Solano County
Health and Social Services Department
Behavioral Health Division
Solano Mental Health Plan
FY 2016 - 2017

Gerry Huber, Director, Department of Health and Social Services
Sandra Sinz, Deputy Director, Behavioral Health Division
Emery Cowan, Administrator, Behavioral Health Division
Rob George, Manager, Quality Improvement Unit
Amanda Davis, Supervisor, Quality Improvement Unit

Quality Improvement Work Plan for FY 2016/2017

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Quality Improvement Work Plan for FY 2016/2017

QUALITY IMPROVEMENT PROGRAM OVERVIEW

The Quality Improvement (QI) unit is responsible for providing support services to the Mental Health Plan (MHP) and its administration, programs, providers, consumers and family members. The QI unit is designed to develop, implement, coordinate, monitor and evaluate performance activities throughout the Mental Health Plan (MHP).

Quality Improvement Program

Staffing
11.75 FTE

.25 Mental Health Administrator
1.0 Mental Health Program Manager
1.0 Mental Health Clinical Supervisor
5.0 Licensed Mental Health Clinicians
0.5 Registered Nurse
4.0 Clerical Support Staff

QUALITY ASSURANCE	QUALITY MANAGEMENT	QUALITY IMPROVEMENT
Site Certifications	Utilization Management	Training Coordination
Clinical Records Review	Consumer Surveys	Continuing Education
Problem Resolution/SIR Process	Provider Satisfaction Surveys	Core Competencies
Concurrent Review Process	Treatment Authorization Requests	Mental Health Intranet Site
Staff Eligibility Verification	Performance Improvement Projects	Network of Care
Service Verification	Evidence-Based Practices	Technical Assistance
Service Authorization	Performance Outcomes	Policies & Procedures

<u>QI Program Areas of Focus for FY 2016-2017</u>:

The Quality Improvement unit continues its efforts to develop the quality improvement culture and activities within MHP programs so that there is a collective responsibility and owning of quality improvement throughout the MHP. Quality improvement, assurance and management are vital to the success of any health system, and this plan endeavors to create collaboration between program and quality teams in collecting and monitoring data, and utilizing data to incentivize and guide improvement efforts.

Quality Improvement continues to steer the MHP toward developing Work Plan goals that help the system to remain in compliance with Federal and California State regulations, most notably FCR 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 Quality Improvement to include in this year's Work Plan:

- Beneficiary Satisfaction and Protection
- Beneficiary and System Outcomes
- System Utilization Management
- Cultural Competence
- Program Integrity
- Quality Improvement
  - Utilization Review Audits
  - Credentialing
  - Provider Eligibility
- Service Timeliness and Access
- Wellness and Recovery

Quality Improvement staffing was finally again at capacity as of July of FY 2016-2017. It is our hope that these staffing levels can assist us to continue to take on the challenges of all areas covered by this Work Plan, including areas that are either newly required or have become of an increased area of focus in the new 1915b Waiver/associated terms and conditions, EQRO or DHCS Triennial System/Chart Review protocols.

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 quarterly basis, and progress and data are reported back to the Quality Improvement Committee once per quarter to inform committee membership and obtain any feedback and recommendations from the committee for consideration to improve current practices.

I. Beneficiary Satisfaction & Protection

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

I-A. Grievance, Appeal and Expedited Appeal

Authority:
- DHCS Annual Review Protocols, FY 16-17, Quality Improvement - Section I, Item # 2b, #5, and #6b; Beneficiary Protection – Section D, Item #2, #8a & 8b

Frequency of Evaluation:
Monthly/Quarterly

Name of Data Report:
- Problem Resolution Log
- QIC Problem Resolution Report

Sub-committee/Staff Responsible:
Problem Resolution Coordinator

Annual Goal Met:
- ☒ **Met:** Item # 1-3
- ☐ **Partially Met:** Item # ____
- ☐ **Not Met:** Item # ____

A-1: The Problem Resolution process in the Solano County MHP is responsible for receiving and responding to Grievances, Change of Provider Requests, Provider Appeals and Incident Reports generated by beneficiaries and providers in our system. The issues identified in Grievances, Appeals, and Expedited Appeals are intended to be monitored and communicated to the Quality Improvement Committee (QIC) on a regular and consistent basis.

Baseline: All Grievances, Appeals and Expedited Appeals will be reported to the QIC and significant issues will be presented that may require system changes to address.

Goal: Every QIC meeting will document:

1. **Total # of Grievances, Appeals, Expedited Appeals, State Fair Hearings, Expedited State Fair Hearings reported, & Change of Provider requests, including those resulting in quality of care issues**
2. **Total # of issues from the previous quarter, that require a system change, that were discussed at QIC**
3. **Total # of significant issues that were referred to Policy Committee**

A-1: Q1:

Month Received	Total quarterly # of Problem Resolution issues reported, including quality of care issues	# Requiring a System Change	# Referred to Policy Committee
July	4	0	0
Aug	4	1	0
Sept	12	1	0
Q1 Total	**20**	**2**	**0**

A-1: Q2:

Oct	10	0	0
Nov	12	0	0
Dec	9	0	0
Q2 Total	**31**	**0**	**0**

A-1: Q3:

Jan	5	0	0
Feb	10	1	0
Mar	13	2	0
Q3 Total	**28**	**3**	**0**

A-1: Q4:

Apr	12	0	0
May	10	0	0
Jun	16	5	0
Q4 Total	**38**	**5**	**0**

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

Goal Purpose and Monitoring:

I-B. Grievance, Appeal and Expedited Appeal follow up:

- Tracking and trending of Beneficiary Grievances and Appeals to meet DHCS annual reporting standards

Authority:
- DHCS Annual Review Protocols, FY 16-17, Quality Improvement - Section I, Item # 2b, #5, and #6b. #6b; Beneficiary Protection – Section D, Item #2a, 2b.

Frequency of Evaluation: Quarterly

Name of Data Report:
- Problem Resolution Log
- QIC Problem Resolution Report

Sub-committee/Staff Responsible: Problem Resolution Coordinator

Annual Goal Met:
- ☒ Met: Item # 1
- ☐ Partially Met: Item # ___
- ☐ Not Met: Item # ___

Goal/Objectives:

B-1: The Problem Resolution process in the Solano County MHP is responsible for providing written acknowledgements for every Grievance, Appeal and Expedited Appeal received from beneficiaries of the MHP.

Baseline: MHP Policy requires this to occur in 100% of all cases.

Goal: Quarterly tracking mechanisms will monitor the category of grievance, total #s and types of grievance process, and disposition of the grievance outcome:

1. **Were all problem resolution process areas logged, monitored and reported out to the state on a quarterly basis (complete each tracking log quarterly)?**

Results of Evaluation

B-1: Q1:

Category	Total #	Process					Disposition		
		Grievance	Appeal	Expedited Appeal	State Fair Hearing	Expedited Fair Hearing	Referred Out	Resolved	Still Pending
ACCESS	1	1					0	1	0
Denied Services	0						0	0	0
Change of Provider	10	10					1	9	0
Quality of Care	5	5					2	3	0
Confidentiality	1	1					1	0	0
Other	3	3					0	3	0
Q1 Total:	20	20					4	16	0

B-1: Q2:

Category	Total #	Process					Disposition		
		Grievance	Appeal	Expedited Appeal	State Fair Hearing	Expedited Fair Hearing	Referred Out	Resolved	Still Pending
ACCESS	1	1						1	0
Denied Services	0							0	0
Change of Provider	15	15						15	0
Quality of Care	12	12						12	0
Confidentiality	0	0						0	0
Other	3	3						3	0
Q2 Total:	31	31						31	0

B-1: Q3:

Category	Total #	Process					Disposition		
		Grievance	Appeal	Expedited Appeal	State Fair Hearing	Expedited Fair Hearing	Referred Out	Resolved	Still Pending
ACCESS	2	2					0	2	0
Denied Services	0							0	0
Change of Provider	11	11					0	11	0
Quality of Care	8	8					0	6	2
Confidentiality	0	0					0	0	0
Other	7	7					0	6	1
Q3 Totals:	28	28					0	25	3

B-1: Q4:

Category	Total #	Process					Disposition		
		Grievance	Appeal	Expedited Appeal	State Fair Hearing	Expedited Fair Hearing	Referred Out	Resolved	Still Pending
ACCESS									
Denied Services	1		1					1	
Change of Provider	16	16						15	1
Quality of Care	17	17						15	2
Confidentiality									
Other	4	4						4	
Q4 Totals:	38	37						35	3

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

I-C. Grievance, Appeal and Expedited Appeal follow up:

- Tracking the compliance of sending the beneficiary an acknowledgement and Disposition letter.

Authority:

- DHCS Annual Review Protocols, FY 16-17, Quality Improvement - Section I, Item # 2b, #5, and #6b; Beneficiary Protection – Section D, Item #3, 4, 6

Frequency of Evaluation:
Quarterly

Name of Data Report:

- Problem Resolution Log
- QIC Problem Resolution Report

Sub-committee/Staff Responsible:
Problem Resolution Coordinator

Annual Goal Met:
☐ **Met:** Item # ___
☒ **Partially Met:** Item # ___
☐ **Not Met:** Item # ___

C-1: The Problem Resolution process in the Solano County MHP is responsible for providing written acknowledgements for every Grievance, Appeal and Expedited Appeal received from beneficiaries of the MHP.

Baseline: MHP Policy requires this to occur in 100% of all cases.

Goal: 100% of all **Acknowledgement and Disposition Letters** will be sent to beneficiaries who submitted a Grievance, Appeal or Expedited Appeal within DHCS and MHP timeframes. 100% of Providers cited in the problem resolution process will be notified of the disposition:

1. **Total # of Grievances, Appeals and Expedited Appeals Received**
2. **Total # of Acknowledgement Letters sent**
3. **Total % in compliance with requirement**
4. **Total # of Disposition Letters sent**
5. **Total % in compliance with requirement**
6. **Total # & % of Providers who were notified of Disposition**

C-1: Q1:

Month Rec'd	Total # of Grievances, Appeals and Expedited Appeals Rec'd	Total # of Acknowledgement Letters sent	Total % that Comply	Total # of Dispo Letters sent	Total % that Comply	Total # and % of Providers who were notified of Disposition	
July	4	4	100%	4	100%	4	100%
Aug	4	4	100%	4	100%	4	100%
Sept	12	12	100%	12	100%	12	100%
Q1 Total	20	20	100%	20	100%	20	100%

C-1: Q2:

Oct	10	10	100%	10	100%	10	100%
Nov	12	12	100%	12	100%	12	100%
Dec	9	9	100%	9	100%	9	100%
Q2 Total	31	31	100%	31	100%	31	100%

C-1: Q3:

Jan	5	5	100%	5	100%	5	100%
Feb	10	10	100%	10	100%	10	100%
Mar	13	12	92%	12	3 Pending	10	3 Pending
Q3 Total	28	27	96%	27	100%	25	100%

C-1: Q4:

Apr	12	12	100%	12	12	100%	100%
May	10	10	100%	10	10	100%	100%
Jun	16	15	94%	13	13	81%	81%
Q4 Total	38	37	97%	35	35	92%	92%

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

I-D. **Grievance, Appeal and Expedited Appeal follow up:**

- Tracking and trending of Internal system improvement needs

Authority:

- DHCS Annual Review Protocols, FY 16-17, Quality Improvement - Section I, Item # 1a; #5; 6b.

Frequency of Evaluation:
Quarterly

Name of Data Report:
- Problem Resolution Log
- QIC Internal System Improvement Report

Sub-committee/Staff Responsible:
Problem Resolution Coordinator

Annual Goal Met:
☒ **Met:** Item # 1-3
☐ **Partially Met:** Item # ___
☐ **Not Met:** Item # ___

D-1: The Problem Resolution process in the Solano County MHP is responsible for reviewing the internally identified system needs of the MHP. These system needs result from incident reports initiated by county or contract providers, and identify an outcome that was out of the ordinary. Problem Resolution prompts the system to evaluate which incidents point out the need for a system/process change, a referral to Policy Committee, an Adverse Outcome Case Review, or perhaps even all of these processes.

