A Tradition of Stewardship
A Commitment to Service

2020-2021

Napa County
Health & Human Services Agency
Mental Health Division

QUALITY IMPROVEMENT WORK PLAN

Napa County Mental Health Plan
Quality Coordination
Napa, CA 94558
www.countyofnapa.org

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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.

OVERVIEW

Napa County Mental Health recognizes that the core activities of quality improvement lie within the everyday work of every employee in our organization. Quality improvement is not a standalone process, but instead requires the ongoing commitment of all staff, a collective spirit of embracing change and growth, and proactive alignment of our programs and systems. The most meaningful and sustainable improvements come when our staff at every level feel a shared desire to make processes better every day, boldly and continuously.

The Napa County Mental Health Quality Improvement (QI) Work Plan is designed to drive our culture of continuous quality improvement and progress our efforts to deliver the most person-centered specialty mental health services to the right people, in the right amount, at the right time. The QI Work Plan is a key element of our Quality Management (QM) Program. Through our QM program, we work to ensure that the services we provide are timely, efficient, equitable and culturally competent, person-centered, and effective for all beneficiaries, payers and stakeholders.

Our QM Program operates in accordance with the California Department of Health Care Services (DHCS) requirements in Title 9, Section 1810.440. The Napa County Mental Health Plan (NCMHP) established its Quality Management and Coordination unit and developed this 2020-2021 QI Work Plan to meet these requirements.

Contracts between the NCMHP and affiliated providers require: 1) cooperation with, and participation in, the MHP's QM Program, 2) regular reporting of efficiency, utilization, quality and outcomes data, and 3) MHP access to relevant clinical records to the extent permitted by State and Federal Laws.

QUALITY IMPROVEMENT PHILOSOPHY AND GOALS

The Napa County Mental Health Plan is committed to a quality improvement program to drive and achieve measurable improvements in the mental health and well-being of our beneficiaries. The NCMHP strives to be a high-performing organization that systematically evaluates and improves the quality of our programs, processes and services to achieve a high level of efficiency, effectiveness, and customer satisfaction. NCMHP's QI program operates under a commitment to the following goals:

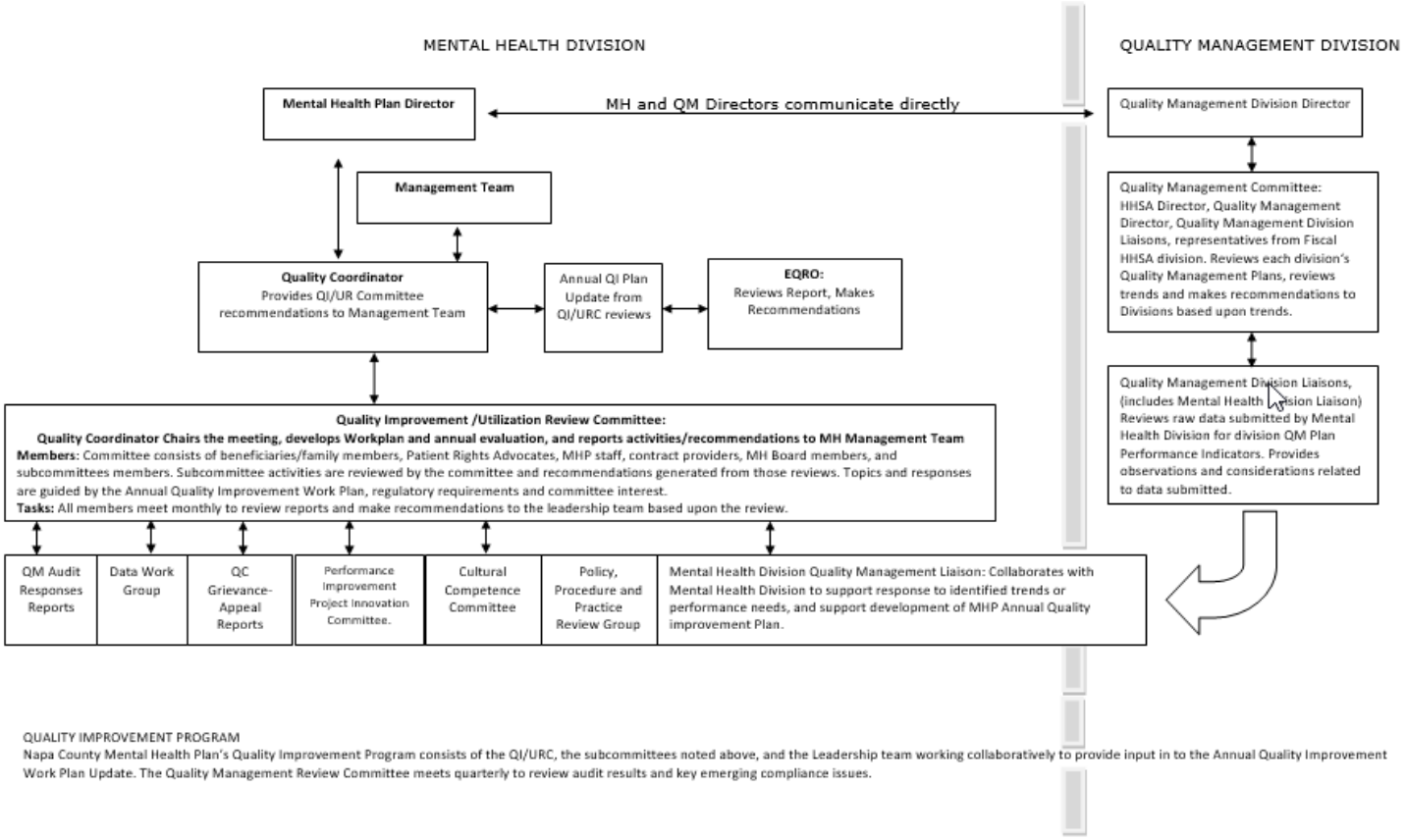
- Preserve the dignity and rights of our beneficiaries and optimize their service experience;
- Deliver timely, effective, efficient, person-centered services that are culturally and linguistically appropriate;
- Engage beneficiaries, families, contract providers and stakeholders in the planning and execution of quality improvement activities;
- Efficiently and effectively use available mental health resources and support decision-making based on performance data;
- Ensure that services meet State and Federal standards;
- Foster a culture of continuous quality improvement throughout the system of care;
- Monitor quality assurance and improvement activities throughout the NCMHP, including but not limited to:
    - monitoring access to care,
    - monitoring timeliness of services,
    - beneficiary and system outcome measurement,
    - cultural competency and equity initiatives,
    - utilization review,
    - monitoring and resolution of beneficiary grievances, fair hearings and provider appeals,
    - assessment of beneficiary and provider satisfaction,
    - network adequacy monitoring,
    - clinical records reviews,
    - development and implementation of performance improvement projects.
- Communicate quality performance activities and findings to beneficiaries, staff, contract providers and stakeholders.

QUALITY MANAGEMENT PROGRAM STRUCTURE

Program Structure Overview

The NCMHP Quality Management Program is accountable to the Mental Health Director and is directly overseen by the Assistant Mental Health Director-Administration. The QM Program is executed by the Mental Health Quality Coordinator and Utilization Review Coordinator. The Quality Coordinator is tasked with oversight and execution of key assurance and improvement activities driving service quality and efficacy, and chairs the Quality Improvement/Utilization Review Committee. The Utilization Review Coordinator is tasked with oversight and monitoring of service utilization and authorization, documentation compliance and documentation quality and accuracy. Beneficiaries, family members and stakeholders are actively encouraged to participate in quality and utilization committee meetings and actively participate in deliberations of the Mental Health Board, outreach activities of the NCMHP, the Cultural Competence Committee and in Mental Health Division stakeholder advisory groups. The Napa County Health and Human Services Agency's (HHSA) Quality Management Division supports the program by providing consultation and additional auditing/review support.

