SONOMA COUNTY
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION (DHS-BHD)

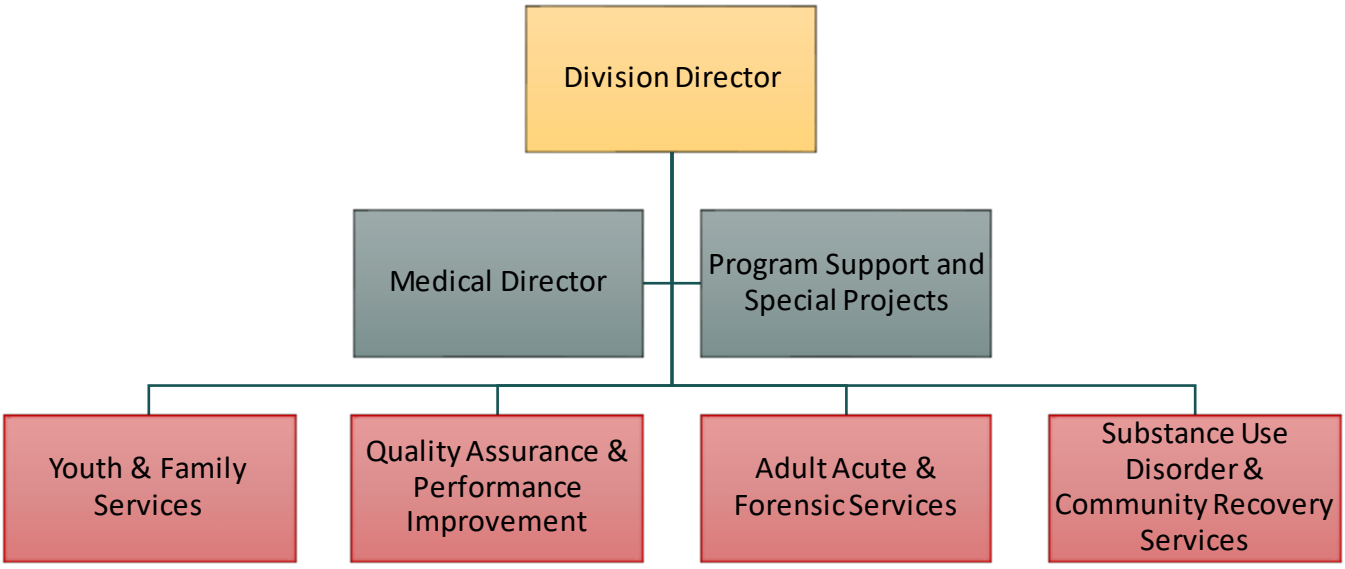
Bill Carter, LCSW
Behavioral Health Director

ANNUAL QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT WORK PLAN EVALUATION FISCAL YEAR 2019—2020

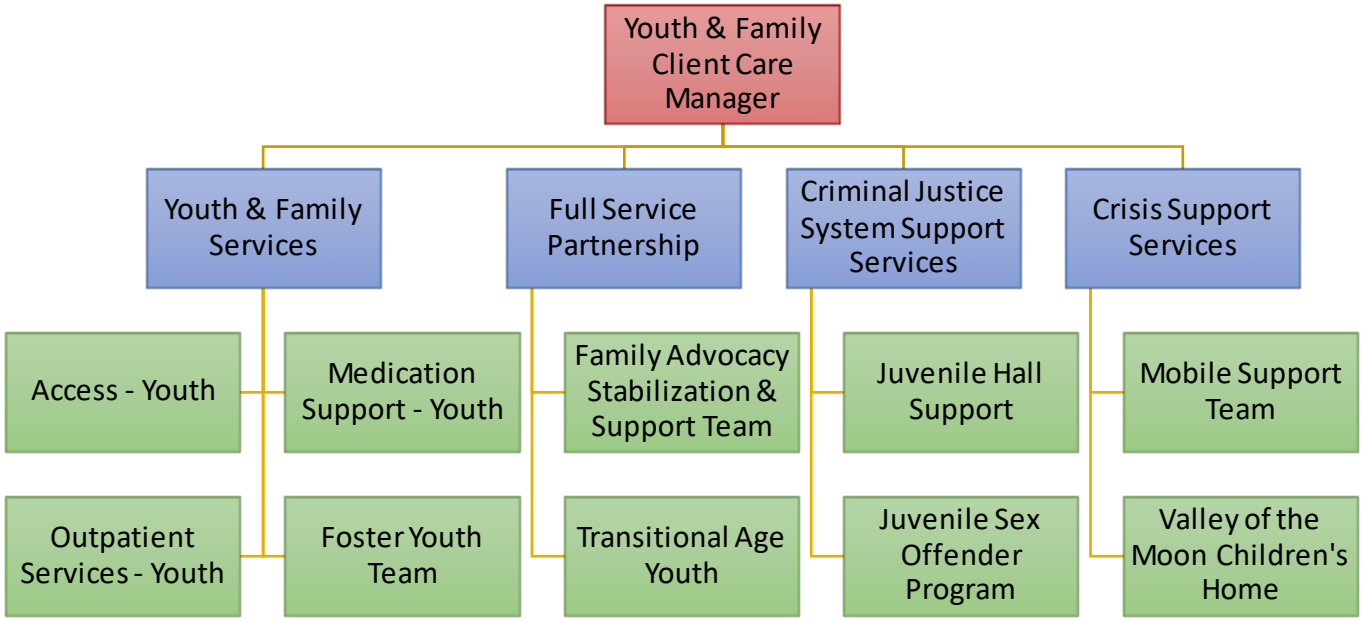
The Quality Improvement Plan is a required element of the Quality Management Program, as specified by DHCS contract, Exhibit A Attachment I (relevant sections: 22-25), and by CCR Title 9, Chapter 11, § 1810.440.

Overview of Sonoma County Behavioral Health Division Organizational Chart – July 2020

Behavioral Health Division



Youth & Family Services



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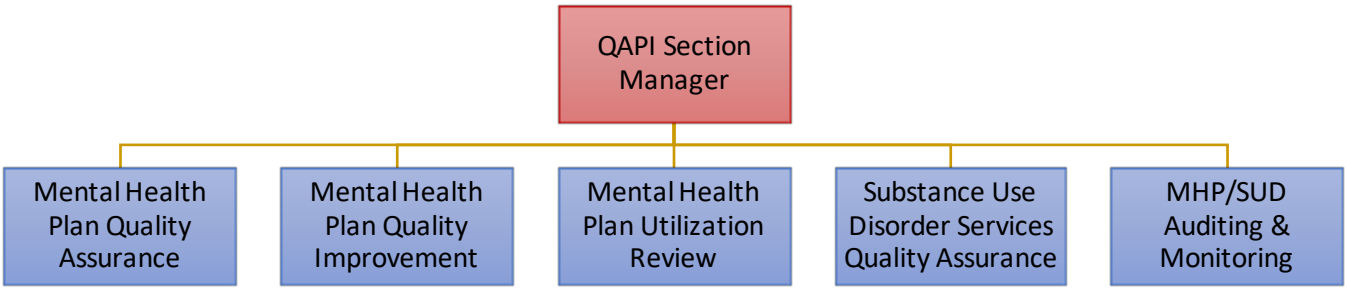
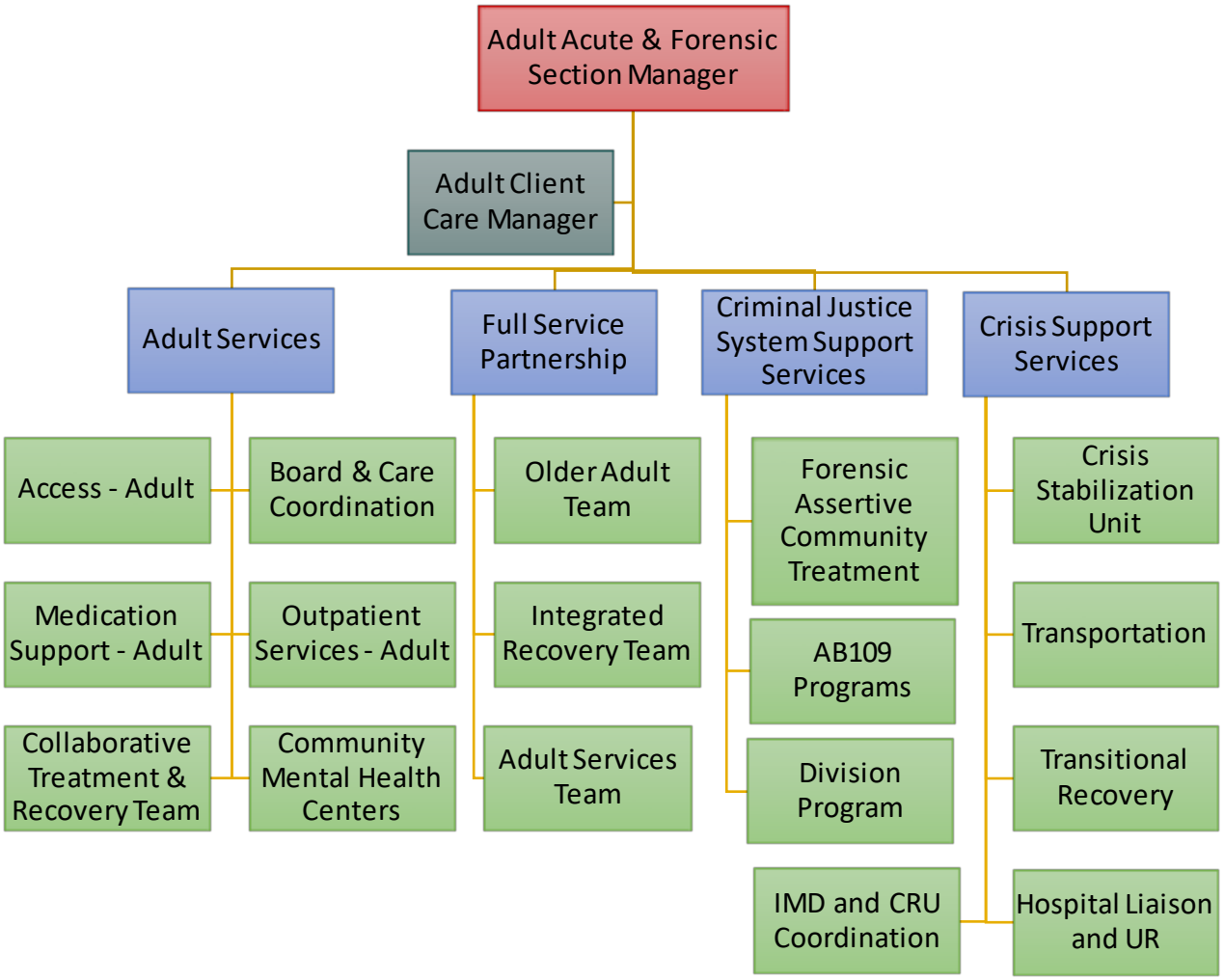
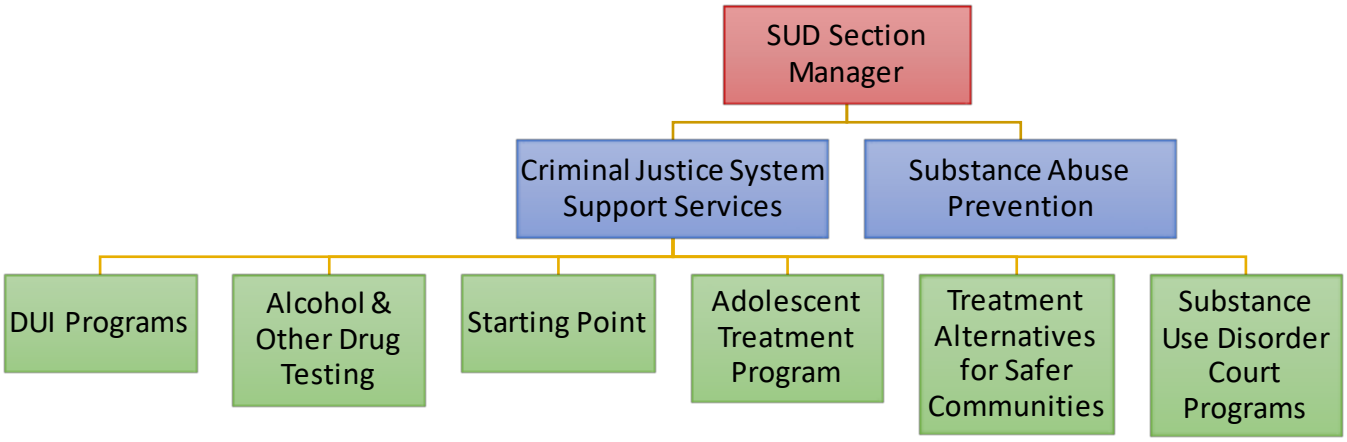


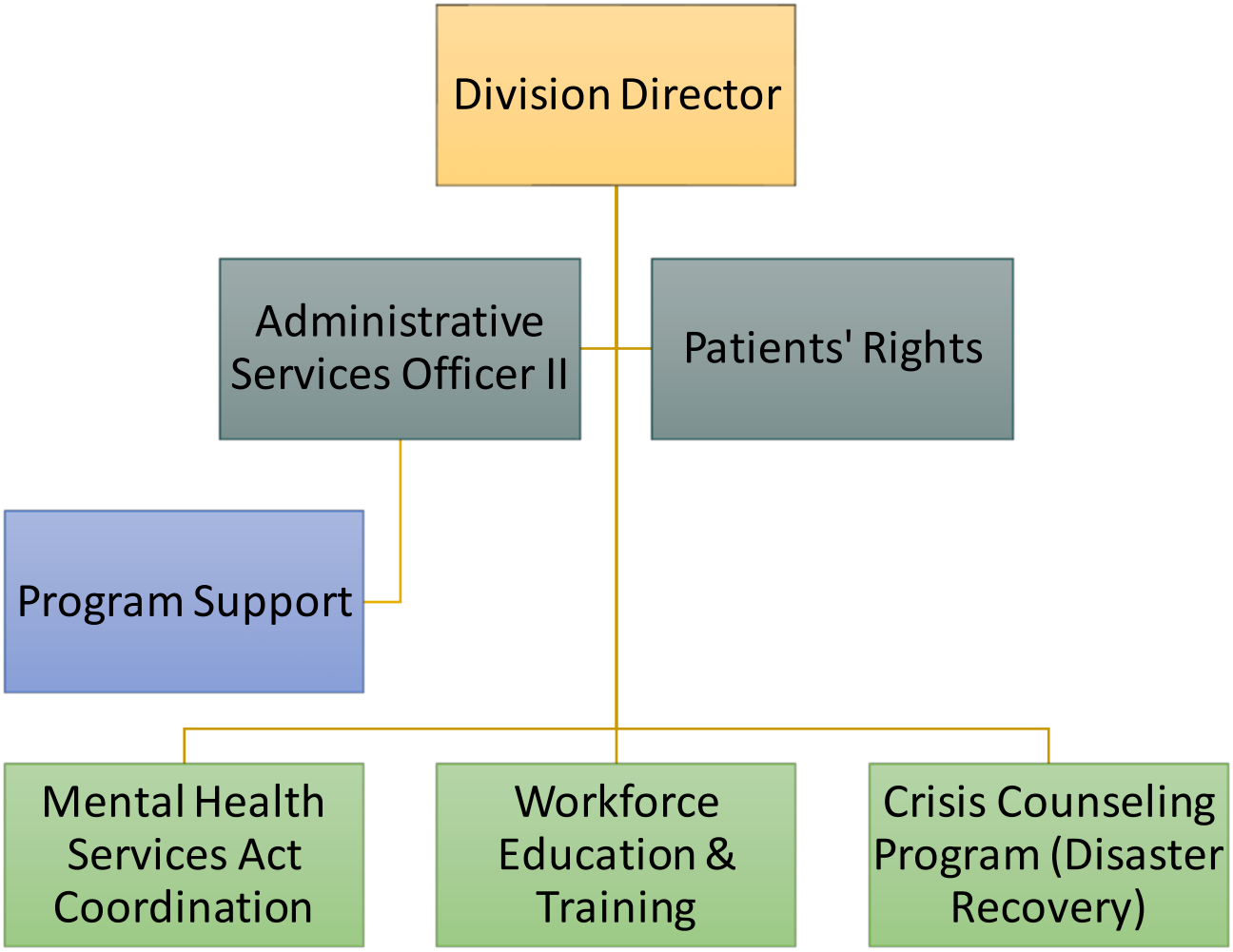
Adult Acute & Forensic Services



Substance Use Disorder & Community Recovery Services



Program Support & Special Projects



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SUMMARY OF QUALITY IMPROVEMENT PLAN GOALS & METRICS

Plan Section	Met	Partially Met	Not Met	Abandoned
Reporting Elements	5/5	0/5	0/5	0/5
Performance Metrics	11/17	1/17	5/17	0/17
Beneficiary Satisfaction	3/5	1/5	1/5	0/5
Plan Goals	5/16	4/16	5/16	2/16
Overall Percentage	55.81%	13.95%	25.58%	4.65%

Note: Goals scored “Partially Met” if results were > 75% of target, and constitute an improvement over previous year. Goal categorized as “Abandoned” if completion was impossible due to COVID.

SECTION 5: STAFF TRAINING

SECTION 1: SERVICE DELIVERY CAPACITY

Geographic Capacity: **The MHP tracks the number, service type, and geographic distribution of mental health services provided by DHS-BHD and contractors.**

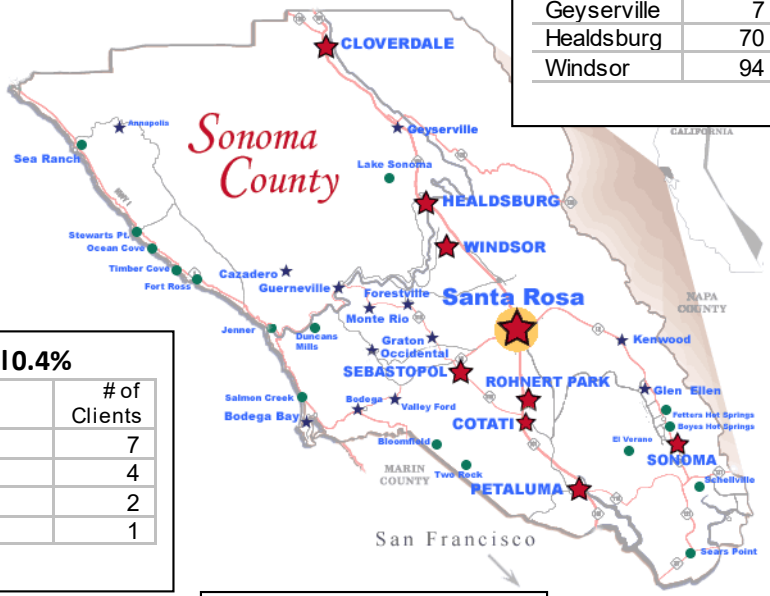
PROCESS USED TO EVALUATE
Sonoma MHP Network Adequacy Database – data system tracking all network providers, sites, and organizations.
Sonoma County Provider Directory – Provider Directory English; Provider Directory Spanish
AVATAR Demographic Data Reports

RESPONSIBLE STAFF – QI Manager

RESULTS

North 6.8%

City	# of Clients
Cloverdale	69
Fulton	4
Geyserville	7
Healdsburg	70
Windsor	94



Central 65.7%

City	# of Clients
Santa Rosa	2236
Rohnert Park	235

Costal 0.4%

City	# of Clients
Bodega Bay	7
Jenner	4
Sea Ranch	2
Valley Ford	1

East 4.1%

City	# of Clients
El Verano	1
Glen Ellen	13
Kenwood	4
Sonoma	130

West County 7.0%

City	# of Clients
Annapolis	2
Cazadero	5
Forestville	29
Graton	2
Guerneville	60
Monte Rio	10
Occidental	4
Rio Nido	7
Sebastopol	135

South 9.0%

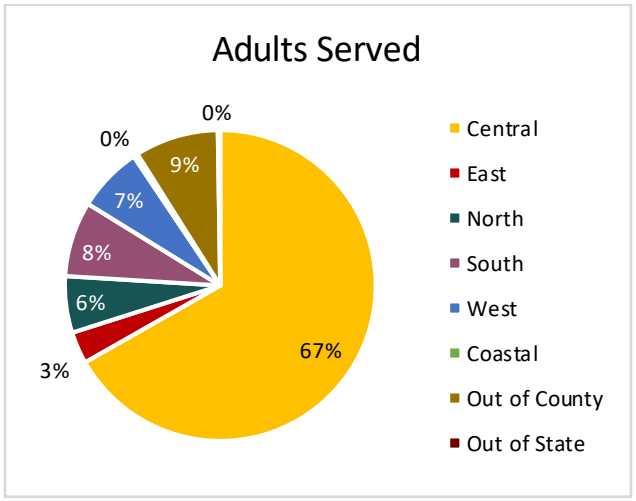
City	# of Clients
Cotati	64
Penngrove	14
Petaluma	246

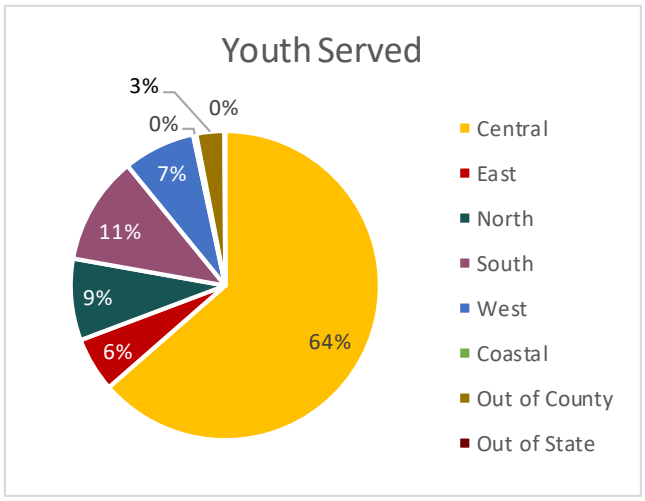
Out of County 7.0%

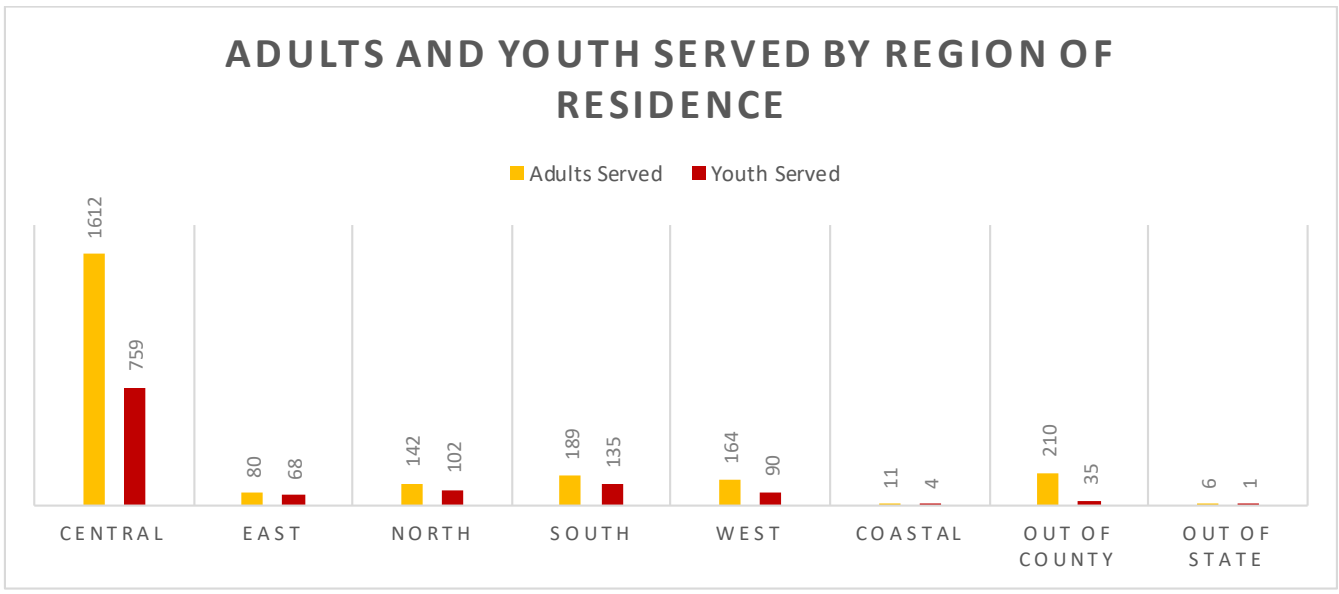
City	# of Clients
Out of County	245
Out of State	7

Adults and Youth by Region of Residence

Region	Adults Served	Youth Served	Total Served
Central	1612	759	2371
East County	80	68	148
North County	142	102	244
South County	189	135	324
West County	164	90	254
Coastal	11	4	14
Out of County	210	35	245
Out of State	6	1	7
Grand Total	**2414**	**1193**	**3607**



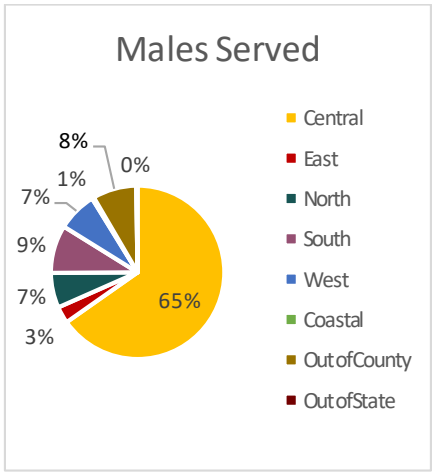


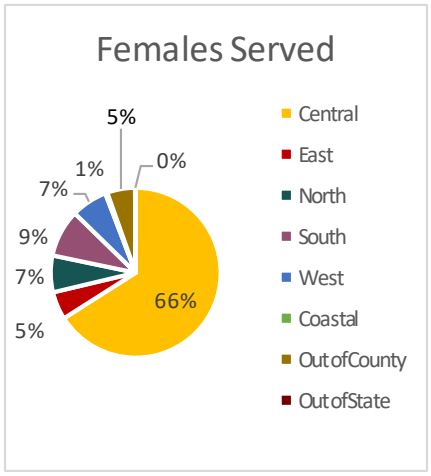


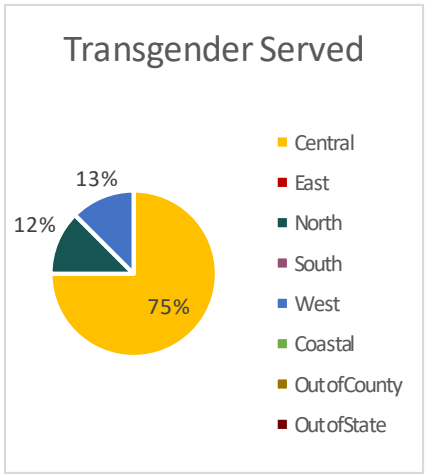
When comparing the percentage of clients served in the Central versus Regional segments of Sonoma County, it is noteworthy that, relative to the whole, a larger percentage of Child/Youth clients reside in the Regional areas than adult clients. This would indicate greater need for service locations accessible to the outlying regions, particularly the Eastern Region.

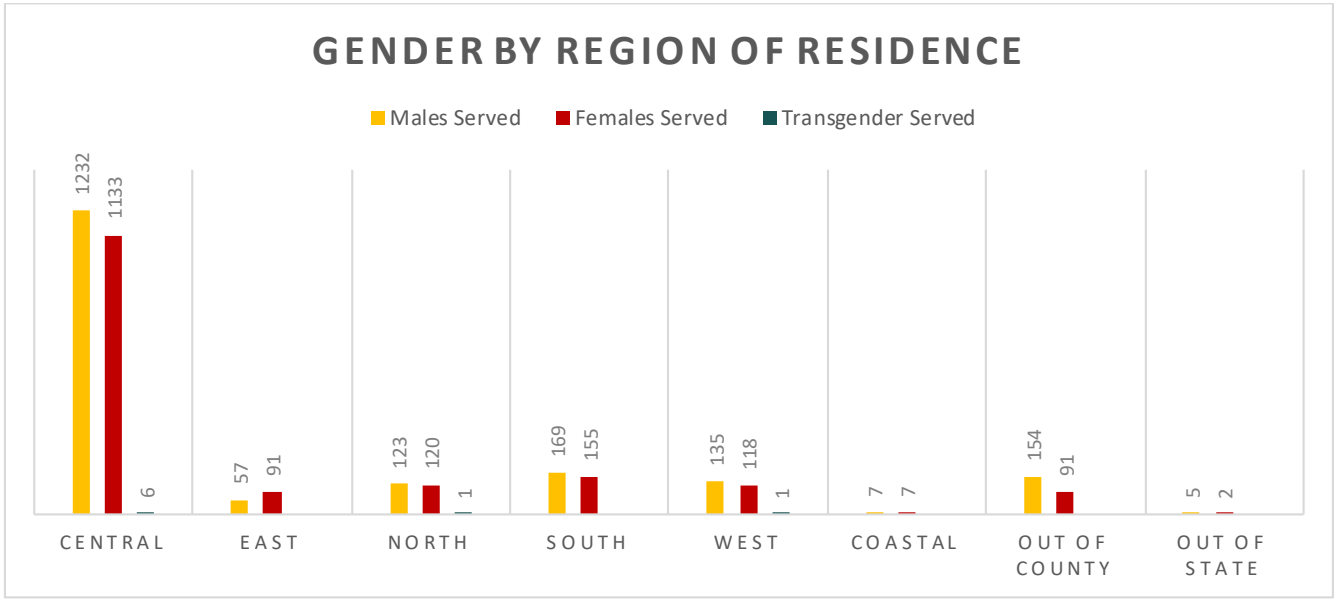
Gender by Region of Residence

Region	Males Served	Females Served	Transgender Served	Total Served
Central	1232	1133	6	2371
East	57	91		148
North	123	120	1	244
South	169	155		324
West	135	118	1	254
Coastal	7	7		14
Out of County	154	91		245
Out of State	5	2		7
Grand Total	**1882**	**1717**	**8**	**3607**





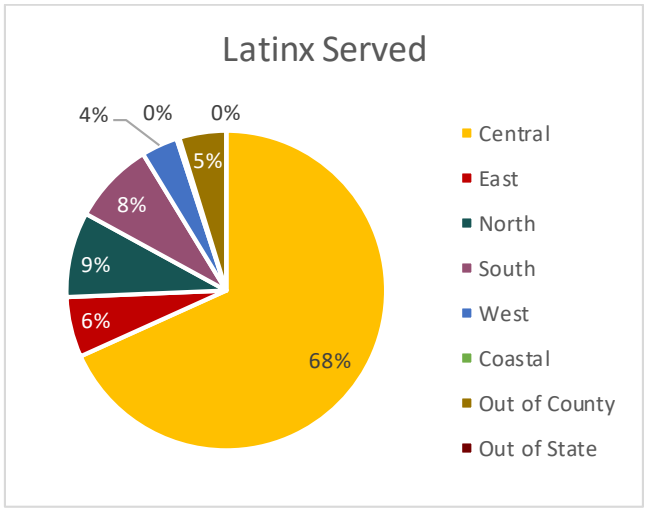


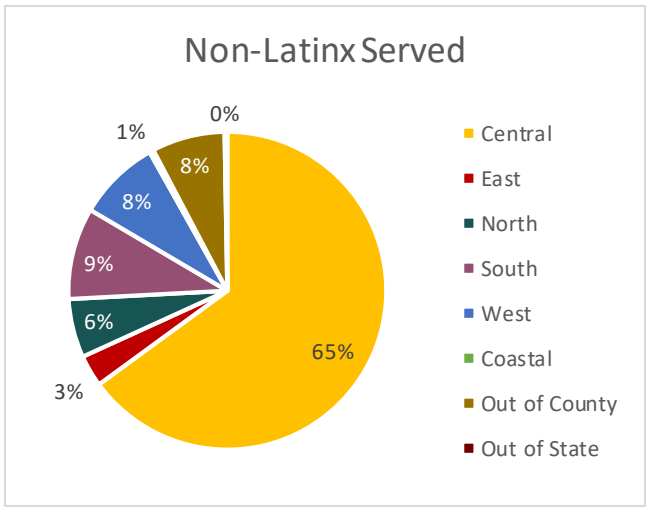


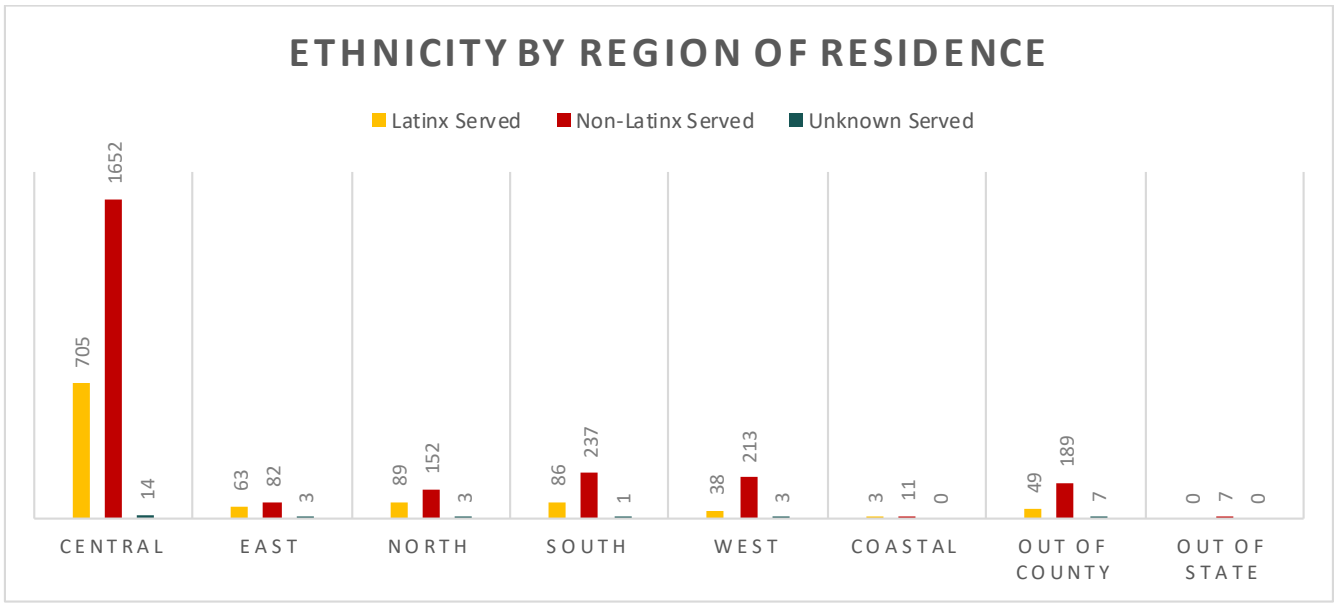
Regarding Gender and regional distribution, overall more males are served in Behavioral Health than females; however, in the Eastern Region, more females are receiving services than males, by almost double. Additionally, significantly more males are served out-of-county than females, indicating that significantly more males are on conservatorship than females.

Ethnicity by Region of Residence

Region	Latinx Served	Non-Latinx Served	Unknown Ethnicity	Total Served
Central	705	1652	14	2371
East County	63	82	3	148
North County	89	152	3	244
South County	86	237	1	324
West County	38	213	3	254
Coastal	3	11	0	14
Out of County	49	189	7	245
Out of State	0	7	0	7
Grand Total	**1033**	**2543**	**31**	**3607**







Of note, nearly half of the Behavioral Health clients residing in East County identify as Latinx. Approximately one third of clients residing in the North County and the Central region identify as Latinx, while one quarter of the clients residing in South County identify as Latinx. By way of comparison, 42% of Medi-Cal eligible residents of Sonoma County identify as Latinx.