Baseline: MHP requires that all such incidents are tracked and evaluated, and any that indicate further action are addressed (see Q1 for baseline)

Goal: Quarterly tracking mechanisms will monitor the category of internal system needs. Internally identified system needs will be identified via an incident report review process and result in the following:

1. **Led to a system/process change**
2. **Led to a referral to Policy Committee**
3. **Resulted in an Adverse Outcome Case Review**

D-1: Q1:

Month Received	Total quarterly # of Problem Resolution issues reported, 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	11	2	0	1
Aug	9	1	0	0
Sept	13	1	1	1
Q1 Total	33	4	1	2

D-1: Q2:

Oct	12	3	0	1
Nov	10	1	0	0
Dec	7	0	0	1
Q2 Total	29	4	0	2

D-1: Q3:

Jan	11	1 (meds issue)	0	0
Feb	12	0	0	0
Mar	10	1 (meds issue)	0	1 (pending)
Q3 Total	33	2	0	1

D-1: Q4:

Apr	12	1	0	1
May	17	0	0	0
Jun	18	1	0	1
Q4 Total	47	2	0	2

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

I-E. Consumer Perception:

- Annual Surveying of Client/Family Satisfaction

Authority:
- DHCS Annual Review Protocols, FY 16-17, Quality Improvement – Section I, Item #2a, 2d

Frequency of Evaluation: Quarterly

Name of Data Report:
- State Consumer Perception Surveys

Sub-committee/Staff Responsible: Problem Resolution Coordinator

Annual Goal Met:
☒ **Met:** Item # 1
☒ **Partially Met:** Item # 2
☒ **Not Met:** Item # 3

E-1: Solano MHP participates in the annual California DHCS Consumer Perception Survey Process, in which surveys are distributed at service programs throughout the MHP over the period of one week (designated by the state). Quality Improvement obtains copies of the results and inputs the data into an MHP database. The Problem Resolution Coordinator is responsible for reviewing the results and making recommendations for service areas to target as areas to be addressed with improvement goals.

Baseline: MHP participates in the Consumer Perception Survey at least annually and works to create related goals.

Goal: Problem Resolution Coordinator will ensure:

- **Measurement #1:** Did Solano MHP participate in one of the Annual Consumer Perception Surveys and is the MHP currently working on a goal to improve consumer perception?
- **Measurement #2:** Did Solano MHP obtain survey results from CIBHS website for those that were most recently posted, and were those results shared with the MHP's Providers?
- **Measurement #3:** Solano MHP will receive consumer ratings exceeding 90% for those who indicate they Strongly agree, somewhat agree, or agree with the following Consumer Satisfaction Survey item:

E-1: Q1:

Q#	Date range for most recent survey	Is the MHP working on a goal?	Date range for most recent survey results obtained	Were results shared with providers?	List the most recent survey goal & outcome.	
Q1	5/16/16 – 5/20/16	Working on previous goal.	11/16/16 – 11/20/16	☒ Yes ☐ No	Q15: Staff told me what side effects to watch out for.	
					Adult:	70%
					Older Adult:	78%
					Youth:	31%
					Families:	16%

E-1: Q2:

Q#						
Q2	11/14/16- 11/18/16	Working on previous goal.	5/16/16-5/20/16	☒ Yes ☐ No	Q15: Staff told me what side effects to watch out for.	
					Adult:	69%
					Older Adult:	75%
					Youth:	43%
					Families:	25%

E-1: Q3:

Q#						
Q3	Upcoming: 5/15/17- 5/19/17	Working on previous goal.	5/16/16-5/20/16	☐ Yes ☒ No Pending	Q15: Staff told me what side effects to watch out for.	
					Adult:	69%
					Older Adult:	75%
					Youth:	43%
					Families:	25%

E-1: Q4:

Q#						
Q4	5/15/17- 5/19/17	Working on previous goal.	5/16/16-5/20/16	☐ Yes ☐ No Pending	Q15: Staff told me what side effects to watch out for.	
					Adult:	69%
					Older Adult:	75%
					Youth:	43%
					Families:	25%

II. Beneficiary and System Outcomes

Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
II-A. **Clinical Care:** • Child and Adolescent Needs and Strengths Assessment • Adult Needs and Strengths Assessment **Authority:** • DHCS Annual Review Protocols, FY 16-17, Quality Improvement – Section I, Item #6c **Frequency of Evaluation:** Quarterly **Name of Data Report:** TBD – Either an Avatar Crystal Report or reporting generated by an external vendor **Sub-committee/Staff Responsible:** • Utilization Management Sub-Committee • Quality Improvement **Annual Goal Met:** ☐ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☒ **Not Met:** Item # 1-5	**A-1:** CANS/ANSA assessment measures were rolled out to Solano County's MHP between April 2013 and spring of 2015. **Baseline:** See below: **Goal:** CANS/ANSA data reporting mechanisms will be developed: • **Measurement #1**: 100% of d/cing clients will receive a CANS/ANSA at discharge – develop policy (**Baseline:** 0% providers complete at d/c) • **Measurement #2:** Implement a process for tracking Contract Agency clients' CANS and ANSA outcomes - either thru Avatar or an external vendor (**Baseline**: 100% collect ANSA, but do not submit data to MHP) • **Measurement #3:** Improve existing report to measure CANS and ANSA outcomes at the clinical provider/ client level **(county and contract programs)** • **Measurement #4:** Create and implement a report to measure CANS and ANSA outcomes at caseload and program levels **(county and contract programs)** • **Measurement #5:** Create and implement a report to measure CANS and ANSA outcomes at the system level **(county and contract programs)**	**A-1: Q1: PENDING** **A-1: Q2: PENDING** **A-1: Q3: PENDING** **A-1: Q4: PENDING**

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

II-B. Evidence-Based Practice:

- TF-CBT

Authority:

- DHCS Annual Review Protocols, FY 16-17, Quality Improvement – Section I, Item #6c

Frequency of Evaluation:
Quarterly

Name of Data Report:
No current report

Sub-committee/Staff Responsible:

- Quality Improvement
- MHSA

Annual Goal Met:

☐ **Met:** Item #

☒ **Partially Met:** Item # 1-2, 5

☒ **Not Met:** Item # 3-4

B-1: Trauma-Focused Cognitive Behavioral Therapy is an evidence-based practice that uses CBT techniques to help decrease PTSD symptoms, decrease negative attitudes about the traumatic event, decrease problem behaviors, improve parent-child relationships, improve parenting. Solano MHP has been committed to facilitating a TF-CBT training process since FY 2014-15 and implementing TF-CBT into outpatient treatment settings.

Baseline: During FY 15-16, 49 clients were served utilizing the model and 50 Clinicians were trained.

*Goal: TF-CBT goals include:

1. **Increase baseline # of Clients treated with TF-CBT by 15%**
2. **20% of staff will make an audio tape for clinical critique**
3. **50% of Clients will complete Post-Test**
4. **50% of clients measured will show clinical Improvement on the Post-Test**
5. **50 staff will be trained in TF-CBT**

*Amendments were made to this goal during Q1

B-1: Q1:

County or Contract Program	Total # Clients treated with TF-CBT this Quarter	Total # of approved audio tapes	Total # of Clients to complete Post-Assessment	Total # who showed Clinical Improvement on the Post-Test	Total # staff who were trained in TF-CBT
Child Haven	4	1	0	0	0
Uplift	0	0	0	0	0
A Better Way	3	0	0	0	0
SCBH Children's Clinics	14	0	0	0	0
Q1 TOTAL:	**21**	**0**	**0**	**0**	**0**

B-1: Q2:

Child Haven	4	2	1	1	0
Uplift	1	0	0	0	0
A Better Way	2	0	0	0	0
SCBH Children's Clinics	16	3	3	3	0
Q2 TOTAL:	**23**	**5**	**4**	**4**	**0**

B-1: Q3:

Child Haven	12	1	3	3	0
Uplift	1	0	0	0	0
A Better Way	2	1	2	2	-
SCBH Children's Clinics	9	1	1	1	0
Q3 TOTAL:	**24**	**3**	**6**	**6**	**0**

B-1: Q4:

Child Haven	-	-	-	-	2
Uplift	0	0	0	0	1
A Better Way	2	1	2	2	1
SCBH Children's Clinics	5	3	3	3	5
Q4 TOTAL:	**incomplete**	**incomplete**	**Incomplete**	**incomplete**	**10***

Quality Improvement Work Plan for FY 2016/2017

III. Utilization Management

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

III-A. Managed Care Provider Network

Authority:
DHCS Annual Review Protocols, FY 16-17, Network Adequacy and Array of Services – Section A, Item #3a-3e

Frequency of Evaluation:
Quarterly

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

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

Goal/Objectives:

A-1: Historically, Solano MHP has worked diligently to build and maintain our provider network, yet we have experienced challenges due to various factors.
Baseline: Based on FY 15-16 Q4 report, the total # of Network Providers was 32 and the geographic distribution throughout the county was: South County: 12, Central County: 10, North County: 10. Total # of Bilingual providers was: 6.
Goal: Solano MHP will maintain or increase items 1 and 4-9 below by 5%:

1. # of Network providers in South, Central and North County Regions
2. % of Network providers in each county region (MONITORING ONLY GOAL) - based on 2014 Medi-Cal eligible distribution: 39% South County, 38 % Central County, 23% North County)
3. # of anticipated Medi-Cal eligible clients (based on previous quarter network provider referrals)
4. # of Beacon Referrals last quarter
5. # of Bilingual Providers
6. # Trained to use an interpreter
7. # of Providers who have not accepted a referral in the last 3 months.
8. # of providers who are within 10 mins walking distance of public transportation
9. # of providers with physical access for disabled services.

A-1: Q1:

County Region	# of Providers in ea. Region	% of Providers in ea. Region	# of Clients Served During the Quarter	# of Beacon Referral	# of Bilingual Provider	# trained to use Interp.	# 3 mons w/o taking a referral	# of Providers w/in 10 mins. of Pub Trans.	# of Providers w/ physical access for the Disabled
N/A	N/A	N/A	53	113	4	36	25	36	23
North	13	36%							
Central	11	31%							
South	12	33%							

A-1: Q2:

County Region	# of Providers in ea. Region	% of Providers in ea. Region	# of Clients Served During the Quarter	# of Beacon Referral	# of Bilingual Provider	# trained to use Interp.	# 3 mons w/o taking a referral	# of Providers w/in 10 mins. of Pub Trans.	# of Providers w/ physical access for the Disabled
N/A	N/A	N/A	51	115	5	38	21	38	20
North	13	34%							
Central	12	32%							
South	13	34%							

A-1: Q3:

County Region	# of Providers in ea. Region	% of Providers in ea. Region	# of Clients Served During the Quarter	# of Beacon Referral	# of Bilingual Provider	# trained to use Interp.	# 3 mons w/o taking a referral	# of Providers w/in 10 mins. of Pub Trans.	# of Providers w/ physical access for the Disabled
N/A	N/A	N/A	64	100	6	32	17	32	22
North	11	30.5%							
Central	11	30.5%							
South	14	39%							

A-1: Q4:

County Region	# of Providers in ea. Region	% of Providers in ea. Region	# of Clients Served During the Quarter	# of Beacon Referral	# of Bilingual Provider	# trained to use Interp.	# 3 mons w/o taking a referral	# of Providers w/in 10 mins. of Pub Trans.	# of Providers w/ physical access for the Disabled
N/A	N/A	N/A	56	101	6	28	3	28	19
North	9	29%							
Central	9	29%							
South	13	42%							

Quality Improvement Work Plan for FY 2016/2017

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

III-B. Full Service Partnership Utilization and Outcomes

Authority:
DHCS Annual Review Protocols, FY 16-17, Quality Improvement – Section I, Item # 8a

Frequency of Evaluation:
Quarterly

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

Sub-committee/Staff Responsible:
UM Committee

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

*Lack of baseline makes goals

B-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 to measure success in FY 15-16, Solano MHP will explore the feasibility of having all FSP programs being able to use Avatar E.H.R to enter DCR data into.
Baseline: Data recovery thru the State ITWS system was a challenge during FY 15-16, so baseline is difficult to determine at this time.
Goal: Solano MHP will maintain or increase items 2-8 below by 5%:

1. Total # of Clients – Improve FSP capacity (# of clients seen) by 5%
2. Decrease total FSP inpatient hospitalizations by 10%
3. Decrease the percentage of FSP clients hospitalized by 5%
4. Maintain/Reduce # hospitalized more than once during Quarter
5. Decrease total FSP clients incarcerated by 5%
6. Reduce # of FSP clients without stable housing
7. Increase average # of services per week delivered to FSP clients to meet or exceed the minimal standard.