The following diagram illustrates the relationships among the key constituents of the Napa County Quality Management Program.



Quality Improvement/Utilization Review Committee (QI/URC)

The Quality Improvement/Utilization Review Committee (QI/URC) is responsible for the overall quality and utilization review of Short-Doyle/Medi-Cal and MHP services provided in Napa County. The Committee meets on a monthly basis to monitor and evaluate the quality, appropriateness and utilization of services to beneficiaries, pursue opportunities to improve services, and address systemic and/or operational issues affecting service value. The QI/URC reviews and analyzes the QI Work Plan performance data and as a result, may recommend policy positions to managers and other decision- makers and/or initiate action.

Dated and signed minutes reflect all QI/URC decisions and actions. On an annual basis, the QI/URC issues a final evaluation of the QI Work Plan and establishes the goals and objectives for the coming year.

QI/URC membership includes:

- the Quality Improvement Coordinator – Chair,
- the Utilization Review Coordinator – Co-Chair,
- beneficiaries of the MHP and/or their family members,
- a Mental Health Patient's Rights Advocate,

- a Mental Health Board representative,
- a Mental Health Supervisor,
- Mental Health clinical line staff,
- a Staff Services Analyst(s) (SSA),
- a representative from the Quality Management Division,
- a Mental Health Division manager,
- one or more representatives from MHP contracted organizational providers and/or community service providers,
- MHP administrative secretary,
- Members as designated by the MH Director.

The MHP Director or designee, the Quality Coordinator, appoints Committee members to two-year terms, which may be renewed upon completion of the term.

Subcommittees/Work Groups of the QI/URC:

- **Behavioral Health Cultural Competence Committee**

  Quality improvement activities related to improving the MHP's cultural competence are the primary responsibility of the Cultural Competence Committee (CCC), a sub- committee of the QI/URC. Members of the QI/URC sit on the CCC and provide periodic reports to the QI/URC of the CCC's activities. The Ethnic Services Manager chairs the CCC.

  The mission of the Cultural Competence Committee is to assure that the MHP implements and provides culturally and linguistically competent services to meet the diverse needs of Napa County residents and eliminate health disparities.

  CCC members collaborate to develop the MHP's Cultural Competence Plan, evaluate policies and procedures related to diversity, equity and inclusion, and provide culturally competent, sustainable, feasible recommendations and solutions to QI/URC.

Cultural Competence Committee membership includes:

- NCMH Staff and Contractors
- Mental Health Providers
- MH Board Members
- Community Members
- Napa County Alcohol and Drug Services Staff
- Mental Health Stakeholders including consumers, family members, caregivers, etc.

- **Performance Improvement Project (PIP) Committee**

  The PIP Innovation Committee supports the development and implementation of the NCMHP performance improvement projects. The committee serves as an "incubator" for idea generation and identifying improvement opportunities. Activities of the PIP Innovation Committee include brainstorming, idea sharing, making recommendations, driving Plan-Do-

Study-Act (PDSA, Deming) cycles, and troubleshooting PIP implementation issues. The Quality Coordinator chairs the PIP Committee.

PIP Committee membership includes NCMHP staff, one or more organizational contract providers, and one or more stakeholders and/or beneficiaries or family members.

- **Data Development Work Group**
  This work group meets monthly and is comprised of the Quality Coordinator, Utilization Review Coordinator, the NCMHP's three Staff Services Analysts and a representative from the HHSA Quality Management Division. The Data Development Work Group develops performance indicator quarterly reports for the QI/URC and continuously assesses the data needs of the MHP.

- **Policy, Procedure and Practice Review Group**
  The Policy, Procedure and Practice (PPP) Review Group reviews policies and procedures as they become due for renewal or update, new or established practices, contracts, proposals and/or manuals, and any other operational document to ensure for accuracy, integration of the most current regulation and evidence based practice, and integrity of cultural competence and equity. The PPP Review Group meets monthly, or as needed for a time-sensitive review, and is led by the Quality Coordinator and the senior Staff Services Analyst. Review group participation includes staff and stakeholders who have expertise and/or an interest in particular operations. Policies and procedures that are new or with significant changes are presented to the QI/URC for review and feedback.

QI WORK PLAN STRUCTURE

The QI Work Plan establishes the core performance indicators, goals and objectives upon which we measure success. These performance indicators, goals and objectives are determined through the Federal and State laws and regulations governing our operations and through ongoing quality improvement efforts that include these steps:

1. Collecting and analyzing performance data and comparing to benchmark and baseline data,
2. Identifying opportunities for improvement and deciding which opportunities to pursue and which performance indicators to apply,
3. Designing and implementing interventions to improve performance,
4. Measuring the effectiveness of the interventions,
5. Reporting on the effectiveness of the interventions,
6. Building upon what we learn in order to drive continuous performance and quality improvement.

The Napa County MHP FY 20-21 core performance indicators are organized under six primary performance components:

ACCESS TO CARE	Performance Indicators • Responsiveness of the 24/7 toll free Access line • Ethnic engagement rates • 0-5 age group engagement rates
TIMELINESS OF CARE	Performance Indicators • Timeliness of first offered appointments for non-urgent services • Timeliness of first offered psychiatry appointments • Timeliness of appointments for urgent services • Timeliness of first contact following discharge from a psychiatric facility
QUALITY OF CARE	Performance Indicators • Results of the Consumer Perception Survey • Results of the Crisis Stabilization Unit Episode Survey • Grievances and appeals resolutions • Medication Management
EFFECTIVENESS OF CARE/ OUTCOMES	Performance Indicators • Results of the Milestones of Recovery Scale (MORS) for Adults • Results of the Child and Adolescent Needs and Strengths (CANS) for children ages 6-21 • Results of Clinical Global Impression (CGI) Scale from Aldea (contract provider) SOAR program for young adults demonstrating early symptoms of psychosis

RACIAL AND CULTURAL EQUITY	Performance Indicators • Administration of the DSM 5 Cultural Formulation Interview (CFI) • Diversity, Equity and Inclusion (DEI) training completions • Application of the Race and Cultural Equity Policy, Procedures and Practices Review Tool
UTILIZATION MANAGEMENT	Performance Indicators • Documentation standards compliance • No show rates for Medication Clinics • Psychiatric inpatient admissions and re-admissions • Adult service drop-out rate

PERFORMANCE IMPROVEMENT PROJECTS

In addition to the 21 performance indicators monitored and measured, the MHP executes two active performance improvement projects (PIPs).

CLINICAL PIP - Promoting Outpatient Mental Health Services Engagement and Treatment Completion for Hispanic/Latinx Adults

The Quality Coordinator oversees the clinical PIP. The PIP aim is to improve outpatient service engagement and completion rates for Hispanic/Latinx adults, while decreasing the dropout rate.

The intervention is the implementation of the DSM-5 Cultural Formulation Interview (CFI) core questionnaire into the comprehensive intake/assessment and reassessment processes.