Program Census Report

Regional Summary of Service Catchment Areas (Hospital Admissions Removed)

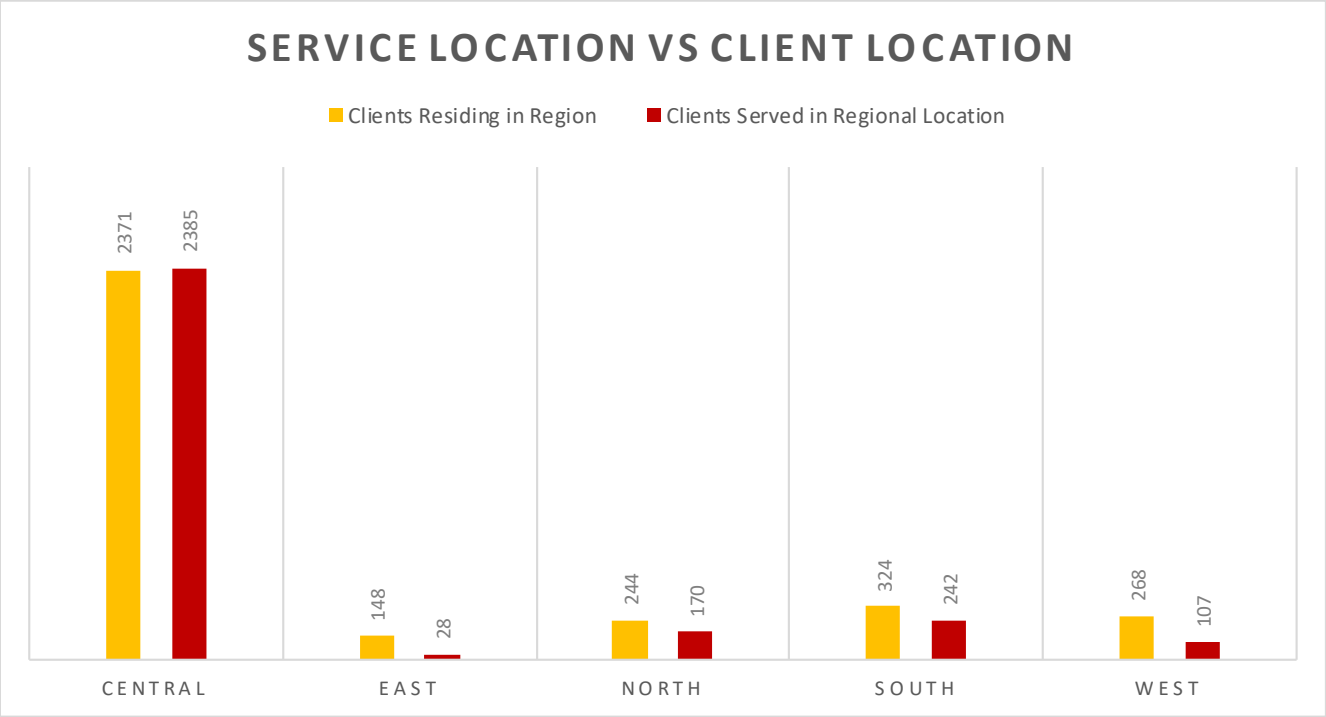
REGION	UNIQUE CLIENTS SERVED	ADMISSIONS DURING FY 19-20	DISCHARGES DURING FY 19-20
CENTRAL	2385	2696	2738
EAST	28	10	5
NORTH	170	112	102
SOUTH	242	97	95
WEST	107	34	25
COUNTYWIDE SERVICE	1671	2803	2821
OUT OF COUNTY	210	32	20
GRAND TOTAL	**3584**	**5784**	**5806**

County Programs by Service Catchment Area

Program	Region	Unique Clients Served	Admissions During FY 19-20	Discharges During FY 19-20
Access Team Adult	Central	540	428	509
Adult Med Support	Central	1279	414	392
Adult Services	Central	690	179	169
CMHC Cloverdale	North	39	9	5
CMHC Guerneville	West	64	11	11
CMHC Petaluma	South	144	32	37
CMHC Sonoma	East	28	10	5
Collaborative Treatment Recovery	Central	209	140	83
Crisis Stabilization Unit	Countywide	1228	1926	1922
FACT	Countywide	1228	1926	1922
Diversion	Countywide	5	5	1
FASST	Central	267	246	70
Foster Youth Team	Countywide	215	147	150
Integrated Recovery Team	Central	178	96	61
Older Adult Team	Central	50	12	18
SonomaWorks	Central	88	58	62
Transitional Age Youth	Central	67	29	29
Transitional Recovery	Out of County	200	29	19
Youth Access	Central	169	168	156
Youth and Family	Central	403	128	416
YFS Juvenile Hall	Countywide	138	161	177
YFS Valley of Moon	Countywide	40	42	36
Youth Med Support	Central	569	260	296

Community Providers by Service Catchment Area

Program	Region	Unique Clients Served	Admissions During FY 19-20	Discharges During FY 19-20
Alternate Family Services	West	15	4	5
Buckelew CTRT	Central	79	79	16
Buckelew FACT	Central	27	15	12
Buckelew ISHP	Central	18	10	8
Buckelew SCIL	Central	154	42	52
Buckelew TAY	Central	19	12	4
CPI Therapy Clinic	Central	27	0	27
CPI Urgent Response	Central	13	0	13
CSN A Step Up	Countywide	25	15	19
CSN Bridges	Countywide	21	12	13
CSN E Street Residential	Countywide	24	16	21
CSN Opportunity House	Countywide	67	68	70
Harstad House CRU	Countywide	148	189	189
Lifeworks TBS	Central	52	42	30
Lifeworks Therapy	Central	81	53	41
PPSC Therapy Clinic	South	37	1	38
Progress Sonoma CRU	Countywide	141	176	176
Parker Hill Residential	Countywide	26	14	18
SAY FASST	Central	99	102	45
SAY Tamayo Village	Central	14	8	6
SAY TBS	Central	4	4	1
SAY Therapy Clinic	Central	88	60	66
Seneca Kuck Therapy	South	57	57	18
Seneca Kuck TBS	South	7	7	2
Seneca Wikiup Wrap	North	133	103	97
St Vincent's MH Service	Out of County	8	3	1
St Vincent's TBS	Out of County	5	0	0
Sunny Hills TBS	Central	19	0	19
Telecare Sonoma ACT	Central	75	9	7
TLC Services	West	29	19	9
Victor Treatment Center	Countywide	25	16	8



Client Residence vs Service Location reveals gaps in service accessibility in the regional areas, particularly the East Region.

Service Location distribution analysis specific to age groups served reveals the following:

Region	Adult Service Providers	Youth Service Providers
Central	Adult Services Team Integrated Recovery Team Older Adult Team Telecare Sonoma ACT	Youth and Family Services Social Advocates for Youth Lifeworks Therapy Clinic and Therapeutic Behavioral Services (TBS)
East	CMHC Sonoma	
North	CMHC Cloverdale	Seneca (Therapy and TBS)
South	CMHC Petaluma	Seneca (Therapy and TBS)
West	CMHC Guerneville	Alternate Family Services TLC for Kids
County Wide	Crisis Services Residential Services Mobile Support Team Justice-Related Services	Foster Youth Team Justice-Related Services Valley of Moon Children's Home

The youth equivalent of the Mobile Support Team was previously provided by the CAPE Team (Crisis Assessment Prevention Education). The CAPE team was co-located within secondary schools, providing dedicated regional coverage for youth. The newly passed Ballot Measure will enable DHS-BHD to restore these services.

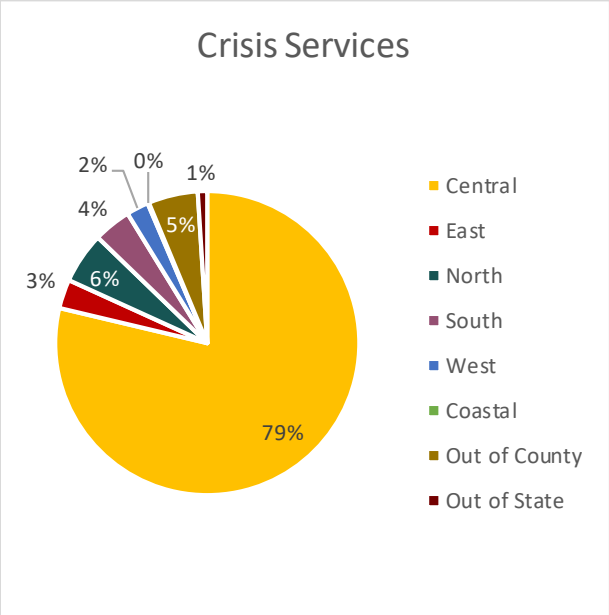
Services Delivered by Region of Residence

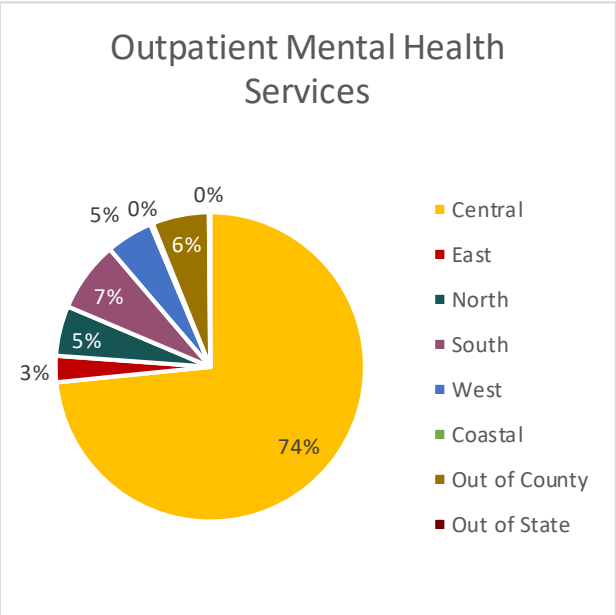
Service	Central	East	North	South	West	Coastal	OOC	OOS
Adult Residential	6735	8	406	1172	67		829	
Assessment	3226	185	320	445	310	23	183	4
Board and Care	48520	107	2829	761	1007		24035	
Collateral	3754	310	439	501	342	27	144	40
Crisis Intervention	603	10	55	33	12	1	20	
Crisis Residential	4975	168	279	178	70		254	96
Crisis Stabilization	2663	145	234	208	165	14	278	9
ECT	9		2		20		9	
Family Therapy	533	49	101	67	95	10	39	
Group Therapy	179		68		170		253	
ICC	3553	59	87	236	310		33	
IHBS	1444	22	34	212	120		7	
Individual Therapy	7719	330	823	987	589	66	549	10
Med Support	14827	616	1671	1736	1421	44	943	22
MHRC	227	15		57	98		2576	
NPC	9822	530	1164	1379	957	40	503	8
Plan Development	5531	243	481	689	436	14	339	12
Rehab Group	6528	76	52	176	131		663	
Rehab Individual	11888	278	518	1074	459	5	1080	17
SNF/IMD	10611	89					14950	
Targeted Case Management	10686	527	880	1006	717	44	1137	26
TBS	1072	21	197	243	72	10	107	
Unlicensed Residential	2053		39				170	
Grand Total	**157158**	**3788**	**10679**	**11160**	**7568**	**298**	**49101**	**244**

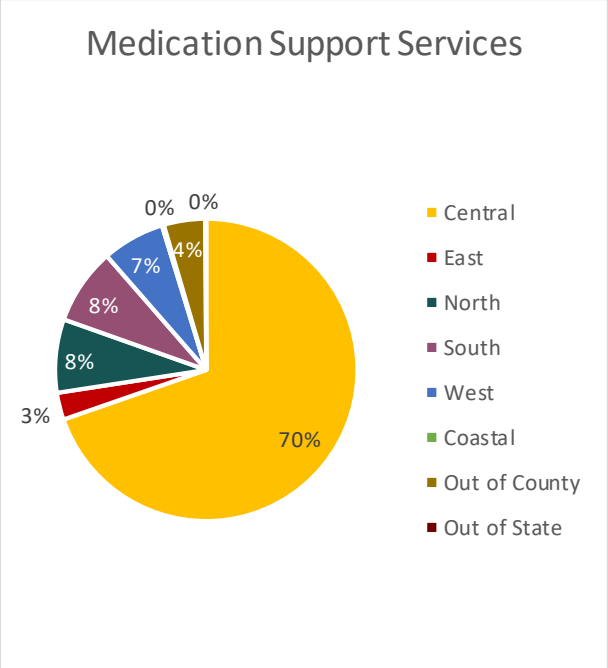
Gaps in Service Type

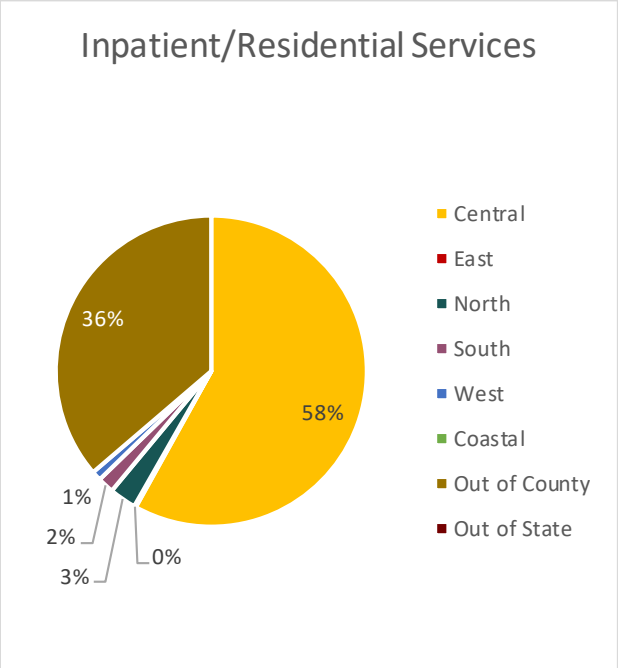
Service Detail by Region shows that there are limited Group Therapy options available across our system of care.

Service Categories by Region of Residence







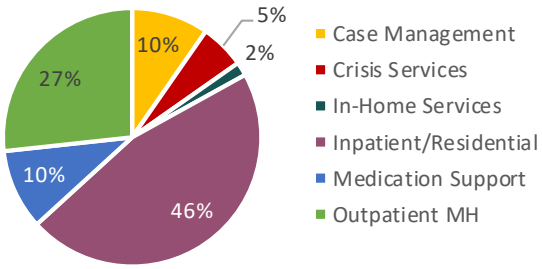


A disproportionate number of crisis services are delivered to residents of the central region versus the outlying regions. This might be due to transportation barriers from the outlying regions to the CSU located in the Central Region. Further exploration of this disparity is warranted.

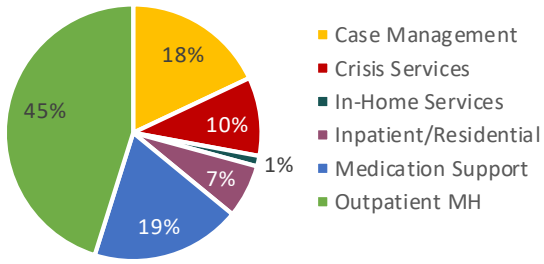
It appears from the charts above that a disproportional amount of residential/inpatient services goes to residents of the Central Region. However, in most cases, address of record changes to the residential facility upon admission, which artificially inflates this number.

Portrait of Service Utilization by Region

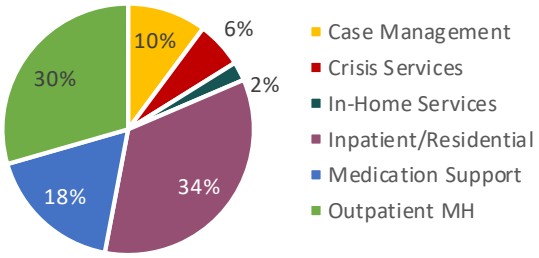
Central Region



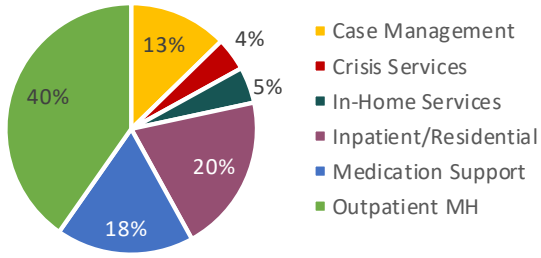
East Region



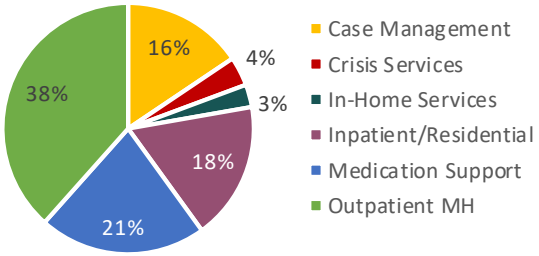
North Region



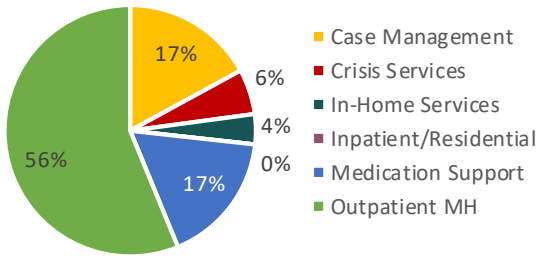
South Region



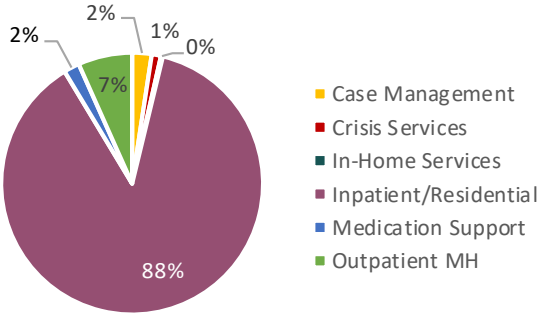
West Region



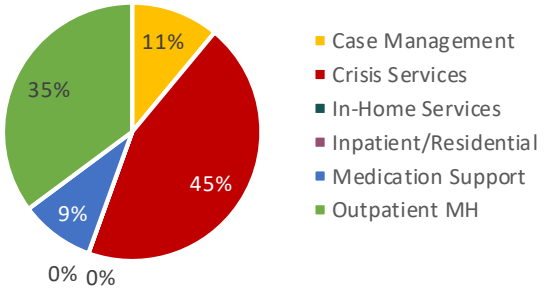
Coastal Region



Out of County



Out of State



Narrative Summary of Findings

In Sonoma County, 65.7% of Mental Health clients reside in the Central Region, with 27.3% of clients reside in the outlying regions and 7.0% of clients reside out of county. Analysis of services rendered shows that a comparable percentage of services were delivered to residents of the Central Region (65.48%); however, only 14.06% of services were delivered to residents of the outlying regions, while 20.56% of services were delivered to clients residing out-of-county.

Region	Percentage of Clients Residing in Region	Percentage of Services Delivered in Region
Central	65.7%	65.48%
East	4.1%	1.58%
North	6.8%	4.45%
South	9.0%	4.65%
West	7.0%	3.15%
Coastal	0.4%	0.12%
Out of County	7.0%	**20.56%**

Age Differences

Relative to the whole, a larger percentage of Child/Youth clients reside in the Regional areas than adult clients. This would indicate greater need for service locations accessible to the outlying regions, particularly the Eastern Region.

Gender Differences

Overall more males are served in Behavioral Health than females; however, in the Eastern Region, more females are receiving services than males, by almost double. Additionally, significantly more males are served out-of-county than females, indicating that significantly more males are on conservatorship than females.

Ethnic Differences

Of note, nearly half of the Behavioral Health clients residing in East County identify as Latinx. Approximately one third of clients residing in the North County and the Central region identify as Latinx, while one quarter of the clients residing in South County identify as Latinx. By way of comparison, 42% of Medi-Cal eligible residents of Sonoma County identify as Latinx.

Gaps in Service Delivery

Client Residence vs Service Location reveals gaps in service accessibility in the regional areas, particularly the East Region. Service Detail by Region shows that there are limited Group Therapy options available across the system of care.

A disproportionate number of crisis services are delivered to residents of the central region versus the outlying regions. This might be due to transportation barriers from the outlying regions to the CSU located in the Central Region. Further exploration of this disparity is warranted.

Recommendations

Based upon the analysis above, the following is recommended:

- Increased bilingual/bicultural staffing in the outlying regions
- Explore youth service provider options in the East Region
- Consider expanding youth services to include a YFS unit at each CMHC location
- Implement group therapy options across the system of care, including youth focused and parent focused groups
- Explore early intervention and prevention evidence-based practices to reduce out-of-county placements

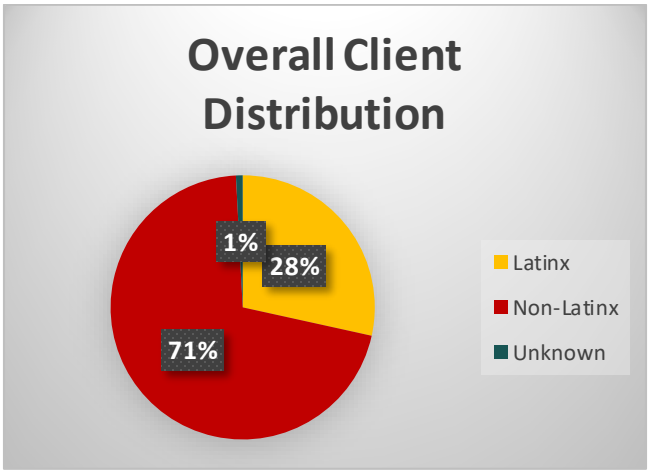
Latinx Services: **The MHP tracks Latinx service utilization and seeks to increase the Latinx service penetration rate in order to match community Medi-Cal eligible demographics.**

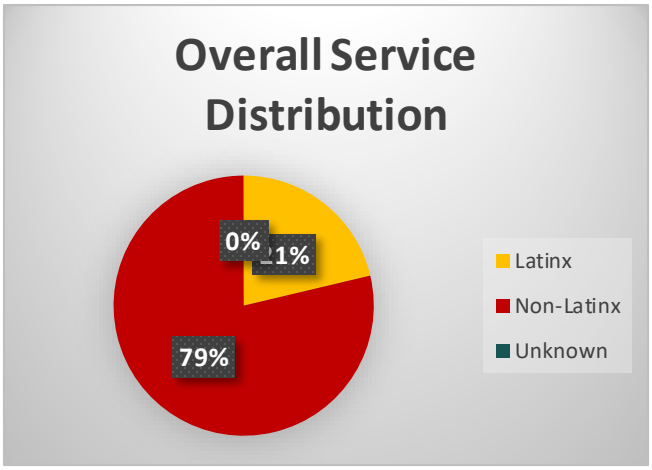
PROCESS USED TO EVALUATE
Avatar – Demographic Report
DHCS Data Portal – Medi-Cal Eligibility by Race/Ethnicity Report

RESPONSIBLE STAFF – QI Manager

RESULTS

DHCS Medi-Cal eligibility data indicates that 42% of Sonoma County Medi-Cal eligible residents identify as Latinx. DHS-BHD served 3543 unique clients in FY 19-20. 1008 unique clients identified as Latinx. 2506 unique clients identified as non-Latinx. 29 unique clients had unknown ethnic identity.



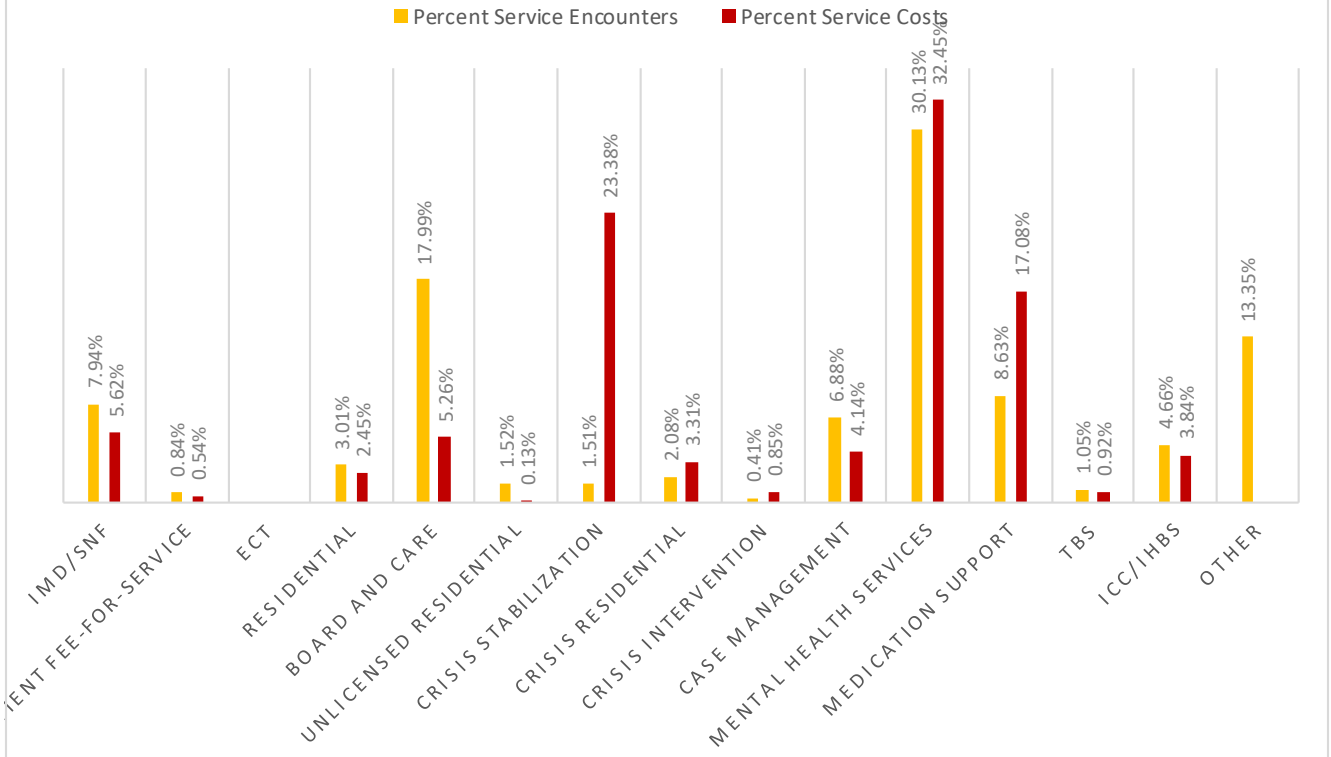


This represents a 2% increase from FY 18-19. Of note is that while 28% of unique clients identified as Latinx, they only received 21% of the total services.

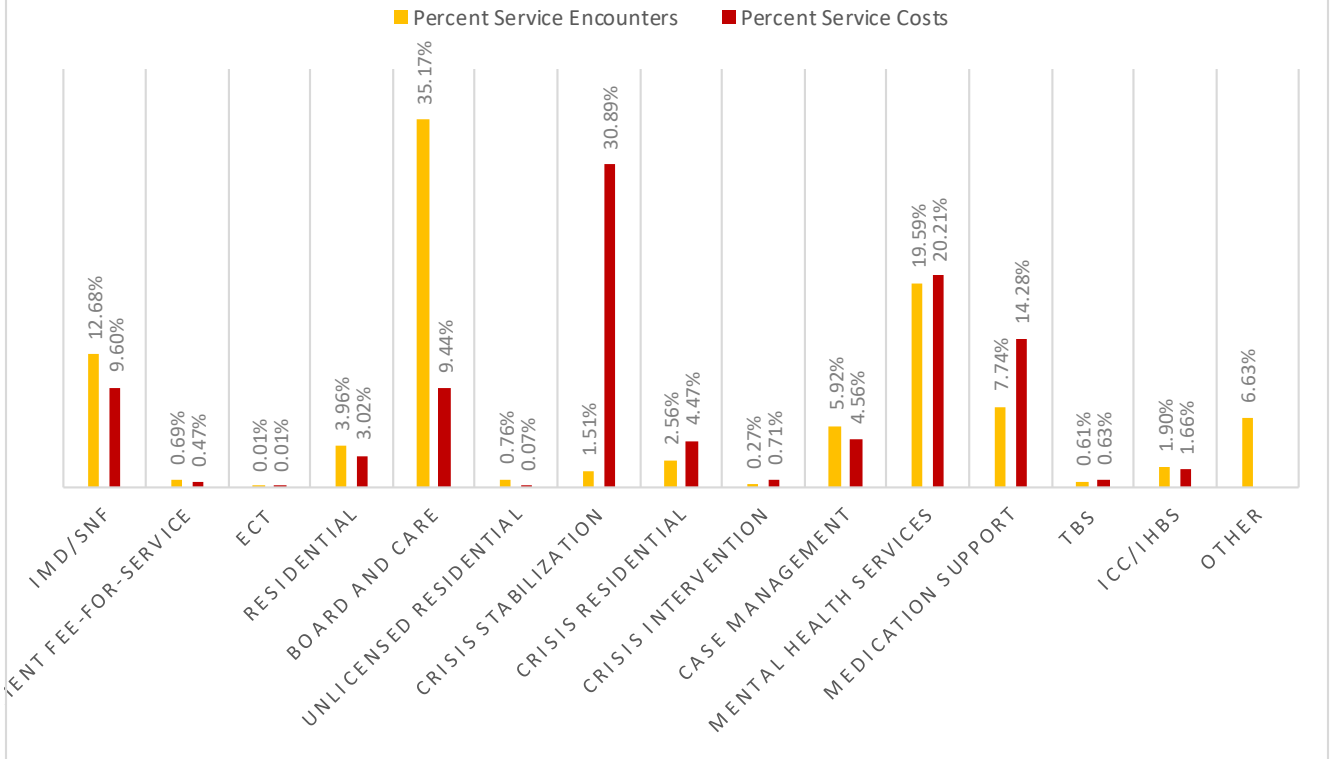
Service Counts vs Cost

Service Categories	Service Counts			Service Costs		
	Latinx	*Non-Latinx*	*Unknown*	*Latinx*	*Non-Latinx*	*Unknown*
IMD/SNF Services	4,148	24,475		662,755.12	3,896,685.98	
Inpatient Fee-for-Services	439	1,338	30	63,884.15	189,352.40	4,548.60
ECT		22	18		4,395.60	3,596.40
Residential Services	1,571	7,646		289,511.30	1,223,939.30	
Board and Care Services	9,396	67,863		620,650.91	3,831,234.35	
Unlicensed Residential	795	1,467		15,900.00	29,340.00	
Crisis Stabilization	791	2,906	19	2,757,583.22	12,537,568.51	42,384.02
Crisis Residential	1,085	4,935		390,226.00	1,813,944.00	
Crisis Intervention	213	521		100,819.37	286,498.07	
Case Management	3,596	11,420	7	488,686.73	1,848,948.61	462.56
Mental Health Services	15,742	37,801	37	3,827,023.95	8,201,850.08	13,992.24
Medication Support Service	4,508	14,942	23	2,014,615.90	5,796,695.41	7,736.20
Therapeutic Behavioral Services	549	1,173		108,918.55	255,940.34	
Katie A ICC/IHBS	2,433	3,670	14	453,188.13	672,235.59	1,437.27
Other (NPC, No-Show, etc.)	6,974	12,784	17			
Grand Total	52,240	192,963	165	11,793,763.33	40,588,628.24	74,157.29

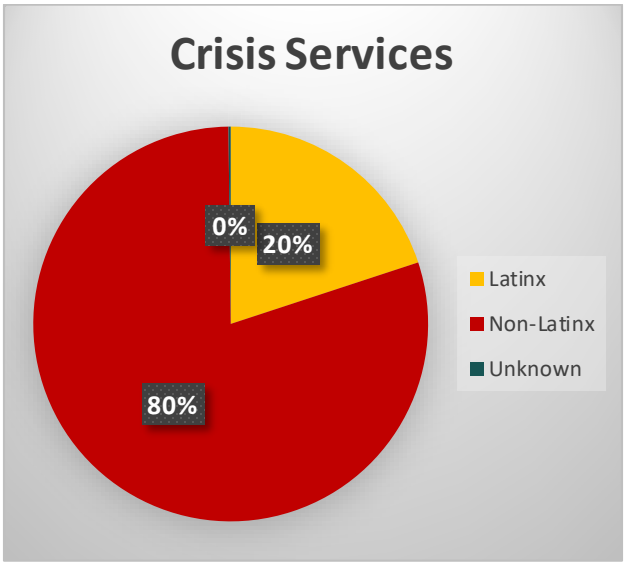
SERVICE ENCOUNTERS VS COST: LATINX

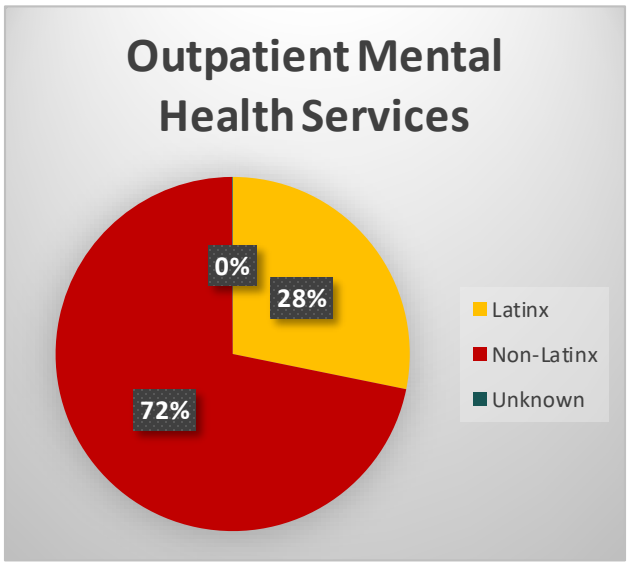


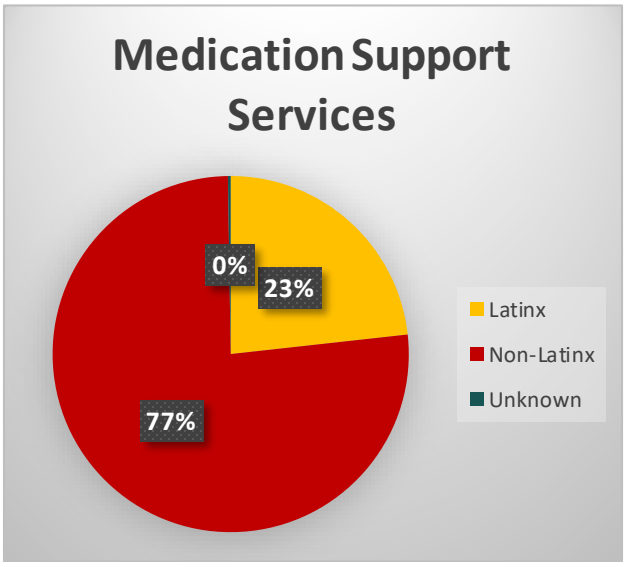
SERVICE ENCOUNTERS VS COST: NON-LATINX

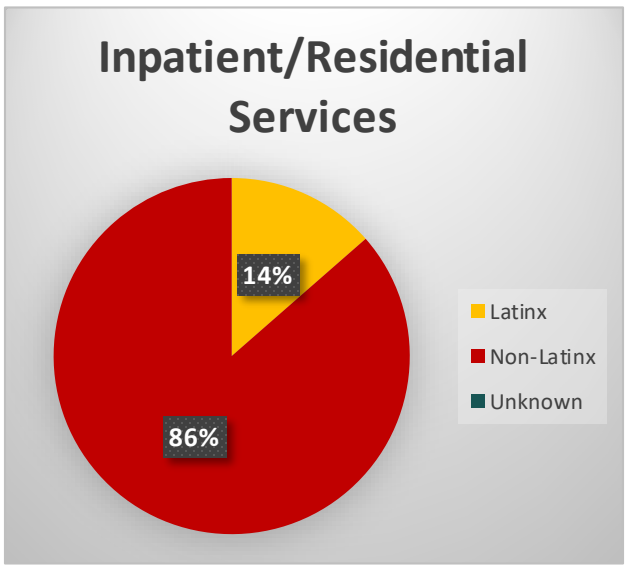


Service Categories by Ethnicity







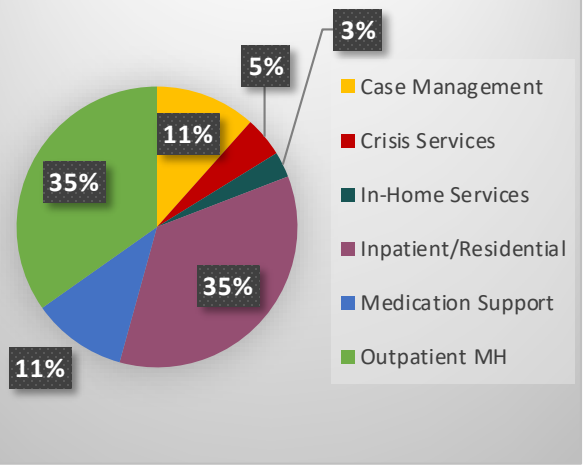


Latinx clients utilize Outpatient Mental Health and Med Support services at a higher rate than Non-Latinx clients. In contrast, non-Latinx clients utilize Board & Care and IMD/SNF level services at a much higher rate than Latinx clients.

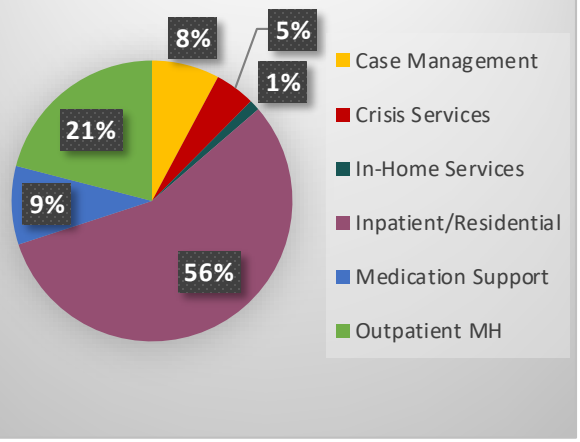
The following charts break-down the service distribution by age group. Of note is the higher percentage of Inpatient/Residential service utilization among non-Latinx clients and the correlating higher utilization of Outpatient Mental Health services among Latinx clients. This is particularly evident in the Adult system. The Youth system does not show this pattern.

