

# NAPA COUNTY MENTAL HEALTH PLAN



A Tradition of Stewardship  
A Commitment to Service

## QUALITY IMPROVEMENT PROGRAM WORK PLAN

**2018**

*January 1, 2018 – December 31, 2018*

**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.*

**Evaluation - 2019**

# Napa County Mental Health Quality Improvement Work Plan 2018

## **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, family members and stakeholders 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 performance monitoring activities throughout the organization, including but not limited to: beneficiary and system outcomes, utilization review and 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 Napa County Health and Human Services Agency's Quality Management Division supports the program by providing additional auditing and processing of grievances.

The Quality Improvement Work Plan helps guide the NCMHP in managing: (i) conformity with federal and state requirements for quality improvement, and (ii) the behavioral health system's priorities for quality improvement and quality management. With this in mind, NCMHP developed its **2018 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 affiliated 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 Work Plan 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 2018 QI WORKPLAN & PROGRAM**

### **Introduction - QI Work Plan:**

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

- The QI Work Plan 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 Work Plan gives us the opportunity to frame issues using data. We use qualitative and quantitative data to construct baselines, develop intervention strategies, create methodologies

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and measure outcomes to see “what worked” and if we reached our goals. 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.

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.

### **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. 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 member of the Mental Health Division Management team
- 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.

Currently, QI activities related to Utilization Review and Management are commonly delegated to the Utilization Review Steering Committee (URSC). The Quality Coordinator sits on both committees and

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acts as a liaison. A summary report of the activities of the URSC and the Mental Health Data Dashboard is presented periodically at QIC meetings.

### **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 Work Plan incorporates elements and data in the domains of both committees.

### **Annual QI Work Plan Evaluation**

The QI Work Plan Goals and Objectives are evaluated annually approximately one month prior to the development of the next year's QI Work Plan. The statuses of the goals are noted in the left hand column under: "Annual Goal Items Met." Data detail and notes are listed in the section at the bottom of each goal listing entitled: Evaluation: Data Detail. A draft of the Evaluation is reviewed by the QIC prior to finalization and posting to the county web site.

***This document is the evaluation of the 2018 QI Work Plan.***

2018 QI Work Plan Goals

Section	GOAL DOMAIN	Page Number
I	Monitoring the Service Capacity of the MHP	p.6
II	Monitoring the Accessibility of Services	p.8
II contd.	Monitoring the Timeliness of Mental Health Services for Routine and Urgent Conditions	p.10
III	Monitoring Beneficiary and Client Satisfaction	p.18
IV	Monitoring the Mental Health Plan's Service Delivery System and Clinical Issues Affecting Beneficiaries	p.21
V	Monitoring Continuity and Coordination of Care with Physical Health Care Providers and other Human Services Agencies	p.26
VI	Monitoring Provider Satisfaction	p.28
VII	Strengthen the MHP's Quality Improvement Program Infrastructure	p.29
VIII	Monitoring Requirements for Cultural Competence and Linguistic Competence as specified in Title 9 CCR 1810.410	p.31

**SECTION I: Monitoring the Service Capacity of the MHP**

**GOALS 1 & 2: Cultural & Ethnic Penetration Rates**

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 2018 remain similar to those of 2017

1. Increase the Hispanic penetration rate from 3.24% to 5.00%
2. Improve the 0-5 Age group population penetration rate of 1.82% to goal of 2.0%

**BASELINE**

Based on EQRO reported data plus local report- compared to statewide small county averages.  
EQRO Data for 2017

Data Sources:	DHCS Approved Claims and MMEF Data - Notes (1) and (2)
Data Process Dates:	05/19/2017, 07/22/2017, and 04/06/2017 - Note (3)

Footnotes:

- 1 - Includes approved claims data on DHCS eligible beneficiaries who were served by other MHPs, based on Medi-Cal recipient's "County of Fiscal Responsibility"
- 2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding
- 3 - The most recent data processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DHCS for the reported calendar year
- 4 - County total number of yearly unduplicated Medi-Cal eligibles is 39,123
- 5 - Includes the Affordable Care Act Expansion Population

	NAPA				
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year
<b>Total</b>	33,290	1,611	\$12,524,044	4.84%	\$7,774
<b>Age Group</b>					
0-5	4,347	79	\$473,661	1.82%	\$5,996
6-17	9,053	632	\$5,299,239	6.98%	\$8,385
18-59	15,416	742	\$5,449,250	4.81%	\$7,344
60 +	4,474	158	\$1,301,895	3.53%	\$8,240
<b>Gender</b>					

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	Female	17,637	728	\$5,927,306	4.13%	\$8,142
	Male	15,653	883	\$6,596,738	5.64%	\$7,471
	<b>Race/Ethnicity</b>					
	White	10,190	740	\$5,979,128	7.26%	\$8,080
	Hispanic	18,927	613	\$4,246,792	3.24%	\$6,928
	African-American	592	33	\$374,827	5.57%	\$11,358
	Asian/Pacific Islander	1,892	37	\$204,632	1.96%	\$5,531
	Native American	72	4	\$17,335	5.56%	\$4,334
	Other	1,619	184	\$1,701,330	11.37%	\$9,246

**ACTION STEPS**  
 The MHP will continue to assertively recruit for and hire bi-lingual staff in all programs.  
 Utilization data for services to 0-5 children will be monitored. The expectation is that the penetration rate will return to close to recent rates.

**MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY**  
**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.).  
**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.  
**Frequency of Review:** Annual

**STAKEHOLDERS**  
 QIC, URSC, MH Leadership, Clinical staff and Supervisors, Partner Agency staff, Consumers and their families

**EVALUATION DATA DETAIL**

Annual Goal Items Met:	NAPA					
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Approved Claims	Penetration Rate	Approved Claims per Beneficiary Served per Year	
Item # 1 Not Met: While total number of Hispanics served remained stable, the penetration rate dipped slightly from 3.24 to 3.19%	Total	33,032	1,552	\$10,623,972	4.70%	\$6,845
Item # 2 Not Met: Both number	0-5	4,110	71	\$447,892	1.73%	\$6,308
	6-17	9,026	591	\$4,327,686	6.55%	\$7,323
	18-59	15,304	734	\$4,783,471	4.80%	\$6,517
	60 +	4,592	156	\$1,064,922	3.40%	\$6,826

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<p>served and rate dipped slightly, from 1.82 to 1.73%</p>	Female	17,519	713	\$4,964,786	4.07%	\$6,963
	Male	15,513	839	\$5,659,185	5.41%	\$6,745
<p>Both Items Continued. Hispanic penetration rate goal to be reexamined in light of changes that have introduced new challenges to meeting that goal.</p>	White	9,849	680	\$4,494,035	6.90%	\$6,609
	Hispanic/Latino	19,012	607	\$3,221,961	3.19%	\$5,308
	African-American	587	34	\$240,572	5.79%	\$7,076
	Asian/Pacific Islander	1,687	28	\$189,317	1.66%	\$6,761
	Native American	71	3	\$2,791	4.23%	\$930
	Other	1,828	200	\$2,475,296	10.94%	\$12,376

- *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 an offer of an initial appointment for assessment.</p> <ul style="list-style-type: none"> <li>• Continue to monitor wait times for initial appointments to meet target of 10 days. <ul style="list-style-type: none"> <li>• Adults</li> <li>• Children</li> <li>• All</li> </ul> </li> </ul>
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<b>BASELINE</b>	<b>ALL - Requests for MH Services</b>						
	<b>MONT</b>	<b>N=</b>	<b>Same Day</b>	<b>1-10 Days</b>	<b>11+ Days</b>	<b># Met Target</b>	<b>% Met Target</b>
	Jan-17	70	69	1	0	70	100%
	Feb-17	113	113	0	0	113	100%
	Mar-17	88	87	1	0	88	100%
	Apr-17	91	88	3	0	91	100%
	May-17	83	83	0	0	83	100%
	Jun-17	83	83	0	0	83	100%
	Jul-17	82	82	0	0	82	100%
	Aug-17	102	102	0	0	102	100%
	Sep-17	96	96	0	0	96	100%
	Oct-17	63	63	0	0	63	100%
	Nov-17	97	97	0	0	97	100%
<p>The MH Quality Coordinator participates in the DHCS Metrics Workgroup which has concluded its work on defining timeliness metrics. The state hopes to utilize CSI and Claims data to track these indicators and the workgroup is currently working with DHCS to finalize the business rules for electronic implementation.</p>							
<b>ACTION STEPS</b>	<ol style="list-style-type: none"> <li>1. Monitor DHCS' adaptation and implementation of the statewide timeliness metrics and adjust methodologies accordingly.</li> <li>2. Continue to track timeliness indicators on the MH Data and QM Dashboards</li> <li>3. Monitor data collection and analysis for outliers.</li> </ol>						
<b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY OF COLLECTION</b>	<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. 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 Medi-Cal beneficiary.</p>						