The performance measures are:

1. % of Hispanic/Latinx adult outpatient cases closed as a result of completing treatment.
2. % of Hispanic/Latinx adult outpatient cases closed as a result of dropping out of treatment.
3. Average # of outpatient services received by Hispanic/Latinx adults before dropping out of treatment.
4. % of adult outpatient cases closed as a result of completing treatment.
5. % of adult outpatient cases closed as a result of dropping out of treatment.
6. Average # of outpatient services received by adults before dropping out of treatment.

An increase in % of Hispanic/Latinx adults whose cases are closed as a result of completing treatment, a decrease in % of Hispanic/Latinx adults whose cases are closed as a result of dropping out of treatment, and an increase in average number of services received by Hispanic/Latinx adults will serve as evidence that administration of the DSM-5 Cultural Formulation Interview supports outpatient treatment engagement, adherence and completion among this population.

This PIP is expected to conclude in November 2022.

NON-CLINICAL PIP - Promoting Reduction of Average Length of Time from First Request for Adult Psychiatry to First Scheduled Psychiatry Appointment

The Utilization Review Coordinator oversees the non-clinical PIP. The PIP aim is to reduce average length of time from first request for adult psychiatry to first scheduled psychiatry appointment.

The improvement strategy is the implementation of new timeliness standards for assessment completion and for processing psychiatry referrals. Our intention is to provide first adult psychiatry appointments more timely and efficiently.

The performance measure is the number of first scheduled psychiatry appointments meeting the 15 business day standard.

This PIP is also expected to conclude in November 2022.

EVALUATION OF THE QI WORK PLAN

Performance indicator data is collected quarterly and presented to the QI/UR Committee and to other operational committees, staff and stakeholders.

Annually, the QI Work Plan goals, objectives and performance indicators are evaluated in aggregate, approximately one month prior to the development of the next year's QI Work Plan, typically in November/December. A draft of the Work Plan is reviewed by the QI/URC prior to finalization. This evaluation is then posted on the county website and submitted to the State governing agency.

The QI Work Plan:
Performance Indicators, Goals and Objectives

Performance Component 1:	**ACCESS TO CARE**

Performance Indicator 1	**Responsiveness of the 24/7 toll free Access line.**
Performance Goal	Calls into the 24/7 toll-free Access line consistently meet state requirements of providing: • Information in threshold languages, • information on accessing non-urgent services, • information on accessing urgent services, • information on how to use the problem resolution/grievance process.
Performance Objective	80% of test calls into the 24/7 toll-free Access line meet the state requirements.
Performance Measure	# of test calls meeting the state requirements.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: Test calls are conducted monthly. Data Source: Data sheets submitted by test callers+ Access log
Responsibility	Staff Services Analyst Team, Quality Coordinator
Authority	*DHCS Site Review Protocol Category 1: Network Adequacy/Access* *MHP Contract Element: Timely Access (Exhibit A, Attachment B)*

BASELINE PERFORMANCE DATA: Reporting for FY 19-20 was focused on after-hours calls to the Access line.

	# Meeting Criteria	% Meeting Criteria
Language Capability (N=1)	1	100%
Non-Urgent Service Access (N=21)	21	100%
Info on Urgent Conditions (N=10)	8	80%
Info on Grievance Process (N=6)	5	83.33%

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

	# Meeting Criteria	% Meeting Criteria
Language Capability (N=)		
Info on Service Access (N=)		
Info on Urgent Conditions (N=)		
Info on Grievance Process (N=)		

SUMMARY:

Performance Component:	**ACCESS TO CARE**

Performance Indicator 2	**Ethnic engagement rates**
Performance Goal	MHP Hispanic/Latinx engagement rates meet statewide benchmark.
Performance Objective	Increase the Hispanic/Latinx engagement rate from 3.14% to 4.00%.
Performance Measure	MHP Hispanic/Latinx engagement rate.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Annually Monitoring Methodology: State published "penetration rate" data for people who are Medi-Cal eligible, who enroll in treatment with the Napa MHP and have at least one service, divided by the total Napa population of Medi-Cal eligibles. Data Source: Prepared report from CAEQRO "Medi-Cal Approved Claims Data for Napa County MHP. This report is produced annually.
Responsibility	Staff Services Analyst Team, Quality Coordinator
Authority	*DHCS Site Review Protocol Category 1: Network Adequacy/Access MHP Contract Element: Assessment of Capacity (Exhibit A, Attachment 8)*

BASELINE PERFORMANCE DATA: Based on EQRO reported data, plus local reports of small county and statewide averages, the 2019 Hispanic/Latinx engagement rate data for the MHP is:

CY 2019

	Avg # Eligible/Mo	# Bene Served	Napa	Small Co.	Statewide
Race/Ethnicity					
Hispanic	18649	585	3.14%	4.47%	4.08%

In FY 19-20 the Napa MHP Hispanic engagement rate increased by .02%. With the onset of the public health emergency and the shift in platforms for service provision, challenges in reaching the work plan target were anticipated.

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

CY	Average # Eligibles/ Month	#Beneficiaries Served	Target Engagement Rate	Napa	Small County	Statewide

SUMMARY:

Performance Component:	**ACCESS TO CARE**

Performance Indicator 3	**0-5 Age group engagement rates**
Performance Goal	MHP 0-5 age group engagement rates meet statewide benchmark.
Performance Objective	Increase the 0-5 age group engagement rate from 1.35% to 2.00%.
Performance Measure	MHP 0-5 age group engagement rate.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Annually Monitoring Methodology: State published "penetration rate" data for people ages 0-5, who are Medi-Cal eligible, who enroll in treatment with the Napa MHP and have at least one service, divided by the total Napa 0-5 population of Medi-Cal eligibles. Data Source: Prepared report from CAEQRO "Medi-Cal Approved Claims Data for Napa County MHP. This report is produced annually.
Responsibility	Staff Services Analyst Team, Quality Coordinator
Authority	*DHCS Site Review Protocol Category 1: Network Adequacy/Access MHP Contract Element: Assessment of Capacity (Exhibit A, Attachment 8)*

BASELINE PERFORMANCE DATA: Based on EQRO reported data, plus local reports of small county and statewide averages, the 2019 0-5 age group engagement rate data for the MHP is:

CY 2019

Age Group	Avg # Eligible/Mo	# Bene Served	Napa	Small Co.	Statewide
0 to 5	3702	50	1.35%	1.61%	2.23%

In FY 19-20 the Napa MHP 0-5 age group engagement rate increased by .01%. With the onset of the public health emergency and the shift in platforms for service provision, challenges in reaching the work plan target were anticipated.

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

CY	Average # Eligibles/ Month	#Beneficiaries Served	Target Engagement Rate	Napa	Small County	Statewide

SUMMARY:

Performance Component:	**TIMELINESS OF CARE**

Performance Indicator 4	**Timeliness of first offered appointments for non-urgent services**
Performance Goal	First appointment dates offered for non-urgent services are within 10 days of initial request.
Performance Objective	80% of first offered appointment dates for non-urgent services are within 10 business days of initial request.
Performance Measure	# of first offered appointment dates for non-urgent services within 10 business days of initial request.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: The difference between the date of the request for service and the date of the offered appointment is calculated to determine the length of time. Data will be sorted to determine number of same day appointments and the number of appointments dates within 10 business days that were offered. Data is calculated for adults, children, and foster care. Data Source: Central Access and Authorization Team (CAAT) Log
Responsibility	Access Team, Staff Services Analyst Team, Quality Coordinator
Authority	*DHCS Site Review Protocol Category 1: Network Adequacy/Access* *MHP Contract Element: Assessment of Capacity (Exhibit A, Attachment 8)*

BASELINE PERFORMANCE DATA: In FY 19-20, the MHP was 100% compliant as the measure was based on date when the appointment was first offered, not the date of the actual first appointment. Going forward, the measure will the based on the date of the first appointment offered after the initial request.

