Solano County
Health and Social Services Department
Behavioral Health Division
Solano Mental Health Plan
FY 2017 - 2018

Quality Assessment and Performance Improvement Plan

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 Assessment and Performance Improvement Work Plan for FY 2017/2018

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Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

QUALITY ASSESSMENT AND PEFORMANCE IMPROVEMENT PROGRAM OVERVIEW

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

Quality Improvement Program

Staffing
11.25 FTE

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

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

QAPI Program Areas of Focus for FY 2017-2018:

The Quality Assessment and Performance Improvement program will continue support and emphasize performance assessment via quantitative measures in order to identify areas of improvement within the MHP.

Quality Improvement continues to steer the MHP toward using system data to identify needs, and to develop Work Plan goals that help with system improvements that improve access, timeliness, outcomes and quality, and overall patient care. The QAPI plan is also developed with the focus and intention of ensuring that Solano MHP remains in compliance with Federal and California State regulations, most notably 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 the MHP to include in this year's QAPI Work Plan:

- Cultural Competence
- Wellness and Recovery
- Beneficiary Satisfaction and Protection
- Beneficiary Outcomes and System Utilization
- Service Timeliness and Access
- Program Integrity
- Quality Improvement
- Network Adequacy

The QAPI Work Plan areas of focus are divided into "Active Goals" and "Data Monitoring" sections. Active Goals represent sectors of the system in which data indicated a need for system improvement. Data Monitoring sections include sectors of the system in which the data is not indicating a need for a specific QAPI goal, but that the MHP monitors on a regular basis to ensure the MHP operates with expected parameters.

Quality Improvement team staffing was relatively stable during FY 2017-2018. The QI team members act as liaisons to the MHP to monitor progress being made on QAPI goals on a quarterly basis. Contract Managers and Clinical Supervisors with a specialty role are encouraged to monitor data to look for areas of the system that could benefit from corrective action.

Solano MHP has taken on the practice of treating the Quality Improvement Work Plan as the "treatment plan" for the MHP, and therefore it guides the various Quality Improvement Committee (QIC) subcommittees during their monthly efforts. Progress is tracked on a 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.

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

I. Cultural Competence (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
I. **Cultural Competence**: • **AG-1**: Pending **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #11, 12a-12c, &13a-13b **Name of Data Report:** • Pending **Sub-committee/Staff Responsible:** • Cultural Competence Committee **Annual Goal Items Met:** ☐ **Met:** Item # ____ ☐ **Partially Met:** Item # ____ ☐ **Not Met:** Item # ____	**AG-1:** Solano County MHP Cultural Competence Committee (CCC) endeavors to implement the goals and initiatives contained with the Solano Cultural Competency Plan. The committee accomplishes this by utilizing a diverse group of stakeholders, including county and contract providers, Consumer family members, and MH Consumers with lived experience. Committee members also help to improve the system by being involved in other county committees in order to ensure the CC Plan is being implemented. **FY 16-17 Baseline:** • Pending **Goal:** • Pending	**Q1:** **Q2:** **Q3:** **Q4:**

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I. Cultural Competence (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: • **DM-1: CC Plan, Training Plan and Committee** **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #11, 12a-12c, &13a-13b **Name of Data Report:** • None **Sub-committee/Staff Responsible:** • Cultural Competence Committee **Previous FY Baseline Averages:** • CCC meetings per Quarter: 1 • Were all county staff offered annual CC training: • Were all Contract staff offered annual CC training: **FY 17-18 Quarterly Averages:** • CCC meetings per Quarter: • Were all county staff offered annual CC training: • Were all Contract staff offered annual CC training:	**Q1:** **Q2:** **Q3:** **Q4:**

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?

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?

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?

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?

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: • **DM-2:** HOLA Community Information and Education Plans – Outreach re: cultural/linguistic services **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access - Section B, Item #7b, 8b, 12b **Name of Data Report:** TBD **Sub-committee/Staff Responsible:** Cultural Competence Coordinator **Previous FY Baseline Averages:** • Outreach Initiatives per Quarter: • HOLA calls per quarter: **FY 17-18 Quarterly Averages:** • Outreach Initiatives per Quarter: ___ • HOLA calls per quarter: ___	**Q1:** 	Month	Region	Community Agencies willing to Partner with HOLA	# of HOLA Calls received
---	---	---	---
			| **Q2:** | Month	Region	Community Agencies willing to Partner with HOLA	# of HOLA Calls received
---	---	---	---
			| **Q3:** | Month	Region	Community Agencies willing to Partner with HOLA	# of HOLA Calls received
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			| ***Outreach Coordinator on extended leave** **Q4:** | Month	Region	Community Agencies willing to Partner with HOLA	# of HOLA Calls received
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Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

Quality Improvement Area of Data Monitoring	Results of Evaluation
I. Cultural Competence: • **DM-3:** Kaagapay Community Information and Education Plans – Outreach re: cultural/linguistic services **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access - Section B, Item #7b, 8b, 12b **Name of Data Report:** TBD **Sub-committee/Staff Responsible:** Cultural Competence Coordinator **Previous FY Baseline Averages:** • Outreach Initiatives per Quarter: • Kaagapay calls per quarter: **FY 17-18 Quarterly Averages:** • Outreach Initiatives per Quarter: ___ • Kaagapay calls per quarter: ___	Q1: Q2: Q3: Q4:

Q1:

Month	Region	Community Agencies willing to Partner with Kaagapay	# of Kaagapay Calls received by

Q2:

Month	Region	Community Agencies willing to Partner with Kaagapay	# of Kaagapay Calls received by

Q3:

Month	Region	Community Agencies willing to Partner with Kaagapay	# of Kaagapay Calls received

Q4:

Month	Region (North, Central, South)	Community Agencies willing to Partner with Kaagapay	# of Kaagapay Calls received

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II. Wellness and Recovery (Active Goals - AG)

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

II. Wellness and Recovery:

- **AG-1:** 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

Purpose for Monitoring:
DHCS Annual Review Protocols, FY 17-18, Quality Improvement - Section I, Item # 1.

