NAPA COUNTY
Health & Human Services Agency

2021-2022

Napa County
Health & Human Services Agency
Mental Health Division

QUALITY ASSURANCE AND PERFORMANCE 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 assurance and improvement lie within the everyday work of every employee in our organization. Quality service delivery 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 Assurance and Performance Improvement (QAPI) 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 QAPI 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 (MHP) established its Quality Management and Coordination unit and developed this 2021-2022 QI Work Plan to meet these requirements.

Contracts between the MHP 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 ASSURANCE AND PERFORMANCE IMPROVEMENT PHILOSOPHY AND GOALS

The Napa County Mental Health Plan is committed to a quality assurance and improvement program to drive consistency in meeting quality standards and achieve measurable improvements in the mental health and well-being of our beneficiaries. The MHP 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 QAPI 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.

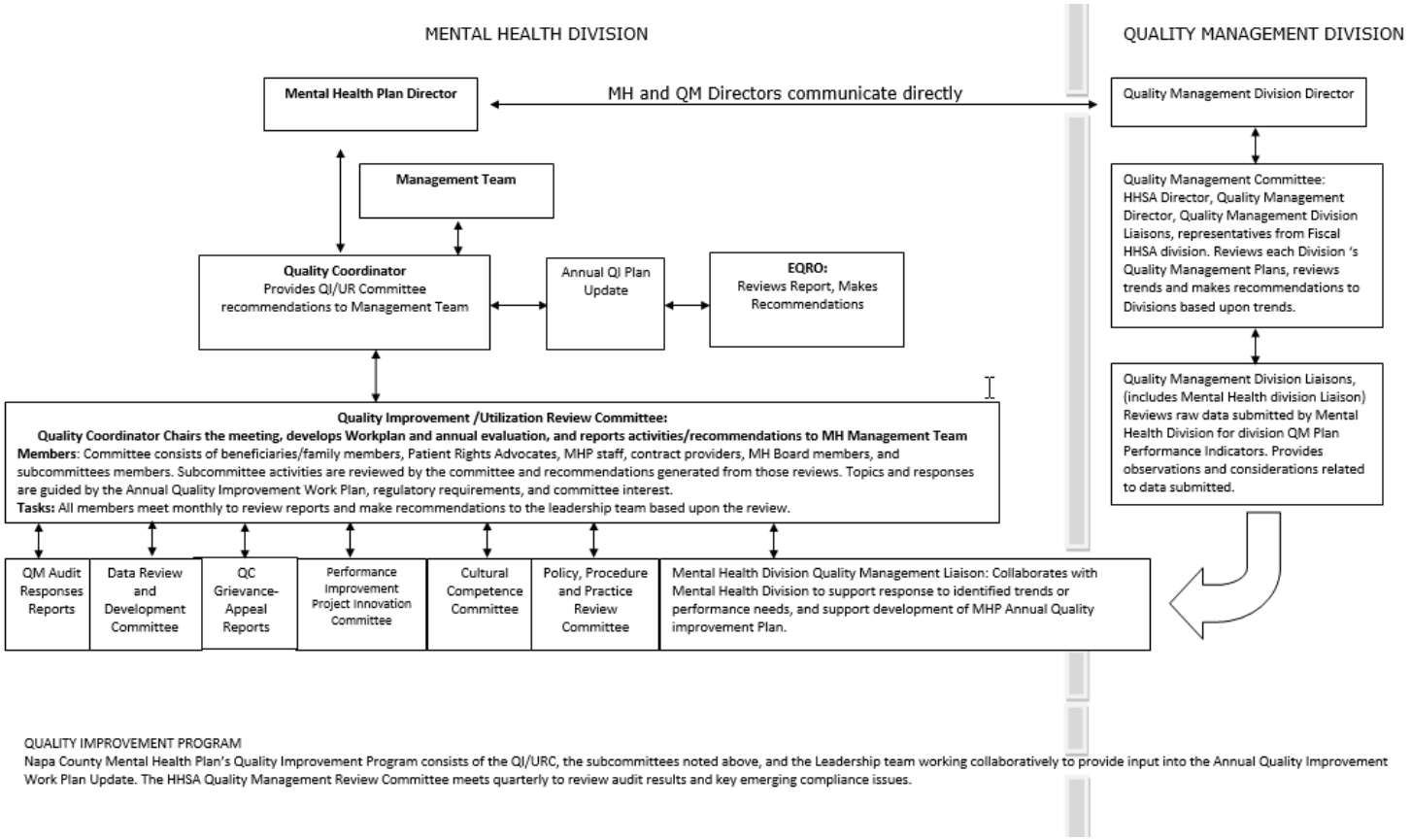
QUALITY MANAGEMENT PROGRAM STRUCTURE

Program Structure Overview

The MHP 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 MHP, 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 QAPI 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 QAPI 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 assurance and 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 serve 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 MHP leadership and 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 MHP 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 MHP staff, one or more organizational contract providers, and one or more stakeholders and/or beneficiaries or family members.

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

- **Policy, Procedure and Practice Review Committee**
  The Policy, Procedure and Practice (PPP) Review Committee 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 Committee meets monthly, or as needed for a time-sensitive review, and is led by the senior Staff Services Analyst. Committee 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.

QAPI WORK PLAN STRUCTURE

The QAPI Work Plan establishes the core indicators, goals, and objectives upon which we measure performance. These 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, monitoring, 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 21-22 core performance indicators are organized under six primary performance components:

ACCESS TO CARE	Performance Indicator • Responsiveness of the 24/7 toll free Access line
TIMELINESS OF CARE	Performance Indicators • 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 (Beneficiaries and Providers) • Medication Monitoring
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/Youth 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 • Diversity, Equity, and Inclusion (DEI) training completions required for FY 21-22
UTILIZATION MANAGEMENT	Performance Indicators • Documentation standards compliance • No Show Rates for Medication Clinic • No Show Rates for Adult Outpatient Services

PERFORMANCE IMPROVEMENT PROJECTS

In addition to the 14 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 assessment date 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 a 15-business day target.

This PIP is also expected to conclude in November 2022.

EVALUATION OF THE QAPI 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 QAPI Work Plan goals, objectives and performance indicators are evaluated in aggregate, approximately one month prior to the development of the next year's QAPI 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 QAPI 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: In FY 20-21 the MHP met target in all requirement areas:

	# Meeting Criteria	% Meeting Criteria
Language Capability (N=3)	3	100%
Non-Urgent Service Access (N=25)	25	100%
Info on Urgent Conditions (N=12)	10	83.33%
Info on Grievance Process (N=7)	7	100%

FY 21-22 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:	**TIMELINESS OF CARE**

Performance Indicator 2	**Timeliness of first offered psychiatry appointments**
Performance Goal	First appointment dates offered for psychiatry services are within 15 days of clinical determination of need.
Performance Objective	80% of first offered appointment dates for psychiatry services are within 15 business days of clinical determination of need.
Performance Measure	% of first offered appointment dates for psychiatry services within 15 business days of clinical determination of need.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: The difference between first clinical determination of need 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 20-21, data demonstrates that the MHP met the target of 80% of first psychiatry offered within 15 business days of clinical determination of need for all populations.

