

NAPA COUNTY MENTAL HEALTH PLAN



A Tradition of Stewardship
A Commitment to Service

QUALITY IMPROVEMENT PROGRAM WORK PLAN

2017

January 1, 2017 – December 31, 2017

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.

Napa County Mental Health Quality Improvement Work Plan 2017

INTRODUCTION

The Napa County Mental Health Quality Improvement (QI) Program is accountable to the Mental Health Director. It is designed to assure to all payers and stakeholders that the processes for obtaining services are fair, efficient, cost-effective, and produce results consistent with the belief that people with mental illness may recover. In addition to attendance at the Quality Improvement Committee (QIC) and Utilization Steering Committee (URSC), beneficiaries 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, performance improvement projects, and clinical records reviews.

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 **2017 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 and assurance 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 and reviews relevant activities to measure against the goals, or prioritized areas of improvement that have been identified.
- 2) Identifies opportunities for improvement and decides which opportunities to pursue.
- 3) Designs and implements interventions to improve its performance.
- 4) Measures the effectiveness of the interventions.
- 5) Formulates reports and shares the information collected to improve the efficient and effective functioning of the system and organization.
- 6) Adheres to directives issued by the State of California Department of Healthcare Services pertaining to required content for Quality Improvement Plans.

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 at 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 reviewing data and making recommendations to staff, supervisors, and managers on beneficiary and system outcomes as well as beneficiary and provider satisfaction.

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

The QIC is composed of the following:

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

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Utilization Review Steering Committee

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

- Utilization Review Coordinator (chairperson)
- Quality Coordinator
- Mental Health 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 Committee and Utilization Review Committee are the two key committees charged with implementation and oversight of the QI/QA Program, and regularly collaborate to integrate and present current data into the Quality Improvement Committee's review process and formulation of recommendations. The QI WorkPlan incorporates elements and data in the domains of both committees.

2017 QI WorkPlan Goals

Section	GOAL DOMAIN	Page Number
I	Monitoring the Service Capacity of the MHP	p.6
II	Monitoring the Accessibility of Services	p.7
II contd.	Monitoring the Timeliness of Mental Health Services for Routine and Urgent Conditions	p.10
III	Monitoring Beneficiary and Client Satisfaction	p.17
IV	Monitoring the Mental Health Plan's Service Delivery System and Clinical Issues Affecting Beneficiaries	p.20
V	Monitoring Continuity and Coordination of Care with Physical Health Care Providers and other Human Services Agencies	p.23
VI	Monitoring Provider Satisfaction	p.25
VII	Strengthen the MHP's Quality Improvement Program Infrastructure	p.26
VIII	Monitoring Requirements for Cultural Competence and Linguistic Competence as specified in Title 9 CCR 1810.410	p.28

SECTION I: Monitoring the Service Capacity of the MHP	
GOALS 1 & 2: Cultural & Ethnic Penetration Rates	<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. Goals for 2017 remain the same as 15-16.</p> <ol style="list-style-type: none"> 1. Increase the Hispanic penetration rate from 3.12% to 5.00% 2. Maintain the 0-5 Age group population penetration rate of 2.30%
BASELINE	Based on EQRO reported data plus local report- compared to statewide small county averages.
ACTION STEPS	The MHP will continue to assertively recruit for and hire bi-lingual staff in all programs.
MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY	<p>Methodology: Data is taken from state published data of individuals who are Medi-Cal eligible, who enroll in treatment within the Napa Mental Health Plan (MHP) delivery system, and have at least one service divided by the total population (Medi-Cal eligible). This data can be evaluated in a number of ways (i.e., looking at Medicaid population eligibility, comparing against SMI/SED prevalence rates, cultural and ethnic populations, etc.).</p> <p>Data Source: Prepared report from CAEQRO “Medi-Cal Approved Claims Data for Napa County MHP”. Report data is based on DMH approved claims and MMEF Data. Target is set based on Small County penetration rate data.</p> <p>Frequency of Review: Annual</p>
STAKEHOLDERS	QIC, URSC, MH Leadership, Clinical staff and Supervisors, Partner Agency staff, Consumers and their families
EVALUATION	DATA DETAIL
Annual Goal Items Met: Item # _____ Partially Met: Item # _____ Not Met: Item # _____ Continued: Item # _____	

