routine requests for service, County Adult programs will: a. Achieve goal of 60% resulting in an Assessment (FY 19-20 baseline: 59.4%) b. Achieve goal of 45% resulting in initiation of treatment (FY 19-20 baseline: 39.9%) 2. For Urgent requests for service, County Adult programs will: a. Maintain goal of 85% resulting in an assessment (FY 19-20 baseline: 89.5%) b. Achieve goal of 60% resulting in initiation of treatment (FY 19-20 baseline: 58.75%)	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Request Type	# of Service Requests	% did not accept Ax offer dates	% did not show for Ax	% show to Ax, but did not complete Ax	% received Ax	% declined Tx	% did not meet medical necessity	% Received Tx
Routine	274	2.19%	24.45%	1.46%	67.88%	1.09%	5.11%	54.01%
Urgent	8	0%	12.5%	0%	87.50%	0%	0%	87.50%
Total:	282	2.13%	12.76%	1.42%	68.44%	1.42%	4.96%	54.96%

Q2:

Request Type	# of Service Requests	% did not accept Ax offer dates	% did not show for Ax	% show to Ax, but did not complete Ax	% received Ax	% declined Tx	% did not meet medical necessity	% Received Tx
Routine	261	0.77%	25.29%	0.77%	62.45%	3.07%	3.45%	38.7%
Urgent	11	0%	27.27%	0%	72.73%	9.09%	0%	36.36%
Total:	272	0.74%	25.37%	0.74%	62.87%	3.31%	3.31%	38.60%

Q3:

Request Type	# of Service Requests	% did not accept Ax offer dates	% did not show for Ax	% show to Ax, but did not complete Ax	% received Ax	% declined Tx	% did not meet medical necessity	% Received Tx
Routine	309	0%	37.22%	1.9%	62.78%	0.32%	4.5%	37.22%
Urgent	12	8.3%	33.33%	0%	66.67%	0%	8.3%	33.33%
Total:	321	0.31%	37.07%	1.8%	62.93%	0.31%	4.6%	37.07%

Q4:

Request Type	# of Service Requests	% did not accept Ax offer dates	% did not show for Ax	% show to Ax, but did not complete Ax	% received Ax	% declined Tx	% did not meet medical necessity	% Received Tx
Routine	315	0.32%	36.19%	1.59%	63.81%	0.63%	6.35%	42.86%
Urgent	14	0.00%	14.29%	0.00%	85.71%	0.00%	0.00%	78.57%
Total:	329	0.30%	35.26%	1.52%	64.74%	0.61%	6.08%	44.38%

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
V. Access & Timeliness: • **AG-5**: Access: Test Call Performance **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, I - Item F1; Access and Information Requirements – Section D, VI. – Items B & C **Name of Data Report:** Avatar Access Screen Tree form and QI Test Call Log **Sub-committee/Staff Responsible:** • Quality Improvement Test Call Coordinator • Access Supervisor **Annual Goal Items Met:** ☒ **Met:** Item # 2, 3, 4 ☐ **Partially Met:** Item # ___ ☒ **Not Met:** Item # 1	**AG-5:** All calls to (800) 547-0495 MH Access unit are routed to a Care Manager, 24 hours/day, 7 days/week. Care Managers provide or arrange for Access services in any language spoken in Solano County. Additionally, calls should: • Provide information about how to access specialty MH services, including how to access an intake assessment. • Provide information about urgent services. • Provide information about how to access Problem Resolution and State Fair Hearing processes. **Baseline:** See % that met standards from FY 19-20 **Goal:** During QI initiated test calls, the MHP will demonstrate the following in Business and Afterhours calls: • **Measure #1:** Provide a Minimum of 4 test calls/month. • **Measure #2:** Testing for language capabilities (Spanish & Tagalog primarily) • **Measure #3:** Testing for appropriate information given (SMHS access, Urgent conditions, and Problem Resolution): 75% • **Measure #4:** Logging all appropriate data 90% of the time	**Q1:** **Q2:** **Q3:**