Name of Data Report: Family Support Group sign-in sheets and Post Group Survey

Sub-committee/Staff Responsible: Wellness Recovery Unit/Family Liaison

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

Objectives:

AG-1: Provide Family Support Groups facilitated by the Family Liaison and a community family member

Baseline: There were no FY 16-17 averages, b/c this is a new goal

- **FY 17-18 Q1 Baseline:**

Goal : Increase the % of unduplicated participants in WR Peer Support Groups who respond to post group survey that they felt welcome, that they worked on something important to them, and that they believe life is improving b/c of the group (per Session Rating Scale).

Results of Evaluation

Q1:

Month	# of total unique group members who participated	% that Felt Welcome in the Group	% that worked on something today that was important to him/her	% that believes that his/her life is improving b/c of the group
Jul				
Aug				
Sep				

Q2:

Month				
Oct				
Nov				
Dec				

Q3:

Month				
Jan				
Feb				
Mar				

Q4:

Month				
Apr				
May				
Jun				

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

II. Wellness and Recovery:

- **AG-2:** 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

Purpose for Monitoring:
DHCS Annual Review Protocols, FY 17-18, Quality Improvement - Section I, Item # 1.

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

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

Objectives column:

AG-1 : Provide WR Peer Support Groups

Baseline: There were no FY 16-17 averages, b/c this is a new goal

- **FY 17-18 Q1 Baseline**::

Goal: Increase the % of unduplicated participants in WR Peer Support Groups who respond to post group survey that they felt welcome, that they worked on something important to them, and that they believe life is improving b/c of the group.

Results of Evaluation:

Q1 :

Month	# of total unique group members who participated	% that Felt Welcome in the Group	% that worked on something today that was important to him/her	% that believes that his/her life is improving b/c of the group
Jul				
Aug				
Sep				

Q2 :

Month				
Oct				
Nov				
Dec				

Q3 :

Month				
Jan				
Feb				
Mar				

Q4 :

Month				
Apr				
May				
Jun				

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II. Wellness and Recovery (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation			

II. Wellness and Recovery:

- **DM-1:** Maintain the pool of 20(+) Consumers/Family Members' Directory to contact to provide them with opportunities to participate in committees

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item #7

Name of Data Report: 2017-2018 WR QI Work Plan Goal Report, Sign-in Sheets, & Meeting Minutes

Sub-committee/Staff Responsible:
Wellness Recovery Unit

Previous FY Baseline Averages:
- Average # of Committees per Quarter:
- Average number of participants per quarter:

FY 17-18 Quarterly Averages:
- Average # of Committees per Quarter: ___
- Average number of participants per quarter:___

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			
Aug			
Sep			

Q2:

Month			
Oct			
Nov			
Dec			

Q3:

Month			
Jan			
Feb			
Mar			

Q4:

Month			
Apr			
May			
Jun			

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Quality Improvement Area of Data Monitoring	Results of Evaluation			

II. Wellness and Recovery:

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

Purpose of Monitoring:
To ensure that Consumers are becoming educated and empowered with in the MHP

Name of Data Report: WRAP group sign-in sheets

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

Previous FY Baseline Averages:
- Total # of Wrap Groups Annually:
- Average number of participants per quarter:

FY 17-18 Quarterly Averages:
- Total # of Wrap Groups Annually: ___
- Average number of participants per quarter:___

C-1: Q1:

Month	Were any WRAP groups provided this month?	How many MH Consumers participated?	How many WRAP groups have been provided?
Jul			
Aug			
Sep			

C-1: Q2:

Month			
Oct			
Nov			
Dec			

C-1: Q3:

Month			
Jan			
Feb			
Mar			

C-1: Q4:

Month			
Apr			
May			
June			

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

Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation
III. Consumer Perception: • **AG-1:** Annual Surveying of Client/Family Satisfaction **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item #2a, 2d **Name of Data Report:** • State Consumer Perception Surveys; Follow up surveys **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Annual Goal Met:** ☐ **Met:** ☐ **Partially Met:** ☐ **Not Met:**	**AG-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:** Pending	See tables below

Q1:

Q#	List the most recent survey goal & outcome.
Q1	Q#:
Adult:	
Older Adult:	
Youth:	
Families:	

Q2:

Q#	List the most recent survey goal & outcome.
Q2	Q#:
Adult:	
Older Adult:	
Youth:	
Families:	

Q3:

Q#	List the most recent survey goal & outcome.
Q3	Q#:
Adult:	
Older Adult:	
Youth:	
Families:	

Q4:

Q#	List the most recent survey goal & outcome.
Q4	Q#:
Adult:	
Older Adult:	
Youth:	
Families:	

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

Quality Improvement Area of Data Monitoring	Results of Evaluation				

III. Consumer Perception:

- **DM-1:** Annual Surveying of Client/Family Satisfaction

Purpose of Monitoring:
- DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item #2a, 2d

