A Tradition of Stewardship
A Commitment to Service

2020-2021

Napa County
Health & Human Services Agency
Mental Health Division

ANNUAL EVALUATION

QUALITY IMPROVEMENT WORK PLAN

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

Table of Contents

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 safest, most person-centered, equitable, efficient, timely and efficient 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:

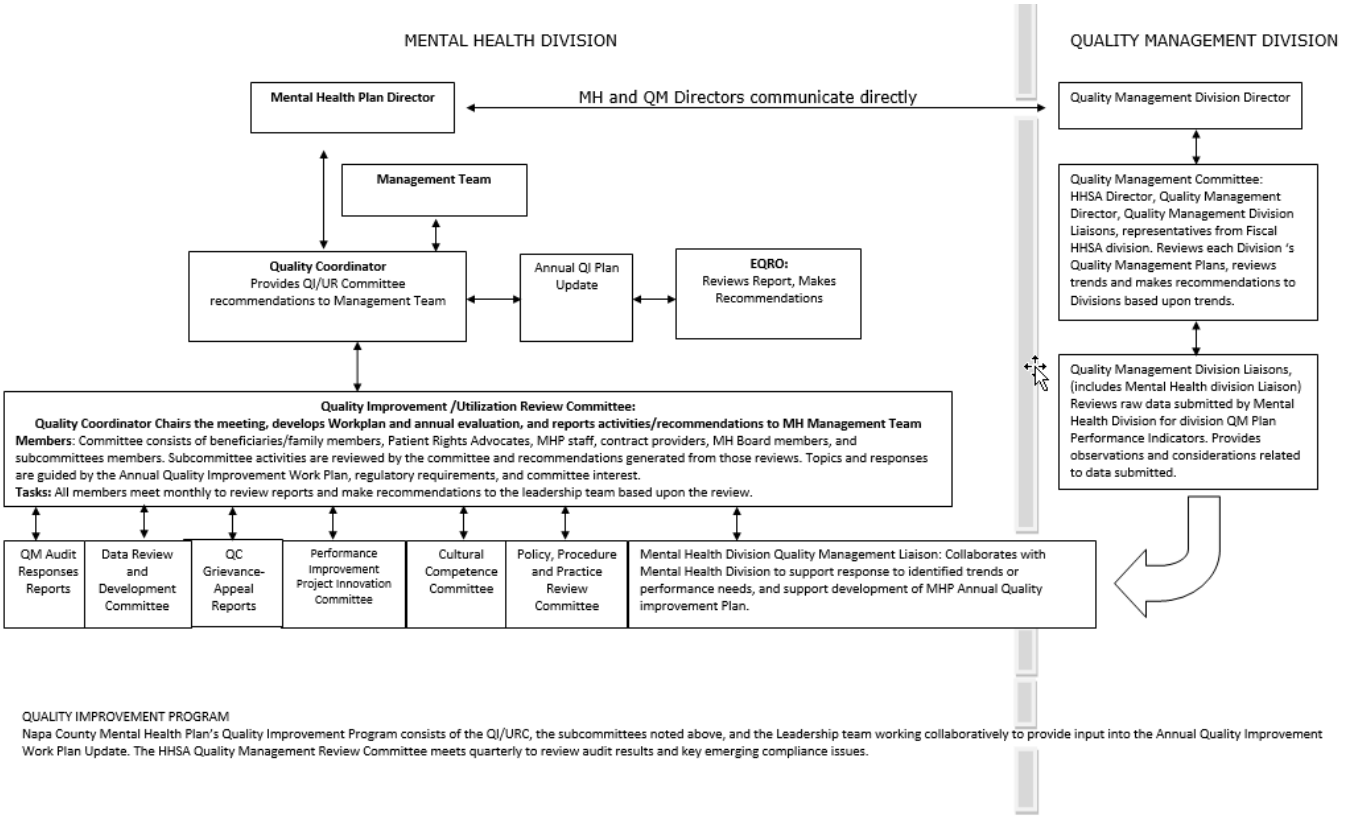
- Preserve the dignity and rights of our beneficiaries and optimize their service experience;
- Deliver timely, effective, efficient, person-centered services that are culturally and linguistically appropriate;
- Engage beneficiaries, families, contract providers and stakeholders in the planning and 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 Review and Development Committee**
  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 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 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 offered psychiatry appointments occurring within 15 days of first assessment visit.

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, both during business and after hours. 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:

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

SUMMARY:
Data demonstrates an increase in the overall effectiveness for test calls pertaining to Urgent conditions and addressing beneficiary problem resolutions (Grievances) for FY 20/21 from FY 19/20. Methodology Changes: Test calls for FY 20/21 included testing Access staff during the business hours for the 24/7 Access Line.

