Introduction

As required by the California State Department of Health Care Services and the Medi-Cal Managed Care Plan, the Shasta County Health and Human Services Agency through its Mental Health Plan (MHP) annually prepares a Quality Management Plan which describes the quality improvement activities, goals and objectives for the MHP.

The purpose of the Quality Management Work Plan is to provide up-to-date and useful information that can be used by internal stakeholders as a resource and practical tool for informed decision making and planning. Below is a Quality Management Program Description and an evaluation of the FY 2014-15 plan.

I. Quality Management Program Description

Managed Care and Compliance staff are responsible for facilitating Quality Improvement Committee (QIC) meetings and ensuring participants receive up-to-date information. In addition, the QIC ensures that scheduled program updates are provided to the Health and Human Services Agency Cabinet and Expanded Cabinet, and the Mental Health Alcohol and Drug Advisory Board.

The QIC is responsible for monitoring MHP effectiveness. This involves review and evaluation of QM activities, auditing, tracking and monitoring, communication of findings, implementation of needed actions, ensuring follow-up for Quality Management (QM) Program processes, and recommending policy or procedural changes related to these activities.

The QIC monitors:

- 24/7 Crisis Line Response
- Accessibility to Services
- Assessments of Beneficiary and Provider Satisfaction
- Clinical Documentation and Chart Review
- Credentialing Processes
- Cultural Competency Activities
- Notices of Action
- Performance Improvement Projects
- Practice Guidelines
- Resolution of Grievances, Appeals, and Fair Hearings
- Resolution of Provider Appeals
- Training
- Utilization Management/Review

The QIC is comprised of representatives from Adult and Children's Services, Access Team, Crisis Services, Medical Services, Mental Health Services Act (MHSA), Managed Care, Compliance, Fiscal, Business Office, electronic health records (EHR), contracted providers, Patient Rights, and client/family members.

It is the goal of the QIC to build a structure that ensures the overall quality of services, including detecting both underutilization of services and overutilization of services. This will be accomplished by realistic and effective quality improvement activities and data-driven decision making; collaboration amongst staff, including consumer/family member staff; utilization of technology for data analysis. Executive management and program leadership must be present in order to ensure that analytical findings are used to establish and maintain the overall quality of the service delivery system and organizational operations.

The QIC meets monthly to monitor the status of the above items and make recommendations for improvement. Meeting reminders, information, and minutes are sent in advance and available on the HHSA share drive reflecting all activities, reports, and decisions made by the QIC. The QIC ensures that client confidentiality is protected at all times during meetings, in minutes, and all other communications related to QIC activities.

Each participant is responsible for communicating QIC activities, decisions, and policy or procedural changes to their program areas and reporting back to the QIC on action items, questions, and/or areas of concern. In an effort to ensure that ongoing communication and progress is made to improve service quality, the QIC defines goals and objectives on an annual basis that may be directed toward improvement in any area of operation providing specialty mental health services.

The QM Work Plan is evaluated and updated annually by the Quality Assurance Coordinator, QIC, and MHP Management Team. The Managed Care Program is responsible for finalization and submission of the QM Work Plan but will rely on the input and subject matter expertise of program and other work groups as needed to ensure an appropriate plan is written. In addition, QIC will collaborate with other stakeholders, work groups, and committees including but not limited to:

- Mental Health Performance Measures Committee
- MHP Cultural Competency Committee
- Compliance Committee
- Medi-Cal Claiming and Workgroup
- Medical Services Staff Meetings
- Mental Health Alcohol and Drug Programs Board
- MHP Client Services Committee
- MHP Community Education Committee
- MHP & Public Guardian Placement Meetings
- MHP Clinical Care Meetings
- MHP Electronic Medical Records

- MHP Management Team
- MHSA Advisory Committee
- Organizational Provider Meetings
- Performance Improvement Process Committees
- Shasta County Homeless Continuum of Care
- Suicide Prevention Workgroup
- Utilization Review Committee

II. Annual Quality Management Work Plan Evaluation

The QI Coordinator completes an annual QM Work Plan. There is an annual evaluation of the overall effectiveness of the QM Program activities and whether they have contributed to meaningful improvement in clinical services and in the quality of services provided by the MHP.

The annual QM Work Plan allows the MHP to regularly review its QM activities. Each of the four areas of the QM Work Plan is reported to the QIC, three times per year (four areas, one area per month). This reporting allows the MHP to analyze the data on areas of improvement that have been identified and further identify areas for improvement.

A summary of the FY2014-15 recent QM Workplan is included below. The summary is current through dates noted.

Area 1 - Accessibility of Services

Goal 1: Foster new and sustain existing collaborations with HHSA staff and other partners to create a community-based spectrum of mental health treatment services.	
Objective 1	Evaluate current system for processing initial service requests to determine if resources can be reallocated, improved, or created for continued support of client wellness and recovery.

Measurement 1.A.1.	**Increase the percentage of clients who receive first clinical assessment within 20 days from the first request for services from 86% to 90%.**

This table is based on the first Access assignment within the quarter with an associated assessment service within 60 days of the open date. The table shows the percent of those within 60 day records that the associated assessment service occurred within 20 days of the Access assignment open date.

Age Group	SCMH Fiscal Year 2014-2015				
	Access Assignment Date to Assessment Service Date				
	Quarter 1 (Jul-Sep)	Quarter 2 (Oct-Dec)	Quarter 3 (Jan-Mar)	Quarter 4 (Apr-Jun)	Fiscal Year
Adult 21+					
Within 20 Days	292	233	268	253	**1046**
More than 20 Days	11	14	12	4	**41**
Total Within 60 Days	**303**	**247**	**280**	**257**	**1087**
Percent w/in 20 Days*	***96%***	***94%***	***96%***	***98%***	***96%***
Youth (MH)					
Within 20 Days	183	167	141	110	**601**
More than 20 Days	17	19	36	10	**82**
Total Within 60 Days	**200**	**186**	**177**	**120**	**683**
Percent w/in 20 Days*	***92%***	***90%***	***80%***	***92%***	***88%***
All Ages w/in 20 Days*	***94%***	***92%***	***89%***	***96%***	***93%***

*Percent highlighting: Red is below 86%, Yellow 86%-89%, and Green 90% and above.

The target was met for all ages and quarters except for youth in Q3.

Measurement 1.A.2.	Increase the percentage of clients who receive first appointment with an Organizational Provider within 20 days from the first request for services.

This table is based on an Access assignment within the quarter with an associated scheduled appointment with an Organizational Provider where the appointment is within 60 days of the open date. The table shows the percent of those with a scheduled appointment within 60 days where the appointment date was under 20 days from the open date and the percent of appointments were within 30 days from the open date.

	FY13-14	Fiscal Year 2014-2015				
Provider	**Total**	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**FY Total**
NVCSS						
Appt. within 20 Days	**143**	55	44	54	41	**194**
Appt. 20-29 Days	**15**	5	9	6	5	**25**
Appt. Over 29 Days	**11**	3	4	5	8	**20**
Total w/ an Appt. in 60 Days	*169*	*63*	*57*	*65*	*54*	*239*
Percent appts. within 20 Days	**85%**	**87%**	**77%**	**83%**	**76%**	**81%**
Percent appts. within 30 Days	**93%**	**95%**	**93%**	**92%**	**85%**	**92%**
Remi Vista						
Appt. within 20 Days	**92**	32	22	44	39	**137**
Appt. 20-29 Days	**10**	3	6	6	2	**17**
Appt. Over 29 Days	**4**	3	4	3	2	**12**
Total w/ an Appt. in 60 Days	*106*	*38*	*32*	*53*	*43*	*166*
Percent appts. within 20 Days	**87%**	**84%**	**69%**	**83%**	**91%**	**83%**
Percent appts. within 30 Days	**96%**	**92%**	**88%**	**94%**	**95%**	**93%**
VCSS						
Appt. within 20 Days	**31**	47	37	27	31	**142**
Appt. 20-29 Days	**26**	6	18	28	13	**65**
Appt. Over 29 Days	**96**	9	8	18	28	**63**
Total w/ an Appt. in 60 Days	*153*	*62*	*63*	*73*	*72*	*270*
Percent appts. within 20 Days	**20%**	**76%**	**59%**	**37%**	**43%**	**53%**
Percent appts. within 30 Days	**37%**	**85%**	**87%**	**75%**	**61%**	**77%**

No specific baseline or target was set for Organizational Providers. VCSS showed an increase in percent of first appointments within 20 days of access assignment from FY 2013-14 to FY 2014-15 and NVCSS and Remi Vista both showed a decrease.

