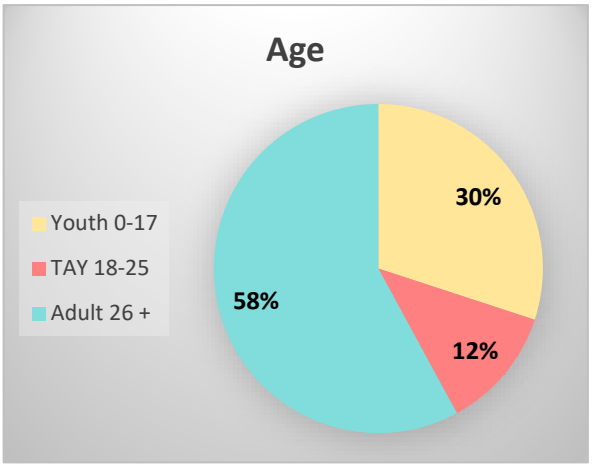
sonoma county
DEPARTMENT OF HEALTH SERVICES
BEHAVIORAL HEALTH DIVISION

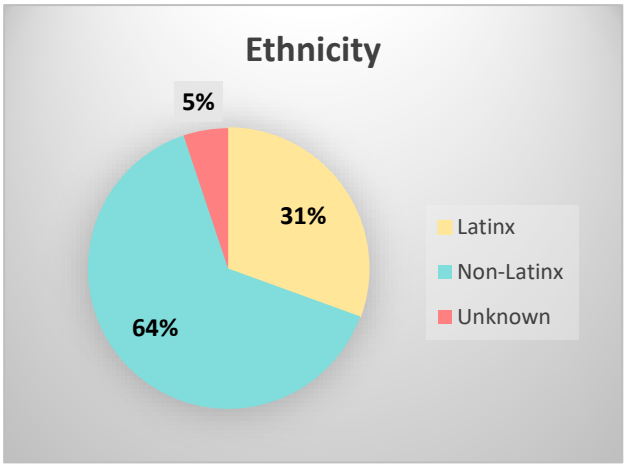
ANNUAL QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT WORK PLAN EVALUATION FISCAL YEAR 2021 – 2022

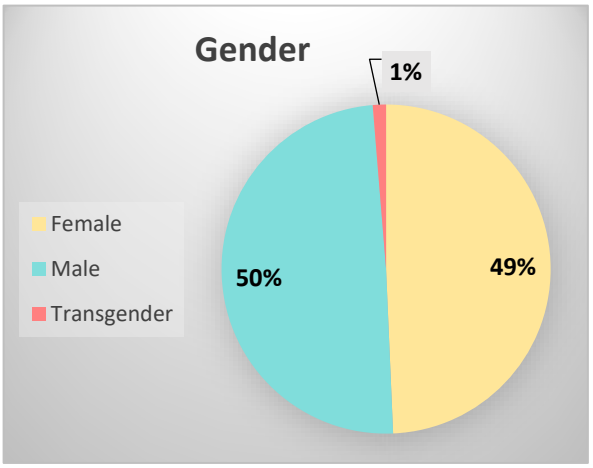
The Quality Improvement Plan is a required element of the Quality Assessment and Performance Improvement (QAPI) Program, as specified by DHCS contract, Exhibit A Attachment 5 (relevant sections: 2A), and by Cal. Code Regs., Tit. 9, § 1810.440(a)(5) and 42 C.F.R. § 438.416(a)

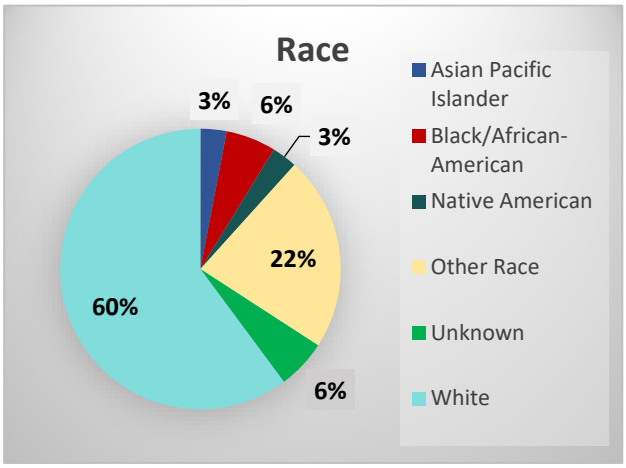
FY 21-22 DEMOGRAPHICS MHP BENEFICIARIES SERVED

AGE	UNIQUE BENEFICIARIES	PERCENT
Youth (0-17)	1,038	30.04%
TAY (18-25)	416	12.04%
Adult (26+)	2,001	57.92%
RACE		
Asian Pacific Islander	104	3.01%
Black/African American	199	5.76%
Native American	101	2.92%
Other Race	776	22.46%
Unknown	197	5.70%
White	2,078	60.14%
ETHNICITY		
Latinx	1,055	30.54%
Non-Latinx	2,222	64.31%
Unknown	178	5.15%
GENDER		
Female	1,704	49.29%
Male	1,705	49.35%
Transgender	46	1.30%
GRAND TOTAL	**3,455**	**100%**









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GEOGRAPHIC LOCATION OF MHP BENEFICIARIES SERVED

North 7.04%

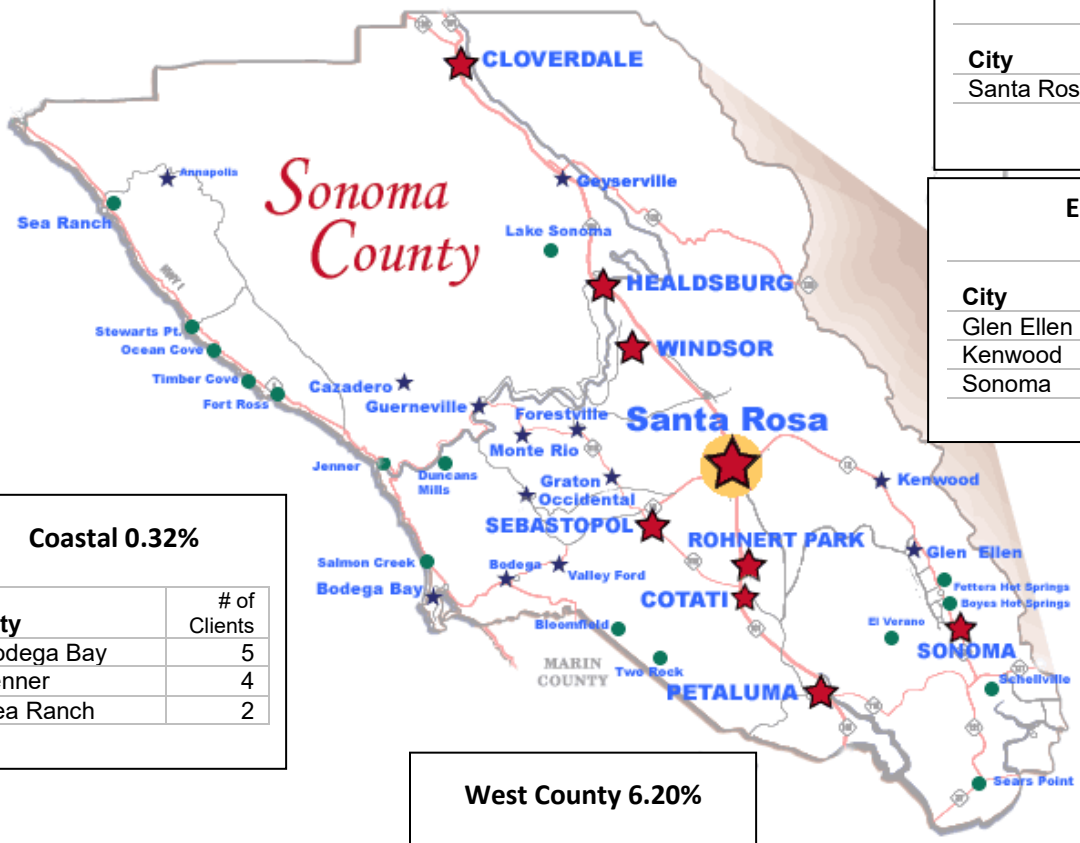
City	# of Clients
Cloverdale	71
Fulton	3
Geyserville	9
Healdsburg	58
Windsor	102