Portrait of Service Utilization by Ethnicity

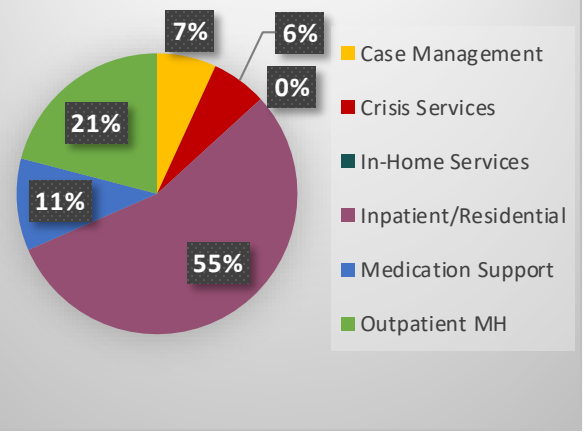
All Services: Latinx



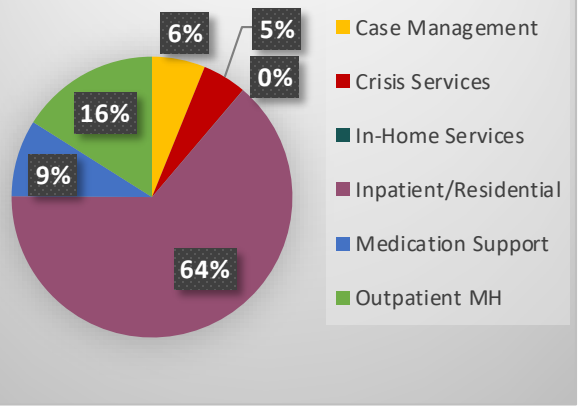
All Services: Non-Latinx



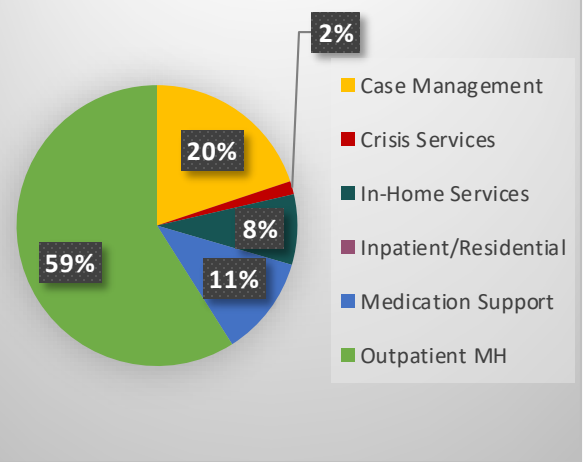
Adult Services: Latinx



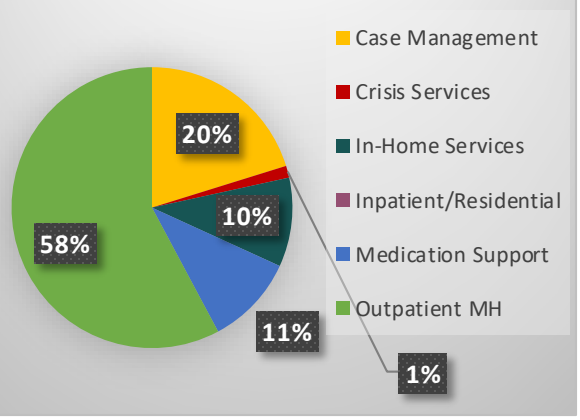
Adult Services: Non-Latinx



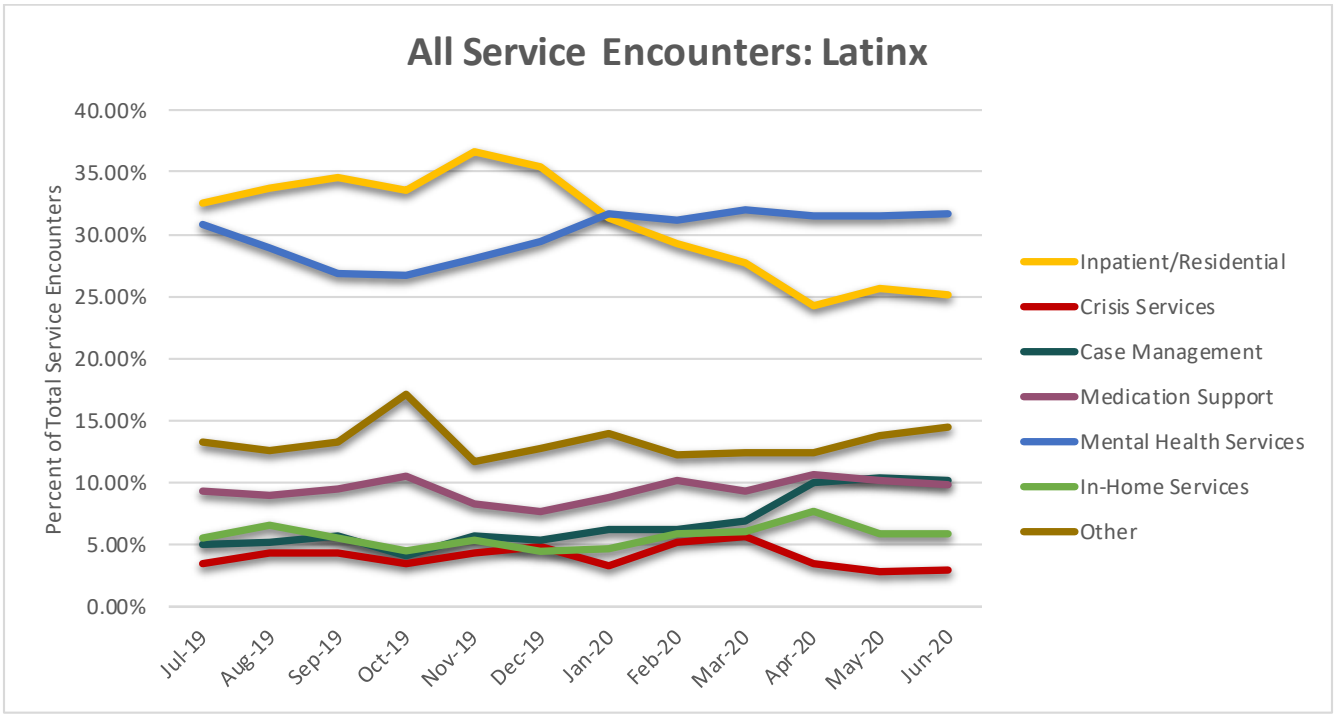
Youth Services: Latinx

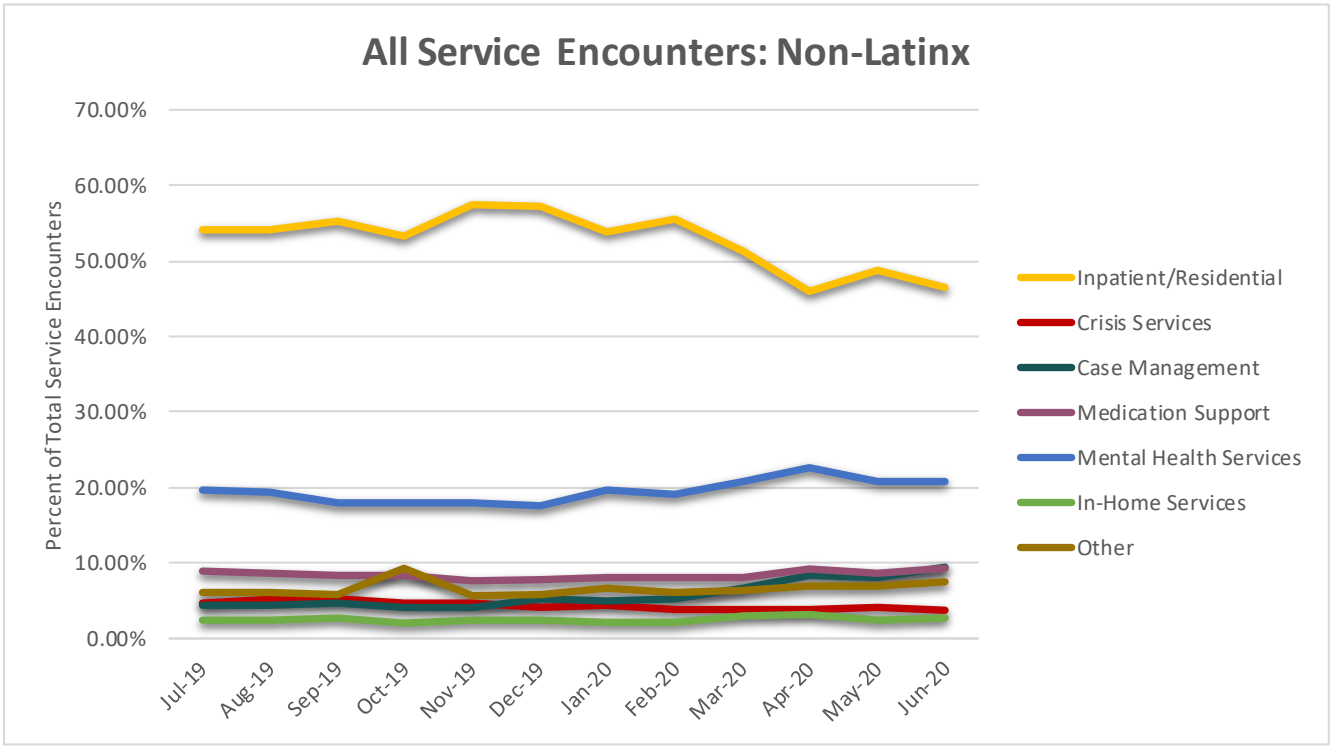


Youth Services: Non-Latinx

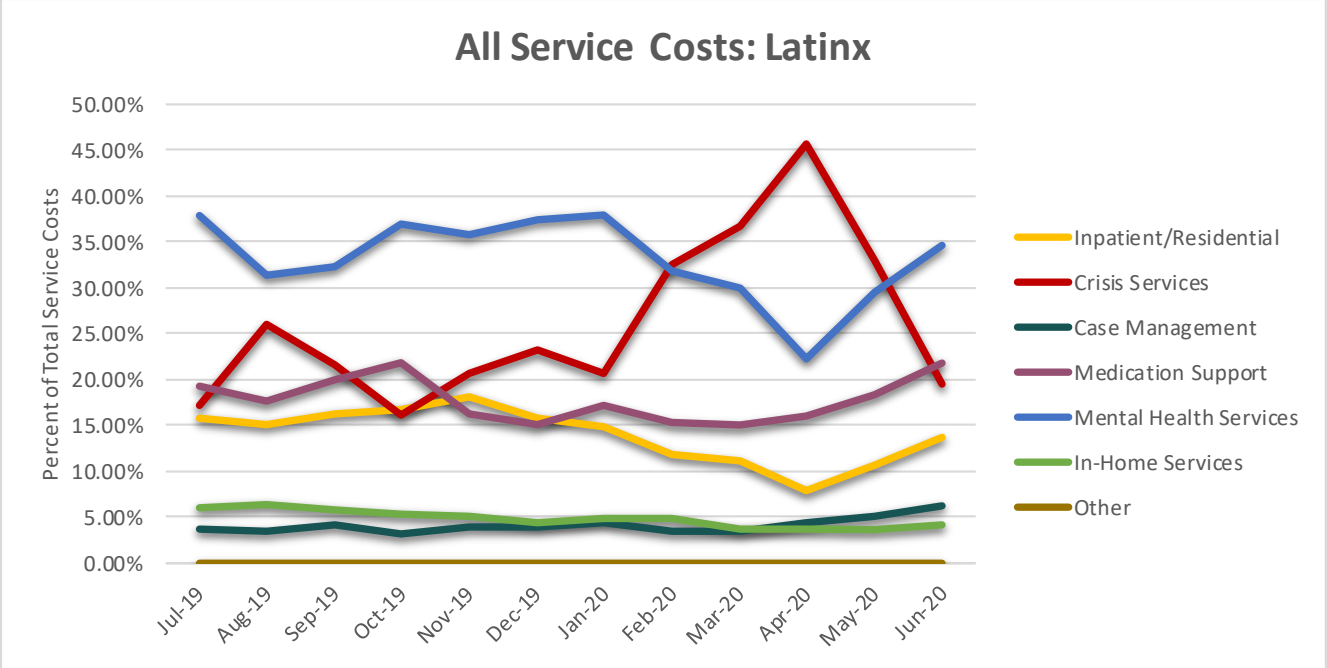


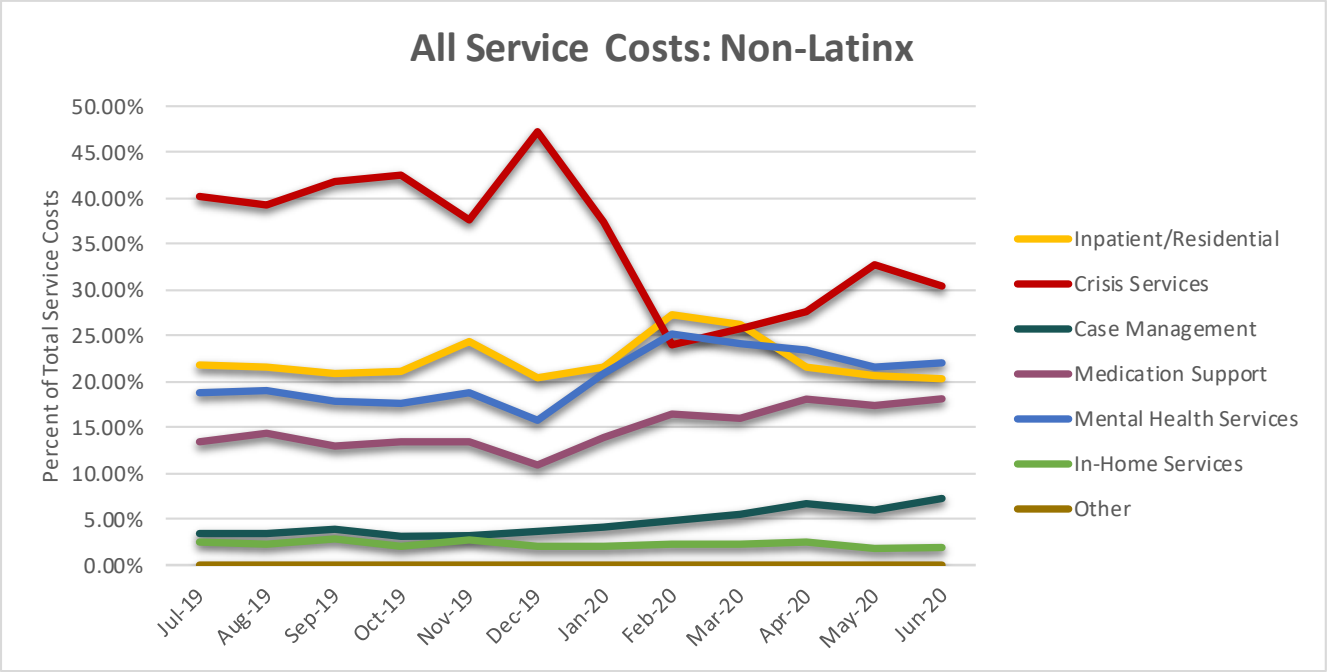
Service Trends





Latinx service trends show a drop in Inpatient/Residential utilization in the latter part of the year, corresponding to an increase in case-management utilization. Whereas, non-Latinx service trends hold relatively steady over time, with a slight reduction in Inpatient/Residential utilization post-COVID.





Of note is the spike in Crisis service costs in April for Latinx clients. This sharp increase corresponds with the initial onset of COVID shelter-in-place orders. As a corollary, Mental Health Services declines at the same rate. However, by June, both trends equalized to prior levels. In contrast, Non-Latinx Crisis service cost trends show a sharp decline during initial COVID response, with an associated increase in Mental Health Services that later equalizes.

Staff Training: **DHS-BHD provides at least two mandatory staff development trainings annually on topics related to Cultural Responsiveness. Topics are selected from the top three issues identified in the FY 16-17 Staff Cultural Responsiveness Survey.**

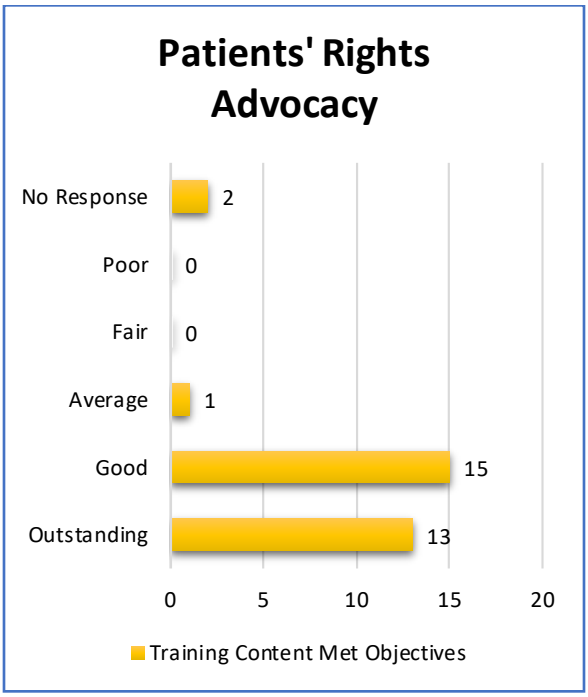
PROCESS USED TO EVALUATE
Staff Development Training CEU Program Evaluation Forms

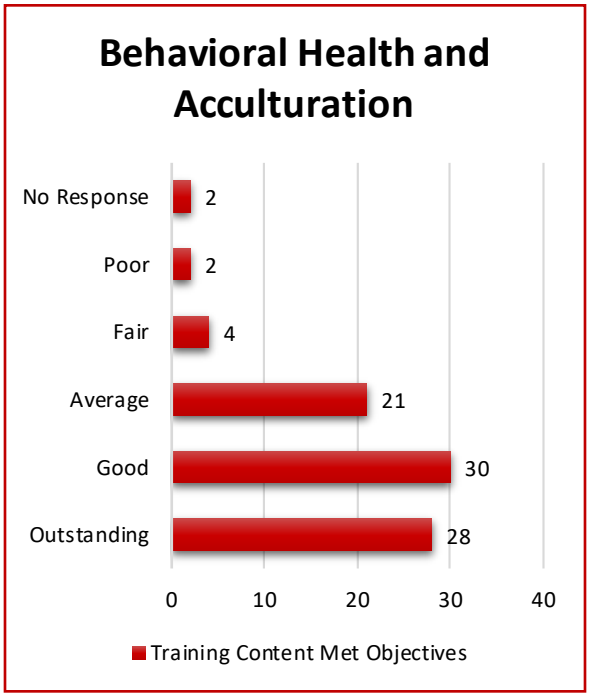
RESPONSIBLE STAFF – QI Manager and WET Manager

RESULTS

DHS-BHD scheduled or sponsored four staff development training opportunities in FY19-20 to further cultivate cultural competency among staff; however, two of these trainings were cancelled due to COVID. A new Staff Cultural Responsiveness Survey is scheduled for FY 20-21.

	Date	Training	Facilitated by
1	7/3/2019	Patients' Rights Advocacy: History, Process and Resources	Bill SmithWaters, Frank SmithWaters
3	3/11/2020	Behavioral Health and Acculturation	Yatiel Owens, Jessica Hetherington
4	5/13/2020	LGBTQ	Cancelled due to COVID
5	6/10/2020	Peer Panel	Cancelled due to COVID





Staff/Attendees were asked to rate their knowledge of strategies to assist clients of culturally diverse communities. Staff reported overall high marks for the Patients' Rights training, and Average to Good marks for the Acculturation training; however, training attendance was lower than previous years.

Peer Providers: **DHS-BHD tracks and trends the number of Peer Provider positions allocated throughout the service system.**

PROCESS USED TO EVALUATE
Consumer and Family Employment Fiscal Summary FY19-20

RESPONSIBLE STAFF – QI Manager and MHSA Coordinator

RESULTS

	FY18-19	FY19-20	FY18-19	FY19-20
County Contractors	**# of Employees**	**# of Employees**	**FTE**	**FTE**
Goodwill Programs:				
Wellness and Advocacy Center	11	14	11.73	11.88
Consumer Relations Program	3	N/A	1.74	N/A
Peer Education and Training	N/A	3	N/A	1.59
Interlink Self-Help center	10	10	6.18	5.85
Petaluma Peer Recovery Program	5	5	1.34	1.37
Peer Support for Mobile Support Team	3	3	0.11	0.61
Whole Person Care Peer Outreach	3	3	1.21	1.21
Buckelew Programs:				
Family Service Coordinator	3	3	0.90	0.97
West County Community Services Programs:				
Russian River Empowerment Center	6	4	2.93	2.48
NAMI:				
Family Education Advocacy and Support Program	4	3	3.09	2.44
Total of County Contractors	48	48	29.23	28.40
SCBHD Staff	**# of Employees**	**# of Employees**	**Working extra-help hours equivalent to FTE**	**Working extra-help hours equivalent to FTE**
Peer Providers Peer positions combined EH hours to calculate equivalent FTE	6	5	1.95	1.19
Total FTE for all County-funded peer positions	**54**	**53**	**31.18**	**29.59**

Total number of consumer and family member staff at MHSA and other funded programs: 53 employees at 29.59 FTE

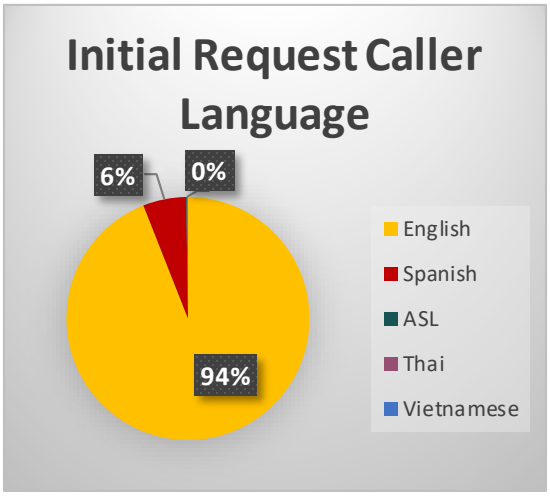
In FY19-20 the FTE for county-funded peer positions was 29.59 FTE, a decrease of 5.10% from FY18-19. This is due in part to budget reductions across the system of care.

Language Capacity: The MHP tracks and trends language line utilization and service utilization in languages other than English.

PROCESS USED TO EVALUATE
Access to MH Services Database
Language Line Reports
AVATAR Service Reports

RESPONSIBLE STAFF – QI Manager

RESULTS



Access to Services

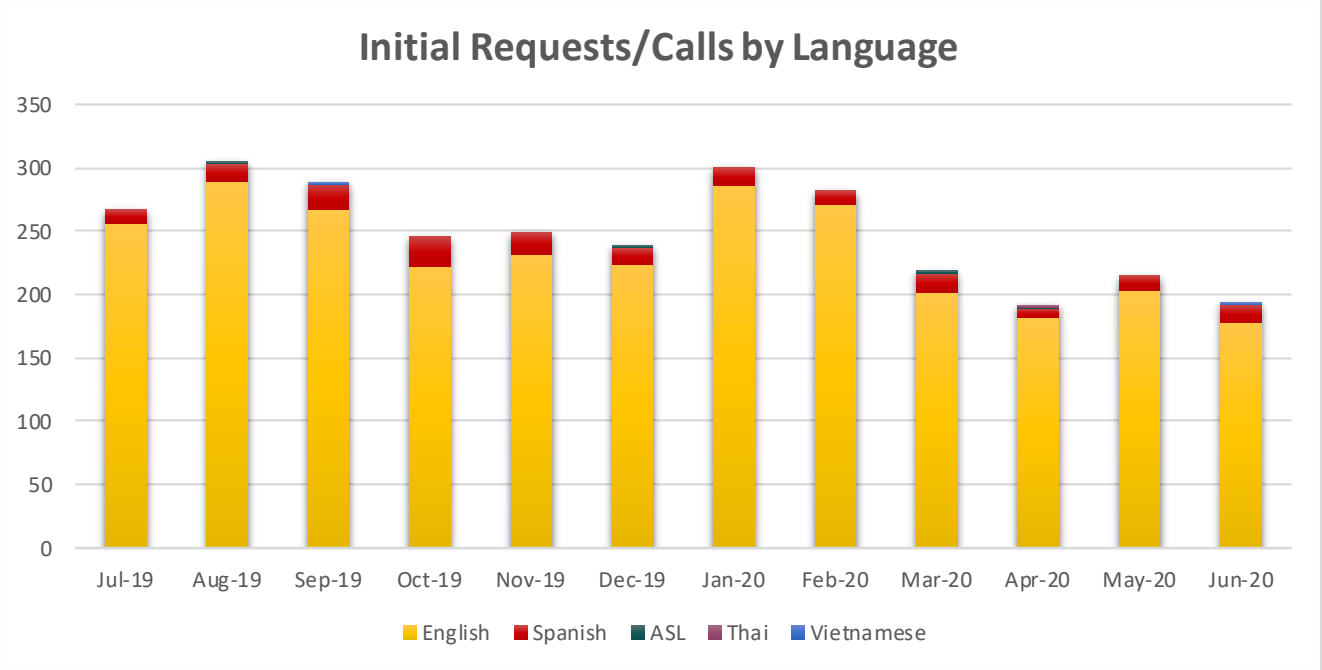
Access to services at DHS-BHD begins with a request for services to the Access Team. Requests are received by way of the 24/7 ACD line, faxed/emailed referrals, and walk-ins to the Access Clinic.

Call Log

The following data includes calls to the 24/7 ACD line and faxed/emailed referrals (not walk-in requests).

Caller Language

Month of Call	English	Spanish	ASL	Thai	Vietnamese	Total
July	256	11				**267**
August	289	14	1			**304**
September	267	20			1	**288**
October	222	24				**246**
November	232	17				**249**
December	224	13	1			**238**
January	286	14				**300**
February	271	11				**282**
March	202	15	1			**218**
April	182	7	1	1		**191**
May	203	12				**215**
June	178	14			1	**193**
Total	**2812**	**172**	**4**	**1**	**2**	**2991**

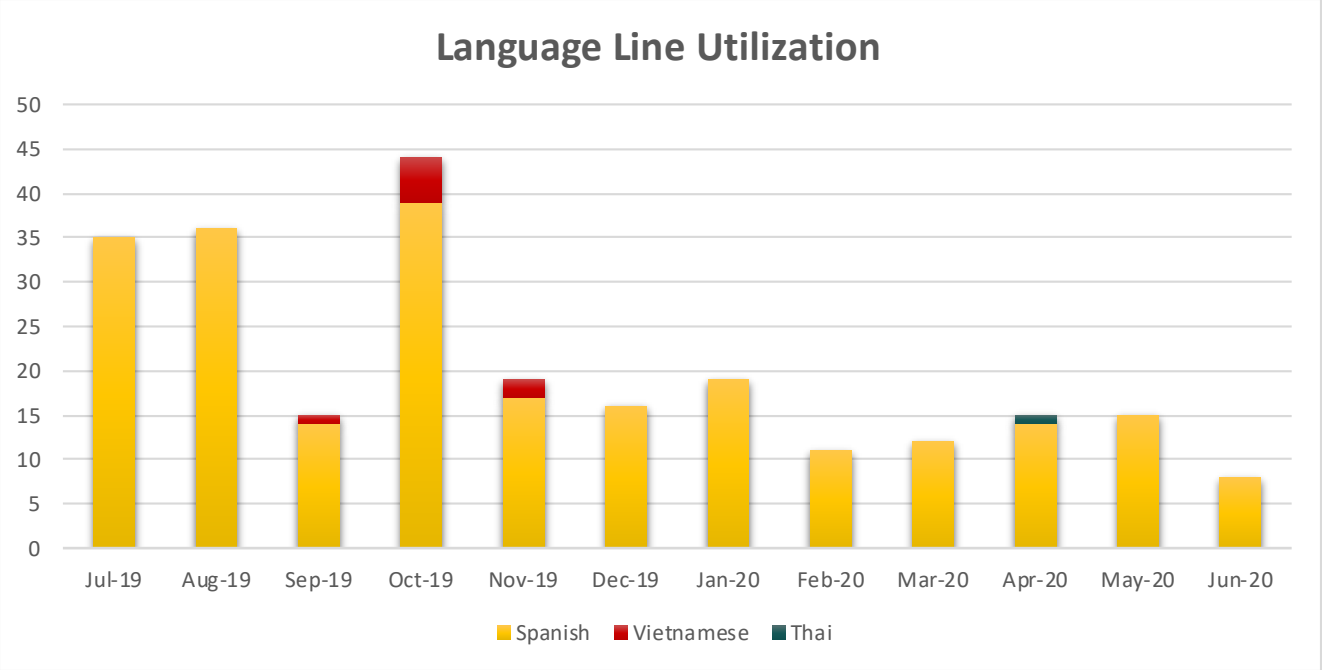


Language Line Utilization – Access

The Adult and Youth Access teams staff the 24/7 call line with bilingual staff. But in the event that a bilingual staff member is not available for call backs or screenings, the Language Line is available to provide telephonic interpretation services. Utilization of the Language Line for Access purposes is as follows:

Month of Call	Spanish	Vietnamese	Thai	Total
July	35			**35**
August	36			**36**
September	14	1		**15**
October	39	5		**44**
November	17	2		**19**
December	16			**16**
January	19			**19**
February	11			**11**
March	12			**12**
April	14		1	**15**
May	15			**15**
June	8			**8**
Total Utilization	**236**	**8**	**1**	**245**

Language Line utilization on the Access Teams trended downward when comparing the first half of the year to the second half. This is due to expanded bilingual capacity on both teams as well as a system workflow shift implemented partway through the year, in which the Youth Access Team began taking calls for service directly rather than filtering through the Adult Access Team first. The overall trend pattern is illustrated in the following chart.



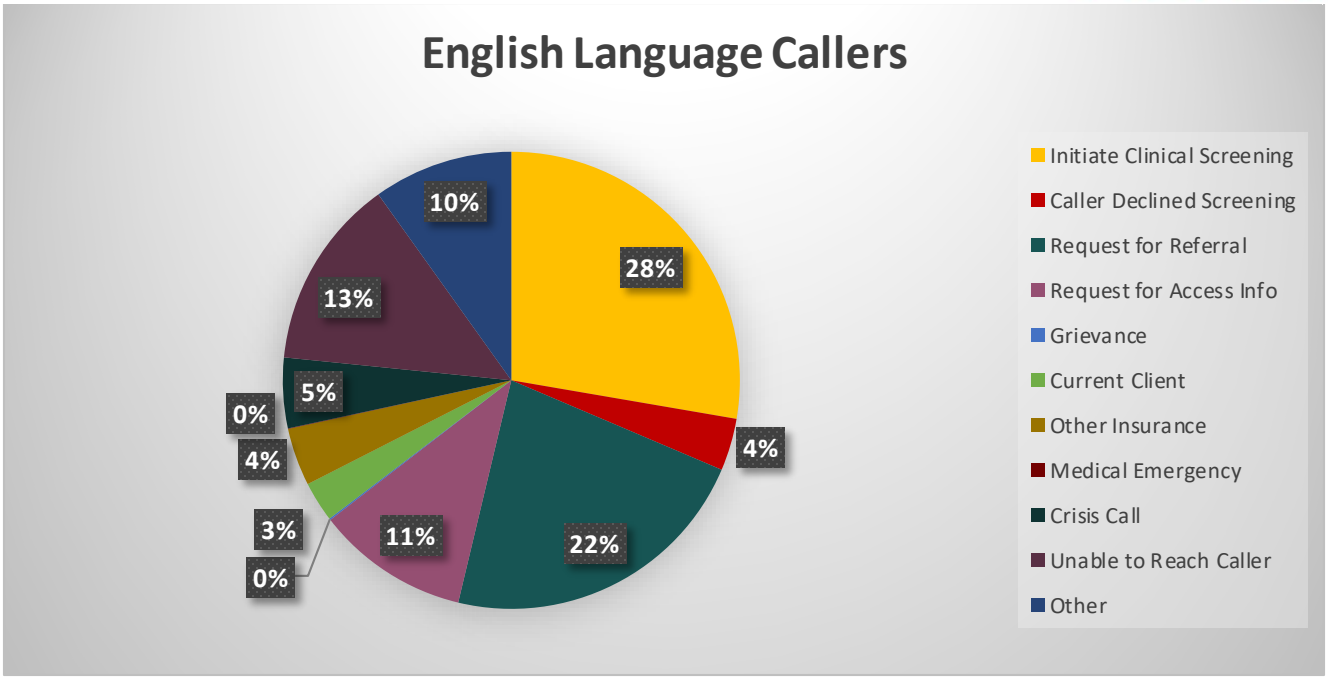
Call Log Disposition by Language

The Access Teams fielding the request call line receive several types of inquiries. Examples include:

- Requests for Specialty Mental Health Services
- Requests for information about mental health
- Requests for referral to a community resource
- Referral from a community provider
- Inquiries from concerned family members for their loved one
- Post-hospital referrals

The following tables and charts depict the call disposition by preferred language of the caller.

Call Disposition	English	Spanish	ASL	Thai	Vietnamese	Total
Initiate Clinical Screening	779	82	2		1	**864**
Caller Declined Screening	104	5				**109**
Request for Referral	628	27		1		**656**
Request for Access Information	304	17				**321**
Grievance	3					**3**
Current Client	80	1				**81**
Other Insurance: Not Medi-Cal/Medi-Care	115	3				**118**
Medical Emergency: Transferred 911	1					**1**
Crisis Call: Transferred CSU	140	7				**147**
Unable to Reach Caller	380	20				**400**
Other	278	10	2		1	**291**
Total	**2812**	**172**	**4**	**1**	**2**	**2991**



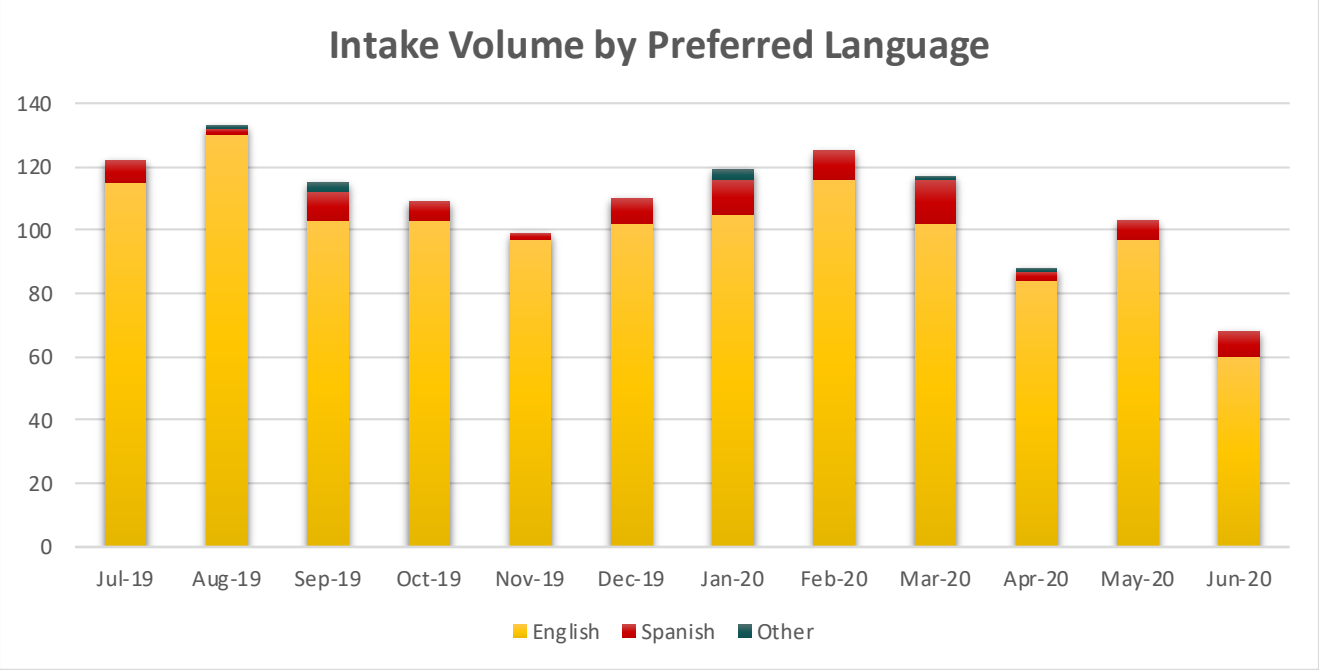
A significantly larger percentage of Spanish-speaking callers initiated a clinical screening versus English-speaking callers. Amongst English-speaking callers, there was a higher incidence of calls requesting referral rather than assessment. Similarly, there was a higher percentage of English-speaking clients that could not be reached for the return call.

