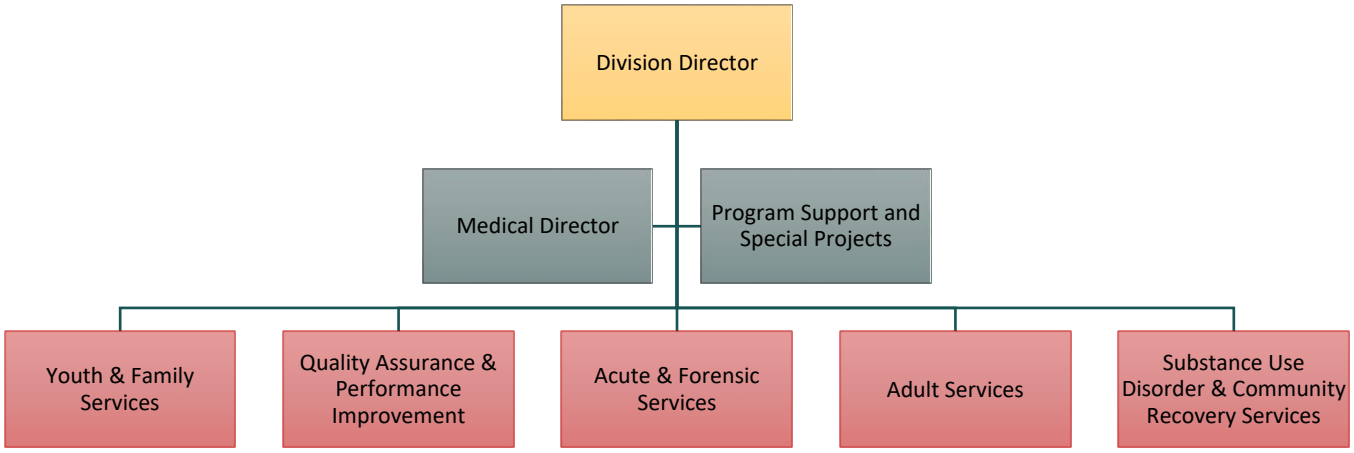
SONOMA COUNTY
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION (DHS-BHD)

ANNUAL QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT WORK PLAN EVALUATION FISCAL YEAR 2020—2021

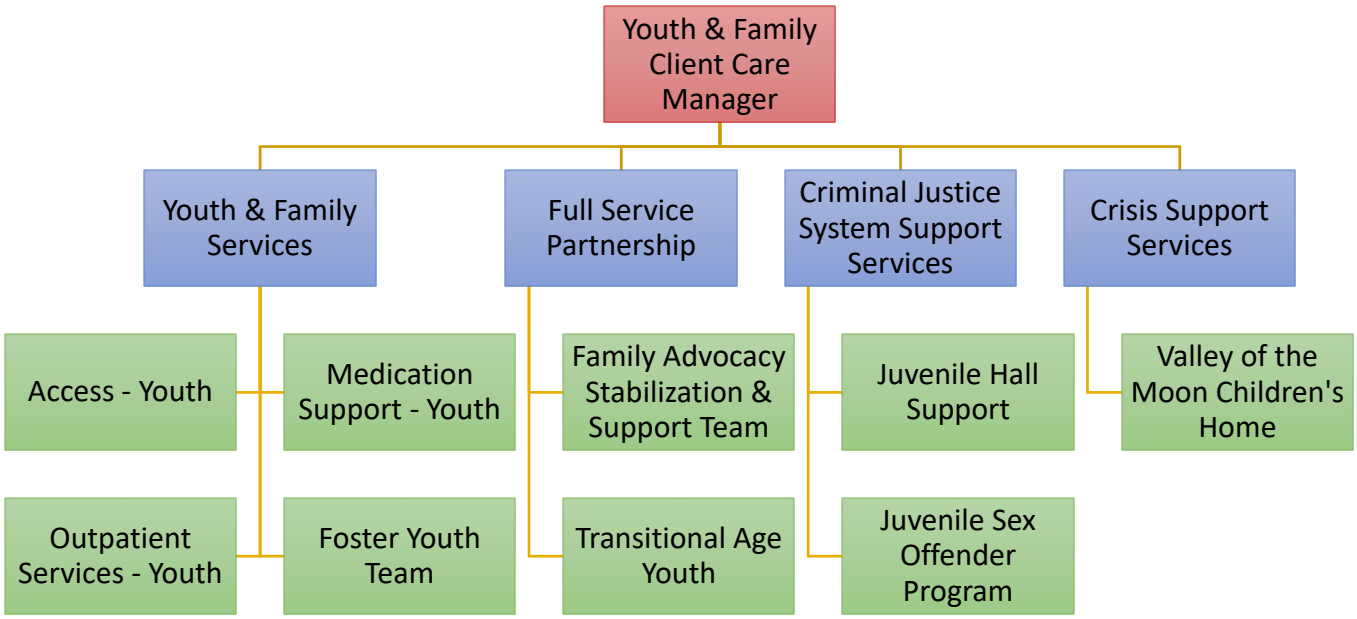
The Quality Improvement Plan is a required element of the Quality Management Program, as specified by DHCS contract, Exhibit A Attachment I (relevant sections: 22-25), and by CCR Title 9, Chapter 11, § 1810.440.

Overview of Sonoma County Behavioral Health Division Organizational Chart – November 2021

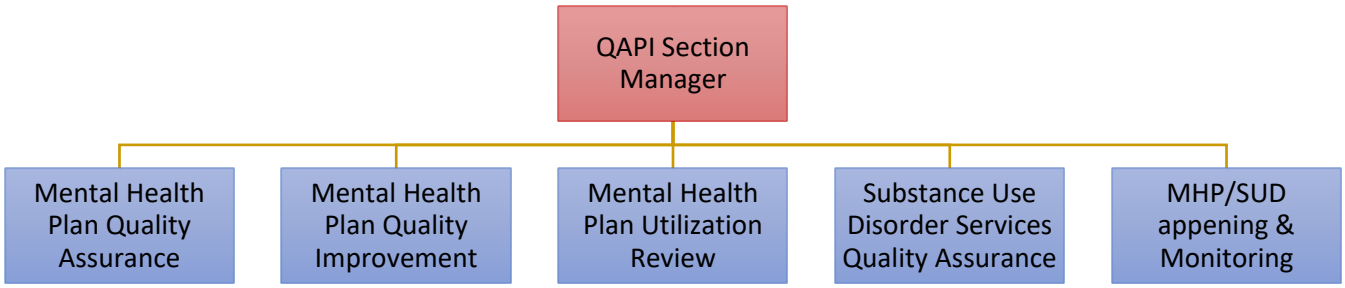
Behavioral Health Division



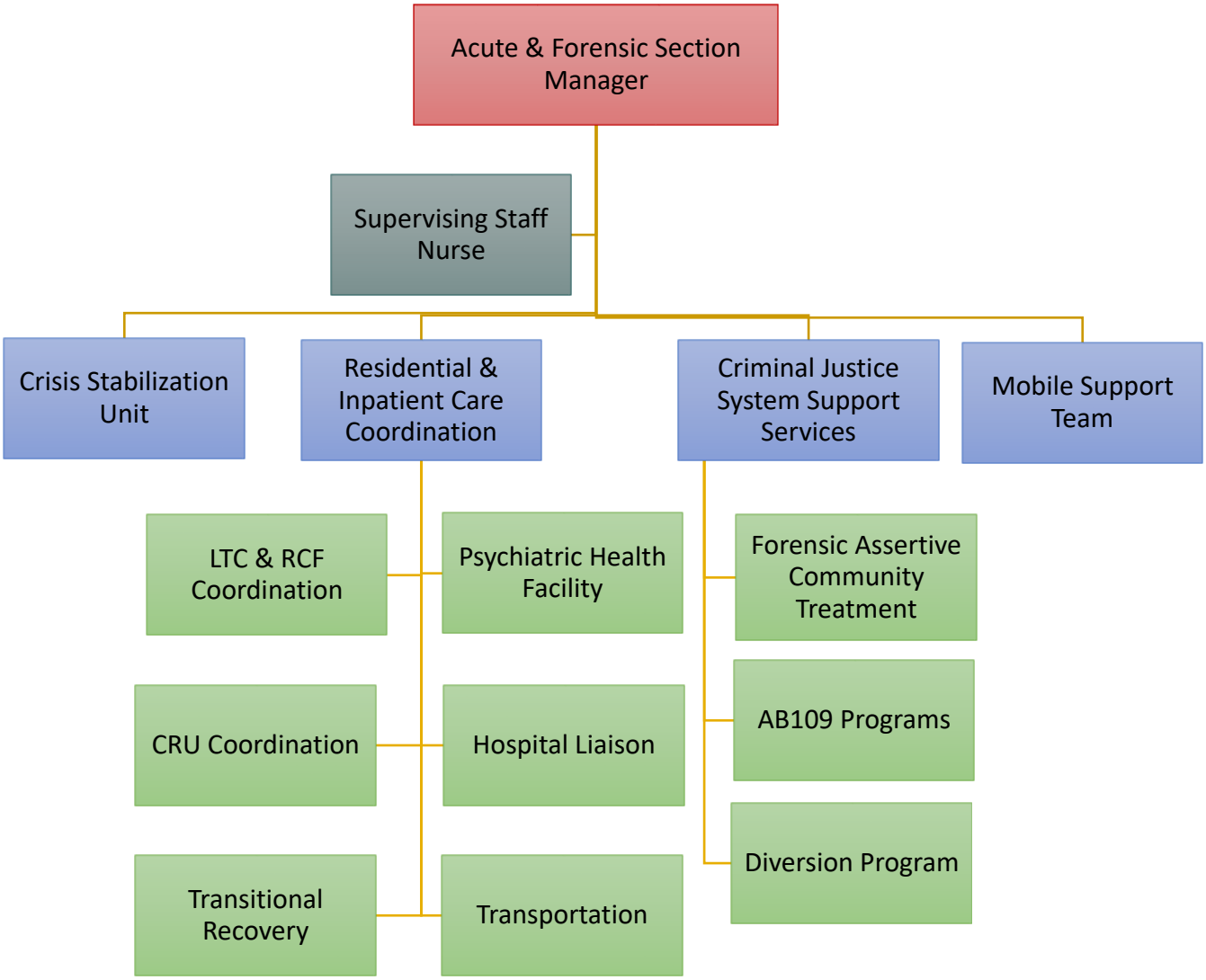
Youth & Family Services



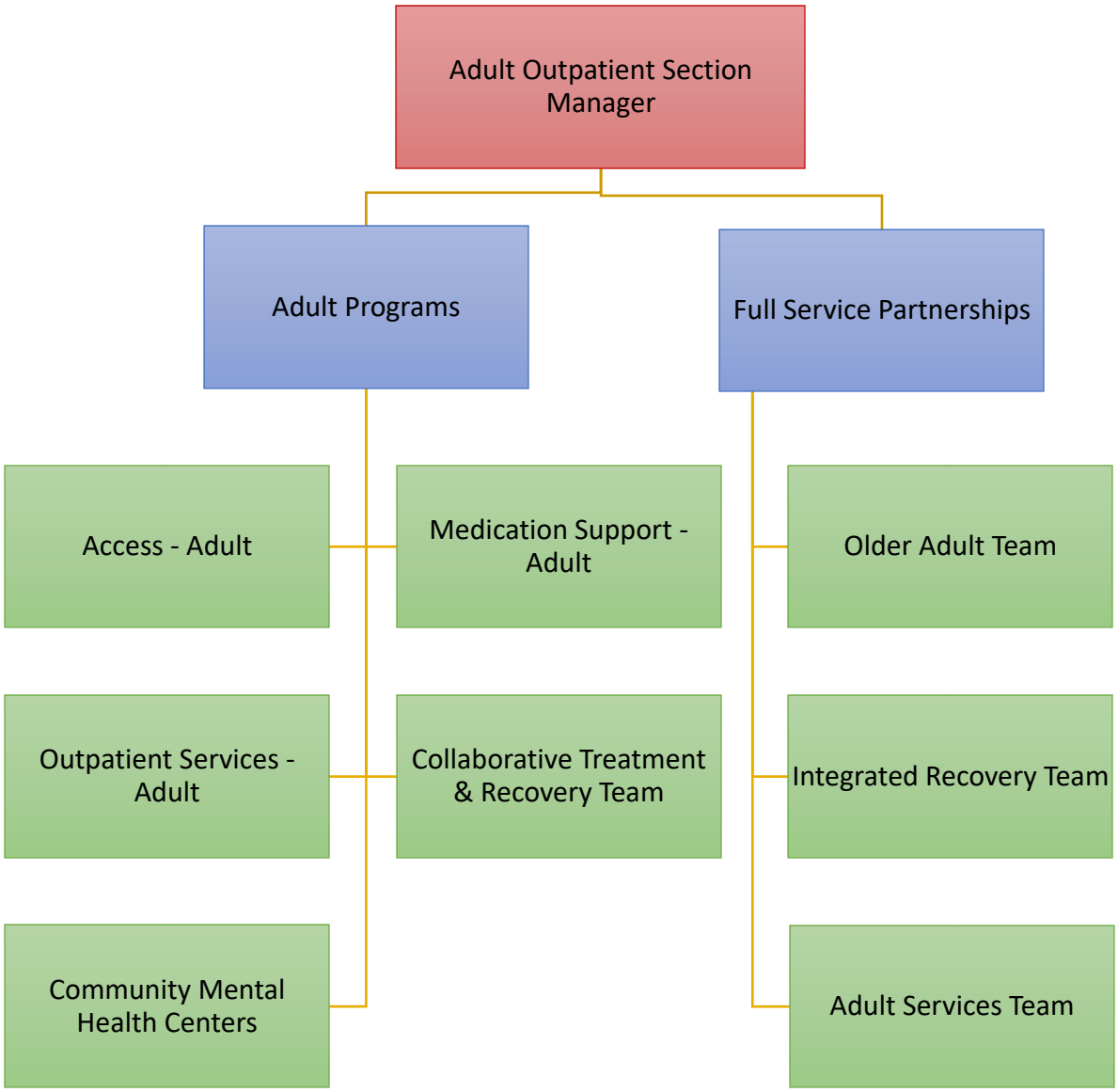
Quality Assurance & Performance Improvement (QAPI)



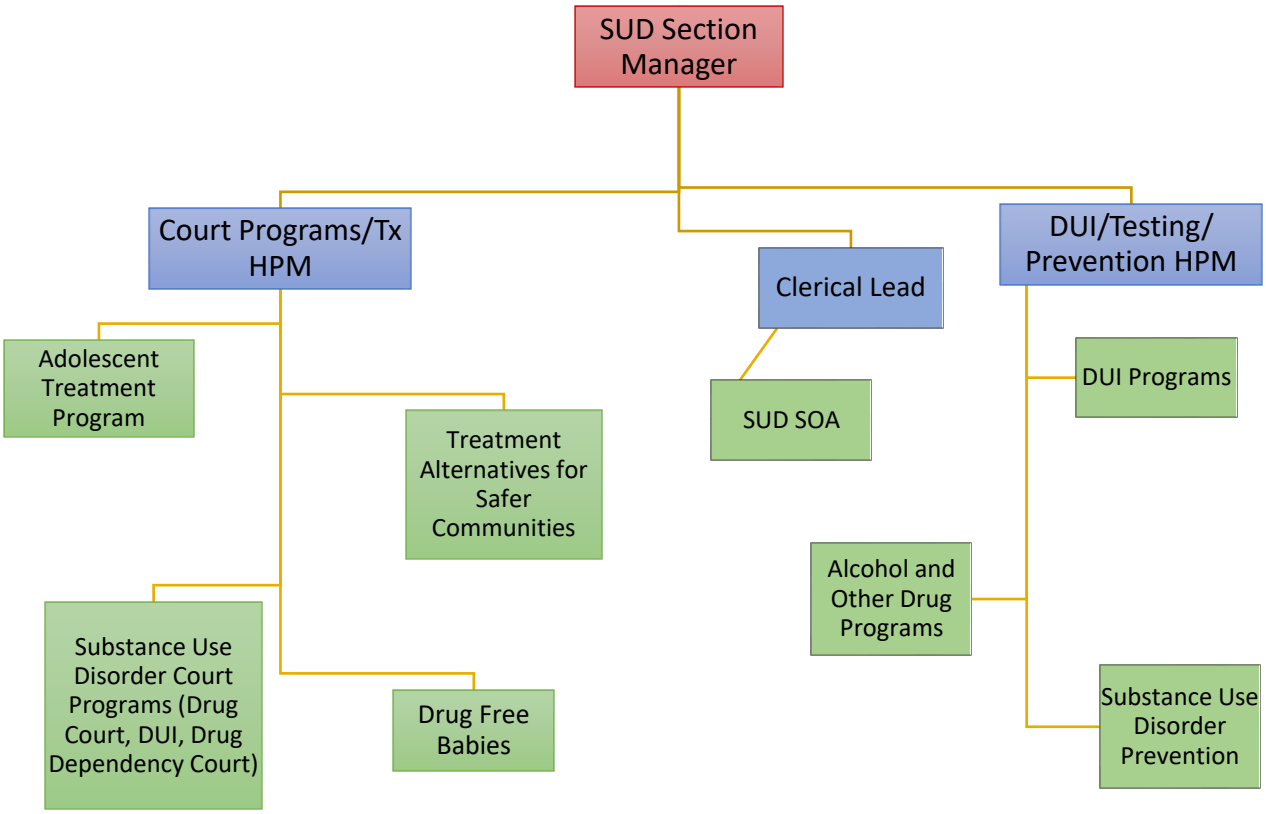
Acute & Forensic Services



Adult Outpatient Services



Substance Use Disorder & Community Recovery Services



Program Support & Special Projects

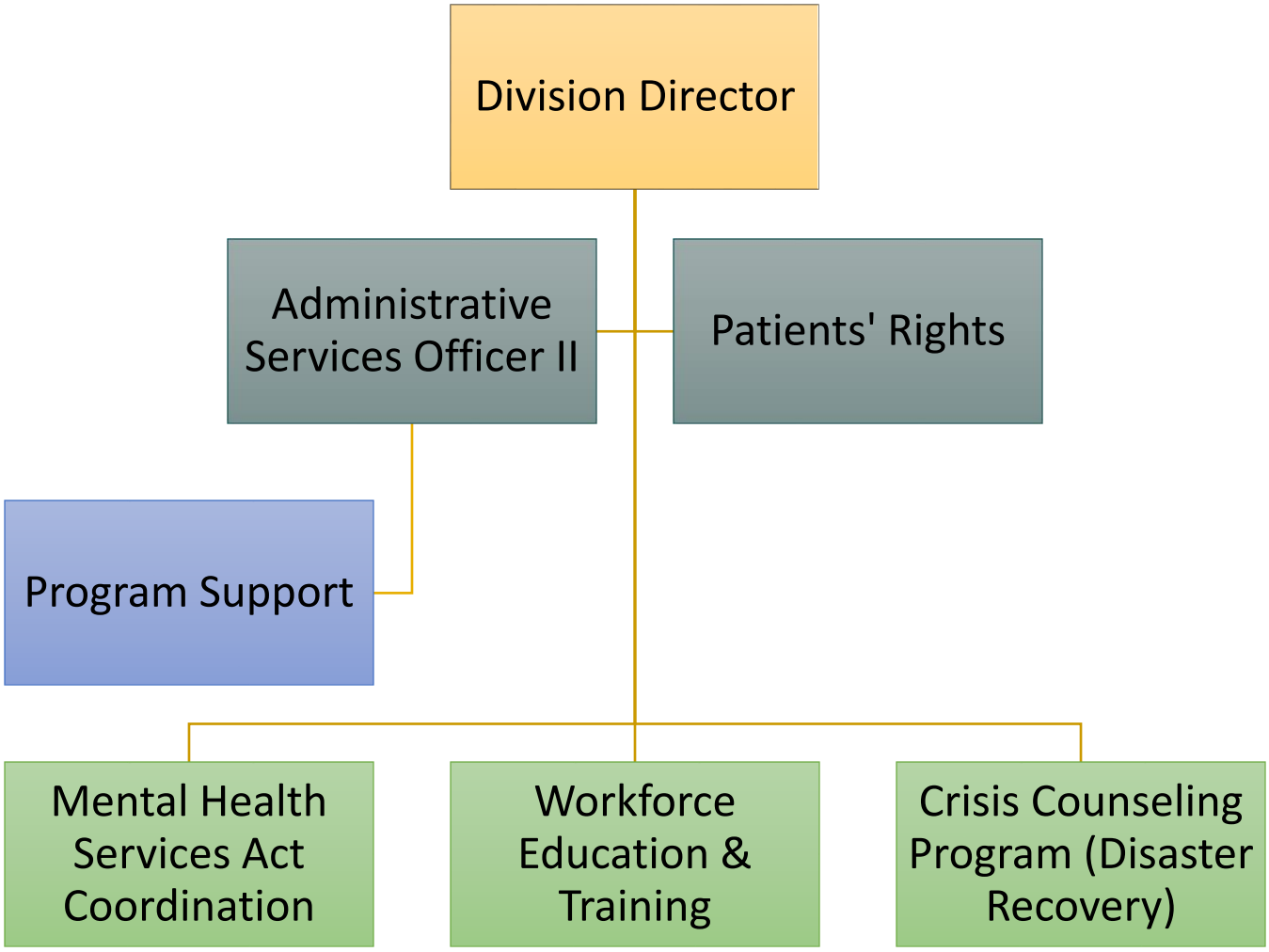


TABLE OF CONTENTS

SECTION 1: SERVICE DELIVERY CAPACITY ANALYSIS

Element	Element Description	Page
Geographic Analysis	The MHP tracks the number, service type, and geographic distribution of mental health services provided by DHS-BHD and contractors.	10
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.	21
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.	27
Peer Providers	DHS-BHD tracks and trends the number of Peer Provider positions allocated throughout the service system.	28
Language Capacity	The MHP tracks and trends language line utilization and service utilization in languages other than English.	29

SECTION 2: SERVICE ACCESSIBILITY PERFORMANCE METRICS

Metric	Performance Standard	Page
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.	40
METRIC 2	100% of non-urgent after-hours callers requesting a service will receive a call back the next business day.	41
METRIC 3	The average length of time from initial request for services to first offered assessment appointment will be 10 business days or less.	42
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.	44
METRIC 5	The average length of time from initial request for services to first kept appointment will be 10 business days or less.	45
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.	47
METRIC 7	The average length of time from initial request to first offered psychiatry appointment will be 15 business days or less.	48
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.	50
METRIC 9	The average length of time from **urgent** service request to actual encounter will be 48 hours or less.	51
METRIC 10	95% of the beneficiaries who are screened as needing an **urgent** mental health assessment will receive services within 48 hours.	53
METRIC 11	The average length of time between post-hospital inpatient discharge and follow-up appointment will be 7 calendar days or less.	52
METRIC 12	50% of follow-up post-hospital appointments will be scheduled within 7 calendar days of inpatient discharge.	55
METRIC 13	The 30-day psychiatric inpatient re-admission rate will be 10% or less.	57
METRIC 14	The no-show rate for initial assessment appointments will be less than 10%.	59
METRIC 15	The no-show rate for psychiatry services will be less than 10%.	61
METRIC 16	The no-show rate for outpatient clinical services other than psychiatry will be less than 10%.	61
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.	62

SECTION 3: BENEFICIARY SATISFACTION

Measure	Measure Description	Page
Consumer Perception Survey	The MHP collects and submits completed Adult, Older Adult, Youth, and Family/Parents of Youth Consumer Perception Satisfaction Survey data during the review period to CIBHS; analyzes the results; and disseminate the results and analysis to DHS-BHD staff and providers.	63
Grievances	100% of client grievances will be decided upon and communicated back to the client within 90 days of receiving the grievance.	70
Appeals	100% of client/family outpatient appeals will be decided upon and communicated back to the client within 60 days of receiving the appeal.	71
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 hearing results.	73
Change of Provider Requests	100% of client requests to change persons providing services will be evaluated and addressed within 30 days of the request.	73

SECTION 4: QUALITY GOALS PROGRESS EVALUATION

Goal	Goal Descriptions	Page
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	74
OBJECTIVE 1.1	At the annual Network Adequacy certification, DHS-BHD will meet the provider-beneficiary ratio standards identified by DHCS	74
OBJECTIVE 1.2	By the end of FY 20-21, DHS-BHD will implement a streamlined BRS/COC process through the Electronic Health Record system	77
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	78
OBJECTIVE 2.1	Non-Clinical PIP: increase the percentage of Latino/Hispanic clients served to meet/exceed 42%	78
OBJECTIVE 2.2	During FY 20-21, 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	79
OBJECTIVE 2.3	During FY 20-21, schedule and facilitate 4 Cultural Responsiveness Committee Meetings	80
TIMELINESS GOAL 3	DHS-BHD ensures timely access to high quality, culturally sensitive services for individuals and their families	81
OBJECTIVE 3.1	By the end of FY 20-21, the average length of time from initial request for psychiatry to first offered psychiatry appointment will be 15 business days or less	81
QUALITY OF CARE GOAL 4	DHS-BHD designs quality services that are informed by and responsive to consumer feedback	83
OBJECTIVE 4.1	For Native American Consumer Perception surveys collected in FY 20-21, the satisfaction rate will exceed the 3.5 minimum satisfaction threshold on all domains	83
QUALITY OF CARE GOAL 5	DHS-BHD seeks best-practice refinements in service delivery to provide consistent high-quality care	83
OBJECTIVE 5.1	During FY 20-21, 100% of new staff will attend a Documentation NEO within 3 months of hire	83
OBJECTIVE 5.2	By the end of FY 20-21, complete an initial draft of the DHS-BHD Provider Handbook	85
OUTCOMES GOAL 6	DHS-BHD provides recovery-oriented services that promote the ability of consumers to live a meaningful life in a community of their choosing	85
OBJECTIVE 6.1	By the end of FY 20-21, re-development of the Clinical PIP will be complete and a Strengths Model pilot program will commence at FY 21-22	85
OBJECTIVE 6.2	By the end of FY 21-22, the average actionable items for Factors One and Two for Adult HCBs will reduce by 10%	86

Goal	Goal Descriptions	Page
OBJECTIVE 6.3	By the end of FY 20-21, establish a peer-provider pipeline program with rotations at the Crisis Stabilization Unit to reduce Crisis Service utilization by 10%	87
FOSTER CARE GOAL 7	DHS-BHD works collaboratively with FY&C to provide equal access to SMHS for minor and non-minor dependents in foster care	87
OBJECTIVE 7.1	By the end of FY 20-21, consolidate SB 1291 Medication Monitoring metrics into the Electronic Health Record	87
INFORMATION SYSTEMS GOAL 8	DHS-BHD utilizes centralized information systems to inform mental health planning and service delivery at community and individual levels	89
OBJECTIVE 8.1	By end of FY 21-22, consolidate all external service data tracking systems into the Electronic Health Record, including all requisite reports	89
OBJECTIVE 8.2	By end of FY 20-21, implement prototype Audits and Monitoring database to expand compliance tracking and trending capabilities	89
STRUCTURE & OPERATIONS GOAL 9	DHS-BHD seeks for continuous process improvement of service system structures and operations to maximize utilization of best-practices	91
OBJECTIVE 9.1	During FY 20-21, conduct a formal assessment of organizational quality culture, utilizing the QI SAT 2.0 Tool	91
OBJECTIVE 9.2	By end of FY 20-21, complete a formal quality risk assessment and mitigation plan	92
OBJECTIVE 9.3	By end of FY 20-21, complete and implement a QAPI Communication Plan: Phase II	93

SUMMARY OF QUALITY IMPROVEMENT PLAN GOALS & METRICS

Plan Section	Met	Partially Met	Not Met	Abandoned
Performance Metrics	8/17	4/17	5/17	0/17
Beneficiary Satisfaction	2/4	1/4	1/4	0/4
Plan Goals	7/18	7/18	3/18	1/18
Overall Percentage	43.59%	30.77%	23.08%	2.56%

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	Section Description	Page
7	Schedule of Staff Trainings	89

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

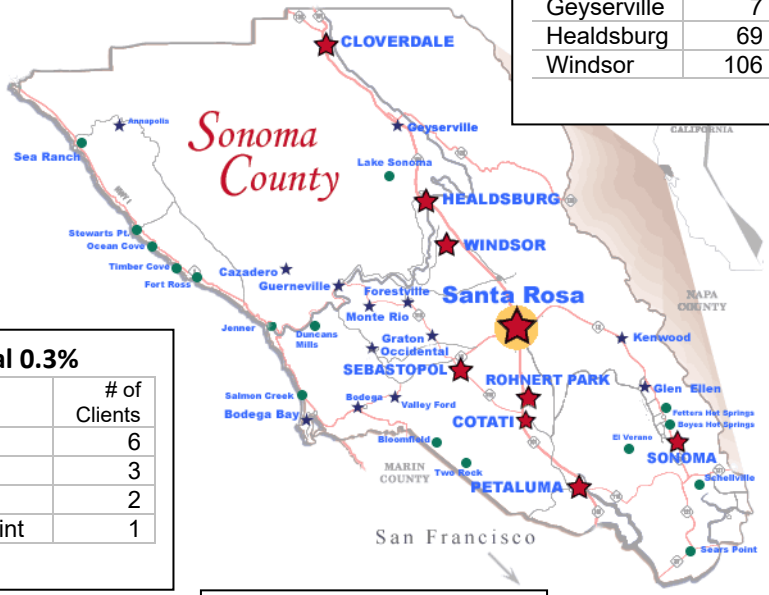
RESULTS

North 7.3%

City	# of Clients
Cloverdale	71
Fulton	2
Geyserville	7
Healdsburg	69
Windsor	106

Central 57%

City	# of Clients
Santa Rosa	1989



Coastal 0.3%

City	# of Clients
Bodega Bay	6
Jenner	3
Sea Ranch	2
Stewart's Point	1

East 5.2%

City	# of Clients
El Verano	3
Glen Ellen	21
Kenwood	4
Sonoma	151
Eldridge	1

West County 6.9%

City	# of Clients
Annapolis	1
Cazadero	2
Forestville	28
Graton	4
Guerneville	49
Monte Rio	9
Occidental	5
Rio Nido	7
Sebastopol	137

South 15.6%

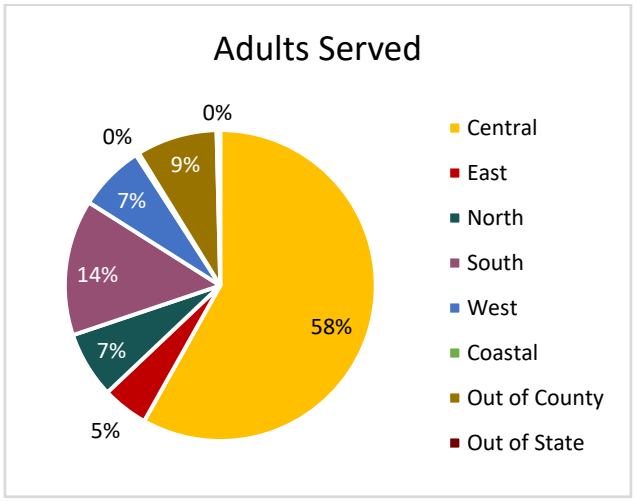
City	# of Clients
Cotati	65
Penngrove	12
Petaluma	257
Rohnert Park	211

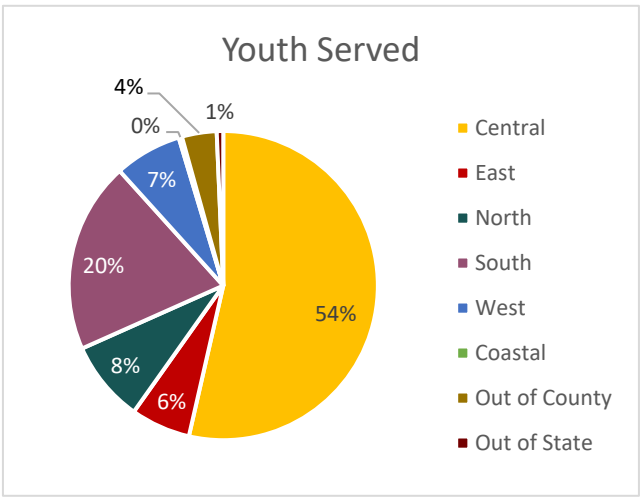
Out of County 7.7%

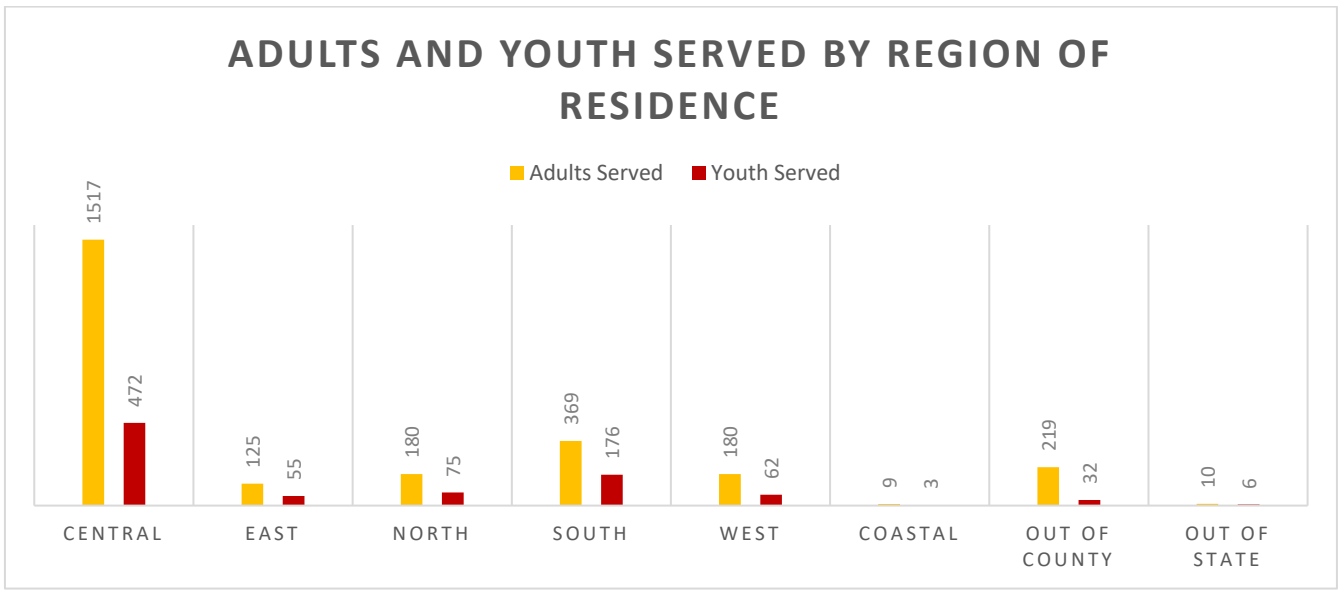
City	# of Clients
Out of County	251
Out of State	16

Adults and Youth by Region of Residence

Region	Adults Served	Youth Served	Total Served
Central	1517	472	1989
East County	125	55	180
North County	180	75	255
South County	369	176	545
West County	180	62	242
Coastal	9	3	12
Out of County	219	32	251
Out of State	10	6	16
Grand Total	**2609**	**881**	**3490**



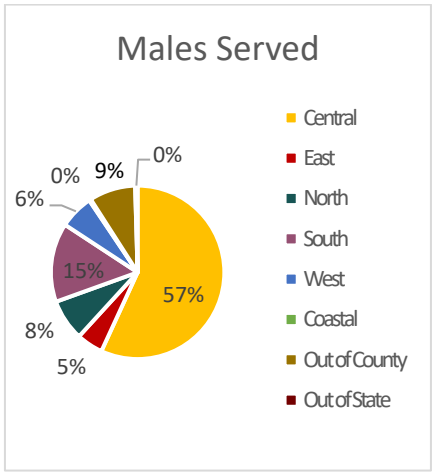


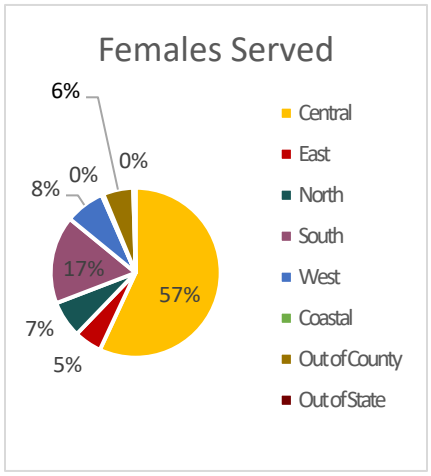


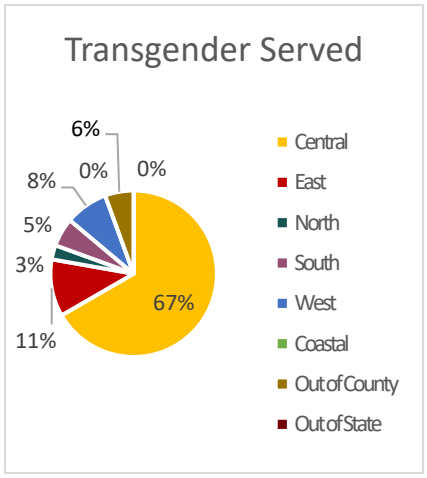
Of note, the numbers of youth who accessed care declined by 26% relative to the previous fiscal year. Residents of the outlying regions are accessing care at an increasing rate, however some of this is related to the reclassification of Rohert Park (from Central County to South County).