FY 19-20	All Services	Adult Services	Children's Services	Foster Care
Length of time from first request for service to first offered appointment (in business days)	0.0059 Mean 0 Median 0.0886 Std. Dev.	0.0046 Mean 0 Median 0.0882 Std. Dev.	0.0084 Mean 0 Median 0.0914 Std. Dev.	0 Mean 0 Median 0 Std. Dev.
DHCS standard	10 business days			
Count of appointments that met this standard	1014/1014	641/641	357/357	16/16
Percent of appointments that met this standard	100%	100%	100%	100%
Range (min – max)	0 to 2 days	0 to 2 days	0 to 1 days	0 to 0 days

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

FY 19-20 (Non-Urgent Svcs)	**All Services**	**Adult Services**	**Children's Services**	**Foster Care**
Length of time from first request for service for first appointment date offered (in business days)				
DHCS Standard	10 business days			
Count of appointments that met this standard				
Percent of appointments that met this standard				
Range (min-max)				

SUMMARY:

Performance Component:	**TIMELINESS OF CARE**

Performance Indicator 5	**Timeliness of first offered psychiatry appointments**
Performance Goal	First appointment dates offered for psychiatry services are within 15 days of initial request.
Performance Objective	80% of first offered appointment dates for psychiatry services are within 15 business days of initial request.
Performance Measure	# of first offered appointment dates for psychiatry services within 15 business days of initial request.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: The difference between the date of the request for service and the date of the offered appointment is calculated to determine the length of time. Data will be sorted to determine the number of appointments dates within 15 business days that were offered. Data is collected for adults and children. Data Source: Central Access and Authorization Team (CAAT) Log
Responsibility	Access Team, Psychiatric Medical Director, Staff Services Analyst Team, Quality Coordinator
Authority	*DHCS Site Review Protocol Category 1: Network Adequacy/Access* *MHP Contract Element: Assessment of Capacity (Exhibit A, Attachment 8)*

BASELINE PERFORMANCE DATA: In FY 19-20, the numbers and percentages of appointments meeting the 15 business day criteria are indicated below:

FY 2019-2020 (July 1, 2019 through April 30, 2020)	All Services	Adult Services	Children's Services
Average length of time from first request for service to first SMHS (in business days)	15.35 Mean 11 Median 16.59 Std. Dev.	13.62 Mean 10.5 Median 16.60 Std. Dev.	17.57 Mean 13 Median 16.46 Std. Dev.
State standard	15 business days		
Count of appointments that meet this standard	97/153	55/86	42/67
Percent of appointments that meet this standard	63.40%	63.95%	62.69%

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

FY 19-20 (Psychiatry Svcs)	**All Services**	**Adult Services**	**Children's Services**
Length of time from first request for service for first appointment date offered (in business days)			
DHCS Standard	15 business days		
Count of appointments that met this standard			
Percent of appointments that met this standard			
Range (min-max)			

SUMMARY:

Performance Component:	**TIMELINESS OF CARE**

Performance Indicator 6	**Timeliness of first offered appointments for urgent services**
Performance Goal	First appointment times offered for urgent services are within 24 hours of initial request.
Performance Objective	100% of first offered appointment times for urgent services are within 24 hours of initial request.
Performance Measure	# of first offered appointment time for urgent services within 24 hours of initial request.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: The difference between the time of the request for service and the time of the offered appointment is calculated to determine the length of time. Data will be sorted to determine the number of appointments dates within 24 hours. Data is collected for adults, children and foster care. Data Source: Central Access and Authorization Team (CAAT) Log
Responsibility	Access Team, Crisis Stabilization Unit (CSU) Provider, Staff Services Analyst Team, Quality Coordinator
Authority	*DHCS Site Review Protocol Category 1: Network Adequacy/Access MHP Contract Element: Assessment of Capacity (Exhibit A, Attachment 8)*

BASELINE PERFORMANCE DATA: In FY 19-20, 100% of appointments met the 24 hour criteria as indicated below:

FY 19-20	All Services	Adult Services	Children's Services	Foster Care
Length of time for urgent appointments that do not require prior authorization	00:08:30 Mean 00:06:30 Median 00:08:53 Std. Dev.	00:08:30 Mean 00:06:30 Median 00:08:53 Std. Dev.	NA Mean NA Median NA Std. Dev.	NA Mean NA Median NA Std. Dev.
DHCS standard	48 Hours			
Percent of appointments that met this standard	100%	100%	NA%	NA%
Range	00:19:00	00:19:00	NA	NA
Length of time for urgent appointments that requires prior authorization	NA Mean NA Median NA Std. Dev.	NA Mean NA Median NA Std. Dev.	NA Mean NA Median NA Std. Dev.	NA Mean NA Median NA Std. Dev.

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

FY 19-20 (Urgent Svcs)	**All Services**	**Adult Services**	**Children's Services**	**Foster Care**
Length of time from first request for service for first appointment date offered for urgent appointments that do not require prior authorization (in business days)				
DHCS Standard	48 hours			
Count of appointments that met this standard				
Percent of appointments that met this standard				
Range (min-max)				

SUMMARY:

Performance Component:	**TIMELINESS OF CARE**

Performance Indicator 7	**Timeliness of first support contact following discharge from a psychiatric facility**
Performance Goal	First support contacts post discharge from a psychiatric facility are within 7 days of discharge.
Performance Objective	80% of first support contacts post discharge from a psychiatric facility are within 7 days of discharge.
Performance Measure	# of first support contacts post discharge from a psychiatric facility within 7 days of discharge.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: Eligible "Discharges" are all individuals discharged from a psychiatric inpatient facility (community and State) who meet criteria for specialty mental health services and are the responsibility of the MHP for follow up. Length of time is calculated from the date of discharge to date contacted. Data is collected for adults, children and foster care. Data Source: Assignment Report Cerner Anasazi EHR
Responsibility	Hospital Liaison, Staff Services Analyst Team, Quality Coordinator
Authority	*Health Care Effectiveness Data Information Set (HEDIS) Measure: Follow Up After Hospitalization for Mental Illness*

BASELINE PERFORMANCE DATA: In FY 19-20, 88.76% of eligible individuals post-discharge received support contact. 82.58% of eligible individuals post-discharge received post discharge support contact within 7 days of discharge.