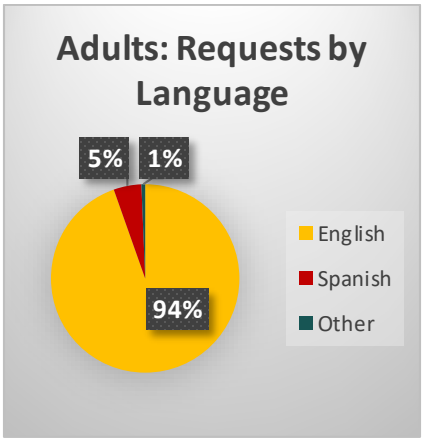
Clinical Screening/Intake Volume

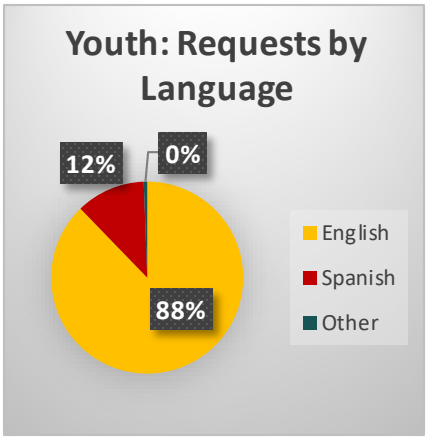
Overall, 28.89% of calls resulted in clinical intake. However, the walk-in percentages are much higher. The following charts include walk-in requests as well as calls and email/fax referrals.

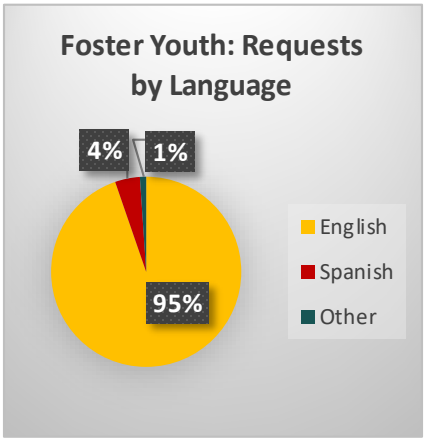
By Preferred Language

Month of Intake	English	Spanish	Other	Total
July	115	7		**122**
August	130	2	1	**133**
September	103	9	3	**115**
October	103	6		**109**
November	97	2		**99**
December	102	8		**110**
January	105	11	3	**119**
February	116	9		**125**
March	102	14	1	**117**
April	84	3	1	**88**
May	97	6		**103**
June	60	8		**68**
Total	**1214**	**85**	**9**	**1308**





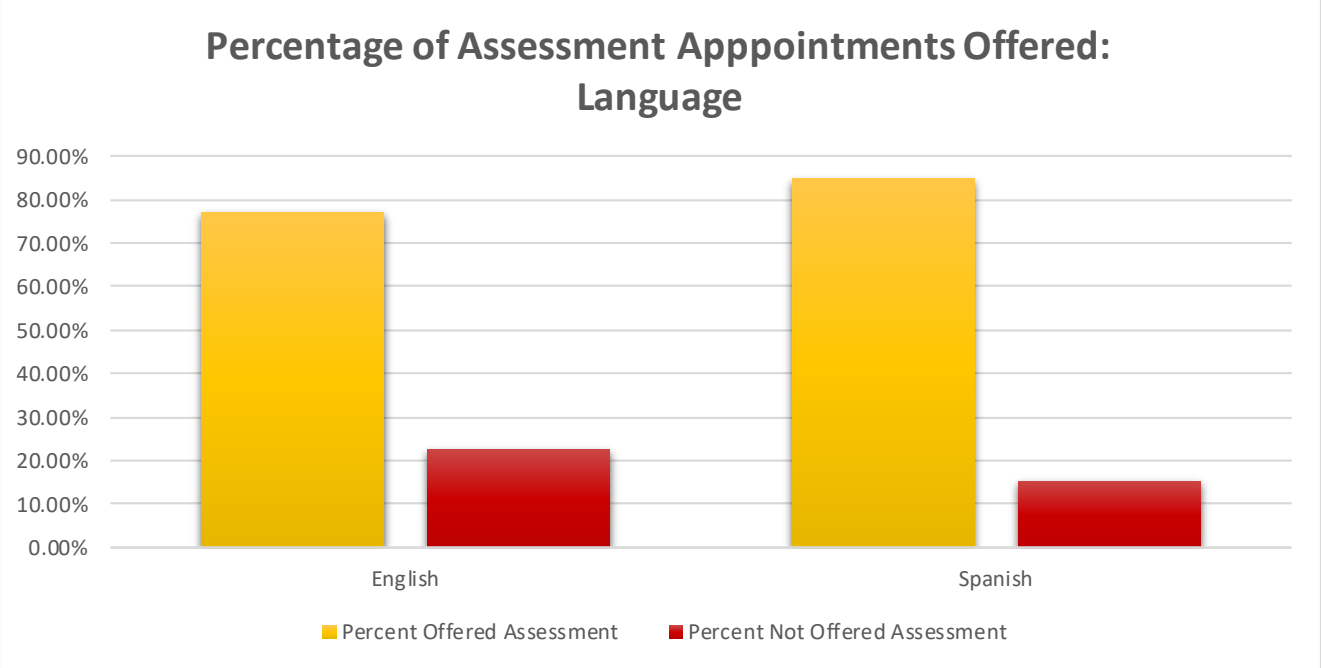




There is a significantly higher proportion of Spanish-speaking clinical intakes in the Youth System versus Adult system.

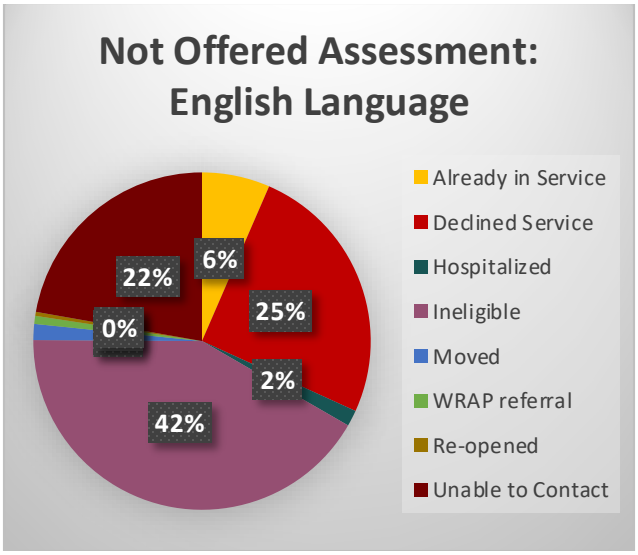
Clinical Screening/Intake Disposition by Preferred Language

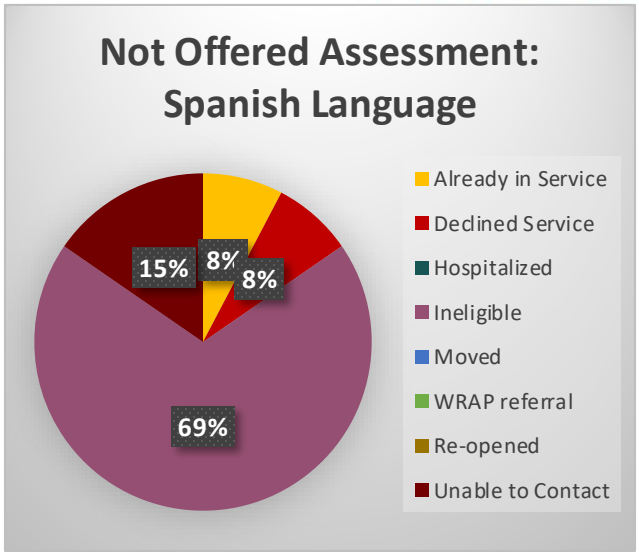
Intake Disposition Status	English	Spanish	Other	Total
Offered Assessment Appointment	935	72	7	**1032**
Not Offered Appointment	261	13	2	**276**
Total	**1214**	**85**	**9**	**1308**



Overall, a higher percentage of Spanish-speaking clients versus English-speaking clients are offered Assessment appointments through the Adult and Youth Access teams. For those not assessed, the reasons are as follows:

Not Assessed: Disposition	English	Spanish	Other	Total
Client Already in Services	17	1		**18**
Client Declined Services	66	1	1	**68**
Hospitalized	4			**4**
Client Ineligible for SMHS	109	9		**118**
Client Moved Out-of-County	4			**4**
Client Referred Directly to WRAP	2			**2**
Client Re-Opened to Services	1			**1**
Unable to Establish Contact	58	2	1	**61**
Total	**261**	**13**	**2**	**276**





Of concern is the higher percentage of Spanish-speaking clients deemed ineligible for services due to not meeting medical necessity, especially given that this determination is made prior to Assessment completion. Data analysis also reveals that Spanish-speaking clients are much less likely to decline services or drop out due to non-contact.

Service Utilization

Language Line Utilization – Service Delivery

The following tables depict Language Line utilization for Adult Services, Youth Services, and Crisis Services. This dataset does not include Access Services reported above.

Adult Services

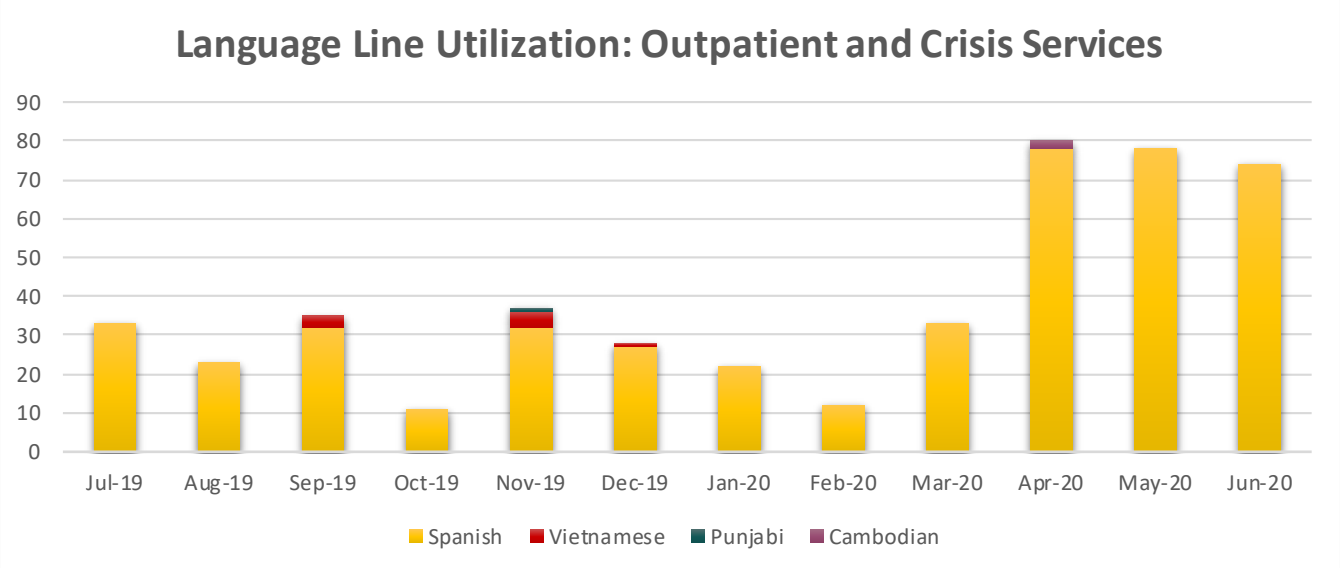
Month of Call	Spanish	Vietnamese	Total
July			
August	2		**2**
September	10		**10**
October	1		**1**
November	2	1	**3**
December			
January			
February			
March			
April			
May			
June	1		**1**
Total Utilization	**16**	**1**	**17**

Youth Services

Month of Call	Spanish	Vietnamese	Total
July	31		**31**
August	15		**15**
September	17	1	**18**
October	6		**6**
November	18	3	**21**
December	27	1	**28**
January	17		**17**
February	8		**8**
March	28		**28**
April	65		**65**
May	73		**73**
June	64		**64**
Total Utilization	**369**	**5**	**374**

Crisis Services

Month of Call	Spanish	Punjabi	Cambodian	Vietnamese	Total
July	2				**2**
August	6				**6**
September	5			2	**7**
October	4				**4**
November	12	1			**13**
December					
January	5				**5**
February	4				**4**
March	5				**5**
April	13		2		**15**
May	5				**5**
June	9				**9**
Total Utilization	**70**	**1**	**2**	**2**	**75**



DHS-BHD Bilingual Service Delivery

The following tables depict Bilingual service delivery of County-operated programs only (CBO data not included).

All Services

Service Category	Service Provided in English	Service Provided in Other Language	Total
Case Management	11,962 (98.05%)	238 (1.95%)	**12,200**
Crisis Intervention	576 (96.16%)	23 (3.84%)	**599**
ICC/IHBS	612 (91.48%)	57 (8.52%)	**669**
Medication Support Services	16,344 (96.66%)	564 (3.34%)	**16,908**
Outpatient Mental Health Services	17,610 (94.24%)	1,077 (5.76%)	**18,687**
Other	17,102 (95.86%)	738 (4.14%)	**17,840**
Total	**64,206 (95.96%)**	**2,697 (4.03%)**	**66,903**

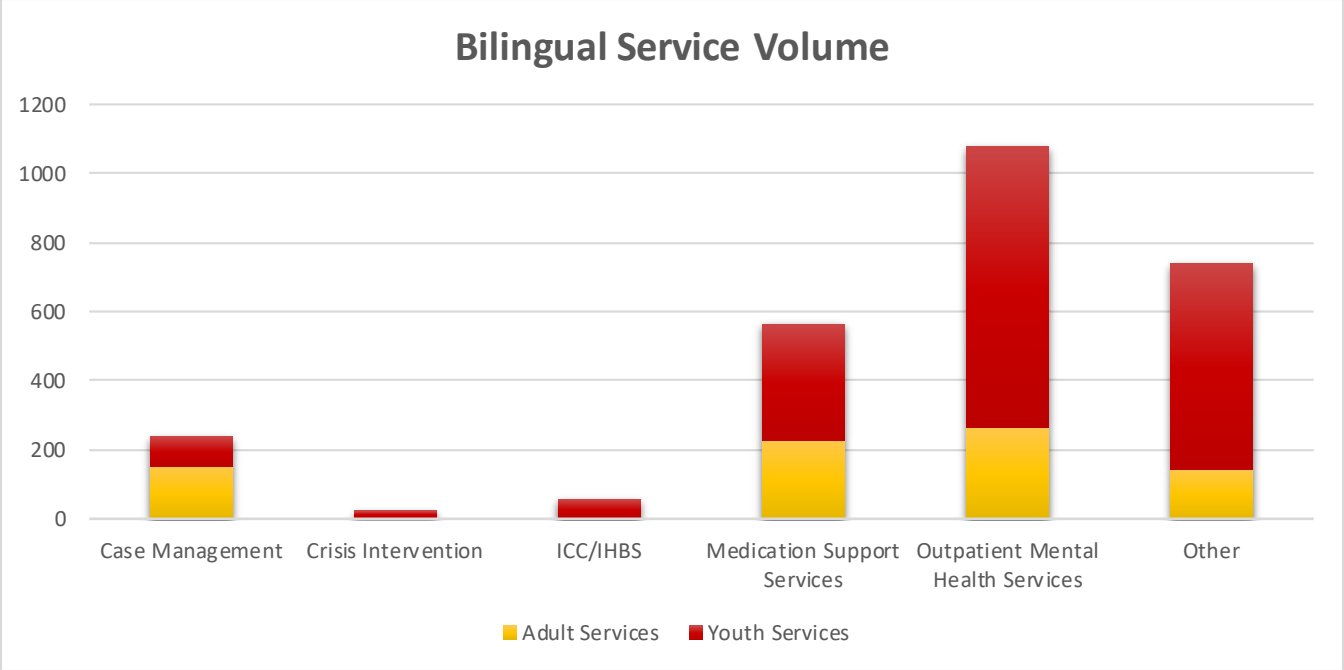
Adult Services

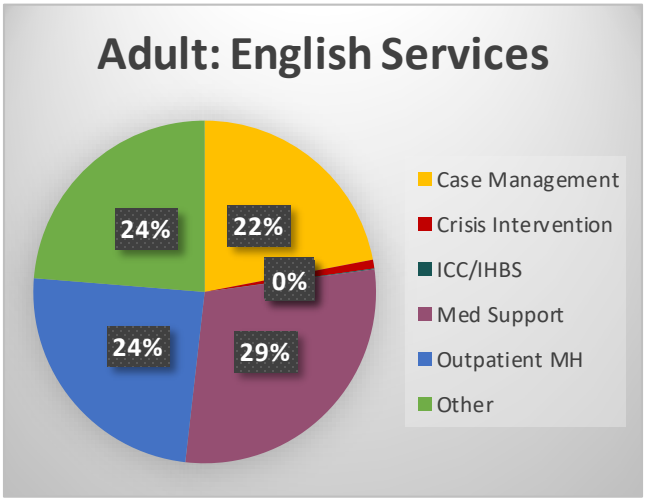
Service Category	Service Provided in English	Service Provided in Other Language	Total
Case Management	10,272 (98.53%)	153 (1.47%)	**10,425**
Crisis Intervention	387 (98.98%)	4 (1.02%)	**391**
ICC/IHBS	38 (100.00%)	0 (0.00%)	**38**
Medication Support Services	13,516 (98.36%)	226 (1.64%)	**13,742**
Outpatient Mental Health Services	11,440 (97.74%)	264 (2.26%)	**11,704**
Other	11,085 (98.72%)	144 (1.28%)	**11,229**
Total	**46,738 (98.34%)**	**791 (1.66%)**	**47,529**

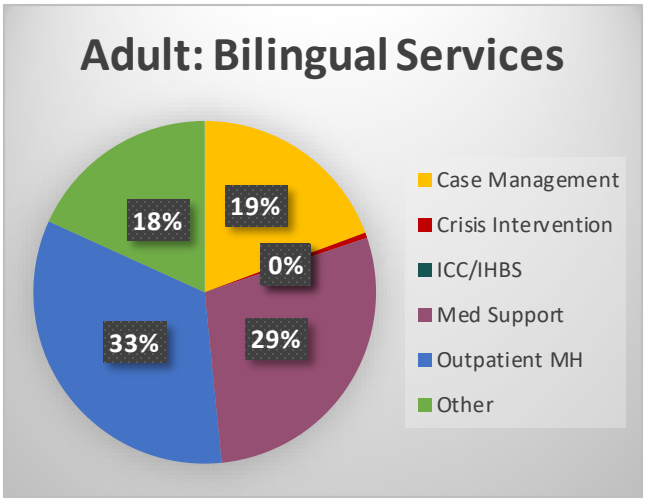
Youth Services

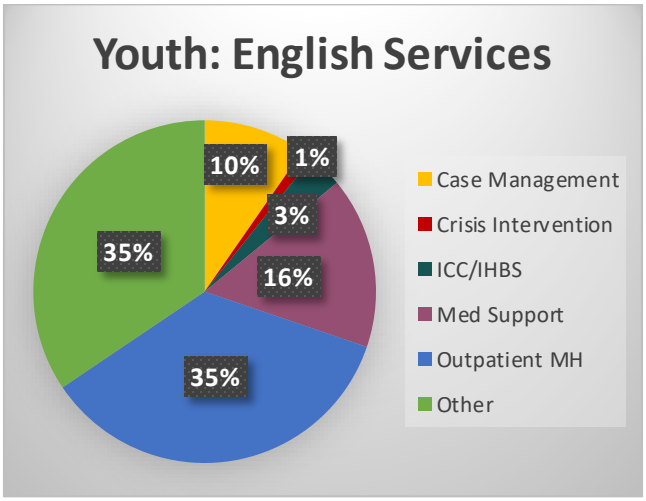
Service Category	Service Provided in English	Service Provided in Other Language	Total
Case Management	1,690 (95.21%)	85 (4.79%)	**1,775**
Crisis Intervention	189 (90.87%)	19 (9.13%)	**208**
ICC/IHBS	574 (90.97%)	57 (9.03%)	**631**
Medication Support Services	2,828 (89.32%)	338 (10.68%)	**3,166**
Outpatient Mental Health Services	6,170 (88.36%)	813 (11.64%)	**6,983**
Other	6,017 (91.01%)	594 (8.99%)	**6,611**
Total	**17,468 (90.16%)**	**1,906 (9.84%)**	**19,374**

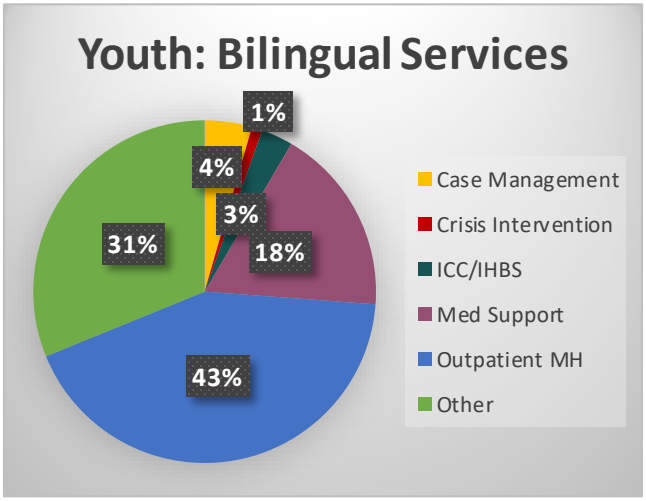
Of note is the significantly larger proportion of Youth bilingual services compared to Adult bilingual services, particularly in the areas of Outpatient Mental Health and Medication Support Services. The following charts compare bilingual service volume and distribution in the Adult and Youth service systems. There is a significantly larger proportion of Outpatient Mental Health services for non-English language services, in both the Adult and Youth systems.


Bilingual Service Volume
1200
1000
800
600
400
200
0
Case Management
Crisis Intervention
ICC/IHBS
Medication Support Services
Outpatient Mental Health Services
Other
Adult Services
Youth Services


Adult: English Services
22%
0%
29%
24%
24%
Case Management
Crisis Intervention
ICC/IHBS
Med Support
Outpatient MH
Other


Adult: Bilingual Services
19%
0%
29%
33%
18%
Case Management
Crisis Intervention
ICC/IHBS
Med Support
Outpatient MH
Other


Youth: English Services
10%
1%
3%
16%
35%
35%
Case Management
Crisis Intervention
ICC/IHBS
Med Support
Outpatient MH
Other


Youth: Bilingual Services
1%
4%
3%
18%
43%
31%
Case Management
Crisis Intervention
ICC/IHBS
Med Support
Outpatient MH
Other

SECTION 2: SERVICE ACCESSIBILITY PERFORMANCE METRICS

METRIC 1: **95% of calls to the 24-hour toll free telephone number will be answered by a live person to provide information to beneficiaries about how to access specialty mental health services.**

Goal Calculation: $\frac{Calls\ Answered\ and\ Logged\ by\ Access/Optum}{Total\ Calls\ Logged\ by\ Access/Optum} * 100\%$

PROCESS USED TO EVALUATE
- Access to MH Services Database
- OPTUM Reports

RESPONSIBLE STAFF – QI Manager and Access Manager.

RESULTS

Year – Month	Access Team calls Answered	Access Team calls Abandoned	OPTUM Calls Answered	OPTUM Calls Abandoned	Total Calls Answered	Total Calls Abandoned	Response Percentage
2019 - 07 July	708	72	144	15	852	87	90.7%
2019 - 08 August	664	56	146	10	810	66	92.5%
2019 - 09 September	658	95	150	7	808	102	88.8%
2019 - 10 October	664	104	98	5	762	109	87.5%
2019 - 11 November	605	64	130	6	735	70	91.3%
2019 - 12 December	613	61	107	6	720	67	91.5%
2020 - 01 January	688	58	118	7	806	65	92.5%
2020 - 02 February	571	70	140	14	711	84	89.4%
2020 - 03 March	616	113	113	5	729	118	86.1%
2020 - 04 April	544	84	103	3	647	87	88.1%
2020 - 05 May	708	97	150	7	858	104	89.2%
2020 - 06 June	801	158	115	7	916	165	84.7%
FY Total =	**7840**	**1032**	**1514**	**92**	**9354**	**1124**	**89.4%**
FY Monthly Average =	653	86	126	8	780	94	**89.3%**

89.4% of calls to the 24-hour toll free number at the Access team and/or OPTUM with requests for specialty mental health services were answered by a live person. This is an improvement from last year.

STANDARD PARTIALLY MET

METRIC 2: **100% of non-urgent after-hours callers requesting Specialty Mental Health Services will receive a call back the next business day.**

Goal Calculation: $\frac{Total\ Screenings\ Completed}{After\text{–}Hours\ Calls\ Referred\ to\ Access\ for\ Callback} * 100\%$

PROCESS USED TO EVALUATE

- OPTUM Logs
- Access to Mental Health Services Database.

RESPONSIBLE STAFF – QI Manager and Access Manager.

RESULTS

Call Year – Month	After-Hours Calls Referred to Access for Callback	Adult Clinical Screenings Completed	Youth Clinical Screenings Completed	Total Screenings Completed	% of Non-urgent after hours requests clinically screened
2019 - 07 July	29	25	4	29	100%
2019 - 08 August	23	23	0	23	100%
2019 - 09 September	24	21	3	24	100%
2019 - 10 October	20	18	2	20	100%
2019 - 11 November	37	34	3	37	100%
2019 - 12 December	29	26	3	29	100%
2020 - 01 January	30	27	3	30	100%
2020 - 02 February	37	32	5	37	100%
2020 - 03 March	22	20	2	22	100%
2020 - 04 April	20	16	4	20	100%
2020 - 05 May	25	23	2	25	100%
2020 - 06 June	24	23	1	24	100%
Totals =	**320**	**288**	**32**	**320**	**100%**

320/320 or 100% of calls logged by OPTUM as needing specialty mental health services and referred to Access called back the next business day.

STANDARD MET

METRIC 3: **The average length of time from initial request for services to first offered assessment appointment will be 10 business days or less.**

Goal calculation: $\frac{Offer\ Date - Request\ Date\ (Business\ Days)}{Total\ Offered\ Appointments}$

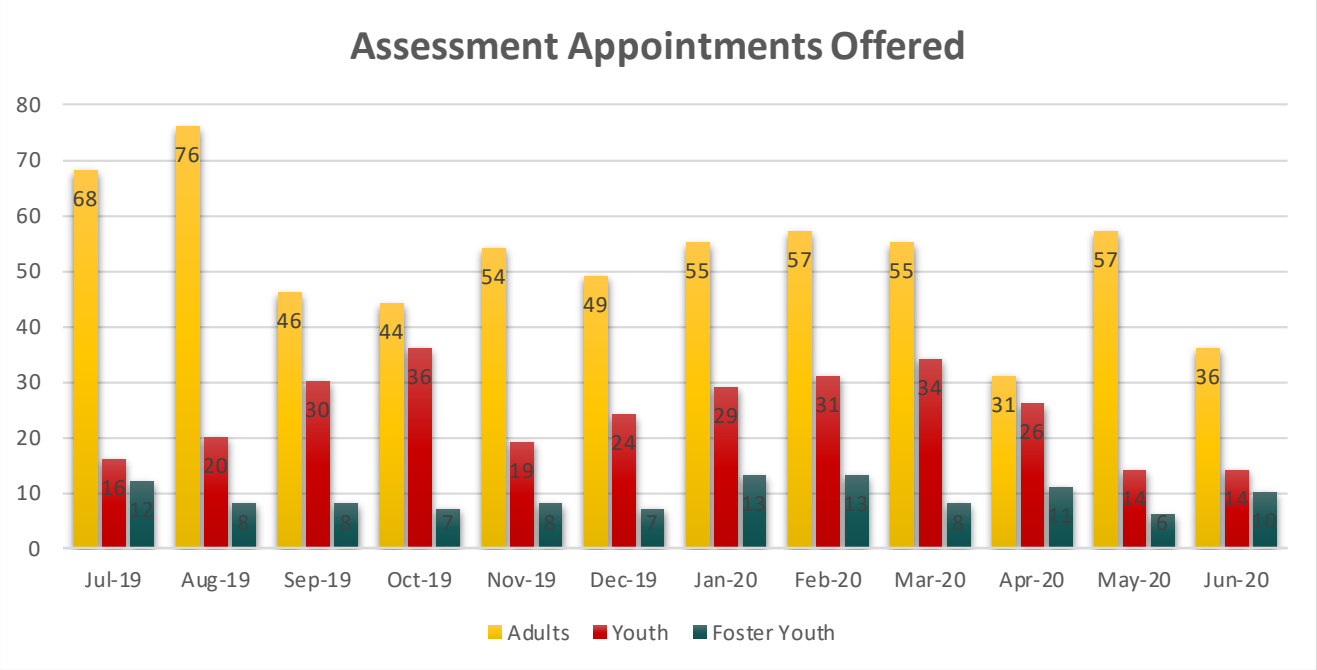
PROCESS USED TO EVALUATE
Access to MH Services Database

RESPONSIBLE STAFF – QI Manager and Access Manager

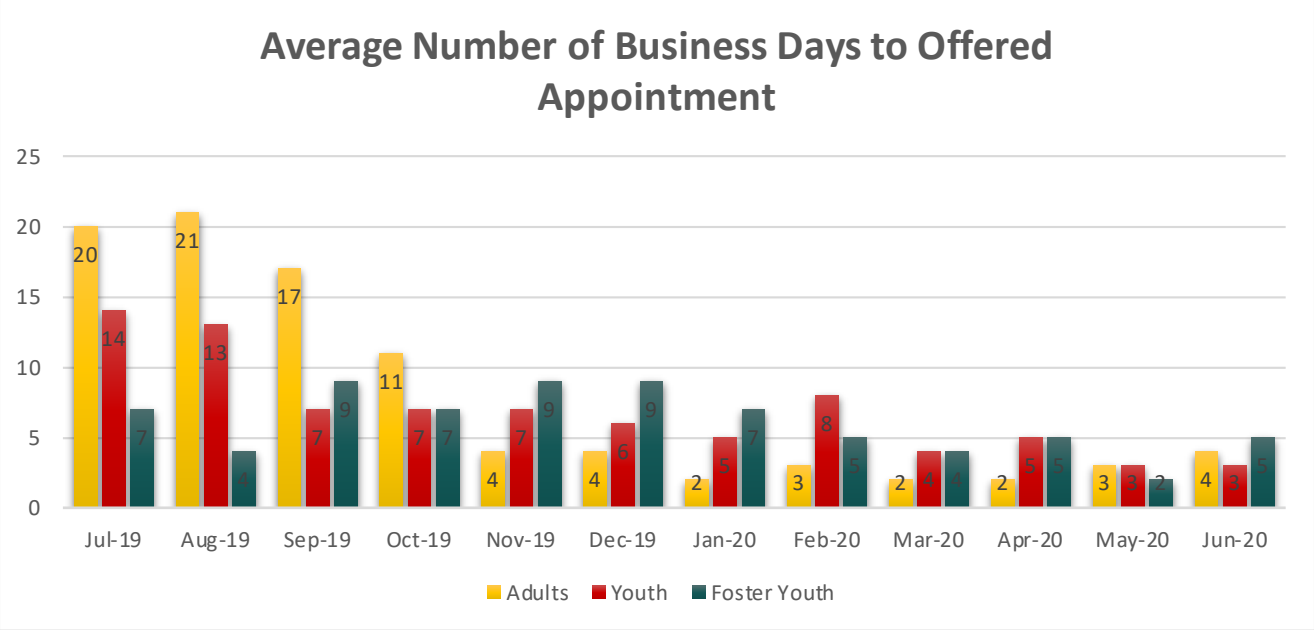
RESULTS

	All Services	Adult Services	Children's Services	Foster Care
Average length of time from first request for service to first offered appointment (in business days)	7.79 days (mean) 4 days (median) 10.56 Std. Dev.	8.62 days (mean) 4 days (median) 12.75 Std. Dev.	6.39 days (mean) 5 days (median) 5.44 Std. Dev.	6.15 days (mean) 5 days (median) 5.15 Std. Dev.
DHCS Standard	10 days	10 days	10 days	10 days
Percent of appointments that met this standard	78.78%	74.52%	85.40%	85.59%
Range	**0-96 days**	**0-96 days**	**0-33 days**	**0-30 days**

Adult/Youth Initial Assessments Offered per Month



Timeliness to Offered Assessment Appointment



The charts above depict the volume of offered assessments and the timeliness to the offered appointments. Target timeliness metric is 10 business days or less. Assessments offered reduced overall in the month of April (COVID on-set), with adult assessment offers increasing again in May while Youth assessment offers continued to decline. Timeliness metrics improved dramatically after the introduction of the Non-Clinical Performance Improvement Project (PIP) on Access Timeliness in October. Additionally, despite disruptions in service delivery caused by COVID-19, timeliness metrics are excellent for the second half of the year.

STANDARD MET

METRIC 4: **70% of beneficiaries requesting a mental health assessment will be offered an initial assessment appointment within 10 business days from the date of the initial request for service.**

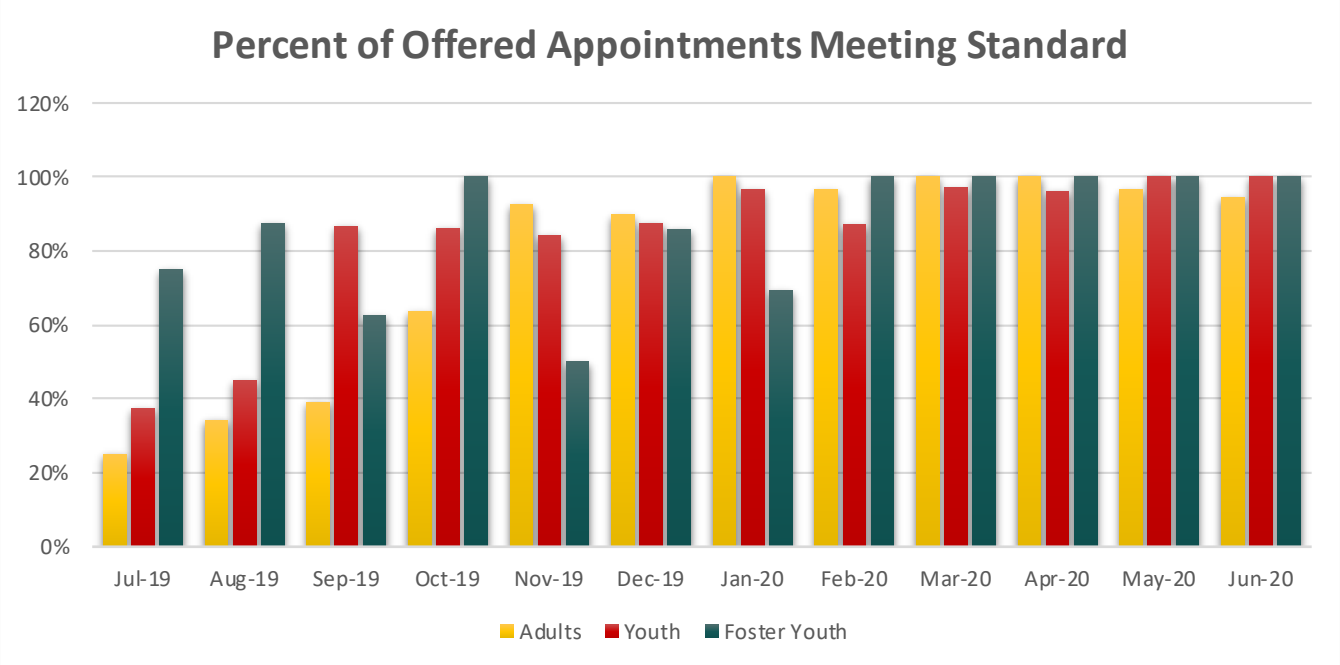
Goal calculation: $\frac{Assessment\ Offers\ Under\ 10\ B.Days}{Total\ Offered\ Assessments} * 100\%$

PROCESS USED TO EVALUATE
Access to MH Services Database

RESPONSIBLE STAFF – QI Manager and Access Manager

RESULTS

	All Services	Adult Services	Youth Services	Foster Care
Total Offered Assessment Appointments	1032	628	404	111
Count of Appointments that Met 10 Day Standard	813	468	345	95
Percent of Appointments that Met Standard	78.78%	74.52%	85.40%	85.59%



The percentage of offered assessment appointments meeting the 10 business day standard improved significantly over the course of FY19-20, particularly in the Adult timeliness standards. This coincides with the introduction of the Adult Access Walk-In Clinic in October. November saw a reduction in the percentage of compliance for Foster Care due to the Kincade Fire and evacuation of the emergency foster shelter. The onset of COVID in March-April does not appear to have negatively impacted this metric.