Q1:

Test Category	Bus or After Hours	# of Test Calls	# of Test Calls That Met Standards	% of Test Calls That Met Standards	% of Test Calls that Met Standards in FY 19-20
Languages Tested: Spanish	B	6	6	100%	100%
	A	5	2	40%	25%
Was Information given about how to access SMHS, including how to get an Ax.	B	5	5	100%	96%
	A	2	1	100%	34%
Info about how to treat a client's urgent condition	B	0	---	---	100%
	A	2	1	50%	(not tested)
Info about how to use the Problem Resolution/Fair Hearing process	B	1	1	100%	100%
	A	1	0	0%	50%
Logging Name of client, date of request, & initial disposition	B	5	5	100%	96%
	A	4	2	50%	54%

Q2:

Test Category	Bus or After Hours	# of Test Calls	# of Test Calls That Met Standards	% of Test Calls That Met Standards	% of Test Calls that Met Standards in FY 19-20
Languages Tested: Spanish	B	3	3	100%	100%
	A	3	1	33%	25%
Was Information given about how to access SMHS, including how to get an Ax.	B	2	2	100%	96%
	A	6	3	50%	34%
Info about how to treat a client's urgent condition	B	2	2	100%	100%
	A	0	---	---	(not tested)
Info about how to use the Problem Resolution/Fair Hearing process	B	2	2	100%	100%
	A	0	---	---	50%
Logging Name of client, date of request, & initial disposition	B	4	4	100%	96%
	A	6	2	33%	54%

Q3:

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

Test Category	Bus or After Hours	# of Test Calls	# of Test Calls That Met Standards	% of Test Calls That Met Standards	% of Test Calls that Met Standards in FY 19-20
Languages Tested: Spanish	B	3	3	100%	100%
	A	3	3	100%	25%
Was Information given about how to access SMHS, including how to get an Ax.	B	4	4	100%	96%
	A	5	4	80%	34%
Info about how to treat a client's urgent condition	B	1	1	100%	100%
	A	1	1	100%	(not tested)
Info about how to use the Problem Resolution/Fair Hearing process	B	1	1	100%	100%
	A	0	---	---	50%
Logging Name of client, date of request, & initial disposition	B	5	5	100%	96%
	A	6	5	83%	54%

Q4:

Test Category	Bus or After Hours	# of Test Calls	# of Test Calls That Met Standards	% of Test Calls That Met Standards	% of Test Calls that Met Standards in FY 19-20
Languages Tested: Spanish	B	3	3	100%	100%
	A	3	3	100%	25%
Was Information given about how to access SMHS, including how to get an Ax.	B	6	6	100%	96%
	A	5	5	80%	34%
Info about how to treat a client's urgent condition	B	0	0	N/A	100%
	A	2	2	100%	(not tested)
Info about how to use the Problem Resolution/Fair Hearing process	B	0	0	N/A	100%
	A	0	0	N/A	50%
Logging Name of client, date of request, & initial disposition	B	6	6	100%	96%
	A	7	3	42.86%	54%

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

Quality Improvement Area of Data Monitoring	Results of Evaluation
V. Access and Timeliness: • **DM-1:** Access Calls Handled **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, I - Item F1 **Name of Data Report:** CISCO-Contact Service Queue Activity Report (by CSQ) **Sub-committee/Staff Responsible:** • Quality Improvement unit • Access Supervisor **Previous FY Baseline Averages:** • Quarterly Average of % of Calls Handled "Live" during FY 19-20: **98.5%** • Quarterly Average of % of Abandoned calls in FY 19-20: 1.5**%** **FY 20-21 Quarterly Averages:** • Quarterly Average of % of Calls Handled "Live" during FY 20-21: **98.7%** • Quarterly Average of % of Abandoned calls in FY 20-21: 1.3**%**	

