

NAPA COUNTY MENTAL HEALTH PLAN



A Tradition of Stewardship
A Commitment to Service

QUALITY IMPROVEMENT PROGRAM WORK PLAN

2019

January 1, 2019 – December 31, 2019

Napa County Mental Health Mission Statement:

Our mission is to responsibly provide mental health services that promote individual strengths, inspire hope, and improve the quality of life for people within Napa County.

INTRODUCTION

The Napa County Mental Health Quality Improvement (QI) Program is accountable to the Mental Health Director. It is designed to assure to all payers and stakeholders that the processes for obtaining services are fair, efficient, cost-effective, and produce results consistent with the belief that people with mental illness may recover. In addition to attendance at the Quality Improvement Committee (QIC) and Utilization Steering Committee (URSC), beneficiaries, family members and stakeholders are encouraged to actively participate in the deliberations of the Mental Health Board, the outreach activities of the Napa County Mental Health Plan (NCMHP), Mental Health Service Act (MHSA) Stakeholder processes and in self-help education. All these efforts assist in the planning, design, and execution of the QI Program. The QI Program coordinates performance monitoring activities throughout the organization, including but not limited to: beneficiary and system outcomes, utilization review and management, credentialing, monitoring and resolution of beneficiary grievances, fair hearings and provider appeals, assessment of beneficiary and provider satisfaction, performance improvement projects, and clinical records reviews. The Napa County Health and Human Services Agency's Quality Management Division supports the program by providing additional auditing and processing of grievances.

The Quality Improvement Work Plan helps guide the NCMHP in managing: (i) conformity with federal and state requirements for quality improvement, and (ii) the behavioral health system's priorities for quality improvement and quality management. With this in mind, NCMHP developed its **2019 Quality Improvement Program and Work Plan** to meet California Department of Health Care Services (DHCS) requirements in Title 9, Section 1810.440.

Contracts between the NCMHP and affiliated providers require: 1) cooperation with and participation in, the MHP's QI Program and 2) MHP access to relevant clinical records to the extent permitted by State and Federal laws.

The NCMHP QI Program and Work Plan is designed to:

- implement quality improvement and assurance activities across the NCMHP;
- detail some of the mechanisms and key indicators addressing beneficiary outcomes, program development and system change;
- support decision-making based on performance improvement measures and
- promote continuous quality improvement in programs operating across the continuum of care

CONTENT AND ORGANIZATION OF THE 2019 QI WORKPLAN & PROGRAM

Introduction - QI Work Plan:

QI Work Plan Goals invite us to understand, in concrete terms, how our services "make a difference" in the lives of beneficiaries and family members:

- The QI Work Plan gives us the opportunity to be accountable to the rights of beneficiaries and family members to receive publically funded services that are easily accessible, "do no harm" (at a minimum) and improve the quality of their lives.
- The QI Work Plan gives us the opportunity to frame issues using data. We use qualitative and quantitative data to construct baselines, develop intervention strategies, create methodologies and measure outcomes to see "what worked" and if we reached our goals. A data-informed decision making approach allows us to make adjustments to program implementation.

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- The QI Program gives us the opportunity to engage stakeholders throughout the system in a collaborative management approach to mutual learning and developing and implementing solutions.

The NCMHP follows these steps for each of the QI activities:

- 1) Collects and analyzes data and reviews relevant activities to measure against the goals, or prioritized areas of improvement that have been identified.
- 2) Identifies opportunities for improvement and decides which opportunities to pursue.
- 3) Designs and implements interventions to improve its performance.
- 4) Measures the effectiveness of the interventions.
- 5) Formulates reports and shares the information collected to improve the efficient and effective functioning of the system and organization.
- 6) Adheres to directives issued by the State of California Department of Healthcare Services.

Quality Improvement Committee (QIC)

The QIC is responsible for the overall quality review of all Short-Doyle/Medi-Cal and NCMHP mental health services provided in the County of Napa. It meets formally on a monthly basis. Its goal is to monitor and evaluate the quality and appropriateness of services to beneficiaries, pursue opportunities to improve services, and resolve identified problems. It is responsible for reviewing data and making recommendations to staff, supervisors, and managers on beneficiary and system outcomes as well as beneficiary and provider satisfaction.

The QIC may recommend policy positions to managers and other decision-makers; review and evaluate the results of QI activities; institute needed QI actions; and ensures the follow-up of QI processes. Dated and signed minutes reflect all QIC decisions and actions. On an annual basis the QIC reviews the QI Program instituted by the NCMHP and assesses its effectiveness as well as pursues opportunities to improve the plan.

The QIC is composed of the following:

- beneficiaries of the MHP and family members,
- representatives of Mental Health Patient's Rights Advocate,
- a Mental Health Board representative,
- a Contracted Organizational Providers Representative
- Mental Health Program adult and child services supervisors,
- Mental Health Program adult and child services staff
- Chair: the Quality Coordinator
- other Quality Improvement staff,
- a member of the Mental Health Division Management team
- a representative from the Quality Management Division,
- other members designated by the Mental Health Director.

The Mental Health Director or designee appoints the Committee representatives to 2 year terms, which may be renewed upon completion of the term.

Currently, QI activities related to Utilization Review and Management are commonly delegated to the Utilization Review Steering Committee (URSC). The Quality Coordinator sits on both committees and

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acts as a liaison. A summary report of the activities of the URSC and the Mental Health Data Dashboard is presented periodically at QIC meetings.

Utilization Review Steering Committee

The Utilization Review Steering Committee is responsible for administratively monitoring the utilization of all treatment services provided by the NCMHP. The URSC maintains and reviews monthly the data indicators on the **Mental Health Data Dashboard**. The URSC develops, implements, evaluates, and improves utilization review processes, reviews reports of service utilization and makes recommendations for actions when patterns of over or under utilization, barriers to service access and service delivery, and qualitative customer service concerns have not been resolved at the program level. The Committee is intended to ensure the most efficient and effective use of the NCMHP clinical care resources. The Utilization Review Steering Committee is composed of the following:

- Utilization Review Coordinator (chairperson)
- Quality Coordinator
- Mental Health Clinical Manager
- Mental Health Director (ad hoc)
- Mental Health Staff Services Analyst
- Fiscal Representative
- Consumer and/or family member
- Organizational Provider – Children's
- Organizational Provider – Adult

Cultural Competence Committee

Quality Improvement activities related to improving the Mental Health Division's cultural competence are the primary responsibility of the Cultural Competence Committee (CCC), which is considered a sub-committee of the QIC. Members of the QIC sit on the CCC and provide periodic reports to the QIC of the CCC's activities.