FY 19-20	All Services	Adult Services	Children's Services	Foster Care
TOTAL number of hospital admissions with Napa County responsibility for follow-up	184	169	14	1
TOTAL number of hospital discharges with Napa County responsibility for follow-up	178	163	14	1
Number of follow up appointments within 7 days	147	132	14	1
Number of follow up appointments 8+ days	11	11	0	0
Number with no follow up contact after discharge by MHP staff	5	5	0	0
Number with attempted contact by MHP staff but no follow through by Client	15	15	0	0
MHP Standards or Goal	7 days	7 days	7 days	7 days
% of appointments that met MHP Standard	82.58%	80.98%	100.00%	100.00%
% of clients with follow up contact	88.76%	87.73%	100.00%	100.00%

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

FY 19-20 Contacts Post-Discharge from psychiatric facility	**All Services**	**Adult Services**	**Children's Services**	**Foster Care**
Total number of hospital admissions with Napa County responsibility for follow up				
Total number of hospital discharges with Napa County responsibility for follow up				
Number of follow up appointments within 7 days				
Number of follow up appointments 8+ days				
Number with no follow up contact after discharge by MHP staff				
Number with attempted contact by MHP staff but no follow through by clients				
MHP Standards or Goal	7 days	7 days	7 days	7 days
% of appointments that met MHP standard				
% of clients with follow up contact				

SUMMARY:

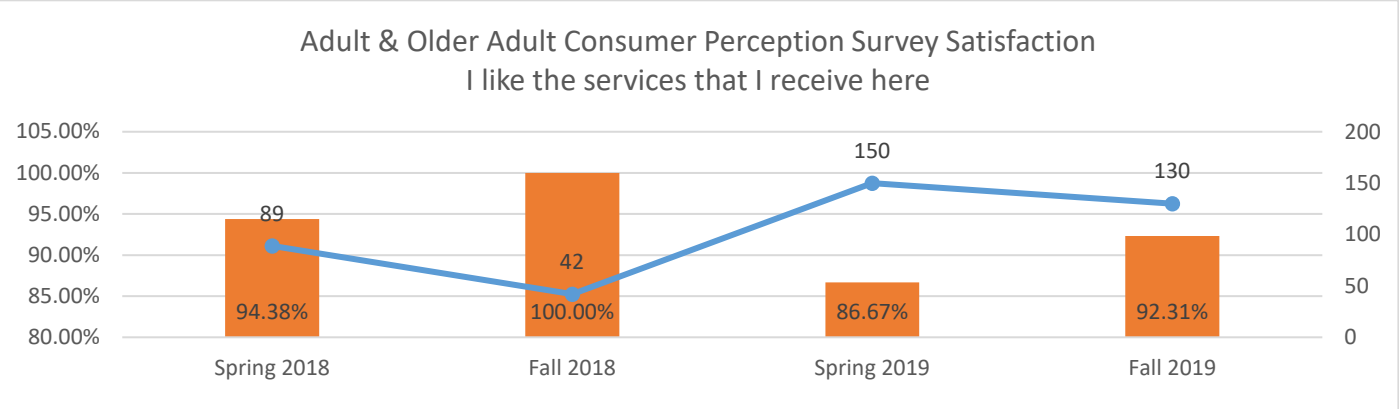
Performance Component:	**Quality of Care**

Performance Indicator 8	**Results of the Consumer Perception Satisfaction Survey (CPS) for beneficiaries and families**
Performance Goal	Beneficiary and family satisfaction with the MHP service experience.
Performance Objective	90% satisfaction rate for three core satisfaction survey questions: 1. Adult and Older Adult CSP: "I like the services I receive here." 2. Youth CSP: "Overall, I am satisfied with the services I received." 3. Family CSP: "Overall, I am satisfied with the services my child received."
Performance Measure	% satisfaction rates on CSP core questions.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Every six months Monitoring Methodology: Bi-annual analysis of CPS data as collected by CIBHS Data Source: EBHS data analysis system
Responsibility	Staff Services Analyst Team, Quality Coordinator, MH Admin Support
Authority	*DHCS Site Review Protocol Category 3: QA/Performance Improvement* *MHP Contract Element: Quality Assessment and Performance Improvement (Exhibit A, Attachment 5)*

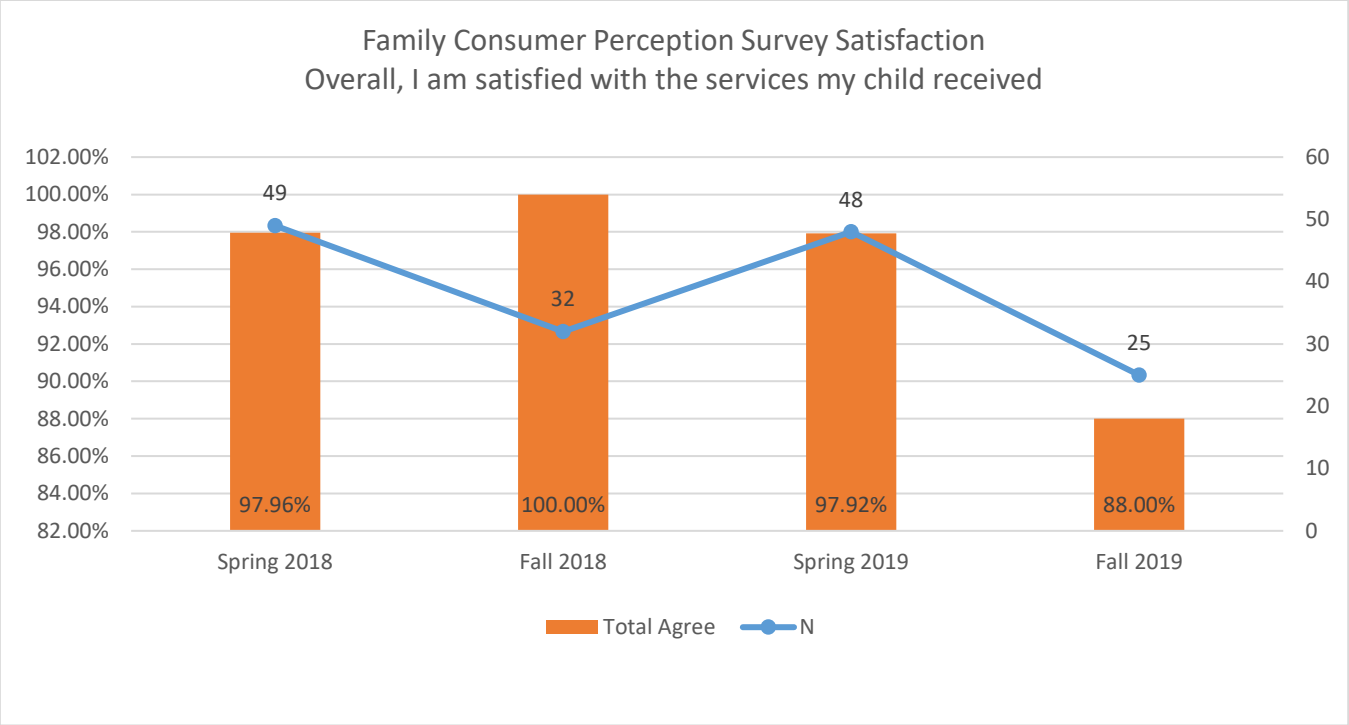
BASELINE PERFORMANCE DATA: In FY 19-20: As indicated by the trend data detail below, the most current Consumer Perception Survey (CPS) response percentages for satisfaction are as follows for each of the three core questions:

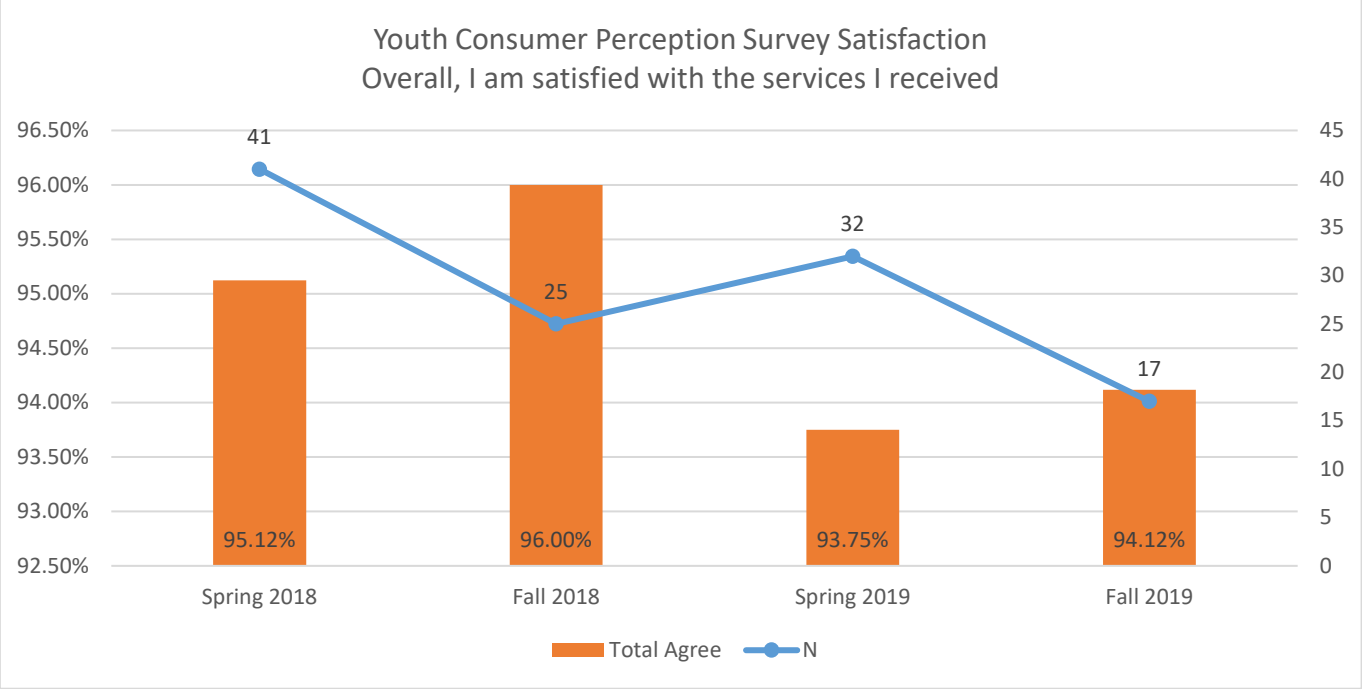
- Adult and Older Adult CPS: 92.31%
- Youth CPS: 94.12%
- Family CPS: 88%

These scores demonstrate achievement of the consumer satisfaction level goal of 85%.



BASELINE PERFORMANCE DATA, continued:





FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

SUMMARY:

Performance Component:	**Quality of Care**

Performance Indicator 9	**Results of the Crisis Stabilization Unit (CSU) Episode Survey for adults and youth**
Performance Goal	Beneficiary and family satisfaction with the MHP CSU service experience.
Performance Objective	80% aggregate satisfaction rate.
Performance Measure	% satisfaction rate on CSU Episode Survey.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: Survey is offered to all CSU beneficiaries upon discharge. Survey are collected weekly and results are scored by totaling the response values and dividing the total by the best possible score for the survey. Data Source: CSU Episode Survey collection.
Responsibility	Crisis Stabilization Unit (CSU) Provider, Staff Services Analyst Team, Quality Coordinator
Authority	*DHCS Site Review Protocol Category 3: QA/Performance Improvement MHP Contract Element: Quality Assessment and Performance Improvement (Exhibit A, Attachment 5)*

BASELINE PERFORMANCE DATA: FY 20-21 is the first year of reporting. Data collected this year will serve as baseline data for the successive year.

Performance Component:	**Quality of Care**

Performance Indicator 10	**Grievances and appeals resolutions**
Performance Goal	Resolve grievances and appeals according to state timelines.
Performance Objective	80% of grievances and appeals are resolved according to state timelines.
Performance Measure	% grievances resolved according to the state timelines 90 days, and % of appeals resolved according to the state timelines of 30 days for a standard appeal.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: Grievances and appeals are investigated and resolved by the Quality Coordinator. The Quality Coordinator tracks grievances and appeals ongoing via a HIPAA compliant spreadsheet log. Data Source: Grievance and appeals spreadsheet log maintained by Quality Coordinator
Responsibility	Quality Coordinator
Authority	*DHCS Site Review Protocol Category 6: Beneficiary Rights/Protections* *MHP Contract Element: Quality Assessment and Performance Improvement (Exhibit A, Attachment 5)* *Information Notice 18-010E*

BASELINE PERFORMANCE DATA: For FY 19-20, 13 grievances were filed with NCMH. Of the 13 grievances, 10 were resolved in the 90 day time frame. For the 3 resolved outside of the 90 day time frame, NOABDs for Delay in Grievance Resolution were issued. No appeals were filed.

Grievances FY 19-20		
Category	**# Grievances**	**Disposition (Resolved or Referred)**
Staff behavior concerns	4	Resolved
Treatment Issues or concerns	5	Resolved
Medication concern	1	Resolved
Confidentiality concern	1	Resolved
Other	1	Resolved
Appeals FY 19-20		
Category	**# Grievances**	**Disposition (Resolved or Referred)**
N/A	0	N/A

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

Grievances FY 20-21		
Category	**# Grievances**	**Disposition (Resolved or Referred)**
Appeals FY 20-21		
Category	**# Grievances**	**Disposition (Resolved or Referred)**

Summary:

Performance Component:	**Quality of Care**

Performance Indicator 11	**Medication Management**
Performance Goal	Medications are prescribed according to standards indicated on the Napa County Medication Clinic "Medication Management Peer Review Form."
Performance Objective	90% of cases peer reviewed meet all standards on the Napa County Medication Clinic Peer Review Form.
Performance Measure	% of peer reviewed cases meeting the standards in the Napa County Medication Clinic Peer Review Form.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Bi-Annually Monitoring Methodology: Psychiatric Medical Director will submit peer review reports indicating percentages of cases reviewed that meet the standards on the Peer Review Form. Reports will be submitted starting quarterly to the Assistant Director, Admin and to the Quality Coordinator. Data Source: Peer review data sheets.
Responsibility	Psychiatric Medical Director, Assistant Director, Admin and Quality Coordinator
Authority	*NCMH Policy: Medication Clinic Medication Management and Peer Review*

BASELINE PERFORMANCE DATA: FY 20-21 is the first year of reporting. Data collected this year will serve as baseline data for the successive year.

Performance Component:	**Effectiveness of Care/Outcomes**

Performance Indicator 12	**Results of the Milestone of Recovery Scale (MORS) for Adults**
Performance Goal	Functional improvement over time for adult clients ages 18-65.
Performance Objective	75% of adult clients ages 18-65 average a move to a higher milestone during the course of service participation.
Performance Measure	% of adult clients ages 18-65 who average a move to a higher milestone during the course of service participation.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: MORS data is collected monthly from internal adult programs as well as from contract providers Buckalew and Progress Foundation. Data for each client is trended over time and averaged to determine functional improvement status. Data Source: MORS scores reports from Anasazi + contract provider MORS data reports.
Responsibility	Staff Services Analyst Team, Office Assistant, Quality Coordinator
Authority	*DHCS Site Review Protocol A + C* *MHP Contract Elements: Quality Assessment and Performance Improvement (Exhibit A, Attachment 5; and Documentation of Network Adequacy (Exhibit A, Attachment 8)*

BASELINE PERFORMANCE DATA: FY 20-21 is the first year of reporting. Data collected this year will serve as baseline data for the successive year.