Month	Calls Received	Calls Handled/ Received	% Handled/ Received	Calls Abandoned/ Dropped	% Abandoned/ Dropped
Jul	328	328	100%	0	0%
Aug	336	332	99%	4	1%
Sep	295	292	99%	3	1%
Oct	349	344	99%	5	1%
Nov	294	290	99%	4	1%
Dec	323	319	99%	4	1%
Jan	323	318	98%	5	2%
Feb	332	326	98%	6	2%
Mar	367	362	99%	5	1%
Apr	391	382	98%	9	2%
May	328	325	98%	3	1%
Jun	381	376	99%	5	1%

VI. Performance Improvement Projects (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
VI. PIPs: • **AG-1: PIP #1 Measuring the impact of telehealth and telephone services** **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Quality Assurance and Performance Improvement – Section C, II. - Item C. **Name of Data Report:** TBD **Sub-committee/Staff Responsible:** • QI PIP Coordinator and PIP Team **Annual Goal Items Met:** ☒ **Met:** Item # 1 ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-1:** Federal and State requirements stipulate that an MHP shall have two active and ongoing performance improvement projects. **Baseline:** TBD **Goal:** TBD • **Measurement #1:** Increases in telehealth and phone visits during 2020.	**Q1: TBD** **Q2: TBD** **Q3:** **Q4:**

Performance Measures	Baseline (Jul – Dec 2019)	Re-Measure (Jul – Dec 2020)	Final Measure
Total Adult Services	8,770	9,562	+9%
Telehealth Services	1,432	2,248	+57%
Telephone Services	145	2,509	+1630%
No Show's	3791	3464	-4%

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

• AG-2: PIP #2: Measuring Solano MHP's ability to increase show rates for follow up care after discharge from inpatient hospitalization and Crisis Stabilization.

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 19-20, Quality Assurance and Performance Improvement – Section C, II. - Item C.

Name of Data Report:
TBD

Sub-committee/Staff Responsible:
• QI PIP Coordinator and PIP Team

Annual Goal Items Met:
☐ Met: Item # ___
☒ Partially Met: Item # ___
☐ Not Met: Item # ___
</td>
<td>
AG-: Federal and State requirements stipulate that an MHP shall have two active and ongoing performance improvement projects.
Baseline: TBD
Goal: TBD

• Measurement #1: Measure show rates for follow up care after discharge from inpatient hospitalization and Crisis Stabilization.
</td>
<td>
Q1: TBD

Q2: TBD

Q3:
<table>
<tr><th>Baseline: First Assessment</th><th>Baseline: First Treatment</th><th>Post Initial Intervention: First Assessment</th><th>Post Initial Intervention: First Treatment</th></tr>
<tr><td>52.58%</td><td>47.77%</td><td>41.43%</td><td>23.29%</td></tr>
</table>
Q4:
</td>
</tr>
</table>

VI. Program Integrity (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
VI. Program Integrity: • **AG-1: Service Verification County Programs** **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Program Integrity – Section G, III. - Item A. **Name of Data Report:** QI-Compliance Service Verification Spreadsheet **Sub-committee/Staff Responsible:** • Quality Improvement Service Verification Coordinator • Compliance Committee **Annual Goal Items Met:** ☒ **Met:** Item # 1 ☒ **Partially Met:** Item # 2 ☐ **Not Met:** Item # ___	**AG-1:** According to Program Integrity requirements of 42 CFR §455.1(a)(2) as set forth in the MHP Contract between the State of California and the County of Solano, there is a need to maintain a process of verifying whether services were actually furnished to beneficiaries. **Baseline:** The MHP began implementing a service verification process during FY 2013-14. Expectation is that all programs will participate in Service Verification. **Goal:** The MHP will continue to implement a service verification model during Q1 and Q3, and endeavor to demonstrate 90-100% accountability for each service identified during the sampling period (services not verified will be repaid). • **Measurement #1:** 100% of all applicable County programs participate in the service verification process? • **Measurement #2:** 90-100% of services will be verified during the week of Service Verification.	**Q1:** **Q2:** ***(Per MHP Policy, No County SV required during Q2 and Q4)*** **Q3:** **Q4:** ***(Per MHP Policy, No County SV required during Q2 and Q4)***