The mission of the Cultural Competence Committee is to assure that Napa County Mental Health (NCMH) implements and provides culturally and linguistically competent services to reduce health disparities and meet the diverse needs of Napa County residents.

The CCC is a sub-committee of the NCMH Quality Improvement Committee (QIC). Members are responsible for providing culturally competent, sustainable, feasible recommendations and solutions to QIC. Committee members will primarily hold an advisory role and provide input on NCMH's Cultural Competence Plan (CCP).

Membership will include:

1. NCMH Staff and Contractors
2. Mental Health Providers
3. MH Board Members
4. Community Members
5. Mental Health Stakeholders including consumers, family members, caregivers, etc.

The Quality Improvement Committee, Utilization Review Committee and Cultural Competence Committee are the three key committees charged with implementation and oversight of the QI/QA Program, and regularly collaborate to integrate and present current data into the Quality Improvement

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Committee's review process and formulation of recommendations. The QI Work Plan incorporates elements and data in the domains of these committees.

Annual QI Work Plan Evaluation

The QI Work Plan Goals and Objectives are evaluated annually approximately one month prior to the development of the next year's QI Work Plan, typically in December/January. The statuses of the goals are noted in the left hand column under: "Annual Goal Items Met." Data detail and notes are listed in the section at the bottom of each goal listing entitled: "Evaluation: Data Detail". A draft of the Evaluation is reviewed by the QIC prior to finalization and posting to the county web site.

2019 QI Work Plan Goals

Section	GOAL DOMAIN	Page Number
I	Monitoring the Service Capacity of the MHP	p.7
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IV	Monitoring the Mental Health Plan's Service Delivery System and Clinical Issues Affecting Beneficiaries	p.20
V	Monitoring Continuity and Coordination of Care with Physical Health Care Providers and other Human Services Agencies	p.26
VI	Monitoring Provider Satisfaction	p.27
VII	Strengthen the MHP's Quality Improvement Program Infrastructure	p.28
VIII	Monitoring Requirements for Cultural Competence and Linguistic Competence as specified in Title 9 CCR 1810.410	p.29

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SECTION I: Monitoring the Service Capacity of the MHP

**GOALS 1 & 2:
Cultural & Ethnic
Penetration Rates**

Penetration rates establish information on the number of individuals who receive (utilize) mental health related services relative to the general population. These rates of utilization can be compared to state, regional, and national figures. They allow a rough analysis of patterns of utilization across various key demographics. Goals for 2018 remain similar to those of 2017

1. Increase the Hispanic penetration rate from 3.19% to 4.00%
2. Improve the 0-5 Age group population penetration rate of 1.73% to goal of 2.0%

BASELINE

Based on EQRO reported data plus local report- compared to statewide small county averages. **2018:**

	NAPA				
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year
Total	33,032	1,552	\$10,623,972	4.70%	\$6,845
0-5	4,110	71	\$447,892	1.73%	\$6,308
6-17	9,026	591	\$4,327,686	6.55%	\$7,323
18-59	15,304	734	\$4,783,471	4.80%	\$6,517
60 +	4,592	156	\$1,064,922	3.40%	\$6,826
Female	17,519	713	\$4,964,786	4.07%	\$6,963
Male	15,513	839	\$5,659,185	5.41%	\$6,745
White	9,849	680	\$4,494,035	6.90%	\$6,609
Hispanic/Latino	19,012	607	\$3,221,961	3.19%	\$5,308
African-American	587	34	\$240,572	5.79%	\$7,076
Asian/Pacific Islander	1,687	28	\$189,317	1.66%	\$6,761
Native American	71	3	\$2,791	4.23%	\$930
Other	1,828	200	\$2,475,296	10.94%	\$12,376

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ACTION STEPS	<ul style="list-style-type: none"> • The MHP will continue to assertively recruit for and hire bi-lingual staff in all programs. • MHP staff will continue to deliver services in the Latino community, including schools, churches, markets, services centers and workforce housing • Utilization data for services to 0-5 children will be monitored. The expectation is that the penetration rate will return to close to recent rates once recently vacated staff positions are filled
MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY	<p>Methodology: Data is taken from state published data of individuals who are Medi-Cal eligible, who enroll in treatment within the Napa Mental Health Plan (MHP) delivery system, and have at least one service divided by the total population (Medi-Cal eligible). This data can be evaluated in a number of ways (i.e., looking at Medicaid population eligibility, comparing against SMI/SED prevalence rates, cultural and ethnic populations, etc.).</p> <p>Data Source: Prepared report from CAEQRO “Medi-Cal Approved Claims Data for Napa County MHP”. Report data is based on DMH approved claims and MMEF Data. Target is set based on Small County penetration rate data.</p> <p>Frequency of Review: Annual</p>
STAKEHOLDERS	QIC, URSC, MH Leadership, Clinical staff and Supervisors, Partner Agency staff, Consumers and their families
EVALUATION	DATA DETAIL
<p>Annual Goal Items Met: Item # Not Met: Item # Not Met: Continued.</p>	

- *DHCS Site Review Protocol Section E*
- *MHP Contract Element: Monitor and Set Goals for the Current Number, Types and Geographic Distribution of Mental Health Services within the Delivery System (Sections 22 & 24)*

