

# NAPA COUNTY MENTAL HEALTH PLAN



A Tradition of Stewardship  
A Commitment to Service

## QUALITY IMPROVEMENT PROGRAM WORK PLAN

**EVALUATION OF**  
**Fiscal Year 2015/2016**  
*(July 1, 2015 – June 30, 2016)*

**Napa County Mental Health Mission Statement:**

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

## **INTRODUCTION**

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

The Quality Improvement Work Plan helps guide the NCMHP in managing: (i) conformance with federal and state requirements for quality improvement, and (ii) behavioral health system's priorities for quality improvement and quality management. With this in mind, NCMHP developed its **FY 15/16 Quality Improvement Program and Work Plan** to meet California Department of Health Care Services (DHCS) requirements in Title 9, Section 1810.440.

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

The NCMHP QI Program and Workplan is designed to:

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

## **CONTENT AND ORGANIZATION OF THE FY 15/16 QI WORKPLAN & PROGRAM**

### **Introduction - QI Workplan:**

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

- The QI Workplan gives us the opportunity to be accountable to the rights of beneficiaries and family members to receive publically funded services that are easily accessible, “do no harm” (at a minimum) and improve the quality of their lives.
- The QI Workplan gives us the opportunity to frame issues using data. We use qualitative and quantitative data to construct a baseline, develop an intervention, create a methodology and measure outcomes to see “what worked” and if we reached our goal. A data-informed decision making approach allows us to make adjustments to program implementation.
- The QI Program gives us the opportunity to engage stakeholders throughout the system in a collaborative management approach to mutual learning and developing and implementing solutions.

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

- 1) Collects and analyzes data to measure against the goals, or prioritized areas of improvement that have been identified.
- 2) Identifies opportunities for improvement and decides which opportunities to pursue.
- 3) Designs and implements interventions to improve its performance.
- 4) Measures the effectiveness of the interventions.
- 5) Formulates reports and shares the information collected to improve the efficient and effective functioning of the system and organization.

### **Quality Improvement Committee (QIC)**

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

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

The QIC is composed of the following:

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

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

If the NCMHP elects to delegate any QI activity to a separate entity, the NCMHP will describe how the relationship meets DHCS standards. Currently, QI activities related to Utilization Management are delegated to the Utilization Review Steering Committee (URSC). The Quality Coordinator sits on both committees and acts as a liaison.

### **Utilization Review Steering Committee**

The Utilization Review Steering Committee is responsible for administratively monitoring the utilization of all treatment services provided by the NCMHP. The URSC develops, implements, evaluates, and

## Napa County Mental Health Quality Improvement Work Plan FY 15-16

improves utilization review processes, reviews reports of service utilization and makes recommendations for actions when patterns of over or under utilization, barriers to service access and service delivery, and qualitative customer service concerns have not been resolved at the program level. The Committee is intended to ensure the most efficient and effective use of the NCMHP clinical care resources. The Utilization Review Steering Committee is composed of the following:

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

The Quality Improvement and Utilization Review Committees collaborate to integrate current utilization data into the Quality Improvement Committee's review process and formulation of recommendations. The QI Workplan incorporates elements in the domains of both committees.

FY 15/16 QI Workplan Goals

Section	GOAL DOMAIN	Page Number
I	Monitoring the Service Capacity of the MHP	p.6
II	Monitoring the Timeliness of Mental Health Services for Routine and Urgent Conditions	p.9
III	Monitoring Beneficiary and Family Satisfaction.	p.14
IV	Monitoring Mental Health Plans' Service Delivery System and Clinical Issues Affecting Beneficiaries	p.16
V	Monitoring Continuity and Coordination of Care with Physical Health Care Providers and other Human Services Agencies	p.18
VI	Monitoring Provider Satisfaction	p.19
VII	Strengthen the MHP's Quality Improvement Program Infrastructure	p.20
VIII	Monitoring Requirements for Cultural Competence and Linguistic Competence as specified in Title 9 CCR 1810.410	p.21