Note: Contracted service provider for after business hours for the 24/7 Access line changed from Exodus to Crestwood Behavioral Health during the last quarter of testing during FY 20/21.

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: CY 2020 Data:

Race/ Ethnicity	Average # Eligibles/ Month	#Beneficiaries Served	Target Engagement Rate	Napa	Small County	Statewide
Hispanic/ Latinx	19379	480	4.00%	**2.48%**	**3.87%**	**3.83%**

SUMMARY: The Napa County MHP Hispanic/Latinx engagement rate for SMHS in CY 2020 is 2.48%, which represents and decline of -0.66% from CY 2019. The target of 4.00% engagement was not met for this reporting year.

It should be noted that Hispanic/Latinx engagement rates also declined for California small counties by 0.60% and Statewide by 0.25%. The MHP rate of decline is congruent with the small county decline.

In the next months, the MHP will be reviewing the intake and assessment process and collecting service encounter survey data to better understand factors impacting ethnic engagement with the MHP.

**** This indicator is determined to lack true representation of NCMH ethnic engagement rates as it does not include data from MHSA programs, which target underserved and ethnic minority communities. This indicator will be retired from monitoring on the QI Work Plan and will be monitored going forward through administrative data review meetings.**

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: CY 2020 Data:

CY	Average # Eligibles/ Month	#Beneficiaries Served	Target Engagement Rate	Napa	Small County	Statewide
2020	3744	36	2.0%	**0.96%**	**1.24%**	**2.0%**

SUMMARY: In FY 20-21 the Napa MHP achieved a 0.96% engagement rate for 0-5 population. This rate does not meet the target of 2.0% and the rate declined by 0.39%. With the onset of the public health emergency and the continued shift in platforms for service provision, challenges in reaching the work plan target were anticipated.

It should also be noted that the Small County rate also declined by 0.37% from 1.61% to 1.24.% and the Statewide rate declined by 0.23% from 2.23% to 2.0%.

**** This indicator is determined to lack true representation of NCMH 0-5 age group engagement as it does not include data from MHSA programs, which target underserved communities and offer prevention and early intervention programs. This indicator will be retired from monitoring on the QI Work Plan and will be monitored going forward through administrative data review meetings.**

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:

	All Services	**Adult Services**	**Children's Services**	**Foster Care**
Business days from first request for service to first offered appointment	1.01 Average 1 Median Range: 1 to 15 days	1.05 Average 1 Median Range: 1 to 15 days	1 Average 1 Median Range: 1 to 1 days	1 Average 1 Median Range: 1 to 1 days
DHCS Standard	10 business days			
Count of first service requests	944	613	323	8
Count of appointments that met this standard	943	612	323	8
Percent of offered appointments that met this standard	99%	99%	100%	100%

SUMMARY: Data demonstrates that the MHP met the target of 80% of Non-Urgent first offered appointment met the 10-business day standard for all populations. For Adult Services, the standard was me 99% of the time. For Children's Services and Foster Care, the standard was met 100% of the time.

****Objective consistently met. This indicator will be retired from monitoring on the QI Work Plan and will be monitored going forward through administrative data review meetings.**

Performance Component:	**TIMELINESS OF CARE**

Performance Indicator 5	**Timeliness of first offered non-urgent psychiatry appointments**
Performance Goal	First appointment dates offered for psychiatry services are within 15 days 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 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:

	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%

SUMMARY: Data demonstrates that the MHP met the target of 80% of non-urgent first offered psychiatry appointments meeting the 15-business day standard for all populations. For Adult Services the standard was met at 88%. For Children's Services, the standard was met at 91%. For Foster Care, the standard was met at 100%. The methodology has been updated to calculate timeliness based on "first clinical determination of need" for this indicator.

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 20-21 (Urgent Svcs)	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)	N/A	N/A	N/A	N/A
DHCS Standard	48 hours			
Count of appointments that met this standard	N/A	N/A	N/A	N/A
Percent of appointments that met this standard	N/A	N/A	N/A	N/A
Range (min-max)	N/A	N/A	N/A	N/A

SUMMARY: 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 Mental Health Division's Access unit in need of urgent mental health services to be transferred or walked over and assisted by the Crisis Stabilization Services Unit (CSS). A review of the data showed that the majority of those calls or walk-ins were being directed to the Mental Health Division'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.