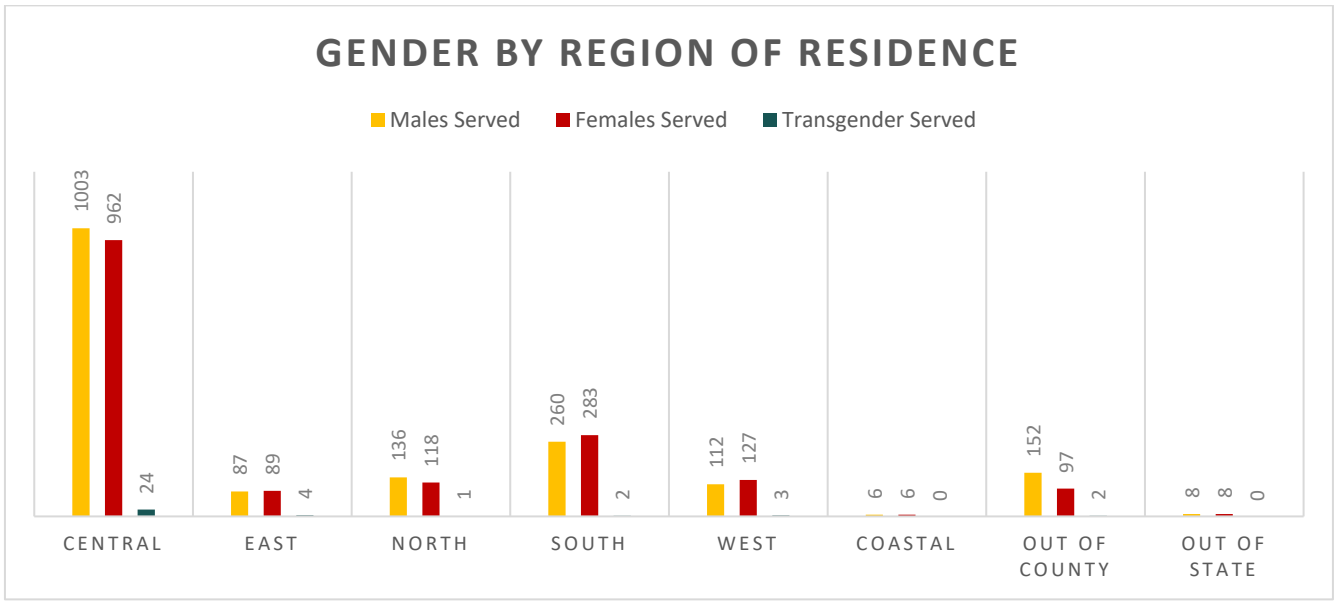
Gender by Region of Residence

Region	Males Served	Females Served	Transgender Served	Total Served
Central	1003	962	24	1989
East	87	89	4	180
North	136	118	1	255
South	260	283	2	545
West	112	127	3	242
Coastal	6	6	0	12
Out of County	152	97	2	251
Out of State	8	8	0	16
Grand Total	**1764**	**1690**	**36**	**3490**





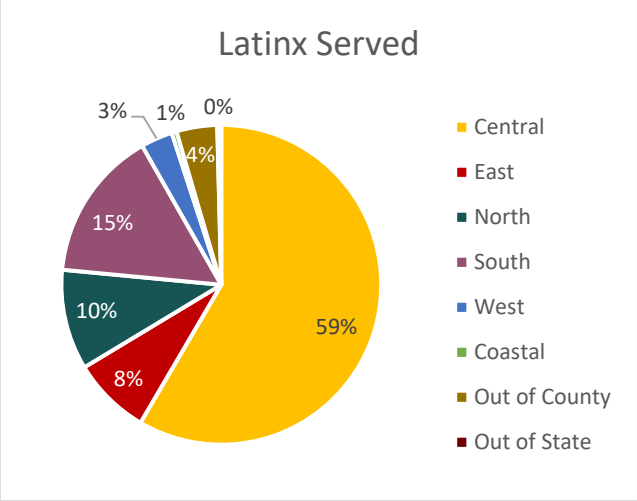


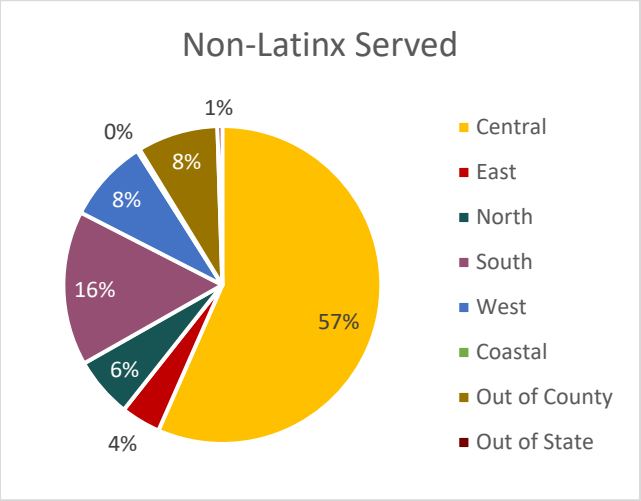


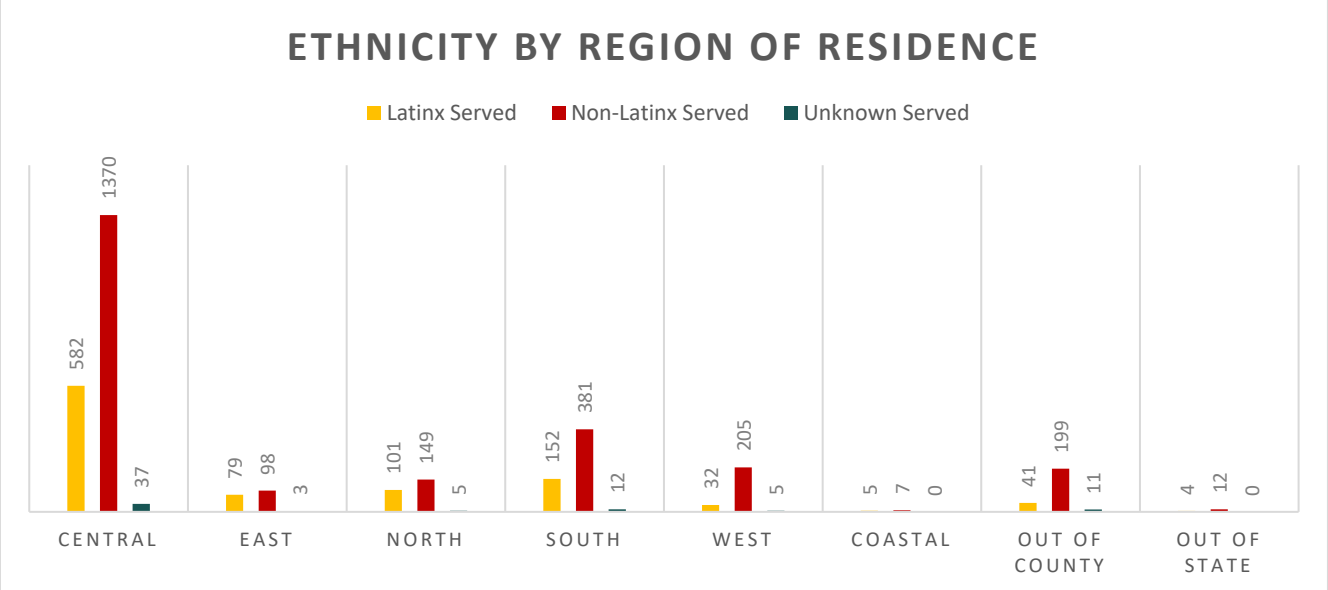
Slightly more males than females are served overall. The Out of County region had the greatest gender disparity, with more males than females being served outside of Sonoma County. Additionally, a significant increase in transgender individuals are accessing care (4x more than last year).

Ethnicity by Region of Residence

Region	Latinx Served	Non-Latinx Served	Unknown Ethnicity	Total Served
Central	582	1370	37	2371
East County	79	98	3	148
North County	101	149	5	244
South County	152	381	12	324
West County	32	205	5	254
Coastal	5	7	0	14
Out of County	41	199	11	245
Out of State	4	12	0	7
Grand Total	**996**	**2421**	**73**	**3490**







While overall Sonoma County saw a 3% reduction in beneficiaries served in FY20-21, due to the reclassification of Rohert Park (from Central County to South County the Southern part of the county reflects an increase in beneficiaries served and a concomitant decrease in the Central region.

Program Census Report

Regional Summary of Service Catchment Areas (Hospital Admissions Removed)

REGION	UNIQUE CLIENTS SERVED	ADMISSIONS DURING FY 20-21	DISCHARGES DURING FY 20-21
CENTRAL	2410	2352	3258
EAST	37	14	6
NORTH	171	90	95
SOUTH	269	126	102
WEST	144	66	53
COUNTYWIDE SERVICE	1205	1922	1937
OUT OF COUNTY	223	61	52
GRAND TOTAL	**3281**	**4164**	**5044**

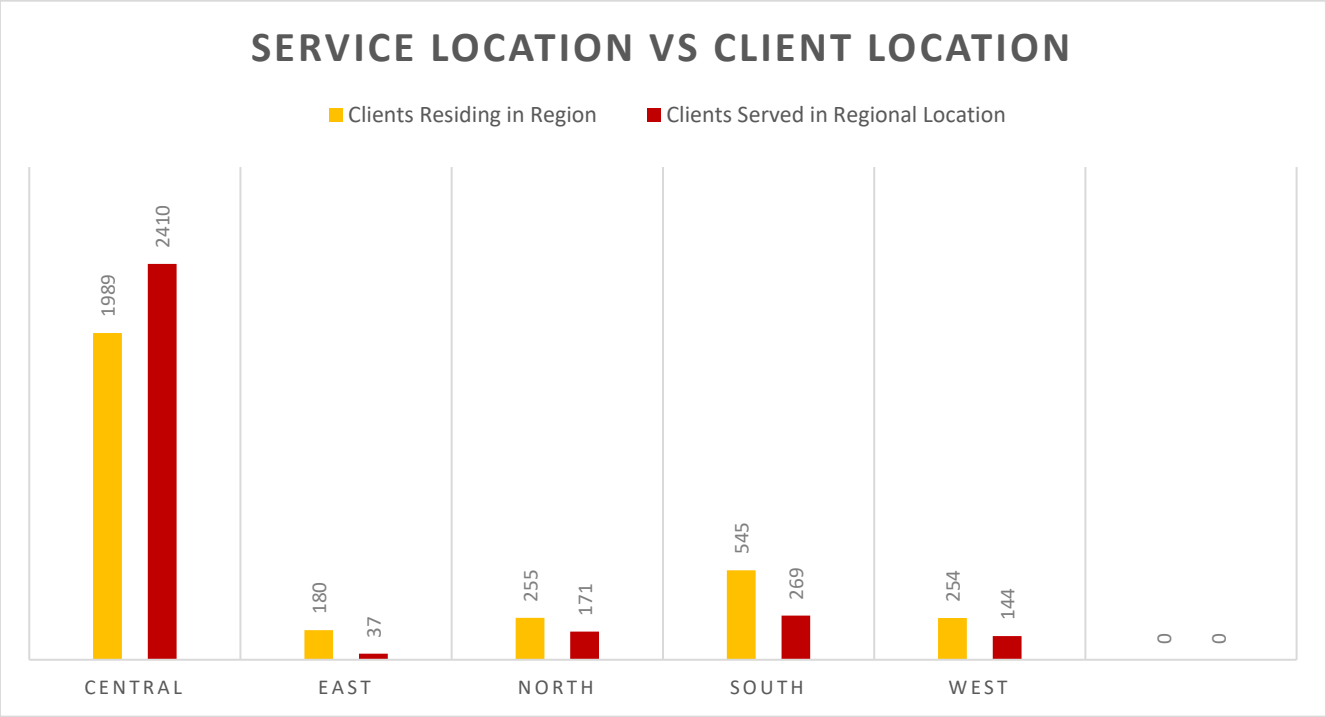
County Programs by Service Catchment Area

Program	Region	Unique Clients Served	Admissions During FY 20-21	Discharges During FY 20-21
Access Team Adult	Central	497	468	460
Adult Med Support	Central	1007	86	930*
Adult Services	Central	632	108	171
CMHC Cloverdale	North	50	16	11
CMHC Guerneville	West	72	20	14
CMHC Petaluma	South	151	46	43
CMHC Sonoma	East	37	14	6
Collaborative Treatment Recovery	Central	357	228	165
Crisis Stabilization Unit	Countywide	790	1188	1192
FACT	Countywide	63	18	23
Diversion	Countywide	16	12	3
FASST	Central	455	265	187
Foster Youth Team	Countywide	176	101	120
Integrated Recovery Team	Central	161	45	72
Older Adult Team	Central	75	41	14
SonomaWorks	Central	85	60	66
Transitional Age Youth	Central	60	21	14
Transitional Recovery	Out of County	211	58	51
Youth Access	Central	388	389	375
Youth and Family	Central	106	106	114
YFS Juvenile Hall	Countywide	64	63	71
YFS Valley of Moon	Countywide	42	43	43
Youth Med Support	Central	456	137	402*

* Clients were closed to duplicate med episodes so med services could be provided in the clinical episode.

Community Providers by Service Catchment Area

Program	Region	Unique Clients Served	Admissions During FY 20-21	Discharges During FY 20-21
Alternate Family Services	West	23	8	10
Buckelew CTRT	Central	146	92	57
Buckelew FACT	Central	44	29	23
Buckelew ISHP	Central	40	29	20
Buckelew SCIL	Central	126	33	26
Buckelew TAY	Central	22	10	5
CSN A Step Up	Countywide	22	16	15
CSN Bridges	Countywide	19	12	13
CSN E Street Residential	Countywide	19	16	12
CSN Opportunity House	Countywide	50	47	42
Harstad House CRU	Countywide	132	162	164
Lifeworks TBS	Central	72	55	52
Lifeworks Therapy	Central	105	69	53
Progress Sonoma CRU	Countywide	126	152	152
Parker Hill Residential	Countywide	25	17	15
SAY FASST	Central	124	71	103
SAY Tamayo Village	Central	12	6	4
SAY TBS	Central	32	29	22
SAY Therapy Clinic	Central	68	45	35
Seneca Kuck TBS	South	118	80	59
Seneca Wikiup Wrap	North	121	74	84
St Vincent's MH Service	Out of County	9	2	1
St Vincent's TBS	Out of County	6	1	0
Telecare Sonoma ACT	Central	74	8	13
TLC Services	West	63	38	29
Victor Treatment Center	Countywide	29	16	17



Client Residence vs Service Location reveals gaps in service accessibility in the regional outlying areas, particularly in 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

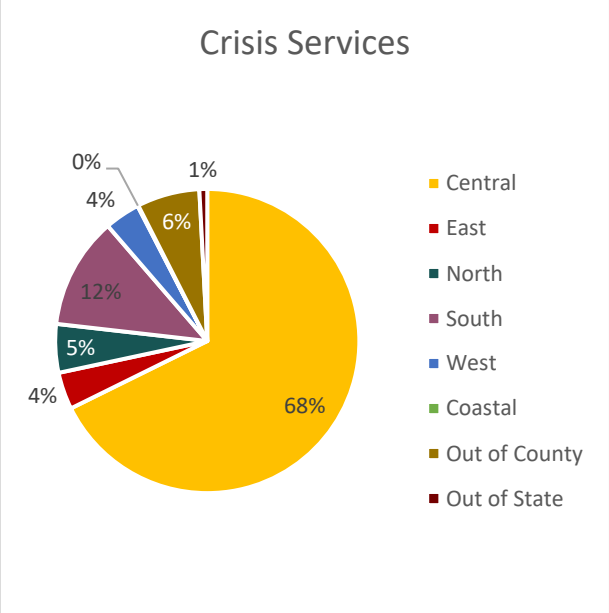
Services Delivered by Region of Residence

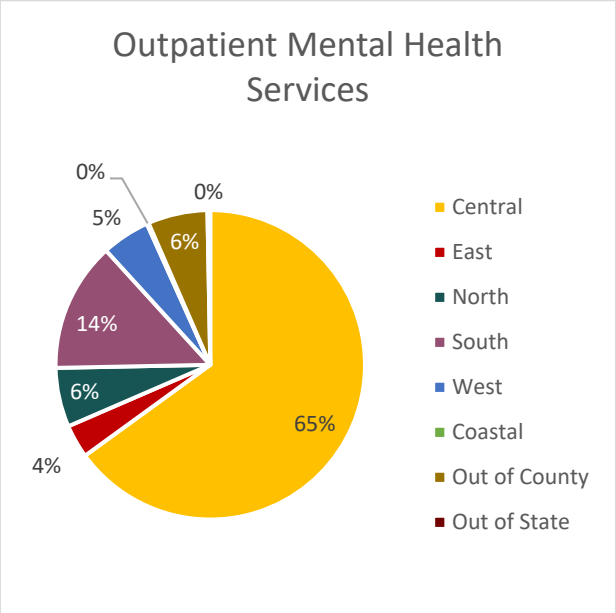
Service	Central	East	North	South	West	Coastal	Out County	Out of State
Adult Residential	5,296	62		1,315			761	
Assessment	3,995	333	524	1,073	394	21	340	24
Board and Care	52,511	79	3,808	474	516		24,849	
Collateral	4,170	347	602	1,392	556	17	269	12
Crisis Intervention	733	31	51	123	50		32	2
Crisis Residential	3,742	181	257	630	123		393	41
Crisis Stabilization	1,687	147	162	326	169	8	181	33
ECT	13	16						
Family Therapy	535	82	78	213	100	1	50	11
FSP Other	1,038	36	105	236	81		51	
Group Therapy	270	10	7	21	188		203	
Individual Therapy	8,222	687	958	2,488	881	44	952	75
Intensive Care Coordination	2,878	329	592	397	262		553	132
Intensive Home Based Service	918	146	258	245	222		192	75
Long Term Care	10,871			224			16,579	
Medication Support	16,807	984	2,098	3,804	1,631	93	1,548	106
No Procedure Code/non-billable	9,761	901	1,297	3,030	1,059	109	573	82
Plan Development	4,703	343	687	1,317	451	14	383	49
Rehabilitation Group	8,395	53	319	530	149		753	
Rehabilitation Individual	13,826	512	1,024	2,163	696	39	1,282	28
Targeted Case Management	18,265	1,022	1,374	4,323	1,519	70	2,568	126
TBS	1,646	154	251	885	223	42	42	
Unlicensed Residential	4,925	16	120	205			68	
Grand Total	**175,207**	**6,471**	**14,572**	**25,414**	**9,270**	**458**	**52,622**	**796**

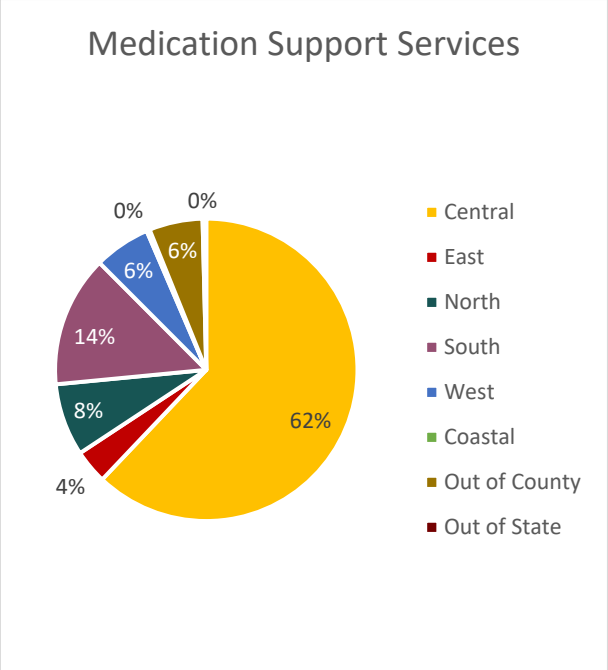
Gaps in Service Type

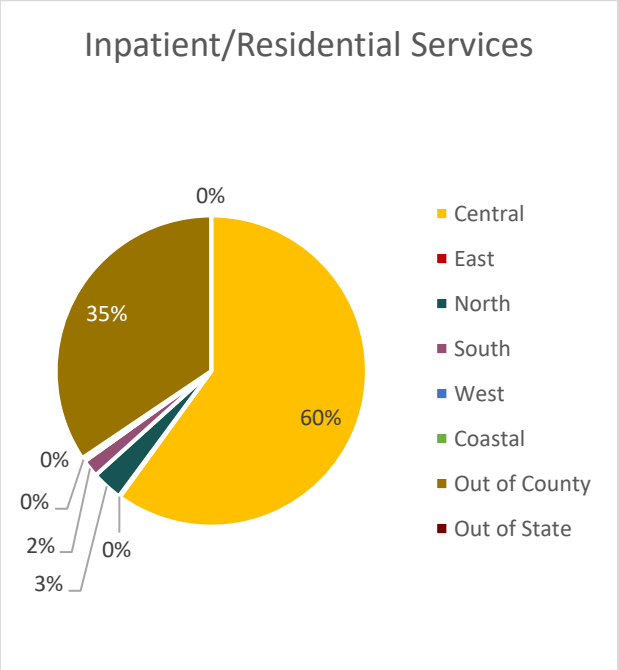
Service Detail by Region shows that a limited amount of Group Therapy and Family therapy is conducted across the system. Very few services were performed for coastal residents, consistent with previous years. Board and Care, Medication Support, and Targeted Case Management were the top 3 billed services.

Service Categories by Region of Residence







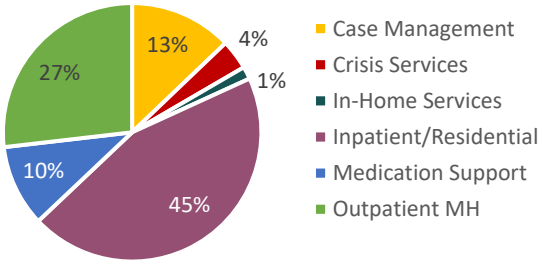


The regional service utilization is similar to the previous fiscal year (FY19-20), with the exception of the reclassification of Rohnert Park, which changed the regional distribution of clients in the south and central regions.

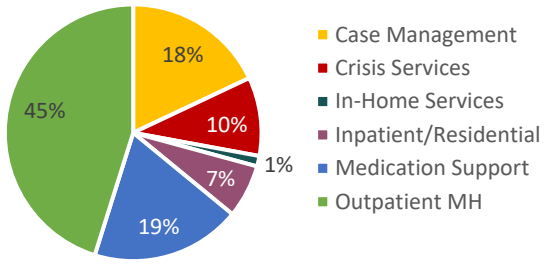
It appears from the charts above that a disproportional amount of residential/inpatient services goes to residents of the Central Region. However, in most cases, address of record changes to the residential facility upon admission, which artificially inflates this number.

Portrait of Service Utilization by Region

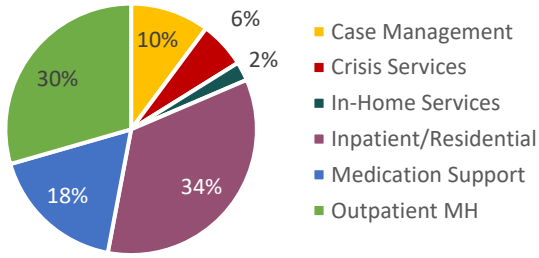
Central Region



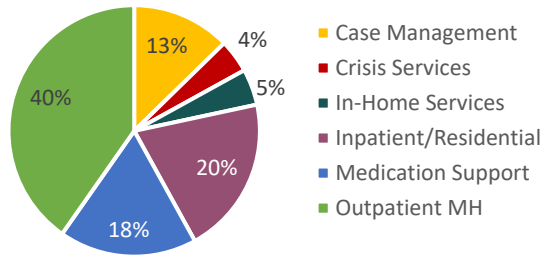
East Region



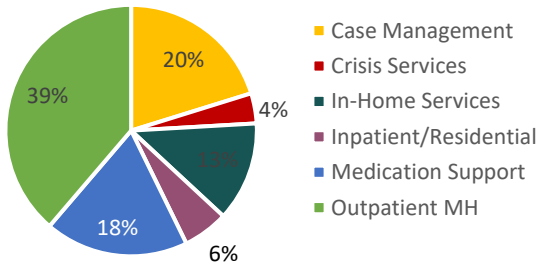
North Region



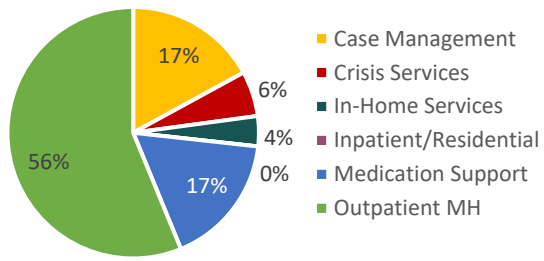
South Region



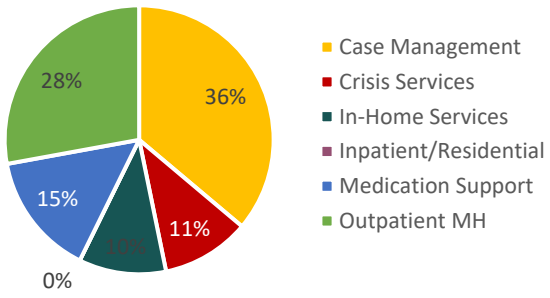
West Region



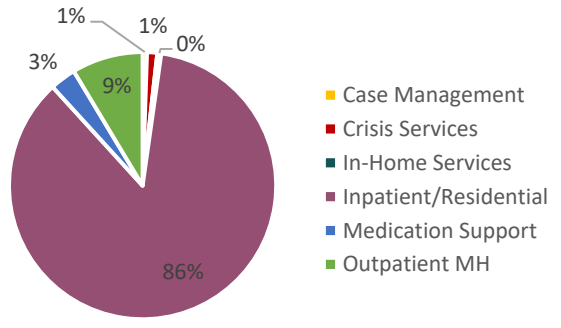
Coastal Region



Out of State



Out of County



Narrative Summary of Findings

In Sonoma County, 56.99% of Mental Health clients reside in the Central Region (now defined as the City of Santa Rosa), while 35.36% of clients reside in the outlying regions, and 7.19% 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 (61.42%); however, only 20.19% of services were delivered to residents of the outlying regions, while 18.39% of services were delivered to clients residing out-of-county.

Region	Percentage of Clients Residing in Region	Percentage of Services Delivered to Residents of Region
Central	56.99%	61.42%
East	5.16%	2.33%
North	7.31%	5.19%
South	15.62%	9.14%
West	6.93%	3.34%
Coastal	0.34%	0.17%
Out of County	7.19%	18.39%

Age Differences

The numbers of youth who accessed care declined by 26% relative to the previous fiscal year.
In addition, compared to adults, a somewhat larger percentage of Child/Youth clients reside outside Santa Rosa (46%) vs 42% for adults.

Gender Differences

Overall slightly more males are served in Behavioral Health than females. Of note, significantly more males are served out-of-county than females, indicating that more males are on conservatorship than females. Also of importance this year, Transgender clients increased fourfold over last year (from 8 clients last year to 36 this year).

Ethnic Differences

Both Latinx and Non Latinx clients decreased from the previous year, although not in equal proportions. Non LatinX population realized a sharper decrease (4.8%) than did Latinx (3.6%). The majority of Latinx clients live in Santa Rosa/Central region, however significant numbers of Latinx clients live in East County and North County—where over 40% of clients identify as Latino/x/Hispanic. Of note, the number of clients with unknown or undeclared ethnicity doubled in size from last year.

Gaps in Service Delivery

Clients living in the outlying regions outside Santa Rosa/Central are travelling to Santa Rosa for services outside their regional communities of residence. The problem is most pronounced for clients living in the East and South portions of the county.

Recommendations

Based upon the analysis above, the following is recommended:

- Training and management practices to reinforce collection of ethnicity data at screening and assessment
- Increased bilingual/bicultural staffing, particularly in the outlying regions
- Implement family therapy and group therapy options across the system of care, as well as youth focused and parent focused groups. As a higher percentage of the youth service population lives in outlying regions, consider piloting new family therapy and parenting groups there.
- Explore early intervention and prevention evidence-based services to reduce out-of-county placements

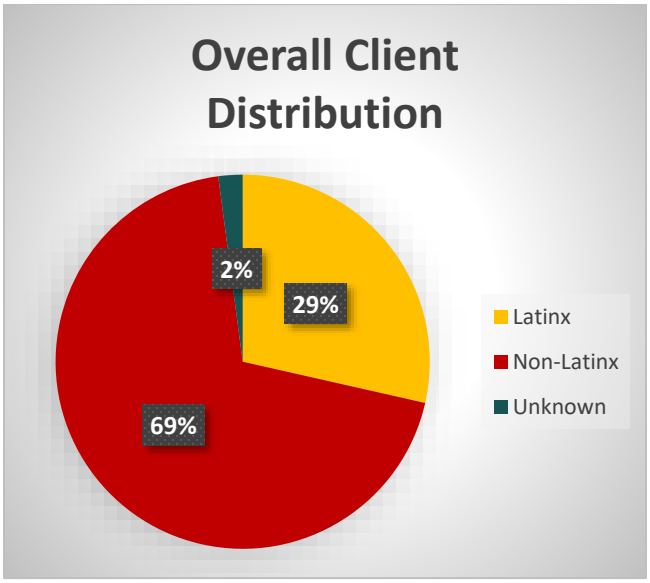
Latinx Services: **The MHP tracks Latinx service utilization and seeks to increase the Latinx service penetration rate in order to match community Medi-Cal eligible demographics.**

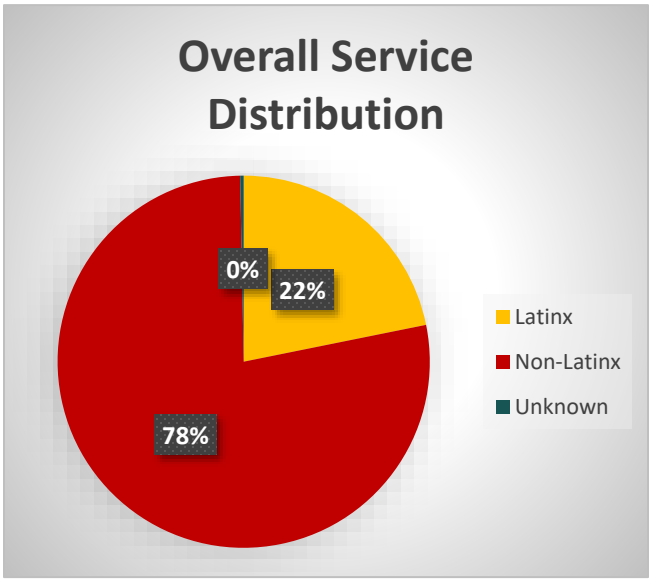
PROCESS USED TO EVALUATE
Avatar – Demographic Report
DHCS Data Portal – Medi-Cal Eligibility by Race/Ethnicity Report

RESPONSIBLE STAFF – QI Manager

RESULTS

Approximately 42% of Sonoma County Medi-Cal eligible residents identify as Latino/Hispanic/Latinx. SCBH served 3,490 unique clients in FY 20-21. 996 unique clients identified as Latino/Hispanic/Latinx. 2,421 unique clients were non-Latinx. 73 unique clients had unknown ethnic identity.



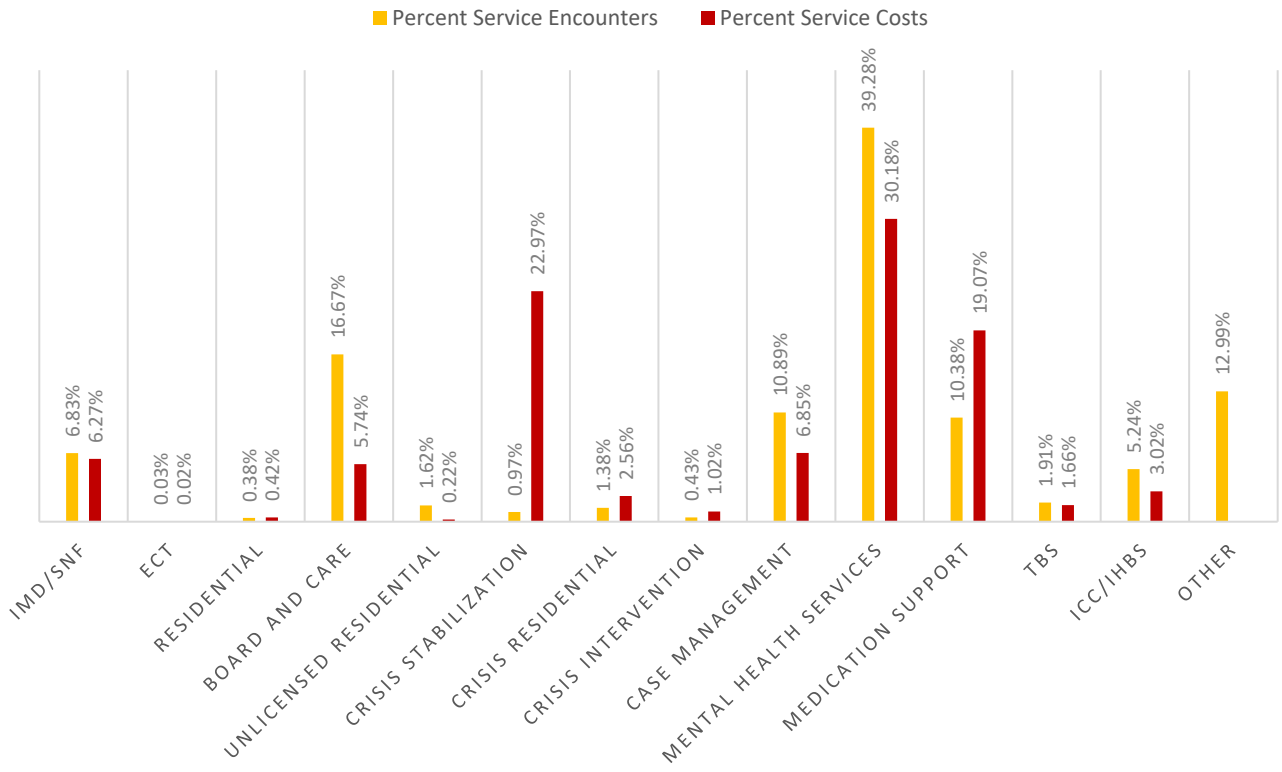


*Of note is that while 29% of unique clients identified as Latinx, they only received 22% of the total services.