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

I. SECTION II: Monitoring the Accessibility of Services

<p>GOAL II.A.</p> <p>Percentage of non-urgent mental health services/appointments offered within 10 business days of the initial request</p>	<p>Timely access to services is a core value of the MHP. The Department of Health Care Services (DHCS) requires counties to track how long it takes individuals requesting non-urgent mental health services to receive an initial appointment for assessment.</p> <ul style="list-style-type: none"> • Continue to monitor wait times for initial appointments to meet target of 10 days. <ul style="list-style-type: none"> • Adults • Children • All 																																																																																											
<p>BASELINE</p>	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr style="background-color: #800000; color: white;"> <th colspan="7">ALL - Requests for MH Services FY 15-16</th> </tr> <tr style="background-color: #800000; color: white;"> <th>MONTH</th> <th>N=</th> <th>Same Day</th> <th>1-10 Days</th> <th>11+ Days</th> <th># Met Target</th> <th>% Met Target</th> </tr> </thead> <tbody> <tr><td>Jul-15</td><td>89</td><td>39</td><td>49</td><td>1</td><td>88</td><td>99%</td></tr> <tr><td>Aug-15</td><td>67</td><td>63</td><td>4</td><td>0</td><td>67</td><td>100%</td></tr> <tr><td>Sep-15</td><td>75</td><td>73</td><td>2</td><td>0</td><td>75</td><td>100%</td></tr> <tr><td>Oct-15</td><td>68</td><td>61</td><td>5</td><td>2</td><td>66</td><td>97%</td></tr> <tr><td>Nov-15</td><td>63</td><td>59</td><td>4</td><td>0</td><td>63</td><td>100%</td></tr> <tr><td>Dec-15</td><td>76</td><td>72</td><td>3</td><td>1</td><td>75</td><td>99%</td></tr> <tr><td>Jan-16</td><td>57</td><td>52</td><td>4</td><td>1</td><td>56</td><td>98%</td></tr> <tr><td>Feb-16</td><td>112</td><td>101</td><td>7</td><td>4</td><td>108</td><td>96%</td></tr> <tr><td>Mar-16</td><td>107</td><td>100</td><td>3</td><td>4</td><td>103</td><td>96%</td></tr> <tr><td>Apr-16</td><td>108</td><td>103</td><td>5</td><td>0</td><td>108</td><td>100%</td></tr> <tr><td>May-16</td><td>65</td><td>63</td><td>0</td><td>2</td><td>63</td><td>97%</td></tr> </tbody> </table>	ALL - Requests for MH Services FY 15-16							MONTH	N=	Same Day	1-10 Days	11+ Days	# Met Target	% Met Target	Jul-15	89	39	49	1	88	99%	Aug-15	67	63	4	0	67	100%	Sep-15	75	73	2	0	75	100%	Oct-15	68	61	5	2	66	97%	Nov-15	63	59	4	0	63	100%	Dec-15	76	72	3	1	75	99%	Jan-16	57	52	4	1	56	98%	Feb-16	112	101	7	4	108	96%	Mar-16	107	100	3	4	103	96%	Apr-16	108	103	5	0	108	100%	May-16	65	63	0	2	63	97%
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	Jun-16	88	88	0	0	88	100%
	TOTAL	975	874	86	15	960	98%
	<p>During FY 15-16, 874 individuals (90%) were offered an appointment on the same day as their initial request. The average number of days from Request to Offer for those that were not offered an appointment on the same day as their initial request was 6 days (range 1-43 days).</p>						
ALL - Requests for MH Services FY 16-17							
	MONTH	N=	Same Day	1-10 Days	11+ Days	# Met Target	% Met Target
	Jul-16	60	60	0	0	60	100%
	Aug-16	70	70	0	0	70	100%
	Sep-16	76	76	0	0	76	100%
	Oct-16	74	74	0	0	74	100%
	Nov-16	64	60	3	1	63	98%
	Dec-16	85	77	6	2	83	98%
	Jan-17	66	62	3	1	65	98%
	Feb-17	109	105	3	1	108	99%
ACTION STEPS	<ol style="list-style-type: none"> 1. Monitor DHCS' adaptation of the statewide timeliness metric and adjust methodology accordingly. 2. Continue to track timeliness indicators on the UR and QM Dashboards 3. Monitor data collection and analysis for outliers. 						
MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY OF COLLECTION	<p>Methodology: The difference between the date of the request for service and the date an appointment/service was offered is calculated to determine the length of time. Date offered means the date an appointment time is offered, not the date of the appointment. Because DHCS is in the process of changing from "business days" versus "calendar days", the formula used for the calculation is =NETWORKDAYS(start date, end date)-1 where start date is the date of request and end date is the date appointment/service offered. Data will be sorted to look at the number of same day offers, the number offered within 1-10 days of the request, the number offered within 11+ days of the request, and the percentage that met the 10 business day target. For the purposes of the Mental Health Division Quality Management Performance Measure, data will be reported for all individuals; however, the Mental Health Division will also track and report to the State the data breakdowns for adults, children and by Medical beneficiary.</p> <p>Data Source: Central Access and Authorization Team (CAAT) Log</p> <p>Frequency of Review: Monthly</p>						