Measurement 1.B.1.	Increase the percentage of clients who receive first psychiatrist appointment within 30 days of first request for services from 64% to 68%.

This table is based on the first Access assignment within the quarter with an associated initial in-depth/psychiatric diagnosis service within 60 days of the open date. The table shows the percent of those records that the associated initial in-depth/psychiatric diagnosis service occurred within 30 days of the Access assignment open date.

Adult 21+ Access Open Date to First IME Service Recorded					
Days from Access Open to IME Service	Fiscal Year 2014-2015 (IME)				
	Quarter 1 (Jul-Sep)	Quarter 2 (Oct-Dec)	Quarter 3 (Jan-Mar)	Quarter 4 (Apr-Jun)	Fiscal Year
Adult 21+					
Within 30 Days	43	19	37	26	**125**
Outside 30 Days	17	20	25	9	**71**
Total Within 60 Days	**60**	**39**	**62**	**35**	**196**
Percent w/in 30 Days*	***72%***	***49%***	***60%***	***74%***	***64%***

*Percent highlighting: Red is below 64%, Yellow 64-67%, and Green 68% and above.

The target was met in Q1 and Q4 and was not met in Q2 and Q3.

Measurement 1.B.2.	Increase the percentage of clients who receive first psychiatrist appointment within 30 days of first request for services.

These tables are based on the date of the request for referral to an IME appointment or service for youth clients (ages 0 – 20). The first table shows the number of referral requests received and the number of IME appointments scheduled within 30 days, outside 30 days, or not scheduled. The second table shows the same information from the request for referral to the IME service, again within 30 days, outside 30 days, or no service performed.

Youth IME Referral - Time to First Appointment Scheduled										
Days from Received Referral to IME Scheduled	Fiscal Year 2013-2014 (IME)					Fiscal Year 2014-2015 (IME)				
	Quarter 1 (Jul-Sep)	Quarter 2 (Oct-Dec)	Quarter 3 (Jan-Mar)	Quarter 4 (Apr-Jun)	Fiscal Year	Quarter 1 (Jul-Sep)	Quarter 2 (Oct-Dec)	Quarter 3 (Jan-Mar)	Quarter 4 (Apr-Jun)	Fiscal Year
Within 30 Days	1	2	3	4	**10**	2	-	2	1	**5**
Outside 30 Days	4	11	2	6	**23**	10	8	9	3	**30**
No Appointment	2	5	3	-	**10**	1	4	4	3	**12**
Total Referred	**7**	**18**	**8**	**10**	**43**	**13**	**12**	**15**	**4**	**47**
Percent w/in 30 Days	***14%***	***11%***	***38%***	***40%***	***23%***	***15%***	***0%***	***13%***	***25%***	***11%***

Youth IME Referral - Time to First IME Service Recorded										
Days from Received Referral to IME Service	Fiscal Year 2013-2014 (IME)					Fiscal Year 2014-2015 (IME)				
	Quarter 1 (Jul-Sep)	Quarter 2 (Oct-Dec)	Quarter 3 (Jan-Mar)	Quarter 4 (Apr-Jun)	Fiscal Year	Quarter 1 (Jul-Sep)	Quarter 2 (Oct-Dec)	Quarter 3 (Jan-Mar)	Quarter 4 (Apr-Jun)	Fiscal Year
Within 30 Days	1	2	3	2	**8**	2	-	-	-	**2**
Outside 30 Days	5	12	3	6	**26**	8	8	8	3	**27**
No Service	1	4	2	2	**9**	3	5	7	4	**19**
Total Referred	**7**	**18**	**8**	**10**	**43**	**13**	**13**	**15**	**7**	**48**
Percent w/in 30 Days	***14%***	***11%***	***38%***	***20%***	***19%***	***15%***	***0%***	***0%***	***0%***	***4%***

No specific baseline or target was set for Youth Services. The percent of youth clients with appointments scheduled and who received a first IME service within 30 days of access assignment both showed a decrease from FY 2013-14 to FY 2014-15.

Measurement 1.C.	**All random test calls requesting crisis services will comply with 24/7 crisis response protocols.**

This table is a summary of all test calls performed during the reporting period in English and those that were answered. Percent Satisfactory are the test calls that met criteria. Percent Satisfactory of the Contact Log are the test calls that were completed in the Initial Request for Specialty Mental Health Services Database.

Count of English Test Calls						
Fiscal Year 2014-15	**Test Calls Made**	**Test Calls Answered***	**Met the 3 Main Criteria**	**Percent Satisfactory** (of answered)	**Test Calls Completed In Contact Log**	**Percent Recorded** (of answered)
Quarter 1 (Jul - Sep)	1	1	0	0%	0	0%
Quarter 2 (Oct - Dec)	0	0	0	0%	0	0%
Quarter 3 (Jan - Mar)	0	0	0	0%	0	0%
Quarter 4 (Apr - Jun)	2	1	0	0%	0	0%
Fiscal Year Total	**3**	**2**	**0**	**0%**	**0**	**0%**

*Test calls that went to voicemail are not counted when calculating the percent of satisfaction. No voice mail message was left and no return trace call was performed by staff.

"Percent Satisfactory": Required for a satisfactory test call did they:
1. Do a Risk Assessment
2. Ask the Caller's Name
3. Give Referrals

"Percent Recorded": Required completed crisis response Title IX 1810.405(f) protocol recorded in Initial Request for Specialty Mental Health Services Database (aka Contact Log):
1. Date Received recorded
2. Client Name recorded (if refused "None Given" is included)
3. Received by Phone, Walk-In and/or Written recorded
4. Contact disposition recorded (i.e. explained services, referred to clinician)

The target was not met in any quarter of FY2014-15.

Measurement 1.D.	Decrease average length of time between medical clearance and client disposition determination by 10% from FY12/13 baseline.

This table is a summary of the average number of hours between medical clearance and client disposition at the local emergency rooms.

Reporting Period	Average Hours	Percent Growth (+/-) vs. SCMH Baseline	Count Included	Count Excluded*	Total ER Record Count
FY12-13 Baseline (Restpadd YTD Mar13)	2.6		1,297	31	**1,328**
FY12-13 Baseline (SCMH Apr13-Jun13)	3.9		490	9	**499**
January-14	6.6	69%	156	9	**165**
February-14	5.2	33%	125	7	**132**
March-14	5.2	33%	150	4	**154**
April-14	6.5	67%	152	6	**158**
May-14	5.0	28%	144	3	**147**
June-14	4.5	15%	156	10	**166**
July-14	6.8	74%	155	1	**156**
August-14	5.4	38%	134	4	**138**
September-14	5.2	33%	125	1	**126**
October-14	7.1	82%	111	2	**113**
November-14	5.9	51%	132	4	**136**
December-14	5.7	46%	131	5	**136**
January-15	5.4	38%	129	7	**136**
February-15	6.1	56%	122	6	**128**
March-15	7.0	79%	160	3	**163**
April-15	6.3	62%	134	1	**135**
May-15	6.8	74%	145	4	**149**
June-15	6.0	54%	134	7	**141**

*Excluded due to incomplete data or data in error (i.e. client disposition prior to medical clearance)

The target was not met in FY2014-15.

Goal 1: Foster new and sustain existing collaborations with HHSA staff and other partners to create a community-based spectrum of mental health treatment services.	
Objective 2	Assess accessibility of services for underrepresented cultures including, but not limited to, Hispanic, Mien, Black, Native American, Indian, and Lesbian/Gay/Bisexual/Transgender/ Questioning (LGBTQ).

Measurement 2.A.	**85% of random test calls requesting mental health services will demonstrate staff proficiency with language line transfers, accessibility of interpreted materials and interpreters.**

This table reflects those test calls that were performed in a language other than English. Languages tested in FY14-15 were Spanish (19), Lao (12), Mien (3), and Portuguese (1)

Count of Non- English Test Calls										
Fiscal Year	Test Calls Made	Test Calls Answered*	Staff Use Interpreter Correctly?	Percent Satisfactory (of answered)~	Test Calls Using Language Line	Language Line Satisfactory	Percent Satisfactory (of answered)~	Recorded in Log	Percent Recorded (of answered)~
Quarter 1 (Jan - Mar)	6	4	3	75%	3	1	25%	1	25%
Quarter 2 (Apr - Jun)	16	13	10	77%	10	9	69%	2	15%
Quarter 3 (Jul - Sep)	15	13	13	100%	13	8	62%	4	31%
Quarter 4 (Oct - Dec)	6	5	3	60%	1	1	20%	0	0%
Fiscal Year Total	**43**	**35**	**29**	**83%**	**27**	**19**	**54%**	**7**	**20%**

*Test calls that went to voicemail are not counted when calculating the percent of satisfaction. No voice mail message was left and no return trace call was performed by staff.