STANDARD MET

METRIC 5: **The average length of time from initial request for services to first kept appointment will be 10 business days or less.**

Goal calculation: $\frac{Attended\ Date - Request\ Date\ (Business\ Days)}{Total\ Attended\ Appointments}$

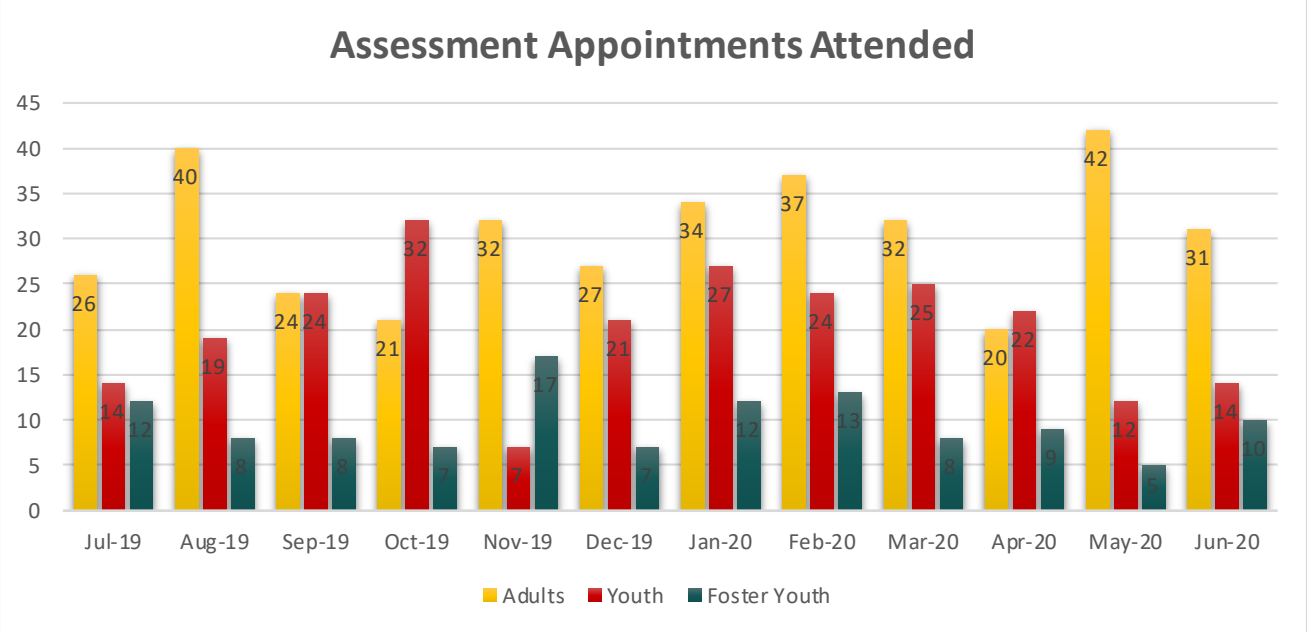
PROCESS USED TO EVALUATE
Access to MH Services Database

RESPONSIBLE STAFF – QI Manager and Access Manager

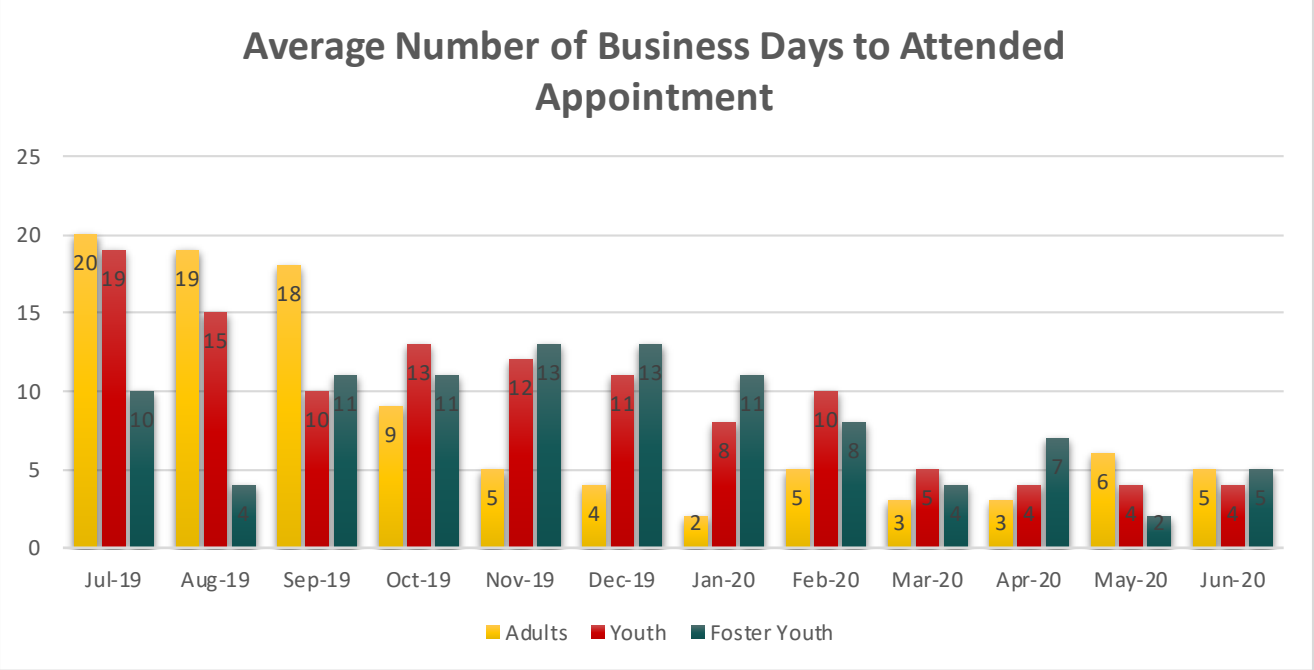
RESULTS

	All Services	Adult Services	Children's Services	Foster Care
Average length of time from first request for service to first kept appointment (in business days)	8.76 days (mean) 5 days (median) 10.97 Std. Dev.	8.23 days (mean) 2 days (median) 12.98 Std. Dev.	9.30 days (mean) 7 days (median) 8.40 Std. Dev.	8.38 days (mean) 6 days (median) 8.37 Std. Dev.
MHP Standard	10 days	10 days	10 days	10 days
Percent of appointments that met this standard	74.41%	78.42%	70.31%	74.53%
Range	**0-100 days**	**0-100 days**	**0-51 days**	**0-51 days**

Adult/Youth Initial Assessments Attended per Month



Timeliness to Attended Assessment Appointment



Timeliness to attended assessments does not fall under set standards, as clients have the latitude to change/decline appointments. DHS-BHD's goal is to stay within a 5-point range of 10 business days. These charts show that attended appointments had a small decrease in April which rebounded in May in the Adult system, but not in Youth. Additionally, there is a sharp drop in youth attended appointments in November due to Kincade Fire. For both Adults and Youth, timeliness is on an improving trend.

STANDARD MET

METRIC 6: **70% of beneficiaries scheduled for an initial mental health assessment will attend the assessment appointment within 10 business days from the date of the initial request for service.**

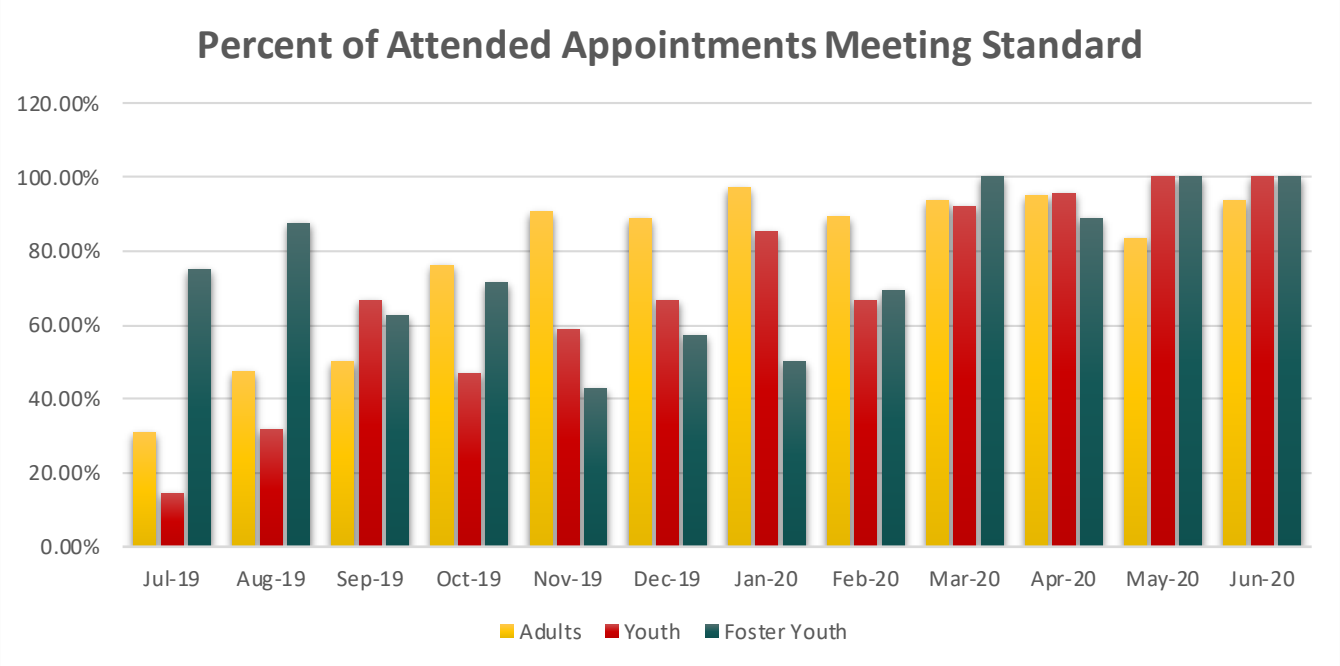
Goal calculation: $\frac{Assessment\ Attended\ Under\ 10\ B.Days}{Total\ Attended\ Assessments} * 100\%$

PROCESS USED TO EVALUATE
Access to MH Services Database

RESPONSIBLE STAFF – QI Manager and Access Manager

RESULTS

	All Services	Adult Services	Youth Services	Foster Care
Total Attended Assessment Appointments	723	366	357	106
Count of Appointments that Met 10 Day Standard	538	287	251	79
Percent of Appointments that Met Standard	74.41%	78.42%	70.31%	74.53%



The percentage of attended assessment appointments meeting the 10 business day standard showed similar improvement over the course of FY19-20, particularly in the Adult timeliness standards. The onset of COVID in March-April does not appear to have negatively impacted this metric.

STANDARD MET

METRIC 7: **The average length of time from initial request to first offered psychiatry appointment will be 15 business days or less.**

Goal calculation: $\frac{Psychiatry\ Offered\ Date - Request\ Date\ (Business\ Days)}{Total\ Psychiatry\ Offered\ Appointments}$

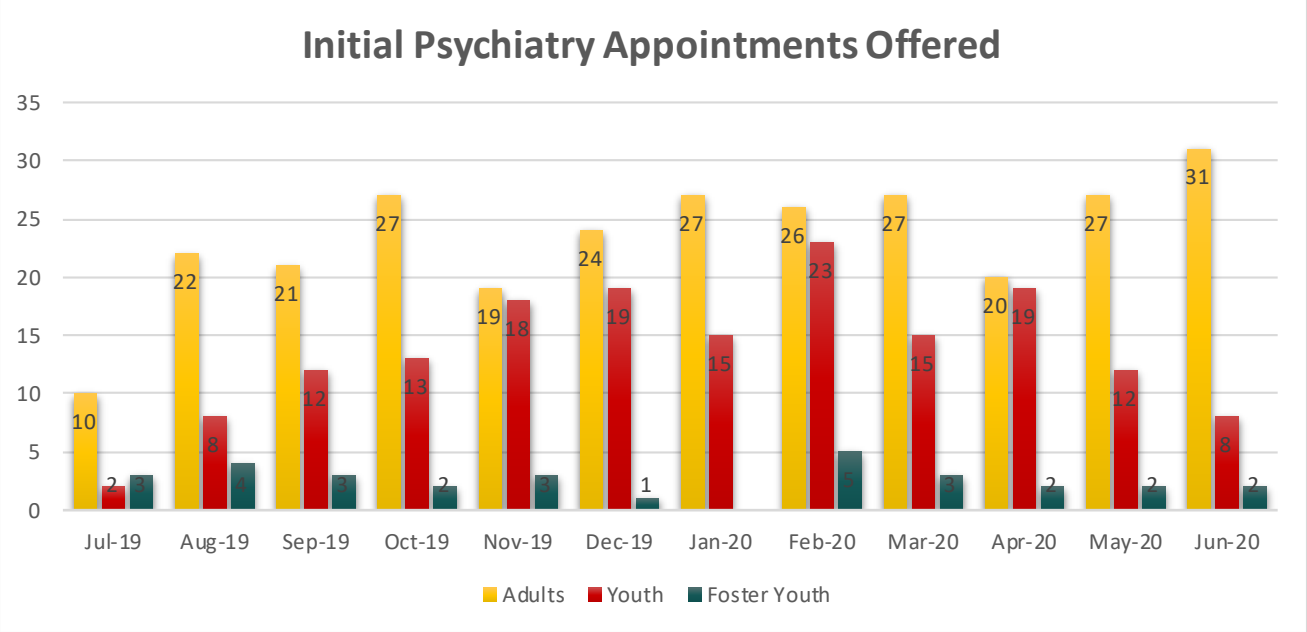
PROCESS USED TO EVALUATE
Access to MH Services Database
AVATAR Psychiatry Service Data

RESPONSIBLE STAFF – QI Manager and Medical Director

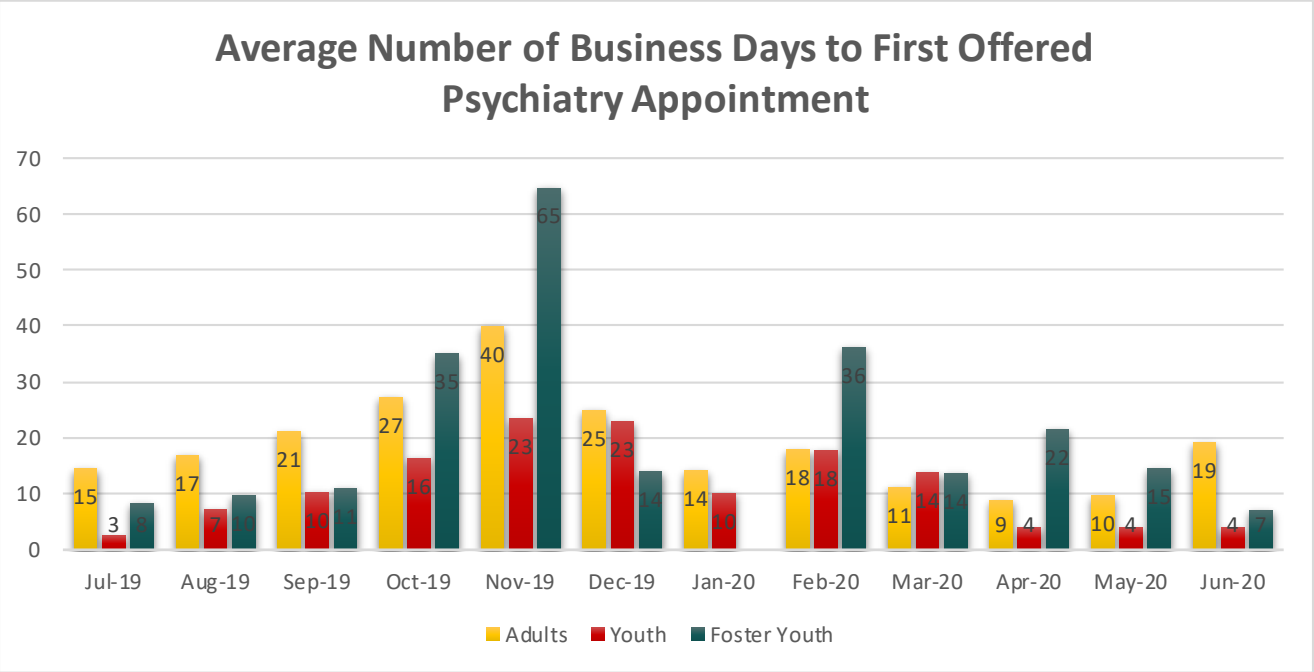
RESULTS

	All Services	Adult Services	Children's Services	Foster Care
Average length of time from first request for service to first offered psychiatry appointment (in business days)	17.67 days (mean) 13 days (median) 19.59 Std. Dev.	18.63 days (mean) 13 days (median) 18.71 Std. Dev.	17.67 days (mean) 8 days (median) 19.59 Std. Dev.	23.13 days (mean) 14 days (median) 24.33 Std. Dev.
DHCS Standard	15 days	15 days	15 days	15 days
Percent of appointments that met this standard	56.49%	55.99%	57.21%	51.61%
Range	**0-138 days**	**0-138 days**	**0-110 days**	**0-110 days**

Adult/Youth Initial Psychiatry Appointments Offered per Month



Timeliness to First Offered Psychiatry Appointment



Of note is the dramatic negative spike in Timeliness during the month of November. This coincides with the Kincade Fire, which resulted in a County-wide evacuation for a significant portion of that month. As a result, overall performance on this metric declined significantly since last year.

STANDARD NOT MET

METRIC 8: **70% of beneficiaries requesting psychiatry services will be offered a psychiatry appointment within 15 business days from the date of the initial request for psychiatry.**

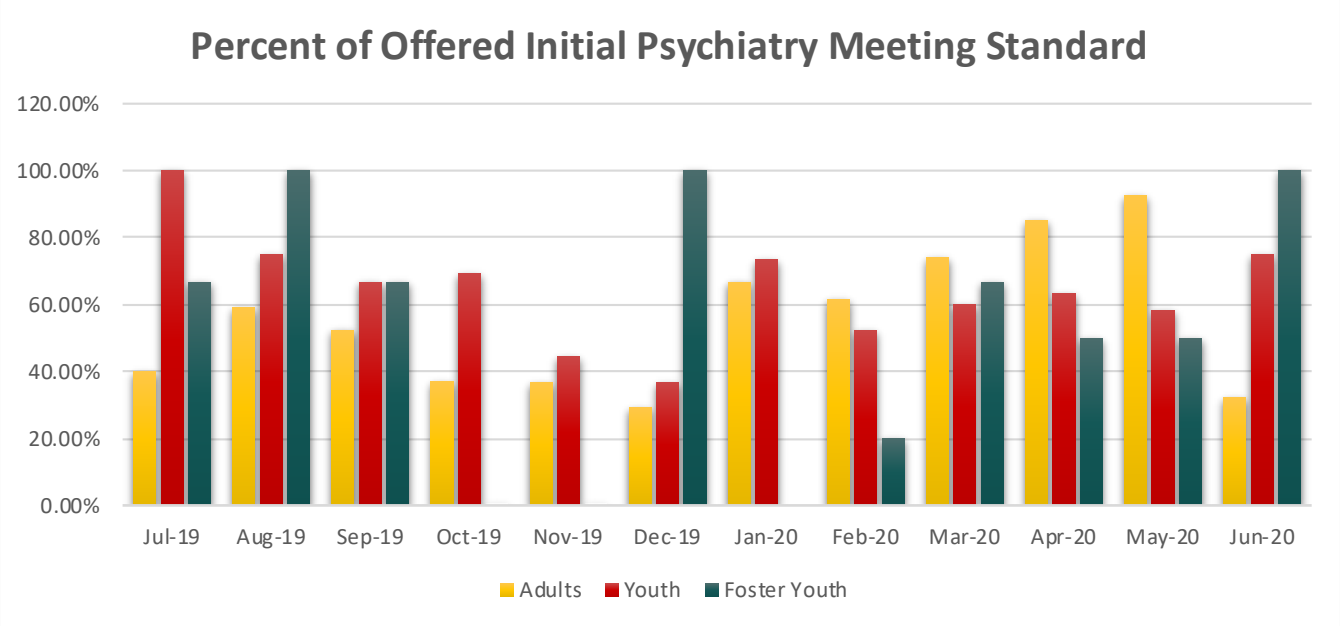
Goal calculation: $\frac{Psychiatry\ Offered\ Under\ 15\ B.Days}{Total\ Offered\ Psychiatry} * 100\%$

PROCESS USED TO EVALUATE
Access to MH Services Database
AVATAR Psychiatry Service Data

RESPONSIBLE STAFF – QI Manager and Medical Director

RESULTS

	All Services	Adult Services	Youth Services	Foster Care
Total Offered Initial Psychiatry Appointments	485	284	201	31
Count of Appointments that Met 10 Day Standard	274	159	115	16
Percent of Appointments that Met Standard	56.49%	55.99%	57.21%	51.61%



The percentage of offered initial psychiatry appointments meeting the 15 business day standard declined significantly in November, as a result of the Kincade Fire county-wide evacuations. This particularly evident in the Foster Youth metrics due to the emergency foster shelter evacuating out-of-county. Subsequent to this disaster event, performance on this metric shows an improving trend, which the exception of the Adult psychiatry in June. This anomaly is most likely due to increased COVID restrictions. Overall, performance on this standard declined from the previous year.

STANDARD NOT MET

METRIC 9: **The average length of time from urgent service request to actual encounter will be 48 hours or less.**

Goal calculation: $\frac{Service\ Date - Urgent\ Request\ Date\ (in\ Hours)}{Total\ Urgent\ Requests}$

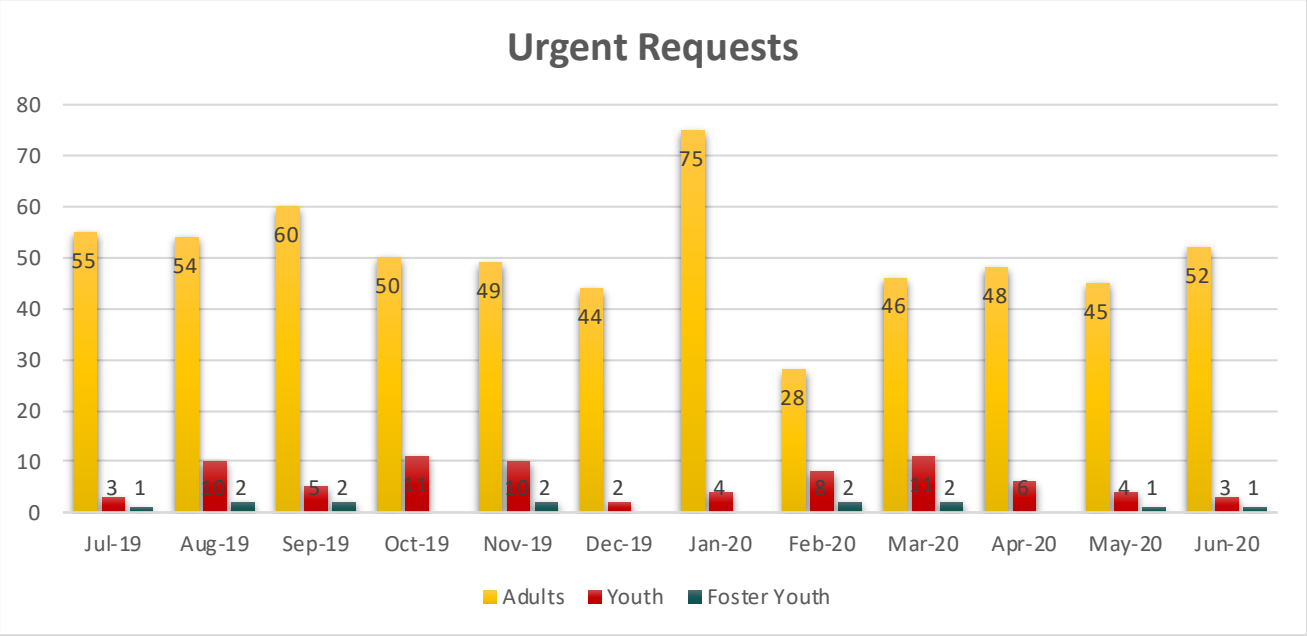
PROCESS USED TO EVALUATE
Access to MH Services Database
AVATAR Service Data
SWITS Encounter Data
CSU Census Database

RESPONSIBLE STAFF – QI Manager and Access Manager

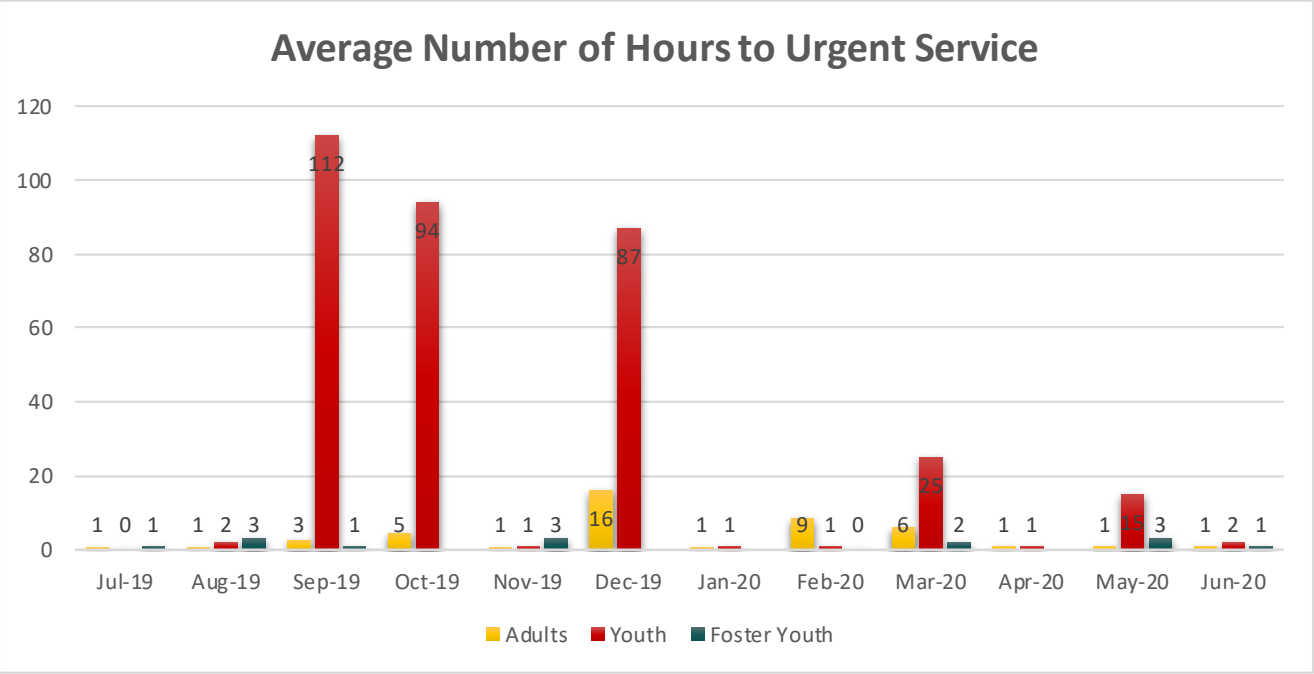
RESULTS

	All Services	Adult Services	Children's Services	Foster Care
Average length of time for urgent appointments (in hours)	11 hours (mean) 1 hour (median) 59 Std. Dev.	6 hours (mean) 1 hour (median) 38 Std. Dev.	38 hours (mean) 2 hours (median) 118 Std. Dev.	2 hours (mean) 2 hours (median) 1 Std. Dev.
DHCS Standard	48 hours	48 hours	48 hours	48 hours
Percent of appointments that met this standard	95.92%	97.41%	878.76%	100.00%
Range	**0-675 hours**	**0-478 hours**	**0-675 hours**	**0-3 hours**

Adult/Youth Urgent Request Volume per Month



Timeliness to Urgent Services



Though overall Urgent timeliness metrics are excellent, there are some significant outliers in the non-Foster Youth requests during the first half of the year. This is due to delays between receiving the request on the main Access Line and the transfer of the request over to Youth Access. The Youth Access Team revised this workflow mid-year and now takes the Youth Intakes directly, which significantly improved their metrics.

STANDARD MET

METRIC 10: 95% of the adult beneficiaries who are screened as needing an urgent mental health assessment will receive services within 48 hours.

Goal calculation: $\frac{Assessments\ Under\ 48\ Hours}{Total\ Urgent\ Requests} * 100\%$

PROCESS USED TO EVALUATE
Access to MH Services Database
AVATAR Service Data
SWITS Encounter Data
CSU Census Database

RESPONSIBLE STAFF – QI Manager and Access Manager

RESULTS
Adults

Year - Month	Urgent Requests To Access	Attended under 48 Hours	MST/CAPE Requests	MST Contacts Under 48 Hours	CSU Walk-Ins	CSU Admits Under 48 Hours	Total Urgent Request	Service Under 48 Hours	% Met Standard
2019 - 07 July	0	0	21	21	34	34	55	55	100.0%
2019 - 08 August	0	0	20	20	34	34	54	54	100.0%
2019 - 09 September	1	0	27	27	29	29	57	56	98.3%
2019 - 10 October	1	0	16	16	33	33	50	49	98.0%
2019 - 11 November	0	0	19	19	29	29	48	48	100.0%
2019 - 12 December	4	2	14	14	24	24	42	40	95.2%
2020 - 01 January	1	1	32	32	41	41	74	74	100.0%
2020 - 02 February	2	1	10	10	16	16	28	27	96.4%
2020 - 03 March	2	0	18	18	25	25	45	43	95.6%
2020 - 04 April	1	1	24	24	23	23	48	48	100.0%
2020 - 05 May	0	0	20	20	25	25	45	45	100.0%
2020 - 06 June	0	0	37	37	15	15	52	52	100.0%
Grand Totals	12	5	258	258	328	328	598	591	98.8%

98.8% of adults who were screened as needing an urgent mental health assessment received services within 48 hours.

Youth

Year - Month	Urgent Requests To Access	Attended under 48 Hours	MST/CAPE Requests	MST Contacts Under 48 Hours	CSU Walk-Ins	CSU Admits Under 48 Hours	Total Urgent Request	Service Under 48 Hours	% Met Standard
2019 - 07 July	0	0	1	1	2	2	3	3	100.0%
2019 - 08 August	0	0	6	6	3	3	9	9	100.0%
2019 - 09 September	1	0	1	1	3	3	5	4	80.0%
2019 - 10 October	2	0	7	7	2	2	11	9	81.8%
2019 - 11 November	0	0	6	6	4	4	10	10	100.0%
2019 - 12 December	1	0	1	1	0	0	2	1	50.0%
2020 - 01 January	0	0	3	3	1	1	4	4	100.0%
2020 - 02 February	0	0	2	2	6	6	8	8	100.0%
2020 - 03 March	2	0	8	8	1	1	11	9	81.8%
2020 - 04 April	0	0	2	2	4	4	6	6	100.0%
2020 - 05 May	1	1	2	2	0	0	3	3	100.0%
2020 - 06 June	0	0	3	3	0	0	3	3	100.0%
Grand Totals	7	1	42	42	26	26	75	69	92.0%

92.0% of Youth who were screened as needing an urgent mental health assessment received services within 48 hours.

Foster Youth

Year - Month	Urgent Requests To Access	Attended under 48 Hours	MST/CAPE Requests	MST Contacts Under 48 Hours	CSU Walk-Ins	CSU Admits Under 48 Hours	Total Urgent Request	Assessment Under 48 Hours	% Met Standard
2019 - 07 July	0	0	1	1	0	0	1	1	100.0%
2019 - 08 August	0	0	2	2	0	0	2	2	100.0%
2019 - 09 September	0	0	1	1	1	1	2	2	100.0%
2019 - 10 October	0	0	0	0	0	0	0	0	100.0%
2019 - 11 November	0	0	2	2	0	0	2	2	100.0%
2019 - 12 December	0	0	0	0	0	0	0	0	100.0%
2020 - 01 January	0	0	0	0	0	0	0	0	100.0%
2020 - 02 February	0	0	0	0	2	2	2	2	100.0%
2020 - 03 March	0	0	2	2	0	0	2	2	100.0%
2020 - 04 April	0	0	0	0	0	0	0	0	100.0%
2020 - 05 May	0	0	1	1	0	0	1	1	100.0%
2020 - 06 June	0	0	1	1	0	0	1	1	100.0%
Grand Totals	0	0	10	10	3	3	13	13	100.0%

100.0% of Foster Youth who were screened as needing an urgent mental health assessment received services within 48 hours.

Total Beneficiaries

Year - Month	Urgent Requests To Access	Attended under 2 B days	MST/CAPE Requests	MST Contacts Under 2 B Days	CSU Walk-Ins	CSU Admits Under 2 B days	Total Urgent Request	Assessment Under 2 B days	% Met Standard
2019 - 07 July	0	0	22	22	36	36	58	58	100.0%
2019 - 08 August	0	0	26	26	37	37	63	63	100.0%
2019 - 09 September	2	0	28	28	32	32	62	60	96.8%
2019 - 10 October	3	0	23	23	35	35	61	58	95.1%
2019 - 11 November	0	0	25	25	33	33	58	58	100.0%
2019 - 12 December	5	2	15	15	24	24	44	41	93.2%
2020 - 01 January	1	1	35	35	42	42	78	78	100.0%
2020 - 02 February	2	1	12	12	22	22	36	35	97.2%
2020 - 03 March	4	0	26	26	26	26	56	52	92.9%
2020 - 04 April	1	1	26	26	27	27	54	54	100.0%
2020 - 05 May	1	1	22	22	25	25	48	48	100.0%
2020 - 06 June	0	0	40	40	15	15	55	55	100.0%
Grand Totals	19	6	300	300	354	354	673	660	98.1%

98.1% of **all clients** who were screened as needing an urgent mental health assessment received services within 48 hours.

STANDARD MET

METRIC 11: The average length of time between post-hospital inpatient discharge and follow-up appointment will be 7 calendar days or less.

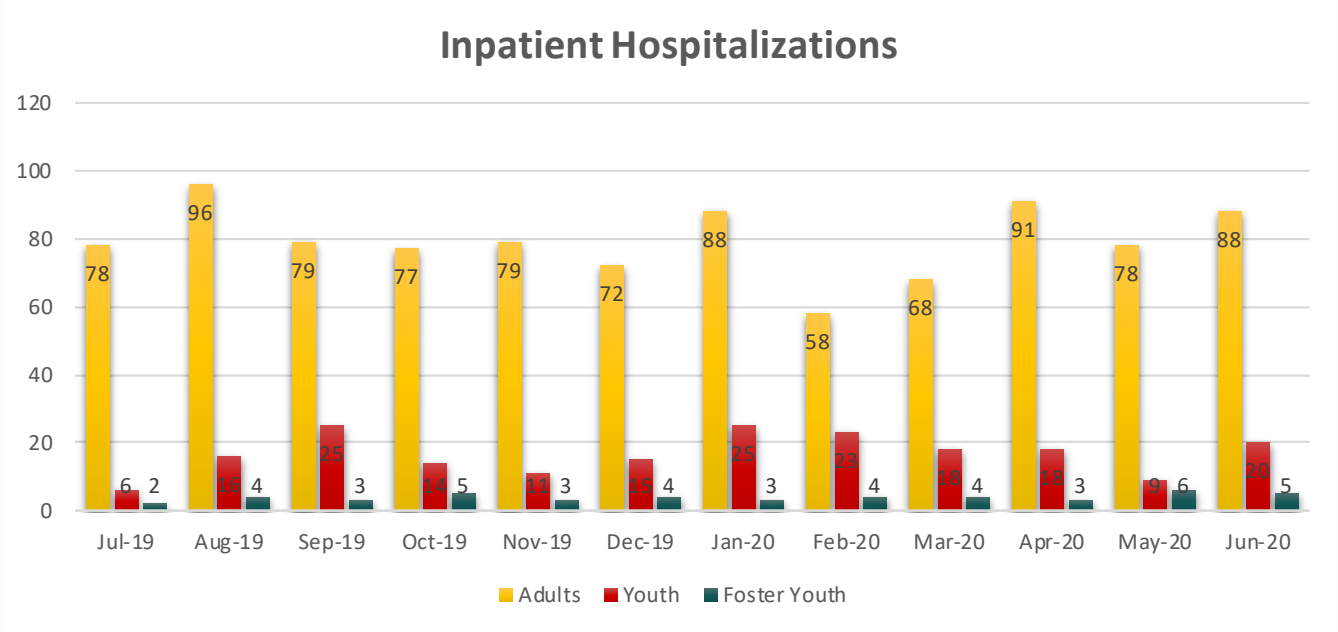
Goal calculation: $\frac{Outpatient\ Service\ Date - Hopital\ Discharge\ Date}{Total\ Post-Hospital\ Services}$

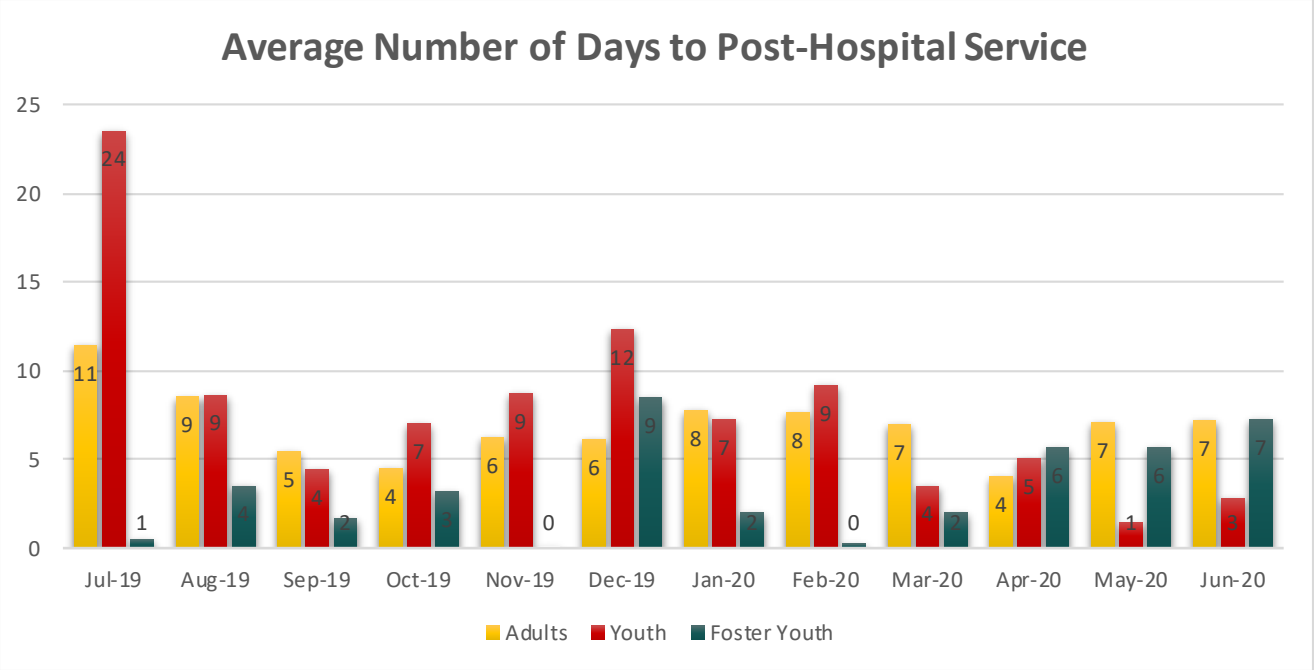
PROCESS USED TO EVALUATE
Inpatient Hospitalization Database
AVATAR Service Data

RESPONSIBLE STAFF – QI Manager and Hospital UR

RESULTS

	All Services	Adult Services	Children's Services	Foster Care
Total number of hospital admissions	1198	953	247	47
Total number of hospital discharges	1156	919	238	46
Number of follow-up appointments within 7 days	610	464	146	39
Length of time for a follow-up appointment after hospital discharge	6.63 days (mean) 3 days (median) 10.28 Std. Dev.	6.82 days (mean) 3 days (median) 10.64 Std. Dev.	6.07 days (mean) 3 days (median) 9.09 Std. Dev.	3.67 days (mean) 1 day (median) 7.28 Std. Dev.
HEDIS Measure Standard	7 days	7 days	7 days	7 days
Percent of appointments that meet this standard	**50.92%**	**48.74%**	**59.35%**	**84.78%**





Overall post-hospital timeliness metrics are good. There are a few outliers in the non-foster youth dataset that skew the average up in July and December. But the overall trend holds steady under the 7 day metric.