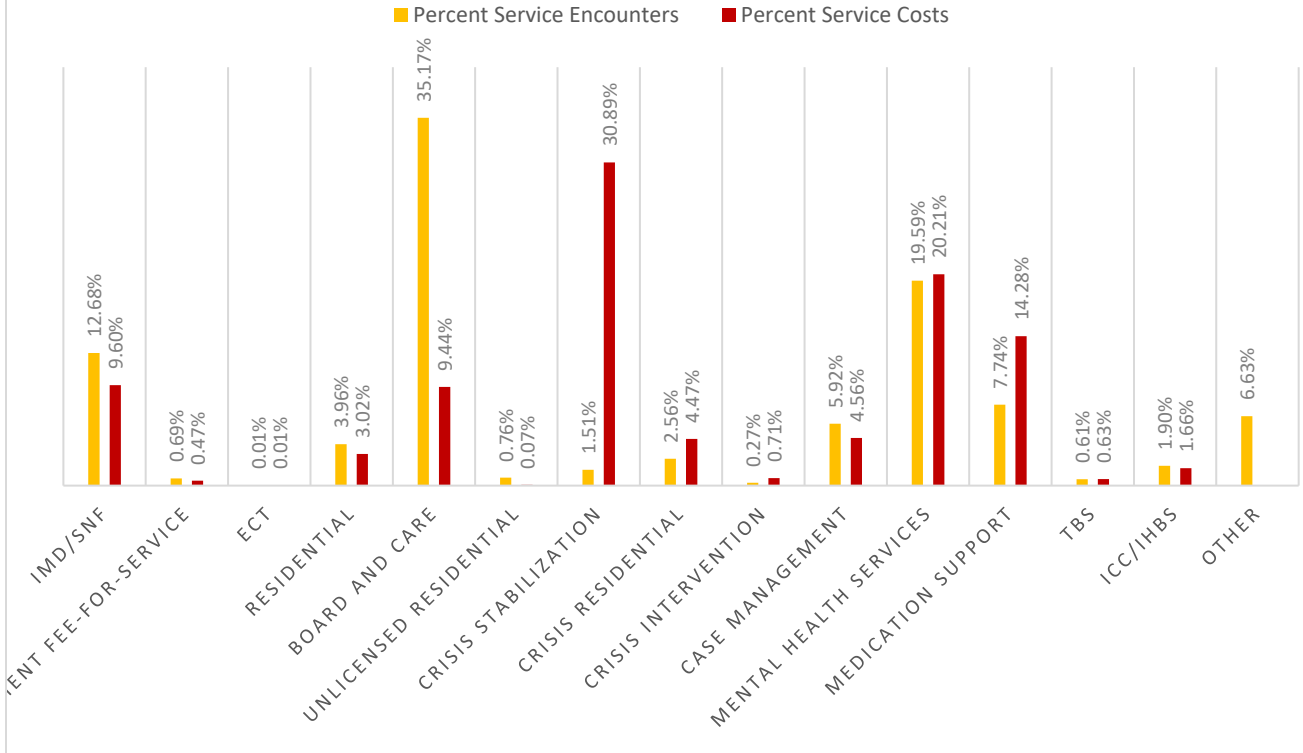
Service Counts vs Cost

Service Categories	Service Counts			Service Costs		
	Latinx	*Non-Latinx*	*Unknown*	*Latinx*	*Non-Latinx*	*Unknown*
IMD/SNF Services	4,342	23,332		893,207.40	3,924,250.70	
ECT	16	13		3,196.80	2,597.40	
Residential Services	239	7,195		59,690.20	1,613,610.92	
Board and Care Services	10,594	71,504	139	816,973.79	4,782,762.33	24,200.00
Unlicensed Residential	1,028	4,306		31,855.36	179,306.72	
Crisis Stabilization	617	2,089	7	3,270,680.56	11,188,632.28	51,820.44
Crisis Residential	876	4,491		363,995.40	1,870,489.41	
Crisis Intervention	271	747	4	145,229.97	479,957.14	453.72
Case Management	6,924	22,199	144	974,553.46	3,652,461.11	23,260.83
Mental Health Services	19,246	49,830	338	3,166,752.02	9,995,424.27	104,541.73
Medication Support Service	6,598	20,322	151	2,715,668.31	7,598,848.06	50,266.50
Therapeutic Behavioral Services	1,214	2,029		236,786.86	392,367.51	
Katie A ICC/IHBS	3,332	3,864	3	430,058.58	573,747.43	213.64
Other (NPC, No-Show, etc.)	8,258	14,839	99			
Grand Total	63,555	226,760	885	14,237,200.11	46,254,455.28	254,756.86

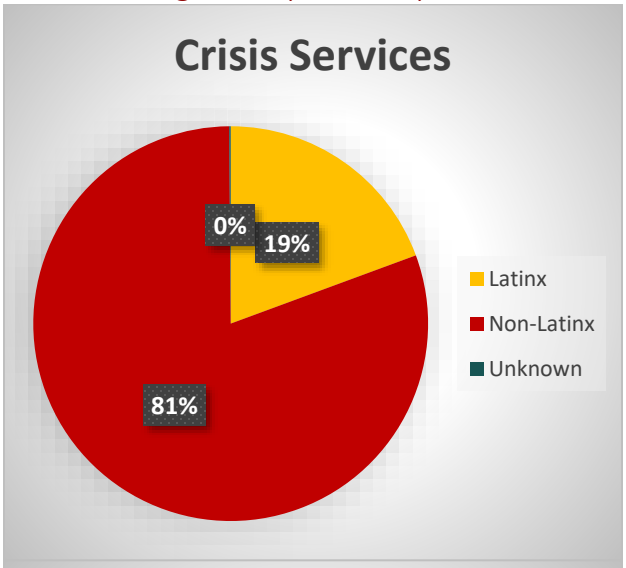
SERVICE ENCOUNTERS VS COST: LATINX

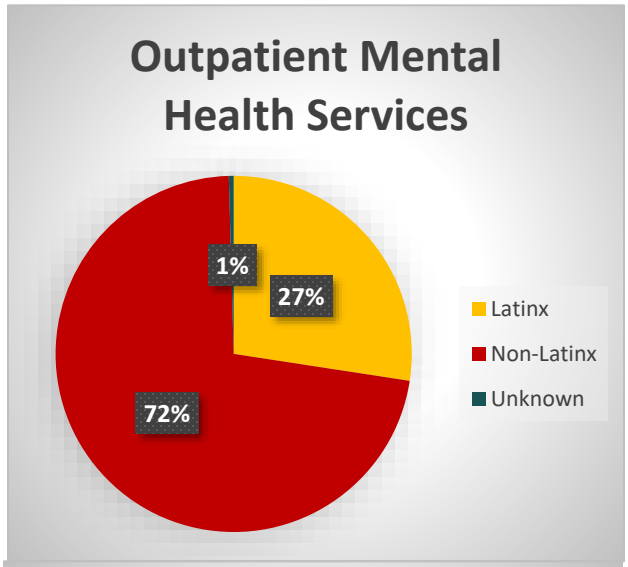


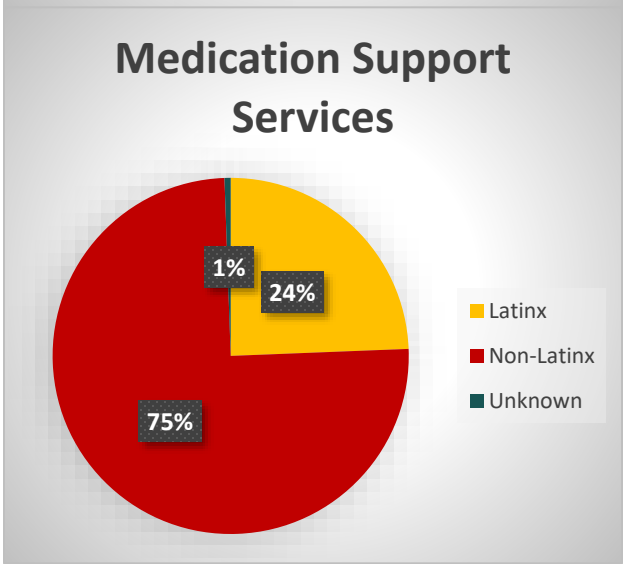
SERVICE ENCOUNTERS VS COST: NON-LATINX

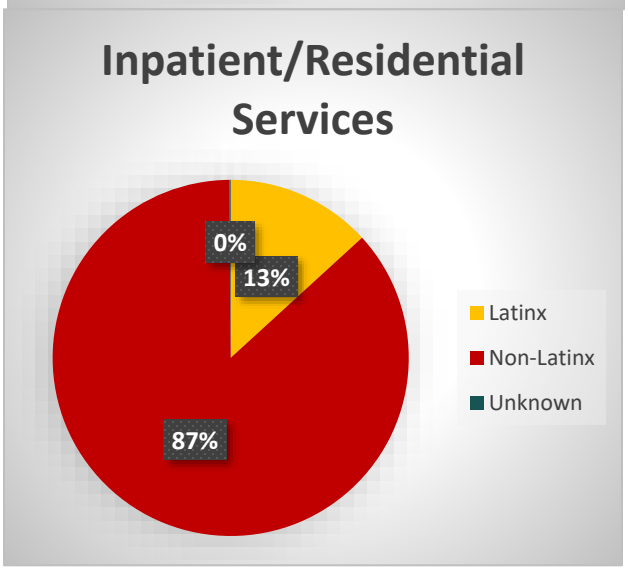


Service Categories by Ethnicity







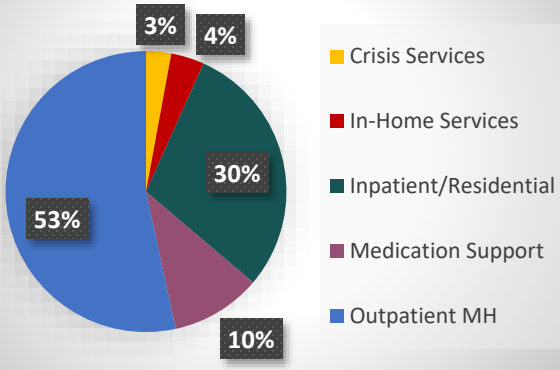


Latinx clients utilize Outpatient Mental Health and Med Support services at a higher rate than Non-Latinx clients. In contrast, non-Latinx clients utilize Board & Care and IMD/SNF level services at a much higher rate than Latinx clients.

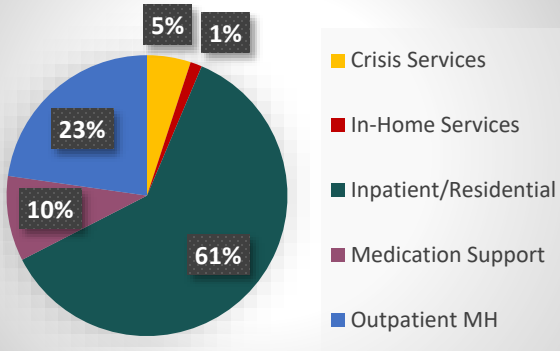
The following charts break down the service distribution by age group. Of note is the higher percentage of Inpatient/Residential service utilization among non-Latinx clients and the correlating higher utilization of Outpatient Mental Health services among Latinx clients. This is particularly evident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

Portrait of Service Utilization by Ethnicity

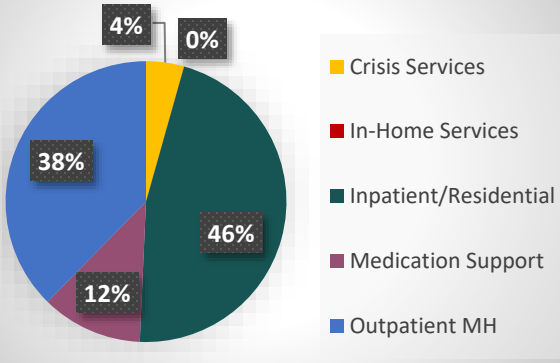
All Services: Latinx



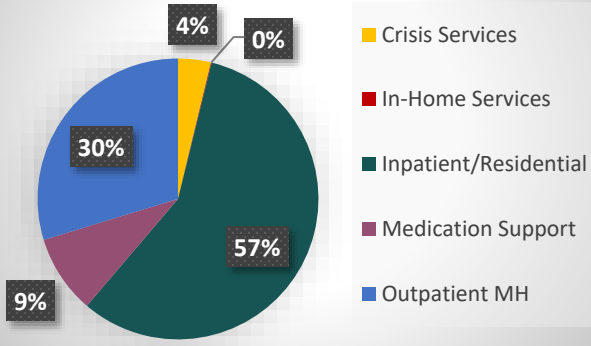
All Services: Non-Latinx



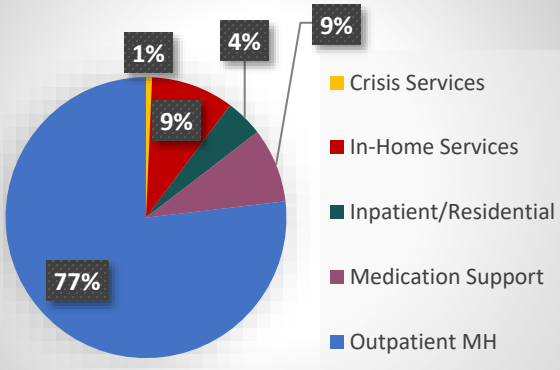
Adult Services: Latinx



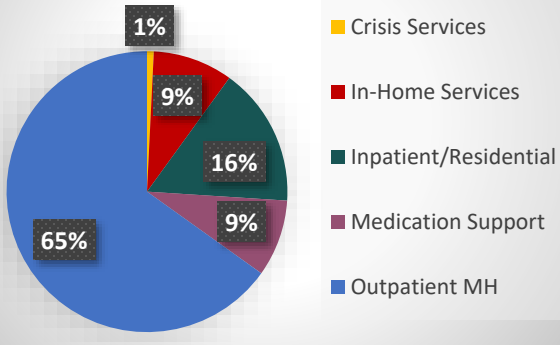
Adult Services: Non-Latinx



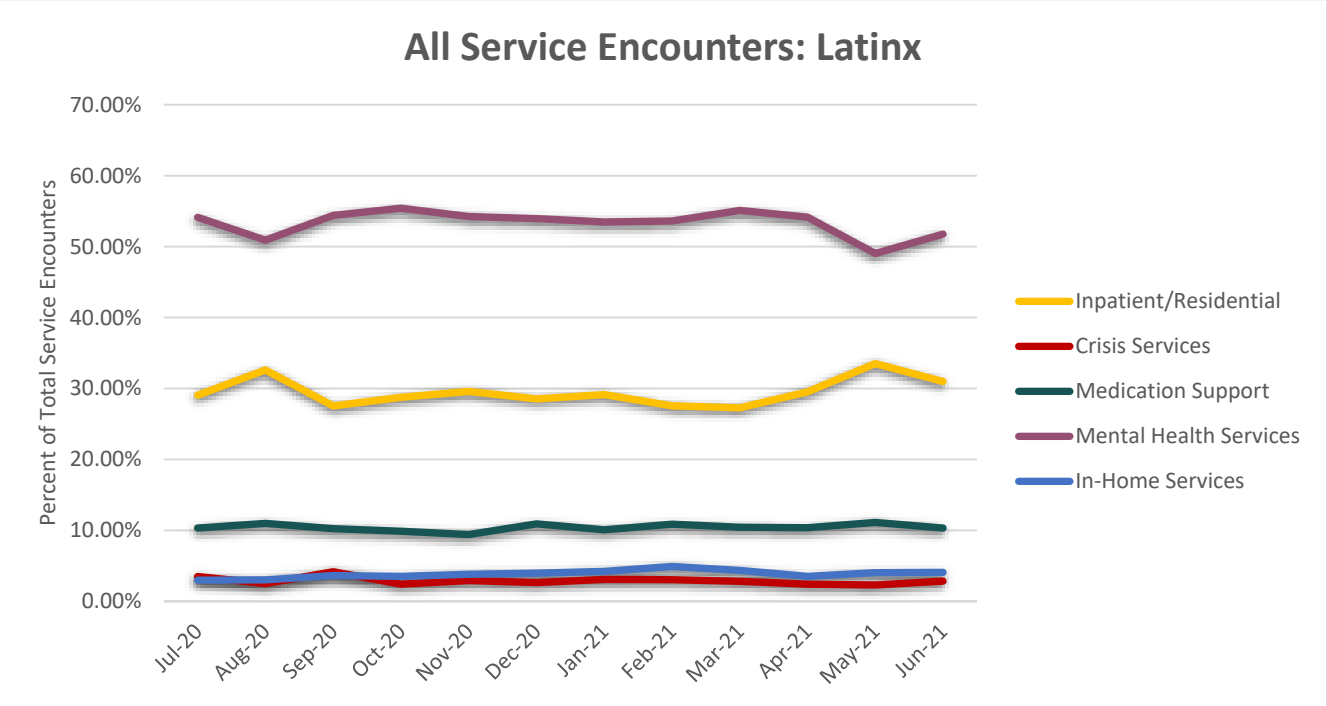
Youth Services: Latinx

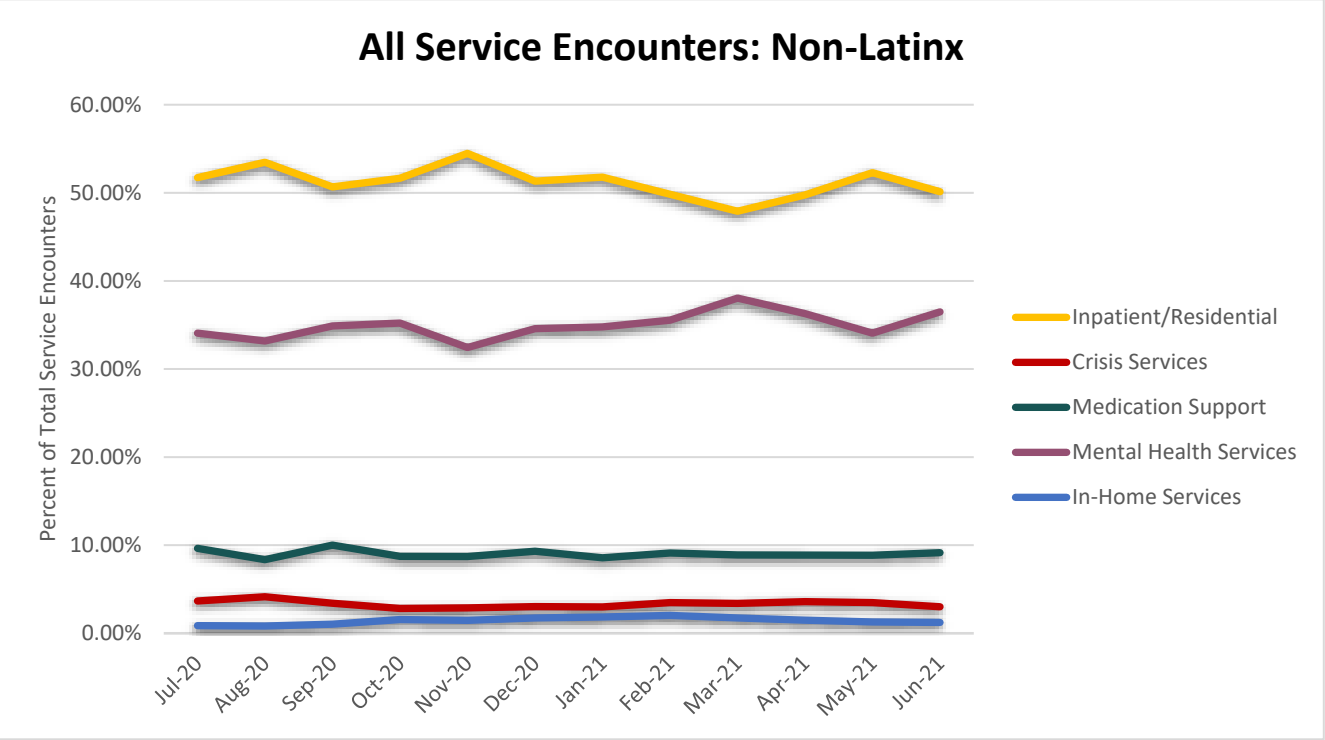


Youth Services: Non-Latinx

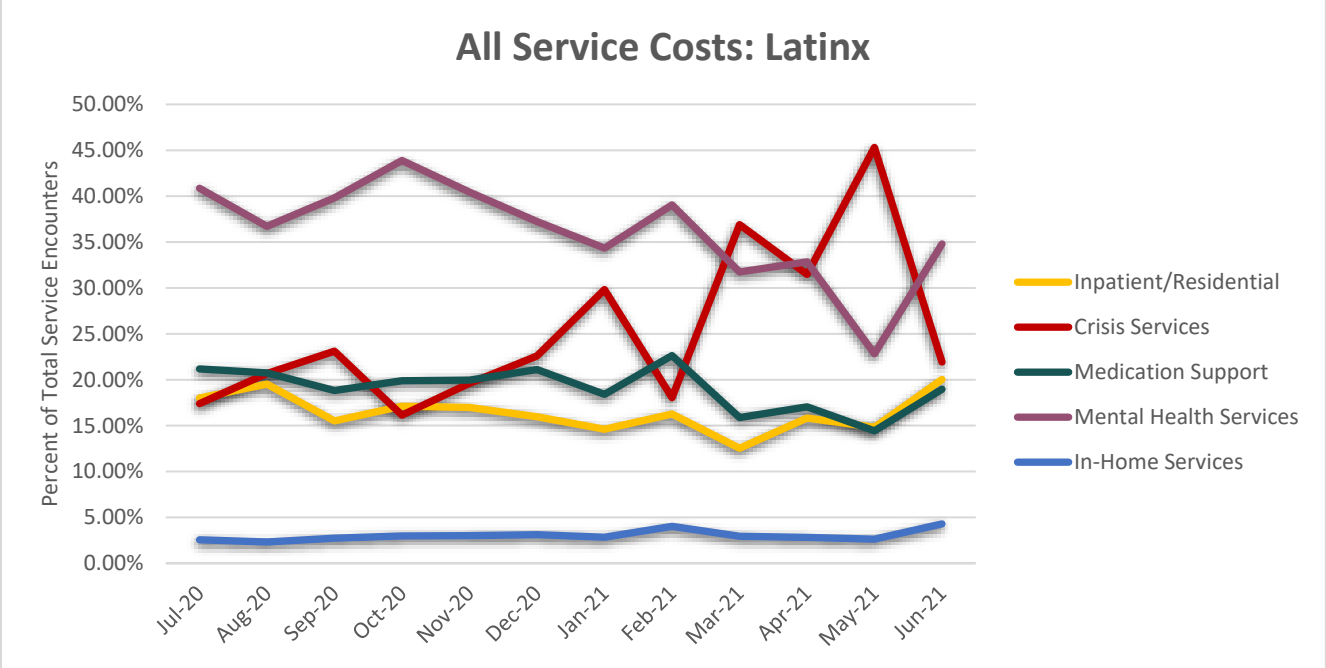


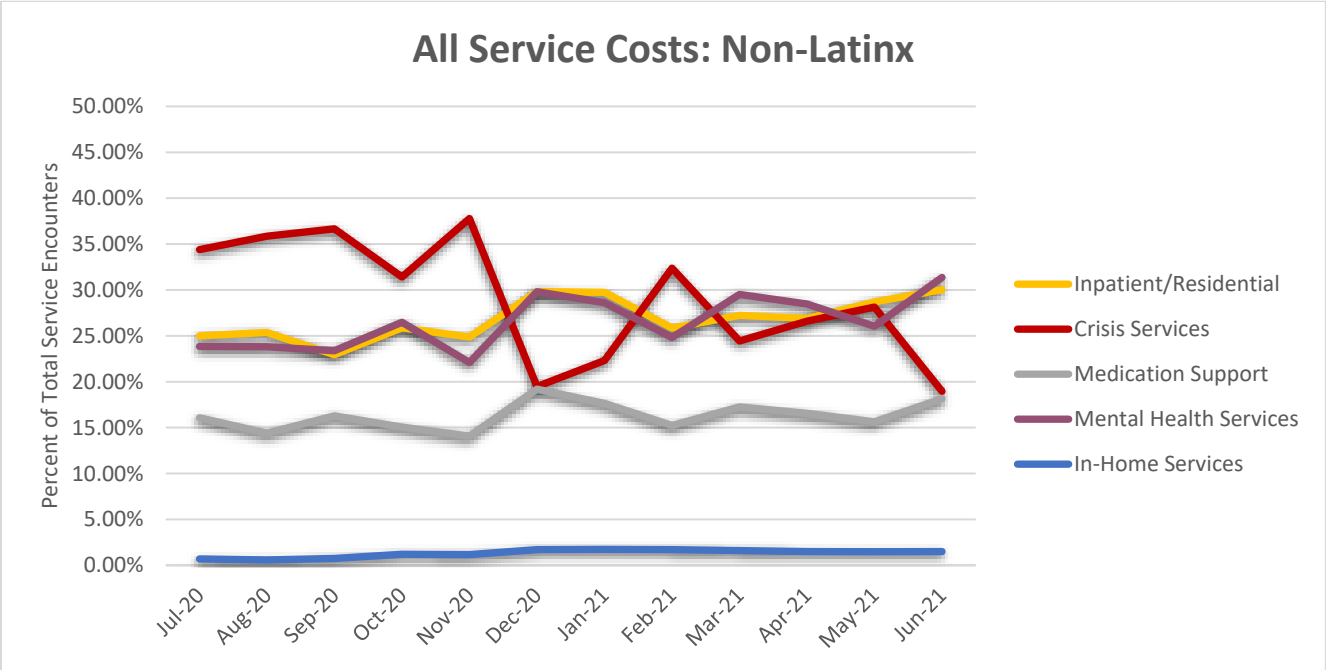
Service Trends





Both Latinx and non-Latinx service trends hold relatively steady over time.





Of note is the spike in Crisis service costs in May for Latinx clients. As a corollary, Mental Health Services declines at a similar rate. In contrast, Non-Latinx Crisis service cost trends show a sharp decline in November-December.

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.**

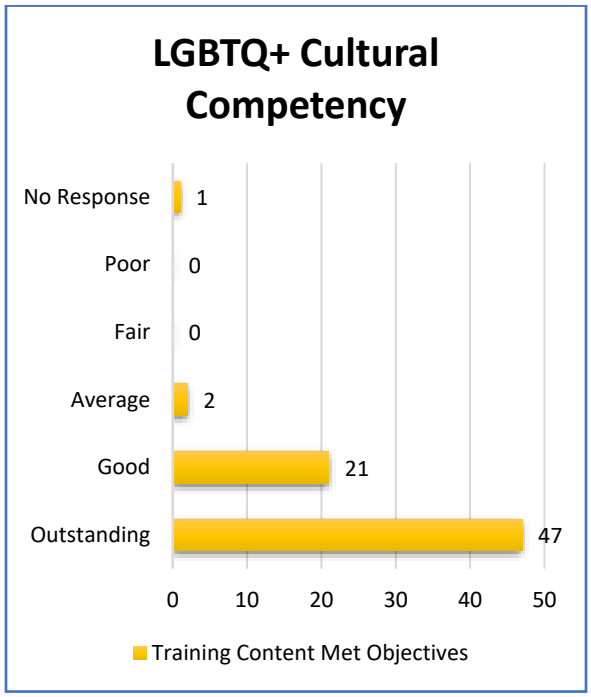
PROCESS USED TO EVALUATE
Staff Development Training CEU Program Evaluation Forms

RESPONSIBLE STAFF – QI Manager and WET Manager

RESULTS

DHS-BHD scheduled or sponsored two staff development training opportunities in FY20-21 to further cultivate cultural competency among staff; however, one of these trainings was cancelled. A new Staff Cultural Responsiveness Survey was completed during FY 20-21.

	Date	Training	Facilitated by
1	3/10/2021	LGBTQ+ Cultural Competency	Jessica Carroll, Maxwell Anderson, Mell Browning
2	5/12/2021	Peer Panel	Cancelled



Staff/Attendees were asked to rate the effectiveness of the presentation, including experiential or active learning. Staff reported overall high marks for the LGBTQ+ Cultural Competency training.

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 FY20-21

RESPONSIBLE STAFF – QI Manager and MHSA Coordinator

RESULTS

	FY19-20	FY 20-21	FY19-20	FY 20-21
County Contractors	**# of Employees**	**# of Employees**	**FTE**	**FTE**
West County Community Services:				
Wellness and Advocacy Center	14	14	11.88	12.55
Interlink Self-Help center	10	10	5.85	8.13
Petaluma Peer Recovery Program	5	6	1.37	3.1
Peer Support for Mobile Support Team	3	4	1.59	1.11
Senior Peer Counseling	N/A	2	N/A	0.72
Russian River Empowerment Ctr	N/A		N/A	
Whole Person Care Peer Outreach	3	6	1.21	1.2
Buckelew Programs:				
Family Service Coordinator	3	3	0.97	0.9
West County Community Services Programs:				
Russian River Empowerment Center	4	4	2.48	2.42
NAMI:				
Family Education Advocacy and Support Program	3	3	2.48	2.44
Total of County Contractors	**45**	**52**	**27.83**	**32.57**
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	5	1	1.19	0.5
Total FTE for all County-funded peer positions	**50**	**52**	**29.02**	**33.07**

Total number of consumer and family member staff at MHSA and other funded programs: 52 employees at 32.57 FTE

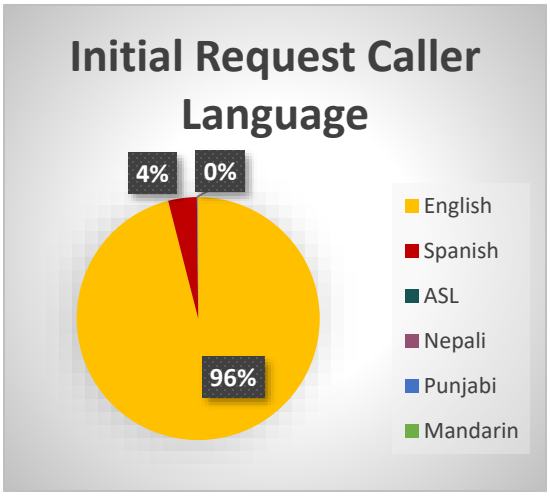
In FY20-21 the FTE for county-funded peer positions was 33.07 FTE, an increase of 14% from FY19-20.

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

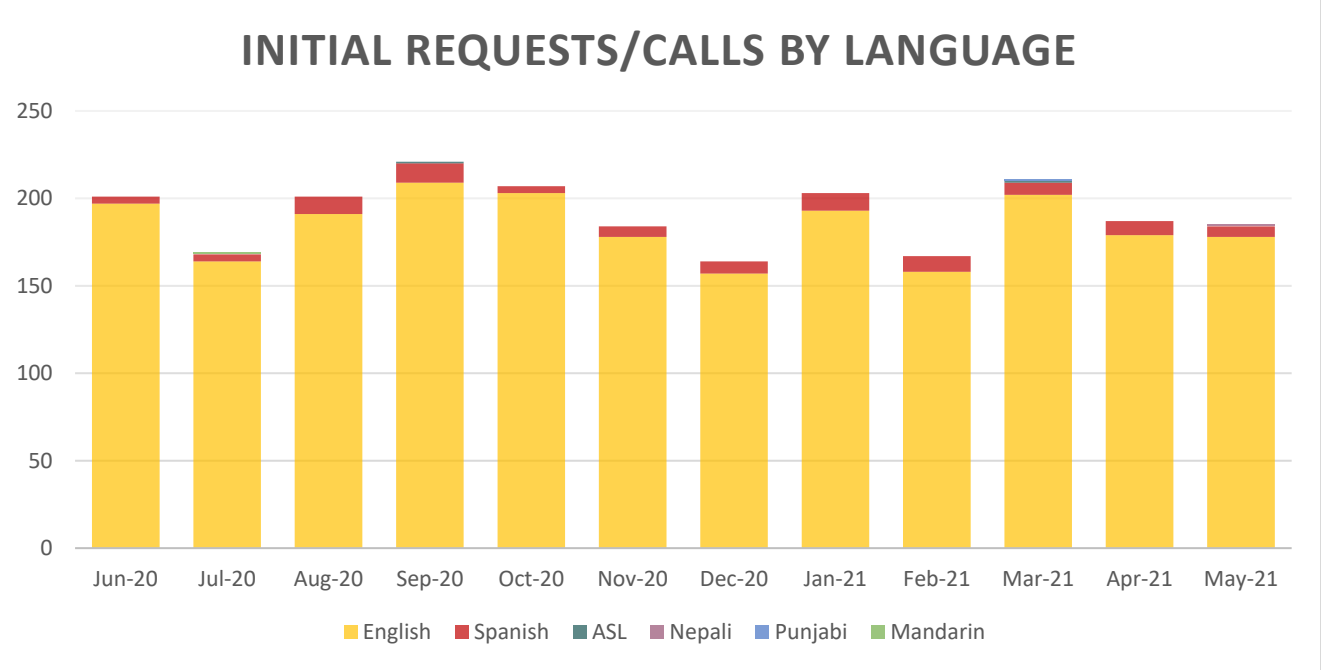
Access to services at DHS-BHD begins with a request for services to the Access Team. Requests are received by way of the 24/7 ACD line, faxed/emailed referrals, and walk-ins to the Access Clinic.