B-1: Q1:

FSP Programs this Quarter (Adults)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospital-ized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homelessness	Ave. # of Tx services per client/ week	Ave. # of CM services per client/ week
VJO Adult FSP	59	13/ 22%	1	-	-	.42	.49
FACT/AB 109	70	3/ 4%	0	-	-	.72	.01
Caminar Adult FSP	31	0	0	-	-	.23	.27
Caminar OA FSP	18	1/ 6%	0	-	-	.21	.26
Caminar HOME FSP	16	1/ 6%	0	-	-	.12	.38
Seneca TAY FSP	13	2/ 15%	0	-	-	1.59	.15
Totals	**207**	**20/ 53%**	**1**	**-**	**-**	**.55**	**.26**

FSP Programs this Quarter (Children's)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospitalized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homeless-ness	Ave. # of Tx services per client/ week	Ave. # of CM services per client/ week	Youth in out-of-home placement
VJO FSP	Started 10/1	-	-	-	-	-	-	-
FF FSP	101	7/ 7%	2	-	-	0.82	0.07	-
VV FSP	Stated 11/15	-	-	-	-	-	-	-

B-1: Q2:

FSP Programs this Quarter (Adults)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospital-ized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homelessness	Ave. # of Tx services per client/ week	Ave. # of CM services per client/ week
VJO Adult FSP	62	4/ 6%	0	1	4	.39	.39
FACT/AB 109	80	1/ 1%	0	4	12	.42	.16
Caminar Adult FSP	32	1/ 3%	0	0	1	.15	.13
Caminar OA FSP	14	1/ 7%	0	0	0	.15	.08
Caminar HOME FSP	16	0	0	0	5	.17	.13
Seneca TAY FSP	12	0	1	1	3	1.5	.22
Totals	**216**	**7/3%**	**1**	**6**	**25**		

FSP Programs this Quarter (Children's)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospitalized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homeless-ness	Ave. # of Tx services per client/ week	Ave. # of CM services per client/ week	Youth in out-of-home placement
VJO FSP	22	1/ 5%	0	0	0	.62	.06	0
FF FSP	92	2/ 2%	1	0	2	.76	.08	3
VV FSP	22	3/ 14%	1	1	1	.42	.04	1
Totals	**136**	**6/ 4%**	**2**	**1**	**3**			**4**

Quality Improvement Work Plan for FY 2016/2017

difficult to measure.

B-1: Q3:

FSP Programs this Quarter (Adults)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospital-ized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homelessness	Ave. # of Tx services per client/ week	Ave. # of CM services per client/ week
VJO Adult FSP	59	4/ 7%	3	2	9	.37	.50
FACT/AB 109	73	2/ 3%	2	10	7	.53	.17
Caminar Adult FSP	39	3/ 8%	1	0	0	.49	.38
Caminar OA FSP	16	1/ 6%	0	0	0	.60	.49
Caminar HOME FSP	23	1/ 4%	0	1	6	.20	.34
Seneca TAY FSP	14	1/ 7%	1	1	3	1.26	.28
Totals	224	12/ 5%	7	14	25		

FSP Programs this Quarter (Children's)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospitalized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homeless-ness	Ave. # of Tx services per client/ week	Ave. # of CM services per client/ week	Youth in out-of-home placement
VJO FSP	25	2/ 8%	2	2	1	.96	.09	0
FF FSP	57	2/ 4%	0	1	1	1.03	.05	5
VV FSP	25	2/ 8%	1	1	3	1.06	.06	2
FCTU	71	1/ 1%	0	0	0	.47	.05	39
Totals	178	7/ 4%	3	4	5			46

B-1: Q4:

FSP Programs this Quarter (Adults)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospital-ized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homelessness	Ave. # of Tx services per client/ week	Ave. # of CM services per client/ week
VJO Adult FSP	52	6	1	1	5	0.47	0.48
FACT/AB 109	75	5	2	12	8	0.40	0.18
Caminar Adult FSP	34	0	0	0	1	0.51	0.24
Caminar OA FSP	15	1	0	0	0	0.45	0.27
Caminar HOME FSP	30	0	0	0	3	0.18	0.22
Seneca TAY FSP	12	0	1	0	2	1.38	0.22
Totals	216	12	4	14	19		

FSP Programs this Quarter (Children's)	# of Clients Served	Total #/% of clients hospitalized 1x	# of clients hospitalized > 1x	Total # incar-cerated 1x	# of clients exp. 1x incidence of homeless-ness	Ave. # of Tx services per client/ week	Ave. # of CM services per client/ week	Youth in out-of-home placement
VJO FSP	22	1	2	1	1	1.08	0.15	1
FF FSP	56	2	0	1	1	0.91	0.17	5
VV FSP	25	4	1	0	2	1.07	0.09	2
FCTU	52	1	0	1	0	0.69	0.41	46
Totals	155	8	3	3	4			54

14

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

III-C. Hospital-Related Measures

- Adult & Child Hospitalizations

Authority:
DHCS Annual Review Protocols, FY 16-17, Quality Improvement Section I, Item #6c.

Frequency of Evaluation:
Quarterly

Name of Data Report:
Inpatient Tracking Avatar Report #109

Sub-committee/Staff Responsible:
Utilization Management team

Annual Goal Items Met:
☒ **Met:** Item # 1
☒ **Partially Met:** Item # 2
☐ **Not Met:** Item # ___

C-1: The Utilization Management Committee is charged with monitoring the effectiveness of the MHP's infrastructure to reduce inpatient stays and recidivism.
Baseline: FY 15-16 Averages
Goal: Maintain or improve the following hospital-related measures for Adult Solano County Medi-Cal clients and clients with no insurance, excluding 0-17 year olds, private insurance, Kaiser Medi-Cal, or other county Medi-Cal:

1. Maintain FY15-16 baseline average of 150 inpatient hospitalizations per quarter.
2. Maintain FY15-16 baseline average of 12% or less of clients re-hospitalized within 30 days of discharge from inpatient hospitalization.

C-1: Q1:

Month	Total # of Adult Inpatient Hospitalizations	Total # of Adult Discharges	Total # of Adult Rehospitalizations within 30 days of discharge & % of total of discharges	
Jul	42	41	1	2.4%
Aug	51	49	3	6.1%
Sep	49	49	10	20.4%
TOTALS:	**142**	**139**	**14**	**10.1%**

C-1: Q2:

Month	Total # of Adult Inpatient Hospitalizations	Total # of Adult Discharges	Total # of Adult Rehospitalizations within 30 days of discharge & % of total of discharges	
Oct	37	37	5	13.5%
Nov	34	31	1	3.2%
Dec	34	35	6	17.1%
TOTALS:	**105**	**103**	**12**	**11.6%**

C-1; Q3:

Month	Total # of Adult Inpatient Hospitalizations	Total # of Adult Discharges	Total # of Adult Rehospitalizations within 30 days of discharge & % of total of discharges	
Jan	42	46	7	15.2%
Feb	33	33	4	12.1%
Mar	37	34	5	14.7%
TOTALS:	**112**	**113**	**16**	**14.1%**

C-1; Q4

Month	Total # of Adult Inpatient Hospitalizations	Total # of Adult Discharges	Total # of Adult Rehospitalizations within 30 days of discharge & % of total of discharges	
Apr	44	40	5	12.5%
May	46	49	7	14.3%
Jun	42	46	7	15.2%
TOTALS:	**132**	**135**	**19**	**14.1%**

C-1; FY 16-17

Average # of Adult Inpatient Hospitalizations per Quarter	FY Average Percentage of Adult Clients Rehospitalized within 30 days of discharge from inpatient hospitalization
123	**12.4%**

Quality Improvement Work Plan for FY 2016/2017

C-2: The Utilization Management Committee is charged with monitoring the effectiveness of the MHP's infrastructure to reduce inpatient stays and recidivism.
Baseline: Goal is to establish a baseline using data for FY 16-17
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).

C-2; Q1:

Month	Total # of Child Inpatient Hospitalizations	Total # of Child Discharges	Total # of Child Rehospitalizations within 30 days of discharge & % of total of discharges	
Jul	6	3	1	33.3%
Aug	8	11	3	27.3%
Sep	7	6	1	16.7%
TOTALS:	**21**	**20**	**5**	**25%**

C-2; Q2:

Month	Total # of Child Inpatient Hospitalizations	Total # of Child Discharges	Total # of Child Rehospitalizations within 30 days of discharge & % of total of discharges	
Oct	7	9	2	22.2%
Nov	8	7	2	28.6%
Dec	4	6	0	0%
TOTALS:	**19**	**22**	**4**	**18.1%**

C-2: Q3:

Month	Total # of Child Inpatient Hospitalizations	Total # of Child Discharges	Total # of Child Rehospitalizations within 30 days of discharge & % of total of discharges	
Jan	6	5	0	0%
Feb	5	6	2	33%
Mar	9	6	0	0%
TOTALS:	**20**	**17**	**2**	**11.8%**

C-2: Q4:

Month	Total # of Child Inpatient Hospitalizations	Total # of Child Discharges	Total # of Child Rehospitalizations within 30 days of discharge & % of total of discharges	
Apr	6	8	1	12.5%
May	5	6	0	0%
Jun	3	3	0	0%
TOTALS:	**14**	**17**	**1**	**5.9%**

C-2; FY 16-17

Average # of Child Inpatient Hospitalizations per Quarter	FY Average Percentage of Child Clients Rehospitalized within 30 days of discharge from inpatient hospitalization
18.5	**15.8%**

III-D. Special Populations:	D-1: Solano MHP will ensure that all children screened and identified by CWS will be assessed by Solano MHP and/or referred to Beacon for mild-moderate level treatment as part of the Pathways to Wellness initiative.

III-D. Special Populations:

- Pathways to Well-Being (Katie A.)

Authority:
DHCS Annual Review Protocols, FY 16-17, Section A Item #4a-4d

Frequency of Evaluation:
Quarterly

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

Sub-committee/Staff Responsible:
- Katie A. Implementation Team

Annual Goal Items Met:
☐ **Met:** Item # ____
☒ **Partially Met:** Item # 1-3
☐ **Not Met:** Item # ____

D-1: Solano MHP will ensure that all children screened and identified by CWS will be assessed by Solano MHP and/or referred to Beacon for mild-moderate level treatment as part of the Pathways to Wellness initiative.

Baseline: See Q1

Goal: Improve the following measures:

- **#1:** 100% of those screened/referred to MHP will be either assessed and referred to MHP for Pathway services or referred to MCP for services.
- **#2:** 100% of Subclass members who are assigned an ICC Coordinator will receive an initial Child and Family Team meeting.
- **#3:** Solano will maintain a network with the overall capacity to serve clients who meet criteria for ICC/IHBS services (**Based on program average caseload size**).