STANDARD MET

METRIC 12: 50% of follow-up post-hospital appointments will be scheduled within 7 calendar days of inpatient discharge.

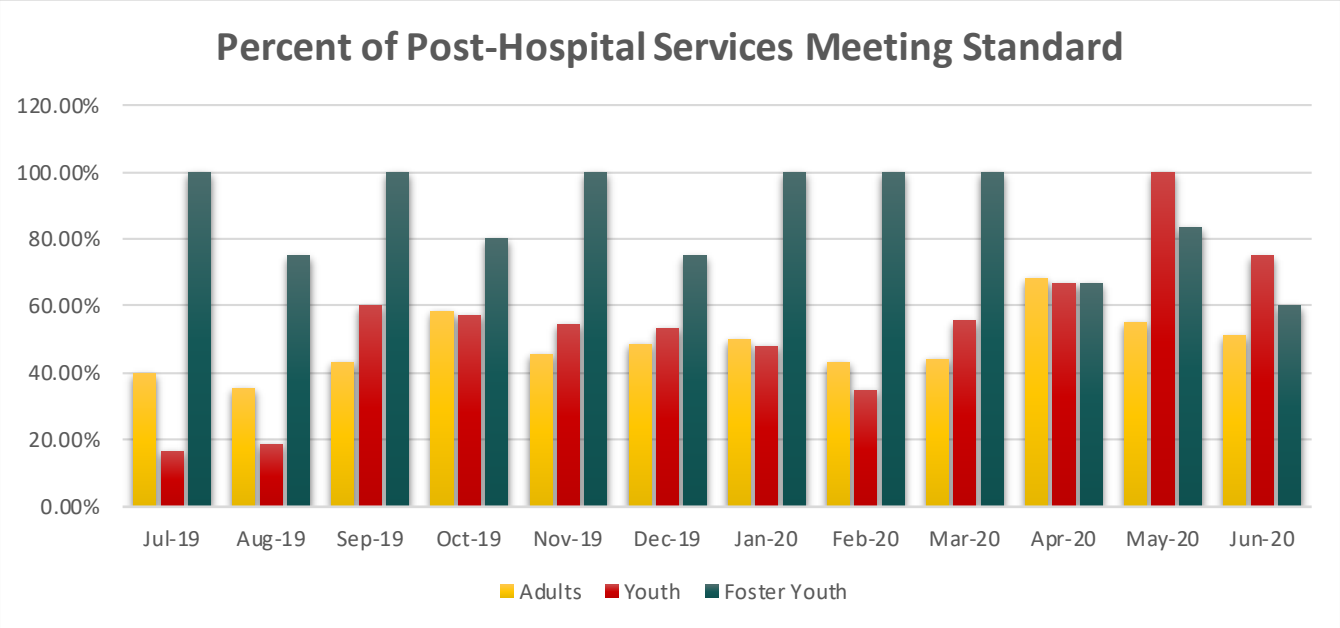
Goal calculation: $\frac{Post-Hospital\ Services\ Under\ 7\ Days}{Total\ Post-Hospital\ Services} * 100\%$

PROCESS USED TO EVALUATE
Inpatient Hospitalization Database
AVATAR Service Data

RESPONSIBLE STAFF – QI Manager and Hospital UR

RESULTS

	All Services	Adult Services	Children's Services	Foster Care
Total number of hospital admissions	1198	953	247	47
Total number of hospital discharges	1156	919	238	46
Number of follow-up appointments within 7 days	610	464	146	39
Percent of appointments that meet this standard	**50.92%**	**48.74%**	**59.35%**	**84.78%**



Of note, 31.78% of hospital admissions for FY 19-20 did not have a follow-up service date due to the client being in one of the following categories:

- Re-hospitalized
- Incarcerated
- Conserved out-of-county
- Declined post-hospital appointment

Overall, DHS-BHD exceeds the State average on this metric, and shows and improving trend throughout the year. Post-hospital timeliness for Foster Youth is excellent.

STANDARD MET

METRIC 13: The 30-day psychiatric inpatient re-admission rate will be 10%or less.

Goal calculation: $\frac{Hospital\ Re{-}Admissions\ Under\ 30\ Days}{Total\ Hospital\ Admissions} * 100\%$

PROCESS USED TO EVALUATE
Inpatient Hospitalization Database

RESPONSIBLE STAFF – QI Manager and Hospital UR

RESULTS

	All Services	Adult Services	Children's Services	Foster Care
Total number of hospital admissions	1198	953	247	47
Total number of hospital discharges	1156	919	238	46
Total number with readmissions within 30 days	164	133	31	11
Readmission Rate	**13.69%**	**13.96%**	**12.55%**	**23.40%**

DHS-BHD has a higher re-admission rate than the State average. Re-admission rates increased compared to the previous year.

STANDARD NOT MET

METRIC 14: The no-show rate for initial assessment appointments will be less than 10%

Goal calculation: $\frac{Assessment\ No{-}Shows}{Total\ Offered\ Assessments} * 100\%$

PROCESS USED TO EVALUATE
Access to MH Services Database

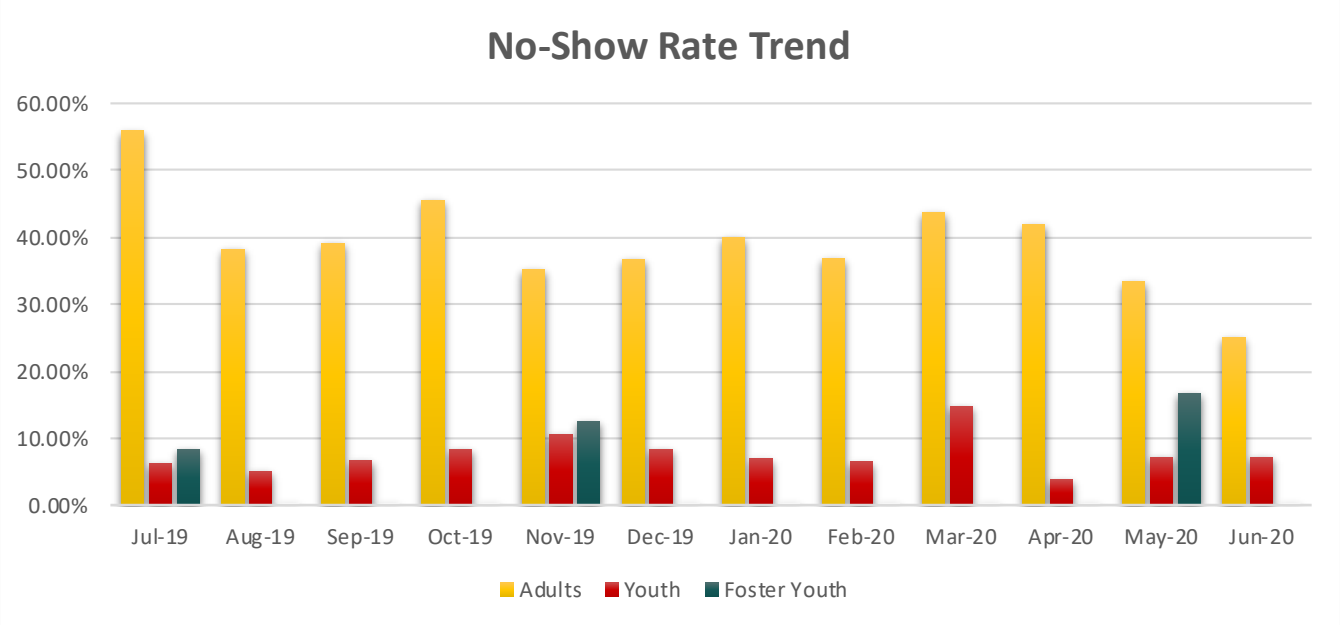
RESPONSIBLE STAFF – QI Manager and Access Manager

RESULTS

Offered Appointment Status	All Services	Adult Services	Children's Services	Foster Care
Accepted	611	313	298	97
Cancelled	92	46	46	4
Declined	21	11	10	4
No-Show	276	250	26	3
Rescheduled	24	2	22	3
Transferred to CSU	8	6	2	0
Total	**1032**	**628**	**404**	**111**
No Show Rate	***26.74%***	***39.81%***	***6.44%***	***2.70%***

No-Show Analysis

Service Category	No-Show Rate	Percent of No-Shows that Attended Later Appointment	Percent of No-Shows that Declined Later Appointment	Percent of No-Shows Unable to Contact
All Services	26.74%	17.39%	6.52%	70.65%
Adult Services	39.81%	14.00%	6.40%	73.60%
Youth Services	6.44%	50.00%	7.69%	34.62%
Foster Care	2.70%	66.67%	33.33%	N/A



No-Show rates are significantly higher in Adult Services than Youth Services. Additionally, the majority of Youth No-Shows attend a subsequent appointment; whereas the majority of Adult No-Shows lose contact with services. However, Adult no-show rates showed an improving trend over the course of the year.

STANDARD NOT MET

METRIC 15: The no-show rate for psychiatry services will be less than 10%

Goal calculation: $\frac{Psychiatry\ No-Shows}{Total\ Psychiatry\ Services} * 100\%$

PROCESS USED TO EVALUATE
AVATAR Service Data

RESPONSIBLE STAFF – QI Manager and Medical Director

RESULTS

	All Services	Adult Services	Children's Services	Foster Care
Average no-show rate for psychiatrists	**8.65%**	**9.89%**	**4.02%**	3.34%

Data reporting accuracy for Psychiatry no-shows has improved considerably, leading to more reliable measures. So while the reported no-show rate increased compared to last year, this is due to improvements in no-show coding. Psychiatry no-show rates are higher in Adult Services than Youth Services. Overall performance on this metric meets the targeted threshold.

STANDARD MET

METRIC 16: The no-show rate for outpatient clinical services other than psychiatry will be less than 10%

Goal calculation: $\frac{Non-Psychiatry\ No-Shows}{Total\ Non-Psychiatry\ Services} * 100\%$

PROCESS USED TO EVALUATE
AVATAR Service Data

RESPONSIBLE STAFF – QI Manager and Adult/Youth Section Managers

RESULTS

	All Services	Adult Services	Children's Services	Foster Care
Average no-show rate for clinicians other than psychiatrists	**1.76%**	**1.59%**	**2.01%**	0.63%

Though these no-show rates are excellent, consistent no-show coding for non-psychiatry is still under reported in the service system. The dataset for this metric may not be reliable.

STANDARD MET

METRIC 17: The MHP will provide Therapeutic Behavioral Services (TBS) at a minimum of a 4% utilization rate of all unique Medi-Cal beneficiaries under the age of 21.

Goal Calculation: $\frac{TBS\ Services\ (Code\ 345\ \&M345)}{Total\ Services\ for\ clients\ under\ 21\ year\ of\ age\ on\ service\ date} * 100\%$

PROCESS USED TO EVALUATE
AVATAR Service Data

RESPONSIBLE STAFF – QI Manager & Youth and Family Section Manager

RESULTS
In FY19-20, DHS-BHD provided 1,722 TBS services at a 3.55% utilization rate for beneficiaries under the age of 21. Services in this category were disrupted by COVID.

STANDARD NOT MET

SECTION 3: BENEFICIARY SATISFACTION

Consumer Perception Surveys: **The MHP collects and submits to DHCS/CIBHS completed Adult, Older Adult, Youth, and Family/Parents of Youth Consumer Perception Satisfaction Survey data during the review period; analyzes the results; and disseminate the results and analysis to DHS-BHD staff and providers**

PROCESS USED TO EVALUATE
Consumer Perception Satisfaction Surveys

RESPONSIBLE STAFF – QI Manager

RESULTS

Each year DHS-BHD, administers the Consumer Perception Survey in May and November. The goal of this survey is to collect data for the federal National Outcome Measures (NOMs) required by the Substance Abuse and Mental Health Services Administration (SAMHSA). Receipt of federal Community Mental Health Services Block Grant funding is contingent upon the submission of this data. Counties are required to conduct the survey and submit data per §3530.40 of Title 9 of the California Code of Regulations. Section 3530.40 of Title 9 of the California Code of Regulations requires that semi-annual surveys be conducted (May and November). However, in November 2019, survey collection was disrupted due to county-wide evacuations during the Kincade Fire.

DHCS has contracted with the California Institute for Behavioral Health Solutions (CIBHS) to scan and process the submitted forms and aggregate the data, once the counties have mailed the surveys. There are a total of four surveys for consumer populations:

- Adults
- Older Adults
- Youth
- Family/Parents of Youth

The surveys contain items in the form of statements that consumers rate. These responses are aggregated into the following categories:

Adults and Older Adults	Youth and Family
General Satisfaction	General Satisfaction
Perception of Access	Perception of Access
Perception of Participation in Treatment Planning	Perception of Participation in Treatment Planning
Perception of Quality and Appropriateness	Perception of Outcomes of Services
Perception of Outcomes of Services	Perception of Social Connectedness
Perception of Social Connectedness	Perception of Cultural Sensitivity
Perception of Functioning	Perception of Functioning

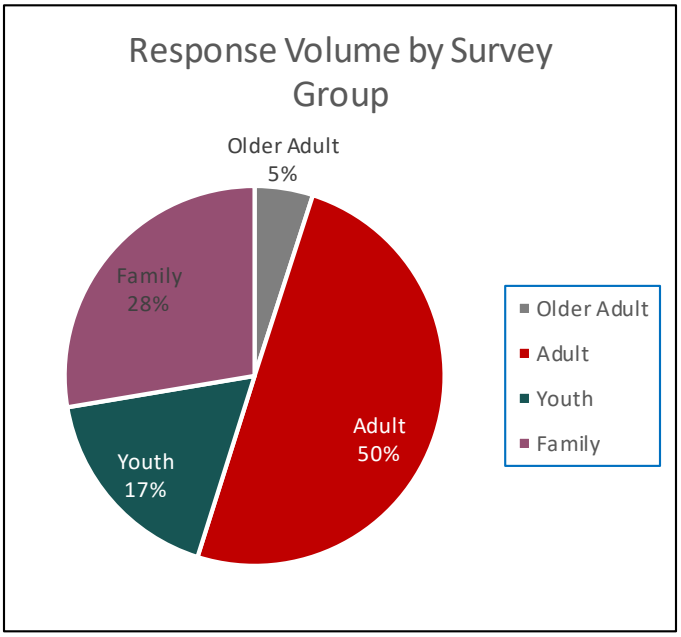
Response Volume

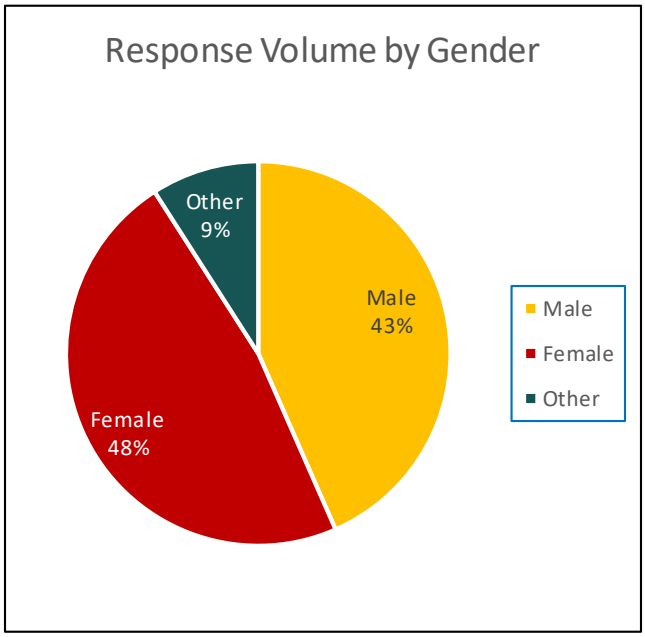
The table below details consumer participation in Sonoma County for calendar year 2019.

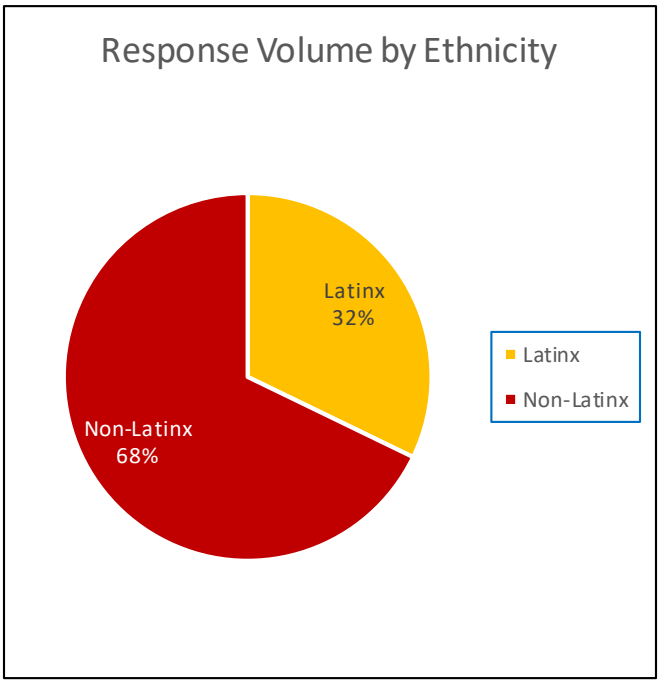
Consumer Population	Items Scored	Survey Participants
Older Adult	36	23
Adult	36	231
Youth	26	81
Family/Parents of Youth	26	128

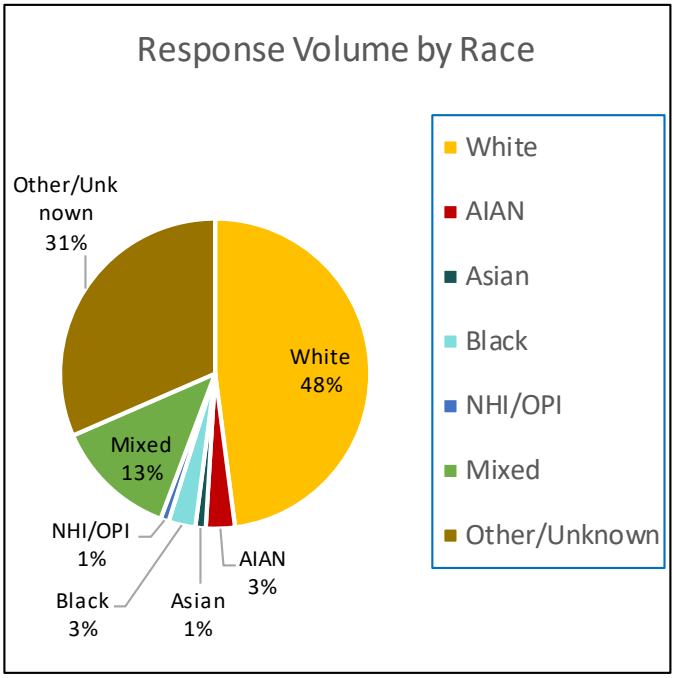
Overall, the number of Surveys collected in 2019 decreased from 2018; however, this decrease is due to the missing November dataset resulting from Kincade Fire. Had the November survey administration proceeded with the same volume as the May administration, then overall response volume would have increased substantially, especially for Older Adults. The response rate from clients/family of Hispanic/Latino ethnicity remained strong.

Response Volume by Category







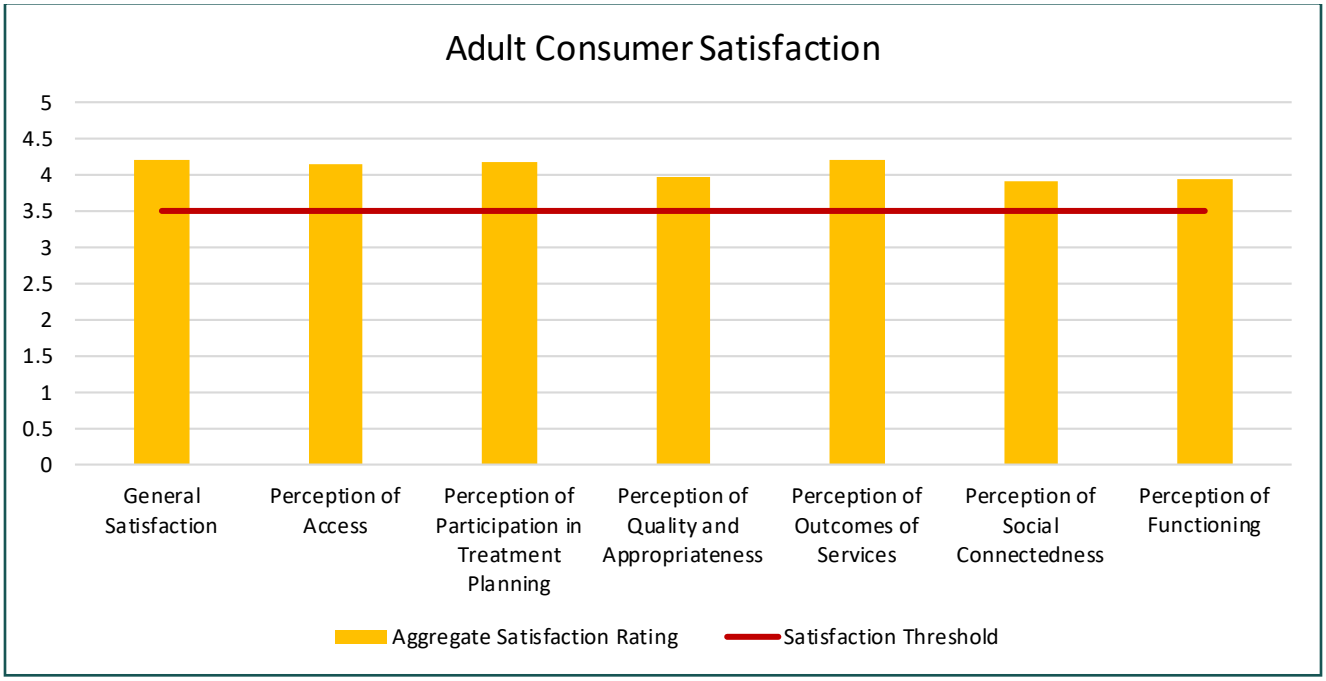


Data Analysis

Overall, 463 Consumer Perception Surveys were collected in calendar year 2019 for Sonoma County Behavioral Health. There are a total of 45 mean scores that are under Satisfaction Threshold. The consumer populations that ranked satisfaction lower than the Satisfaction Threshold and the categories with the under Satisfaction Threshold scores are detailed below.

Adult Consumers

Among adult clients completing the survey, the overall 2019 mean scores were above the satisfaction threshold standard of 3.5. Mean scores decreased slightly for adult males and females. Adult clients identifying as Other Gender scored below the satisfaction threshold on all domains. Whereas clients identifying as Native American, Asian, and Black saw significant improvement in scores from the previous year. However, clients indicating Unknown Ethnicity showed scores below the satisfaction threshold on Outcome, Social Connectedness, and Functioning domains.



Results by Gender

Satisfaction Domain	Male (n=117)	Female (n=98)	Other (n=3)
General Satisfaction	4.19	4.19	3.06
Perception of Access	4.17	4.09	3.56
Perception of Participation in Treatment Planning	4.14	4.26	2.83
Perception of Quality and Appropriateness	4.12	4.25	3.31
Perception of Outcomes of Services	3.95	3.97	3.10
Perception of Social Connectedness	3.92	3.94	2.67
Perception of Functioning	3.96	3.94	3.06

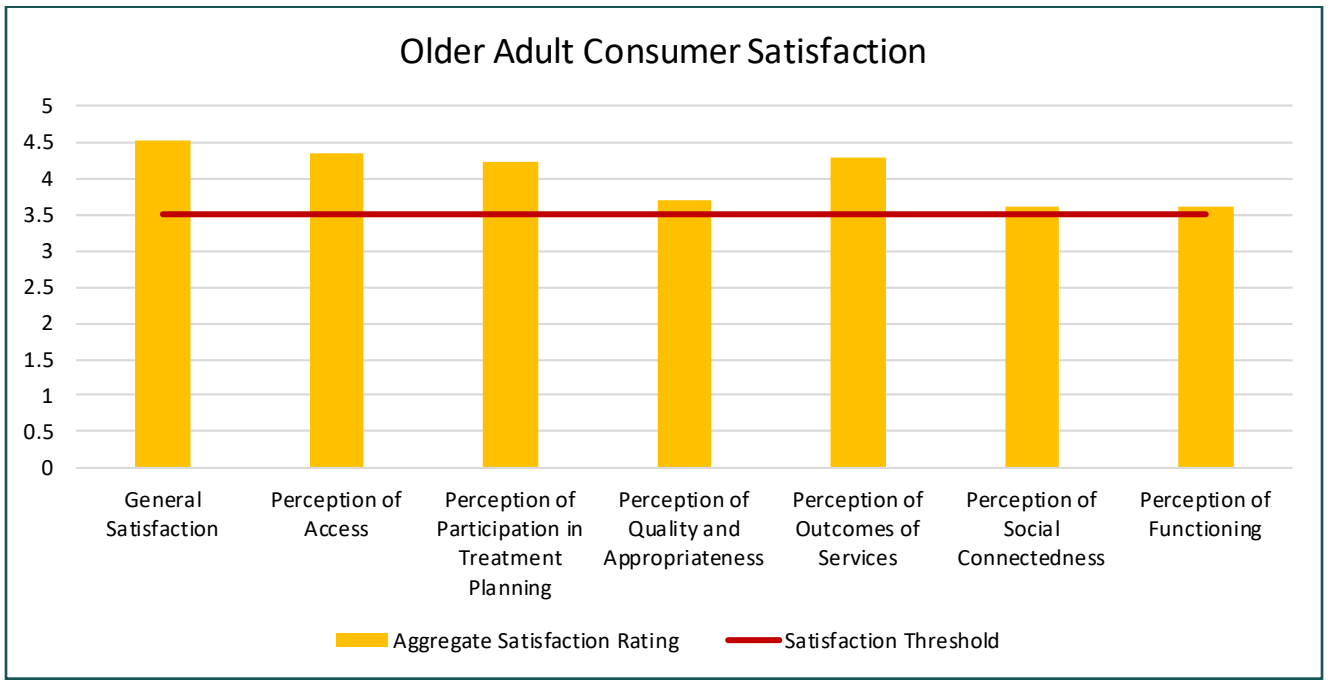
Results by Ethnicity

Satisfaction Domain	White n=164	Latinx n=39	AIAN n=17	Asian n=7	Black n=14	NHI/OPI n=9	Other n=23	Unknown n=13
General Satisfaction	4.17	4.22	4.49	4.43	4.45	4.17	3.95	4.10
Perception of Access	4.09	4.26	4.49	4.21	4.24	4.00	4.03	4.04
Perception of Participation in Treatment Planning	4.13	4.44	4.63	4.71	4.35	4.25	4.33	4.17
Perception of Quality and Appropriateness	4.14	4.40	4.52	4.55	4.29	4.38	4.23	4.10
Perception of Outcomes of Services	3.97	4.05	4.43	4.57	4.24	4.05	3.94	3.47
Perception of Social Connectedness	3.88	4.09	4.58	4.43	4.50	3.97	3.73	3.37
Perception of Functioning	3.96	3.98	4.53	4.62	4.35	4.11	3.86	3.32

Older Adult Consumers

To address the isolation and support concerns identified in the prior year surveys, the Older Adult Team piloted a depression/anxiety treatment and support group in 2019, which received good attendance and favorable consumer response. Overall, mean scores among Older Adults showed significant improvement in 2019. Older Adult Males showed substantial improvement from 2018, however, both males and females still fall below threshold on Perception of Functioning. Older Adult females also report less satisfaction in Social Connectedness.

Older Adult persons of Black Ethnicity showed the highest satisfaction rates overall. Persons of Latinx, Asian, Pacific Islander, and Other Ethnicity reported low satisfaction rates for Outcomes, Social Connectedness, and Functioning domains. Continued efforts to improve social connection are warranted.



Results by Gender

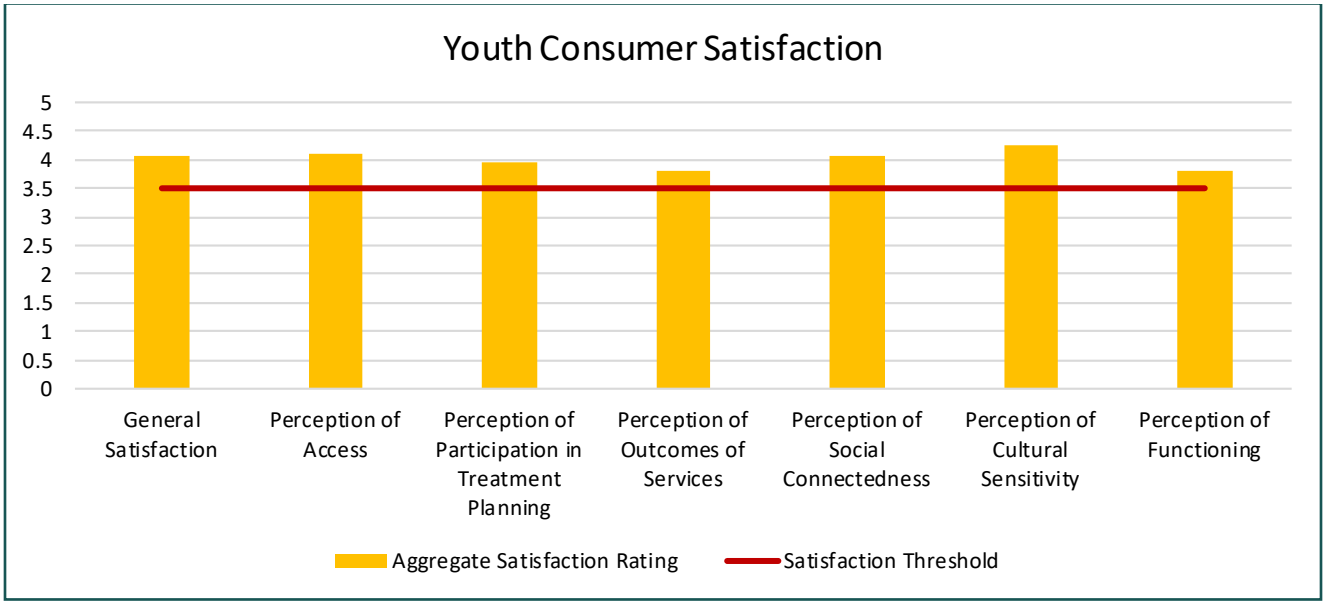
Satisfaction Domain	Male (n=8)	Female (n=12)	Other (n=0)
General Satisfaction	4.50	4.49	N/A
Perception of Access	4.25	4.38	N/A
Perception of Participation in Treatment Planning	4.21	4.27	N/A
Perception of Quality and Appropriateness	3.95	4.26	N/A
Perception of Outcomes of Services	3.69	3.69	N/A
Perception of Social Connectedness	3.66	3.58	N/A
Perception of Functioning	3.58	3.58	N/A

Results by Ethnicity

Satisfaction Domain	White n=15	Latinx n=3	AIAN n=0	Asian n=1	Black n=2	NHI/OPI n=1	Other n=4	Unknown n=1
General Satisfaction	4.41	4.67	N/A	4.00	4.83	4.33	4.50	4.50
Perception of Access	4.23	4.67	N/A	3.33	4.50	4.00	4.38	4.33
Perception of Participation in Treatment Planning	4.23	4.17	N/A	4.00	4.50	4.50	3.88	5.00
Perception of Quality and Appropriateness	3.98	4.63	N/A	3.63	4.50	3.67	4.32	4.78
Perception of Outcomes of Services	3.69	3.07	N/A	3.13	4.25	3.00	2.80	4.88
Perception of Social Connectedness	3.53	3.58	N/A	2.50	4.25	3.00	3.38	4.75
Perception of Functioning	3.53	3.27	N/A	3.00	4.40	3.20	3.25	4.60

Youth Consumers

For Youth, all domains showed mean scores higher than the satisfaction threshold of 3.5. This parallels the same level of high satisfaction in 2018. Youth identified as Other Gender reported scores below threshold for Outcomes and Functioning. For Youth of Native American ethnicity, mean scores fell below the satisfaction threshold on almost all domains. However, scores for Cultural Sensitivity were very high across all ethnicities.