I. SECTION II: Monitoring the Accessibility of Services

<p>GOAL II.A.</p> <p>Percentage of non-urgent mental health services/appointments offered within 10 business days of the initial request</p>	<p>Timely access to services is a core value of the MHP. The Department of Health Care Services (DHCS) requires counties to track how long it takes individuals requesting non-urgent mental health services to receive an offer of an initial appointment for assessment.</p> <ul style="list-style-type: none"> • Continue to monitor offers for initial appointments to meet target of 10 business days. <ul style="list-style-type: none"> • Adults • Children • All 																																																																																																		
<p>BASELINE</p>	<p>The specific indicator for time of request to offer continues to be 100% compliant. The state’s new timeliness indicators appear to finally be imminent and will be incorporated in future Work Plan goals.</p> <table border="1" data-bbox="548 982 1511 1556"> <thead> <tr> <th>MONTH</th> <th>N=</th> <th>Same Day</th> <th>1-10 Days</th> <th>11+ Days</th> <th># Met Target</th> <th>% Met Target</th> </tr> </thead> <tbody> <tr><td>Jul-17</td><td>73</td><td>73</td><td>0</td><td>0</td><td>73</td><td>100%</td></tr> <tr><td>Aug-17</td><td>100</td><td>100</td><td>0</td><td>0</td><td>100</td><td>100%</td></tr> <tr><td>Sep-17</td><td>96</td><td>96</td><td>0</td><td>0</td><td>96</td><td>100%</td></tr> <tr><td>Oct-17</td><td>61</td><td>61</td><td>0</td><td>0</td><td>61</td><td>100%</td></tr> <tr><td>Nov-17</td><td>97</td><td>97</td><td>0</td><td>0</td><td>97</td><td>100%</td></tr> <tr><td>Dec-17</td><td>85</td><td>85</td><td>0</td><td>0</td><td>85</td><td>100%</td></tr> <tr><td>Jan-18</td><td>110</td><td>110</td><td>0</td><td>0</td><td>110</td><td>100%</td></tr> <tr><td>Feb-18</td><td>94</td><td>94</td><td>0</td><td>0</td><td>94</td><td>100%</td></tr> <tr><td>Mar-18</td><td>103</td><td>103</td><td>0</td><td>0</td><td>103</td><td>100%</td></tr> <tr><td>Apr-18</td><td>112</td><td>112</td><td>0</td><td>0</td><td>112</td><td>100%</td></tr> <tr><td>May-18</td><td>93</td><td>93</td><td>0</td><td>0</td><td>93</td><td>100%</td></tr> <tr><td>Jun-18</td><td>70</td><td>70</td><td>0</td><td>0</td><td>70</td><td>100%</td></tr> <tr> <td>TOTAL</td> <td>1094</td> <td>1094</td> <td>0</td> <td>0</td> <td>1094</td> <td>100%</td> </tr> </tbody> </table> <p>The MH Quality Coordinator participates in the DHCS Metrics Workgroup which has concluded its work on defining timeliness metrics. The state hopes to utilize CSI and Claims data to track these indicators and the workgroup is currently working with DHCS to finalize the business rules for electronic implementation.</p>	MONTH	N=	Same Day	1-10 Days	11+ Days	# Met Target	% Met Target	Jul-17	73	73	0	0	73	100%	Aug-17	100	100	0	0	100	100%	Sep-17	96	96	0	0	96	100%	Oct-17	61	61	0	0	61	100%	Nov-17	97	97	0	0	97	100%	Dec-17	85	85	0	0	85	100%	Jan-18	110	110	0	0	110	100%	Feb-18	94	94	0	0	94	100%	Mar-18	103	103	0	0	103	100%	Apr-18	112	112	0	0	112	100%	May-18	93	93	0	0	93	100%	Jun-18	70	70	0	0	70	100%	TOTAL	1094	1094	0	0	1094	100%
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<p>ACTION STEPS</p>	<ol style="list-style-type: none"> 1. Monitor DHCS' adaptation and implementation of the statewide timeliness metrics and adjust methodologies accordingly. 2. Continue to track timeliness indicators on the MH Data and QM Dashboards 3. Monitor data collection and analysis for outliers.
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY OF COLLECTION</p>	<p>Methodology: The difference between the date of the request for service and the date an appointment/service was offered is calculated to determine the length of time. Date offered means the date an appointment time is offered, not the date of the appointment. Because DHCS is in the process of changing from "business days" versus "calendar days", the formula used for the calculation is =NETWORKDAYS(start date, end date)-1 where start date is the date of request and end date is the date appointment/service offered. Data will be sorted to look at the number of same day offers, the number offered within 1-10 days of the request, the number offered within 11+ days of the request, and the percentage that met the 10 business day target. For the purposes of the Mental Health Division Quality Management Performance Measure, data will be reported for all individuals; however, the Mental Health Division will also track and report to the State the data breakdowns for adults, children and by Medi-Cal beneficiary.</p> <p>Data Source: Central Access and Authorization Team (CAAT) Log</p> <p>Frequency of Review: Monthly</p>
<p>STAKEHOLDERS</p>	<p><i>ACCESS Staff and Supervisor, Psychiatric Medical Director, QIC, URSC</i></p>
<p>EVALUATION</p>	<p>DATA DETAIL</p>
<p>Annual Goal Items Met: Partially Met: Item # ____ Not Met: Item # ____ Continued: Item #</p>	

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- *MHP Contract Element: Goals are Set and Mechanisms Established to Monitor Timeliness of Routine Mental Health Appointments (Sections 22 & 24)*

SECTION II continued: Monitoring the Timeliness of Mental Health Services for Routine and Urgent Conditions

<p>GOAL II.B. The average number of days from the last initial assessment service in Mental Health Access to the first Specialty Mental Health Service (SMHS) provided</p>	<p>It is a priority of the MHP to provide timely specialty services to individuals who are assessed to meet medical necessity criteria.</p> <ol style="list-style-type: none"> 1. The MH Analyst reached the conclusion that the original data sourcing and methodology for this indicator was seriously flawed and excessively complex, leading to a lack of confidence in the accuracy of the data. As a result, efforts are underway to improve the methodology, including examining the reporting functionality of the E.H.R. The MHP has instituted a new PIP that creates new work flows, systems and data tracking methodologies to address ensuring that clients who meet medical necessity for SMHS (Specialty Mental Health Services) receive a service within 15 business days of referral. Implementation of this project is a primary goal. 2. DHCS plans to release business rules that will implement an EHR based CSI/BHIS methodology for collecting this and a number of other timeliness metrics. When that occurs, anticipated to possibly occur during calendar year 2019, the goal in this section will become one of adopting the new methodologies and ensuring timely data submission and cross-tracking accuracy.
<p>BASELINE</p>	<p>No valid baseline has yet been established.</p>
<p>ACTION STEPS</p>	<ul style="list-style-type: none"> • Implement Non-Clinical “Referrals” PIP establishing new practices and data tracking methodologies. • Once DHCS implements CSI/BHIS based reporting for this and other timeliness metrics, adapt work flows as needed and monitor. If Cerner promotes adequate utilization management functionality, develop tracking methodology for this measure. Otherwise, design and implement administrative work-arounds to accomplish the goal.
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY OF COLLECTION</p>	<p>To be developed either by the PIP or by implementation of DHCS mandated reporting methodologies.</p>
<p>STAKEHOLDERS</p>	<p>Community members seeking MH services, MH Access staff, MHP clinical staff</p>