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STAKEHOLDERS	<i>ACCESS Staff and Supervisor, Psychiatric Medical Director, QIC, URSC</i>
EVALUATION	DATA DETAIL
Annual Goal Items Met: Item # ____ Partially Met: Item # ____ Not Met: Item # ____ Continued: Item # ____	

- *DHCS Site Review Protocol Section: A*
- *MHP Contract Element: Goals are Set and Mechanisms Established to Monitor 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>The average number of days from the last initial assessment service in Mental Health Access to the first Specialty Mental Health Service (SMHS) provided</p>	<p>It is a priority of the MHP to provide timely specialty services to individuals who are assessed to meet medical necessity criteria.</p>																																																																																																		
<p>BASELINE</p>	<p>ALL FY 16-17</p> <table border="1"> <thead> <tr> <th>MONTH</th> <th>TARGET</th> <th>N=</th> <th>Average # of Days</th> <th>1-21 Days</th> <th>21+ Days</th> <th>% Met Target</th> </tr> </thead> <tbody> <tr> <td>May-16</td> <td>21</td> <td>18</td> <td>32</td> <td>9</td> <td>9</td> <td>50%</td> </tr> <tr> <td>Jun-16</td> <td>21</td> <td>20</td> <td>24</td> <td>11</td> <td>9</td> <td>55%</td> </tr> <tr> <td>Jul-16</td> <td>21</td> <td>12</td> <td>19</td> <td>7</td> <td>5</td> <td>58%</td> </tr> <tr> <td>Aug-16</td> <td>21</td> <td>14</td> <td>27</td> <td>7</td> <td>7</td> <td>50%</td> </tr> <tr> <td>Sep-16</td> <td>21</td> <td>13</td> <td>25</td> <td>7</td> <td>6</td> <td>54%</td> </tr> <tr> <td>Oct-16</td> <td>21</td> <td>14</td> <td>23</td> <td>10</td> <td>4</td> <td>71%</td> </tr> <tr> <td>Nov-16</td> <td>21</td> <td>11</td> <td>19</td> <td>9</td> <td>2</td> <td>82%</td> </tr> <tr> <td>Dec-16</td> <td>21</td> <td></td> <td></td> <td></td> <td></td> <td>#DIV/0!</td> </tr> <tr> <td>Jan-17</td> <td>21</td> <td></td> <td></td> <td></td> <td></td> <td>#DIV/0!</td> </tr> <tr> <td>Feb-17</td> <td>21</td> <td></td> <td></td> <td></td> <td></td> <td>#DIV/0!</td> </tr> <tr> <td>Mar-17</td> <td>21</td> <td></td> <td></td> <td></td> <td></td> <td>#DIV/0!</td> </tr> <tr> <td>Apr-17</td> <td>21</td> <td></td> <td></td> <td></td> <td></td> <td>#DIV/0!</td> </tr> <tr> <td>TOTAL</td> <td></td> <td>102</td> <td>25</td> <td>60</td> <td>42</td> <td>59%</td> </tr> </tbody> </table>	MONTH	TARGET	N=	Average # of Days	1-21 Days	21+ Days	% Met Target	May-16	21	18	32	9	9	50%	Jun-16	21	20	24	11	9	55%	Jul-16	21	12	19	7	5	58%	Aug-16	21	14	27	7	7	50%	Sep-16	21	13	25	7	6	54%	Oct-16	21	14	23	10	4	71%	Nov-16	21	11	19	9	2	82%	Dec-16	21					#DIV/0!	Jan-17	21					#DIV/0!	Feb-17	21					#DIV/0!	Mar-17	21					#DIV/0!	Apr-17	21					#DIV/0!	TOTAL		102	25	60	42	59%