Name of Data Report:
- State Consumer Perception Surveys

Sub-committee/Staff Responsible:
Problem Resolution Coordinator

Previous FY Baseline Averages:
- **Goal(s) for FY 16-17:** DHCS Consumer Perception Survey, Q #15: Staff told me about Side Effects
- **Were results shared with Providers**: Yes

FY 17-18 Quarterly Averages:
- Goal(s) for FY 17-18:
- Were results shared with Providers:

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?
Q1				

Q2:

Q2				

Q3:

Q3				

Q4:

Q4				

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Quality Improvement Area of Data Monitoring	Results of Evaluation

III. Beneficiary Protection:

- **DM-2:** Grievance, Appeal and Expedited Appeal

Purpose of Monitoring:
- DHCS Annual Review Protocols, FY 17-18, Quality Improvement - Section I, Item # 2b, #5, and #6b; Beneficiary Protection – Section D, Item #2, #8a & 8b

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

Sub-committee/Staff Responsible:
Problem Resolution Coordinator

Previous FY Baseline Averages:
- Total # of Problem Resolution issues:
- # of issues requiring a system change:
- # Referred to Policy Committee:

FY 17-18 Quarterly Averages:
- Total # of Problem Resolution issues: ___
- # of issues requiring a system change: ___
- # of System Changes Initiated: ___
- # Referred to Policy Committee: ___
- # of Policies created or amended: ___

Q1:

Month Received	Total quarterly # of Problem Resolution issues reported, including quality of care issues	# of issues Requiring a System Change	# of System Changes initiated	# Referred to Policy Committee	# of Policies created or amended b/c of identified Problem
July					
Aug					
Sept					
Q1 Total					

Q2:

Oct					
Nov					
Dec					
Q2 Total					

Q3:

Jan					
Feb					
Mar					
Q3 Total					

Q4:

Apr					
May					
Jun					
Q4 Total					

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Quality Improvement Area of Data Monitoring	Results of Evaluation
III. **Beneficiary Protection:** • **DM-3**: Tracking and trending of Beneficiary Grievances and Appeals to meet DHCS annual reporting standards **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 17-18, Quality Improvement - Section I, Item # 2b, #5, and #6b; Beneficiary Protection – Section D, Item #2a, 2b. **Name of Data Report:** • Problem Resolution Log • QIC Problem Resolution Report **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Previous FY Baseline Averages:** • Were all Problem Resolution processes logged and monitored: Yes • Data Trends: **FY 17-18 Quarterly Averages:** • Were all Problem Resolution processes logged and monitored: • Data Trends:	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Category	Total #	Process					Disposition		
		Grievance	Appeal	Expedited Appeal	State Fair Hearing	Expedited Fair Hearing	Referred Out	Resolved	Still Pending
ACCESS									
Denied Services									
Change of Provider									
Quality of Care									
Confidentiality									
Other									
Q1 Total:									

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Quality Improvement Area of Data Monitoring	Results of Evaluation
III. **Beneficiary Protection:** • **DM-4**: Tracking the compliance of sending the beneficiary an acknowledgement and Disposition letter. **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 17-18, Quality Improvement - Section I, Item # 2b, #5, and #6b; Beneficiary Protection – Section D, Item #3, 4, 6 **Name of Data Report:** • Problem Resolution Log • QIC Problem Resolution Report **Sub-committee/Staff Responsible:** Problem Resolution Coordinator **Previous FY Baseline Averages:** • % of Acknowledgement letters sent within timeframes: • % of Disposition letters sent within timeframes: **FY 17-18 Quarterly Averages:** • % of Acknowledgement letters sent within timeframes: • % of Disposition letters sent within timeframes:	(see tables below)

Q1:

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

Q2:

Oct							
Nov							
Dec							
Q2 Total							

Q3:

Jan							
Feb							
Mar							
Q3 Total							

Q4:

Apr							
May							
Jun							
Q4 Total							

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Quality Improvement Area of Data Monitoring	Results of Evaluation			
III. Beneficiary Protection: • **DM-5**: Tracking and trending of Internal system improvement needs **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 17-18, 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 **Previous FY Baseline Averages:** • Total # of Problem Resolution issues: • # of issues requiring a system change: • # Referred to Policy Committee: • # Referred for Adverse Outcome Mtg: **FY 17-18 Quarterly Averages:** • Total # of Problem Resolution issues: ___ • # of issues requiring a system change: ___ • # of System Changes Initiated: ___ • # Referred to Policy Committee: ___ • # of Policies created or amended: ___ • # Referred for Adverse Outcome Mtg: ___	**Q1:** See table below			

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				
Aug				
Sept				
Q1 Total				

Q2:

Oct				
Nov				
Dec				
Q2 Total				

Q3:

Jan				
Feb				
Mar				
Q3 Total				

Q4:

Apr				
May				
Jun				
Q4 Total				

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

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

IV. Outcomes & Utilization

- **AG-1:** Full Service Partnership Utilization and Outcomes

Authority:
DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item # 8a

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

Sub-committee/Staff Responsible:
UM Committee & FSP Work Groups

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

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

Baseline: FY 16-17 showed the following:
- 7% (24) adult FSP Programs clients were hospitalized 1x and 1% (5) were hospitalized 2 or more times.
- 3% (9) Children/Youth FSP Programs clients were hospitalized 1x and 1% (3) were hospitalized 2 or more times.
- Unduplicated counts for incarcerations and unstable housing was not available.

Goal: Solano MHP will:

1. Decrease total FSP clients in inpatient hospitalizations by 5%
2. Decrease the percentage of t FSP clients hospitalized by 5%
3. Decrease total FSP clients incarcerated by 5%
4. Reduce # of FSP clients without stable housing.