~Percent highlighting: Red is below 85% and Green 85% and above.

"Percent Satisfactory": Required for a satisfactory test call did they:
1. Did the staff use the interpreting services proficiently?
2. Were Language Line Services satisfactory?

"Percent Recorded": Required completed crisis response Title IX 1810.405(f) protocol recorded in Initial Request for Specialty Mental Health Services Database (aka Contact Log):
1. Date Received recorded
2. Client Name recorded (if refused "None Given" is included)
3. Received by Phone, Walk-In and/or Written recorded
4. Contact disposition recorded (i.e. explained services, referred to clinician)

The target was met in Q3 and was not met in Q1, Q2, and Q4 of FY2014-15.

Measurement 2.B.	**Increase participation of MHP and organizational provider staff in cultural competency training activities from 50% to 75%.**
Cultural Competency Training was held May 20-21, 2015 on interpreter/language line usage and military culture. There were a total of 205 attendees (190 MHP staff and 15 contracted provider staff). Of the 238 MHP staff, 190 attended (79.8%) ***The target was met in FY2014-15.***	

Measurement 2.C.	**The MHP Cultural Competency Committee will meet a minimum of quarterly and will:** **1. Develop a FY14/15 Cultural Competency Plan; and** **2. Develop a FY15/16 QM Workplan Goal.**
1. Pending receipt of DCHS Information notice regarding submission of the MHP Cultural Competency Plan. Although a new Cultural Competency Plan has not been done, the MHP maintains an active Cultural Competency Committee. The Committee recently (June 2015) surveyed MHP staff regarding cultural training needs. The survey was very successful with over 100 responses. The Committee will use the information from the survey to draft the next cultural competency plan and address future training needs. 2. The Cultural Competency Committee reviewed the FY1415 Workplan and have no recommendations for any additional workplan goals for FY1516. ***The target was not met in FY2014-15.***	

Goal 1: Foster new and sustain existing collaborations with HHSA staff and other partners to create a community-based spectrum of mental health treatment services.

Objective 3	Improve penetration rates of underserved populations.

Measurement 3.A.	Increase Medi-Cal penetration rates among underserved populations identified in the 2011 External Quality Review Organization (EQRO) report by 10% based on the most recent available data.

This table reflects the annual penetration rates for the various demographic groups for 2010 through 2013.

	EQRO REPORT				MMEF	
	2010	2011	2012	2013	2013	2014
Race/Ethnicity	Penetration Rate	Penetration Rate	Penetration Rate	Penetration Rate	Penetration Rate	Penetration Rate
Total	**6.84%**	**6.75%**	**7.05%**	**7.61%**	**8.59%**	**8.29%**
0-5	1.32%	1.47%	1.99%	2.24%	3.14%	2.86%
6-17	12.08%	10.67%	11.41%	11.85%	13.69%	11.83%
18-59	7.23%	7.48%	7.65%	8.45%	9.29%	8.91%
60+	2.77%	3.36%	3.18%	3.33%	3.37%	4.17%
Female	6.26%	6.05%	6.23%	6.96%	8.10%	7.60%
Male	7.55%	7.62%	8.04%	8.40%	9.14%	9.08%
Gender Not Recorded	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Ratio of Female versus Male PR	0.83	0.79	0.78	0.83	0.89	0.84
1 White	6.96%	7.16%	7.46%	8.02%	8.84%	8.64%
2 Hispanic	3.17%	2.95%	3.55%	4.56%	5.15%	4.76%
Ratio of Hispanic versus White PR	0.45	0.41	0.48	0.57	0.58	0.55
3 Black	8.83%	10.26%	11.11%	10.65%	10.14%	12.99%
4 Asian or Pacific Islander*	8.86%	8.43%	15.86%	6.41%	7.01%	5.54%
5 Alaskan Native or American Indian	4.55%	4.32%	4.26%	4.87%	5.74%	6.39%
Z Other**	10.10%	5.98%	2.96%	8.05%	11.14%	9.95%

The Monthly Medi-Cal Eligibility File (MMEF) penetration rates for calendar years 2013 and 2014 were calculated using the MMEF demographic information during that calendar year for clients that received direct billable outpatient services (excluding no show, cancelations, Fee for Service, and psychiatric inpatient) and were matched to MMEF consumers during the same calendar year. Sources: Anasazi Report: "Client Services Listing Report". MMEF Eligibility File April 2015.
*Asian or Pacific Islander includes: Asian, Pacific Islander, Filipino, Chinese, Cambodian, Japanese, Korean, Samoan, Asian Indian, Hawaiian, Guamanian, Laotian, and Vietnamese.

**Other includes: Null, No Valid Data (MMEF), No Response, and Other.

No specific underserved populations were identified for Shasta County. The penetration rates for state-wide underserved Female and Hispanic populations both showed a decrease from CY 2013 to CY 2014.

Area 2 – Service Delivery Capacity

Goal 2: Ensure the MHP services and resources are appropriately allocated to address mental health treatment needs.	
Objective 1	**Maintain an ongoing evaluation of clients by geographic area to assess population needs and allocation of treatment resources in areas of most need**

Measurement 1.A.	Resources for the provision of services will be allocated throughout Shasta County based on needs identified by ongoing data collection and reporting.

This table is an unduplicated count of clients with a Redding, Shasta County, or other address types at the time the service was rendered. Therefore a client could be counted in the residential area of Redding and Non-Residential (Shasta Co.) during the same quarter if during that quarter they were homeless and then were placed in housing. Therefore the table below is an unduplicated client count by residential area and quarter.

Unduplicated Count of Clients by Residential Area and Service Quarter

	Fiscal Year 2013-2014													Avg Monthly Population FY13-14	Penetration Rate
Residential Areas	Q1	Pop	Pen Rate	Q2	Pop	Pen Rate	Q3	Pop	Pen Rate	Q4	Pop	Pen Rate	Undup Total		
Redding	1,547	22,138	7%	1,571	22,698	7%	1,607	23,225	7%	1,699	25,398	7%	**2,937**	23,365	12.6%
Shasta County	772	16,775	5%	764	17,043	4%	737	16,925	4%	774	18,314	4%	**1,438**	17,265	8.3%
Non-Residential (Shasta Co.)	433	N/A	N/A	417	N/A	N/A	386	N/A	N/A	381	N/A	N/A	**877**	N/A	N/A
Out of County/ Unknown	75	N/A	N/A	89	N/A	N/A	90	N/A	N/A	104	N/A	N/A	**251**	N/A	N/A
Grand Total	**2,827**	**38,913**	7%	**2,841**	**39,741**	7%	**2,820**	**40,150**	7%	**2,958**	**43,712**	7%	**5,503**	**40,630**	**10.8%**

	Fiscal Year 2014-2015													Avg Monthly Population FY14-15	Penetration Rate
Residential Areas	Q1	Pop	Pen Rate	Q2	Pop	Pen Rate	Q3	Pop	Pen Rate	Q4	Pop	Pen Rate	Undup Total		
Redding	1,643	29,910	5%	1,574	31,279	5%	1,586	33,207	5%	1,566	33,981	5%	**2,849**	27,042	10.5%
Shasta County	733	21,907	3%	697	22,855	3%	703	23,814	3%	704	23,644	3%	**1,326**	19,375	6.8%
Non-Residential (Shasta Co.)	344	N/A	N/A	298	N/A	N/A	325	N/A	N/A	311	N/A	N/A	**742**	N/A	N/A
Homeless	*210*			*175*			*204*			*206*			***539***		
PO Box	*78*			*78*			*71*			*67*			***104***		
Other	*60*			*46*			*51*			*40*			***111***		
Out of County/ Unknown	78	N/A	N/A	52	N/A	N/A	72	N/A	N/A	58	N/A	N/A	**179**	N/A	N/A
Grand Total (undup)	**2,726**	**51,817**	5%	**2,586**	**54,134**	5%	**2,618**	**57,021**	5%	**2,554**	**57,625**	4%	**4,846**	**46,417**	**8.5%**

No specific baseline or target was set. The penetration rates for Redding and Shasta County (non-Redding) were slightly lower in FY2014-15 than in FY 2013-14.