A review of the Coordinator and Access Call Logs for FY 20-21 showed that call times were not being noted so no data is available for this reporting period. The MHP is in the process of meeting to review 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 necessary data. Training will be provided to staff once updated. Additionally, the current electronic health record system makes it difficult to identify non-Katie A. classified/ recorded foster youth within the database. Staff training has been implemented to appropriately identify foster youth upon entering the MHP's system of care moving forward.

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:

	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%

SUMMARY: For 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%.

The MHP has one team member with the role of hospital liaison, coordinator of follow up post discharge from a psychiatric hospital stay. The MHP will explore with the team member challenges presented that led to achieving only 77% and 76% achievement of 7 business day standard for all services and adult services.

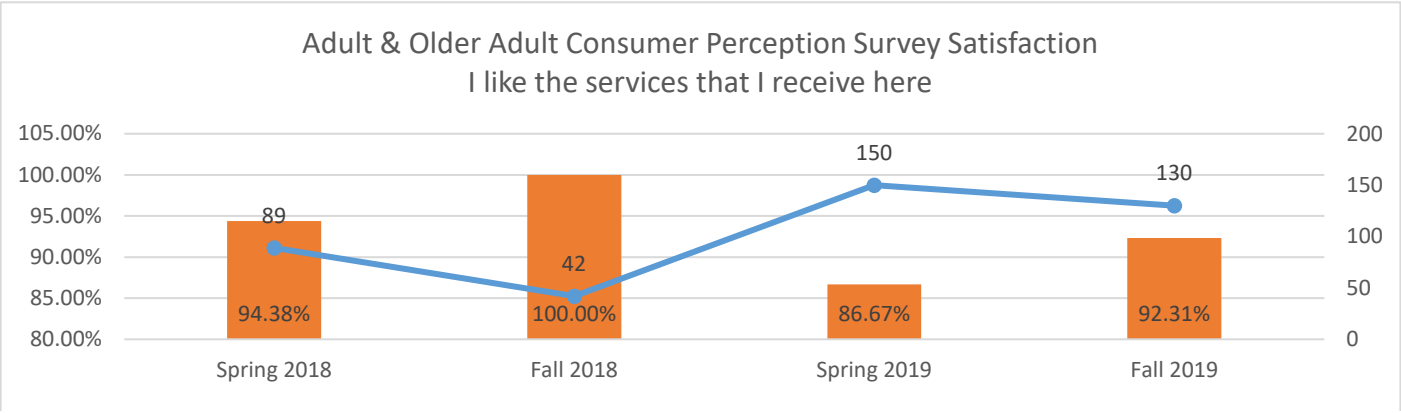
Performance Component:	**Quality of Care**

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 UCLA. 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)*

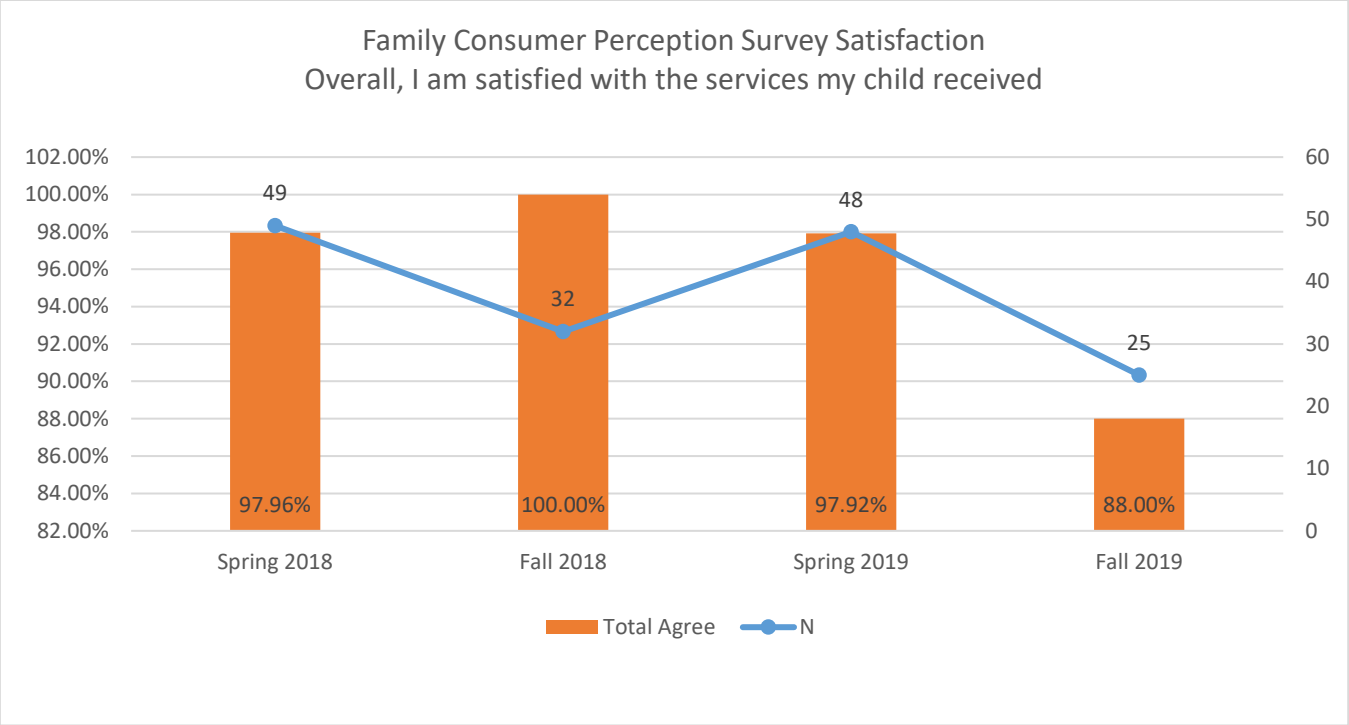
BASELINE PERFORMANCE DATA: In FY 19-20: As indicated by the trend data detail below, the most current Consumer Perception Survey (CPS) response percentages for satisfaction are as follows for each of the three core questions:

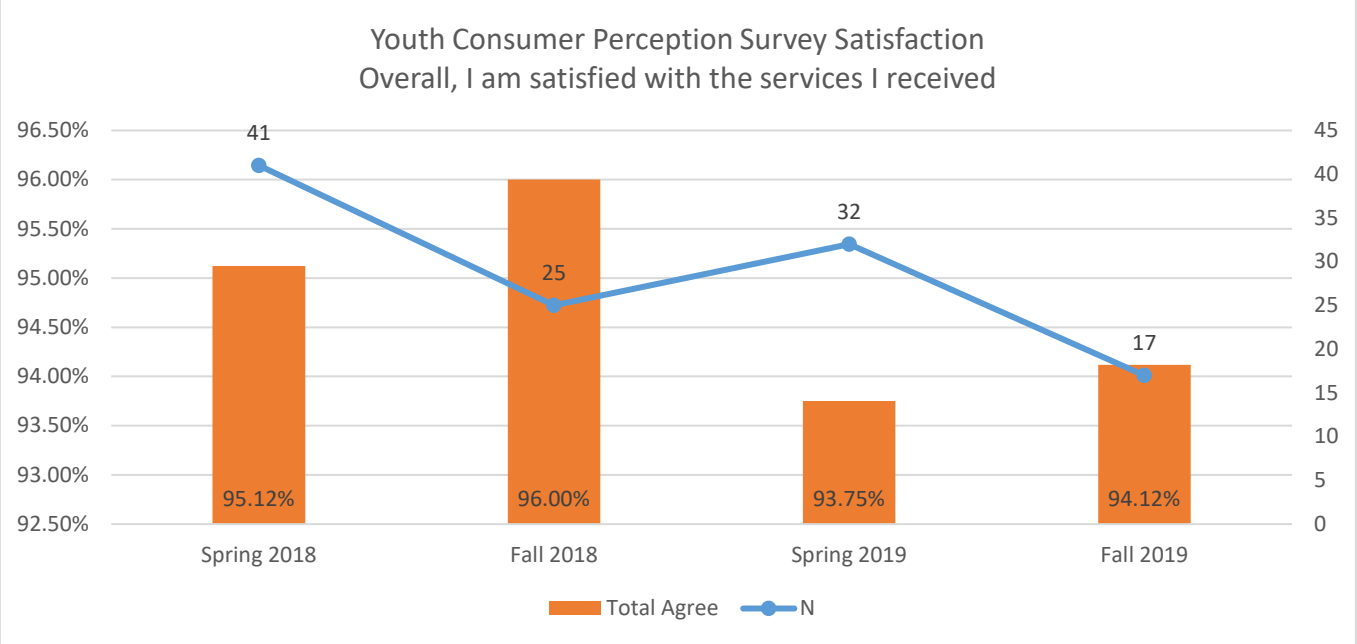
- Adult and Older Adult CPS: 92.31%
- Youth CPS: 94.12%
- Family CPS: 88%

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



BASELINE PERFORMANCE DATA, continued:

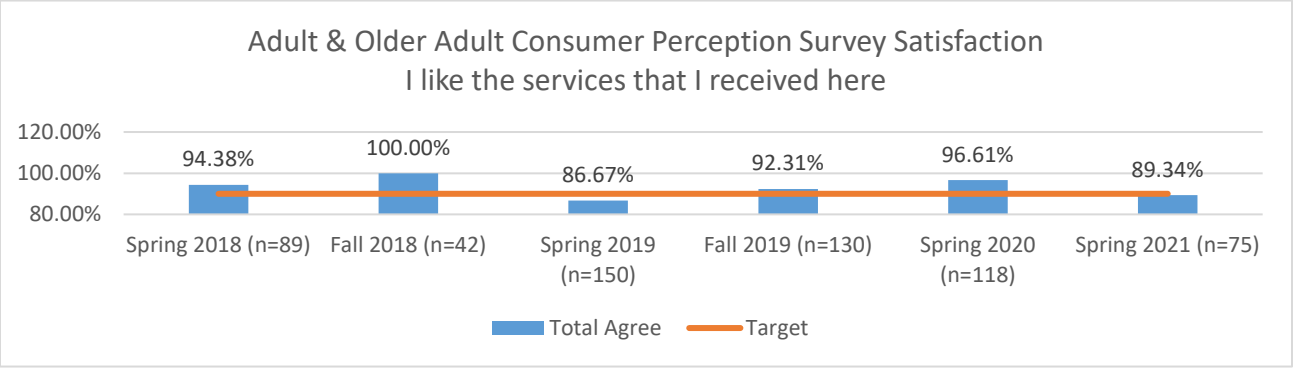


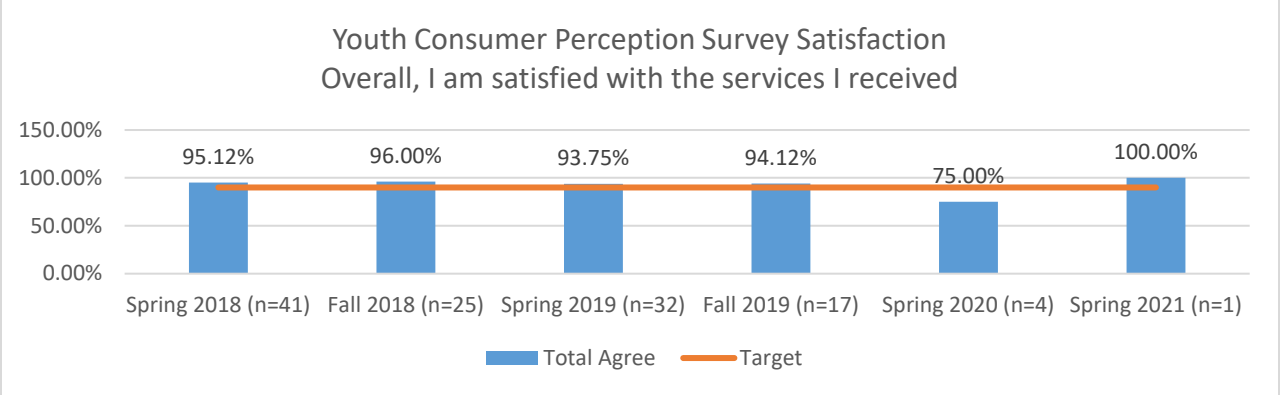


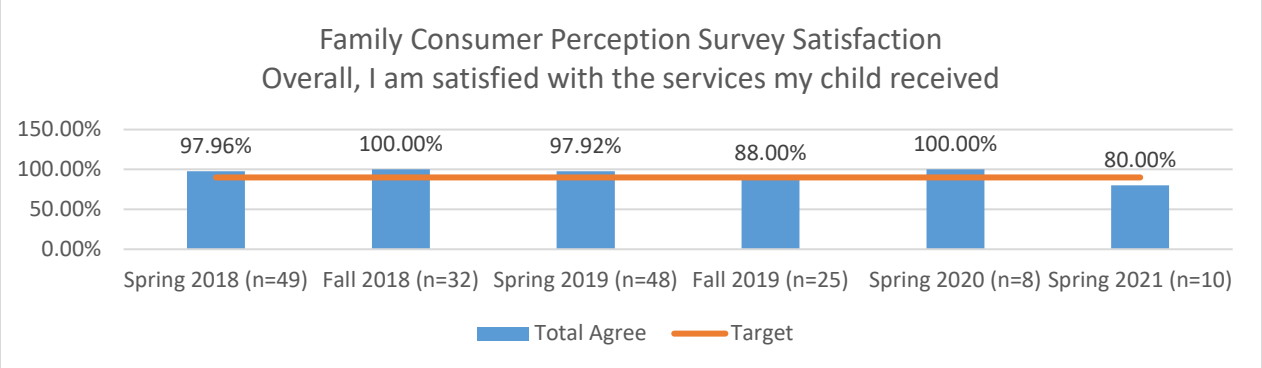
FY 20-21 PERFORMANCE DATA: In FY 20-21: As indicated by the trend data detail below, the most current Consumer Perception Survey (CPS) response percentages for satisfaction are as follows for each of the three core questions:

- 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%.