Results by Gender

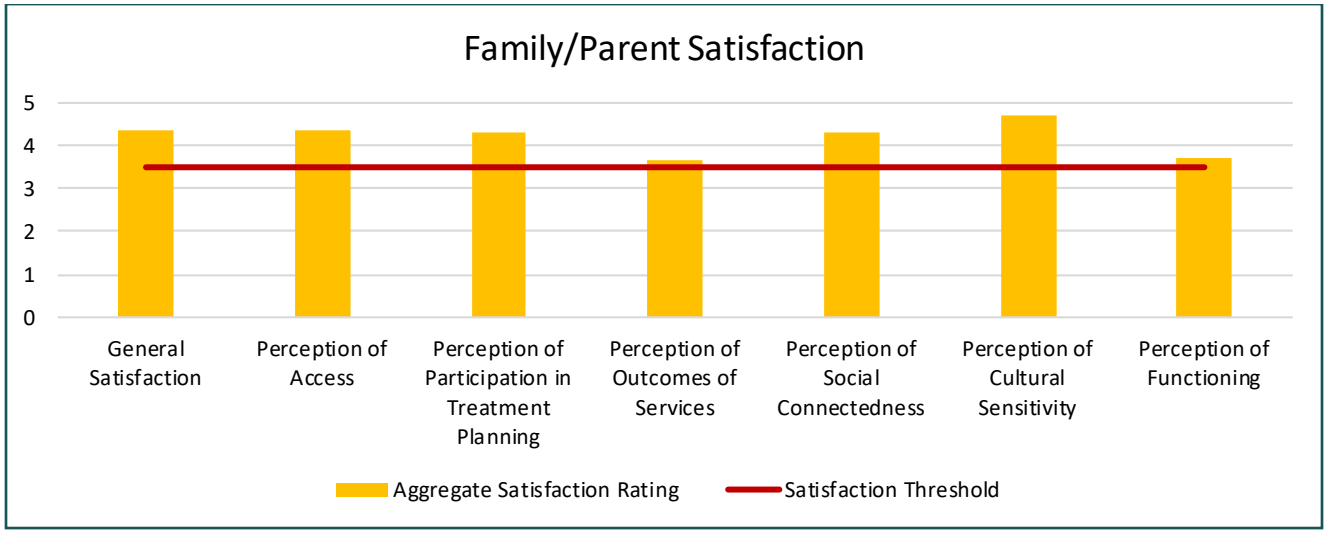
Satisfaction Domain	Male (n=27)	Female (n=41)	Other (n=4)
General Satisfaction	3.98	4.14	4.13
Perception of Access	3.88	4.28	4.00
Perception of Participation in Treatment Planning	3.74	4.09	4.00
Perception of Outcomes of Services	3.86	3.78	3.46
Perception of Social Connectedness	4.04	4.07	4.00
Perception of Cultural Sensitivity	4.15	4.33	4.19
Perception of Functioning	3.85	3.78	3.58

Results by Ethnicity

Satisfaction Domain	White n=32	Latinx n=38	AIAN n=11	Asian n=3	Black n=7	NHI/OPI n=1	Other n=22	Unknown n=6
General Satisfaction	4.25	4.14	3.59	4.17	4.11	4.83	4.01	4.06
Perception of Access	4.20	4.29	3.59	3.67	4.00	4.50	3.95	4.50
Perception of Participation in Treatment Planning	4.07	4.05	3.53	3.78	3.93	4.33	3.84	3.78
Perception of Outcomes of Services	3.87	3.76	3.47	3.72	3.57	4.83	3.66	3.95
Perception of Social Connectedness	4.42	4.15	3.82	3.72	4.27	5.00	4.27	4.00
Perception of Cultural Sensitivity	4.44	4.26	4.40	4.67	4.63	4.34	4.48	4.47
Perception of Functioning	3.89	3.74	3.38	3.72	3.60	4.83	3.66	3.93

Family/Parents of Youth Consumers

Overall Family Satisfaction also scored above the threshold standard of 3.5, with an excellent response rate compared to total clients served. Parents of Other Gender Youth reported lower satisfaction for Outcomes, Functioning, and General Domains; however, they reported highest satisfaction on Cultural Sensitivity. Mean scores for Outcomes and Functioning showed scores below satisfaction threshold for Native Americans and Other Ethnicity. However, Cultural Sensitivity scores were extremely high across all Ethnicities. Of the four survey types, the Family/Parent group had the highest overall ratings. The lower scores in Outcomes and Function indicate reporting of challenges with their Youth, but satisfaction of the quality of services delivered.



Results by Gender

Satisfaction Domain	Male (n=49)	Female (n=69)	Other (n=2)
General Satisfaction	4.42	4.34	3.25
Perception of Access	4.42	4.32	4.25
Perception of Participation in Treatment Planning	4.38	4.28	4.17
Perception of Outcomes of Services	3.81	3.60	3.08
Perception of Social Connectedness	4.29	4.33	4.13
Perception of Cultural Sensitivity	4.75	4.66	5.00
Perception of Functioning	3.82	3.63	3.08

Results by Ethnicity

Satisfaction Domain	White n=61	Latinx n=69	AIAN n=14	Asian n=6	Black n=13	NHI/OPI n=0	Other n=28	Unknown n=2
General Satisfaction	4.32	4.35	4.30	4.28	4.49	N/A	4.15	4.42
Perception of Access	4.34	4.41	4.36	4.40	4.00	N/A	4.30	4.50
Perception of Participation in Treatment Planning	4.33	4.26	4.17	4.44	4.46	N/A	4.21	4.00
Perception of Outcomes of Services	3.66	3.61	3.52	3.77	3.69	N/A	3.48	3.08
Perception of Social Connectedness	4.30	4.28	4.58	4.17	4.44	N/A	4.30	4.38
Perception of Cultural Sensitivity	4.71	4.67	4.85	4.79	4.80	N/A	4.65	5.00
Perception of Functioning	3.67	3.62	3.46	3.77	3.68	N/A	3.48	3.08

Summary and Recommendations

Survey results improved significantly in the Adult and Older Adult populations, while remaining high in the Youth and Family populations.

The following identified areas of concern may warrant staff development training:

- Adult Non-Binary/Other Gender Populations
- Native American Youth Populations

The following areas of concern may warrant programmatic clinical intervention:

- Older Adult Clinical Outcomes
- Older Adult Social Connectedness
- Older Adult Functional Skill Interventions
- Native American Youth Clinical Outcomes
- Native American Youth Functional Skill Interventions

Grievances: 100% of client grievances will be decided upon and communicated back to the client within 90 days of receiving the grievance.

Goal Calculation: $\frac{Grievances\ Resolved\ under\ 90\ days}{Number\ of\ Grievances} * 100\%$

PROCESS USED TO EVALUATE
- Grievance Database
- ABGAR

RESPONSIBLE STAFF – QA Manager and Grievance Coordinators

RESULTS

Access Category	Grievance	Exempt Grievance	Pending Resolution	Resolved	Referred
Service not available	3	0	0	3	0
Service not accessible	2	0	0	1	0
Timeliness of services	5	0	0	5	0
24/7 Toll-free access line	0	0	0	0	0
Linguistic services	0	0	0	0	0
Other access issues	1	0	0	1	0
Total	**10**	**0**	**0**	**10**	**0**

Quality of Care Category	Grievance	Exempt Grievance	Pending Resolution	Resolved	Referred
Staff behavior concerns	16	2	1	17	0
Treatment issues or concerns	9	2	0	8	3
Medication concern	7	1	1	7	0
Cultural appropriateness	3	0	0	0	3
Other quality of care issues	8	3	0	11	0
Total	**43**	**8**	**2**	**43**	**6**

Other Category	Grievance	Exempt Grievance	Pending Resolution	Resolved	Referred
Financial	3	0	0	1	2
Lost Property	3	0	2	1	0
Operational	1	0	0	1	0
Patients' rights	6	0	0	1	5
Peer behaviors	3	0	0	1	2
Physical environment	2	0	0	1	1
Other not listed above	3	0	0	3	0
Total	**21**	**0**	**2**	**9**	**10**

Confidentiality Concerns: None filed.

Number of grievances = 82, Resolved over 90 days = 2, Resolved under 90 days = 80.

80/82 or 97.6% of grievances were decided and communicated back to the client within 90 days of receiving the grievance.

TARGET PARTIALLY MET

Appeals: **100% of client/family outpatient appeals will be decided upon and communicated back to the client within 60 days of receiving the appeal.**

Goal Calculation: $\frac{Appeals\ Resolved\ under\ 60\ days}{Number\ of\ Appeals} * 100\%$

PROCESS USED TO EVALUATE
Grievance and Appeals Database
AVATAR NOABD Data

RESPONSIBLE STAFF – QA Manager

RESULTS

NOABD Category	NOABDs Issued	Appeal	Expedited Appeal	Pending Resolution	Decision Upheld	Decision Overturned
Denial Notice	56	1	0	0	1	0
Payment Denial Notice	164	1	0	0	0	1
Delivery System Notice	34	0	0	0	0	0
Modification Notice	2	0	0	0	0	0
Termination Notice	2	0	0	0	0	0
Authorization Delay Notice	98	0	0	0	0	0
Timely Access Notice	83	0	0	0	0	0
Financial Liability Notice	0	0	0	0	0	0
Grievance & Appeal Timely Resolution Notice	1	0	0	0	0	0
Total	**440**	**2**	**0**	**0**	**1**	**1**

Number of appeals = 2, Resolved over 60 days = 0, Resolved under 60 days = 2.

2/2 or 100% of appeals were decided and communicated back to the client within 60 days of receiving the grievance.

TARGET MET

STATE FAIR HEARINGS: **100% of client fair hearing results will be evaluated and if issues are identified, they will be addressed within 60 days of the fair**

PROCESS USED TO EVALUATE
- Grievance and Appeals Database

RESPONSIBLE STAFF – QA Manager and Grievance Coordinators

RESULTS

1 State Fair Hearing was conducted in FY19-20. All issues identified were addressed within 60 days of the fair hearing results.

TARGET MET

CHANGE OF PROVIDER REQUESTS: **100% of client requests to change persons providing services will be evaluated and addressed within 30 days of the request.**

Goal Calculation: $\frac{Change\ of\ provider\ requests\ address\ within\ 30\ days}{Number\ of\ Change\ of\ provider\ requests} * 100\%$

PROCESS USED TO EVALUATE
- Request for Change of Provider Database

RESPONSIBLE STAFF – QA Manager and Grievance Coordinators

RESULTS

There were 46 Requests for Change of Provider received in FY19-20.

41/46 or 89.13% of requests to change persons providing services were evaluated and addressed within 30 days of the request. This is a decline from the previous fiscal year.

TARGET NOT MET

SECTION 4: QUALITY GOALS PROGRESS EVALUATION

ACCESS GOAL 1: **DHS-BHD develops and maintains an adequate provider network to ensure provision of timely, appropriate, and quality care within the reasonable capacity of the service system**

OBJECTIVE 1.1: **At each quarterly Network Adequacy certification, DHS-BHD will meet the provider-beneficiary ratio standards identified by DHCS**

Goal Calculation: $\frac{Actual\ MHP\ Network\ FTE}{DHCS\ Target\ Network\ FTE} * 100\%$

PROCESS USED TO EVALUATE
Network Adequacy Certification Tool

RESPONSIBLE STAFF – Division Leadership (Recruitment & Structural Changes) & QI Manager (Data Tracking/Monitoring)

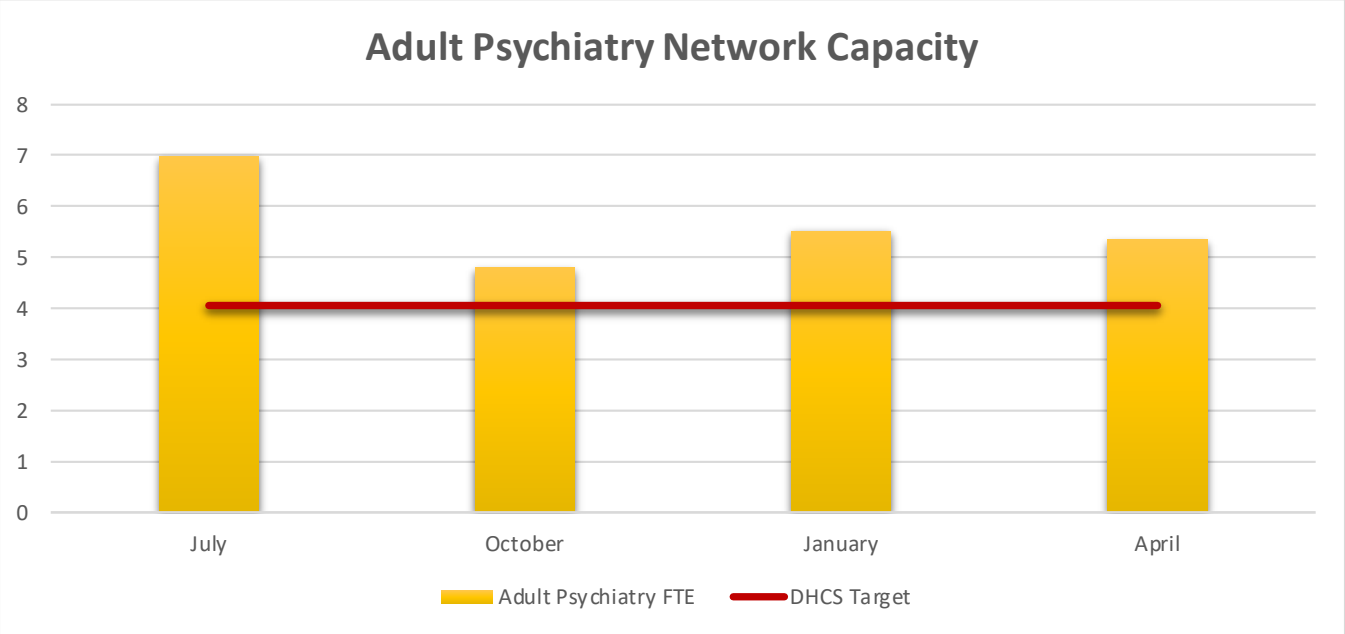
ACTION STEPS STATUS UPDATE

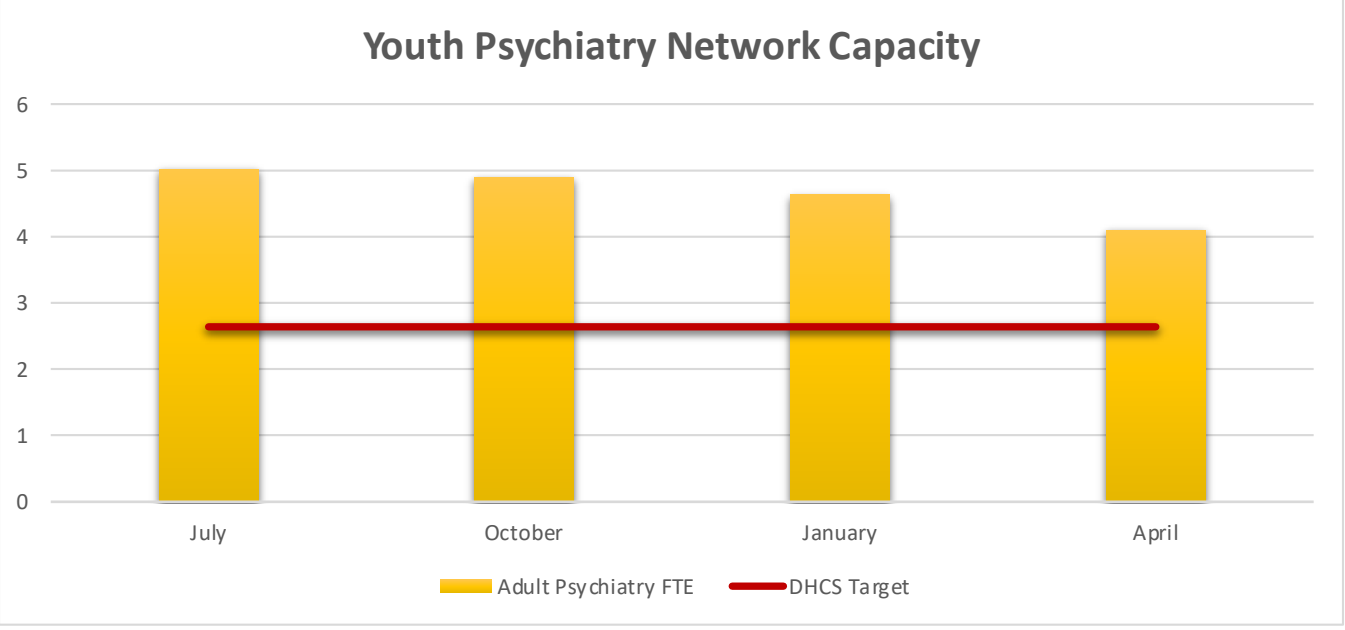
Key Activity	Update	Status
Prioritize staffing recruitments for direct service programs	The Admin Program Support Unit of DHS-BHD recruited for and filled 97 positions in FY19-20 for multiple levels of staffing in both Mental Health services and Substance Use Disorder services; of these recruitments, 40 staff positions were allocated for direct outpatient mental health services (excludes Crisis Stabilization Unit, In-Custody programs, and Diversion programs); this results in 35.90 FTE plus 3 Extra Help FTE fulfilled in direct service programs	**Complete**
Maximize contract site capacity through competitive procurement	The youth services system RFP cycle was completed and contracts executed	**Complete**
Expand the student-intern and peer-provider pipeline programs	The number of participating Universities increased to 16; a Nurse Practitioner pathway was added to the pipeline program; implementation began on a peer-provider fieldwork pathway through the CSU	**In Progress (90%)**
Enhance the Adult and Youth Access Teams	The Adult Access Walk-In Clinic was fully implemented; the Youth Access team implemented direct call-intake and expanded staffing	**Complete**
Streamline the integration of the multi-service HUB	The Adult Services Team expanded staffing and added grad student pipelines; the Buckelew partnership with CTRT was implemented	**Complete**
Right-size caseloads on Full Service Partnership Teams	Staffing expanded on the FSP teams and caseloads were redistributed	**Complete**
Consolidate Provider Network data tracking into a centralized database	A Network Provider Access Database was designed and implemented; historic and current state data collection completed and validated	**Complete**

RESULTS

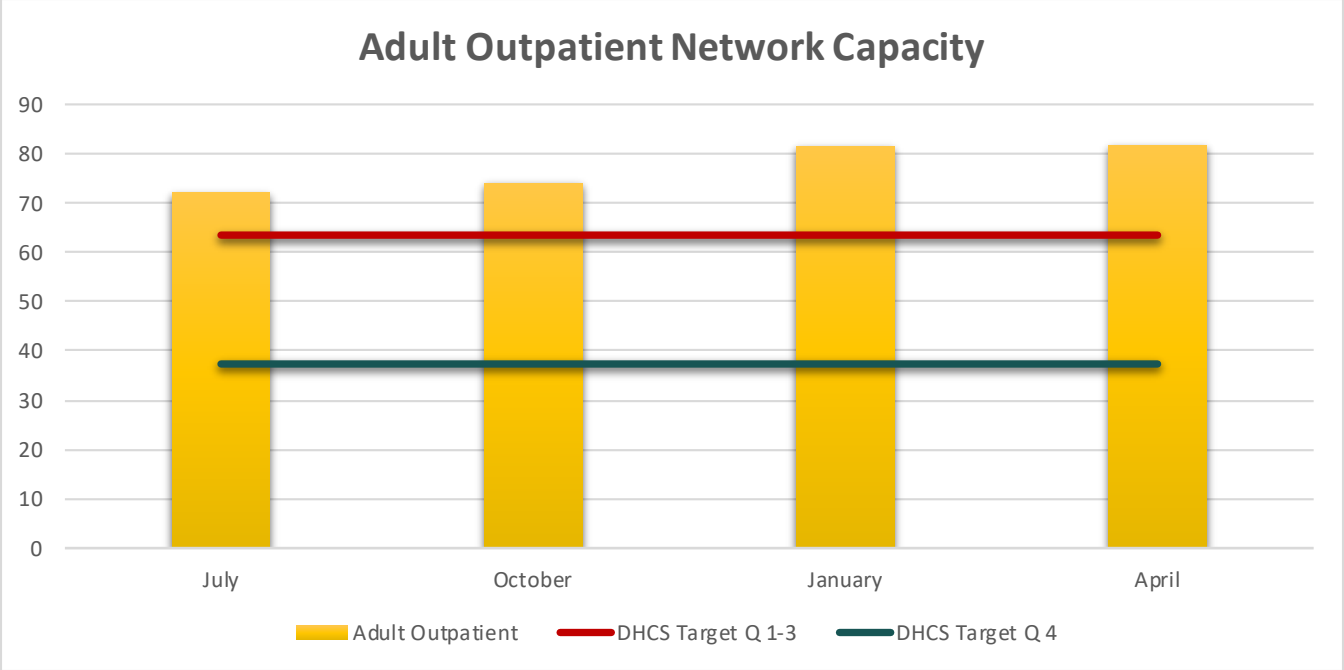
NACT Category	DHCS Target Q 1-3	DHCS Target Q4	July 2019	Oct 2019	Jan 2020	Apr 2020
Adult Psychiatry	4.06 FTE	4.06 FTE	6.99 FTE	4.80 FTE	5.52 FTE	5.35 FTE
Youth Psychiatry	2.64 FTE	2.64 FTE	5.02 FTE	4.90 FTE	4.63 FTE	4.10 FTE
Adult Outpatient	63.49 FTE	37.35 FTE	72.15 FTE	74.03 FTE	81.56 FTE	81.76 FTE
Youth Outpatient	98.03 FTE	68.39 FTE	116.38 FTE	102.90 FTE	98.10 FTE	97.07 FTE

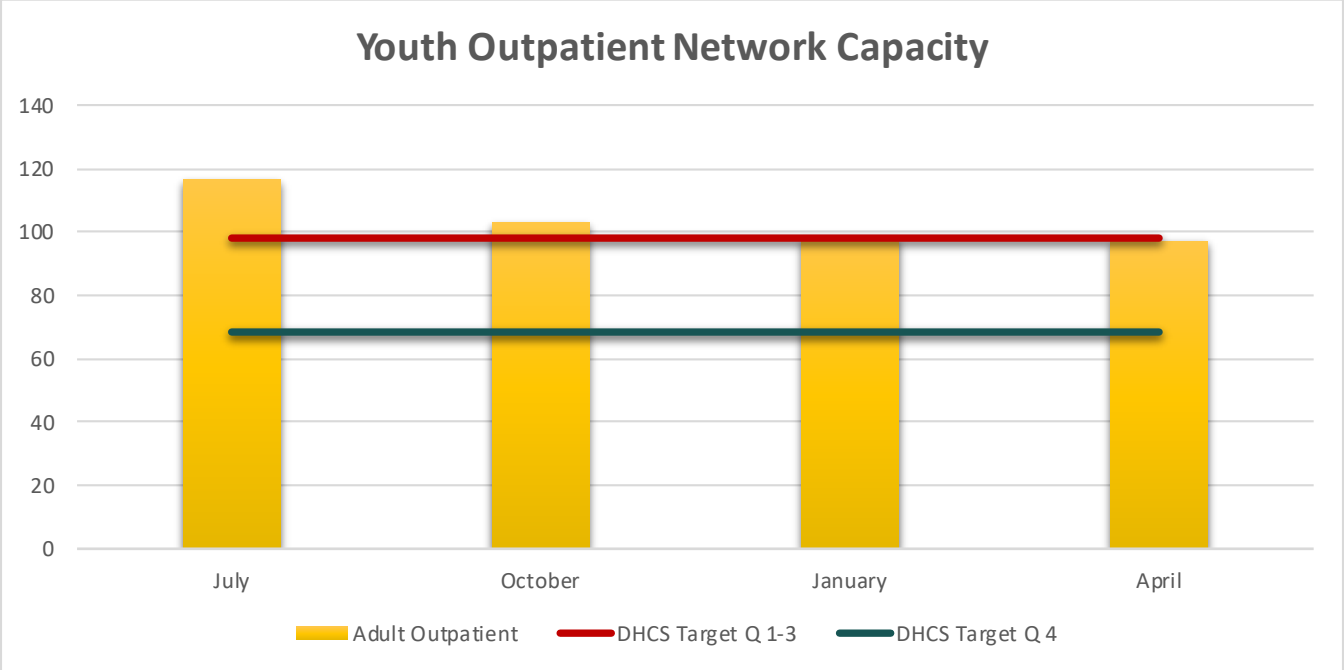
Of note: DHCS lowered the outpatient target FTE for the April NACT submission. DHS-BHD exceeded the target for all submissions. The following charts indicate network trends.





At the April submission, Adult Psychiatry was at 132% of target capacity and Youth Psychiatry was at 155% of target capacity. Adult Psychiatry showed an initial drop between first and second quarter, but ended the fiscal year on an upward trend. Youth Psychiatry is showing a slight downward trend, however.





At the April submission, Adult Outpatient was at 219% of target capacity and Youth Outpatient was at 142% of target capacity. Adult Outpatient capacity is trending upward; however, Youth Outpatient capacity trended downward. This was due to an initial change in the number of contract site providers in the youth system. Of note, in FY 20-21, Youth Outpatient staffing recruitments continue to be prioritized as youth contract sites expand to target capacity.

Overall, each quarterly submission met the target FTE requirements for all provider categories.

GOAL MET

ACCESS GOAL 2: **DHS-BHD provides culturally responsive services, ensuring equal access for all cultures and demonstrating parity in mental health services for all cultures**

OBJECTIVE 2.1: **During FY 19-20, schedule and facilitate 4 Cultural Responsiveness Committee Meetings**

PROCESS USED TO EVALUATE
Cultural Responsiveness Committee Schedule

RESPONSIBLE STAFF – Ethnic Services Manager

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Define roles and responsibilities	In August of 2019, DHS-BHD appointed a new Ethnic Services Manager to identify strategies and efforts for reducing racial, ethnic, cultural and linguistic mental health disparities; in May of 2020, DHS-BHD initiated a recruitment for a Clinical Specialist to take on the roles of ESM and Workforce Education and Training Coordinator	**Complete**
Recruit and select participants	In January 2020 an application to serve on the CRC was disseminated to staff, contract providers, stakeholders and the community; DHS-BHD received 20 applications in the first quarter of 2020; in March 2020 twelve new members were selected from the applicants based on diversity, experience and representation of unserved/underserves populations	**Complete**
Develop planning agenda	The CRC planning group reconvened in October 2019 and established CRC goals, strategies and schedule	**Complete**
Schedule meetings	The first CRC meeting was held in October 2019, with follow-up meeting scheduled in November; however, due to the Kincade Fire and evacuations, the meeting was cancelled; a subsequent meeting was scheduled in April 2020 with the newly recruited members, but had to be cancelled due to the COVID pandemic; virtual CRC meetings are now scheduled and proceeding for FY 20-21	**In Progress (75%)**

RESULTS

Four CRC meetings were scheduled for FY 19-20, but only one meeting was held due to disruptions caused by the Kincade Fire evacuations, several Public Safety Power Shut-Offs, and the COVID pandemic. Virtual meetings have now been implemented for FY 20-21.

GOAL NOT MET

OBJECTIVE 2.2: **During FY 19-20, provide at least two mandatory staff training opportunities on Cultural Competence topics, in which Training Evaluation scores surpass a minimum satisfaction threshold of 4.00**

PROCESS USED TO EVALUATE
Staff Training Evaluation Aggregate and Item Scores
Staff Training Schedule

RESPONSIBLE STAFF – Ethnic Services Manager & Workforce Education and Training Coordinator

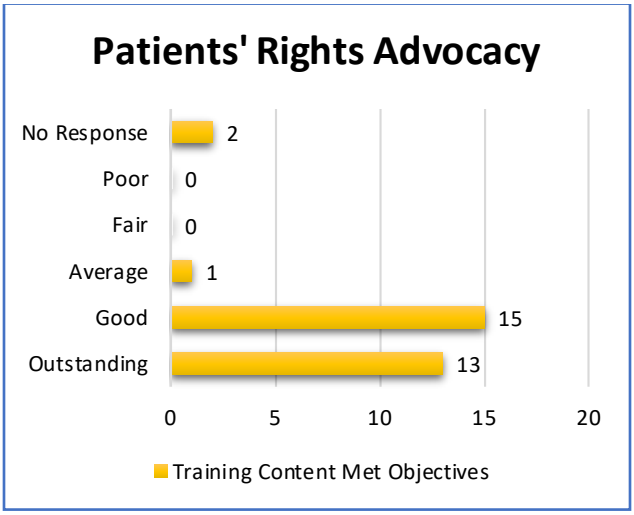
ACTION STEPS STATUS UPDATE

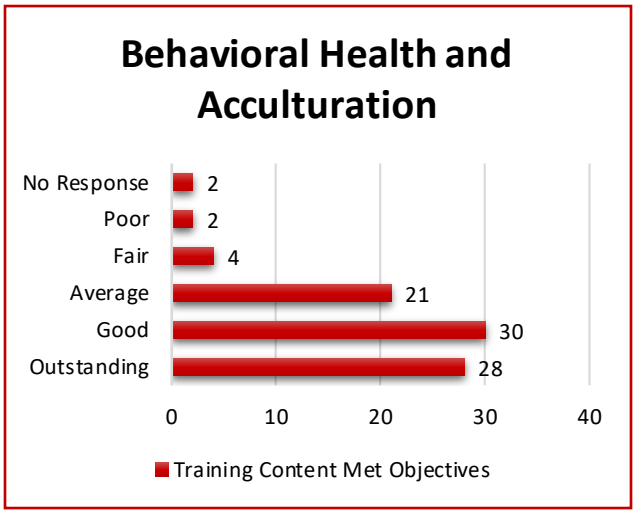
Key Activity	Update	Status
Identify cultural responsiveness gaps from Consumer Perception Survey results	Gaps identified in Older Adult male population and also in Adult Other Gender population	**Complete**
Identify staff knowledge gaps from Cultural Responsiveness Survey	Gaps identified in training levels on UndocuTrauma, Latinx, and LGTBQ populations	**Complete**
Select and schedule applicable topics	Four Cultural Responsiveness trainings were scheduled in FY 19-20, however two were cancelled due to COVID	**Complete**

RESULTS

Of Note: A new Staff Cultural Responsiveness Survey is scheduled for FY 20-21.

	Date	Training	Facilitated by
1	7/3/2019	Patients' Rights Advocacy: History, Process and Resources	Bill SmithWaters, Frank SmithWaters
3	3/11/2020	Behavioral Health and Acculturation	Yatiel Owens, Jessica Hetherington
4	5/13/2020	LGBTQ	Cancelled due to COVID
5	6/10/2020	Peer Panel	Cancelled due to COVID





Satisfaction rating: Patients' Rights Advocacy = 4.41; Behavioral Health and Acculturation = 3.91, which is below minimum threshold.

GOAL PARTIALLY MET

OBJECTIVE 2.3: **Increase the percentage of Latino/Hispanic clients served to meet/exceed 27%(Sonoma County population statistic)**

Goal Calculation: $\frac{Unique\ Latinx\ Beneficiaries\ Served}{Total\ Unique\ Beneficiaries\ Served} * 100\%$

PROCESS USED TO EVALUATE
AVATAR Demographic Data

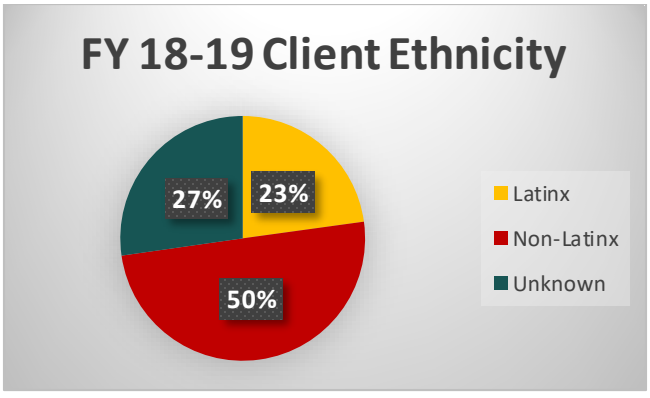
RESPONSIBLE STAFF – Ethnic Services Manager (Planning) & QI Manager (Data Analytics)

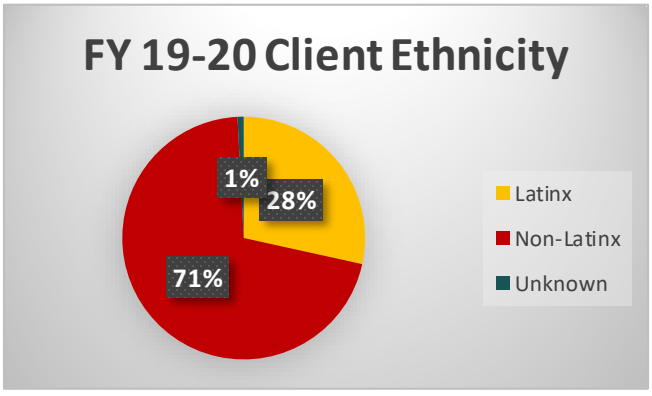
ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Engage PDSA process to analyze low penetration rates	An extensive data analysis of ethnic services was initiated and shared with the Ethnic Services Manager and QIC; a potential systemic implicit-bias Access barrier was identified; a Non-Clinical PIP is now in development to examine root cause and address the identified issues; details of the data analysis are included in the Cultural Competence Plan	**In Progress (80%)**
Continue to remediate CSI data issues	The UR Manager implemented monthly CSI data checking through the Clinical Specialist workgroup; the QI Team data remediation of the FY 19-20 demographic dataset reduced the percentage of unknown/not-reported ethnicity from 27% in FY 18-19 to 0.8% in FY 19-20	**Complete**
Recruit/retain bilingual/bicultural staff	The Admin Program Support Unit of DHS-BHD successfully recruited and filled bilingual staff positions on both the Adult and Youth Access teams	**Complete**

RESULTS

Current population demographics indicate that 27% of Sonoma County residents identify as Latinx; however, DHCS Medi-Cal eligibility data indicates that 42% of Sonoma County Medi-Cal eligible residents identify as Latinx. DHS-BHD served 3543 unique clients in FY 19-20. 1008 unique clients identified as Latinx. 2506 unique clients identified as non-Latinx. 29 unique clients had unknown ethnic identity.





This represents a 5% increase from FY 18-19, which exceeds the general population metric and meets the current goal; however, this goal will be re-focused next year on the Medi-Cal population demographics.

GOAL MET

TIMELINESS GOAL 3: **DHS-BHD ensures timely access to high quality, culturally sensitive services for individuals and their families**

OBJECTIVE 3.1: **(Non-Clinical PIP) By January 15, 2020, the monthly average for initial assessment appointments offered within the 10 business day standard will increase to 70% and remain at this level or better for the remainder of FY 19-20**

Goal calculation: $\frac{Assessment\ Offers\ Under\ 10\ B.Days}{Total\ Offered\ Assessments} * 100\%$

PROCESS USED TO EVALUATE
Access to MH Services Database

RESPONSIBLE STAFF – Access Team Leadership (System Implementation) & QI Manager (Data Analytics)

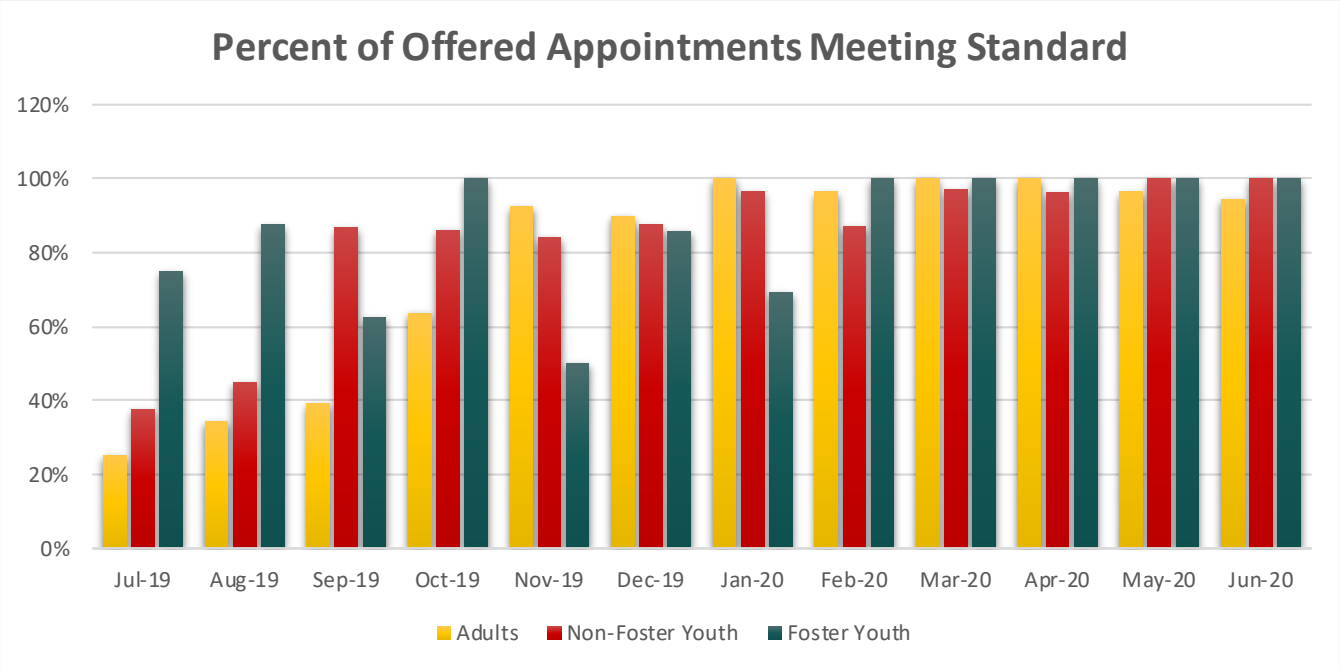
ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Fully staff adult and youth access teams	Both Adult and Youth Access teams increased staffing	**Complete**
Transfer Access Team caseloads to Service Teams	Access Team caseloads have been greatly reduced with transfer times averaging 1-2 months	**Complete**
Route Youth requests directly to Youth Access Team	The ACD line calls for youth request for service are now transferred directly to the Youth Access Team	**Complete**
Replace lengthy CANS/ANSA screening tools with brief Beacon screening tools	The Beacon screening tool was implemented in place of the CANS/ANSA screening tool	**Complete**
Transfer Access Line business hours and after hours call center to OPTUM contract	Optum declined to contract for this service; Access Team re-configured to include dedicated Screen Team	**Cancelled**
Provide Trauma-Informed assessment training to Access Team staff	Curriculum selected; however, the training schedule was disrupted by COVID; a planning meeting is scheduled with the Adult and Youth Access Teams to re-initiate the training plan	**In Progress (50%)**
Streamline and consolidate timeliness data tracking into the Electronic Health Record	Workflow mapping is complete; the timeliness tracking form has been implemented in AVATAR; next steps: 1) the migration of historical data; 2) training of Access Teams on new workflow; 3) implement on go-live date	**In Progress (75%)**
Implement daily walk-in clinic hours to offer next-day appointments	Walk-In Clinic established and fully implemented at Access Team	**Complete**

RESULTS

The following charts depict the monthly percentage of offered assessment appointments meeting the 10 business day standard.