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	<p style="text-align: center;">Average # of Days from Last Access Assessment to First SMHS Service Compared to Target FY 16-17 All Served</p> <table border="1"> <caption>Data for Average # of Days from Last Access Assessment to First SMHS Service</caption> <thead> <tr> <th>Month</th> <th>Target (Days)</th> <th>Average # of Days</th> </tr> </thead> <tbody> <tr><td>May-16</td><td>21</td><td>32</td></tr> <tr><td>Jun-16</td><td>21</td><td>24</td></tr> <tr><td>Jul-16</td><td>21</td><td>19</td></tr> <tr><td>Aug-16</td><td>21</td><td>27</td></tr> <tr><td>Sep-16</td><td>21</td><td>25</td></tr> <tr><td>Oct-16</td><td>21</td><td>23</td></tr> <tr><td>Nov-16</td><td>21</td><td>19</td></tr> <tr><td>Dec-16</td><td>21</td><td>21</td></tr> <tr><td>Jan-17</td><td>21</td><td>21</td></tr> <tr><td>Feb-17</td><td>21</td><td>21</td></tr> <tr><td>Mar-17</td><td>21</td><td>21</td></tr> </tbody> </table>	Month	Target (Days)	Average # of Days	May-16	21	32	Jun-16	21	24	Jul-16	21	19	Aug-16	21	27	Sep-16	21	25	Oct-16	21	23	Nov-16	21	19	Dec-16	21	21	Jan-17	21	21	Feb-17	21	21	Mar-17	21	21
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Mar-17	21	21																																			
<p>ACTION STEPS</p>	<p>Several initiatives have been implemented and are being assessed for effectiveness:</p> <ul style="list-style-type: none"> • A brief screener was designed and a beta test is being run to determine if by screening and referring to managed care individuals more likely to fit the mild to moderate eligibility criteria greater efficiency for MHP eligible individuals can be realized. • An EHR based referral process has been implemented. • Staffing in MH Access is being increased. 																																				
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY OF COLLECTION</p>	<p>The “n” is the number of initial assessments completed by Mental Health Access each month that had a SMHS that followed. The difference between the date of the first SMHS and the date of the last initial assessment service is calculated to determine the length of time. Data will be sorted to look at (by month) the average number of days it took from last initial assessment service to first SMHS, the number of times that the first SMHS took place within the target (1-21 days of the last initial assessment service), the number of times that the SMHS that took place outside the target (within 21+ days of the last initial assessment service), and the percentage that met the target. For the purposes of the Mental Health Division Quality Management Performance Measure, data will be reported for all individuals; however, the Mental Health Division will also track and report to the State the data breakdowns for adults and children.</p> <p>Data Source: Anasazi Client Assessment and Treatment Plan Listing, Anasazi Client Services Report <i>(for date of service verification)</i></p> <p>Frequency of Review: Monthly (90 day lag)</p>																																				
<p>STAKEHOLDERS</p>	<p>Community members seeking MH services, MH Access staff, MHP clinical staff</p>																																				
<p>EVALUATION</p>	<p>DATA DETAIL</p>																																				