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	<p><b>Data Source:</b> Central Access and Authorization Team (CAAT) Log</p> <p><b>Frequency of Review:</b> Monthly</p>																																																																																																		
<b>STAKEHOLDERS</b>	<i>ACCESS Staff and Supervisor, Psychiatric Medical Director, QIC, URSC</i>																																																																																																		
<b>EVALUATION</b>	<b>DATA DETAIL</b>																																																																																																		
<p><b>Annual Goal Items</b>  <b>Met: 1</b>  <b>Partially Met:</b>  <b>Item # ___</b>  <b>Not Met:</b>  <b>Item # ___</b>  <b>Continued:</b>  <b>Item # tbd</b></p>	<p>The specific indicator for time of request to offer continues to be 100% compliant. The state's new timeliness indicators appear to finally be imminent and will be incorporated in future Work Plan goals.</p> <table border="1"> <thead> <tr> <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><b>Jul-17</b></td> <td>73</td> <td>73</td> <td>0</td> <td>0</td> <td>73</td> <td>100%</td> </tr> <tr> <td><b>Aug-17</b></td> <td>100</td> <td>100</td> <td>0</td> <td>0</td> <td>100</td> <td>100%</td> </tr> <tr> <td><b>Sep-17</b></td> <td>96</td> <td>96</td> <td>0</td> <td>0</td> <td>96</td> <td>100%</td> </tr> <tr> <td><b>Oct-17</b></td> <td>61</td> <td>61</td> <td>0</td> <td>0</td> <td>61</td> <td>100%</td> </tr> <tr> <td><b>Nov-17</b></td> <td>97</td> <td>97</td> <td>0</td> <td>0</td> <td>97</td> <td>100%</td> </tr> <tr> <td><b>Dec-17</b></td> <td>85</td> <td>85</td> <td>0</td> <td>0</td> <td>85</td> <td>100%</td> </tr> <tr> <td><b>Jan-18</b></td> <td>110</td> <td>110</td> <td>0</td> <td>0</td> <td>110</td> <td>100%</td> </tr> <tr> <td><b>Feb-18</b></td> <td>94</td> <td>94</td> <td>0</td> <td>0</td> <td>94</td> <td>100%</td> </tr> <tr> <td><b>Mar-18</b></td> <td>103</td> <td>103</td> <td>0</td> <td>0</td> <td>103</td> <td>100%</td> </tr> <tr> <td><b>Apr-18</b></td> <td>112</td> <td>112</td> <td>0</td> <td>0</td> <td>112</td> <td>100%</td> </tr> <tr> <td><b>May-18</b></td> <td>93</td> <td>93</td> <td>0</td> <td>0</td> <td>93</td> <td>100%</td> </tr> <tr> <td><b>Jun-18</b></td> <td>70</td> <td>70</td> <td>0</td> <td>0</td> <td>70</td> <td>100%</td> </tr> <tr> <td><b>TOTAL</b></td> <td><b>1094</b></td> <td><b>1094</b></td> <td><b>0</b></td> <td><b>0</b></td> <td><b>1094</b></td> <td><b>100%</b></td> </tr> </tbody> </table>	MONTH	N=	Same Day	1-10 Days	11+ Days	# Met Target	% Met Target	<b>Jul-17</b>	73	73	0	0	73	100%	<b>Aug-17</b>	100	100	0	0	100	100%	<b>Sep-17</b>	96	96	0	0	96	100%	<b>Oct-17</b>	61	61	0	0	61	100%	<b>Nov-17</b>	97	97	0	0	97	100%	<b>Dec-17</b>	85	85	0	0	85	100%	<b>Jan-18</b>	110	110	0	0	110	100%	<b>Feb-18</b>	94	94	0	0	94	100%	<b>Mar-18</b>	103	103	0	0	103	100%	<b>Apr-18</b>	112	112	0	0	112	100%	<b>May-18</b>	93	93	0	0	93	100%	<b>Jun-18</b>	70	70	0	0	70	100%	<b>TOTAL</b>	<b>1094</b>	<b>1094</b>	<b>0</b>	<b>0</b>	<b>1094</b>	<b>100%</b>
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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>  <b>The average number of days from the last initial assessment</b></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> <ol style="list-style-type: none"> <li>1. The MH Analyst reached the conclusion that the data sourcing and methodology for this indicator was seriously flawed and excessively complex, leading to a lack of confidence in the accuracy of the data. As a result, efforts are underway to improve the methodology, including</li> </ol>
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Napa County Mental Health Quality Improvement Work Plan 2018

<p>service in Mental Health Access to the first Specialty Mental Health Service (SMHS) provided</p>	<p>examining the reporting functionality of the E.H.R. Once a revised and reliable methodology has been decided upon, the data will again be tracked. The MHP has enlisted the assistance of a data analyst in the HHSA QM division to assist in redesigning the data tracking log and methodology.</p> <p>2. DHCS plans to release business rules that will implement an EHR based CSI methodology for collecting this and a number of other timeliness metrics. When that occurs, anticipated to possibly during this calendar year, the goal in this section will become one of adopting the new methodologies and ensuring timely data submission and cross-tracking accuracy.</p>																																																																																																		
<p><b>BASELINE</b></p>	<p><b>ALL FY 16-17</b></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><b>TOTAL</b></td> <td></td> <td><b>102</b></td> <td><b>25</b></td> <td><b>60</b></td> <td><b>42</b></td> <td><b>59%</b></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!	<b>TOTAL</b>		<b>102</b>	<b>25</b>	<b>60</b>	<b>42</b>	<b>59%</b>
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Napa County Mental Health Quality Improvement Work Plan 2018

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<p><b>ACTION STEPS</b></p>	<ul style="list-style-type: none"> <li>• Develop and implement a new data source and methodology to build an accurate measure.</li> <li>• Once DHCS implements CSI/Claims based reporting for this and other timeliness metrics, adapt work flows as needed and monitor.</li> </ul>																																	
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<p>Annual Goal Items Met: Item # ___ Partially Met: Item # ___ Not Met: 1 Item # ___ Continued: Item # ___1</p>	<p><b>Time from last assessment to initial specialty mental health service:</b> The methodology for this metric remains challenging. However, a PIP has been initiated to address both the data collection and the process of referral. Start date was 12/10, so initial baselines are not yet available.</p>																																	

• DHCS Site Review Protocol Section: A

**Napa County Mental Health Quality Improvement Work Plan 2018**

- *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><b>All individuals requesting urgent mental health services are seen or referred for emergent care within 24 hours 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 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>Napa has designed a system to respond immediately to urgent care requests.</p>									
<p><b>BASELINE</b></p>	<p>People who call the MH Access Line and need urgent care are transferred to Exodus CSS by the Access secretaries.</p> <table border="0"> <tr> <td data-bbox="511 1003 803 1066"> <p><b>MONTH</b> <b>December 2017</b></p> </td> <td data-bbox="828 1003 1461 1455"> <p><b>Analysis</b></p> <p>Data collection began December 2017. Review of the Access Call Log for the month of December 2017 shows three entries for urgent services:</p> <ul style="list-style-type: none"> <li>• Access call transferred to CSSP – no name match on CSSP Call Log, no service data available</li> <li>• Access call requesting not to be transferred to CSSP, transferred to MH Division Responder of the Day – no service data available</li> <li>• Access walk-in looking for family member already admitted to CSSP</li> </ul> </td> </tr> <tr> <td data-bbox="511 1455 803 1833"> <p><b>January 2018</b></p> </td> <td data-bbox="828 1455 1461 1833"> <p>Review of the Access Call Log for the month of January 2018 shows two entries for urgent services:</p> <ul style="list-style-type: none"> <li>• Access walk-in brought over to CSSP – no name match on CSSP Call Log, did receive crisis service, service data available</li> <li>• Staff call to Access, individual in lobby in need of urgent services requesting not to go to CSSP, MH Division Responder of the Day contacted – no service data available</li> </ul> </td> </tr> </table> <table border="1"> <thead> <tr> <th data-bbox="511 1843 576 1875">Date</th> <th data-bbox="690 1843 917 1875">Access Disposition</th> <th data-bbox="966 1843 1112 1875">Access Time</th> <th data-bbox="1144 1843 1274 1875">CSSP Time</th> <th data-bbox="1323 1843 1388 1875">LOT</th> </tr> </thead> </table>	<p><b>MONTH</b> <b>December 2017</b></p>	<p><b>Analysis</b></p> <p>Data collection began December 2017. Review of the Access Call Log for the month of December 2017 shows three entries for urgent services:</p> <ul style="list-style-type: none"> <li>• Access call transferred to CSSP – no name match on CSSP Call Log, no service data available</li> <li>• Access call requesting not to be transferred to CSSP, transferred to MH Division Responder of the Day – no service data available</li> <li>• Access walk-in looking for family member already admitted to CSSP</li> </ul>	<p><b>January 2018</b></p>	<p>Review of the Access Call Log for the month of January 2018 shows two entries for urgent services:</p> <ul style="list-style-type: none"> <li>• Access walk-in brought over to CSSP – no name match on CSSP Call Log, did receive crisis service, service data available</li> <li>• Staff call to Access, individual in lobby in need of urgent services requesting not to go to CSSP, MH Division Responder of the Day contacted – no service data available</li> </ul>	Date	Access Disposition	Access Time	CSSP Time	LOT
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**Napa County Mental Health Quality Improvement Work Plan 2018**