	All Services	**Adult Services**	**Children's Services**	**Foster Care**
Business days from first request for service to first offered psychiatry appointment	7.71Average 6 Median Range: 1 to 51 days	7.89 Average 6 Median Range: 1 to 51 days	7.24 Average 5 Median Range: 1 to 27 days	5 Average 5 Median Range: 4 to 6 days
DHCS Standard	15 business days			
Count of initial psychiatry service requests	145	110	33	2
Count of appointments that met this standard	128	96	30	1
Percent of appointments that met this standard	88%	87%	91%	100%

FY 21-22 PERFORMANCE DATA: TBD at Annual Evaluation

FY 21-22 (Psychiatry Services)	**All Services**	**Adult Services**	**Children's Services**
Length of time from first request for service to 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 3	**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 20-21, 100% of appointments met the 24-hour criteria as indicated below:

The MHP Began tracking data for this indicator in December 2017. Originally, the MHP tracked this indicator as the length of time it took for a call or walk-in to the MHP's Access unit in need of urgent mental health services to be transferred for walked over to the Crisis Stabilization Services Unit (CSS) for further assistance. A review of the data showed that the majority of those calls or walk-ins were being directed to the MHP's Coordinator and/or Officer of the day instead of the CSS. The MHP reported the data reflecting the new methodology in FY 18-19. Data is reviewed annually, comparing the Coordinator and Access Call Logs for date of service/name matches between the two.

Data collection issues: A review of the Coordinator and Access Call Logs for FY 20-21 showed that call times were not being noted, therefore no data is available for this reporting period. The MHP is in the process of amending the methodology and data collection process for this indicator and has identified that updates need to be made to the Coordinator log to better capture the data. Training is planned for when the amendments are completed. Additionally, the current electron health record system presents challenges in identifying non-Katie A. classified/recorded foster youth within the database. Staff training have been implemented to appropriately identify foster youth upon entering the MHP's system of care moving forward.

FY 21-22 PERFORMANCE DATA: TBD at Annual Evaluation

FY 21-22 (Urgent Services)	**All Services**	**Adult Services**	**Children's Services**	**Foster Care**
Length of time from first request for service to 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 4	**Timeliness of First Support Contact Following Discharge from a Psychiatric Facility**
Performance Goal	First support contacts post discharge from a psychiatric facility are within seven (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 seven (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 20-21, the MHP fell short of the 80% target for meeting the 7-business day standard for all services, adult services. The foster care data set (n=2) is too small to firmly demonstrate performance, but it should be noted that for the Children's Services data set, the standard was met at 90%.

	All Services	**Adult Services**	**Children's Services**	**Foster Care**
Days from discharge to first follow-up appointment	3.01 Average 1 Median	3.1 Average 1.5 Median	2.56 Average 1 Median	0 Average 0 Median
MHP standard or goal (HEDIS Standard is 7 days)	7 business days	7 business days	7 business days	7 business days
Total number of hospital admissions	184	162	20	2
Total number of hospital discharges	187	165	20	2
Total number of follow-up services delivered within *7-days of discharge*	126	109	16	1
Percent of follow-up services delivered within *7-days of discharge*	67.38%	66.06%	80%	50%
Total number of follow up services delivered within *30-days of discharge*	145	126	18	1
Percent of services delivered within *30-days of discharge*	77.54%	76.36%	90%	50%

FY 21-22 PERFORMANCE DATA: TBD at Annual Evaluation

FY 21-22 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:

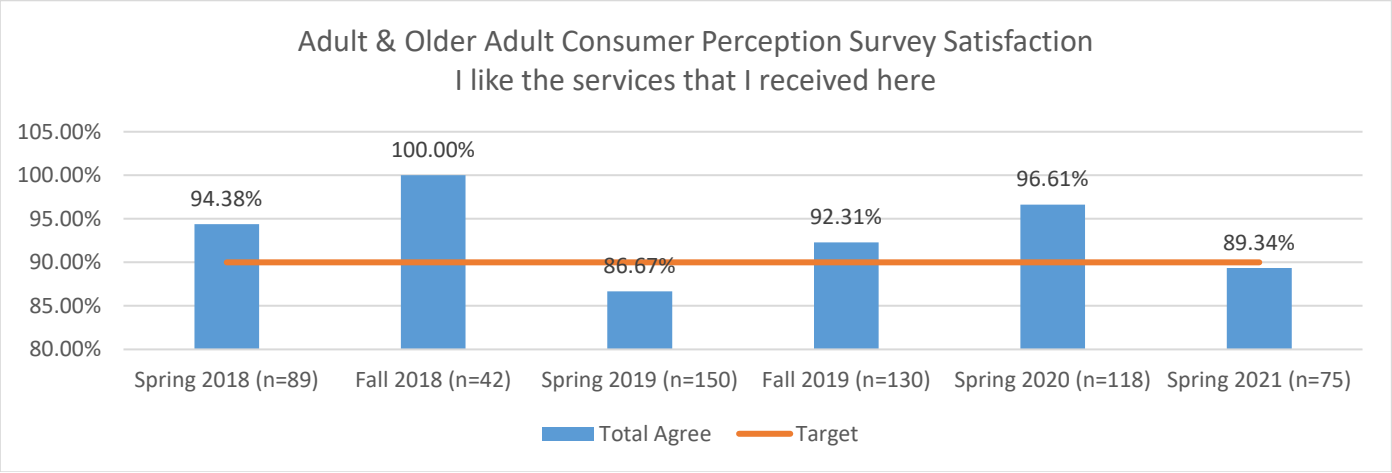
Performance Component:	**Quality of Care**

Performance Indicator 5	**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)*

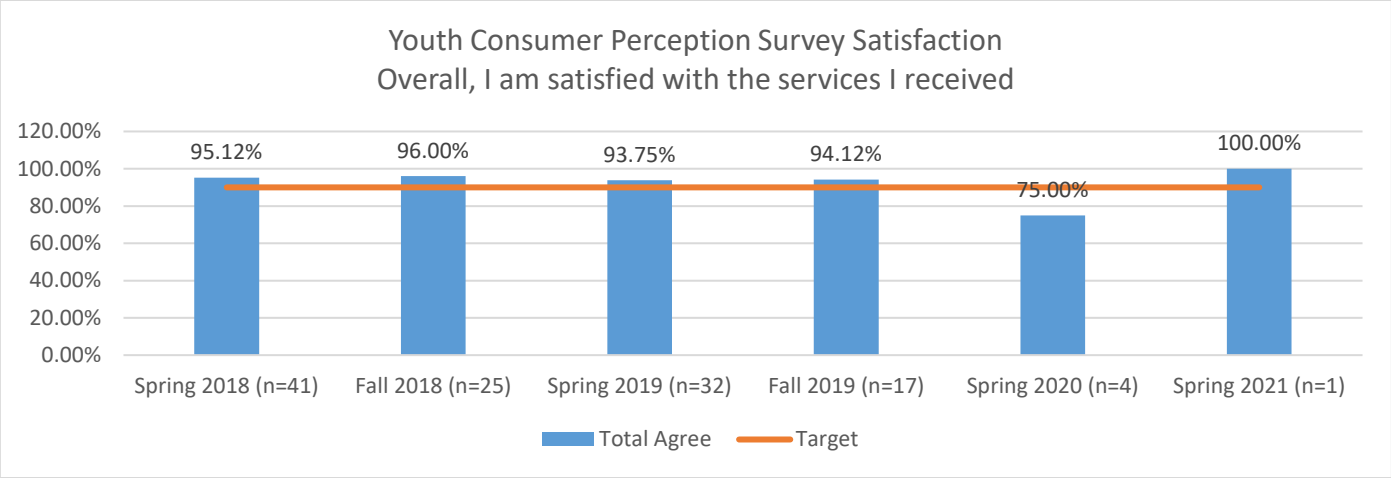
BASELINE PERFORMANCE DATA: In FY 20-21: As indicated by the trend data detail below, the most current Consumer Perception Survey (CPS) response percentages for satisfaction are as follows for each of the three core questions:

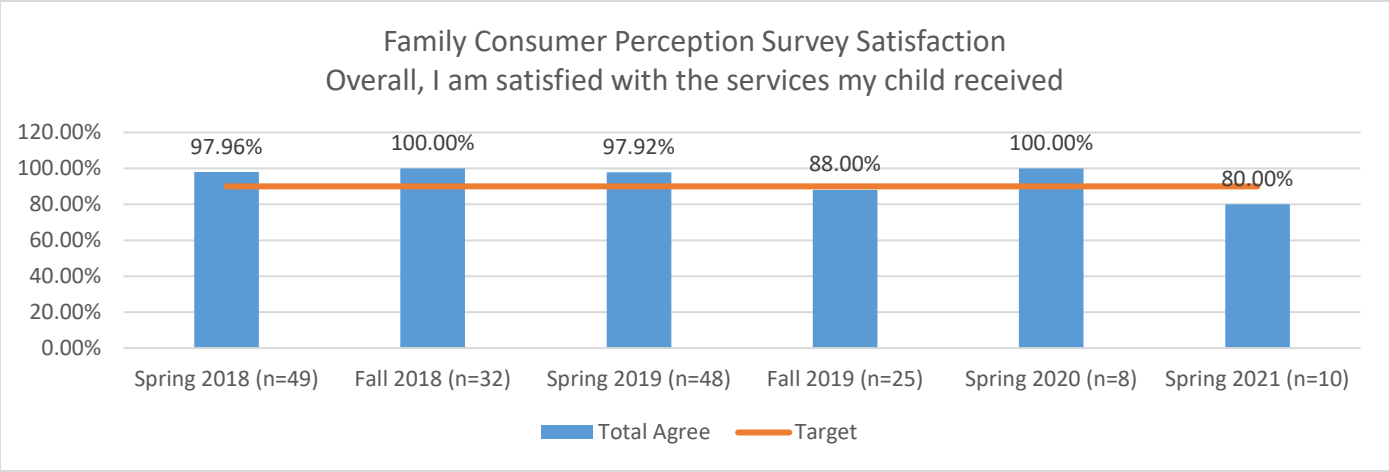
- Adult and Older Adult CPS: 89.34%
- Youth CPS: 100%
- Family CPS: 80%

These scores demonstrate approximate achievement of the consumer satisfaction level goal of 88.37%.



BASELINE PERFORMANCE DATA, continued:





FY 21-22 PERFORMANCE DATA: TBD at annual evaluation

Performance Component:	**Quality of Care**

Performance Indicator 6	**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 is 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: For FY 20-21, a total of 78 surveys were completed during this period. The target of 80% aggregate satisfaction rate was met. This data is from the former CSU contract provider. Data for FY 21-22 will be from the new CSU provider, Crestwood.

Survey Question	n	Yes	Somewhat	No	Total
Staff were professional and treated me with respect.	78	94.87%	3.85%	1.28%	100%
The cleanliness of the facility met my expectations.	77	87.01%	10.39%	2.60%	100%
The staff respected my cultural preferences.	75	93.33%	6.67%	0.00%	100%
I was involved in my treatment/discharge planning.	78	85.90%	11.54%	2.56%	100%
The experience was helpful in getting necessary services/ supports/help needed.	78	87.18%	11.54%	1.28%	100%

FY 21-22 PERFORMANCE DATA: TBD at annual evaluation

Performance Component:	**Quality of Care**

Performance Indicator 7	**Grievances and Appeals Resolutions (Beneficiaries and Provider)**
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 20-21, 12 beneficiary grievances were submitted. Six (6) of the grievances (50%) were submitted in the category of "Staff behavior concerns or Dissatisfaction with Provider." Complaints were investigated and no trend was noted. One appeal was filed and resolved. No provider grievances or appeals were submitted.