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Annual Goal Items Met: Item # ____ Partially Met: Item # ____ Not Met: Item # ____ Continued: Item # ____	
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- *DHCS Site Review Protocol Section: 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

GOAL II.C. All individuals requesting urgent mental health services are seen or referred for emergent care within 24 hours of the initial request.	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). Napa has designed a system to respond immediately to urgent care requests
BASELINE	Current practice is immediate care upon demand.
ACTION STEPS	Exodus CSS will provide immediate on demand urgent care services. In the last review, EQRO rejected the MHP’s urgent care indicator. The MHP will continue to seek T.A. from EQRO to define an urgent care indicator that meets their standards.
MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY	To be determined pending creation of a new Urgent Care indicator.
STAKEHOLDERS	Access Staff and Supervisor, ERT Staff and Supervisor, Clinical

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	Director, Quality Coordinator, Staff Services Analyst
EVALUATION	DATA DETAIL
Annual Goal Items Met: Item # ____ Partially Met: Item # ____ Not Met: Item # ____ Continued: Item # ____	

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<p>GOAL II.E.</p> <p>Responsiveness of the 24/7 toll-free number</p>	<p>Ensure that NCMH has after-hours Access line capability which provides information in threshold languages on how to access routine mental health services and how to use the problem resolution processes.</p>
<p>BASELINE</p>	<p>At least 2 calls monthly Recent test calls have revealed that calls are handled acceptably by ERT, but there have been ongoing problems logging the calls.</p>
<p>ACTION STEPS</p>	<ul style="list-style-type: none"> • Train new staff at Exodus • Conduct at least 2 test calls a month • Record results of test calls • Meet with Access and Exodus Supervisor regularly to improve performance • Report Test Call results to QIC annually • Report Test Call results to DHCS quarterly
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</p>	<p>Data entered on DHCS Reporting Spreadsheet quarterly. Collected from filled out call report sheets by test callers. Quarterly</p>
<p>STAKEHOLDERS</p>	<p>Exodus Staff and Supervisor, Access Staff and Supervisor, Quality Coordinator, QIC</p>
<p>EVALUATION</p>	<p>DATA DETAIL</p>
<p>Annual Goal Items Met: Item # ____ Partially Met: Item # ____ Not Met: Item # ____ Continued: Item # ____</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

<p>GOAL II.F.</p> <p>Medication services are efficiently managed</p>	<p>1. 90% of intake appointments scheduled are kept 2. 88% of appointments scheduled are kept</p>																																																																																																																																																																																	
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Napa County Mental Health Quality Improvement Work Plan 2017

	ALL Med Clinic Intake Appointments by Month FY 16-17						
		Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
	# scheduled appts	14	19	17	14	15	15
	# of no shows	2	6	4	4	4	5
	# showed	12	13	13	10	11	10
	%	86%	68%	76%	71%	73%	67%
ACTION STEPS	<ol style="list-style-type: none"> 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 2. Continue to monitor quarterly on QM Plan: % of all scheduled Adult medication appointments kept <p>The MHP has determined that the sharp decrease in the Adult Medication Clinic appointment show rate between FY 14-15 and FY 15-16 may be a direct result of the discontinuance of appointment reminder calls. This change was made due to staffing issues within the clinic. The Adult Medication clinic reinstated reminder calls in December 2016.</p>						
MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY	Data collected from Anasazi Scheduler report: individuals who kept appointments/individuals scheduled for appointments Quarterly report.						
STAKEHOLDERS	Psychiatric Medical Director and Psychiatric Staff, Staff Services Analyst						
EVALUATION	DATA DETAIL						
Annual Goal Items Met: Item # ___ Partially Met: Item # ___ Not Met: Item # ___ Continued: Item # ___							

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- *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>GOAL III.A. 1) Beneficiary and family satisfaction surveys of the NCMHP continue to be conducted bi-annually using the Performance Outcome Quality Improvement (POQI)</p>	<ol style="list-style-type: none"> 1. Beneficiary Satisfaction Survey target: 85 % of survey questions are ranked satisfied to very satisfied. 2. Continue re-formatting and focused analysis of survey results and produce more recommendations for improvements. 3. With more public-friendly presentations of data, routinely share results with all stakeholders. 4. Refine administration protocols to ensure higher quality data input. 5. Use social connectedness domain item results as an outcome measure for Social Engagement Clinical PIP.
<p>BASELINE</p>	