Q1:

County Program	% of services verified	Cost of unverified services	Were NOBE's submitted for all unverified services?
FACT	92%	$1,260.50	Yes
Fairfield ICC	97%	$110.75	Yes
Fairfield Youth	94%	$565.29	Yes
Fairfield Youth FSP	100%	N/A	N/A
FCTU	96%	$622.39	Yes
ICS	NA	N/A	N/A
Vacaville ICC	75%	$785.32	Yes
Vacaville Youth	80%	$793.69	Yes
Vallejo Adult FSP	87%	$1,088.81	Yes
Vallejo ICC	79%	$3,394.75	Yes
Vallejo Youth	100%	N/A	N/A
FACT	92%	$1,260.50	Yes

Q3:

County Program	% of services verified	Cost of unverified services	Were NOBE's submitted for all unverified services?
ACT Team	92%	$2,397.57	Yes
Embedded	50%	$739.70	Yes
Fairfield ICC	92%	$1,472.80	Yes
Fairfield Youth	100%	N/A	N/A
Fairfield Youth FSP	96%	$1,098.48	Yes
FCTU	100%	N/A	N/A
FCTU - CANS Ax	100%	N/A	N/A
FCTU - CFT ICC	100%	N/A	N/A
ICS	100%	N/A	N/A
Vacaville ICC	74%	$4,397.40	Yes
Vacaville Youth	71%	$938.85	Yes
Vallejo ICC	91%	$3,180.53	Yes
Vallejo Youth	100%	N/A	N/A

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

• AG-2: Service Verification Contract Programs

Authority:
DHCS Annual Review Protocols, FY 19-20, Program Integrity – Section G, III. - Item A.

Name of Data Report:
QI-Compliance Service Verification Spreadsheet

Sub-committee/Staff Responsible:
• Quality Improvement Service Verification Coordinator
• Compliance Committee

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

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

Q2:
<table>
<tr><th>Contract Program</th><th>% of services verified</th><th>Cost of unverified services</th><th>Was a NOBE submitted for all unverified services?</th></tr>
<tr><td>BACS</td><td>100%</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Psynergy</td><td>100%</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Seneca</td><td>100%</td><td>N/A</td><td>N/A</td></tr>
<tr><td>Uplift Family Services</td><td>100%</td><td>N/A</td><td>N/A</td></tr>
</table>
Q3: (Per MHP Policy, No Contract Agency SV required during Q1 and Q3)

Q4:
<table>
<tr><th>Contract Program</th><th>% of services verified</th><th>Cost of unverified services</th><th>Was a NOBE submitted for all unverified services?</th></tr>
<tr><td>A Better Way</td><td>75%</td><td>$1,171.22</td><td>Yes</td></tr>
<tr><td>Seneca</td><td>100%</td><td>N/A</td><td>N/A</td></tr>
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</table>

VI. Program Integrity (Data Monitoring - DM)

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

• DM-1: Compliance Committee

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 19-20, Program Integrity – Section G, I. - Item B3.

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

Sub-committee/Staff Responsible:
Compliance Committee</td><td>Q1:
<table>
<tr><th>Month</th><th>Compliance Meeting Held?</th><th>Date of Mtg(s) and General Issues Addressed</th></tr>
<tr><td>July</td><td>Yes</td><td>7/22/2020</td></tr>
</table>
Q2:
<table>
<tr><th>Month</th><th>Compliance Meeting Held?</th><th>Date of Mtg(s) and General Issues Addressed</th></tr>
<tr><td>October</td><td>Yes</td><td>10/28/2020</td></tr>
</table>
Q3:
<table>
<tr><th>Month</th><th>Compliance Meeting Held?</th><th>Date of Mtg(s) and General Issues Addressed</th></tr>
<tr><td>January</td><td>Yes</td><td>01/27/2021</td></tr>
</table>
Q4:
<table>
<tr><th>Month</th><th>Compliance Meeting Held?</th><th>Date of Mtg(s) and General Issues Addressed</th></tr>
<tr><td>April</td><td>Yes</td><td>04/28/2021</td></tr>
</table></td></tr>
</table>