Grievances FY 20-21			
Category	**# Grievances**	**% Grievances**	**Disposition Achieved within 90 Days of Grievance Receipt**
Staff behavior concerns	4	33%	Resolved
Treatment issues or concerns	2	17%	Resolved
Medication concern	2	17%	Resolved
Confidentiality concern	1	08%	Resolved
Changes of Provider (Dissatisfaction with Provider)	2	17%	Resolved
Other – Peer Behavior	1	08%	Resolved
TOTALS	**12**	**100%**	
Appeals FY 20-21			
Category	**# Appeals**	**Disposition (Resolved or Referred)**	
NOABD Delivery System	1	Resolved - Overturned	

FY 21-22 PERFORMANCE DATA: TBD at Annual Evaluation

Grievances FY 21-22		
Category	**# Grievances**	**Disposition (Resolved or Referred)**
Appeals FY 21-22		
Category	**# Grievances**	**Disposition (Resolved or Referred)**

Summary:

Performance Component:	**Quality of Care**

Performance Indicator 8	**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.

Med Clinic Peer Review Report			
Reporting Period: January 1, 2021 - June 30, 2021			
Adult Reviews	**Total Number Counted for Each Question**	**# Meeting Criteria**	**% Meeting Criteria**
Medications prescribed are appropriate based on identified diagnoses and target symptoms.	9	8	88%
Polypharmacy is justified/supported by documentation in the progress notes.			
For benzodiazepines or other stimulants prescribed, the dosages are justified and appropriate.	9	8	88%
There is an appropriate description of the client's response to treatment.	9	8	88%
Functional impairments are identified and addressed.	9	8	88%
The physician's treatment approach is consistent with the client's current Wellness and Recovery Plan (WRP).	9	9	88%
The progress notes provide evidence of sound clinical thinking and interventions.	9	8	88%

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.

Med Clinic Peer Review Report			
Reporting Period: January 1, 2021 - June 30, 2021			
Adult Reviews	**Total Number Counted for Each Question**	**# Meeting Criteria**	**% Meeting Criteria**
Medications prescribed are appropriate based on identified diagnoses and target symptoms.	9	8	88%
Polypharmacy is justified/supported by documentation in the progress notes.			
For benzodiazepines or other stimulants prescribed, the dosages are justified and appropriate.	9	8	88%
There is an appropriate description of the client's response to treatment.	9	8	88%
Functional impairments are identified and addressed.	9	8	88%
The physician's treatment approach is consistent with the client's current Wellness and Recovery Plan (WRP).	9	9	88%
The progress notes provide evidence of sound clinical thinking and interventions.	9	8	88%

For the reporting period of January-June 2021, Med Clinic peer review data demonstrated that for Adult Review, quality criteria was met 88% for six indicators. To address the discrepancy with the adult case that did not meet criteria under peer review, the Medical Director reviewed the case and determined that the reviewer has a different style of practice leading to the review results. Medical Director has since determined that the case does meet criteria. The data demonstrates that for Children/Youth review (including foster care), quality criteria was met 100% for the five applicable indicators.

PERFORMANCE DATA: FY 21-22 TBD at Evaluation

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

Performance Indicator 9	**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 adults, 18-65 years of age, experience a move to a higher milestone or avoid a decline in functioning.
Performance Measure	% of adults, 18-65 years of age, experience a move to a higher milestone or avoid a decline in functioning during the data measurement period.
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 Buckelew and Progress Foundation. Data for each client is trended over time and averaged to determine functional improvement status. Data Source: MORS scores report 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: Data indicates that 88% of Adult beneficiaries served during FY 20-21 moved to a higher milestone or had no decline. Programs administering the MORS include NCMH programs of Adult FSP, Adult CM, and contract providers Buckelew and Progress. 41% of Adult beneficiaries experienced a positive change in functioning.

MORS Data Summary		
	FY 20-21 Q1-Q4	
	Totals	%
Total Records	**425**	**100%**
Once Score - Total Records	225	53%
Net Total Records for Sample	**200**	**100%**
Positive Change	82	41%
No Decline	94	47%
Negative Change	25	12%
Positive Change or No Decline	**176**	**88%**

FY 21-22 PERFORMANCE DATA: TBD at annual evaluation

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

Performance Indicator 10	**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 report 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:

The CANS is administered according to established protocols and practices guidelines for children/youth beneficiaries of the MHP. However, data is unavailable for FY 20-21 due to challenges with report capability of the MHP EHR data system. Staff Services Analyst is developing a new data report acquisition plan.