Q1:

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

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

Q2:

Q3:

Q4:

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Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation			
IV. Outcomes & Utilization: • **AG-2:** ADULT: CSU-Exodus, Bay Area Community Services, Hospital Liaison **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Quality Improvement Section I, Item #6c. **Name of Data Report:** Quality and Utilization Review of CSU services **Sub-committee/Staff Responsible:** Utilization Management team **Annual Goal Items Met:** ☐ **Met:** Item # ____ ☐ **Partially Met:** Item # ____ ☐ **Not Met:** Item # ____	**AG-2:** The Utilization Management Committee is charged with monitoring the effectiveness of the MHP's infrastructure to reduce inpatient stays and recidivism. **Baseline:** FY 16-17 Averages **Goal:** Maintain or improve the following hospital-related measures (based on Solano Adult Medi-Cal clients, excludes 0-17 y.o., private insurance, Kaiser Medi-Cal, or other county insurance): • **Measurement #1:** Maintain FY16-17 baseline **Baseline:** Quarterly average of 125 average Adult inpatient hospitalizations. • **Measurement #2** Establish a baseline average of 12% or less of clients re-hospitalized within 30 days of discharge from inpatient hospitalization. **Baseline:** Quarterly average of 12.4% readmission rate in FY16-17.	**Q1:**			

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				
Aug				
Sep				
TOTALS:				

Q2:

Q3:

Q4:

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Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation			
IV. Outcomes & Utilization: • **AG-3:** CHILD: CSU-Exodus, Bay Area Community Services, Hospital Liaison **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Quality Improvement Section I, Item #6c. **Name of Data Report:** Quality and Utilization Review of CSU services **Sub-committee/Staff Responsible:** Utilization Management team **Annual Goal Items Met:** ☐ **Met:** Item # ____ ☐ **Partially Met:** Item # ____ ☐ **Not Met:** Item # ____	**AG-3:** The Utilization Management Committee is charged with monitoring the effectiveness of the MHP's infrastructure to reduce inpatient stays and recidivism. **Baseline:** FY 16-17 Averages **Goal:** Monitor data on hospitalization and re-hospitalization rates for Solano County Child clients age 0-17 (excluding private insurance, Kaiser Medi-Cal, and other county Medi-Cal clients): • **Measurement #1:** Improve FY 16-17 baseline average to under 18 Inpatient hospitalizations per quarter. **Baseline:** 18.5 Child inpatient hospitalizations in FY 16-17 • **Measurement #2:** Improve quarterly average to 15% or less clients re-hospitalized within 30 days of discharge from inpatient hospitalization. **Baseline:** 15.8% average readmission rate in FY16-17	**Q1:**			

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				
Aug				
Sep				
TOTALS:				

Q2:

Q3:

Q4:

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation							
IV. Outcomes & Utilization: • **AG-4: Homeless Outreach Services (HOS) to SMI populations:** Provide outreach, engagement, and support to homeless mentally Ill adults toward acquiring benefits, resources, and services they need. **Name of Data Report:** WR Unit Homeless Outreach monthly reports and/or PATH Grant Quarterly Performance Outcome Reports **Sub-committee/Staff Responsible:** Wellness Recovery Unit/Homeless Outreach Specialist. **Annual Goal Met:** ☐ **Met:** ☐ **Partially Met:** See Note ☐ **Not Met:**	**AG-4:** MHP Staff will continue to provide support, outreach, and assistance to homeless mentally ill individuals who are brought to the attention of SCBH Services. The MHP hired two Homeless Outreach staff during FY 16-17: Mental Health Specialist and Mental Health Clinician. Services started in January 2017. These staff members go to homeless shelters, encampments, ride alongs with law enforcement, and in the community to identify mentally ill homeless individuals, and assist these individuals to access benefits and services needed. The Specialist focuses on the adult population and the Clinician is focused on the TAY population. **Baseline:** In the previous FY 16-17 a total of 111 adults were provided ARCH services and 86% of those were screened for MH/SA need and 59% were linked to other basic needs. FY 16-17 30 TAY individuals were provided ARCH Services and of those 100% were screened for MH/SA needs and 47% were linked to other basic needs. **Goal:** 1. At least 85% of the individuals contacted will be screened for MH/SA needs. 2. Of those screened, at least 50% of the individuals will be linked to Access or an existing MH provider. 3. At least 50% of the individuals contacted will be linked to other basic need services.	**Q1:** (see table below) **Q2:** **Q3:** **Q4:**							

Q1:

Program	# of Homeless Outreach Activities	Total # of individuals contacted at least 1 X	Total # unduplicated individuals screened	Total # unduplicated individuals new to MHP linked to Access	Total # unduplicated individuals re-connected w/ existing Tx provider	Total # unduplicated individuals linked to Sub. Abuse	Total #unduplicated individuals linked to other basic needs (food, clothing, etc.)
Adult ARCH							
TAY ARCH							

Goal Purpose and Monitoring	Goal/Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation			
IV. Outcomes & Utilization: • **AG-5**: TF-CBT **Purpose of Monitoring:** • DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item #6c **Name of Data Report:** No current report **Sub-committee/Staff Responsible:** • Quality Improvement • MHSA **Annual Goal Met:** ☐ **Met:** Item # ____ ☐ **Partially Met:** Item # ____ ☐ **Not Met:** Item # ____	**AG-5:** 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 16-17: • Quarterly average # of clients served w/ TFCBT by county programs was 11. • 1.75 average # of county program clients completed the post assessment quarterly (range=0-3 per quarter) • 100% who completed the post assessment showed clinical improvement. ***Goal: TF-CBT goals include:** 1. **Increase baseline # of Clients treated with TF-CBT by 15%** 2. **50% of Clients will complete Post-Test** 3. **75% of clients measured will show clinical Improvement on the Post-Test**	**Q1:** *(table below)* **Q2:** **Q3:** **Q4:**			