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EVALUATION	DATA DETAIL
<p>Annual Goal Items Met: Item # ____ Partially Met: Item # ____ Not Met: Item # ____ Continued: Item # ____</p>	

- *DHCS Site Review Protocol Section: A*
- *MHP Contract Element: Goals are Set and Mechanisms Established to Monitor Timeliness of Routine Mental Health Appointments (Sections 22 & 24)*

SECTION II continued: Monitoring the Timeliness of Mental Health Services for Routine and Urgent Conditions

<p>GOAL II.C.</p> <p>All individuals requesting urgent mental health services are seen or referred for emergent care within 24 hours of the initial request.</p>	<p>Timely access to services is a core value of the MHP. The Department of Health Care Services (DHCS) requires counties to track how long it takes individuals requesting urgent mental health services to receive the requested services. Despite discussion at the state level, there remains no consensual definition of “Urgent” care. Some counties are defining urgent as a condition which, if not addressed, could result in an emergent condition. Operationally, counties and DHCS have defined urgent by level of care (e.g. a condition that requires the MHP to address same day and does not result in a crisis residential/stabilization or 5150 level of care), which aligns with Title 9’s broad service based definition. Napa has designed a system to respond immediately to urgent care requests.</p>
<p>BASELINE</p>	
<p>ACTION STEPS</p>	<ul style="list-style-type: none"> • Exodus CSS provides immediate on demand urgent care services. • MH Administrative staff will examine the feasibility of tracking officer of the day responses to urgent care requests.
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</p>	<p>Methodology: For individuals that call Mental Health Access and need urgent mental health services, we track the length of time it takes from the time their call is answered by Access staff to the time they are assisted by crisis stabilization staff.</p> <p>Data Source: Access Call Log, CSSP Call Log</p>

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	<p>Frequency of Review: Monthly The MH analyst reports very small numbers of contacts registered on the log that meet the criteria for urgent care. It may make sense to re-visit the methodology for this indicator as it appears urgent care requests may be now getting more commonly diverted to the on-call MH staff.</p>
<p>STAKEHOLDERS</p>	<p>Access Staff and Supervisor, ERT Staff and Supervisor, Clinical Director, Quality Coordinator, Staff Services Analyst</p>
<p>EVALUATION</p>	<p>DATA DETAIL</p>
<p>Annual Goal Items Met: Item # ____ Partially Met: Item # ____ Not Met: Item # ____ Continued: Item #</p>	

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<p>GOAL II.D.</p> <p>Responsiveness of the 24/7 toll-free number</p>	<p>Ensure that NCMH has after-hours Access line capability which provides information in threshold languages on how to access routine mental health services and how to use the problem resolution processes.</p>								
<p>BASELINE</p>	<p>1/18 – 10/18</p> <table border="1" data-bbox="500 596 1445 856"> <thead> <tr> <th>Total Test Calls</th> <th>Calls Handled Accurately</th> <th>Successfully recorded on Access Log</th> <th>Call in Spanish, Korean or Cantonese/translated successfully</th> </tr> </thead> <tbody> <tr> <td align="center">8</td> <td align="center">6 (3 business hrs)</td> <td align="center">3 (B)</td> <td align="center">1/1</td> </tr> </tbody> </table> <p>Exodus continues to fail nearly all after hours test calls. The greatest challenge is getting call information to the Access secretaries to be entered on the log. More test calls by our grad students need to be made to ensure accuracy of results. Calls made during business hours are answered accurately and recorded by Access secretaries.</p>	Total Test Calls	Calls Handled Accurately	Successfully recorded on Access Log	Call in Spanish, Korean or Cantonese/translated successfully	8	6 (3 business hrs)	3 (B)	1/1
Total Test Calls	Calls Handled Accurately	Successfully recorded on Access Log	Call in Spanish, Korean or Cantonese/translated successfully						
8	6 (3 business hrs)	3 (B)	1/1						
<p>ACTION STEPS</p>	<ul style="list-style-type: none"> • Continue conducting at least 2 test calls a month • Record and report results of test calls • Meet with Exodus Supervisor as needed to improve performance • Report Test Call results to QIC annually • Report Test Call results to DHCS quarterly 								
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</p>	<p>Data entered on DHCS Reporting Spreadsheet quarterly. Collected from filled out call report sheets by test callers. Quarterly</p>								
<p>STAKEHOLDERS</p>	<p>Exodus Staff and Supervisor, Access Staff and Supervisor, Quality Coordinator, QIC</p>								
<p>EVALUATION</p>	<p>DATA DETAIL</p>								
<p>Annual Goal Items Met: Item # ____ Partially Met:</p>									

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Apr	399	52	13 %	116	16	14 %	515	68	13 %
TOTAL	3506	583	17 %	1024	150	15 %	4530	733	16 %

INDIVIDUAL THERAPY SERVICES FY 2017-2018

	Adult (1015)			Children (5015)			TOTAL		
	Total Appts	No Show	%	Total Appts	No Show	%	Total Appts	No Show	%
July	42	10	24 %	0	0	#DIV/0!	42	10	24 %
Aug	48	8	17 %	0	0	#DIV/0!	48	8	17 %
Sept	27	5	19 %	0	0	#DIV/0!	27	5	19 %
Oct	24	5	21 %	0	0	#DIV/0!	24	5	21 %
Nov	27	5	19 %	0	0	#DIV/0!	27	5	19 %
Dec	32	9	28 %	1	1	100%	33	10	30 %
Jan	29	3	10 %	0	0	#DIV/0!	29	3	10 %
Feb	26	3	12 %	0	0	#DIV/0!	26	3	12 %
Mar	21	3	14 %	0	0	#DIV/0!	21	3	14 %
Apr	36	6	17 %	0	0	#DIV/0!	36	6	17 %
TOTAL	312	57	18 %	1	1	100%	313	58	19 %

ACTION STEPS

1. Continue to monitor monthly on the MH Dashboard in URSC: % of individuals (children and adults) scheduled for Medication clinic intake evaluations who show up for their appointments
2. Continue to monitor monthly on the MH Dashboard in URSC: % of all scheduled Adult medication appointments kept
3. Appointment reminder calls will continue.