FY 21-22 PERFORMANCE DATA: TBD at annual evaluation

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

Performance Indicator 11	**Results of the Clinical Global Impression (CGI) Scale for young adult 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 20-21 SOAR outcomes data is as indicated. SOAR treatment services include psychiatric medication management, individualized clinical case management, weekly psychoeducation and support groups, weekly multi-family support groups, peer advocate support, and education and employment support.

During Napa SOAR's 2020-2021 fiscal year:

- 3 clients were assessed and did not meet criteria for the program.
- 19 clients were enrolled in Napa SOAR treatment.
- 12 (63%) clients were under the age of 18.
- 7 (37%) clients were 18 or over (or turned 18 during the fiscal year).
- 1 (5%) client was hospitalized during this period.
- 2 of the 3 discharged clients successfully graduated from the program.
- Of the 3 clients discharged from Napa SOAR during the fiscal year, 67% (2 clients) experienced improvement in overall symptoms and functioning.
- The third client required a higher level of care due to the nature and medical complexity of his case.

FY 21-22 PERFORMANCE DATA: TBD at Annual Evaluation

During Napa SOAR's 2021-2022 fiscal year:

Summary:

Performance Component:	**Race and Cultural Equity**

Performance Indicator 12	**Staff completion of Diversity, Equity, and Inclusion training**
Performance Goal	In FY 21-22, NCMH staff will complete mandatory annual Diversity Equity and Inclusion (DEI) training.
Performance Objective	95% completion rate within FY 21-22 of the two-part training series on LGBTQ Best Practices and Equity.
Performance Measure	% of training completions within FY 21-22.
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: Data for this indicator is from July 1, 2020, through September 17, 2021. The "n" does not include Locum Tenens staff psychiatrists. The "n" does include Mental Health Division interns. This series is required for all HHSA staff who will have until December 31, 2021, to complete all three parts. New hires will have one year from hire date to complete.

Training Component	N=	# completed	% completed
Embrace Diversity (2 hours)	81	54	67%
Understand Equity (3 hours)	81	63	78%
Commit to Inclusion (3 hours)	81	58	72%

FY 21-22 PERFORMANCE DATA: TBD at annual evaluation

Performance Component: **Utilization Management**

Performance Indicator 13	**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 meet compliance standards.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly 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 20-21, the Mental Health Division is demonstrating a 99% average compliance percentage as indicated.

Month of Review	Months Reviewed	Total # of Potentially Billable Claims Reviewed	Total Claims Written Off/BCFd	Total Claims Potentially Billable	% in Compliance	Target
Jul-20	May 2020, June 2020	101	1	100	99%	96%
Aug-20	June 2020, July 2020	87	0	87	100%	96%
Sep-20	July 2020, Aug 2020	61	2	59	97%	96%
Oct-20	Aug 2020, Sept 2020	81	0	81	100%	96%
Nov-20	Sept 2020, Oct 2020	86	1	85	99%	96%
Dec-20	Oct 2020, Nov 2020	109	0	109	100%	96%
Jan-21	Nov 2020, Dec 2020	61	0	61	100%	96%
Feb-21	Dec 2020, Jan 2021	125	3	122	98%	96%
Mar-21	Jan 2021, Feb 2021	87	0	87	100%	96%
Apr-21	Feb 2021, Mar 2021	62	3	59	95%	96%
May-21	Mar 2021, Apr 2021	119	0	119	100%	96%
Jun-21	Mar-21	290	8	282	97%	96%
	TOTAL	**1269**	**18**	**1251**	**99.6%**	**96%**

FY 21-22 PERFORMANCE DATA: TBD at Annual Evaluation

Summary:

Performance Component:	**Utilization Management**

Performance Indicator 14	**No Show Rates for Adult and Children's 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 20-21, the the Mental Health Division's Adult and Children's Medication Clinics have an aggregate show rate of 87%, falling just short of its 88% show rate target.