Quality Improvement Area of Data Monitoring	Results of Evaluation
VI. Program Integrity: • **DM-2: Compliance Training and Communication to the MHP** **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Program Integrity – Section G, III. - Item B4-6 **Name of Data Report:** TBD **Sub-committee/Staff Responsible:** Compliance Committee meeting minutes/Compliance Unit report	**Q1:**

Month	Did Dept. Offer Compliance Training this month?	How many Behavioral Health staff completed the training?	Did Compliance Officer send out communication of compliance issues?	Dates and Topics of Communication
Jul	Yes	6	1	
Aug	Yes	1	2	
Sep	Yes	1	1	
Oct	Yes	0	0	
Nov	Yes	1	1	
Dec	Yes	0	0	12/18/20: OCR Audit report on compliance w/ HIPAA rules
Jan	Yes	1	0	
Feb	Yes	20	1	
Mar	Yes	54	2	3/22/21: OCR settles 14th inquiry into right to access records
Apr	Yes	6	1	4/13/21: Agency pays $28K for not running sanction checks
May	Yes	1	0	
Jun	Yes	22	0	6/3/21: OCR settles 19th inquiry into right to access records

VII. Quality Improvement (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
VII. Quality Improvement: • **AG-1:** Annual Utilization Review Audits - Timeliness and Appropriate Resolution of Annual Utilization Review Audit Findings **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services – Section A, VI. – Item D10, D12 & F. **Name of Data Report:** UR Audit Tracking Log (to be created) **Sub-committee/Staff Responsible:** QI Audit Supervisor and team **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☒ **Partially Met:** Item # 1-2 ☐ **Not Met:** Item # ___	**AG-1:** Solano County MHP Quality Improvement (QI) unit conducts Annual Utilization Review Audits of all County and Contracted Organizational Providers who bill Medi-Cal services, to ensure all such providers utilized by Solano MHP are in compliance with the documentation standards requirements, per CCR Title 9. **Baseline:** See Quality Improvement annual UR Audits during FY 19-20. **Goal:** The following processes are in place for FY 20-21 to monitor Provider compliance with CCR Title 9 documentation standards requirements: • **Measurement #1**: At least 90% of UR Audit Reports will be submitted within 60 days after the audit alert period. • **Measurement #2:** At least 90% of reviewed programs requiring a CAP will submit one that meets QI standards, within prescribed timelines.	**Q1:** **Q2:** **Q3:**

Q1:

Program	Days to Complete Report (60 days or less)	% of Programs Requiring a CAP	Days to Submit a CAP (60 days or less)	% of Resolved CAPs
CBO Youth A	Due 11/28/20	Pending	Pending	Pending
CBO Youth B	Due 12/5/2020	Pending	Pending	Pending
CBO Youth C	Due 12/25/20	Pending	Pending	Pending
CBO Adult D1	Due 1/5/21	Pending	Pending	Pending
CBO Adult D2	Due 1/5/21	Pending	Pending	Pending
CBO Youth E	Pending Audit Alerts	Pending	Pending	Pending
Running Averages	---	---	---	---

Q2:

Program	Days to Complete Report (60 days or less)	% of Programs Requiring a CAP	Days to Submit a CAP (60 days or less)	% of Resolved CAPs
CBO Youth A	121	Yes	Due 3/29/21	Pending
CBO Youth B	118	Yes	Due 4/28/21	Pending
CBO Youth C	Due 12/25/20	Pending	Pending	Pending
CBO Adult D1	59	Yes	Due 3/5/21	Pending
CBO Adult D2	Due 1/5/21	Pending	Pending	Pending
CBO Youth E	65	Yes	Due 2/20/21	Pending
CBO Adult F	34	Yes	Due 6/3/21	Pending
CBO Youth G	Due 2/14/21	Yes	Pending	Pending
CBO Youth H	Due 3/6/21	Yes	Pending	Pending
Running Averages	79.4	100%	---	---