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	<b>SECTION I: Monitoring the Service Capacity of the MHP</b>
<b>GOALS 1 &amp; 2: Cultural &amp; Ethnic Penetration Rates</b>	<p>Penetration rates establish information on the number of individuals who receive (utilize) mental health related services relative to the general population. These rates of utilization can be compared to state, regional, and national figures. They allow a rough analysis of patterns of utilization across various key demographics</p> <ol style="list-style-type: none"> <li>1. Increase the Hispanic penetration rate from 3.12% to 5.00%</li> <li>2. Maintain the 0-5 Age group population penetration rate of 2.30%</li> </ol>
<b>BASELINE</b>	Based on EQRO reported data plus local report- compared to statewide small county averages.
<b>ACTION STEPS</b>	<ul style="list-style-type: none"> <li>• Under the auspices of the QIC, a focus workgroup will be convened to make recommendations on strategies to increase the Hispanic penetration rate.</li> </ul>
<b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b>	<p><b>Methodology:</b> Data is taken from state published data of individuals who are Medi-Cal eligible, who enroll in treatment within the Napa Mental Health Plan (MHP) delivery system, and have at least one service divided by the total population (Medi-Cal eligible). This data can be evaluated in a number of ways (i.e., looking at Medicaid population eligibility, comparing against SMI/SED prevalence rates, cultural and ethnic populations, etc.).</p> <p><b>Data Source:</b> Prepared report from CAEQRO “Medi-Cal Approved Claims Data for Napa County MHP”. Report data is based on DMH approved claims and MMEF Data. Target is set based on Small County penetration rate data.</p> <p><b>Frequency of Review:</b> Annual</p>
<b>STAKEHOLDERS</b>	QIC, URSC, MH Leadership, Clinical staff and Supervisors, Partner Agency staff, Consumers and their families
<b>EVALUATION</b>	<b>DATA DETAIL</b>
<p>Annual Goal Items Met: Item # <u>  2  </u> Partially Met: Item # <u>    </u> Not Met: Item # <u>  1  </u> Continued: Item # <u>  2  </u></p>	<ol style="list-style-type: none"> <li>1. While total served (per EQRO-491) Hispanic population remained stable and represents approximately 40% of total clients served, due in large part to a significant jump in total Hispanic Medi-Cal eligible beneficiaries as a result of Medicaid expansion, the penetration rate percentage rose to only 3.30% for CY 15.</li> <li>2. A similar phenomenon occurred in the 0-5 penetration rate. Total individuals served remains historically high (per EQRO-81), however the penetration rate for CY 15 was 1.86%</li> </ol>

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

**I. SECTION II: Monitoring the Accessibility of Services**

<p><b>GOAL II.A.</b></p> <p><b>Percentage of non-urgent mental health services/appointments offered within 10 business days of the initial request</b></p>	<p>Timely access to services is a core value of the MHP. The Department of Health Care Services (DHCS) requires counties to track how long it takes individuals requesting non-urgent mental health services to receive the requested services. DHCS is in the process of setting a statewide metric for counties to track the percentage of non-urgent mental health services/appointment offered within 10-15 business days of the initial request by the beneficiary or legal guardian for an appointment.</p> <ul style="list-style-type: none"> <li>• Continue to monitor wait times for routine mental health services to meet service delivery target of 10 days.             <ul style="list-style-type: none"> <li>• Adults</li> <li>• Children</li> <li>• All</li> </ul> </li> </ul>
<p><b>BASELINE</b></p>	<p>Initial data analysis for this indicator was completed for May and June 2015. During that period:</p> <ul style="list-style-type: none"> <li>• There were a total of 97 requests by Medi-Cal beneficiaries for mental health services in May, of which 93 (<b>96%</b>) were offered an appointment for mental health services within 10 business days.</li> <li>• There were a total of 134 requests for mental health services in June, of which 129 (<b>96%</b>) were offered an appointment for mental health services within 10 business days.</li> </ul>
<p><b>ACTION STEPS</b></p>	<ol style="list-style-type: none"> <li>1. Monitor DHCS' adaptation of the statewide timeliness metric and adjust methodology accordingly.</li> <li>2. Continue to track the indicators on the UR Dashboard</li> <li>3. Monitor data collection and analysis for outliers.</li> </ol>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY OF COLLECTION</b></p>	<p><b>Methodology:</b> The difference between the date of the request for service and the date an appointment/service was offered is calculated to determine the length of time. Because DHCS is in the process of changing from "business days" versus "calendar days", the formula used for the calculation is =NETWORKDAYS(start date, end date)-1 where start date is the date of request and end date is the date appointment/service offered. Data will be sorted to look at the number of same day offers, the number</p>