Napa County Mental Health Quality Improvement Work Plan 2017

	<p>Consumer Perception Survey Satisfaction Rates by Domain</p> <table border="1"> <thead> <tr> <th>Domain</th> <th>Spring 2014 (n=92)</th> <th>Fall 2014 (n=102)</th> <th>Spring 2015 (n=115)</th> <th>Fall 2015 (n=92)</th> <th>Spring 2016 (n=102)</th> <th>Avg.</th> </tr> </thead> <tbody> <tr> <td>General Satisfaction</td> <td>95</td> <td>95</td> <td>92</td> <td>92</td> <td>92</td> <td>93%</td> </tr> <tr> <td>Perception of Access</td> <td>94</td> <td>94</td> <td>93</td> <td>95</td> <td>92</td> <td>92%</td> </tr> <tr> <td>Perception of Quality &...</td> <td>92</td> <td>86</td> <td>83</td> <td>90</td> <td>86</td> <td>87%</td> </tr> <tr> <td>Perception of Participation...</td> <td>85</td> <td>94</td> <td>83</td> <td>91</td> <td>90</td> <td>89%</td> </tr> <tr> <td>Perception of Outcomes of...</td> <td>81</td> <td>81</td> <td>77</td> <td>77</td> <td>78</td> <td>79%</td> </tr> <tr> <td>Perception of Social...</td> <td>78</td> <td>77</td> <td>78</td> <td>72</td> <td>77</td> <td>76%</td> </tr> <tr> <td>Perception of Functioning</td> <td>85</td> <td>82</td> <td>79</td> <td>71</td> <td>73</td> <td>78%</td> </tr> </tbody> </table> <p>Legend: Spring 2014 (n=92) (pink), Fall 2014 (n=102) (red), Spring 2015 (n=115) (purple), Fall 2015 (n=92) (blue), Spring 2016 (n=102) (green)</p>	Domain	Spring 2014 (n=92)	Fall 2014 (n=102)	Spring 2015 (n=115)	Fall 2015 (n=92)	Spring 2016 (n=102)	Avg.	General Satisfaction	95	95	92	92	92	93%	Perception of Access	94	94	93	95	92	92%	Perception of Quality &...	92	86	83	90	86	87%	Perception of Participation...	85	94	83	91	90	89%	Perception of Outcomes of...	81	81	77	77	78	79%	Perception of Social...	78	77	78	72	77	76%	Perception of Functioning	85	82	79	71	73	78%
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ACTION STEPS	Move forward on implementing goals 1-5.																																																								
MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY	Bi-annual analysis of CPS data as collected by CIBHS, utilizing the EBHS data analysis system.																																																								
STAKEHOLDERS	QIC, Quality Coordinator, Staff Services Analyst, Social Engagement PIP Team, Stakeholders																																																								
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- DHCS Site Review Protocol Section: I
- MHP Contract Element: The Contractor shall implement mechanisms to assess beneficiary/family satisfaction by: surveying beneficiary/family satisfaction annually; evaluating beneficiary grievances, appeals and fair hearings at least annually, evaluating requests to change persons providing services at least annually (Sections 22 & 23)

SECTION III continued: Monitoring Beneficiary and Client Satisfaction

<p>GOAL III.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>BASELINE</p>	<p>100% of Appeals, Grievances and 95% of Requests for Change of Providers are successfully resolved within mandated timeframes.</p>
<p>ACTION STEPS</p>	<p>Continue tracking and reports.</p>
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</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>STAKEHOLDERS</p>	<p>QIC, QM, Quality Coordinator, MH Director</p>
<p>EVALUATION</p>	<p>DATA DETAIL</p>
<p>Annual Goal Items Met: Item # ____ Partially Met: Item # ____ Not Met: Item # ____ Continued: Item # ____</p>	

- *DHCS Site Review Protocol Section: I*
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SECTION IV: Monitoring Mental Health Plans' Service Delivery System and Clinical Issues Affecting Beneficiaries

<p>GOAL In Coordination with Exodus Crisis Stabilization and Services Unit, develop Quantitative and Qualitative data indicators</p>	<ol style="list-style-type: none"> 1. Develop at least 1 quantitative utilization measure to track and evaluate the performance of the new CSSU, such as: total # of clients seen and dispositions. 2. Develop at least 1 qualitative outcome measure to monitor and evaluate clinical effectiveness of CSSU, such as implementing use of standard brief assessment tools.
<p>BASELINE</p>	<p>TBD based on new measures</p>
<p>ACTION STEPS</p>	<ul style="list-style-type: none"> • Coordinate Quality Assurance and Improvement efforts with Exodus staff.
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</p>	<p>tbd based on measures selected.</p>
<p>STAKEHOLDERS</p>	<p>MHP Administrative staff, Exodus staff, QIC</p>
<p>EVALUATION</p>	<p>DATA DETAIL</p>
<p>Annual Goal Items Met: Item # ___ Partially Met: Item # ___ Not Met: Item # ___ Continued: Item # ___</p>	