Central 58.08%

City	# of Clients
Santa Rosa	2006

East 4.63%

City	# of Clients
Glen Ellen	14
Kenwood	4
Sonoma	142



Coastal 0.32%

City	# of Clients
Bodega Bay	5
Jenner	4
Sea Ranch	2

West County 6.20%

City	# of Clients
Camp Meeker	1
Cazadero	2
Forestville	26
Graton	2
Guerneville	62
Monte Rio	8
Occidental	2
Rio Nido	3
Sebastopol	108

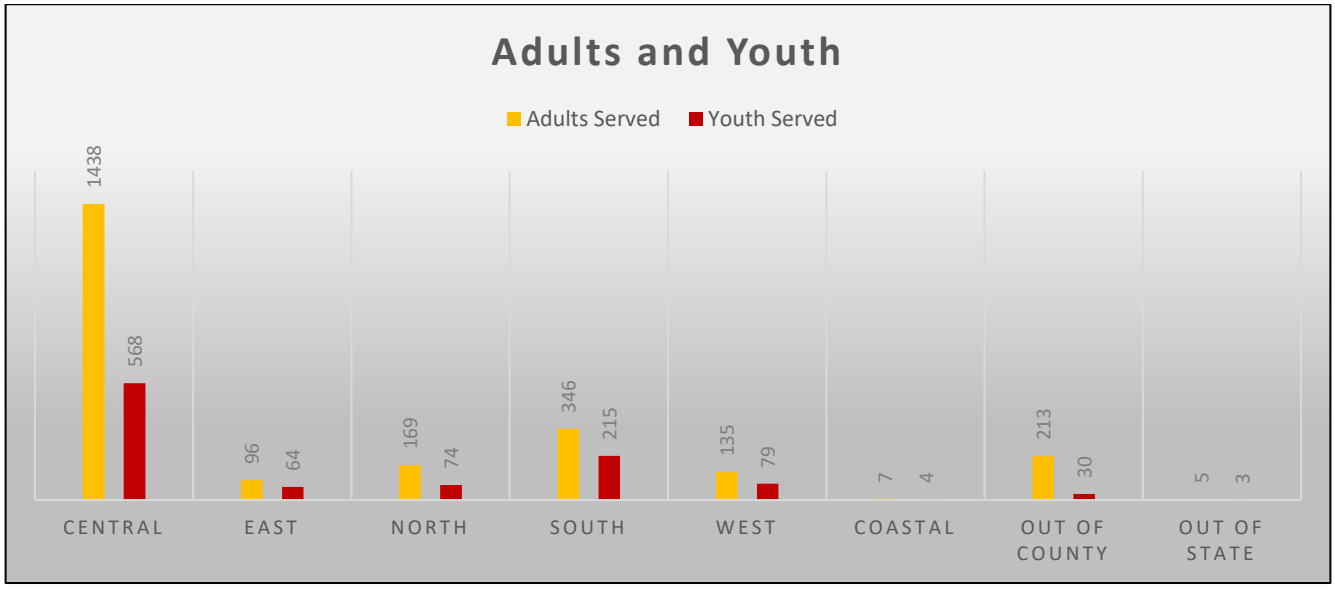
South 16.21%

City	# of Clients
Cotati	52
Penngrove	18
Petaluma	244
Rohnert Park	247

Out of County 7.27%

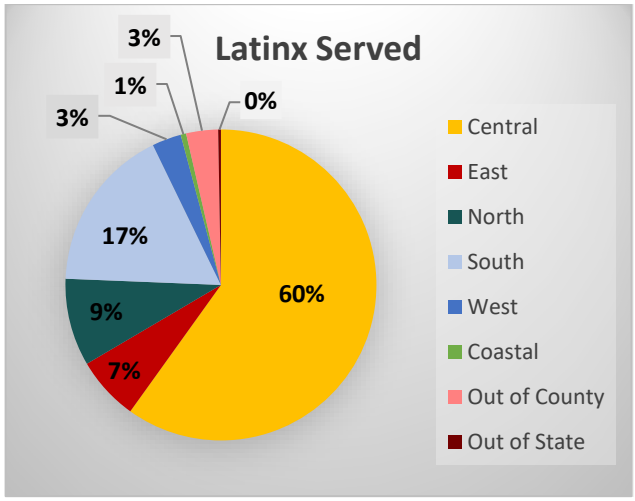
City	# of Clients
Out of County	243
Out of State	8

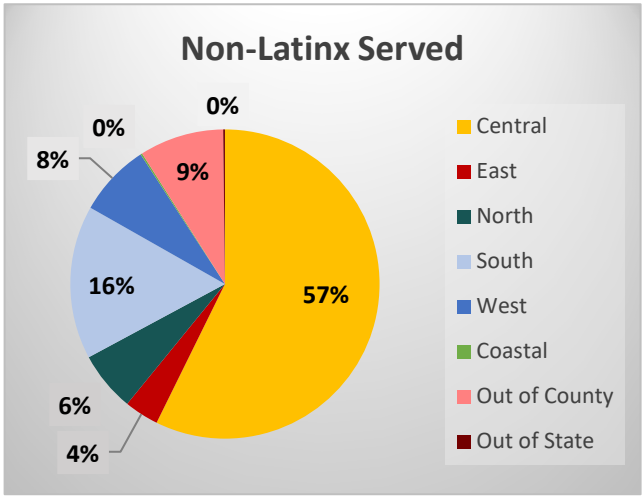
AGE GROUP MHP BENEFICIARIES BY REGION OF RESIDENCE



In every region of the county, the number of youth served increased. The total number of youth served (n=1,038) increased by 18% over last fiscal year, while the number of Transitional Age Youth (TAY) (416) decreased by 20%. Adults served (2,001) decreased by 4% in comparison to last year. A higher percentage of youth served resided in the southern part of Sonoma County. Twenty one percent of youth (215) lived in South Sonoma County, vs 16% (66) for TAY and 14% (280) for adults. As consistent in previous years, adults were over 3 times more likely to be served out-of-county than youth.