Performance Component:	**Effectiveness of Care/Outcomes**

Performance Indicator 13	**Results of the Child and Adolescent Needs Assessment (CANS) for children ages 6-21**
Performance Goal	Functional improvement over time for child participants, ages 6-21.
Performance Objective	80% of participants engaged in ongoing services demonstrate functional improvement over time.
Performance Measure	# of participants engaged in ongoing services demonstrating functional improvement through comparative time data.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: CANS data is collected from internal children's programs as well as from contract provider Aldea. Data for each client will be trended over time and averaged to determine functional improvement status. Data Source: CANS scores reports from Anasazi + contract provider CANS data reports
Responsibility	Staff Services Analyst Team, Office Assistant, Quality Coordinator
Authority	*DHCS Site Review Protocol A + C* *MHP Contract Elements: Quality Assessment and Performance Improvement (Exhibit A, Attachment 5; and Documentation of Network Adequacy (Exhibit A, Attachment 8)*

BASELINE PERFORMANCE DATA: FY 20-21 is the first year of reporting. Data collected this year will serve as baseline data for the successive year.

Performance Component:	**Effectiveness of Care/Outcomes**

Performance Indicator 14	**Results of the Clinical Global Impression (CGI) Scale for young adults clients demonstrating early symptoms of psychosis who are participating in the Aldea Supportive Outreach and Access to Resources (SOAR) program.**
Performance Goal	Decrease symptom severity for clients in the SOAR program.
Performance Objective	85% of participants discharged from the SOAR program will demonstrate improvement in overall symptoms and functioning.
Performance Measure	# of clients discharged from SOAR who demonstrate improvement in overall symptoms and functioning.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Annually Monitoring Methodology: Aldea reports annually on program outcomes. Data Source: Reports submitted by Aldea
Responsibility	Aldea Staff Services Analyst Team, Quality Coordinator
Authority	*DHCS Site Review Protocol A + C* *MHP Contract Elements: Quality Assessment and Performance Improvement (Exhibit A, Attachment 5; and Documentation of Network Adequacy (Exhibit A, Attachment 8)*

BASELINE PERFORMANCE DATA: FY 19-20 outcomes data is as indicated:

During Napa SOAR's 2019-2020 fiscal year:

- 18 Clients received Napa SOAR Services
- 11 Clients were under the age of 18
- 7 Clients were 18 or over (or turned 18 during the fiscal year)
- 4 Clients successfully graduated this program during this period (were planned discharges)
- 3 Clients were assessed and did not meet criteria for the program
- Total number of clients hospitalized during this period: 1
- Of the 11 clients discharged from Napa SOAR during the fiscal year, 91% (10/11 clients) experienced improvement in overall symptoms and functioning.

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

During Napa SOAR's 2020-2021 fiscal year:

Summary:

Performance Component:	**Race and Cultural Equity**

Performance Indicator 15	**Administration of the DSM5 Cultural Formulation Interview**
Performance Goal	As of January 1, 2021, all comprehensive assessments for new clients meeting SMHS criteria will include administration of the DSM 5 Cultural Formulation Interview (CFI)
Performance Objective	100% of comprehensive assessments completed for new clients meeting SMHS criteria will include administration of the DSM 5 CFI.
Performance Measure	# of comprehensive assessments including administration of the DSM 5 CFI.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: A CFI reporting form is submitted to the Quality Coordinator for each CFI completed. This data indicator is an element driving outcomes of the clinical PIP. Data Source: CFI reporting forms.
Responsibility	Quality Coordinator
Authority	*DHCS Site Review Category 4: Access and Information Requirements* *MHP Contract Element: Cultural Competence (Exhibit A, Attachment 7)* *CCR Title 9, Section 1810.410*

BASELINE PERFORMANCE DATA: FY 20-21 is the first year of reporting. Data collected this year will serve as baseline data for the successive year.

Performance Component:	**Race and Cultural Equity**

Performance Indicator 16	**Staff completion of Diversity, Equity and Inclusion training**
Performance Goal	In FY 20-21, NCMH staff will complete a three part training series on Diversity, Equity and Inclusion (DEI).
Performance Objective	95% completion rate within FY 20-21 of the three part training series on Diversity, Equity and Inclusion (DEI).
Performance Measure	% of training completions within FY 20-21.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: Staff Services Analyst provides collects data ongoing through the Napa County Network of Care eLearning system. Data Source: Network of Care eLearning system.
Responsibility	Staff Services Analyst
Authority	*DHCS Site Review Category 4: Access and Information Requirements* *MHP Contract Element: Cultural Competence (Exhibit A, Attachment 7)* *CCR Title 9, Section 1810.410*

BASELINE PERFORMANCE DATA: FY 20-21 is the first year of reporting. Data collected this year will serve as baseline data for the successive year.

Performance Component:	Race and Cultural Equity

Performance Indicator 17	Application of the Race and Cultural Equity Policy, Procedures and Practices Review Tool
Performance Goal	Starting in FY 20-21, apply the new Race and Cultural Equity Policy, Procedures and Practices (PPP) Review Tool to new policies and policies due for review.
Performance Objective	100% application of the Race and Cultural Equity PPP Review Tool to all policies due for review.
Performance Measure	% of policies due for review for which the tool is applied.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: The Policy work group will transition to the Policy, Procedures and Practices Review Committee and will meet monthly to apply the tool to new policies and policies due for review that are presented to the committee. Data Source: Policy review log maintained by Staff Services Analyst.
Responsibility	Staff Services Analyst, Quality Coordinator
Authority	*DHCS Site Review Category 4: Access and Information Requirements* *MHP Contract Element: Cultural Competence (Exhibit A, Attachment 7)* *CCR Title 9, Section 1810.410*

BASELINE PERFORMANCE DATA: FY 20-21 is the first year of reporting. Data collected this year will serve as baseline data for the successive year.

Performance Component:	**Utilization Management**

Performance Indicator 18	**Documentation standards compliance**
Performance Goal	Clinical progress notes meet State and Federal documentation standards.
Performance Objective	96% documentation compliance standard (<5% error rate) met as assessed by monthly Chart Review process.
Performance Measure	% of clinical progress notes reviewed that meetcompliance standards.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Monthly Monitoring Methodology: The monthly number of claims (individual clinical progress notes) reviewed varies depending on the total number of potentially billable claims in each month's random sample. The total number of claims written off is divided by the total number of that month's claims universe to determine the error rate percentage. Data Source: Claims review reports from Anasazi.
Responsibility	Staff Services Analyst, UR Coordinator
Authority	*DHCS Site Review Category 8: Chart Review Non-Hospital Services* *MHP Contract Element: Documentation Standards (Exhibit A, Attachment 9)* *CCR Title 9, Section 1810.440b and 42 CFR, Sections 438.416,438.430*

BASELINE PERFORMANCE DATA: For FY 19-20, the MHP demonstrated a 97% average compliance percentage as indicated:

Month	Months Reviewed	Claims Reviewed	Write Offs	Claims Billable	% Compliant
Aug-19	June 2019, July 2019	89	5	84	94%
Sep-19	July 2019, Aug 2019	139	17	122	88%
Oct-19	Aug 2019, Sept 2019	69	4	65	94%
Nov-19	Sept 2019, Oct 2019	56	0	56	100%
Dec-19	Oct 2019, Nov 2019	59	0	59	100%
Jan-20	Nov 2019, Dec 2019	67	0	67	100%
Feb-20	Dec 2019, Jan 2020	89	1	88	99%
Mar-20	Jan 2020, Feb 2020	138	1	137	99%
Apr-20	Feb 2020, Mar 2020	229	5	224	98%
May-20	Mar 2020, Apr 2020	67	0	67	100%
Jun-20	Apr 2020, May 2020	125	3	122	98%
Jul-20	May 2020, June 2020	101	1	100	99%
Aug-20	June 2020, July 2020	87	0	87	100%
	TOTAL	1315	37	1278	97%

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

Summary:

Performance Component:	**Utilization Management**

Performance Indicator 19	**No Show Rates for Medication Clinics**
Performance Goal	Minimize the number of no-shows for Medication Clinic appointments.
Performance Objective	88% of adult and children's Medication Clinic scheduled appointments are kept.
Performance Measure	% of adult and children's Medication Clinic scheduled appointments kept.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Monthly Monitoring Methodology: Data is collected on individuals who were seen for scheduled appointments and compared to all scheduled appointments. Data Source: Scheduler report from Anasazi.
Responsibility	Staff Services Analyst, UR Coordinator
Authority	*DHCS Site Review Protocol Section: C* *MHP Contract Element: Quality Assessment and Performance Improvement (Exhibit A, Attachment 5)*

BASELINE PERFORMANCE DATA: For FY 19-20, the MHP Adult and Children's Medication Clinics had an aggregate show rate of 90%.

	ADULT (1005)			CHILD (5005/6005)			TOTAL		
	Total Appts	No Show	%	Total Appts	No Show	%	Total Appts	No Show	%
FY 13-14	527	59	11%	879	57	6%	1406	116	8%
FY 14-15	556	37	7%	1022	96	9%	1588	133	8%
FY 15-16	375	45	12%	650	79	12%	1025	124	12%
FY 16-17	512	80	16%	30	1	3%	360	52	14%
FY 17-18	401	73	18%	1	1	100%	402	74	18%
FY 18-19	622	56	9%	0	0	0%!	622	56	9%
FY 19-20	810	26	3%	0	0	0%	810	26	3%
OVERALL	**2993**	**350**	**12%**	**2582**	**234**	**9%**	**5403**	**555**	**10%**

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

Summary:

Performance Component:	**Utilization Management**

Performance Indicator 20	**Psychiatric inpatient admissions and re-admissions**
Performance Goal	Minimize the number of re-admissions to psychiatric inpatient within 30 days of discharge.
Performance Objective	≤15% re-admission rate within 30 days of discharge.
Performance Measure	% of re-admissions within 30 days of discharge.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: Data is collected and analyzed by the Staff Services Analyst team. Data is collected for adults, children and foster care Data Source: Assignment report from Anasazi.
Responsibility	Staff Services Analyst, UR Coordinator
Authority	*DHCS Site Review Protocol Category 3: QA/Performance Improvement MHP Contract Element: Quality Assessment and Performance Improvement (Exhibit A, Attachment 5)*

BASELINE PERFORMANCE DATA: For FY 19-20, the total number of hospital re-admissions within 30 days was consistently ≤15% for adults, children and foster care, and in aggregate.

FY 19-20	All Services	Adult Services	Children's Services	Foster Care
Total number of hospital admissions *(duplicated)*	231	209	20	2
Total number with readmission within 30 days *(duplicated)*	24	22	2	0
Readmission rate (30 days)	10.39%	10.53%	10.00%	0.00%
Goal readmission rate (30 days)	< 15%	< 15%	< 15%	< 15%

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

Summary:

Performance Component:	**Utilization Management**

Performance Indicator 21	**Adult service drop-out rate**
Performance Goal	Reduce the adult service drop-out rate.
Performance Objective	≤35% adult services drop-out rate.
Performance Measure	% of adults dropping out of treatment.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: Case status data is collected monthly through the Cerner EHR. Reason for closure is recorded at each instance of case closure in the client's case record. The drop out rate is calculated by dividing the number of closed case with drop-out disposition by the total number of closed cases. Data Source: Case status and disposition reports from the Cerner EHR.
Responsibility	Staff Services Analyst, UR Coordinator, Quality Coordinator
Authority	*DHCS Site Review Protocol Category 3: QA/Performance Improvement MHP Contract Element: Quality Assessment and Performance Improvement (Exhibit A, Attachment 5)*

BASELINE PERFORMANCE DATA: For FY 19-20, the drop out rate for adults clients was 40%.

All Adults - Reason for Closure FY 19-20	Percentage of Total (N = 176)	Number of Clients
Completed Treatment	6%	8
Jail/Prison	13%	23
Dropped Out (Lost to Care, Refused or Withdrew from Services)	40%	72
Moved/Out of County	7%	13
Referred to Psych Inpatient or Residential	10%	17
Referred to CBO Provider (Did not meet SMHS criteria)	24%	43
TOTAL	100%	176

FY 20-21 PERFORMANCE DATA: TBD at Annual Evaluation

All Adults - Reason for Closure FY 20-21	Percentage of Total (N =)	Number of Clients
Completed Treatment		
Jail/Prison		
Lost to Care, Refused or Withdrew from Services		
Moved/Out of County		
Referred to Psych Inpatient or Residential		
Referred to CBO Provider (Did not meet SMHS criteria)		
TOTAL	100%	

Summary:

PERFORMANCE IMPROVEMENT PROJECTS
ANNUAL STATUS UPDATE – TBD at Evaluation

CLINICAL PIP - Promoting Outpatient Mental Health Services Engagement and Treatment Completion for Hispanic/Latinx Adults

Status of performance measures:

1. % of Hispanic/Latinx adult outpatient cases closed as a result of completing treatment:
2. % of Hispanic/Latinx adult outpatient cases closed as a result of dropping out of treatment:
3. Average # of outpatient services received by Hispanic/Latinx adults before dropping out of treatment:
4. % of adult outpatient cases closed as a result of completing treatment:
5. % of adult outpatient cases closed as a result of dropping out of treatment:
6. Average # of outpatient services received by adults before dropping out of treatment:

NON-CLINICAL PIP - Promoting Reduction of Average Length of Time from First Request for Adult Psychiatry to First Scheduled Psychiatry Appointment

Status of performance measure:

Number of first scheduled psychiatry appointments meeting the 15 business day standard, versus total of first scheduled psychiatry appointments:

QI WORK PLAN REVISION LOG

Revision Date	Description of Changes	Revised By
12/15/2020	- Full layout revision - Narrative content revision - Addition of Performance Indicators: • Quality of Care: Results of Crisis Stabilization Episode Survey • Quality of Care: Medication Management • Effectiveness of Care/Outcomes: Results of MORS (Adults) • Effectiveness of Care/Outcomes: Results of CANS (Children/Youth 6-21) • Racial and Cultural Equity: Administration of the DSM5 Cultural Formulation Interview • Racial and Cultural Equity: Diversity, Equity and Inclusion Training • Racial and Cultural Equity: Application of the Racial and Cultural Equity Review Tool • Utilization Management: No-Show Rates for Medication Clinics • Utilization Management: Adult Service Drop-Out Rate	Quality Coordinator: Jennifer Menges, LCSW