SUMMARY: Due to the public health emergency, DHCS directed counties to collect CPS data only once for FY 20-21. As a result, less responses were obtained. This data is informative by limited in strength.

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 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: FY 20-21 is the first year of reporting. Data collected this year will serve as baseline data for the successive year. Data from FY 20-21 is from CSU contract provider Exodus.

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%

SUMMARY: For FY 20-21. A total of 78 surveys were completed during this period. The target of 80% aggregate satisfaction rate was met. In June 2021, the MHP engaged a new Crisis Stabilization Unit provider, Crestwood Behavioral Health. For FY 21-22, data will be collected from the new provider.

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 Achieved within 90 days of Grievance Receipt**
Staff behavior concerns	4	Resolved
Treatment Issues or concerns	5	Resolved
Medication concern	1	Resolved
Confidentiality concern	2	Resolved
Other	1	Resolved
Appeals FY 19-20		
Category	**# Grievances**	**Disposition (Resolved or Referred)**
N/A	0	N/A

FY 20-21 PERFORMANCE DATA: FY 20-21:

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)**	
None	0	N/A	

SUMMARY: For FY 20-21, 12 grievances were submitted. Six (6) of the grievances (50%) were submitted in the category of "Staff behavior concerns or Dissatisfaction with Provider." Investigation into potential trends in this category yielded the following complaint specifics:

- Complaint of excessive time to receive verification letter
- Complaint of multiple canceled or delayed appointments
- Complaint of provider lateness and inappropriate responses
- Complaint of transition to alternate provider
- Complaint of provider inappropriate comments toward a minor

A trend is established if three or more complaints similar in nature are submitted. For this reporting period, the complaint type frequency does not indicate a definitive trend. Quality Coordinator will continue to monitor grievance submissions for trending.

The total number of 12 grievances for FY 20-21 has decreased by one (1) grievance from FY 19-20 where 13 grievances were reported.

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.

Med Clinic Peer Review Report			
Reporting Period: January 1, 2020 - June 30, 2020 (December 2020 Review)			
Adult Reviews	**Total Number Counted for Each Question**	**# Meeting Criteria**	**% Meeting Criteria**
Medications prescribed are appropriate based on identified	15	15	100%
Polypharmacy is justified/supported by documentation in the progress notes.	15	14	93%
For benzodiazepines or other stimulants prescribed, the dosages are justified and appropriate.	15	15	100%
There is an appropriate description of the client's response to treatment.	15	15	100%
Functional impairments are identified and addressed.	15	15	100%
The physician's treatment approach is consistent with the client's current Wellness and Recovery Plan (WRP).	15	15	100%
The progress notes provide evidence of sound clinical thinking and interventions.	15	15	100%

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, 2020 - June 30, 2020 (December 2020 Review)			
Children/Youth (including Foster Care) Reviews	**Total Number Counted**	**# Meeting Criteria**	**% Meeting Criteria**
For children/youth on antipsychotic medication, there is evidence in the record that the client received psychosocial/psychoeducational interventions/support 90 days before through 30 days after receiving a new prescription for an antipsychotic medication.	3	3	100%
For any children/youth who are prescribed one or more antipsychotics, there is evidence of testing for glucose or HbA1c and lipid or cholesterol.	3	3	100%
For children/youth who are prescribed one or more antipsychotics, if applicable, problematic metabolic monitoring findings are addressed by the provider.	3	3	100%
For children/youth ages 6 through 12 who have a diagnosis of ADHD or any type, there is evidence of aa visit with a provider with prescribing authority within 30 days of the new prescription.	3	3	100%
If a diagnosis of ADHD of any type is given AND the child/youth is prescribed psychotropic medication for this diagnosis, there is evidence that the client received psychosocial/psychoeducational interventions/support.	3	3	100%
For a child/youth psychiatrically hospitalized during the review period, there is evidence in the record that the county followed up with the child/youth/family within 7 days AND 30 days of the inpatient hospitalization.	3	3	100%

SUMMARY: For the reporting period of January-June 2020, Med Clinic peer review data demonstrated that for Adult Review, quality criteria was met 100% for 6 indicators and 93% for one indicator. Med Clinic leadership will conduct a further review of the case for which the indicator was not met. The data demonstrates that for Children/Youth (including Foster Care) Review, quality criteria was met 100% for all six indicators.