ETHNICITY OF MHP BENEFICIARIES BY REGION OF RESIDENCE





The ethnicity analysis of beneficiaries served revealed a growing trend seen in previous years. Latinx clients are significantly more likely to be served in the Youth System of Care--approximately 51% of the youth served in FY21-22 identified as Latinx, versus 22% for adults. Regarding this year's growth in youth services, the majority of that growth (68%) was attributed to increases in Latinx youth served. In FY20-21, 417 Latinx youth were served, whereas a total of 525 Latinx youth were served in FY21-22. Finally, in terms of region of residence, Latinx beneficiaries are less likely to live in the West County area, and somewhat more likely to live in the East, North, and Central/Santa Rosa areas.

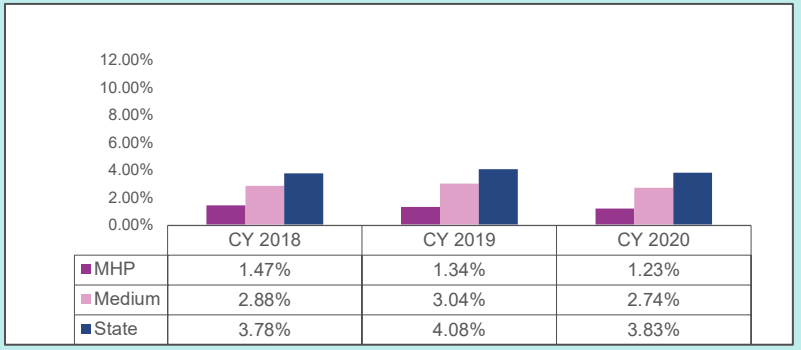
MHP BEHAVIORAL HEALTH NETWORK

Program	Contracted or County Operated	Unique Beneficiaries Served	Admissions During FY 21-22	Discharges During FY 21-22
Access Team Adult	County	472	437	415
Adult Med Support	County	122	34	18
Adult Services	County	589	125	126
Alternative Family Services	Contractor	11	11	3
Buckelew Collaborative Treatment Recovery Team	Contractor	143	56	60
Buckelew Forensic Assertive Community Tx	Contractor	26	12	20
Buckelew Programs ISHP	Contractor	20	7	8
Buckelew Sonoma County Independent Living	Contractor	130	28	19
Buckelew TAY Sonoma County Independent Living	Contractor	23	7	8
Community Mental Health Clinic Cloverdale	County	46	8	12
Community Mental Health Clinic Guerneville	County	72	14	18
Community Mental Health Clinic Petaluma	County	142	36	34
Community Mental Health Clinic Sonoma	County	38	7	8
Collaborative Treatment Recovery	County	365	181	170
Crisis Stabilization Unit	County	565	818	809
Community Service Network Bridges MH Services	Contractor	20	14	18
Community Service Network Opportunity House	Contractor	71	76	78
Forensic Assertive Community Treatment Diversion	County	26	13	8
Forensic Assertive Community Treatment	County	62	22	22
Family Advocacy Stabilization Support Team	County	442	181	274
Foster Youth Team	County	191	132	118
Integrated Recovery Team	County	107	12	59
Lifeworks – Therapeutic Behavioral Services	Contractor	69	48	50
Older Adult Team	County	68	7	19
Social Advocates Youth Tamayo Village	Contractor	14	6	10
Social Advocates Youth Therapy Clinic	Contractor	79	45	46
Seneca – Kuck Outpatient	Contractor	160	115	127
Seneca – Wikiup Wraparound	Contractor	122	91	85
SonomaWorks	County	93	77	62
Telecare Sonoma Assertive Community Treatment	Contractor	66	6	11
TLC Outpatient Services Program	Contractor	39	18	13
Transitional Age Youth	County	64	18	17
Transitional Recovery	County	231	70	63
Victor Treatment Center – Santa Rosa	Contractor	20	6	19
Youth Family Services Juvenile Hall	County	65	78	74
Youth Family Services Valley of Moon	County	51	55	54
Youth Access	County	425	407	343
Youth and Family	County	20	17	15
Youth Med Support	County	203	121	93

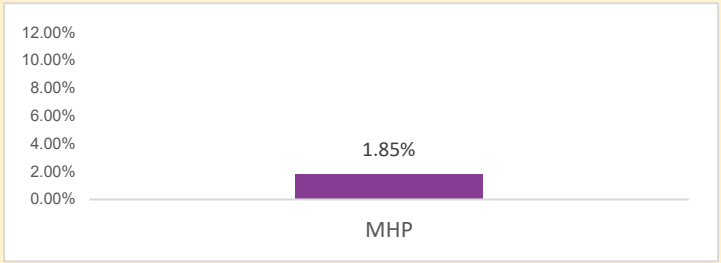
QUALITY IMPROVEMENT ACTIVITIES

Quality Improvement works closely with System of Care to assess performance, monitor QI efforts for previously identified performance issues, and target areas of improvement within Sonoma County's mental health service delivery system. The following table summarizes the evaluation of Quality Improvement Objectives for this year based on review and analysis of MHP system performance. Objectives were scored "Partially Met" in the Status column if results were improved over the previous year, but not yet achieved target.