This table is an unduplicated count of clients by the residential area of the client at the time that the service was rendered. Again, if the client moved from Anderson to Shasta Lake City they would be counted in both areas for that quarter. Therefore it is an unduplicated client count by residential area and quarter.

City - Zip	Fiscal Year 2013-14		FY13-14 Monthly Avg. Pop	Pen Rate**	Fiscal Year 2014-2015		FY14-15 Monthly Avg. Pop	Pen Rate**
	Undup. Total*	%			Undup. Total*	%		
ANDERSON - 96007	721	50.1%	**7,153**	**10.1%**	637	**49.7%**	**9,407**	**6.8%**
SHASTA LAKE CITY - 96019	291	20.2%	**3,156**	**9.2%**	269	**20.8%**	**3,962**	**6.8%**
COTTONWOOD - 96022	184	12.8%	**1,997**	**9.2%**	178	**12.9%**	**2,738**	**6.5%**
BURNEY - 96013	xx	**<2.0%**	**1,066**	**<8.3%**	28	**2.2%**	**1,466**	**1.9%**
SHINGLETOWN - 96088	58	4.0%	**845**	**<8.3%**	62	**3.8%**	**1,132**	**5.5%**
PALO CEDRO - 96073	38	2.6%	**369**	**10.3%**	35	**3.1%**	**580**	**6.0%**
BELLA VISTA - 96008	xx	**<2.0%**	**340**	**<8.3%**	Xx	**<2.0%**	**474**	**<6.8%**
FALL RIVER MILLS - 96028	xx	**<2.0%**	**368**	**<8.3%**	Xx	**<2.0%**	**447**	**<6.8%**
LAKEHEAD - 96051	25	**<2.0%**	**282**	**8.9%**	24	**<2.0%**	**403**	**<6.8%**
MCARTHUR - 96056	xx	**<2.0%**	**262**	**<8.3%**	Xx	**<2.0%**	**361**	**<6.8%**
OLD SHASTA - 96087	xx	**<2.0%**	**185**	**9.2%**	Xx	**<2.0%**	**257**	**<6.8%**
OAK RUN - 96069	xx	**<2.0%**	**171**	**<8.3%**	Xx	**<2.0%**	**249**	**<6.8%**
MILLVILLE - 96062	xx	**<2.0%**	**134**	**<8.3%**	Xx	**<2.0%**	**223**	**<6.8%**
IGO/ONO - 96047	xx	**<2.0%**	**176**	**<8.3%**	Xx	**<2.0%**	**231**	**<6.8%**
WHITMORE - 96096	xx	**<2.0%**	**123**	**<8.3%**	Xx	**<2.0%**	**212**	**>6.8%**
ROUND MOUNTAIN - 96084	xx	**<2.0%**	**155**	**<8.3%**	Xx	**<2.0%**	**198**	**<6.8%**
MONTGOMERY CREEK - 96065	xx	**<2.0%**	**143**	**<8.3%**	Xx	**<2.0%**	**179**	**<6.8%**
FRENCH GULCH - 96033	xx	**<2.0%**	**121**	**>8.3%**	Xx	**<2.0%**	**172**	**<6.8%**
BIG BEND - 96011	xx	**<2.0%**	**72**	**<8.3%**	Xx	**<2.0%**	**128**	**<6.8%**
HAT CREEK - 96040	xx	**<2.0%**	**48**	**<8.3%**	Xx	**<2.0%**	**71**	**<6.8%**
CASSEL - 96016	xx	**<2.0%**	**32**	**<8.3%**	Xx	**<2.0%**	**64**	**<6.8%**
CASTELLA - 96017	xx	**<2.0%**	**25**	**<8.3%**	Xx	**<2.0%**	**43**	**<6.8%**
PLATINA - 96076	xx	**<2.0%**	**27**	**<8.3%**	Xx	**<2.0%**	**37**	**<6.8%**
OLD STATION - 96071	xx	**<2.0%**	**xx**	**<8.3%**	Xx	**<2.0%**	**20**	**<6.8%**
WHISKEYTOWN - 96095	xx	**<2.0%**	**xx**	**<8.3%**	Xx	**<2.0%**	**xx**	**<6.8%**

No specific baseline or target was set. The relative percent of unduplicated clients by zip code for Shasta County (non-Redding) for FY 2014-15 were similar to FY 2013-14.

This table is a count of visits by the residential area of the client at the time that the service was rendered. If the client moved from Redding to Shasta Lake City they would be counted in both areas for that quarter. Therefore it is a count of visits by the client's residential area, quarter, and service type rendered.

Redding	Assess.	CRRC	Case Man.	Coll.	Crisis	Day Tx	Group	Individual	ICC	IHBS	Meds	Plan Dev.	Rehab	TBS	Triple P	Total Visits
FY13-14 Qrtr 1	830	45	3,600	1,161	144	25	281	1,279	65	5	3,142	651	392	67	118	**11,805**
FY13-14 Qrtr 2	774	32	4,034	1,101	274	15	212	1,341	101	9	2,887	579	376	15	78	**11,828**
FY13-14 Qrtr 3	924	45	5,011	1,130	352	55	171	1,599	56	1	3,229	662	640	64	81	**14,020**
FY13-14 Qrtr 4	1,056	39	4,891	1,260	357	38	228	1,700	66	3	3,043	689	835	93	92	**14,390**
FY14-15 Qrtr 1	1,005	45	4,737	1,356	257	-	235	1,858	325	27	2,929	691	812	78	137	**14,492**
FY14-15 Qrtr 2	959	35	4,169	1,225	272	-	127	1,676	248	16	2,985	573	712	65	144	**13,206**
FY14-15 Qrtr 3	1,044	39	3,736	1,141	323	-	167	1,834	251	26	2,938	578	694	52	171	**12,994**
FY14-15 Qrtr 4	1,030	35	3,623	1,070	334	-	136	1,686	242	24	2,851	612	781	100	97	**12,621**
Shasta County	**Assess.**	**CRRC**	**Case Man.**	**Coll.**	**Crisis**	**Day Tx**	**Group**	**Individual**	**ICC**	**IHBS**	**Meds**	**Plan Dev.**	**Rehab**	**TBS**	**Triple P**	**Total Visits**
FY13-14 Qrtr 1	388	19	1,503	679	64	-	80	560	31	-	1,151	348	217	63	40	**5,143**
FY13-14 Qrtr 2	335	7	1,613	645	122	-	93	675	67	1	1,010	347	205	-	49	**5,169**
FY13-14 Qrtr 3	407	18	1,963	641	123	-	72	745	16	-	1,133	367	177	-	33	**5,695**
FY13-14 Qrtr 4	426	18	1,884	531	122	-	74	624	21	5	1,101	392	209	25	51	**5,483**
FY14-15 Qrtr 1	503	27	1,795	627	129	-	73	565	13	-	1,057	400	181	13	20	**5,403**
FY14-15 Qrtr 2	423	13	1,522	596	128	-	22	647	7	-	1,022	342	151	4	33	**4,910**
FY14-15 Qrtr 3	422	7	1,393	590	114	-	16	706	9	-	945	267	150	5	34	**4,658**
FY14-15 Qrtr 4	396	7	1,189	532	158	-	19	605	14	-	926	286	216	-	31	**4,379**

No specific baseline or target was set. The ratio of the number of visits for Redding and Shasta County (non-Redding) for FY 2014-15 was similar to the ratio of the number of unduplicated clients listed in table 1 of this measure.

This table is a count of visits by the residential areas of Anderson, Cottonwood, and Shasta Lake City for the client at the time that the service was rendered. If the client moved from one area to another they would be counted in both areas for that quarter. Therefore it is a count of visits by the client's residential area, quarter, and service type rendered.