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	Nepali	Punjabi	Mandarin	Total
July	161	4				1	**166**
August	184	10					**194**
September	207	10	1				**218**
October	201	4					**205**
November	173	6					**179**
December	155	7					**162**
January	192	10					**202**
February	157	9					**166**
March	198	7			1		**206**
April	176	8					**184**
May	174	6		1			**181**
June	192	4					**196**
Total	**2170**	**86**	**1**	**1**	**1**	**1**	**2259**

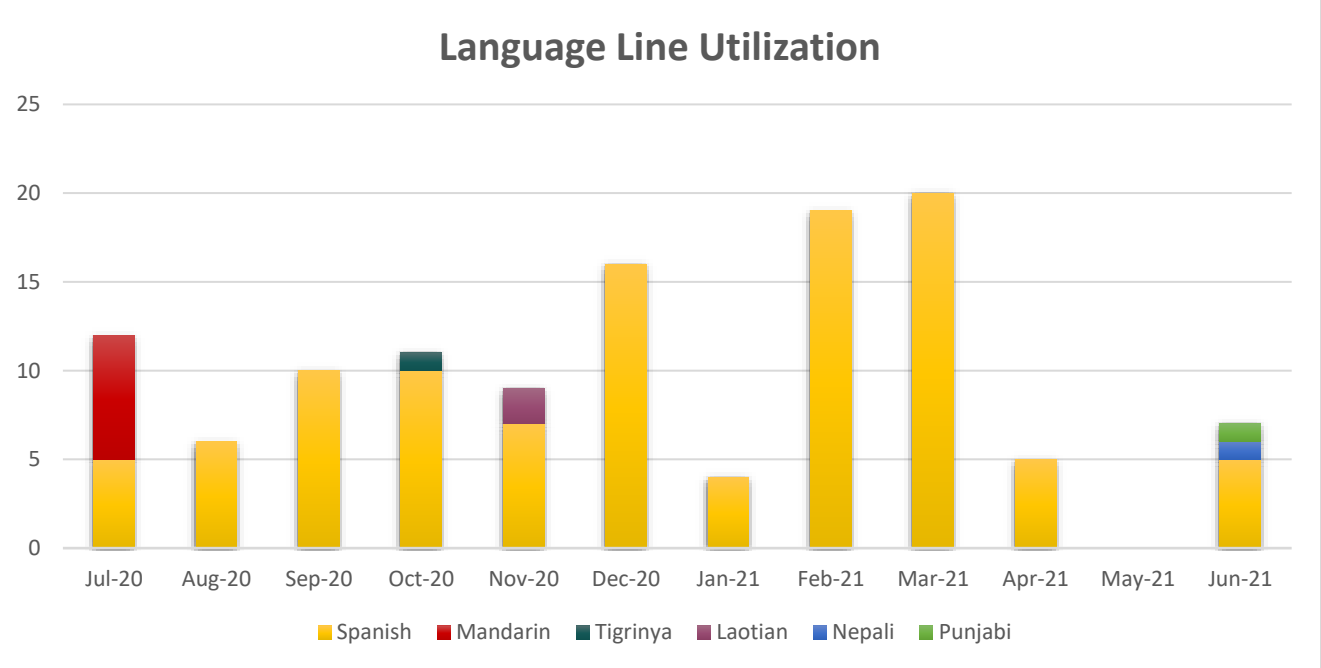


Language Line Utilization – Access

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	Mandarin	Tigrinya	Laotian	Nepali	Punjabi	Total
July	5	7					**12**
August	6						**6**
September	10						**10**
October	10		1				**11**
November	7			2			**9**
December	16						**16**
January	4						**4**
February	19						**19**
March	20						**20**
April	5						**5**
May							**0**
June	5				1	1	**7**
Total	**107**	**7**	**1**	**2**	**1**	**1**	**119**

Language Line utilization on the Access Teams peaked in February and March and returned to baseline by June.



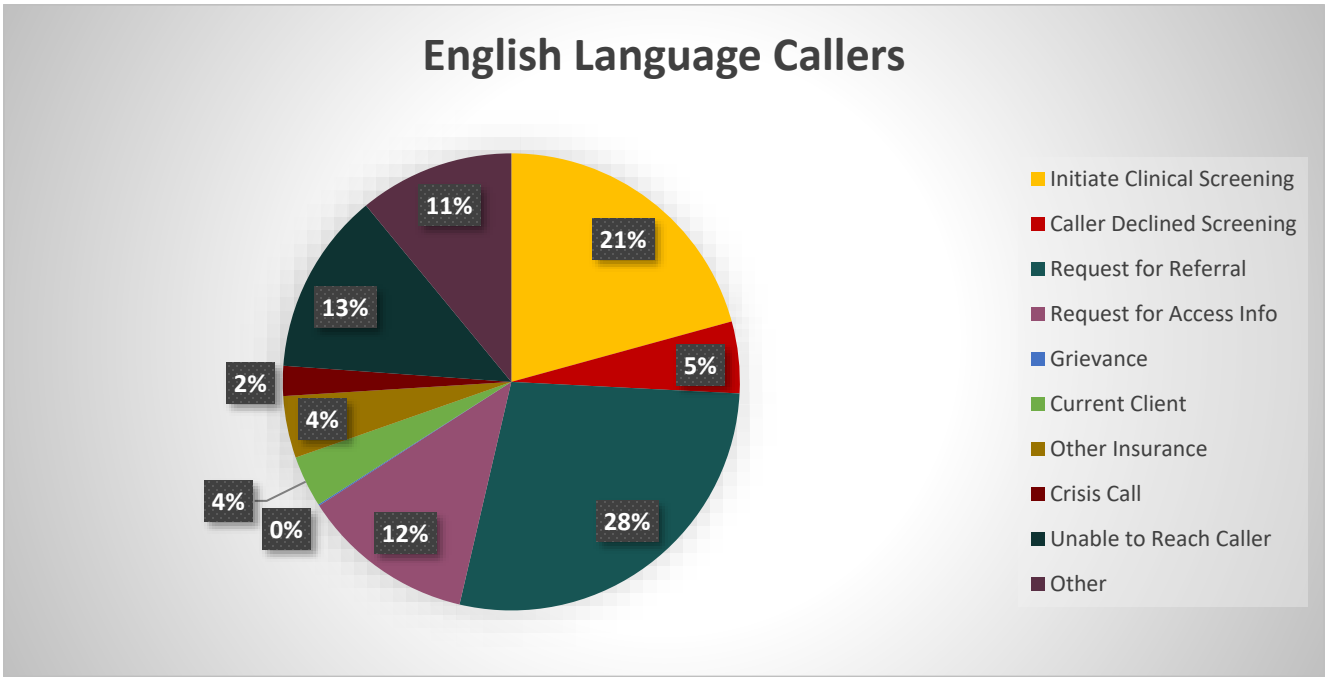
Call Log Disposition by Language

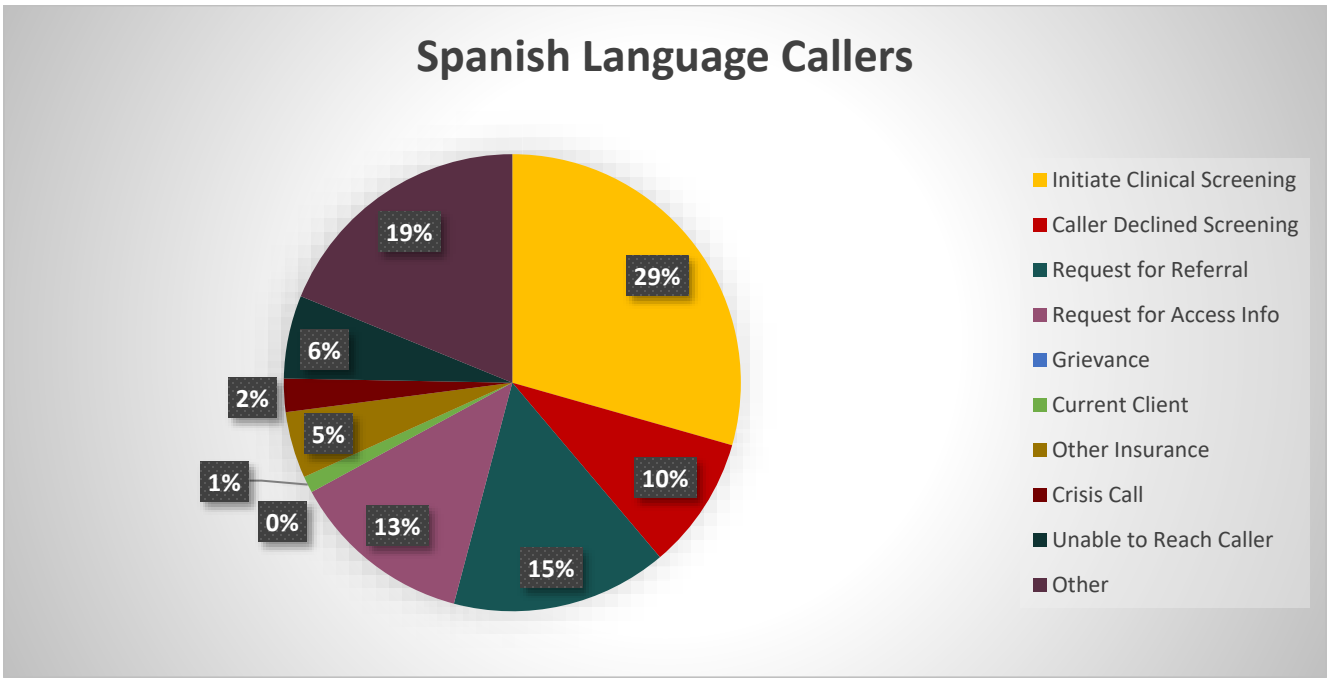
The Access Teams fielding the request call line receive several types of inquiries. Examples include:

- 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	Nepali	Punjabi	Mandarin	Total
Initiate Clinical Screening	450	25		1		1	**477**
Caller Declined Screening	110	8					**118**
Request for Referral	604	13			1		**618**
Request for Access Information	266	11					**277**
Grievance	2						**2**
Current Client	79	1					**80**
Other Insurance: Not Medi-Cal/Medi-Care	95	4					**99**
Crisis Call: Transferred CSU	46	2					**48**
Unable to Reach Caller	280	5					**285**
Other	238	16	1				**255**
Total	**2170**	**85**	**1**	**1**	**1**	**1**	**2259**





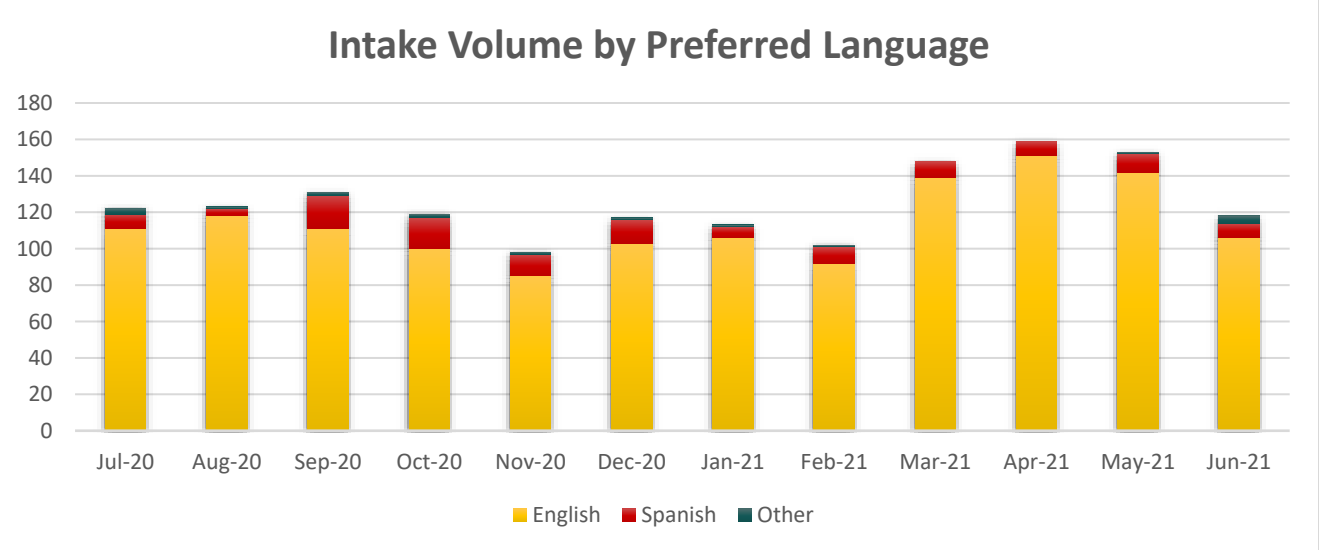
A larger percentage of Spanish-speaking callers initiated a clinical screening versus English-speaking callers. Amongst English-speaking callers, there was a higher incidence of calls requesting referral rather than assessment. Similarly, more than double the percentage of English-speaking clients could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

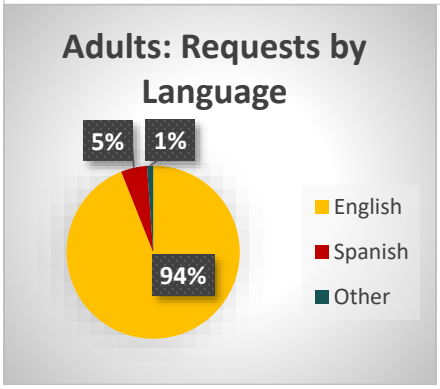
Clinical Screening/Intake Volume

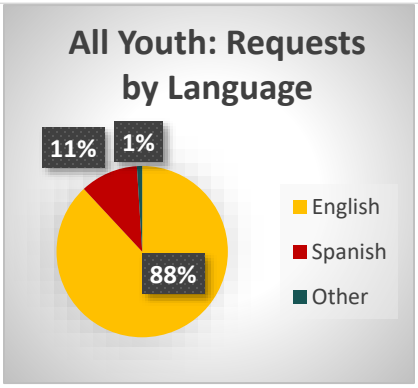
Overall, 21.12% of calls resulted in clinical intake. The following charts include walk-in requests as well as calls and email/fax referrals.

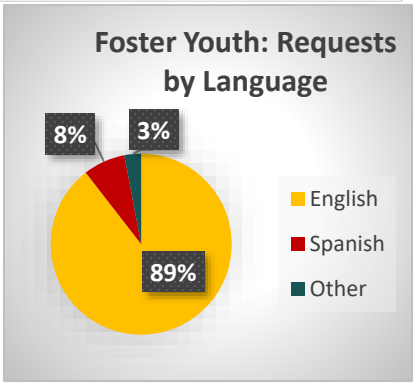
By Preferred Language

Month of Intake	English	Spanish	Other	Total
July	111	8	3	**122**
August	118	4	1	**123**
September	111	18	2	**131**
October	100	17	2	**119**
November	85	12	1	**98**
December	103	13	1	**117**
January	106	6	1	**113**
February	92	9	1	**102**
March	139	9		**148**
April	151	8		**159**
May	142	10	1	**153**
June	106	8	4	**118**
Total	**1364**	**122**	**17**	**1503**









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

Clinical Screening/Intake Disposition

Of the 1503 Clinical Intakes completed in FY 20-21, 1110 (73.85%) resulted in an offered assessment appointment. Details by age group shown in the following table:

Intake Disposition Status	Adults	Non-Foster Youth	Foster Youth	Total
Offered Assessment Appointment	586	453	71	**1110**
Not Offered Appointment	112	152	129	**393**
Total	**698**	**605**	**200**	**1503**

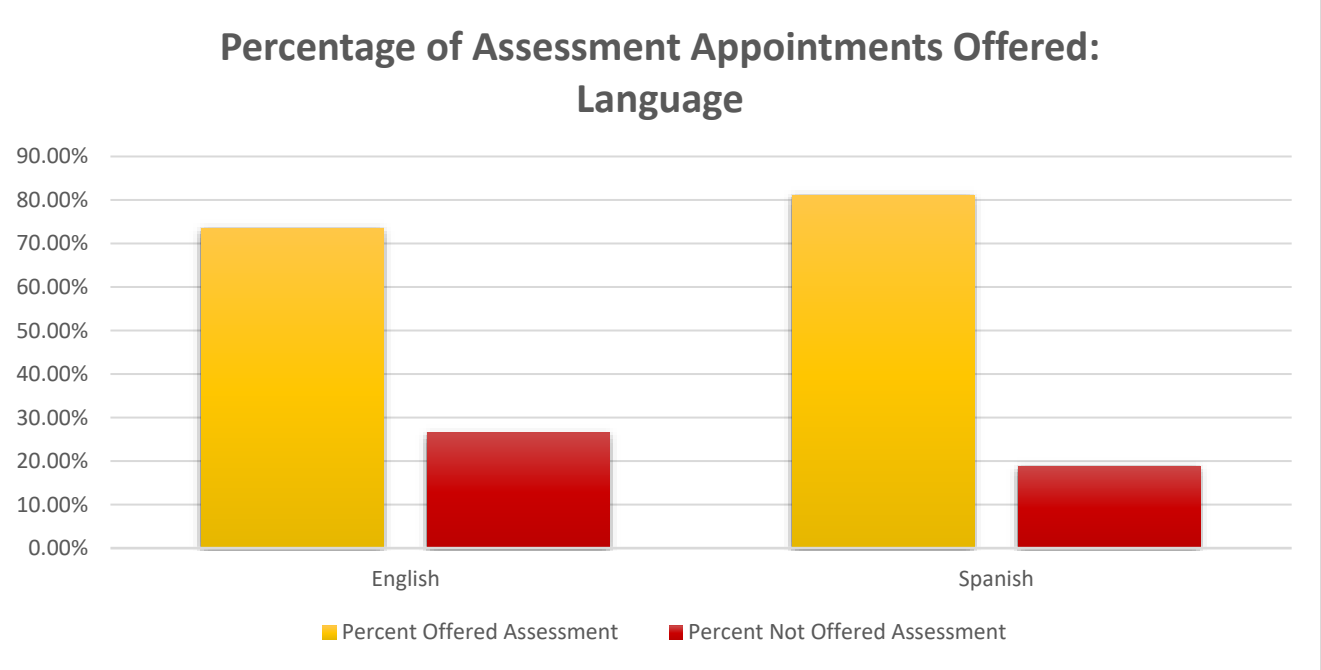
The high percentage of non-offered appointments for foster youth stems from the practice of all foster youth at Valley of the Moon being screened for Specialty Mental Health Services, whether the family is requesting or not; whereas in the youth system, requests for service are made by the family or treating provider.
For the 393 requests that were not offered an appointment, the primary reasons for this were:

- Client declined services
- Client was ineligible for Specialty Mental Health Services
  - Did not meet medical necessity criteria
  - Ineligible for Medi-Cal
- Unable to establish contact with client after multiple attempts
  - Did not return calls
  - No working phone number

Not Assessed: Disposition	Adults	Non-Foster Youth	Foster Youth	Total
Client Already in Services	1	15	17	**33**
Client Declined Services	40	37	9	**86**
Client Hospitalized	2	4	1	**7**
Client Incarcerated		1	1	**2**
Client Ineligible for SMHS	34	63	69	**166**
Client Moved Out-of-County	1	1	2	**4**
Client Referred Directly to WRAP			21	**21**
Referral Made in Error		1		**1**
Taken to ER by Friends/Family	1			**1**
Unable to Establish Contact	33	30	9	**72**
Total	**112**	**152**	**129**	**393**

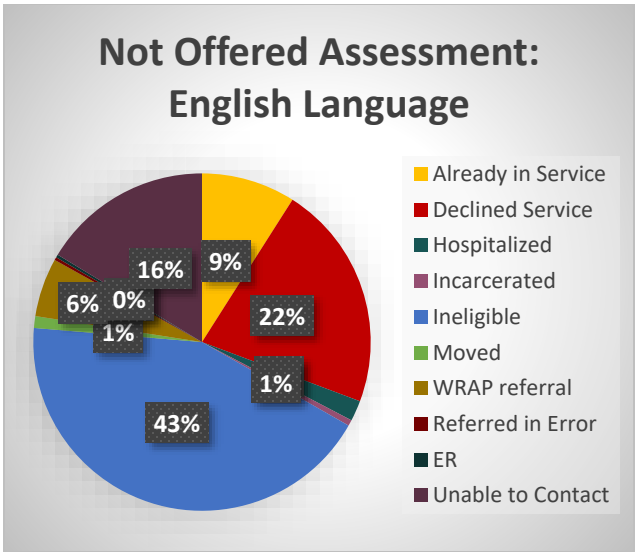
Clinical Screening/Intake Disposition by Preferred Language

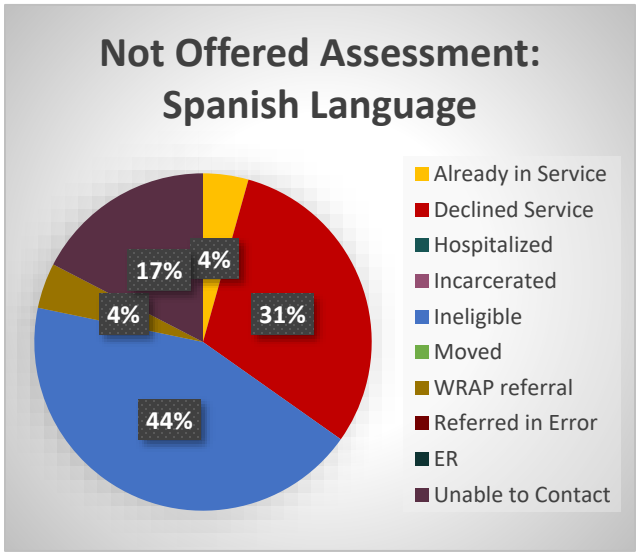
Intake Disposition Status	English	Spanish	Other	Total
Offered Assessment Appointment	1003	99	8	**1110**
Not Offered Appointment	361	23	9	**393**
Total	**1364**	**122**	**17**	**1503**



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	32	1		**33**
Client Declined Services	77	7	2	**86**
Client Hospitalized	7			**7**
Client Incarcerated	2			**2**
Client Ineligible for SMHS	153	10	3	**166**
Client Moved Out-of-County	4			**4**
Client Referred Directly to WRAP	20	1		**21**
Referral Made in Error	1			**1**
Taken to ER by Friends/Family	1			**1**
Unable to Establish Contact	64	4	4	**72**
Total	**361**	**23**	**9**	**393**





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

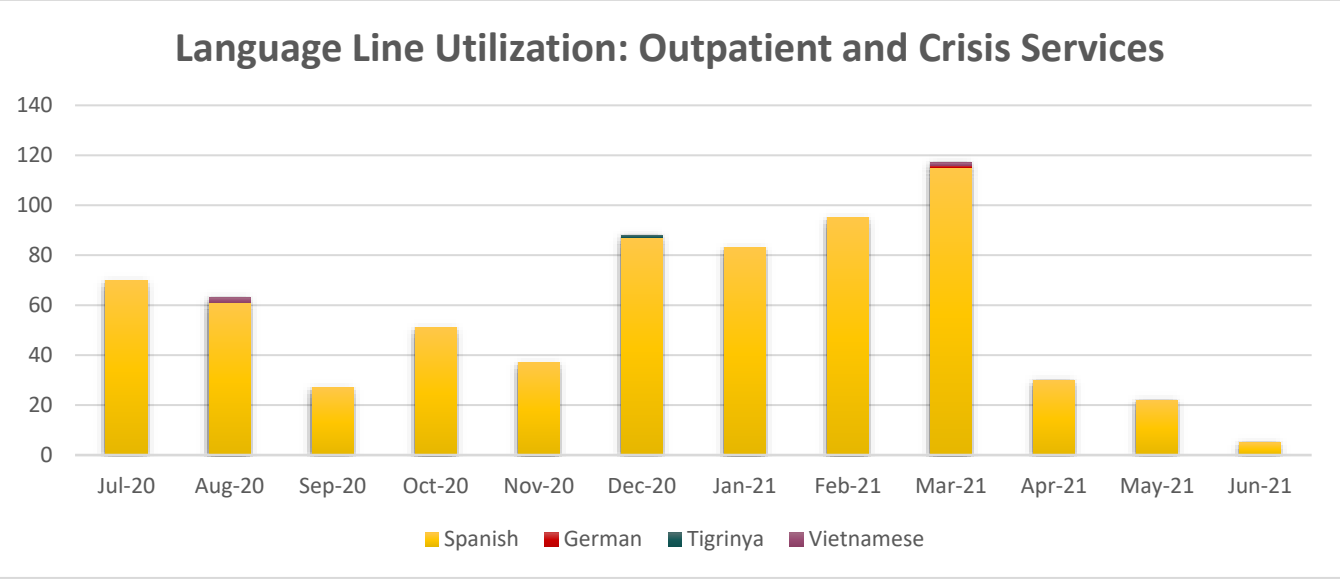
Month of Call	Spanish	German	Tigrinya	Vietnamese	Total
July					**0**
August	2			2	**4**
September					**0**
October					**0**
November					**0**
December	14		1		**15**
January					**0**
February					**0**
March	15	1		1	**17**
April	3				**3**
May	1				**1**
June	5				**5**
Total Utilization	**40**	**1**	**1**	**3**	**45**

Youth Services

Month of Call	Spanish	Total
July	68	**68**
August	57	**57**
September	21	**21**
October	42	**42**
November	26	**26**
December	70	**70**
January	83	**83**
February	95	**95**
March	98	**98**
April	30	**30**
May	20	**20**
June	35	**35**
Total Utilization	**645**	**645**

Crisis Services

Month of Call	Spanish	Total
July	2	**2**
August	2	**2**
September	6	**6**
October	9	**9**
November	11	**11**
December	3	**3**
January	0	**0**
February	0	**0**
March	2	**2**
April	0	**0**
May	2	**2**
June	1	**1**
Total Utilization	**38**	**38**



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	24,896 (98.11%)	479 (1.89%)	**25,375**
Crisis Intervention	794 (96.36%)	30 (3.64%)	**824**
ICC/IHBS	27 (56.25%)	21 (43.75%)	**48**
Medication Support Services	19,451 (95.47%)	923(4.53%)	**20,374**
Outpatient Mental Health Services	24,075 (94.19%)	1,485 (5.81%)	**25,560**
Other	21,720 (96.03%)	899 (3.97%)	**22,619**
Total	**90,963 (95.95%)**	**3,837 (4.05%)**	**94,800**

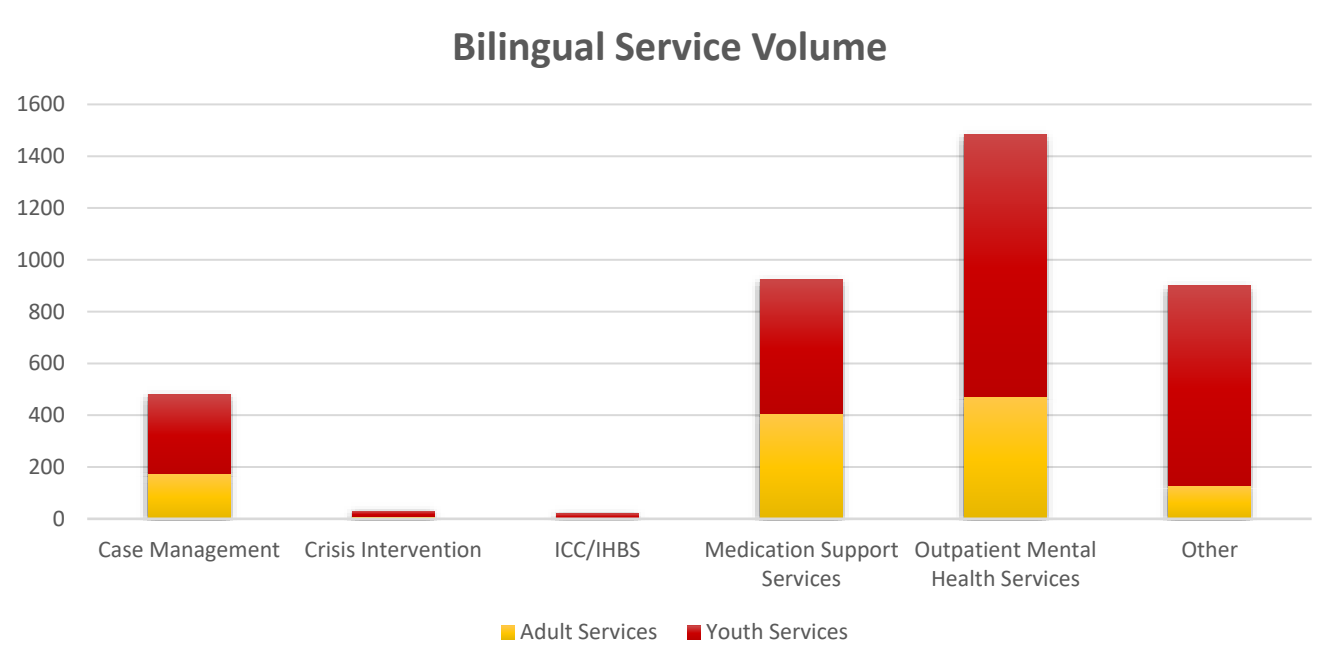
Adult Services

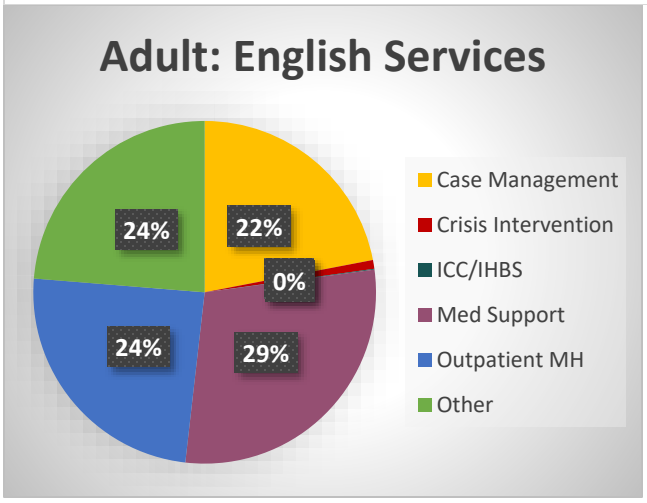
Service Category	Service Provided in English	Service Provided in Other Language	Total
Case Management	19,972 (99.13%)	175 (0.87%)	**20,147**
Crisis Intervention	585 (98.48%)	9 (1.52%)	**594**
ICC/IHBS			
Medication Support Services	15,946 (97.51%)	408 (2.49%)	**16,354**
Outpatient Mental Health Services	15,934 (97.12%)	472 (2.88%)	**16,406**
Other	13,131 (99.03%)	128 (0.97%)	**13,259**
Total	**65,568 (98.21%)**	**1192 (1.79%)**	**66,760**

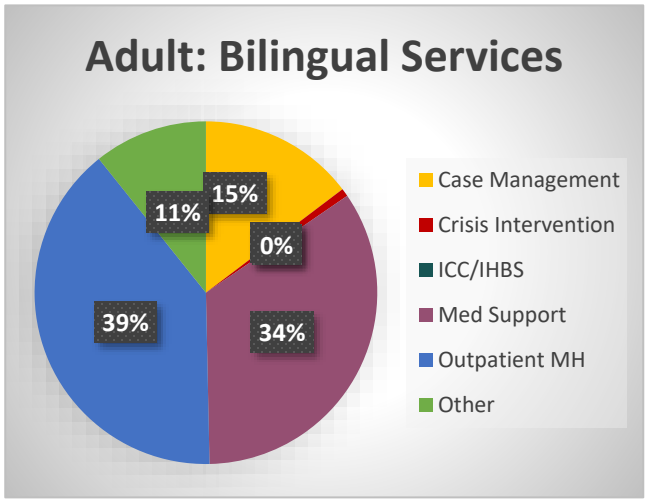
Youth Services

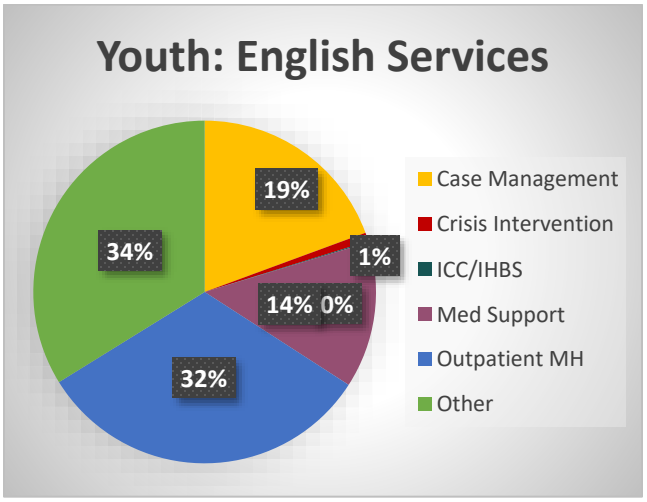
Service Category	Service Provided in English	Service Provided in Other Language	Total
Case Management	4,924 (94.19%)	304 (5.81%)	**5,228**
Crisis Intervention	209 (90.87%)	21 (9.13%)	**230**
ICC/IHBS	27 (56.25%)	21 (43.75%)	**48**
Medication Support Services	3,505 (87.19%)	515 (12.81%)	**4,020**
Outpatient Mental Health Services	8,141 (88.93%)	1,013 (11.07%)	**9,154**
Other	8,589 (91.76%)	771 (8.24%)	**9,360**
Total	**25,395 (90.57%)**	**2,645 (9.43%)**	**28,040**

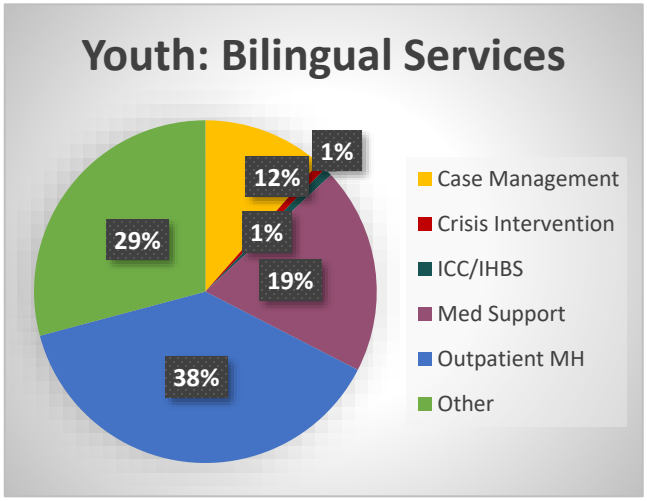
Of note is the significantly larger proportion of Youth bilingual services compared to Adult bilingual services. The following charts compare bilingual service volume and distribution in the Adult and Youth service systems. The largest proportion of bilingual services were conducted in Outpatient Mental Health programs, in both the Adult and Youth systems.