Q3:

Program	Days to Complete Report (60 days or less)	% of Programs Requiring a CAP	Days to Submit a CAP (60 days or less)	% of Resolved CAPs
County Youth A	121	Yes	59	Pending
County Youth B	118	Yes	Due 6/23/21	Pending
County Youth C	133	Yes	48	Resolved

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

County Adult D1	59	Yes	55	Resolved
County Adult D2	85	Yes	57	Pending
County Youth E	65	Yes	60	Resolved
County Adult F	34	Yes	Due 6/3/21	Pending
County Youth G	86	Yes	59	Pending
County Youth H	77	Yes	57	Pending
County Youth I	55	Yes	Due 5/29/21	Pending
Running Averages	85	100%	57	43% Resolved

Q4:

Program	Days to Complete Report (60 days or less)	% of Programs Requiring a CAP	Days to Submit a CAP (60 days or less)	% of Resolved CAPs
County Youth A	121	Yes	59	Pending
County Youth B	118	Yes	Due 6/23/21	Pending
County Youth C	133	Yes	48	Resolved
County Adult D1	59	Yes	55	Resolved
County Adult D2	85	Yes	57	Pending
County Youth E	65	Yes	60	Resolved
County Adult F	34	Yes	Due 6/3/21	Pending
County Youth G	86	Yes	59	Pending
County Youth H	77	Yes	57	Pending
County Youth I	55	Yes	Due 5/29/21	Pending
County Youth J				
County Youth K				
County Adult L				
Running Averages		100%		% Resolved

VII. Quality Improvement (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation
VII. Quality Improvement: • **DM-1:** Documentation Training and Avatar User Training **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, VI - Item F. **Name of Data Report:** QI Excel Monitoring Spreadsheet **Sub-committee/Staff Responsible:** QI Training Lead and team	

Month	Doc Training Attendees	Avatar Phase 1 Attendees	Avatar Phase 2 Attendees
Jul	14	4	0
Aug	1	0	0
Sep	4	6	6
Oct	16	0	0
Nov	4	0	0
Dec	3	4	0
Jan	5	0	0
Feb	4	7	0
Mar	6	1	0
Apr	11	9	0
May	12	0	2
Jun	3	5	0

Quality Improvement Area of Data Monitoring	Results of Evaluation
VII. Quality Improvement: • **DM-2:** Site Certifications **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, VI - Item E. **Name of Data Report:** Monthly Site Certification Tracking Report **Sub-committee/Staff Responsible:** QI Site Certification Lead and team	

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	1	Yes	100%
Aug	1	Yes	100%
Sep	2	Yes	100%
Oct	4	Yes	100%
Nov	2	Yes	100%
Dec	1	Yes	100%
Jan	1	Yes	100%
Feb	5	Yes	100%
Mar	0	Yes	100%
Apr	0	Yes	100%
May	0	Yes	100%
Jun	4	Yes	100%

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

• DM-3: Medi-Cal Provider Eligibility and Verification

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 19-20, Program Integrity - Section G, V - Item A.

Name of Data Report:
Provider Eligibility and Verification Tracking Report

Sub-committee/Staff Responsible:
QI Provider Eligibility Verification Lead</td><td>Q1:
<table><tr><th>Month</th><th>Were 100% of County, Contract and Network Providers verified on the exclusion lists?</th></tr><tr><td>Jul</td><td>100%</td></tr><tr><td>Aug</td><td>100%</td></tr><tr><td>Sep</td><td>100%</td></tr><tr><td>Oct</td><td>100%</td></tr><tr><td>Nov</td><td>100%</td></tr><tr><td>Dec</td><td>100%</td></tr><tr><td>Jan</td><td>100%</td></tr><tr><td>Feb</td><td>100%</td></tr><tr><td>Mar</td><td>100%</td></tr><tr><td>Apr</td><td>100%</td></tr><tr><td>May</td><td>100%</td></tr><tr><td>Jun</td><td>100%</td></tr></table></td></tr>
</table>