	<b>1/26/2018</b> Walk-in 10:36 AM 10:42 AM 0:06															
<b>ACTION STEPS</b>	Exodus CSS provides immediate on demand urgent care services.															
<b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b>	<p><b>Methodology:</b> For individuals that call Mental Health Access and need urgent mental health services, we track the length of time it takes from the time their call is answered by Access staff to the time they are assisted by crisis stabilization staff.</p> <p><b>Data Source:</b> Access Call Log, CSSP Call Log</p> <p><b>Frequency of Review:</b> Monthly</p>															
<b>STAKEHOLDERS</b>	Access Staff and Supervisor, ERT Staff and Supervisor, Clinical Director, Quality Coordinator, Staff Services Analyst															
<b>EVALUATION</b>	<b>DATA DETAIL</b>															
<p>Annual Goal Items</p> <p>Met: Item # ___</p> <p>Partially Met: 1 Item # ___</p> <p>Not Met: Item # ___</p> <p>Continued: Item #</p>	<p>Urgent care metric:</p> <table border="1"> <tr> <td>2/16/18</td> <td>Walk-in</td> <td>10:55 AM</td> <td>11:00 AM</td> <td>0:05</td> </tr> <tr> <td><b>Date</b></td> <td><b>Access Disposition</b></td> <td><b>Access Time</b></td> <td><b>CSSP Time</b></td> <td><b>LOT</b></td> </tr> <tr> <td>1/26/2018</td> <td>Walk-in</td> <td>10:36 AM</td> <td>10:42 AM</td> <td>0:06</td> </tr> </table> <p><b>Methodology:</b> For individuals that call or walk into Mental Health Access and need urgent mental health services, the length of time it takes for their call to be answered by Access staff to the time they are assisted by crisis stabilization staff. Review of Access Call Log to determine number of referrals for urgent services and CSSP Call Log for name match and length of time.</p> <p><b>Analysis:</b> The MH analyst reports very small numbers of contacts registered on the log that meet the criteria for urgent care. It may make sense to re-visit the methodology for this indicator as it appears urgent care requests may be now getting more commonly diverted to the on-call MH staff.</p>	2/16/18	Walk-in	10:55 AM	11:00 AM	0:05	<b>Date</b>	<b>Access Disposition</b>	<b>Access Time</b>	<b>CSSP Time</b>	<b>LOT</b>	1/26/2018	Walk-in	10:36 AM	10:42 AM	0:06
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<p><b>GOAL II.D.</b></p> <p><b>Responsiveness of the 24/7 toll-free number</b></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>At least 2 calls monthly 6/17 – 12/17:</p> <table border="1" data-bbox="500 667 1445 821"> <thead> <tr> <th>Total Test Calls</th> <th>Calls Handled Accurately</th> <th>Successfully recorded on Access Log</th> <th>Call in Spanish or Cantonese/translated successfully</th> </tr> </thead> <tbody> <tr> <td align="center">8</td> <td align="center">3</td> <td align="center">3</td> <td align="center">2/0</td> </tr> </tbody> </table>	Total Test Calls	Calls Handled Accurately	Successfully recorded on Access Log	Call in Spanish or Cantonese/translated successfully	8	3	3	2/0
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8	3	3	2/0						
<p><b>ACTION STEPS</b></p>	<ul style="list-style-type: none"> <li>• Continue conducting at least 2 test calls a month</li> <li>• Record results of test calls</li> <li>• Meet with Exodus Supervisor as needed 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>Exodus Staff and Supervisor, Access Staff and Supervisor, Quality Coordinator, QIC</p>								
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>								
<p><b>Annual Goal Items Met: Item # ___</b>  <b>Partially Met: Item # 1</b>  <b>Not Met: Item # ___</b>  <b>Continued: Item # 1</b></p>	<p>1/18 – 10/18</p> <table border="1" data-bbox="500 1457 1445 1682"> <thead> <tr> <th>Total Test Calls</th> <th>Calls Handled Accurately</th> <th>Successfully recorded on Access Log</th> <th>Call in Spanish or Cantonese/translated successfully</th> </tr> </thead> <tbody> <tr> <td align="center">5</td> <td align="center">3 (2 business hrs)</td> <td align="center">2 (B)</td> <td align="center">0/0</td> </tr> </tbody> </table> <p>Exodus continues to fail nearly all after hours test calls. More test calls by our grad students need to be made to ensure accuracy of results. Calls made during business hours are answered accurately and recorded by Access secretaries.</p>	Total Test Calls	Calls Handled Accurately	Successfully recorded on Access Log	Call in Spanish or Cantonese/translated successfully	5	3 (2 business hrs)	2 (B)	0/0
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## Napa County Mental Health Quality Improvement Work Plan 2018

- *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><b>GOAL II.E.</b></p> <p><b>Medication services are efficiently managed</b></p>	<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>																																																																																																																		
<p><b>BASELINE</b></p>	<table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th colspan="6"><b>Adult Medication Clinic Show Rate Trend Analysis</b></th> </tr> <tr> <th></th> <th>Total Appts</th> <th>NO SHOW</th> <th>SHOW</th> <th>%SHOW</th> <th>TARGET</th> </tr> </thead> <tbody> <tr><td>FY 08-09</td><td>4721</td><td>493</td><td>3960</td><td>84%</td><td>88%</td></tr> <tr><td>FY 09-10</td><td>4198</td><td>347</td><td>3817</td><td>91%</td><td>88%</td></tr> <tr><td>FY 10-11</td><td>4188</td><td>396</td><td>3545</td><td>85%</td><td>88%</td></tr> <tr><td>FY 11-12</td><td>4552</td><td>428</td><td>3868</td><td>85%</td><td>88%</td></tr> <tr><td>FY 12-13</td><td>4906</td><td>479</td><td>4135</td><td>84%</td><td>88%</td></tr> <tr><td>FY 13-14</td><td>4528</td><td>477</td><td>3809</td><td>84%</td><td>88%</td></tr> <tr><td>FY 14-15</td><td>4342</td><td>485</td><td>3701</td><td>85%</td><td>88%</td></tr> <tr><td>FY 15-16</td><td>4648</td><td>1076</td><td>3572</td><td>77%</td><td>88%</td></tr> <tr><td>FY 16-17</td><td>4271</td><td>881</td><td>3390</td><td>79%</td><td>88%</td></tr> <tr><td>FY 17-18</td><td>1771</td><td>316</td><td>1455</td><td>82%</td><td>88%</td></tr> <tr><td><b>OVERALL</b></td><td><b>42125</b></td><td><b>5378</b></td><td><b>35252</b></td><td><b>84%</b></td><td><b>88%</b></td></tr> </tbody> </table> <div style="text-align: center;"> <p><b>Show Rates % for Adult Medication Clinic</b></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <caption>Monthly Show Rates Data</caption> <thead> <tr> <th>Month</th> <th>%SHOW</th> <th>Target (88%)</th> </tr> </thead> <tbody> <tr><td>Jan-17</td><td>76%</td><td>88%</td></tr> <tr><td>Feb-17</td><td>83%</td><td>88%</td></tr> <tr><td>Mar-17</td><td>79%</td><td>88%</td></tr> <tr><td>Apr-17</td><td>87%</td><td>88%</td></tr> <tr><td>May-17</td><td>82%</td><td>88%</td></tr> <tr><td>Jun-17</td><td>83%</td><td>88%</td></tr> <tr><td>Jul-17</td><td>85%</td><td>88%</td></tr> <tr><td>Aug-17</td><td>85%</td><td>88%</td></tr> <tr><td>Sep-17</td><td>84%</td><td>88%</td></tr> <tr><td>Oct-17</td><td>73%</td><td>88%</td></tr> <tr><td>Nov-17</td><td>82%</td><td>88%</td></tr> </tbody> </table> </div>	<b>Adult Medication Clinic Show Rate Trend Analysis</b>							Total Appts	NO SHOW	SHOW	%SHOW	TARGET	FY 08-09	4721	493	3960	84%	88%	FY 09-10	4198	347	3817	91%	88%	FY 10-11	4188	396	3545	85%	88%	FY 11-12	4552	428	3868	85%	88%	FY 12-13	4906	479	4135	84%	88%	FY 13-14	4528	477	3809	84%	88%	FY 14-15	4342	485	3701	85%	88%	FY 15-16	4648	1076	3572	77%	88%	FY 16-17	4271	881	3390	79%	88%	FY 17-18	1771	316	1455	82%	88%	<b>OVERALL</b>	<b>42125</b>	<b>5378</b>	<b>35252</b>	<b>84%</b>	<b>88%</b>	Month	%SHOW	Target (88%)	Jan-17	76%	88%	Feb-17	83%	88%	Mar-17	79%	88%	Apr-17	87%	88%	May-17	82%	88%	Jun-17	83%	88%	Jul-17	85%	88%	Aug-17	85%	88%	Sep-17	84%	88%	Oct-17	73%	88%	Nov-17	82%	88%
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Feb-17	83%	88%																																																																																																																	
Mar-17	79%	88%																																																																																																																	
Apr-17	87%	88%																																																																																																																	
May-17	82%	88%																																																																																																																	
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Aug-17	85%	88%																																																																																																																	
Sep-17	84%	88%																																																																																																																	
Oct-17	73%	88%																																																																																																																	
Nov-17	82%	88%																																																																																																																	