D-1: Q1:

# Refer'd to MHP	# Assessed & Refer'd for Services		# ID'd as Katie A. subclass		Received CFT Mtg	Declined Services	AWOL	Awaiting Response
	MHP	MCP						
11	7	2	In County	91	81	5	1	4
			Out of County	40	25	4	3	2

Program Name	ICC Clients	IHBS Clients
Seneca	40	23
TFCU	59	9
SC Children's FSP	0	0

D-1: Q2:

# Refer'd to MHP	# Assessed & Refer'd for Services		# ID'd as Katie A. subclass		Received CFT Mtg	Declined Services	AWOL	Awaiting Response
	MHP	MCP						
11	7	2	In County	91	81	5	1	4
			Out of County	40	25	4	3	2

Program Name	ICC Clients	IHBS Clients
Seneca	40	23
TFCU	59	9
SC Children's FSP	0	0

D-1: Q3:

# Refer'd to MHP	# Assessed & Refer'd for Services		# ID'd as Katie A. subclass		Received CFT Mtg	Declined Services	AWOL	Awaiting Response
	MHP	MCP						
11	7	2	In County	91	81	5	1	4
			Out of County	40	25	4	3	2

Program Name	ICC Clients	IHBS Clients
Seneca	40	23
TFCU	59	9
SC Children's FSP	0	0

D-1: Q4:

# Refer'd to MHP	# Assessed & Refer'd for Services		# ID'd as Katie A. subclass		Received CFT Mtg	Declined Services	AWOL	Awaiting Response
	MHP	MCP						
21	19	2	In County	120	113	3		4
			Out of County	42	19	2		

Program Name	ICC Clients	IHBS Clients
Seneca	13	14
TFCU	40	9
SC Children's FSP	0	0

IV. Cultural Competence

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

IV-A. Cultural Competence:

- Community Information and Education Plans – Outreach re: cultural/linguistic services

Authority:
DHCS Annual Review Protocols, FY 16-17, Access - Section B, Item #7b, 8b, 12b

Frequency of Evaluation:
Quarterly

Name of Data Report:
TBD

Sub-committee/Staff Responsible:
Cultural Competence Coordinator

Annual Goal Items Met:
☒ **Met:** Item # 2 (53.25 avg calls per quarter)
☒ **Partially Met:** Item # 1
☐ **Not Met:** Item # ___

A-1: Solano *MHP 2014 Cultural Competency Plan Update* states, "Individuals and groups will gain access to and be provided behavioral health services by Solano County in proportion to their representation in the overall county population. Specific attention will be directed at increasing the number and percentage of clients who are Latino/bilingual Spanish, Filipino-American and LGBTQ." (Part 1, Goal #1).

Baseline:
- **Measurement #1:** Average # of quarterly outreach initiatives in FY 15-16 was 13.25
- **Measurement #2:** Average # of quarterly HOLA calls in FY 15-16 was 17.25

Goal: Solano MHP's Outreach Coordinator will continue to develop partnerships w/ community organizations, in an effort to generate HOLA calls for some level of MH services:
- **Measurement #1:** Engage in 10-15 Outreach initiatives per quarter (presentations at community events, visits to a community partner agency to provide info, etc.)
- **Measurement #2:** Work to an average of 15-20 calls per quarter to the HOLA line as a result of outreach efforts?

A-1: Q1:

Month	Region	Community Agencies willing to Partner with HOLA	# of HOLA Calls received
Jul	North, Central	1. Solano County Family Justice Center Support Group 2. Dixon Migrant Camp Youth Mental Health First Aid Training 3. Maternal/Infant/Family Health Presentation 4. Hispanic Chamber of Commerce	18
Aug	North, Central, South	1. Voces Unidas 2. Solano County Family Justice Center 3. Solano County Family Justice Center Support Group 4. Uplift Outreach 5. First Baptist Church 6. Vallejo GA and FSU Units Mental Health First Aid	43
Sept	Central	1. SCOE Presentation 2. Safe Talk Presentation 3. Solano County Family Justice Center Support Group 4. Will C. Wood Presentation 5. ASIST Training Vacaville First Baptist Church 6. Solano County CWS Presentation	32
Totals	**-**	**16**	**93**

A-1: Q2:

Month	Region	Community Agencies willing to Partner with HOLA	# of HOLA Calls received
Oct	North, Central, South	1. Vacaville First Healthy Family 2. Solano County Family Justice Center Support Group 3. Solano County Office of Education 4. California Highway Patrol 5. Goodwill	24
Nov	North, Central	1. Solano County Family Justice Center Support Group 2. Winters Migrant Camp	21
Dec	-	-	14
Totals	**-**	**7**	**59**

A-1: Q3:

Month	Region	Community Agencies willing to Partner with HOLA	# of HOLA Calls received
Jan	-	0	8
Feb	-	0	16
Mar	-	0	10
Totals	**-**	**0**	**34**

*Outreach Coordinator on extended leave

A-1: Q4:

Month	Region	Community Agencies willing to Partner with HOLA	# of HOLA Calls received
Apr	---	---	10
May	Central	1. Voces Unidas 2. Public Health Nurses of Solano County	16
Jun	Central, South	1. SCOE 2. Vallejo City Leadership	11
Totals	**---**	**4**	**27**

Quality Improvement Work Plan for FY 2016/2017

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

IV-B. Cultural Competence:

- Community Information and Education Plans – Outreach re: cultural/linguistic services

Authority:
DHCS Annual Review Protocols, FY 16-17, Access - Section B, Item #7b, 8b, 12b

Frequency of Evaluation:
Quarterly

Name of Data Report:
TBD

Sub-committee/Staff Responsible:
Cultural Competence Coordinator

Annual Goal Items Met:
☒ **Met:** Item # 2
☒ **Partially Met:** Item # 1
☐ **Not Met:** Item # ___

B-1: Solano *MHP 2014 Cultural Competency Plan Update* states, "Individuals and groups will gain access to and be provided behavioral health services by Solano County in proportion to their representation in the overall county population. Specific attention will be directed at increasing the number and percentage of clients who are Latino/bilingual Spanish, Filipino-American and LGBTQ." (Part 1, Goal #1).

Baseline:

- **Measurement #1:** Average # of quarterly outreach initiatives in FY 15-16 was 17.25
- **Measurement #2:** Average # of quarterly HOLA calls in FY 15-16 was 12.75

Goal: Solano MHP's Kaagapay Outreach Coordinator will continue to develop partnerships with community organizations in an effort to generate Kaagapay calls for some level of MH services:

- **Measurement #1:** Engage in 15-20 Outreach initiatives per quarter (presentations at community events, visits to a community partner agency to provide information and education, etc.)
- **Measurement #2:** Work to an average of 10-15 calls per quarter to the Kaagapay line and/or ACCESS as a result of outreach efforts?

B-1: Q1:

Month	Region	Community Agencies willing to Partner with Kaagapay	# of Kaagapay Calls received by
Jul	Central, South	1. Faith In Action 2. Child Haven 3. Caminar 4. SC Family Health Services Presentation 5. Legal Services of Northern California	4
Aug	Central, South	1. SC Nutrition Program (WIC) 2. One Justice 3. Jesus Reigns Ministry 4. Healthy Families 5. SC Emergency Preparedness Unit 6. American Cancer Society	5
Sept	North, Central, South	1. Touro University 2. American Heart Association 3. My Sister's House 4. SC Black Infant Health 5. Solano Coalition for Better Health 6. SCOE Presentation	5
Totals	**-**	**17**	**14**

B-1: Q2:

Month	Region	Community Agencies willing to Partner with Kaagapay	# of Kaagapay Calls received by
Oct	Central, South	1. SOLIDA 2. Andrea's Restaurant 3. EVENT: Health & Wellness Fair	7
Nov	Central, South	1. Mount Carmel Church Presentation 2. Fighting Back Partnership – Tobacco Prevention Unit 3. Wayside Methodist Church	4
Dec	-	1. Dr. Joyce: Filipino Family Health Initiative (L.A.)	3
Totals	**-**	**7**	**14**

Quality Improvement Work Plan for FY 2016/2017

B-1: Q3:

Month	Region	Community Agencies willing to Partner with Kaagapay	# of Kaagapay Calls received
Jan	Central, North	1. Suisun Library 2. Bright Minds Residential Care 3. St. Joseph Catholic Church 4. UPLIFT Family Services 5. Care Network, Inc 6. District Attorney's Victim Witness Program (VWP) 7. SC Family Liaison	5
Feb	Central, South	1. CWS: Family Strengthening Program 2. My Sister's House 3. Vallejo PD 4. UPLIFT Family Services 5. District Attorney's VWP	5
Mar	Central, South	1. UPLIFT Family Services 2. Lily's Home Care 3. Loving Hearts Care Home 4. Nene's Rest Home 5. Tagalog Speaking MH Practitioner 6. St. Basil's Catholic Church 7. St. Basil's CFC Chapter	4
Totals	**-**	**19**	**14**

B-1: Q4:

Month	Region (North, Central, South)	Community Agencies willing to Partner with Kaagapay	# of Kaagapay Calls received
Apr	South	1. Vallejo Charter School 2. Jollibee 3. St. Catherine 4. Tina's Hair Salon 5. Seneca 6. Suisun Library	7
May	Central, South	1. Safequest Presentation 2. All Seasons Care Home 3. Diamond Care Home 4. Migrante 707	8
Jun	Central, South	1. A Better Way Presentation 2. District Attorney's 3. Ms. Ro's Storytelling/ Tagalog Class I, II, III	3
Totals	**---**	**13**	**18**

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

IV-C. Quality Improvement:

- Regional Utilization and Service Penetration by cultural group

Authority:
DHCS Annual Review Protocols, FY 16-17, Network Adequacy and Array of Services – Section A, Item #2b, 2c

Frequency of Evaluation:
Quarterly

Name of Data Report:
- **Avatar Report # 326** Cultural Competence Service Listing **(Goal #1-4)**
- **Avatar Report # 347** Clients Served by Region **(Goal #5)**

Sub-committee/Staff Responsible:
- Utilization Management Committee membership
- Cultural Competence Committee
- Quality Improvement

Annual Goal Items Met:
☒ **Met:** Item # 5
☒ **Partially Met:** Item # 2-3
☒ **Not Met:** Item # 1,4

C-1: Solano County MHP encourages services in every geographic area and to persons in all ethnic groups to ensure access by members of the target population for all age groups.

Baseline:
- **Quarterly Goal**: Based on FY 15-16 Q4 totals
- **Annual Goal**: Based on FY 15-16 Annual totals

Goal:

- **Goal #1**: Total # of Black/African American unique clients will be maintained at 15-16 Q average – Future goal will be developed to look at ensuring that services are provided to this population at the lower (correct) levels of care
- **Goal #2**: Total # of Hispanic/Latino unique clients will increase 5% annually
- **Goal #3**: Total # of Filipino unique clients will increase 5% annually
- **Goal #4**: FY 16-17 will be a data gathering and Report Developing year for LGBTQ
- **Goal #5**: Services are being provided in all regions of the county to Black/African American, Hispanic/Latino, Filipino, and LGBTQ unique clients

C-1: Q1:

Date Range	Black/AA	Hispanic/ Latino	Filipino	LGBTQ	Are services in all regions?
FY 16-17 Q1	959	577	148	In Progress	Yes
FY 15-16 Q Ave (Baseline)	391.25	230.5	51	Data Not Available	Yes
FY 16-17 Q1 Percentage of Total served	26.1%	15.7%	4%	In Progress	Yes
FY 15-16 Annual Percentage of Total Served	26.3%	15.5%	3.4%	Data Not Available	Yes
FY 16-17 Annual Total	TBD	TBD	TBD	TBD	TBD
FY 15-16 Annual Total (Baseline)	1565	922	204	Data Not Available	Yes

C-1: Q2:

Date Range	Black/AA	Hispanic/ Latino	Filipino	LGBTQ	Are services in all regions?
FY 16-17 Q2	955	561	143	In Progress	Yes
FY 15-16 Qtr Ave (Baseline)	999.5	562.25	141.75	Data Not Available	Yes
FY 16-17 Q2 Percentage of Total served	26.16%	15.34%	4%	In Progress	Yes
FY 15-16 Annual Percentage of Total Served	26.93%	15.15%	3.82%	Data Not Available	Yes
FY 16-17 Annual Total	TBD	TBD	TBD	TBD	TBD
FY 15-16 Annual Total (Baseline)	1565	922	204	Data Not Available	Yes

Quality Improvement Work Plan for FY 2016/2017

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation				
		C-1: Q3:				

C-1: Q3:

Date Range	Black/AA	Hispanic/Latino	Filipino	LGBTQ	Are services in all regions?
FY 16-17 Q3	951	557	150	No Data Available	Yes
FY 15-16 Qtr Ave (Baseline)	999.5	562.25	141.75	No Data Available	Yes
FY 16-17 Q3 Percentage of Total served	26.12%	15.27%	4.12%	No Data Available	NA
FY 15-16 Annual Percentage of Total Served	26.3%	15.5%	3.4%	No Data Available	NA
FY 16-17 Annual Total	TBD	TBD	TBD	No Data Available	NA
FY 15-16 Annual Total (Baseline)	1565	922	204	No Data Available	NA

C-1: Q4:

Date Range	Black/AA	Hispanic/Latino	Filipino	LGBTQ	Are services in all regions?
FY 16-17 Q4	956	566	149	In Progress	Yes
FY 15-16 Q Ave (Baseline)	999.50	562.25	141.75	Data Not Available	Yes
FY 16-17 Q1 Percentage of Total served	26.72%	15.57%	4.13%	In Progress	Yes
FY 15-16 Annual Percentage of Total Served	26.3%	15.5%	3.4%	Data Not Available	Yes
FY 16-17 Annual Total	1558	944	221	TBD	Yes
FY 15-16 Annual Total (Baseline)	1565	922	204	Data Not Available	Yes

Quality Improvement Work Plan for FY 2016/2017

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation						
IV-D. **Quality Improvement**: • Cultural Competence **Authority:** DHCS Annual Review Protocols, FY 16-17, Access – Section B, Item #11, 12a-12c, &13a-13b **Frequency of Evaluation:** Quarterly **Name of Data Report:** **Sub-committee/Staff Responsible:** • Cultural Competence Committee **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☒ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**D-1:** Solano County MHP Cultural Competence Committee (CCC) endeavors to include a diverse group of stakeholders, including county and contract providers, Consumer family members, and MH Consumers with lived experience, and to help the system to be changed and improved through the implementation of the Cultural Competence Plan. **Baseline:** • Baseline is to accomplish these goals annually, 100% of the time **Goal:** • **Goal #1**: CCC will update the CC plan annually • **Goal #2**: The CCC will meet at least quarterly as a sub-committee of the QIC • **Goal #3**: The CCC will produce an annual report of CCC activities as required in the CCPR • **Goal #4**: The CCC will report quarterly progress on CC Plan activities and goals at QIC • **Goal #5**: CCC will plan for and monitor and track attendance of management, clinical providers and front office staff at annual CC training	**D-1: Q1:**						

D-1: Q1:

Date CC Plan Updated	Date CCC met this Quarter	Date of Annual Report	Date of report to QIC	CC Training Offered this Quarter (Y/N)?	What was the title of the training?	How many staff attended?
NA	9/1/16	TBD	11/15/16	Yes (12/6 & 12/13)	Cultural Competence Training	TBD

D-1: Q2:

Date CC Plan Updated	Date CCC met this Quarter	Date of Annual Report	Date of report to QIC	CC Training Offered this Quarter (Y/N)?	What was the title of the training?	How many staff attended?
Pending	12/1/16 1/18/17	---	Presented at Each QIC	Yes (12/6 & 12/13)	Cultural Competence 101 (new)	147

D-1: Q3:

Date CC Plan Updated	Date CCC met this Quarter	Date of Annual Report	Date of report to QIC	CC Training Offered this Quarter (Y/N)?	What was the title of the training?	How many staff attended?
1/18/17	3/2/17	TBD	TBD	Yes	Structural Racism 101	9

D-1: Q4:

Date CC Plan Updated	Date CCC met this Quarter	Date of Annual Report	Date of report to QIC	CC Training Offered this Quarter (Y/N)?	What was the title of the training?	How many staff attended?
1/18/17	6/8/17	TBD	TBD	Yes	Cultural Competence 101	45

V. Program Integrity

Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation		
V-A. Compliance Committee **Authority:** DHCS Annual Review Protocols, FY 16-17, Program Integrity – Section H, Item # 2c **Frequency of Evaluation:** Quarterly **Name of Data Report:** Compliance Meeting Minutes **Sub-committee/Staff Responsible:** Compliance Committee **Annual Goal Met:** ☒ Met ☐ Partially Met ☐ Not Met	**A-1:** Solano MHP's Deputy Compliance Director works directly with the MHP as head of the Compliance Committee and to direct and guide the MHP's compliance enforcement and training/education efforts to improve compliance and consumer privacy, and to guard against fraud, waste, and abuse. **Baseline:** The MHP held quarterly Compliance Committee meetings during FY 2015-16. **Goal:** The MHP will continue to hold Compliance Committee meetings at least quarterly, adhere to a consistent agenda targeting consumer privacy, policy needs, and MHP practices for training/ education, and monitor fraud, waste, and abuse.	**A-1: Q1:**		

A-1: Q1:

Month	Compliance Meeting Held?	Date of Mtg(s) and General Issues Addressed
Sep	Yes	9/13 - TBD

***Additional Objectives:**

A-1: Q2:

Month	Compliance Meeting Held?	Date of Mtg(s) and General Issues Addressed
Nov	Yes	11/15 – Medical Records Work Group (medical records policy revisions)

A-1: Q3:

Month	Compliance Meeting Held?	Date of Mtg(s) and General Issues Addressed
Feb	Yes	2/27 – Medical Records Work Group (medical records release policy and the subpoena policy)

A-1: Q4:

Month	Compliance Meeting Held?	Date of Mtg(s) and General Issues Addressed
Jun	Yes	

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

V-B. Compliance Officer Training and Communication

Authority:
DHCS Annual Review Protocols, FY 16-17, Program Integrity – Section H, Item # 2e, 2f & 2g

Frequency of Evaluation:
Quarterly

Name of Data Report:
TBD

Sub-committee/Staff Responsible:
Compliance Committee meeting minutes/ spreadsheet

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

B-1: Solano MHP's Deputy Compliance Director works directly with the MHP as head of the Compliance Committee and to direct and guide the MHP's compliance enforcement and training/education efforts to improve compliance.

Baseline: The Solano Department of Health and Social Services, which houses the MHP, now requires at least annual participation in Compliance training.

Goal: The MHP, via the Deputy Compliance Director, will provide training and regular communication in the following manner:

- **Measurement #1:** Compliance training will be offered at least quarterly and Behavioral Health staff will attend.
- **Measurement #2:** All MHP staff will receive quarterly communication regarding compliance issues and enforcement of compliance standards/disciplinary guidelines.

B-1: 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
Oct	-	-	-	-
Nov	-	-	-	-
Dec	-	-	-	-

B-1: Q2:

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
Oct	Yes	2	No	---
Nov	No	0	Yes	11/21 – Custodian of Record Evidence Code
Dec	No	0	Yes	12/20 – DOJ Recoveries

B-1: Q3:

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
Jan	Yes	0	Yes	1/5, 1/10, 1/25 – Fraud, HIPAA Enforcement
Feb	Yes	0	Yes	2/22 - $5.5mil HIPAA Settlement
Mar	Yes	0	Yes	3/9 – Cal Supreme Court Stance

B-1: Q4:

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
Apr	Yes	1	Yes	4/25 – HIPAA Settlement
Mar	Yes	6	No	---
Jun	Yes	5	Yes	6/27 – DoIT Security Advisory 6/29 – HHS ASPR/CIP Cyber Notice

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation			
V-C. Service Verification **Authority:** DHCS Annual Review Protocols, FY 16-17, Program Integrity – Section H, Item # 3a & 3b **Frequency of Evaluation:** Quarterly **Name of Data Report:** QI-Compliance Service Verification Spreadsheet **Sub-committee/Staff Responsible:** • Compliance Committee • Quality Improvement unit **Annual Goal Items Met:** ☒ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**C-1:** According to Program Integrity requirements of 42 CFR §455.1(a)(2) as set forth in the MHP Contract between the State of California and the County of Solano, there is a need to develop and implement a means to verify whether services were actually furnished to beneficiaries. **Baseline:** The MHP began implementing a service verification process during FY 2013-14. Expectation is that all programs will participate in Service Verification. **Goal:** The MHP will continue to implement a service verification model and demonstrate 100% accountability for each service identified during the sampling period. • **Measurement #1:** Did all applicable County programs participate in the service verification process? • **Measurement #2:** Did all applicable Contracted programs participate in the service verification process? • **Measurement #3:** Were 100% of services billed during the sampling period accounted for?	**C-1: Q1:** | Program	Did all applicable programs participate in Service Verification?	Were 100% of services accounted for?	Were unaccounted services investigated?
---	---	---	---
FF Youth FSP	Yes	No	Yes
FF Youth	Yes	No	Yes
FF Adult	Yes	No	Yes
VV Youth FSP	Yes	Yes	Yes
VV Youth	Yes	No	Yes
VV Adult	Yes	Yes	Yes
VJO Youth FSP	Yes	No	Yes
VJO Youth	Yes	No	Yes
VJO Adult	Yes	Yes	Yes
VJO Adult FSP	Yes	No	Yes
FCTU	Yes	No	Yes
FACT/AB 109	Yes	No	Yes | **C-1: Q2:** *see note below quarter 3 data* **C-1: Q3:** | FF Youth & FSP	Yes	No	Yes
FF Adult	Yes	No	Yes
VV Youth & FSP	Yes	No	Yes
VV Adult	Yes	No	Yes
VJO Youth & FSP	Yes	Yes	NA
VJO Adult	Yes	No	Yes
VJO Adult FSP	Yes	No	Yes
FCTU	Yes	No	Yes
FACT/AB 109	Yes	No	Yes | ***The sampling period included both quarter 2 & quarter 3** **C-1: Q4: * No Service Verification was done during this quarter**			

C-1: Q1:

Program	Did all applicable programs participate in Service Verification?	Were 100% of services accounted for?	Were unaccounted services investigated?
FF Youth FSP	Yes	No	Yes
FF Youth	Yes	No	Yes
FF Adult	Yes	No	Yes
VV Youth FSP	Yes	Yes	Yes
VV Youth	Yes	No	Yes
VV Adult	Yes	Yes	Yes
VJO Youth FSP	Yes	No	Yes
VJO Youth	Yes	No	Yes
VJO Adult	Yes	Yes	Yes
VJO Adult FSP	Yes	No	Yes
FCTU	Yes	No	Yes
FACT/AB 109	Yes	No	Yes

C-1: Q2: *see note below quarter 3 data*

C-1: Q3:

Program			
FF Youth & FSP	Yes	No	Yes
FF Adult	Yes	No	Yes
VV Youth & FSP	Yes	No	Yes
VV Adult	Yes	No	Yes
VJO Youth & FSP	Yes	Yes	NA
VJO Adult	Yes	No	Yes
VJO Adult FSP	Yes	No	Yes
FCTU	Yes	No	Yes
FACT/AB 109	Yes	No	Yes

*The sampling period included both quarter 2 & quarter 3

C-1: Q4: * No Service Verification was done during this quarter

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VI. Quality Improvement

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation					
VI-A. Quality Improvement: • Documentation Training and Avatar User Training **Authority:** DHCS Annual Review Protocols, FY 16-17, Section G, Item #1 **Frequency of Evaluation:** Quarterly **Name of Data Report:** TBD **Sub-committee/Staff Responsible:** QI Training Lead and team **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☒ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**A-1:** Solano County MHP Quality Improvement unit conducts annual documentation trainings to help providers within the MHP maintain or improve their documentation skills. **Baseline:** Annually to every 18 months. **Goal:** Quality Improvement will provide Documentation Training based on the following frequencies: • **Measurement #1**: Offer at least 2 Documentation Trainings per quarter • **Measurement #2**: Offer at least two Avatar Phase I trainings per quarter • **Measurement #3**: Offer at least one Avatar Phase II trainings per quarter	**A-1: Q1:**					

A-1: Q1:

Month	Doc Training offered?	Date Training Offered	Avatar Phase I training offered?	Date Training Offered	Avatar Phase II training offered?	Date Training Offered
Jul	Yes	7/27/16	Yes	7/13/16	Yes	7/21/16
Aug	Yes	8/4/16	Yes	8/3/16	Yes	8/11/16 8/26/16 8/31/16
Sep	Yes	9/26/16	Yes	9/26/16 9/28/16	No	---

A-1: Q2:

Month	Doc Training offered?	Date Training Offered	Avatar Phase I training offered?	Date Training Offered	Avatar Phase II training offered?	Date Training Offered
Oct	Yes	10/3/16 10/21/16	Yes	10/24/16	Yes	10/5/16
Nov	Yes	11/3/16	Yes	11/9/16	Yes	11/4/16
Dec	Yes	12/1/16	Yes	12/7/16 12/12/16 12/19/16	Yes	12/8/16 12/9/16 12/16/16 12/21/16

A-1: Q3:

Month	Doc Training offered?	Date Training Offered	Avatar Phase I training offered?	Date Training Offered	Avatar Phase II training offered?	Date Training Offered
Jan	Yes	1/5/17	No	-	No	-
Feb	Yes	2/2/17	Yes	2/2/17 2/23/17	No	-
Mar	Yes	3/2/17	Yes	3/8/17 3/23/17	No	-

A-1: Q4:

Month	Doc Training offered?	Date Training Offered	Avatar Phase I training offered?	Date Training Offered	Avatar Phase II training offered?	Date Training Offered
Apr	Yes	4/6/17	No	-	No	-
May	Yes	5/4/17	Yes	5/3/17 5/10/17 5/24/17	No	-
Jun	Yes	6/1/17	Yes	6/15/17 6/22/17	Yes	6/14/17

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation		
VI-B. Quality Improvement: • Annual Utilization Review Audits **Authority:** DHCS Annual Review Protocols, FY 16-17, Provider Relations – Section G, Item # 1 **Frequency of Evaluation:** Quarterly **Name of Data Report:** UR Audit Monthly schedule **Sub-committee/Staff Responsible:** QI Site Certification Lead and team **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☒ **Not Met:** Item # ___	**B-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. Solano MHP is committed to having an ongoing monitoring process in place that ensures all such providers utilized by Solano MHP are in compliance with the documentation standards requirements, per CCR Title 9. **Baseline:** Quality Improvement engaged in annual UR Audits during FY 2015-16. **Goal:** The following processes are in place for FY 2016-17 to monitor Provider compliance with CCR Title 9 documentation standards requirements: • **Measurement #1:** Less than 20% of Programs selected for audit will receive a UR Audit Plan of Correction. • **Measurement #2:** 100% of programs audited who did not meet all compliance standards will submit a Plan of Correction within 30 days of final report?	**B-1: Q1:** (table below)		

B-1: Q1:

Month	How many programs received an Annual UR Audit this month?	What % of all County/Contract programs audited exceeded the 10% fiscal disallowance rate, triggering a Plan of Correction?	Did 100% of programs audited who did not meet all compliance standards submit a Plan of Correction within 30 days of final report?
Jul	0	NA	NA
Aug	0	NA	NA
Sep	6	Pending Reports	Pending Reports
Q1 Totals	6	---	---

B-1: Q2:

Month			
Oct	5	80%	Pending
Nov	0	NA	NA
Dec	0	NA	NA
Q2 Totals	5	80%	---

B-1: Q3:

Month			
Jan	1	100%	0%
Feb	0	---	NA
Mar	6	100%	17%
Q3 Totals	7		-

B-1: Q4:

Month			
Apr	7	71%	PENDING
May	6	PENDING	PENDING
Jun	6	PENDING	PENDING
Q4 Totals	20		

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation				
VI-B.1. Quality Improvement: • Annual Utilization Review Audits - Timeliness and Appropriate Resolution of Annual Utilization Review Audit Findings **Authority:** DHCS Annual Review Protocols, FY 16-17, Provider Relations – Section G, Item # 1 **MHP Utilization Review Policy (to be revised)** **Frequency of Evaluation:** Quarterly **Name of Data Report:** UR Audit Tracking Log (to be created) **Sub-committee/Staff Responsible:** QI Audit Supervisor and team **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☒ **Not Met:** Item # ___	**B-1.1:** 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:** Quality Improvement engaged in annual UR Audits during FY 2015-16. This is a new area of tracking and monitoring. **Goal:** The following processes are in place for FY 2016-17 to monitor Provider compliance with CCR Title 9 documentation standards requirements: • **Measurement #1**: At least 75% of UR Audit Reports will be completed and submitted to Programs' head of service within 60 days after the review. • **Measurement #2:** For reviewed programs that require a Plan of Correction, at least 75% of programs will submit a POC that adequately addresses the unsatisfactory review findings. • **Measurement #3:** At least 75% of reviewed programs will provide evidence of their adherence to their Plan of Correction.	**B-1.1: Q1:**				

B-1.1: Q1:

Q #	# Programs Audited this Quarter	What % of all County/Contract programs reviewed this Quarter received a UR Audit Report within 60 days after the review?	# Programs requiring a CAP	What % of all County/Contract programs reviewed this Quarter submitted a Corrective Action Plan (CAP) that adequately addressed areas of documentation noncompliance?	What % of all County/Contract programs reviewed this Quarter submitted evidence of adhering to their Corrective Action Plan?
Q1	6	0%	100%	40%	Mechanism Not In Place

B-1.1: Q2:

Q2	5	0%	80%	0%	Mechanism Not In Place

B-1.1: Q3:

Q3	7	86%	100%	14%	Mechanism Not In Place

B-1.1: Q4:

Q4	20	PENDING	90%	PENDING	Mechanism Not In Place

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

VI-B.2. Quality Improvement:

- Annual Utilization Review Audits - QI Inter-rater Reliability for Concurrent Review and Annual Utilization Review Audits

Authority:
DHCS Annual Review Protocols, FY 16-17, Quality Improvement – Section I, Item #6d

Frequency of Evaluation:
Quarterly

Name of Data Report:
Concurrent Review Database and UR Audit Tracking Log (to be created)

Sub-committee/Staff Responsible:
QI Audit Supervisor and team

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

B-1.2: 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 in place that ensures all such providers utilized by Solano MHP are in compliance with the documentation standards requirements, per CCR Title 9.

Baseline: Quality Improvement engaged in annual UR Audits during FY 2015-16. This is a new area of tracking and monitoring.

Goal: The following processes are in place for FY 2016-17 to monitor Provider compliance with CCR Title 9 documentation standards requirements:

- **Measurement #1:** Is the percentage of returned Concurrent Review cases within one standard deviation amongst the QI Clinical reviewers?
- **Measurement #2:** Did the results of each UR Audit Warm-Up Review yield less than 5% variation in responses among the reviewers present?

B-1.2: Q1:

Month	Is the % of returned Concurrent Review cases within 1 std/dev amongst the QI reviewers?	Did the UR Audit Warm-Up Review yield <5% response variation amongst participating reviewers?
Jul	---	---
Aug	---	---
Sep	---	---

B-1.2: Q2:

Month		
Oct	---	---
Nov	---	---
Dec	---	---

B-1.2: Q3:

Month		
Jan	---	---
Feb	---	---
Mar	---	---

B-1.2: Q4:

Month		
Apr	---	---
May	---	---
Jun	---	---

Quality Improvement Work Plan for FY 2016/2017

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

VI-C. Quality Improvement:

• Site Certifications

Authority:
DHCS Annual Review Protocols, FY 16-17, Provider Relations – Section G, Item # 3a

Frequency of Evaluation:
Quarterly

Name of Data Report:
Monthly Site Certification Tracking Report

Sub-committee/Staff Responsible:
QI Site Certification Lead and team

Annual Goal Met:
☒ Met: 100% Cert'ed
☐ Partially Met: ___ % Cert'ed
☐ Not Met: ___ % Cert'ed

C-1: Solano County MHP Quality Improvement (QI) unit conducts Medi-Cal Site Certifications with Contract programs within the MHP every three years. The QI unit also works with County programs to ensure that they are prepared for Medi-Cal Site Certifications conducted by representatives from California Department of Health Care Services. The MHP also works with DHCS and other counties to determine when a change to a "piggy-backed" certification needs to occur.

Baseline: FY 15-16 was 91% of new or expiring programs were certified/recertified in a timely manner

Goal: 100% of Programs will be tracked, notified and given the opportunity to be certified in a timely manner or recertified prior to current certification expiring:

- **Met**: 100% New or Expiring Programs were certified/recertified in a timely manner
- **Partially Met:** 80% or more New or Expiring Programs were certified/recertified in a timely manner
- **Not Met:** Less than 80% of New or Expiring Programs were certified/recertified in a timely manner

---

C-1: Q1:

Month	Which Programs were Certified this Month?	Was the MHP's tracking report reviewed to ensure no Solano MHP programs were missed?	Were 100% of Site Certifications due this month facilitated in a timely manner?
Jul	3	Yes	Partially Met
Aug	6	Yes	Partially Met
Sep	13	Yes	Yes

C-1: Q2:

Month			
Oct	4	Yes	Yes
Nov	2	Yes	Yes
Dec	4	Yes	Yes

C-1: Q3:

Month			
Jan	2	Yes	Yes
Feb	1	Yes	Yes
Mar	5	Yes	Yes

C-1: Q4:

Month			
Apr	2	Yes	Yes
May	1	Yes	Yes
Jun	2	Yes	Yes

Quality Improvement Work Plan for FY 2016/2017

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

VI-D. Quality Improvement:

- Medi-Cal Provider Eligibility and Verification

Authority:
DHCS Annual Review Protocols, FY 16-17, Program Integrity – Section H, Item # 5

Frequency of Evaluation:
Quarterly

Name of Data Report:
Provider Eligibility and Verification Tracking Report

Sub-committee/Staff Responsible:
QI Provider Eligibility Verification Lead

Annual Goal Met:
☐ Met
☒ Partially Met
☐ Not Met

D-1: Solano County MHP Quality Improvement (QI) unit conducts Medi-Cal Provider eligibility verification checks on a monthly basis. 100% of all active providers within the MHP are verified on a monthly basis.
Baseline: All providers went through our eligibility verification process monthly during FY 15-16.
Goal: 100% of providers will have their eligibility verified on a monthly basis during FY 16-17, based on the following sites:

- **OIG List of Excluded Individuals/Entities (LEIE)**
- **DHCS Medi-Cal List of Suspended or Ineligible Providers**
- **Excluded Parties List System (EPLS)**

D-1: Q1:

Month	How many providers initially showed up on one of the lists?	Was action taken to investigate provider's ability to work in the MHP?	How many providers were determined to be ineligible to practice?	Were 100% of County, Contract and Network Providers verified on the exclusion lists?
Jul	24	Yes	0	Yes
Aug	23	Yes	0	Yes
Sep	---	---	---	No

D-1: Q2:

Oct	35	Yes	0	Yes
Nov	51	Yes	0	Yes
Dec	39	Yes	0	Yes

D-1: Q3:

Jan	7	Yes	0	Yes
Feb	7	Yes	0	Yes
Mar	28	Yes	0	Yes

D-1: Q4:

Apr	-	-	-	-
May	-	-	-	-
Jun	-	-	-	-

- Process for monitoring transferred from MHP QI to Solano County H&SS Dept. Compliance Unit – Data reports are pending.

Quality Improvement Work Plan for FY 2016/2017

VII. Service Access and Timeliness

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

VII-A. Access Calls:

- Handled

Authority:
DHCS Annual Review Protocols, FY 16-17, Access – Section B, Item #9

Frequency of Evaluation:
Quarterly

Name of Data Report:
CISCO-Contact Service Queue Activity Report (by CSQ)

Sub-committee/Staff Responsible:
- Quality Improvement unit
- Access Supervisor

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

A-1: All calls to (800) 547-0495 enter the MH Access Contact Service Queue. Based on the total number of calls presented to this service queue, data is collected for the number of callers who reach a care manager. Additionally, data is collected for the number of callers who abandoned (hang up) before reaching a care manager and the number of callers who de-queue (leave message before reaching a care manager).

Baseline:
The FY 2016-17 Calls Handled rate averaged over 95% over all four Quarters.