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	<p>offered within 1-10 days of the request, the number offered within 11+ days of the request, and the percentage that met the 10 business day target. The MHP will evaluate the data for Medi-Cal beneficiaries only and all individuals requesting services.</p> <p><b>Data Source:</b> Central Access and Authorization Team (CAAT) Log</p> <p><b>Frequency of Review:</b> Monthly</p>																																																																																																									
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- *DHCS Site Review Protocol Section: A*
- *MHP Contract Element: Goals are Set and Mechanisms Established to Monitor Timeliness of Routine Mental Health Appointments (Sections 22 & 24)*

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

<p><b>GOAL II.B.</b></p> <p>EQRO Timeliness Self-Report Metric: Average length of time from initial contact to first psychiatry appointment</p>	<p>Continue to monitor wait times for psychiatric appointments to meet service delivery target of 14 days.</p>
<p><b>BASELINE</b></p>	<p>As seen in the data report, this indicator has extremely broad variances and establishing a reliable baseline is not possible at this time.</p>
<p><b>ACTION STEPS</b></p>	<p>Per the 14/15 Work Plan Evaluation Report: Over Fiscal year 2014-2015 the target goal was only met 2 out of 12 months and the average wait times were well over 14 days. However, the MHP is re-assessing this indicator as it measures wait times only for individuals who are initially assessed in the Access unit and then referred to psychiatry. Over the past year, the MHP set up several triage processes to prioritize faster psychiatry services for individuals who were discharging from psychiatric care or referred directly by the FQHC. These processes bypass Access and result in much quicker assessments and appointments. However, they are not included in the data tracked for this indicator. Therefore it is doubtful that this indicator is providing accurate information regarding actual timeliness.</p> <p>The Quality Coordinator will work with the Staff Services Analyst and other stakeholders to re-examine the methodologies for this indicator with the goal of capturing more reliable data.</p>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>Tracked on the QM Dashboard monthly.</p>
<p><b>STAKEHOLDERS</b></p>	<p>Quality Coordinator, Staff Services Analyst, Administrative Manager, Psychiatric Medical Director, Access Staff and Supervisor, QM Division Manager</p>
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>
<p>Discontinued</p>	<p>After review and discussion, it was decided by the MHP to abandon this indicator. New timeliness indicators will be substituted on next year's QI Work Plan</p>

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

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

<p><b>GOAL II.C.</b></p> <p>All individuals requesting urgent mental health services are seen or referred for emergent care within 24 hours of the initial request.</p>	<p>1. Timely access to services is a core value of the MHP. The Department of Health Care Services (DHCS) requires counties to track how long it takes individuals requesting urgent mental health services to receive the requested services. Despite discussion at the state level, there remains no consensual definition of “Urgent” care. Some counties are defining urgent as a condition which, if not addressed, could result in an emergent condition. Operationally, counties and DHCS have defined urgent by level of care (e.g. a condition that requires the MHP to address same day and does not result in a crisis residential/stabilization or 5150 level of care).</p> <p>This is a new goal and indicator for 15/16.</p>												
<p><b>BASELINE</b></p>	<p>100%</p>												
<p><b>ACTION STEPS</b></p>	<p>Now that the indicator has been created, continue to monitor data in URSC monthly.</p>												
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p><b>Methodology:</b> For individuals requesting <b>urgent mental health services only</b>, the number of assignments opened to Adult and Children’s Emergency Response Team (ERT) minus those individuals whose urgent mental health request resulted in a crisis residential or 5150 level of care placement.</p> <p><b>Data Source:</b> Anasazi Assignment Report for Adult/Children’s ERT and Progress Place (subunits 1001, 5001, and 1602); Anasazi Assessment and Treatment Plan Listing Report by MH Hospital Admission Form</p> <p><b>Frequency of Review:</b> Monthly</p>												
<p><b>STAKEHOLDERS</b></p>	<p>Access Staff and Supervisor, ERT Staff and Supervisor, Clinical Director, Quality Coordinator, Staff Services Analyst</p>												
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>												
<p>Annual Goal Items Met: Item # _1_ Partially Met:</p>	<table border="1"> <thead> <tr> <th colspan="4">FY 15-16</th> </tr> <tr> <th>MONT H</th> <th>TOTAL Requests for Urgent ERT Services</th> <th># of Requests for Urgent ERT Services met within 24 Hours</th> <th>% Met Target</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	FY 15-16				MONT H	TOTAL Requests for Urgent ERT Services	# of Requests for Urgent ERT Services met within 24 Hours	% Met Target				
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**Napa County Mental Health Quality Improvement Work Plan FY 15-16**