Napa County Mental Health Quality Improvement Work Plan 2018

	<p>Percentage of individuals scheduled for medication clinic intake appointments that show for their appointment ALL:</p> <table border="1"> <thead> <tr> <th></th> <th>Jul-17</th> <th>Aug-17</th> <th>Sep-17</th> <th>Oct-17</th> <th>Nov-17</th> </tr> </thead> <tbody> <tr> <td># scheduled appts</td> <td>14</td> <td>22</td> <td>23</td> <td>17</td> <td>15</td> </tr> <tr> <td># of no shows</td> <td>1</td> <td>2</td> <td>3</td> <td>1</td> <td>2</td> </tr> <tr> <td># showed</td> <td>13</td> <td>20</td> <td>20</td> <td>16</td> <td>13</td> </tr> <tr> <td>%</td> <td>93%</td> <td>91%</td> <td>87%</td> <td>94%</td> <td>87%</td> </tr> </tbody> </table>		Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	# scheduled appts	14	22	23	17	15	# of no shows	1	2	3	1	2	# showed	13	20	20	16	13	%	93%	91%	87%	94%	87%																													
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<p><b>ACTION STEPS</b></p>	<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 medication appointments kept</li> <li>3. Appointment reminder calls will continue.</li> </ol> <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>																																																											
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>Data collected from Anasazi Scheduler report: individuals who kept appointments/individuals scheduled for appointments Quarterly report.</p>																																																											
<p><b>STAKEHOLDERS</b></p>	<p>Psychiatric Medical Director and Psychiatric Staff, Staff Services Analyst</p>																																																											
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>																																																											
<p>Annual Goal Items Met: Item # ___ Partially Met: Item # Not Met: Item # 1,2 Continued: Item # 1,2</p>	<p>Only partial data available for CY 2018:</p> <table border="1"> <thead> <tr> <th colspan="10">MEDICATION CLINIC FY 2017-2018</th> </tr> <tr> <th rowspan="2"></th> <th colspan="3">ADULT (1005)</th> <th colspan="3">CHILD (5005/6005)</th> <th colspan="3">TOTAL</th> </tr> <tr> <th>Total Appts</th> <th>No Show</th> <th>%</th> <th>Total Appts</th> <th>No Show</th> <th>%</th> <th>Total Appts</th> <th>No Show</th> <th>%</th> </tr> </thead> <tbody> <tr> <td><b>July</b></td> <td>319</td> <td>47</td> <td>15%</td> <td>66</td> <td>11</td> <td>17%</td> <td>385</td> <td>58</td> <td>15%</td> </tr> <tr> <td><b>Aug</b></td> <td>412</td> <td>60</td> <td>15%</td> <td>120</td> <td>19</td> <td>16%</td> <td>532</td> <td>79</td> <td>15%</td> </tr> <tr> <td><b>Sept</b></td> <td>353</td> <td>57</td> <td>16%</td> <td>110</td> <td>16</td> <td>15%</td> <td>463</td> <td>73</td> <td>16%</td> </tr> </tbody> </table>	MEDICATION CLINIC FY 2017-2018											ADULT (1005)			CHILD (5005/6005)			TOTAL			Total Appts	No Show	%	Total Appts	No Show	%	Total Appts	No Show	%	<b>July</b>	319	47	15%	66	11	17%	385	58	15%	<b>Aug</b>	412	60	15%	120	19	16%	532	79	15%	<b>Sept</b>	353	57	16%	110	16	15%	463	73	16%
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**Napa County Mental Health Quality Improvement Work Plan 2018**

<b>Oct</b>	328	88	27 %	119	23	19 %	447	111	25 %
<b>Nov</b>	357	65	18 %	103	15	15 %	460	80	17 %
<b>Dec</b>	344	58	17 %	76	10	13 %	420	68	16 %
<b>Jan</b>	378	67	18 %	102	12	12 %	480	79	16 %
<b>Feb</b>	318	47	15 %	97	10	10 %	415	57	14 %
<b>Mar</b>	298	42	14 %	115	18	16 %	413	60	15 %
<b>Apr</b>	399	52	13 %	116	16	14 %	515	68	13 %
<b>TOTAL</b>	<b>3506</b>	<b>583</b>	<b>17 %</b>	<b>1024</b>	<b>150</b>	<b>15 %</b>	<b>4530</b>	<b>733</b>	<b>16 %</b>

**INDIVIDUAL THERAPY SERVICES FY 2017-2018**

	Adult (1015)			Children (5015)			TOTAL		
	Total Appts	No Show	%	Total Appts	No Show	%	Total Appts	No Show	%
<b>July</b>	42	10	24 %	0	0	#DIV/0!	42	10	24 %
<b>Aug</b>	48	8	17 %	0	0	#DIV/0!	48	8	17 %
<b>Sept</b>	27	5	19 %	0	0	#DIV/0!	27	5	19 %
<b>Oct</b>	24	5	21 %	0	0	#DIV/0!	24	5	21 %
<b>Nov</b>	27	5	19 %	0	0	#DIV/0!	27	5	19 %
<b>Dec</b>	32	9	28 %	1	1	100%	33	10	30 %
<b>Jan</b>	29	3	10 %	0	0	#DIV/0!	29	3	10 %
<b>Feb</b>	26	3	12 %	0	0	#DIV/0!	26	3	12 %
<b>Mar</b>	21	3	14 %	0	0	#DIV/0!	21	3	14 %
<b>Apr</b>	36	6	17 %	0	0	#DIV/0!	36	6	17 %
<b>TOTAL</b>	<b>312</b>	<b>57</b>	<b>18 %</b>	<b>1</b>	<b>1</b>	<b>100%</b>	<b>313</b>	<b>58</b>	<b>19 %</b>

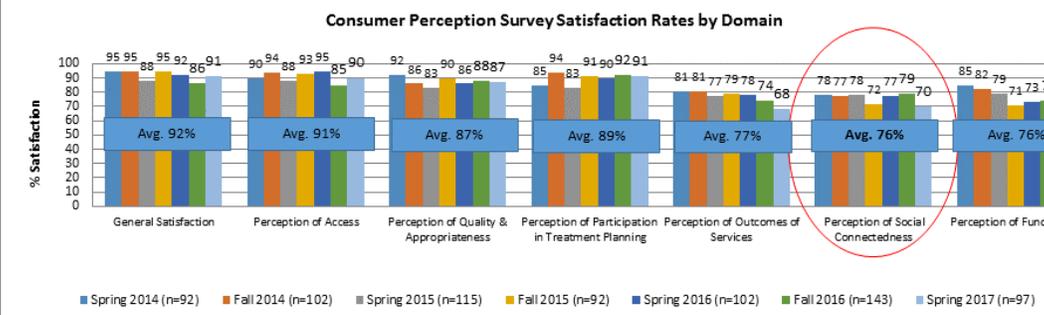
Despite some progress, the goals have not yet been met.