Bilingual Service Volume
1600
1400
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
15%
0%
34%
39%
11%
Case Management
Crisis Intervention
ICC/IHBS
Med Support
Outpatient MH
Other


Youth: English Services
19%
1%
14%
0%
32%
34%
Case Management
Crisis Intervention
ICC/IHBS
Med Support
Outpatient MH
Other


Youth: Bilingual Services
1%
12%
1%
19%
38%
29%
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
2020 - 07 July	607	125	151	8	758	133	82.45%
2020 - 08 August	753	85	164	4	917	89	90.29%
2020 - 09 September	754	132	154	5	908	137	84.91%
2020 - 10 October	733	109	147	0	880	109	87.61%
2020 - 11 November	569	56	137	3	706	59	91.64%
2020 - 12 December	713	64	120	1	833	65	92.20%
2021 - 01 January	720	95	141	3	861	98	88.62%
2021 - 02 February	777	170	111	1	888	171	80.74%
2021 - 03 March	853	141	188	11	1041	152	85.40%
2021 - 04 April	742	85	83	1	825	86	89.58%
2021 - 05 May	682	59	96	4	778	63	91.90%
2021 - 06 June	825	81	114	5	939	86	90.84%
FY Total =	**8728**	**1202**	**1606**	**46**	**10334**	**1248**	**87.92%**
FY Monthly Average =	727	100	134	4	861	104	87.92%

87.92% 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 a slight decrease 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
2020 - 07 July	37	34	3	37	100%
2020 - 08 August	39	31	8	39	100%
2020 - 09 September	39	37	2	39	100%
2020 - 10 October	48	44	4	48	100%
2020 - 11 November	40	35	5	40	100%
2020 - 12 December	32	29	3	32	100%
2021 - 01 January	48	46	2	48	100%
2021 - 02 February	35	32	3	35	100%
2021 - 03 March	36	35	1	36	100%
2021 - 04 April	28	26	2	28	100%
2021 - 05 May	26	26	0	26	100%
2021 - 06 June	29	26	3	29	100%
Totals =	**437**	**401**	**36**	**437**	**100%**

437/437 or 100% of calls logged by OPTUM as needing specialty mental health services and referred to Access called back the next business day. This is an increase in volume from the previous year.

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

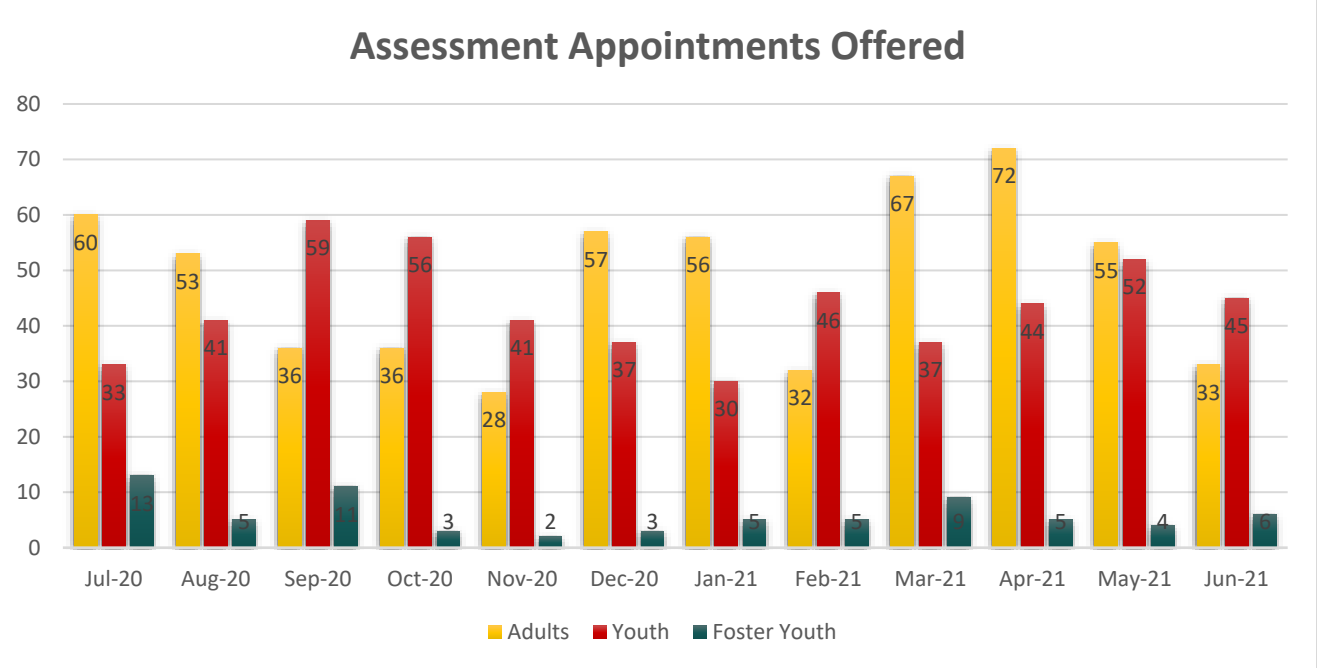
PROCESS USED TO EVALUATE
Access to MH Services Database

RESPONSIBLE STAFF – QI Manager and Access Manager

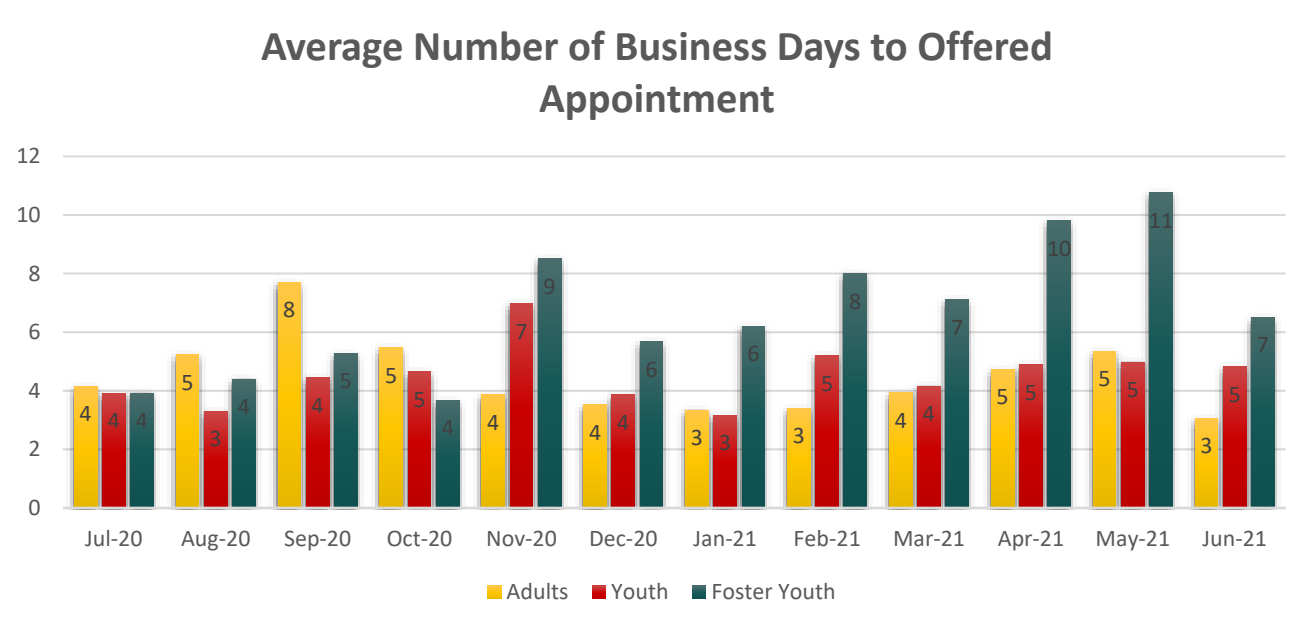
RESULTS

	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)	4.52 days (mean) 4 days (median) 3.41 Std. Dev.	4.45 days (mean) 4 days (median) 3.45 Std. Dev.	4.60 days (mean) 4 days (median) 3.38 Std. Dev.	6.23 days (mean) 4 days (median) 5.46 Std. Dev.
DHCS Standard	10 days	10 days	10 days	10 days
Percent of appointments that met this standard	96.47%	97.95%	94.82%	81.69%
Range	**0-45 days**	**0-45 days**	**0-27 days**	**0-27 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. Youth offered assessments increased in the months of September & October (reflecting possibly a return to in-person school services), and surpassed the number of adult assessments. Adult assessments decreased during this same time period but returned to more normal levels in December. Overall timeliness metrics were improved over last year's figures, however the impressive gains made in adult timeliness during the second half of FY19-20 were less substantial this year. In addition, the average time to first offered appointment for foster youth increased noticeably in 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.**

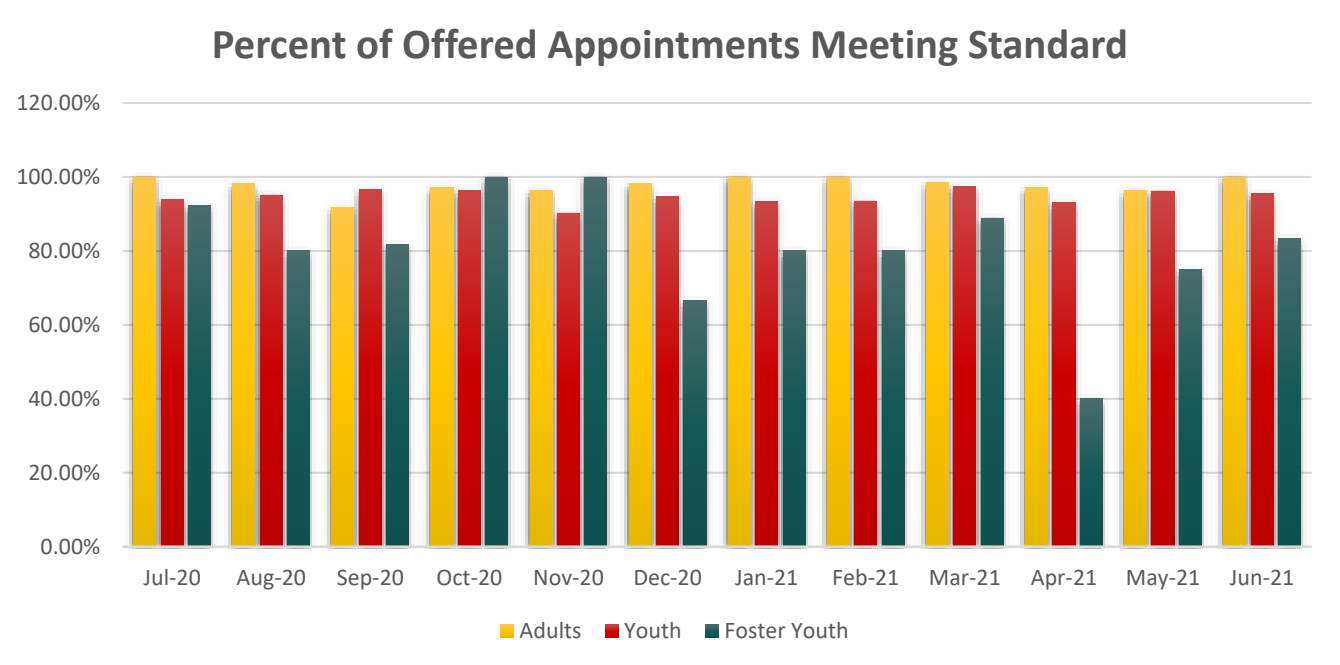
Goal calculation: $\frac{Assessment\ Offers\ Under\ 10\ B.Days}{Total\ Offered\ Assessments} * 100\%$

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	1106	585	521	71
Count of Appointments that Met 10 Day Standard	1067	573	494	58
Percent of Appointments that Met Standard	96.47%	97.95%	94.82%	81.69%



The overall percentage of offered assessment appointments meeting the 10 business day standard improved over last year, with the exception of foster youth. For adults, this trend in improvement started in November FY19-20 and continued throughout the present fiscal year. It is largely attributed to the Adult Access Walk-In Clinic, which opened October 2019. Foster youth performance on this measure is comparatively low, however the small number of foster youth assessments should also be taken into consideration when analyzing this performance metric for foster youth.

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

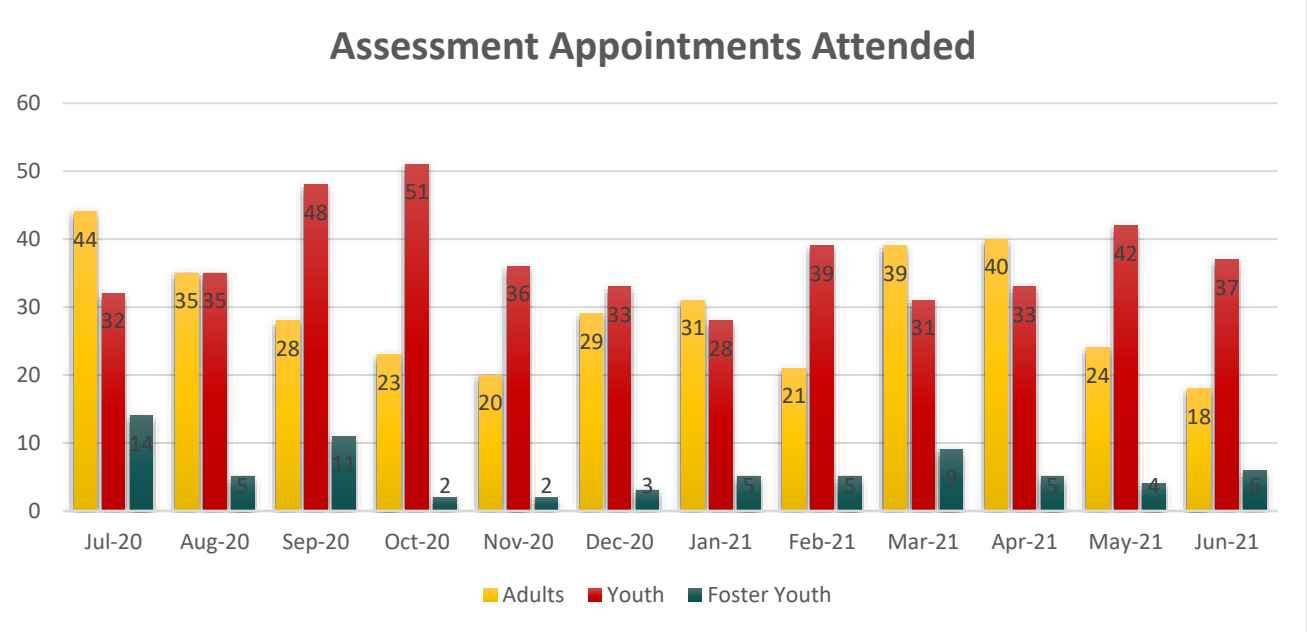
PROCESS USED TO EVALUATE
Access to MH Services Database

RESPONSIBLE STAFF – QI Manager and Access Manager

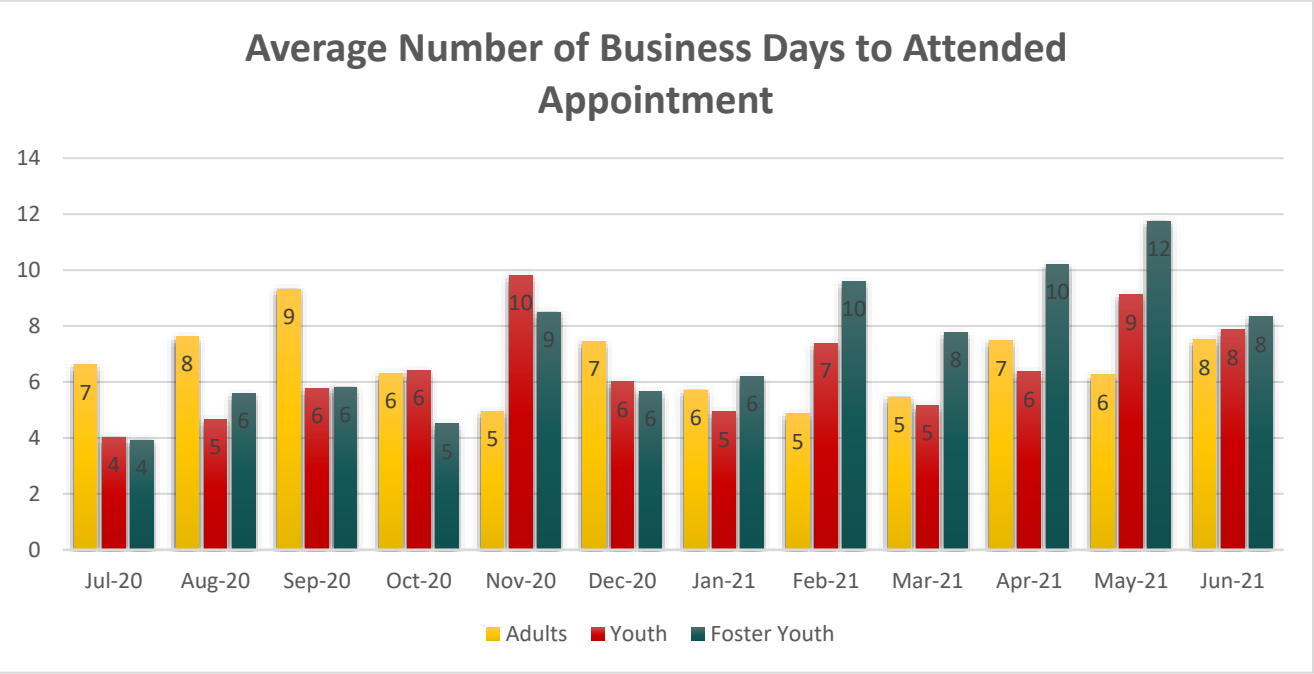
RESULTS

	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)	6.62 days (mean) 5 days (median) 5.81 Std. Dev.	6.69 days (mean) 5 days (median) 6.72 Std. Dev.	6.56 days (mean) 5 days (median) 4.98 Std. Dev.	6.90 days (mean) 6 days (median) 5.65 Std. Dev.
MHP Standard	10 days	10 days	10 days	10 days
Percent of appointments that met this standard	84.19%	85.51%	83.15%	77.46%
Range	**0-75 days**	**0-75 days**	**0-33 days**	**0-27 days**

Adult/Youth Initial Assessments Attended per Month



Timeliness to Attended Assessment Appointment



DHS-BHD's goal is to stay within a 5-point range of 10 business days for timeliness to attended assessments. Overall the average time taken for clients to attend their initial appointments decreased in FY20-21, relative to the previous year. Of interest is that even though the number of attended appointments clearly trended down in the first quarter, the average number days clients took to attend their first appointment trended up in those same months. Consistent with performance patterns on previous metrics, foster youth consistently had the highest times to attend first appointments in the second half of FY20-21.

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.**

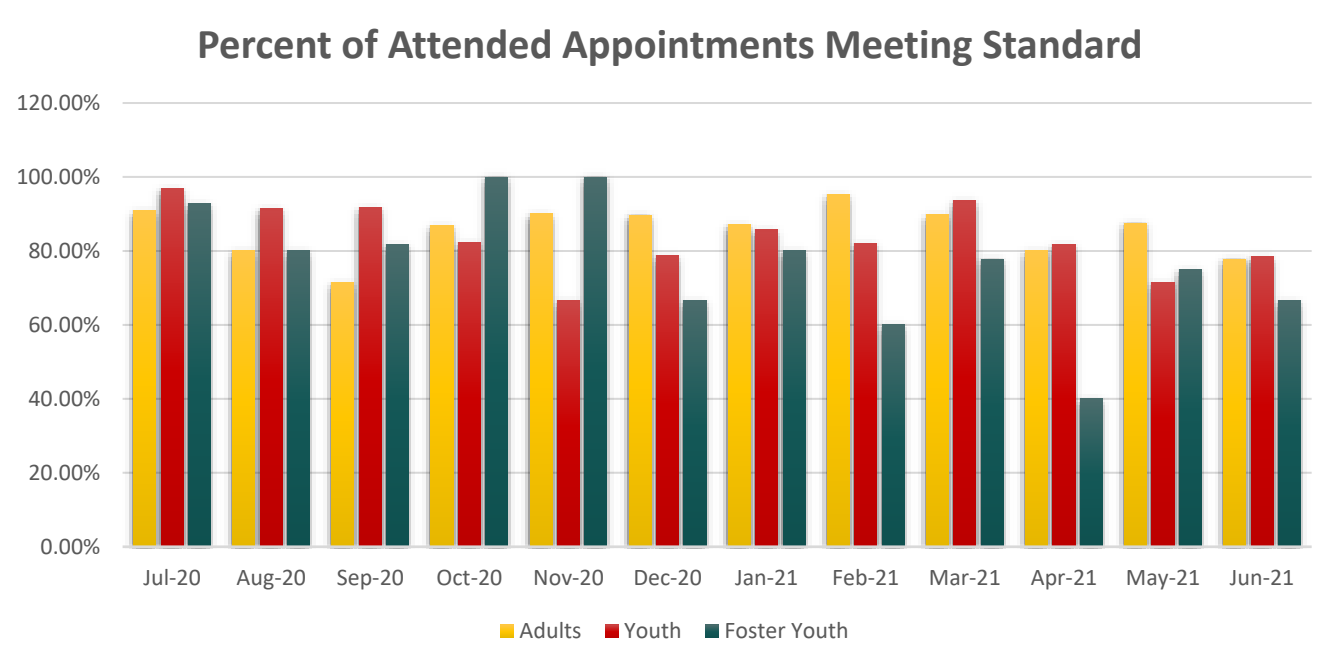
Goal calculation: $\frac{Assessment\ Attended\ Under\ 10\ B.Days}{Total\ Attended\ Assessments} * 100\%$

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	797	352	445	71
Count of Appointments that Met 10 Day Standard	671	301	370	55
Percent of Appointments that Met Standard	84.19%	85.51%	83.15%	77.46%



The percentage of attended assessment appointments meeting the 10 business day standard in FY20-21 improved relative to the previous fiscal year. Generally, youth and adult performance was similar. Foster youth performance was the exception, and achieved less than 70% performance on this goal in the months of December, February, and April.

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

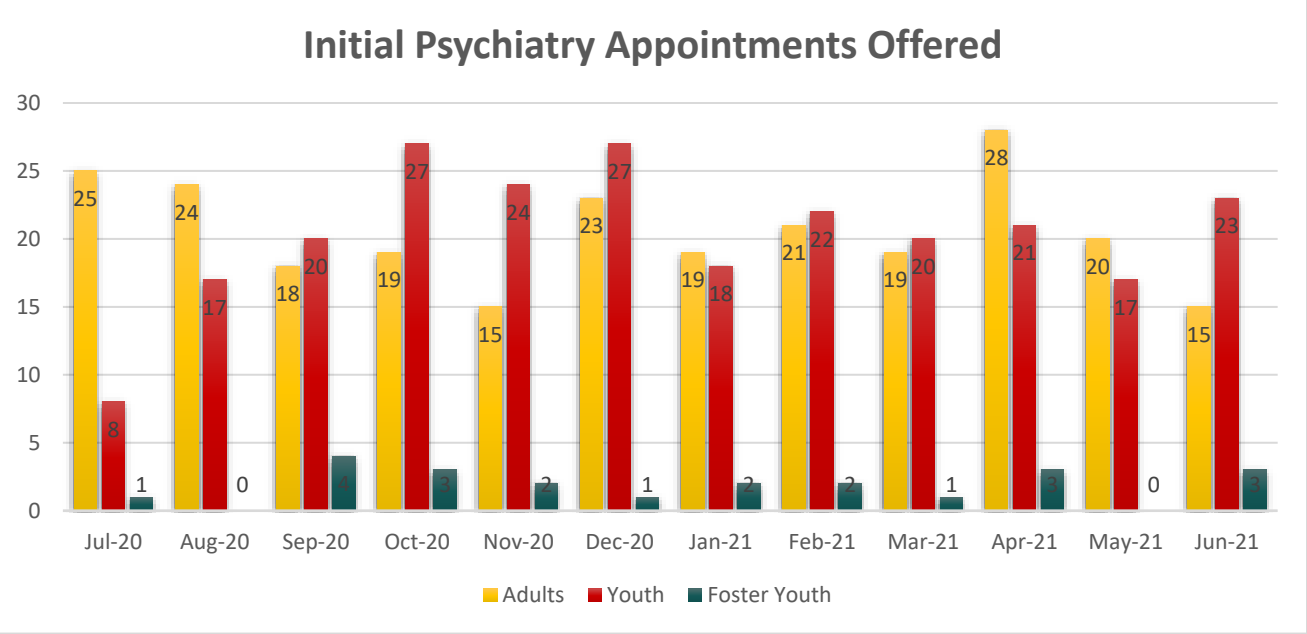
PROCESS USED TO EVALUATE
Access to MH Services Database
AVATAR Psychiatry Service Data

RESPONSIBLE STAFF – QI Manager and Medical Director

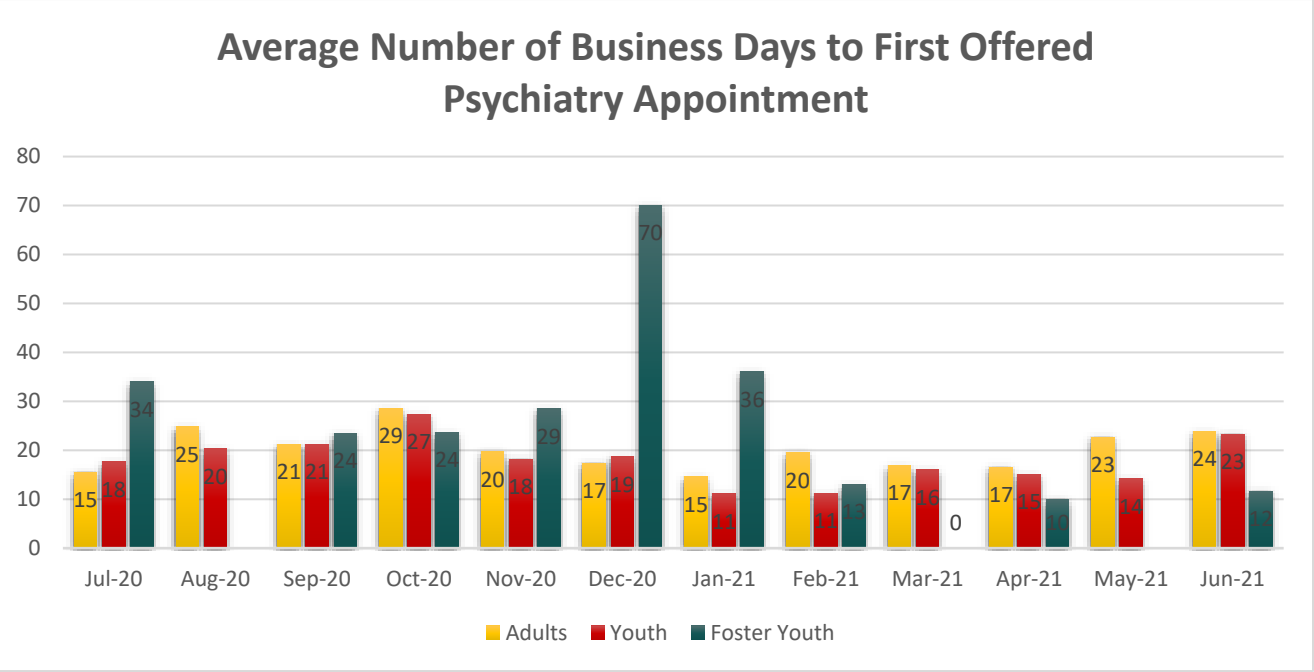
RESULTS

	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)	19.21 days (mean) 18 days (median) 19.21 Std. Dev.	19.86 days (mean) 21 days (median) 13.45 Std. Dev.	18.56 days (mean) 14 days (median) 17.70 Std. Dev.	22.23 days (mean) 20 days (median) 18.23 Std. Dev.
DHCS Standard	15 days	15 days	15 days	15 days
Percent of appointments that met this standard	44.94%	36.59%	53.23%	45.45%
Range	**0-87 days**	**0-65 days**	**0-87 days**	**0-70 days**

Adult/Youth Initial Psychiatry Appointments Offered per Month



Timeliness to First Offered Psychiatry Appointment



Overall performance on timely first offered appointments for psychiatry worsened in FY20-21, relative to the previous fiscal year. This is evident in both this year's higher average days (19.21 vs 17.67) and higher median days (18 vs 13) to first offered psychiatry appointment. Foster youth had the highest psychiatry wait times in July, November, December, and January, and these times were relatively higher in comparison to youth and adults. Foster youth psychiatry performance improved in the last five months of the fiscal 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.**

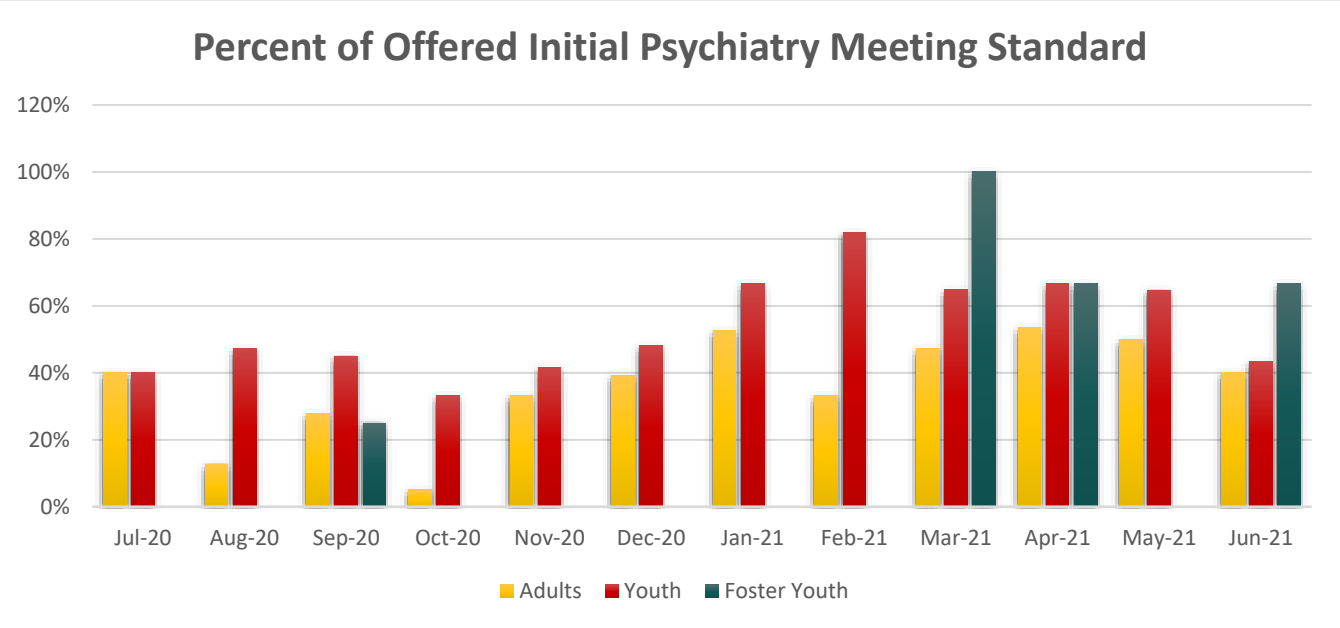
Goal calculation: $\frac{Psychiatry\ Offered\ Under\ 15\ B.Days}{Total\ Offered\ Psychiatry} * 100\%$

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	494	246	248	22
Count of Appointments that Met 15 Day Standard	222	90	132	10
Percent of Appointments that Met Standard	44.94%	36.59%	53.23%	45.45%



The percentage of offered initial psychiatry appointments meeting the 15-business day standard in FY 20-21 declined further, relative to the previous fiscal year. This trend continues a pattern of declining performance that was also evident in the previous fiscal year. Relative to last year's performance, adult performance dropped the most.

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

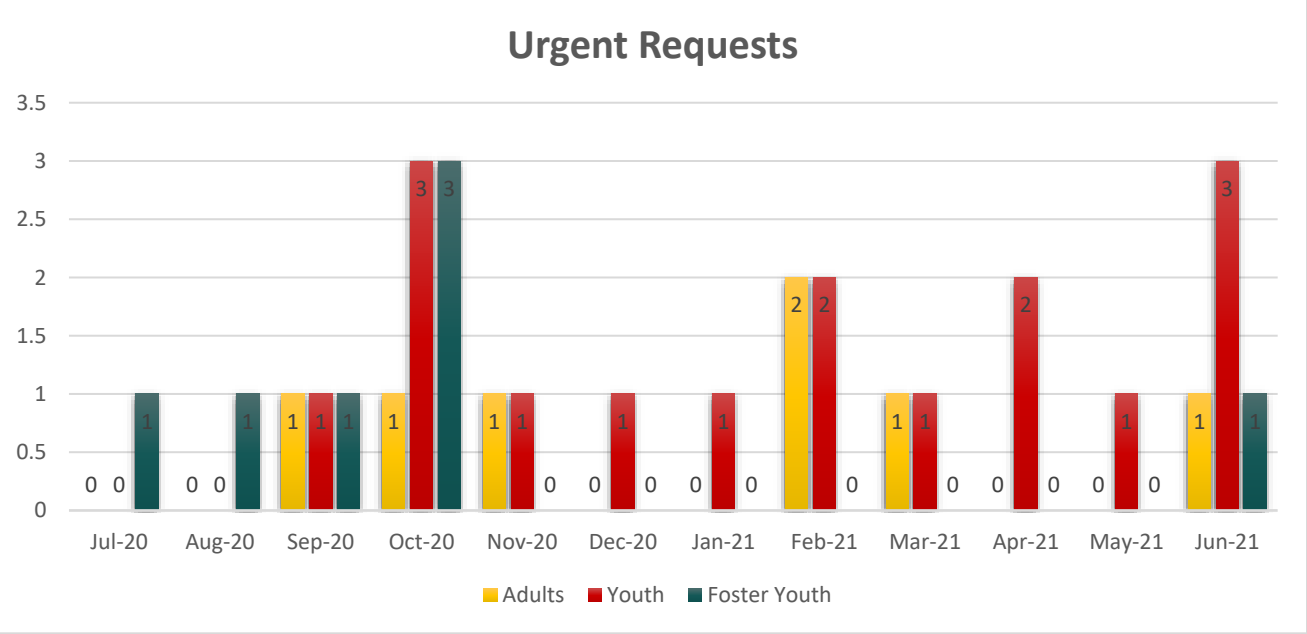
PROCESS USED TO EVALUATE
Access to MH Services Database
AVATAR Service Data
SWITS Encounter Data
CSU Census Database

RESPONSIBLE STAFF – QI Manager and Access Manager

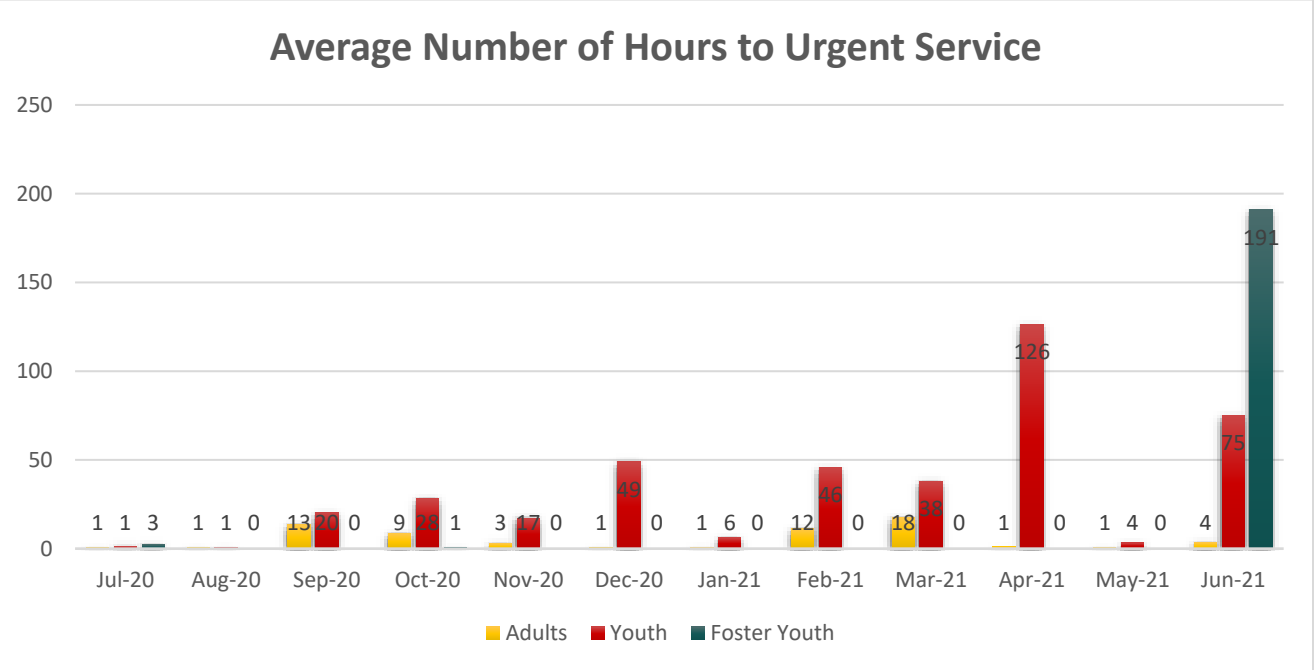
RESULTS

	All Services	Adult Services	Children's Services	Foster Care
Average length of time for urgent appointments (in hours)	9 hours (mean) .5 hour (median) 51 Std. Dev.	5 hours (mean) .35 hour (median) 42 Std. Dev.	32 hours (mean) 1.5 hours (median) 80 Std. Dev.	28 hours (mean) .28 hour (median) 71 Std Dev.
DHCS Standard	48 hours	48 hours	48 hours	48 hours
Percent of appointments that met this standard	96.25%	98.44%	84.52%	85.71%
Range	**0-740 hours**	**0-740 hours**	**0-385 hours**	**0-191 hours**

Adult/Youth Urgent Request Volume per Month



Timeliness to Urgent Services



The overall Urgent timeliness metrics are good, although there are some significant outliers for both the youth and adult requests for urgent requests originating from the Access line. Last year the Youth Access Team revised its workflow to accept Youth Intakes directly, which improved their performance over last year.