DOMAIN	NO.	OBJECTIVE	STATUS	PAGE
ACCESS TO CARE	1	Increase Latino/Hispanic/Latinx penetration rate to 1.68% or more over a 15 month period (Non-Clinical PIP)	MET	7
ACCESSIBILITY OF SERVICES	2	Improve the average length of time from initial request to first offered psychiatry appointment to 15 business days or less.	PARTIALLY MET	8
	3	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.	PARTIALLY MET	9
	4	95% of urgent initial requests originating from Access Line, will receive services within 48 hours or less.	PARTIALLY MET	10
	5	At least 50% of Adult post-hospital discharge follow-up appointments will be scheduled within 7 calendar days of inpatient discharge.	NOT MET	11
BENEFICIARY SATISFACTION	6	Increase response rate for Consumer Perception Survey to at least 15% of all beneficiaries served annually.	NOT MET	12
	7	For Native American Consumer Perception surveys collected in FY 21-22, the satisfaction rate will exceed the 3.5 minimum satisfaction threshold on all domains	PARTIALLY MET	13
CALAIM/ACCESS TO CARE	8	Complete plans for Universal Behavioral Health screening & Transition of Care Tool implementation (screening workflow, P&P, training plan, report metrics) by FY21-22.	PARTIALLY MET	14
CLINICAL CARE	9	Provide Therapeutic Behavioral Services (TBS) at a minimum of a 4% utilization rate of all unique Medi-Cal beneficiaries under the age of 21.	MET	15
	10	Reduce High Cost Beneficiary (HCB) count by 10% and HCB utilization of Crisis Stabilization Unit (CSU) by 20% over a 2 year period; Reduce HCB average actionable ANSA scores items by 15%. (Clinical PIP)	IN PROCESS/NOT MET	16
CULTURALLY RESPONSIVE	11	At least 70% of DHS-BHD clinical staff will attend a cultural competence training by FY 21-22.	NOT MET	17
	12	Complete DEI policy review workflow, structure and committee development and implement review process for at least one MHP policy by FY21-22	NOT MET	18
SERVICE CAPACITY	13	Increase the peer provider FTE positions allocated throughout the service system by 15% over FY20-21 numbers.	NOT MET	19
	14	Reduce the number of Adult post-hospital follow-up "no-show" appointments by 50% from FY 20-21 base year.	NOT MET	20
PERFORMANCE MEASUREMENT	15	Consolidate all SB 1291 Medication Monitoring metrics into the Electronic Health Record	NOT MET	21

OBJECTIVE 1	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
ACCESS TO CARE Increase Latino/Hispanic/ Latinx penetration rate to 1.68% or more over a 15 month period (Non Clinical PIP)	**Latino/Hispanic/Latinx Penetration Rate** • Promotores mental health outreach • Diversity Equity & Inclusion Recruitment activities to hire and retain bilingual/bicultural clinical staff • All staff participate in cultural competence trainings annually • Staff participate in trainings and consultations to strengthen culturally appropriate clinical treatment for Latinx beneficiaries	1. Latino/Hispanic Sonoma County MHP Penetration Rates 3-year trend  2. % Latino/Hispanic/Latinx clients served in MHP: • 29% (FY 20-21) 3. % Latino/Hispanic/Latinx Sonoma County MediCal Eligible Pop • 41% (CY 2020)	DEI Manager MHSA Manager WET Coordinator Adult Section Mgr Youth Section Mgr Acute & Forensics Section Manager QI Manager

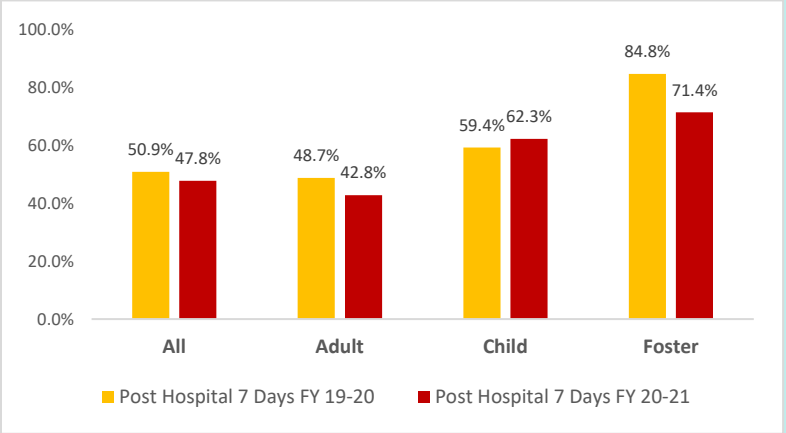
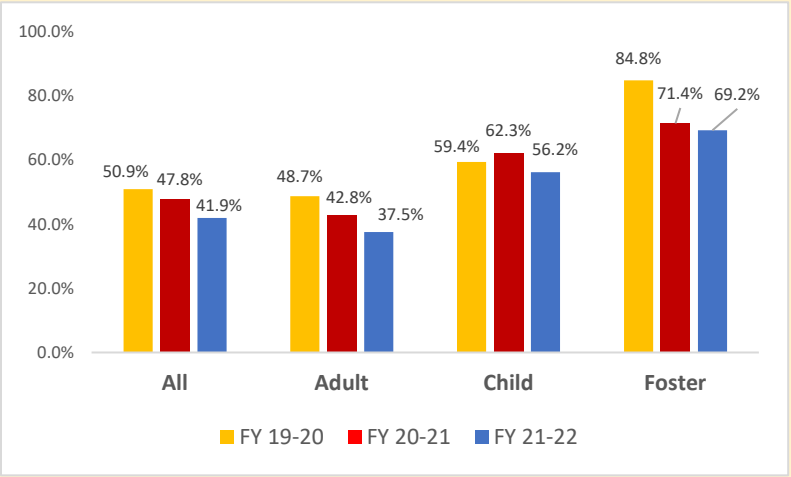
	CY 2018	CY 2019	CY 2020
MHP	1.47%	1.34%	1.23%
Medium	2.88%	3.04%	2.74%
State	3.78%	4.08%	3.83%

FY21-22 EVAL	ACTIONS ACCOMPLISHED	RESULTS	STATUS
ACCESS TO CARE *(Changed to Quality Improvement, Project Aug. 2022)*	• Latinx MH Access Workgroup formed March 2022, meeting monthly • 2 cultural competence trainings conducted for bi-lingual and mono-lingual county staff • 2 staff recruitment events attended • Bi-lingual, Bi-cultural staff recruitment materials developed • 3 Pro-Promotores interns starting • Emerging plan to train Community Health Workers in MH outreach and referral • Data cleaning to accurately identify ethnicity in FY 21-22 data set Some Setbacks: • Ethnic Services Coordinator resignation June, 2022; vacant for 6+ months • Bi-lingual Spanish speaking clinical staff losses (49 staff in 2022 -vs- 74 in 2021)	1. Latino/Hispanic Sonoma County MHP Penetration Rate FY21-22 977 Latinx Unique Served SMHS Medi-Cal billed / 52,694 Average Monthly Medi-Cal Latinx  2. % Latino/Hispanic/Latinx clients served in MHP: • 30.5% (FY21-22) 3. 39.5% Latino/Hispanic/Latinx Sonoma County MediCal Eligible Pop (FY21-22)	OBJECTIVE MET