Q1:

County Program	Total # Clients treated with TF-CBT this Quarter	Total # of Clients to complete Post-Assessment	Total # who showed Clinical Improvement on the Post-Test
SCBH Children's Clinics			
Q1 TOTAL:			

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

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

Quality Improvement Area of Data Monitoring	Results of Evaluation

IV. Outcomes & Utilization:

- **DM-1: Youth Medication Monitoring**

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item #3

Name of Data Report:
Avatar Report # ____

Sub-committee/Staff Responsible:
Quality Review Committee

Previous FY Baseline Averages:
- **FY 16-17 # of Youth on Psychotropic Medication:**
- **FY 16-17 # of Youth on 4 or more Psychotropic Medications:**
- **FY 16-17 # of Youth on Antipsychotic Medication:**
- **FY 16-17 # of Youth on 2 or more Antipsychotic Medications:**

FY 17-18 Quarterly Averages:

Q1:

Month	# of Youth on Psychotropic Medication:	# of Youth on 4 or more Psychotropic Medications:	# of Youth on Antipsychotic Medication:	# of Youth on 2 or more Antipsychotic Medications:
Jul				
Aug				
Sep				

Q2:

Q3:

Q4:

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

Quality Improvement Area of Data Monitoring	Results of Evaluation				
IV. Outcomes & Utilization: • **DM-2:** Regional Utilization and Service Penetration by cultural group **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Network Adequacy and Array of Services – Section A, Item #2b, 2c **Name of Data Report:** • Avatar Report # 347 **Sub-committee/Staff Responsible:** • Utilization Management Committee membership • Cultural Competence Committee **Previous FY Baseline Averages:** • FY 16-17 African American Quarterly Average Served: • FY 16-17 Hispanic/Latino Quarterly Average Served: • FY 16-17 Filipino Quarterly Average Served: • FY 16-17 LGBT Quarterly Average Served: **FY 17-18 Quarterly Averages:**	**Q1:**				
	Date Range	Black/AA	Hispanic/ Latino	Filipino	LGBTQ
	North County Region				
	Central County Region				
	South County Region				
	Out of County				
	Unknown				
	Quarter Total:				
	Previous Quarter:				
	FY 16-17 Q Ave (Baseline)				
	Q2: **Q3:** **Q4:**				

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

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

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation		
V. Access & Timeliness: • **AG-1: CHILD:** Service Request to First Offered Assessment Appointment **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #9 and #10 **Name of Data Report:** Avatar Timeliness Report #; MHP Access Referral form (under construction) **Sub-committee/Staff Responsible:** Access Supervisor **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-1:** Solano MHP made significant progress in FY 2015-16 to improve timeliness from point of access to the date of first-offered assessment appointment. **Baseline:** See FY 2016-17 average timeliness for Children's services **Goal:** 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 (FY16-17 baseline: 82%) b. Maintain goal of an average of 10 business days or less from service request to actual assessment (FY16-17 baseline: 9.8 days) c. Achieve goal of an average of 30 business days or less from service request to service initiation (FY16-17 baseline: 32.4 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 (FY16-17 baseline: 76%) b. Achieve goal of an average of 3 business days or less from service request to actual assessment (FY16-17 baseline: 4.2 days)	See tables below.		

Q1:

Request Type	Service Request to Offered Ax Appt (% w/in 10 bus days for Routine & 3 bus days for Urgent)	Average # of Business Days from Service Request to Actual Ax Appt	Average # of Business Days from Service Request to First Tx Service
Routine			
Urgent			
Total:			

Q2:

Request Type			
Routine			
Urgent			
Total:			

Q3:

Request Type			
Routine			
Urgent			
Total:			

Q4:

Request Type			
Routine			
Urgent			
Total:			

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

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

V. Access & Timeliness:

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

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #9 and #10

Name of Data Report:
Avatar Timeliness Report #; MHP Access Referral form (under construction)

Sub-committee/Staff Responsible:
Access Supervisor

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

AG-2: Solano MHP made significant progress in FY 2015-16 to improve timeliness from point of access to the date of first-offered assessment appointment.
Baseline: See FY 2016-17 average timeliness for Adult services
Goal:
1. For Routine requests for service, VV and VJO County Adult programs will:
   a. Achieve goal of 80% resulting in an offered assessment within 10 business days
   (FY16-17 baseline for all Adults: 84%)
   b. Achieve goal of an average of 10 business days or less from service request to actual assessment
   (FY16-17 baseline for all adults: 8.4 days)
   c. Achieve goal of an average of 30 business days or less from service request to service initiation
   (FY16-17 baseline for all adults: 26.5 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
   (FY16-17 baseline for all adults: 76%)
   b. Achieve goal of an average of 3 business days or less from service request to actual assessment
   (FY16-17 baseline for all adults: 5.4 days)
   c. Achieve goal of an average of 23 business days or less from service request to service initiation
   (FY16-17 baseline for all adults: 16.7 days)

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	
Clinic	VV OP	VJO OP	VV OP	VJO OP	VV OP	VJO OP
Routine						
Urgent						
Total:						