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
2020 - 07 July	0	0	36	36	15	15	**51**	**51**	**100.0%**
2020 - 08 August	0	0	23	23	11	11	**34**	**34**	**100.0%**
2020 - 09 September	1	0	20	20	4	4	**25**	**24**	**96.0%**
2020 - 10 October	1	0	25	25	6	6	**32**	**31**	**96.9%**
2020 - 11 November	1	0	26	26	10	10	**37**	**36**	**97.3%**
2020 - 12 December	0	0	24	24	15	15	**39**	**39**	**100.0%**
2021 - 01 January	0	0	18	18	10	10	**28**	**28**	**100.0%**
2021 - 02 February	2	0	23	23	7	7	**32**	**30**	**93.8%**
2021 - 03 March	1	0	31	31	12	12	**44**	**43**	**97.7%**
2021 - 04 April	0	0	27	27	16	16	**43**	**43**	**100.0%**
2021 - 05 May	0	0	27	27	13	13	**40**	**40**	**100.0%**
2021 - 06 June	1	0	29	29	11	11	**41**	**40**	**97.6%**
Grand Totals	**7**	**0**	**309**	**309**	**130**	**130**	**446**	**439**	**98.4%**

98.4% 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
2020 - 07 July	0	0	5	5	0	0	**5**	**5**	**100.0%**
2020 - 08 August	0	0	5	5	1	1	**6**	**6**	**100.0%**
2020 - 09 September	1	0	4	4	1	1	**6**	**5**	**83.3%**
2020 - 10 October	3	0	12	12	0	0	**15**	**12**	**80.0%**
2020 - 11 November	1	0	5	5	0	0	**6**	**5**	**83.3%**
2020 - 12 December	1	0	6	6	0	0	**7**	**6**	**85.7%**
2021 - 01 January	1	1	2	2	2	2	**5**	**5**	**100.0%**
2021 - 02 February	2	1	6	6	1	1	**9**	**8**	**88.9%**
2021 - 03 March	1	0	4	4	1	1	**6**	**5**	**83.3%**
2021 - 04 April	2	0	2	2	0	0	**4**	**2**	**50.0%**
2021 - 05 May	1	1	6	6	0	0	**7**	**7**	**100.0%**
2021 - 06 June	3	0	3	3	2	2	**8**	**5**	**62.5%**
Grand Totals	**16**	**3**	**60**	**60**	**8**	**8**	**84**	**71**	**84.5%**

84.5% 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
2020 - 07 July	0	0	1	1	0	0	1	**1**	**100%**
2020 - 08 August	0	0	1	1	0	0	1	**1**	**100%**
2020 - 09 September	0	0	1	1	0	0	1	**1**	**100%**
2020 - 10 October	0	0	3	3	0	0	3	**3**	**100%**
2020 - 11 November	0	0	0	0	0	0	0	**n/a**	**n/a**
2020 - 12 December	0	0	0	0	0	0	0	**n/a**	**n/a**
2021 - 01 January	0	0	0	0	0	0	0	**n/a**	**n/a**
2021 - 02 February	0	0	0	0	0	0	0	**n/a**	**n/a**
2021 - 03 March	0	0	0	0	0	0	0	**n/a**	**n/a**
2021 - 04 April	0	0	0	0	0	0	0	**n/a**	**n/a**
2021 - 05 May	0	0	0	0	0	0	0	**n/a**	**n/a**
2021 - 06 June	1	0	0	0	0	0	1	**0**	**0%**
Grand Totals	**1**	**0**	**6**	**6**	**0**	**0**	**7**	**6**	**85.7%**

85.7% 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
2020 - 07 July	0	0	41	41	15	15	**56**	**56**	**100.0%**
2020 - 08 August	0	0	28	28	12	12	**40**	**40**	**100.0%**
2020 - 09 September	2	0	24	24	5	5	**31**	**29**	**93.5%**
2020 - 10 October	4	0	37	37	6	6	**47**	**43**	**91.5%**
2020 - 11 November	2	0	31	31	10	10	**43**	**41**	**95.3%**
2020 - 12 December	1	0	30	30	15	15	**46**	**45**	**97.8%**
2021 - 01 January	1	1	20	20	12	12	**33**	**33**	**100.0%**
2021 - 02 February	4	1	29	29	8	8	**41**	**38**	**92.7%**
2021 - 03 March	2	0	35	35	13	13	**50**	**48**	**96.0%**
2021 - 04 April	2	0	29	29	16	16	**47**	**45**	**95.7%**
2021 - 05 May	1	1	33	33	15	15	**49**	**49**	**100.0%**
2021 - 06 June	4	0	32	32	11	11	**47**	**43**	**91.5%**
Grand Totals	**23**	**3**	**369**	**369**	**138**	**138**	**530**	**510**	**96.2%**

96.2% of **all clients** who were screened as needing an urgent mental health assessment received services within 48 hours. The lowest performance related to timely responses coming from urgent requests made to Access.

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

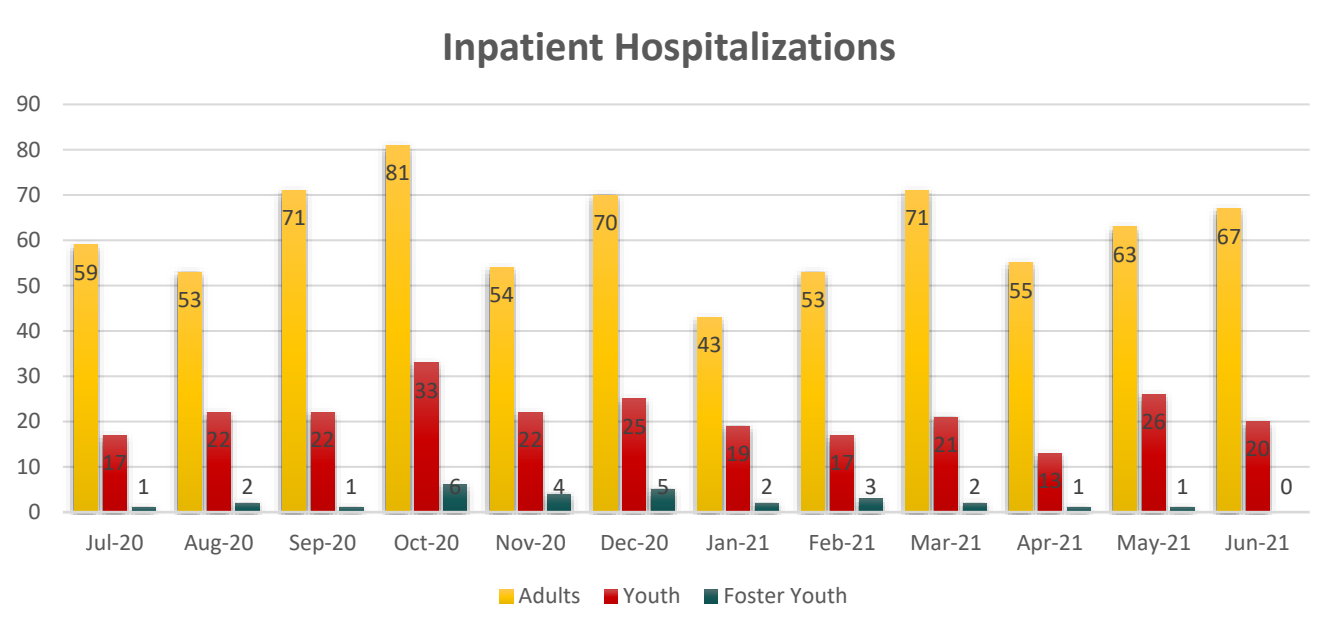
PROCESS USED TO EVALUATE
Inpatient Hospitalization Database
AVATAR Service Data

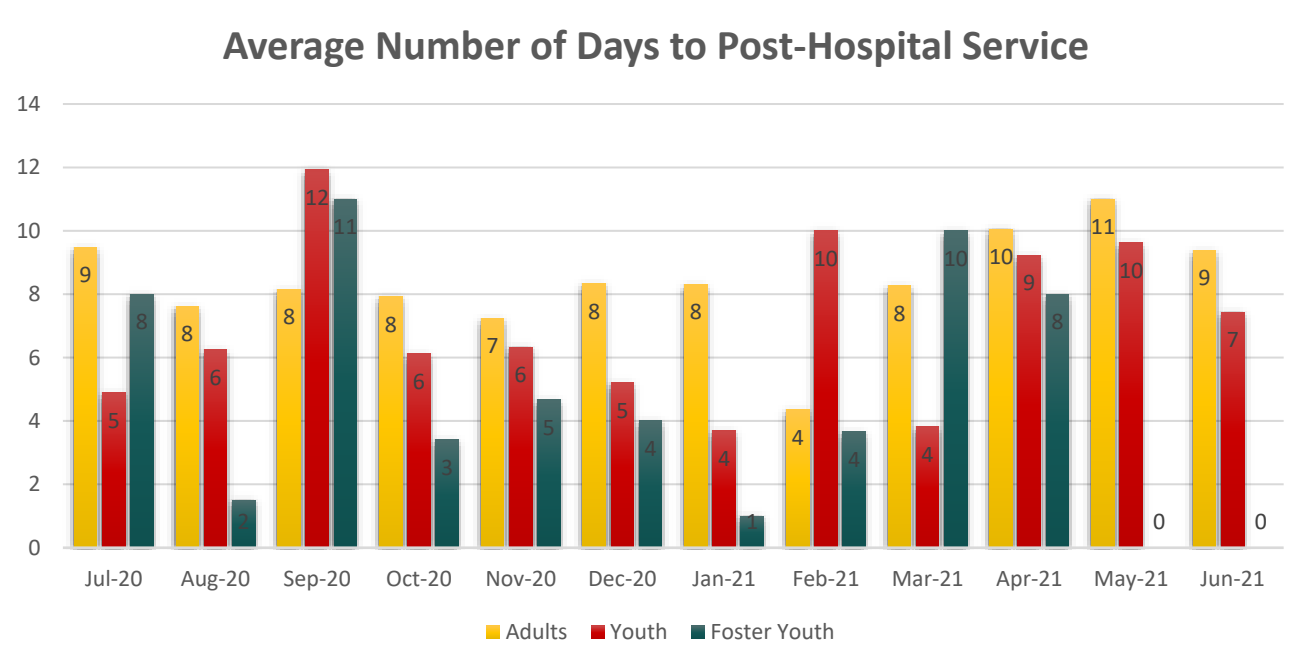
RESPONSIBLE STAFF – QI Manager and Hospital UR

RESULTS

	All Services	Adult Services	Children's Services	Foster Care
Total number of hospital admissions	989	734	255	28
Total number of hospital discharges	997	740	257	28
Number of follow-up appointments within 7 days	477	317	160	20
Length of time for a follow-up appointment after hospital discharge	7.90 days (mean) 5 days (median) 9.97 Std. Dev.	8.56 days (mean) 5 days (median) 10.61 Std. Dev.	6.50 days (mean) 4 days (median) 8.32 Std. Dev.	4.28 days (mean) 4 day (median) 3.48 Std. Dev.
HEDIS Measure Standard	7 days	7 days	7 days	7 days
Percent of appointments that meet this standard	**47.84%**	**42.84%**	**62.26%**	**71.43%**

The total number of hospital admissions decreased by 17% from the previous year. The percent of post-hospital follow-up services that met the 7-day standard improved slightly for youth, but deteriorated for adults and foster youth comparison to the previous year. In the case of 332 hospital discharge episodes (33% of the total), these clients received either no follow-up service, or a service beyond 60 days of discharge. Note: For purposes of calculating the average and median follow-up time, 80 outliers with post-hospital services beyond 60 days were excluded.





August and September saw two large scale fire emergencies declared in Sonoma county. The Walbridge and Glass fires, which became part of the LNU Complex fire, which burned for a month and a half across five counties, including Sonoma. These fire incidents not only affected a county that has been ravaged by fire every summer since 2017, it also calls much of the staff of County of Sonoma, as disaster services workers, away from their day-to-day duties and onto emergency response and management. Over such an extended period of time, staff as well as community at large was experiencing disaster responses fatigue in epic proportions. This in part, coupled with the overlaying pandemic, has had an effect on hospitalization rate as well as post hospital service.

STANDARD PARTIALLY MET

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

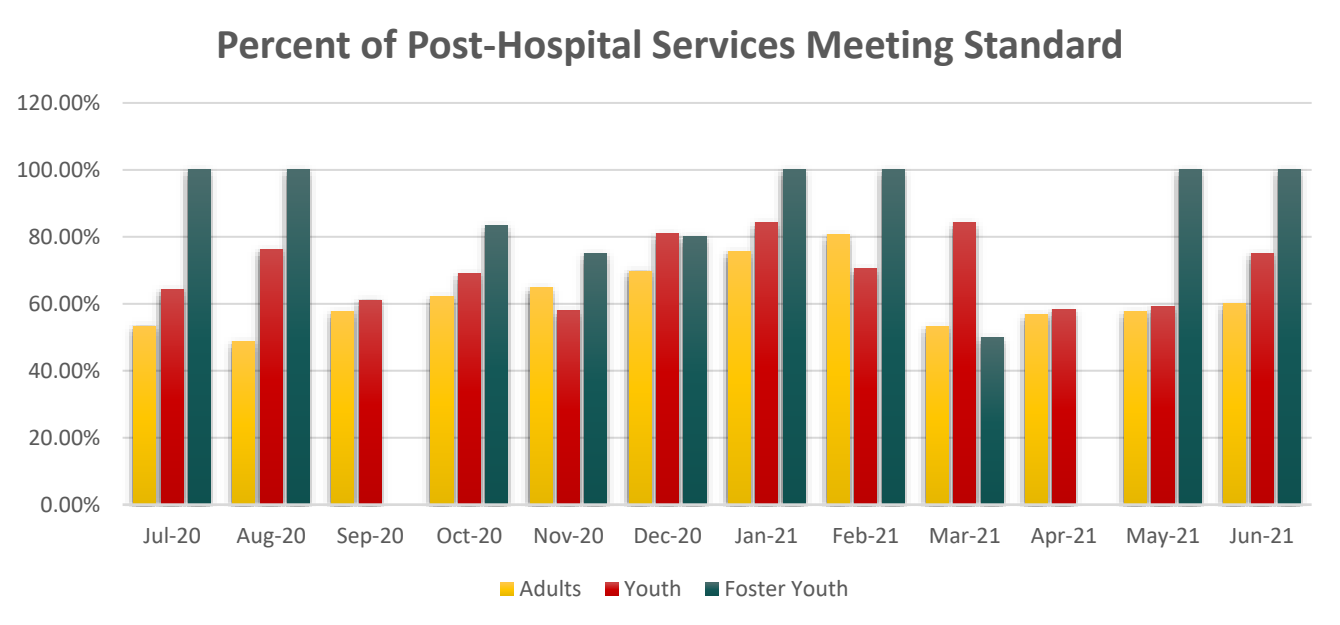
Goal calculation: $\frac{Post-Hospital\ Services\ Under\ 7\ Days}{Total\ Post-Hospital\ Services} * 100\%$

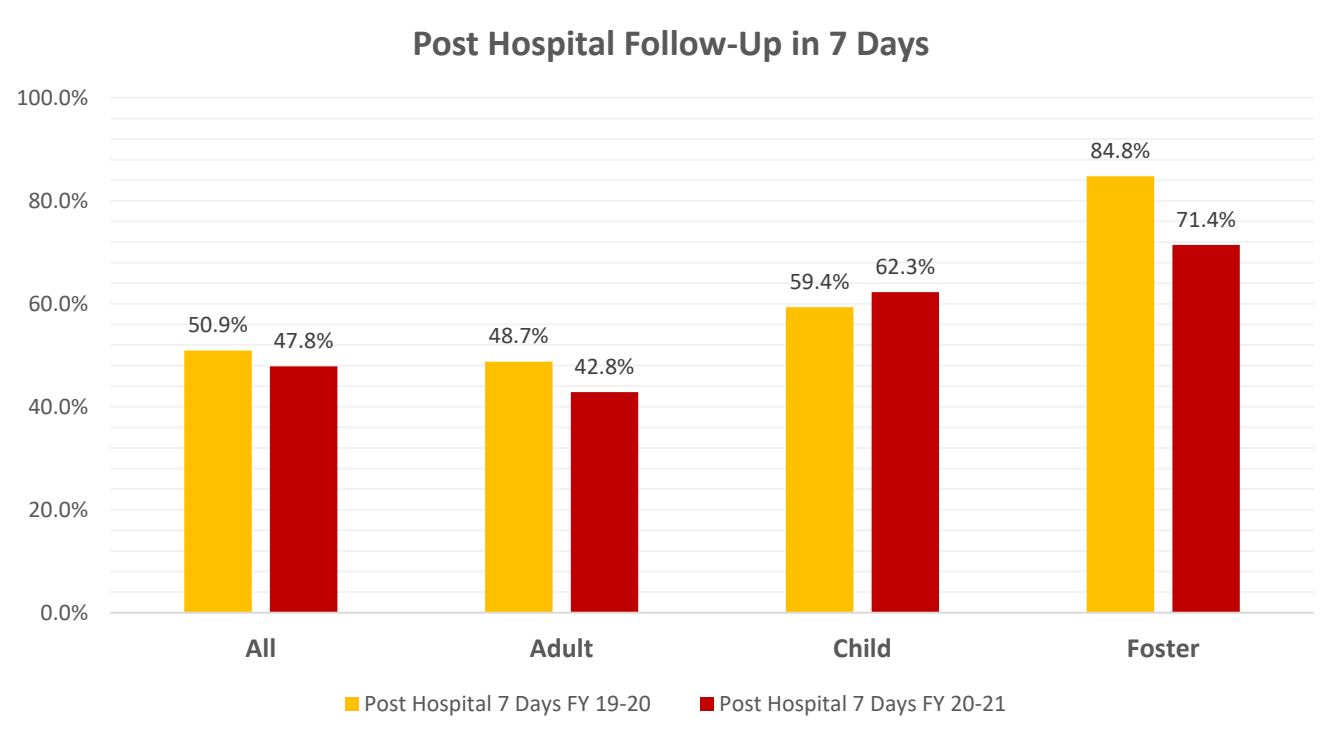
PROCESS USED TO EVALUATE
Inpatient Hospitalization Database
AVATAR Service Data

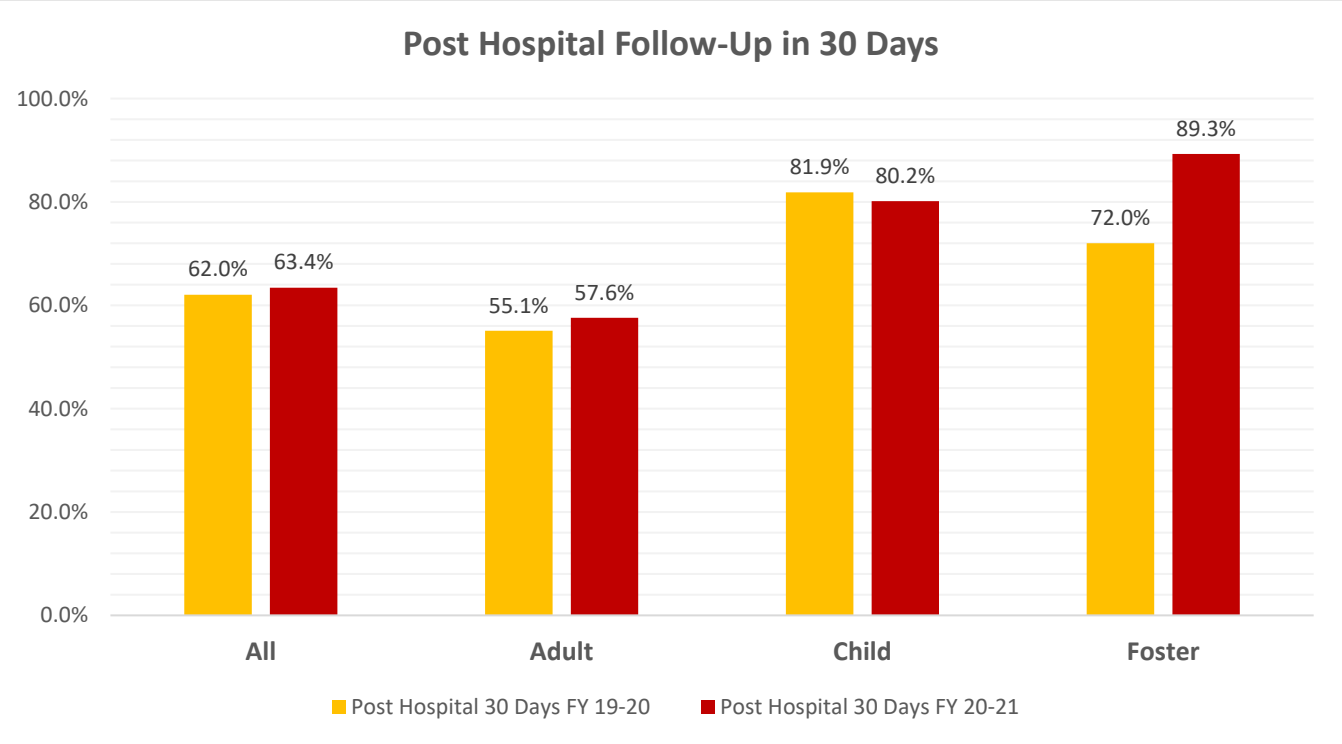
RESPONSIBLE STAFF – QI Manager and Hospital UR

RESULTS

	All Services	Adult Services	Children's Services	Foster Care
Total number of hospital admissions	989	734	255	28
Total number of hospital discharges	997	740	257	28
Number of follow-up appointments within 7 days	477	317	160	20
Percent of appointments that meet this standard	**47.84%**	**42.84%**	**62.26%**	**71.43 %**







Performance on post-hospital connection to services improved for youth on the 7 day metrics, but deteriorated for adults and foster youth. Adult performance in particular fell below the 50% state standard for 7- day follow-up. On the 30-day follow-up, adults were much less likely than youth to receive post-hospital services.

STANDARD PARTIALLY MET

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

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

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	989	734	255	28
Total number of hospital discharges	997	740	257	28
Total number with readmission within 7 days	61	42	19	4
7 Day Readmission Rate	**6.12%**	**5.68%**	**7.39%**	**43.28%**
Total number with readmissions within 30 days	168	133	35	7
30 Day Readmission Rate	**16.85%**	**17.97%**	**13.62%**	**25.00%**

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

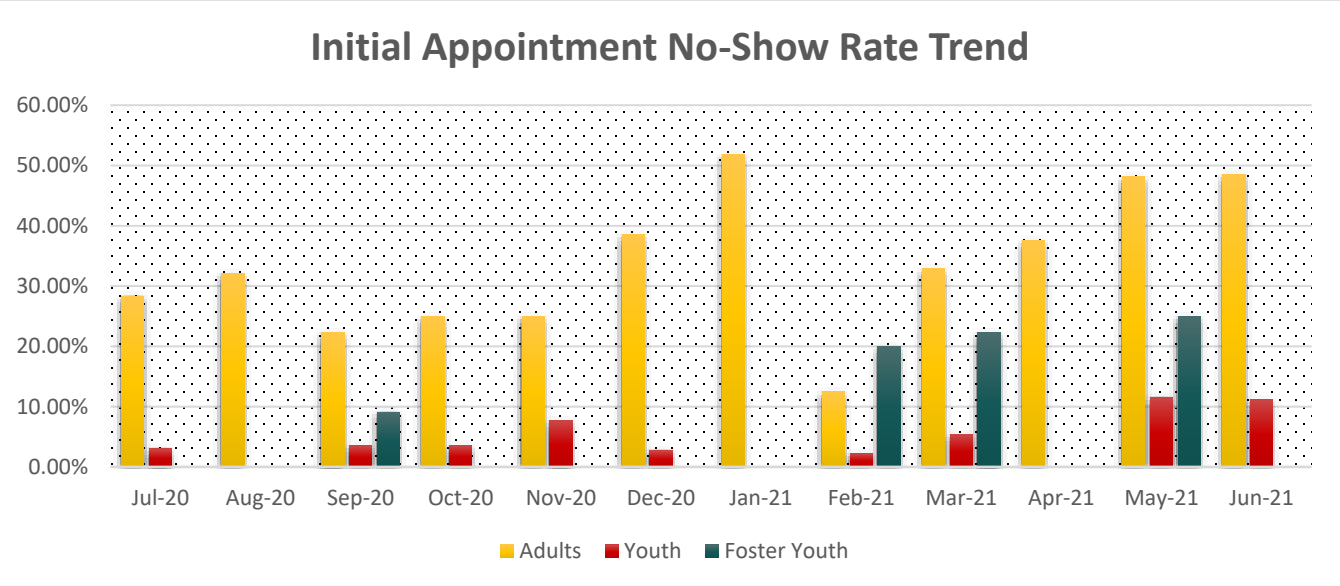
RESULTS

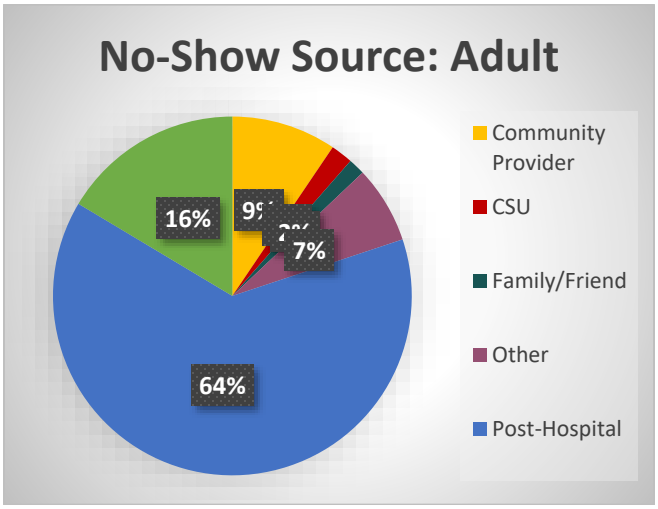
Offered Appointment Status	All Services	Adult Services	Children's Services	Foster Care
Accepted	720	304	416	63
Cancelled	142	70	72	4
Declined	8	6	2	0
No-Show	227	204	23	5

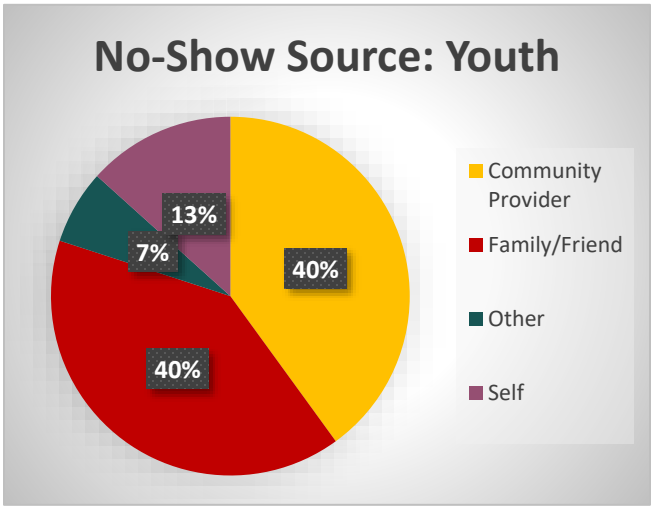
Offered Appointment Status	All Services	Adult Services	Children's Services	Foster Care
Rescheduled	1	0	1	1
Total	**1098**	**584**	**514**	**71**
No Show Rate	***20.67%***	***34.93%***	***4.47%***	***7.04%***

No-Show Analysis

Service Category	Initial Appointment 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	20.67%	26.87%	7.05%	63.44%
Adult Services	34.93%	23.04%	6.86%	67.16%
Youth Services	4.47%	60.87%	8.70%	30.43%
Foster Care	7.04%	100.00%	N/A	N/A







No-Show rates are lower than the previous year; however, no-show rates remain significantly higher in Adult Services than Youth Services. Additionally, the majority of Youth No-Shows attend a subsequent appointment and all of the Foster Youth No-Shows attended subsequent appointments; whereas the majority of Adult No-Shows lose contact with services. However, Adult no-show rates improved compared to last year, but show an increasing trend over the course of the year. The majority of Adult no-shows are post-hospital referrals.

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	**11.52%**	**12.41%**	**8.24%**	11.86%

The no-show rate increased compared to last year. Psychiatry no-show rates are higher in Adult Services than Youth Services. Overall performance on this metric does not meet the targeted threshold.

STANDARD PARTIALLY 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	**3.52%**	**3.29%**	**3.88%**	3.08%

No-show rates for outpatient clinical services increased, but this is most likely due to improved data reporting. Standard is met for all categories.

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 FY 20-21, DHS-BHD provided 1,664 TBS services at a 3.21% utilization rate for beneficiaries under the age of 21.

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 Sonoma County Department of Health Services, Behavioral Health Division (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 2020, the Department of Health Care Services (DHCS) cancelled one of the survey periods due to the implementation of a system shift in submission processes. Also of note is the outbreak of COVID-19 in the months prior to the survey collection period in June. Due to the global pandemic, survey collection was entirely on-line, which reduced participation due to access issues.

DHCS has contracted with the University of California Los Angeles (UCLA) 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

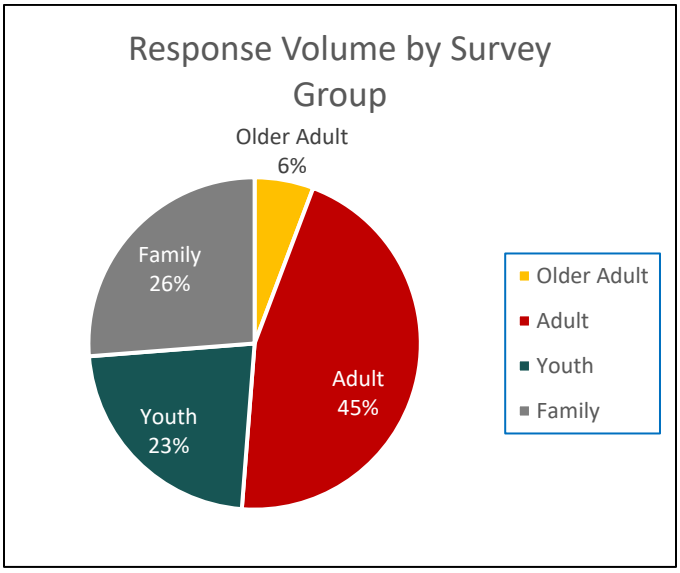
Response Volume

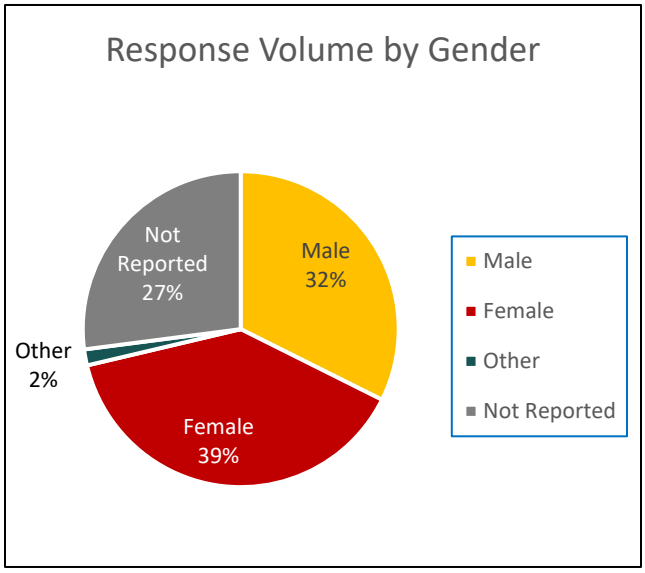
The table below details consumer participation in Sonoma County for calendar year 2020.