- *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**

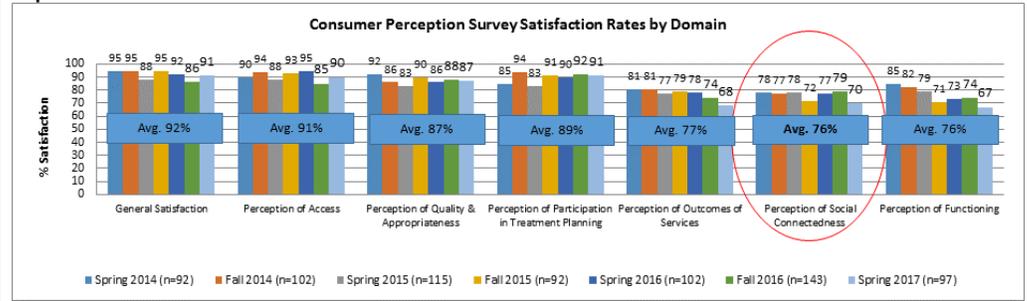
<p><b>GOAL III.A.</b>  <b>Beneficiary and family satisfaction surveys of the NCMHP continue to be conducted bi-annually using the Performance Outcome Quality Improvement (POQI)</b></p>	<p>Continued from last year:</p> <ol style="list-style-type: none"> <li>1. Beneficiary Satisfaction Survey target: 85 % of survey questions are ranked satisfied to very satisfied.</li> <li>2. Continue re-formatting and focused analysis of survey results and produce more recommendations for improvements.</li> <li>3. With more public-friendly presentations of data, routinely share results with all stakeholders.</li> <li>4. Refine administration protocols to ensure higher quality data input.</li> <li>5. Use social connectedness domain item results as an outcome measure for Social Engagement Clinical PIP.</li> </ol>
<p><b>BASELINE</b></p>	<p>Re. goal #1: current aggregate adult score average over the past 7 administrations of the survey = 84%. For Spring 2016 =81%. Areas of concern in addition to perception of social connectedness, include perception of the outcome of services and perception of functioning.</p> <p>Re. goal #2: Some analysis and discussion of results occurs at the MHP administrative level, but more in-depth analysis and discussion with stakeholders remains a goal.</p> <p>Re. goal #3: Some of the results, formatted as above, were shared at an all staff Division meeting with discussion. The social connectedness data has been routinely analyzed and discussed at meetings of the Social Engagement PIP team. It remains a goal to produce a more thorough report to publish and distribute to stakeholders. The persistent problem of the delays in providing survey results to the county by DHCS and CIBHS remains unresolved.</p> <p>Re. goal #4: The MH Office Assistant responsible for distribution of the surveys made significant upgrades to the distribution process, such as pre-filling program codes to ensure greater accuracy of determination of the source of the completed surveys. More detailed and specific</p>

Napa County Mental Health Quality Improvement Work Plan 2018

	<p>administration instructions were provided to staff and providers. The success of these steps will be evaluated when we receive the results. Re. goal #5, the graph below represents adult results only and shows the most recent results for the social connectedness domain, dated before the commencement of the PIP. More recent results have not yet been made available by DHCS and CIBHS.</p>  <table border="1"> <caption>Consumer Perception Survey Satisfaction Rates by Domain</caption> <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>Fall 2016 (n=143)</th> <th>Spring 2017 (n=97)</th> <th>Avg.</th> </tr> </thead> <tbody> <tr> <td>General Satisfaction</td> <td>95</td> <td>95</td> <td>88</td> <td>95</td> <td>92</td> <td>86</td> <td>91</td> <td>92%</td> </tr> <tr> <td>Perception of Access</td> <td>90</td> <td>94</td> <td>88</td> <td>93</td> <td>95</td> <td>85</td> <td>90</td> <td>91%</td> </tr> <tr> <td>Perception of Quality &amp; Appropriateness</td> <td>92</td> <td>86</td> <td>83</td> <td>90</td> <td>86</td> <td>88</td> <td>87</td> <td>87%</td> </tr> <tr> <td>Perception of Participation in Treatment Planning</td> <td>85</td> <td>94</td> <td>83</td> <td>91</td> <td>90</td> <td>92</td> <td>91</td> <td>89%</td> </tr> <tr> <td>Perception of Outcomes of Services</td> <td>81</td> <td>81</td> <td>77</td> <td>79</td> <td>78</td> <td>74</td> <td>68</td> <td>77%</td> </tr> <tr> <td>Perception of Social Connectedness</td> <td>78</td> <td>77</td> <td>78</td> <td>72</td> <td>77</td> <td>79</td> <td>70</td> <td>76%</td> </tr> <tr> <td>Perception of Functionality</td> <td>85</td> <td>82</td> <td>79</td> <td>71</td> <td>73</td> <td>77</td> <td>73</td> <td>76%</td> </tr> </tbody> </table>	Domain	Spring 2014 (n=92)	Fall 2014 (n=102)	Spring 2015 (n=115)	Fall 2015 (n=92)	Spring 2016 (n=102)	Fall 2016 (n=143)	Spring 2017 (n=97)	Avg.	General Satisfaction	95	95	88	95	92	86	91	92%	Perception of Access	90	94	88	93	95	85	90	91%	Perception of Quality & Appropriateness	92	86	83	90	86	88	87	87%	Perception of Participation in Treatment Planning	85	94	83	91	90	92	91	89%	Perception of Outcomes of Services	81	81	77	79	78	74	68	77%	Perception of Social Connectedness	78	77	78	72	77	79	70	76%	Perception of Functionality	85	82	79	71	73	77	73	76%
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<p><b>ACTION STEPS</b></p>	<p>Continue working on implementing goals 1-5. If possible, consider implementing a briefer, county designed satisfaction survey.</p>																																																																								
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>Bi-annual analysis of CPS data as collected by CIBHS, utilizing the EBHS data analysis system.</p>																																																																								
<p><b>STAKEHOLDERS</b></p>	<p>QIC, Quality Coordinator, Staff Services Analyst, Social Engagement PIP Team, Stakeholders</p>																																																																								
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<p>Annual Goal Items Met: 4, 5 Item # _Partially Met: 3 Item # Not Met: 1, 2, Item # Continued: Item # 1,2</p>	<ol style="list-style-type: none"> <li>Beneficiary Satisfaction Survey target: 85 % of survey questions are ranked satisfied to very satisfied. – The most recent CPS results have not yet been analyzed in their entirety.</li> <li>Continue re-formatting and focused analysis of survey results and produce more recommendations for improvements. – not yet done</li> <li>With more public-friendly presentations of data, routinely share results with all stakeholders. – results were shared with all org providers</li> <li>Refine administration protocols to ensure higher quality data input. – MH Admin OA has for the last 2 administrations, been distributing forms that are pre-filled out with org provider and team identifiers.</li> <li>Use social connectedness domain item results as an outcome measure for Social Engagement Clinical PIP. – used, but the PIP team determined that the CPS is ill suited for use as an outcome measure for the PIP due to it's infrequent administration, lengthy delays in data return from DHCS/CIBHS and diluted rather than targeted results.</li> </ol>																																																																								

## Napa County Mental Health Quality Improvement Work Plan 2018

### Updated Social Connectedness PIP Data:



- *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

<b>GOAL III.B.</b> Monitor Grievances, Appeals, Requests for Change of Providers and Fair Hearings resolutions	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.
<b>BASELINE</b>	100% of Appeals, Grievances and 95% of Requests for Change of Providers are successfully resolved within mandated timeframes.
<b>ACTION STEPS</b>	Continue tracking and reports.

## Napa County Mental Health Quality Improvement Work Plan 2018

<b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b>	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.
<b>STAKEHOLDERS</b>	QIC, QM, Quality Coordinator, MH Director
<b>EVALUATION</b>	<b>DATA DETAIL</b>
Annual Goal Items Met: Item # 1 Partially Met: Item # ____ Not Met: Item # ____ Continued: Item # _ 1	The Division and QM presented the grievance, appeal and change of provider annual report to QIC in October, 2018. The goal of 100% of Appeals, Grievances and 95% of Requests for Change of Providers are successfully resolved within mandated timeframes was met.

- *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

<b>GOAL In Coordin ation with Exodus Crisis Stabiliz ation and Service</b>	Track and analyze the 2 new measures: <ol style="list-style-type: none"> <li>1. Total number of clients seen in the CSSP and the percentage hospitalized</li> <li>2. Length of stay in the CSSP with an emphasis on the number that stay longer than 24 hours</li> </ol>
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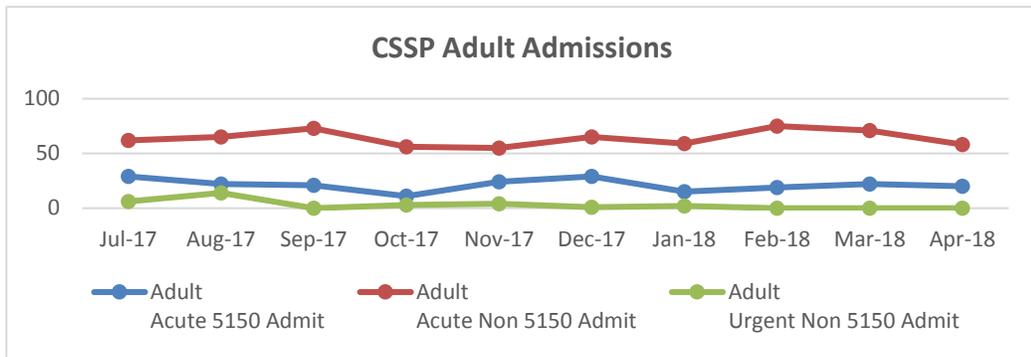
Napa County Mental Health Quality Improvement Work Plan 2018