Item # ____ Not Met: Item # ____ Continued: Item # _1_	Jun-15	221	221	100%
	Jul-15	230	230	100%
	Aug-15	195	195	100%
	Sep-15	189	189	100%
	Oct-15	172	172	100%
	Nov-15	145	145	100%
	Dec-15	169	169	100%
	Jan-16	164	164	100%
	Feb-16	153	153	100%
	Mar-16	215	215	100%
	Apr-16	164	164	100%
	May-16	177	177	100%
	Jun-16	219	219	100%
	<b>TOTAL</b>	<b>2413</b>	<b>2413</b>	<b>100%</b>

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

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

<b>GOAL II.D.</b>	Continue to provide 24/7 after hours access to care for emergent, urgent, or routine conditions
Access to after-hours care	
<b>BASELINE</b>	100%
<b>ACTION STEPS</b>	NCMHP currently staffs a 24/7 Emergency Response Unit which responds to all emergent and urgent conditions, as well as responding to the 24/7 Access line for requests for routine access to services or information about problem resolution.
<b>MONITORING</b>	

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METHODOLOGY/ DATA SOURCE/ FREQUENCY	Not data monitored.
STAKEHOLDERS	Entire Community
EVALUATION	DATA DETAIL
Annual Goal Items Met: Item # _1_ Partially Met: Item # __ Not Met: Item # __ Continued: Item # __	Not a data monitored item.

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

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<p><b>GOAL II.E.</b></p> <p>Responsiveness of the 24/7 toll-free number</p>	<p>Ensure that NCMH has after-hours Access line capability which provides information in threshold languages on how to access routine mental health services and how to use the problem resolution processes.</p>	
<p><b>BASELINE</b></p>	<p>2 calls monthly</p>	
<p><b>ACTION STEPS</b></p>	<ul style="list-style-type: none"> <li>• Conduct at least 2 test calls a month</li> <li>• Record results of test calls</li> <li>• Meet with Access Supervisor regularly to improve performance</li> <li>• Report Test Call results to QIC annually</li> <li>• Report Test Call results to DHCS quarterly</li> </ul>	
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>Data entered on DHCS Reporting Spreadsheet quarterly. Collected from filled out call report sheets by test callers. Quarterly</p>	
<p><b>STAKEHOLDERS</b></p>	<p>ERT Staff and Supervisor, Access Staff and Supervisor, Quality Coordinator, QIC</p>	
<p><b>EVALUATION DATA DETAIL</b></p>		
<p>Annual Goal Items Met: Item # <u>  All  </u> Partially Met: Item # <u>  </u> Not Met: Item # <u>  </u> Continued: Item # <u>  All  </u></p>	<p><b>COUNTY NAME: Napa</b></p>	<p><b># TEST CALLS MADE DURING BUSINESS HOURS: 3</b></p>
	<p><b>TESTING PERIOD: Aggregate 2015-2016</b></p>	<p><b># TEST CALLS MADE DURING AFTER-HOURS: 13</b></p>
	<p><b>DID MHP TEST AFTER-HOURS CONTRACTOR? YES, NO, N/A: N/A</b></p>	<p><b>TOTAL TEST CALLS MADE: 16</b></p>
	<p><b>IF YES, CONTRACTOR NAME(S):</b></p>	<p><b>NON-ENGLISH TEST CALLS: 2</b></p>

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Does the 24/7 Statewide Toll-Free Access Line provide: <i>(Reference: Compliance Protocol: Section A - Access Questions 9/9a (1-4))</i>		Number of test calls made	Number of test calls where requirements were met	Percentage of test calls where requirements were met	
1	Language capability in all languages (non-English) spoken by beneficiaries of the County? Language(s) Tested:	B	0	0	
		A	2	2	100%
2	Information about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met? (e.g. directing the caller where they can obtain a clinical assessment, providing clinic locations and hours of operation, information about walk-in services, etc.)	B	3	3	100%
		A	10	10	100%
3	Information about services needed to treat a beneficiary's urgent condition? (e.g. crisis services)	B	0	0	
		A	0	0	
4	Information about how to use the beneficiary problem resolution and fair hearing process?	B	0	0	
		A	2	2	100%
Does the written log of the initial requests for specialty mental health services include: <i>(Reference: Compliance Protocol: Section A - Access Questions 10 (a-c))</i>		Number of test calls required to be logged	Number of test calls logged that met requirements	Percentage of test calls logged that met requirements	
5	Name of the beneficiary?	B	3	3	100%
		A	11	4	36%
6	Date of the request?	B	3	3	100%
		A	11	4	36%
7	Initial disposition of the request (e.g.	B	3	3	100%