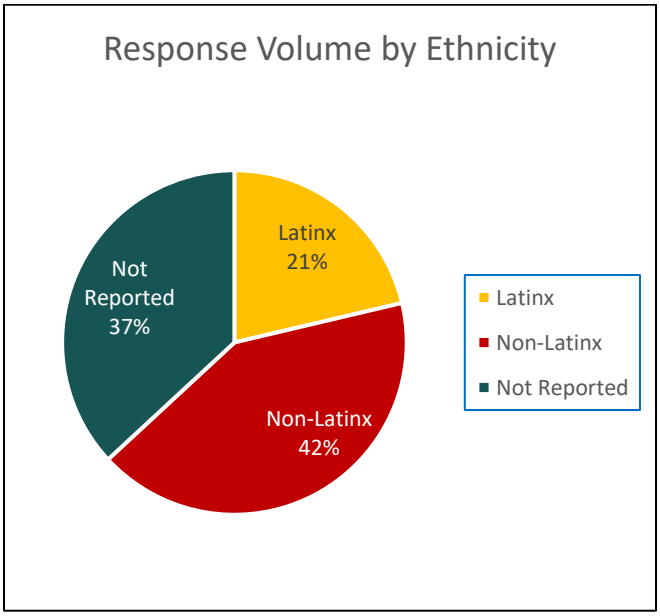
Consumer Population	Items Scored	Survey Participants
Older Adult	36	14
Adult	36	111
Youth	26	55
Family/Parents of Youth	26	64

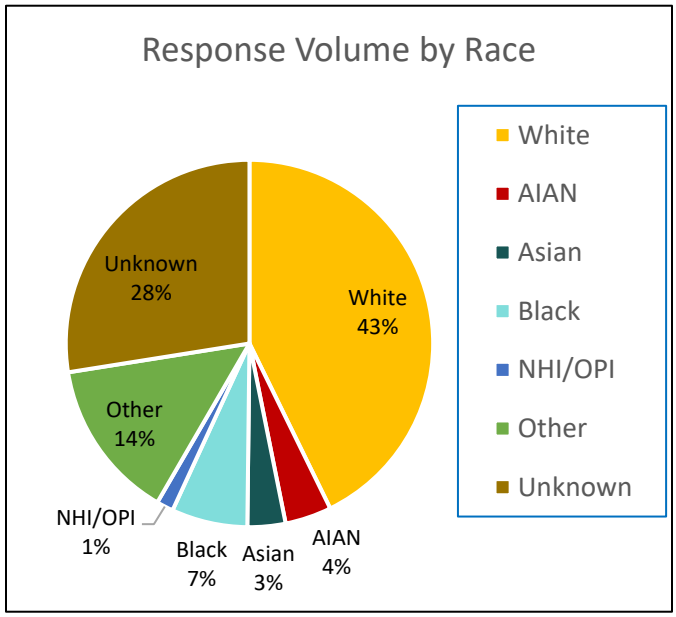
Overall, the number of Surveys collected in 2020 decreased from 2019. This decrease is due to the single data collection period in 2020, which took place on-line only, and just after the outbreak of the COVID-19 global pandemic. Results are significantly impacted by these events. Additionally, a significant number of the Youth and Family submissions uploaded with blank data, indicating there may have been technical issues with those surveys.

Response Volume by Category







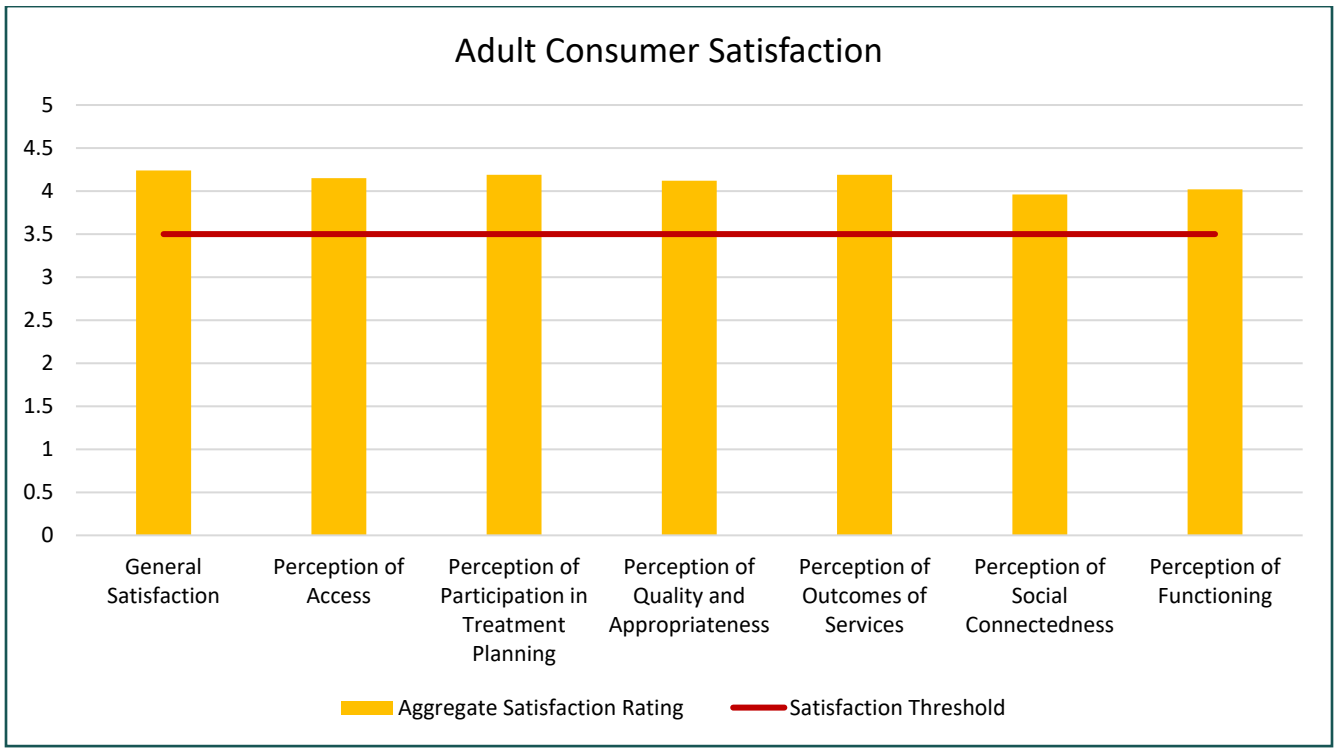


Data Analysis

Overall, 244 Consumer Perception Surveys were collected in calendar year 2020 for Sonoma County Behavioral Health. There are a total of 27 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 2020 mean scores were above the satisfaction threshold standard of 3.5, and increased slightly from 2019. For adult males, satisfaction with services increased, but perception of Outcome, Connectedness, and Functioning decreased. However, scores for adult females improved considerably on Outcome, Connectedness, and Functioning. Adult clients identifying as Other Gender scored much higher than last year, but the sample size is one, and satisfaction is still below threshold on Participation in Treatment Planning. Clients identifying as Latinx, Native American, Asian, or Black saw an overall reduction in scores from the prior year, with Outcome and Functioning falling below the satisfaction threshold for Native American clients; whereas, Native Hawaiian/Pacific Islander scores improved.



Results by Gender

Satisfaction Domain	Male (n=50)	Female (n=58)	Other (n=1)
General Satisfaction	4.17	4.30	5.00
Perception of Access	4.17	4.14	4.00
Perception of Participation in Treatment Planning	4.21	4.19	3.50
Perception of Quality and Appropriateness	4.14	4.11	4.11
Perception of Outcomes of Services	3.87	4.15	4.75
Perception of Social Connectedness	3.80	4.09	4.50
Perception of Functioning	3.86	4.15	5.00

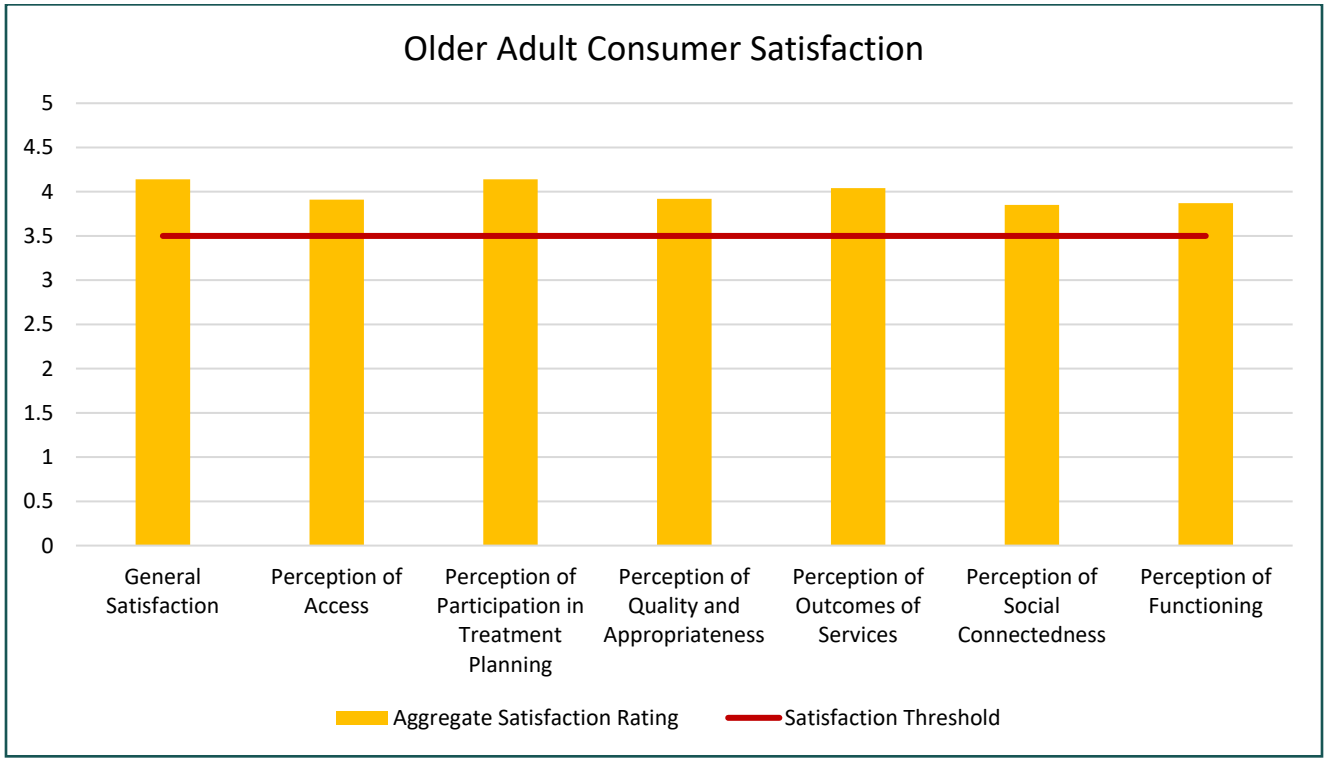
Results by Ethnicity

Satisfaction Domain	White n=72	Latinx n=22	AIAN n=6	Asian n=7	Black n=8	NHI/OPI n=9	Other n=23	Unknown n=10
General Satisfaction	4.20	4.18	3.94	4.52	4.42	4.44	4.10	4.26
Perception of Access	4.09	4.15	3.97	4.04	3.99	3.98	4.08	3.96
Perception of Participation in Treatment Planning	4.13	4.07	4.40	4.43	4.56	4.67	3.98	3.89
Perception of Quality and Appropriateness	4.08	3.99	3.90	4.31	4.34	4.44	3.89	4.00
Perception of Outcomes of Services	3.96	4.08	3.38	4.25	3.79	4.21	3.92	3.69
Perception of Social Connectedness	3.95	3.90	3.90	3.93	3.54	3.83	3.52	4.06
Perception of Functioning	3.99	4.10	3.56	4.35	3.76	4.16	3.84	3.91

Older Adult Consumers

Overall, mean scores among Older Adults improved in 2020. Older Adult Males showed comparable scores to 2019, however, Older Adult Females showed substantial improvement in satisfaction. Older Adults identifying as Other Gender fell below the satisfaction threshold for Access, Quality, Connection, and Functioning.

The small sample size of responses presents challenges to meaningful data interpretation by Ethnicity. In general, Older Adult persons of White Ethnicity showed a reduction in satisfaction rates overall. Whereas, persons of color showed an increase in satisfaction scores. A reduction in Perception of Access is noted across all groups, and may be influenced by the transition to virtual appointments necessitated by COVID.



Results by Gender

Satisfaction Domain	Male (n=7)	Female (n=5)	Other (n=1)
General Satisfaction	3.95	4.40	4.33
Perception of Access	4.00	3.92	3.33
Perception of Participation in Treatment Planning	4.00	4.40	4.00
Perception of Quality and Appropriateness	3.96	4.33	3.00
Perception of Outcomes of Services	3.89	4.26	4.00
Perception of Social Connectedness	3.98	4.10	1.75
Perception of Functioning	3.77	4.24	2.75

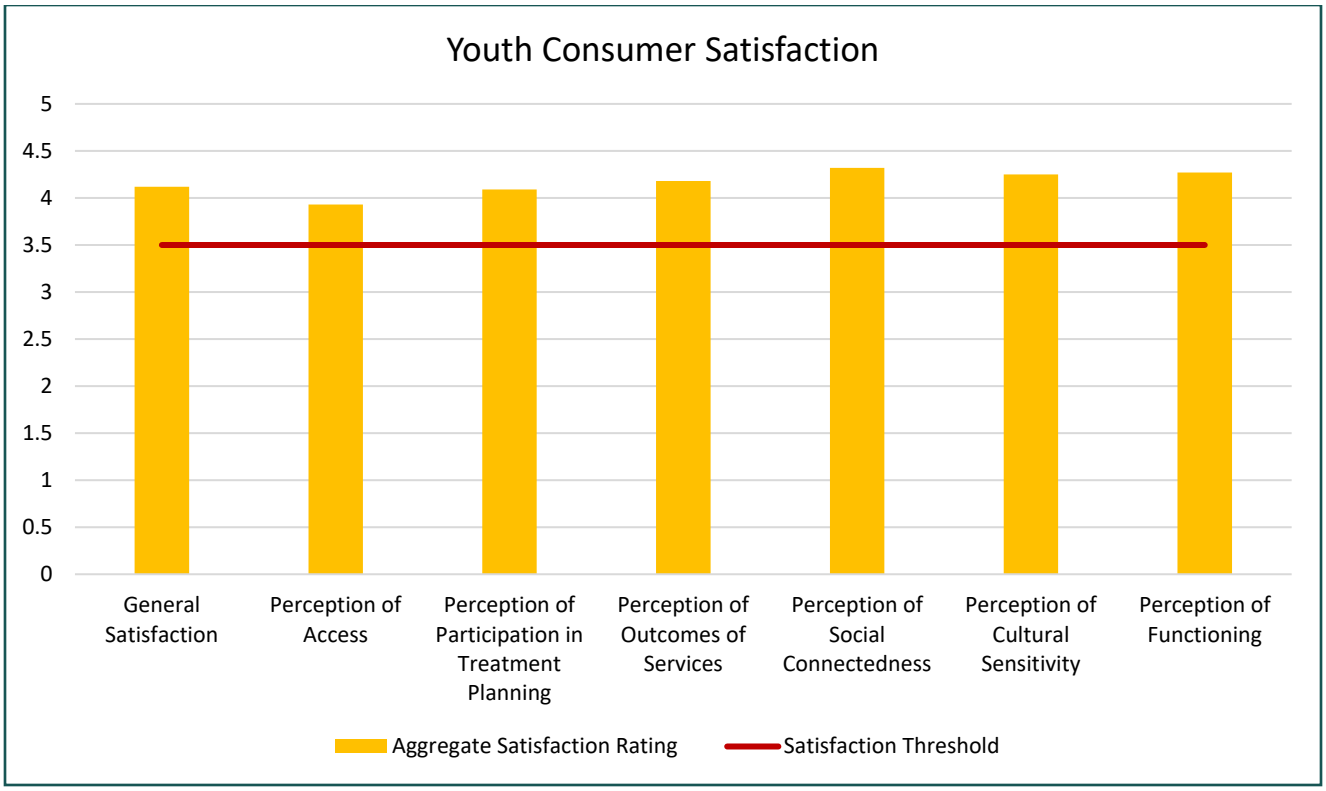
Results by Ethnicity

Satisfaction Domain	White n=8	Latinx n=1	AIAN n=1	Asian n=1	Black n=3	NHI/OPI n=1	Other n=2	Unknown n=1
General Satisfaction	3.96	4.67	5.00	4.60	4.44	4.67	4.50	4.00
Perception of Access	3.73	3.67	5.00	5.00	4.70	4.60	3.50	3.75
Perception of Participation in Treatment Planning	3.75	5.00	5.00	5.00	5.00	5.00	4.50	4.00
Perception of Quality and Appropriateness	3.78	4.56	5.00	5.00	4.85	5.00	3.78	2.50
Perception of Outcomes of Services	3.78	4.29	4.00	5.00	4.67	5.00	4.14	N/A
Perception of Social Connectedness	3.89	4.00	4.00	5.00	4.42	5.00	2.88	N/A
Perception of Functioning	3.68	4.40	4.00	4.90	4.60	5.00	3.58	N/A

Youth Consumers

For Youth, mean scores improved in 2020. However, there were a substantial number of blank submissions in the Youth dataset, indicating there may have been technological issues with accessing the survey process. Female Youth showed a significant increase in satisfaction scores across all domains, whereas Male youth showed a slight decrease, with Access falling below the satisfaction threshold. Youth identified as Other Gender reported the highest satisfaction overall.

For Youth of Native American ethnicity, mean scores fell significantly below the satisfaction threshold on all domains. Additionally, Access scores were below satisfaction threshold for Latinx and Black Youth. However, Function and Outcome scores improved for almost all groups.



Results by Gender

Satisfaction Domain	Male (n=13)	Female (n=16)	Other (n=2)
General Satisfaction	3.86	4.30	4.00
Perception of Access	3.40	4.18	4.75
Perception of Participation in Treatment Planning	3.90	4.18	4.50
Perception of Outcomes of Services	3.93	4.30	4.45
Perception of Social Connectedness	4.17	4.43	4.50
Perception of Cultural Sensitivity	3.99	4.40	4.63
Perception of Functioning	4.10	4.35	4.55

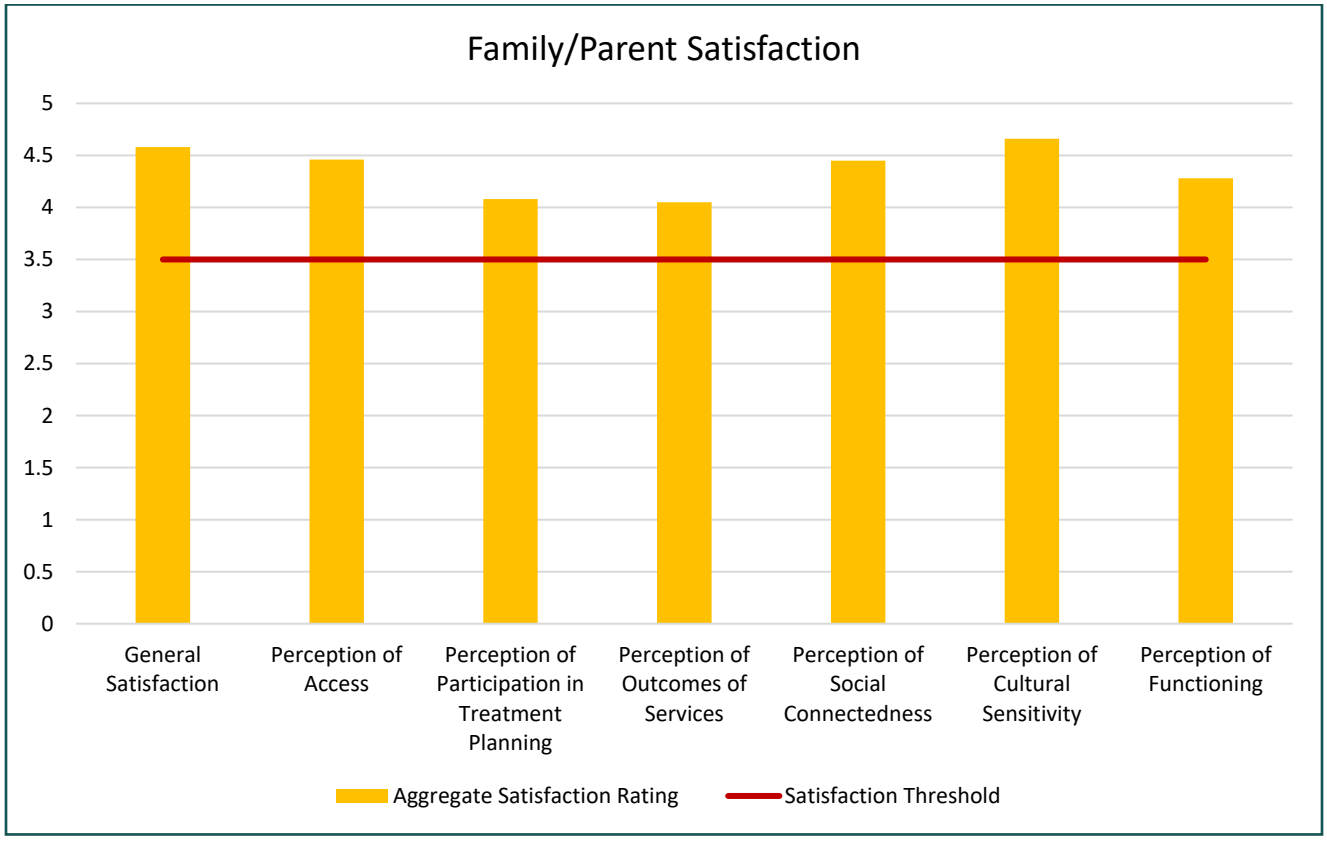
Results by Ethnicity

Satisfaction Domain	White n=20	Latinx n=16	AIAN n=2	Asian n=0	Black n=6	NHI/OPI n=0	Other n=6	Unknown n=24
General Satisfaction	4.06	3.99	2.67	N/A	3.77	N/A	4.19	N/A
Perception of Access	3.76	3.50	1.00	N/A	3.20	N/A	3.80	N/A
Perception of Participation in Treatment Planning	4.18	3.85	2.33	N/A	4.00	N/A	3.97	N/A
Perception of Outcomes of Services	4.27	3.92	1.00	N/A	4.20	N/A	4.13	N/A
Perception of Social Connectedness	4.39	4.03	1.00	N/A	4.05	N/A	4.32	N/A
Perception of Cultural Sensitivity	4.20	3.88	1.50	N/A	3.97	N/A	3.97	N/A
Perception of Functioning	4.36	4.01	1.00	N/A	4.32	N/A	4.18	N/A

Family/Parents of Youth Consumers

Overall Family Satisfaction scores improved in 2020, with the highest mean score in Cultural Sensitivity. However, there were a substantial number of blank submissions in the Family dataset, indicating there may have been technological issues with accessing the survey process.

Mean scores on Outcome and Functioning improved for most Ethnic Groups. However, satisfaction scores fell below the threshold for Asian Family members. The low sample size creates difficulty in interpreting this result.



Results by Gender

Satisfaction Domain	Male (n=9)	Female (n=16)	Other (n=0)
General Satisfaction	4.67	4.53	N/A
Perception of Access	4.22	4.60	N/A
Perception of Participation in Treatment Planning	4.24	3.99	N/A
Perception of Outcomes of Services	3.96	4.09	N/A
Perception of Social Connectedness	4.53	4.41	N/A
Perception of Cultural Sensitivity	4.39	4.81	N/A
Perception of Functioning	4.42	4.20	N/A

Results by Ethnicity

Satisfaction Domain	White n=15	Latinx n=13	AIAN n=2	Asian n=1	Black n=1	NHI/OPI n=0	Other n=7	Unknown n=39
General Satisfaction	4.65	4.50	4.63	3.50	5.00	N/A	4.57	N/A
Perception of Access	4.20	4.79	4.75	5.00	5.00	N/A	4.75	N/A
Perception of Participation in Treatment Planning	4.16	3.92	3.67	2.50	5.00	N/A	3.89	N/A
Perception of Outcomes of Services	3.97	4.10	4.00	2.00	4.00	N/A	4.43	N/A
Perception of Social Connectedness	4.58	4.31	4.75	5.00	5.00	N/A	4.04	N/A
Perception of Cultural Sensitivity	4.57	4.80	5.00	5.00	5.00	N/A	4.70	N/A
Perception of Functioning	4.34	4.18	4.88	2.75	4.20	N/A	4.31	N/A

Summary and Recommendations

Survey results improved in the Adult and Older Adult populations, while remaining high in the Youth and Family populations. Of note is the significant improvement in Outcomes/Functional Skills for Youth and their Family Members.

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

- Native American Youth Populations
- Asian-American/Pacific-Islander Family Populations

The following areas of concern may warrant programmatic clinical intervention:

- Adult Social Connectedness
- Youth Perception of Access

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	1	0	0	1	0
Timeliness of services	5	0	0	5	0
24/7 Toll-free access line	0	0	0	0	0

Access Category	Grievance	Exempt Grievance	Pending Resolution	Resolved	Referred
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	22	4		18	0
Treatment issues or concerns	14	1	0	13	0
Medication concern	3	0	0	3	0
Cultural appropriateness	0	0	0	0	0
Other quality of care issues	4	1	0	3	
Total	**43**	**5**	**0**	**38**	**0**

Other Category	Grievance	Exempt Grievance	Pending Resolution	Resolved	Referred
Financial	1	0	0	1	0
Lost Property	0	0	0	0	0
Operational	0	0	0	0	0
Patients' rights	2	0	0	2	0
Peer behaviors	0	0	0	0	0
Physical environment	1	0	0	0	0
Other not listed above	10	0	0	0	10
Total	**14**	**0**	**0**	**3**	**10**

Confidentiality Concerns: One filed. Resolved Not in Favor.

Number of grievances = 70, Resolved over 90 days = 1, Resolved under 90 days = 69.

68/69 or 99% 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	106	0	0	0	1	0
Payment Denial Notice	17	0	0	0	0	1
Delivery System Notice	31	0	0	0	0	0
Modification Notice	8	0	0	0	0	0

NOABD Category	NOABDs Issued	Appeal	Expedited Appeal	Pending Resolution	Decision Upheld	Decision Overturned
Termination Notice	2	0	0	0	0	0
Authorization Delay Notice	42	2	0	0	1	2
Timely Access Notice	181	0	0	0	0	0
Financial Liability Notice	1	0	0	0	0	0
Grievance & Appeal Timely Resolution Notice	1	0	0	0	0	0
Total	**392**	**3**	**0**	**0**	**1**	**3**

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 hearing results.**

PROCESS USED TO EVALUATE
- Grievance and Appeals Database

RESPONSIBLE STAFF – QA Manager and Grievance Coordinators

RESULTS

No State Fair Hearing was conducted in FY20-21. 100% of appeals were addressed within 60 days.

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 FY20-21.

44/46 or 96% 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 the annual 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)

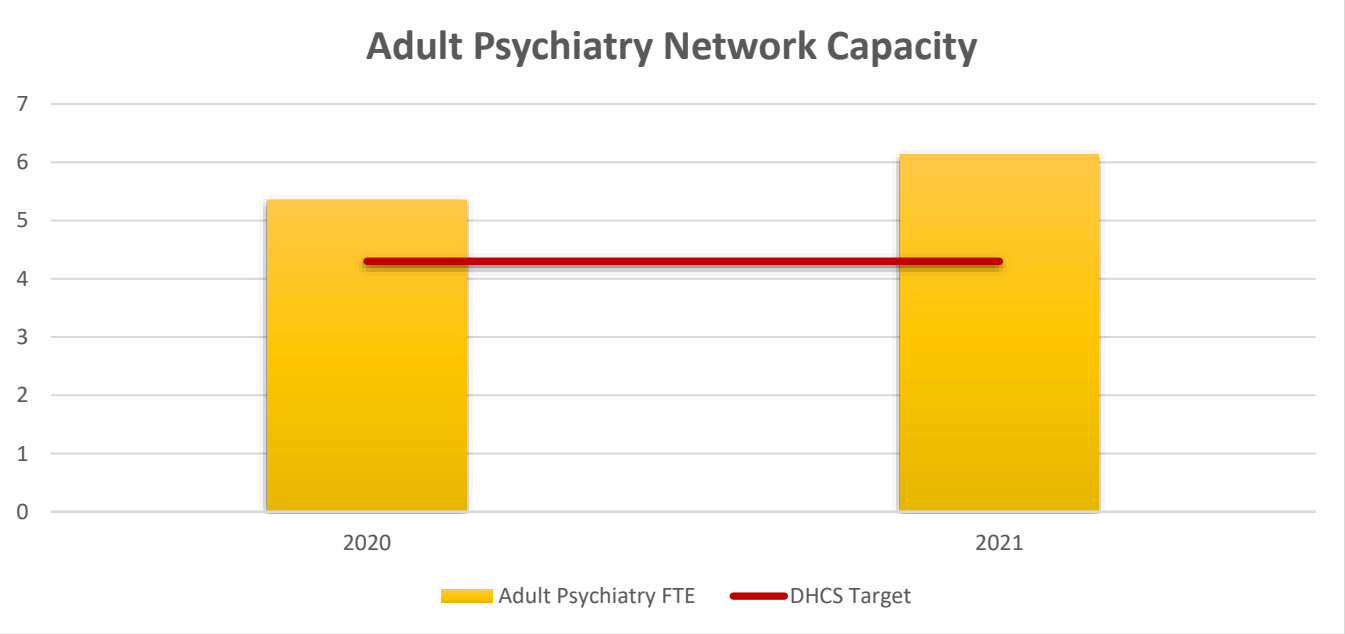
ACTION STEPS STATUS UPDATE

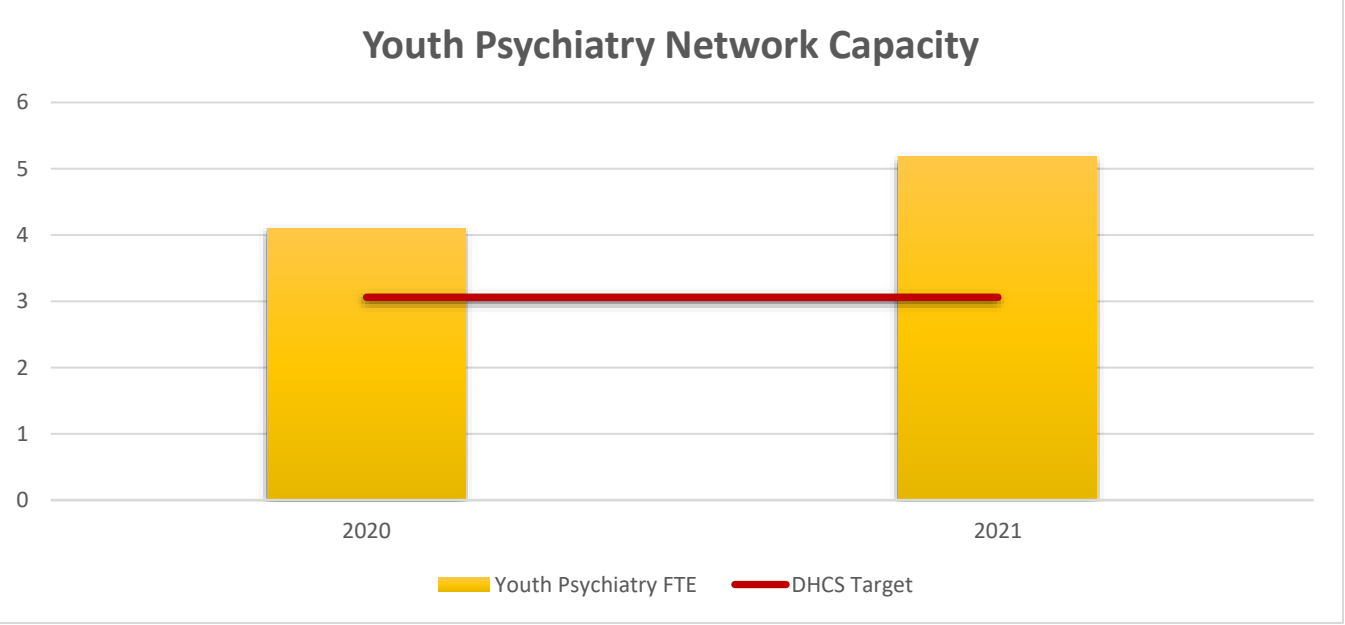
Key Activity	Update	Status
Prioritize staffing recruitments for direct service programs	The Admin Program Support Unit continued active recruitment for direct service teams, filling multiple vacancies in both the adult and youth systems; the MST program is expanding and recruitment is on-going for crisis services.	**Complete**
Maximize contract site capacity through competitive procurement	The adult services system RFP cycle was delayed by COVID, but is scheduled for FY 21-22.	**Deferred**
Expand the student-intern and peer-provider pipeline programs	The number of participating Universities increased to 20; a Physician Assistant pathway was added to the pipeline program; implementation continued on a peer-provider fieldwork pathway through the CSU; peer positions were added to the CSU	**Complete**
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**
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

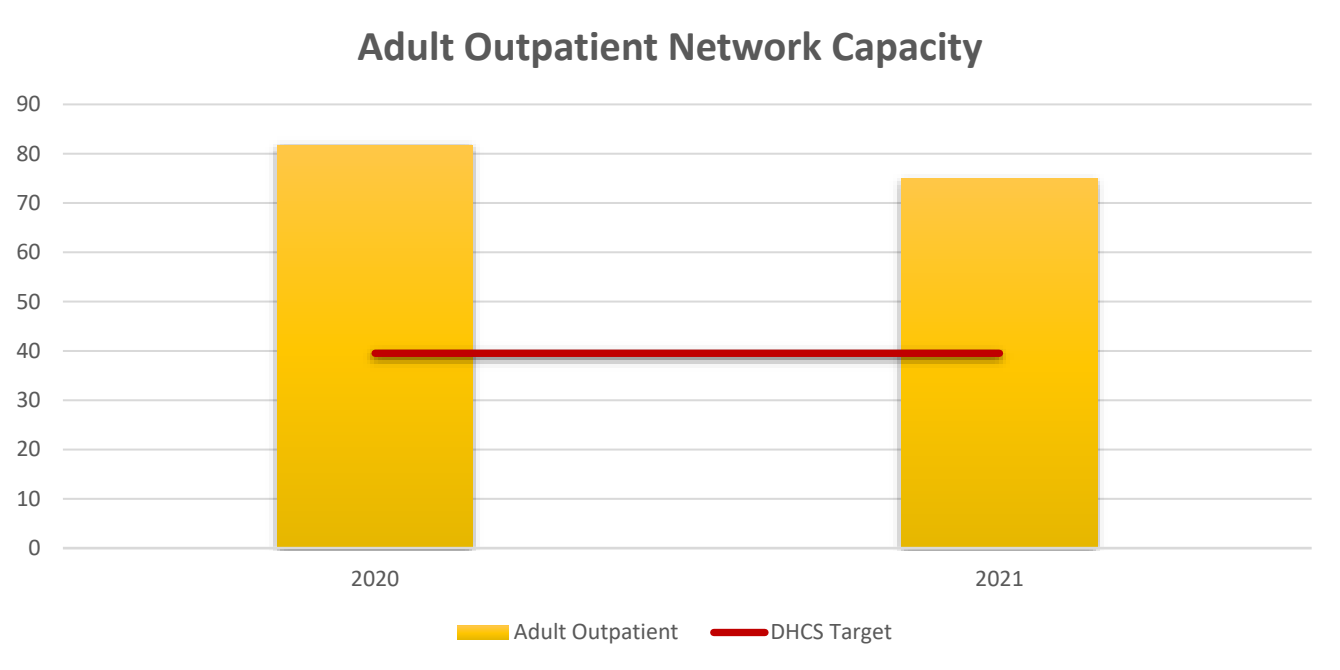
NACT Category	DHCS Target 2021	Sonoma April 2020	Sonoma July 2021
Adult Psychiatry	4.30 FTE	5.35 FTE	6.13 FTE
Youth Psychiatry	3.06 FTE	4.10 FTE	5.18 FTE
Adult Outpatient	39.52 FTE	81.76 FTE	75.01 FTE
Youth Outpatient	79.31 FTE	97.07 FTE	113.45 FTE

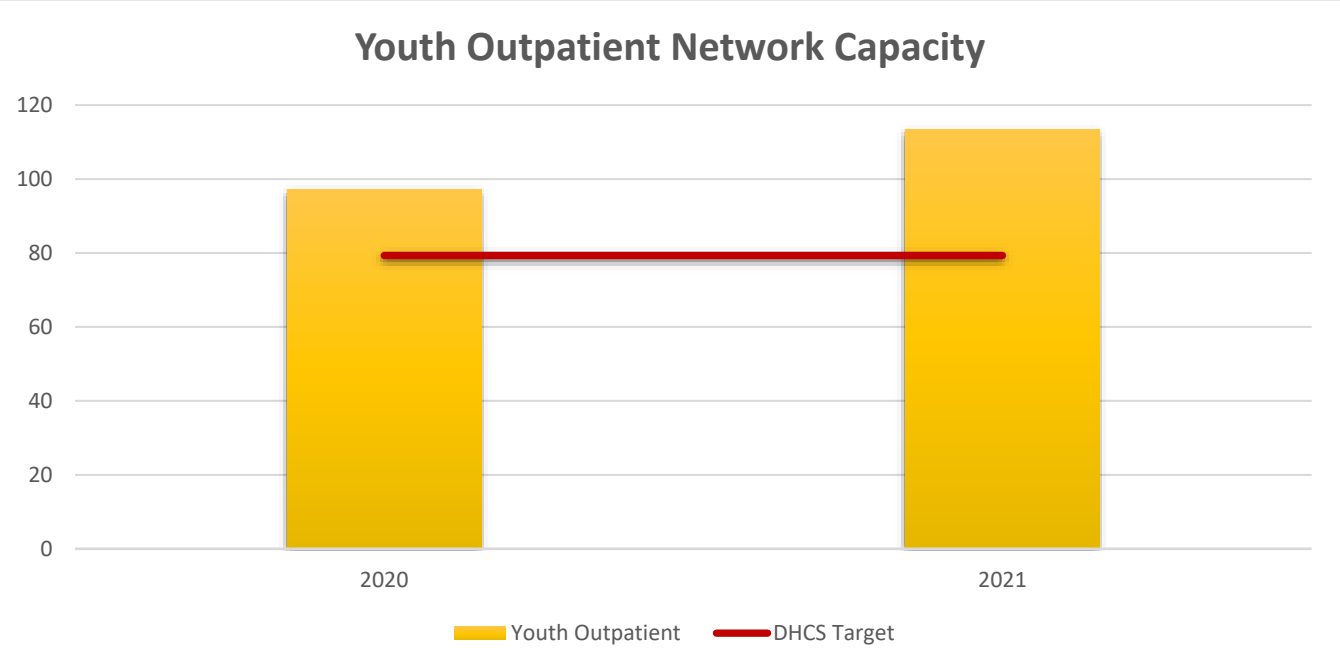
DHS-BHD exceeded the target for the 2021 submission. The following charts indicate network trends.