<p><b>s Unit, develop Quantitative and Qualitative data indicators</b></p>																																													
<p><b>BASELINE</b></p>	<p>TBD</p>																																												
<p><b>ACTION STEPS</b></p>	<ul style="list-style-type: none"> <li>As data becomes available, analyze and make appropriate recommendations.</li> <li>Coordinate Quality Assurance and Improvement efforts with Exodus staff.</li> </ul>																																												
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>Cerner Anasazi reports.</p>																																												
<p><b>STAKEHOLDERS</b></p>	<p>MHP Administrative staff, Exodus staff, QIC</p>																																												
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>																																												
<p><b>Annual Goal Item # 1 Partially Met: Item # Not Met:</b></p>	<p>Goal #1:</p> <table border="1"> <caption>CSSP Adolescent Admissions</caption> <thead> <tr> <th>Month</th> <th>Adolescent Acute 5150 Admit</th> <th>Adolescent Acute Non 5150 Admit</th> <th>Adolescent Urgent Non 5150 Admit</th> </tr> </thead> <tbody> <tr><td>Jul-17</td><td>5</td><td>8</td><td>0</td></tr> <tr><td>Aug-17</td><td>4</td><td>10</td><td>0</td></tr> <tr><td>Sep-17</td><td>5</td><td>22</td><td>0</td></tr> <tr><td>Oct-17</td><td>4</td><td>10</td><td>0</td></tr> <tr><td>Nov-17</td><td>6</td><td>12</td><td>5</td></tr> <tr><td>Dec-17</td><td>5</td><td>11</td><td>1</td></tr> <tr><td>Jan-18</td><td>5</td><td>10</td><td>0</td></tr> <tr><td>Feb-18</td><td>10</td><td>22</td><td>0</td></tr> <tr><td>Mar-18</td><td>8</td><td>21</td><td>0</td></tr> <tr><td>Apr-18</td><td>6</td><td>20</td><td>0</td></tr> </tbody> </table>	Month	Adolescent Acute 5150 Admit	Adolescent Acute Non 5150 Admit	Adolescent Urgent Non 5150 Admit	Jul-17	5	8	0	Aug-17	4	10	0	Sep-17	5	22	0	Oct-17	4	10	0	Nov-17	6	12	5	Dec-17	5	11	1	Jan-18	5	10	0	Feb-18	10	22	0	Mar-18	8	21	0	Apr-18	6	20	0
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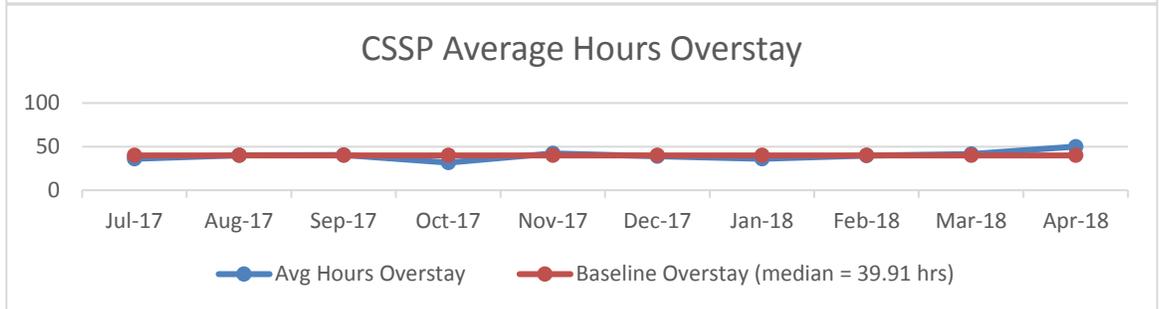
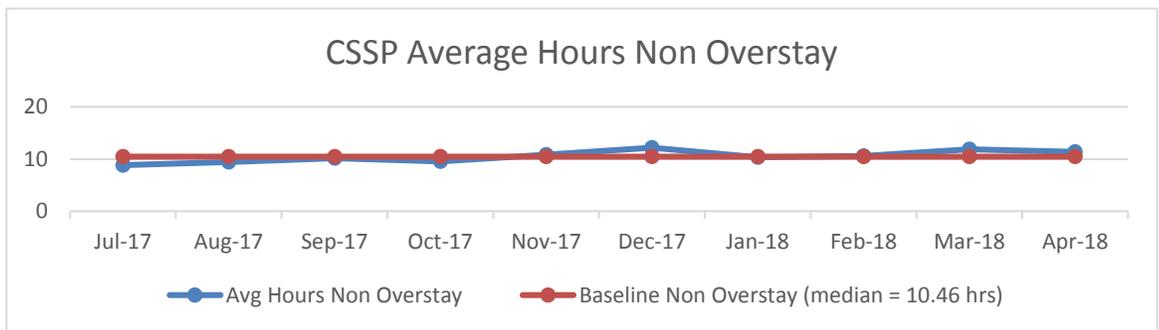
## Napa County Mental Health Quality Improvement Work Plan 2018

Item #

Continued:  
Item #



Now that baseline data is available, the URSC will set goals for these indicators. Length of Stay data:



Month	# Non Overstay	Avg Hours Non Overstay	Baseline Non Overstay (median = 10.46 hrs)	# Overstay	Avg Hours Overstay	Baseline Overstay (median = 39.91 hrs)
Jul-17	87	8.83	10.46	20	35.87	39.91
Aug-17	98	9.42	10.46	14	40.16	39.91
Sep-17	94	10.13	10.46	26	40.35	39.91
Oct-17	69	9.56	10.46	12	31.67	39.91

## Napa County Mental Health Quality Improvement Work Plan 2018

	<b>No</b>						
	<b>v-</b>						
	<b>17</b>	83	10.84	10.46	23	42.15	39.91
	<b>Dec</b>						
	<b>-17</b>	92	12.18	10.46	19	38.85	39.91
	<b>Jan</b>						
	<b>-18</b>	74	10.33	10.46	16	36.04	39.91
	<b>Feb</b>						
<b>-18</b>	91	10.59	10.46	34	39.66	39.91	
<b>Ma</b>							
<b>r-</b>							
<b>18</b>	90	11.86	10.46	30	41.63	39.91	
<b>Apr</b>							
<b>-18</b>	72	11.35	10.46	28	50.03	39.91	
<b>TO</b>							
<b>TAL</b>							
<b>S</b>	850	<b>10.44</b>		222	<b>39.12</b>		

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

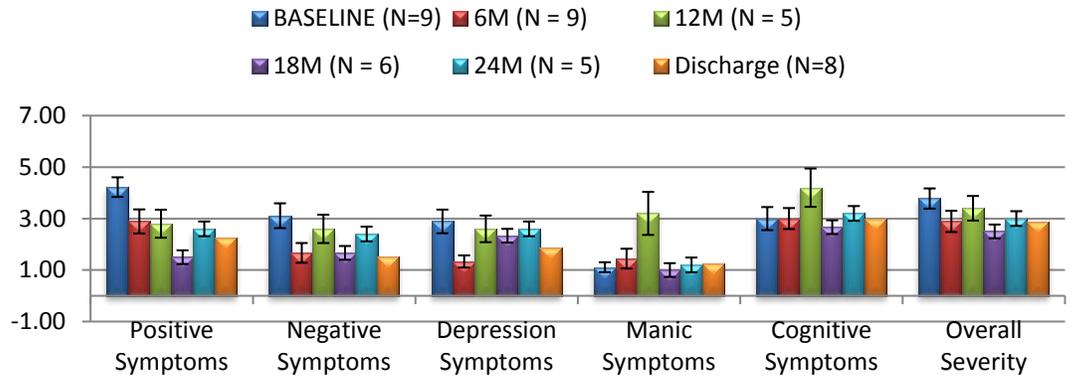
### SECTION IV: Monitoring Mental Health Plans' Service Delivery System and Clinical Issues Affecting Beneficiaries

<p><b>GOAL</b>  <b>Provide Effective Early Interventions to Young Adults with Onset of Psychotic Symptoms</b></p>	<p>Through Supportive Outreach &amp; 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 <a href="#">Early Diagnosis and Preventative Treatment (EDAPT) Clinic</a>, 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>
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**BASELINE**