Anderson	Assess.	CRRC	Case Man.	Coll.	Crisis	Day Tx	Group	Ind	ICC	IHBS	Meds	Plan Dev.	Rehab	TBS	Triple P	Total Visits
FY2013-14 Q1	177	3	735	318	25	-	41	283	6	-	593	173	149	33	11	**2,547**
FY2013-14 Q2	189	1	815	355	52	-	39	342	4	-	512	209	136	-	17	**2,671**
FY2013-14 Q3	225	8	1,008	369	57	-	28	360	10	-	540	224	102	-	8	**2,939**
FY2013-14 Q4	210	8	964	271	52	-	34	281	16	5	511	244	86	-	19	**2,701**
FY2014-15 Q1	253	7	878	309	60	-	26	243	1	-	495	206	78	13	12	**2,581**
FY2014-15 Q2	198	1	765	341	53	-	-	337	-	-	495	221	72	4	26	**2,513**
FY2014-15 Q3	189	3	733	332	47	-	1	408	-	-	512	140	56	5	22	**2,448**
FY2014-15 Q4	187	1	583	287	54	-	8	357	-	-	411	149	108	-	13	**2,158**

Cottonwood	Assess.	CRRC	Case Man.	Coll.	Crisis	Day Tx	Group	Ind	ICC	IHBS	Meds	Plan Dev.	Rehab	TBS	Triple P	Total Visits
FY2013-14 Q1	57	2	188	78	6	-	3	60	18	-	126	40	19	-	1	**598**
FY2013-14 Q2	41	2	221	57	19	-	7	77	23	-	121	34	36	-	-	**638**
FY2013-14 Q3	41	2	235	73	11	-	4	75	3	-	163	51	30	-	-	**688**
FY2013-14 Q4	50	2	219	71	21	-	8	81	2	-	169	59	38	-	15	**735**
FY2014-15 Q1	46	1	142	98	21	-	10	86	-	-	104	56	19	-	1	**584**
FY2014-15 Q2	60	3	158	62	23	-	4	97	-	-	140	51	12	-	-	**610**
FY2014-15 Q3	56	-	150	43	16	-	1	82	-	-	105	50	4	-	6	**513**
FY2014-15 Q4	64	2	111	40	25	-	1	75	-	-	100	58	9	-	9	**494**

Shasta Lake City	Assess.	CRRC	Case Man.	Coll.	Crisis	Day Tx	Group	Inl	ICC	IHBS	Meds	Plan Dev.	Rehab	TBS	Triple P	Total Visits
FY2013-14 Q1	94	8	354	235	26	-	15	173	2	-	280	85	16	30	20	**1,338**
FY2013-14 Q2	69	2	370	191	27	-	36	198	38	1	234	49	25	-	28	**1,268**
FY2013-14 Q3	59	3	439	148	34	-	35	223	3	-	281	44	27	-	11	**1,307**
FY2013-14 Q4	109	2	414	140	25	-	22	167	3	-	260	52	62	25	6	**1,287**
FY2014-15 Q1	147	14	463	160	27	-	14	136	12	-	269	79	60	-	4	**1,385**
FY2014-15 Q2	95	6	337	136	14	-	18	124	7	-	258	34	52	-	7	**1,088**
FY2014-15 Q3	115	4	277	153	25	-	14	132	9	-	223	47	55	-	4	**1,058**
FY2014-15 Q4	79	2	241	144	37	-	9	108	14	-	235	46	36	-	9	**960**

No specific baseline or target was set. The ratio of the number of visits for the top three Shasta County (non-Redding) cities for Q1 and Q2 FY 2014-15 was similar to the ratio of the number of unduplicated clients listed in table 1 of this measure.

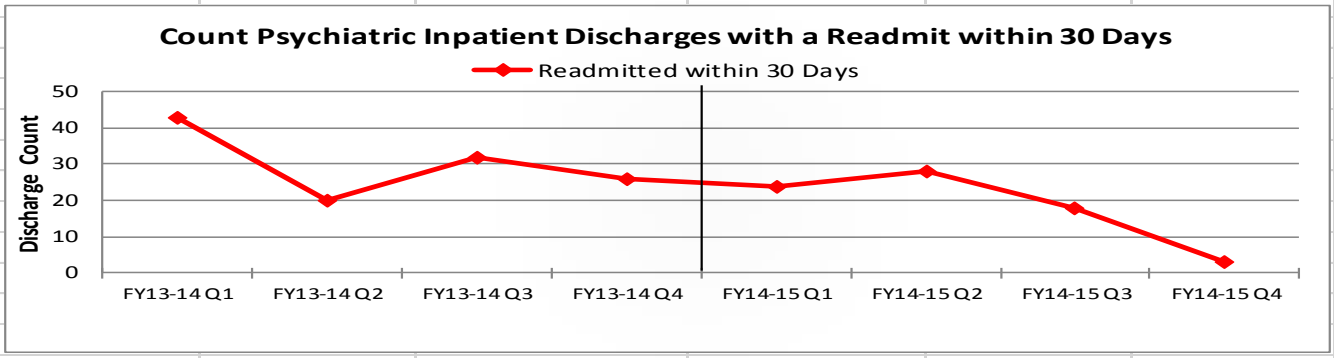
Goal 2: Ensure the MHP services and resources are appropriately allocated to address mental health treatment needs.

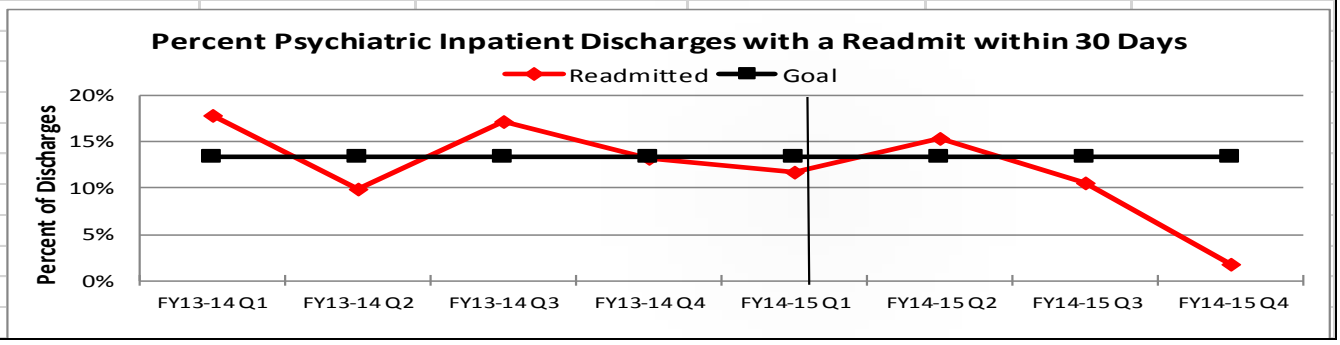
Objective 2	**Evaluate crisis prevention and discharge planning activities for clients at risk of hospitalization or have been hospitalized in the previous 12 months. Identify options for training, reallocation of resources, or other supports to assist staff with workload.**

Measurement 2.A.	Decrease psychiatric inpatient re-hospitalizations within 30 days by 10% from FY09/10 percentage of re-hospitalizations.

This table includes the count and percent of Adult Clients discharged from a Psychiatric Inpatient Facility that were readmitted within 30 days of discharge.

Readmitted within 30 Days of Discharge					
Discharge Quarter	**Total Discharges**	**Not Readmitted**	**Readmitted within 30 Days**	**Readmitted**	**Growth +/-**
FY13-14 Q1	**242**	199	43	17.8%	
FY13-14 Q2	**202**	182	20	9.9%	-44%
FY13-14 Q3	**187**	155	32	17.1%	73%
FY13-14 Q4	**197**	171	26	13.2%	-23%
FY14-15 Q1	**206**	182	24	11.7%	-12%
FY14-15 Q2	**182**	154	28	15.4%	32%
FY14-15 Q3	**172**	154	18	10.5%	-32%
FY14-15 Q4	**170**	167	**3**	2%	-83%





The target was met in Q1, Q3, and Q4 and was not met in Q2 of FY2014-15.

Goal 2: Ensure the MHP services and resources are appropriately allocated to address mental health treatment needs.