Both Adult and Youth Psychiatry FTE increased in 2021. The DHCS target FTE also increased, but DHS-BHD was able to meet this higher target.





The DHCS targets for Outpatient services increased for both Adults and Youth. While the number of Youth outpatient providers increased, the number of Adult outpatient providers trended downward. A Request for Proposals for Adult Case-Management services will be released in FY 21-22 to help increase Adult services capacity.

Overall, the annual NACT submission met the target FTE requirements for all provider categories.

GOAL MET

OBJECTIVE 1.2: **By the end of FY 20-21, DHS-BHD will implement a streamlined BRS/COC process through the Electronic Health Record system**

PROCESS USED TO EVALUATE
Behavioral Health Plan Administration Committee
BRS/COC Data Reporting

RESPONSIBLE STAFF – Quality Assurance Manager; AVATAR Implementation Lead

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Map the required data elements on the BRS/COC Form	The AVATAR Implementation Lead and the Quality Assurance Manager mapped the specifications for the BRS/COC form and submitted the results to NetSmart for rendering in the system	**Complete**
Render and test the BRS/COC From in AVATAR	NetSmart completed the rendering of the BRS/COC form in AVATAR; initial testing was completed and the form was implemented in the LIVE environment; subsequent clarification of DHCS requirements necessitated additional changes, which have been completed in the testing environment and approved for implementation in LIVE	**Complete**
Map the workflow from beneficiary request through final approval	The Quality Assurance Manager mapped the complete workflow from beneficiary request through final approval, and provided both a step-wise procedure and visual workflow document to assist with staff training	**Complete**
Develop the User's Manual to support process implementation in AVATAR	This project has commenced now that the final approved version of the form has been rendered in AVATAR	**In Progress (25%)**
Conduct staff and management trainings on form use	The Quality Assurance Manage has conducted multiple staff and manager trainings on form use. An additional training will be needed on the shift to full electronic process.	**In Progress (75%)**
Transition to fully electronic process	Go LIVE date is pending final staff trainings.	**In Progress (25%)**

RESULTS

A fully electronic working form has been developed, tested, and rendered within the Electronic Health Record. Detailed mapping of the BRS/COC process workflow has been completed and multiple trainings conducted at both the staff and management levels. Development of a User's Manual to support the electronic version has now commenced. Go LIVE date planned for FY 21-22.

GOAL PARTIALLY 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: **Non-Clinical PIP: increase the percentage of Latino/Hispanic clients served to meet/exceed 42%**

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

PROCESS USED TO EVALUATE
AVATAR Demographic Data

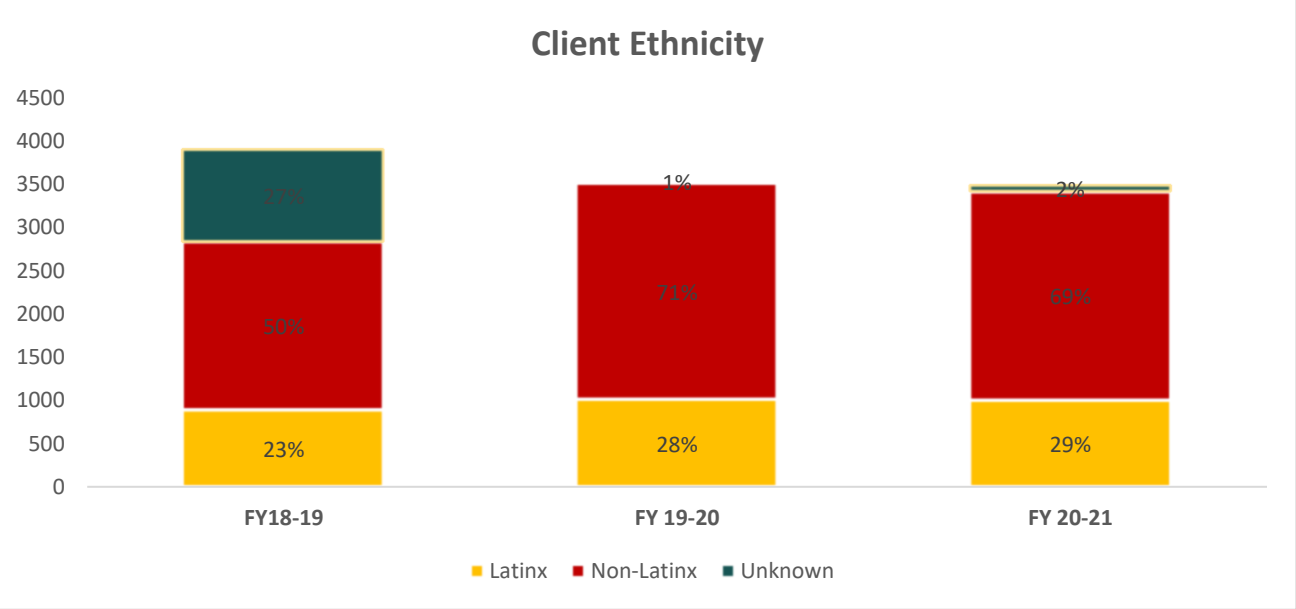
RESPONSIBLE STAFF – Ethnic Services Manager (Planning) & QI Manager (Data Analytics)

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Engage PDSA process to analyze low penetration rates	An extensive data analysis of ethnic services was completed and shared with the Ethnic Services Manager and QIC	**Complete**
Conduct root-cause analysis into Access Barriers	A root-cause analysis revealed less screening disparity in FY20-21 than originaly detected in FY19-20; in addition the amount of screened out callers did not account for the lower amount of Latinx screens conducted relative to non-latinx population. This indicated Latinx population is not accessing the screening "front door" of the MHP as frequently, and a latinx outreach intervention is warranted.	**Complete**
Meet with promotores contractors, gain further input on outreach intervention design	Initial meetings with promotores contractors will start January 2022	**In Progress**
Develop common MHP service and access training for promotores		
Train promotores – MHP services and access		
Begin promotores outreach activities		
Evaluate effectiveness of activities on # of screens		

RESULTS

Root-cause analysis completed. A non-clinical outreach intervention has been identified in order to increase the number of Latinx calls to the Access line. We will develop the training and intervention more fully with promotores over January – March 2022, with the goal of initiating promotores outreach activities in April 2022.



The percent of clients Latinx clients has increased over the last three years. From 23% in FY18-19 to 29% of all client served in FY 20-21.

GOAL NOT MET

OBJECTIVE 2.2: **During FY 20-21, 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

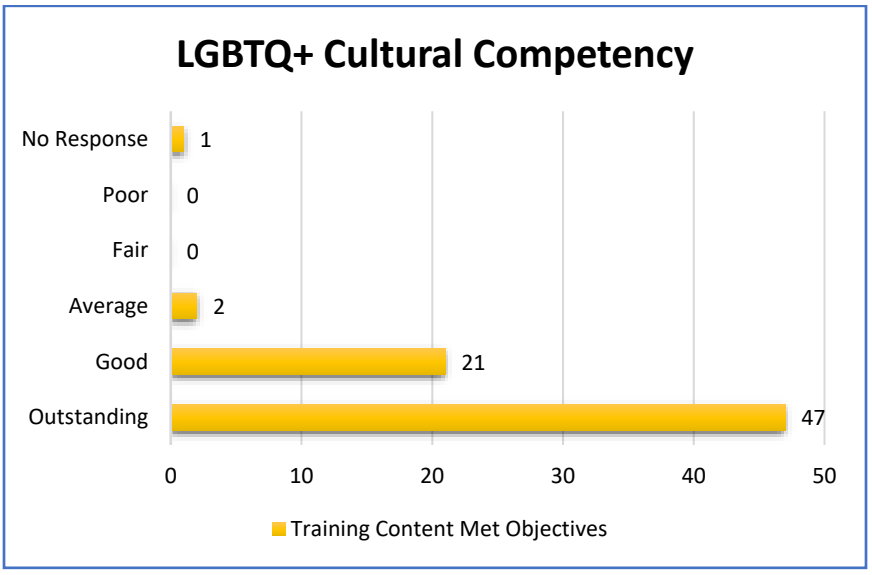
ACTION STEPS STATUS UPDATE

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	Two Cultural Responsiveness trainings were scheduled in FY 20-21, however one was cancelled	**Complete**
Conduct the trainings	One training occurred; one was cancelled	**In progress**

RESULTS

Of Note: A new Staff Cultural Responsiveness Survey was completed during FY 20-21.

	Date	Training	Facilitated by
1	3/10/2021	LGBTQ+ Cultural Competency	Jessica Carroll, Maxwell Anderson, Mell Browning
2	5/12/2021	Peer Panel	Cancelled



Satisfaction rating: LGBTQ+ Cultural Competency = 4.64, which exceeds the minimum threshold.

GOAL PARTIALLY MET

OBJECTIVE 2.3: During FY 20-21, schedule and facilitate 4 Cultural Responsiveness Committee Meetings

PROCESS USED TO EVALUATE
Cultural Responsiveness Committee Schedule

RESPONSIBLE STAFF – Ethnic Services Manager; Diversity, Equity and Inclusion 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 March of 2021, DHS-BHD initiated a recruitment for, and hired, a Diversity, Equity and Inclusion Manager.	**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**

Key Activity	Update	Status
Develop planning agenda	The CRC planning group reconvened in October 2019 and established CRC goals, strategies and schedule	**Complete**
Schedule meetings	The CRC held 5 virtual meetings during FY20-21	**Complete**

RESULTS

Date	Topics Covered
10/20/2020	Review Purpose and Assignment of CRC Cultural Competence Plan
11/17/2020	Cultural Responsiveness Survey Cultural Competency Plan PEI Contracts: looking at demographics of unserved/underserved and at-risk populations, current populations served, fund allocation to populations, regulations/program types
12/15/2020	Cultural Responsiveness Survey Cultural Competency Plan PEI Contracts
01/19/2021	Developing Goals for Cultural Responsiveness Committee Identifying Areas of Work for 2021
02/23/2021	PEI Contracts DEI Trainings for Managers Developing Goals for CRC

GOAL MET

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

OBJECTIVE 3.1: **By the end of FY 20-21, the average length of time from initial request for psychiatry to first offered psychiatry appointment will be 15 business days or less**

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

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
Analyze prescriber caseloads & develop target caseload maximums.	In August & November 2021, QI analyzed psychiatry prescriber workload for youth and adult medical staff. Developed target caseload maximums for youth and adults that take into	**Complete**

Key Activity	Update	Status
	account the various types of psychiatry appointments.	
Review scheduling workflow and revise for efficiency	Started a workgroup in December to implement caseload capacity and management recommendations. Will review scheduling workflow and other business processes.	**In Progress**
Right-size prescriber caseloads		**In Progress**
Develop and implement Prescriber Caseload report in AVATAR for monthly monitoring	This report was implemented over the last year and is available for monitoring.	**Complete**
Designate a point-person to case-manage Adult Med Clinic post-hospital referrals and Meds-Only clients		**In Progress**

RESULTS

The first charts below represents the average length of time from request for a psychiatry service to first offered psychiatry appointment. The graph represents the percentage of psychiatry appointments that met the 15 day standard throughout the FY20-21 year. Psychiatry appointments meeting this declined even further, relative to the previous fiscal year.

	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)	19.21 days (mean) 18 days (median) 19.21 Std. Dev.	19.86 days (mean) 21 days (median) 13.45 Std. Dev.	18.56 days (mean) 14 days (median) 17.70 Std. Dev.	22.23 days (mean) 20 days (median) 18.23 Std. Dev.
Goal & DHCS Standard	15 days	15 days	15 days	15 days
Percent of appointments that met this standard	44.94%	36.59%	53.23%	45.45%
Range	**0-87 days**	**0-65 days**	**0-87 days**	**0-70 days**

GOAL NOT MET

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

OBJECTIVE 4.1: **For Native American Consumer Perception surveys collected in FY 20-21, the satisfaction rate will exceed the 3.5 minimum satisfaction threshold on all domains**

PROCESS USED TO EVALUATE
Consumer Perception Survey Results
Staff Development Training Records

RESPONSIBLE STAFF – QI Manager and WET Coordinator

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Invite Native American stakeholders to participate in the Quality Improvement Committee and Cultural Responsiveness Committee	Representatives from Sonoma County Indian Health Project have been consistently attending and participating in the Quality Improvement Committee during FY 20-21. Additionally, the Cultural Responsiveness Committee was re-constituted with membership from a variety of underserved populations, including the Native American community.	**Complete**
Provide staff development training focused on Native American clinical interventions and best-practices	Delayed due to COVID, and staff change in Workforce Education and Training Coordinator position.	**Not Started**

RESULTS

Native American Consumer Perception Survey results worsened for Youth in FY 20-21; however, the sample size was very small due to the COVID Pandemic disrupting the survey collection process. Moreover, there was a change in staffing of the WET Coordinator position. Additional training on this topic is recommended.

GOAL NOT MET

QUALITY OF CARE GOAL 5: **DHS-BHD seeks best-practice refinements in service delivery to provide consistent high-quality care**

OBJECTIVE 5.1: **During FY 20-21, 100% of new staff will attend a Documentation NEO within 3 months of hire**

Goal Calculation: $\frac{Staff\ Attending\ NEO\ within\ 3\ months}{Number\ of\ staff\ attending\ NEO\ for\ year} * 100\%$

PROCESS USED TO EVALUATE

NEO Staff Training Records

RESPONSIBLE STAFF – Documentation Manager

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Develop NEO Curriculum and training materials	Eight hours of training was split from one full day, to four 2-hour trainings. Video recorded trainings were created in January to meet the need of the new virtual working situation.	**Complete**
Establish notification pathway for tracking new hires	Tracking of new hires and training needs established as part of the new hire process.	**Complete**
Implement NET training schedule	Training schedule created, although interrupted due to in-person/group gathering restraints implemented in response to the health emergency declaration.	**Complete**

RESULTS

18 Staff persons were hired in FY 20-21 who required NEO training. 18 of 18, or 100%, attended NEO within 3 months. COVID in person restrictions and staff capacity affected the training rate. Video recorded trainings were implemented in January to alleviate some of the delay in offerings.

GOAL MET

OBJECTIVE 5.2: **By the end of FY 20-21, complete an initial draft of the DHS-BHD Provider Handbook**

PROCESS USED TO EVALUATE
Provider Handbook Project Workplan

RESPONSIBLE STAFF – QAPI Leadership Team

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Designate included content	Content and framework was designation	**Complete**
Obtain stakeholder feedback	Stakeholder group was identified and convened to provide feedback and create content	**Complete**
Finalize Handbook and publish to website	Finalized Version is ready to published to website expected in January-Feb 2021	**Complete**

RESULTS

Handbook was designed and drafted with input from stakeholders and personnel. It was reviewed and approved by the Board of Supervisors and posted to the new QAPI website in December 2021.

GOAL MET

OUTCOMES GOAL 6: **DHS-BHD provides recovery-oriented services that promote the ability of consumers to live a meaningful life in a community of their choosing**

OBJECTIVE 6.1: **(Clinical PIP) By the end of FY 20-21, re-development of the Clinical PIP will be complete and a Strengths Model pilot program will commence at FY 21-22**

PROCESS USED TO EVALUATE
ANSA Actionable Item Scores
Strengths Model Case-Management Implementation Plan

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

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Re-assess baseline data to add FY 19-20 results	Baseline re-assessed, further validating the primary factors for targeted intervention	**Complete**
Adapt curriculum to COVID impacted service system	Strengths Model selected as appropriate curriculum for COVID impacted service system	**Complete**

Key Activity	Update	Status
Develop inclusion criteria for pilot program participation	Adult FSP clients selected as target population	**Complete**
Produce treatment manual	Intervention materials have been assembled; charting guide in development	**In Progress (50%)**
Develop training plan	Training plan steps are drafted	**In Progress (75%)**

RESULTS

This PIP was revised to adjust for COVID restrictions. CIBHS has been engaged to implement the Strengths Model curriculum. Pre-implementation planning has commenced. This goal caries over for FY 21-22.

GOAL PARTIALLY MET

OBJECTIVE 6.2: **By the end of FY 21-22, the average actionable items for Factors One and Two for Adult HCBs will reduce by 10%**

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

PROCESS USED TO EVALUATE
AVATAR ANSA 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 Strengths Model facilitators	Initial cohort of managers trained in Strengths model; pre-implementation engagement has begun	**In Progress (25%)**
Recruit and select group participants	FSP Teams selected as group participants	**Complete**
Implement Strengths Model Pilot Program	Pre-implementation planning has commenced	**In Progress (25%)**
Administer Strengths Assessment to program participants	Pending completion of prior steps	**Not Started**
Create Personal Recovery Plan	Pending completion of prior steps	**Not Started**

RESULTS

Pre-Implementation planning has begun for this project. The Adult FSP teams have been selected as the target population and a training implementation plan is drafted. This project carries over into FY 21-22.

GOAL PARTIALLY MET

OBJECTIVE 6.3: **By the end of FY 20-21, 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 peer providers through the Wellness Center	The Wellness Center trained a cohort of peer providers for potential field rotations at the CSU	**Complete**
Customize the curriculum to fit a crisis setting	The QIC CSU subcommittee customized an intervention curriculum for the CSU	**Complete**
Deliver one-on-one Peer Provider interventions at the CSU	Candidate was selected to pilot the program; on-boarding in progress	**In Progress (50%)**

RESULTS

This project was revised to adjust for COVID safety measures. The MOU between the Wellness Center and CSU was completed, peer providers were trained, and a candidate was selected to pilot the program. On-boarding in progress.

GOAL PARTIALLY MET

FOSTER CARE GOAL 7: **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 7.1: **By the end of FY 20-21, 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, Clozaril monitoring, ADD and APC	**Complete**
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; Med Note Module project commenced	**In Progress (75%)**

RESULTS

Prescribing Physician	# of Charts Reviewed	# of Practices Guidelines Adhered to on Average	% of Practice Guidelines Adhered to on Average
1	5	12.8	85.33%
2	5	12.4	82.67%
3	5	14.2	94.67%
4	5	11.8	78.67%
5	5	15	100.00%
6	5	14.6	97.33%
7	0	Not Reviewed	Not Reviewed
8	5	12	80.00%
9	5	14.4	96.00%
10	5	14.2	94.67%
11	5	13.6	90.67%
12	5	13.6	90.67%
13	0	Not Reviewed	Not Reviewed
14	0	Not Reviewed	Not Reviewed
15	5	15	100%
16	0	Not Reviewed	Not Reviewed
	Average =	**13.71**	**90.89%**

75.00% of psychiatric staff received peer reviews on five charts in FY20-21. Results of the peer reviews indicated 90.89% adherence to practice guidelines. This is a slight decrease from FY 19-20. Significant progress was made on implementing HEDIS tracking through AVATAR.

GOAL PARTIALLY MET

INFORMATION SYSTEMS GOAL 8: **DHS-BHD utilizes centralized information systems to inform mental health planning and service delivery at community and individual levels**

OBJECTIVE 8.1: **By end of FY 20-21, 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, Hospital UR, and Audits	**Complete**
Design QAPI data reporting dashboard	Design completed and submitted for rendering	**Complete**
Render reporting capacity in the Electronic Health Record	Report building commenced and is in progress	**In Progress (25%)**
Train QAPI and Management staff on utilization and interpretation of the reports	Initiate pending prior steps completion	**Not Started**

RESULTS

In FY 20-21, significant progress was made on AVATAR implementation of QAPI reports. All report specifications completed and submitted, and several reports have now been completed and delivered. Project on-going.

GOAL PARTIALLY MET

OBJECTIVE 8.2: **By end of FY 20-21, implement a prototype Audits and Monitoring database to expand compliance tracking and trending capabilities**

PROCESS USED TO EVALUATE
AMT Access Database

RESPONSIBLE STAFF – AMT Manager

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Map existing Audits and Monitoring team tools	The Audit Universe was mapped to a centralized spreadsheet; current audit tool was mapped for an Access Database	**Complete**
Design Audits and Monitoring Access database	Collaborated with technical resource from ISD to design new AMT database	**Complete**
Implement and test prototype	Database was implemented and tested by end of FY 20-21	**Complete**
Import 3-year lookback of historical audit results data	Data importing in progress	**In Progress (50%)**

RESULTS

The prototype database was completed and is now in use. Importing of the historical audit data is in progress.

GOAL MET

STRUCTURE & OPERATIONS GOAL 9: **DHS-BHD seeks for continuous process improvement of service system structures and operations to maximize utilization of best-**

OBJECTIVE 9.1: **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	**Abandoned**
Distribute survey to direct service staff and managers	Project disrupted due to COVID	**Abandoned**
Analyze results to establish baseline state	Project disrupted due to COVID	**Abandoned**
Review recommended strategies for each domain	Project disrupted due to COVID	**Abandoned**
Select and implement strategies in next QI Plan	Project disrupted due to COVID	**Abandoned**

RESULTS

Project continued to be significantly disrupted by COVID, with the QI Manager and several QIC members unavailable for extensive periods of time due to disaster deployment. This goal was abandoned and replaced with Goal 9.2, in which a formal risk assessment was conducted.

GOAL ABANDONED

OBJECTIVE 9.2: **By end of FY 20-21, complete a formal quality risk assessment and mitigation plan**

PROCESS USED TO EVALUATE
Behavioral Health Risk Assessment

RESPONSIBLE STAFF – QI Leadership Team

PROCESS USED TO EVALUATE
Behavioral Health Risk Assessment

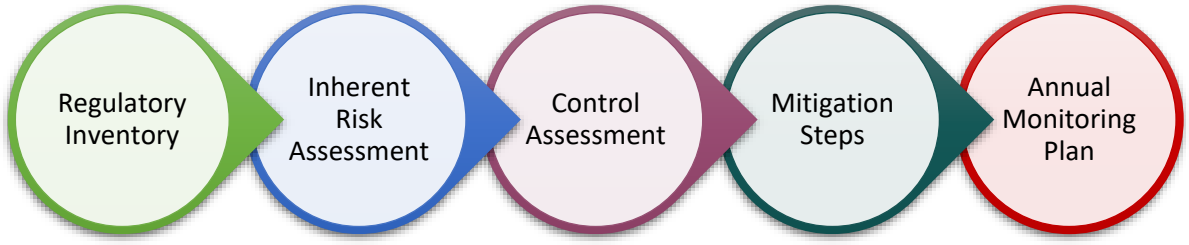
RESPONSIBLE STAFF – QI Leadership Team

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Identify key regulatory requirements	Analysis completed in FY 20-21	**Completed**
Conduct Compliance Risk Assessment	Compliance Risk Assessment completed in FY 20-21	**Completed**
Designate lead monitors for top compliance risks	Designated project leads appointed for the six highest-ranking risks, and QI began meeting on a monthly with project leads in October 2021.	**Completed**
Conduct Control Assessment	Control assessment completed in FY 20-21	**Completed**
Initiate Mitigation Plan	Risk Project Leads developed action steps to mitigate risk, and QI is closely tracking progress on benchmarks on a monthly basis. Bi-monthly progress reports are made to DHS Compliance Officer.	**In Progress**

RESULTS

A complete risk assessment was completed utilizing the following process:



The following areas were identified and scored.

Risk Area	Inherent Risk Rating	Control Rating	Residual Risk Score
AVATAR Implementation	15 – High	Adequate	12 – High
AVATAR Support and Maintenance	20 – Extreme	Inadequate	20 – Extreme
Data Reporting Requirements	15 – High	Inadequate	15 – High

Risk Area	Inherent Risk Rating	Control Rating	Residual Risk Score
Documentation Compliance	25 – Extreme	Excellent	10 – High
CSU Overstay	25 – Extreme	Inadequate	25 – Extreme
Auditing & Monitoring Program	15 – High	Inadequate	15 – High
DHCS Info Notice Implementation	20 – Extreme	Inadequate	15 – High
Final Rule Requirements	25 – Extreme	Inadequate	20 – Extreme
Contract Monitoring	15 – High	Inadequate	15 – High
Utilization Review	20 – Extreme	Inadequate	20 – Extreme
Sentinel Event Process	15 - High	Adequate	10 - High
ICC/IHBS Implementation	15 – High	Adequate	15 – High
Service Capacity	25 – Extreme	Inadequate	25 – Extreme
Overutilization of High Cost & Acute Services	25 – Extreme	Inadequate	25 – Extreme

Mitigation plans were developed and assigned to leads for top risks identified. Monthly progress monitored.

GOAL MET

OBJECTIVE 9.3: By end of FY 20-21, complete and implement a QAPI Communication Plan: Phase II

PROCESS USED TO EVALUATE
Communication Plan

RESPONSIBLE STAFF – QI Manager

ACTION STEPS STATUS UPDATE

Key Activity	Update	Status
Identify Quality Tools, Reports, and Content for QAPI website	A task force was convened, consisting of stakeholders/QAPI managers, content was determined.	**Complete**
Complete wireframe model of hierarchy of content	This content was used to create a wireframe model	**Complete**
Establish navigation and design features	Navigation and Design features were established with input from information services staff.	**Complete**
Launch QAPI website	QAPI webpage set to launch in July 2021	**Complete**
Newsletter (Phase III)	Not yet started; realistic launch would be March/April 2022	**In progress**

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 and completed in FY 20-21. Phase III (newsletter) has not started.

GOAL MET

SECTION 5: STAFF TRAINING OVERVIEW

FY20-21

Date	Training Topic	Type of Training	CEUs	Target Audience
Aug 12	Professional Resiliency	Specialty: Professional Development	2.0	Recommended for all SCBH Staff
Aug 18	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	SCBH Staff: Licensed/License-Eligible Clinicians
Sep 2	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	SCBH Staff: Licensed/License-Eligible Clinicians
Sep 4	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	Aurora Hospital: Licensed/License-Eligible Clinicians
Sep 9	MHSA Issue Resolution	Specialty: MHSA Policy Specific	1.0	SCBH Staff and Contractors in MHSA funded programs
Sep 10	MHSA Issue Resolution	Specialty: MHSA Policy Specific	1.0	SCBH Staff and Contractors in MHSA funded programs
Sep 24	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	Kaiser, Sutter, Seneca, and SCBH: Licensed/License-Eligible Clinicians
Dec 3	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	SCBH, Kaiser, Telecare/ACT, and Wellpath: Licensed/License-Eligible Clinicians
Jan 7	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	SCHC, Wellpath, Sutter, and Buckelew: Licensed/License-Eligible Clinicians
Jan 13	ACEs Aware: We Are Resilient™ by Dovetail Learning (part 1)	Specialty: Best Practices	1.5	SCBH Staff
Jan 20	ACEs Aware: We Are Resilient™ by Dovetail Learning (part 2)	Specialty: Best Practices	1.5	SCBH Staff
Jan 28	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	Sonoma Valley Hospital: ER Doctors
Feb 10	Staff Development: Law and Ethics	Staff Development: Law & Ethics	3.0	SCBH Staff
Mar 10	Topic – LGBTQ+ Cultural Competency	Staff Development: Cultural Responsiveness	2.0	SCBH Staff: Mandatory
Apr 14	Panaptic- Cannabis Use & Mental Health: A Review of Current Research and	Specialty: Best Practices	2.0	SCBH Staff

Date	Training Topic	Type of Training	CEUs	Target Audience
	Strategies for Brief Intervention			
Apr 15	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	Aurora Hospital: Licensed/License-Eligible Clinicians
Apr 27 & Apr 29	AMSR: Assessing and Managing Suicide Risk	Specialty: Suicide Assessment & Intervention	6.5	SCBH Staff
Apr 28	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	SCBH and Healdsburg District Hospital: Licensed/License-Eligible Clinicians
May 5 & May 7	AMSR: Assessing and Managing Suicide Risk	Specialty: Suicide Assessment & Intervention	6.5	SCBH Staff
May 6	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	Aurora Hospital: Licensed/License-Eligible Clinicians
May 19	5150 – Review of 5150's and Other Legal Holds in Mental Health	Specialty: 5150 Certification	2.0	SCBH, Wellpath, Sutter, and Kaiser: Licensed/License-Eligible Clinicians
May 19	AMSR: Assessing and Managing Suicide Risk	Specialty: Suicide Assessment & Intervention	6.5	SCBH Staff

Documentation Trainings FY 20-21

Date	Training Topic	Type of Training	Target Audience
Jul 1	FSP Procedure Code	Team Training: Documentation	FASST Staff
Jul 9	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Jul 10	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Jul 14	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists
Jul 16	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Jul 16	Documenting Location	All Division Training: Documentation Tip	SCBH Staff
Jul 17	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Jul 23	Medical Staff Training: Documentation	Team Training: Documentation	Medical Staff
Aug 2	YFS Section Training: Documentation	Team Training: Documentation	YFS Staff
Aug 3	PIRPL Progress Note Format	Team Training: Documentation	SonomaWorks Staff
Aug 11	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists

Date	Training Topic	Type of Training	Target Audience
Aug 13	Appending and Correcting Notes	All Division Training: Documentation Tip	SCBH Staff
Aug 26	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Aug 27	Medical Staff Training: Documentation	Team Training: Documentation	Medical Staff
Aug 28	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Sep 2	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Sep 3	PIRPL Progress Note Format	Team Training: Documentation	SonomaWorks Staff
Sep 4	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Sep 10	NPC Code	All Division Training: Documentation Tip	SCBH Staff
Sep 15	Procedure Codes and Medical Necessity in Progress Notes	Contractor Training: Documentation	Lifeworks Clinical Staff
Sep 23	Clerical Training: Documentation	Team Training: Documentation	Clerical Staff
Sep 24	Medical Staff Training: Documentation	Team Training: Documentation	Medical Staff
Oct 8	Discharge Summaries	All Division Training: Documentation Tip	SCBH Staff
Oct 13	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists
Oct 22	Medical Staff Training: Documentation	Team Training: Documentation	Medical Staff
Oct 27	Client Plans	Contractor Training: Documentation	Lifeworks Clinical Staff
Oct 28	Clerical Training: Documentation	Team Training: Documentation	Clerical Staff
Nov 4	Consultations and Multiple Providers	All Division Training: Documentation Tip	SCBH Staff
Nov 4	YFS Section Training: Documentation	Team Training: Documentation	YFS Staff
Nov 30	Rehab	Contractor Training: Documentation	Social Advocates for Youth (SAY) Clinical Staff
Dec 2	YFS Section Training: Documentation	Team Training: Documentation	YFS Staff
Dec 8	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists
Dec 9	Targeted Case Management for CSU	Team Training: Documentation	CSU Staff
Dec 10	Medical Necessity in Progress Notes	Contractor Training: Documentation	Petaluma People Services Center (PPSC) Clinical Supervisor
Dec 10	Medical Staff Training: Documentation	Team Training: Documentation	Medical Staff
Dec 10	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees

Date	Training Topic	Type of Training	Target Audience
Dec 11	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Dec 16	Voicemail and Social Security Paperwork	All Division Training: Documentation Tip	SCBH Staff
Dec 17	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Dec 18	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Jan 12	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists
Feb 24	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Feb 25	Medical Staff Training: Documentation	Team Training: Documentation	Medical Staff
Feb 25	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Mar 3	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Mar 3	YFS Section Training: Documentation	Team Training: Documentation	YFS Staff
Mar 4	New Employee Orientation: Documentation Training	NEO: Documentation	SCBH New Employees
Mar 9	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists
Mar 11	Respectful & Inclusive Language	All Division Training: Documentation Tip	SCBH Staff
Mar 11	Client Plans	Team Training: Documentation	Adult Access Staff
Apr 8	Respectful & Inclusive Language for SUD	All Division Training: Documentation Tip	SCBH Staff
Apr 13	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists
Apr 15	Client Plans	Team Training: Documentation	IRT/OAT Staff
Apr 22	Medical Staff Training: Documentation	Team Training: Documentation	Medical Staff
Apr 29	Client Plans	Team Training: Documentation	CTRT Staff
May 5	Abbreviation, Progress Notes	Team Training: Documentation	YFS Staff
May 11	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists
May 13	Face to Face for Telehealth and Phone	All Division Training: Documentation Tip	SCBH Staff
May 13	Client Plans	Team Training: Documentation	Adult Services Team (AST) Staff
May 20	Client Plans	Team Training: Documentation	CMHC Staff
May 27	Medical Staff Training: Documentation	Team Training: Documentation	Medical Staff

Date	Training Topic	Type of Training	Target Audience
Jun 8	Clinical Specialist Training: Documentation	Training: Documentation	Behavioral Health Clinical Specialists
Jun 22	Procedure Codes	Contractor Training: Documentation	Social Advocates for Youth (SAY) Clinical Staff
Jun 23	Client Plans	Team Training: Documentation	FASST/TAY Staff
Jun 24	Client Plans	Team Training: Documentation	IRT/OAT Staff
Jun 24	Medical Staff Training: Documentation	Team Training: Documentation	Medical Staff