Q2:

Clinic	VV OP	VJO OP	VV OP	VJO OP	VV OP	VJO OP
Routine						
Urgent						
Total:						

Q3:

Clinic	VV OP	VJO OP	VV OP	VJO OP	VV OP	VJO OP
Routine						
Urgent						
Total:						

Q4:

Clinic	VV OP	VJO OP	VV OP	VJO OP	VV OP	VJO OP
Routine						
Urgent						
Total:						

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

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

V. Access & Timeliness:

- **AG-3: Retention:** Service Request to First Offered Assessment Appointment

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #9 and #10

Name of Data Report:
Avatar Timeliness Report #; MHP Access Referral form (under construction)

Sub-committee/Staff Responsible:
Access Supervisor

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

AG-3: Maintain or improve the following engagement & attrition measures for Children:
Baseline: See FY 2016-17 average engagement & attrition for Children's services
Goal:
1. For Routine requests for service, County Adult programs will:
   a. Maintain goal of 95% resulting in an Assessment
   (FY16-17 baseline: 95%)
   b. Achieve goal of 75% resulting in initiation of treatment
   (FY16-17 baseline: 72%)
2. For Urgent requests for service, County Adult programs will:
   a. Maintain goal of % resulting in an assessment
   (FY16-17 baseline: 95%)
   b. Achieve goal of 75% resulting in initiation of treatment
   (FY16-17 baseline: 71%)

Q1:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine			
Urgent			
Total:			

Q2:

Request Type			
Routine			
Urgent			
Total:			

Q3:

Request Type			
Routine			
Urgent			
Total:			

Q4:

Request Type			
Routine			
Urgent			
Total:			

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

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

V. Access & Timeliness:
 	
• **AG-4: Retention:** Service Request to First Offered Assessment Appointment
 	
Purpose of Monitoring:
DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #9 and #10
 	
Name of Data Report:
Avatar Timeliness Report #; MHP Access Referral form (under construction)
 	
Sub-committee/Staff Responsible:
Access Supervisor
 	
Annual Goal Items Met:
☐ **Met:** Item # ___
☐ **Partially Met:** Item # ___
☐ **Not Met:** Item # ___
	AG-4: Maintain or improve the following engagement & attrition measures for Children:
	Baseline: See FY 2016-17 average engagement & attrition for Children's services
	Goal:
	1. For Routine requests for service, County Adult programs will:
	  a. Achieve goal of 65% resulting in an Assessment
	  (FY16-17 baseline: 59%)
	  b. Achieve goal of 55% resulting in initiation of treatment
	  (FY16-17 baseline: 46%)
	2. For Urgent requests for service, County Adult programs will:
	  a. Maintain goal of 60% resulting in an assessment
	  (FY16-17 baseline: 55%)
	  b. Achieve goal of 55% resulting in initiation of treatment
	  (FY16-17 baseline: 46%)
		Q1:			

Q1:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine			
Urgent			
Total:			

Q2:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine			
Urgent			
Total:			

Q3:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine			
Urgent			
Total:			

Q4:

Request Type	# of Service Requests	% Receiving an Assessment	% Who Initiated Treatment
Routine			
Urgent			
Total:			

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

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

V. Access & Timeliness:

• **AG-5**: Access: Test Call Performance

Purpose of Monitoring:
DHCS Annual Review Protocols, FY 17-18, Access – Section A, Item #9 and #10

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 # ____

Objectives:

AG-5: All calls to (800) 547-0495 MH Access unit are routed to a Care Manager, 24 hours/day, 7 days/week. Care Managers provide or arrange for Access services in any language spoken in Solano County. Additionally, calls should:

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

Baseline:
See FY 15-16 % that met standards
Goal:
During QI initiated test calls, the MHP will demonstrate in 75%-100% Business and Afterhours calls:

• **Measure #1:** Provide a Minimum of 4 test calls/month.
• **Measure #2:** Testing for language capabilities
• **Measure #3:** Testing for appropriate information given (SMHS access, Urgent conditions, and Problem Resolution)
• **Measure #4:** Logging all appropriate data

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

Q2:

Q3:

Q4:

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

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

Quality Improvement Area of Data Monitoring	Results of Evaluation
V. Access and Timeliness: • **DM-1:** Access Calls Handled **Purpose for Monitoring:** DHCS Annual Review Protocols, FY 17-18, Access – Section B, Item #9 **Name of Data Report:** CISCO-Contact Service Queue Activity Report (by CSQ) **Sub-committee/Staff Responsible:** • Quality Improvement unit • Access Supervisor **Previous FY Baseline Averages:** • Quarterly Average of % of Calls Handled "Live" during FY 16-17: **99.5%** • Quarterly Average of % of Abandoned calls in FY 16-17: **.5%** **FY 17-18 Quarterly Averages:** • Total # of Problem Resolution	(see tables below)

Q1:

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

Q2:

Month/ Quarter	Calls Received	Calls Handled	% (Handled/ Received)	Calls Abandoned	% (Abandoned/ Received)
Oct					
Nov					
Dec					
Q2 Total					

Q3:

Month/ Quarter	Calls Received	Calls Handled	% (Handled/ Received)	Calls Abandoned	% (Abandoned/ Received)
Jan					
Feb					
Mar					
Q3 Totals					

Q4:

Month/ Quarter	Calls Received	Calls Handled	% (Handled/ Received)	Calls Abandoned	% (Abandoned/ Received)
Apr					
May					
Jun					
Q4 Totals					