<table>
<tr><th>OBJECTIVE 2</th><th>ACTION STEPS</th><th>PERFORMANCE INDICATOR & BASELINE</th><th>RESPONSIBLE PARTNERS</th></tr>
<tr>
<td>ACCESSIBILITY OF SERVICES
Improve the average length of time from initial request to first offered psychiatry appointment to 15 business days or less.</td>
<td>Psychiatry Appointment Timeliness
Increase psychiatry staff by 2.0 FTE
Establish expectation for target caseloads (230 adults; 130 youth per FTE), and right-size caseloads accordingly.
Adopt team-based model of psychiatry caseloads used in previous years.
Add additional 1.0 FTE scheduling staff
Adult Med Clinic scheduling staff to adopt one Avatar-based scheduling system</td>
<td>Average length of time (Mean and Median days) from initial request to first offered psychiatry appointment
Baseline Performance (FY20-21)
<table>
<tr><th></th><th>All</th><th>Adult</th><th>Youth</th><th>Foster Care</th></tr>
<tr><td>Average length of time from first request for</td><td>19.21 days (mean)</td><td>19.86 days (mean)</td><td>18.56 days (mean)</td><td>22.23 days (mean)</td></tr>
<tr><td>service to first offered psychiatry appointment</td><td>18 days (median)</td><td>21 days (median)</td><td>14 days (median)</td><td>20 days (median)</td></tr>
<tr><td>(in business days)</td><td>19.21 Std. Dev.</td><td>13.45 Std. Dev.</td><td>17.70 Std. Dev.</td><td>18.23 Std. Dev.</td></tr>
</table></td>
<td>Medical Director
Adult Section Mgr
Youth Section Mgr
Acute & Forensics Section Manager
QI Manager</td>
</tr>
<tr><th>FY21-22 EVAL</th><th>ACTIONS ACCOMPLISHED</th><th>RESULTS</th><th>STATUS</th></tr>
<tr>
<td></td>
<td>Psychiatry Workforce Task Force
Inaccurate psychiatry caseloads corrected in Avatar for selected programs
Additional youth psychiatrist FTE hired.
Max Psychiatry Caseload standards established in NACT and 274 (230 adults; 130 youth per FTE)
Not yet recruited 1.0 FTE scheduling staff
Adult Med Clinic scheduling staff have not adopted one Avatar-based scheduling system.</td>
<td>Average length of time (Mean and Median days) from initial request to first offered psychiatry appointment
FY21-22 Results
<table>
<tr><th></th><th>All</th><th>Adult</th><th>Youth</th><th>Foster Care</th></tr>
<tr><td>Average length of time from first request for</td><td>18.48 days (mean)</td><td>19.99 days (mean)</td><td>17.08 days (mean)</td><td>18.48 days (mean)</td></tr>
<tr><td>service to first offered psychiatry appointment</td><td>18 days (median)</td><td>21 days (median)</td><td>14 days (median)</td><td>14 days (median)</td></tr>
<tr><td>(in business days)</td><td>12.69 Std. Dev.</td><td>12.60 Std. Dev.</td><td>12.64 Std. Dev.</td><td>12.69 Std. Dev.</td></tr>
</table></td>
<td>OBJECTIVE PARTIALLY MET</td>
</tr>
</table>

OBJECTIVE 3	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
ACCESSIBILITY OF SERVICES 95% of calls to the 24-hour access line will be answered by a live person to provide information to beneficiaries about how to access specialty mental health services.	**Access Line Call Abandonment** • Identify times of day with highest call volumes, as well as times that calls are most likely to be abandoned. • Explore staffing needs and call center workflow to maximize call answering capacity during highest volume times and times during which calls are abandoned during normal business hours.	1. % of All Calls to the 24-hour toll free Access line Answered by Live Person • 87.92% (FY20-21). This represented a decrease from the previous year. 2. Average # of calls to the 24-hour toll free Access line that are abandoned by caller. • 100/month (FY20-21)	Adult Section Mgr Youth Section Mgr Adult Access Manager Youth Access Manager
FY21-22 EVAL	**ACTIONS ACCOMPLISHED**	**RESULTS**	**STATUS**
	• Adult & Youth Access are in the process of actively recruiting for additional FTE screening staff. The additional screening staff are expected to further decrease instances of call abandonment. • Telephone script analysis associated with the quarterly test call process in July 2022 resulted in several improvements intended to decrease call abandonment, including: a) Voicemail script on Youth Access Line referencing the 1-800 number only for after-hours and weekends b) Adult Access giving out Youth Access Line direct number when transferring calls to Youth	*Reflecting Business Hours Calls Only:* 1. % of All Calls to the 24-hour toll free Access line Answered by Live Person • 90% (10,780 Answered /11,989 Total) (FY21-22). This represented an improvement from the previous year. 2. Average # of calls to the 24-hour toll free Access line that are abandoned by caller. • 95/month (FY21-22). This represents a decrease from the previous year	OBJECTIVE PARTIALLY MET

<table>
<tr><th>OBJECTIVE 4</th><th>ACTION STEPS</th><th>PERFORMANCE INDICATOR & BASELINE</th><th>RESPONSIBLE PARTNERS</th></tr>
<tr>
<td>ACCESSIBILITY OF SERVICES
95% of urgent initial requests originating from Access Line, will receive services within 48 hours or less.</td>
<td>Access Line Urgent Requests for Service
Conduct Adult and Youth Access staff training on criteria for urgent requests, & timely assessment service requirements for urgent requests
Examine and address any workflow barriers that delay initiation of timely assessment services from the point of an urgent initial request.</td>
<td>% of Urgent Requests to Access Line that received services within the Standard of 48 Hours or Less
Baseline Performance (FY 20-21)
<table>
<tr><th></th><th>All</th><th>Adult</th><th>Children’s</th><th>Foster Care</th></tr>
<tr><td># Urgent Requests</td><td>23</td><td>7</td><td>16</td><td>1</td></tr>
<tr><td># Served in 48 hrs</td><td>3</td><td>0</td><td>3</td><td>0</td></tr>
<tr><td>% Met Standard</td><td>13%</td><td>0%</td><td>19%</td><td>0%</td></tr>
</table></td>
<td>Adult Section Mgr
Youth Section Mgr
Adult Access Manager
Youth Access Manager</td>
</tr>
<tr><th>FY21-22 EVAL</th><th>ACTIONS ACCOMPLISHED</th><th>RESULTS</th><th>STATUS</th></tr>
<tr>
<td></td>
<td>Trained Access Call Center staff on definition of “Urgent” requests, and timelines required for these requests; July 20, 2022</td>
<td>% of Urgent Requests to Access Line that received services within the Standard of 48 Hours or Less
FY 21-22 Results
<table>
<tr><th></th><th>All</th><th>Adult</th><th>Children’s</th><th>Foster Care</th></tr>
<tr><td># Urgent Requests</td><td>25</td><td>8</td><td>17</td><td>0</td></tr>
<tr><td># Served in 48 hrs</td><td>11</td><td>2</td><td>9</td><td>0</td></tr>
<tr><td>% Met Standard</td><td>44%</td><td>25%</td><td>53%</td><td>N/A</td></tr>
</table></td>
<td>OBJECTIVE PARTIALLY MET</td>
</tr>
</table>