Goal: Improve the following measures:
- **Measurement #1:** Maintain Access Calls Handled "live" at an average of 95% in FY 2015-16 during FY 2016-17.
- **Measurement #2:** Maintain % of Access calls abandoned at a quarterly average of 5-8% in FY 2015-16 during FY 2016-17

A-1: Q1:

Month/ Quarter	Calls Received	Calls Handled	% (Handled/ Received)	Calls Abandoned	% (Abandoned/ Received)
Jul	378	377	99.7%	1	0.26%
Aug	451	450	99.7%	1	0.26%
Sep	395	393	99.4%	2	0.51%
Q1 Totals	1224	1220	99.6%	4	0.34%

A-1: Q2:

Month/ Quarter	Calls Received	Calls Handled	% (Handled/ Received)	Calls Abandoned	% (Abandoned/ Received)
Oct	404	400	99%	4	1%
Nov	438	436	99.5%	2	0.5%
Dec	369	366	99%	3	1%
Q2 Total	1211	1202	99.2%	9	0.83%

A-1: Q3:

Month/ Quarter	Calls Received	Calls Handled	% (Handled/ Received)	Calls Abandoned	% (Abandoned/ Received)
Jan	453	452	99.8%	1	0.2%
Feb	364	364	100%	0	0%
Mar	451	448	99.3%	3	0.7%
Q3 Totals	1268	1264	99.7%	4	0.3%

A-1: Q4:

Month/ Quarter	Calls Received	Calls Handled	% (Handled/ Received)	Calls Abandoned	% (Abandoned/ Received)
Apr	375	372	99.2%	3	0.8%
May	378	377	99.7%	1	0.3%
Jun	384	382	99.4%	2	0.6%
Q4 Totals	1137	1131	99.4%	6	0.6%

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

VII-B. Access Calls:

Performance

Authority:
DHCS Annual Review Protocols, FY 15-16, Access – Section A, Item #9 and #10

Frequency of Evaluation:
Quarterly

Name of Data Report:
Avatar Access Screen Tree form and QI Test Call Log

Sub-committee/Staff Responsible:
• Quality Improvement unit
• Access Supervisor

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

B-1: All calls to (800) 547-0495 MH Access unit are routed to a Care Manager, 24 hours/day, 7 days/week. Care Managers provide or arrange for Access services in any language spoken in Solano County. Additionally calls should:

• Provide information about how to access specialty MH services, including how to access an intake assessment.
• Provide information about urgent services.
• Provide information about how to access Problem Resolution and State Fair Hearing processes.

Baseline:
See FY 15-16 % that met standards

Goal:
During QI initiated test calls, the MHP will demonstrate in 80%-100% Business hour calls and 80-100% of Afterhours calls, that Access Care Managers provide the required information re: service access for both Business and After-hours test calls while:

• **Item #1:** Testing for language capabilities
• **Item #2-4:** Testing for appropriate information given (SMHS access, Urgent conditions, and Problem Resolution)
• **Item #5:** Logging all appropriate data

B-1: Q1:

	Bus or after hrs	# of Test Calls/ Quarter	# of Test Calls that meet Standards	% of Test Calls that meet Standards this Quarter	% of Test Calls that met standards in FY 15-16
Languages Tested: Spanish	B	0	NA	NA	NA
	A	0	NA	NA	NA
Was Information given about how to access SMHS, including how to get an Ax.	B	1	1	100%	100%
	A	3	3	100%	100%
Info about how to treat a client's urgent condition	B	0	0	100%	100%
	A	2	2	100%	100%
Info about how to use the Problem Resolution/Fair Hearing process	B	1	1	100%	100%
	A	1	1	100%	100%
Logging Name of client, date of request, & initial disposition	B	2	2	100%	100%
	A	6	1	16.67%	16.67%

B-1: Q2:

	Bus or after hrs	# of Test Calls/ Quarter	# of Test Calls that meet Standards	% of Test Calls that meet Standards this Quarter	% of Test Calls that met standards in FY 15-16
Languages Tested:	B	1	0	0%	0%
	A	0	0	0%	0%
Was Information given about how to access SMHS, including how to get an Ax.	B	2	1	50%	67%
	A	1	0	0%	75%
Info about how to treat a client's urgent condition	B	0	0	0%	0%
	A	3	2	66.67%	80%
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	2	1	50%	75%
	A	4	1	25%	20%

B-1: Q3:

	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 15-16
Languages Tested:	B	0	0	0%	0%
	A	0	0	0%	0%
Was Information given about how to access SMHS, including how to get an Ax.	B	0	0	0%	0%
	A	1	0	0%	0%
Info about how to treat a client's urgent condition	B	0	0	0%	0%
	A	0	0	0%	0%
Info about how to use the Problem Resolution/Fair Hearing process	B	2	2	100%	100%
	A	3	2	66.6%	60%
Logging Name of client, date of request, & initial disposition	B	2	2	100%	83%
	A	4	0	0%	14%

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation					
		B-1: Q4:					
		Languages Tested:	B	3	Pending	0%	0%
			A	1	Pending	0%	0%
		Was Information given about how to access SMHS, including how to get an Ax.	B	3	Pending	Pending	Pending
			A	1	Pending	Pending	Pending
		Info about how to treat a client's urgent condition	B	0	0	0%	0%
			A	0	0	0%	80%
		Info about how to use the Problem Resolution/Fair Hearing process	B	0	0	0%	100%
			A	0	0	0%	60%
		Logging Name of client, date of request, & initial disposition	B	Pending	Pending	Pending	Pending
			A	Pending	Pending	Pending	Pending

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

VII-C. Timeliness & Engagement

Authority:
DHCS Annual Review Protocols, FY 16-17, Access – Section B, Item #9 and #10

Frequency of Evaluation:
Quarterly

Name of Data Report:
Service Timeliness Avatar Report #333

Sub-committee/Staff Responsible:
Mental Health Administration

Annual Goal Items Met:
☒ **Met:** Item # 2c
☒ **Partially Met:** Item # 1a,b,c; 2a,
☒ **Not Met:** Item # 2b,

C-1: Maintain or improve service timeliness measures for children.
Baselines: See individual objectives below.
Goals:
1. For **Routine** requests for service, County Children's programs will:
a. Maintain goal of 90% resulting in an offered assessment within 10 business days
(FY15-16 baseline: 95%)
b. Maintain goal of an average of 10 business days or less from service request to actual assessment
(FY15-16 baseline: 8.25 days)
c. Achieve goal of an average of 30 business days or less from service request to service initiation
(FY15-16 baseline: 40.9 days)
2. For **Urgent** requests for service, County Children's programs will:
a. Achieve goal of 90% resulting in an offered assessment within 3 business days
(FY15-16 baseline: 68%)
b. Achieve goal of an average of 3 business days or less from service request to actual assessment
(FY15-16 baseline: 4.05 days)
c. Achieve goal of an average of 23 business days or less from service request to service initiation
(FY15-16 baseline: 29.6 days)

C-1: Q1:

Request Type	Service Request to Offered Ax Appt (% w/in 10 bus days for Routine & 3 bus days for Urgent)	Average # of Business Days from Service Request to Actual Ax Appt	Average # of Business Days from Service Request to First Tx Service
Routine	90%	8.5	34.9
Urgent	100%	6.2	15.5
Total:	**91%**	**8.4**	**34.4**

C-1: Q2:

Routine	86%	10.1	35.8
Urgent	75%	3.5	21.0
Total:	**85%**	**9.4**	**34.5**

C-1: Q3:

Routine	88%	9.9	28.9
Urgent	67%	3.7	20.0
Total:	**87%**	**9.7**	**28.5**

C-1: Q4:

Routine	64%	10.7	28.4
Urgent	50%	4.5	35.0
Total:	**63%**	**10.6**	**28.6**

C-1: FY 16-17

Routine	82%	9.8	32.4
Urgent	76%	4.2	21.9
Total:	**82%**	**9.5**	**31.8**

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation		
VII-C. Timeliness & Engagement **Authority:** DHCS Annual Review Protocols, FY 16-17, Access – Section B, Item #9 and #10 **Frequency of Evaluation:** Quarterly **Name of Data Report:** Service Timeliness Avatar Report #333 **Sub-committee/Staff Responsible:** Mental Health Administration **Annual Goal Items Met:** ☒ **Met:** Item # 1a,b,c ☒ **Partially Met:** Item # 2a,c ☒ **Not Met:** Item # 2b	**C-2:** Maintain or improve service timeliness measures for adults. **Baselines:** See individual objectives below. **Goals:** 1. For **Routine** requests for service, County Adult programs will: a. Achieve goal of 80% resulting in an offered assessment within 10 business days (FY15-16 baseline: 77%) b. Achieve goal of an average of 10 business days or less from service request to actual assessment (FY15-16 baseline: 13.3 days) c. Achieve goal of an average of 30 business days or less from service request to service initiation (FY15-16 baseline: 32.3 days) 2. For **Urgent** requests for service, County Adult programs will: a. Maintain goal of 80% resulting in an offered assessment within 3 business days (FY15-16 baseline: 81%) b. Achieve goal of an average of 3 business days or less from service request to actual assessment (FY15-16 baseline: 11.5 days) c. Achieve goal of an average of 23 business days or less from service request to service initiation (FY15-16 baseline: 32.6 days)	**C-2: Q1:**		

C-2: Q1:

Request Type	Service Request to Offered Ax Appt (% w/in 10 bus days for Routine & 3 bus days for Urgent)	Average # of Business Days from Service Request to Actual Ax Appt	Average # of Business Days from Service Request to First Tx Service
Routine	80%	9.1	28.5
Urgent	78%	4.4	16.2
Total:	**80%**	**8.8**	**27.4**

C-2: Q2:

Routine	83%	9.2	30.1
Urgent	92%	4.4	10.3
Total:	**84%**	**8.9**	**28.9**

C-2: Q3:

Routine	91%	6.4	23.4
Urgent	87.5%	4.3	8.0
Total:	**91%**	**6.3**	**22.9**

C-2: Q4:

Routine	82%	8.7	24.2
Urgent	56%	8.6	29.5
Total:	**80%**	**8.7**	**24.5**

C-2: FY 16-17

Routine	84%	8.4	26.5
Urgent	76%	5.4	16.7
Total:	**83%**	**8.3**	**25.9**

Quality Improvement Work Plan for FY 2016/2017

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

VII-C. Timeliness & Engagement

Authority:
DHCS Annual Review Protocols, FY 16-17, Access – Section B, Item #9 and #10

Frequency of Evaluation:
Quarterly

Name of Data Report:
Service Timeliness Avatar Report #333

Sub-committee/Staff Responsible:
Mental Health Administration

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

C-3: Maintain or improve engagement & attrition measures for children:
Baselines: See individual objectives below.
Goals:
1. For **Routine** requests for service, County Children's programs will:
   a. Maintain goal of 80% resulting in an assessment (FY15-16 baseline: 90%)
   b. Achieve goal of 75% resulting in initiation of treatment (FY15-16 baseline: 65%)
2. For **Urgent** requests for service, County Children's programs will:
   a. Maintain goal of 85% resulting in an assessment (FY15-16 baseline: 91%)
   b. Achieve goal of 80% resulting in initiation of treatment (FY15-16 baseline: 77%)

C-3: Q1:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine	92	94%	74%
Urgent	4	100%	50%
Total:	**96**	**94%**	**73%**

C-3: Q2:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine	96	95%	82%
Urgent	12	92%	67%
Total:	**108**	**94%**	**81%**

C-3: Q3:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine	94	94%	68%
Urgent	3	100%	100%
Total:	**97**	**94%**	**69%**

C-3: Q4:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine	89	97%	64%
Urgent	2	100%	100%
Total:	**91**	**97%**	**65%**

C-3: FY 16-17

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine	371	95%	72%
Urgent	21	95%	71%
Total:	**392**	**95%**	**72%**

Quality Improvement Work Plan for FY 2016/2017

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

VII-C. **Timeliness & Engagement**
 	
Authority:
DHCS Annual Review Protocols, FY 16-17, Access – Section B, Item #9 and #10
 	