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

VI. Program Integrity (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation			
VI. <mark>Service Verification –</mark> • **AG-2: SV County Programs** **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Program Integrity – Section H, Item # 3a & 3b **Name of Data Report:** QI-Compliance Service Verification Spreadsheet **Sub-committee/Staff Responsible:** • Compliance Committee • Quality Improvement unit **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-1:** According to Program Integrity requirements of 42 CFR §455.1(a)(2) as set forth in the MHP Contract between the State of California and the County of Solano, there is a need to develop and implement a means to verify whether services were actually furnished to beneficiaries. **Baseline:** The MHP began implementing a service verification process during FY 2013-14. Expectation is that all programs will participate in Service Verification. **Goal:** The MHP will continue to implement a service verification model during Q1 and Q3, and endeavor to demonstrate 90-100% accountability for each service identified during the sampling period (services not verified will be repaid). • **Measurement #1:** 100% of all applicable County programs participate in the service verification process? **FY 16-17 Baseline**: 100% • **Measurement #2:** 90-100% of services will be verified during the week of Service Verification. **FY 16-17 Baseline**:	**Q1:** (see table below) **Q2:** *(Per MHP Policy, No County SV required during Q2 and Q4)* **Q3:** **Q4:** *(Per MHP Policy, No County SV required during Q2 and Q4)*			

Q1:

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

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation			
VI. Service Verification – • **AG-2: SV Contract Programs** **Authority:** DHCS Annual Review Protocols, FY 17-18, Program Integrity – Section H, Item # 3a & 3b **Name of Data Report:** QI-Compliance Service Verification Spreadsheet **Sub-committee/Staff Responsible:** • Compliance Committee • Quality Improvement unit **Annual Goal Items Met:** ☐ **Met:** Item # ___ ☐ **Partially Met:** Item # ___ ☐ **Not Met:** Item # ___	**AG-2:** According to Program Integrity requirements of 42 CFR §455.1(a)(2) as set forth in the MHP Contract between the State of California and the County of Solano, there is a need to develop and implement a means to verify whether services were actually furnished to beneficiaries. **Baseline:** The MHP began implementing a service verification process during FY 2013-14. Expectation is that all programs will participate in Service Verification. **Goal:** The MHP will continue to implement a service verification model during Q2 and Q4, and endeavor to demonstrate 90-100% accountability for each service identified during the sampling period (services not verified will be repaid). • **Measurement #1:** 100% of all applicable Contract Agency programs participate in the service verification process? **FY 16-17 Baseline**: • **Measurement #2:** 90-100% of services will be verified during the week of Service Verification. **FY 16-17 Baseline**:	**Q1:** *(Per MHP Policy, No Contract Agency SV required during Q1 and Q3)* **Q2:** (see table below) **Q3:** *(Per MHP Policy, No Contract Agency SV required during Q1 and Q3)* **Q4:**			

Q2:

Contract Program	Did all applicable programs participate in Service Verification?	Were 100% of services accounted for?	Were unaccounted services investigated?

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

VI. Program Integrity (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation
VI. Program Integrity • **DM-1: Compliance Committee** **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Program Integrity – Section H, Item # 2c **Name of Data Report:** Compliance Meeting Minutes **Sub-committee/Staff Responsible:** Compliance Committee	**Q1:** | Month	Compliance Meeting Held?	Date of Mtg(s) and General Issues Addressed | |---|---|---| | | | | **Q2:** | Month	Compliance Meeting Held?	Date of Mtg(s) and General Issues Addressed | |---|---|---| | | | | **Q3:** | Month	Compliance Meeting Held?	Date of Mtg(s) and General Issues Addressed | |---|---|---| | | | | **Q4:** | Month	Compliance Meeting Held?	Date of Mtg(s) and General Issues Addressed | |---|---|---| | | | |

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

Quality Improvement Area of Data Monitoring	Results of Evaluation				
VI. Program Integrity – • **DM-2: Compliance Training and Communication to the MHP** **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Program Integrity – Section H, Item # 2e, 2f & 2g **Name of Data Report:** TBD **Sub-committee/Staff Responsible:** Compliance Committee meeting minutes/ spreadsheet	**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				
	Q2:				
	Oct				
	Nov				
	Dec				
	Q3:				
	Jan				
	Feb				
	Mar				
	Q4:				
	Apr				
	Mar				
	Jun				

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

VII. Quality Improvement (Active Goals - AG)

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation			
VII. Quality Improvement: • **AG-1:** Annual Utilization Review Audits - Timeliness and Appropriate Resolution of Annual Utilization Review Audit Findings **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Provider Relations – Section G, Item # 1 **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 # ___	**AG-1:** Solano County MHP Quality Improvement (QI) unit conducts Annual Utilization Review Audits of all County and Contracted Organizational Providers who bill Medi-Cal services, to ensure all such providers utilized by Solano MHP are in compliance with the documentation standards requirements, per CCR Title 9. **Baseline:** 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 2017-18 to monitor Provider compliance with CCR Title 9 documentation standards requirements: • **Measurement #1**: At least 90% of UR Audit Reports will be submitted within 60 days after the review. • **Measurement #2:** At least 90% of reviewed programs requiring a CAP will submit one that meets QI standards, within prescribed timelines.	**Q1:** **Q2:** **Q3:** **Q4:**			

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?	What % of all County/Contract programs audited exceeded the 10% fiscal disallowance rate, triggering a Plan of Correction?	What % of all County/Contract programs reviewed this Quarter submitted a Corrective Action Plan (CAP) that adequately addressed areas of documentation noncompliance?
Q1				