The MHP has determined that the sharp decrease in the Adult Medication Clinic appointment show rate between FY 14-15 and FY 15-16 may be a direct result of the discontinuance of appointment reminder calls. This change was made due to staffing issues within the clinic. The Adult Medication clinic reinstated reminder calls in December 2016.

MONITORING METHODOLOGY/ DATA

Data collected from Anasazi Scheduler report: individuals who kept appointments/individuals scheduled for appointments Quarterly report.

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SOURCE/ FREQUENCY	
STAKEHOLDERS	Psychiatric Medical Director and Psychiatric Staff, Staff Services Analyst
EVALUATION	DATA DETAIL
Annual Goal Items Met: Item # ____ Partially Met: Item # Not Met: Item # Continued: Item #	

- *DHCS Site Review Protocol Section: A*
- *MHP Contract Element: Goals are Set and Mechanisms Established to Monitor Responsiveness of the 24/7 Toll Free Number (Sections 22 & 24)*

SECTION III: Monitoring Beneficiary and Client Satisfaction

GOAL III.A. Beneficiary and family satisfaction surveys of the NCMHP continue to be conducted bi-annually using the Performance Outcome Quality Improvement (POQI)	Continued from last year: <ol style="list-style-type: none"> 1. Beneficiary Satisfaction Survey target: 85 % of survey questions are ranked satisfied to very satisfied. 2. Continue re-formatting and focused analysis of survey results and produce more recommendations for improvements. 3. With more public-friendly presentations of data, routinely share results with all stakeholders. 4. Refine administration protocols to ensure higher quality data input. 5. Use social connectedness domain item results as an outcome measure for Social Engagement Clinical PIP.
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<p>BASELINE</p>	<p>Re. goal #1: current aggregate adult score average over the past 7 administrations of the survey = 84%. Areas of concern in addition to perception of social connectedness, include perception of the outcome of services and perception of functioning.</p> <p>Re. goal #2: Some analysis and discussion of results occurs at the MHP administrative level, but more in-depth analysis and discussion with stakeholders remains a goal.</p> <p>Re. goal #3: Some of the results, formatted as above, were shared at an all staff Division meeting with discussion. The social connectedness data has been routinely analyzed and discussed at meetings of the Social Engagement PIP team. It remains a goal to produce a more thorough report to publish and distribute to stakeholders. The persistent problem of the delays in providing survey results to the county by DHCS and CIBHS remains unresolved.</p> <p>Re. goal #4: The MH Office Assistant responsible for distribution of the surveys made significant upgrades to the distribution process, such as pre-filling program codes to ensure greater accuracy of determination of the source of the completed surveys. More detailed and specific administration instructions were provided to staff and providers. The success of these steps will be evaluated when we receive the results.</p> <p>Re. goal #5, the graph below represents adult results only and shows the most recent results for the social connectedness domain, dated before the commencement of the PIP. More recent results have not yet been made available by DHCS and CIBHS.</p> <table border="1"> <caption>Consumer Perception Survey Satisfaction Rates by Domain</caption> <thead> <tr> <th>Domain</th> <th>Spring 2014 (n=92)</th> <th>Fall 2014 (n=102)</th> <th>Spring 2015 (n=115)</th> <th>Fall 2015 (n=92)</th> <th>Spring 2016 (n=102)</th> <th>Fall 2016 (n=143)</th> <th>Spring 2017 (n=97)</th> <th>Avg.</th> </tr> </thead> <tbody> <tr> <td>General Satisfaction</td> <td>95</td> <td>95</td> <td>88</td> <td>95</td> <td>92</td> <td>86</td> <td>91</td> <td>92%</td> </tr> <tr> <td>Perception of Access</td> <td>90</td> <td>94</td> <td>88</td> <td>93</td> <td>95</td> <td>85</td> <td>90</td> <td>91%</td> </tr> <tr> <td>Perception of Quality & Appropriateness</td> <td>92</td> <td>86</td> <td>83</td> <td>90</td> <td>86</td> <td>88</td> <td>87</td> <td>87%</td> </tr> <tr> <td>Perception of Participation in Treatment Planning</td> <td>85</td> <td>94</td> <td>83</td> <td>91</td> <td>90</td> <td>92</td> <td>91</td> <td>89%</td> </tr> <tr> <td>Perception of Outcomes of Services</td> <td>81</td> <td>81</td> <td>77</td> <td>78</td> <td>74</td> <td>68</td> <td>77</td> <td>77%</td> </tr> <tr> <td>Perception of Social Connectedness</td> <td>78</td> <td>77</td> <td>78</td> <td>72</td> <td>77</td> <td>79</td> <td>70</td> <td>76%</td> </tr> <tr> <td>Perception of Functioning</td> <td>85</td> <td>82</td> <td>79</td> <td>71</td> <td>73</td> <td>74</td> <td>67</td> <td>76%</td> </tr> </tbody> </table>	Domain	Spring 2014 (n=92)	Fall 2014 (n=102)	Spring 2015 (n=115)	Fall 2015 (n=92)	Spring 2016 (n=102)	Fall 2016 (n=143)	Spring 2017 (n=97)	Avg.	General Satisfaction	95	95	88	95	92	86	91	92%	Perception of Access	90	94	88	93	95	85	90	91%	Perception of Quality & Appropriateness	92	86	83	90	86	88	87	87%	Perception of Participation in Treatment Planning	85	94	83	91	90	92	91	89%	Perception of Outcomes of Services	81	81	77	78	74	68	77	77%	Perception of Social Connectedness	78	77	78	72	77	79	70	76%	Perception of Functioning	85	82	79	71	73	74	67	76%
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<p>ACTION STEPS</p>	<p>Continue working on implementing goals 1-5. If possible, consider implementing a briefer, county designed satisfaction survey.</p>																																																																								
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</p>	<p>Bi-annual analysis of CPS data as collected by CIBHS, utilizing the EBHS data analysis system.</p>																																																																								
<p>STAKEHOLDERS</p>	<p>QIC, Quality Coordinator, Staff Services Analyst, Social Engagement PIP Team, Stakeholders</p>																																																																								
<p>EVALUATION</p>	<p>DATA DETAIL</p>																																																																								