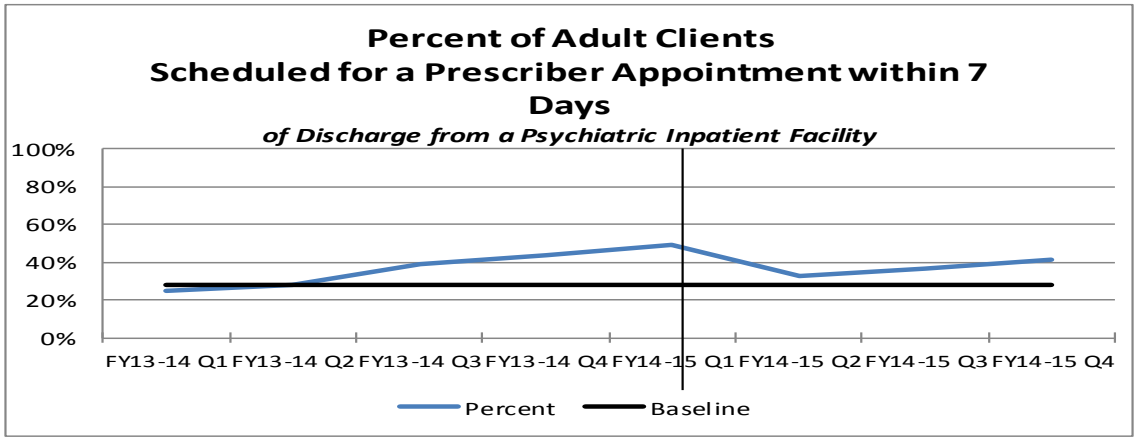
Objective 3	Ensure all clients experiencing inpatient hospitalization receive appropriate follow up discharge contact.

Measurement 3.A.	Establish a baseline of Adult clients that receive follow up psychiatrist contact within 7 days of discharge, and increase by 10% over baseline.

The following table includes the count and percent of Adult Clients scheduled for a prescriber appointment within 7 days of discharge from a Psychiatric Inpatient Facility, adult clients with a scheduled appointment outside the 7-day follow-up window, and adult clients with no appointment scheduled.

Referred to SCMH for appointment with a prescriber Baseline 28.1% (FY12-13)

Discharge Month/Yr	Qrtr Total Discharges	Appointment Scheduled	
		At/Under 7 Days	Percent
FY13-14 Q1	102	25	24.5%
FY13-14 Q2	76	21	27.6%
FY13-14 Q3	74	29	39.2%
FY13-14 Q4	80	35	43.8%
FY14-15 Q1	78	38	48.7%
FY14-15 Q2	56	18	32.2%
FY14-15 Q3	63	23	36.5%
FY14-15 Q4	56	23	41.1%



Note: There are clients referred to SCMH who are also referred elsewhere and choose to schedule follow-up appointments with the other provider. It is not possible to differentiate these clients from the aggregate as this information is not always recorded. It follows that the "No Appointment Scheduled" figures may be falsely inflated by this unknown factor.

*These are scheduled appointments and do not reflect actual appointments fulfilled.
**Prescribers only include Psychiatrists and Nurse Practitioners
***Clients admitted to CRRC are not included in these calculations as they have regular access to a prescriber.

The target was met in all quarters of FY2014-15.

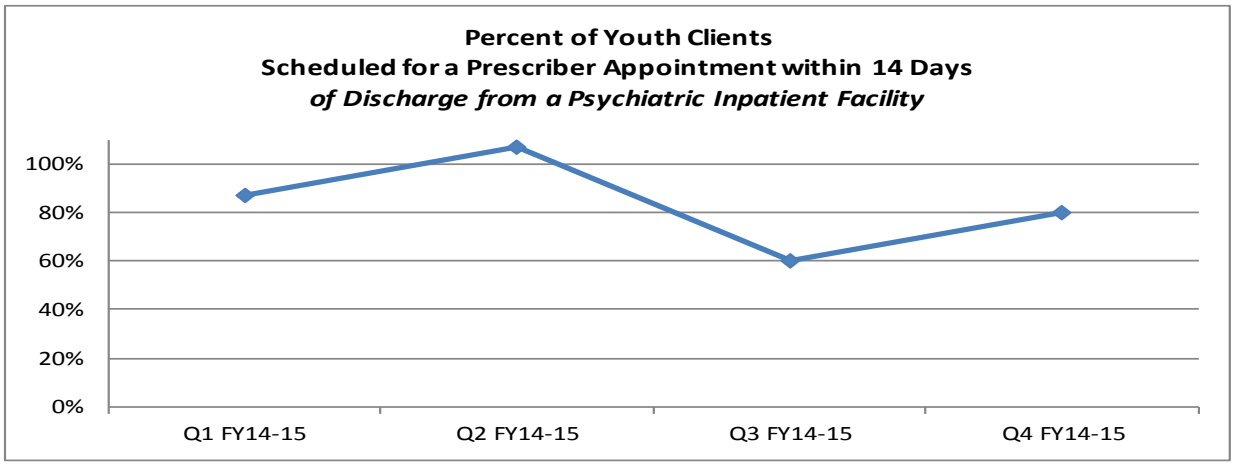
Measurement 3.B.	Establish a baseline of Youth clients that receive follow up psychiatrist contact within 14 days of discharge, and increase by 10% over baseline.

The following table includes the count and percent of youth Clients scheduled for a prescriber appointment within 14 days of discharge from a Psychiatric Inpatient Facility. Also included are youth clients with a scheduled appointment outside the 14-day follow-up window and youth clients with no appointment scheduled.

Note: These only include the discharges where a follow-up appointment is expected.
*These are scheduled appointments and do not reflect actual appointments fulfilled.
**Prescribers only include Psychiatrists and Nurse Practitioners
***Clients admitted to CRRC are not included in these calculations as they have regular access to a prescriber.

The following table only includes clients who should have received a prescriber appointment following discharge (no reason was provided for any record in the *No Appointment Scheduled* category):

Discharge Quarter/Year	Total Discharges requiring IME follow-up	Appointment Scheduled within 14 days	
		Count	%
Q1 FY14-15	**15**	13	86.7%
Q2 FY14-15	**15**	16	106.7%
Q3 FY14-15	**20**	12	60.0%
Q4 FY14-15	**10**	8	80.0%



A youth client would have to be referred back to SCMH OP Youth Services and need prescription medication to be included on this list for scheduling an appointment with a prescriber.

No specific baseline or target was set. During the FY2014-15, 81.7% (49 of 60) of youth clients were scheduled for a prescriber appointment within 14 days of discharge from a psychiatric inpatient facility.

Area 3 – Beneficiary Satisfaction

Goal 3: Provide a meaningful experience for individuals who receive mental health services in Shasta County.	
Objective 1	**Conduct client satisfaction surveys (POQI) annually as required by DHCS.**

Measurement 1.A.	Evaluate POQI 2012 survey results and improve client satisfaction by 10% of the difference between 2012 baseline and the goal of 95% that Agree or Strongly Agree in: Adult 1. "I like the services that I received here". 2. "I was able to get all the services I thought I needed". Youth 1. "Overall, I am satisfied with the services I received". 2. "I got as much help as I needed." Youth Caregiver 1. "My family got as much help as we needed for my child"

Question:	2012 Baseline		4/14 Survey		11/14 Survey		5/15 Survey	
	Agree	Strongly Agree	Agree	Strongly Agree	Agree	Strongly Agree	Agree	Strongly Agree
Adult/Older Adult 1. "I like the services that I received here". Q1	45.95%	48.65%	33.8%	60.0%	32.4%	64.9%	38.9%	61.1%
Adult/ Older Adult 2. "I was able to get all the services I thought I needed". Q8	37.84%	45.95%	38.0%	49.4%	29.7%	58.3%	44.4%	55.6%
Youth/Youth Family 1. "Overall, I am satisfied with the services I received". Q1	36.28%	52.21%	42.7%	46.2%	41.8%	51.8%	34.4%	56.3%
Youth/Youth Family 2. "I got as much help as I needed." Q11	27.93%	41.44%	45.6%	34.2%	42.1%	40.0%	38.8%	42.5%

Question:	2012 Baseline	Agree or Strongly Agree						
		Goal	Spring 2014	(+/-)	Fall 2014	(+/-)	Spring 2015	(+/-)
Adult/Older Adult 1. "I like the services that I received here". Q1	**94.59%**	94.64%	✗ 93.8%	-0.9%	✓ 97.3%	2.8%	✓ 100.0%	5.7%
Adult/ Older Adult 2. "I was able to get all the services I thought I needed". Q8	**83.78%**	84.91%	✓ 87.3%	2.9%	✓ 88.0%	3.6%	✓ 100.0%	17.8%
Youth/Youth Family 1. "Overall, I am satisfied with the services I received". Q1	**88.50%**	89.15%	✗ 88.9%	-0.3%	✓ 93.6%	5.0%	✓ 90.7%	1.7%
Youth/Youth Family 2. "I got as much help as I needed." Q11	**69.37%**	71.93%	✓ 79.8%	11.0%	✓ 82.1%	14.1%	✓ 81.3%	13.0%

For the 2014 Spring POQI, the target was met for one adult and one youth/youth caregiver question and was not met for one adult and one youth/youth caregiver question. The target was met for all questions on the Fall 2014 and Spring 2015 POQI surveys.