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	caller provided with clinic hours/location, beneficiary scheduled for assessment with [Provider] at [Date/time], warm hand off to 24-hour Crisis Clinician, etc.)?	A	11	4	36%
	Prepared by (name, title): Harry Collamore	<b>Key:</b> <b>B: Business Hours</b> <b>A: After-Hours</b>			
	Telephone: Harry Collamore				
	E-Mail Address: harry.collamore@countyofnapa.org				
<p>Data analysis as well as the results of DHCS auditor’s test calls indicate a consistent pattern of calls being well handled in all respects by the staff answering the line. However, there remains a persistent issue with after-hours calls being logged. The issue is the focus of a Plan of Correction and will be prioritized as the new after-hours contractor takes on the responsibility in Spring, 2017.</p>					

- *DHCS Site Review Protocol Section: A*
- *Goals are Set and Mechanisms Established to Monitor Access to After Hours Care(Sections 22 & 24)*

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

<b>GOAL II.F.</b>  Medication services are efficiently managed	<ol style="list-style-type: none"> <li>1. 90% of intake appointments scheduled are kept</li> <li>2. 88% of appointments scheduled are kept</li> </ol>
<b>BASELINE</b>	<p>Goal #1: The target of 90% was not met in 14/15. The annual average was ~80%.</p> <p>Goal # 2: The goal of 88% was not met in 2014-2015. The annual average was ~ 82%</p>
<b>ACTION STEPS</b>	<ol style="list-style-type: none"> <li>1. Continue to monitor quarterly on QM Plan: % of individuals (children and adults) scheduled for Medication clinic intake evaluations who show up for their appointments</li> <li>2. Continue to monitor quarterly on QM Plan: % of all scheduled Adult</li> </ol>

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	<p align="center">medication appointments kept</p> <p>A new Psychiatric Medical Director joined NCMH in January, 2016. These goals will be discussed with her to determine if the goal percentages meet practice standards and what action steps should be implemented.</p>																																																						
<b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b>	Data collected from Anasazi Scheduler report: individuals who kept appointments/individuals scheduled for appointments Quarterly report.																																																						
<b>STAKEHOLDERS</b>	Psychiatric Medical Director and Psychiatric Staff, Staff Services Analyst																																																						
<b>EVALUATION</b>	<b>DATA DETAIL</b>																																																						
<p>Annual Goal Items Met: Item # __1-childrens_</p> <p>Partially Met: Item # __</p> <p>Not Met: Item # __1-adult; 2__</p> <p>Continued: Item # __1&amp;2__</p>	<p>1.</p> <table border="1"> <thead> <tr> <th colspan="6">Adult Medication Clinic Intake Appointments By FY</th> </tr> <tr> <th>FY</th> <th>Total Intake Appts</th> <th>SHOW</th> <th>%SHOW</th> <th colspan="2">TARGET</th> </tr> </thead> <tbody> <tr> <td>FY 15-16</td> <td>181</td> <td>132</td> <td>73%</td> <td colspan="2">90%</td> </tr> </tbody> </table> <table border="1"> <thead> <tr> <th colspan="6">Children's Medication Clinic Intake Appointments By FY</th> </tr> <tr> <th>FY 15-16</th> <th>Total Intake Appts</th> <th>SHOW</th> <th>%SHOW</th> <th colspan="2">TARGET</th> </tr> </thead> <tbody> <tr> <td>FY 15-16</td> <td>47</td> <td>46</td> <td>98%</td> <td colspan="2">90%</td> </tr> </tbody> </table> <p>2.</p> <table border="1"> <thead> <tr> <th colspan="6">Adult Medication Clinic Appointment Show Rates by FY</th> </tr> <tr> <th>FY 15-16</th> <th>Total Appts</th> <th>NO SHOW</th> <th>SHOW</th> <th>%SHOW</th> <th>TARGET</th> </tr> </thead> <tbody> <tr> <td>FY 15-16</td> <td>4648</td> <td>1076</td> <td>3572</td> <td>77%</td> <td>88%</td> </tr> </tbody> </table>	Adult Medication Clinic Intake Appointments By FY						FY	Total Intake Appts	SHOW	%SHOW	TARGET		FY 15-16	181	132	73%	90%		Children's Medication Clinic Intake Appointments By FY						FY 15-16	Total Intake Appts	SHOW	%SHOW	TARGET		FY 15-16	47	46	98%	90%		Adult Medication Clinic Appointment Show Rates by FY						FY 15-16	Total Appts	NO SHOW	SHOW	%SHOW	TARGET	FY 15-16	4648	1076	3572	77%	88%
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- *DHCS Site Review Protocol Section: A*
- *MHP Contract Element: Goals are Set and Mechanisms Established to Monitor Responsiveness of the 24/7 Toll Free Number (Sections 22 & 24)*