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

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

<p>GOAL Provide Effective Early Interventions to Young Adults with Onset of Psychotic Symptoms</p>	<p>Through Supportive Outreach & Access to Resources (SOAR), Aldea provides services to people who are experiencing the symptoms of early psychosis to reduce and manage their symptoms so they may succeed in education, careers and relationships.</p> <p>Based on the model developed by Cameron Carter, MD of the UC Davis Early Diagnosis and Preventative Treatment (EDAPT) Clinic, SOAR.</p> <p>Utilizing the Clinical Global Impression (CGI), the program will track the severity of illness in the past week and degree of change (improvement/worsening) compared to status at baseline (prior to starting treatment program)</p>																																										
<p>BASELINE</p>	<p style="text-align: center;">CGI Ratings: Average Severity of Illness</p> <table border="1"> <caption>CGI Ratings: Average Severity of Illness</caption> <thead> <tr> <th>Category</th> <th>BASELINE (N=19)</th> <th>6M (N=9)</th> <th>12M (N=15)</th> <th>18M (N=7)</th> <th>24M (N=1)</th> </tr> </thead> <tbody> <tr> <td>Positive Symptoms</td> <td>4.3</td> <td>2.1</td> <td>2.8</td> <td>2.2</td> <td>1.0</td> </tr> <tr> <td>Negative Symptoms</td> <td>3.2</td> <td>2.5</td> <td>1.8</td> <td>1.9</td> <td>1.0</td> </tr> <tr> <td>Depression Symptoms</td> <td>3.2</td> <td>2.4</td> <td>1.8</td> <td>1.8</td> <td>1.0</td> </tr> <tr> <td>Manic Symptoms</td> <td>2.9</td> <td>1.8</td> <td>1.5</td> <td>1.1</td> <td>1.0</td> </tr> <tr> <td>Cognitive Symptoms</td> <td>3.8</td> <td>2.9</td> <td>2.5</td> <td>2.5</td> <td>1.0</td> </tr> <tr> <td>Overall Severity</td> <td>4.3</td> <td>2.7</td> <td>2.5</td> <td>2.8</td> <td>1.0</td> </tr> </tbody> </table>	Category	BASELINE (N=19)	6M (N=9)	12M (N=15)	18M (N=7)	24M (N=1)	Positive Symptoms	4.3	2.1	2.8	2.2	1.0	Negative Symptoms	3.2	2.5	1.8	1.9	1.0	Depression Symptoms	3.2	2.4	1.8	1.8	1.0	Manic Symptoms	2.9	1.8	1.5	1.1	1.0	Cognitive Symptoms	3.8	2.9	2.5	2.5	1.0	Overall Severity	4.3	2.7	2.5	2.8	1.0
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<p>ACTION STEPS</p>	<p>Analyze data and consult with program to ensure continuing positive outcomes.</p>																																										
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</p>	<p>In the first two years of the program, efforts have been made toward refining our data collection to provide more comprehensive and relevant outcomes to report. In collaboration with UC Davis Aldea is in the process of analyzing/collating the data from the CGI and further details regarding</p>																																										

Napa County Mental Health Quality Improvement Work Plan 2017

	outcomes such as hospitalization/ER utilization, justice involvement, housing status/homelessness, family involvement, and treatment involvement which we look forward to presenting next year.
STAKEHOLDERS	QIC, Aldea providers and clients, MHP Administrative staff.
EVALUATION	DATA DETAIL
Annual Goal Items Met: Item # ___ Partially Met: Item # ___ Not Met: Item # ___ Continued: Item # ___	

- *DHCS Site Review Protocol Section: I*
-

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

GOAL Review clinical records	Continue to internally audit chart documentation. Develop and implement new data indicator to track recently implemented holistic chart review.
BASELINE	TBD based on new measures
ACTION STEPS	<ul style="list-style-type: none"> • Utilization Review Coordinator, in consultation with the Utilization Review Steering Committee will develop a new indicator for the Mental Health dashboard that will track the results of concurrent chart review.
MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY	tbd based on measures selected.

Napa County Mental Health Quality Improvement Work Plan 2017

STAKEHOLDERS	UR Coordinator, URSC
EVALUATION	DATA DETAIL
Annual Goal Items Met: Item # ____ Partially Met: Item # ____ Not Met: Item # ____ Continued: Item # ____	

- Cal. Code Regs., tit. 9, § 1810.440(a)(5) and 42 C.F.R. § 438.416;
- §438.330

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

GOAL V.A. Improved Coordination of mental health and physical health care is a primary focus of NCMHP and the FQHC, Ole Health	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: <ul style="list-style-type: none"> • Continue working on objectives developed in CIC charter. • Identify new opportunities for integration of services • Improve and implement Sensitive Information Exchange mechanisms • Explore means of developing a master client list
BASELINE	
ACTION STEPS	<ul style="list-style-type: none"> • Explore means of implementing Sensitive Information