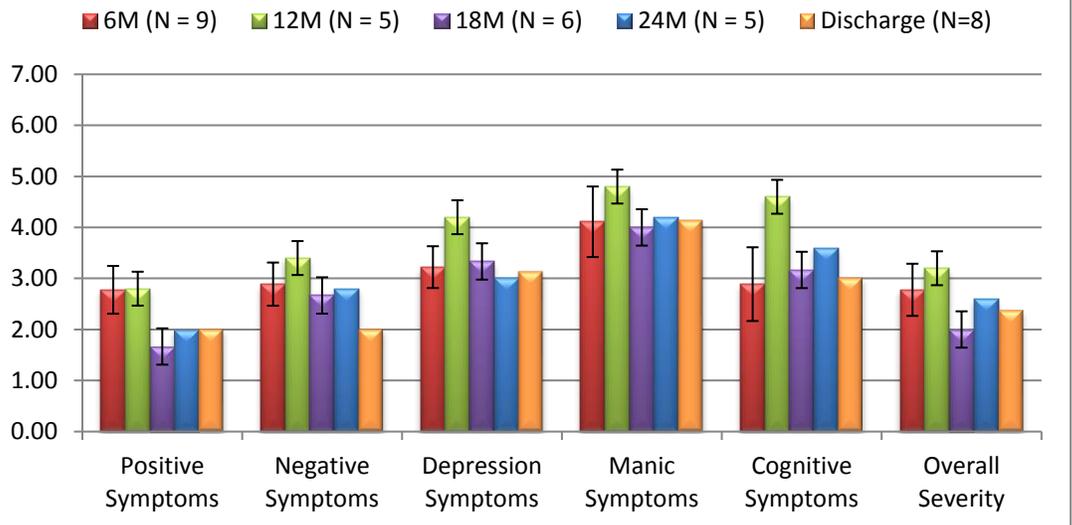
- CGI SEVERITY ILLNESS KEY**  
 1 NORMAL NOT ILL  
 2 MINIMALLY ILL  
 3 MILDLY ILL  
 4 MODERATELY ILL  
 5 MARKEDLY ILL  
 6 SEVERLY ILL  
 7 AMONGST THE MOST  
 9 NOT ENOUGH INFO

**CGI Ratings: Average Severity of Illness**



- DEGREE OF CHANGEKEY**  
 1 VERY MUCH IMPROVED  
 2 MUCH IMPROVED  
 3 MINIMALLY IMPROVED  
 4 NO CHANGE  
 5 MINIMALLY WORSE  
 6 MUCH WORSE  
 7 VERY MUCH WORSE  
 9 NOT ENOUGH INFO

**CGI Ratings: Degree of Change**

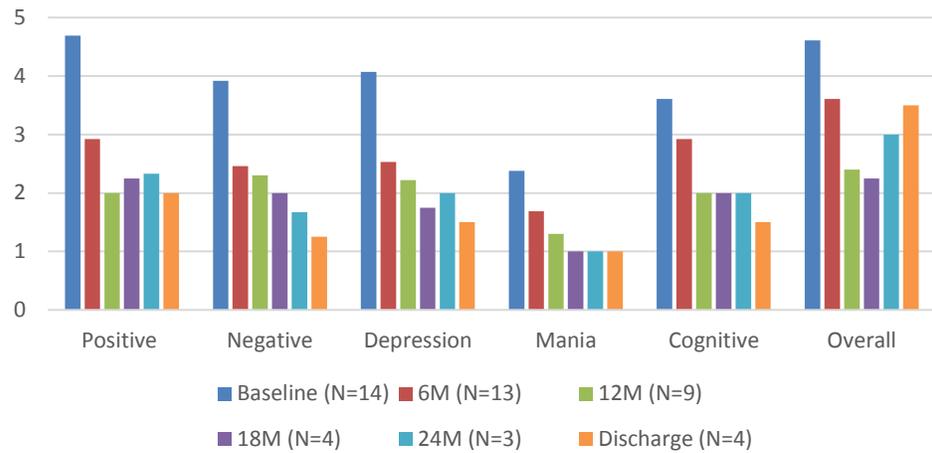


**Napa County Mental Health Quality Improvement Work Plan 2018**

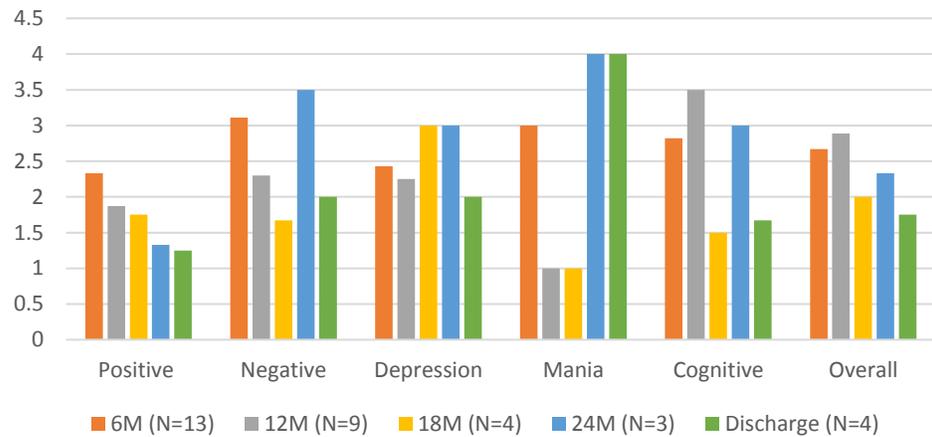
<b>ACTION STEPS</b>	Analyze data and consult with program to ensure continuing positive outcomes.
<b>MONITORING METHODOLOGY / DATA SOURCE/ FREQUENCY</b>	In the first two years of the program, efforts have been made toward refining data collection to provide more comprehensive and relevant outcomes to report. In collaboration with UC Davis, Aldea is in the process of analyzing/collating the data from the CGI and further details regarding outcomes such as hospitalization/ER utilization, justice involvement, housing status/homelessness, family involvement, and treatment involvement which we look forward to presenting next year.
<b>STAKEHOLDERS</b>	QIC, Aldea providers and clients, MHP Administrative staff.
<b>EVALUATION</b>	<b>DATA DETAIL</b>

Annual Goal  
 Items  
 Met: 1  
 Item #  
 Partially Met:  
 Item #  
 Not Met:  
 Item #  
 Continued:  
 Item #

CGI Ratings: Average Severity of Illness



CGI Ratings: Average Degree of Change



- 15 clients received SOAR services in Q1 & Q2 (2018-2019)
  - 10 clients were under the age of 18
  - 5 clients were over 18
- 3 clients successfully graduated this program during this period
- 2 clients are near completion
- 1 client was referred to substance abuse treatment
- 1 client was assessed and did not meet criteria for the program
- Total number of clients hospitalized during this period: 0
- Of the 4 clients discharged in Q1 & Q2, 100% experienced improvement in overall symptoms and functioning

## Napa County Mental Health Quality Improvement Work Plan 2018

	<p>Program Updates:</p> <ul style="list-style-type: none"><li>○ Current SOAR Staff: 1 Nurse Practitioner and 1 full-time Therapist (I am currently providing supervision)</li><li>○ We will be sending 3 Therapists (2 Bi-lingual, 1 English) to UC Davis (SOAR model) training next month (to replenish staff and return to previous program structure and capacity)</li><li>○ We've hired a Behavioral Specialist (currently in training) that will serve as a part-time Family Advocate/Education &amp; Employment support for the program</li><li>○ We hope to begin offering Groups and providing community outreach this Spring</li></ul>
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<ul style="list-style-type: none"><li>• <i>DHCS Site Review Protocol Section: I</i></li><li>•</li></ul>
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### SECTION IV: Monitoring Mental Health Plans' Service Delivery System and Clinical Issues Affecting Beneficiaries

<p><b>GOAL</b> <b>Review clinical records</b></p>	<p>Continue to internally audit chart documentation. Track recently implemented holistic chart review.</p> <ol style="list-style-type: none"><li>1. 95% compliance/5% error rate each month.</li></ol>
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Napa County Mental Health Quality Improvement Work Plan 2018

BASELINE	<u>Mont</u>	<u>Months</u>	<u>Total # of</u>	<u>Total</u>	<u>#</u>	<u>#</u>	<u>#</u>	<u>% in</u>	<u>Target</u>
	<u>h of</u>	<u>reviewe</u>	<u>potentially billable</u>	<u>Claims</u>	<u>Written Off</u>	<u>Written Off</u>	<u>Written Off</u>	<u>compliance</u>	<u>t</u>
	<u>Review</u>	<u>d</u>	<u>claims</u>	<u>Written Off</u>	<u>to</u>	<u>to</u>	<u>to Dx</u>		
	<u>w</u>		<u>reviewed</u>		<u>Note</u>	<u>Plan</u>			
	Jan-17	Nov- Dec 16	130	4	4	0	0	97%	95%
	Feb-17	Dec 16- Jan 17	76	6	4	2	0	92%	95%
	Mar-17	Jan-Feb 17	93	13	13	0	0	86%	95%
	Apr-17	Feb- Mar 17	67	17	3	14	0	75%	95%
	May-17	Mar- Apr 17	136	14	8	0	6	90%	95%
	Jun-17	Apr- May 17	108	4	4	0	0	96%	95%
	Jul-17	May- June 17	130	6	5	1	0	95%	95%
	Aug-17	June- July 17	130	6	6	0	0	95%	95%
	Sep-17	July- Aug 17	98	2	2	0	0	98%	95%
	Oct-17	Aug- Sept 17	71	3	3	0	0	96%	95%
	Nov-17	Sept- Oct 17	93	4	4	0	0	96%	95%
	Dec-17	Oct-Nov 17	52	4	4	0	0	93%	95%
	<b>Total</b>		1184	83	60	17	6	92%	
<b>ACTION STEPS</b>	<ul style="list-style-type: none"> <li>Utilization Review Coordinator will coordinate ongoing chart review and make review adaptations as needed.</li> <li>The UR Coordinator will continue to provide documentation training and support to staff.</li> </ul>								
<b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b>	<p>The measure tracks the results of monthly chart reviews. The “N” varies depending on the total number of potentially billable claims in each month’s random sample. The total # of claims written off is divided by the “N” of that month’s review universe to determine the percentage error rate. Reasons for write off are also tracked: e.g. due to note, plan or diagnosis failure.</p> <p>The goal is 95% compliance/5% error rate each month.</p>								