**SECTION III: Monitoring Beneficiary and Client Satisfaction**

<p><b>GOAL III.A.</b></p> <p>1) Beneficiary and family satisfaction surveys of the NCMHP</p>	<ol style="list-style-type: none"> <li>1. Beneficiary Satisfaction Survey target: 85 % of survey questions are ranked satisfied to very satisfied.</li> <li>2. Re-format and focus analysis of survey results and produce recommendations for improvements.</li> <li>3. Develop new baselines and metrics based on new data analysis.</li> </ol>
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continue to be conducted bi-annually using the Performance Outcome Quality Improvement (POQI)	
BASELINE	Due to staffing resources changes, the Quality Management Division was no longer able to provide analysis of the POQI. The MHP has taken this analysis on and is developing a new approach to analyzing the POQI data.
ACTION STEPS	Continue to analyze data and develop new metrics.
MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY	TBD
STAKEHOLDERS	QIC, Quality Coordinator, Staff Services Analyst
EVALUATION	DATA DETAIL
Annual Goal Items Met: Item # _2&3_ Partially Met: Item # ___ Not Met: Item # _1_ Continued: Item # _2&3_	<ol style="list-style-type: none"> <li>1. Data not analyzed to this goal, which was retired. (see 2017 Work Plan for revised goals)</li> <li>2. In coordination with CIBHS and the EBHS data analysis software, the MHP has commenced a revised process for analyzing the results of the Consumer Perception Survey (POQI) results.</li> <li>3. One of the new metrics established is attached to the new Social Engagement PIP. Having analyzed the CPS data, it was noted that ~25% of adult respondents expressed neutral to dissatisfaction with 4 key questions related to social engagement and isolation. A PIP related goal was established to improve this result to 15%.</li> </ol>

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

**SECTION III continued: Monitoring Beneficiary and Client Satisfaction**

<p><b>GOAL III.B.</b> Monitor Grievances, Appeals, Requests for Change of Providers and Fair Hearings resolutions</p>	<p>Beneficiary grievance, appeals, requests for change of providers and fair hearings are tracked by the HHS Quality Management team and the Mental Health Quality Coordinator. A summary report is reviewed by the QIC annually, given to the Mental Health Program Manager and Mental Health Director, and reported annually to DHCS.</p>
<p><b>BASELINE</b></p>	<p>100% of Appeals, Grievances and 95% of Requests for Change of Providers are successfully resolved within mandated timeframes.</p>
<p><b>ACTION STEPS</b></p>	<p>Continue tracking and reports.</p>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>Grievances, Appeals and Requests For Change of Providers are tracked over the course of the year on spread sheets with original copies and correspondence kept in secure files. An annual summary report, now based on a mandated reporting form from DHCS is compiled and presented to QIC.</p>
<p><b>STAKEHOLDERS</b></p>	<p>QIC, QM, Quality Coordinator, MH Director</p>
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>
<p>Annual Goal Items Met: Item # <u>  1  </u> Partially Met: Item # <u>  </u> Not Met: Item # <u>  </u> Continued: Item # <u>  1  </u></p>	<p>The data was collected and presented to the QIC and DHCS. At this time, the data will remain confidentially sequestered from this evaluation.</p>

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

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

<p><b>GOAL</b> Improve monitoring of the safety and effectiveness of Medication Practices</p>	<p>Improve monitoring of the safety and effectiveness of Medication Practices</p> <ul style="list-style-type: none"> <li>• Define new methodologies for monitoring medication effectiveness.</li> <li>• Implement Med Clinic Peer Review</li> </ul>
<p><b>BASELINE</b></p>	<p>TBD based on new measures</p>
<p><b>ACTION STEPS</b></p>	<ul style="list-style-type: none"> <li>• Coordinate Quality Assurance and Improvement efforts with new Psychiatric Medical Director and team.</li> </ul>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>Design and implement annual report on physician peer review activities.</p>
<p><b>STAKEHOLDERS</b></p>	<p>Psychiatric Medical Director, Quality Coordinator, QIC</p>
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>
<p>Annual Goal Items Met: Item # _2_ Partially Met: Item # ___ Not Met: Item # _1_ Continued: Item # _1_</p>	<ol style="list-style-type: none"> <li>1. The Psychiatric Medical Director position was vacant for most of 15-16. A new Psychiatric Medical Director joined the MHP in Fall, 2016, so this goal will be revisited.</li> <li>2. Completed.</li> </ol>