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	<p>Exchange technology between partners</p> <ul style="list-style-type: none"> • Implement universal release of information form • Continue to convene oversight and stakeholder planning groups
MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY	Work group minutes, QIC meeting minutes
STAKEHOLDERS	Ole Health County Campus Director and staff, MH Access Supervisor and Staff, MH and ADS Leadership and designated staff, Quality Coordinator, QIC
EVALUATION	DATA DETAIL
<p>Annual Goal Items Met: Item # ___ Partially Met: Item # ___ Not Met: Item # ___ Continued: Item # ___</p>	

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

SECTION VI: Monitoring Provider Satisfaction

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

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

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

<p>GOAL VI. B. Refine and Improve QI Activities</p>	<ul style="list-style-type: none"> • Review and refine all data metrics on MH Dashboard for rationale, targets, where applicable, methodologies, and frequency • Update master data list and initiate gathering of qualitative metrics into a more accessible format • Maintain 1 Clinical and 1 Non-clinical PIP • Maintain relevant RBA indicators; revise as needed. • Revise practices, policies and procedures as required by the Medicaid Managed Care Mega Rule 					
<p>BASELINE</p>	<p>RBA:</p> <table border="1"> <tr> <td data-bbox="370 1003 859 1346"> <p><u>HOW MUCH DID WE DO?</u> # of clients that attend the ICC bimonthly Planning meeting # of activities planned</p> </td> <td data-bbox="862 1003 1529 1346"> <p><u>HOW WELL DID WE DO IT?</u> % of planned activities that actually occurred</p> </td> </tr> <tr> <td data-bbox="370 1350 859 1787"> <p><u>IS ANYONE BETTER OFF?</u> # of adults that respond agree or strongly agree to the Consumer Perception Survey domain questions related to Perception of Social Connectedness</p> </td> <td data-bbox="862 1350 1529 1787"> <p><u>IS ANYONE BETTER OFF?</u> % of adults that respond agree or strongly agree to the <u>Consumer Perception Survey domain questions related to Perception of Social Connectedness</u></p> </td> </tr> </table>		<p><u>HOW MUCH DID WE DO?</u> # of clients that attend the ICC bimonthly Planning meeting # of activities planned</p>	<p><u>HOW WELL DID WE DO IT?</u> % of planned activities that actually occurred</p>	<p><u>IS ANYONE BETTER OFF?</u> # of adults that respond agree or strongly agree to the Consumer Perception Survey domain questions related to Perception of Social Connectedness</p>	<p><u>IS ANYONE BETTER OFF?</u> % of adults that respond agree or strongly agree to the <u>Consumer Perception Survey domain questions related to Perception of Social Connectedness</u></p>
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<p>ACTION STEPS</p>	<p>Implement goals</p>					

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<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</p>	<p>QIC Minutes, PIP documents; MH Data Dashboard and Master List; QM Dashboard of RBA indicators</p>
<p>STAKEHOLDERS</p>	<p>QIC, MH Leadership, Quality Coordinator, PIP Committees</p>
<p>EVALUATION</p>	<p>DATA DETAIL</p>
<p>Annual Goal Items Met: Item # ____ Partially Met: Item # ____ Not Met: Item # ____ Continued : Item # ____</p>	

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

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

<p>GOAL Develop Strategies to Improve Access to services for underserved ethnic and cultural groups</p>	<ul style="list-style-type: none"> • Revise and Update MHP Cultural Competence Plan • Develop Cultural Competence Training Plans for MHP providers • Analyze barriers to service for specified underserved ethnic and cultural groups • Develop improvement project(s) to increase capacity, efficiency and quality of culturally and linguistically appropriate services
<p>BASELINE</p>	<p>2011 Cultural Competence Plan</p>
<p>ACTION STEPS</p>	<p>As above</p>
<p>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</p>	<p>MH Dashboard EQRO Annual Data TBD</p>
<p>RESPONSIBLE PARTNERS</p>	<p>MHP Ethnic Services Manager, Quality Coordinator, MH Leadership, QIC, Community Stakeholders, Supervisors, Staff, Provider Directors and staff</p>
<p>EVALUATION</p>	<p>DATA DETAIL</p>
<p>Annual Goal Items Met: Item # ____ Partially Met: Item # ____ Not Met: Item # ____ Continued: Item # ____</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)*