Frequency of Evaluation:
Quarterly
 	
Name of Data Report:
Service Timeliness Avatar Report #333
 	
Sub-committee/Staff Responsible:
Mental Health Administration
 	
Annual Goal Items Met:
☐ **Met:** Item # ____
☒ **Partially Met:** Item # 1a,
☒ **Not Met:** Item # 1b, 2a, 2b
	C-4: Maintain or improve engagement & attrition measures for adults:
	Baselines: See individual objectives below.
	Goals:
	3. For **Routine** requests for service, County Adult programs will:
	  a. Achieve goal of 60% resulting in an Assessment (FY15-16 baseline: 57%)
	  b. Achieve goal of 50% resulting in initiation of treatment (FY15-16 baseline: 35%)
	4. For **Urgent** requests for service, County Adult programs will:
	  a. Maintain goal of 65% resulting in an assessment (FY15-16 baseline: 70%)
	  b. Achieve goal of 55% resulting in initiation of treatment (FY15-16 baseline: 44%)
		C-4: Q1:
		
		| Request Type
			# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment

Routine	343	62%	45%
Urgent	28	57%	50%
Total:	**371**	**61%**	**46%** | **C-4: Q2:** | Routine	311	58%	43%
Urgent	16	56%	50%
Total:	**327**	**57.5%**	**43%** | **C-4: Q3:** | Routine	298	59%	48%
Urgent	11	64%	45.5%
Total:	**309**	**59%**	**48%** | **C-4: Q4:** | Routine	306	59.5%	48%
Urgent	21	48%	38%
Total:	**327**	**59%**	**47%** | **C-4: FY 16-17** | Routine	1258	59%	46%
Urgent	76	55%	46%
Total:	**1334**	**59%**	**46%**				

C-4: Q1:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine	343	62%	45%
Urgent	28	57%	50%
Total:	**371**	**61%**	**46%**

C-4: Q2:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine	311	58%	43%
Urgent	16	56%	50%
Total:	**327**	**57.5%**	**43%**

C-4: Q3:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine	298	59%	48%
Urgent	11	64%	45.5%
Total:	**309**	**59%**	**48%**

C-4: Q4:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine	306	59.5%	48%
Urgent	21	48%	38%
Total:	**327**	**59%**	**47%**

C-4: FY 16-17

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine	1258	59%	46%
Urgent	76	55%	46%
Total:	**1334**	**59%**	**46%**

Quality Improvement Work Plan for FY 2016/2017

VIII. Wellness and Recovery

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

VIII-A. Maintain the pool of 20(+) Consumers/Family Members' Directory to contact if need more members on committees

Frequency of Evaluation: Quarterly

Name of Data Report: 2016-2017 WR QI Work Plan Goal Report, Sign-in Sheets, & Meeting Minutes

Sub-committee/Staff Responsible: Wellness Recovery Unit

Annual Goal Met:
☒ **Met:** 4.4 average consumers per committee
☐ **Partially Met:**
☐ **Not Met:**

A-1: Maintain the list of Consumers and Family Members interested in participating on SCBH planning Committees.

Baseline: Numbers from the previous fiscal year (2015-2016) reflect an average of 3.1 Consumers/Family Members attending SCBH committees for the year

Goal: Maintain an average participation of 3-4 Consumers/Family Members on SCBH Planning Committees

LEGEND:
- Mental Health Collaborative - MHC
- Suicide Prevention Committee – SPC
- Mental Health Advisory Board – MHAB
- Quality Improvement Committee – QIC
- Care Coordination Collaborative Meeting – CCCM
- Cultural Competence Committee – CCC
- MHSA Steering Committee – MHSA

A-1: Q1:

Month	Were Consumers and/or Family Members invited to attend a committee?	In what committees were Consumers and/or Family members invited to participate?	How many participated in each committee?
Jul	Yes	MHC, MHAB	2, 3
Aug	Yes	SPC, MHAB	2, 4
Sep	Yes	SPC, MHAB, CCCM, CCC	3, 3, 1, 3

A-1: Q2:

Month	Were Consumers and/or Family Members invited to attend a committee?	In what committees were Consumers and/or Family members invited to participate?	How many participated in each committee?
Oct	Yes	MHAB, CFAC, CCCM	3, 7, 1
Nov	Yes	SPC, MHAB, CFAC, QIC	3, 4, 12, 3
Dec	Yes	SPC, MHAB, CFAC	2, 3, 10

A-1: Q3:

Month	Were Consumers and/or Family Members invited to attend a committee?	In what committees were Consumers and/or Family members invited to participate?	How many participated in each committee?
Jan	Yes	SPC, CFAC, MHAB	2, 8, 3
Feb	Yes	SPC, CFAC, MHAB, QIC	2, 10, 4, 2
Mar	Yes	CFAC, MHAB	8, 8

A-1: Q4:

Month	Were Consumers and/or Family Members invited to attend a committee?	In what committees were Consumers and/or Family members invited to participate?	How many participated in each committee?
Apr	Yes	MHAB, CFAC	4, 6
May	Yes	SPC, MHAB, CFAC	2, 5, 8
Jun	Yes	MHAB, CFAC	5, 5

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

VIII-B. 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.

Frequency of Evaluation: Quarterly

Name of Data Report:
WR Unit Homeless Outreach monthly reports and/or PATH Grant Quarterly Performance Outcome Reports

Sub-committee/Staff Responsible:
Wellness Recovery Unit/Homeless Outreach Specialist.

Annual Goal Met:
☐ Met:
☒ Partially Met: See Note
☐ Not Met:

NOTE: There was an average of 15.75 outreach activities per month. This number is lower due to significantly fewer activities after the February closure of First Christian Church in Suisun.

B-1: WR Staff will continue to provide support, outreach, and assistance to homeless mentally ill individuals who are brought to the attention of SCBH Services. Recruit to hire the Homeless Outreach (PATH) Specialist who will go to homeless shelters to identify mentally ill, homeless individuals, and assist these individuals to access benefits and services needed.

Baseline: In the previous fiscal year (15-16) a total of 395 HOS were provided for the year with an average of 99 services per quarter and an average of 33/month.

Goal: Maintain the same average numbers of HOS this year of 99/quarter or 33/month as the previous fiscal year. Continue to reach as many homeless, mentally ill individuals in Solano County as possible to provide support and assistance toward meeting their on-going mental health and community living needs.

B-1: Q1:

Month	Did Solano MPH provide any Homeless Outreach services?	In what county regions did Homeless outreach services occur?	# of Homeless Outreach Activities
Jul	Yes	All Regions	20
Aug	Yes	Central and South	37
Sep	Yes	All	18

B-1: Q2:

Oct	Yes	Central	14
Nov	Yes	North, Central, South	25
Dec	Yes	North, Central, South	19

B-1: Q3:

Jan	Yes	-	23
Feb	Yes	-	6
Mar	Yes	-	7

B-1: Q4:

Apr	Yes	Mare Is, SS, FF	12
May	Yes	Mare Is, FF	2
Jun	Yes	Mare Is, FF	6

Quality Improvement Work Plan for FY 2016/2017

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

VIII-C. Provide Wellness Recovery Action Plan (WRAP) Groups to support Behavioral Health Consumers to better understand their BH issues and personal strengths and support them in taking personal responsibility for their BH stability, wellness and recovery

Frequency of Evaluation: Quarterly

Name of Data Report: WRAP group sign-in sheets

Sub-committee/Staff Responsible: Wellness Recovery Unit/Office of Consumer Affairs

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

C-1 : Provide WRAP groups facilitated by at least 1 Certified WRAP Facilitator

Baseline: There are currently 18 SCBH and Contract Staff Certified to conduct WRAP groups. Last year's goal of providing 6 WRAP Groups was met

Goal: Continue to provide at least **6 WRAP groups to MH Consumers for FY 16/17**.

C-1: Q1:

Month	Were any WRAP groups provided this month?	How many MH Consumers participated?	How many WRAP groups have been provided?
Jul	Yes	10	2
Aug	Yes	1	5
Sep	Yes	1	5

C-1: Q2:

Month	Were any WRAP groups provided this month?	How many MH Consumers participated?	How many WRAP groups have been provided?
Oct	Yes	8	2
Nov	Yes	7	2
Dec	No	0	0

C-1: Q3:

Month	Were any WRAP groups provided this month?	How many MH Consumers participated?	How many WRAP groups have been provided?
Jan	Yes	2	14
Feb	Ongoing from Jan	0	Ongoing from Jan
Mar	Yes	2	12

C-1: Q4:

Month	Were any WRAP groups provided this month?	How many MH Consumers participated?	How many WRAP groups have been provided?
Apr	Yes	5	3
May	Yes	2	1
June	No	0	-

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation			
VIII-D. Provide Support Groups to Behavioral Health Family members to better support their understanding of BH challenges their loved one is going through and learn effective ways to interact with the BH loved one **Frequency of Evaluation:** Quarterly **Name of Data Report:** Family Support Group sign-in sheets **Sub-committee/Staff Responsible:** Wellness Recovery Unit/Family Liaison **Annual Goal Met:** ☐ **Met:** Item # ____ ☒ **Partially Met:** See Note ☐ **Not Met:** Item # ____ NOTE: Average number of participants was 29.9. Groups are being offered in 4 cities as of Q4.	**D-1:** Provide Family Support Groups facilitated by the Family Liaison and a community family member **Baseline:** Currently there are Family Support Groups provided in 2 regional areas (Fairfield and Rio Vista) with an average of 22 participants per month **Goal :** Increase the number of participants in these groups to 36 by increasing the number of regional areas/cities from 2 to 4 in which support groups are offered	**D-1: Q1:**			

D-1: Q1:

Month	# of Family Support Groups	# of Participants	Regions/Cities Where Groups Were Offered
Jul	3	19	FF, VV, RV
Aug	3	24	FF, VV, RV
Sep	3	21	FF, VV, RV

D-1: Q2:

Month	# of Family Support Groups	# of Participants	Regions/Cities Where Groups Were Offered
Oct	9	21	FF, VV, RV
Nov	11	31	FF, VV, RV
Dec	13	33	FF, VV, FV, VJO

D-1: Q3:

Month	# of Family Support Groups	# of Participants	Regions/Cities Where Groups Were Offered
Jan	10	31	FF, VV, RV
Feb	9	33	FF, VV, RV
Mar	10	35	FF, VV, RV, VJO

D-1: Q4:

Month	# of Family Support Groups	# of Participants	Regions/Cities Where Groups Were Offered
Apr	13	38	FF, VV, RV, VJO
May	13	25	FF, VV, RV, VJO
Jun	13	33	FF, VV, RV, VJO

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

VIII-E. Provide Wellness Recovery (WR) Peer Support Groups to Behavioral Health Adult Consumers to better support their understanding of BH challenges and learn effective tools to handle these challenges

Frequency of Evaluation: Quarterly

Name of Data Report: Wellness Recovery Peer Support Group sign-in sheets

Sub-committee/Staff Responsible : Wellness Recovery Unit/Consumer Affairs Liaison

Annual Goal Met :
☐ **Met:** Item # ____
☐ **Partially Met:** Item # ____
☐ **Not Met:** Item # ____

Goal added 1/31/2017

E-1 : Provide WR Peer Support Groups

Baseline: Currently there is 1 WR Peer Support Group provided in 1 region (Fairfield) with an average of 10 participants per quarter

Goal: Increase the number of unduplicated participants in WR Peer Support Groups from 10 to 25 per quarter. Increase the number of regions/cities these groups are offered in from 1 to 3.

E-1: Q1 :

Month	# of Peer Support Groups	# of Participants	Regions/Cities Where Groups Were Offered
Jul			
Aug			
Sep			

E-1: Q2 :

Month	# of Peer Support Groups	# of Participants	Regions/Cities Where Groups Were Offered
Oct	12	19	FF, VV, VJO
Nov	12	22	FF, VV, VJO
Dec	12	24	FF, VV, VJO

E-1: Q3 :

Month	# of Peer Support Groups	# of Participants	Regions/Cities Where Groups Were Offered
Jan			
Feb			
Mar			

E-1: Q4 :

Month	# of Peer Support Groups	# of Participants	Regions/Cities Where Groups Were Offered
Apr	12	27	FF, VV, VJO
May	13	29	FF, VV, VJO
Jun	13	22	FF, VV, VJO

- **Data for Q1 and Q3 was unavailable.**

Quality Improvement Work Plan for FY 2016/2017