- *DHCS Site Review Protocol Section: I*
- *MHP Contract Element: implement mechanisms to monitor safety and effectiveness of medication practices (Section 22)*

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

<p><b>GOAL</b>          Improve Efficiency and Effectiveness of Spanish Language Services</p>	<ul style="list-style-type: none"> <li>• Convene Work Group(s) including stakeholders in order to define measurable objectives to improve MHP capacity to provide appropriate Spanish language services</li> <li>• Based on group recommendations, select defined improvement project(s) and initiate PDSA's</li> </ul>
<p><b>BASELINE</b></p>	<p>3.18 % Demographic penetration rate and others TBD</p>
<p><b>ACTION STEPS</b></p>	<p>Develop implementation plans and set new targets based on work of Work Group(s)</p>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>EQRO demographic penetration rate data; other data models tbd</p>
<p><b>STAKEHOLDERS</b></p>	<p>QIC, Ethnic Services Manager, HHSA Multi-Lingual Task Force, MHSA Stakeholders Advisory Group, MH Leadership Team, MH Administration, MHP Program Supervisors and Staff, MHP Customers</p>
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>
<p>Annual Goal Items Met:          Item # ___          Partially Met:          Item # ___          Not Met:          Item # _1&amp;2_          Continued:          Item # discontinued</p>	<p>These goals await the creation and implementation of a revised Cultural Competence Plan.</p>

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

<p><b>GOAL V.A.</b> Improved Coordination of mental health and physical health care is a primary focus of NCMHP and on campus FQHC Ole Health</p>	<p>Over a 12 month period, Napa County’s partnership of consumers, the Mental Health and Alcohol and Drug Services Divisions of the Health and Human Services Agency and Community Health Clinic Ole, working with Partnership Health Plan our local public safety net health plan will:</p> <ul style="list-style-type: none"> <li>• Continue working on objectives developed in CIC charter.</li> <li>• Identify new opportunities for integration of services</li> <li>• Improve and implement Sensitive Information Exchange mechanisms</li> </ul>
<p><b>BASELINE</b></p>	<p>30 Individuals are currently enrolled in the pilot services</p>
<p><b>ACTION STEPS</b></p>	<ul style="list-style-type: none"> <li>• Implement Sensitive Information Exchange technology between partners</li> <li>• Implement universal release of information form</li> <li>• Continue to convene oversight and stakeholder planning groups</li> </ul>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>Work group minutes, QIC meeting minutes</p>
<p><b>STAKEHOLDERS</b></p>	<p>Ole Health County Campus Director and staff, MH Access Supervisor and Staff, MH and ADS Leadership and designated staff, Quality Coordinator, QIC</p>
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>
<p>Annual Goal Items Met:</p>	<p>1. The universal ROI draft was completed, but has remained unimplemented due to concerns raised by county counsel</p>

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Item # ____ Partially Met: Item # _1, 2, 3__ Not Met: Item # ____ Continued: Item # _2, 3__	<p>that a universal ROI that includes Alcohol and Drug Services will likely violate 42CFR confidentiality standards.</p> <ol style="list-style-type: none"> <li>2. Ole Health has actively participated with NCMH in a Performance Improvement Project intended to improve the speed and accuracy of Ole Health to Mental Health referrals.</li> <li>3. Sensitive Information Exchange remains a technological IT challenge and efforts will continue to develop methods for real time information exchange of records between primary care providers at Ole Health and, in particular, psychiatrists at NCMH.</li> </ol>
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- *DHCS Site Review Protocol Section: F*
- *MHP Contract Element: implement mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.(Section 22)*