Month of Request	All Beneficiaries	Adults	Youth	Foster Youth
July 2019	33.33%	25.00%	53.57%	75.00%
August 2019	40.38%	34.21%	57.14%	87.50%
September 2019	58.33%	39.13%	81.58%	62.50%
October 2019	75.86%	63.64%	88.37%	100.00%
November 2019	86.42%	92.59%	74.07%	50.00%
December 2019	88.75%	89.80%	87.10%	85.71%
January 2020	94.85%	100.00%	88.10%	69.23%
February 2020	94.06%	96.49%	90.91%	100.00%
March 2020	98.97%	100.00%	97.62%	100.00%
April 2020	98.53%	100.00%	97.30%	100.00%
May 2020	97.40%	96.49%	100.00%	100.00%
June 2020	96.67%	94.44%	100.00%	100.00%
Overall Percentage	***78.78%***	***74.52%***	***85.40%***	***85.59%***



By January of 2020, the monthly average of offered assessment appointments which met the 10 business day standard increased to 94% and remained at this level or better for the remainder of the year.

GOAL MET

QUALITY OF CARE GOAL 4: **DHS-BHD designs quality services that are informed by and responsive to consumer feedback**

OBJECTIVE 4.1: **During FY 19-20, implement and facilitate at least 2 cycles of a 6-week Depression/Anxiety treatment group for Older Adults (one for men; one for women)**

PROCESS USED TO EVALUATE
Treatment Group Proposal Plan
Attendance Sheets

RESPONSIBLE STAFF – Older Adult Team Leadership (Planning and Implementation) & QI Manager (Data Tracking/Monitoring)

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Utilize student-intern pipeline to increase group facilitator capacity	WET Coordinator attended Intern/Traineeship fairs at Sonoma State University and University of San Francisco; DHS-BHD received 16 applicants	**Complete**
Develop and refine curriculum	Curriculum developed and submitted for approval to the UR Manager	**Complete**
Recruit and select participants	Unable to initiate group due to COVID	**Cancelled**
Schedule group treatment cycle	Unable to initiate group due to COVID	**Cancelled**

RESULTS

Due to COVID pandemic, this goal was abandoned. In-person group interventions were suspended for the duration of the health emergency. Additionally, the technology requirement for converting this intervention to virtual groups creates a barrier for the older adult client population to participate.

GOAL ABANDONED

OBJECTIVE 4.2: **For Older Adult Consumer Perception surveys collected in FY 19-20, increase the response rate to 25%**

Goal Calculation: $\frac{Older\ Adult\ Surveys\ Collected}{Older\ Adult\ Client\ Census\ During\ Year} * 100\%$

PROCESS USED TO EVALUATE
Consumer Perception Survey Data

RESPONSIBLE STAFF – Older Adult Team Leadership (Planning and Implementation) & QI Manager (Data Tracking/Monitoring)

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Collaborate with Peer Centers to form a survey support team	Unable to engage this step in November due to Kincade Fire county-wide evacuations; unable to engage this step in June due to COVID	**Cancelled**
Utilize survey support team to assist clients in residential setting sin completing the survey	Unable to engage this step in November due to Kincade Fire county-wide evacuations; unable to engage this step in June due to COVID	**Cancelled**
Ensure clerical and clinical staff are distributing the correct survey to Older Adults	Detailed instructions and guidance was shared with clerical and clinical staff on administering the correct survey types	**Complete**

RESULTS

Administration and collection of Consumer Perception Surveys in FY 19-20 was disrupted by several disasters. The Kincade Fire in November resulted in county-wide evacuations during the survey collection period. Consequently, no surveys were collected. The spring survey collection was postponed by DHCS to June due to COVID. Survey collection was a hybrid of paper forms and online application.

Data on Consumer Perception surveys is analyzed by Calendar Year due to the length of time post-survey before the data files are available. Though there is only a half-dataset for CY 2019, if extrapolated for the whole year (i.e., multiple by 2), the number of Older Adult surveys collected would have increased from 24 in CY2018 to 46 in CY 2019. This represents a 10.7% response rate, which is an improvement, but does not meet the target goal.

GOAL NOT MET

OBJECTIVE 4.3: **For Older Adult Consumer Perception surveys collected in FY 19-20, the satisfaction rate will exceed the 3.5 satisfaction threshold on all domains**

PROCESS USED TO EVALUATE
Consumer Perception Survey Data

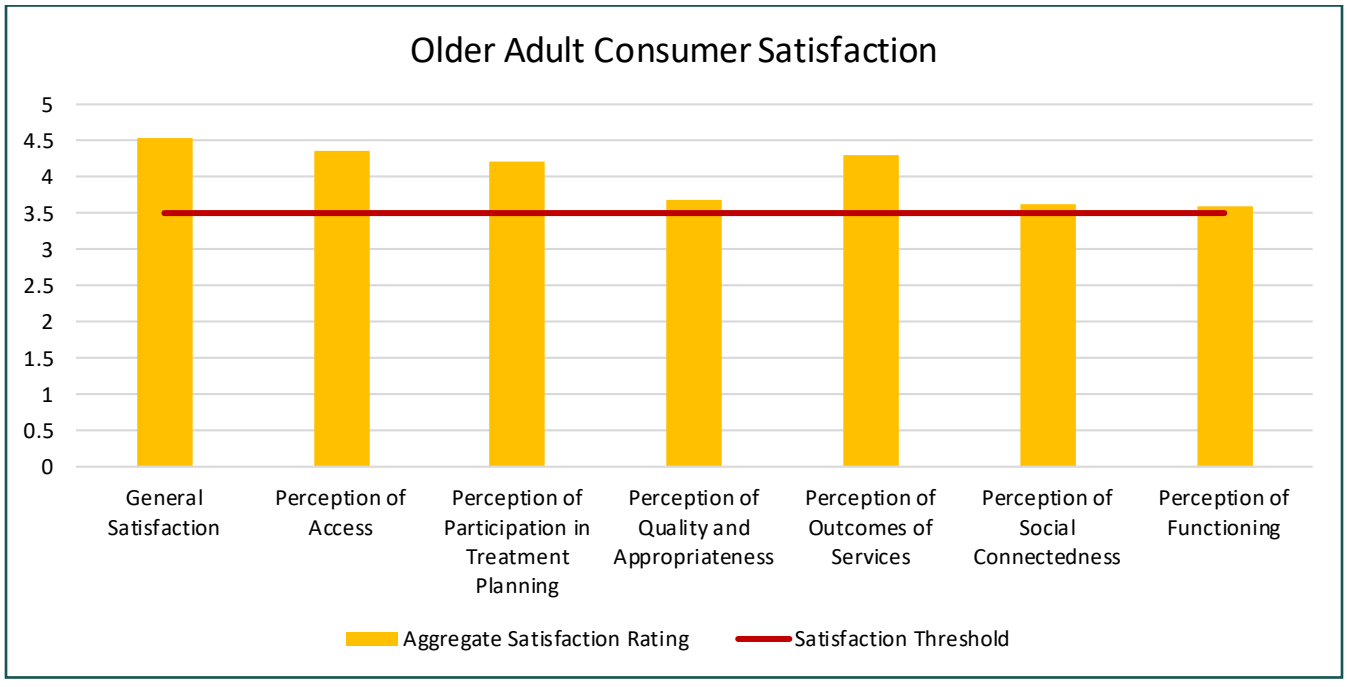
RESPONSIBLE STAFF – Older Adult Team Leadership (Planning and Implementation) & QI Manager (Data Tracking/Monitoring)

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Fully staff the Older Adult Team to increase availability	The Admin Program Support Unit of DHS-BHD successfully recruited and filled staff positions on the Older Adult Team	**Complete**
Implement group treatment support described in Objective 4.1	Unable to initiate group due to COVID	**Cancelled**

RESULTS

Data on Consumer Perception surveys is analyzed by Calendar Year due to the length of time post-survey before the data files are available. The Older Adult Survey results are as follows:



This is a significant improvement over CY 2018, in which all domains fell below the minimum satisfaction threshold of 3.5.

GOAL MET

OUTCOMES GOAL 5: **DHS-BHD provides recovery-oriented services that promote the ability of consumers to live a meaningful life in a community of their choosing**

OBJECTIVE 5.1: **(Clinical PIP) By the end of FY 19-20, the average actionable items for Factors One and Two for Adult HCBs, and the average monthly service costs per Adult HCB, will reduce by 10%**

Goal calculation: $\frac{Difference\ in\ Average\ ANSA\ Actionable\ Items}{Total\ ANSA\ Items} * 100\%$

PROCESS USED TO EVALUATE
ANSA Actionable Item Scores
AVATAR Service Cost Data

RESPONSIBLE STAFF – Adult Services Program Leadership (Implementation) & QI Manager (Planning, Training, Data Tracking/Monitoring)

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Train a staff cohort of PRA facilitators	Unable to initiate due to COVID	**Cancelled**
Recruit and select group participants	Unable to initiate group due to COVID	**Cancelled**
Schedule and facilitate 6 week PRA groups	Unable to initiate group due to COVID	**Cancelled**
Report Readiness Assessment results to case-managers	Unable to complete due to COVID	**Cancelled**
Provide individualized follow-up support	Unable to complete due to COVID	**Cancelled**

RESULTS

This PIP is currently under revision to adjust for COVID restrictions.

GOAL ABANDONED

OBJECTIVE 5.2: **By the end of FY 19-20, establish a peer-provider pipeline program with rotations at the Crisis Stabilization Unit to reduce Crisis Service utilization by 10%**

Goal calculation: $\frac{CSU\ Services\ per\ Client}{Total\ Services\ per\ Client} * 100\%$

PROCESS USED TO EVALUATE
AVATAR Service Data

RESPONSIBLE STAFF – QIC CSU Subcommittee (Planning and Implementation) & QI Manager (Data Analytics)

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Design peer-provider rotations through the CSU	The QIC CSU subcommittee commenced planning and design of a peer-provider pipeline through the CSU	**Complete**
Train a peer cohort of PRA facilitators	Unable to complete due to COVID	**Cancelled**
Customize the curriculum to fit a crisis setting	Customized crisis curriculum selected	**Complete**
Deliver one-on-one PRA interventions to CSU clients	Unable to complete due to COVID	**Cancelled**

RESULTS

This project is currently under revision to adjust for COVID safety requirements. Project will proceed with modification in FY 20-21.

GOAL NOT MET

FOSTER CARE GOAL 6: **DHS-BHD works collaboratively with Child Welfare Systems to provide equal access to specialty mental health services for minor and non-minor dependents in foster care**

OBJECTIVE 6.1: **By the end of FY 19-20, consolidate SB 1291 Medication Monitoring metrics into the Electronic Health Record**

PROCESS USED TO EVALUATE
AVATAR Medication Monitoring Reports

RESPONSIBLE STAFF – QI Manager & AVATAR Change Governance Committee

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Identify and map existing data systems for tracking HEDIS measures	Existing systems mapped for HEDIS ADD, APC, APP, and APM	**Complete**
Consolidate into single data needs summary and validate against HEDIS standards	List consolidated; validation completed for metabolic monitoring and Clozaril monitoring; validation in progress for ADD and APC	**In Progress (75%)**
Render applicable reports in the Electronic Health Record	Metabolic Monitoring report rendered in AVATAR; Clozaril Monitoring Report rendered in AVATAR; ADD and APC tracking reports in progress	**In Progress (50%)**

RESULTS

Prescribing Physician	# of Charts Reviewed	# of Practices Guidelines Adhered to on Average	% of Practice Guidelines Adhered to on Average
1	5	13.8	92.00%
2	5	14	93.33%
3	5	13	86.67%
4	5	15	100.00%
5	5	13.8	92.00%
6	5	15	100.00%
7	5	13.6	90.67%
8	5	14	93.33%
9	5	14.8	98.67%
10	5	14.6	97.33%
11	5	13.2	88.00%
12	5	11.4	76.00%
13	5	14.2	94.67%
	Average =	**13.88**	**92.51%**

81.25% of psychiatric staff received peer reviews on five charts in FY19-20. Results of the peer reviews indicated 92.51% adherence to practice guidelines. This is an improvement from FY18-19. Significant progress was made on implementing HEDIS tracking through AVATAR.

GOAL PARTIALLY MET

OBJECTIVE 6.2: **By January 2020, resume providing monthly reports to the Child Welfare System summarizing mental health service provision to foster youth**

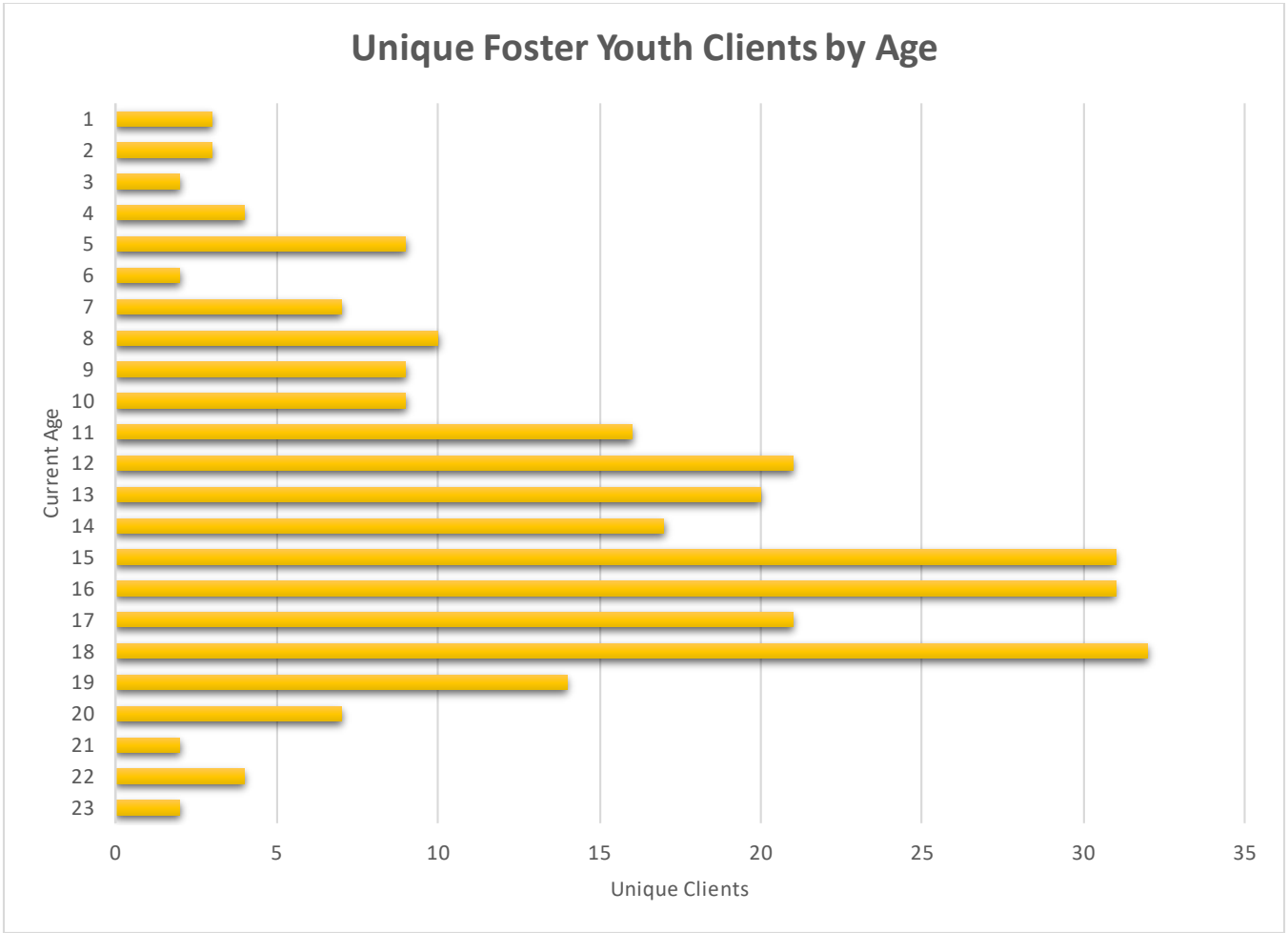
PROCESS USED TO EVALUATE
AVATAR Foster Youth Services Report

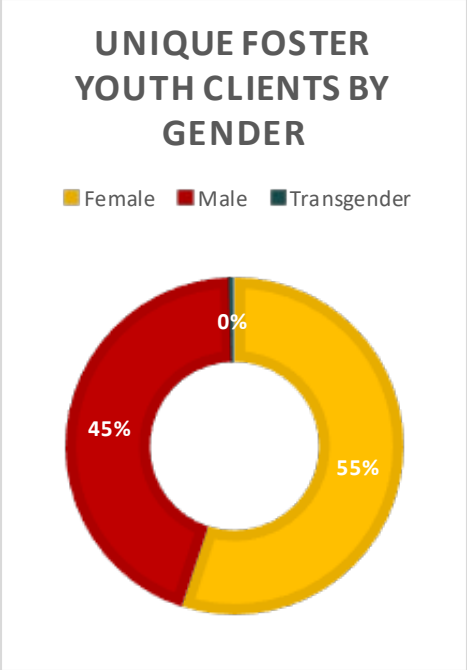
RESPONSIBLE STAFF – QI Manager (Report Creation) & Youth and Family Services Leadership (Distribution)

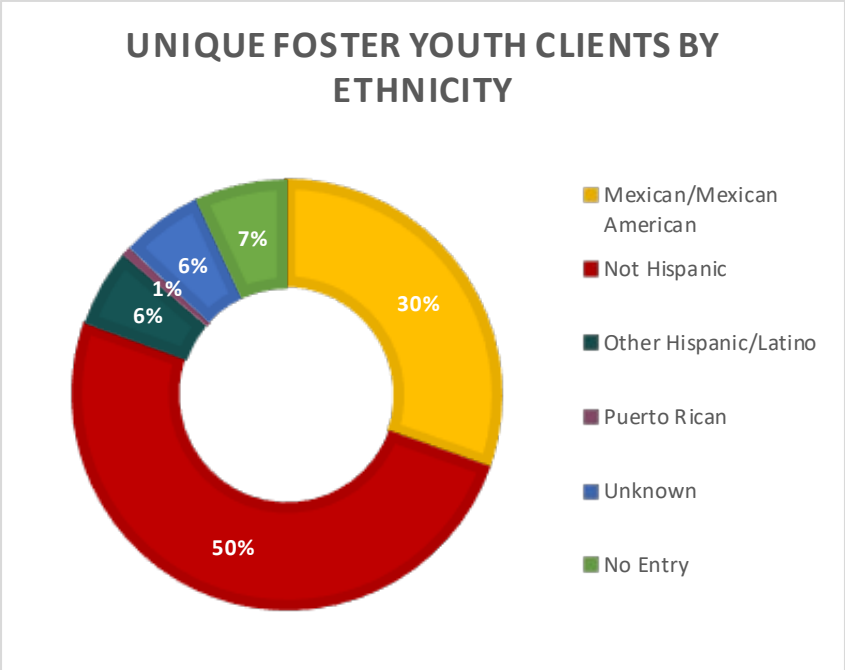
ACTION STEPS STATUS UPDATE

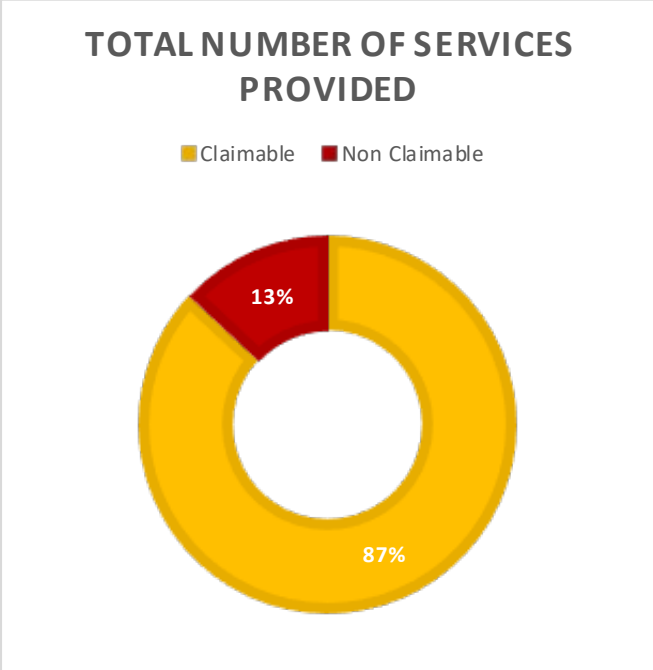
Key Activity	Update	Status
Identify and map the reporting specifications	The QI Manager mapped the reporting specifications and submitted to AVATAR IT Lead	**Complete**
Render the report in the Electronic Health Record	AVATAR IT Lead rendered the new report in the Electronic Health Record	**Complete**
Implement a report distribution schedule	Youth and Family leadership is working with Child Welfare to establish a distribution pathway and schedule	**In Progress (25%)**

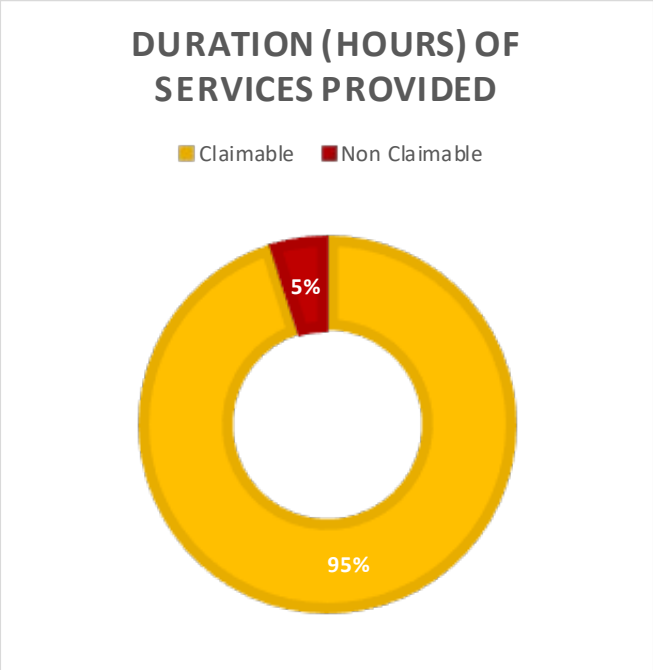
RESULTS











Report design, creation, and implementation has been completed in the Electronic Health Record. The distribution pathway and schedule requires further refinement.

GOAL PARTIALLY MET

INFORMATION SYSTEMS GOAL 7: **DHS-BHD utilizes centralized information systems to inform mental health planning and service delivery at community and individual levels**

OBJECTIVE 7.1: **By end of FY 19-20, consolidate all external service data tracking systems into the Electronic Health Record, including all requisite reports**

PROCESS USED TO EVALUATE
AVATAR Monitoring Reports

RESPONSIBLE STAFF – QI Manager

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Locate and map all external tracking databases	External databases identified and mapped on tracking spreadsheet	**Complete**
Develop data reporting needs list	Data reporting needs listed for QI, QA, Medical, and Clinical Management; data reporting needs listing in progress for Hospital UR and Audits Team	**In Progress (75%)**
Design QAPI data reporting dashboard	Foundational research complete; design in progress	**In Progress (25%)**
Render reporting capacity in the Electronic Health Record	Initiate pending prior steps completion	**Not Started**
Train QAPI and Management staff on utilization and interpretation of the reports	Initiate pending prior steps completion	**Not Started**

RESULTS

In FY 19-20, progress was made on AVATAR implementation; however, both Kincade Fire and COVID disaster response significantly impacted the Implementation Team with key Project Leads unavailable for extensive periods of time due to disaster deployment.

GOAL NOT MET

STRUCTURE & OPERATIONS GOAL 8: DHS-BHD seeks for continuous process improvement of service system structures and operations to maximize utilization of best-practices

OBJECTIVE 8.1: During FY 19-20, conduct a formal assessment of organizational quality culture, utilizing the QI SAT 2.0 Tool

PROCESS USED TO EVALUATE
QI SAT 2.0 Tool

RESPONSIBLE STAFF – QI Manager

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Review the QI SAT Tool in QIC and QIS	Review of tool completed in both QIC and QIS; QIC subcommittee formed to implement project	**Complete**
Select survey questions	Survey questions selected; editing in process for recovery-oriented language	**In Progress (90%)**
Schedule survey window	Project disrupted due to COVID	**On Hold**
Distribute survey to direct service staff and managers	Project disrupted due to COVID	**On Hold**
Analyze results to establish baseline state	Project disrupted due to COVID	**On Hold**
Review recommended strategies for each domain	Project disrupted due to COVID	**On Hold**
Select and implement strategies in next QI Plan	Project disrupted due to COVID	**On Hold**

RESULTS

Implementation of this project was scheduled for the second half of FY 19-20, which was unfortunately significantly disrupted by COVID. The COVID disaster response significantly impacted this project, with the QI Manager and several QIC member unavailable for extensive periods of time due to disaster deployment. This goal will be continued for FY 20-21.

GOAL NOT MET

OBJECTIVE 8.2: **By end of FY 19-20, all follow-up tasks identified in Sentinel Event review will be completed within 30 days**

Goal calculation: $\frac{Sentinel\ Events\ with\ Completed\ Action\ Items}{Total\ Sentinel\ Events\ with\ Action\ Items} * 100\%$

PROCESS USED TO EVALUATE
Sentinel Events Action Items Report

RESPONSIBLE STAFF – QI Manager

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Complete a retrospective review to remediate past data	QI Manager and Sentinel Events Admin Aide review all open events from prior fiscal years, verified outcomes, reviewed in committee as required, and remediated missing data elements	**Complete**
Design a new Sentinel Event Resolution process	QI Manager and Sentinel Events Admin Aide initiated bi-weekly meetings to review action items and prepare for Sentinel Events committee meetings	**Complete**
Update the Sentinel Event Policy and Procedure	Draft update completed; final edits and review in progress	**In Progress (90%)**
Implement the new process through the Sentinel Event Committee	Sentinel event form update completed; all staff training completed on reporting elements and process	**Complete**

RESULTS

Incident Category	Incidents	Percentage
Open Incidents	5	2.56%
Closed Incidents	190	97.44%
Total Incidents	195	100%

Action Category	Actions	Percentage
Incomplete Actions	0	0%
Completed Actions	42	100%
Total Actions	42	100%

100% of assigned Action Items were completed in FY 19-20.

GOAL MET

OBJECTIVE 8.3: By January 2020, complete and implement a QAPI Communication Plan

PROCESS USED TO EVALUATE
Communication Plan

RESPONSIBLE STAFF – QI Manager

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Identify quality initiatives in the category of leadership, training, projects, outcomes, and policies	Leadership initiatives identified in DMT and QAPI team meetings targeting key quality risk areas; training initiatives identified by UR Manager for inclusion in Division staff meetings; project initiatives brainstormed at QIC; outcomes initiatives identification in progress in combination with QI and BH Contracts Unit; policies initiatives identified by QA manager	**In Progress (90%)**
Identify potential target audiences	Target audience levels identified: staff; community providers; Mental Health Board; peers/families; public	**Complete**
Establish communication frequencies and methods	Phase I: monthly Documentation minute trainings in Division staff meetings; Phase II: website update to include dedicated QAPI page; Phase III: newsletter distribution to Providers and Peers/Families	**Complete**
Distribute communications	Monthly distribution of Documentation Minute implemented; annual distribution of QI reporting implemented; planning and initial draft ideas for website update have commenced; newsletter not started	**In Progress (50%)**

RESULTS

A Communication Plan is now included in the Annual QAPI Plan. Phase I (monthly documentation training and updates at Division Staff Meetings) is fully implemented. Phase II (website presence) commenced in FY 20-21. Phase III (newsletter) has not started.

GOAL PARTIALLY MET

SECTION 5: STAFF TRAINING OVERVIEW
FY19-20

Date	Training Topic	Type of Training	CEUs	Target Audience
Jul 3	Staff Development: Patients' Rights Advocacy—History, Process, and Resources	Staff Development: Cultural Responsiveness	1.5	SCBH Staff: Mandatory
Sep 6	Health and Wellness During an Emergency	Community Training: Disaster Recovery	N/A	Community
Sep 10	AMSR: Assessing and Managing Suicide Risk	Specialty: Suicide Assessment & Intervention	6.5	Behavioral Health Professionals
Sep 13	Suicide Prevention Week: Collaborative Crisis Management	Specialty: Best Practices	3.0	Behavioral Health Professionals
Sep 24	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.5	Licensed/License-Eligible Clinicians
Oct 1	Child and Adolescent Assessment	Specialty: Best Practices	3.0	YFS Clinical Staff
Oct 1 & 2	Full Service Partnership Services for Children and Youth	Specialty: Best Practices	6.0	YFS Clinical Staff
Oct 2	Staff Development: The Era of Marijuana Legalization: Research and Best Practices for Working with Adolescents and Adults	Staff Development: Best Practices	2.0	SCBH Staff
Nov 6	Staff Development: Notice of Adverse Benefit Determination (NOABD) Issuance and Tracking	Staff Development: Regulatory Compliance	2.0	SCBH Staff: Mandatory
Nov 19	Suicide Prevention: Recognizing the Signs and Finding the Help	Community Training: Suicide Prevention	N/A	Community
Dec 17	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.5	Licensed/License-Eligible Clinicians
Jan 8	Staff Development: Clients Rights: Grievances and Beneficiary Requests for Service Procedures	Staff Development: Regulatory Compliance	2.0	SCBH Staff
Jan 8	Contractor Development: Grievances, NOABDs and Beneficiary Requests for Service – Policy and Procedures	Contractor Development: Regulatory Compliance	2.0	SCBH Contractors
Jan 10	Managers Meeting: Clients Rights: Grievances and Beneficiary Requests for Service Procedures	Staff Development: Regulatory Compliance	1.5	SCBH Managers

Date	Training Topic	Type of Training	CEUs	Target Audience
Jan 28	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.5	Licensed/License-Eligible Clinicians
Feb 11	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.5	Aurora Hospital: Licensed/License-Eligible Clinicians
Feb 19	Staff Development: Law & Ethics	Staff Development: Law & Ethics	6.0	SCBH Staff: Mandatory
Mar 11	Staff Development: Behavioral Health and Culture	Staff Development: Cultural Responsiveness	2.0	SCBH Staff: Mandatory
Apr 28	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	Licensed/License-Eligible Clinicians
May 7	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	Licensed/License-Eligible Clinicians
May 26	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	Kaiser Permanente: Licensed/License-Eligible Clinicians
May 28	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	Kaiser Permanente: Licensed/License-Eligible Clinicians
Jun 2	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	Kaiser Permanente: Licensed/License-Eligible Clinicians
Jun 4	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	Kaiser Permanente: Licensed/License-Eligible Clinicians
Jun 23	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	Kaiser Permanente: Licensed/License-Eligible Clinicians

Documentation Trainings FY 19-20

Date	Training Topic	Type of Training	Target Audience
Jun 25	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Jul 9	YFS/FASST Team Training: Documentation	Team Training: Documentation	YFS/FASST Employees
Jul 11	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Jul 17	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Jul 17	CSU Team Training: Documentation	Team Training: Documentation	CSU Staff
Jul 24	Clerical Training: Documentation	Team Training: Documentation	Clerical Staff
Jul 29	CSU Team Training: Documentation	Team Training: Documentation	CSU Staff

Date	Training Topic	Type of Training	Target Audience
Aug 8	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Aug 7	CSU Team Training: Documentation	Team Training: Documentation	CSU Staff
Aug 7	CSU Team Training: Documentation	Team Training: Documentation	CSU Staff
Aug 15	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Aug 21	OAT/IRT/TAY Team Training: Client Plans	Team Training: Documentation	OAT/IRT/TAY Staff
Aug 23	FACT Team Training: Client Plans	Team Training: Documentation	FACT Staff
Aug 27	YFS Team Training: Client Plans	Team Training: Documentation	YFS Staff
Aug 29	AST/CTRT Team Training: Client Plans	Team Training: Documentation	AST/CTRT Staff
Sep 4	CMHC Team Training: Cilent Plans	Team Training: Documentation	CMHC Staff
Sep 25	Clerical Training: Documentation	Team Training: Documentation	Clerical Staff
Sep 26	Access Team Training: Client Plans	Team Training: Documentation	Adult Access Staff
Oct 2	Youth Access Team Training: Documentation	Team Training: Documentation	Youth Access Staff
Oct 3	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Oct 9	Youth Access Team Training: Documentation	Team Training: Documentation	Youth Access Staff
Oct 9	YFS/FASST Team Training: Documentation	Team Training: Documentation	YFS/FASST Staff
Oct 9	IRT Team Training: Client Plans	Team Training: Documentation	IRT Staff
Oct 16	Documenting Functional Impairments	All Division Training: Documentation	SCBH Staff
Oct 16	Procedure Codes, Claiming for Time	Contractor Training: Documentation	Lifeworks Clinical Staff
Oct 23	CMHC Team Training: Cilent Plans	Team Training: Documentation	CMHC Staff
Nov 6	CSU Team Training: Documentation	Team Training: Documentation	CSU Staff
Nov 12	Youth Collaborative Meeting: Documentation	Team Training: Documentation	Youth Collaborative Members
Nov 13	IRT/OAT Team Training: Documentation	Team Training: Documentation	IRT/OAT Staff
Nov 18	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Nov 20	YFS Team Training: Intensive Care Coordination & Intensive Home Based Services	Team Training: Documentation	YFS Staff
Nov 20	CSU Team Training: Documentation	Team Training: Documentation	CSU Staff

Date	Training Topic	Type of Training	Target Audience
Nov 20	Psychiatric Rehab	All Division Training: Documentation	SCBH Staff
Nov 21	Adult Access Team Training: Assessment Workflow and Streamlining	Team Training: Documentation	Adult Access Staff
Nov 27	CMHC Team Training: Documentation Time and Scheduling	Team Training: Documentation	CMHC Staff
Dec 2	CSU Team Training: Documentation	Team Training: Documentation	CSU Staff
Dec 3	Client Plans	Contractor Training: Documentation	Lifeworks Clinical Staff
Dec 9	CSU Team Training: Documentation	Team Training: Documentation	CSU Staff
Dec 11	CSU Team Training: Documentation	Team Training: Documentation	CSU Staff
Dec 11	IRT/OAT Team Training: Documentation	Team Training: Documentation	IRT/OAT Staff
Dec 11	YFS/FASST Team Training: Documentation	Team Training: Documentation	YFS/FASTT Staff
Dec 12	CSU Team Training: Documentation	Team Training: Documentation	CSU Staff
Dec 16	CSU Team Training: Documentation	Team Training: Documentation	CSU Staff
Dec 18	Group Notes	All Division Training: Documentation	SCBH Staff
Dec 19	CSU Team Training: Documentation	Team Training: Documentation	CSU Staff
Jan 2	AST/CTRT Team Training: Documentation	Team Training: Documentation	AST/CTRT Staff
Jan 7	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Jan 7	Clerical Training: Documentation	Team Training: Documentation	Clerical Staff
Jan 9	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Jan 10	IRT Team Training: Group Notes	Team Training: Documentation	IRT Staff
Jan 13	TBS Documentation	Contractor Training: Documentation	Lifeworks Clinical Staff
Jan 14	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists
Jan 22	Medical Necessity in Re-Assessments	All Division Training: Documentation	SCBH Staff
Jan 23	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Feb 5	IRT/OAT Team Training: Progress Notes, Procedure Codes	Team Training: Documentation	IRT/OAT Staff
Feb 20	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Feb 20	YFS Team Training: Documentation	Team Training: Documentation	YFS Staff

Date	Training Topic	Type of Training	Target Audience
Feb 26	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Feb 26	IRT/OAT Team Training: Documentation	Team Training: Documentation	IRT/OAT Staff
Feb 26	FYT Team Training: Documentation	Team Training: Documentation	FYT Staff
Feb 27	ORNC (Outpatient RN Committee) Training: Documentation	Team Training: Documentation	ORNC Staff
Mar 4	Targeted Case Management	All Division Training: Documentation	SCBH Staff
Mar 4	YFS Team Training: Documentation	Team Training: Documentation	YFS Staff
Apr 9	Medical Staff Training: Documentation	Team Training: Documentation	Medical Staff
Apr 14	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists
Apr 20	FACT Team Training: Client Plans	Team Training: Documentation	FACT Staff
May 4	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
May 12	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists
May 18	FACT Team Training: Adult Needs and Strengths Assessment, Level of Care, Medical Necessity	Team Training: Documentation	FACT Staff
Jun 1	FACT Team Training: Progress Notes	Team Training: Documentation	FACT Staff
Jun 9	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists
Jun 16	Client Plans	Contractor Training: Documentation	Buckelew Clinical Staff
Jun 18	Connecting Clients to Telehealth	All Division Training: Documentation	SCBH Staff