Measurement 1.B.	Client participation and response rate to annual POQI surveys will increase by 10% for each subsequent year from August 2012 survey results.

Client Participation rate compared to prior period	Baseline	Survey Count							
Survey Participation Count	2012	2013 Goal	2013	2014 Goal	Spring 2014	2014 Goal	Spring 2014	2014 Goal	Spring 2014
Adult/Older Adult	37	41	✗ 36	40	✓ 80	88	✗ 37	41	✗ 18
Youth/Youth Family	114	125	✓ 129	142	✗ 121	133	✓ 142	156	✓ 161

For the 2014 Spring POQI, the target was met for adult participation and was not met for youth/youth caregiver participation. For the Fall 2014 and Spring 2015 POQI the target was met for youth/youth caregiver and was not met for Adult/Older Adult.

Goal 3: Provide a meaningful experience for individuals who receive mental health services in Shasta County.

Objective 2	**Conduct client satisfaction surveys on a regularly scheduled basis and include the adult, youth and organizational provider clients.**

Measurement 2.A.	Client participation and response rate to ongoing Service Satisfaction Surveys and Crisis Residential and Recovery Center (CRRC) surveys will increase by 10% from FY12/13 response rate.

Service Satisfaction Survey - Quarter Reported	FY12-13 Baseline*	Goal	FY13-14 Service Satisfaction Survey*	Percent Growth (+/-) of Goal	FY14-15 Service Satisfaction Survey*	Percent Growth (+/-) of Goal
Qrtr 1 (Jul-Sep)	*13*	*14*	✗ *11*	-15%	✓ *18*	64%
Qrtr 2 (Oct-Dec)	*4*	*4*	✓ 5	25%	✓ 7	40%
Qrtr 3 (Jan - Mar)	9	*10*	✓ 12	33%	✗ 3	-75%
Qrtr 4 (Apr-Jun)	18	*20*	✗ *7*	-61%	✗ 1	-86%

*Italicized numbers indicate a period where the MHSA Surveys were not offered during the Consumer Perception Survey (AKA POQI) period or other department wide survey.

Crisis Residential and Recovery Center - Quarter Reported	FY13-14 CRRC Baseline	Goal	FY14-15 CRRC	Percent Growth (+/-) of Goal
Qrtr 1 (Jul-Sep)	11	*12*	✗ 11	0%
Qrtr 2 (Oct-Dec)	8	*9*	✓ 9	13%
Qrtr 3 (Jan - Mar)	16	*18*	✗ 7	-56%
Qrtr 4 (Apr-Jun)	11	*12*	✓ 13	**18%**

For the Service Satisfaction Survey, the target was met for Q1 and Q2 and was not met for Q3 or Q4 of FY 2014-15. For the CRRC Survey, the target was met for Q2 and Q4, and was not met for Q1 and Q3 of FY 2014-15.

Goal 3: Provide a meaningful experience for individuals who receive mental health services in Shasta County.

Objective 3	Timely resolution of all client grievances.

Measurement 3.A.	Ensure 100% of client grievances are appropriately resolved within 60 days, or within the 14 day extension if applicable.

Month	Count of Grievances	Referred Out	Resolved	Pending	Under 60 Days	% under 60 Days	Used 14 Day Ext	% with 14 Day Ext.	Percent Resolved Within Allotted Time (60 Days+14 Days)	Over 74 Days	% over 74 Day Total
Jul-14	4	-	4	-	4	100%	-	0%	✓ 100%	-	0%
Aug-14	-	-	-	-	-	N/A	-	N/A	N/A	-	N/A
Sep-14	1	1	-	-	1	100%	-	0%	✓ 100%	-	0%
Oct-14	1	-	1	-	1	100%	-	0%	✓ 100%	-	0%
Nov-14	1	1	-	-	1	100%	-	0%	✓ 100%	-	0%
Dec-14	-	-	-	-	-	N/A	-	N/A	N/A	-	N/A
Jan-15	-	-	-	-	-	N/A	-	N/A	N/A	-	N/A
Feb-15	-	-	-	-	-	N/A	-	N/A	N/A	-	N/A
Mar-15	-	-	-	-	-	N/A	-	N/A	N/A	-	N/A
Apr-15	-	-	-	-	-	N/A	-	N/A	N/A	-	N/A
May-15	1	-	1	-	1	100%	-	0%	✓ 100%	-	0%
Jun-15	-						-	0%	N/A	-	N/A
FY14-15	**8**	**2**	**6**	**-**	**8**	100%	**-**	**0%**	✓ 100%	**-**	**0%**

The target was met for FY 2014-15.

Measurement 3.B.	Maintain FY11/12 level of zero NOA-E's issued.

	Count of Recorded NOAs	NOA A	NOA B	NOA C	NOA D	NOA E
Jul-14	**17**	17	-	-	-	✓ -
Aug-14	**18**	18	-	-	-	✓ -
Sep-14	**11**	11	-	-	-	✓ -
Oct-14	**13**	9	-	4	-	✓ -
Nov-14	**8**	7	-	1	-	✓ -
Dec-14	**18**	15	-	3	-	✓ -
Jan-15	**17**	16	-	1	-	✓ -
Feb-15	**10**	5	2	3	-	✓ -
Mar-15	**18**	12	-	6	-	✓ -
Apr-15	**9**	8	-	1	-	✓ -
May-15	**16**	14	-	2	-	✓ -
Jun-15	**13**	9	-	4	-	✓ -
FY13-14	**168**	**141**	**2**	**25**	**-**	✓ **-**

The target was met for FY 2014-15.

Goal 3: Provide a meaningful experience for individuals who receive mental health services in Shasta County.

Objective 4	**Consumers and family members are employed and/or volunteer in key roles throughout the MHP.**

Measurement 4.A.	Maintain consumer and family member participation in MHP committees, by attendance of a minimum of once per quarter, including the Mental Health Alcohol and Drug Advisory Board (MHADAB), Quality Improvement Committee (QIC), Advancing Recovery Performance Improvement Project (ARC), Triple P Performance Improvement Project, and Cultural Competency Committee (CCC).

Meeting (Period Reported: JULY 2014 - SEPTEMBER 2014)	Recruitment Efforts				Family Member/Consumer Participation During Previous 6 Months?			
	Posters	Brochures Available	Electronic/Voice Communication	Brown Act*	July - September 2014	October - December 2014	January - March 2015	April - May 2015
Mental Health Alcohol and Drug Advisory Board **(MHADAB)***	No	Yes	Yes	Yes	**Yes**	**Yes**	**Yes**	**Yes**
Quality Improvement Committee **(QIC)**	No	Yes	Yes	N/A	**Yes**	**Yes**	**Yes**	**Yes**
Advancing Recovery Performance Improvement Project **(ARC PIP/Adult PIP)**	No	Yes	Yes	N/A	No	No	No	No
Triple P Performance Improvement Project **(Youth PIP)**	No	Yes	Yes	N/A	No	No	No	No
Cultural Competency Committee **(CCC)**	No	Yes	Yes	N/A	No	No	No	No

*Brown Act Meeting: Must send a press release out at least one week in advance announcing the upcoming meeting and the agenda must be faxed to the media, posted at the site of the meeting, and posted on the front door of Mental Health at least 72 hours prior to the meeting.

No specific target was set. During FY2014-15, two committees had family member/consumer participation and three did not.

Goal 3: Provide a meaningful experience for individuals who receive mental health services in Shasta County.

Objective 5	Implement MORS throughout Adult Services as a recovery measurement tool.

Measurement 5.A.	Upon implementation of MORS, 90% of adult clients participating in the Advancing Recovery (ARC) Performance Improvement Project will receive a MORS assessment at least quarterly.