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

Quality Improvement Goal and Means to Accomplish it	Objectives (Include standards, baselines, annual goal, etc.)	Results of Evaluation		
VII. Quality Improvement: • **AG-2**: Annual Utilization Review Audits - QI Inter-rater Reliability for Concurrent Review and Annual Utilization Review Audits **Authority:** DHCS Annual Review Protocols, FY 17-18, Quality Improvement – Section I, Item #6d **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 # ___	**AG-2:** Solano County MHP Quality Improvement (QI) unit conducts ongoing Concurrent Review of assessments and treatment plans for all County and Contracted Organizational Providers as well as Annual Utilization Review Audits of all providers who bill Medi-Cal services. Solano MHP is committed to having an ongoing monitoring process that is in compliance with the documentation standards requirements, per CCR Title 9. **Baseline:** Quality Improvement engaged in annual UR Audits during FY 2016-17. This is a new area of tracking and monitoring. **Goal:** The following processes are in place for FY 2017-18 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? • **Measurement #3:** 90% of Service Authorization requests reviewed by QI Liaisons will be responded to within 10 business days?	**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?	Are 90% of Service Authorization requests reviewed by QI Liaisons responded to within 10 business days?
---	---	---	---
Jul	---	---	
Aug	---	---	
Sep	---	---	| **Q2:** **Q3:** **Q4:**		

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

VII. Quality Improvement (Data Monitoring - DM)

Quality Improvement Area of Data Monitoring	Results of Evaluation					
VII. **Quality Improvement:** • **DM-1:** Documentation Training and Avatar User Training **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Section G, Item #1 **Name of Data Report:** TBD **Sub-committee/Staff Responsible:** QI Training Lead and team	**Q1:**					

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						
Aug						
Sep						

Q2:

Month						
Oct						
Nov						
Dec						

Q3:

Month						
Jan						
Feb						
Mar						

Q4:

Month						
Apr						
May						
Jun						

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

Quality Improvement Area of Data Monitoring	Results of Evaluation			
VII. **Quality Improvement**: • **DM-2:** Site Certifications **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Provider Relations – Section G, Item # 3a **Name of Data Report:** Monthly Site Certification Tracking Report **Sub-committee/Staff Responsible:** QI Site Certification Lead and team	**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			
	Aug			
	Sep			
	Q2:			
	Oct			
	Nov			
	Dec			
	Q3:			
	Jan			
	Feb			
	Mar			
	Q4:			
	Apr			
	May			
	Jun			

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

Quality Improvement Area of Data Monitoring	Results of Evaluation				
VII. Quality Improvement: • **DM-3:** Medi-Cal Provider Eligibility and Verification **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Program Integrity – Section H, Item # 5 **Name of Data Report:** Provider Eligibility and Verification Tracking Report **Sub-committee/Staff Responsible:** QI Provider Eligibility Verification Lead	Q1:				
	Month	**How many providers initially showed up on one of the lists?**	**Was action taken to investigate provider's ability to work in the MHP?**	**How many providers were determined to be ineligible to practice?**	**Were 100% of County, Contract and Network Providers verified on the exclusion lists?**
	Jul				
	Aug				
	Sep				
	Q2:				
	Oct				
	Nov				
	Dec				
	Q3:				
	Jan				
	Feb				
	Mar				
	Q4:				
	Apr				
	May				
	Jun				

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

VIII. Network Adequacy (Data Monitoring - DM)

VIII. Network Adequacy:	**Q1:**

VIII. Network Adequacy:

- **DM-1**: Pathways to Well-Being (Katie A.)

Authority:
DHCS Annual Review Protocols, FY 17-18, 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

Q1:

# Refer'd to MHP	# Assessed & Refer'd for Services		# ID'd as Katie A. subclass		Received CFT Mtg	Declined Services	AWOL	Awaiting Response
	MHP	MCP						
			In County					
			Out of County					

Program Name	ICC Clients	IHBS Clients
Seneca		
TFCU		
SC Children's FSP		

Q2:

Q3:

Q4:

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

VIII: Network Adequacy: • **DM-2**: Pathways to Well-Being **Purpose of Monitoring:** DHCS Annual Review Protocols, FY 17-18, Section A Item #4a-4d **Name of Data Report:** Katie A. Database maintained by Foster Children's Treatment Unit; Foster Care Tx Unit Referral Log: **Sub-committee/Staff Responsible:** • CCR Coordinator **Monitoring**: • # of County Pathways Clients Identified: • % of County Pathways Clients provided with a CFT Quarterly: • # of Contract Agency Pathways Clients Identified: • % of Contract Agency Pathways Clients provided with a CFT Quarterly:	**Q1:** **Q2:** **Q3:** **Q4:**

Q1:

Month	# of County Pathways Clients Identified	% of County Pathways Clients provided with a CFT Quarterly	# of Contract Agency Pathways Clients Identified	% of Contract Agency Pathways Clients provided with a CFT Quarterly
Jul				
Aug				
Sep				

Quality Assessment and Performance Improvement Work Plan for FY 2017/2018

Goal Purpose and Monitoring	Results of Evaluation

VIII: Network Adequacy:

• **DM-3**: Provider Network Data

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

Name of Data Report:
Solano County Mental Health (MH) Managed Care Tracking; CALWIN Medi-Cal Eligible crystal report

Sub-committee/Staff Responsible:
Managed Care/Provider Relations

Q1:

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									
North									
Central									
South									

Q2:

Q3:

Q4:

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