OBJECTIVE 5	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
ACCESSIBILITY OF SERVICES At least 50% of Adult post-hospital discharge follow-up appointments will be scheduled within 7 calendar days of inpatient discharge.	**Adult Post-Hospital Follow-Up Appointments** • Review communication loop between Hospital Liaison Team and Clinical Treatment Team, including Access. • Hire MHRS/SCSS to support tracking, and communication between Hospital Team and Clinical teams • Review caseload distribution on Clinical Team to optimize capacity for post-hospital coverage. • Review and potentially revise scheduling calendar to implement post-hospital dedicated slots for assessors and psychiatrists	1. Percent of Post-Hospital Follow-Up appointments that met the 7 day post-hospital discharge standard. • Baseline FY19-20, FY20-21 	Adult Section Manager Adult Access Team Manager QI Manager (data tracking)
FY21-22 EVAL	**ACTIONS ACCOMPLISHED**	**RESULTS**	**STATUS**
	• Post-Hospital Workgroup meetings, results reviewed regularly in monthly BHPA. • Two Analyses revealed post-hospital patients not already open to MHP services were much less likely to connect for post-hospital follow-ups. • Patient Follow-Up letter developed for patients not already open to MHP. Setbacks: • Patient Follow-Up letter not yet implemented • Additional Adult Post-Hospital Liaison Staff capacity still in recruitment	1. Percent of Post-Hospital Follow-Up that met the 7 day post-hospital discharge standard. (FY19-20 – FY21-22) 	OBJECTIVE NOT MET

<table>
<tr><th>OBJECTIVE 6</th><th>ACTION STEPS</th><th>PERFORMANCE INDICATOR & BASELINE</th><th>RESPONSIBLE PARTNERS</th></tr>
<tr><td>BENEFICIARY SATISFACTION
Increase response rate for Consumer Perception Survey to at least 15% of all beneficiaries served annually</td><td>Consumer Perception Survey Response Rate
Administer the Consumer Perception Survey bi-annually (2x per year)
For electronic survey, ensure technical issues are investigated and resolved to minimize blank data submissions.
Offer paper survey administration (in addition to electronic) option to maximize participation for beneficiaries without access to electronic means of submission.</td><td>1. CPS Participation Rate (Beneficiaries Surveyed/Total Beneficiaries served MHP)
FY 20-21 CPS Participation Rate
<table><tr><th></th><th>Adults</th><th>Older</th><th>Youth</th></tr><tr><td>Total Client Surveyed</td><td>111</td><td>14</td><td>55</td></tr><tr><td>Total Served MHP</td><td>2,170</td><td>439</td><td>881</td></tr><tr><td>% Response Rate</td><td>5%</td><td>3%</td><td>6%</td></tr></table></td><td>QI Manager
CBO & County Providers</td></tr>
<tr><th>FY21-22 EVAL</th><th>ACTIONS ACCOMPLISHED</th><th>RESULTS</th><th>STATUS</th></tr>
<tr><td></td><td>Consumer Perception Survey (CPS) administered May/June 2021
Participation rate increased among adults, although decreased slightly among youth. The lower response rate for youth was primarily due larger numbers of youth served in FY21-22.
Since 2020, DHCS has required only one CPS survey to be administered per year.</td><td>1. CPS Participation Rate (Beneficiaries Surveyed/Total Beneficiaries served MHP)
FY 21-22 CPS Participation Rate
<table><tr><th></th><th>Adults</th><th>Older</th><th>Youth</th></tr><tr><td>Total Client Surveyed</td><td>207</td><td>23</td><td>54</td></tr><tr><td>Total Served MHP</td><td>2,021</td><td>396</td><td>1,038</td></tr><tr><td>% Response Rate</td><td>10%</td><td>5.8%</td><td>5.2%</td></tr></table></td><td>OBJECTIVE NOT MET</td></tr>
</table>

<table>
<tr><th>OBJECTIVE 7</th><th>ACTION STEPS</th><th>PERFORMANCE INDICATOR & BASELINE</th><th>RESPONSIBLE PARTNERS</th></tr>
<tr><td>BENEFICIARY SATISFACTION

For Native American Consumer Perception surveys collected in FY 21-22, the satisfaction rate will exceed the 3.5 minimum satisfaction threshold on all domains</td><td>Native American Consumer Perception

• Provide staff development training focused on Native American clinical interventions and best practices, particularly for youth focused staff
• Invite Native American stakeholders to participate in the QIC and Cultural Responsiveness Committee
• Increase Native American participation rate in Consumer Perception Survey</td><td>1. Surveyed/total Native Americans served MHP)
• 10% 9/99 served (FY 20-21)
2. Consumer Perception Survey Domains. Minimum threshold goal: 3.5 on a Likert scale 1-5.
• FY 20-21 Native American CPS Score results (RED indicates below minimum satisfaction threshold of 3.5)
<table>
<tr><th></th><th>Adults (6)</th><th>Older (1)</th><th>Youth (2)</th></tr>
<tr><td>General Satisfaction</td><td>3.94</td><td>5.0</td><td>2.67</td></tr>
<tr><td>Access</td><td>3.97</td><td>5.0</td><td>1.00</td></tr>
<tr><td>Participation Treatment Planning</td><td>4.40</td><td>5.0</td><td>2.33</td></tr>
<tr><td>Quality & Appropriateness</td><td>3.90</td><td>5.0</td><td>1.00</td></tr>
<tr><td>Outcome of Service</td><td>3.38</td><td>4.0</td><td>1.00</td></tr>
<tr><td>Social Connection</td><td>3.90</td><td>4.0</td><td>1.50</td></tr>
<tr><td>Functioning</td><td>3.56</td><td>4.0</td><td>1.00</td></tr>
</table></td><td>DEI Manager

Cultural Responsiveness Committee

QI Manager</td></tr>
<tr><th>FY21-22 EVAL</th><th>ACTIONS ACCOMPLISHED</th><th>RESULTS</th><th>STATUS</th></tr>
<tr><td></td><td>• Of Native American respondents who completed the CPS survey, all scores exceeded min. satisfaction threshold score of 3.5.
• However, compared to FY20-21, fewer Native American respondents completed the survey this year.
• No specialized Native American clinical staff trainings were sponsored by DHS-BD during FY21-22</td><td>1. Surveyed/total Native Americans served MHP)
• 3.37% (3/89 served) (FY 21-22)
2. Consumer Perception Survey Domains. Minimum threshold goal: 3.5 on a Likert scale 1-5.
• FY 21-22 Native American CPS Score results
<table>
<tr><th></th><th>Adults (3)</th><th>Older (0)</th><th>Youth (0)</th><th>Family (1)</th></tr>
<tr><td>General Satisfaction</td><td>4.11</td><td>n/a</td><td>n/a</td><td>5.0</td></tr>
<tr><td>Access</td><td>4.21</td><td>n/a</td><td>n/a</td><td>5.0</td></tr>
<tr><td>Participation Treatment Planning</td><td>3.83</td><td>n/a</td><td>n/a</td><td>5.0</td></tr>
<tr><td>Quality & Appropriateness</td><td>4.00</td><td>n/a</td><td>n/a</td><td>5.0</td></tr>
<tr><td>Outcome of Service</td><td>3.79</td><td>n/a</td><td>n/a</td><td>5.0</td></tr>
<tr><td>Social Connection</td><td>4.17</td><td>n/a</td><td>n/a</td><td>5.0</td></tr>
<tr><td>Functioning</td><td>3.93</td><td>n/a</td><td>n/a</td><td>5.0</td></tr>
</table></td><td>OBJECTIVE PARTIALLY MET</td></tr>
</table>