Fiscal Year	Quarter	Count of Participants *	Goal	Clients who Received MORS **	Percent Received MORS Assessment
FY13-14	Qrtr 3 (Jan-Mar)	117	105	15	✗ **12.8%**
	Qrtr 4 (Apr-Jun)	178	160	174	✓ **97.8%**
FY14-15	Qrtr 1 (Jul-Sep)	202	182	167	✗ **82.7%**
	Qrtr 2 (Oct-Dec)#	172	155	121	✗ **70.3%**

* Count of participants is average monthly number of participants in each quarter.
** Count of clients who received at least one MORS Assessments during the quarter. The first MORS was conducted in March 2014.
# No PIP data available after November 2014.

While not part of the PIP, the following MORS data had been entered into Anasazi/Cerner:

Fiscal Year	Quarter	Unduplicated Clients who Received at least one MORS	Count of MORS Conducted
FY14-15	Qtr 1 (Jul-Sep)	97	98
	Qtr 2 (Oct-Dec)	91	99
	Qtr 3 (Jan-Mar)	257	274
	Qtr 4 (Apr-Jun)	225	266

The target was not met in FY 2014-15.

Area 4 – Service Delivery System and Meaningful Clinical Issues

Goal 4: Develop an infrastructure of continuous quality improvement that supports wellness and recovery in Shasta County.	
Objective 1	**Ensure that clinical practices are safe, effective and support wellness and recovery in Shasta County.**

Measurement 1.A.	All newly hired staff, in job specifications that require it, will receive Core Skills training.
Core skills training in development. ***The target was not met in FY 2014-15.***	

Measurement 1.B.	Increase the percentage of Medi-Cal beneficiaries with a physical activity (4.0%) and/or contact with nature (1.4%) related objective included in their Treatment Plan by 10% from FY1213.

Treatment Plan Dates Reported	Treatment Plans Reviewed	Included Physical Activity Goal	Percent Included Physical Activity	Goal	Included Contact with Nature Goal	Percent Included Contact with Nature	Goal
Total Baseline Period:	1384	56	4.0%	4.4%	19	1.4%	1.5%

Baseline period is January 2013 through July 2014 prior to training of staff to include physical activity and/or contact with nature in their treatment plan goals.
Adult or youth are not differentiated in this measure.
This measure will be developed to be reported quarterly. The above data represents the baseline data that does not include August and September 2014 of the first quarter. The report will be based on the treatment plan review date over a period of time.

No data was collected for this measure in FY14-15.

Goal 4: Develop an infrastructure of continuous quality improvement that supports wellness and recovery in Shasta County.

Objective 2	Utilize the two Performance Improvement Projects (PIPs) to improve wellness and recovery.

Measurement 2.A.	Ensure clients participating in the Advancing Recovery PIP demonstrate the following objectives: 1) At least 50% will be able to identify one family or community support 2) At least 30% will report participation in meaningful relationships and/or activities when surveyed 3) At least 50% will identify a short-term recovery goal linked to usable strengths 4) At least 80% have a designated PCP 5) At least 50% have at least one PCP visit in the last 12 months 6) Less than 10% are homeless

		Report Period				
	Objectives	Jul-14	Aug-14	Sep-14	Oct-14	14-Nov
1)	At least 50% will be able to identify one family or community support	218 in target population (**10.1%**)	203 in target population (**0%**)	186 in target population (**4.8%**)	173 in target population (**16.2%**)	170 in target population (**4.1%**)
		24 were surveyed (**91.7%**)	25 were surveyed (**0.0%**)	24 were surveyed (**37.5%**)	39 were surveyed (**71.8%**)	13 were surveyed (**53.8%**)
		22 Answered the question (**100.0%**)	1 Answered the question (**0.0%**)	10 Answered the question (**90.0%**)	28 Answered the question (**100.0%**)	7 Answered the question (**100.0%**)
		22 answered "Yes"	0 answered "Yes"	9 answered "Yes"	28 answered "Yes"	7 answered "Yes"
2)	At least 30% will report participation in meaningful relationships and/or activities	218 in target population (**8.3%**)	203 in target population (**8.4%**)	186 in target population (**4.8%**)	173 in target population (**8.1%**)	170 in target population (**2.9%**)
		24 were surveyed (**75.0%**)	25 were surveyed (**68.0%**)	24 were surveyed (**37.5%**)	39 were surveyed (**35.9%**)	13 were surveyed (**38.5%**)
		23 Answered the question (**78.3%**)	20 Answered the question (**85.0%**)	12 Answered the question (**75.0%**)	15 Answered the question (**93.3%**)	7 Answered the question (**71.4%**)
		18 answered "Yes"	17 answered "Yes"	9 answered "Yes"	14 answered "Yes"	5 answered "Yes"
3)	At least 50% will identify a short-term recovery goal linked to usable strengths	218 in target population (**7.8%**)	203 in target population (**10.3%**)	186 in target population (**8.6%**)	173 in target population (**16.2%**)	170 in target population (**3.5%**)
		24 were surveyed (**70.8%**)	25 were surveyed (**84.0%**)	24 were surveyed (**66.7%**)	39 were surveyed (**71.8%**)	13 were surveyed (**46.2%**)
		22 Answered the question (**77.3%**)	21 Answered the question (**100.0%**)	17 Answered the question (**94.1%**)	29 Answered the question (**96.6%**)	6 Answered the question (**100.0%**)
		17 answered "Yes"	21 answered "Yes"	16 answered "Yes"	28 answered "Yes"	6 answered "Yes"
4)	At least 80% have a designated PCP	165 of 218 (**75.7%**)	143 of 203 (**70.4%**)	159 of 186 (**85.5%**)	143 of 173 (**82.7%**)	142 of 170 (**83.5%**)
5)	At least 50% have at least one PCP visit in the last 12 months	218 in target population (**7.8%**)	203 in target population (**6.4%**)	186 in target population (**4.3%**)	173 in target population (**14.5%**)	170 in target population (**5.9%**)
		24 were surveyed (**70.8%**)	25 were surveyed (**52.0%**)	24 were surveyed (**33.3%**)	39 were surveyed (**64.1%**)	13 were surveyed (**76.9%**)
		23 Answered the question (**73.9%**)	23 Answered the question (**56.5%**)	12 Answered the question (**66.7%**)	31 Answered the question (**80.6%**)	10 Answered the question (**100.0%**)
		17 answered "Yes"	13 answered "Yes"	8 answered "Yes"	25 answered "Yes"	10 answered "Yes"
6)	Less than 10% are homeless	12 of 218 (**5.5%**)	13 of 203 (**6.4%**)	14 of 186 (**7.5%**)	14 of 173 (**8.1%**)	13 of 170 (**7.6%**)

Target 1 was met in Jul., Oct., and Nov., and was not met in Aug. and Sep. Target 2 was met in all five months. Target 3 was met in all five months. Target 4 was met in Sep., Oct., and Nov., and was not met in Jul. and Aug. Target 5 was met in Jul., Aug., Oct., and Nov., and was not met in Sep. Target 6 was met in all five months. Percentages are based on number who answered "Yes" out of those who were surveyed for targets 1, 2, 3, and 5. Percentages for targets 4 and 6 are based on EHR data.

Measurement 2.B.	Set wellness and recovery measurements for youth PIP, including process to evaluate.
Our aim is to decrease the functional impairments measured by the Child and Adolescent Needs and Strengths assessment tool by increasing the utilization of Triple P, increasing individual, rehab, and/or collateral services, and evaluating current medication support. Our objective is a 20% reduction in the measurement of the functional impairments identified by the CANS assessment tool in youth clients (under the age of 21) diagnoses with ODD or DBD. ***No data was collected for this measure in FY14-15.***	

Goal 4: Develop an infrastructure of continuous quality improvement that supports wellness and recovery in Shasta County.	
Objective 3	**Review medication practices that will be evaluated for safety and effectiveness.**

Measurement 3.A.	Define the medication practices that will be evaluated for safety and effectiveness.
To be determined ***The target was not met in FY 2014-15.***	

Measurement 3.B.	Develop data measures and collection methodologies to monitor medication practices.
To be determined ***The target was not met in FY 2014-15.***	

Goal 4: Develop an infrastructure of continuous quality improvement that supports wellness and recovery in Shasta County.	
Objective 4	**Monitor provider appeals for timeliness resolution.**

Measurement 4.A.	100% of provider appeals will be resolved within the state mandated timeframe.
During Fiscal Year 2013-2014 there were 15 provider appeals 100% were within mandated time frame. For Fiscal Year 2014-2015 there were 17 provider appeals, again, 100% resolved within the mandated period. ***The target was met in FY 2014-15.***	