VIII. Network Adequacy (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation
VIII: Network Adequacy: • **DM-1**: Pathways to Well-Being (Subclass) **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, III. - Item A-E. **Name of Data Report:** Pathways Database maintained by CCR Team **Sub-committee/Staff Responsible:** • Pathways/Katie A. Implementation Team	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

# Referred to MHP	# Assessed & Referred for Services	# of Clients Identified as Katie A. Subclass	# of Clients Who Received a CFT Mtg	# of Clients Who Declined Services	# of Clients AWOL	# of Clients Awaiting Response
78	51	90	85	3	0	2

Q2:

# Referred to MHP	# Assessed & Referred for Services	# of Clients Identified as Katie A. Subclass	# of Clients Who Received a CFT Mtg	# of Clients Who Declined Services	# of Clients AWOL	# of Clients Awaiting Response
112	59	97	85	4	0	8

Q3:

# Referred to MHP	# Assessed & Referred for Services	# of Clients Identified as Katie A. Subclass	# of Clients Who Received a CFT Mtg	# of Clients Who Declined Services	# of Clients AWOL	# of Clients Awaiting Response
118	98	72	67	4	0	1

Q4:

# Referred to MHP	# Assessed & Referred for Services	# of Clients Identified as Katie A. Subclass	# of Clients Who Received a CFT Mtg	# of Clients Who Declined Services	# of Clients AWOL	# of Clients Awaiting Response
91	53	68	61	2	0	5

Quality Improvement Area of Data Monitoring	Results of Evaluation
VIII: Network Adequacy: • **DM-2**: Pathways to Well-Being (non-Sub-class) **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:** **Q2:** **Q3:** **Q4:**

Q1:

	# of Pathways Clients Identified	Offered ICC Services # and %		Declined or AWOL	Accepted	Assigned an ICC Coordinator # and %		CFT Meeting Held or Scheduled	
SCMH	75	78	100%	23	52	52	100%	52	100%
Contract Agency	43	43	100%	11	28	28	100%	28	100%

Q2:

	# of Pathways Clients Identified	Offered ICC Services # and %		Declined or AWOL	Accepted	Assigned an ICC Coordinator # and %		CFT Meeting Held or Scheduled	
SCMH	104	104	100%	19	51	51	100%	51	100%
Contract Agency	44	44	100%	10	24	24	100%	24	100%

Q3:

	# of Pathways Clients Identified	Offered ICC Services # and %		Declined or AWOL	Accepted	Assigned an ICC Coordinator # and %		CFT Meeting Held or Scheduled	
SCMH	102	102	100%	24	78	78	100%	78	100%
Contract Agency	52	52	100%	18	32	31	97%	31	97%

Q4:

	# of Pathways Clients Identified	Offered ICC Services # and %		Declined or AWOL	Accepted	Assigned an ICC Coordinator # and %		CFT Meeting Held or Scheduled	
SCMH	96	49	100%	29	67	66	99%	66	99%
Contract Agency	96	49	100%	20	24	24	100%	24	100%

Goal Purpose and Monitoring	Results of Evaluation
VIII: Network Adequacy: • **DM-3**: Provider Network Data **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 19-20, Network Adequacy and Availability of Services - Section A, I. - Item D. **Name of Data Report:** Solano County Mental Health (MH) Managed Care Tracking; CALWIN Medi-Cal Eligible crystal report **Sub-committee/Staff Responsible:** Managed Care/Provider Relations	**Q1:**

Quarter	Clients Served	Network Providers	# of Providers Billing for Services	# of Providers Not Billing for Services	# of Providers Not Billing or Accepting New Clients (3+ months)	Bilingual Providers	Trained to Use Interpreter Services	Near Public Transportation	Access for the Physically Disabled	Beacon Referrals
Q1	36	21	16	5	5	4	21	21	13	80
Q2	15	18	5	13	10	4	18	18	13	56
Q3	28	17	6	11	11	4	17	17	12	70
Q4	23	17	5	12	12	4	17	17	12	88