OBJECTIVE 8	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
CALAIM/ACCESS TO CARE Complete plans for universal Behavioral Health screening & Transition of Care Tool (screening workflow, P&P, training plan, report metrics) by FY21-22.	**CALAIM/ACCESS TO CARE** • Review and finalize BH screening and Transition of Care tool with stakeholders • Render tools in Avatar for production • Develop reporting metrics based on data collected in new tools • Develop staff training plan on new universal screening tools	1. New Objective, No baseline. The following completed deliverables will serve as performance indicators: • Universal BH Screening Tool & Transition of Care Tool • Screening Workflow for Youth and Adult Access Teams • Staff Training Plan for Youth and Access Teams • Report Metrics based on Screening and Transition of Care Tools.	Adult Section Mgr Youth Section Mgr Acute & Forensics Section Manager WET Coordinator QI Manager Interoperability Committee
FY21-22 EVAL	**ACTIONS ACCOMPLISHED**	**RESULTS**	**STATUS**
	• County has developed a Training Plan for the new Universal Screening Tool & Transition Tool, in collaboration with CalMHSA. • Finalized screening and transition tools are still in process with DHCS, as of this writing; no tools can be rendered into the E.H.R. until the state finalizes them. • Sonoma County will be transitioning to a new semi-statewide E.H.R., expected go live is 7/1/2023	1. The following deliverables were accomplished: • Staff Training Plan for Youth and Adult Access Teams is developed and approved by DHCS	OBJECTIVE PARTIALLY MET

OBJECTIVE 9	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
CLINICAL CARE Provide Therapeutic Behavioral Services (TBS) at a minimum of a 4% utilization rate of all unique Medi-Cal beneficiaries under the age of 21.	**Therapeutic Behavioral Services (TBS)** • By examination of data determine extent this is a provider capacity issue, &/or a referral training issue. • Explore existing TBS staff capacity and staffing workforce needs at providers (vs. contract capacity) • Explore possibility of adding an additional TBS provider in FY21-22 if needed, based on analysis. • Regular data reporting on TBS utilization within BHPA	1. TBS Utilization Rate: Number of TBS services provided to beneficiaries under the age of 21 (Code 345 & M345) / Total Services for clients under 21 on service date. • In FY 20-21, DHS-BHD provided 1,664 TBS services at a 3.21% utilization rate for beneficiaries under age 21. Further decrease from FY 19-20 rate of 3.55%.	Youth Section Manager TBS Manager QI Manager
FY21-22 EVAL	**ACTIONS ACCOMPLISHED**	**RESULTS**	**STATUS**
	• The previously reported baseline data (FY20-21) did not include "TBS telehealth" services (code 445). Adjusting for the corrected TBS baseline number 3,243 (FY20-21) with "TBS telehealth", this year's TBS service number (2,933) represents a 9.5% reduction over last year. Nevertheless, the FY21-22 TBS service rate (5.71%) still exceeds the utilization rate goal of 4%. • TBS programs presented at the YFS Section Meeting on 1/4/23 to promote understanding of TBS services, referral process, answer questions, and encourage greater utilization of TBS within YFS. • Recommendations around contract deliverable standards for maximum and minimum number of clients in development	1. TBS Utilization Rate: Number of TBS services provided to beneficiaries under the age of 21 / Total Claimable Services for clients under 21 on service date. • In FY 21-22, DHS-BHD provided 2,933 TBS services to a total of 132 unique youth. This constitutes a 5.71% utilization rate for beneficiaries under age 21. • Numerator (2,933=TBS) and denominator (51,408=All Outpatient Services for Youth Under 21); TBS Services = (445 Telehealth TBS, 345 TBS, and 384 TBS Non Claimable)	OBJECTIVE MET

OBJECTIVE 10	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS

CLINICAL CARE
Reduce High Cost Beneficiary (HCB) count by 10% and HCB utilization of CSU by 20% over a 2 year period; Reduce HCB average actionable ANSA scores items by 15%.
(Clinical PIP)
	Strengths Model Case Management
	• Implement Staff Training and coaching in Strengths Model Case Management on three Full Service Partnership Teams
	• Begin implementation of following Strengths Model interventions for beneficiaries served on 3 FSP teams:
	  ○ Strengths Assessment Tool
	  ○ Personal Recovery Plan
	  ○ Increased community contact
	  ○ Increased natural supports to achieve client goals
		1. Average ANSA Actionable Item Score for High Cost Beneficiaries:
		• 21.65 (FY 19-20)
		2. Percent of Adult High Cost Beneficiary who utilized Crisis Stabilization Unit (CSU):
		• 59% (FY 19-20)
		3. Rate of High Cost Beneficiaries by Count: (defined with service costs exceeding $30,000 per year)
		• 11.94% (FY 19-20)
			Adult Section Manager
			QI Manager

FY21-22 EVAL	**ACTIONS ACCOMPLISHED**	**RESULTS**	**STATUS**
	• Strengths Model Case Management began implementation June 2022, on the TAY FSP, Adult Service Team, and Integrated Recovery Team. • Teams are currently using Strengths Assessment Tool on highest need cases; staff participate in weekly group supervision to strengthen fidelity practice. • Early implementation issues are addressed at monthly Strengths Model steering committee • Given the timing of the intervention, a new baseline data is reflected in the "RESULTS" Column.	Revised Baseline data, FY21-22: 1. Average ANSA Actionable Item Score for High Cost Beneficiaries: • 20.49 (FY 21-22) 2. Percent of Adult High Cost Beneficiary who utilized Crisis Stabilization Unit (CSU): • 41.92% (FY 21-22) 3. Rate of High Cost Beneficiaries by Count: (defined with service costs exceeding $30,000 per year) • 18.11% (FY 21-22) (625/3,455)	IN PROCESS/ OBJECTIVE NOT MET