**Napa County Mental Health Quality Improvement Work Plan 2018**

<b>STAKEHOLDERS</b>	UR Coordinator, URSC, MH Staff										
<b>EVALUATION</b>	<b>DATA DETAIL</b>										
<b>Annual Goal Items Met: 1 Item # Partially Met: Item # ___ Not Met: Item # ___ Continued: Item #</b>	The data shows the division currently meeting its target. In addition, the most recent SDMC audit performed by QM resulted in a 4.8% error rate.										
			<u>Total # of Potentially Billable Claims</u>	<u>Total Claims n</u>	<u># Written Off to Note</u>	<u># Written Off to Plan</u>	<u># Written Off to Dx</u>	<u># BCFd</u>	<u>% in Compliance</u>	<u>Target</u>	
	<u>Month of Review</u>	<u>Months Review</u>	<u>Claims</u>	<u>n</u>	<u>to</u>	<u>to</u>	<u>to</u>				
	Jan-18	Nov 17-Dec 17	102	13	2	11	0	0	87%	95%	
	Feb-18	Dec 17-Jan 18	91	4	4	0	0	0	96%	95%	
	Mar-18	Jan-Feb 18	78	8	0	0	0	8	90%	95%	
	Apr-18	Feb-Mar 18	250	20	16	2	0	2	92%	95%	
	May-18	Mar-Apr 18	216	27	14	12	0	1	88%	95%	
	Jun-18	Mar thru May 18 (3)	154	11	6	0	4	1	93%	95%	
	Jul-18	May-June 18	140	1	0	1	0	0	99%	95%	
	Aug-18	June-July 18	90	1	1	0	0	0	99%	95%	
	Sep-18	July-Aug 18	113	2	2	0	0	0	98%	95%	
	Oct-18	Aug-Sept 18	79	1	1	0	0	0	99%	95%	
	Nov-18	Sept-Oct 18	86	0	0	0	0	0	100%	95%	
	Dec-18	Oct-Nov 18								95%	
	<b>Total</b>		1399	88	46	26	4	12			
										AVERAG E=	95%

- 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**

<p><b>GOAL V.A.</b>  <b>Improved Coordination of mental health and physical health care is a primary focus of NCMHP and the FQHC, Ole Health</b></p>	<ul style="list-style-type: none"> <li>• Ole Health, NCMH and NCADS will continue to conduct MDT's as needed.</li> <li>• NCMH will co-locate a MH Access clinician at Ole Health's primary campus clinic.</li> <li>• Improve and implement Sensitive Information Exchange mechanisms. The Psychiatric Medical Director and Chief Physician at Ole Health will continue to explore means of re-instituting the P to P mechanisms and providing FQHC EMR access to medication lists.</li> </ul>
<p><b>BASELINE</b></p>	
<p><b>ACTION STEPS</b></p>	<ul style="list-style-type: none"> <li>• Continue to explore means of implementing Sensitive Information Exchange between partners</li> <li>• Co-locate NCMH Access clinician at Ole Health</li> <li>• Convene MDT's as needed</li> </ul>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>Medical Director report</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:  Item # __3  Partially Met:  Item # __  Not Met:  Item # 1,2  Continued:  Item # _</p>	<ul style="list-style-type: none"> <li>• Unfortunately, little progress has been made on establishing sensitive information exchange or an HIE due to lack of interest on the part of Ole Health at this time.</li> <li>• This goal has not yet been achieved.</li> <li>• MDT's continue to meet routinely and as needed and are considered by all stakeholders an integral and important element of care delivery, especially across multiple providers.</li> </ul>

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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) Process and track MHSA Problem Resolution Requests</p>	<ul style="list-style-type: none"> <li>• Successfully resolve 95% of provider appeals.</li> <li>• Resolve 100% of MHSA Problem Resolution Requests.</li> </ul>
<p><b>BASELINE</b></p>	<p>100% of each item resolved (N = 0)</p>
<p><b>ACTION STEPS</b></p>	<p>Continue to monitor as needed.</p>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>Appeal and MHSA Problem Resolution Logs reviewed annually by QIC</p>
<p><b>STAKEHOLDERS</b></p>	<p>Provider Services Coordinator, Quality Coordinator, MHSA Program Manager, QIC</p>
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>
<p>Annual Goal Items Met:                  Item # 1                  Partially Met:                  Item # ____                  Not Met:                  Item # ____                  Continued:                  Item #</p>	<p>There were no MHSA Provider appeals during 2018.</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><b>GOAL VI. B. Refine and Improve QI Activities</b></p>	<ul style="list-style-type: none"> <li>• Continue to monitor, review and refine all data metrics on MH Dashboard for rationale, targets, where applicable, methodologies, and frequency</li> <li>• Maintain 1 Clinical and 1 Non-clinical PIP</li> <li>• Maintain relevant RBA indicators; revise as needed.</li> <li>• Revise practices, policies and procedures as required by the Medicaid Managed Care Mega Rule</li> <li>• Implement new DHCS regulatory requirements regarding Network Adequacy</li> <li>• Implement mandated state outcome measures, e.g. CANS and PSC-35 and adult measure(s) when announced</li> </ul>
<p><b>BASELINE</b></p>	
<p><b>ACTION STEPS</b></p>	<p>Implement goals listed above</p>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>QIC Minutes, PIP documents; MH Data Dashboard and Master List; QM Dashboard of RBA indicators</p>
<p><b>STAKEHOLDERS</b></p>	<p>QIC, MH Leadership, Quality Coordinator, PIP Committees</p>
<p><b>EVALUATION</b></p>	<p><b>DATA DETAIL</b></p>
<p>Annual Goal Items Met: Item # Partially Met: Item # 1, 2, 4, 5 Not Met: Item # 3 Continued:Item #</p>	<ul style="list-style-type: none"> <li>• Continue to monitor, review and refine all data metrics on MH Dashboard for rationale, targets, where applicable, methodologies, and frequency – Some progress has been made, especially with the creation of 2 Exodus metrics.</li> <li>• Maintain 1 Clinical and 1 Non-clinical PIP- The clinical PIP was recently retired. A new clinical PIP will be launched this year. The previous non-clinical PIP was also retired. A new non clinical PIP has ben designed and launched.</li> <li>• Maintain relevant RBA indicators; revise as needed. - Napa County HHSa withdrew its support of RBA, so, although the</li> </ul>

## Napa County Mental Health Quality Improvement Work Plan 2018

	<p>model has proven its efficacy in measuring specific and general population impacts through data, RBA measures will only be utilized in cases where they bring value to a specific project.</p> <ul style="list-style-type: none"><li>• Revise practices, policies and procedures as required by the Medicaid Managed Care Mega Rule – The division undertook significant efforts rewriting and creating many new policies and implementing new procedures to comply with new CMS/DHCS Mega Rule mandates.</li><li>• Implement new DHCS regulatory requirements regarding Network Adequacy – The Division successfully implemented the complex requirements to demonstrate Network Adequacy and successfully submitted all required documentation on time.</li><li>• Implement mandated state outcome measures, e.g. CANS and PSC-35 and adult measure(s) when announced – CANS and PSC-35 were implemented on 10/1/18 as required.</li></ul>
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- *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</p>
<p><b>ACTION STEPS</b></p>	<p>As above</p>
<p><b>MONITORING METHODOLOGY/ DATA SOURCE/ FREQUENCY</b></p>	<p>MH 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 # 1, 3 Partially Met: Item # 2, 4 Not Met: Item # ____ Continued: Item #</p>	<ul style="list-style-type: none"> <li>• Revise and Update MHP Cultural Competence Plan – A completely new and updated Cultural Competence Plan was completed and published.</li> <li>• Develop Cultural Competence Training Plans for MHP providers – Progress has been made on implementing new trainings, such as a series on Native American culture and new implicit bias trainings. More refinement is needed.</li> <li>• Analyze barriers to service for specified underserved ethnic and cultural groups- This is an ongoing high priority and has been the subject of a number of initiatives having culturally appropriate staff provide access and services in the community.</li> <li>• Develop improvement project(s) to increase capacity, efficiency and quality of culturally and linguistically</li> </ul>

## Napa County Mental Health Quality Improvement Work Plan 2018

	appropriate services. – Many initiatives have been undertaken, though not as formal PIPs.
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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)*