FY 20-21 Performance Data:

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%

Med Clinic Peer Review Report			
Reporting Period: January 1, 2021 - June 30, 2021			
Children/Youth (including Foster Care) Reviews	**Total Number Counted for Each Question**	**# Meeting Criteria**	**% Meeting Criteria**
For children/youth on antipsychotic medication, there is evidence in the record that the client received psychosocial/psychoeducational interventions/support 90 days before through 30 days after receiving a new prescription for an antipsychotic medication.	5	4	80%
For any children/youth who are prescribed one or more antipsychotics, there is evidence of testing for glucose or HbA1c and lipid or cholesterol.	5	5	100%
For children/youth who are prescribed one or more antipsychotics, if applicable, problematic metabolic monitoring findings are addressed by the provider.	5	5	100%
For children/youth ages 6 through 12 who have a diagnosis of ADHD or any type, there is evidence of aa visit with a provider with prescribing authority within 30 days of the new prescription.	5	5	100%
If a diagnosis of ADHD of any type is given AND the child/youth is prescribed psychotropic medication for this diagnosis, there is evidence that the client received psychosocial/psychoeducational interventions/support.	5	5	100%
For a child/youth psychiatrically hospitalized during the review period, there is evidence in the record that the county followed up with the child/youth/family within 7 days AND 30 days of the inpatient hospitalization.	n/a (no hosp. in group reviewed)	n/a	n/a

Summary: 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 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 adults, 18-65 years ofage, experience a move to a higher milestone or avoid a decline in functioning.
Performance Measure	% of adults, 18-65 years ofage, 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: FY 20-21 is the first year of reporting. Data collected this year will serve as baseline data for the successive year.

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%**

SUMMARY: 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.

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

The CANS is administered according to established protocols and practices guidelines for children/youth beneficiaries of the MHP. However, data is unavailable for this fiscal year due to challenges with report capability of the MHP data system.

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

Performance Indicator 14	**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 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:

- 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.

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:

*Data collected this year will serve as baseline data for the successive year.

Number of Comprehensive Assessments for Adults meeting SMHS Criteria that were Completed	**Number of Comprehensive Assessments for Adults meeting SMHS Criteria that Included Administration or Attempted Administration of the CFI**	**% Administration of the DSM 5 CFI**
110	110	100%

Summary: For FY 20-21 110 assessments were completed with adults who met SMHS criteria. Within those 110 assessments, 102 adults (92%) participated in the administration of the DSM5 CFI. According to information provided by Access assessing clinicians, 10 adults (9%) refused to engage in administration of the DSM5 CFI. Upon further discussion with Access team and review of the QI/URC, it is determined that good faith attempts were made to engage clients in participating in administration of the CFI. Therefore, within the 110 assessments, 110 ATTEMPTS were made to administer the CFI, yielding 100% administration.

**** Objective is met. This indicator will be retired from monitoring on the QI Work Plan and will be monitored going forward through administrative data review meetings.**

Performance Component:	**Race and Cultural Equity**

Performance Indicator 16	**Staff completion of Diversity, Equity, and Inclusion training**
Performance Goal	In FY 21-22, 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: Data collection period: 7/1/20-9/17/21

*Data collected this year will serve as baseline data for the successive year.

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%

SUMMARY: 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.

****This indicator will be retired from monitoring on the QI Work Plan and will be monitored going forward through administrative data review meetings. An updated indicator for DEI training will be included in the FY 21-22 QI Work Plan.**

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

Number of Policies Due for Review	Number of Policies Due for Review for which the Race and Cultural Equity Review Tool was applied	% of Policies Due for Review for which the tool was applied
22	18	82%

SUMMARY: The Mental Health Division has a total of 55 policies and procedures. The number of policies due for review includes current due and overdue policies during FY 20-21. Of the four policies that were not reviewed using the Race and Cultural Equity Review Tool, three were overdue for review and have yet to be reviewed; and one was reviewed prior to the implementation of the tool. As this is baseline data, no target has been set yet for this indicator.