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Annual Goal Items Met: Item # _Partially Met: Item # Not Met: Item # Continued: Item #	
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- *DHCS Site Review Protocol Section: I*
- *MHP Contract Element: The Contractor shall implement **mechanisms** to assess beneficiary/family satisfaction by: surveying beneficiary/family satisfaction annually; evaluating beneficiary grievances, appeals and fair hearings at least annually, evaluating requests to change persons providing services at least annually (Sections 22 & 23)*

SECTION III continued: Monitoring Beneficiary and Client Satisfaction

GOAL III.B. Monitor Grievances, Appeals, Requests for Change of Providers and Fair Hearings resolutions	Beneficiary grievance, appeals, requests for change of providers and fair hearings are tracked by the HHS Quality Management team and the Mental Health Quality Coordinator. A summary report is reviewed by the QIC annually, given to the Mental Health Program Manager and Mental Health Director, and reported annually to DHCS.
BASELINE	100% of Appeals, Grievances and 95% of Requests for Change of Providers are successfully resolved within mandated timeframes.
ACTION STEPS	Continue tracking and reports.
MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY	Grievances, Appeals and Requests For Change of Providers are tracked over the course of the year on spread sheets with original copies and correspondence kept in secure files. An annual summary report, now based on a mandated reporting form from DHCS is compiled and presented to QIC.

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STAKEHOLDERS	QIC, QM, Quality Coordinator, MH Director
EVALUATION	DATA DETAIL
Annual Goal Items Met: Item # Partially Met: Item # ____ Not Met: Item # ____ Continued: Item # _	

- *DHCS Site Review Protocol Section: I*
- *MHP Contract Element: The Contractor shall implement **mechanisms** to assess beneficiary/family satisfaction by: surveying beneficiary/family satisfaction annually; evaluating beneficiary grievances, appeals and fair hearings at least annually, evaluating requests to change persons providing services at least annually (Sections 22 & 23)*

SECTION IV: Monitoring Mental Health Plans' Service Delivery System and Clinical Issues Affecting Beneficiaries

GOAL In Coordination with Exodus Crisis Stabilization and Services Unit, develop Quantitative and Qualitative data indicators	Develop, Track and analyze 2 new measures: The Utilization Review Steering Committee will create 2 new measures to track utilization of CSSP services and develop baselines for future analysis of performance.
BASELINE	TBD
ACTION STEPS	<ul style="list-style-type: none"> • As data becomes available, analyze and make appropriate recommendations. • Coordinate Quality Assurance and Improvement efforts with Exodus staff.

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MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY	Cerner Anasazi reports. Data logs.
STAKEHOLDERS	MHP Administrative staff, Exodus staff, QIC
EVALUATION	DATA DETAIL
Annual Goal Items Met: Item # Partially Met: Item # ____ Not Met: Item # ____ Continued: Item #	

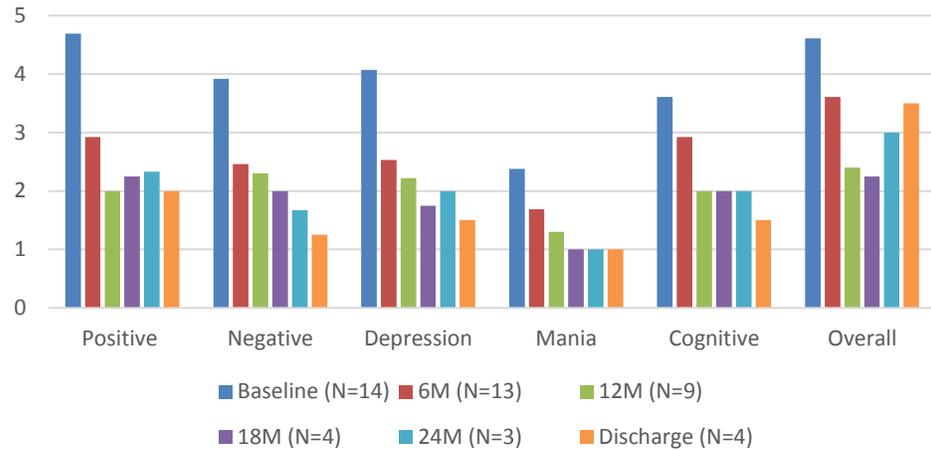
- *DHCS Site Review Protocol Section: F*
- *MHP Contract Element: implement mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.(Section 22)*

SECTION IV: Monitoring Mental Health Plans' Service Delivery System and Clinical Issues Affecting Beneficiaries