	ADULT (1005)			CHILD (5005/6005)			TOTAL		
	Total Appts	No Show	%	Total Appts	No Show	%	Total Appts	No Show	%
FY 08-09	4721	493	10%	1528	160	10%	6249	653	10%
FY 09-10	4198	347	8%	1801	176	10%	5999	523	9%
FY 10-11	4188	396	9%	1642	196	12%	5830	592	10%
FY 11-12	4552	428	9%	1440	172	12%	5992	600	10%
FY 12-13	4906	479	10%	1209	106	9%	6115	585	10%
FY 13-14	4528	477	11%	1234	133	11%	5762	610	11%
FY 14-15	4342	485	11%	1252	150	12%	5594	635	11%
FY 15-16	4648	1076	23%	1184	214	18%	5832	1288	22%
FY 16-17	4271	881	21%	1183	190	16%	5454	1071	20%
FY 17-18	4319	702	16%	1219	181	15%	5538	883	16%
FY 18-19	4461	685	15%	1171	178	15%	5632	863	15%
FY 19-20	4774	698	15%	936	114	12%	5710	812	14%
FY 20-21	4194	630	15%	719	80	11%	4913	710	14%
OVERALL	**58102**	**7777**	**13%**	**16518**	**2050**	**12%**	**74620**	**9825**	**13%**

FY 21-22 PERFORMANCE DATA: TBD at Annual Evaluation

Summary:

Performance Component:	**Utilization Management**

Performance Indicator 15	**No-Show Rates for Adult Outpatient Services (Adult Treatment Services Unit only)**
Performance Goal	Increase the percentage of attended appointments for Adult Outpatient Services appointments.
Performance Objective	75% of adult outpatient services appointments are attended
Performance Measure	% of adult outpatient service appointments kept.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Quarterly Monitoring Methodology: Data is collected and analyzed by the Staff Services Analyst team. Data Source: 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: FY 20-21 will serve as baseline data as this is the first year of reporting. The no-show rate for adult outpatient services was 38%.

	All Services (Adults, Children, FC)	Adult Services
Average no-show rate for adult outpatient treatment services	42%	38%
Average attended appointment rate for adult outpatient treatment services	58%	62%

FY 21-22 PERFORMANCE DATA: TBD at Annual Evaluation

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 NEW 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
5/3/2021	- Clarification of methodology for calculating timeliness of first offered psychiatry appointment: changed "first request for service" to "first assessment date" as the first assessment date is the date assigned a first request date.	Quality Coordinator, Jennifer Menges
11/17/21	- Change document title from QI Workplan to Quality Assurance and Performance Improvement (QAPI) Workplan - Change NCMHP to "MHP" - Update Data Review and Development Subcommittee composition - Minor grammatical and semantic updates - Addition of NEW Performance Indicator: No-Show Rates for Adult Outpatient Services	Quality Coordinator, Jennifer Menges and QI/URC

	- Retire the following indicators from monitoring on QI Work Plan due to monitoring transitioned to Data Dashboard, indicator replaced, or goal achieved: • Ethnic Engagement Rate (monitor on Data Dashboard) • 0-5 Age Group Engagement Rate (monitor on Data Dashboard) • Timeliness of First Offered Appointment for Non-Urgent Services (monitor on Data Dashboard) • Administration of the DSM 5 Cultural Formulation Interview (goal achieved) • Psychiatric Inpatient Re-Admission Rate (monitor in Data Dashboard) • Adult Cases Closed Due to Dropping Out of Treatment (replaced by Adult No-Shows as an indicator of engagement)	