**** A consistent process has been implemented for reviewing policies applying the Race and Cultural Equity Review Tool. This indicator will be retired from monitoring on the QI Work Plan and will be monitored going forward through administrative data review meetings.**

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 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 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:

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%**

SUMMARY: For FY 20-21, the Mental Health Division demonstrated a 99% average compliance percentage as indicated. The Mental Health Division fell below its target of 96% only one time during the fiscal year (month of April). 16 claims were written off (11 due to note; 5 due to plan) and 2 claims required the completion of a Billing Change Form.

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:

	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%**

Summary: For FY 20-21, the the Mental Health Division's Adult and Children's Medication Clinics had an aggregate show rate of 87%, falling just short of its 88% show rate target.

Performance Component:	**Utilization Management**

Performance Indicator 20	**Psychiatric inpatient re-admission rates**
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:

	All Services	Adult Services	Children's Services	Foster Care Services
Total number of hospital admissions	221	193	25	3
Total number of hospital discharges	227	199	25	3
Total number with readmission *within 7-days*	8	8	0	0
Percent of readmission rate *within 7-days*	3.62%	4.15%	0.00%	0.00%
Total number with readmission *within 30-days*	25	24	1	0
Percent of readmission rate *within 30-days*	11.31%	12.44%	4.00%	0.00%

Summary: For FY 20-21, the total number of hospital re-admissions within 30 days was consistently ≤15% for adults, children, and foster care, and in aggregate.

**** Objective consistently met. This indicator will be retired from monitoring on the QI Work Plan and will be monitored going forward through administrative data review meetings.**

Performance Component:	**Utilization Management**

Performance Indicator 21	**Adult cases closed since assessment due to treatment drop out**
Performance Goal	Reduce the rate of cases closed due to drop out
Performance Objective	≤35% Adult service cases closed due to drop-out.
Performance Measure	% of adults who meet medical necessity and who do not engage in further service after initial assessment.
Reporting Frequency/ Monitoring Methodology/ Data Source	Reporting Frequency: Bi-annually Monitoring Methodology: Case status data is collected through the Cerner EHR. Reason for closure is recorded at each instance of case closure in the client's case record. The dropout 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's 18-19 and 19-20, the rate of cases closed due to drop out for adults clients was 54%.

FY18-20: Adults who met Medical Necessity Criteria and Who Did Not Engage in Further Services - Reason for Closure	Percentage of Total (N = 176)	Number of Clients
Completed Treatment	6%	8
Jail/Prison	17%	23
Dropped Out (Lost to Care, Refused or Withdrew from Services)	54%	72
Moved/Out of County	5%	13
Referred to Psych Inpatient or Residential	13%	17
TOTAL	100%	133

FY 20-21 PERFORMANCE DATA: FY 20-21

FY 20-21: Adults who met Medical Necessity Criteria and Who Did Not Engage in Further Services - Reason for Closure	Percentage of Total (N=)	Number of Clients (n=31)
Completed Treatment	3%	1
Jail/Prison	3%	1
Dropped Out of Treatment: Lost to Care, Refused or Withdrew from Services	68%	21
Moved/Out of County	10%	3
Referred to Psych Inpatient or Residential/SUD	16%	5
TOTAL	100%	31

SUMMARY: The FY 20-21 data indicates that the rate of cases closed due to drop out is 68%. This data is based on clients who received a comprehensive assessment within the 8-month period of December 2020-July 2021. The baseline data covers a two-year time span.

****This FY 20-21 performance data is limited does not account for key variables such as clinician engagement skills, transportation concerns, technology availability for telehealth engagement, client involvement in multiple programs, and other social determinants of engagement. Due to these complex influencing factors, the QI/URC determined that this is not a reliable indicator of utilization.**

****This indicator will be retired from monitoring on the QI Work Plan and will be monitored going forward through administrative data review meetings as needed.**

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 for Q3-Q4 FY 20-21:

1. % of Hispanic/Latinx adult outpatient cases closed as a result of completing treatment: 0%
2. % of Hispanic/Latinx adult outpatient cases closed as a result of dropping out of treatment: 100%
3. Average # of outpatient services received by Hispanic/Latinx adults before dropping out of treatment: 5.3
4. % of adult outpatient cases closed as a result of completing treatment: 3%
5. % of adult outpatient cases closed as a result of dropping out of treatment: 68%
6. Average # of outpatient services received by adults before dropping out of treatment: 5.52

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 for FY 20-21:

Number of first scheduled psychiatry appointments meeting the 15-business day standard, versus total of first scheduled psychiatry appointments: 41 of 75 (54.6%)

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
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
7/15/21	- Update of Subcommittee names	Quality Coordinator, Jennifer Menges