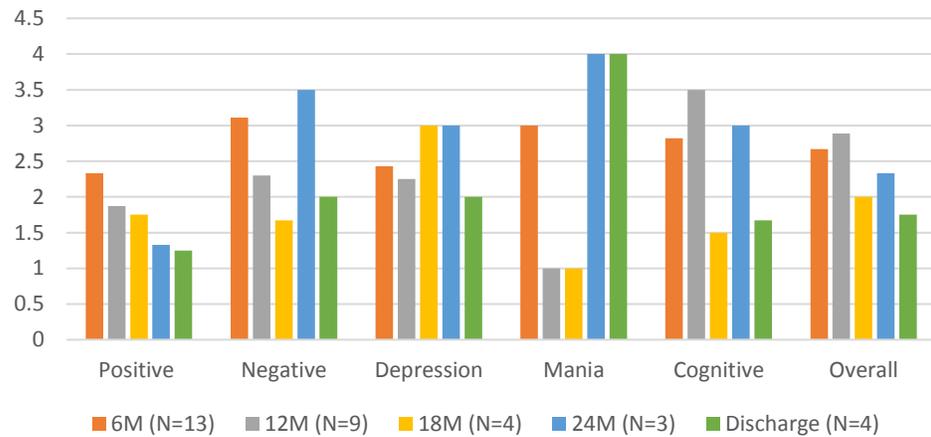
GOAL Provide Effective Early Interventions to Young Adults with Onset of Psychotic Symptoms	<p>Through Supportive Outreach & Access to Resources (SOAR), Aldea provides services to people who are experiencing the symptoms of early psychosis to reduce and manage their symptoms so they may succeed in education, careers and relationships.</p> <p>Based on the model developed by Cameron Carter, MD of the UC Davis Early Diagnosis and Preventative Treatment (EDAPT) Clinic, SOAR.</p> <p>Utilizing the Clinical Global Impression (CGI), the program will track the severity of illness in the past week and degree of change (improvement/worsening) compared to status at baseline (prior to starting treatment program)</p>
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BASELINE

CGI Ratings: Average Severity of Illness



CGI Ratings: Average Degree of Change



- 15 clients received SOAR services in Q1 & Q2 (2018-2019)
 - 10 clients were under the age of 18
 - 5 clients were over 18
- 3 clients successfully graduated this program during this period
- 2 clients are near completion
- 1 client was referred to substance abuse treatment
- 1 client was assessed and did not meet criteria for the program
- Total number of clients hospitalized during this period: 0
- Of the 4 clients discharged in Q1 & Q2, 100% experienced improvement in overall symptoms and functioning

Program Updates:

- Current SOAR Staff: 1 Nurse Practitioner and 1 full-time Therapist (I am currently providing supervision)

Napa County Mental Health Quality Improvement Work Plan 2019

	<ul style="list-style-type: none"> ○ We will be sending 3 Therapists (2 Bi-lingual, 1 English) to UC Davis (SOAR model) training next month (to replenish staff and return to previous program structure and capacity) ○ We've hired a Behavioral Specialist (currently in training) that will serve as a part-time Family Advocate/Education & Employment support for the program ○ We hope to begin offering Groups and providing community outreach this Spring
ACTION STEPS	Analyze data and consult with program to ensure continuing positive outcomes.
MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY	In the first two years of the program, efforts have been made toward refining data collection to provide more comprehensive and relevant outcomes to report. In collaboration with UC Davis, Aldea is in the process of analyzing/collating the data from the CGI and further details regarding outcomes such as hospitalization/ER utilization, justice involvement, housing status/homelessness, family involvement, and treatment involvement which we look forward to presenting next year.
STAKEHOLDERS	QIC, Aldea providers and clients, MHP Administrative staff.
EVALUATION	DATA DETAIL
<p>Annual Goal Items Met: Item # Partially Met: Item # ___ Not Met: Item # ___ Continued: Item #</p>	

- *DHCS Site Review Protocol Section: I*
-

Napa County Mental Health Quality Improvement Work Plan 2019

SECTION IV: Monitoring Mental Health Plans' Service Delivery System and Clinical Issues Affecting Beneficiaries

<p>GOAL Review clinical records</p>	<p>Continue to internally audit chart documentation. Track recently implemented holistic chart review. 1. 95% compliance/5% error rate each month.</p>									
<p>BASELINE</p>	<p><i>Month of Review</i></p>	<p><i>Months Review</i></p>	<p><i>Total # of Potentially Billable Claims</i></p>	<p><i>Total Claims Written Off/BCFd</i></p>	<p><i># Written Off to Note</i></p>	<p><i># Written Off to Plan</i></p>	<p><i># Written Off to Dx</i></p>	<p><i># BCFd</i></p>	<p><i>% in Compliance</i></p>	<p><i>Target</i></p>
<p>Jan-18</p>	<p>Nov 17-Dec 17</p>	<p>102</p>	<p>13</p>	<p>2</p>	<p>11</p>	<p>0</p>	<p>0</p>	<p>87%</p>	<p>95%</p>	
<p>Feb-18</p>	<p>Dec 17-Jan 18</p>	<p>91</p>	<p>4</p>	<p>4</p>	<p>0</p>	<p>0</p>	<p>0</p>	<p>96%</p>	<p>95%</p>	
<p>Mar-18</p>	<p>Jan-Feb 18</p>	<p>78</p>	<p>8</p>	<p>0</p>	<p>0</p>	<p>0</p>	<p>8</p>	<p>90%</p>	<p>95%</p>	
<p>Apr-18</p>	<p>Feb-Mar 18</p>	<p>250</p>	<p>20</p>	<p>16</p>	<p>2</p>	<p>0</p>	<p>2</p>	<p>92%</p>	<p>95%</p>	
<p>May-18</p>	<p>Mar-Apr 18</p>	<p>216</p>	<p>27</p>	<p>14</p>	<p>12</p>	<p>0</p>	<p>1</p>	<p>88%</p>	<p>95%</p>	
<p>Jun-18</p>	<p>Mar thru May 18 (3)</p>	<p>154</p>	<p>11</p>	<p>6</p>	<p>0</p>	<p>4</p>	<p>1</p>	<p>93%</p>	<p>95%</p>	
<p>Jul-18</p>	<p>May-June 18</p>	<p>140</p>	<p>1</p>	<p>0</p>	<p>1</p>	<p>0</p>	<p>0</p>	<p>99%</p>	<p>95%</p>	
<p>Aug-18</p>	<p>June-July 18</p>	<p>90</p>	<p>1</p>	<p>1</p>	<p>0</p>	<p>0</p>	<p>0</p>	<p>99%</p>	<p>95%</p>	
<p>Sep-18</p>	<p>July-Aug 18</p>	<p>113</p>	<p>2</p>	<p>2</p>	<p>0</p>	<p>0</p>	<p>0</p>	<p>98%</p>	<p>95%</p>	
<p>Oct-18</p>	<p>Aug-Sept 18</p>	<p>79</p>	<p>1</p>	<p>1</p>	<p>0</p>	<p>0</p>	<p>0</p>	<p>99%</p>	<p>95%</p>	