**SECTION VI: Monitoring Provider Satisfaction**

<p><b>GOAL VI. A.</b>                  1) Monitor Provider appeal resolution                  2) Provider Satisfaction Surveys administered annually</p>	<ul style="list-style-type: none"> <li>• Successfully resolve 95% of provider appeals.</li> <li>• Design and administer updated Provider Satisfaction Surveys</li> <li>• Provider Satisfaction Surveys: 85% respond somewhat satisfied to very satisfied.</li> </ul>
<p><b>BASELINE</b></p>	<p>85%</p>
<p><b>ACTION STEPS</b></p>	<p>Design and administer updated Provider Satisfaction Surveys</p>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>TBD (Analysis previously performed by QM Division which no longer has the capacity to do so.)</p>
<p><b>STAKEHOLDERS</b></p>	<p>Provider Services Coordinator, Quality Coordinator, Contract Providers of the MHP, QIC</p>
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>
<p>Annual Goal Items                  Met:                  Item # _1_                  Partially Met:                  Item # _3_                  Not Met:                  Item # _2_                  Continued:                  Item # _1&amp;3_</p>	<ol style="list-style-type: none"> <li>1. There were no appeals during FY 15-16.</li> <li>2. This goal was discontinued in favor of working to upgrade the analysis of satisfaction survey results.</li> <li>3. As noted above, one of the new metrics established is attached to the new Social Engagement PIP. Having analyzed the CPS data, it was noted that ~25% of adult respondents expressed neutral to dissatisfaction with 4 key questions related to social engagement and isolation. A PIP related goal was established to improve this result to 15%.</li> </ol>

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

**SECTION VII: Strengthen the MHP's Quality Improvement Program Infrastructure**

<p><b>GOAL VI. B.</b> Strengthen the Quality Improvement Committee</p>	<ul style="list-style-type: none"> <li>• Review and Revise Committee representation to better reflect all stakeholders</li> <li>• Recruit new members; set term lengths</li> <li>• Prepare and disseminate Committee Orientation packets</li> </ul>
<p><b>BASELINE</b></p>	<p>The QIC is composed of the following:</p> <ul style="list-style-type: none"> <li>• beneficiaries of the MHP,</li> <li>• representatives of Mental Health Patient's Rights Advocate,</li> <li>• a Mental Health Board representative,</li> <li>• mental health program supervisors,</li> <li>• the Quality Improvement Coordinator and/or other Quality Improvement staff,</li> <li>• a representative from the Quality Management Division,</li> <li>• other members designated by the Mental Health Director.</li> </ul>
<p><b>ACTION STEPS</b></p>	<ul style="list-style-type: none"> <li>▪ Propose revised representative roster, terms and required topics to MH Leadership and current QIC</li> <li>▪ Recruit new members</li> <li>▪ Orient new members</li> </ul>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>QIC Minutes</p>
<p><b>STAKEHOLDERS</b></p>	<p>QIC, MH Leadership, Quality Coordinator</p>

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EVALUATION	DATA DETAIL
<p>Annual Goal Items  Met:  Item # __3_  Partially Met:  Item # __1 &amp; 2__  Not Met:  Item # __  Continued:  Item # __2__</p>	<p>1/2- During 15-16, the QIC membership added a new Mental Health Board representative, the Patient’s Rights Advocate, and Organizational Provider representative and identified formally the need to add consumer and staff supervisor representatives. The last 2 remain to be recruited.</p> <p>3 The QIC description and composition materials were updated and distributed.</p>

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

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

<p><b>GOAL</b> Develop Strategies to Improve Access to services for underserved ethnic and cultural groups</p>	<ul style="list-style-type: none"> <li>• Revise and Update MHP Cultural Competence Plan</li> <li>• Develop Cultural Competence Training Plans for MHP providers</li> <li>• Analyze barriers to service for specified underserved ethnic and cultural groups</li> <li>• Develop improvement project(s) to increase capacity, efficiency and quality of culturally and linguistically appropriate services</li> </ul>
<p><b>BASELINE</b></p>	<p>2011 Cultural Competence Plan EQRO Demographic Penetration rate for Hispanics of 3.18%</p>
<p><b>ACTION STEPS</b></p>	<p>As above</p>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>URSC Dashboard EQRO Annual Data TBD</p>
<p><b>RESPONSIBLE PARTNERS</b></p>	<p>MHP Ethnic Services Manager, Quality Coordinator, MH Leadership, QIC, Community Stakeholders, Supervisors, Staff, Provider Directors and staff</p>
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>
<p>Annual Goal Items Met: Item # ___ Partially Met: Item # ___ Not Met: Item # All Continued: Item # All</p>	<p>A revised Cultural Competence Plan has not yet been completed.  This goal and associated goals will remain on the Work Plan.</p>

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- *DHCS Site Review Protocol Section: A*
- *MHP Contract Element: Evidence of compliance with the requirements for cultural competence and linguistic competence specified Title 9, CCR, Section 1810.410. Section 22 J5)*