OBJECTIVE 11	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
CULTURALLY RESPONSIVE **At least 70% of DHS-BHD staff will attend a cultural competence training by FY 21-22.**	**Staff Cultural Competence Trainings** • Offer 2+ cultural competence training opportunities throughout FY21-22 • Track training attendance and report on goal and attendance progress at the All Staff meetings	1. 40% of DHS-BHD staff completed a cultural competence training sponsored by DHS-BHD in FY20-21. • (120/303) 40% (FY 20-21) • 303 DHS-BHD staff Workforce - Point in Time (includes extra hires)	DEI Manager WET Coordinator Cultural Responsiveness Committee
FY21-22 EVAL	**ACTIONS ACCOMPLISHED**	**RESULTS**	**STATUS**
CULTURAL RESPONSIVENESS	**Staff Cultural Competence Trainings** • National Latino BH Association interpreter trainings on 1/25, 1/26 for bi-lingual staff; 2/2 training for English speaking staff • Additional trainings addressed cultural competence, and tracked in Provider Database Setbacks: • Ethnic Services Coordinator/Workforce Education Training Coordinator resignation June, 2022; vacant for 6+ months	1. 36% of DHS-BHD staff completed a cultural competence training sponsored by DHS-BHD in FY21-22.. • (156/431) 36% (FY 21-22) • 431 staff Workforce - Point in Time (includes contractors). Denominator represents the total number of active providers in the Provider Database on 05/26/2022	Not Met

OBJECTIVE 12	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
CULTURALLY RESPONSIVE Complete DEI policy review workflow, structure and committee development and implement review process for at least one MHP policy by FY21-22	**Diversity, Equity, Inclusion in Policies** • Establish structure for DEI Review of policies and procedures, including workflow from development to review and implementation • Develop criteria for DEI review standards • Establish a committee and process for DEI review • Implement DEI review process for at least one new or existing policy	1. New Objective, No baseline. The following completed deliverable will serve as a performance indicator: • One MHP Policy & Procedure (revised or new) vetted through the new DEI policy review committee as part of its finalization.	DEI Manager Cultural Responsiveness Committee Policy and Procedure Subcommittee
FY 21-22 EVAL	**ACTIONS ACCOMPLISHED**	**RESULTS**	**STATUS**
	• Pilot Process for DEI Policy Review made at the Cultural Responsiveness Committee meeting. Please reference "Using a Diversity, Equity, and Inclusion Lens for Policy Development: Evolving Inclusive Practice". • DEI Manager resigned in June 2022, and subsequent vacancy in this position vacant for 6 months. The pilot DEI policy review process stalled. • A new DEI manager has been hired (January 2023), and is expected to champion this initiative in collaboration with QAPI, and within the context of the wider departmental DEI work and priorities.	1. Not yet accomplished.	OBJECTIVE NOT MET

OBJECTIVE 13	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
SERVICE CAPACITY Increase the peer provider FTE positions allocated throughout the service system by 15% over FY20-21 numbers.	**Expand Peer Provider Workforce** • Establish a peer-provider program (2.0 FTE) with rotations at the CSU to reduce crisis service utilization. • Hire 1.0 FTE peer housing specialist to work within Adult Services. • Participate in the SB803 peer certification program hosted by CalMHSA. • Develop peer internship and peer run housing program (West County Community Services)	1. # Peer FTE allocated at county contractors • 32.57 FTE (FY20-21) 2. # Peer county "Extra Help" FTE employees • 0.5 FTE (FY20-21)	Acute & Forensics Section Manager Adult Section Manager WET Coordinator
FY21-22 EVAL	**ACTIONS ACCOMPLISHED**	**RESULTS**	**STATUS**
	• Peer provider program established in CSU, 1 FTE in process pending HR procedure. • Filled 1.0 FTE peer housing specialist position within Adult Services • Submitted a list of 59 names to CalMHSA for their peer certification scholarship program. • Peer Internship program developed currently 5 interns with 1 intern about to graduate with 160 hours complete. Peer Run Housing program developed with currently 15 residents.	1. # Peer FTE Currently 25.12 at contractor positions. • 25.12 FTE (FY 21-22), representing a decrease in peer FTE 2. # Peer County FTE employees • 1.0 FTE peer filled, addition 1.0 FTE in HR process.	OBJECTIVE NOT MET

OBJECTIVE 14	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
SERVICE CAPACITY Reduce the number of Adult post-hospital follow-up "no-show" appointments by 50% from FY 20-21 base year.	**Adult No-Show Rate – Post Hospital Follow Up** • Develop an introductory outreach document that explains post-hospital follow-up services available • Implement outreach document with hospital partners • Review and revise post-hospital scheduling workflow and implement new coordinated client and hospital staff scheduling confirmation process • Recruit a dedicated MHRS/SCSS level staff to support Adult Med clinic, and support post-hospital aftercare connection and engagement.	1. # of Adult No-Show Post-Hospital Appointments • 128 no-show appointments (FY20-21) baseline	Adult Section Manager Adult Access Team QI Manager (data tracking)
FY21-22 EVAL	**ACTION STEPS**	**RESULTS**	**STATUS**
SERVICE CAPACITY Reduce the number of Adult post-hospital follow-up "no-show" appointments by 50% from FY 20-21 base year.	**Adult No-Show Rate – Post Hospital Follow Up** • Develop an introductory outreach document that explains post-hospital follow-up services available • Implement outreach document with hospital partners • Review and revise post-hospital scheduling workflow and implement new coordinated client and hospital staff scheduling confirmation process • Recruit a dedicated MHRS/SCSS level staff to support Adult Med clinic, and support post-hospital aftercare connection and engagement.	1. # of Adult No-Show Post-Hospital Appointments • 145 no-show appointments (FY21-22) • No-Show rate for Post-Hospital outpatient mental health appointments is 50% (not including psychiatry). These are individuals who did not show for their first accepted appointment (145/290)	OBJECTIVE NOT MET

OBJECTIVE 15	ACTION STEPS	PERFORMANCE INDICATOR & BASELINE	RESPONSIBLE PARTNERS
PERFORMANCE MEASUREMENT Consolidate all SB1291 medication monitoring metrics into the Electronic Health Record	**SB 1291 medication monitoring metrics** • Identify and map existing data systems for tracking HEDIS measures • Consolidate into single data needs summary • Validate against HEDIS standards • Render applicable reports in the Electronic Health Record.	**Avatar Electronic Health Record SB 1291 Reports:** 1. Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD) • FY 20-21: in progress 2. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC) • FY 20-21: in progress 3. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP) • FY 20-21: in progress 4. Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM) • FY 20-21: complete	Avatar Change Governance Committee QI Manager
FY21-22 EVAL	**ACTIONS ACCOMPLISHED**	**RESULTS**	**STATUS**
	• As Sonoma County will be transitioning to a new semi-statewide E.H.R. on 7/1/2023, QAPI made the decision to hold on investing additional resources to update current E.H.R. (Avatar) with the SB 1291 HEDIS metrics. • QAPI is exploring the possibility of adding SB1291 HEDIS metric informatics within the new E.H.R. (Streamline) • SB1291 medication monitoring at the Psychotropic Oversight Committee (POC) for foster youth every 2 months; and a recent (Dec 2022) presentation was made to the QIC about this.	1. Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder Medication (HEDIS ADD) • Not rendered 2. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS APC) • Not rendered 3. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS APP) • Not rendered	OBJECTIVE NOT MET