SECTION V: Monitoring Continuity and Coordination of Care with Physical Health Care Providers and other Human Services Agencies

<p>GOAL V.A. Improved Coordination of mental health and physical health care is a primary focus of NCMHP</p>	<ul style="list-style-type: none"> • Ole Health, NCMH and NCADS will continue to conduct MDT's as needed. • Explore coordinated care with Ole Health for shared clients with eating disorders • Update MOU with Partnership Healthcare
<p>BASELINE</p>	
<p>ACTION STEPS</p>	<ul style="list-style-type: none"> • Convene MDT's as needed • Based on negotiated changes to our MOU with Partnership, implement updated coordinated care activities. • Implement strategies with Ole Health to address clinical needs of shared clients diagnosed with eating disorders.
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</p>	<p>Reports from MH managers and staff.</p>
<p>STAKEHOLDERS</p>	<p>MH Access Supervisor and Staff, MH and ADS Leadership and designated staff, Quality Coordinator, QIC , Ole Health and Partnership Health Care staff</p>
<p>EVALUATION</p>	<p>DATA DETAIL</p>
<p>Annual Goal Items Met: Item # _ Partially Met: Item # ___ Not Met: Item # Continued: Item # _</p>	

- *DHCS Site Review Protocol Section: F*
- *MHP Contract Element: implement mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.(Section 22)*

SECTION VI: Monitoring Provider Satisfaction

<p>GOAL VI. A. 1) Monitor Provider appeal resolution 2) Process and track MHSA Problem Resolution Requests</p>	<ul style="list-style-type: none"> • Successfully resolve 95% of provider appeals. • Resolve 100% of MHSA Problem Resolution Requests.
<p>BASELINE</p>	<p>100% of each item resolved (N = 0)</p>
<p>ACTION STEPS</p>	<p>Continue to monitor as needed.</p>
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</p>	<p>Appeal and MHSA Problem Resolution Logs reviewed annually by QIC</p>
<p>STAKEHOLDERS</p>	<p>Provider Services Coordinator, Quality Coordinator, MHSA Program Manager, QIC</p>
<p>EVALUATION</p>	<p>DATA DETAIL</p>
<p>Annual Goal Items Met: Item # Partially Met: Item # ____ Not Met: Item # ____ Continued: Item #</p>	

- *DHCS Site Review Protocol Section: G*
- *MHP Contract Element: The QI Program shall include active participation by the contractor's practitioners and providers as well as consumers and family members in the planning design and execution of the QI program, as described in Title 9 CCR Section 1810.440 a.2.A-C (Section 23E)*

SECTION VII: Strengthen the MHP’s Quality Improvement Program Infrastructure

<p>GOAL VI. B. Refine and Improve QI Activities</p>	<ul style="list-style-type: none"> • Continue to monitor, review and refine all data metrics on MH Dashboard for rationale, targets, where applicable, methodologies, and frequency • Maintain 1 Clinical and 1 Non-clinical PIP • • Revise practices, policies and procedures as required by the Medicaid Managed Care Mega Rule and DHCS Information Notices •
<p>BASELINE</p>	
<p>ACTION STEPS</p>	<p>Implement goals listed above</p>
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</p>	<p>QIC Minutes, PIP documents; MH Data Dashboard and Master List; QM Dashboard of RBA indicators</p>
<p>STAKEHOLDERS</p>	<p>QIC, MH Leadership, Quality Coordinator, PIP Committees</p>
<p>EVALUATION</p>	<p>DATA DETAIL</p>
<p>Annual Goal Items Met: Item # Partially Met: Item # Not Met: Item # Continued:Item #</p>	

- *DHCS Site Review Protocol Section: I*
- *MHP Contract Element: The QI Program shall be accountable to the Contractor’s Director as described in Title 9 CCR, Section 1810.440(a)(1). (Section 23C) Operation of the QI Program shall include substantial involvement by a licensed mental health staff person, as described in Title 9 CCR, Section 1810.440(a)(4). (Section 23 D)*

SECTION VIII: Monitoring Requirements for Cultural Competence and Linguistic Competence as specified in Title 9 CCR 1810.410

<p>GOAL Develop Strategies to Improve Access to services for underserved ethnic and cultural groups</p>	<ul style="list-style-type: none"> • Revise and Update MHP Cultural Competence Plan • Develop Cultural Competence Training Plans for MHP providers • Analyze barriers to service for specified underserved ethnic and cultural groups • Develop improvement project(s) to increase capacity, efficiency and quality of culturally and linguistically appropriate services
<p>BASELINE</p>	<p>2011 Cultural Competence Plan</p>
<p>ACTION STEPS</p>	<p>As above</p>
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</p>	<p>MH Dashboard EQRO Annual Data TBD</p>
<p>RESPONSIBLE PARTNERS</p>	<p>MHP Ethnic Services Manager, Quality Coordinator, MH Leadership, QIC, Community Stakeholders, Supervisors, Staff, Provider Directors and staff</p>
<p>EVALUATION</p>	<p>DATA DETAIL</p>
<p>Annual Goal Items Met: Item # 1, 3 Partially Met: Item # 2, 4 Not Met: Item # ____ Continued: Item #</p>	<ul style="list-style-type: none"> • Revise and Update MHP Cultural Competence Plan – A completely new and updated Cultural Competence Plan was completed and published. • Develop Cultural Competence Training Plans for MHP providers – Progress has been made on implementing new trainings, such as a series on Native American culture and new implicit bias trainings. More refinement is needed. • Analyze barriers to service for specified underserved ethnic and cultural groups- This is an ongoing high priority and has been the subject of a number of initiatives having culturally appropriate staff provide access and services in the community. • Develop improvement project(s) to increase capacity, efficiency and quality of culturally and linguistically

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	appropriate services. – Many initiatives have been undertaken, though not as formal PIPs.
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- *DHCS Site Review Protocol Section: A*
- *MHP Contract Element: Evidence of compliance with the requirements for cultural competence and linguistic competence specified Title 9, CCR, Section 1810.410. Section 22 J5)*